External Distribution Channel (EDC) Agent Guide

UnitedHealthcare®
Medicare Solutions

Proprietary and confidential to UnitedHealth Group.

The materials comprising this External Distribution Channel (EDC) Agent Guide ("Guide") are provided by UnitedHealthcare Medicare Solutions ("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 EDC agent use only.

Version 1.4 Release Date – February 07, 2014

Table of Contents

Table of Contents

Section 1: Introduction

Welcome to UnitedHealthcare Medicare Solutions!

Using this Guide

UnitedHealth Group Overview

UnitedHealthcare Medicare Solutions Overview

Welcome to UnitedHealthcare Medicare Solutions!

In order to achieve our mission of providing innovative health and well-being solutions that help Medicare consumers achieve healthier and more secure lives, we rely on exceptional agents.

We are committed to providing you with tools that enable you to be successful. One such tool is the *External Distribution Channel (EDC) Agent Guide* – a comprehensive resource that will provide you with the information you need to conduct business with UnitedHealthcare Medicare Solutions ("UnitedHealthcare") in an efficient and compliant manner.

We expect our agents to share our commitment to compliance and to act with integrity by putting the best interest of our consumers first in everything they do on behalf of the company. You will find compliance guidelines integrated into each section of the guide.

An electronic version of this guide is available on www.UnitedHealthProducers.com and will be updated regularly. Your comments, suggestions, and recommendations for additional content are encouraged. Please submit feedback to your NMA/FMO.

Again, I am confident that you will find this guide to be a key resource and a tool that enables you to be successful. Your success will ultimately drive UnitedHealthcare toward achieving our shared mission of providing healthier and more secure lives for our consumers and members.

Sincerely,

Tim Harris
Vice President, External Distribution Channel
UnitedHealthcare Medicare & Retirement

Using this Guide

The *External Distribution Channel (EDC) Agent Guide* has been developed for use by all NMA/FMO agents and solicitors. Throughout the guide the word "agent" will be used to refer to any NMA/FMO agent or solicitor. In instances where information relates specifically to an agent, but not a solicitor or vice versa, it will be clearly noted.

- Agent – a licensed, certified, and appointed (if applicable) representative who is contracted with UnitedHealthcare through an External Distribution Channel (EDC).

- Solicitor – an appropriately licensed captive agent employed by or independently contracted with an EDC agent, appointed (if applicable) by the Company, and is free to exercise his or her own judgment as to the time and manner of performing services pursuant to a direct or indirect agreement between the Solicitor Agent and the EDC agent.

This guide consists of answers to agents' most frequently asked questions when it comes to doing business with UnitedHealthcare Medicare Solutions. It provides the business procedures to guide you through getting started with the company, to finding the materials needed to market products in your area, enrolling a consumer, and much more.

UnitedHealth Group Overview *

UnitedHealth Group is a diversified health and well-being company whose mission is to help people live healthier lives and make health care work better. Our business model has evolved and is informed by more than three decades serving the needs of the markets and people of health care. Today, UnitedHealth Group is:

Helping consumers access quality care at an affordable cost;

Simplifying health care administration and delivery;

Strengthening the physician/patient relationship;

Promoting evidence-based care, and

Empowering physicians, health care professionals, consumers, employers, and other participants in the health system with actionable data to make better, more informed decisions.

Through our diversified family of businesses, we leverage core competencies in advanced, enabling technology; health care data, information and intelligence; and care management and coordination to meet the evolving needs and demands of the health system. These core competencies are deployed within our two distinct, but strategically aligned, business platforms: UnitedHealthcare for Health Benefits and Optum for Health Services.

UnitedHealthcare serves the health benefits needs of consumers across every life stage through five businesses: UnitedHealthcare Employer & Individual, serving individual consumers and employers of all sizes; UnitedHealthcare Medicare & Retirement, serving the unique needs of Medicare eligible consumers; UnitedHealthcare Community & State, serving the public health marketplace, offering states innovative Medicaid solutions; UnitedHealthcare Military & Veterans, serving the health care needs of approximately 2.9 million* active duty and retired U.S. military personnel and their families; and UnitedHealthcare International, serving the international health care marketplace.

Optum serves health system participants – including consumers, physicians, hospitals, governments, insurers, and life sciences companies – through its OptumHealth, OptumInsight and OptumRx businesses.

Our expanding role in helping the health system work better means we have a growing and deeper relationship with people in a socially and personally sensitive part of their lives – their health and health care. To meet the rising expectations of the people we serve and earn their trust, we are focused on integrity, compassion, relationships, innovation and accountable performance – the values that are the foundation of our culture as a company.

**UnitedHealth Group serves more than 85 million individuals worldwide, employs approximately 133,000 people and operates in all 50 states in the United States and 20 other nations, worldwide.

For more information: www.UnitedHealthGroup.com.

*Effective April 2013
** Sourced from the 2013 Q1 Corporate Facts

UnitedHealthcare Medicare Solutions Overview

UnitedHealthcare Medicare Solutions is dedicated to providing innovative health and well-being solutions that help Medicare eligible consumers live healthier and more secure lives.

UnitedHealthcare Medicare Solutions is one of the largest businesses dedicated to the health and well-being needs of Medicare eligible consumers.

UnitedHealthcare Medicare Solutions manages a full array of products and services such as:

- Medicare Advantage Plans
- Medicare Advantage Special Needs Plans
- Prescription Drug Plans (PDP)
- Medicare Supplement Plans
- Retiree Services

For more information:
www.UHCMedicareSolutions.com.

Section 2: How Do I Get Started?

Contracting

Certification and Training

UnitedHealth Group Learning Management System Access Guide

UnitedHealth Group Learning Management System Website Tips

Contracting

Overview

You must be contracted, licensed, appointed (if applicable), and certified (fully credentialed) in order to market and sell the UnitedHealthcare Medicare Solutions portfolio of products.

You must also have an active insurance license in Life, Accident and Health lines of authority (as determined by each state's Department of Insurance) and be appointed, where applicable, in your state of residence and in any state where you perform regulated activity (i.e., sales, educational event, etc.).

The External Distribution Channel (EDC) has control over the contracting process of their down-line hierarchy. Therefore, contracting packets, that include all documentation required to contract with and/or be appointed (if applicable) by UnitedHealthcare, are requested through the EDC. Completed packets are to be submitted to UnitedHealthcare by the EDC.

Welcome Letter

The writing number is emailed to the agent (or solicitor), with a copy to the EDC, by the Agent On-Boarding specialist via the Welcome Letter. The executed copy of their agreement is secure delivered via email only to the agent.

All agents and solicitors are required to provide and keep current a valid email address.

You can update your contact information by updating your user profile on www.UnitedHealthProducers.com or by sending written requests to the Agent On-Boarding group via fax to (877) 863-3105 or via email to uhpcred@uhc.com.

Errors and Omissions (E&O) Coverage

Each agent representing UnitedHealthcare must carry and maintain proof of E&O coverage (may also be known as professional liability insurance). General Agent (GA) level and above producers, must have individual coverage. Agents and solicitors may be covered under their immediate up line blanket policy, as long as, the blanket policy specifically indicates individual names or that all employees and contractors are included. Failure to carry and maintain proof of E&O is grounds for termination and you are required to provide documentation upon request.

Updated E&O coverage information can be sent via fax to (877) 863-3105 or via email to producer.update@uhc.com.

Producer License(s)

All agents must be licensed in their state of residence and in all states they wish to market and sell. An agent is responsible for maintaining an active license(s), including all educational requirements. Agent On-Boarding will verify license status using National Insurance Producers Registry (NIPR). Failure to maintain valid licensing or loss of licensing is grounds for termination of your agent agreement.

Unqualified Sale Termination

You will be terminated if you are not licensed at the time of a sale (see "Termination Due to an Unqualified Sale" in this guide).

Certification and Training Process

Agent is recruited by EDC/Agency

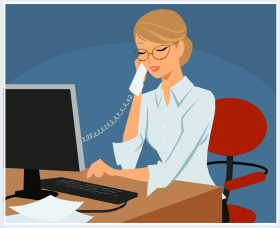
Agent must be Licensed, Contracted, Certified, and Appointed (if applicable)

Agent is required to take all prerequisite and product certification modules

Agent must pass each certification module in 3 attempts or less with a minimum of 85%

Agent is certified

Agent is qualified to sell applicable products



Certification and Training

General Overview

Sales training is a business process that begins during the on-boarding of an agent and is repeated annually, prior to the start of a new selling season, to ensure that plan benefit and regulatory changes are appropriately communicated to the agent in a consistent manner.

To ensure you have a fundamental understanding of the UnitedHealthcare organization, products, and enrollment process, as well as applicable regulations, a foundational course and certification process is required.

Ongoing training and development is required on an annual basis, upon significant benefit or regulatory changes, or as the need is identified for individual agents.

Under no circumstance may you market or sell UnitedHealthcare Medicare Solutions portfolio of products until you are fully certified in the products you are authorized to sell.

You must be certified for the plan year for which an Enrollment Application is written. For example, if in December 2013, you write an Enrollment Application with a January 1, 2014 effective date, you must have completed your 2014 product certification.

No incentive will be paid on any Enrollment Application written by an agent who was not fully credentialed at the time the Enrollment Application was written.

Sales Training and Certification Program

An online certification program, developed by UnitedHealthcare Sales Development personnel in collaboration with subject matter experts, consists of a series of in-depth product training modules and certification tests. The program includes certification tests for Medicare Marketing Guidelines, compliance regulations, federal and state regulations, and product line training modules. Content is revised as new regulations are released or at least on an annual basis.

Mandatory Modules will contain, at a minimum, the following content:

- Medicare Basics - Gives a broad overview of Original Medicare and its products.
- Ethics and Compliance - Includes the Pledge of Compliance, marketing Medicare Advantage and Prescription Drug Plan products along with a focus on fraud, waste, and abuse, and privacy and security.
- AARP 101

You may receive partial credit if you elect to certify by America's Health Insurance Plan (AHIP) and agree to UnitedHealthcare's Pledge of Compliance. You are still responsible for completing the four mandatory certification prerequisites and any other product courses as required. The partial credit will apply to the Medicare Advantage (MA) Plans – HMO, PPO, POS, and Medicare prescription Drug Plans product courses.

Mandatory Modules for any agent listed as the presenting agent for an educational event, marketing/sales event, and/or a MedicareStore.

- Event Basics – Provides a basic awareness of how the Centers for Medicare and Medicaid Services (CMS)

regulations affect event planning, preparation, and execution.

Passing Scores and Allowed Attempts

For each UnitedHealthcare Medicare Solution certification module, mandatory and product specific, you are allowed three attempts to successfully complete the module and score a minimum of 85% on the test.

Mandatory Modules:

Failure to achieve the minimum passing score of 85% within three attempts on Medicare Basics, Ethics and Consumer Sensitivity, or AARP 101 module, prohibits you from selling ***any*** UnitedHealthcare Medicare Solution product for the remainder of the applicable selling year. Example: if you fail 2014 Medicare Basics, you will be ineligible to sell for the 2014 selling year.

Failure to achieve the minimum of 85% within three attempts on the Event Basics module, will prohibit you from presenting an educational event, marketing/sales event, and/or a MedicareStore for the remainder of the applicable selling year.

Product Line Module:

Failure to achieve the minimum passing score of 85% within three attempts on a specific product module prohibits you from selling that product for the remainder of the selling year.

- You are prohibited from marketing or selling a specific product until you have completed and passed the related product module.
- Until you have successfully passed the certification course for a specific product, you will not be able to order marketing materials for that product.

No incentive will be paid on any Enrollment Application taken prior to certification in the mandatory modules ***and*** in the related product.

Agent Certification Requirements

Prior to appointment, you must complete the initial registration on the agent website to access the UnitedHealth Group learning management system and successfully complete all four mandatory modules and at least one product module.

- Upon receipt of your Welcome Letter, you will need to re-register on www.UnitedHealthProducers.com using the writing number included in your letter.

You must complete certification, including the Pledge of Compliance, on an annual basis.

Pledge of Compliance

In order to begin the Ethics and Compliance module you must review and electronically sign the Pledge of Compliance.

If you do not indicate acceptance of the terms and conditions of the Pledge of Compliance, you cannot continue your course of study or market any UnitedHealthcare Medicare Solutions product.

AHIP Certification

UnitedHealthcare Medicare Solution accepts (with limitation) America's Health Insurance Plans (AHIP) certification and recertification in place of 2014 Medicare Basics, 2014Medicare Advantage Plans, and 2014 Medicare Part D Plans (PDP).

The minimum passing score for an AHIP module is 90%. While AHIP allows an unlimited number of attempts to achieve the minimum score, UnitedHealthcare will only accept the AHIP certification if the passing score was achieved within the first three attempts. If you transmit AHIP certification data to UnitedHealthcare and your passing score was not achieved within the first three attempts, you will not receive credit for the AHIP module ***and*** will not be allowed to take UnitedHealthcare Medicare Solution equivalent module. See *Passing Scores and Allowed Attempts* section for selling restrictions as a result of failing to pass a module.

If you are a returning AHIP user, your AHIP account will direct you to the appropriate recertification modules. To be fully certified using the AHIP path, you must log onto www.UnitedHealthProducers.com and complete the modules and pass the corresponding tests for each of the following:

- 2014 AHIP
- 2014 Ethics and Compliance
- 2014 AARP 101

If you choose to certify through AHIP, you must complete the 2014 AHIP Certification before any other 2014 certification modules. Failure to do so will result in AHIP score rejection.

Certification Status Verification

UnitedHealth Group learning management system allows you to verify the status of your certification development and history. Product certifications are displayed in your development plan in the product certification window for each year and can be printed to demonstrate certification status.

Requests for Certification Related Information

Requests for certification related information including the certification process, module and/or test content, certification status, or to submit an appeal should be directed to the Producer Help Desk at phd@uhc.com (the subject line should contain the agent's Writing ID number, available 24 hours). Requests that cannot be resolved by the help desk representative will be documented and escalated to the certification team.

New Training Modules

- You will receive notification through standard agent communications of the availability of new training modules.
- For new product related modules, you must pass the test with a score of 85% or better within three attempts to be allowed to order materials, submit Enrollment Applications, and receive commission for the specific product covered in the completed module.

Elective and Supplemental Learning and Development

Opportunities are generally available to all agents for ongoing learning and development. This is supplemented with dedicated sales training and development resources that may include needs assessments, training, and tools.

Agent Remedial Training

Remedial education and/or training may be provided to or required of specific agents.

Product Line Modules include:

- Medicare Advantage (MA) Plans, including Health Maintenance Organization (HMO), Point of Service (POS), and Preferred Provider Organization (PPO), Regional Preferred Provider Organizations (RPPO).
- Private Fee-for-Service (PFFS) Plans – Includes specific details about the provider deeming process and the member's options should a provider choose not to be deemed.
- Special Needs Plans (SNP) including Chronic Illness, Dual Eligible, and Institutional.
- Prescription Drug Plan (PDP).
- UnitedHealthcare Medicare Supplement Insurance Plans.
- AARP Medicare Supplement Insurance Plans, AARP Medicare Advantage, and AARP Prescription Drug Programs.

Agents who are not literate in English, are allowed to have an interpreter present while completing certification modules. A proctor must be present in the UnitedHealthcare office where the modules are being taken. The proctor should be a UnitedHealthcare employee or a UnitedHealthcare contracted vendor proctor. The use and name of a proctor must be documented.

The product line modules featured in this section are illustrative only and may not reflect the Company's current plan, product, and module offerings.

You are required to take and pass the certification modules on your own behalf for the plans you wish to sell.

In the completion of any module and/or associated exam, you are not to use any aid or assistance not contained within the module, including, but not limited to sharing or comparing answers, taking the exam as part of a group, or using answer keys.

If you are found to have used any aid or assistance not contained within the module, in completing any module and/or associated exam, you will be subject to discipline up to and including termination with cause.

UnitedHealth Group Learning Management System Access Guide

Upon receipt of a complete contracting packet, you will receive a Party ID Notification Letter. The Party ID notification letter includes your permanent Party ID number and information regarding access to online certification training. The Party ID links all your subsequent Writing IDs to you (where applicable). You will receive only one Party ID with UnitedHealthcare.

Online certification training is available through the agent website at www.UnitedHealthProducers.com

You must register to use the website by clicking on the "Register Now" button located on the lower right portion of the welcome page. The following information is needed in order to register:

- Party ID Number (communicated in Party ID Notification Letter)
- Social Security number or Tax identification number
- ZIP code

Once registered, you are able to take courses to obtain product certification. Registering with your Party ID limits your website access to certification modules.

Upon successfully completing the contracting, licensing, and appointment process, you will receive your Welcome Letter. The Welcome Letter provides you with your writing number and information regarding re-registering on UnitedHealthProducers.com. Re-registering with the agent writing number allows you access to additional features and functionality of the website.

For additional guidance on registering on the agent website, refer to section "What Tools and Resources are Available to Help Me?"

UnitedHealth Group Learning Management System Website Tips

Before beginning a certification session:

- Verify they are using an acceptable version of Windows Internet Explorer (Internet Explorer version 7.x or 8.x)).
- Set screen resolution to 1024 x 768.
- Have Acrobat reader version 6 or higher.
- Have Macromedia Flash Player 9 or higher.
- Turn off pop-up blockers.

From the "Resources" tab within each course, content of the certification module can be printed or saved as a PDF. You are encouraged to print or save the course content as it may be used for review purposes.

Any questions regarding certification and access to www.UnitedHealthProducers.com can be addressed to the Producer Help Desk at phd@uhc.com (the subject line should contain the agent's Writing ID number, available 24 hours).

Section 3: What Tools and Resources are Available to Help Me?

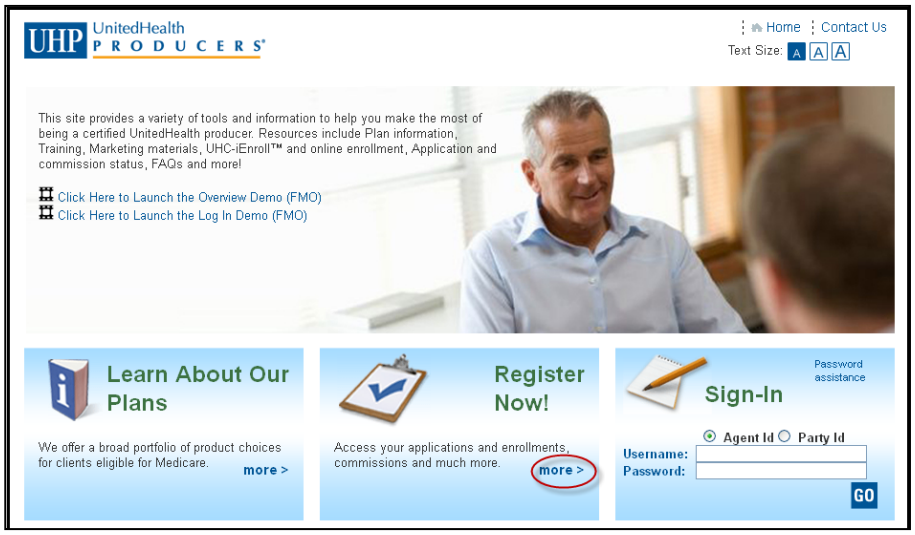
Distribution Portal

Producers Help Desk

Quick Resource Tip Sheet

Agent Communications

Distribution Portal



The Distribution Portal provides you a secure one-stop-shop access to the tools and information needed to conduct business with UnitedHealthcare. By accessing the Distribution Portal at www.UnitedHealthProducers.com, you can conduct certification, obtain product information and sales materials, conduct online enrollment, view Enrollment Application status, view commission statements and status, and acquire sales and compliance information, and much more.

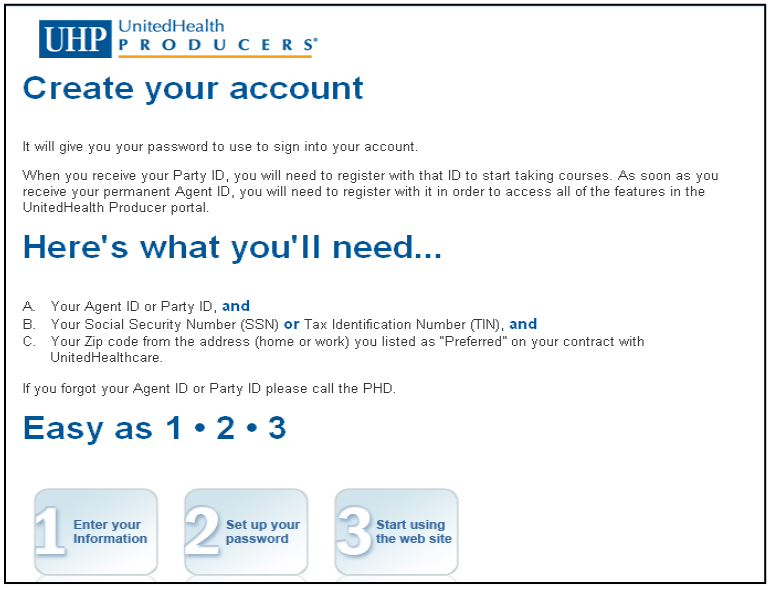
Information on the portal is organized into categories including Learning Center, Product Information and Materials, Online Enrollment, Enrollment Applications and Enrollments, Commission Status, Manage Your Account, and Resource Center.

The Distribution Portal is available through the following link: www.UnitedHealthProducers.com.

Initial Registration

You must register upon first time use of the Distribution Portal. Registration is begun by clicking on the “more” button in the “Register Now” section located on the home page. The following information is needed in order to register for account activation:

- Party ID (communicated in the Party ID Notification Letter) or writing number (communicated in Welcome Letter)
- Social Security number or Tax identification number
- ZIP code

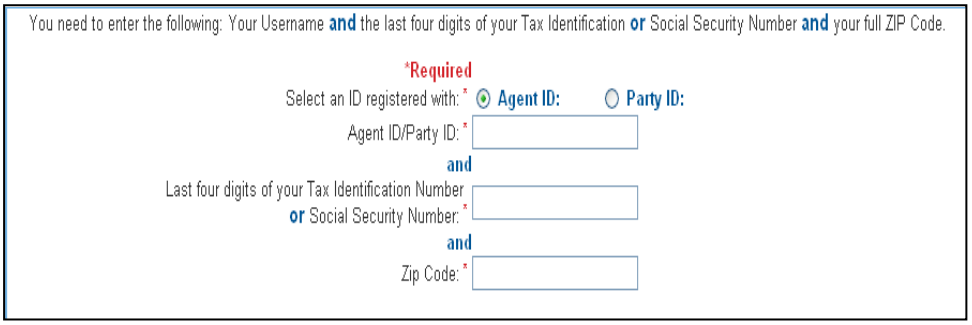


- Registering with your Party ID limits your access to The UnitedHealth Group learning management system (Learning Center tab), but enables you to start the certification process while the contracting process is being completed. When the contracting process is complete, you will need to re-register using your agent writing number provided in your Welcome Letter.
- Registration and login using your writing number provides you full access to the site based on those products and states in which you are contracted and certified to sell. The Producer Help Desk is available if you are having difficulties with registration or login at phd@uhc.com (the subject line should contain the agent's Writing ID number, available 24 hours).

Producer Password Resets

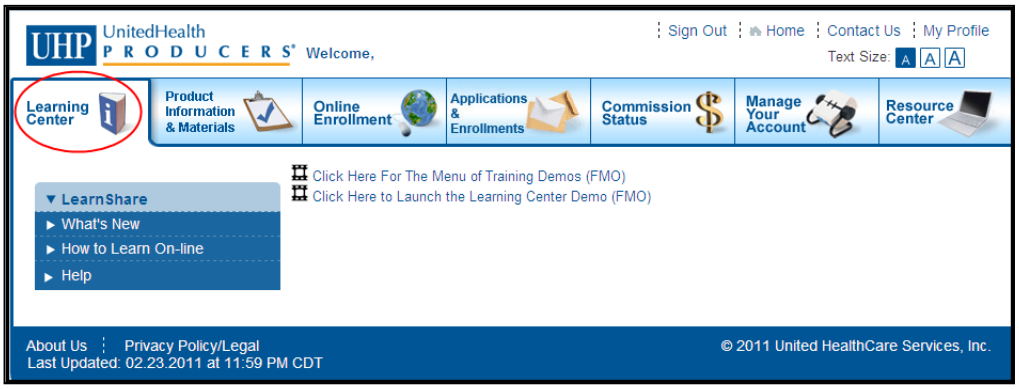
The Distribution Portal allows you to reset your password by following these steps:

- Open www.UnitedHealthProducers.com
- Click on "Password Assistance"



- Enter Agent ID or Party ID, last four digits of your tax identification number or Social Security number, and ZIP code
- Click "Next"

Learning Center



The Learning Center provides one-click access to your courses on the Learning Center Home, as well as general information about online learning.

Product Information

The Product Information section contains a complete overview of all plans available including Medicare Advantage, Part D, and Medicare Supplement. Within each product category, based on those products and states in which you are certified to sell, you can access information such as available plans, providers, drugs, and pharmacies. Included are links to each product's consumer-facing site.

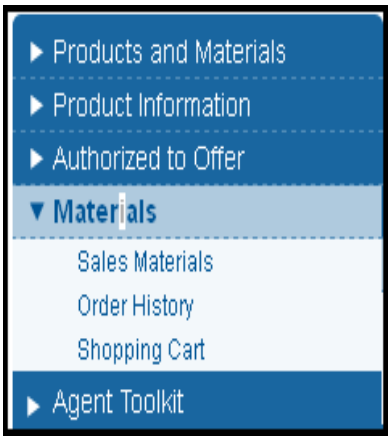
Authorized to Offer

- The Authorized to Offer (A2O) section provides information regarding the Authorized to Offer AARP Medicare plans program. Information includes an overview of the program, marketing guidelines, and frequently asked questions.

Materials

The Product Information and Materials section provides access to order and download centers, where you can order Pre-Enrollment Sales Kits or download the marketing materials you need. You will only see the plans that you are certified to sell in this section.

> **Note:** Prior to the Open Enrollment Period (OEP), there is a pre-order timeframe where field agents can order pre-enrollment sales materials via the Distribution Portal. The 'Pre-order' page is placed under the 'Materials' left-hand navigation and appears for approximately two weeks each year in advance of OEP. Refer to FOCUS News in the months leading up to the OEP to find out when pre-ordering will be available for the upcoming plan year.

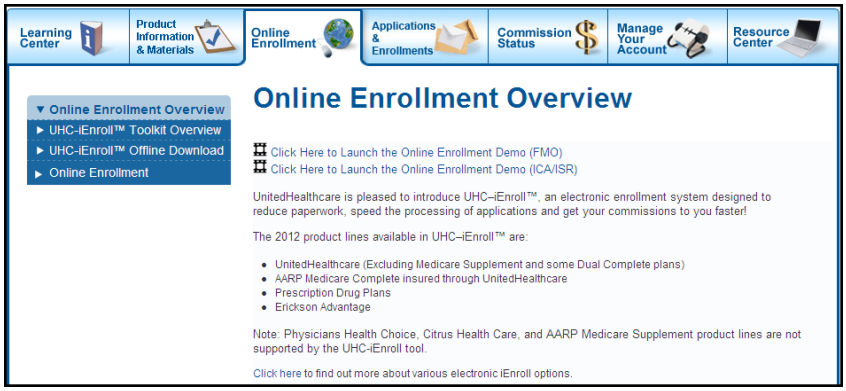


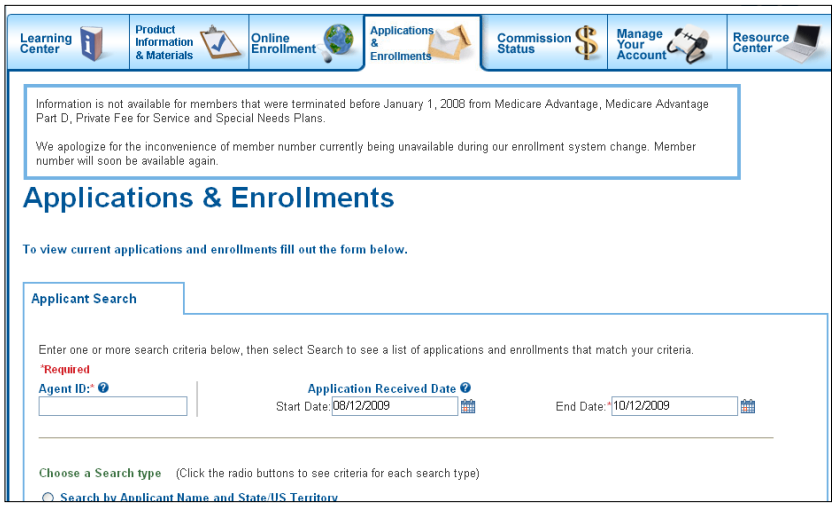
Agent Toolkit

- The Agent Toolkit section provides access to the Agent Toolkit. Additionally, this section provides helpful materials to guide the agent through the Agent Toolkit.

Online Enrollment

The "Online Enrollment" tab will allow you to conduct an electronic enrollment through iEnroll, for the products listed.



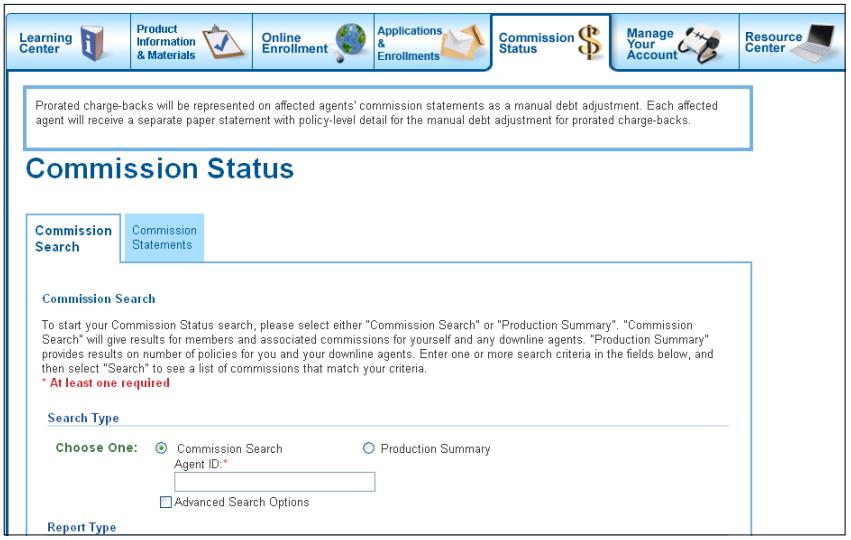


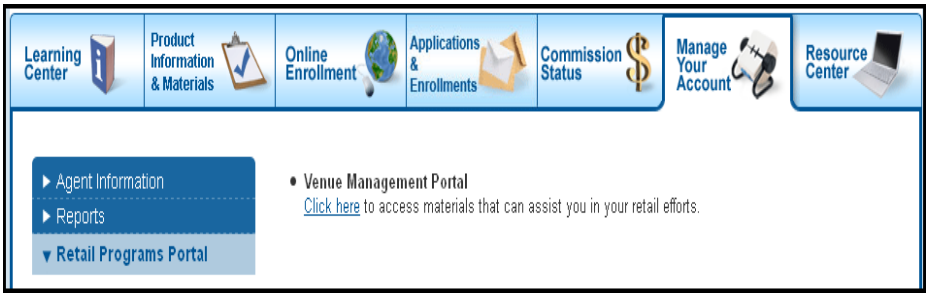
Applications and Enrollments

The Applications and Enrollments tab allows you to view your current Enrollment Applications and enrollments. Search by Consumer Name and State/US Territory, Consumer Identification Numbers, or Consumer State.

Commission Status

The Commission Status tab allows you to view your commission status and statements, as well as your Production Summary. You can export your Production Summary and Commission Statement results for easier viewing.





Manage Your Account

In this section, you can access your certification, appointment, and personal profile information; as well as access to the Venue Management Portal.

Resource Center

The Resource Center provides you with a variety of supporting information including Compliance Corner, External Resources, Agent Communications, Frequently Asked Questions, and Glossaries.

Producers Help Desk

The agent website, www.UnitedHealthProducers.com, is available 24 hours a day, seven days a week, providing you access to Enrollment Applications and commission status, plan information, marketing materials, and much more. (See previous section for details.) If, however, you are unable to locate what you need on the agent website, need assistance with a pending Enrollment Application, or have a commission inquiry, the Producer Help Desk (PHD) is available.

Email: phd@uhc.com (the subject line should contain the agent's Writing ID number, available 24 hours) or icssupport@uhc.com (Enrollment Application status and updates)

Telephone: 1-888-381-8581 (Available Monday-Friday 7a.m. to 7p.m. CST).

The PHD is a contact center that strives to maximize the effectiveness of the agent community while enhancing agent knowledge and effective use of company tools and resources by:

- Helping you use self-service tools and access resources including providing first-level technical support of the tools.
- Providing you with information on the certification and commission process as well as, resolving certification and/or commission questions and disputes.
- Supporting the UnitedHealthcare Medicare Solutions product portfolio including answering product support inquiries.
- Educating you on the company's material fulfillment process.
- Assisting you with contracting or commission inquiries.

The PHD email address is for agent use only and is not to be shared or distributed to members or consumers.

Inquiries Made on Behalf of an Existing Member

Email inquiries must be sent via secure email. **All** of the following information must be available when you call or included within your email:

- Your full name
- Your agent writing number
- Name of the agency for which you work
- Member or consumer's full name
- 2 of the following:
  - Member or consumer's date of birth, Member or consumer's ID number, Last 4 digits of the Medicare ID (Health Insurance Claim Number - HICN) number or address
- Member's AARP member number (if call is regarding AARP Medicare Supplement Insurance)

Quick Resource Tip Sheet

Throughout this guide there are references made to websites, email addresses, and telephone numbers. You will find all of those resources listed below for quick reference right when you need it most.

General Agent Support

Producer Help Desk
7 a.m. to 7 p.m. Central Standard Time (CST)
Monday through Friday
Telephone: 1-888-381-8581

phd@uhc.com (the subject line should contain the agent's Writing ID number, available 24 hours)

Marketing and Advertising Material

Agent Marketing
Agent_Marketing_Requests@uhc.com

Scope of Appointment

Fax: 1-866-994-9659

Medicare Marketing Guidelines

The Centers for Medicare & Medicaid Services
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c03.pdf

Compliance Questions - Contact for questions regarding marketing or for access to Medicare marketing guidelines; for privacy, security or fraud, waste and abuse issues; or for ethics-related questions.
Compliance_Questions@uhc.com

Customer Service Resources

Customer Service – PFFS
8 a.m. to 8 p.m. Central Standard Time (CST)
7 days a week
Telephone: 1-866-579-8774
TTY: 711

Customer Service – HMO/PPO/RPPO/POS
8 a.m. to 8 p.m. CST, 7 days a week
Telephone: Plan specific numbers can be found on page 3 of the Summary of Benefits or the back of the member's ID card.

Customer Service – AARP Medicare Supplement Insurance Plan
7 a.m. to 11 p.m. Eastern Standard Time (EST)
Monday - Friday
9 a.m. to 5 p.m. EST Saturday
Telephone: 1-800-523-5800
TTY: 1-800-232-7773

Agent On-Boarding (Contracting, Appointment, Licensing)

UHPCred@uhc.com

Compliance Support

Contact

For answers to questions about UnitedHealthcare Sales Distribution policies and procedures, Medicare Marketing Guidelines, or privacy, security or ethics issues, send an email to Compliance_Questions@uhc.com.

Report violations

To report illegal or unethical conduct, including violations of law, contractual obligations, and company policies (including the Principles of Ethics and Integrity); privacy issues; or suspected fraud, waste and abuse; employees should call 1 (800) 455-4521.

Non-employees should email issues regarding illegal or unethical conduct, including violations of law, contractual obligations and company policies (including the Principles of Ethics and Integrity); privacy issues; or suspected fraud, waste and abuse that impacts UnitedHealthcare to Compliance_Questions@uhc.com.

Websites

There are many websites that provide tools and content for you and your consumer audience.

For compliance and product information, sales materials, conduct online enrollment, view Enrollment Application and commission status, and take your certification modules, go to www.UnitedHealthProducers.com

Websites by Product Brand

For additional information on UnitedHealth Group, go to www.UnitedHealthGroup.com

- Medicare Advantage

  www.aarpmedicareplans.com
  www.uhcmedicaresolutions.com

- Medicare Supplement Insurance Plan

  www.AARPMedicarePlans.com

- Prescription Drug Plans

  www.AARPMedicarePlans.com
  www.uhcmedicaresolutions.com

- UnitedHealthcare Nursing Home Plan

  Medicaid: www.myevercare.com
  Medicare: www.uhccommunityplans.com
  Nursing Home: www.myevercare.com
  Hospice: www.evercarehospice.com
  Caregivers:
  www.whatissolutionsforcaregivers.com

Websites for Medicare Information

www.cms.gov
www.medicare.gov
Medicare and You (2014)

Agent Communications

Communications Methods

UnitedHealthcare is committed to providing agents ongoing communications about its product portfolio, policies and procedures, applicable federal and state regulations, and company rules and business requirements.

Routinely communicated topics include, but are not limited to:

- Updates to applicable federal and state regulations that affect the agent.
- Operational policies and procedures, especially those around commissions and certification.
- Event reporting requirements reminders.
- Updates to product rates, sales materials, the Distribution Portal, and sales procedures.
- Updates to the Private Fee-for-Service non-deemed provider listing.
- Information to drive change in agent behavior as identified through noncompliant behavior and trends.

Email Method

Email is the primary method of communication.

As such, you:

- Must provide and maintain a valid email address available to UnitedHealthcare.
- Must receive and read all communications emailed from UnitedHealthcare.
- Are prohibited from opting out or unsubscribing in any way from receiving email sent by UnitedHealthcare.

Other Communications Methods

Communications may also be disseminated through the following methods:

- Mailings
- Manager meetings
- Outbound calls
- Distribution Portal
- National Agent Oversight SharePoint for sales management use

You can update your contact information by updating your user profile on www.UnitedHealthProducers.com or by contacting your manager/supervisor.

Focus News

Focus News is a bi-weekly agent newsletter published by UnitedHealthcare Medicare Solutions. Newsletter topics include compliance, compensation, marketing, customer service, operations, processes and procedures, products, regulatory issues, and sales.

Focus News is normally published each Wednesday and is distributed to you via email. Occasionally there will be additional individual messages that, due to its regulatory or compensatory nature, must be published to the field immediately.

Disclosing Proprietary Information, Media Requests, and Public Relations Materials

- UnitedHealthcare proprietary information is not to be disclosed to anyone outside of the company, including the media, under any circumstances without prior approval from the Chief Sales and Distribution Officer.
- Request for information from any media source, including informational interviews, must be directed to the Director of Corporate Communications.
- All public relations material must be submitted for approval to the Vice President of Corporate Communications.

Section 4: Product Portfolio

Product Portfolio Overview

Medicare Advantage Health Plans

Medicare Advantage Special Needs Plans

Medicare Supplement Insurance Plans

Prescription Drug Plans

5-Star Rating Overview

Product Portfolio Overview

The information contained within this section regarding plans and plan benefits is illustrative only and cannot be relied upon as a reflection of UnitedHealthcare's current product offering. Please contact the Producer Help Desk at phd@uhc.com (the subject line should contain the agent's Writing ID number, available 24 hours) for information on current plans and plan benefits.

UnitedHealthcare Medicare Solutions

The portfolio of UnitedHealthcare Medicare Solutions plans includes Medicare Advantage Plans, Medicare Supplement Insurance Plans, and Part D Prescription Drug Plans. Plans are insured or covered by an affiliate of UnitedHealthcare, a Medicare Advantage organization and a Prescription Drug Plan sponsor with a Medicare contract.

These plans provide a portfolio of services to the rapidly growing Medicare population, including Medicare Advantage, Part D Prescription Drug Plans, and Medicare Supplement Insurance Plans. The Medicare Advantage products include network (Health Maintenance Organization (HMO), Point-of-Service (POS), Preferred Provider Organization (PPO), and Regional Preferred Provider Organization (RPPO)) and non-network-based (Private Fee-For-Service (PFFS)) plans.

AARP® Brand and UnitedHealthcare Relationship

UnitedHealthcare has a long-standing relationship with AARP. UnitedHealthcare and AARP are aligned in caring about individuals over the age of 50 and their access to affordable, quality healthcare.

UnitedHealthcare offers Medicare Advantage, Part D Medicare, and Medicare Supplement Plans with the AARP name and trademark as part of its portfolio. UnitedHealthcare pays a royalty fee to AARP for use of the AARP name and trademark. AARP uses this fee to fund advocacy efforts and various programs and services.

AARP is not an insurance provider and makes informed decisions about what products and services include their name. AARP has a choice on what plans carry its name and UnitedHealthcare feels privileged to be one of those selected.

Before you can be authorized to offer AARP branded Medicare plans, you must go through special training that helps you to better understand the issues faced by people as they age and which product may be best suited for their needs.

Authorized to Offer (A2O) AARP® Medicare Plans Program

The Authorized to Offer (A2O) AARP Medicare Plans program recognizes agents who meet all certification standards, demonstrate competency on AARP Medicare Plans and serve AARP members' best interests. The A2O program allows A2O agents to differentiate themselves from non-A2O agents in the marketplace.

There are two levels in the A2O program.

Level 1 Benefits

- Ability to offer AARP branded products
- Access to product-level marketing materials

Level 2 Benefits

- Ability to offer AARP branded products
- Access to Level 1 marketing materials
- Exclusive access to additional sales and marketing pieces

A2O Level 1

In order to obtain A2O Level 1 agent status, the agent must:

- Complete one AARP branded certification requirement
- Produce a minimum of five AARP Medicare Supplement active and paid sales during a one-year period between April 1 and March 31 each year

Agents who fail to attain the quality production minimum will be de-authorized from selling AARP Medicare Supplement plans for 90 days. The agent will be sent a communication if the agent has not attained the quality production minimum. Agents that fail to meet the quality production minimum for two consecutive years will be permanently de-authorized from selling the AARP Medicare Supplement plans.

Starting in 2014, active Level 1 agents with 100 or more AARP Medicare Supplement **active** members in their book of business at the end of the measurement period will not be de-authorized.

Agents de-authorized from selling AARP Medicare Supplement Plans can continue to sell AARP® MedicareComplete and AARP® MedicareRX Plans during the de-authorization period.

A2O Level 2

In order to obtain A2O Level 2 agent status, the agent must:

- Complete all three AARP branded certification requirement
  - ~ AARP MedicareComplete
  - ~ AARP MedicareRx
  - ~ AARP Medicare Supplement Insurance Plans

- Produce 30 or more AARP Medicare Supplement active and paid sales during a one-year period between April 1 and March 31 each year

- Successfully complete the Mature Markets (AARP 231) course

Note: Invitations to take the Mature Markets (AARP 231) course to become an A2O Level 2 agent are distributed by UnitedHealthcare to qualified agents on a monthly basis.

A2O Level 2 agents have access to all Level 1 materials as well as exclusive Level 2 marketing materials. Level 2 marketing materials include a business card with the AARP name or logo on it, web banner, a brochure, a letter of introduction, AARP-branded thank you cards, tent cards, personalized promotional items and window cling/signage. Level 2 materials also include AARP Medicare Supplement marketing materials that promote the product as well as the agent as the local go-to resource for the product.

A2O Level 2 agents must maintain the Level 2 quality production minimum and certification requirements during the measurement period of April 1 and March 31 each year to continue using Level 2 materials.

Starting in 2014, active Level 2 agents with 200 or more AARP Medicare Supplement active members in their book of business at the end of the measurement period will retain Level 2 status and will continue to have access to Level 2 A2O program materials.

For additional information about the A2O program the Program Guidelines are available on the Distribution Portal. Agents may also email the Producer Help Desk (PHD).

Medicare Advantage Health Plans

UnitedHealthcare Medicare Solutions offers Medicare Advantage health plans that cover benefits in addition to those covered under Original Medicare. Residents in some counties have several plans from which to choose. The plans often include an integrated Part D drug benefit with the medical coverage. Most Medicare Advantage HMO, PPO, and POS plans carry the AARP name - "AARP MedicareComplete insured through UnitedHealthcare." Plans include:

- **MedicareComplete® Plans** are Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and Point of Service (POS) plans that offer benefits in addition to those covered under Original Medicare. Many plans have a $0 monthly plan premium. Most MedicareComplete plans carry the AARP name - "AARP MedicareComplete insured through UnitedHealthcare." The remaining MedicareComplete plans are UnitedHealthcare branded. Following are details on the three types of MedicareComplete plans:

  ~ **MedicareComplete HMO Plans** enable members to receive care through a network of contracted local doctors and hospitals that coordinate their care. Out-of-pocket costs are typically lower for these plans than for other MedicareComplete plans. Some plans do not require referrals for specialty care.

  ~ **MedicareComplete Choice Plans** give members access to a network of contracted local doctors and hospitals, but also allow them the flexibility to seek covered services from physicians or hospitals outside of the contracted network, usually at a higher cost. Members never need a referral for specialty care.

  ~ **MedicareComplete Plus POS Plans** are HMO plans that offer a Point-of-Service (POS) option. These plans include all of the features of MedicareComplete HMO plans plus the ability to go outside the contracted network for certain health care services, typically at a higher cost. Many POS plans offer open access to providers with no referrals needed.

- **Care Improvement Plus Medicare Advantage Plans** offer benefits in addition to those covered under Original Medicare, comprehensive care management, and a $0 monthly plan premium. Local PPO and Regional PPO plan options are available in 12 states. Members never need a referral for specialty care.

- **UnitedHealthcare MedicareDirect℠ Plans** are Private Fee-for-Service (PFFS) plans, offering the freedom to receive care from any Medicare eligible provider that agrees to accept the plan's terms and conditions of payment. PFFS plans may or may not use networks, referrals, or prior authorization for care. This depends on whether the PFFS plan is a network or non-network plan. UnitedHealthcare only offers non-network PFFS plans. These plans do not require referrals for care.

In Florida, plans are also marketed under the brands of Preferred Care Partners and Medica Healthcare Plans. In Utah and Nevada, plans are also marketed under the brands of Sierra Spectrum and Senior Dimensions.

Medicare Advantage Special Needs Plans

The UnitedHealthcare Medicare Solutions portfolio of Special Needs Plans (SNP) offer additional benefits, provide enhanced care management, and coordinate care from a variety of health service providers – which Original Medicare and Medicaid alone do not offer. All SNPs include Part D prescription drug coverage. Plans and benefits vary depending on location and plan type.

Special Needs Plan Types

- **Chronic Condition Special Needs Plans** are designed for consumers diagnosed with chronic conditions such as diabetes chronic heart failure, and/or cardiovascular disorders. These plans offer benefits in addition to those covered under Original Medicare such as dental, vision, transportation, and routine podiatry. Consumers must have a qualifying chronic condition to enroll. UnitedHealthcare offers Local PPO and Regional PPO Chronic Condition plans through Care Improvement Plus in 12 states. In addition, the UnitedHealthcare Chronic Complete HMO plan is available in select counties in Texas and the Preferred Special Care Miami-Dade HMO plan is available in Miami-Dade county, Florida

- **Dual Eligible Special Needs Plans (Dual SNP)** are intended for consumers with Medicare & Medicaid benefits. Dual SNP plans are tailored to low-income consumers who need help to get the most from what is available to them through Medicare and Medicaid. Plans provide benefits in addition to those covered under Original Medicare, such as routine eyewear and transportation to doctor appointments. Members must have Medicaid to enroll. UnitedHealthcare offers Dual SNP plans in 20 states plus the District of Columbia under the brands of UnitedHealthcare, Care Improvement Plus, Preferred Care Partners, or Medica Healthcare Plans, depending on the service area.

- **UnitedHealthcare Nursing Home Plans** provide personalized, closely monitored, and coordinated care to nursing home residents. These plans supplement coverage of nursing facility services with the added support of a nurse practitioner and provide benefits in addition to those covered under Original Medicare. Members must reside in a contracted Skilled Nursing Facility. The Institutional SNP is sold exclusively by Optum staff and may not be sold telephonically. For additional information, agents may contact their local Optum office, dial 1-877-386-0736 (8 a.m. to 8 p.m., 7 Days a week, Central Time (CT)), or visit www.uhcmedicaresolutions.com.

Medicare Supplement Insurance Plans

A Medicare supplement insurance plan can help protect Medicare consumers against the rising cost of health care by covering some of the out-of-pocket expenses associated with Medicare. Medicare supplement plans are designed to complement Medicare and help enhance the member's overall health care coverage. Plans include:

- **AARP Medicare Supplement Insurance Plans** - benefits vary by plan, but all offer hospitalization coverage for Medicare Part A coinsurance, medical expenses coverage for Medicare Part B coinsurance, and portability – the plan goes with the policyholder wherever they are in the United Sates. AARP Medicare Supplement Plans are the only Medicare supplement plans available in all states and United States territories. Consumers must be an AARP member or a spouse or partner of an AARP member living in the same household to enroll in an AARP Medicare Supplement Insurance Plan. Membership is available at the time of enrollment.

- **AARP Medicare Select Plan C and Select Plan F** are available in certain areas in certain states. The AARP Medicare Select Plans provide the same benefit coverage as standardized Medicare Supplement Plans C and F, but insured members pay a lower cost premium because they are required to use a network hospital for coverage of inpatient and outpatient hospital services. In a medical emergency, members do not have to use a network hospital.

AARP Medicare Supplement Insurance Plans Enrollment Applications are state specific. For the state you are selling in, you should always refer to the AARP Medicare Supplement Insurance Plans enrollment materials for specific information on plans and benefits and use the included Enrollment Application for submission.

There is an AARP Medicare Supplement Plan Enrollment Application Guide available for your use. The Enrollment Application Guide provides useful hints and information that will help ensure smooth processing of AARP Medicare Supplement Plans Enrollment Applications. The Guide features a sample annotated Enrollment Application that includes notes, helpful tips, and points of reference to help guide agents in completing the Enrollment Application. There are several variations of the Guide, so be sure to look for the appropriate state version.

Pre-Enrollment Sales Kits and the Application Guides can be found on the Distribution Portal at www.UnitedHealthProducers.com. For additional information, please contact your AARP Medicare Supplement Insurance Plans Regional Sales Manager or call the Producer Help Desk at phd@uhc.com (the subject line should contain the agent's Writing ID number, available 24 hours).

Prescription Drug Plans

UnitedHealthcare Medicare Solutions is a provider of stand-alone Medicare Part D Prescription Drug Plans (PDP) offered under the AARP MedicareRx brand. Note: AARP membership is not required to enroll in an AARP MedicareRx plan.

AARP MedicareRx Part D plans include:

- Broad formularies, ranging from a plan that includes nearly all generic drugs covered by Medicare Part D and most commonly used brand-name drugs to another plan that includes ***all*** generic drugs covered by Medicare Part D and to include the most commonly used brand-name and generic drug coverage.
- More than 65,000 pharmacies nationwide.
- Preferred mail order pharmacy with savings over retail.
- Customer service available seven days a week (8 am - 8 pm local time).
- AARP MedicareRx plans offered in all fifty states.
- Only the AARP MedicareRx preferred plan is offered in the 5 United States territories.

Prescription Drug Plans

- *** AARP MedicareRx Enhanced** formulary includes more than 95% of drugs covered by Medicare Part D and most commonly used brand-name drugs plus additional coverage for Tier 1 and Tier 2 drugs while in the coverage gap.
- **AARP MedicareRx Preferred** formulary includes nearly all generic drugs covered by Medicare Part D and most commonly used brand-name drugs.

* Sourced from the 2013 Prescription Drug Plan Product Overview

5-Star Rating Overview

Medicare Star Ratings is a government pay-for-performance program for Medicare Advantage (MA) and Part D Prescription Drug Plans. Medicare uses a five-star rating system to measure how well plan sponsors perform in different categories. These ratings help consumers and members compare plans based on quality and performance. Detecting and preventing illness, ratings from patients, patient safety, and customer service are examples of categories measured. The Centers for Medicare & Medicaid Services (CMS) utilizes one to five stars to determine a plan's performance in a particular category; one star denotes poor quality and five stars represents excellent quality.

Plan performance summary ratings are issued in October of the previous plan contract year. Consumers and members may compare plan rating information by making a request, visiting www.medicare.gov, or checking plan websites.

A plan can receive ratings between one and five stars.

- 5 Stars - "Excellent"
- 4 Stars - "Very Good"
- 3 Stars - "Good"
- 2 Stars - "Fair"
- 1 Star - "Poor"

When asked, agents must use the accurate CMS provided terms above when describing the star rating for the plan they are marketing.

CMS uses more than 50 types of measures to determine Plan Ratings, considering such things as: How often our enrollees use specific benefits (flu shots, etc.), a consumer's access to care, complaints, and measureable improvements in the health outcomes of our members. By simply being accurate when you the plans you sell, and encouraging consumers to use benefits that are covered (and ultimately measured by CMS), you can help improve our plan's Star Ratings.

Star Ratings is also a 'pay for performance' program, so higher Star Ratings mean greater reimbursements or funding to the Plan – which helps us offer enhanced benefits for more competitive products.

What you do **today** to be sure you're selling accurately and professionally, can impact Star Ratings and reimbursements to the Plan. What we did in 2011, affected our current Star Ratings. What we do **today**, will affect our Star Ratings for 2015.

Starting in 2015, only plans with 4 stars will be eligible for additional performance funding.

PERFORMANCE (on which plans are rated)	DATA COLLECTION	STAR RATINGS CALCULATED	PAYMENT
2010	2011	2012	2013
2011	2012	2013	2014
2012	2013	2014	2015
2013	2014	2015	2016

What am I required to say or do, when it relates to Star Ratings?

When presenting our plans at an event or an individual appointment, you are required to say and do the following:

- **State out loud** what Star Ratings are
- **State out loud** what the Star Rating is for the plan you are presenting (the ratings are found in the sales materials for the plan you are presenting)
- **Show** the audience where the Star Rating is located, within the materials. Tell them they can find more information on www.Medicare.gov
- **Mention** 1-2 measures CMS considers when establishing a Plan's Star Ratings.
  Examples you can mention:
  - ~ Consumer use of preventive care (such as annual screenings)
  - ~ Access to Care
  - ~ Consumer use of prescribed medications – use as prescribed to improve your health (ie: adherence)
  - ~ Customer Satisfaction

How can I impact Star Ratings?

- Know the benefits you're selling, to accurately explain the plan and determine the best fit for the individual. This supports the consumer with their plan selection, strengthens your relationship, and may also help avoid complaints.
- Encourage consumers and members to use their benefits because Star Ratings are partially based on whether or not our members obtain specific services, such as: Annual screenings and preventive care, visiting their Primary Care Physician (PCP), and properly using their medications (referred to as 'medication adherence.)
- Reduce the chance that any type of complaint would be filed, by doing what's required in all sales presentations and appointments and lending proper support to your enrollees.

- Take the Star Ratings training through WebEx or as provided to your Agent Manager, to know what services you should be mentioning to encourage consumers to use those benefits. Certain services are monitored by CMS and when consumers obtain those services, this can help our Star Ratings. Healthier outcomes of our members are also measured, so you do have the ability to influence those healthy habits and outcomes. Who knows – you may even save a live through these recommendations.
- Earn high scores on your sales events if Agents are secret-shopped, by mentioning all required statements and showing consumers all required materials. One of the things you are required to cover, is information on Star Ratings.
- Take the Event Basics module if you are conducting sales events, or, even to improve your knowledge for hosting individual appointments. The Event Basics module will teach you what is required to say or do when selling our plans, and it's based on what CMS uses for scoring when they secretly shop your events.
- Use the sales presentations tools: "Hello Clarity," accompanying Agent Workbook, and, the sales events video to be sure you are covering all the required statements so consumers understand what they are buying. This will help avoid consumer complaints resulting from any misunderstandings.

UnitedHealthcare has a focused effort to achieve 5-Star plans. UnitedHealthcare is committed to the health and well-being of the members we serve and is committed to achieving the highest rating possible.

UnitedHealthcare is dedicated to:

- Increasing members access to health and well-being services
- Simplifying the way health care is delivered
- Improving the quality of the care our members receive

Section 5: How Do I Get Marketing and Enrollment Materials

UnitedHealthcare Agent Toolkit

Brand and Logo Usage – Marketing and Advertising Materials, Web Links, and Websites

Ordering Marketing and Enrollment Materials and Supplies

UnitedHealthcare Agent Toolkit

The UnitedHealthcare Agent Toolkit allows you to access marketing and advertising materials that can be customized and/or personalized with targeted messages that can be downloaded and used immediately. A variety of materials are available, including ads, flyers, and postcards with an assortment of pre-approved options from which to choose.

When used appropriately, all pre-approved marketing materials are compliant with regulatory, the Centers for Medicare & Medicaid Services, state Department of Insurance offices, and company brand standards. Note that any changes to these materials makes them non-compliant.

The UnitedHealthcare Agent Toolkit is available to agents that are contracted, licensed, appointed (if applicable), and certified. Your access is limited to those products in which you are certified and states in which you are licensed.

Accessing the UnitedHealthcare Agent Toolkit

To access the UnitedHealthcare Agent Toolkit, follow these steps:

- Log on to www.UnitedHealthProducers.com and navigate to the "Product Information and Materials" tab.
- Click on "Agent Toolkit" located on the left navigation bar.
- Then click on "Agent Toolkit" details
- Lastly, click on the "click here to link to Agent Toolkit" hyperlink.

Materials are categorized by language and then by product or theme and event. Many approved materials are available in both meeting (formal marketing/sales events) and non-meeting formats.

UnitedHealthcare Agent Toolkit Training and Information

A variety of resources are available to guide the agent in the use of the UnitedHealthcare Agent Toolkit. You can view this information as follows in the United Distribution Portal

- Log on to www.UnitedHealthProducers.com and navigate to the "Product Information and Materials" tab.
- Click on "Agent Toolkit" located on the left navigation bar.
- Then click on "Agent Toolkit" details Scroll down to the "Helpful Materials" section where you will see both the "Agent Toolkit Quick Start Guide" and the "Agent Toolkit FAQ Guide."
  - ~ Quick Start Guide – a downloadable, written training guide on how to use the Toolkit.
  - ~ Agent Toolkit FAQ Guide - Frequently Asked Questions that provide information on common inquiries.

Once inside the Agent Toolkit you can view additional resources including online video tutorials. These tutorials provide step-by-step instruction on how to use the Agent Toolkit and create marketing materials. Simply click on the "Support" tab when in the Agent Toolkit to access these resources.

Brand and Logo Usage – Marketing and Advertising Materials, Web Links, and Websites

Marketing Materials and Generic Materials

Marketing Materials

Based on the Centers for Medicare & Medicaid Services (CMS) definition, UnitedHealthcare defines "marketing materials" to mean any informational materials or communications targeted to Medicare consumers that do the following:

- Promote the plan sponsor, or any Medicare Advantage (MA) plan, Medicare Advantage Prescription Drug Plan (MA-PD), section 1876 cost plan, or Prescription Drug Plan (PDP) offered by the plan sponsor.
- Inform Medicare consumers that they may enroll, or remain enrolled in, an MA plan, MA-PD plan, section 1876 cost plan, or PDP offered by the plan sponsor.
- Explain the benefits of enrollment in an MA plan, MA-PD plan, section 1876 cost plan, or PDP or rules that apply to enrollees.
- Explain how Medicare services are covered under an MA plan, MA-PD plan, section 1876 cost plan, or PDP plan, including conditions that apply to such coverage.

Materials that meet the definition of "marketing materials" above will be subject to prior approval by UnitedHealthcare and submission to CMS by UnitedHealthcare. If the marketing piece does not include plan specific information, but does reference our Company/Brand name or logos, it will require prior approval from UnitedHealthcare through the exception request process.

The instructions for downloading the exception request form:

- Access the Agent Toolkit
- Click on "Support Tab"
- Click on the "Agent Marketing Exception Request Form."

Generic Materials

It is UnitedHealthcare policy that agents may create generic materials that mention MA and/or PDP products in a general way, but that do not specifically mention UnitedHealthcare MA and/or PDP plans nor describe benefits, costs, or promote or provide information about UnitedHealthcare plans.

Although generic materials do not require UnitedHealthcare and/or CMS approval, they must be compliant with any CMS guidelines. Generic materials are not required to be submitted for prior approval, but may be reviewed retrospectively.

If compliance issues or concerns are identified in a retrospective review, UnitedHealthcare will ask the agent to resolve the issue or concern, as necessary, including ceasing the use of any such material until it is revised.

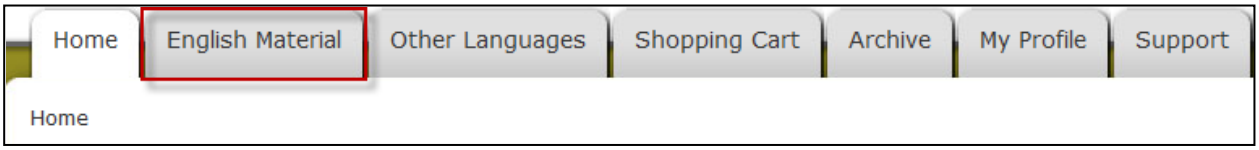
In order for material to be considered generic, it may not contain:

- UnitedHealthcare Logos or Brands (Example: UnitedHealthcare, AARP®, etc.)
- Plan Specific Names (Example: Plan A)
- Product Specific (Example: Medicare Complete)
- Benefit Information

If you are unsure whether a material is marketing material or generic, you may submit the document for review to Compliance_Questions@uhc.com.

Marketing and Advertising Materials Featuring UnitedHealthcare Medicare Solutions Brands

UnitedHealthcare Medicare Solutions is committed to providing pre-approved and customizable marketing materials in support of its distribution channels. The extensive library of branded marketing materials offers consistency of branding and messaging, in addition to ensuring legal and regulatory compliance and partner approval.



Pre-Approved Materials*

You may use, at your discretion, any pre-approved marketing materials provided by UnitedHealthcare Medicare Solutions brands without further approval provided the materials are not altered, beyond applicable and allowed customization and/or personalization, and they are used in a manner consistent with all applicable regulations and UnitedHealthcare policy.

To access pre-approved marketing material, follow these steps:

- Access the Agent Toolkit
- Click on “English Materials”
- Select the desired category:
  - ~ Plan-specific Materials
  - ~ Comprehensive Marketing Programs
  - ~ Informational Sales Support Materials

* Materials and options may vary by channel, license, and product certification.

Agent Titles

You are prohibited from using titles that imply that you are in any way affiliated with the Centers for Medicare & Medicaid Services (CMS), the Social Security Administration, or any other regulatory entity.

In addition, using the word Medicare and/or any language in a title that implies that you have additional knowledge, skill, or certification above licensing requirements that cannot be verified are prohibited.

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

Examples of prohibited agent titles:

- Medicare Sales Agent
- Senior Advisor

Examples of approved agent titles:

- Sales Agent (may add EDC organization if desired)

Agent Business Cards

You may not use the UnitedHealthcare brand or logo on your business cards, letterheads, labels, envelopes, or in an e-mail signature.

Authorized to Offer Level 2 agents may have additional options; see the program for details.

You may add professional and educational credentials (e.g. CLU, ChFC, CFP, PhD). However, you must be able to provide documentation to substantiate credentials upon request. Certifications must be current and removed from business cards upon expiration (if applicable).

Requests for Custom Materials

Every effort should be made to use pre-approved materials prior to requesting a custom piece. All material, agent-created and/or requests to create ad hoc material, which references or uses UnitedHealthcare Medicare Solutions brands in any manner, must be submitted for approval.

Use of agent-created marketing materials featuring UnitedHealthcare Medicare Solutions brands without prior written approval by the company is expressly forbidden.

In the event that no pre-approved material meets the desired purpose, you must follow the instructions found on the Agent Toolkit ("Support Tab") to complete a request for approval to use an agent-created piece or to request the creation of an ad-hoc piece. The completed Agent Marketing Exception Request Form must be routed to your Regional Sales Director for evaluation through your EDC Manager.

Approvals for logo use will be granted only for the marketing materials submitted; they may not be taken as blanket approvals. Approval may also be limited to one-time use.

You must send a finalized version of the marketing material to agent_marketing_requests@uhc.com prior to use and must keep a written record of all approvals granted.

You are prohibited from using symbols, emblems, names (including acronyms), and colors schemes on websites or business cards in reference to Medicare, CMS, the Social Security Administration, or any other regulatory entity.

Web Links and Logo Usage on Agent Websites

The promotion of your affiliation with UnitedHealthcare Medicare Solutions, through the use of Web links and logos, must comply with Company and the Centers for Medicare & Medicaid Services (CMS) marketing guidelines. Please refer to: *UnitedHealthcare Medicare Solutions Logo and Brand Usage Guidelines for Agency/Agent Website* and *Guidelines for Developing Agent Materials* located in the Resource Center Tab on the Distribution Portal, for complete details.

You may not use UnitedHealthcare Medicare Solutions brands and/or logos on your website(s) that are not included in the Guidelines without written permission from UnitedHealthcare Medicare Solutions.

The following provisions apply when any agent Web page features a UnitedHealthcare Medicare Solutions brand element (e.g. logo, product name) or a link to the Website of UnitedHealthcare Medicare Solutions, or any of its brands.

- Determine whether your website is consumer facing or agent facing
  - ~ Consumer Facing websites are directed to any consumer, including but not limited to Medicare eligible consumers. These public facing sites may be for marketing or informational purposes. Consumer facing websites may not include materials or plan benefits without permission from the Centers for Medicare & Medicaid Services (CMS).
  - ~ Agent Facing websites are directed to agents for agent recruitment activities, education and communication. Agent facing websites often include passwords or sign in requirements.
- Register your website with UnitedHealthcare. Regardless if your website carries the UnitedHealthcare logo, branding or materials, or if it is meant for consumers or agents, all websites owned by ***contracted*** agents or agencies are subject to review and should be registered.
  - ~ Agents may register their agent website (URLs address) to: agent_marketing_requests@uhc.com.
  - ~ Include on your registration a carbon copy to your sales leadership, your sales identification number and the date the website became active.
- Approval to use the AARP name or logo will not be considered (Exception: Qualified Level 2 agents may post the Authorized to Offer web banners, which contain the AARP Medicare Plans logo).
- Any agent Web page featuring an approved UnitedHealthcare Medicare Solutions brand element is subject to review and approval and may require regulatory filing.
- Agent Web pages may not contain material, including product descriptions and benefits, which were copied from the UnitedHealthcare Medicare Solutions website or other UnitedHealthcare Medicare Solutions sources. Permission is limited to the use of brand elements, not website content.
- Agents who have received approval to use UnitedHealthcare Medicare Solutions brand elements on the agent's website, are encouraged to embed a hotlink with the brand element.
- Embedded links must direct the user to the brand's homepage (e.g. www.UHCMedicareSolutions.com) rather than to any page within the brand's website to ensure the user is not misdirected due to deleted or substantially altered web pages or content.

- Agents are not permitted to register or operate internet domain names incorporating the name of any UnitedHealth Group brand or affiliate (e.g. AARP).
- Agents are not permitted to use the word Medicare in an internet domain name that may give the perception that the website is in anyway affiliated with Medicare.
- Agents may not use CMS in an internet domain name that may give the perception that the website is in anyway affiliated with the Centers for Medicare & Medicaid Services (CMS).
- Agents may not use symbols, colors, or color schemes that may give the perception that the website is affiliated with Medicare, CMS, state, or federal entities.
- A random number of websites are reviewed monthly by the UnitedHealthcare Compliance team to ensure they are compliant.
- Do not speak disparagingly of CMS, UnitedHealthcare or the competition.
- You may not include contracts or appointment forms from UnitedHealthcare.
- The same Sales and Marketing rules set by CMS for presentations and materials apply to websites. These include, but are not limited to:
  - ~ Do not cross-sell (e.g. market MA products with Funeral Planning information)
  - ~ Superlatives are not allowed (e.g. **the Most** recognizable name in market)
  - ~ Scare tactics are not allowed (e.g. **You Must** enroll, Required to elect)
  - ~ Logos and branding must be current
  - ~ Agent titles should be appropriate

Brand and Logo Usage Monitoring and Corrective Action

UnitedHealthcare will randomly review brand and logo use, including the review of websites and the use of materials provided at marketing/sales events.

External Distribution Channel (EDC) sales leaders, as well as the EDC, are responsible for the appropriate use of brands and logos used by their agents.

If you are found to have used a brand or logo inappropriately or without prior written permission, you will be directed to immediately stop usage. You will be referred to the Disciplinary Action Committee (DAC) and subject to progressive discipline including corrective and/or up to and including termination.

Use of Social Media

The use of social media, including, but not limited to Facebook, LinkedIn, Twitter, etc., is subject to the same policies and regulations as websites. You are prohibited from posting any plan or benefit information and may not use social medium's interactive functionality as a means to communicate with consumers and/or members.

Live Radio/Television Programming

You must receive permission from UnitedHealthcare prior to conducting or participating in live radio or television programming.

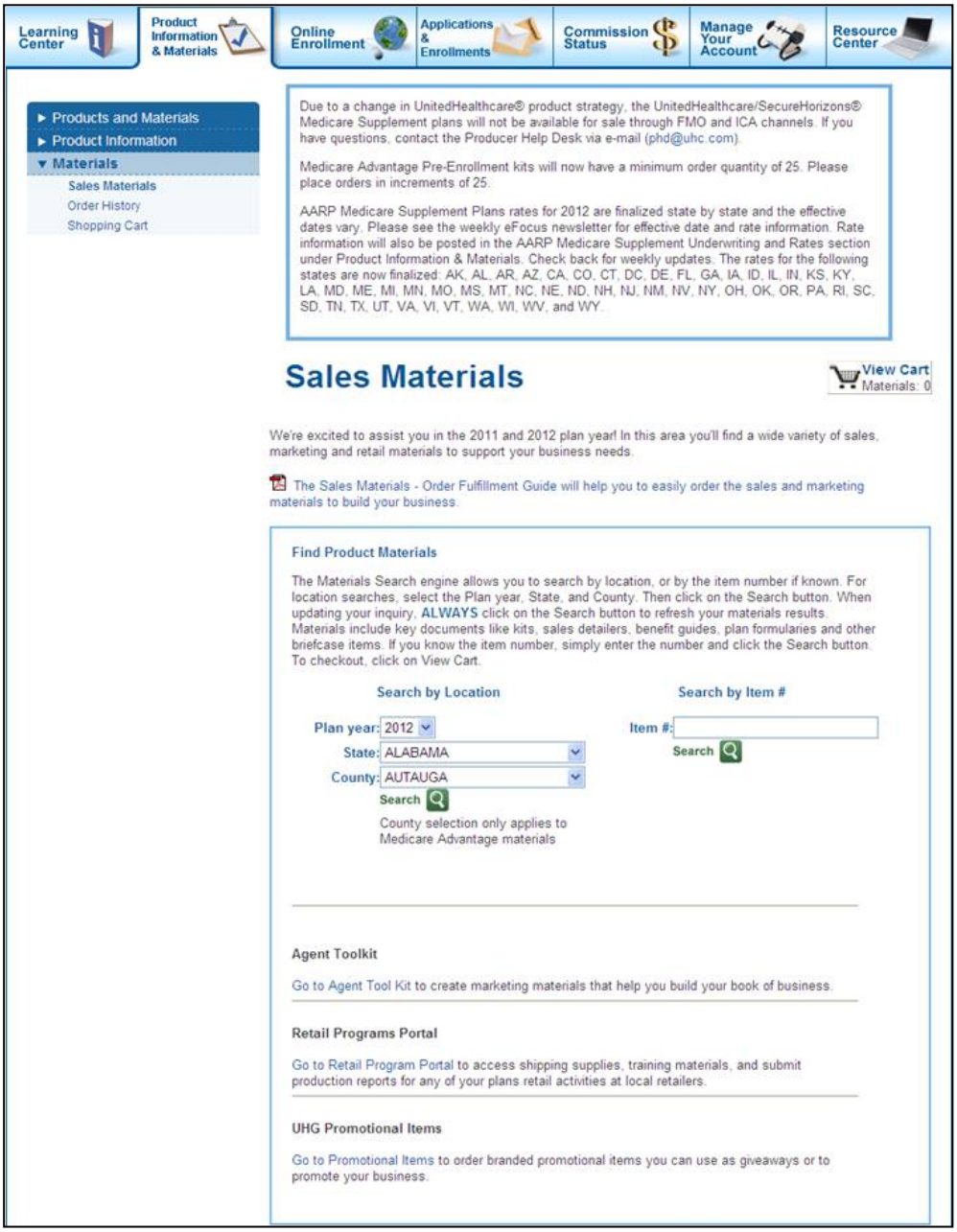
Ordering Marketing and Enrollment Materials and Supplies

Sales Materials

Sales and marketing materials are available through the UnitedHealthcare Medicare & Retirement Distribution Portal to licensed, contracted and appointed (if applicable) agents once they have taken and passed a product certification module.

Log onto www.UnitedHealthProducers.com and select the "Product Information & Materials" tab.

- The Sales Materials section allows you to search for materials by plan year, state and county, or by item number. Once you find the sales and marketing materials you need, you can order and/or download them. Access is limited to those products in which you are certified and states in which you are licensed and appointed (if applicable). Marketing and enrollment materials may vary by state, (i.e. they may be state-specific).



Section 6: How Do I Conduct Educational and Marketing/Sales Activities?

Characteristics of Activities and Events

Event Reporting

Marketing to Consumers with Individual Impairments or Disabilities

Lead Generation

Scope of Appointment

Interacting with the Field

Quick Reference Guide: Compliant Sales Practices

Medicare Marketing Guidelines

Characteristics of Activities and Events

Educational Activities and Events

An educational activity or event is used to provide general information about the Medicare program and/or health improvement and wellness. An educational activity or event is designed to solely inform consumers about Original Medicare, Medicare Advantage (MA), Prescription Drug Plan (PDP), or other Medicare program. During an educational activity or event agents are prohibited from steering or attempting to steer a consumer toward a specific plan.

An educational event is defined by the way in which it is described to the consumer. An education event must be advertised with the appropriate disclaimer, must always be held at a public venue, and must be open to the public.

Agents Must

- Advertise or promote the event as "educational" or in a manner that informs that the event is solely for educational purposes.
- Report all educational events (see Event Reporting Section).
- All events are subject to Secret Shopping by UnitedHealthcare, the Centers for Medicare & Medicaid Services (CMS) and/or AARP.
- Conduct all educational events in public venues.
- Include the following disclaimer on all announcements (advertising or explanatory), "This event is only for educational purposes and no plan-specific benefits and details will be shared."

Agents Must Not

- Proactively approach or engage the consumer at an informal (table/booth/kiosk) setting.
- Engage in any activity at an event that would meet the Centers for Medicare & Medicaid Services (CMS) definition of marketing.
- Distribute or display plan-specific materials such as Pre-Enrollment Sale Kits or brochures.
- Attach personal business cards or plan/agent contact information to educational materials.
- Distribute or display business reply cards, lead cards, Scope of Appointment (SOA) forms, sign-in sheets, agent business cards, and/or Permission to Call (PTC) forms.
- Have any form of "Ask Me" button (or similar) that may lead to the consumer to believe the agent is a representative of CMS, and/or Medicare, or to ask health related questions.
- Distribute or collect Enrollment Applications.
- Discuss plan-specific premiums and/or benefits.
- Schedule a separate personal/individual marketing/sales appointment, SOA form, and/or obtain PTC.
- Solicit consumers for personal/individual marketing/sales appointments under the premise that the appointment is for education purposes.
- Invite consumers to or accept RSVPs for future marketing/sales events.
- Provide cash gifts, gifts easily converted to cash, or charitable contributions made on behalf of a consumer regardless of dollar amount.
- Immediately (i.e., within one hour) follow an educational event with a marketing/sales event in the same general area (e.g., same venue).

Agents May

- Provide educational information, including the UnitedHealthcare-branded "Medicare Made Clear" booklet, that is free of plan specific information.
- Have a banner or table skirt with the plan logo displayed.
- Wear an approved and unmodified shirt, badge, etc. with plan names and/or logos (e.g., purchased from UnitedHealth Group Merchandise eStore accessible via the Distribution Portal).
- Distribute healthcare educational materials (not specific to any plan) on general topics, such as, diabetes awareness and prevention and high blood pressure information.
- If requested by a consumer, hand out a business card free of any marketing or benefit information.
- If asked about plan benefits, premiums, or copayments agents may suggest that consumers call UnitedHealthcare for further information.
- Provide meals or food items (provided they are permitted by the venue) as long as the nominal retail value, when combined with any other giveaways, does not exceed $15 on a per person basis.
- Provide promotional items with plan names, logos, a toll-free customer service number, and/or website as long provided the aggregate retail value of the giveaways (including food items) does not exceed $15 on a per person basis.
- Respond to questions asked at an educational event provided that the scope of the response does not go beyond the question asked and does not include the distribution or acceptance of Enrollment Applications and/or marketing materials.

Marketing/Sales Event

A marketing/sales event is one which is used to market to consumers and steer them toward specific plans. Events may be conducted in a variety of venues, but also include any kind of sales booth (e.g. table, kiosk, tabletop display, etc.) located in a specific location such as a retail store, provider office site, or healthcare facility. Events can be sponsored by the plan or another entity. A marketing/sales event is defined by the range of plan information provided to the consumer and the way in which the information is presented to the consumer. A Scope of Appointment form is not to be used at a sales event. If a consumer requests a follow-up appointment, a Scope of Appointment must be obtained (see Scope of Appointment section for additional information).

Marketing/Sales Events are defined as Formal or Informal.

Formal marketing/sales events are typically structured in an audience-presenter style where the agent formally provides specific plan 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. Presenting agents must be contracted, licensed, appointed (if applicable), certified, and complete and pass with a score of 85% or better within three attempts on the Events Basic training module.

Informal marketing/sales events are a less structured presentation and/or in a less formal environment. They typically utilize a booth, table, kiosk, and/or a recreational vehicle (RV) that is manned by an agent who can discuss the merits of the plan's products. Informal marketing/sales events are usually intended for a passer-by audience and agents cannot approach others in the informal marketing/sales events setting.

Section 6: How Do I Conduct Educational and Marketing/Sales Activities?

The following guidelines apply to all marketing/sales activities and events.

Agents must

- Be contracted, licensed, appointed (if applicable), and certified in order to represent UnitedHealthcare during any marketing/sales activity and/or event.
- Take and pass with a score of 85% or better within three attempts the Event Basics training module made available for sales events prior to conducting an event.
- Report all marketing/sales events (formal and informal) (see Event Reporting Section).
- Populate the field in bConnected for special needs requests to ensure documentation for CMS.
- All events must be open to the general public, even if reported as private in bConnected. Note: marking an event private (EDC agents only) in bConnected simply prevents a UnitedHealthcare Telesales agent from promoting the event to a consumer and/or entering an RSVP to the event.
- Conduct marketing/sales events in appropriate venues. Prohibited venues include gambling areas of casinos, for-profit bingo facilities, and areas where health care is provided (pharmacy counter, exam room, etc.). Discretion should be used when selecting a venue to ensure the reputation of UnitedHealthcare is not compromised.
- Notify front desk staff/employees at the venue of the event, room number, and time of event so the staff can direct consumers appropriately. If allowed, post signage directing the consumer to the event location.
- Include on all advertisements and invitations that are used to invite consumers to attend a group event with the possibility of enrolling those consumers the two required statements, “A sales person will be present with information and applications.” and “For accommodation of persons with special needs at sales meetings call <phone number and TTY number, and hours of operation>.” Such invitations must also clearly state all of the products that will be discussed during the event (e.g., HMO, PDP).
- Include on all advertisements and explanatory materials promoting drawings, prizes, or any promise of a free gift that there is no obligation to enroll in the plan. For example, “Eligible for free drawing and prizes with no obligation.” or “Free drawing without obligation.” (See Gifts and Meals section for additional information.)
- Keep all consumer information secure (e.g., secure completed Scope of Appointment forms and Enrollment Applications to prevent disclosure of Protected Health and/or Personal Identifying Information).
- Announce all products/plan types that will be covered during the presentation at the beginning of that presentation (e.g., HMO, PFFS, PDP, SNP, MA, MA-PDP, POS, PPO).
- State that they are compensated for enrollments.
- Use only approved sales presentations and marketing materials and ensure that all materials have the appropriate disclaimer.
- Use and follow the materials provided by the plan to ensure that all required elements are covered.
- Clearly read or state the following disclaimer during a formal marketing/sales presentation, “Pre-Enrollment Sales Kits are available to you. Please take one as they contain valuable information such as summary benefit information, appeal and grievance information, plan renewal information, and written notice on low income subsidies.”
- Specify where the Plan Star Ratings and Multi-Language Insert are located in the Pre-Enrollment Sales Kit.
- Clearly explain the following during Special Needs Plans (SNP) presentations:
  ~ Eligibility limitations (e.g., required special needs status).
  ~ Special Election Period (SEP) to enroll in, change, or leave SNPs.
  ~ Process for involuntary disenrollment if the member loses his/her SNP eligibility.

~ A description of how drug coverage works with the plan.

- Provide or make available to all in attendance at all marketing/sales events and appointments, their agent contact information
- Provide a Scope of Appointment (SOA) form for a subsequent personal/individual marketing/sales appointment; if a consumer requests a one on one meeting, then the consumer must fill out a SOA form no less than 48 hours in advance of the future appointment unless not practicable. Every effort must be made to obtain the SOA 48 hours in advance of the appointment. When 48 hours advance notice is not practicable, agents must document the reason why on the SOA form.

Agent Must Not

- Require consumers to provide any contact information as a prerequisite for attending the event. This includes requiring an email address or any other contact information as a condition to RSVP for an event online or through postal mail. Any sign-in sheet or agent contact sheet must clearly indicate that providing contact information is optional.
- Use prohibited statements or use superlatives (e.g., the best provider network, the largest health plan.). Make unsubstantiated statements (e.g., "UnitedHealthcare is the best" or "CMS recommends UnitedHealthcare").
- Solicit or accept Enrollment Applications from individuals who are not eligible for a qualifying election period (e.g., Open Enrollment Period (OEP) or Special Election Period (SEP)) as set by CMS.
- Engage in discriminatory practices such as targeting/marketing to consumers from higher income areas or state and/or otherwise imply that plans are unavailable only to seniors and not all Medicare eligible consumers.
- Conduct an event at a venue when a free or subsidized meal is being served. If a meal is served as part of the venue's daily activity, (e.g. senior center), the event may not be conducted during the period starting one hour prior to serving time to one hour after serving time of the meal.
- Provide meals to attendees. (See Gifts and Meals section for additional information.).
- Conduct an event in any area of a healthcare facility where a patient receives or waits to receive care, including, but not limited to, waiting and examination rooms, pharmacy counters, hospital patient rooms, etc.
- Conduct an event at a casino in a location where gambling is being conducted. It is acceptable to hold an event in an area completely separate from gambling activities, such as a conference room.
- Conduct health screening or other like activities that could give the impression of "cherry picking" which is engaging in any practice that may reasonably be expected to have the effect of denying or discouraging enrollment of individuals whose medical condition or history indicates a need for substantial future medical services (e.g., blood pressure checks, cholesterol checks, blood work).
- Steer consumers to specific providers or provider groups, practitioners, or suppliers. You may provide the names and contact information of providers contracted with a particular plan when asked by a consumer.
- Discuss plan options that were not agreed to by the consumer in advance on the Scope of Appointment (SOA), sales event signage, or promotional notification.
- Market non-health related products (such as annuities or life insurance) while marketing a Medicare related product.
- Ask a consumer for referrals, accept referrals from a consumer, or offer any incentives as an inducement for referrals.
- Compare one plan sponsor to another by name unless both plan sponsors have concurred.

- Provide any gifts to consumers that are associated with gambling and/or have the potential to result in a conversion to cash (e.g., lottery tickets, pull-tabs, meat raffles). This would include coupons that can be redeemed for meals and items for consumption. Gift cards are also prohibited.

Agent May

- Conduct marketing/sales activities and events in common areas of healthcare facilities, (e.g., conference rooms and recreation rooms).
- Provide a nominal gift and refreshments to attendees with no obligation. (See Gifts and Meals section for additional information)
- Distribute approved brochures and enrollment materials.
- Discuss plan specific information (e.g. premiums, cost sharing, or benefits).
- Distribute approved business reply cards, lead cards, and sign-in sheets as long as all required disclaimers are included and the consumer understands that completing any of them is completely optional.
- Hand out business cards.
- Discuss plan specific information (e.g., premiums, cost sharing, or benefits).
- Provide educational content.
- Formally present benefit information to the consumers using a scripted talk, electronic slides, handouts, etc.
- Accept and perform enrollments during a valid marketing and election period.
- Provide a Scope of Appointment (SOA) form for a subsequent personal/individual marketing appointment; if a consumer requests a one-on-one meeting.
- Discuss products on an individual basis, when only one attendee is present at a formal marketing/sales event.

Informal Marketing/Sales Event

Agents must be licensed, contracted, appointed (if applicable), and certified in order to staff an informal marketing/sales event. In addition to the previous guidelines, the following guidelines apply to informal marketing/sales activities.

Agents Must

- Report in bConnected a start and end time to the event and staff the event during the entire reported event time.
- Post a visible notice, indicating the time of return, when leaving the event unattended for any reason (e.g., lunch break, assisting another consumer).
- Post the dates an agent will be onsite if recurring events are scheduled.
- Ensure that all required materials and benefits are covered with a consumer should they decide to enroll.

Agents Must Not

- Conduct an event in such a way as to obstruct the consumer's entrance or exit from the venue or to give any impression that attending the event is a requirement to visiting the venue.
- Approach consumers in common areas (e.g., parking lots, hallways, lobbies, sidewalks). Consumers must initiate contact with the agent.

- Move or relocate a kiosk/booth/table from the plan-designated location within the reported venue a and/or position a kiosk/booth/table within 20 feet of a pharmacy counter.
- Leave the event unattended when time is advertised or posted that the agent will be available.

Agents May

- Wait behind the booth/table for a customer to request information.
- Answer questions about UnitedHealthcare plans and products.
- Distribute and collect Enrollment Applications.
- Provide refreshments if permitted by venue.

UnitedHealthcare MedicareStore and Resource Centers

A UnitedHealthcare MedicareStore/UnitedHealthcare Resource Center is a physical and more permanent UnitedHealthcare space, in a local market with a location for consumers and members to meet with UnitedHealthcare agents. Consumers and members can have questions answered, review new benefits, and/or enroll. Formal and/or informal marketing/sales events may take place at these venues.

UnitedHealthcare MedicareStore/UnitedHealthcare Resource Centers are managed by the Venue Management Team and are considered a UnitedHealthcare office. In addition to all other regulations, rules, policies, and procedures related marketing/sales activities, the following guidelines apply:

- Days and hours of operations must be reported in bConnected. However, when operated as a UnitedHealthcare office, the activity is not considered a marketing/sales event.
- Agent must obtain a Scope of Appointment (SOA) prior to discussing any Medicare Advantage and/or Prescription Drug Plan with consumer who visit the UnitedHealthcare MedicareStore.
- A SOA may be obtained immediately prior to plan discussion in the event of a walk-in.
- If a formal or informal marketing/sales event takes place within a UnitedHealthcare MedicareStore, all guidelines, regulations, rules, policies, and procedures related to marketing/sales events apply.

A UnitedHealthcare Resource Center is also known as an enrollment center. A resource center is considered an informal marketing/sales event. All rules applicable to informal marketing/sales events, including event reporting apply to a resource center.

Nominal, Promotional, and Reward Gifts and Meals

Nominal, promotional, and reward gifts are the three types of gifts that the Centers for Medicare & Medicaid Services (CMS) recognizes for marketing/sales activities.

The agent may offer promotional gifts to consumers at all marketing/sales activities as long as the gifts are of nominal value and are provided to the consumer regardless if they choose to enroll or not. Nominal retail value is defined as an individual item/service worth $15 or less (based on the retail value of the item).
The nominal value rule applies to gifts, rewards, incentives, and snacks. A nominal value requires that the following rules must be followed when providing gifts:

- Gifts must not be items that are considered a health benefit (e.g., a free checkup, health screening, hearing test, blood pressure checks, and cholesterol checks).

- The nominal value of the promotional gift is determined by its retail value and the aggregate value of all gifts and food items and may not exceed $15 per consumer or less with a maximum aggregate of $50 per consumer, per year.
- If a nominal gift is one large gift that is enjoyed by all in attendance (i.e., a concert), the total retail cost must be $15 or less when it is divided by the estimated attendance. For planning purposes, anticipated attendance may be used, but must be based on venue size, response rate, or advertisement circulation.
- Nominal gifts may not be in the form of cash or other monetary rebates. Cash gifts are prohibited even if their worth is less than $15. Cash gifts include charitable contributions made on behalf of a consumer and gift certificates or gift cards that can be converted to cash, regardless of dollar amount.
- The agent must provide any and all disclaimers if the gift is in the form of a prize, drawing, or raffle. For example:
  - "Eligible for a free drawing and prizes with no obligation."
  - "Free drawing without obligation."
- Additionally, the drawing or raffle mechanism must not require the consumer to provide personal contact information.
- Promotional items may include the plan names, logos, toll-free customer service numbers and/or websites

Meals may not be provided during a marketing/sales event or when any marketing/sales activity is performed, even if the meal is not sponsored by the plan and is a normal activity in that location (e.g., soup kitchen, senior center). Meals may be provided at educational events, but the cost of the meal must comply with the nominal gift requirement.

- Providing alcoholic beverages at any event is prohibited
- Agents may provide light refreshments or snacks at marketing/sales events, as long as they are permitted by the venue, but cannot bundle them in a manner that would constitute a meal.
- The aggregate nominal retail value of food items in combination with any other gift may not exceed $15 per consumer.

Additional rules for providing gifts to consumers at marketing/sales activities and events.

- Must be worth $15 or less with a maximum aggregate of $50 per person, per year.
- Must be offered to all consumers regardless of enrollment and without discrimination.
- Must not consist of lowering or waving co-payments.
- Gifts may not be items that are considered a health benefit (e.g., a free check-up).
- Cash gifts are prohibited. Cash gifts include any form of monetary rebate, charitable contributions made on behalf of the consumer, gift certificates, and gift cards that can be readily converted to cash.

Agents are allowed to provide refreshments and lights snacks. Agents must use their best judgment on the appropriateness of food products provided and must ensure that items provided could not be reasonably considered a meal and/or that multiple items are not being bundled and provided as a meal.
Meals may be provided at educational events, provided the event meets CMS strict definition of educational.

Agents are recommended to maintain invoices of any give-aways so they can validate the cost versus retail value if they are ever asked to confirm the cost.

Provider-based Activity at a Marketing/Sales Activity or Event

A provider includes, but is not limited to physicians, staff, hospitals, nursing homes, pharmacies, and vendors contracted with the plan to provide services to plan members, and subcontractors.

Providers at a marketing/sales event may:

- Provide general health information
- Refer to their affiliation with the plan, but should not provide additional information (e.g., why they contracted with the plan).
- Discuss their practice in generic, factual terms such as name, clinic affiliation, and areas of medical expertise as it relates to the topic being discussed.
- Leave information about their practice on tables for consumers to take. There must be a physical separation between provider material and plan material.

Providers at a marketing/sales event must not:

- Promote health plans or events.
- Distribute sales materials or assist with enrollment activities (including collecting Enrollment Applications).
- Speak to or answer questions related to UnitedHealthcare plans, plan benefits, or pricing.
- Provide any health screenings or tests.
- Discuss specific products/services or how the products/services relate to plan or plan benefits.
- Actively promote their practice (e.g., distribute business cards), but may passively promote their practice by leaving material for a consumer to take.
- Use superlatives when discussing their practice or the plan.
- Directly accept compensation for attending events.
- Give any gifts or services to consumers.
- Accept appointments for future clinical services while a guest at an event.
- Sell products or offer demonstration devices that consumers can take with them.

Tribal Lands Marketing

Tribal land is sovereign. As the Bureau of Indian Affairs explains, “Tribal sovereignty ensures that any decisions about the tribes with regard to their property and citizens are made with their participation and consent. Tribes, therefore, possess the right to form their own governments; to make and enforce laws, both civil and criminal; to tax; to establish and determine membership (i.e., tribal citizenship); to license and regulate activities within their jurisdiction; to zone; and to exclude persons from tribal lands.” (Reference: http://www.bia.gov/FAQs/index.htm.)

Prior to conducting marketing/sales or educational activities on tribal land, the agent must:

- Familiarize themselves with the customs and instructions of the tribe as they pertain to such activities and
- Contact tribal elders to confirm custom and instructions, as well as to receive permission to market, sell, or conduct educational activities.

In addition, agents must also adhere to all other applicable federal, state, and UnitedHealthcare rules, regulations, guidelines, and policies and procedures when marketing, selling, or conducting educational activities on tribal land.

A personal/individual marketing/sales appointment, that requires a signed Scope of Appointment form and is not considered a sales event for the Centers for Medicare & Medicaid Services (CMS) reporting purposes.

A marketing/sales event is defined by the following characteristics:

- The range of plan information which may be provided to the consumer, including any discussions of plan benefits.
- The ***proactive*** way in which plan information may be presented to the consumer.
- The Plan's ability to ***collect Enrollment Applications*** and ***enroll*** consumers during the event.
- The event is open to the general public and to all Medicare eligible consumers.
- Plan sponsors must submit all sales scripts and presentations for approval to UnitedHealthcare for CMS approval prior to their use during a marketing/sales event.

The presenting agent is required to announce at the beginning of both formal and informal marketing/sales events, their name, the company name, and ***all*** products that will be covered during the marketing/sales event.

Event Reporting

Event Reporting Process

All educational or marketing/sales events, formal and informal, must be reported.

- All events, educational or marketing/sales, formal or informal must be reported to UnitedHealthcare (via bConnected) as soon as they are scheduled and prior to advertising, and no less than 14 calendar days prior to the date of the event.
- Report all events in bConnected through the Administration drop-down tool. Refer to the bConnected Community Meeting (Formal Marketing/Sales Event) and Venue Management Job Aid, located in the Help tab in bConnected, for step-by-step procedures on entering and editing venues and meetings.
  - ~ External Distribution Channel (EDC) agents without access to bConnected must utilize the *Sales Event Form* available on the Distribution Portal to report events.
  - ~ The completed *Sales Event Form* must be emailed to the Producers Help Desk (PHD) at PHD@uhc.com (the subject line should contain the agent's Writing ID number, available 24 hours).
  - ~ The agent is responsible for ensuring that the event is submitted to the PHD to submit within the 14 calendar day reporting requirement (a minimum of seven calendar days is recommended).
- Each informal marketing/sales event (e.g., kiosk, booth) shift must be reported separately with a start and end time.
- The agent who will conduct the event must be identified and listed as the Event Contact in bConnected.

- Agents who fail to report events or do not report events prior to advertising within 14 calendar days of the date of the event are subject to corrective and/or disciplinary action.
- All events are subject to Secret Shopping by UnitedHealthcare, CMS, and/or AARP.

Request for American Sign Language (ASL) Interpreter

Upon reasonable request by a consumer, UnitedHealthcare will provide a sign language interpreter at formal marketing/sales events or personal/individual marketing/sales appointments.

- There is a drop down field in bConnected when entering and reporting Formal Marketing/Sales Events to indicate a consumer's request for a sign language interpreter.
  - ~ A national vendor provides the interpreters.
  - ~ The agent must use UnitedHealthcare's national vendor to ensure a qualified sign language interpreter as well as Protected Health Information (PHI) and Personally Identifiable Information (PII) protection through the vendor contract.
  - ~ A 14 calendar day notice is required to guarantee an interpreter; notices within 14 calendar days may not be able to be satisfied.
- UnitedHealthcare will make a reasonable attempt to schedule an interpreter to be present at the requested formal marketing/sales event or personal/individual marketing appointment (e.g. in-home) if all business requirements are met including confirmation of the date and time of the consumer's attendance by the agent.
- To cancel an interpreter request, the contact must be closed in bConnected. Cancellation with less than three business days notice will be billable for the scheduled event/appointment duration or a two-hour minimum.
- The presenting agent will receive a confirmation call within 72 hours of request to the phone number on record in bConnected.
- EDC agents who do not have access to bConnected should work through their EDC to secure an interpreter.

Making Changes to a Reported Event

- All changes to an event must be entered in bConnected as soon as they are realized, but no later than three business days prior to the scheduled start of the event.
- Changes may include updates, corrections, and cancellations (see following section on requirements to cancel a reported event).
- If the "Sent to Marketing" box is checked, the entry is locked and the Producer Help Desk (PHD) must be utilized to report the change.
- If the "sent to Marketing" box is not checked, theagent must immediately make the changes in bConnected.
- EDC agents without access to bConnected must utilize the *Sales Event Form* available on the Distribution Portal to report events.
  - ~ The completed *Sales Event Form* must be emailed to the Producer Help Desk (PHD) at PHD@uhc.com (the subject line should contain the agent's Writing ID number, available 24 hours).
  - ~ The agent is responsible for ensuring that the event is submitted to the PHD to file within the three business days requirement (a minimum of seven calendar days is recommended).
- If a change must be made within three business days of the start time, the agent must immediately contact his/her manager or supervisor to discuss any required actions.

- The agent manager/supervisor is responsible for ensuring any necessary changes are made to reported events upon termination of an agent.

Cancellation of a Marketing/Sales Event

Every effort should be made to avoid cancelling a reported event. If possible, another agent should be utilized to conduct the event. Cancelling an event within three business days of 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.

A change in venue, date, and/or start time of a Marketing/Sales Event is considered a cancellation. All cancellation requirements apply.

Marketing/Sales Event Cancellation Process

- The agent should avoid changing or cancelling a marketing/sales event once it is reported.

- If a change to the venue, date, and/or time or an event cancellation is unavoidable a sales manager/supervisor approves the cancellation request determine if the "Sent to Marketing" box has been checked in bConnected.

- If the "Sent to Marketing" box has been checked:
  - ~ The agent must fill out a *Sales Event Form*
  - ~ Email the completed *Sales Event Form* as an attachment to the Producer Help Desk (PHD) at PHD@uhc.com (the subject line should contain the agent's Writing ID number, available 24 hours).
  - ~ The PHD will arrange for the marketing/sales event to be cancelled in bConnected.
  - ~ The agent is responsible for ensuring the cancellation request was submitted to the PHD (a minimum of seven calendar days is recommended) with sufficient time to meet the three business days requirement.

- If the "Sent to Marketing" box has not been checked, the agent must immediately make the changes or cancellation in bConnected.

- The agent manager/supervisor is responsible for ensuring any necessary cancellations are made to reported events upon termination of an agent.

Events may not be cancelled within three business days of the scheduled start of the event. In such cases, agent should immediately contact his/her direct manager or supervisor to arrange for another agent to attend the event.

Marketing/Sales Event Cancellation Notification Requirements

Notification of a cancelled marketing/sales event should be made, whenever possible, more than seven calendar days prior to the originally scheduled date and time. The following items describe the agent's requirements depending upon the length of time between the date/time of cancellation and the date/time of the originally scheduled event:

- The agent is required to notify all consumers that RSVP'd to the event that the event has been cancelled (only consumers who provided Permission to Call (PTC) can be contacted by telephone).
- If the event has been advertised by any means, the agent is responsible for communicating the change/cancellation of the event through the same means. For example, if the event was advertised through a newspaper advertisement, the change/cancellation must also be advertised through the same newspaper. If it is not feasible to advertise the change/cancellation through the same means, the agent is responsible for working with their manager/supervisor on appropriate notification.
- 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 within seven days of 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 for at least thirty minutes after the scheduled start time to advise anyone arriving for the event of the change/cancellation and redirect him or her 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.
- Agents who fail to cancel an event and/or fail to be at the site (or secure another plan representative to be at the site) of cancelled event, may be subject to corrective and/or disciplinary action up to and including termination.
- If consumers are notified of cancellation more than seven calendar days before the event, then there is no expectation that a representative of the plan should be present at the site of the event.

If the cancellation is due to inclement weather, arrange with the venue to post signage indicating cancellation.

Marketing to Consumers with Individual Impairments or Disabilities

UnitedHealthcare is devoted to serving our consumers with integrity and sensitivity. The agent is responsible for ensuring that all regulations, policies, and/or procedures are complied with when conducting marketing activities with any consumer with a linguistic barrier and/or disability.

The agent is expected to correctly handle situations where they are unable to accommodate the consumer's need(s) due to a linguistic barrier and/or a disability. If you are unable to accommodate the consumer's needs, you must request to reschedule the appointment in order to be able to better prepared to meet the consumer's needs.

Agents may not discriminate based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location.

Consumers with Linguistic Barriers

Written Materials

In accordance with the Centers for Medicare & Medicaid Services (CMS) and UnitedHealthcare policies, the UnitedHealthcare Marketing Department and Regulatory Affairs Department will review the demographic area (county) in which a Medicare Advantage (MA) plan is offered and determine the primary language(s) of the area.

Materials are available for agents to order or copy from the Distribution Portal; often in multiple languages to accommodate the requirements of each service area demographic.

The Multi-Language Insert is a CMS required document that contains information translated in to multiple languages (e.g., Spanish, Chinese, Tagalog, French, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, and Japanese). This document cannot be modified except to include additional language.

> The Multi-Language Insert that is included with the Summary of Benefits and the ANOC/EOC states, "We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter just call us at 1-xxx-xxx-xxxx. Someone who speaks (language) can help you. This is a free service."

Written Materials (Medicare Advantage Plans)

- If UnitedHealthcare is required to provide the Summary of Benefits, Enrollment Application (including Statement of Understanding), and the Evidence of Coverage in an alternative language for an identified geographic area, approved materials will be available through the agent website. Sierra managed plans materials are available on the Distribution Portal. For agent materials not on the Distribution Portal, the agent materials will be available through the Sierra Sales Department. Care Improvement Plus plan materials are available on the Distribution Portal. There will be links on the Distribution Portal and the Care Improvement Plus agent portal to access the portal needed without leaving the site the agent is currently using.
- Agents requesting the development of custom materials or the approval of materials to be translated for a specific linguistic purpose must submit a request using the Agent Marketing Exception Request Form found on the Distribution Portal (Product Information and Materials>Materials>Sales Materials>Agent Toolkit>Toolkit Customer Support>Agent Marketing Exception Request Form). For Sierra managed plans, requests for custom materials should be submitted to the Sierra Sales Department.

Translation / Interpreter Services

If the consumer requests a language other than English and/or is having difficulties understanding the conversation in English, the agent should utilize the one of the following resources:

- The consumer may be accompanied by an individual who can translate/interpret for the information and/or materials

- The agent may enlist the assistance of a bilingual UnitedHealthcare employee.
  - ~ The use of a third-party individual who is not an employee of UnitedHealthcare or an approved language translation vendor is prohibited.
- Contact the PHD and request translation services.

If the consumer prefers to communicate in a language other than English, you should ensure the consumer's preference is indicated in the appropriate field on the Enrollment Application.

Consumers with Disabilities

Upon request, the agent is required to make available and provide basic consumer information to consumers with disabilities. To ensure compliance and sensitivity the agent must abide by the following policies.

Hearing Impaired:

- Members Services makes available a TDD/TTY line to respond to marketing and membership questions from hearing impaired individuals. The TDD/TTY telephone number will be listed on the Enrollment Application per the Centers for Medicare & Medicaid Services (CMS) requirements.
- The agent should provide a complete sales packet in writing enabling the consumer to read the materials.
- The agent should work directly with the consumer's responsible party or the person that may be assisting the consumer.
- Upon reasonable request by a consumer as set forth below, an American Sign Language (ASL) interpreter will be provided at a formal marketing/sales event or personal/individual marketing appointment.
- The agent may request an ASL Interpreter (See Request for American Sign Language (ASL) Interpreter section).

Vision Impaired:

The agent may:

- In the presence of a witness, read the complete Pre-Enrollment Sales Kit verbatim to the consumer.
- Provide a complete Pre-Enrollment Sales Kit to the consumer's Power of Attorney (POA), authorized representative, or responsible party to allow that person to assist the consumer.
- Provide the consumer with the Customer Service telephone number provided with the complete sales packet to request any enrollment and benefit information in an alternate format. The requested material is provided at no charge to the consumer.

Physically Impaired:

The agent is required to ensure that event sites are accessible to a physically impaired consumer. If the event site is not handicap accessible, the event must be rescheduled or cancelled until a handicap accessible location is found. It is recommended to choose a location that is Americans with Disabilities Act (ADA) compliant. The following are accessibility features to consider when selecting a site:

- Ramps and/or elevators as an alternative to stairs.
- Handrails along stairways and/or ramps.

- Appropriate lighting and noise levels.
- Appropriate seating options (e.g., not just booths or stools, include stand-alone chairs and tables).
- Handicap or senior parking near entrances.
- Doors that open automatically or a resource available to welcome and assist the consumer.
- Restrooms which include handicap stall options.
- Walkways, entrances, and hallways that are clear and dry.
- Appropriate clearance in aisles and between rows for wheelchair clearance.

Cognitively Impaired

Agents are required to work with the consumer's Power of Attorney (POA), authorized representative, or responsible party if there is any question about the cognitive ability of the consumer. The agent should be aware that cognitively impaired consumers may live independently or within a residential facility.

Lead Generation

Overview

The agent is expected to adhere to the Centers for Medicare & Medicaid Services (CMS) regulations, state and federal laws, guidelines, and UnitedHealthcare rules, policies, and procedures when receiving leads, setting appointments, and meeting with consumers to discuss the UnitedHealthcare Medicare Solutions portfolio of products. The agent must advise the consumer of the products that will be discussed at the future appointment, secure consumer agreement on a Scope of Appointment (SOA) form 48 hours prior to the appointment, and follow procedures for submitting and retaining the form.

The agent may not discuss or leave Pre-Enrollment Sales Kit related to products not previously agreed upon with the consumer in the Scope of Appointment (SOA). Cross-selling of non-healthcare related products is strictly prohibited.

Guidelines for Direct Contact with Consumers

Unsolicited contact with a consumer is prohibited. Permission to Call (PTC) must be secured prior to making contact with the consumer and renewed in order to make on-going contact.

- Unsolicited contact includes in-person (e.g. door-to-door marketing), telephonic (e.g. outbound telemarketing), email, leaving electronic voicemail messages on answering machines, and text messaging. Postal mail is not considered unsolicited contact.

- Permission to Call (PTC):
  - ~ Is given by the consumer to be called or otherwise contacted – including in-person, telephonic, text message, leaving electronic voice messages and email contact.
  - ~ Is to be considered limited in scope, event-specific, and may not be treated as open-ended permission for future contacts.
  - ~ In the absence of renewed and documented PTC, previously provided permission expires 90 days after the date received if the consumer is on the federal Do-Not-Call-Registry or nine months after the date received.

~ Must be documented (in bConnected, if available to the agent) and kept on file and available upon request for the remainder of the selling year plus ten additional years and should be updated with each contact with the consumer.

- In the absence of document PTC, the following are examples of prohibited unsolicited contact:
  ~ Approaching a consumer in a common area such as a parking lot, hallway, lobby, or sidewalk.
  ~ Depositing marketing materials (e.g., flyer, door hanger, leaflet) outside a residence, under a door to a residence, on a vehicle, or similar.
  ~ Telephoning or emailing a consumer whose contact information was gained from a consumer referral, or purchased lead list.
  ~ Follow up contact via telephone or email with a consumer who attended a marketing/sales or educational activity/event or to whom a marketing item was mailed, even if the consumer requested the item.
  ~ Contacting, for the purpose of marketing a product or plan a consumer identified in bConnected as a contact with whom the agent does not have a relationship, unless delegated PTC has been provided by UnitedHealthcare.
  ~ Contacting, for the purpose of marketing a product or plan, any former member who disenrolled or current member in the process of voluntarily disenrolling.

PTC must be obtained and appropriately documented in order to contact the consumer in-person or by telephone, email, or text. Contact is always limited to the scope of products and timeframe contained within the documented permission.

When PTC is documented, acceptable forms of contact include:

- Consumers who have initiated (solicited) contact by the following means may be contacted:

  ~ The consumer made an inbound telephone call, gave permission for an agent to call, and the PTC was documented. Any subsequent discussion with the consumer must be limited to the product(s) identified in the PTC.
  ~ The consumer returned a business reply card or submitted an online contact form granting PTC. Any discussion with the consumer must be limited to the products advertised on the business reply card or in the contact form.
    1. Telephonic contact is prohibited if the consumer did not provide a telephone number and/or the telephone number provided is invalid.
  ~ The consumer submitted an online contact form. Any subsequent discussion with the consumer must be limited to the product(s) identified in the PTC.
  ~ The consumer requested a Pre-Enrollment Sales Kit either in-person at a sales event, online, telephonically, or by business reply card; gave permission for an agent to call; or the permission has been documented. Any subsequent discussion with the consumer must be limited to the product(s) identified in the PTC.

- Plan sponsors (UnitedHealthcare) may contact any existing UnitedHealthcare member, who meets the following criteria:
  ~ A commercial member who is aging-in
  ~ A Medicare Advantage (MA) or Part D member to discuss other MA or Part D products
  ~ A Medicare Supplement plan member to discuss MA or Part D products
  ~ Medicaid members enrolled in a UnitedHealthcare product.

- An agent, who is not the Agent of Record (AOR), is only permitted to call an existing member in one of the following categories if PTC has been delegated to the agent:
  - ~ Delegation of PTC occurs when the plan sponsor (UnitedHealthcare) provides the member's contact information (e.g., a lead) to the agent.
  - ~ The agent is only permitted to use the member's Protected Health Information and Personal Identifying Information (PHI/PII) to the extent necessary to conduct business on behalf of the plan sponsor (UnitedHealthcare).
  - ~ Any other use of PHI/PII obtained through delegated PTC is prohibited.

- Agents may contact their current clients with whom they have a current, active contract or business relationship in other products (Example: In-Force Life Policy, Homeowners, or Dental Insurance).
  - ~ If the agent is in the process of establishing a new relationship, PTC must be obtained and documented.

- Prohibited telephonic activities include, but are not limited to the following:
  - ~ A commercial member who is aging-in
  - ~ A Medicare Advantage (MA) or Part D member to discuss other MA or Part D products.
  - ~ A Medicare Supplement plan member to discuss MA or Part D products.
  - ~ Medicaid members enrolled in a UnitedHealthcare product.
  - ~ Bait-and-switch strategies – making unsolicited calls about other business as a means of generating leads for Medicare plans.
  - ~ Calls based on referrals. If an individual would like to refer a friend or relative to an agent or plan sponsor, the agent or plan sponsor may provide contact information such as a business card that the individual may give to the friend or family member. In all cases, a referred individual needs to contact the plan or agent/broker directly.
  - ~ Calls to former members who have disenrolled, or to current members who are in the process of voluntarily disenrolling, to market plans or products. Members who are voluntarily disenrolling from a plan should not be contacted for sales purposes or be asked to consent in any format to further sales contacts.
  - ~ Calls to members who attended a sales event, unless the member gave express permission at the event for a follow-up call (including documentation of permission to be contacted).

Scope of Appointment

Scope of Appointment –Personal/Individual Marketing Appointment Initiated by Agent

The agent must advise and get an agreement from the consumer, including current members, of the Medicare Advantage (MA) and/or Prescription Drug Plan (PDP) products that will be discussed during a scheduled personal/individual marketing appointment.

A Scope of Appointment (SOA) form is not required at marketing/sales events since the scope of products has been defined through advertisement and announced at the beginning of the event. Any follow-up or secondary personal/individual appointments with the consumer after an event requires a Scope of Appointment form.

A SOA is required for personal/individual sales appointments where the agent intends to present MA and/or PDP products. The completed SOA is required to be obtained 48 hours prior to the appointment. A SOA may be sent to a consumer via postal mail, fax, or email (permission to email must be obtained and documented). Situations that require a completed SOA include but are not limited to:

- A completed SOA form is required for any personal/individual marketing appointment for any MA and/or PDP plan.
- A completed SOA form is required from each attending Medicare-eligible consumer.
  - ~ If the agent's appointment is with a husband and wife the agent must obtain a SOA form from both consumers.
- A new SOA form is required for any and all subsequent face-to-face personal/individual marketing appointments; even to discuss previously discussed products.
- If setting a future or second appointment, the agent must fill in all required fields on an approved SOA form, identify all products that might be discussed with the consumer at the future appointment, and secure the consumer's agreement to discuss the identified products.
  - ~ Send the consumer the SOA form to the consumer for signature and receive it back from the consumer prior to the appointment.
  - ~ The future or second appointment cannot occur within 48 hours of the initial appointment.
- In certain circumstances, an exception can be made when obtaining the consumer's signature in advance of the meeting is not feasible the agent may secure the consumer's signature in-person immediately prior to the start of the appointment. Indicate on the form the reason why the signature could not be obtained in advance.

Scope of Appointment (SOA) - Consumer-Initiated Situations

There are specific situations that allow or require the agent to complete a SOA form and secure the consumer's signature at the time of the appointment. The agent must note on the form the particular situation (e.g. walk-in). Situations in which the 48 hour waiting period is waived and the SOA form must be signed before the meeting may begin include:

- A consumer walk-in to an agent office.
- A consumer visits a MedicareStore/Resource Center. All SOA rules apply at a MedicareStore and Resource Center if there is any discussion of plan benefits. The SOA should indicate a walk-in and why the SOA was received less than 48 hours in advance.
  - ~ If the Resource Center was reported to CMS as an informal marketing/sales event, a SOA should not be obtained.
- An unexpected Medicare eligible consumer is in attendance at an otherwise properly solicited, scheduled, and documented appointment.
- The **consumer requests** the presentation of previously unidentified and agreed upon Medicare Advantage or Part D product, at an otherwise properly solicited, scheduled, and documented appointment.

- The consumer requests an individual meeting following a marketing/sales event presentation that is held at another location and/or at a different time.
- In the UnitedHealthcare contracted skilled nursing facility, the SOA form can be signed at the beginning of a meeting held in a common area. A meeting held in a resident's room must follow the same rules as agent initiated meetings described previously.

Scope of Appointment (SOA) Expiration

- A SOA is valid until used or until the end of the applicable election period. For example, on October 1 an agent schedules an appointment for October 16 and mails a SOA to the consumer. The consumer signs the SOA and the agent receives it back on October 8. On October 15, the consumer calls and reschedules the appointment for October 17. On October 17, the agent and consumer meet. The SOA sent out October 1 and received October 8 is valid for the October 17 appointment.

- A SOA must not be confused with PTC**.** The SOA does not give the agent permission to contact the consumer after the meeting. PTC should be renewed with the consumer with every contact. In addition, a SOA may be enclosed in a direct mail campaign (in the same envelope), but the PTC would need to be documented and established separately.

Scope of Appointment (SOA) Form Submission and Retention Requirements

All SOA forms must be retained, including those for cancelled or rescheduled appointments, consumer no-shows, or appointments that do not result in a consumer enrollment, and made available upon request. It is the agent's responsibility to submit his/her SOA forms for electronic storage in UnitedHealthcare's centralized document management system.

Submission Requirements

The following guidelines apply to the submission of SOA forms:

- SOA forms must be faxed (866-994-9659) within 2 business days following the appointment. **Do not** submit the SOA form with an Enrollment Application or submit a hardcopy.
- The SOA form may be a multi-page document. ***All*** pages must be submitted.
- Forms from more than one appointment and/or consumer can be combined in a single fax. However, if an office manager/sales coordinator is submitting forms on behalf of several agents, each agent's forms must be sent in a separate fax.
- Faxed forms should include a coversheet that contains the agent's writing ID, number of pages included, and a contact name and telephone number. Note: Writing on the SOA form except in the provided blanks is prohibited per CMS regulations.

Retention Requirements

In addition to submitting SOA forms for electronic storage in a centralized document management system, the agent is required to retain and store a copy of the SOA forms for a minimum of ten years from the date of the appointment. The agent must be able to provide a SOA within 48 hours of request.

48 Hour Cooling Off Period

Scope of Appointment (SOA) cooling off period:

At an appointment, agents are not to discuss or conduct marketing activity related to a healthcare product not previously identified and agreed upon by the consumer at the time the appointment was originally scheduled.

If, however, the **consumer requests** the presentation of a plan type not previously agreed upon, such as a Medicare Advantage (MA) and/or Prescription Drug Plan (PDP) product, the agent must secure a new SOA and then can proceed with the discussion. If during an appointment **the agent determines** that a MA or PDP outside of the original SOA may be a better fit, the following would apply:

- A future appointment may be scheduled to discuss the newly identified healthcare related product as long as the new appointment is no less than 48 hours in the future from the present appointment. A new SOA will need to be immediately obtained for the future appointment.
- A new SOA form must be completed, signed by the consumer, and filed for the future appointment scheduled to discuss the newly identified healthcare related product.
- A Pre-Enrollment Sales Kit may be left with the consumer. No discussion or related marketing activity may be conducted.
- Although cross-selling of non-healthcare related products during a marketing activity related to Medicare Advantage (MA) or Part D is strictly prohibited, the 48 hour cooling off period does not apply to follow-up appointments for non-healthcare related products. Marketing materials for the non-healthcare related products may not be left with the consumer during a marketing activity related to MA or Part D.

Product Cross-Selling

Marketing of non-healthcare related products, such as annuities and life insurance, during a personal/individual appointment is considered cross-selling and is a prohibited activity. Under no circumstance can an agent to market or sell a non-healthcare related product during the marketing of a Medicare Advantage or Part D plan. Examples of non-healthcare related products include life, annuities, and final expenses insurance. It is permissible to market healthcare related products during marketing activity for Medicare Advantage or Part D plans. Examples of healthcare related products include Medicare Supplement insurance, medical, dental, prescription, and hospital indemnity. These guidelines apply to both personal/individual marketing appointment and marketing/sales events.

Provider-Based Activities

A provider includes, but is not limited to physicians, staff, hospitals, nursing homes, pharmacies, and vendors contracted with the Plan to provide services to plan members.

- Providers are subject to CMS regulations and guidelines.
- Providers are subject to fines and penalties for violating CMS regulations and guidelines.
- Providers can be audited because of contracted relationship with the Plan.

Providers should remain neutral parties in assisting plan sponsors with marketing to consumers or assisting with enrollment decisions. Providers may not be fully aware of all plan benefits and costs, which could result in consumers not receiving all required information to make an informed decision about their health care options.

Providers may:

- State the names of all of the plans with which they contract and/or participate.
- Assist their patients who are applying for Low Income Subsidy (LIS) assistance.
- Make available and/or distribute plan marketing materials (not including Pre-Enrollment Sales Kits) in non-patient care areas, including plan affiliation materials for a subset of contacted plans as long as providers offer the option of making available and/or distributing marketing materials from all plans in which they participate.
- Share objective information regarding UnitedHealthcare plans and specific pharmacy formularies based on the patient's health care needs and medications.
- Make available and/or distribute plan marketing materials including Prescription Drug Plan (PDP) Enrollment Applications, except Medicare Advantage or Medicare Advantage-Prescription Drug Enrollment Applications for all plans with which the provider participates.
- Refer their patients to other sources of information, such as State Health Insurance and Assistance Programs (SHIPs), plan marketing representatives, State Medicaid Office, local Social Security Office, and CMS.

Agents may not engage providers to do the following on behalf of the agent:

- Offer Scope of Appointment forms, call an agent on behalf of a consumer to schedule a sales appointment, or invite a consumer to a marketing/sales event.
- Distribute or accept Enrollment Applications for Medicare Advantage/Medicare Advantage-Prescription Drug plans or Prescription Drug Plans.
- Make phone calls, direct, urge, or attempt to persuade consumers to enroll in a specific plan based on financial or any other interest of the provider.
- Mail marketing materials on behalf of a plan or agent.
- Offer anything of value to induce consumers/members to select them as their provider.
- Offer inducements to persuade consumers to enroll in a particular plan or organization.
- Participate in any enrollment activities on behalf of or with the agent.
- Accept compensation directly or indirectly from the plan or agent for conducting consumer marketing/sales activities.
- Identify, provide names, or share information about existing patients with the plan or agent for marketing/sales purposes.
- Distribute marketing materials, including agent business cards, within an exam room setting.
- Accept business reply cards (BRC) on behalf of the agent.

- Collect Scope of Appointment (SOA) forms from consumers
- Steer or attempt to steer a consumer/member toward a particular agent or agency

Providers must remain neutral parties in assisting plan sponsors with marketing to consumers or assisting with enrollment decisions.

Agents may not steer or attempt to steer a consumer/member toward a particular provider, or limited number of providers based on the financial interest of the provider and/or agent.

Quick Reference Guide: Compliant Sales Practices

The following Quick Reference Guide provides compliant sales practices based on the activity or subject matter. The Quick Reference Guide may also be found in PDF format under the Resource Center tab on the distribution portal.

This document is an agent resource that provides an abbreviated listing of compliance guidelines. It is not an all-inclusive listing of applicable federal and state regulations and UnitedHealthcare rules, policies, and procedures that apply to the marketing and sale of UnitedHealthcare Medicare Solutions products.

Licensure, Appointment and Certification

In order to sell Medicare products, plan sponsors must comply with applicable State licensure and/or appointment laws. An agent must be licensed, appointed (if applicable), and certified (fully credentialed) in order to solicit and sell the UnitedHealthcare Medicare Solutions portfolio of products.

Risk of Non-Compliance

The consumer could be enrolled in an unsuitable plan if an agent has sold a plan whereby he/she has not been properly trained. Agents can be quickly terminated for having either represented, or having sold a product they are not qualified to sell; violating standards within the Operational Behavior Allegation Family.

Do's

- Be licensed and appointed (if applicable) in the state(s) you intend to conduct marketing/sales activities.
- Complete and pass required certification training and testing, including product training and testing each year on the Centers for Medicare & Medicaid Services (CMS) and UnitedHealthcare rules and regulations prior to selling.
- Check the system periodically to make sure your current status is up to date and displayed properly.

Do Not's

- Solicit or enroll consumers in a product you are not licensed, appointed or certified to sell.
- Sign or enter your agent writing number for an Enrollment Application when the agent did not assist with the enrollment.

Certification Courses

Prerequisite Modules:

- Medicare Basics
- Ethics and Compliance
- AARP 101

Product Modules:

- Medicare Advantage Plans (HMO, POS, PPO)
- Private Fee-for-Service Plan (PFFS)
- AARP Medicare Supplement Plans
- SecureHorizons Medicare Supplement Plans[1]
- Medicare Prescription Drug Plans
- Chronic Illness Special Needs Plans (CSNP)
- Dual Special Needs Plans (DSNP)
- Institutional Special Needs Plans (ISNP)[2]
- Senior Care Options2

[1] Available only to Internal Sales Representatives (ISR)
[2] Available by invitation only

Educational Events

An educational event is an event designed to inform Medicare beneficiaries about Medicare Advantage, Prescription Drug or other Medicare programs and does not include marketing, (i.e., the event sponsor does not steer, or attempt to steer, potential enrollees toward a specific plan or limited number of plans). An educational event is not an event that allows us to 'educate' about plans we sell. Rather its purpose is to offer information generically either on Medicare or all plan types, and also health-related information.

Risk of Non-Compliance

The risk of non-compliance for not following these steps can be a finding against the agent and the plan for marketing at an educational event. Doing so can also violate a Prohibited Activity Allegation of "bait and switch."

Do's

- Use the following disclaimer on all marketing materials that are for educational events, if the agent or plan is sponsoring or co-sponsoring the event: "*This event is only for educational purposes and no plan specific benefits or details will be shared.*"
- Host all Educational Events at public venues.
- Report all Educational Events to UnitedHealthcare prior to the event date or advertised date, whichever is earlier.
- Sponsor or co-sponsor education events and present approved Medicare educational materials.
- Have a banner or table skirt with the plan name and logo displayed.

- Distribute educational materials free of plan-specific information (this include plan-specific premiums, copayments or contact information). An example of an educational material might be the 'Medicare Made Clear' items, or something purely educational about health such as an exercise log.
- Distribute healthcare educational materials (not specific to any plan) on general topics such as diabetes awareness and prevention and high blood pressure information.
- Provide promotional items of combined nominal retail amount not to exceed $15. Promotional items may include the plan names, logos and toll-free customer service numbers and/or websites.
- Wear shirts or jackets with current plan approved logos only.
- Offer a meal (the nominal retail value limitation of $15 applies to meals and would include the retail value of any additional giveaways).
- Provide business cards only if requested by the consumer.

Do Not's

- Attach business cards or plan/agent contact information to educational materials.
- Collect RSVPs for any upcoming sales events.
- Conduct a sales presentation.
- Schedule an Informal/formal Marketing/Sales event that immediately follows an Educational meeting or presentation.
- Discuss or distribute plan-specific benefits, premium information, and materials.
- Distribute and/or collect Enrollment Applications.
- Distribute event fliers or promote future sales/marketing events.
- Collect names, addresses, email address or telephone numbers of consumers.
- Distribute or display business reply cards (BRCs), Scope of Appointment (SOA) forms or sign-in sheets.
- Ask consumers if they want information about a specific plan or limited number of plans.
- Schedule personal/individual marketing/sales appointments or get permission for an outbound call to the consumer.
- Use an educational event to generate leads or appointments.
- Schedule an Educational Event to occur at a consumer's home or at an individual/face-to-face marketing/sales appointment.
- Conduct lead generation activities.
- Wear T-Shirts or buttons that say "Ask me about Medicare" or any similar statement.
- Conduct health screenings or other like activities.

Formal Marketing/Sales Events

Risk of Non-Compliance

Formal marketing/sales events are typically structured in an audience/presenter style with a sales person or plan representative formally providing specific plan sponsor information via a presentation on the products being offered.

Do's

- Complete and pass the Events Basic module. Pay close attention to the things you are required to state aloud during your event.
- Clearly announce your name, your title, the company you represent and the product that will be formally presented at the beginning of every presentation.
- Complete a full, formal sales presentation even if only one consumer or representative of a consumer attends.
- Structure the event in a presenter/audience type style.
- Report all Sales/Marketing Events to UnitedHealthcare prior to the event date or advertised date, whichever is earlier.
- Use only plan approved/CMS approved marketing/sales materials
- Have an Enrollment kit available for all attending consumers. This ensures you will have the required materials available for explaining the plan accurately to a consumer.
- Review the prescription drug benefit including, where to find out what prescriptions are covered, copayments, coinsurance, tiers, coverage gap, pharmacy network and catastrophic coverage.
- Host the event at a public venue. Make sure you explain to consumers, how they can confirm provider network status and offer to help them with this after the event.

Do Not's

- Cross-sell by promoting or displaying materials for non-health related products at Marketing/Sales Events.
- Offer a meal or individual snacks that could be "bundled" as a meal.
- Make any inappropriate, inaccurate or misleading statements.
- Use any superlative statements.
- Use scare tactics or statements that may be interpreted as scare tactics.
- Fail to be present or have a plan representative present at any event filed and not cancelled within 72 hours of the event.
- Advertise a personal/individual or sales/marketing event as educational.
- Provide gift cards, gift certificates, or cash giveaways.
- Conduct health screenings or other like-activities.
- Request or accept a referral.
- Restrict event admission to an exclusive organization membership list or specific social group.

Informal Marketing/Sales Events

Informal marketing/sales events are conducted with a less structured presentation or in a less formal environment. They typically utilize a table, kiosk or a recreational vehicle (RV) that is manned by a plan sponsor representative who can discuss the merits of the plan's products.

Risk of Non-Compliance

Approaching a consumer at an informal event violates a Lead and Contact Issue Allegation of unsolicited contact. Informal events must be more of a passer-by opportunity. Agents need to allow individuals to approach them, rather than vice-versa.

Do's

- Complete and pass the Events Basic module. Pay close attention to the things you are required to state aloud during your event.
- Report all Sales/Marketing Events to UnitedHealthcare prior to the event date or advertised date, whichever is earlier.
- Announce or post signage as to the plan types that will be promoted at Informal Marketing/Sales Events.
- Agents must only promote plans they are certified to sell.
- Host the event at a public venue.
- Greet consumers with a general "Hello" or "Good morning/afternoon."
- Have enrollment kits on-hand. This ensures you will have the required materials available for explaining the plan accurately to a consumer.

Do Not's

- Advertise the events as an Educational event.
- Offer a meal or individuals snacks that could be "bundled" as a meal.
- Provide gift cards, gift certificates, or cash as giveaways.
- Conduct health screenings or other like activities.
- Request or accept a referral.
- Solicit consumers for personal/individual marketing/sales appointments under the premise that the appointment is for education purposes.
- Restrict event admission to an exclusive organization membership list or specific social group.
- Approach consumers.
- Fail to be present or have a plan representative present at any event filed and not cancelled within 72 hours of the event.
- Move or relocate a kiosk or table from the location for which the event is filed.
- Gesture or "call over" consumers to speak with a consumer at an informal event/retail event.
- Describe a catalog benefit, emergency call benefit, or giveaways in a manner that may be perceived as an enticement to enroll or confuse the beneficiary regarding enrollment with the Medicare Advantage plan.
- Leave an event prior to the reported end time.
- Cross-sell by promoting or displaying materials for non-health related products at Marketing/Sales Events.

Required Marketing/Sales Practices

The Plan and CMS require agents to follow specific marketing and sales practices when meeting with consumers and beneficiaries.

Risk of Non-Compliance

There are numerous risks of non-compliance when these steps are not followed accordingly. Violation of any of these required practices can lead to agent termination and the Plan's receipt of a notice of non-compliance.

Do's

- Complete and pass the Events Basic module. Pay close attention to the things you are required to state aloud during your event.
- Clearly announce your name, your title, the company you represent and the products that will be presented at the beginning of each appointment or event.
- Market only health care related products during any Medicare Advantage (MA) or Prescription Drug Plans (PDP) sales activity or presentation.
- Only discuss the products identified on a Business Reply Card (BRC) and/or Scope of Appointment form.
- Announce and identify applicable plan disclaimers.
- Clearly identify that a gift or prize does not obligate a consumer to enroll.
- Clearly inform each consumer in writing of their relationship with the plan they represent, including potential compensation based on the consumer's enrollment.
- Emphasize to a member they are still part of the Medicare program.
- Review the Outbound Enrollment and Verification (OEV) Process with consumers.
- Explain and point out the location of the Multilanguage-Insert and the Star Ratings. (Review the Events Basic Module for specific points you must share about Star Ratings.)
- Review the CMS Statement of Understanding (SOU) located on the back of the Enrollment Application with each consumer.
- Disclose election periods and limitations and understand the Election Period date restrictions.
- Leave each consumer their own copy of the Pre-Enrollment kit along with your agent contact information.
- Review plan provider network limitations, including the need for referrals when applicable, but also check to see if providers are in the contracted network, including specialists, ancillary and home health providers.
- Provide a Scope of Appointment (SOA) form if scheduling additional or future at home or individual/face-to-face marketing/sales appointments.
- Obtain proof of Power of Attorney, where applicable, or ensure the Authorized Representative is present.
- Protect member information (PHI and PII)
- Review participating status of providers, as applicable
- Review current medications and disclose tier, copayment/coinsurance, quantity limits and prior authorization requirements.
- Provide educational material at sales / marketing events

Do Not's

- Plan sponsors must not discriminate based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, generic information, evidence of insurability or geographic location within the service area.
- Knowingly accept an Enrollment Application outside of Elections Periods as set by CMS.
- Market non-health care related products (e.g., life insurance, annuities) at a MA or PDP marketing/sales appointment.

- Return to a home or residence without a newly rescheduled appointment, even after an earlier 'no show' at home appointment.
- Require a consumer to interact with an agent in order to obtain information and/or enroll.
- Require a face-to-face appointment to provide plan information or to enroll a consumer.
- Ask for referrals.
- Sign up a consumer to a plan if he/she has better benefits with their current health plan unless the consumer insists on enrolling.
- Share, store or use member information inappropriately.
- Make disparaging statements about CMS or any competitor plan.
- Charge the consumer a marketing or administration fee.
- Use high pressure sales tactics.
- Use absolute superlatives.
- Example: state this is the best or biggest plan.
- Say a MA or Private-fee-for-Service (PFFS) product is the same as an Original Medicare or a Medigap product.
- Encourage consumers to enroll based on their current health status unless the plan is a Special Needs Plan (SNP).
- Provide any meal or allow an entity to provide or subsidize a meal at any event or meeting in which plan benefits are discussed or materials distributed. (Light snacks are allowed.)
- Accept a lead or appointment to sell that resulted from an unsolicited contact.
- Claim "Medicare," "CMS" or any government agency endorses or recommends the plan.
- Conduct health screenings or other like activities that could give the impression of 'cherry picking.'
- Compare one plan to another without express permission from the other plan.
- Require a consumer's contact information in order to participate in a raffle or drawing.
- Solicit Enrollment Application for a January 1 effective date prior to the start of the Annual Election Period (AEP).
- Fail to be present or have a plan representative present at any event filed and not cancelled within 72 hours of the event.
- Use a catalog benefit, emergency call benefit, or give away in a manner that may be perceived as an enticement to enroll or confuse the consumer regarding enrollment with the Medicare Advantage plan.
- Leave an event prior to the reported end time.
- Conduct an Enrollment through an outbound call.

Marketing Materials

Marketing materials are used to advertise and market the Plans products. These materials could be radio and newspaper ads, direct mail materials and flyers.

Risk of Non-Compliance

One of the most common risks is using marketing materials that have not been approved by the Plan or CMS. This would include the alternation of preapproved materials. Using unapproved marketing materials is a direct violation of the Operational Behavior Allegation Family.

Section 6: How Do I Conduct Educational and Marketing/Sales Activities?

Do's

- Use only approved marketing materials and use only for their original intended purpose.
- Submit self-created materials to the plan for review and approval prior to use.
- Replace bracketed information with your own information when using the approved materials within the toolkit.
- Use appropriate material for event type as determined by the plan.

Do Not's

- Use unapproved marketing materials.
- Add, enhance, delete, modify, edit or create any content in the marketing materials provided by the health plan, except in bracketed areas.
- Add his or her own company logo to UnitedHealthcare branded materials.
- Create your own marketing materials, without submitting for review and approval, including Business Reply Cards (BRC), lead cards, sign-in sheets and mailers that are not available through the health plan.

Reporting Events

Plan sponsors must upload all formal and informal marketing/sales events via HPMS prior to advertising the event or seven (7) calendar days prior to the event's scheduled date, whichever is earlier. Plan sponsors have the option to upload educational events.

Risk of Non-Compliance

Inaccurate event reporting, such as not reporting events, not canceling events, or not updating event information, is a direct violation of the Operational Behavior Allegation Family and can put the plan at risk for receiving a notice of non-compliance.

Do's

- Report updates to any event timely. Note: For agents who use the bConnected system, some bConnected fields may not be able to be updated without prior approval, due to event advertising.
- Use placeholders as the exception and not the rule.
- Understand closed events (i.e., group retirees) are submitted as private in bConnected.
- Understand private events must be reported to CMS and must be open to the general public and eligible Medicare consumers.
- Coordinate for a plan representative to be at the event site to direct attendees when circumstances prevent you from cancelling in 72 hours or less. (30 minutes before the scheduled start time and 30 minutes after the scheduled start time to meet company requirements).
- Update placeholder areas no less than 72 hours prior to the event.
- Accurately register the venue name, date and time of event into the appropriate designated system.
- Report all Educational and/or Marketing Sales events to UnitedHealthcare.
- Recognize all events; including educational events are subject to be secret shopped.

Do Not's

- Neglect to report all scheduled events.
- Change the date, time or location of the event within 7 days of the event date. (This would be considered a cancellation.)
- Neglect to take appropriate actions that would result in the event being a "no show."
- Note: a "no show" can result from a late cancellation or change.
- Conduct an event that was not reported.
- Conduct a formal presentation at an event that has been filed as informal and vice versa.

Venue Management Program Events

The Retail program allows agents to interact with consumers in a variety of retail environments, such as pharmacies, grocery stores, and malls.

Risk of Non-Compliance

Agents must follow information presented in the required trainings for Event Basics, Selling at Retail Kiosks e-Learning, and Selling at UnitedHealthcare Medicare Stores WebEx.

Do's

- Adhere to the Retail Code of Conduct agreement.
- Post sign when you are away and an anticipated return time.
- Lock and secure all consumers' documented personal information.
- Post the dates the agent will be onsite.
- Report all events as a sales/marketing event – informal.

Do Not's

- Move the plan designated location of the kiosk within the store.
- Approach consumers.
- Leave a Kiosk or table unattended when time is advertised or posted that agent will be present.
- Dress or appear as an employee of the Retail location.

Gifts and Promotional Items

Plan sponsors may offer gifts or promotional items to potential enrollee's as long as the gifts are of nominal value and provided regardless of enrollment. Nominal value is defined as an individual item/service worth $15 or less (based on the retail value of the item).

Risk of Non-Compliance

The risk of non-compliance is the appearance of inducement to enroll.

Do's

- Include a disclaimer on any statement concerning a prize or drawing that there is no obligation to enroll if the event is sponsored by the Plan or agent.
- Ensure gifts are offered to all consumers without discrimination.

- Only offer large gifts that can be enjoyed by all attending the event. The total cost must be $15 or less when divided by the estimated attendance.
- State that accepting a gift or prize does not obligate a consumer to enroll.
- Give nominal gifts to consumers as long as they do not exceed $15 nominal retail value, are not convertible to cash and are provided whether or not the consumer enrolls.
- Offer more than one gift, but the combined amount cannot exceed the nominal retail value.
- Offer a gift over $15 to the general public as long as it is not offered just to Medicare eligible consumers and is not routinely awarded.

Do Not's

- Give cash gifts regardless of the actual dollar amount.
- Give anything that can be converted into cash such as charitable contributions, rebates, gift cards, gift certificates or lottery tickets (in any amount).
- Give gifts in order to solicit referrals.
- Purchase AARP® membership for consumers.
- Provide flu shots. The retail value of a flu shot exceeds the nominal value of $15.
- Give gift cards and/or certificates to a restaurant or any place food is sold, regardless of the value.
- Give items that are otherwise available to the general public for free.
- Structure promotional items to steer consumers to particular providers, practitioners or suppliers.
- Use health benefits (i.e., a free checkup) to steer consumers to enroll.
- Use drawing slips or raffle tickets to obtain or secure consumer contact.

Scope of Appointment

In conducting marketing activities, a plan sponsor may not market any health care related product during a marketing appointment beyond the scope agreed upon by the beneficiary, and documented by the plan, prior to the appointment (48-hours in advance when practicable).

Risk of Non-Compliance

Inappropriate use or absence of the SOA form can lead to confusing the member with multiple product options.

Do's

- Obtain a SOA form prior to all face-to- face personal/individual marketing/sales appointments where a Medicare Advantage (MA) and/or a Prescription Drug Plan is/are presented (including Medicare Supplement appointments where the Prescription Drug Plan is included).
- Indicate on the SOA form or generic SOA coversheet why the SOA was not obtained prior to the appointment, any time it is applicable.
- Obtain SOA for office walk-ins as well as unexpected Medicare eligible guests at appointments who wish to attend a sales presentation at a scheduled appointment.
- Retain completed SOA forms for no less than 10 years.
- Be able to produce completed SOA forms upon request by CMS or UnitedHealthcare.

- Submit a completed SOA form to UnitedHealthcare even if the appointment is cancelled and/or did not result in an enrollment.
- Have a SOA for each individual Medicare eligible consumer who attends a personal marketing/sales appointment.
- Complete a new or second SOA form if the consumer requests to discuss a health related product outside of the original SOA.
- Complete a new or second SOA form and schedule a second appointment no sooner than 48 hours if the agent requests to discuss a product outside of the original agreement.
- Complete a SOA form if an appointment is scheduled as a result of a sales/marketing community event and/or retail event.

Do Not's

- Require a consumer to complete a SOA form to attend a public or advertised marketing/sales event.
- Make available or request consumers to complete a SOA form at educational events.
- Assume a SOA form was completed if the appointment was obtained by UnitedHealthcare telesales; always check bConnected system for documentation.

Unsolicited Contact

Plan sponsors may not market through any unsolicited contacts. For example, a plan sponsor may not send e-mails unless an individual has agreed to receive those e-mails.

Risk of Non-Compliance

Marketing through unsolicited contacts can lead to agent complaints and may also involve privacy infractions.

Do's

- Call a consumer who has submitted a SOA form, but only to confirm the appointment (RSVP).
- Mail marketing information to consumers.
- Provide extra business cards in a mailing for consumers to distribute to friends.
- Request and document continued Permission to Call (PTC).

Do Not's

- Conduct door-to-door solicitation including; leaving leaflets, fliers or door hangers at a consumer's door, residence or car.
- Approach a consumer in a common area such as a parking lot, hallway, sidewalk or lobby.
- Telephone a consumer in response to a BRC where a telephone number was not included or when an incorrect telephone number was provided.
- Telephone a consumer who attended a sales event, unless you have documented Permission to Call.
- Visit a consumer who attended a sales event, unless you have a documented SOA from.

- Conduct outbound marketing calls; unless the consumer explicitly requests the call.
- Conduct telephonic or electronic solicitation including leaving voicemail messages on answering machines, text messages or email contact unless there is a documented Permission to Call (PTC).
- Call former members who have disenrolled or members who are in the process of voluntarily disenrolling.
- Call a consumer to confirm receipt of mailed information.
- Email, text or telephone consumers if the consumer elects to 'opt out' or requests to end contact by any of these methods.
- Purchase and/or rent email lists or acquire email addresses through directories for marketing purposes or purchase call lists or leads where PTC has not been established.
- Telephone, email or text a consumer when contact information is obtained through a friend or referral.
- Contact a member who is in the process of or has disenrolled from the plan in which you enrolled them.
- Contact a consumer or member who has filed a complaint against you.

Provider Marketing Activities

Agents may engage with providers to conduct marketing activities under a limited set of circumstances. While the provider cannot market the plan for the agent, the agent can coordinate with the provider to display plan-related materials and market in a provider's common areas.

Risk of Non-Compliance

Some risks with provider marketing activities include agents engaging the providers in marketing that are not within their scope. Such as providers may not be fully aware of all plan benefits and costs.

Do's

- Schedule appointments with consumers residing in a residential health care facility (SOA is required).
- Market in common areas of health care settings (i.e., conference rooms, community or recreational rooms, etc.).
- Request providers to display CMS approved Health Plan materials, such as fliers promoting upcoming sales events.
- Add business cards to materials with a single piece of tape or staple.

Do Not's

- Mislead or pressure patients into participating in presentations.
- Market in areas where patients primarily intend to receive care or wait to receive care. This includes, but is not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas and pharmacy counter areas.
- Request providers offer sales/appointment forms (lead cards and/or business reply cards).
- Request providers mail marketing materials on behalf of plans.
- Request providers make phone calls or steer their patients, in any way, to the plan.

- Offer inducements to persuade consumers to enroll in the plan.
- Offer inducements to providers or their staff to steer or influence patients to enroll in the plan.
- Accept referrals from providers.
- Accept a list of Medicare eligible consumers from a provider.

Telesales

Plan sponsors must operate a toll-free call center for both current and prospective enrollees seven (7) days a week, at least from 8:00 A.M. to 8:00 P.M., according to the time zones for the regions in which they operate.

Risk of Non-Compliance

Telesales agents are at greatest risk if the pre-approved scripts are not followed during a call. See general do's and don't's below.

Do's

- Comply with the Plan's telesales policies and procedures and CMS guidance.
- Use only telesales scripts approved by the plan and CMS.
- Comply with all Health Insurance Portability and Accountability Act (HIPAA) privacy/marketing rules.
- Comply with all Federal Trade Commission (FTC) and Federal Communications Commission (FCC) requirements.
- Comply with the Federal and State "Do Not Call" lists and federal calling hours rules.
- Secure and document recorded SOA (for UnitedHealthcare telemarketing only).
- Secure and document Permission to call.
- Verify a Legal Authorized Representative, if applicable.
- Conduct enrollments through inbound call only.
- Review participating status of providers, as applicable
- Review current medications and disclose tier, copayment/coinsurance, quantity limits, pharmacy networks and prior authorization requirements.
- Provide a confirmation number to the consumer.

Do Not's

- Place outbound calls to former members who have disenrolled, or to current members who are in the process of voluntarily disenrolling, to market plans or products.
- Conduct an enrollment through an outbound call.

Enrollment Applications

When the consumer completes the Enrollment Application, confirm that every required section is thoroughly completed prior to submission.

Risk of Non-Compliance
Providing the business with an incomplete Enrollment Application puts the consumer at risk for not having coverage when they expect to, because their enrollment will be delayed in processing. Signing the Enrollment Application for the consumer is also considered forgery and corrective action will be taken immediately, including agent termination.

Do's

- Present the Pre-Enrollment Kit Booklet in its entirety and leave it with the consumer and ensure that the Important Enrollment Information page (enrollment receipt) is completed.
- Help the consumer sign up for the most appropriate plan based on his/her needs.
- Ensure the consumer understands and agrees with the plan effective date, premium (when applicable) and benefits.
- Ensure the consumer understands how to access a provider; explaining any network or provider limitations including referrals as applicable.
- Ensure the enrollment application is complete (Medicaid status, Agent ID, etc.) prior to having the consumer sign the application.
- Provide the physical address in the residential address portion and the
- P.O. Box in the billing address portion of the enrollment application, if applicable.
- Explain that Authorized Representative must provide documentation of authorized representation to the Health Plan or CMS if requested.
- Review Enrollment Application Cancellation process with the consumer.
- Review the OEV process with the consumer.

Do Not's

- Enter an online enrollment without the presence of the consumer.
- Sign the Enrollment Application or have anyone else, who is not an authorized representative, sign on behalf of the consumer, even with the consumer's permission.
- Sign or add your writing number to an application when you did not assist with the enrollment.
- Enroll a consumer through an outbound call.
- Assist a consumer in completing a web based enrollment.

Outbound Enrollment and Verification (OEV)

All plan sponsors are required to conduct outbound enrollment and verification (OEV) calls for enrollments effectuated by both independent and employed agents/brokers.

Risk of Non-Compliance
To confirm that individuals requesting enrollment in the plan intended to enroll and in the plan of their choice.

Do's

- Review the OEV process with each consumer.
- Ask the consumer to contact the agent if they have questions with the OEV process or outcome.

- Obtain the best telephone number of the consumer so the OEV call may be completed – may be POA or Authorized Representative's telephone number.
- Educate the consumer that the OEV call will be conducted by a representative of UnitedHealthcare or one of its third party vendors.
- Explain participation by the consumer is completely voluntary.
- Explain the vendor will ask for the consumer's date of birth to confirm their identity.
- Explain that the vendor will try to contact the member by telephone up to three (3) times. If the first attempt to contact is not successful, the consumer will receive an Enrollment Verification letter.
- Explain all out reaches are conducted within 15 days of receiving the Enrollment Applications.

Do Not's

- Be present with the consumer at the time of the OEV telephone call.

Fraud, Waste, and/or Abuse

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program. Waste is over-utilization of services or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary.

Risk of Non-Compliance

By not complying with the regulations regarding Fraud, Waste and/or Abuse, you can be charged with criminal activity.

Do's

- Report fraud, waste and abuse to either the Producer Help Desk (PHD) at 1-888-381-8581 or the UnitedHealthcare Fraud Tip Line at 1-866-242-7727.

Do Not's

- Offer cash reimbursements in exchanges for an Enrollment Application or referral.
- Offer gifts or services greater than the nominal amount permitted by federal guidelines.
- Offer gifts or services dependent on an enrollment or referral.
- Enroll a consumer without their permission.

Privacy and Security

Plan sponsors and providers are responsible for following all Federal and State laws regarding confidentiality and disclosure of patient information to plan sponsors for marketing purposes. This obligation includes compliance with the provisions of the HIPAA Privacy Rule and its specific rules regarding uses and disclosures of beneficiary information.

Risk of Non-Compliance
By not following these steps, you are putting consumers and beneficiaries at risk for fraud and identity theft. You also put the Plan at risk for receiving a notice of non-compliance.

Do's

- Carry only the minimum amount of hard copy documents with member/consumer personal information necessary to complete the day's activities.
- Keep documents containing member/consumer health information with you at all times while out on other sales activities, placing documents in a folder or locked briefcase.
- Keep documents in a secure locked area (example a file cabinet).
- Report violations of privacy to the PSMG Privacy office, your manager/leadership, the Segment Compliance Lead, or the UnitedHealthcare Ethics & Compliance Help center.

Do Not's

- Leave hard copy documents unattended in an area where they can be viewed by others (i.e., desk, vehicle, table and booth).
- Discuss member/consumer information in public spaces including restaurants or elevators.
- Leave laptops and/or documents unattended in the car.
- Share, store or use member/consumer information inappropriately.
- Put consumer/member information on a jump drive (or similar portable storage device).
- Scan and/or store documents electronically.

Chronic Illness Special Needs Plans (SNP)

Chronic Illness SNPs are for consumers with severe or disabling chronic conditions.

Risk of Non-Compliance
Agent must take care not to put consumers at risk for enrollment in an unsuitable plan, when considering a SNP as a plan choice. Agents must ensure they are properly certified for any Special Needs Plan they wish to sell.

Do's

- Verify the consumer has indicated that they have one of the chronic illness' qualifying conditions established by the Plan and approved by CMS.
- Complete the Chronic Illness Verification Authorization form.
- Tell the consumer if their qualifying condition cannot be confirmed by their physician or their offices, their Enrollment Application will be denied.
- Document the provider and their office who diagnosed the Chronic condition (Note: it may be a non-participating provider) to verify the chronic condition.
- Explain to the consumer they will be contacted to conduct a Health Risk Assessment (HRA).
- Explain the Outbound Enrollment and Verification process.

Do Not's

- Guarantee enrollment – enrollment is contingent upon verification of the chronic condition.

Dual Special Needs Plans (SNP)

Dual SNPs are for consumers who are enrolled in Medicare and Medicaid.

Risk of Non-Compliance

Agent must take care not to put consumers at risk for enrollment in an unsuitable plan, when considering a SNP as a plan choice. Agents must ensure they are properly certified for any Special Needs Plan they wish to sell.

Do's

- Verify Medicaid eligibility and place Medicaid ID on the Enrollment Application.
- Explain that the consumer will be contacted to conduct a Health Risk Assessment (HRA).
- Provide a thorough explanation of the cost sharing in the event that the consumer's circumstances change.
- Verify that the consumer has full Medicaid benefits or is a Qualified Medicare Beneficiary (QMB).
- Explain use of contracted provider networks and access to specialists.
- Review eligibility requirements.
- Review Special Election Periods.
- Review the involuntary disenrollment process.
- Review the description of how the prescription drug plan works to include the use of contracted pharmacies.
- Explain the Outbound Enrollment and Verification process.

Do Not's

- Advise a consumer that the DSNP is a zero dollar premium plan. Instead, explain that Full and Partial Dual members will likely not pay a Part D premium because of their Medicaid eligibility and the extra help they receive in paying these premiums.
- Guarantee a consumer the state Medicaid agency will pay health premiums.
- Guarantee a consumer enrollment in the plan as enrollment is contingent of Medicaid status.
- Enroll a Medicaid consumer in a PFFS plan, unless the consumer insists.

Medicare Part D (PDP)

A Medicare Part D Plan is a stand-alone prescription drug plan that can be coupled with an Original Medicare plan, Medicare Supplement plan, or a Private Fee-For-Service (PFFS) Medicare Advantage plan that does not come with a drug plan.

Risk of Non-Compliance

One of the most common risks to both agents and consumers is a lack of clarity regarding drugs that are on the formulary, and understanding the cost sharing. Agents must take the time to confirm which drugs are on the formulary, and explain all related cost sharing to consumers, before effectuating the enrollment.

Do's

- Clearly describe the Coverage Gap to consumers so they are not surprised if they reach the threshold and no longer have coverage.
- Explain the 1% per month Late-Enrollment Penalty (LEP) to consumers if they are uncertain whether it makes sense to join a plan or wait until later.
- Explain the 1% per month Late-Enrollment Penalty (LEP) to consumers who did not obtain Prescription Drug coverage when first eligible or who have had a gap in Prescription Drug coverage.
- Look beyond premium and cost sharing to determine whether a plan is right for the consumer.
- Review the formulary and the applicable drug tiers that may impact the value of a plan to specific consumers.
- Disclose to each consumer they must purchase their prescriptions from contracted and/or in-network participating pharmacies.
- Review the consumer's current medications prior to enrollment.
- Review where the consumer may obtain information regarding what prescriptions are covered (formulary, Medicare.gov, Plan web site)
- Review the Outbound Enrollment & Verification process.
- Request the consumer apply for the Low-Income Subsidy if they believe they are financially eligible.

Do Not's

- Tell consumers that they will reach the Coverage Gap.
- Tell consumers every plan has the same medications listed on their formularies.
- Enroll consumers in a stand-alone Part D plan that is already enrolled in a Medicare Advantage Plan (other than PFFS).

Medicare Supplement

A Medicare Supplement insurance policy is private health insurance specifically designed to supplement Original Medicare (Part A and Part B). A Medicare Supplement Plan can help protect the member against the rising cost of health care by covering some of the out-of-pocket costs associated with Original Medicare.

Risk of Non-Compliance

Agents must ensure that consumers know the difference between a Medicare Supplement plan and a Medicare Advantage plan before effectuating the enrollment.

Do's

- Check the consumers Medicare card to verify they are enrolled in Medicare Parts A and B.
- Confirm the consumer's plan of choice on the enrollment application.
- Check the state-specific Guaranteed Issue and Open Enrollment guidelines to see if the consumer is eligible for them.

- Explain to the consumer that once they are accepted for coverage, they will receive a Post-Enrollment Kit.
- Obtain a copy of appropriate legal documentation if someone is acting as the legal representative for the consumer and enclose a copy of appropriate legal documentation (Example: Power of Attorney).
- Provide a copy of "Documentation of loss of prior coverage" in order to be eligible for Guaranteed Issue.
- Provide a copy of the Replacement Notice, signed and dated by you and the consumer, if the Medicare Supplement Plan will replace another Medicare Supplement or Medicare Advantage Plan.
- Provide rate and underwriting disclosures.
- Provide the consumer with the customer service phone number so they can contact customer service for application status.
- Inform the consumer to retain existing coverage until the consumer has been accepted in the new coverage.

Do Not's

- Claim that a Medicare Advantage Plan is a Medicare Supplement policy.
- Suggest that the Medicare Supplement policy is part of the Medicare Program or any other federal program.
- Offer a Medicare consumer a second Medicare Supplement policy unless the consumer intends to cancel their existing Medicare Supplement policy.
- Offer a Medicare consumer a Medicare Supplement policy if they also have Medicaid, except in certain situations.
- Assume if a Medicare Advantage member can disenroll, he/she has "Guaranteed Issue" of Medicare Supplement.
- Offer a consumer a Medicare Supplement policy if they also have a Medicare Advantage Plan so there will be no overlap in coverage (unless their Medicare Advantage coverage will end before the effective date of the Medicare Supplement policy).
- Cold call or go door-to-door for AARP or UnitedHealthcare Medicare Supplement plans.
- Cold call for Medicare Supplement plans with the intention of selling Medicare Advantage or Part D plans.
- Inform the consumer that enrollment in a Medicare Supplement Policy will automatically terminate their current Medicare Advantage Plan or vice versa.

Private Fee-for-Service (PFFS)

A Private Fee-For-Service plan is one type of Medicare Advantage (MA) plan that combines Medicare Part A (hospital coverage) and Medicare Part B (medical coverage) and can also include Part D (prescription drug coverage).

Risk of Non-Compliance

Agents must ensure that the consumer understands that this plan can be more costly, and that the consumer knows to check with their provider before every appointment to ensure that the provider accepts the terms of the plan

Do's

- Review consumer and physician 'Deeming' documents within the Enrollment Kit.
- Explain that PFFS plans are not the same as Original Medicare, Medicare Supplement/Medigap, Medicare Select Policies or a Stand-alone Prescription Drug Plans (PDP).
- Explain that the consumer will need to select a different provider if the provider of choice is not willing to be "deemed" (Example: Provider chooses not to accept the PFFS Plans terms and condition of payment).
- Advise consumers they are responsible for applicable copayment and coinsurance amounts and all other charges should be submitted by their provider to UnitedHealthcare.
- Explain that while consumers are not limited to a contracted provider network, their doctor or hospital must agree to the plan's terms and conditions of payment prior to providing health care services (except in emergencies). Not all participating Medicare providers agree to accept PFFS members.
- Verbally read or state the PFFS disclaimer verbatim during all PFFS sales presentations and appointments.
- Explain the Outbound Enrollment and Verification process.

Do Not's

- Refer to the PFFS Plans as supplement, replacement, no cost, free plan or zero cost plan.
- Enroll Dual Eligibles without explaining potential member financial implications, as in most cases this is an inappropriate sale.

Medicare Marketing Guidelines

Medicare Marketing Guidelines

The 2014 Medicare Marketing Guidelines are posted at http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html

The Medicare Marketing Guideline may be updated at any time by the Centers for Medicare and Medicaid Services (CMS). The above guidelines are contingent to change at time of approval of the 2015 Medicare Marketing Guidelines.

Frequently Asked Questions

For the latest Compliance guidance and for copies of published Focus News, please refer to "Compliance Corner" found in the "Resource Center" section on www.UnitedHealthProducers.com.

Compliance Questions

Contact for questions regarding marketing or for access to Medicare marketing guidelines; for privacy, security or fraud, waste and abuse issues; or for ethics-related questions.
Compliance_Questions@uhc.com

Section 7: How Do I take an Enrollment Application

Enrollment Methods

Election Periods

Enrollment Process – Medicare Advantage Products

Enrollment Process – AARP Medicare Supplement Insurance Plans

Enrollment Process – SecureHorizons Medicare Supplement Insurance Plans

Pre-Enrollment Verification Process

Post-Enrollment Customer Experience

Enrollment Application Cancellation, Withdrawal, or Disenrollment Requests for CMS Regulated Plans

Customer Service Resources

Enrollment Methods

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

All Enrollment Applications must be submitted promptly to UnitedHealthcare. Applications received by Enrollment more than three days (sixteen days for AARP Medicare Supplement) after the agent signature will be considered a late Enrollment Application and the agent may be subject to disciplinary action.

Electronic Enrollment

UnitedHealthcare offers several options for you to submit enrollment applications electronically. Submitting enrollment applications electronically allows for quicker processing time, reduction in errors and paperwork, and faster commission payments. There are two types of electronic enrollment tools available based on the product lines:

- UnitedHealthcare–iEnroll™ - Medicare Advantage (MA) Plans, Medicare Advantage with Prescription Drug (MA-PD) Plans and Prescription Drug Plans (PDP)
- Online Enrollment for AARPR® Medicare Supplement Plans - AARP® Medicare Supplement Insurance Plans, insured by UnitedHealthcare

UnitedHealthcare iEnroll Toolkit

The UnitedHealthcare iEnroll toolkit is comprised of powerful electronic enrollment systems designed to reduce paperwork and speed the processing of a consumer's new Enrollment Application. Refer to "Online Enrollment" section on www.UnitedHealthProducers.com for information on the different electronic enrollment methods. UnitedHealthcare iEnroll cannot be used to enroll consumers into AARP Medicare Supplement Insurance plans. However, consumers can be enrolled using the Online Enrollment tool or the paper Enrollment Application for AARP Medicare Supplement Insurance Plans.

Utilizing an electronic enrollment method provides these benefits:

- Simplifies and accelerates new business enrollment.
- Available for select UnitedHealthcare Medicare Advantage plans and PDP Plans.
- System will accept an Enrollment Application only when all necessary information is provided, therefore fewer problems due to missing information. (Agents cannot refuse to take an Enrollment Application. If the Enrollment Application is missing information, the best practice is to submit a traditional paper Enrollment Application.)
- Expedited continuity of service for new members.
- Fewer new member enrollment issues.
- Ability to trace information and resolve problems more quickly.

There are three electronic enrollment methods available in the UnitedHealthcare iEnroll Toolkit: Offline Self Service, Online Self Service, and eModel Office.

- To utilize Offline or Online Self Service methods, you must have a PC Notebook or a signature pad device connected to a laptop. Either of which enables you to collect a consumer's signature in addition to all other information necessary to process an Enrollment Application. If you need a signature pad, contact your EDC or the Producer Help Desk at 1-888-381-8581. (A signature pad is not needed if you are using a PC Notebook.)

Method 1 – Offline Self Service: Prior to your appointment with the consumer, download to your computer the applicable Enrollment Application template(s) from UnitedHealthcare iEnroll. At the appointment, complete the appropriate Enrollment Application and secure the consumer's signature electronically. When you return to your office, connect to UnitedHealthcare iEnroll and synchronize with the online system. (For best results when using this enrollment method, perform a nightly synchronization.) When the synchronization has completed, all Enrollment Applications and signatures are submitted electronically. A confirmation will be sent to your computer upon successful completion and you will be able to track the consumer's Enrollment Application progress through the enrollment system on www.UnitedHealthProducers.com.

- The consumer will receive a system produced copy of their electronic Enrollment Application in the mail.

Method 2 – Online Self Service: This method requires you to be connected to the internet at the time the Enrollment Application information and signature is received from the consumer. You can access the Online Self Service method through the Online Enrollment tab on www.UnitedHealthProducers.com. A confirmation will be sent to your computer upon successful submission of the consumer's Enrollment Application.

- The consumer will receive a system produced copy of their electronic Enrollment Application in the mail.

Method 3 – eModel Office: Some External Distribution Channels (EDC) are set up to enter Enrollment Application data directly into the UnitedHealthcare online system. Contact your EDC to see if they are set up as an eModel Office.

To use the eModel Office method, give the designated person within your EDC the completed paper Enrollment Application. All data must be entered into the online Enrollment Application before it can be submitted. Once the Enrollment Application has been successfully submitted, you will be able to track the consumer's Enrollment Application progress through the enrollment system on www.UnitedHealthProducers.com.

Online Enrollment for AARP Medicare Supplement Insurance Plans

UnitedHealthcare is pleased to introduce an online enrollment application for AARP Medicare Supplement Insurance Plans. This online enrollment application will help improve processing time, avoid errors, and enroll consumers more quickly – allowing you to avoid delays of commission payments.

The AARP Medicare Supplement online enrollment application is available via the UnitedHealthcare Distribution Portal. When you access the online tool, an enrollment application is created based on the consumer's zip code, date of birth and Medicare Part B effective date. Based on this information, you are given a plan selection list with estimated rates for each plan. As you click from screen-to-screen, the online enrollment application will display or skip over questions based on previously provided information.

- Enroll, renew or verify AARP membership for the consumer
- Fill out ancillary forms, such as the Replacement Notice, if required
- Sign up the consumer for Electronic Funds Transfer (EFT) for (must choose one):
  - ~ Recurring premium payments, or
  - ~ One-time premium payment and coupon booklet.
- Upload documents such as guaranteed issue and legal documents
- Save/resume an AARP Medicare Supplement enrollment application (up to 90 days)
- Review submitted AARP Medicare Supplement enrollment applications (up to 90 days)

Section 7: How Do I take an Enrollment Application?

The AARP Medicare Supplement online enrollment application is currently not available in all states. The tool requires that the consumer sign up for EFT for a minimum of one monthly premium payment. If the online enrollment application is not available for your state or if a consumer does not want to complete the EFT form, please submit a paper enrollment application. Paper enrollment kits can be ordered from the Sales Materials on the Distribution Portal.

Capturing Signatures

The AARP Medicare Supplement enrollment application requires signatures to be captured from you and the consumer. If you choose to complete an online enrollment application, signatures must be captured via a signature pad. UnitedHealthcare offers a variety of Topaz signature pad devices for you to purchase. Details can be found on the Distribution Portal.

Traditional Paper Method

An electronic method of Enrollment Application submission should be utilized whenever possible to maximize efficiency and reduce error rates and processing time. Paper Enrollment Applications should only be submitted when absolutely necessary.

You may be paid a lower new-business commission if a new business Enrollment Application is submitted through the paper enrollment process when an electronic method is available.

If the paper method is absolutely necessary, there are three ways to submit a paper Enrollment Application once the hard copy is received. Choose only one of the following submission options:

- Regular Mail – to address on Enrollment Application
- Overnight – to address on Enrollment Application
- Fax – to the number provided to you in your sales materials

Paper Enrollment Applications for AARP Medicare Supplement Insurance Plans can be submitted via regular mail or overnight delivery using the pre-addressed Enrollment Application envelope contained within the Pre-Enrollment Sales Kit (UnitedHealthcare Insurance Co., PO Box 105331, Atlanta, GA 30348-9534).

All Enrollment Applications must be submitted promptly to UnitedHealthcare. Enrollment Applications received by Enrollment more than three days (sixteen days for AARP Medicare Supplement) after the agent signature will be considered a late Enrollment Application and the agent may be subject to disciplinary action

UnitedHealthcare Public Website

A web-based enrollment is a ***consumer*** initiated and effectuated electronic enrollment method utilizing the internet. A web-based enrollment can only be conducted via the plan's website www.UHCMedicareSolutions.com.

- Consumers must enter the information and complete the enrollment when using a web-based enrollment. When a consumer uses the site to complete an enrollment they must attest that they are the consumer.
- You ***may not*** use UnitedHealthcare public website to facilitate a consumer enrollment.
- You ***may not*** be physically present with the consumer.
- Web-based enrollment is ***not*** an electronic enrollment method for your use.
- Web-based enrollment is ***not*** available for all plans.

You may compliantly assist a consumer in utilizing a web-based enrollment by:

- Completing all pre-enrollment activities including, but not limited to:
  - ~ Needs assessment, Medicare eligibility verification, and election period validation.
  - ~ Plan determination and providing a Pre-Enrollment Sales Kit.
  - ~ Completed presentation an covering all benefits, cost-sharing, prescription drug cover, etc.,
  - ~ Provider/pharmacy network verification, prescription verification.
  - ~ Appeals and Grievance policy, Outbound Enrollment and Verification (OEV) calls, Statement of Understanding, Multi-language insert, and star rating information.
  - ~ Providing agent contact information.
- Provide the consumer with the enrollment website landing page www.MyMedicareEnroll.com.
- Provide the consumer with your Agent ID.
- You may be on the telephone with the consumer, but ***must not*** be physically present with the consumer (Note: All Telesales agents are prohibited from assisting consumers with a web-based enrollment).

Appropriate times that you may encourage a Web-based enrollment may include:

- Consumer Readiness – when you have conducted an in-person presentation, but the consumer was not ready to enroll at that time.
- Time Constraints – when it is not feasible for the consumer to meet face-to-face with you or for the consumer to mail in a paper Enrollment Application.
- Other Factors – other instances where time, distance, or consumer preference prevents the consumer meeting with you to complete an enrollment.

You are accountable for a Web-based enrollment and any consequences associated with the enrollment.

- You are accountable for OEV infractions, complaints, and/or rapid disenrollments.
- If you enter a Web-based enrollment, you are committing fraud.
- Consequences resulting from inappropriate agent use of the Web-based enrollment method include, but are not limited to, corrective and/or disciplinary action up to and including termination.

Election Periods

Election Periods Available to Medicare Consumers

There are specified election periods available for Medicare eligible consumers. The election periods include an Open Enrollment Period (OEP), Medicare Advantage Disenrollment Period (MADP), an Initial Coverage Election Period (ICEP), Initial Election Period (IEP), or a Special Election Period (SEP) based on specific eligibility criteria. Note: Medicare Supplement products are not restricted to the Centers for Medicare & Medicaid Services (CMS) election periods and may be enrolled throughout the year.

Open Enrollment Period (OEP)

OEP, which runs from October 15 through December 7, enables consumers to change or add Prescription Drug Plans (PDPs), change Medicare Advantage plans, return to Original Medicare, or enroll in a Medicare Advantage plan for the first time even if they did not enroll during their Initial Election Period.

Medicare Advantage Disenrollment Period (MADP)

MADP, which occurs January 1 through February 14, gives consumers an annual opportunity to disenroll from their Medicare Advantage plan and return to Original Medicare. Regardless of whether the Medicare Advantage plan included Part D drug coverage, consumers using the MADP to disenroll from their plan are eligible for a coordinating Part D SEP which allows them to enroll in a PDP during the same timeframe.

Initial Coverage Election Period (ICEP) and Initial Election Period (IEP)

ICEP and IEP occur when consumers first become eligible for Medicare. These periods are for all consumers becoming eligible for Medicare whether it is due to turning 65 or by becoming eligible due to a qualifying disability. Eligible consumers can enroll into a Medicare Advantage Plan (MA) of their choosing, including a Medicare Advantage Prescription Drug Plan (MAPD). Those already enrolled into Medicare due to disability have a second IEP upon turning 65. Note: based upon specific eligibility criteria and election choices, ICEP and IEP may occur together or may occur separately.

Special Election Period (SEP)

A SEP allows consumers to make an election change in accordance with applicable requirements anytime during the year, including during the period outside of the OEP. The SEPs vary in the qualifications to use them as well as the types of elections allowed. Situations such as dual-eligible status and institutionalization provide the ability to switch plans at any time during the year. All SEPs are determined and announced by CMS.

5-Star Special Election Period (SEP)

The 5-Star SEP is an election period available to consumers/members that allows them to enroll in a 5-Star rated plan. Consumers/members can use the 5-Star SEP to enroll in a 5-Star plan one time during the benefit year when changing from a plan that does not have a 5-Star rating. Consumers/members can only join a 5-Star Medicare Advantage (MA) plan if one is available in their area.

Consumers/members may lose their prescription drug coverage if they move from a MA plan that has drug coverage to a MA plan that does not. Consumers/members will have to wait until the next open enrollment period to obtain drug coverage and consumers may have to pay a Late Enrollment Penalty (LEP).

Enrollment Process – Medicare Advantage Products

The Enrollment Application should be completed only after you have thoroughly explained to the consumer the plan benefits and rules, confirmed eligibility, disclosed agent and product specific disclaimers, and the consumer agrees to proceed with enrollment.

Incomplete, incorrect, or illegible Enrollment Applications delay or prevent processing and may result in membership in an incorrect plan and/or the inability to pay the agent commission for the sale.

Confirm Eligibility

- You must verify and document that the consumer is entitled to Medicare Part A and eligible for Medicare Part B.

- To be eligible to elect a Medicare Advantage plan, a consumer must be entitled to Medicare Part A and enrolled in Medicare Part B, and must be entitled to Medicare Part A and Part B benefits as of the effective date of coverage under the Plan. Exceptions for Part B-only grandfathered members are outlined in the CMS Medicare Managed Care Manual. Part B-only consumers currently enrolled in a plan created under &1833 or &1876 of the Social Security Act are not considered to be grandfathered consumers, and must purchase Medicare Part A through the Social Security Administration to become eligible to enroll in an MA plan.

- The consumer must have Medicare Parts A and B at the time they enroll in a Medicare Advantage plan. As a best practice, you should verify the consumer's proof of having Medicare Parts A and B. The following are examples of acceptable proof of eligibility:
  - ~ Copy of Medicare Card
  - ~ Social Security Administration award notice
  - ~ Railroad Retirement Board letter of verification
  - ~ Statement from Social Security Administration or Railroad Retirement Board verifying the consumer's Medicare eligibility

Explain Benefits, Rules, and Member Rights

You must provide and explain all Plan benefits, limitations, and rules thoroughly as outlined in the Summary of Benefits, Statement of Understanding, Prescription Benefits (where applicable), and all required plan specific disclaimers. For Preferred Provider Organization products, in- and out-of-network benefits must be fully described.

- To be eligible to elect a Medicare Advantage plan, a consumer must be fully informed of and agree to abide by the rules of the Plan that are provided during the enrollment process.

- The Statement of Understanding provides the consumer with the Plan rules. The Statement of Understanding for the applicable plan year must be acknowledged, without modification, by the consumer/authorized representative.

Enrollment Application

Proceed with enrollment only after thoroughly explaining all Plan benefits, limitations, and rules to the consumer and receiving consent from them.

- You will ensure that all required information is provided on the Enrollment Application. In the cases of homeless individuals, a Post Office Box, an address of a shelter or clinic, or the address where the individual receives mail, (e.g., social security checks) may be considered the place of permanent residence.
- Determine the proposed effective date based on the election period and the effective date rules. The proposed effective date will be explained and entered on the Enrollment Application. A confirmation of enrollment letter will be sent 10 days within accepting enrollment and will contain the effective date.
- You must explain the Outbound Enrollment and Verification (OEV) call for all plans.
  - ~ Consumers will receive a contact within 15 calendar days verifying their enrollment in the plan and their understanding of its benefits
  - ~ The first two attempts will be made by telephone within 10 calendar days.
  - ~ If the consumer is not reached during the first or second attempt, an enrollment verification letter will be sent. In addition, a third documented OEV call will be made within the 15 calendar days timeline.
- Once all required information has been entered onto the Enrollment Application and upon confirmation that the consumer fully understands all the details of the Plan and has read the Statement of Understanding, ensure that the Enrollment Application is signed and dated by the consumer.
  - ~ If the consumer is unable to sign their name due to blindness or illiteracy, the enrollee may sign with a mark, e.g. “X”, if:
    - o It is the consumer’s intent that the mark be their signature
  - ~ If an authorized representative signs the Enrollment Application, the record of attestation of authority must be maintained as part of the record of the enrollment election and must include contact information.
- You must provide contact information.
- Sign and date the Enrollment Application after verifying all information provided by the consumer is correct and the Enrollment Application is signed by the consumer or authorized representative.
  - ~ Provide your agent writing number on each Enrollment Application you write.
  - ~ Only the agent that completes the Enrollment Application with the consumer or his/her responsible party may affix his/her writing number to, sign, and date the Enrollment Application. “Gifting” an Enrollment Application (i.e. allowing another agent to affix their writing number to, sign, and/or date an Enrollment Application) is strictly prohibited.

All Enrollment Applications must be submitted promptly to UnitedHealthcare. Enrollment Applications received by Enrollment more than three days (sixteen days for AARP Medicare Supplement) after the agent signature will be considered a late Enrollment Application and the agent may be subject to disciplinary action.

Enrollment Process – AARP Medicare Supplement Insurance Plan

As with all products, you must be certified to sell the AARP Medicare Supplement Insurance Plan product as of the date the Enrollment Application is taken and for the applicable year that the Enrollment Application will be effective. For example, if an Enrollment Application is taken in October 2013 for a January 2014 effective date, the agent must be certified for 2014 AARP Medicare Supplement Insurance Plans prior to taking the Enrollment Application.

It is important that you use the agent version of the AARP Medicare Supplement Insurance Plan Enrollment Application which can be identified by the presence of the code 2460720307 at the bottom center of the first page of the Enrollment Application and an agent signature line, agent ID, and specific disclaimer language located at the end of the Enrollment Application. (Note: All Enrollment Applications for the state of New York contain fields for the agent signature and agent ID so it is especially important that the code 246070307 appear on page one.) Agent versions of the Enrollment Applications are included in the Enrollment Materials kits available through the agent website in the "Product Information and Materials" section. Agents will not be commissioned, nor will commission appeals be considered, if page 1 of the Enrollment Application does not contain the code 2460720307.

Incomplete, incorrect, or illegible Enrollment Applications delay or prevent processing and/or the inability to pay the agent commission for the sale.

Confirm Eligibility

- Consumers must be enrolled in Medicare Part A and Part B at the time of the plan effective date.
- Consumers must be residents of the state in which they are applying for coverage.
- The consumer must be an AARP member or a member's spouse or partner living in the same household in order to enroll in an AARP Medicare Supplement Insurance plan. If they consumer is not a member, the agent may assist the consumer in setting up a new membership by calling 1-866-331-1964 or logging in to www.AGNTU.aarpenrollment.com to enroll using a credit card. Alternatively, the agent can mail the AARP membership application and dues (with a *separate* check payable to AARP) with the insurance Enrollment Application. (AARP membership dues are not deductible for income tax purposes.)

Explain Benefits, Rules, and Member Rights

- Review the plan options with the consumer and guide them to the plan that best fits their needs.
- The consumer's plan selection must be indicated on the Enrollment Application.
- If the consumer has current health coverage, it must be noted on the Enrollment Application.

Enrollment Application

- The Enrollment Application should be completed only after you have thoroughly explained to the consumer the plan benefits and rules, confirmed eligibility, disclosed agent and product specific disclaimers, and the consumer agrees to proceed with enrollment.

- Immediately sign and date the Enrollment Application after verifying all information provided by the consumer is correct and the Enrollment Application is signed by the consumer or authorized representative.
  - ~ Include your agent writing number on each Enrollment Application you write.
  - ~ Only the agent that completes the Enrollment Application with the consumer or his/her responsible party may affix their writing number to, sign, and date the Enrollment Application.

"Gifting" an Enrollment Application (i.e. allowing another agent to affix his/her writing number to, sign, and/or date an Enrollment Application) is strictly prohibited.

- Incomplete, incorrect, or illegible Enrollment Applications delay or prevent processing and/or the inability to pay you commission for the sale.

All Enrollment Applications must be submitted promptly to UnitedHealthcare. Enrollment Applications received by Enrollment more than three days (sixteen days for AARP Medicare Supplement) after the agent signature will be considered a late Enrollment Application and the agent may be subject to disciplinary action.

Post-Sale Requirements

The following items must be left with the consumer after the Enrollment Application has been completed:

- Outlines of Coverage and Rate Sheet
- *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*
- Copy of the completed and signed Replacement Notice (where applicable)
- Copy of the Automatic Transfer form (where applicable)
- Additional state-specific documents may also need to be completed and submitted with the Enrollment Application, and/or copies left with the consumer. Directions are on the form. It is the agent's responsibility to adhere to all federal and state regulations.

Replacement Business

- Agents must submit the *Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage* (Replacement Notice) with an Enrollment Application when the consumer is replacing or losing a Medicare supplement or Medicare Advantage plan.

- A Replacement Notice is included with each state-specific Enrollment Materials kit. Consumers who are replacing their existing Medicare Supplement coverage should not cancel their coverage until the new policy's effective date. When replacing an existing policy, request an effective date (always the first of the month) to coincide with the date the existing coverage ends.

- If the consumer is changing from one AARP Medicare Supplement Insurance Plan to another AARP Medicare Supplement Insurance Plan, the Replacement Notice is not required.

- If the consumer currently has a Medicare Advantage plan and would like to enroll in an AARP Medicare Supplement Insurance plan, their coverage under the Medicare Advantage plan must end by the effective date of the AARP Medicare Supplement Insurance Plan.

Enrollment in Medicare Supplement Insurance does not automatically disenroll a consumer from Medicare Advantage. The consumer should contact their current insurer or 1-800-MEDICARE to see if they are eligible to disenroll, and to disenroll if they are able

Enrollment Process – SecureHorizons Medicare Supplement Insurance Plan

As with all products, you must be certified to sell the SecureHorizons Medicare Supplement Insurance Plan product as of the date the Enrollment Application is taken. It is important that you use the agent version of the SecureHorizons Medicare Supplement Insurance Plan Enrollment Application, which can be identified by the presence of an agent signature line and agent ID. Agent versions of the Enrollment Applications will be included in the Pre-Enrollment Sales Kits available through the agent website in the "Product Information and Materials" section.

Incomplete, incorrect, or illegible Enrollment Applications delay or prevent processing and/or the inability to pay the agent commission for the sale.

Confirm Eligibility

Verify and document the consumer's eligibility of Medicare Part A and Part B.

Explain Benefits, Rules, and Member Rights

- Review the plan options with the consumer and guide them to the plan that best fits their needs.
- The consumer's plan selection and payment method must be indicated on the Enrollment Application.
- If the consumer has current health coverage, it must be noted on the Enrollment Application.

Enrollment Application

- The Enrollment Application should be completed only after you have thoroughly explained to the consumer the plan benefits and rules, confirmed eligibility, disclosed agent and product specific disclaimers, and the consumer agrees to proceed with enrollment.
- Immediately sign and date the Enrollment Application after verifying all information provided by the consumer is correct and the Enrollment Application is signed by the consumer or authorized representative.
  - ~ Provide your agent writing number on each Enrollment Application you write.
  - ~ Only the agent that completes the Enrollment Application with the consumer or their responsible party may affix his/her writing number to, sign, and date the Enrollment Application. "Gifting" an Enrollment Application (i.e. allowing another agent to affix his/her writing number to, sign, and/or date an Enrollment Application) is strictly prohibited.
- Incomplete, incorrect, or illegible Enrollment Applications delay or prevent processing and may result in membership in an incorrect plan and/or the inability to pay you commission for the sale.
- Include a completed EZ pay/EFT form or a check/money order for the first month's premium and mail in the postage paid envelope or to the address on the Enrollment Application.

Post-Sale Requirements

The following items must be left with the consumer after the Enrollment Application has been completed:

- Outlines of Coverage and Rate Sheet
- *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*
- Copy of the completed and signed Replacement Notice (if applicable)
- Additional state-specific documents may also need to be left with the consumer. It is the agent's responsibility to adhere to all federal and state regulations.

Replacement Business

- Consumers who are replacing another Medicare Supplement or Medicare Advantage plan must submit the *Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage* (Replacement Notice).

- Two Replacement Notices are included with each state-specific Pre-Enrollment Sales Kit. One replacement notice is given to the consumer the other is sent with the Enrollment Application. Consumers who are replacing their existing Medicare Supplement coverage should not cancel their coverage until the new policy's effective date. When replacing an existing policy, request an effective date (always the first of the month) to coincide with the date the existing coverage ends.

Enrollment in Medicare Supplement Insurance does not automatically disenroll a consumer from Medicare Advantage or any other plan. The consumer should contact their current insurer or 1-800-MEDICARE to see if they are eligible to disenroll, and to disenroll if they are able.

Pre-Enrollment Verification Process

Chronic Illness Special Needs Plan

Only enroll those consumers who have one of the qualifying illnesses into the UnitedHealthcare Chronic Complete. Consumers are only enrolled in the plan ***after their chronic illness is verified by a physician's office.***

- If the qualifying illness is not verified at the time of enrollment, it is UnitedHealthcare Medicare Solutions policy to not enroll the consumer into the Plan.

Prior to taking an Enrollment Application, complete a review of the chronic illness plan and determine the consumer's eligibility. If the consumer is eligible for the chronic illness plan and chooses to enroll, complete the Enrollment Application and submit it along with the required chronic illness authorization form.

Dual Special Needs Plan (DSNP)

Only those consumers who have Medicaid may be enrolled into a Dual Special Needs Plan (DSNP). A pre-enrollment verification process has been implemented whereby consumers are only enrolled in the plan ***after their Medicaid status has been verified by Enrollment.***

- If the Medicaid status is not verified at the time of enrollment, it is UnitedHealthcare Medicare Solutions policy to not enroll the consumer into the Plan.

Prior to taking an Enrollment Application, complete a review of the DSNP and determine the consumer's eligibility. If the consumer is eligible for the DSNP and chooses to enroll, complete the Enrollment Application including the consumer's Medicaid number (from their Medicaid card). In addition, the consumer's social security number can be entered in the appropriate, but optional, field on the Enrollment Application

Post-Enrollment Customer Experience for Medicare Advantage Plans

After Completing the Enrollment Application

Review the following next steps with the consumer.

- Confirm the consumer's effective date (typically the first day of the following month).

- Review the Outbound Enrollment and Verification (OEV) process for all plans. Note: OEV calls will be made on Medicare Advantage (MA) and Prescription Drug Plan (PDP) Enrollment Applications. You should prepare your consumer for the OEV call and its purpose of:
  - ~ Verifying the consumer's intent to enroll in the plan
  - ~ Ensuring the consumer requesting enrollment understands plan rules
  - ~ Verifying that the selling agent obtained from the consumer the best phone number to be sued for verification purposes
  - ~ Verifying that the agent provided a description of the enrollment verification call

- You are responsible for:
  - ~ Reviewing with the consumer the OEV section contained within the Pre-Enrollment Sales Kit
  - ~ Indicating on the Enrollment Application if the consumer prefers to receive materials in a language other than English
  - ~ Advising the call will be made by a vendor on behalf of UnitedHealthcare.
  - ~ Advising the vendor will call within fifteen calendar days of application for enrollment, the first two attempts must be made within the first 10 calendar days. (regardless of enrollment status). Calls are made from 9am to 8pm Monday through Saturday and 9am to 5pm on Sundays.
  - ~ Advising if the consumer is not reached during the first or second attempt, an enrollment verification letter will be sent. In addition, a third document outbound verification call will be made within the 15 calendar days timeframe.

- The types of questions that may be asked during the survey are:
  - ~ Are you aware that the plan in which you are enrolling is a Medicare Advantage (MA) plan, **not** a Medicare Supplement plan?
  - ~ Are you aware that the plan may have cost sharing such as copayments/coinsurance and that it may have certain specific limitations for providers or pharmacies?
  - ~ Were you informed that you would be receiving this call to make sure you understand the purpose of the Enrollment Application and the Medicare plan you chose?

Issuing Coverage

Coverage is approved as applied if:

- A fully completed Enrollment Application is submitted.
- The consumer meets the Medicare Advantage requirements.

Enrollment Denials

If CMS is unable to approve the Medicare Advantage Enrollment Application, a letter of denial is sent to the consumer.

Premium Refunds

Allow ample time for premium refunds to be processed. A refund check cannot be issued until UnitedHealthcare first receives confirmation that the consumer's initial premium payment has cleared successfully.

New Member Welcome Call

You are encouraged to follow-up with new members after enrollment by placing a welcome call. This provides you with an opportunity to help prevent rapid disenrollment and continue to provide exceptional service to members. It also provides you with an opportunity to ask your new members to provide your contact information to their friends and relatives, an excellent way to help build your book of business.

- Make an outbound call to all new UnitedHealthcare members within two to three weeks after the member's effective date.
- Confirm that the member received a member ID card and Welcome Kit.
- Allow the new member to ask any additional questions and address any key satisfaction drivers.
- Provide the member with customer service numbers and contact information as needed.
- Ask the new member to give your contact information to their friends and relatives so you can help them the same way you helped the new member.

This call cannot be used to sell products. If the member wishes to discuss alternative plan options, another call would have to be made. If the member states they wish to disenroll during the call, instruct them to call the customer service number on the back of their member ID card. In a professional manner, close the call.

Enrollment Application Cancellation, Withdrawal, or Disenrollment Requests for CMS Regulated Plans

A consumer or legal representative may request, for any reason, to cancel, after submission to the Centers for Medicare & Medicaid Services (CMS), or withdraw, prior to submission to CMS, their Enrollment Application prior to the effective date of coverage. A consumer's enrollment can only be cancelled or withdrawn if the request is made (based on the date the telephone call or written notification is received by UnitedHealthcare or representative) prior to the effective date of the enrollment. Cancellations are permitted after the members' effective date only when it's the result of an OEV call and is within 7 days of that call.

In addition, the member or legal representative may request to terminate their enrollment in a plan after the effective date.

If a consumer requests to withdraw their Enrollment Application prior to the agent submitting the Enrollment Application, the agent must return the Enrollment Application to the consumer.

You are not permitted to accept any requests to cancel or withdraw an Enrollment Application or terminate enrollment in a plan once the Enrollment Application has been submitted. You must direct all requests to cancel or withdraw Enrollment Applications or terminate enrollment to UnitedHealthcare Member Retention Department at 1-888-867-5554.

You may neither verbally nor in writing, nor by any action or inaction, request or encourage any member to disenroll. Furthermore, you are not permitted to make additional contact with a member or legal representative who requests to cancel or withdraw their Enrollment Application or disenroll from the plan.

Customer Service Resources

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

Below is a listing of the customer service hours of availability and telephone numbers for various plans. Because information may change, it is advised that the member refer to the back of their ID card.

Customer Service – PFFS
8 a.m. to 8 p.m. local time, 7 days a week
Telephone: Please refer to the telephone number on the back of the member's ID card.

Customer Service – HMO/PPO/RPPO/POS
8 a.m. to 8 p.m. local time, 7 days a week
Telephone: Please refer to the telephone number on the back of the member's ID card.

Customer Service – AARP Medicare Supplement Insurance Plan
7 a.m. to 11 p.m. Eastern Standard Time
Monday - Friday
9 a.m. to 5 p.m. Eastern Standard Time - Sunday
Telephone: 1-800-523-5800
TTY: 1-800-232-7773

Section 8: How Do I Get Paid?

Compensation Overview

Note: All references to "FMO" apply to the "EDC".

Effective October 12, 2011, (or October 15, 2012 for Care Improvement Plus and Preferred Care Partners products, or October 1, 2013 for Medica HealthCare products), you will be eligible for a commission if you are the writing agent of an Enrollment Application and properly credentialed (i.e. contracted, certified in the product in which the consumer enrolled, licensed, and appointed (if applicable) in the state in which the consumer resides) at the time of the sale.

Enrollment Applications written prior to October 12, 2011, the writing agent and the writing agent's entire up-line is eligible to receive commission only if both the agent and writing agent's entire up-line is properly credentialed at the time of sale.

Agent Compensation

Compensation is defined by the Centers for Medicare and Medicaid Services (CMS) as monetary or non-monetary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commission, bonuses, gifts, prizes, awards, and finder's fees. Medicare Managed Care Manual, Chapter 3, "Medicare Marketing Guidelines".

Commission

Commission is a form of compensation given to an agent for new enrollments and membership renewals of consumers in the plan that best meets such consumers' health care needs. Plan sponsors are not required to compensate agents or brokers for selling Medicare products. However, if plan sponsors do compensate agents or brokers, such compensation must comply with CMS and other regulatory guidance.

- Plans must establish a compensation structure for new enrollments and renewals effective in a given plan year. The compensation structure:
  - ~ Must be reasonable and reflect fair market value for services performed.
  - ~ Must comply with fraud and abuse laws, including the anti-kickback statute.
  - ~ Must be in place by the beginning of the plan year marketing period, October 1.
  - ~ May not be altered during the plan year.
  - ~ Must be available upon CMS request for audits, investigations, and to resolve complaints.

- If plans pay commissions they must abide by CMS guidance by paying commissions for initial year (i.e. new to Medicare) enrollments and at least five subsequent renewal years (renewal compensation), thus creating, at minimum, a six-year compensation cycle. CMS will determine if an enrollment qualifies as an initial year or renewal year enrollment and will direct the Plan on which compensation level should be paid. Starting with application effective dates 1/1/2009, the following rules pertain to the compensation cycle:
  - ~ The commission amount paid to an agent or broker for enrollment of a Medicare consumer into an MA or PDP plan is as follows:
    - o The prior year's new commission amount for initial year and renewal year rates adjusted by the change in rates CMS announces each year.

- Upon receipt of a CMS approved application and validation of the writing agent's credentials, compensation for a new enrollment will be the renewal year rate. Commission for a new enrollment is as paid as an advance or the full year amount.
- Commission for a new enrollment is as paid as an advance or the full year amount. Beginning with 1/1/2014 effective dates, commission will be paid based on the months the member is enrolled for the plan benefit year. CMS Guidelines state a plan year ends on 12/31 regardless of effective date of the enrollment. For example, the compensation amount paid for 7/1/2014 effective date will be half of the annual renewal rate or 6 months of Per Member Per Month (PMPM).
- Upon notification from CMS that a member qualifies as an initial year member, the commission for the new enrollment will be reversed and repaid at the initial year rate. Note: Beginning with 1/1/2014 effective dates, compensation for enrollments designated as initial year by CMS will be paid the initial rate based on the months the member is enrolled during their initial plan year. An exception to this prorated payment calculation exists for Dual Special Needs Plans and Prescription Drug Plans, which will be paid the full initial year amount regardless of effective date. CMS guidelines state a plan year ends on 12/31 regardless of effective date of the enrollment. Commission for enrollments in a different plan of "like plan type" will be paid at the renewal year rate. "Like plan type" means PDP replaced with another PDP, MA, or MA-PD replaced with another MA or MA-PD, or cost plan replaced with another cost plan. See section below for rules regarding commission payment to the Agent of Record (AOR) in the case of a service area reduction (SAR) or plan exit.
- Renewal commission is an amount equal to fifty percent of the initial year compensation rate and is paid so long as the agent is in good standing according to the terms of the agent's contract and the member is still enrolled. Beginning with 1/1/2014 effective dates renewal compensation will begin in January of the following plan benefit year. For example, Renewal compensation for a July 2014 effective date will begin in January 2015 on a Per Member Per Month basis.

~ Exceptions to above rules:

- Sales of Sierra branded products are paid the initial or renewal year rate upon receiving notification from CMS of the cycle year.
- Sales of Care Improvement Plus products, upon notification from CMS that a member qualifies as an initial year member, the difference between the initial year rate and the previously paid renewal year rate is paid.

~ If the member leaves the plan:

- Voluntarily within the first three months, the full amount of commission paid is charged back.
- Voluntarily in months 4 to 11, commission paid is charged back on a pro-rated basis based on the number of months the member was in the plan
- Involuntarily in months 1 to 11 (for example due to a plan exit) commission paid is charged back on a pro-rated basis based on the number of months the member was a member of the plan. Note in the event of an involuntary disenrollment, the basis for the pro-rated charge back is the renewal year portion of the commission thereby retaining true up dollars. Beginning with 1/1/2014 effective dates, the basis for the pro-rated charge backs will include true up dollars.
- Charge backs will be recovered from both new and renewal commissions in the next available commission cycle. If there is not enough new or renewal commissions to offset the charge back, the balance of the charge back is rolled into the next commission cycle. This continues until the charge back is repaid in full. See also Debt Repayment Plan section.

- All terminations that result in a full or prorated charge back will be processed regardless of the date the termination is received.

Credential Validation Rules

UnitedHealthcare and AARP-Branded Products Care Improvement Plus Products as of 1/1/2013 effectives Preferred Care Partners and Medica HealthCare Products as of 1/1/2014 effectives		
Writing Agent Credential Validation Rules *Includes applications written by a Solicitor*		
Writing Agent Validation	**New Transaction** (submitted during or after the effective date of the status change) *Applies to writing agent and any up-line overrides*	**Renewal/Premium Transaction** *Applies to writing agent and any up-line overrides*
Party Status = Not Active	Pend	Process If New processed
Party Status = Suspended	Do Not Pay	Process If New processed
Party Status = Term For Cause	Do Not Pay	Do Not Pay
Party Status = Term due to Death	Do Not Pay	Do Not Pay
Deauthorized for Product	Do Not Pay	Process If New processed
Appointment not active as of app sign date	Pend	Process If New processed
License not active as of app sign date	Pend	Process If New processed
License Line not active as of app sign date	Pend	Process If New processed
Contract Version not valid as of app sign date	Pend	Process If New processed
Certification for product not valid as of app sign date	Pend	Process If New processed
Sierra Products as of 1/1/2012 effectives		
Writing Agent Credential Validation Rules *Includes applications written by a Solicitor*		
Writing Agent Validation	**New Transaction** (submitted during or after the effective date of the status change) *Applies to writing agent and any up-line overrides*	**Renewal/Premium Transaction** *Applies to writing agent and any up-line overrides*
Party Status = Not Active	Do Not Pay	Process If New processed
Party Status = Suspended	Do Not Pay	Process If New processed
Party Status = Term For Cause	Do Not Pay	Do Not Pay
Party Status = Term due to Death	Do Not Pay	Do Not Pay
Deauthorized for Product	Do Not Pay	Process If New processed
Appointment not active as of app sign date	Do Not Pay	Process If New processed
License not active as of app sign date	Do Not Pay	Process If New processed
License Line not active as of app sign date	Do Not Pay	Process If New processed
Contract Version not valid as of app sign date	N/A	N/A
Certification for product not valid as of app sign date	Do Not Pay	Process If New processed

Commission Payment Schedule and Payment Calculation

Commission Payment Schedule

- Medicare Advantage (MA) Plans and Prescriptions Drug (Part D):
  - ~ New Business – paid twice weekly, Per Member Per Year
  - ~ Renewals – paid monthly, Per Member Per Month, MA renewals are processed the third weekend of the month and PDP renewals are processed the fourth weekend of the month
- AARP Medicare Supplement Insurance Plans
  - ~ New business advances and updates to current book of business - processed weekly*
  - ~ Premiums and Renewals – processed monthly**
- Exceptions to above rules:
  - ~ Sierra Medicare Advantage (MA) plans are paid once a month for New Business and Renewals
  - ~ Sierra pays Sierra Health and Life (SHL) Medicare Supplement as follows:
    - o New business – once a week
    - o Renewals – once a month
  - ~ Care Improvement Plus Plans:
    - o New Business - paid once a week
    - o Renewals – paid once a month
  - ~ Preferred Care Partners Plans
    - o Renewals for effective dates of 2012 and earlier – paid once a month

* AARP Medicare Supplement Insurance products are paid a nine month advance (as noted here or in the contract). The advance is not considered fully earned until the member has been enrolled nine months. As premium is paid for months one through nine, a portion of the advance is considered earned. Example: If the member terminates in month seven, two months of the advance are considered unearned, and will be charged back to the agent. Note: An exception to this rule is when a member enrolls in a plan effective January 1 and pays their premium for the full year through December 31 in advance (by the end of January). Then the commission advance is considered fully earned in the month of February. However, if the plan terminates during the first year, the agent will be charged back for commissions paid for months plan is not in force.

** Monthly premiums and renewals for AARP Medicare Supplement Insurance products begin in month ten and are processed the first weekend after the first full week of a month.

Tax Information

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

Garnishment

All commission payments will be withheld if a formal notification of garnishment is received. Garnishment amounts will be paid to the appropriate agency or organization once per quarter. Garnishment of all commission payments will continue until the total amount of the garnishment is satisfied or a notice of satisfaction is received from the garnishing agency.

AARP Medicare Supplement Insurance plans – Charge backs

- Commissions are earned on paid premiums. Any unearned commission paid on an AARP Medicare Supplement policy will be charged back to all levels that were paid for that policy.
- Charge backs will be recovered from the next available commission payment of any UnitedHealthcare product.

If there is not enough new or renewal commissions to offset the charge back, the balance of the charge back is rolled to the next commission statement. This continues until the charge back is repaid in full

Miscellaneous Forms of Compensation

Commissions, bonuses, gifts, prizes, awards, and finder's fees are examples of compensation. The value of all forms of compensation must be included in the total compensation amount paid to agents for an enrollment and may not exceed the limits set forth in the CMS agent compensation regulations and implementing guidance.

Reimbursement of Costs Associated with Selling

The following are not considered compensation according to CMS:

- Payment of fees to comply with State appointment laws, training and testing, and certification.
- Reimbursement for actual costs associated with consumer sales appointments such as venue rent, materials, and snacks.

Agent of Record

(Does not apply to AARP Medicare Suplement Insurance plans)

In certain circumstances, and when eligibility requirements have been met, a renewal eligible agent's status as Agent of Record (AOR) and associated entitlement to renewal payments for a qualifying consumer enrollment facilitated by a non-renewal eligible agent. Plans that qualify for AOR retention are identified on an annual basis and the list is available upon request. Agents of Record remain responsible for contacting the member to assess needs, answer questions and, where appropriate, facilitate enrollment in a plan that best meets the member's needs.

Eligibility Requirements

All of the following qualifying enrollment requirements must be met in order for a non-employee agent to be eligible to receive AOR protection:

- The current member is leaving the plan due to a Service Area Reduction (SAR)/Plan Exit
  - ~ The member is impacted because the current plan is closing.
  - ~ The member is able to choose a new plan during Open Enrollment Period (OEP) or a Special Election Period (SEP).
- The current member must switch from the current plan to a different UnitedHealthcare Medicare Advantage plan during OEP or SEP, if applicable, granted due to disenrollment (Note: Plan switches between a Medicare Advantage plan and a Medicare Supplement Insurance or Part D plan ***do not*** qualify for retention of the original AOR).
- The original AOR prior to the member's plan switch must be a renewal-eligible agent; and appropriately licensed, appointed, and product certified or the new plan year; and
- The agent enrolling the current member in the new UnitedHealthcare Medicare Advantage plan must be a Telesales agent ineligible for Medicare Advantage renewals, or the plan switch may be via Web or paper Enrollment Application without involvement of a renewal-eligible agent.

Commission Payment

- For qualifying enrollments, the original AOR is retained.
- The retained AOR (and the AOR's up-line, if applicable) will receive a new commission at the renewal year rate for the new enrollment.

- For non-qualifying enrollments, such as switching a member from a plan closure to a Medicare Supplement Insurance or Part D plan, the agent facilitating the plan switch will become the new AOR and, if eligible, will receive any commission payments per standard procedures.

Assignment of Commission

(Assignments for Sierra Legacy Products effective prior to January 1, 2012; continue to be honored for the assignee in place)

Agent Assignment to an Individual or Entity

- The assignor must be contracted, licensed, certified, and appointed (if applicable) in the state in which the consumer resides by UnitedHealthcare.
- The assignee, an individual or entity represented by a principal, must be contracted, licensed, certified, and appointed (if applicable) in the state in which the consumer resides and the principal must have a writing number.
- The assignor and the assignee must belong to the same distribution channel. For example, an Independent Career Agent (ICA) cannot assign commissions to an External Distribution Channel (EDC) agent and an EDC agent cannot assign to an ICA.
- For the EDC, the agent can assign only to another agent or entity within the same EDC hierarchy. For example, an agent that rolls up to the ABC, Inc. cannot assign to an agent that rolls up to XYZ.
- Assignment to an estate, widow(er), or heir(s). Under the Agent Agreement, death of the agent is an Automatic Termination and the company shall cease paying compensation to the agent and no further payment shall be due. Exception: for AARP Medicare Supplement Insurance plans issued in the state of Washington, agent commissions will continue to be paid to a successor agent. (This applies to agents on the 2008 contract. Refer to specific contract for details to assignment of commission in the event of death.)
- Assignment of commissions can only occur to one individual or entity at 100%.

Assignment of Commission Process

Agents can request to assign commissions by submitting a properly executed Assignment of Commissions form to SH_Commissions_administration@uhc.com or faxing it to 1-866-761-9162, Attn: Commissions Department. Forms are available through the Distribution Portal under the Contact Us tab located in the upper-right hand corner of the page. Assignment is effective on the date the Assignment of Commissions form is signed by an authorized officer of UnitedHealthcare.

Termination of Authorization to Assign Commissions

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

- Termination of the assignee.
- Termination of the assignor.
- Assignee's failure to maintain proper credentialing.
- Assignor's failure to maintain proper credentialing.
- The assignor submits a written request to terminate authorization to assign commissions. Note: The assignee has no right to revoke a request to terminate an authorization provided by the assignor.

Electronic Funds Transfer

(Does not apply to SecureHoizons Medicare Supplement products)

There are two ways to submit an Electronic Funds Transfer (EFT) request:

- Online Submission
  - ~ Utilize the self service capability within the Distribution Portal.
    - www.unitedhealthproducers.com
  - ~ Update current EFT account information or add EFT account information to change current payment method from paper to EFT.
  - ~ An email confirmation is sent to email address on file.
  - ~ The updated EFT change may take up to two commission cycles to take effect.
- Email or Fax Submission
  - ~ Complete, sign, and date an Electronic Funds Transfer (EFT) form.
  - ~ Attach a voided check to the Electronic Funds Transfer (EFT) form.
  - ~ Submit, by one of the following methods, the completed form and voided check:
    - Email to the Producer Help Desk (PHD) at phd@uhc.com (the subject line should contain the agent's Writing ID number, available 24 hours).
    - Email to the Commissions Department at SH_Commissions_Administration@uhc.com.
  - ~ Fax to 1-866-761-9162 Attention: Commissions Department. If EFT form is submitted via email or fax the agent will receive a Service Request response with confirmation the change request has been received and the changes have been processed by the Commissions Department within three business days.
  - ~ If the email is sent to the PHD the agent will be notified the change will be processed within three business days. The Commissions Department will notify the agent when the change has been made if an accurate authorization form and voided check submitted.
  - ~ All follow-up calls associated with the request should be directed to the PHD at phd@uhc.com (the subject line should contain the agent's Writing ID number, available 24 hours) referencing the Service Request number.

Commission Payment Audit

An agent can submit an audit request when he/she disagrees with a payment amount, including instances when the agent was not paid, but feels he/she should have been. Effective July 12, 2012, audit requests related to commissions for new enrollments must be submitted within twelve months of the effective date and requests related to commissions for renewals must be submitted within twelve months of the date renewal commissions should have processed. The request must be in writing and must detail the specific applications you are questioning. If an issue with the commission payment system is identified, it will be corrected and the commission will be processed systematically. A follow-up communication will be sent to you. All decisions made by the auditing department are final. (Note: this rule will be waived if required due to a CMS, DOI, or legal proceeding.)

Audits can be submitted for UnitedHealthcare MA/MA-PD, SNP, PFFS and AARP MA/MA-PD, PDP, Medicare Supplement, SecureHorizons Medicare Supplement, and Sierra Products

- You must complete a Producer Help Desk (PHD) Service Request form located on the distribution portal under Contact Us on the home page.
- You must email the completed Service Request form to the PHD at phd@uhc.com (the subject line should contain the agent's Writing ID number, available 24 hours) to

open a Service Request to process a commission payment audit request.
- If the member listed in the Service Request form is verified to be active, enrolled, and assigned to you, the Service Request will be escalated to the Commissions Audit department for additional research.
- If during the course of examination by the Commissions Audit department, an issue is identified with the commission payment system, the issue will be corrected and the commission will be processed systematically to ensure proper payment and/or the correct stream of renewal payments.
- Results of the audit of each application will be communicated to you by the Commissions Audit department.
- All responses will be stored within the PHD Service Request.
- All follow-up calls associated with the request should be directed to the PHD at phd@uhc.com (the subject line should contain the agent's Writing ID number, available 24 hours) with reference to the Service Request provided.

Pended Commission Process **(Does not apply to Sierra, or UnitedHealthcare Medicare Supplement products)**

Commissions are paid to eligible EDC agents for Enrollment Applications that are complete, legible, and accurate. An EDC agent is eligible to receive commission if at the time of sale, as indicated by the date of consumer signature on the Enrollment Application, they were fully credentialed (i.e. contracted with UnitedHealthcare, licensed and appointed, where applicable, in the state in which the consumer resides, and certified in the product in which the consumer enrolled). Commission will be withheld (pended) if the writing agent fails any of the credential validation checks, as well as if an invalid writing number is entered on the Enrollment Application. If the agent is not licensed at the time of sale, they will be terminated and the member will be notified of the sale involving an unqualified agent. (Refer to the section within this guide related to termination due to an unqualified sale.)

Reporting and Communication Process

- Weekly No Pay Agent Communication
  A weekly communication (each Friday) of pending sales and/or payments is sent to the affected agent and his/her NMA/FMO/SMA.
  - ~ A communication is sent primarily via email.
  - ~ An exception process is in place for an instance where the agent has no email on file or the email is invalid.
  - ~ Updated email information is gathered from the agent so the no pay communication can be sent to the agent.
  - ~ In cases where email communication is not possible, a letter will be sent to the agent via postal delivery.
  - ~ A summary of all weekly communication is provided to EDC leadership.

- Pended Commission Status Reporting
  The agent and their up-line, or manager/supervisor, have the ability to review commission status and statements under the Commission Status tab on the distribution portal. If a commission is pended, the reason(s) for payment ineligibility is provided. In addition, the Pended Sales Report is provided to EDC channel leadership on a weekly basis.

- Sales Leadership Reports
  - ~ Pended Sales Report (Weekly Activity Report): The Commissions Department generates a pended transaction report, by channel, on a weekly basis and distributes it to the EDC channel leadership.

Review and Resolution Process

The primary goal of the review process is to determine whether a pended commission is eligible for payment or is legitimately pending due to an issue with agent credentialing and/or Enrollment Application quality. You and your

manager have the ability to review commission status and statements under the Commission Status tab on the distribution portal. If a commission is pended, the reason(s) for payment ineligibility is provided. The process for pended commission review and resolution includes the following steps:

- Appeals process - the communication outlines a clear appeal process that you may utilize if you feel the transaction has been pended inappropriately.
  - ~ You have 30 days from receipt of the communication to submit an appeal to the PHD at PHD@uhc.com (the subject line should contain the agent's Writing ID number, available 24 hours).
  - ~ From there, the Agent On-Boarding, Certification, and/or Commissions team will review the appeal and determine if it will be approved or denied.
  - ~ The appeals process can take up to 14 business days, and you are contacted via email, telephone, or letter with the final decision on the appeal.
- Analyst review – appeals are forwarded to an Agent On-Boarding and/or Certification analyst for review.
- Commission Appeal Committee review – research findings will be forwarded to the Commission Appeal Committee that consists of representatives of Commissions, Certification, Agent On-Boarding, Sales Learning and Development, Compliance, and Broker Sales.
- Agent Notification and System Updating – you and your manager will receive written notification of the Commission Appeal Committee's final decision.

Plan changes

Medicare Advantage and Part D Plans

- Any MA/MA-PD or PDP plan and/or plan benefit package change effective January 1, 2009, or later is a commissionable event and results in a new commission paid on a Per Member Per Year (PMPY) basis. This applies to Care Improvement Plus and Preferred Care Partners from January 1, 2013, forward.

- If the effective date of the plan change is within the rapid disenrollment period of the original /prior effective date, the prior agent will be subject to full or prorated charge back depending on if the termination was involuntary.

- If the effective date of the plan change is in month four through eleven of the original/prior effective date, the prior agent will receive a prorated charge back per CMS guidelines.

- If the effective date of the plan change is in month thirteen or later of the original/prior effective date, the prior agent will not receive renewals on the original/prior policy.

Debt Repayment Plan

UnitedHealthcare Medicare Solutions routinely conducts commission administration audits using the Medicare Membership Report from CMS to validate that an agent no longer received renewal commissions following a member's rapid disenrollment from a Medicare Advantage or Prescription Drug Plan. When the audit process reveals an overpayment, the impacted agent is charged back accordingly.

- In order to minimize the impact of large charge backs created as a result of an audit, an agent may request a debt repayment plan by submitting an appeal to the PHD via email at PHD@uhc.com. Debt repayment options are only available for charge backs for the sale of Medicare Advantage and Prescription Drug plans and in situations where large debt is created due to audits of commission payments. Debt repayment options are not available for charge back debt created as a result of day-to-day commissions processing. To request a debt repayment plan:

- ~ The agent must be in good standing (i.e. agent is not the subject of an open complaint investigation and/or open corrective and/or disciplinary action outreach),
- ~ The agent must have an existing renewal book of business, **and**
- ~ The amount of debt must exceed 2 months of renewal payments.

- If the agent meets those requirements, the following guidelines apply:
  - ~ Debt balances under $10,000 will be spread over 3 months
  - ~ Debt balances greater than or equal to $10,000 will be spread over a 6 month period
  - ~ Debt balances under $25,000 that are more than 3 times the current renewal book will be spread over 9 months
  - ~ Debt balances greater than or equal to $25,000 that are more than 3 times the current renewal book will be spread over 12 months

Commission for SecureHorizons Medicare Supplement Product

SecureHorizons Medicare Supplement commissions pay out weekly at the close of business each Friday. Advanced commissions are paid weekly, while renewal commissions are paid monthly.

All commissions are paid as a percentage of the initially billed premium, regardless of the current premium. In the standard structure, the commissions are paid at the maximum percentage of the initial premium billed. Every new policy sold has the same structure (standard or likewise, with a few exceptions) applied.

Commission Processing Calendar

- UnitedHealthcare pays agents for all business either by check or through Electronic Funds Transfer into the agent's bank account. Commissions for SecureHorizons Medicare Supplement products are administered by CHCS Inc.

- Each contracted entity receives a weekly statement detailing the commission activity for their personal production.

- New Business - Advanced
  - ~ Paid weekly.
  - ~ Cycle closes Wednesday at the close of business.
  - ~ Completed Enrollment Applications are processed from Thursday through Wednesday and commissions are paid Wednesday night.
  - ~ Direct deposits are wired to bank accounts Thursday and funds are available Friday (for most banks).
  - ~ Statements and checks, where applicable, for new business are mailed on Thursday.

- Renewals – All
  - ~ Paid monthly.
  - ~ Cycle closes the last Friday of the month at the close of business.
  - ~ Direct deposits wired to bank accounts Monday and funds are available Tuesday (for most banks).
  - ~ Statements and checks, where applicable, for renewals are mailed on Monday.

For questions about UnitedHealthcare Medicare Supplement commissions, contact CHCS at 1-888-202-4340 (Monday-Friday 7am – 7pm CST) (Licensing, Contracting, and Commission Department).

Section 9: What are Expected Performance Standards?

Compliance and Ethics

Agent Performance Standards

Complaints and Allegations of Agent Misconduct

Suspension of Sales and Marketing

De-authorization of Authority to Sell Specific Products

Termination of Non-Producing Agent

Administrative Termination

Termination Due to Unqualified Sale

Agent Termination – Not-For-Cause and For-Cause

Compliance and Ethics

Code of Conduct

Overview

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

Act with integrity

- Recognize and address conflicts of interest.

Be Accountable

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

Protect Privacy. Ensure Security

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

Your Role and Responsibilities

- To fulfill your Compliance Responsibilities.

Stop. Think. Ask.

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

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

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

Compliance Reporting Resources

- Compliance Question compliance_questions@uhc.com
- Privacy & Security incidents psmg_privacy@uhc.com
- The UnitedHealth Group Compliance & Ethics Help Center 800-455-4521

The complete Code of Conduct can be accessed on the Distribution Portal home page under the 'Documents & Links' section.

Conflict of Interest

A conflict of interest can occur when financial interests or activities (e.g., employment, ownership) could affect the ability of the employee, contractor, or agent to comply with UnitedHealth Group's Code of Conduct. All employees, contractor, and agents contracted with UnitedHealthcare attest that they have read, understand, and will abide by UnitedHealth Group's Code of Conduct.

The activities your immediate family (e.g., parent, spouse/domestic partner, child, and sibling) may also cause a conflict of interest.

Types of Conflict of Interest
There are several situations that create the potential for a conflict of interest when acting as a representative UnitedHealthcare. They include, but are not limited to:

- Employment with UnitedHealth Group or its Affiliate
  An employee of UnitedHealth Group or its affiliate is simultaneously in a non-employee contractual relationship with UnitedHealthcare, (e.g., Independent Career Agent).

- Ownership Interest in a Provider or other Business Partner

  An employee, contractor, or agent has a direct or indirect ownership interest in a health care provider or UnitedHealthcare business partner, including, but not limited to health care service and/or equipment provider, vendor, supplier, or manufacturer.

- Relationship with a Provider or other Business Partner

  An employee, contractor, or agent has an employment or other type of relationship or position of influence with a health care service and/or equipment provider, vendor, supplier, or manufacture or a UnitedHealthcare business partner.

Disclosure of a Conflict of Interest

- You must disclose any real or potential conflicts of interest at the time of hire and as they arise while employed by UnitedHealth Group or its affiliates.
- You must disclose any real or potential conflicts of interest at the time of contracting and as they arise while contracted with UnitedHealthcare. The contracting process will suspend until the conflict has been removed or it is determined that it can be compliantly managed.

Management of Conflict of Interest
If it is determined a conflict of interest exists, UnitedHealthcare will take one or more of the following actions:

- Require the employee, contractor, or agent to divest of the conflict.
- Develop a conflict resolution and management plan approved by the Distribution Compliance Officer and Vice President of Sales Oversight.
- Terminate the employee, contractor, or agent.

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.

Section 9: What are Expected Performance Standards?

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

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

Under HIPAA, if member information is disclosed to an unintended recipient, the UnitedHealthcare Government Programs 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)
- Notify the media
- In addition, individuals, including employees, 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 privacy or security incidents through:

- Incidents should be reported to one of the following:
  - o The Government Program Privacy Office at psmg_privacy@uhc.com
  - o Your supervisor or manager
  - o The Segment Compliance Officer/Compliance Lead
  - o The Ethics & Compliance Help Center at 1-800-455-4521 (24 hours a day, 7 days a week)
- Security incidents (unauthorized access of UHG data/systems, laptop theft) must be ***immediately*** reported to the UHG Support Center at 888-848-3375 (24 hours a day, 7 days a week)
- UnitedHealthcare prohibits retaliatory action against any individual for raising concerns or questions regarding ethics and compliance matters or for reporting suspected violations in good faith.

Protected Health Information (PHI)

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

- Individual + Health Information = PHI
  - o For Example: John Doe has diabetes = PHI
- The fact that someone is applying for coverage or is enrolled in a UnitedHealthcare plan is considered health information

Personal Identifiable Information (PII)

PII is a person's first name or last name in combination with one or more of the following date elements:

- Social Security Number
- Driver's License Number or State Identification Card Number
- Account Number, Credit Care or Debit Card Number in combination with any required security code, access code or password that would permit access to an individual's financial account.

PHI and PII can by in any form or medium, including oral, written or electronic communications.

Examples of disclosures include:

- Leaving hard copy documents behind at a sales/marketing activity
- Faxing documents with PHI to an incorrect fax number
- Mailing documents with PHI to an incorrect address
- Lost or stolen hard copy documents (e.g., Enrollment Applications)
- Stolen unencrypted computers
- Sending an email with PHI to an incorrect email address (outside of UnitedHealthcare walls)

A few best practices you should follow:

- Only carry the minimum amount of hard copy documents containing any PHI or PII information required to complete any tasks.
- Keep documents containing member/consumer PHI or PII with you at all times while out on other sales activities, placing documents in a folder or locked briefcase.
- Keep documents in a secure locked area (e.g., file cabinet).
- Avoid discussing member/consumer information in public locations.
- Ensure that you take all documents containing member/consumer PHI or PII with you when you leave a sales activity.
- Keep your laptop or documents with you at all times – never leave your laptop or hard copy documents in your car.
- Ensure all laptops are protected by encryption software.
- Position monitors or laptops to minimize viewing PHI/PII by unauthorized personnel or the general public.
- Always use a fax cover sheet – with a HIPAA Privacy Statement when faxing PHI or PII.
- Double check the fax number or email address to ensure the intended recipient receives the document. Email documents using secure delivery.

You must not:

- Leave hard copy documents unattended in an area where the documents could be viewed by others (e.g., desk, vehicle, table, or booth).
- Discuss consumer/member information in public spaces (e.g., halls, elevators, lobbies, lunchrooms, cafeterias, restaurants, lavatories, parking lots) or other unsecured public places where the conversation could be overheard. Be cognizant of eavesdroppers and others who may appear to be interested in your business.
- Leave laptops and/or documents containing PHI/PII unattended or unsecured outside the workplace (e.g., at home, at a hotel, while traveling, unattended in a vehicle).
- Share, store, or use consumer/member information inappropriately.
- Put consumer/member information on a jump drive (or similar portable storage device).
- Scan and/or store paper Enrollment Applications electronically.
- Throw hard copy documents containing PHI/PII in the trash. Shred the documents.

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 man an informed decision
- You must inform consumers of the advantages, as well as, the limitations of the products you present
- You must disclose the interest you have in the transaction (e.g., any commissions received for a successful sale)
- Disclose all true out-of-pocket costs including, but not limited to, the fact that the consumer must keep paying their Medicare Part B premium
- Disclose the annual maximum out-of-pocket limit
- Take the time to answer the consumer's questions

Competency

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

Section 9: What are Expected Performance Standards?

Suitability

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

You can report potential misconduct or policy violations to:

- Your Manager, Supervisor, or Sales Director
- Compliance_Question@uhc.com
- UnitedHealth Group Compliance and Ethics Help Center (800) 455-4521 (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

All agents are expected to comply with CMS regulations and guidelines, federal and state laws, and UnitedHealthcare rules, policies and procedures.

- External Distribution Channel (EDC) and company sales management personnel provide ongoing monitoring of your sales activities, performance against business objectives, and compliance to all applicable CMS regulations and guidelines, federal and state laws and UnitedHealthcare rules, policies, and procedures and document any performance or compliance issues and take corrective and disciplinary action when necessary.

- Sales management uses monitoring tools and processes to review your compliance, quality, and performance against minimum required performance thresholds.

- You will receive coaching, required corrective action, and/or other progressive discipline if you fail to meet defined performance thresholds.

One-on-One Evaluations

If you are authorized to sell the UnitedHealthcare Community Plan – Massachusetts product, you are required to complete product specific training, attend periodic meetings, and will be monitored by UnitedHealthcare sales management. Training and monitoring include:

- Attendance at weekly meetings with UnitedHealthcare sales management for continuing education, training, and case reviews for the first three months upon certification for the UnitedHealthcare Community Health Plan - Massachusetts product.

- Attendance at monthly meetings with UnitedHealthcare sales management for continuing education, training, and case reviews after the initial three month period following the UnitedHealthcare Community Health Plan - Massachusetts product certification.

- UnitedHealthcare sales management will perform a monthly ride-along to observe you at a face-to-face personal/individual marketing appointment.

Review and Monitoring of Agent Performance

Sales management will review and monitor agent performance data available for the following monitoring programs:

- Rapid Disenrollment Rates
- Late Enrollment Application Submission
- Secret Shopper Results
- Outbound Enrollment and Verification Call Results
- Call Monitoring Results
- Complaints
- Contracting, Licensing, Appointment, and Certification Status

Thresholds are established for each monitoring program. You will be contacted if your compliance, quality, and/or performance data is of an unacceptable level according to defined thresholds. You may receive progressive outreach and discipline including coaching, training, corrective action, and/or termination.

Compliance Monitoring and Thresholds

UnitedHealthcare Medicare Solutions has implemented a variety of compliance monitoring programs to ensure all agents are conducting sales, marketing, and enrollment activity in accordance with federal, state, and company regulations, rules,

and guidelines. Compliance monitoring programs that are reported in the Agent 360 Dashboard include:

- Call Monitoring
- Complaints
- Late Enrollment Applications
- Outbound Enrollment and Verification (OEV) Calls
- Rapid Disenrollment
- Secret Shopper (The Centers for Medicare and Medicaid Services (CMS) and Vendor)

While monitoring programs are inherently designed to identify weaknesses, the goal is to use the information to consistently and constantly improve future behavior and outcomes, thus increasing the mutual success of the agent, manager, and business.

Calculation methods and thresholds have been established for all compliance monitoring programs and are periodically reviewed. Calculation methods and thresholds may vary between agents and managers. For easy identification, threshold status results within the Agent 360 are color-coded Green, Yellow, and Red to correspond with acceptable evaluation or results; results trending toward becoming unacceptable; and unacceptable evaluation or results, respectively.

Late event reporting and unqualified sales are two additional monitoring programs that are not reported through Agent 360. You may be monitored on late event reporting and unqualified sales.

Each of the monitoring programs, along with the calculation method and thresholds, are described in the following sections. *Agent Threshold* is a consolidated table of each program's calculation method and thresholds and can be found at the end of the Compliance Monitoring and Thresholds section.

Complaints

Complaints can be received from a variety of sources both external and internal to the company. All complaints are received by the Agent Compliant Tracking (ACT) team. Complaints requiring investigation are forwarded to the Compliance Investigations Unit (CIU). Investigated complaints receive a disposition of but not limited to Substantiated, Inconclusive, Unsubstantiated, Inconclusive, Insufficient Information, No Allegation, or Non-Response. The agent may also be referred to the Complaint Education Contact (CEC) process, Complaint Education Contact 2 (CEC2) process, Corrective Action Referral (CAR) process, or Disciplinary Action Committee (DAC) process.

The determination of the threshold in the Agent 360 is based upon the investigation outcome or process to which the agent was referred. A complaint can result in disciplinary action from additional education up to and including termination.

Late Enrollment Applications

Late Enrollment Applications is a compliance program that monitors the timely submission of Enrollment Applications. An Enrollment Application is late when the received date by Enrollment is greater than three calendar days from the agent signature date. For AARP Medicare Supplement Enrollment Applications, an Enrollment Application is late when the received date is greater than 16 calendar days from the agent signature date.

Outbound Enrollment and Verification (OEV)

OEV is a compliance program that has three primary goals: to confirm the consumer's intent to enroll in the plan; to ensure the consumer understood the plan benefits and the plan requirements, as explained by their agent; and to verify that the selling agent complied with established sales guidelines. All Medicare plans, including Part D, participate in the program. Note:

Medicare Supplement, Employer Group, and plan switchers are not included in the program.

Decision Support Systems Research (DSS) is a UnitedHealthcare Medicare and Retirement contracted vendor that performs the verification calls. DSS representatives are not licensed agents and have very limited access to the consumer's information; therefore, consumers will be given the number to Customer Service if they ask any questions.

UnitedHealthcare Medicare and Retirement sends a data file of all new Enrollment Applications to DSS via a secured FTP site on a daily basis. DSS will make three call attempts within 15 days, the first two calls must be within the first 10 days of the Enrollment Application receipt date as indicated by the agent's signature date on the Enrollment Application. If the first and second call attempts are unsuccessful, a letter from DSS is sent explaining the OEV process and requesting the consumer to call DSS. This is a CMS requirement. If the consumer is contacted on the second or third attempt, they will be advised to disregard the letter.

DSS utilizes a CMS approved script to ask the consumer a series of questions based on the product. Any question to which the consumer provides a negative response is considered an infraction. Territories and agents with a high infraction rate will be reported through the Agent 360 Dashboard.

Rapid Disenrollment

Rapid Disenrollment is a compliance program that monitors consumer disenrollment from a plan within three months of the effective date.

You should strive to enroll each consumer in the plan that best meets the consumer's health care needs. In addition, you must meet company and regulatory guidelines during the presentation to ensure the consumer understands the benefits and requirements of the plan in which they are enrolling. By enrolling the consumer in the plan that best meets their needs and ensuring consumer understanding, the agent is reducing the risk of rapid disenrollment.

Secret Shopper - CMS

Secret Shopper - CMS is a compliance program that identifies an agent's improper marketing and sales practices. The outcome of the secret shopper observations are only shared with UnitedHealthcare if the agent fails the review. Reviews are scored on a Pass/Fail basis. UnitedHealthcare has 48 hours after notification of a failed observation to respond to CMS regarding the allegation(s).

CMS monitors agent behavior in order to protect the interests of the Medicare consumer. You are expected to comply with all Medicare marketing guidelines including rules related to reporting marketing/sales events, using CMS approved marketing materials, and conducting promotional activities.

Secret Shopper – Contracted Vendor

Secret Shopper – Contracted Vendor is a compliance program that evaluates agent marketing and sales practices at reported marketing/sales events. UnitedHealthcare uses a contracted vendor to perform the agent evaluations.

The program uses both random and target sampling techniques to select marketing/sales events to secret shop. Marketing/Sales events are selected from those reported each month and include both scheduled formal (i.e. presenter audience format) and informal (e.g. retail booth). The secret shopper may participate in the marketing/sales event by asking specific questions pertaining to the plan such as eligibility, provider network, and benefit features. At the conclusion of their visit, the secret shopper completes an agent evaluation form provided by Distribution Compliance. A score of 85% or higher is considered a passing evaluation score.

Agent Thresholds Matrix (1 of 2)

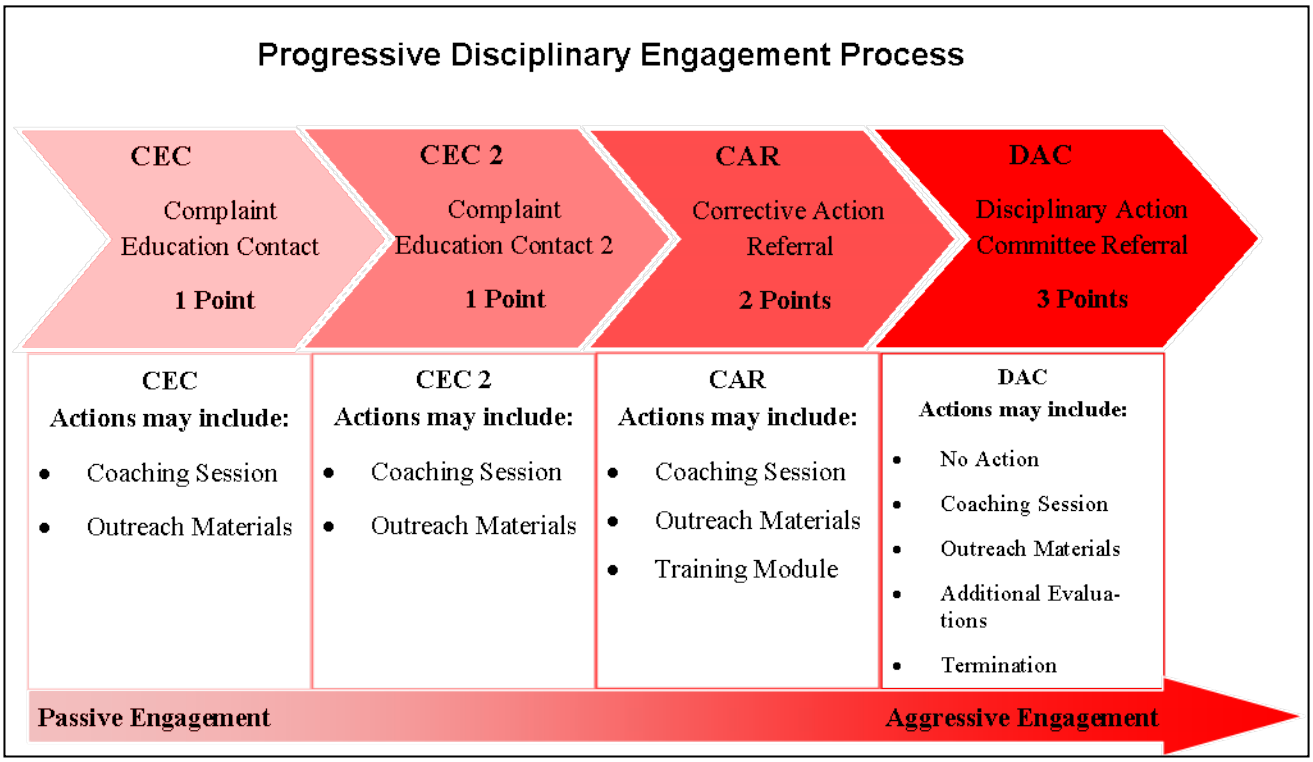
Program	Rapid Disenrollment	OEV	Late Application
Threshold	Agent Threshold	Agent Threshold	Agent Threshold
Minimum Requirement	Minimum of 5 new enrollees	Minimum of 5 completed surveys	N/A
Timeframe	Rolling 12 months (Eff. Date)	Threshold month	Three month period (Agent Signature Date)
Green	Less than or equal to 5%	Less than or equal to 10%	Less than 3 in each month over 2 consecutive months
Yellow	Greater than 5% to less than or equal to 10%	Greater than 10% to less than or equal to 20%	Greater than or equal to 3 late apps in each of 2 consecutive months within the last 3 months
Red	Greater than 10%	Greater than 20%	Greater than or equal to 4 late apps in each of 3 consecutive months within the last 3 months
Threshold Calculations	**Rapid Disenrollment:** Looks at overall % of Rapid Disenrollment. This threshold looks at voluntary disenrollment data from the last 12 completed months. We look back 15 months and exclude the most recent 3 months.Total # RDs divided by Total Accreted Apps.	**OEV:** Total number of OEVs with infractions divided by the Total number of OEV surveys completed.	**Late Apps:** An application is late when the received date is greater than 3 calendar days from the agent signature date. For AARP Medicare Supplement applications, an application is late when the received date is greater than 16 calendar days from the agent signature date.

Agent Thresholds Matrix (2 of 2)

Program	Secret Shopper (Vendor)	Complaint	Call monitoring	Secret Shopper (CMS)
Threshold	Agent Threshold	Agent Threshold	Agent Threshold	Agent Threshold
Minimum Requirement	N/A	N/A	N/A	N/A
Timeframe	Threshold month (Vendor)	Threshold month (Close Date)	Threshold month	Threshold month
Green	100% Vendor score	Agent has complaint, but does not meet yellow or red thresholds	No Infractions	No green threshold.
Yellow	Greater than or equal to 85% to 99.9% Vendor score	The complaint has CIU outcome of Substantiated, Inconclusive, Non-Response from Agent, or CEC. (N/A for CAR and DAC, see Red.)	No yellow threshold at this time	No yellow threshold.
Red	Less than 85% Vendor score	The closed complaint has been referred to CAR or DAC	1 or more Infractions	1 or more Failed Events
Threshold Calculations	**Secret Shopper (Vendor):** Look at overall composite scoring % in the current threshold month.	**Complaints:** Based upon complaints (substantiated, inconclusive, non response from agent, CAR, DAC, CEC)	**Call Monitoring:** Look at overall number of calls with infractions.	**Secret Shopper (CMS):** Look at the number of Pass/Fail infractions.

Complaints and Allegations of Agent Misconduct

Agents are expected to conduct themselves in a manner required by the Centers for Medicare & Medicaid Services (CMS) regulations, state and federal laws, guidelines, and UnitedHealthcare rules, policies, and procedures. Complaints and allegations of misconduct against agents are considered serious matters that require prompt attention.



Progressive Disciplinary Engagement Process

The Progressive Disciplinary Engagement Process is designed to take timely, appropriate, and effective corrective and disciplinary action against offending agents and escalated actions against reoffending agents.

The overall goal of the process is to lead to better educated and more effective agents representing UnitedHealthcare.

In the Progressive Disciplinary Engagement Process there are four levels of complaints.

- Complaint Education Contact (CEC) *
- Complaint Education Contact 2 (CEC2) *
- Corrective Action Referral (CAR)
- Disciplinary Action Committee Referral (DAC)

* Only the Plan and Product Knowledge Issue and the Point of Sale Issues allegation families are CEC and CEC2 eligible.

There are six allegation families that group related complaints together.

- Lead/Contact Issues
- Prohibited Activities
- Risk to Consumers/Enrollees
- Operational Behaviors
- Plan and Product Knowledge Issues
- Point of Sale Issues

<u>Point System</u>

Actionable complaints will be assessed points based on the outcome of the complaint. Points will accumulate over a rolling 12 months. When a point threshold is met or exceeded the agent will receive escalated disciplinary action.

The point break-down is as follows:

- CEC = 1 point
- CEC2 = 1 point
- CAR = 2 points
- DAC = 3 points

Enhanced Training / Outreach

Complaints can originate from both internal and external sources. All complaints against agents will be immediately provided to the Agent Complaint Tracking (ACT) team.

Sources of Complaints and Allegations of Agent Misconduct:

- Internal sources may include UnitedHealthcare Medicare Solutions Service Center, UnitedHealthcare Medicare Solutions National Service Center for Government Programs, and Appeals and Grievances, but could also arise in sales, service integrity and member support, provider services, care coordination, Producer Help Desk (PHD), Ethics Point, or compliance as examples.

- External sources may include the Centers for Medicare & Medicaid Services (CMS), state Departments of Insurance or Departments of Health or Public Welfare, state Attorneys General, providers, state or federal law enforcement, and other state or federal regulatory agencies, as examples.

The ACT team will conduct an initial review of the complaint and will create a record of every complaint. The ACT team will determine the appropriate action for the complaint through the Progressive Disciplinary Engagement Process and/or further investigation of the complaint.

Under no circumstance may the agent referenced in the complaint contact the individual who filed the complaint regarding the allegations in the complaint.

The Progressive Disciplinary Engagement Process

Complaint Education Contact (CEC) or (CEC2)

If the complaint is determined to fall within the criteria to be a CEC or CEC2 complaint, the complaint may not be further investigated. If a CEC is assigned, the agent will be assigned a pre-defined outreach per applicable allegation. A CEC2 will be assigned if an agent receives more than one complaint in any of the two applicable family allegations or receives two complaints that are similar in nature. In addition to addressing the specific issue, the entire allegation family must be addressed when a CEC2 is assigned.

The manager/coach is responsible for completing the assigned coaching session with the agent.

- A Coaching Request (CR) is created in Producer Contact Log (PCL)
- The manager/coach is expected to meet in person or telephonically with the agent.
- The manager/coach is expected to engage the agent and discuss the complaint, review and reiterate any and all applicable rules and regulations.
- The entire allegation family must be addressed when a CEC2 is assigned.
- Once the outreach and engagement session has been completed, the manager/coach is to thoroughly describe and document what actions and discussion took place, and explain how the agent demonstrated understanding, and what the agent will do to avoid repeating the mistake in the future in the "Resolution Details" in PCL.

Corrective Action Referral (CAR)

If the complaint is determined to not be eligible for a CEC or CEC2 or requires escalated review, the complaint will be investigated. If the complaint is assigned as a CAR the agent will be assigned a module for the applicable allegation family the complaint falls into. The assignment of

a CAR following the investigation means that there were findings that warranted escalated outreach.

- A Coaching Request (CR) is created in Producer Contact Log (PCL)
- The manager/coach is expected to meet in person or telephonically with the agent.
- The manager/coach is expected to engage the agent and discuss the complaint, review and reiterate any and all applicable rules and regulations.
- The agent will be required to complete any and all assigned modules and/or materials.
- Once the outreach and engagement session has been completed, the manager/coach is to thoroughly describe and document what actions and discussion took place, and explain how the agent demonstrated understanding, and what the agent will do to avoid repeating the mistake in the future in the "Resolution Details" in PCL.
- The manager may include any related documentation (i.e. screen shots, etc.) that reflects the agent's successful completion of the all the requirements.

Disciplinary Action Committee Referral (DAC)

If the complaint is assigned to the DAC, it will be reviewed by a committee of select Sr. Management. The committee will review the agent comprehensively and determine the appropriate action based on the review.

Possible actions may include, but are not limited to:

- Assignment of applicable module(s)
- Assignment of outreach materials or trainings
- Additional evaluations or ride-a-longs
- Requirement of a formal acknowledgement of the complaint/issue
- Termination
- If the requirements are not met within the allotted timeframe, the agent may be referred for administrative termination.

Submission of Complaints or Allegations of Agent Misconduct to Compliance Investigations Unit (CIU)

Complaints requiring additional investigation are forwarded to the Compliance Investigations Unit (CIU). Upon completion of the investigation process, the ACT team dispositions the complaint.

Investigation Process

- A Request for Agent Response (RAR) will be sent by the CIU in order to obtain the agent's response to the allegations of the complaint. The agent must respond to the request within five business days.
- If a response is not received by the date requested, a Non-Response Letter (NRL) will be sent, which will require a response within two business days.
- An Administrative Termination, termination considered not-for-cause, will be initiated if the agent fails to respond to the Request for Agent Response (RAR) within the prescribed time.

> Under no circumstance may the agent referenced in the complaint contact the individual who filed the complaint regarding the allegations in the complaint.

Investigation Outcome

- The CIU will determine an allegation outcome of Substantiated, Unsubstantiated, Inconclusive, Insufficient Information, No Allegation, or Non-Response. The allegation outcome is considered in the recommendation for a final action which is assigned at the conclusion of the investigation.

- Final action recommendations may include No Action Required, Training, Counseling, or Termination. Terminations may be either For Cause or Not for Cause based on the circumstances of the case. If the recommendation is for training or counseling, the matter is sent through the Corrective Action Referral (CAR) process. Recommendations for termination or suspension are referred to the Disciplinary Action Committee (DAC).

- Sales management will review the allegation, investigation outcome, and final action determination with the agent. The investigation and outcome documentation will be placed in the agent's performance file. Quality Assurance will track completion of training and/or corrective action assigned to the agent as a result of the complaint investigation. Sales management will oversee the agent's completion of training, corrective action and/or disciplinary action resulting from the complaint investigation. Corrective action plans will be documented in the agent's performance file.

Suspension of Sales and Marketing

UnitedHealthcare Medicare Solutions expects you to comply with all Centers for Medicare & Medicaid Services (CMS) regulations, state and federal laws, guidelines, and UnitedHealthcare rules, policies, and procedures.

- If at any time your performance or action damages or threatens to damage the reputation of the Company or does not meet the Company's standards, UnitedHealthcare can, at its discretion, initiate suspension of your sales and marketing activities.

- A determination to suspend can also be based on the severity of an allegation(s), the number of pending complaints or investigations, the nature and credibility of information initially provided, and/or the number of members or consumers affected and can be based on other oversight criteria. In such cases, suspension is effective until the investigation is completed a final disciplinary recommendation has been made.

Suspension Process

- When a recommendation to suspend your sales and marketing activities is made, you will be mailed a suspension notification letter from the Chief Distribution Officer with a copy sent to your EDC.

- 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. Renewals, however, will be paid while on a suspension status.

De-authorization of Authority to Sell Specific Products

Your agent performance is monitored in a variety of areas including rapid disenrollment rates and complaint ratios. Performance in each area is measured against established thresholds and outreach, that may include coaching, corrective action, and/or disciplinary action, is conducted if your performance fails to meet defined performance thresholds. Refer to the Agent Performance section for detailed information on performance standards, oversight, and development.

If you fail to comply with or maintain acceptable complaint ratios and/or rapid disenrollment rates is limited to a specific product and efforts to remediate do not achieve the desired change in the agent's performance against monitoring program threshold(s), UnitedHealthcare will process a termination of your authority to sell the identified product.

Termination of an Agent's Authority to Sell Specific Products Process

Authority to sell specific products is defined within your agent agreement. If your authority to market or sell a specific product is revoked; you will receive a contract amendment. Contact your sales leadership for additional process details.

Appealing Revocation of Authority to Sell a Specific Product Process

An agent, whose authority to sell a specific product has been revoked, may appeal the decision. Contact your sales leadership for additional appeal process details.

Termination of Non-Producing Agent

UnitedHealthcare Medicare Solutions contracts, certifies, and appoints agents whose intent it is to represent and sell UnitedHealthcare Medicare Solutions products.

- Each year, agents who have not sold any UnitedHealthcare Medicare Solutions products within a reasonable period (usually 12 months or more) will be terminated, not-for-cause.

Termination Notification

You will receive a notification letter via email and, in accordance with the terms of your agreement with UnitedHealthcare you will have your agreement and appointment(s) terminated.

Re-Contracting after Termination Due to No Production

If you were terminated due to not having sold any UnitedHealthcare Medicare Solutions products within the identified reasonable period, you may apply to re-contract as long as the following requirements are met.

- A new and complete contract packet must be submitted. The on-boarding process may include a background check and state appointment.
- You must complete and pass all applicable certification modules.

Administrative Termination

Administrative terminations are disciplinary, not-for-cause terminations initiated in two circumstances.

- If you fail to respond within the prescribed timeframes to Request for Agent Response and Non-Response letters sent by an investigator during a complaint investigation.
  - If you do not respond within thirty day termination notification period, your termination process will begin and a Do Not Re-Contract flag to your file.
  - If you respond within the thirty-day termination notification period, your status will be changed in the Complaint Database from Administrative Termination to pending investigation.
- If you fail to complete the required training/coaching resulting from a Complaint Education Contact (CEC/CEC2), Corrective Action Referral (CAR), or DAC referral or any required compliance monitoring program coaching.
  - If the Administrative Termination is related to CEC/CEC2/CAR/DAC coaching not completed, you will be referred for Administrative Termination.
  - If thirty days pass without appropriate notification, the termination will process and a Do Not Re-Contract flag will be added to your file.
  - If the training is completed within the thirty day timeframe, the termination request will be rescinded.

Termination Due to Unqualified Sale

All agents are expected to comply with CMS regulations and guidelines, federal and state laws, and UnitedHealthcare rules, policies and procedures.

An unqualified sale is when an agent who is not contracted, certified, appointed (if applicable), licensed, and/or their license has expired, submits an Enrollment Application.

You will be terminated if you complete an unqualified sale while you are not licensed and/or your license has expired. The termination will be not-for-cause. Corrective action will result if you complete an unqualified sale while you are not properly appointed (if applicable) or certified at the time of the sale.

Termination Notification

You will receive a 30-day notification of your termination due to an unqualified sale. You will receive a notification letter via email and, in accordance with the terms of your agreement with UnitedHealthcare, will have your agreement and appointment(s) terminated. In addition, the member will receive notification by letter that you were not qualified at the time the Enrollment Application was completed.

Solicitors will also receive a 30-day notification of termination.

Appeal

Document that provides proof an active license at the time of the sale(s) may be provided to UnitedHealthcare during the 30-day termination notification period.

Appeals may be submitted to uhpcred@uhc.com and must include a letter with proof.

Agent Termination: Not-For-Cause and For-Cause

All contract and appointment terminations are classified Not-for-Cause or For-Cause. Termination of appointment may be recommended by UnitedHealthcare, the External Distribution Channel (EDC), a regulatory agency, state Department of Insurance, or an agent may request a voluntary termination or an alteration to the EDC hierarchy.

Not-for-Cause Termination

A Not-for-Cause termination can be initiated by your EDC, UnitedHealthcare, or you for any reason including retirement, relocation, expired license, expired errors and omissions insurance coverage, or disciplinary reasons. The following process is followed when a Not-for-Cause termination is requested.

- You will be mailed a termination notification letter that will identify the effective termination date (thirty days notice as required under your Agent Agreement).
- On the termination date, a Not-for-Cause state appointment termination will be processed.
- You can submit the termination request to Agent On-Boarding at UHPCred@uhc.com; name the subject as "Termination."
- Agent On-Boarding will process the appointment termination and update the contracting system with the appropriate termination effective date.
- For terminations requested by UnitedHealthcare, your entire down-line is reassigned to the next hierarchy as of the termination effective date. Any solicitors in the down-line are terminated as of the termination effective date.
- For terminations requested by you or the EDC, your entire down-line is terminated (if applicable).
- You are flagged Do Not Re-contract in the contracting system if directed by the Disciplinary Action Committee (DAC), Legal Counsel, or the Compliance Investigations Unit (CIU).

Note: UnitedHealthcare Medicare Solutions reserves the right to suspend you until the termination becomes effective.

Switching Contracted EDC or Hierarchy

When you request to align under a different contracted EDC or change hierarchy, a Not-for-Cause termination from the current EDC is required. Your appointment, however, is not terminated.

When you change EDC or hierarchy, residual override commissions are retained by the hierarchy structure in place at the time of the original sale.

For-Cause Termination

A For-Cause termination can be initiated by UnitedHealthcare or by an external regulatory agency.

- A For-Cause termination notification letter, detailing the offense, termination effective date, and the appeal process, is sent to you via an overnight delivery vendor.
- Your EDC is sent a copy of your notification letter.
- A For-Cause state appointment termination is processed with the same termination date as indicated in your termination notification letter.
- If you have down-line agents, the entire down-line is reassigned to the next highest

entity in the hierarchy as of your effective termination date. Any solicitors in the down-line are terminated as of your termination effective date.

- You are flagged "Do Not Re-Contract" in the contracting system.

Do Not Re-Contract Reconsideration Process

If you are flagged "Do Not Re-Contract", you may not contract with any UnitedHealth Group company, including commercial products.

The following is the process by which you may request reconsideration of your "Do Not Re-Contract" status.

- Within ninety days of receipt of your termination letter, you must complete and submit a Request for Reconsideration of Appointment form to the Agent Complaint Tracking team via email to Business_Monitoring@uhc.com .
- If there are no open complaints against you, the request will be considered at the next Disciplinary Action Committee (DAC) meeting. If there are open complaints, the appropriate sales leader and you will be notified via email or telephone that the reconsideration request will not go to the committee until the open complaint(s) have been closed.
- The reconsideration request, along with any pertinent new information, is reviewed by the DAC. When a determination has been made by the committee, the outcome will be documented in Producer Contact Log (PCL) and you will be notified in writing with an electronic copy to your EDC.
- If you are approved for reinstatement, you must begin the re-contracting process by submitting a new contracting packet.
- If you are denied reinstatement due to a compliance (e.g., complaint or disciplinary) reason, the Do Not Re-Contract status remains indefinitely.
- The agent may be eligible to re-contract after a minimum of 12 months following the termination effective date.

Section 10: 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.

Term	Definition
	5
5-Star Plan Rating	Medicare has a 5-Star rating system to measure how well plan sponsors perform in different categories. These ratings help consumers compare plans based on quality and performance. Detecting and preventing illness, ratings from patients, patient safety and customer services are examples of categories measured. CMS utilizes one to five stars to determine a Plan's performance in a particular category; one start denotes poor quality and five stars represent excellent quality. Plan performance summary ratings are issued in October of the previous Plan contract year. Consumers and members may compare Plan rating information by making a request, visiting www.medicare.gov, or checking Plan websites.
5-Star Special Election Period (SEP)	A special election period that allows an eligible consumer to enroll in a MA plan or PDP with a Plan Performance Rating of five (5) stars during the year in which that plan has the 5-star overall rating, provided the consumer meets the other requirements to enroll in that plan (e.g., living within the service area as well as requirements regarding end-stage renal disease). As overall ratings are assigned for the plan contract year (January through December), possible enrollment effective dates are the first of the month from January 1 to December 1 during the year for which the plan has been assigned an overall rating of 5 stars. A consumer may use this SEP only one time from December 8 through November 30 of the following year in which the plan has been granted a 5-star overall rating. The enrollment effective date is the first of the month following the month in which the plan receives the enrollment application. Eligible consumers can switch from an MA plan, a PDP, or Original Medicare to an MA-only plan, an MA-PD plan, or a PDP that has a 5-star overall rating. A consumer using this SEP can enroll in an MA-only plan, an MA-PD plan, or a PDP with a 5-star overall rating even if coming from Original Medicare (with or without concurrent enrollment in a PDP). Consumers enrolled in a plan with a 5-star overall rating may also switch to a different plan with a 5-star overall rating. A consumer in an MA-only or MA-PD coordinated care plan who switches to a PDP with a 5-star overall rating will lose MA coverage and will revert to Original Medicare for basic medical coverage. Regardless of whether the consumer has Part D coverage prior to the use of this SEP, any consumer who enrolls in a 5-star PFFS MA-only plan is eligible for a coordinating Part D SEP to enroll in a PDP. This SEP does not guarantee Part D coverage. If a consumer in either an MA-PD plan or a PDP chooses to enroll in an MA-only coordinated care plan with a 5-star overall rating, that consumer would lose Part D coverage and must wait for a subsequent enrollment period to obtain Part D coverage under the normal enrollment rules. Late enrollment penalties might also apply.
	A
Agent A360 Reporting Tool	Agent dashboard reporting tool, refreshed monthly. Provides a monthly snapshot.
AARP®	AARP (formerly known as the American Association of Retired Persons) is a membership organization leading positive social change and delivering value to people age 50 and over through information, advocacy and service.
ACT (Agent Complaint Tracking) Team	The team that manages the intake, review and pre- and post-disposition of complaints. Monitors the completion of related Coaching Requests within Producer Contact Log (PCL) and creates monthly reports that detail key complaint metrics.

Section 10: Glossary of Terms

Term	Definition
Administrative Termination	A not for cause appointment termination that results when an agent fails to respond in the prescribed time to a Request for Agent Response or fails to complete corrective and/or disciplinary action with the prescribed time frame.
Advertising Materials	Advertising materials are intended to attract or appeal to a plan sponsor consumer. Advertising materials contain less detail than other marketing materials and may provide benefit information at a level to entice a consumer to request additional information. Some examples include television, radio advertisements, print advertisements, billboards, and direct mail.
Agency Manager	A UnitedHealthcare employee responsible for the relationship between a contracted agency in the External Distribution Channel (EDC) and UnitedHealthcare.
Agent	A global term to refer to any licensed, certified, and appointed individual soliciting and selling UnitedHealthcare products, including, but not limited to, FMO, SGA, MGA, GA, ICA, ISR, Broker, Solicitor, or Telesales agent. See also Solicitor and Producer.
Agent Manager	A UnitedHealthcare employee responsible for the relationship between the agent and UnitedHealthcare.
Agent of Record	The agent that presented the plan information to the consumer, signed the enrollment application, and continues to service the member once enrolled.. The agent of record is the agent that is eligible for commission.
Agent On-Boarding	The functional area within UnitedHealthcare that manages the centralized contracting and appointment data required to ensure sales agent file information is compliant with CMS and applicable state Department of Insurance (DOI) guidelines.
Allegation	A claim or assertion that an agent violated CMS Medicare Marketing Guidelines, company policy, or engaged in other inappropriate sales activities.
Annual Election Period –AEP	An annual period (October 15 through December 7) when consumers and members can make new plan choices. Consumers may elect to join a Medicare Advantage (MA) or Prescription Drug (Medicare Part D) Plan for the first time. Members can change or add Part D, change MA Plans or return to Original Medicare. Elections made during this period become effective January 1 of the following year.
Annual Notice of Change (ANOC)	Notification to active members of plan premium, benefits and cost sharing changes for the next calendar year. In addition, the name used to describe the process of generating the plan information for the next calendar year notifications.
Anti-Kickback Statute	The primary purpose of the federal anti-kickback statutes or laws is to restrict the corrupting influence of money on health care decisions – including knowingly and willingly offering payment or gifts to induce referrals of items or services covered by Medicare, Medicaid, or other federally funded program. *(See 42 U.S.C. 1320a–7b)* Examples of activities that may be prohibited under the statute: • Offering cash reimbursement in exchange for an enrollment or referral. • Offering gifts or services greater than a nominal amount permitted by federal guidelines. • Offering gifts or services dependent on enrollment or referral. A violation of the federal anti-kickback law is a felony offense that carries criminal fines of up to $25,000 per violation, imprisonment for up to five years and exclusion from government health care programs.

Term	Definition
Appeal (Part C)	Any of the procedures that deal with the review of adverse organization determinations on the health care services a member believes he or she is 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 member), or on any amounts the member must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the Medicare health plan and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.
Appeal (Part D)	Any of the procedures that deal with the review of adverse coverage determinations made by the Part D plan sponsor on the benefits under a Part D plan the member believes he or she is entitled to receive, including a delay in providing or approving the drug coverage (when a delay would adversely affect the health of the member), or on any amounts the member must pay for the drug coverage, as defined in §423.566(b). These procedures include redeterminations by the Part D plan sponsor, reconsiderations by the independent review entity (IRE), Administrative Law Judge (ALJ) hearings, reviews by the Medicare Appeals Council (MAC), and judicial reviews.
Appointment (Agent)	A procedure required by most states that grants limited authority to an individual to market and sell a company's insurance products within that state.
Appointment – Sales Presentation	*See In-Home Appointment and Out-of-Home Appointment.*
ASI	AARP Services, Inc.
ASL Interpreter	American Sign Language – interpreter service for the hearing or speech impaired.
Assets	Property the government may review when Medicare consumers apply for assistance with Medicare Part C or Medicare Part D costs.
Attained Age Rating	A method for establishing health insurance premiums whereby an insurer's premium is based on the current age of the consumer. Attained Age Rating premiums increase as the consumer ages. *See also Community Rating and Issue Age Rating.*
Authorized Representative	A person who is authorized under state law to complete the enrollment application and make health care decisions on behalf of the consumer/member and is authorized to receive health care related information on his/her behalf. Documentation of this authority should be available upon request by the plan or by CMS.
Auto-Enrolled	A process whereby Dual-eligible consumers are automatically enrolled in a Medicare Part D plan without actively selecting a plan. Also called auto-assigned.
B	
Background Check	The investigation of criminal records, credit history, insurance licensing history, Office of Inspector General records, and General Service Administration excluded party records and other factors that UnitedHealthcare reviews regarding an agent applicant's history during the agent contracting and on-boarding process.
bConnected	A software application designed to drive sales effectiveness in both the field and telesales environments. From within one integrated system, bConnected enables agents to efficiently create contact and opportunity records, qualify consumers, select plans, send fulfillment information, and schedule consumers for appointments and community meetings. *See also Lead.*
Book of Business	The collection of leads, contacts, and/or members assigned to a particular agent.
Brand	A name that identifies and distinguishes our product and company and any associated logos, service marks, images, etc. Brand elements are defined for each of the UnitedHealthcare Medicare Solutions brands via a set of brand guidelines which address logos, legal marks and requirements, brand colors, typography, layout requirements and other topics in detail. Complete graphics usage guidelines may also be included.

Term	Definition
Broker Development and Education Specialist (BDE)	UnitedHealthcare staff that reach out to educate agents in the External Distribution Channel (EDC) on specific monitoring program issues such as complaints, rapid disenrollment, and Secret Shopper results. Proactive positive reinforcement contacts are also conducted.
Business Reply Card (BRC)	Paper or electronic document returned to UnitedHealthcare or a UnitedHealthcare agent as a response/request for either more information, permission to be called or contacted by an agent, be removed from a mailing list, etc.
C	
Call Monitoring	A quality assurance function used to evaluate inbound and outbound calls either side-by-side or remotely for the purpose of compliance and training (to identify areas of opportunity), while ensuring an agent's or other plan representative's accountability as a representative of the UnitedHealthcare Group brand is compliant as it pertains to CMS guidelines.
Captive Agent	An agent, who, by virtue of employment or contract, must solicit and sell exclusively a UnitedHealthcare Medicare Solutions product or products. For example, all employee agents are captive to UnitedHealthcare Medicare Solutions and ICA channel agents are for Medicare Advantage products only.
Catastrophic Coverage	Catastrophic coverage is a level of coverage in a Medicare Part D plan that starts for members after they reach the plan's out-of-pocket limit for covered drugs during the coverage gap, and automatically get catastrophic coverage and only pay a small coinsurance amount or a copayment for the rest of the year. *Note: If a member gets "Extra Help" paying their drug costs, they will not have a coverage gap and will either continue to pay a small copayment or no copayment once they reach catastrophic coverage.*
Certified/Certification	The process required by CMS that all agents selling Medicare products are annually trained and tested on Medicare rules and regulations and company rules, policies and procedures specific to the company's products the agent intends to sell.
The Centers for Medicare & Medicaid (CMS)	The federal government agency that oversees the Medicare and Medicaid programs by establishing regulations and guidance for health care providers, assessing quality of care in facilities and services, and ensuring that both programs are run properly by contractors and state agencies. CMS communicates guidance and regulatory requirements and provides oversight to Medicare Advantage Organizations and Prescription Drug Plans.
CMS Data Use Agreement	As part of the Medicare contracts UnitedHealthcare maintains with CMS, the company is required to attest annually that it will only use CMS data and their systems for the administration the Medicare managed care and/or outpatient prescription drug benefit programs. Anyone supporting or performing work on behalf of UnitedHealthcare Medicare programs and who has access to CMS systems is obligated to follow UnitedHealth Group privacy and security policies and practices such as not sharing passwords, using the minimum necessary information and systems access to complete our jobs, and ensure confidential data is protected and secure at all times.
Clinical Parameters	Clinical boundaries for choosing medications within established therapeutic categories for the formulary; often indicates how many therapy options are needed within the therapy category to ensure the formulary is clinically sound. Clinical parameters are often represented by one of three classifications: Essential (Must Have on the Formulary as Offers Unique Clinical Advantages); Non-Essential (Optional addition to the Formulary similar to Other Formulary Alternatives); or Inappropriate (Potentially less safe or obsolete compared to Other Formulary Alternatives).

Term	Definition
Closed Benefit	Benefit excludes medications not housed within the benefit; if a closed benefit applies to a tier structure, only those medications assigned to one of the tiers are covered. Closed benefits can have exception processes in place to support appeals to the benefit for coverage of excluded medications. Also known as a Closed Formulary.
Coaching Request	The documentation in PCL of all coaching interaction between the manager/supervisor or BDE and an agent/agency. *See also Service Request.*
Co-branding	The relationship between two or more separate legal entities, one of which is an organization that sponsors a Medicare plan.
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 its work every day. The Code of Conduct applies to all employees, directors, and contractors and represents a core element of the Company's compliance program. UnitedHealthcare and UnitedHealth Group hold itself to the highest standards of personal and organizational integrity in its interactions with consumers, employees, contractors, and other stakeholders like 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.
Cognitive Ability	The consumer's capacity to understand, assemble and reason based on the information provided. *See Diminished Mental Capacity (Cognitive Impairment)*
Coinsurnace	An amount member may be required to pay as their share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%). Coinsurance for in-network services is based upon contractually negotiated rates (when available for the specific covered service to which the coinsurance applies) or Medicare Allowable Cost, depending on the contractual arrangements for the service.
Cold Calling	The act of cold calling, including, but not limited to, telephone calls, emailing, text messaging and leaving voice mail are all prohibited. CMS has specific regulations in relation to marketing through unsolicited contacts. Agents may not engage in any direct unsolicited contact with consumers, including consumers who are aging-in. (*See also Unsolicited Contact and Door-to-Door Solicitation)*
Community Event/Meeting	See Sales Event. All Community Events/Meetings are considered Formal Marketing/Sales Events.
Community Rating	All members in the same rating class pay the same rate (excludes discounts and surcharges). *See also Issue Age Rating and Attained Age Rating.*
Complaint	Any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by a member made orally or in writing. This can include concerns about the operations of providers or Medicare health plans such as waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to members, the claims regarding the right of the member to receive services or receive payment for services previously rendered. It also includes a plan's refusal to provide services to which the member believes he or she is entitled. A complaint could be either a grievance or an appeal or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.
Complaint Education Contact (CEC)	A process to address agent behavior to prevent repeat complaint infractions through training and coaching.

Term	Definition
Compliance Investigations Unit (CIU)	A unit within UnitedHealthcare Government Programs responsible for the investigation of complaints regarding agents selling UnitedHealthcare Medicare Solutions products. Complaints referred to the CIU are severe allegations of misconduct or repeated complaints of lower severity.
Compliance Program	Federal law requires Medicare plan sponsors to implement and maintain an effective Compliance Program that incorporates measures to detect, prevent, and correct noncompliance and fraud, waste, and abuse. The 7 key elements of a compliance program are: 1. Written Standards of Conduct 2. High Level Oversight 3. Training & Education 4. Effective Lines of Communication / Reporting Mechanisms 5. Enforcement & Disciplinary Guidelines 6. Monitoring & Auditing 7. Response to Identified Issues The program reflects a company's good faith effort to reduce non-compliance with legal, regulatory, and business requirements.
Compliance Reporting Resources	Compliance Questions – compliance_questions@uhc.com Privacy & Security Incidents – psmg_privacy@uhc.com The UnitedHealth Group Compliance & Ethics HelpCenter @ 800-455-4521
Compliance Requirements	A series of directives established by regulatory bodies and UnitedHealth Group that must be adhered to.
Consumer	Refers to the customer, Medicare beneficiary, lead, or prospect for all products who is not currently enrolled in a UnitedHealthcare plan.
Coordinated Care	In Medicare Part C, the health care plans that coordinate a consumer's care by the physicians and hospitals visited. These plans may have some restrictions on the physicians and hospitals used for care. These plans are also referred to as managed care plans. PFFS and MSA Plans are not coordinated care plans.
Copayment	An amount the member may be required to pay as their share of the cost for medical services or supply, like a physician's visit or a prescription. A copayment is usually a set or fixed amount, rather than a percentage.
Corrective Action Plan (CAP)	When it is determined that an organization or business area is not complying with Medicare program requirements, the organization or business area is directed by CMS or the internal stakeholders to take all actions necessary to correct the behavior, issue or process that was identified as noncompliant with Medicare program requirements. A step-by-step plan of corrective action is developed to achieve targeted outcomes for resolution of the identified issues.
Corrective Action Referral (CAR)	A process that supports the progressive disciplinary process and is a measure to address egregious agent behavior with retraining efforts delivered in a timely manner.
Cost Sharing	The amount a member pays for services or drugs received and includes any combination of a deductible, copayment or any coinsurance.
Coverage Determination	Decision to cover (or not cover) prescription drugs within the plan's benefit design that is associated with utilization management programs for Medicare Prescription Drug Plans.

Term	Definition
Coverage Gap	Most Medicare *prescription* drug plans have a coverage gap. This means that after the member and plan have spent a certain amount of money for covered drugs, the member has to pay all costs out-of-pocket for their drugs up to a limit. The member's yearly deductible, coinsurance or copayments, and what they pay in the coverage gap all count toward this out-of-pocket limit. The limit does not include the drug plan's premium. There are plans that offer some coverage in the gap. However, plans with coverage in the gap may charge a higher monthly premium.
Credentialing	Process of contracting, appointment, certification, and approval for an agent to sell any UnitedHealthcare Medicare Solutions products.
Creditable Coverage (Prescription Drug)	Prescription drug coverage, for a plan other than a Medicare Part D Plan, which meets certain Medicare standards. For consumers currently enrolled in a drug plan that gives prescription medication coverage, their plan will tell them if it meets the Medicare standards for creditable coverage. (*See also Late-Enrollment Penalty).*
Creditable Coverage (Medical)	Certain kinds of previous health insurance coverage that can be used to shorten a pre-existing condition waiting period under a Medicare supplement insurance plan. **Note:** This is not the same as creditable prescription medication coverage.
Critical Access Hospital	A small facility that gives limited outpatient and inpatient services to members in rural areas.
Cross-Selling	CMS regulations and guidelines prohibit marketing non-health related products (e.g., annuities, life insurance, and disability) to consumers during any Medicare Advantage or Medicare Part D sales activity or presentation. This activity is prohibited.
D	
Deductible	The amount a member must pay for health care services or prescriptions, before Original Medicare, their prescription drug plan, or other insurance coverage begins to pay.
Deemed Provider	A Medicare-participating provider who agrees to accept the plan's terms and conditions of payment for a specific member visit by virtue of the fact that the provider is aware, in advance, that the patient is a PFFS member and the provider has reasonable access to the plan's terms and conditions of payment. Members must inform providers of PFFS plan membership and present their ID card prior to receiving covered services. If the provider does not agree to be deemed, the PFFS member must find another provider. Providers agree to bill the plan and will not balance bill the member. A provider must agree to be deemed each time a member seeks covered medical services. The provider can decide whether or not to accept the plan's terms and conditions of payment each time they see a PFFS member. A decision to treat one plan member does not obligate the provider to treat other PFFS members, nor does it obligate providers to accept the same member for treatment at a subsequent visit.

Term	Definition
Deeming	A provider is deemed by law to have a contract with the plan when all of the following four criteria are met: 1) The provider is aware, in advance of furnishing health care services, that the patient is a member of the plan. (All members receive a member ID card that includes the plan logo that clearly identifies them as PFFS members.) 2) The provider either has a copy of, or has reasonable access to, the plan's terms and conditions of payment rates. 3) The provider furnishes covered services to a plan member. 4) The provider agrees to submit the bill for covered services directly to the plan. If all of these conditions are met, the provider is deemed to have agreed to the plan's terms and conditions of payment for that member specific to that visit. *Note: The provider can decide whether or not to accept the plan's terms and conditions of payment each time they see a member. A decision to treat one plan member does not obligate them to treat other plan members, nor does it obligate them to accept the same member for treatment at a subsequent visit.*
Diminished Mental Capacity (Cognitive Impairment)	A condition caused by dementia or other disability that affects how clearly a person thinks, learns new tasks, and remembers events that just happened or happened a long time ago. *See Cognitive Ability*
Disciplinary Action Committee (DAC)	Committee responsible for determining appropriate disciplinary and/or correction action up to and including agent termination.
Distribution Channel (Sales)	Categories of individuals or organizations that market and sell UnitedHealthcare Medicare Solutions products. UnitedHealthcare Medicare Solutions utilizes four distribution channels: Telesales, Internal Sales Representative (ISR), Independent Career Agent (ICA), and External Distribution Channel (EDC).
Door-to-Door Solicitation	The practice of *Unsolicited Direct Contact* for the purposes of marketing/selling any product in the UnitedHealthcare Medicare Solutions portfolio and is strictly prohibited. The consumer must first initiate or solicit contact. These guidelines apply to contact made in person, contact made by telephone, and contact made by e-mail. In-home and personal/individual marketing appointments *are allowed* if the consumer initiated and scheduled an appointment prior to the visit and a documented Scope of Appointment (SOA) has been recorded or completed and signed by the consumer prior to the visit. Direct, unsolicited, in-person contact with a consumer may include actual door-to-door solicitation or unauthorized in-person contact with a consumer in any public place, e.g. parking lot, senior center, etc. *See also Cold-Calling and Unsolicited Contact.*
Doughnut Hole	Name for the step in a Medicare Part D Plan in which members pay all expenses for eligible medications up to a specific amount (determined by CMS each year). *See Coverage Gap*. (Note: Doughnut Hole is not a CMS Preferred term – Coverage Gap is the term of choice.)
Down-Line	A term used to describe agents within an NMA or FMO hierarchy that are below the management/reporting level of a specific agent/agency.
Drug Utilization Management (UM)	Prescription drug coverage rules utilized to advocate clinically appropriate, cost-effective medication use in an effort to minimize unnecessary cost to the benefit.
DSS Research	A vendor who was contracted to perform outbound enrollment and verification (OEV) calls for designated UnitedHealthcare Medicare Solutions products in accordance with CMS guidelines.

Term	Definition
Dual Eligible	Consumers and/or members receiving benefits from both Medicare and Medicaid. With the assistance of Medicaid, some Dual-eligibles do not have to pay for certain Medicare costs. The Medicaid benefit categories and type of assistance are listed below: • **Full Benefit Dual Eligible (FBDE)**: Full-benefit dual eligibles have no cost sharing in Medicare Part A or Part B. Medicaid pays for their Medicare Part A hospital deductible, Medicare Part A coinsurance, Medicare Part B monthly premium, and Medicare Part B deductible and 20 percent co-payments. For Part D, full-benefit dual eligibles are exempt from any monthly premium, annual deductible, costs under the doughnut hole, and only nominal co-payments on drugs if they live at home. • **Qualified Disabled and Working Individual (QDWI)**: Payment of the consumer's Medicare Part A premiums. • **Qualifying Individual (QI)**: Payment of the consumer's Medicare Part B premiums. • **Specified Low Income Medicare Beneficiary (SLMB)**: Payment of the consumer's Medicare Part B premiums. • **SLMB-Plus**: Payment of the consumer's Medicare Part B premiums and full Medicaid benefits. • **Qualified Medicare Beneficiary (QMB Only)**: Payment of the consumer's Medicare premiums, deductibles and cost-sharing (excluding Part D). • **QMB-Plus**: Payment of the consumer's Medicare premiums, deductibles, cost-sharing (excluding Part D) and full Medicaid benefits. *Note: QMBs, SLMBs, and QIs are automatically enrolled in the low-income subsidy program which provides assistance with prescription drug costs.*
E	
Educational Event	An event designed to inform Medicare consumers about MA, Prescription Drug or other Medicare programs but do not steer, or attempt to steer consumers toward a specific plan or limited number of plans. Educational events may not include any sales or marketing activities such as the distribution of marketing materials or the distribution or collection of enrollment applications. When advertised, educational events must be advertised as educational; otherwise they are considered marketing/sales events. Educational events are held in public venues, do not extend to personal/individual appointments, and cannot include lead-generation activities.
Educational Information	Communications free of plan specific information or marketing toward a specific plan.
eModel Office	An electronic enrollment method used by approved NMA, FMO, and SGA offices and some internal sales offices to convert a consumer’s paper enrollment application to an electronic format for direct entry into UnitedHealthcare’s enrollment system. When a paper application is converted to an electronic format, the paper application must be scanned and the image submitted to UnitedHealthcare as a record of the consumer’s wet signature.
End Stage Renal Disease (ESRD)	Permanent kidney failure. The stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.
Enrollment Application	Refers to the form used by consumers to request to enroll in a Medicare Advantage Plan, Prescription Drug Plan or Medicare Supplement Plan.
Errors and Omissions (E&O) Insurance	Errors and Omissions insurance covers UnitedHealthcare contracted agents and solicitors in the event they misrepresent a plan and its benefits to a consumer.

Term	Definition
Exception	A type of coverage determination that, if approved, allows the member to get a drug that is not on the plan sponsor's formulary (a formulary exception) or get a non-preferred drug at the preferred cost-sharing level (a tier exception). The member may also request an exception if the plan sponsor requires the member to try another drug before receiving the drug the member is requesting or the plan limits the quantity or dosage of the drug the member is requesting (a formulary exception).
Excluded Medications	Medications that are not housed within the benefit. These medications may be excluded due to a plan sponsor's business or clinical decision to not cover the medication or they could be excluded because the Medicare Modernization Act (MMA) excludes the medications under the Medicare Part D program.
Executive Distribution Oversight Committee (EDOC)	A UnitedHealthcare Government Programs Senior Leadership cross-functional team established to drive overall direction of the Sales and Distribution Oversight activities and to establish an infrastructure that is both receptive and participatory to the Oversight requirements. The EDOC assists the Medicare Compliance Oversight Committee (MCOC) and PSMG Corporate Responsibility & Compliance Program Oversight Committee (PSMG Committee) in ensuring the organization is consistently and fully complying with all laws and regulations pertaining to the services provided to beneficiaries of Medicare.
External Distribution Channel (EDC)	One of four sales distribution channels that market and sell UnitedHealthcare Medicare Solutions products. The channel consists of contracted entities, including NMAs, FMOs, agencies (SGA, MGA, GA), agents, and solicitors (not contracted with UnitedHealthcare, but through their up-line). EDC entities, agencies, agents, and solicitors are not employees of UnitedHealth Group and are not exclusive (captive) to UnitedHealthcare.
Extra Help	A Medicare term used to describe the financial help available to consumers with limited income and resources. Extra Help is the common reference used by the Social Security Administration in reference to the federal LIS program.
F	
False Claim Act	The Federal False Claims Act prohibits any person from submitting or causing the submission of a false claim or dishonest record to the federal government that he or she knows *(or should know)* is false. A claim, broadly defined, includes any record or submission that results or could result in payment. In general, the Federal False Claims Act covers fraud involving any federally funded contract or program, with the exception of tax fraud. Violations of the False Claims Act can result in liability for repayment of up to three times the original dollar amount that the government was defrauded and potential civil penalties of $5,500 to $11,000 for each false claim.
Federal Do not Call List (FDNC)	A national registry for consumers to advise certain entities of their request to not be contacted via telephone. The Federal Trade Commission manages this national registration.
Federal Poverty Level (FPL)	Is used to determine financial eligibility for certain programs. Guidelines vary by family size. In addition, there is one set of FPL figures for the 48 contiguous states and D.C.; one set for Alaska; and one set for Hawaii.
Field Marketing Organization (FMO)	An independent marketing organization that is directly contracted with and appointed by (if applicable) UnitedHealthcare Insurance Company to solicit and sell the UnitedHealthcare Medicare Solutions portfolio of products through its network of down-line contracted and appointed (if applicable) agents. The FMO is the top level in its hierarchy structure.

Term	Definition
For-Cause Termination	A type of termination of agent's contract and appointment that is the result of specified misconduct that violates the agreement.
Formulary	A list of prescription drugs covered by the plan. The list includes both brand-name and generic drugs. The formulary is often published to the web or in a written document. However, the document may only reference the preferred medications. (Often referred to as Preferred Drug List or PDL).
Fraud, Waste, and Abuse	**Fraud** is intentionally obtaining something of value through misrepresentation or concealment of facts. The complete definition has three primary components: • Intentional dishonest actions or misrepresentation of fact, • Committed by a person or entity, and • With knowledge the dishonest action or misrepresentation could result in an inappropriate gain or benefit. This definition applies to all persons and entities. However, it is important to know that there are special rules around false statements to government programs such as Medicare and Medicaid. **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 professionally recognized standards for health care, and are fairly priced.
G	
General Agent (GA)	An independent contractor with a direct contract with UnitedHealthcare at the GA level. May refer agents and solicitors for contracting (if applicable) and appointment (if applicable) to solicit and sell UnitedHealthcare Medicare Solutions products.
Generic Drugs	A prescription drug that has the same active ingredients as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs. Also known as Generic Medications.
Geographic Area	A specific state, county, or zip code.
Grandfathering	Allows for continued coverage of specific therapies that may have been covered previously, but are no longer being covered after a formulary or benefit change.
Grievance	A type of member complaint. Informal verbal complaints are handled by a call center that processes verbal complaints for Medicare consumers. Written complaints are the responsibility of the Appeals and Grievances National Service Center. Grievances may include complaints regarding the timeliness, appropriateness, access to and/or setting of a provided item.
Group Retiree	A consumer who is Medicare eligible, retired from his/her previous employer, and is looking to continue health care and/or prescription coverage with their previous employer. Employer groups contract with health plans, which allow them the opportunity to offer products and administer benefits through contractual agreements and arrangements. With subsidized plans, the employer contributes to the premium, but with endorsed plans, the employer does not.

Term	Definition
Guaranteed Issue	A period of time when insurance companies are required by law to sell or offer consumers a Medicare supplement insurance policy. In these situations, an insurance company cannot deny consumers a Medicare supplement insurance policy or place conditions on a Medicare supplement insurance policy, such as exclusions for pre-existing conditions, and cannot charge consumers more for a Medicare supplement insurance policy because of past or present health conditions.
H	
Health Fair/Expo	An informal educational or marketing/sales event.
Health Insurance Claim Number (HICN)	A consumer's Medicare identification number.
Health Maintenance Organization (HMO)	A type of Medicare Advantage plan in which members select a PCP to help coordinate their care and go to providers in the plan's contracted network, except in the event of an emergency or for renal dialysis. Members need referrals from their PCP to see specialists in some plans.
Hierarchy	The structure of an NMA or FMO down-line that is defined as part of the NMA/FMO/agent contracting process.
HIPAA	Health Insurance Portability and Accountability Act of 1996. HIPAA is a federal law that provides requirements for the protection of health information as well as provisions to combat fraud, waste, and abuse.
HIPAA Privacy Statement	A HIPAA Privacy Statement must always be included on a fax cover sheet when sending PHI/PII via fax machine or electronic/desktop fax. Sample HIPAA Privacy Statement: *This facsimile transmission contains confidential information intended for the parties identified above. If you have received this transmission in error, please immediately notify me by telephone and return the original message to me at the address listed above. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.*
Hold Time Messages	Recorded information played to a consumer while waiting on hold.
HPMS Complaint Tracking Module (CTM)	A CMS database and communication tool used to capture beneficiary complaints received by Medicare and transmit to the appropriate plan sponsor.
I	
Inconclusive Allegation	Following review of the allegations against an agent, appropriate investigation, consideration of the evidence and pertinent circumstances, there is insufficient information to determine the truth or falsity of the allegation(s).
Inconclusive Complaint	Following review of the allegations against an agent, appropriate investigation, consideration of the evidence and pertinent circumstances, there is insufficient information to determine the true or falsity of the complaint.
Independent Career Agent (ICA)	A non-employee agent contracted and appointed (if applicable) by UnitedHealthcare to solicit and sell designated UnitedHealthcare Medicare Solutions products. The ICA contract provides that they are exclusive for UnitedHealthcare Medicare Advantage products.
In-Home Appointment	A personal/individual marketing appointment that takes place in a consumer's residence. Includes a nursing home/facility resident's room. Requires a Scope of Appointment form. *See also Out-of-Home Appointment and Personal/Individual Marketing Appointment.*

Term	Definition
Initial Coverage Election Period (ICEP)	A period during which an individual newly eligible for MA may make an initial enrollment request to enroll in an MA plan. This period begins three months immediately before the individual's first entitlement to both Medicare Part A and Part B and ends on the later of: 1. The last day of the month preceding entitlement to Part A and Part B, or; 2. The last day of the individual's Part B initial enrollment period. The initial enrollment period for Part B is the seven-month period that begins 3 months before the month an individual meets the eligibility requirements for Part B and ends 3 months after the month of eligibility.
Initial Coverage Limit (ICL)	The period after a PDP member has met their deductible and before their total medication expenses have reached a specific amount including amounts the member has paid and what the plan has paid on their behalf.
Internal Sales Representative (ISR)	A UnitedHealthcare employee who is appointed (if applicable) to solicit and sell UnitedHealthcare Medicare Solutions products in the field.
Issue Age Rating	Rates for a consumer enrolling in a Medicare supplement insurance plan are based on his/her age as of his/her
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	A consumer who, by their actions, has demonstrated an interest in a UnitedHealthcare product (includes current members). Company-generated leads are documented and managed in bConnected.
LearnSource *formerly ULearn*	Online training and certification portal for UnitedHealth Group employees.
License	A certificate giving proof of formal permission from a governmental authority to an agent to sell insurance products within a state.
Logo	A mark or symbol that identifies or represents a company, business, product, and/or brand.
Long-Term Care Pharmacy (LTC)	A pharmacy owned by or under contract with a long-term care facility to provide prescription medications to the facility's residents.
Low Income Copayment (LIC)	Reduced prescription copayment level for the member.
Low Income Subsidy (LIS)	A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.
M	
Marketing Materials	Includes any informational materials that perform one or more of the following actions: promotes an organization, provides enrollment information for an organization, describes the rules that apply to members in an organization, explains how Medicare and Medicaid (Fully Integrated Dual SNPs, MME product(s) as applicable) services are covered under an organization (including conditions that apply to such coverage), and/or communicates with the member on the various membership operational policies, rules, and procedures.

Term	Definition
Marketing/Sales Event - Formal and Informal	Are defined both by the range of information provided and the way in which the content is presented. In addition, marketing/sales events are defined by the plan's ability to collect enrollment applications and enroll Medicare consumers during the event. A marketing/sales event is designed to steer, or attempt to steer, consumers toward a plan or limited set of plans. • A **formal** marketing/sales event is structured in an audience/presenter style with sales personal or plan representative formally providing specific sponsor information via a presentation on the products being offered. • An **informal** marketing/sales event is conducted with a less structured presentation or in a less formal environment like a retail booth, kiosk, table, recreational vehicle, or food banks where an agent can discuss plan information when approached by a consumer.
Master General Agent (MGA)	An independent contractor with a direct contract with UnitedHealthcare at the MGA level. May refer agents and solicitors for contracting (if applicable) and appointment (if applicable) to solicit and sell any of the UnitedHealthcare Medicare Solutions products.
Maximum Allowable Cost (MAC)	The highest dollar amounts that the federal government will pay for medication that is dispensed to a Medicare or Medicaid consumer.
Medicaid	A program that pays for medical assistance for certain individuals and families with low incomes and resources. Medicaid is jointly funded by the federal and state governments to assist states in providing assistance to people who meet certain eligibility criteria. A Medicare supplement insurance plan cannot be sold to individuals who receive assistance from Medicaid unless assistance is limited to help with Medicare Part B premiums or Medicaid buys the Medicare supplement insurance policy for the consumer.
Medicare	A federal government health insurance program for: • People age 65 and older • People of all ages with certain disabilities • People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or kidney transplant)
Medicare Advantage Disenrollment Period (MADP)	January 1 – February 14 The 45-day period when Medicare Advantage members may disenroll from their current plan, but only return to Original Medicare (they may also select a PDP for Part D coverage).
Medicare Advantage Plan – MA Only	An MA plan with only medical coverage. It does not have an integrated Medicare Part D prescription medication benefit.
Medicare Advantage Plan	Health plans offered by private insurance companies that contract with the federal government to provide Medicare coverage. MA plans may be available with or without Medicare Part D coverage. MA plans may also be referred to as Medicare Health Plans.
Medicare Advantage Plan with Prescription Drug (MA-PD)	An MA plan that integrates Medicare Part D prescription drug benefits with the medical coverage.
Medicare Beneficiary	One who receives Medicare. Referred to as consumer or member (see separate definitions) throughout this document. One who is entitled to Medicare Part A and eligible for Medicare Part B.
Medicare Part A	The part of Medicare that provides help with the cost of hospital stays, skilled nursing services following a hospital stay, and some other kinds of skilled care.
Medicare Part B	The part of Medicare that provides help with the cost of physician visits and other medical services.

Term	Definition
Medicare Part B Premium	The premium amount deducted from a Medicare consumer's Social Security check. The Medicare Part B Premium varies from year to year.
Medicare Part C	Medicare Part C Plans are referred to as Medicare Advantage Plans. • Include both Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) • Private insurance companies approved by Medicare provide this coverage • In most plans, members need to use plan physicians, hospitals and other providers or they pay more • Members usually pay a monthly premium (in addition to their Medicare Part B premium) and a copayment for covered services • Costs, extra coverage and rules vary by plan
Medicare Part D	Known as Medicare Prescription Drug Plans. The part of Medicare that provides coverage for outpatient prescription medications. These plans are offered by insurance companies and other private companies approved by Medicare. Consumers can get Medicare Part D coverage as part of a MA plan (if offered where a consumer lives), or as a stand-alone PDP.
Medicare Private Fee-for-Service Plan –PFFS	A type of MA plan that allows members to go to any Medicare eligible provider who agrees to accept the PFFS plan's terms and conditions of payment rates. PFFS plans may or may not use networks to provide care, depending on whether the PFFS plan is a network or non-network plan. Note: UnitedHealthcare currently only offers non-network PFFS plans.
Medicare Private Fee-for-Service Plan –PFFS – Network Plans	Requires the plan to meet access standards through written provider contracts or agreements. **Note:** UnitedHealthcare only offers non-network PFFS plans.
Medicare Private Fee-for-Service Plan –PFFS – Non-Network Plans	Requires the use of deemed providers who agree to accept the plan's terms, conditions and payment rates. **Note:** UnitedHealthcare only offers non-network PFFS plans.
Medicare Savings Plan (MSA)	A type of MA plan that combines a high deductible MA plan and a bank account. The plan deposits money from Medicare in the account. Consumers can use it to pay their medical expenses until their deductible is met. **Note:** UnitedHealthcare currently does not offer a MSA plan.
Medical Savings Programs (MSP)	Many older adults have low incomes, but not low enough to qualify for Medicaid. There are several Medicare Savings Programs available under Medicaid to help lower income seniors and disabled individuals pay for some of their out-of-pocket medical expenses. They are: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individual 1 (QI-1), Qualified Disabled and Working Individual (QDWI).
Medicare Supplement Insurance	Medicare Supplement insurance sold by private insurance companies to fill gaps (deductibles, coinsurance and copayments) in Original Medicare. A Medicare supplement insurance policy cannot be sold to a MA plan member unless the member is switching to Original Medicare. A Medicare supplement insurance policy can and is sold to members in Medicare Part D (not MA-PD) Plans. Also referred to as Medigap.
Medication Therapy Management (MTM)	A type of drug use review and associated interventions that look to address members' safety and cost concerns through prescriber consultation and member pharmacist counseling. The service is required by the Medicare Modernization Act and targets members with complex medication regimens and costly medication expenditures.
Medigap Policy	*See Medicare Supplement Insurance.*
Member	The enrollee, Medicare beneficiary, or customer who is currently enrolled in a UnitedHealthcare MA Plan, PDP, and/or Medicare supplement insurance plan.

Term	Definition
MIPPA	Medicare Improvement for Patient and Providers Act of 2008.
Monthly Plan Premium	The fee a member pays if when enrolled in a MA Plan (like HMO or PPO), in addition to the Medicare Part B premium for covered services, if applicable.
Multi-Source Brand	A brand-name medication that has a generic equivalent.
N	
National Drug Code (NDC)	An eleven-digit number assigned to all prescription medication products by the manufacturer or distributor of the product under FDA regulations. An NDC number is composed of three distinct parts: 1) the first five digits identify the drug manufacturer, 2) the next four identify the drug composition, strength, and dosage form, and 3) the last two identify the package size.
National Marketing Alliance (NMA)	An independent marketing organization that is directly contracted with and appointed by (if applicable) UnitedHealthcare Insurance Company to solicit and sell the UnitedHealthcare Medicare Solutions portfolio of products through its network of down-line contracted and appointed agents. The NMA is the top level in its hierarchy structure.
Network	Group of physicians, hospitals, and pharmacies who have contracts with a health insurance plan to provide care/services to the plan's members. The Medicare Part D prescription drug plan's network of pharmacies may help members save money on medications.
Network Pharmacy	A licensed pharmacy that is under contract with a Medicare Part D sponsor to provide covered Medicare Part D drugs at negotiated prices to its Medicare Part D Plan members.
New Agent	An agent who has never contracted with UnitedHealthcare or an agent who has not written business for any six-month period under their current name or other alias.
NIPR (National Insurance Producer Registry)	NIPR developed and implemented the Producer Database (PDB), which provides financial/time savings, reduction in paperwork, real time information, verification of license status in all participating states, ease of access via the internet, and single source of data versus multiple web sites.
Nominal Value	Items or services worth $15 or less based on the retail purchase price.
Non-Captive Agent	A licensed, certified, and appointed, non-exclusive independent contractor in the EDC or ICA channel who solicits and sells any UnitedHealthcare Medicare Solutions product.
Non-Complaint	A member's withdrawal or nullification (verbal or in writing) of an allegation against an agent. Also includes circumstances where, upon review, a complaint fails to state an allegation of agent misconduct.
Non-Resident Agent	An agent who is licensed and appointed (if applicable) to sell in a state other than that where the agent has their primary residency.
Non-Retaliation	UnitedHealth Group and UnitedHealthcare expressly prohibit retaliation against employees and agents who, in good faith, report or participate in the investigation of compliance concerns.
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	
One Breath	UnitedHealthcare Group's policy that requires that it be no longer than "one breath" from the time an employee learns of a sensitive or serious situation to the time the employee reports it. For example, any statement or action that may result in a CMS violation or places the company/beneficiary at risk.

Term	Definition
Open Enrollment Period (for Medicare Supplement)	A one-time only, six-month period when federal law allows consumers to buy any Medicare supplement insurance policy they want that is sold in their state. It starts in the first month that a consumer is covered under Medicare Part B and is age 65 or older. Some states may have additional open enrollment rights under state law. During this period, consumers cannot be denied a Medicare supplement insurance policy or charged more due to past or present health conditions.
Operational Excellence Advisory Council	Committee formed to work with contracted NMA/FMOs to discuss ongoing NMA, FMO, agency or agent issues, resolution, business, and product updates, compliance and complaint issues, training needs, and other actions. The committee consists of members from NMAs and FMOs, UnitedHealthcare Sales Leadership, Quality Assurance, and Performance Management.
Organization Determination	Any determination made by a Medicare health plan with respect to any of the following: • Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services; • Payment for any other health services furnished by a provider other than the Medicare health plan that the member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan; • The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the member believes should be furnished or arranged for by the Medicare health plan; • Reduction, or premature discontinuation of a previously authorized ongoing course of treatment; • Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member; or • Medicare Savings Accounts (MSA) only: Decisions regarding whether expenses, paid for with money from the MSA Bank Account or paid for out-of-pocket, constitute Medicare expenses that count towards the deductible; and, prior to satisfying the deductible, decisions as to the amount the member had to pay for a service.
Original Medicare	One of the consumer's health coverage choices as part of Medicare. • Part A (Hospital Insurance) and Part B (Medical Insurance). • Medicare provides this coverage. • Consumers have a choice of physicians, hospitals and other providers. • Generally, consumers pay deductibles and coinsurance. Consumers usually pay a monthly premium for Medicare Part B.
Outbound Enrollment and Verification Call (OEV)	Outbound calls conducted by the plan to consumers who recently enrolled in a Medicare Advantage plan to ensure consumers requesting enrollment into a plan by agents/brokers understand the plan benefits, costs, and plan rules.
Out-of-Home Appointment	A scheduled one-on-one sales presentation (Scope of Appointment requirements apply) that is conducted anywhere except the consumer's residence. Includes, but is not limited to, any common area/community room of a nursing home/facility. *See also In-Home Appointment and Personal/Individual Marketing Appointment.*
Out-of-Network Pharmacy	A licensed pharmacy that is not under contract with a Medicare Part D sponsor to provide negotiated prices to Medicare Part D plan members.

Term	Definition
Out-of Network Provider	A provider or facility with which UnitedHealthcare does not have a contract; therefore, there is no agreement for the non-participating provider to arrange, coordinate, or provide covered services to members of the UnitedHealthcare plan.
Out-of-Pocket Maximum	An annual limit that some plans set on the amount of money a member will have to spend out of their own pocket for benefits.
P	
Party ID	A number assigned by Agent On-Boarding that provides primary identification of an individual. All writing numbers assigned to the individual are tied to their Party ID.
Permission to Call (PTC)	Permission given by a consumer to be called or otherwise contacted. It is to be considered limited in scope, short-term, event-specific, and may not be treated as open-ended permission for future contacts. Does not apply to postal mail.
Pended Commission	A commission for the sale of a policy that cannot be paid as a result of one or more impedance.
Personal Identifiable Information (PII)	A person's first name or last name in combination with one or more of the following data elements: Social Security Number; driver's license or state identification number; or an account, credit card, or debit card number in combination with any required security or access code or password that would permit access to a consumer's financial account.
Personal/Individual Marketing Appointment	A face-to-face, one-on-one marketing presentation that typically occurs in a consumer's residence (e.g., in-home), but may occur in a coffee shop, library, or other public setting. Includes a resident's room in a nursing home/facility. Requires a Scope of Appointment.
Pharmaceutical & Therapeutic Committee (P&T)	The committee of physicians, pharmacists, and other health care professionals who establish and approve the clinical parameters for a formulary. The P&T includes specialized practitioners such as geriatricians and pharmacists specializing in geriatrics. The committee includes independent consultants and functions under policies that ensure fair/unbiased assessments of therapies and remove conflicts of interest.
Pharmacy Benefit Manager (PBM)	The subcontractor of the plan sponsor responsible for processing the pharmacy claims and/or administering coverage determinations.
Plan Benefit Package (PBP)	The package of benefits offered in a specific geographic area by a sponsor under an MA plan, MA-PD plan, PDP, section 1876 cost plan, or employer group waiver plan, files annually with CMS for approval.
Pledge of Compliance	A document signed (electronically) annually by agents pledging compliance with the CMS guidelines and regulations and UnitedHealthcare rules, policies, and procedures.
Point-of-Service (POS)	A type of HMO plan that give members the option to use providers outside the plan's contracted network for certain benefits, generally at a higher cost. The benefits that are covered out-of-network vary by plan.
Policy Center	An internal website that contains a comprehensive inventory of UnitedHealth Group policies and procedures accessible to UnitedHealth Group employees.
Preferred Provider Organization (PPO)	A type of MA plan in which the member can use either network providers or non-network providers to receive services (going outside the network generally costs more). The plan does not require member to have a referral for specialist care.
Premium	The amount paid by a member to participate in a plan or program. Includes LEP, LIS reductions, Employer Subsidy reductions, and rider premiums.
Prescription Drug Plan (PDP)	A stand-alone plan that offers Medicare Part D prescription medication coverage only.
Preventive Service	Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best.

Term	Definition
Primary Care Physician (PCP)	A physician seen first for most health problems. The PCP may also coordinate a member's care with other physicians and health care providers. In some MA plans, members must see their PCP before seeing any other health care provider.
Prior Authorization	A type of utilization management program that requires that the member or member's physician receive authorization from the plan prior to the member receiving coverage of the prescribed medication.
Producer	A global term introduced in 2007 to refer to any licensed, certified, and appointed individual soliciting and selling UnitedHealthcare Medicare Solutions products, including, but not limited to NMA, FMO, SGA, MGA, GA, ICA, ISR, Broker, Solicitor or Telesales representative.
Producer Contact Log (PCL) *formerly Service Gold*	A contact management system used to document agent/agency interactions with the PHD and/or sales managers/supervisors or BDEs.
Producer Help Desk (PHD)	A UnitedHealthcare call center whose purpose is to provide support to all agents with issues that pertain to the agent experience.
Protected Health Information (PHI)	Individually identifiable information (including demographics) that relates to health condition, the provision of health care, or payment of such care. Identifiable information plus health information creates PHI. The fact that a consumer/member is applying for coverage or is enrolled in a UnitedHealthcare plan is considered health information PHI.
Provider	Any individual who is engaged in the delivery of health care services in a state and is licensed or certified by the state to engage in that activity, and any entity that is engaged in the delivery of health care services in a state and is licensed or certified to deliver those services if such licensing or certification is required by state law or regulation.
Provider Contact Form	Consumers identify preferred physicians and hospitals on the this form during the enrollment in a PFFS plan.
Provider Sponsored Organization (PSO)	A type of MA plan run by a provider group or group of providers. PSO members usually receive their health care from the providers of the plan. Note: UnitedHealthcare currently does not offer a PSO plan.
Q	
Quantity Limit (QL)	A management tool designed to limit the use of selected medications for quality, safety, or utilization reasons. Limits may be on the amount of the medication that the plan covers per prescription or for a defined period of time.
R	
Rapid Disenrollment	A voluntary disenrollment by a member within three months of the plan effective date. Rapid disenrollment is a key metric that agents are measured on; a high volume may indicate problems with the sales process.
Referral – Medical	A formal recommendation by the member's contracting PCP or his/her contracting medical group to receive health care from a specialist, contracting medical provider, or non-contracting medical provider.
Referral – Sales	A consumer who contacts an agent directly upon the recommendation of an existing client, consumer, member, or other third party. In all cases, a referred individual needs to contact the plan or agent directly.
Region	Certain plan types such as PDP and Regional PPO MA plans are offered by regions. CMS created regions based on population size so that plans within a region are able to enroll and provide appropriate service to members. A region may consist of an entire state, several states, or several counties within a state. The service area of a PDP region may vary from a Regional PPO.

Term	Definition
Regional Preferred Provider Organization (RPPO)	A type of Medicare Advantage Plan introduced in an effort to expand the reach of Medicare managed care to Medicare consumers, including those in rural areas. RPPO plans mirror Local PPO plans in functionality and benefit structure, but are available in a defined region as opposed to being limited to a defined market. Members can access network providers throughout the RPPO service area and may access out-of-network services nationwide.
Resident Agent	An agent who is licensed and appointed (if applicable) to sell in their state of residence.
Responsible Party	A person authorized under applicable law or identified in writing by the individual to act on behalf of the individual in making health care and related decisions. Also known as authorized representative.
S	
Sales Distribution	An organization comprised of various distribution channels that market and sell UnitedHealthcare Medicare Solutions portfolio of products.
Sales Leadership	A global term used to describe the sales management hierarchy. Includes both field sales and telesales.
Sales Management	Individual or delegate within UnitedHealthcare Medicare Solutions who is responsible for the management of a sales agent, agency, channel, or geography.
Scope of Appointment	The agreement obtained from the consumer to the scope of products that can be discussed at a personal/individual marketing appointment.
Service Area	The geographic area approved by CMS within which an eligible consumer may enroll in a certain plan.
Service Request	The documentation in PCL of all inbound and outbound contacts between the PHD and an agent. *See also Coaching Request.*
SNF	Skilled Nursing Facility
Solicitor	A licensed, certified, and appointed agent who sells designated UnitedHealthcare Medicare Solutions products through a contract with an agency (NMA, FMO, SGA, MGA and GA), but does not have a direct contract with UnitedHealth Group.
Special Election Period (SEP)	A period when a Medicare consumer may sign up or make changes to their Medicare coverage outside of their initial enrollment period or the Annual Election Period under specified circumstances defined by Medicare.
Special Needs Plan (SNP)	A type of MA plan that provides health care for specific groups of people, such as those who have both Medicare and Medicaid (Dual SNP), or those who reside in a nursing home (Institutional SNP), or those who have certain chronic medical conditions (Chronic SNP).
Specified Low Income Medicare Beneficiary – SLMB	A program in which Medicaid provides payment of the Medicare part B monthly premium only. (SLMB-Plus: Payment of the consumer's Medicare Part B premiums and full Medicaid benefits.)
Spend Down	The Medicaid spend down program (also known as Medicaid excess income or surplus income) is for individuals who have too much income for the regular Medicaid program, but who also have high medical bills. The program pays some, but not all of a person's medical bills. The amount of monthly income over the Medicaid level is excess and must be spent by the individual toward their medical expenses before Medicaid pays any of the medical expense during the specified time. The individual has to spend down to the specified level each time period.
State Pharmaceutical Assistance Programs (SPAP)	A state program that provides help paying for medication coverage based on financial need, age, or medical condition.
Step Therapy (ST)	A utilization tool that requires a member to try first another medication to treat their medical condition before the Medicare Part D plan will cover the medication their physician may have initially prescribed.

Term	Definition
Substantiated Allegation	Following review of the allegation against an agent, appropriate investigation, consideration of the evidence and pertinent circumstances, there is sufficient information to conclude that the allegation is true.
Substantiated Complaint	Following review of the allegation against an agent, appropriate investigation, and consideration of the evidence and pertinent circumstances, there is sufficient information to support the conclusion that the complaint is true.
Super General Agent (SGA)	An independent contractor, with a direct contract with UnitedHealthcare at the SGA level. May refer agents and solicitors for certification and appointment to solicit and sell designated UnitedHealthcare Medicare Solutions products.
Suspension	Temporary removal of an agent's ability to market and sell products. It is based upon the severity of the allegation(s), the number of pending complaint(s) or investigations, the nature and credibility of information initially provided, and/or the number of members or consumers affected.
T	
Telemarketer/ing	A firm or individual who telephonically contacts consumers on behalf of UnitedHealthcare for the purpose of soliciting or selling designated UnitedHealthcare Medicare Solutions products. Telemarketing activities may include lead generation, appointment setting, and/or product marketing.
Telesales Agent	A licensed, certified, and appointed agent who telephonically solicits and sells in a call center environment designated UnitedHealthcare Medicare Solutions products. May be an employee of UnitedHealthcare or an employee of a delegated vendor.
Telesales Non-Licensed Enroller and Concierge Representative	A non-licensed individual, who represents UnitedHealthcare in triaging inbound Telesales calls or taking telephonic enrollment applications and other related activities, but who is prohibited from performing solicitation or selling activities. In addition to taking telephonic enrollments, the representative can set appointments, process sales event RSVPs, and provide basic benefits statements per CMS regulations.
Testimonial	A short presentation or written narrative that a member of the Storytellers Program provides based on their personal experience with a specific UnitedHealthcare Medicare Solutions plan.
Therapeutic Alternatives	Drug products containing different chemical entities, but which provide the same pharmacological action or chemical effect when administered to patients in therapeutically equivalent doses.
Therapeutic Class	Drugs grouped by their purpose, the symptom, or disease they are used to treat.
Therapeutic Substitution	A decision by a physician to replace a prescribed medication with a similar medication that is more effective or equally effective.
Tier	Covered medications have various levels of associated member cost sharing. Example: Tier 1: Preferred Generic – Lowest Copayment – Lower cost commonly used generic drugs. Tier 2: Non-Preferred Generic – Low Copayment – Most generic drugs. Tier 3: Preferred Brand – Medium Copayment – Many common brand-name drugs and some higher cost generic drugs. Tier 4: Non-Preferred – Higher Copayment – Non-preferred generic and non-preferred brand-name drugs. Tier 5: Specialty Tier – Coinsurance – Unique and/or very high cost drugs.

Term	Definition
Tier Exceptions	A type of coverage determination to provide coverage (based on clinical justification) of a tier to a lower tier.
Trademark	A word, phrase, or symbol that signifies or identifies the source of the good or service and describes the level of quality that can be expected from a particular good or service.
Trend (for agent level inconclusive complaints)	At an individual agent level, UnitedHealthcare defines a trend as number of inconclusive complaints in the same category, based on the number of total enrollments within a 12-month rolling basis while under an active contract with UnitedHealthcare or NMA/FMO. Corrective action and active management/oversight of complaints will occur on a concurrent basis to include member counseling and outreach, agent, NMA and/or FMO retraining and certification or possible suspension or termination.
Trend (for global complaints)	A pattern or percentage change in complaints for a particular geography, channel, state, and/or product within a 12-month rolling basis. If a trend is identified, the appropriate Business Unit will be notified, a review for root cause will be conducted and if necessary, the appropriate corrective actions will be carried out in accordance with policies and procedures. Corrective actions may include, but are not limited to revision of training, coaching and counseling of agent, manager, or entity, and termination of agent or entity.
True Out-of-Pocket Expense (TrOOP)	An accumulation of payments – monies spent – by the member of a plan. It includes copayments and deductibles, but does not include premium payments or any payments made by the plan.
TTY	A teletypewriter (TTY) is a communication device used by members and consumers who are deaf, hard-of-hearing, or have severe speech impairment. Members and consumers who do not have a TTY can communicate with a TTY user through a Message Relay Center (MRC). An MRC has TTY operators available to send and interpret TTY messages.
U	
UnitedHealthAdvisors	Branded name that refers to the UnitedHealthcare Distribution Portal for captive agents (includes ICA).
UnitedHealthProducers	Branded name that refers to the UnitedHealthcare Distribution Portal for non-captive agents (i.e. EDC).
UnitedHealthcare Distribution Portal (UDP)	The agent website that provides access to product, commission, and resource information. The distribution portal is the agent's central point of communication and distribution resources.
UnitedHealthcare Government Programs *formerly Public and Senior Markets Group of UnitedHealth Group (PSMG)*	A term used internally to collectively refer to the benefit businesses of UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State, and UnitedHealthcare Military & Veterans.
Unsolicited Contact	Unsolicited contact includes, but is not limited to door-to-door, telephone, and email, voice and text message solicitation without explicit permission from the consumer to be contacted in such a manner for the purpose of marketing any of the products in the UnitedHealthcare Medicare Solutions portfolio. *See also Cold Calling.*

Term	Definition
Unsubstantiated Allegation	Following review of the allegations against an agent, appropriate investigation, and consideration of the evidence and pertinent circumstances, there is sufficient information to support the conclusion that the allegations are unfounded.
Unsubstantiated Complaint	Following review of the allegations against an agent, appropriate investigation, and consideration of the evidence and pertinent circumstances, there is sufficient information to support the conclusion that the complaint is unfounded.
Up-Line	The contracted entities within an NMA/FMO hierarchy that are above the management/reporting level of a specific agent/agency.
V	
Vendor	An entity whose purpose is to perform activities as specified by UnitedHealthcare under mutual agreement.
W	
Waiver State	Massachusetts, Minnesota, and Wisconsin are referred to as waiver states because they already have Medicare requirements before Medicare plans were standardized. These states are permitted by statute to offer Medicare supplement insurance plan options that differ from the standardized Plans A through N.
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.
Y	
Yearly Deductible – Medical	The amount the member must pay for health care before the plan begins to pay.
Yearly Deductible – Prescription	The amount the member must pay for prescriptions before the plan begins to pay. Some drug plans charge no deductible.

Index

Index