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.

All materials contained in this Guide are protected by copyright laws, and may not be reproduced, republished, distributed, transmitted, displayed, broadcast, or otherwise exploited in any manner without the express prior written permission of the Company. The Company's names and logos and all related trademarks, trade names, and other intellectual property are the property of the Company and cannot be used without its express prior written permission.

This Guide is intended for EDC agent use only.

Version 1.7 Release Date – November 19, 2014
©2014, UnitedHealthcare
All Rights Reserved.

Table of Contents

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Table of Contents

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Section 1: Introduction

Welcome to UnitedHealthcare Medicare Solutions!

Using this Guide

UnitedHealth Group Overview

UnitedHealthcare Medicare Solutions Overview

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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 is 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" is 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

UnitedHealth Group Overview

Our mission is to help people live healthier lives and help make the health system work better for everyone.

- We seek to enhance the performance of the health system and improve the overall health and well-being of the people we serve and their communities
- We work with health care professionals and other key partners to expand access to quality health care so people can get the care they need at an affordable price
- We support the physician/patient relationship and empower people with information, guidance, and tools they need to make personal health choices and decisions

UnitedHealthcare and Optum are empowering individuals, expanding consumer choice and strengthening patient-provider relationships. We offer exceptional service, broad capabilities and enduring value in creating a modern health care system.

The people of UnitedHealth Group, Optum and UnitedHealthcare are engaged in the important work of making quality health care more affordable, simpler and easier for people to access, while putting information into the hands of individual consumers and their physicians, so they can make better decisions about healthy behavior and evidence-based care.

UnitedHealth Group is a diversified health care company headquartered in the United States, serving the markets for health benefits through UnitedHealthcare and the growing markets for health services through Optum. These two platforms share and build upon three core competencies: clinical insight, advanced data and information resources and enabling technology. Our business model is highly adaptable, allowing us to quickly and effectively address emerging needs in a changing health care landscape.

UnitedHealthcare serves the health benefits needs of individual consumers and employers of all sizes; individuals age 50 and older through Medicare and other benefit products that fit their unique needs; the public health marketplace, offering states innovative Medicaid solutions; active duty and retired U.S. military personnel and their families; and is expanding in international health care markets.

Optum is focused on population health management, care delivery and improving the clinical and operating elements of the system. Optum is a leader in population health management, serving the physical, mental and financial needs of more than 62 million individuals. It is one of the largest health information, technology, services and consulting companies in the world, as well as a pharmacy benefit management leader in service, affordability and clinical quality.

Together UnitedHealthcare and Optum serve more than 85 million individuals worldwide with a total workforce of more than 160,000 people, and serve members in all 50 states in the United States and more than 125 other countries. We remain dedicated to delivering “more for less”… more and better health care at lower cost to consumers on behalf of employers and governments – while we modernize and help build an ever more effective, simpler and consistently high quality health care system. We take seriously our responsibility to serve others and to bring forward meaningful and sustaining change.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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. You must align under an EDC that is approved and contacted with UnitedHealthcare. 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 you, with a copy to the EDC, by the Agent On-Boarding specialist via the Welcome Letter. The executed copy of your agreement is secure delivered via email only to you.

You are required to provide and retain a current, 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

You 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. You may be covered under your 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.

The following guidelines apply:

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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- ~ General Agent (GA) level and above producers must have their own E&O coverage or their name must appear as the certificate holder (or similar) on the confirmation of insurance of a blanket policy.
- ~ Contracted entities may provide E&O/Professional Liability coverage by submitting a non-carrier produced listing of covered individuals. The listing must be on carrier or business entity's letterhead, provide covered individual's full legal name and signed by the entity's principal or by the carrier. In the External Distribution Channel (EDC), entities may provide coverage for down-line employees, affiliated producers, agents, and/or subcontractors who are contracted at the individual agent level.

- E&O/Professional Liability for a principal will cover the corporation, but not specifically the employees or subcontractors of the corporation.

- If an agent is not insured by a corporate policy, they may have individual E&O/Professional Liability insurance. The policy should be in their name.

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)

You must be licensed in your state of residence and in all states you wish to market and sell. You are 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.

You will be terminated if you were not appropriately licensed at the time of the sale. The termination will be not-for-cause and you will not be able to re-contract for at least 12 months following the termination effective date.

Continuing Education (CE)

UnitedHealthcare is now offering discounted rates for online and live Continuing Education (CE) courses through Kaplan. In the past, you needed to enter vouchers and codes to access CE courses; the new process allows you to take classes with ease.

How do I access the CE courses?

You can access online continuing education courses through the Kaplan website or via the link in the Learning Center on the Distribution Portal. When you arrive at the Kaplan website www.kfeducation.com/portallogin, you will need to create an account by entering your email address and the portal code "EDC".

What courses can I take?

You can get great discounts on both online and live CE sessions. Total access to the CE courses is only $29.25. The total access selection will give you unlimited access to all credit hours.

Party Identification (Party ID) Notification

You are assigned only one Party ID in your lifetime with UnitedHealthcare Medicare Solutions. The Party ID links all subsequently issued writing numbers to you.

An issuance of a Party ID is not a guarantee of an issuance of a writing number. A writing number will be issued upon successful completion of the contracting process.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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).

Access to Certification Modules

You must complete certification requirements in order for Agent On-Boarding to process the appointment request. (Refer to Agent On-Boarding: Certification and Training for details on the certification process and agent requirements.)

The Party ID Notification Letter includes instructions for accessing the UnitedHealth Group Learning Management System within the Distribution Portal. You must complete and successfully pass all required tests and at least one product test, within ninety days of the date of the Party ID Notification Letter, in order to move forward in the contracting process.

If you do not complete certification within ninety days of receiving the Learning Management System login information, the contracting packet is closed. A new contract packet may be submitted without a waiting period.

Background Investigation

You must pass a background investigation in order for Agent On-Boarding to process the appointment request. The investigation is ordered at the time the Party ID is issued or a new contract packet is received.

A background investigation collects information regarding an agent's history of criminal charges, credit history, insurance licensing history, Office of Inspector General records, and General Service Administration excluded party records. Results are examined against predefined criteria. A Pass-Fail scoring methodology is employed.

Upon receipt of a positive (pass) result, the contracting process continues. If a negative (fail) result is returned, a senior Agent On-Boarding analyst reviews the investigation results. If the review supports the initial determination, the contracting process will terminate and you will receive notification of the decline to appoint due to background investigation. The notification letter will include appeal submission instructions. (Refer to your sales leadership for addition details regarding Denial Due to Background Investigation.)

In the event you have adverse information on your background investigation, the background vendor will send a pre-notification letter to you making you aware that there is information contained in your background investigation which may cause you to fail the background review.

On an annual basis, a background investigation is ordered for all non-employee agents (all levels), solicitors, and principals who have an active Party ID. A notification letter is sent to you, solicitor, or principal informing them of the upcoming background investigation. The notification letter provides instruction on how to notify Agent On-Boarding if the individual does not authorize the investigation. Agents, solicitors, and principals who do not authorize the background investigation are immediately terminated upon such notification to Agent On-Boarding. If the principal does not authorize the background investigation, this termination includes agencies of these principals. The annual background investigation review follows the same process outlined above.

If you fail the annual background process, you will receive a 30-day termination notice, regardless of channel or level (solicitors included).

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Appointment

Appointment is an official declaration by an insurance company that the requested agent is authorized to represent the company by selling its products. Appointment methods and timeframes vary by state, as each state uses their own rules and allows for submission of paperwork separately. Department of Insurance interface software is used to perform the appointment based upon each state's requirements.

When all contracting requirements are met and you have taken and passed all mandatory certification tests and at least one product certification test, Agent On-Boarding will appoint you in each state requested (some exceptions apply). Note: The agent's up-line must also be licensed and appointed (if applicable) in the requested state(s).

Effective April 19, 2013, appointment fees are processed as follows:

- UnitedHealthcare pays all appointment fees upon submission to each state.
- All resident state appointment fees are the responsibility of UnitedHealthcare.
- Non-resident state appointment fees on any new or renewal appointments as of January 2013 are the responsibility of the entity requesting appointment (i.e. agent, solicitor, and applicable up-line levels). Note: For a solicitor, the up-line that receives commissions on the solicitor's sales is responsible for the solicitor's non-resident appointment fees.
- Fees for which the entity requesting appointment is responsible are collected by UnitedHealthcare via a debit against the respective entity's commissions or override as applicable.
- Non-resident state appointment fees in states where appointment fee collection from an agent is prohibited are exempt from this requirement.

Writing Number (Agent ID) Notification

Once the appointment request is submitted, you are set to active status in the contracting system, a writing number issued, and the Agreement is executed with the Senior Vice President of Distribution's signature. A Welcome Letter, which contains your writing number and an executed copy of your Agreement (where applicable), is emailed to you with a copy of the Welcome Letter sent to the EDC.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Certification and Training Process

Agent is recruited

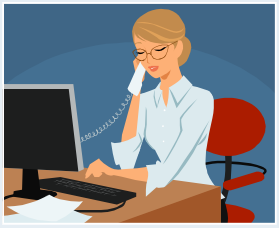
Agent must be Licensed, Contracted, Certified, and Appointed (if applicable)

Agent must complete and pass all applicable certification tests

Agent must pass each certification test within 3 attempts with a minimum score of 85%

Agent is certified

Agent is qualified to sell applicable products



Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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 you 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.

You must become certified as part of your initial on-boarding process and remain certified on an on-going basis in order to market and sell UnitedHealthcare Medicare Solutions products.

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 2014, you write an Enrollment application with a January 1, 2015 effective date, you must have completed your 2015 product certification.

No commission 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 Tests will contain, at a minimum, the following content:

- Medicare Basics – Includes a review of Original Medicare, eligibility, premiums, and benefits.
- Ethics and Compliance - Includes the Pledge of Compliance, Code of Conduct, Medicare marketing guidelines, fraud, waste, abuse, privacy and security content.
- AARP 101

Mandatory Tests for any agent listed as the presenting agent for an educational event, marketing/sales event, UnitedHealthcare MedicareStore event, and/or an agent or sales leader conducting virtual (online) marketing/sales events.

- Events Basics – Includes compliance regulations and rules, policies, and procedures regarding event reporting, conducting educational and/or marketing/sales activities at an event, provider-based activities, and event cancellation procedures. Note: Events Basics is located in the Electives section of the learning management system.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Product Line Modules/Tests 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.
- Chronic Condition Special Needs Plans
- Dual Special Needs Plans
- Institutional Special Needs Plans (invitation only)
- UnitedHealthcare Senior Care Options (invitation only)
- Prescription Drug Plan (PDP).
- UnitedHealthcare Medicare Supplement Insurance Plans.
- AARP Medicare Supplement Insurance Plans

An agent is portfolio certified upon successful completion of all of the following product tests for the applicable plan year: MA, PDP, PFFS, Chronic Condition SNP, Dual SNP, and AARP Medicare Supplement Plans.

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 tests on your own behalf for the plans you wish to sell.

In the completion of any module and/or associated test, 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 test 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 test, you will be subject to discipline up to and including termination with cause.

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 must be a UnitedHealthcare employee or a UnitedHealthcare contracted vendor proctor. The use and name of a proctor must be documented.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

AHIP Certification

You may receive partial credit if you elect to certify by America's Health Insurance Plan (AHIP). You are still responsible for completing remaining prerequisites: Ethics and Compliance, including the Pledge of Compliance, AARP 101 and any other product courses as required. Once the prerequisites are complete, the agent will be certified in Medicare Advantage (MA) Plans – HMO, PPO, POS, and Medicare Prescription Drug Plans product courses.

UnitedHealthcare Medicare Solution accepts (with limitation) America's Health Insurance Plans (AHIP) certification and recertification in place of 2015 Medicare Basics, 2015 Medicare Advantage Plans, and 2015 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.

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 pass the tests for each of the following:

- 2015 AHIP
- 2015 Ethics and Compliance
- 2015 AARP 101

If you choose to certify through AHIP, you must complete the 2015 AHIP Certification before any other 2015 certification modules. Failure to do so will result in AHIP score rejection.

Agent Certification Requirements

Prior to appointment, you must complete the initial registration on the Distribution Portal to access the UnitedHealth Group learning management system and successfully complete a set of tests and at least one product test.

- 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 requirements, including the Pledge of Compliance, on an annual basis.

As part of the contracting and on-boarding process, and on an annual basis (prior to a selling season) thereafter, the agent must complete and pass a set of mandatory tests and at least one product test.

You are required to:

- Review and electronically sign the Pledge of Compliance on an annual basis.
  - ~ The Pledge is part of the Ethics and Compliance course and must be signed (e.g., electronic agreement) prior to selling the UnitedHealthcare Medicare Solutions portfolio of products.
  - ~ The Pledge constitutes an agreement to make a personal commitment to fair and honest marketing practices and to comply with CMS and state regulations regarding the sale of Medicare products.
  - ~ If you do not indicate acceptance of the terms and conditions of the Pledge of Compliance, you cannot continue their course of study or market UnitedHealthcare Medicare Solutions products.
  - ~ If you requests credit for AHIP courses, signing the Pledge of Compliance is required and a prerequisite to the electronic credit request process

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- Complete all mandatory (prerequisite) tests, and at least one product test, and attain a minimum passing score of 85% within three attempts for each test.
  - ~ For each test, you have three attempts to successfully complete the test and score a minimum of 85% on the test.
  - ~ After three unsuccessful attempts to score the minimum of 85% on the Medicare Basics, Ethics and Compliance, and/or AARP 101, you are not allowed to market, sell, write an enrollment application, or be paid a commission for ***any*** UnitedHealthcare Medicare Solutions product for the remainder of the applicable selling year. Example: if an agent fails 2015 Medicare Basics, you will be ineligible to sell for the 2015 selling year.
  - ~ After three unsuccessful attempts to score the minimum of 85% on a specific product test, you are not allowed to sell the product which was the subject matter of the failed test for the remainder of the applicable selling year.
  - ~ You are prohibited from marketing or selling a specific product, will not be able to order member materials for a specific product, and will not be eligible to receive commission for an enrollment application written unless they have completed and passed the related product test.
  - ~ After three unsuccessful attempts to score the minimum of 85% on the Event Basics test, you will be prohibited from being listed as the presenting agent and/or presenting at an educational event, marketing/sales event, UnitedHealthcare MedicareStore and/or virtual marketing/sales event for the remainder of the applicable selling year.

No commission will be paid on any enrollment application taken prior to certification in the mandatory tests and in the related product.

New Product 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 minimum score of 85% 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.

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 PHD at phd@uhc.com (the subject line should contain your Writing ID number), available 24 hours. Requests that cannot be resolved by the PHD are documented and escalated to the certification team.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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 Distribution Portal 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 www.UnitedHealthProducers.com. Re-registering with the agent writing number allows you access to additional features and functionality of the Distribution Portal.

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

UnitedHealth Group Learning Management System Website Tips

Before beginning a certification session, you should:

- In order to take any of the certification modules, for optimal results Internet Explorer version 7.x or 8.x is preferred.
- For Internet Explorer 10 or 11, you must turn on compatibility view. Do this by clicking Tools, then selecting Compatibility View. Make sure "unitedhealthgroup.com" is added to the Compatibility View Settings popup box
- 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.

Submit questions regarding certification and access to the Distribution Portal can be addressed to the PHD at phd@uhc.com (include your Agent ID in the subject line).

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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

Distribution Portal

Producer Help Desk

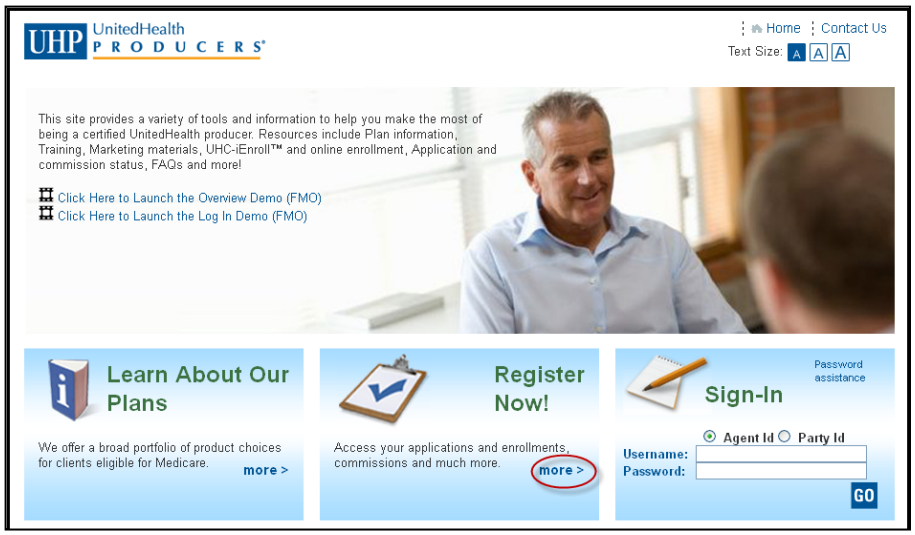
Quick Resource Tip Sheet

Agent Communications

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Distribution Portal

Note: The images are only representative of what may appear on the Distribution Portal and may vary based upon channel and access rights. The Distribution Portal appearance and available resources may change periodically.



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 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.

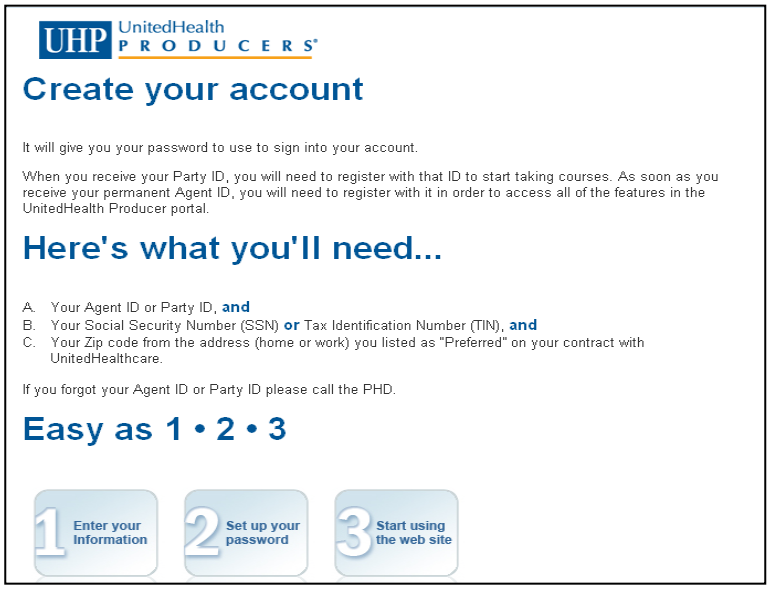
Information on the portal is organized into categories including Learning Center, Product Information and Materials, Online Enrollment, enrollment applications and Enrollments, Commission Status, Manage Your Account, and Resource Center.

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:

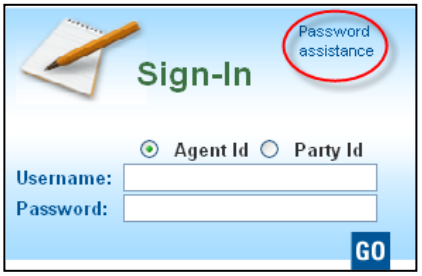
- Party ID (communicated in the Party ID Notification Letter) or writing number (communicated in Welcome Letter)
- Social Security number or Tax identification number
- ZIP code



Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- 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 PHD is available if you are having difficulties with registration or login at phd@uhc.com (include your Agent ID in the subject line).

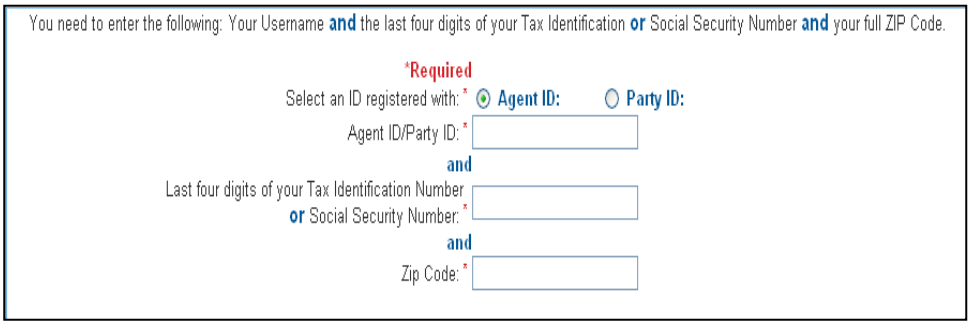
Distribution Portal Password Resets



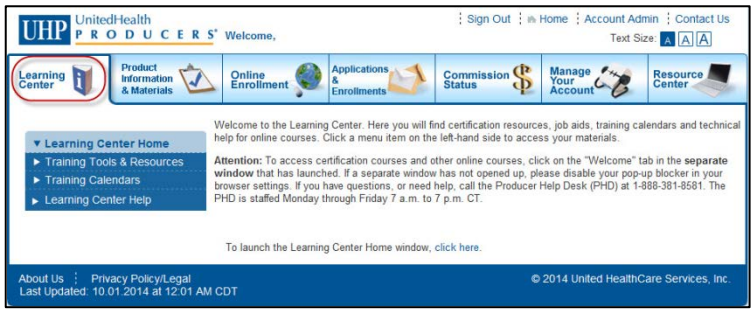
The Distribution Portal allows you to reset your password by following these steps:

- 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.

Home Page

Learning Center | Product Information & Materials | Online Enrollment | Applications & Enrollments | Commission Status | Manage Your Account | Resource Center

Top Documents, Links & Contacts

Documents:

- 2015 Sales Event Resources
- Agent Guides
  - FMO Agent Guide (PDF)
  - ICA Agent Guide (PDF)
  - ISR Agent Guide (PDF)
  - Telesales Agent Guide (PDF)
- Missing/Incomplete Application Update Request Form (PDF)
- UnitedHealth Group Code of Conduct (PDF)
- Election Period Booklet (PDF)
- Enrollment Handbook (PDF)
- American Sign Language Interpreter Request Form (PDF)

Links:

- Access the Agent Toolkit

Contacts:

- Agent Contacts (FMO)
- Agent Contacts (TS/ISR)
- Agent Contacts (ICA)

NEW AGENT MATERIALS PORTAL NOW OPEN!

We have created a new and improved Agent Materials Portal to process your sales material orders. All agent materials (Including MA, PDP, and Medicare Supplement products) will be ordered through the new Agent Materials Portal. Please click the link in Sales Materials to directly be taken to the new Agent Materials Portal.

Feature Focus News

2015 Star Ratings - Now Available on Medicare.gov

October 15, 2014 - The Centers for Medicare & Medicaid Services (CMS) has just released the 2015 Plan Star Ratings. Learn what this means for you as an agent, and look up your plan's new rating today. Full Article

Make sure you submit your enrollment applications correctly

October 15, 2014 - Make sure your applications are being submitted correctly this selling season by reviewing the 2015 Plan Year Paper Enrollment Application Submission Methods. The document contains all enrollment center fax numbers and overnight mailing addresses for UnitedHealthcare's enrollment centers based on plan type. Full Article

Updates have been made to the iEnroll tool

October 15, 2014 - Updates have been made to create a better user experience for both you and the consumer. Make sure you know about these updates before you begin using iEnroll this selling season. Full Article

The Enrollment Handbook for Agents has been updated and is now available!

October 1, 2014 - The 2015 Enrollment Handbook for Agents is a great one-stop resource for you during the upcoming selling season. The Handbook offers sections on Stars, Election Periods, Denials and Disenrollments, Application Examples, Special Needs Plans, Primary Care Physicians and Premiums. The Appendix of the Handbook also contains examples of Enrollment Letters that your consumers and members might receive.

Full Article

View the Enrollment Handbook for Agents

Required content for agents who are certified for 2015

October 1, 2014 - Agents who have already completed or are in the process of completing the 2015 Ethics and Compliance certification module, must read additional required content to market or sell for the 2015 plan year. Full Article

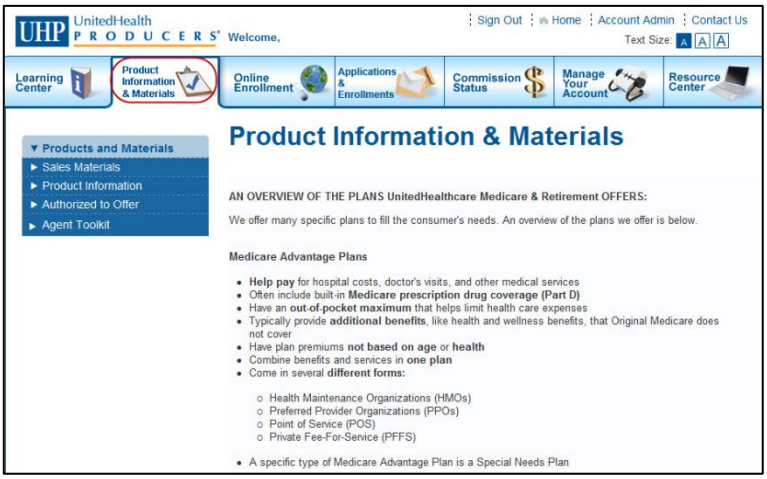
Help your members understand changes to the way they are billed by UnitedHealthcare

October 1, 2014 - UnitedHealthcare has redesigned how monthly premiums are billed to those members who previously received coupon books. As a trusted advisor to UnitedHealthcare members, please ensure that your members who are affected by this change understand the process. Full Article

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Product Information

The Product Information section contains a complete overview of all plans available including Medicare Advantage, Prescription Drug, 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 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 Materials section provides access to order and download centers, where agents can order Enrollment Guides and/or download the marketing materials. The agent will only see the plans they are certified to sell in this section. Please note: the date Medicare Supplement materials become available may vary based on when rates take effect.

Note: Prior to the Open Enrollment, there is a pre-order timeframe where the agent can order Enrollment Guides and consumer workbooks 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 Open Enrollment. Refer to Focus News in the months leading up to the Open Enrollment to find out when pre-ordering will be available for the upcoming plan year. Pre-ordering materials is not available for Medicare Supplement materials.

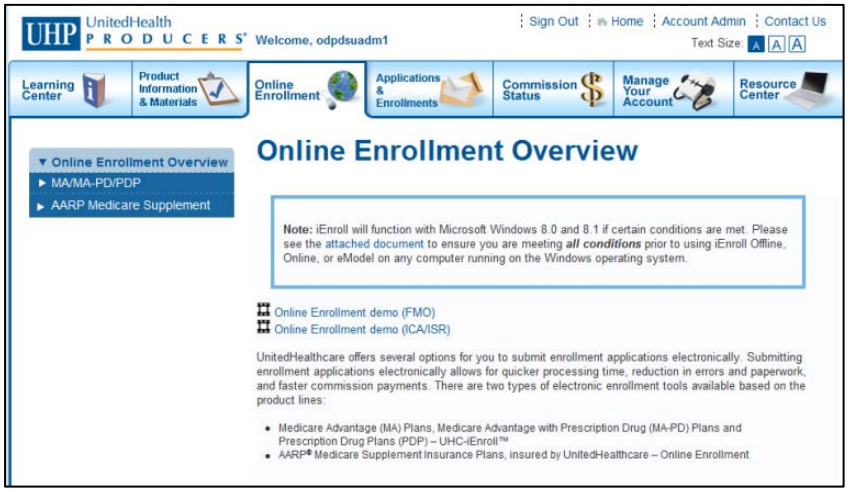
Agent Toolkit

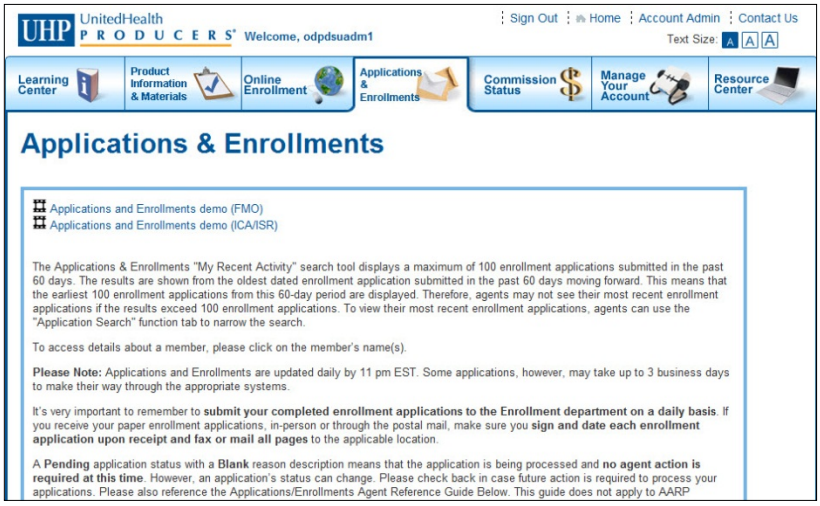
The Agent Toolkit section provides access to the Agent Toolkit. Additionally, this section provides helpful materials to guide you through the Agent Toolkit.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Online Enrollment

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



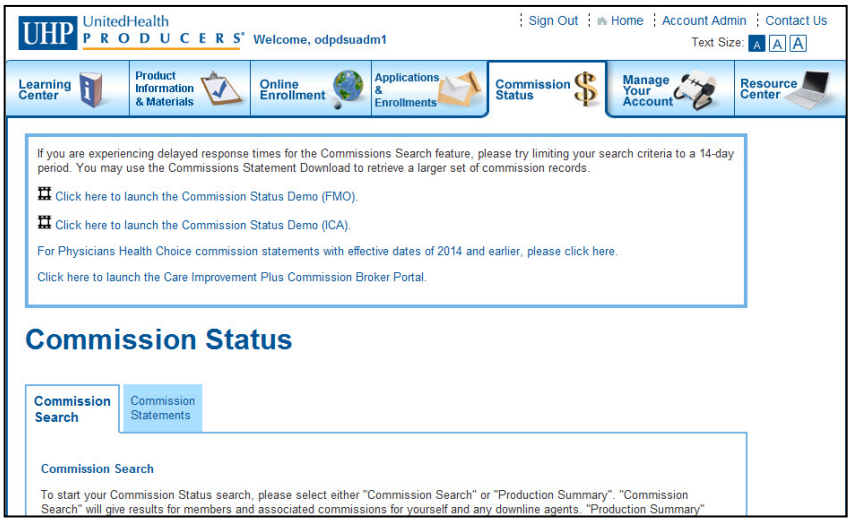


Applications and Enrollments

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.



Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Producer Help Desk

The Distribution Portal, 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 Distribution Portal, need assistance with a pending enrollment application, or have a commission inquiry, the Producer Help Desk (PHD) is available.

Email: phd@uhc.com (include your Agent ID in the subject line) or icssupport@uhc.com (enrollment application status and updates only)

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

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 ID
- 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 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)

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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.

General Agent Support

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

Email: PHD@uhc.com (enter your Agent ID in the subject line)

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/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html

Compliance Questions - Contact for questions regarding marketing or for access to Medicare marketing guidelines
Compliance_Questions@uhc.com

Customer Service Resources

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

Customer Service – HMO/PPO/RPPO/POS
Telephone: Find plan-specific numbers in the plan's Summary of Benefits or the back of the member's ID card. 8 a.m. to 8 p.m. CT, 7 days a week

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

Agent On-Boarding (Contracting, Appointment, Licensing)

UHPCred@uhc.com

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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

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.

Distribution Portal (www.UnitedHealthAdvisors.com): For compliance and product information, sales materials, conduct online enrollment, view enrollment application and commission status, and take your certification modules.

For additional information on UnitedHealth Group, go to www.UnitedHealthGroup.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 (2015)

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Agent Communications

Communications Methods

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

Routinely communicated topics include:

- Updates to applicable federal and state regulations that affect the agent.
- Operational policies and procedures, especially those around commissions and certification.
- Event reporting requirements.
- Updates to product rates, sales materials, and Distribution Portal.
- Updates to the Private Fee-for-Service non-deemed provider listing.
- Information to inform and 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

Update your contact information in your user profile on the Distribution Portal or by contacting the PHD.

Focus News

Focus News is a bi-weekly agent newsletter distributed via email by UnitedHealthcare Medicare Solutions, includes articles on compliance, compensation, marketing, customer service, operations, processes and procedures, products, regulatory issues, and sales.

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, Compliance or Legal.
- Direct media request inquiries, including informational interviews, must be directed to the Director of Corporate Communications. You are prohibited from speaking to the press regarding plan information without prior written permission from the Director of Corporate Communications.
- Submit all press release and other public communications materials to the Vice President of Corporate Communications for approval.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Section 4: Product Portfolio

Product Portfolio Overview

Medicare Advantage Health Plans

Medicare Advantage Special Needs Plans

Medicare Supplement Insurance Plans

Prescription Drug Plans

Medicare Star Rating Overview

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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 PHD at phd@uhc.com (enter your Agent ID in the subject line) 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 Plans, 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, Prescription Drug Plans, and Medicare supplement insurance 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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.

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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- 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.

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 PHD.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Medicare Advantage Health Plans

UnitedHealthcare Medicare Solutions may offer 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 medical coverage.

- **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. 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 PPO 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 do not 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. Some 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 and comprehensive care management. Local PPO and Regional PPO plan options are available in 12 states. Members do not 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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 routine dental, vision, hearing, transportation, and routine podiatry services. 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 eligible for 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 19 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 contracted, licensed, certified, and appointed (if applicable) 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.

- **UnitedHealthcare Assisted Living Plans – Institutional Equivalent Special Needs Plans (IESNP)** - UnitedHealthcare Assisted Living Plans provide personalized, closely monitored, and coordinated care to individuals who require the same level of care as residents of a skilled nursing facility but reside in the community. UnitedHealthcare offers the IESNP plans in 2 states, Washington and Oregon. The IESNP is sold exclusively by contracted, licensed, certified, and appointed (if applicable) 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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 Original 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 of benefits, that means the plan goes with the policyholder wherever they are in the United Sates. AARP Medicare Supplement Plans are supplemental plans available in all states and 5 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. Consumers can sign up for an AARP membership at the time they enroll in an AARP Medicare Supplement plan.

- **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.

Note: Rates, regulatory guidelines, and enrollment materials for AARP Medicare Supplement Insurances plans vary by state.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Prescription Drug Plans

UnitedHealthcare Medicare Solutions is a provider of stand-alone Medicare 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** plan includes nearly 94% of drugs covered by Medicare Part D plus coverage for Tier 1 and Tier 2 drugs and select brand name drugs in Tiers 3 - 5 in the coverage gap. It offers a $0 annual deductible, lower copayments with the Preferred Retail Pharmacy Network and access to more than 65,000 network pharmacies. Note: This plan is not available in: Arkansas, Kansas, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands.
- **AARP MedicareRx Preferred** formulary includes nearly all generic drugs covered by Medicare Part D and most commonly used brand-name drugs.

* Sourced from the 2014 Prescription Drug Plan Product Description

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Medicare Star Rating Overview

Overview: Medicare Star Ratings is a government pay-for-performance program for Medicare Advantage (MA, Part C) and Prescription Drug (Part D) plans, including Special Needs Plans. The Centers for Medicare and Medicaid Services (CMS) uses a five-star rating system to measure how well plan sponsors perform across a variety of performance categories, including clinical quality, health plan operations, and member satisfaction. These ratings help consumers and members compare plans based on quality and performance. Star Ratings are issued by CMS at the contract level and are published on annual basis at www.medicare.gov.

The Star Ratings system has been in place since 2007. Throughout the years the measures and methodology have been modified and may change from year-to-year. The Star Rating system is a result of national legislation. The Patient Protection and Affordable Care Act (PPACA) directed the U.S. Department of Health and Human Services to establish a program to reward high-quality Medicare Advantage plans with a bonus payment and a lesser reduction in their share of rebate dollars. Congress then instructed CMS to measure Medicare Advantage plan quality using a star rating system.

Each MA contract receives a single Star Rating from CMS. A contract is made up of one or more Product Benefit Plans (also known as "PBPs") or simply "plans". Performance data from members enrolled in those plans is collectively used to calculate the contract's overall Star Rating. The Star Rating associated with each plan (as published on the www.medicare.gov) represents the overall contract's Star Rating (e.g., if contract "X" is comprised of three plans, all three plans receive the Star Rating given to the contract).

Although CMS does not issue a single score for UnitedHealthcare's entire portfolio of Medicare Advantage plans, a weighted-average Star Rating is often used by other external parties, such as investors, researchers or associations, for comparative analysis across the industry.

Star Ratings are only published one time per year, typically in October. When the annual Star Ratings are published, there are no additional ratings or updates issued until the following release.

A plan can receive ratings between one and five stars.

- 5 Stars - "Excellent"
- 4 Stars - "Above Average"
- 3 Stars - "Average"
- 2 Stars - "Below Average"
- 1 Star - "Poor"

Achieving strong Star Ratings will help UnitedHealthcare sustain Medicare choice and affordability for millions of Americans. Our Star Ratings performance reflects our commitment and ongoing investment in improving the health care experience for our members. The financial benefits of favorable Star Ratings will also help us keep a strong and consistent value proposition for Medicare customers.

Lagging Timeline: Star Ratings are not on the typical one-year planning cycle, where what we do this year impacts next year. Instead, the annual Star Ratings reflect performance from two years prior. For example, how we **perform in calendar year 2015** will be used by CMS for our **2017 Star Ratings** and will determine our **payments for 2018**.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Your actions **today** can positively impact Star Ratings and future funding. See how this works in the chart illustrated below:

Plan Performance	Data Collection	Star Ratings Released	Enrollment Determines Payment
2013	2014	2015	2016
2014	2015	2016	2017
2015	2016	2017	2018

Rebates & Bonus Payments: Star Ratings is a 'pay for performance' program. Higher Star Ratings provide more funding from CMS, which allows UnitedHealthcare to offer innovative solutions and enhanced benefits for more competitive products. The funding level (also known as rebates and bonuses) can be thought of as the amount of savings a plan can generate because they are more efficient in managing medical care and costs. For example, if a plan has $700 of revenue (including their Star Rating rebate or bonus) and they can provide Medicare benefits for $600, they have $100 in savings or "rebate". That rebate is shared between the plan and the federal government. The plan's portion must be used to fund member benefits. A plan's Star Rating will determine what percentage of the savings a plan can retain and use for member benefits. In payment year 2015, only plans with at least 4 stars will be eligible for additional funding from CMS.

Performance Categories: Forty-five plus measures put forth by CMS are used to evaluate a plan's clinical quality, health plan operations and member satisfaction. The measures and performance thresholds are subject to change on yearly basis, based on the discretion of CMS. Performance data is collected year round and submitted to CMS. Data sources include claim and medical record chart data, member surveys, pharmacy measures, member complaints and appeals and grievances.
The chart below illustrates the high-level Star Ratings performance domains:

Performance Categories	Medicare Advantage (Part C)	Prescription Drug (Part D)
Staying healthy: screenings, tests and vaccines	X	
Managing chronic (long-term) conditions	X	
Member experience	X	X
Member complaints, problems getting services, and improvement in the plan's performance	X	X
Customer service	X	X
Patient safety and accuracy of drug pricing		X

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

The Star Ratings measures are weighted and certain performance domains are more influential in the Star Rating calculation. Each star measure has a weighted factor between 1 and 5. Although every applicable star measure is factored into a contract's overall Star Rating, the measures with a higher weighted factor have a greater influence in the calculation. These highly weighted measures tend to fall into the "Clinical Quality" or "Medication Management" domains (e.g., physical and mental health, diabetes treatment, controlling high blood pressure, high-risk medications, and medication adherence).

While providers' performance is not part of the Star Ratings methodology, providers do play a very important role in helping us achieve favorable Star Ratings by delivering quality care to our members and help close gaps in care. UnitedHealthcare is committed to building a strong provider network and is focused on encouraging closer collaboration with providers to help make health care more accessible and affordable for our members.

Low Performing Plans: Consistently low performing plans are defined by CMS as Medicare plan contracts rated 2.5 stars or lower for three years in a row for any combination of their Part C or Part D summary rating. Members in these contracts typically receive letters from CMS about their plan's Star Ratings status. You should always recommend the plan that is the best fit for the consumer's healthcare needs. You should still recommend a low-rated plan if it is the best fit for the consumer. Remember, Star Ratings reflect how the plan performed approximately 2 years prior and the plan may have improved in the low-rated areas of measurement.

How You Can Positively Impact Star Ratings: You are the 'face of our plan' and how you portray our plans and interact with our consumers can positively affect our Star Ratings. Your professionalism and accuracy are very important to some of the performance categories measured by CMS, especially for the member satisfaction category. You can positively impact these measures by being accurate when you present a plan, encouraging members to use their benefits, complete an annual wellness visit, seek appropriate care, complete preventive screening and tests, and adhere to their medications.

- Know the benefits you are selling, to accurately explain the plan and determine the best fit for the consumer. 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 is required in all sales presentations and appointments and lending proper support to your consumers.
- Take the Star Ratings training through WebEx or as provided to your agent manager or sales leader.
- Earn high scores on your sales events if you 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 Events Basics module if you are conducting sales events, or, even to improve your knowledge for hosting individual appointments. The Events 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 tool "Clarity Starts Here" during presentations to ensure you are covering all the required statements and information a consumer needs to make an enrollment decision.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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:
  ~ Member use of preventive care (such as annual screenings)
  ~ Access to Care
  ~ Member use of prescribed medications – use as prescribed to improve your health (i.e., adherence)
  ~ Member Satisfaction

Questions consumers may have regarding Star Ratings:

Why does this plan not have a Star Rating?

- A plan could be too new or too small with too little date for measurement and calculation. When that information becomes available, the Star Rating will be determined and made available on Medicare.gov and be provided in future enrollment materials. You need not be concerned the Star Rating is not yet published. We have determined this plan meets the needs you have shared with me today.

What really determines the Star Rating your plan might receive?

- CMS uses more than 45 measures that score a plan's clinical quality, health plan operations and member satisfaction.
- Exactly what is measured can change each year depending on what CMS observes across the industry.
- The types of things CMS measures, fall into these overall Performance 'Domains':
  - ~ Staying Healthy – Screenings, tests and vaccines
  - ~ Managing chronic, long-term conditions
  - ~ Member experience with the Health Plan
  - ~ Member complaints, problems getting services, and improvement in the health plan's performance
  - ~ Health Plan customer service
  - ~ Part D: Similar to the above, but also includes:
    - o Accurate pricing of medications
    - o Medication Adherence
    - o Patient Safety

How is UnitedHealthcare improving its Star Ratings: UnitedHealthcare has a focused effort to improve our Star Ratings and is committed to the health and well-being of the members we serve. Our Star Ratings improvement plan centers on the following key areas:

- Driving exceptional performance for **health plan operations** through appeals timeliness, accuracy and fairness, and lower complaints to Medicare.
- Raising **clinical quality** measures by engaging with members and providers to close gaps in care and improving medication adherence.
- Improving **member satisfaction** by delivering a personalized member experience through high-touch customer service and encouraging members to use their benefits and seek appropriate care.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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 you 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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

Marketing Materials

Branded Medicare Advantage (MA) and Prescription Drug Plan (PDP) marketing materials require UnitedHealthcare and/or the Centers for Medicare & Medicaid Services (CMS) approval prior to use. Branded Medicare supplement insurance plans marketing materials require approval from UnitedHealthcare and the Department of Insurance (DOI) for the state(s) in which you plan to market.

Based on CMS definition, UnitedHealthcare defines "marketing materials" to mean any informational materials (e.g., flyers, business reply cards (BRC), print, outdoor, direct mail, radio, or television advertising; and presentation slides/charts) 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, Prescription Drug Plan (PDP), or Medicare supplement insurance plans 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, or Medicare supplement insurance plans, offered by the plan sponsor.
- Explain the benefits of enrollment in an MA plan, MA-PD plan, section 1876 cost plan, PDP, or a Medicare supplement insurance plans or rules that apply to members.
- Explain how Medicare services are covered under an MA plan, MA-PD plan, section 1876 cost plan, PDP, or Medicare supplement insurance plan, including conditions that apply to such coverage.

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 exception process contained in this guide and can be found on the Agent Toolkit ("Support Tab"). You must 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 (RSD) for evaluation through your EDC Manager.

If the RSD agrees that no suitable pre-approved material exists, they will, on your behalf, submit the request to field marketing personnel.

> The UnitedHealthcare Medicare Solutions logo is only allowed to be used on websites. All other materials must not contain a UnitedHealthcare Medicare Solutions logo.

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. Note: If the material requires CMS approval (e.g., listing plan names, plan benefits), the materials typically will not be approved.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Exception Process

Approval requests for custom UnitedHealthcare branded marketing materials will only be considered if all of the following requirements are met:

- Strong evidence of business need
- No existing materials or templates to fulfill the need
- Substantial business impact (e.g., significant increase in lead generation, conversion, or new business sales)
- Proposed marketing material is consistent with established practices for UnitedHealthcare Medicare Solutions brands
- Proposed marketing material does not pose any risk of damage to UnitedHealthcare or any of its brands

The instructions for downloading the exception request form from the Agent Toolkit:

- Access the Agent Toolkit
- Click on "Resources" tab
- Locate "Still don't see what you need?"
- Click on "Agent Marketing Exception Request Form"

After completing the form, submit it through your Sales Manager to the Regional Sales Director. Submission of the form does not constitute approval.

Within ten business days of receipt, the request will be returned with a decision of Approved, Denied, or Changes/Resubmission. The requestor will be notified if additional time is needed if state or CMS filing is required.

The requesting agent must send a finalized version of the marketing material to the appropriate UnitedHealthcare Medicare Solutions product marketing personnel (agent_marketing_requests@uhc.com) prior to use.

The requestor must keep a written record of all approvals granted.

Approval for custom branded UnitedHealthcare branded marketing materials must not be taken generally as a blanket approval. In addition, approval may also be limited to one-time use.

Please note, approval for any ad hoc marketing materials using any AARP® brand and/or logo will not be considered.

Generic Materials

UnitedHealthcare policy states that you 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 Medicare Marketing Guidelines (MMG). 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 you and/or your agency 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 must not contain:

- UnitedHealthcare brand, trademark, service mark, logo and/or domain name (Example: UnitedHealthcare, AARP®, etc.)
- Plan Specific Names (Example: Plan A)
- Product Specific (Example: Medicare Complete)
- Benefit Information

Generic materials must:

- Include any applicable disclaimers
- Use the approved font of Times New Roman 12pt or greater
- Clearly identify who the material owner is

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Generic Materials must not:

- Use the term "free" to describe benefits or services
- Use the term "entitled" except when referencing Part A
- Use the term "senior" to identify audiences
- Use abbreviated product titles when they first appear in a material
- Use absolute superlatives
- Use misleading or inaccurate language
- Use inappropriate agent titles. Your agent title must accurately state your relationship to UnitedHealthcare and provide an accurate title that reflects the intent of the content with the consumer.

Generic Business Reply Cards (BRC) must:

- Clearly identify who the consumer will be contacted by
- Identify the scope of product to be discussed
- Identify the method(s) of contact the agent may use. For example:
  - "By returning this card a sales agent may contact you by phone, mail, or email"

Generic BRCs must not:

- Request the consumer's Date of Birth (DOB)
- Request the consumer's health information
- Require any consumer contact information

If you are unsure whether a material is marketing material or generic material, 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.

Approved marketing materials may not be altered in any way, including handwritten agent notes (e.g., agent contact information) or underlining (e.g., a particular plan benefit). However, you may encourage the consumer to make notes on the marketing materials.

You must be contracted, appointed (if applicable), and certified in order to access and order pre-approved marketing materials through the Agent Toolkit. Your access is limited to the products and/or plans in which you are licensed and certified to sell.

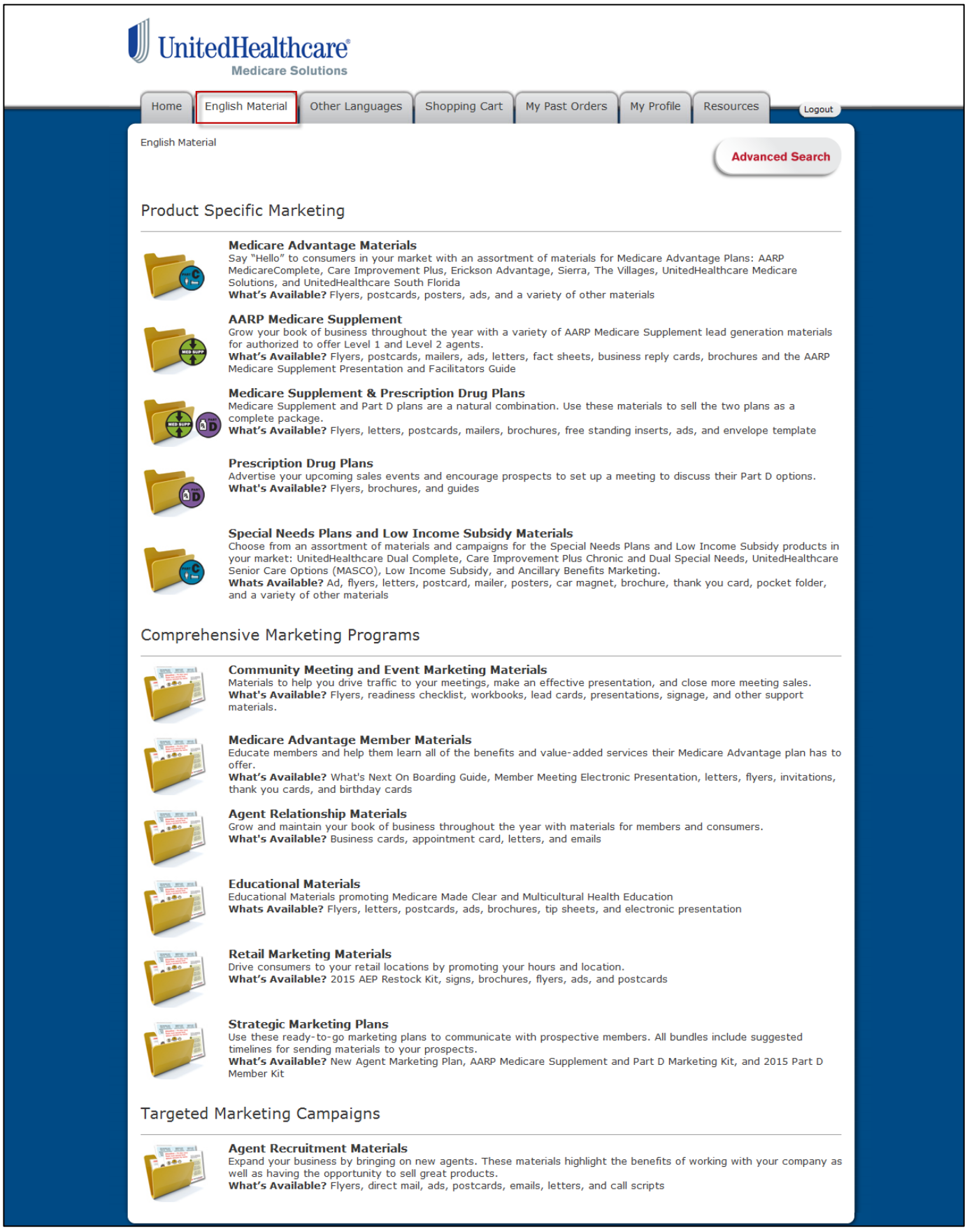
You may access and download and/or order materials through the Distribution Portal using your secure logon. Plan related materials are available through the "Product Information and Materials" tab and marketing materials are available through the Agent Toolkit, which requires separate logon and password. Only products you are allowed to order are visible.

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

- Access the Agent Toolkit (via the Distribution Portal)
- Click on "English Materials"
- Select the desired category:
  - ~ Product-specific Materials
  - ~ Comprehensive Marketing Programs
  - ~ Targeted Marketing Campaigns

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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.



Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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.

Agent titles rules apply to business cards, communications (including e-mail signatures), and any form of advertisement or marketing material.

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
- Sales Representative
- Independent Sales Agent
- Independent Sales Representative
- Licensed Agent
- Licensed Sales Agent
- Licensed Sales Representative

You may add their National Marketing Alliance (NMA)/Field Marketing Organization (FMO) after an approved title.

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.

You may not use symbols, emblems, names (including acronyms), and color schemes on business cards in reference to Medicare, the Social Security Administration, or any other regulatory entity.

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).

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: Agent Website Guidelines Sales Policy Job Aid 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- You must be contracted, appointed (if applicable), and certified in order to announce your affiliation and use the UnitedHealthcare Medicare Solutions brand name and/or logo, product type description, or hyperlink to a UnitedHealthcare website on an agent-created website.

- The UnitedHealthcare Medicare Solutions brand name and logo is the only approved brand name and logo available for use on an agent website.

- When submitting a request to use the UnitedHealthcare Medicare Solutions logo, you must submit the following information to Agent_Marketing_Requests@uhc.com
  - ~ Agent Name
  - ~ Agent writing number
  - ~ Agency name
  - ~ EDC name
  - ~ EDC writing number
  - ~ EDC principal name
  - ~ Name of Regional Sales Director or Sales Manager
  - ~ Phone number
  - ~ Email address
  - ~ Agent or EDC website home page URL
  - ~ Agent-facing or consumer-facing website? (select one)
  - ~ All URLs that include UnitedHealthcare Medicare Solutions brands or logos

- The first time the UnitedHealthcare brand is mentioned on any individual webpage, it needs to be followed by the appropriate trademark symbol (refer to the Agent Website Guidelines for required registered trademark symbols and their placement).

- Hyperlinks may be embedded with the UnitedHealthcare Medicare Solutions logo or brand on an agent website, however, embedded links must direct the user to www.UHCMedicareSolutions.com homepage. The link cannot link to any specific page within the UnitedHealthcare Medicare Solutions website, as the URLs may change at any time.

- Determine whether the 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) or any applicable states for Medicare supplement insurance plans.
  - ~ Agent facing websites are directed to agents for agent recruitment activities, education and communication. Agent facing websites often include passwords or sign-in requirements.

- You are permitted to indicate the **type** of product (e.g., Medicare Advantage, Prescription Drug Plan, Medicare supplement insurance plan, etc.) you are authorized to offer on behalf of UnitedHealthcare.

- Use of product names, descriptions, and/or plan benefits is strictly limited to agent-facing agent websites and expressly prohibited from use on consumer-facing websites. Additionally, use of product names, descriptions, and/or plan benefits is limited to the verbiage provided in the Agent Website Guidelines and the agent-facing website must contain this disclaimer: "The information on this website is for agent use only and is not intended for use by the general public."

- Brand names, product names, logos, plan descriptions, or links are not to be copied and pasted from any source other than those authorized by UnitedHealthcare. Refer to the Agent Website Guidelines for authorized materials and instructions for receiving website ready logo files from Agent_Marketing_Requests@uhc.com .

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- You are prohibited from altering in any way authorized brand names, product names, logos, or plan descriptions.
- Approval to use the AARP logo, brands, and product names will not be considered (Exception: Qualified Level 2 Authorized to Offer (A2O)) agents may post the Authorized to Offer web banners, which contain the AARP Medicare Plans logo).
- The website must be registered with UnitedHealthcare. Regardless if the 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 must be registered.
  - ~ Register the website by emailing the URL to agent_marketing_requests@uhc.com with a copy to the UnitedHealthcare sales leaders.
- 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.
- You are not permitted to register or operate internet domain names incorporating the name of any UnitedHealth Group brand or affiliate (e.g. AARP).
- You 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.
- You may not use CMS in an internet domain name that may give the perception that the website is in anyway affiliated with Centers for Medicare & Medicaid Services (CMS).
- You 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.
- All CMS marketing guidelines 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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

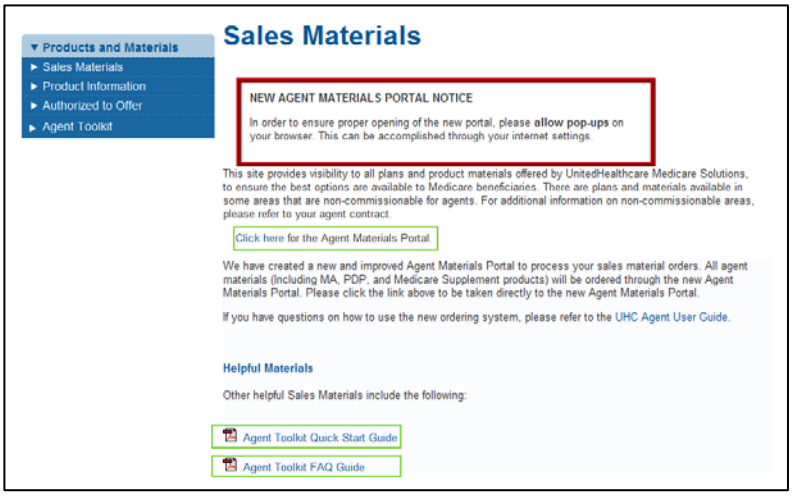
Ordering Marketing and Enrollment Materials and Supplies

Sales Materials

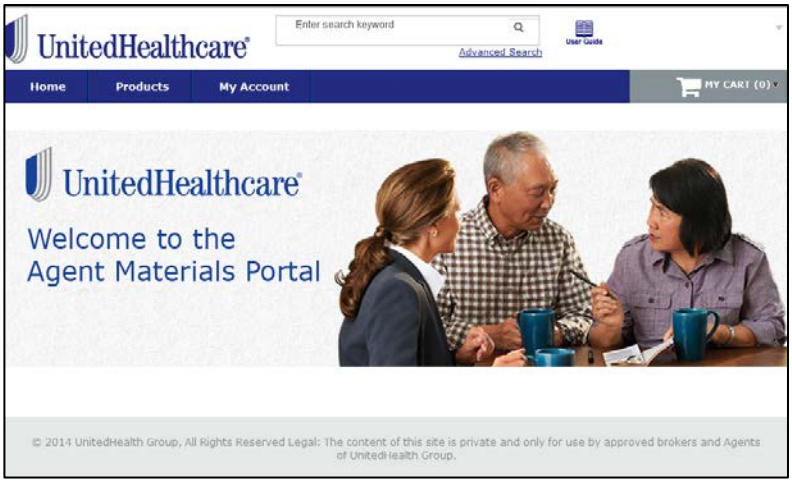
Sales and marketing materials are available through the UnitedHealthcare Medicare & Retirement Distribution Portal to licensed, contracted and appointed (if applicable) agents once they have taken and passed a product certification test.

Log onto www.UnitedHealthProducers.com and select the "Product Information & Materials" tab. Please note that the look of the section may be different based on your channel.

- The Sales Materials section features the link to access the Agent Materials Portal
- In addition, the section features two helpful resources: Agent Toolkit Quick Start Guide and Agent Toolkit FAQ Guide



- The Agent Materials Portal 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?

Educational and Marketing/Sales Activities and Events

Event Reporting

Marketing to Consumers with Impairments or Disabilities

Lead Generation

Scope of Appointment

Interacting with the Field

Quick Reference Guide: Compliant Sales Practices

Medicare Marketing Guidelines

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Educational and Marketing/Sales 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 you 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 educational 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

- Be contracted, licensed, appointed (if applicable), and certified in order to conduct any educational activity and/or event on behalf of UnitedHealthcare.
- Take and pass the Events Basics module prior to reporting, conducting, and/or participating in an educational event. (Refer to the Certification and Training Section for additional details regarding the Events Basics module.)
- 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.

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 Enrollment Guide 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 you are 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- 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 such as plan specific premiums, copayments, or agent contact 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 plan marketing or benefit information.
- If asked about plan benefits, premiums, or copayments agents may suggest that consumers call UnitedHealthcare or visit the plan website 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 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 you formally provide specific plan information is formally provided via a presentation on the products being offered. In this setting, you usually present 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 minimum passing score of 85% 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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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.

Personal/Individual marketing appointments typically take place in the Medicare consumer's residence; however, they may take place in other venues such as a library or coffee shop. Personal/individual marketing appointments are considered marketing/sales events, but are not reported to Centers for Medicare & Medicaid Services (CMS) as formal or informal marketing/sales are. Personal/individual marketing appointments require a Scope of Appointment (SOA) form. 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.

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 the Events Basics training module with a minimum passing score of 85% within three attempts to conduct an event.
- 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).
- Comply with permission to contact guidelines.
- 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.
- Specify where the Plan Star Ratings and Multi-Language Insert are located in the Enrollment Guide.
- 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.
- State that they are compensated for enrollments.
- Provide or make available to all in attendance at all marketing/sales events and appointments, their agent contact information
- 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- ~ 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.)
- ~ 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, and PPO).
- ~ Clearly read or state the following disclaimer during a formal marketing/sales presentation, Enrollment Guide 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."

Agent Must Not

- 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., Annual Election Period (AEP) 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 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.
- For informal or formal marketing/sales events:
  - o 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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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 an RSVP list at an event as a sign-in or attendance sheet. Information on an RSVP list must be protected and not visible to consumers attending an event.
- 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.

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.
- Market health care related products during marketing activity for Medicare Advantage or Part D plans provided the consumer agrees in advance. Examples of health care related products include medical, dental, prescription, and long-term care.
- For a formal event when only one consumer is present, offer to the consumer the option of conducting the event in a sit-down style, similar to a personal/individual marketing appointment, rather than in an audience-presenter format. However, you must still complete a full presentation of the reported plan.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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

- 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.

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.
- Proactively approach consumers in common areas (e.g., parking lots, hallways, lobbies, sidewalks). Consumers must initiate contact with you.
- Move or relocate a kiosk/booth/table from the plan-designated location within the reported venue 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 you 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

UnitedHealthcare MedicareStore
A UnitedHealthcare MedicareStore 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 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 is managed by the Retail Operations and is 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 a consumer who visits the UnitedHealthcare MedicareStore.
- 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

UnitedHealthcare Resource Center

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.

Internet-Based (Virtual) Marketing/Sales Events

Conducting marketing/sales events using internet-based technology is limited to formal marketing/sales events. All virtual events and the corresponding presenting agents must be approved by UnitedHealthcare prior to event planning, reporting and advertising. All CMS guidelines and regulations and UnitedHealthcare rules, policies, and procedures related to conducting marketing/sales events apply, including event reporting and cancellation procedures and using plan-approved materials and presentations.

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.

You 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).
- Gifts must not be food items that in type or quantity, regardless of value, could reasonably be considered a meal.
- 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.
- You 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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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 following are examples of snacks:
  - Fruit or raw vegetables
  - Pastries, cookies, or small dessert items
  - Cheese, chips, yogurt, or nuts
  - Crackers or muffins
- 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 must remain neutral and cannot steer beneficiaries to enroll in a specific plan or provider group.

<u>Providers at a marketing/sales event may:</u>

- 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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.
- Sell products or offer demonstration devices that consumers can take with them.
- 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.
- Mail marketing materials on behalf of Plans/Part D sponsors.

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, you 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 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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 PHD at PHD@uhc.com (the subject line should contain the agent's Writing ID number, available 24 hours).
  - ~ Agents utilizing the PHD to report their events must e-mail a completed Event Request Form to the PHD at PHD@uhc.com 21 calendar days in advance of the event in order to meet the 14 calendar days reporting requirement.
- Each informal marketing/sales event (e.g., kiosk, booth) shift must be reported separately with a start and end time.
- You 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 up to and including termination.
- All events are subject to surveillance and evaluation by UnitedHealthcare, CMS, and/or AARP.

Request for American Sign Language (ASL) Interpreter

Request an ASL interpreter on behalf of a consumer.

- Upon consumer request, an ASL interpreter will be provided at a formal marketing/sales event or personal/individual marketing appointment at no charge to the consumer. ASL interpreters are not provided at informal marketing/sales events or any educational events.
- Whenever possible requests (new and change) should be made 14 or more calendar days prior to the date the interpreter is needed to ensure the vendor (ASL Services, Inc.) has adequate time to schedule an in-person interpreter. Every effort will be made to obtain an in-person interpreter if the request (new or change) is made within 14 calendar days of the date needed; however, alternate arrangement such as rescheduling the appointment, or requesting the consumer attend another event may be needed.
- If you have access to bConnected, you can request an ASL interpreter by selecting "Request an American Sign Language Interpreter" in bConnected. To use bConnected, the request must be entered 14 or more calendar days prior to the date the interpreter is required.
- If you do not have access to bConnected, or have requests (new or change) that cannot be entered in bConnected because they are within 14 calendar days of the date the interpreter is required, you must submit a completed ASL Interpreter Request Form (available on the Distribution Portal) to the PHD via email at PHD@uhc.com.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- Within three business days after the request has been made, ASL Services, Inc. will contact you, at the number on record in bConnected, to confirm the interpreter request and event/appointment logistics. After the event/appointment has occurred, a representative from the PHD will reach out to you to ensure the process was satisfactory.
- To cancel an interpreter request, you must close the contact in bConnected. Cancellation with less than three business days' notice will be billable for the scheduled event/appointment duration or a two-hour minimum. If you do not have access to bConnected, you must contact the PHD to cancel the appointment.
- Using a third-party individual who is not an employee of UnitedHealth Group or an approved American Sign Language interpreter vendor is prohibited.
- Telesales will request an interpreter through ASL Services, Inc. when confirming the consumer's RSVP hard-set appointment to a formal marketing/sales event.
- In the rare occasion that an ASL interpreter is not available at the time of the meeting, the agent can:
  - ~ Utilize the Video Relay Services if the consumer has access to it.
  - ~ Utilize a smartphone, tablet or a computer: When the consumer, agent, and interpreter cannot determine a suitable date/time that coordinates with all parties, the meeting can be conducted via FaceTime or Skype using a smartphone, tablet or computer. The agent must request this appointment with the PHD utilizing the ASL Interpreter Request Form. The PHD will contact ASL services, a minimum of 1 business day in advance, with the date/time/agent contact number and Skype

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.
  - ~ A change to venue location, date, and/or start time of an event is considered a cancellation and requires cancellation of the event in bConnected and entry of a new event (reporting timeframe rules would apply).
- 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 PHD must be utilized to report the change.
- If the "sent to Marketing" box is not checked, you 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 PHD at PHD@uhc.com (enter your Agent ID in the subject line).
  - ~ You are responsible for ensuring that the event is submitted to the PHD to file within the three business days requirement (no less than eight business days prior to the date of the event is recommended).
- If a change must be made within three business days of the start time, you must immediately contact his/her manager or supervisor to discuss any required actions.
- Your manager/supervisor is responsible for ensuring any necessary changes are made to reported events upon termination of an agent.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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, you are 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

- You 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 needs to approve the cancellation request and determine if the "Sent to Marketing" box has been checked in bConnected.
- If the "Sent to Marketing" box has been checked:
  - ~ You must fill out a *Sales Event Form*
  - ~ Email the completed *Sales Event Form* as an attachment to the 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.
  - ~ You are responsible for ensuring the cancellation request was submitted to the PHD (no less than eight business days prior to the date of the event is recommended) with sufficient time to meet the three business days requirement.
- If the "Sent to Marketing" box has not been checked, you must immediately make the changes or cancellation in bConnected.
- Your 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 your requirements depending upon the length of time between the date/time of cancellation and the date/time of the originally scheduled event:

- You are 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, you are responsible for communicating the change/cancellation of the event through the same means. For example, if the event was advertised

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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, you are 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 Impairments or Disabilities

UnitedHealthcare is devoted to serving our consumers with integrity and sensitivity. You are 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.

You are expected to correctly handle situations where you 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.

You must 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

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. If the primary language of five percent or more of the Medicare consumer population of the geographic area is a language other than English, the required materials for enrolling consumers and renewing members (e.g., Summary of Benefits, enrollment application (including Statement of Understanding), Evidence of Coverage (EOC), Annual Notice of Change (ANOC), Star Ratings, the comprehensive or abridged Formulary, Provider Directory and Pharmacy Directory) will be translated into the identified language. After approval of the English versions, the translated materials will be submitted to CMS for approval.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

In addition, UnitedHealthcare provides information regarding the availability of interpreter services in the Multi-Language Insert with the Summary of Benefits and the ANOC/EOC. The Multi-Language Insert instructs members how to obtain free interpret services and it is translated into multiple languages (e.g., Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, and Japanese).

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 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 enrolling consumers and renewing member's materials in an alternate language for an identified geographic area, approved materials in the non-English language will be available to the agent for order and/or download in the same location as the English version (e.g., Distribution Portal).
- You must submit requests for custom, non-English materials or the translation of approved materials into a non-English language to your agent manager for approval from the Regional Vice President.

Translation / Interpreter Services

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

- The consumer may be accompanied by an individual who can translate/interpret for the information and/or materials.
- You may enlist, through your agent manager, the assistance of a bilingual UnitedHealthcare employee as appropriate.
  - ~ The use of a third-party individual who is not an employee of UnitedHealthcare or an approved language translation vendor is prohibited.
- You may contact the PHD at 1-888-381-8581 (Monday – Friday, 7 a.m. – 7 p.m. CT) 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, you are required to make available and provide basic consumer information to consumers with disabilities. To ensure compliance and sensitivity you must abide by the following policies.

Hearing Impaired:

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- 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 advertising materials and the enrollment application per CMS requirements.
- You may provide a complete sales packet in writing enabling the consumer to read the materials.
- You may allow the consumer to be accompanied by an individual of their choosing, who can translate/interpret the information and/or materials.
- If the consumer has an Authorized Representative/Power of Attorney (POA), you may provide a complete Enrollment Guide directly to the consumer's Authorized Representative/POA for review and enrollment purposes.
- You 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. You must be aware that hearing impaired consumers may live independently. If the consumer has an authorized representative/POA, you must reschedule the appointment for a time when the consumer's authorized representative/POA can be present.
- You may request an American Sign Language Interpreter (ASL) Interpreter (See Request for American Sign Language (ASL) Interpreter section).

Vision Impaired:

You may:

- Read the complete Enrollment Guide verbatim to the consumer.
- Allow the consumer to be accompanied by an individual, of the consumer's choosing, who can read/interpret the information and/or materials.
- You 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. You must be aware that vision impaired consumers may live independently. If the consumer has an authorized representative/POA, you must reschedule the appointment for a time when the consumer's authorized representative/POA can be present.
- Provide a complete Enrollment Guide to the consumer's Power of Attorney (POA)/authorized representative for review and enrollment purposes.
- 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:

You must select event sites that are accessible to a physically impaired individual. Accessibility features include appropriate parking, restroom facilities, doorways, ramps, and elevators. Upon reasonable request, you must provide a wheelchair to a disabled individual at a formal marketing/sales event to provide an opportunity for the individual to attend the event. If the facility selected is not handicap accessible, you must be rescheduled or cancelled until a handicap accessible location is found. You should choose a site that is Americans with Disabilities Act 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).

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- 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

You 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. You must be aware that cognitively impaired consumers may live independently or within a residential facility. If the consumer has an authorized representative/POA, you must reschedule the appointment for a time when the consumer's authorized representative/POA can be present.

Lead Generation

Overview

You are 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.

You may not discuss or leave Enrollment Guide 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- ~ 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 you do 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 an Enrollment Guide 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.
- If you are not the Agent of Record (AOR), only you are permitted to call an existing member under certain circumstance, if PTC has been delegated to the agent:

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

~ Delegation of PTC occurs when the plan sponsor (UnitedHealthcare) provides the member's contact information (e.g., a lead) to you.
~ You are 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.

- You may contact their current clients with whom you have a current, active contract or business relationship in other products (Example: In-Force Life Policy, Homeowners, or Dental Insurance).
  ~ If you are 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, you or the plan sponsor may provide contact information such as a business card to the individual to 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).

Lead Collection Stations

Lead boxes and/or collection stations must comply with all CMS regulations and UnitedHealthcare rules, policies, and procedures related to obtaining PTC, contacting consumers, use of marketing materials, and marketing/sales activities. The following guidelines apply to the use of lead collection boxes and/or collection stations:

- The lead box or collection station must be secured in such a manner as to prevent the unauthorized access and use of any consumer's contact information. The collection box must be locked and either integrated in a fixture or attached to a fixture in such a manner that prevents unauthorized removal of the box and/or its contents.
- Permission from the venue must be obtained prior to placing a lead card box or collection station in any location.
- Rules pertaining to marketing materials in provider locations apply (e.g., stations cannot be placed where consumer receive care or wait to receive care).
- Only UnitedHealthcare and/or CMS approved lead cards and marketing materials are permitted.
- Information provided on lead cards must be considered private and must only be used for the purpose intended.
- Providers must not steer consumers to the lead box or collection station.
- Providers must not handle in any manner the leads collected (e.g., empty lead box, forward leads to the agent).

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- Agent must check on and empty lead box or collection station no less than weekly.
- Agent must immediately report to UnitedHealthcare any suspected or known breach or theft of the lead box, collection station, and/or individual lead cards.

Scope of Appointment

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

You 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 you intend 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 your appointment is with a husband and wife, you 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, you 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 you 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 you to complete a SOA form and secure the consumer's signature at the time of the appointment. You 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- 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 your responsibility to submit the 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 your 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Retention Requirements

In addition to submitting SOA forms for electronic storage in a centralized document management system, you are required to retain and store a copy of the SOA forms for a minimum of ten years from the date of the appointment. You 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, you must secure a new SOA and then can proceed with the discussion. If during an appointment **you determine** 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.
- An Enrollment Guide 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 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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

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 Enrollment Guide) 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Quick Reference Guide: Compliant Sales Practices

This document is an agent resource that provides an abbreviated listing of compliance guidelines and risk of non-compliance examples. This document has been designed to retain in whole or divided by sections for focused team discussions. 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. The risk of non-compliance examples that are shown only represent an example for some of the issues that can result when the rules are not followed. Consequences for all situations where rules are not followed, could lead to disciplinary actions which can result in agent termination.

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 you are not properly trained. You may be terminated if you represent or sell a product you are not qualified to sell; violating standards within the Operational Behavior Allegation Family.

Must

- 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.

Must Not

- 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 you 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 Condition Special Needs Plans (CSNP)
- Dual Special Needs Plans (DSNP)

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- Institutional Special Needs Plans (ISNP)[2]
- Institutional Equivalent Special Needs Plan (IESNP)[2]
- UnitedHealthcare Senior Care Options[2]

[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, consumers toward a specific plan or limited number of plans). Agents must not 'educate' on UnitedHealthcare plans at an educational event. Rather the purpose is to offer information generically on Medicare, Medicare plan types, and/or health-related information.

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

Must

- When advertising educational events, use the following disclaimer on all advertising materials: "This event is only for educational purposes and no plan specific benefits or details will be shared."
- Host Educational Events at public venues.
- Report all Educational Events to UnitedHealthcare according to event reporting policies and procedures.
- Distribute healthcare educational materials (not specific to any plan) on general topics such as diabetes awareness and prevention and high blood pressure information.
- Provide business cards only if requested by the consumer.

May

- 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.
- 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).

Must Not

- Attach business cards or plan/agent contact information to educational materials.
- Distribute material, promote, or collect RSVPs for future marketing/sales events.
- Conduct a sales presentation.
- Schedule a marketing/sales event immediately following an educational event.
- 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- 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.
- 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

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.

Risk of Non-Compliance: Some common risks with sales events include when you do not conduct a complete presentation and the appearance of no-shows, due to inaccurate filing of the events. The impression of a no-show and failure to present all required items during a formal presentation could lead to a result in a poor score if your event is secret-shopped.

Must

- Complete and pass the Events Basic module. Pay close attention to the things you are required to state aloud during your event.
- At the beginning of the event, clearly announce your name, your title, the company you represent, and the product that will be formally presented.
- 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 marketing/sales events to UnitedHealthcare according to event reporting policies and procedures.
- Use only plan approved/CMS approved 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.
- If the plan includes prescription drug coverage, review the prescription drug benefit including, formulary, pharmacy network, copayments, coinsurance, tiers, coverage gap, 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.

Must Not

- 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, misleading, or superlative statements.
- Use scare tactics or statements that may be interpreted as scare tactics.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- Fail to be present or have a plan representative present at any event filed and not cancelled in bConnected within three business days of the event.
- Advertise a personal/individual or marketing/sales 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 passerby opportunity. Agents need to allow consumers to approach them, rather than vice-versa.

Must

- Complete and pass the Events Basic module. Pay close attention to the things you are required to state aloud during your event.
- Report all marketing/sales events to UnitedHealthcare according to event reporting policies and procedures.
- 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.

Must Not

- 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 in bConnected at least three business days prior to the date of the event.
- Move or relocate a kiosk or table from the location for which the event is filed.
- Gesture, "call over," or proactively approach consumers.
- Describe a catalog benefit, emergency call benefit, or giveaways in a manner that may be perceived as an enticement to enroll or confuse the member regarding enrollment with the Medicare Advantage plan.
- Leave an event prior to the reported end time.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- Cross-sell by promoting or displaying materials for non-health related products at marketing/sales events.

Marketing/Sales Activities

The Plan and CMS require agents to comply with CMS guidelines and regulations and UnitedHealthcare rules, policies, and procedures when conducting marketing/sales activities and events.

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

Must

- 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 his or her own copy of the Enrollment Guide along with 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 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).
- 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Must Not

- Plan sponsors must not discriminate based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, and evidence of insurability or geographic location within the service area.
- Knowingly accept an enrollment application outside of a valid Election Period as set by CMS.
- Market non-health care related products (e.g., life insurance, annuities) at an MA or PDP marketing/sales appointment or event.
- Return to a home or residence without a newly scheduled 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.
- Enroll a consumer in 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 Original Medicare or a Medicare Supplement 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).
- 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 Plan's 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 violation of the Operational Behavior Allegation Family.

Must

- Use only approved marketing materials and use only for their original intended purpose.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- Ensure all self-created materials comply with CMS guidelines and UnitedHealthcare rules, policies, and procedures 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.

Must Not

- 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.
- Use his or her business card as any type of marketing material.
- 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 to CMS 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. UnitedHealthcare will not accept and enter into bConnected events that are scheduled within 14 calendar days of receipt of the Event Request Form.

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.

Must

- Complete and successfully pass the Events Basics module with a minimum passing score of 85% within three attempts prior to reporting an event where you are listed as the presenting agent.
- Report all educational and marketing/sales events in bConnected prior to advertising and no less than 14 calendar days prior to the date of the event. Submit the Event Request Form to the PHD no less than 21 calendar days prior to the date of the event.
- Report all changes to educational and marketing/sales events in bConnected no less than 3 business days prior to the date of the event. Submit the Event Request Form to the PHD no less than 8 business days prior to the date of the event. Changes that require a new event be entered in bConnected must be entered into bConnected no later than 14 calendar days prior to the date of the event.
- For events cancelled in bConnected within 7 calendar days of the date of the event, be present and remain at the venue at the originally reported time and remain there for 30 minutes for formal events or the entire reported time for informal events. (You may arrange for a plan representative to be at the event site in their place to redirect consumers to another event and/or hand out your business card.)
- Report all Educational and/or Marketing Sales events to UnitedHealthcare.
- Recognize all events; including educational events are subject to be secret shopped.

Must Not

- Neglect to report all scheduled events.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- Cancel or change the date, time or location of the event in bConnected within 3 business days of the event date unless due to inclement weather.
- 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 Events Basics, Selling at Retail Kiosks e-Learning, and Selling at UnitedHealthcare Medicare Stores WebEx.

Must

- 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 you will be onsite.
- Report all events as a sales/marketing event – informal.

Must Not

- 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 & Promotional Items

Plan sponsors may offer gifts or promotional items to consumers as long as the gifts are of nominal value and provided regardless of enrollment. Nominal value is defined as $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.

Must

- 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 any gifts offered 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.

May

- 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- 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.

Must Not

- 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 or any other service or product that is considered a benefit.
- 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 (SOA) Form

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 consumer, 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.

Must

- 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, 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/individual marketing appointment.
- Complete a new SOA form if the consumer requests to discuss a health related product outside of the original SOA.
- Complete a new SOA form and schedule another appointment no sooner than 48 hours if you request to discuss a product outside of the original agreement.
- Complete a SOA form if an appointment is scheduled as a result of a formal or informal marketing/sales event.

Must Not

- Require a consumer to complete a SOA form to attend a formal or informal marketing/sales event.
- Make available or request consumers to complete a SOA form at educational events.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- Assume a SOA form was completed if the appointment was obtained by UnitedHealthcare telesales; always check bConnected system for documentation or obtain a completed SOA form.

Unsolicited Contact

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

Risk of Non-Compliance: Marketing through unsolicited contacts can lead to agent complaints and may also involve privacy infractions.

Must

- Request and document continued Permission to Call (PTC).

May

- 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.

Must Not

- Conduct door-to-door solicitation including leaving leaflets, flyers, or door hangers at a consumer's door, residence, or vehicle.
- 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 form.
- 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 unless there is documented PTC.
- 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

You may engage with providers to conduct marketing activities under a limited set of circumstances. The provider cannot market the plan on your behalf, however, you can coordinate with the provider to display plan- related materials and market in the provider's common areas.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Risk of Non-Compliance: Some risks with provider marketing activities include agents engaging the providers in marketing that are not within their scope. Providers may not be fully aware of all plan benefits and costs.

Must

- Scheduled appointments with consumers residing in a residential health care facility require an SOA.
- Market in common areas of health care settings (i.e., conference rooms, community or recreational rooms, etc.).
- Add business cards to materials with a single piece of tape or staple.

May

- Request providers to display CMS approved Health Plan materials, such as flyers promoting upcoming sales events.

Must Not

- 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 enrollment call center 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.

Must

- 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.
- Verify an authorized legal 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- Provide a confirmation number to the consumer.

May
- Secure and document recorded SOA (for UnitedHealthcare telemarketing only).
- Secure and document Permission to call.

Must Not
- 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: Submitting an incomplete enrollment application puts the consumer at risk for not having coverage when they expect to, because their enrollment may be delayed in processing or denied. Signing the enrollment application for the consumer is considered forgery and is subject to disciplinary action.

Must
- Provide the consumer with an Enrollment Guide and ensure that the Important Enrollment Information page (enrollment receipt) is completed.
- Help the consumer enroll in 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 (e.g., PCP selection, Medicare effective dates) 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 upon request the authorized legal representative must provide documentation of their authorization under state law to the Plan or CMS.
- Review withdrawal, cancellation, and disenrollment processes with the consumer.
- Review the OEV process with the consumer.

Must Not
- Complete an electronic enrollment application unless in the consumer's presence.
- Complete an iEnroll enrollment application unless in the consumer's presence.
- Sign the enrollment application or have anyone else, who is not an authorized legal 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.
- Be physically present with a consumer who is completing a web-based enrollment.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Outbound Enrollment and Verification (OEV)

For applications taken on October 1, 2014 or after, a member-friendly letter will be sent to the member in place of conducting Outbound and Enrollment Verification (OEV) calls.

Must

- Review the OEV process with each consumer.

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.

Must

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

Must Not

- 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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 member information.

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

Must

- 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.

Must Not

- 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 Condition Special Needs Plans (SNP)

Chronic Condition 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.

Must

- Verify the consumer has one of the plan's qualifying conditions.
- Complete the Chronic Condition Verification Authorization form ensuring that the provider noted will be able to verify the chronic condition.
- 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 that they will be contacted to conduct a Health Risk Assessment (HRA).
- Explain the Outbound Enrollment and Verification process.

Must Not

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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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.

Must

- 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.

Must Not

- 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.

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

Must

- Explain provider deeming to the consumer and advise the consumer to indicate their physician and hospital on the enrollment application.
- 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- Explain that to receive coverage under the plan the member will need to select a different provider if the provider of choice is not willing to be deemed; that a provider may agree to be deemed for one appointment/date of service, but not another, or may agree to be deemed for one member, but not another.
- Verbally read or state the PFFS disclaimer verbatim during all PFFS sales presentations and appointments.
- 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 the Outbound Enrollment and Verification process.

Must Not

- Enroll Dual Eligibles without explaining potential member financial implications, as in most cases this is an inappropriate sale.

Medicare Part D (PDP)

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

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 cost sharing stages. Agents must take the time to confirm which drugs are on the formulary and explain all related cost sharing to consumers, before completing the enrollment application.

Must

- Clearly describe the coverage gap.
- Explain the Late-Enrollment Penalty (LEP), creditable coverage and enrollment decision impacts.
- 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.
- Explain to the consumer that using contracted and/or in-network participating pharmacies is required to obtain coverage under the plan.
- 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.

Must Not

- Tell consumers that they will or will not 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).

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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 completing the enrollment application.

Must

- Provide the consumer with a paper enrollment guide, even when submitting via the AARP Medicare Supplement Online Enrollment Tool.
- Check the consumer's 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.
- Include a copy of "Documentation of loss of prior coverage" with the enrollment application in order to be eligible for Guaranteed Issue.
- Include with the enrollment application 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.

Must Not

- Claim that a Medicare Supplement policy is a Medicare Advantage Plan.
- 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, that 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 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

CMS Star Ratings

Medicare Star Ratings is a government pay-for-performance program for Medicare Advantage and Part D Prescription Drug Plans. The Centers for Medicare & Medicaid Services (CMS) uses Star Ratings to rate quality on a scale of one to five on a number of different performance categories, with five being the highest. Star Ratings are issued at the contract level and are published on an annual basis at www.Medicare.gov.

Risk of Non-Compliance: Selling inaccurately can result in complaints, which can hurt our Star Ratings. Poor (1 Star) Star Ratings can:

- Reduce performance funding to our Plan – which has a domino effect toward impacting what we may offer in terms of costs or enhanced benefits in the plans we offer.
- Repeated low (1-3 Stars) Star Ratings can also impact our ability to expand plans into new areas or apply for new health plans to offer the next year.

Must

- 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)
- State out loud why a plan may not have a Star Rating
- 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.

Must Not

- Encourage consumers to enroll, based on the argument that if they are dissatisfied with the plans, they can later request SEPs and change to higher rated plans.
- Misrepresent elements that are rated as being the contract's overall star rating.
- State the company/carrier has an overall Star Rating for the plan they offer.
- Target marketing activities specifically to members enrolled in poor (1 Star) performing plans nor direct them to request special enrollment periods.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Medicare Marketing Guidelines

Medicare Marketing Guidelines

The 2015 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).

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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Section 7: How do I take an Enrollment Application

Enrollment Methods

Election Periods

Enrollment Process – Medicare Advantage and Prescription Drug Plans

Enrollment Process – AARP Medicare Supplement Insurance Plans

Pre-Enrollment Verification Process

Post-Enrollment Customer Experience

General Medicare Advantage and Prescription Drug Plan Enrollment Application Elements

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

Customer Service Resources

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Enrollment Methods

Enrollment applications cannot be solicited or accepted outside of a valid election period. Marketing and/or selling outside of eligible periods is prohibited and subject to corrective and/or disciplinary action up to and including termination. You must be contracted, licensed, appointed (if applicable) and certified in the product in which the consumer is enrolling at the time the enrollment application is completed.

An enrollment application should only be completed after you have thoroughly explained all plan benefits, rules, confirmed eligibility, disclosed agent and product specific information (e.g., Star Rating), disclaimers, and the consumer has agreed to proceed with the enrollment.

All paper enrollment applications must be submitted via fax or overnight delivery to UnitedHealthcare within 24 hours of receipt. The enrollment application is considered in receipt the date you take receipt and sign the enrollment application. Agents utilizing offline iEnroll must upload the enrollment application within 24 hours of receipt. External Distribution Channel (EDC) offices using eModel Office should process a paper enrollment application the same day it is received from the agent whenever possible, but no later than 24 hours after receipt. Medicare Advantage (MA) and Prescription Drug Plan (PDP) enrollment application received by the enrollment center more than three calendar days after the agent's signature are considered a late application and you may be subject to disciplinary action.

Enrollment applications received by Enrollment more than three days (sixteen days for AARP Medicare Supplement) after your signature will be considered a late enrollment application and you 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 AARP® 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Section 7: How do I take an Enrollment Application?

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. (You 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 and only accept the enrollment application once the consumer has provided all the necessary information.)
- 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 PHD 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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)

The AARP Medicare Supplement online enrollment application is currently available in most states except MN and WI. 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.

Note: Planned 2015 enhancements will allow signatures to be captured from a touch-screen device. Look for future announcements.

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 Enrollment Guide (UnitedHealthcare Insurance Co., PO Box 105331, Atlanta, GA 30348-9534).

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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 your signature will be considered a late enrollment application and you 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 an Enrollment Guide.
  - ~ 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Election Periods

You must determine if the consumer is enrolling during a valid election period and indicate the election period on the enrollment application and reason code, if applicable.

Election Periods Available to Medicare Consumers

There are specified election periods available for Medicare eligible consumers. The election periods include an Annual Election Period (AEP), 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.

Annual Election Period (AEP)

AEP, 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).

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Enrollment Process – Medicare Advantage and Prescription Drug Plans

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 the consumer has a valid election period and indicate the election period and reason code (if applicable) on the enrollment application.
- 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
- You must validate the consumer resides in the plan's service area. In the case of a homeless consumer, a post office box, the address of a shelter or clinic, or the address where the consumer receives mail (e.g., Social Security check) may be considered the place of permanent residence.

Verification and Documentation of Chronic Condition

Specific verification and documentation requirements must be met to enroll a consumer in a Chronic Condition Special Needs Plan (C-SNP). In addition to meeting the Medicare requirement identified above, consumers must have at least one of the qualifying illnesses covered under the specific Chronic Condition SNP. You must:

- Complete a review of the C-SNP and determine the consumer's eligibility.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- Enroll only those consumers who have at least one of qualifying illnesses.
- Submit a completed Chronic Condition Verification Authorization form with the enrollment application.
- Explain to the consumer that enrollment in the plan will be denied if a qualifying condition cannot be validated within the required time frame. For post-enrollment verification, the consumer must be informed that they will be involuntarily disenrolled from the plan.

Verification and Documentation of Medicaid Status

Specific verification and documentation requirements must be met to enroll a consumer in a Dual Special Needs Plan (D-SNP) for consumer with Medicare and Medicaid. In addition to meeting the Medicare requirement identified above, consumers must also have Medicaid (may be identified differently depending upon the state) to enroll in a D-SNP. You must:

- Complete a review of the D-SNP and determine the consumer's eligibility.
- Enroll only those consumers who have the appropriate level (e.g., full or partial) of Medicaid based on the specific D-SNP. Eligibility may vary by plan, therefore, you must refer to plan documents to ensure plan eligibility and that the consumer cost sharing level makes the plan suitable for the consumer. Agent may validate Medicaid status at the point-of-sale by contacting the PHD during normal hours of operation. Telesales agents must follow established processes when conducting Medicaid status validation.
- Include the consumer's Medicaid number (from their Medicaid card) appropriately on the enrollment application.
- Explain to the consumer that if their Medicaid status is not verified at the time of enrollment, the consumer will not be enrolled into the plan and if they lose their Medicaid status after enrollment, they will be involuntarily disenrolled.

Enrollment of Medicaid Consumers Residing in a Medicare and Medicaid Plan (MMP) Area

An MMP is a CMS and state run demonstration program where individuals on both Medicare and Medicaid are, generally, passively enrolled into a coordinated care plan. Designed to manage both the Medicare and Medicaid benefits through one single health plan, MMP demonstrations and eligible populations vary by state. Beneficiaries passively enrolled into an MMP receive notification directly from that state's Medicaid governing body, and if they are currently a member in a Medicare Advantage, SNP, or Prescription Drug Plan, they will be disenrolled from the plan upon the effective date of their MMP. The Plan from which the member is disenrolled will send a disenrollment notification letter to the member. Guidance about maintaining current coverage is provided to the beneficiary through state communications. Agents must not influence the beneficiary's decision-making in opting out of an MMP program. Impacted consumers/members must be referred to the state Medicaid consumer information center to answer questions about the MMP. Consumers may also contact Medicare.

Specific rules apply when a Medicaid consumer resides in an area where an MMP exists. You must be aware if an MMP is available and if UnitedHealthcare is participating in the MMP. You must not disparage an MMP, the state Medicaid program, or Medicare when marketing to consumers. When marketing to a Medicaid-eligible consumer requesting information about a Medicare Advantage or SNP, you must:

- Determine if the consumer lives in an MMP service area, typically a county, but might be a partial county.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- If there is no MMP available, you may proceed to market a UnitedHealthcare plan.
- If there is an MMP available (regardless if UnitedHealthcare is a participating carrier or not), you must:
  - ~ Determine if the consumer is full dual eligible. Refer to "Verification and Documentation of Medicaid Status" section for instructions on verifying Medicaid status.
  - ~ If the consumer is not full* dual eligible, you may proceed to market a UnitedHealthcare plan.
  - ~ If the consumer is full dual eligible and resides in a service area where UnitedHealthcare is a participating MMP carrier, you must determine if the consumer is enrolled in or is pending enrollment in an MMP offered by UnitedHealthcare.
    - o You must contact the Producer Help Desk (PHD) (1-888-381-8581 ext. 1, ext. 2) to verify the consumer's MMP enrollment status.
    - o If the consumer is enrolled in or has a pending enrollment in a UnitedHealthcare MMP, you cannot conduct an appointment or discuss other Medicare Advantage options (including SNPs) until the consumer has been contacted by the UnitedHealthcare Members Matter team. The PHD will forward a referral containing your email address and consumer information to the UnitedHealthcare Members Matter team and document your contact in a Producer Contact Log (PCL) Service Request (SR). The Members Matter team will indicate the outcome of their interaction with the consumer in a secure email you. The email will advise you if you may resume contact with the consumer to conduct marketing activities. If the concern or issue that motivated the consumer to consider plan options other than the MMP is resolved by the Member Matter team, the consumer will be invited to rescind the agent marketing activity. You must not contact the consumer if they rescinded their marketing request. (Upon consumer request, the Members Matter representative may transfer the consumer to Telesales.)
    - o Agent-assisted enrollments in any UnitedHealthcare plan, including Medicare Advantage, SNP, or Prescription Drug Plan, in a state where UnitedHealthcare participates in the MMP may be analyzed to determine proper agent procedures. Outreach may be conducted if an agent did not follow the procedures outlined in this policy.
  - ~ If the consumer is a full* dual eligible and resides in a service area where there is an MMP, but UnitedHealthcare is not a participating carrier, you must refer the consumer to the appropriate carrier or MMP contact number and must not conduct an appointment or discuss any UnitedHealthcare Medicare Advantage options (including SNPs). Marketing activities can only be conducted if the consumer has actively opted out of an MMP enrollment.

* Note: eligibility requirements for MMPs vary by state. In some states, consumers that are not full dual may be eligible for the MMP. In which case, you are not permitted to market to any consumer eligible for the MMP.

Verification of Institutional Eligibility

A consumer must reside in a contracted Skilled Nursing Facility (SNF) for at least ninety days, or is likely to stay in the SNF for a minimum of ninety days based on the consumer's Minimum Data Set (MDS) assignment, in order to enroll in an Institutional Special Needs Plan (I-SNP). Note: If the consumer has not resided in the contracted SNF for at least ninety days at the time the enrollment application is taken, you must secure and retain a copy of the applicable page of the MDS assessment that indicates the consumer's eligibility based on a validation of their likelihood of residing in the SNF for ninety days or

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

more as indicated by the checked box.* The retention period is ten years and the applicable page must be available upon request.

* You are permitted to work directly with the contracted SNF to obtain the information needed to complete the enrollment application provided the consumer or their authorized representative has signed an Authorization for Disclosure of Healthcare Information form. The form expires seven days from the signature date and provides authorization to the nursing home to provide the agent the consumer's Medicare number (HICN), Medicaid number (if applicable), date of admission to the identified nursing home, and current insurance plan to help facilitate the consumer's enrollment into the UnitedHealthcare Nursing Home Plan.

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. Elements you must explain include, but are not limited to:

- Election period and effective date for enrollment.
- Plan eligibility requirements.
- Cost sharing including deductible, coinsurance, copayments, and premiums.
- Provider network, if applicable, and coverage and cost-sharing when utilizing in- or out-of-network providers.
- Formulary, drug tiers, step therapy, quantity limits, prior authorization, exception requests, coverage stages (including the coverage gap), and late enrollment penalty if the plan has prescription drug coverage.
- Verify all of the consumer's current prescription medications are on the formulary and in what tier and look up the consumer's pharmacies to verify if they are in the network.
- Selection of a Primary Care Physician (PCP) if required by the plan and any referral requirements.
- For network-based plans, verify if all of the consumer's doctors are in the network. Determine if the consumer would be willing to change to a network doctor if the current doctor(s) are not.
- The plan's Star Rating, including where to find the rating in the Enrollment Guide and where to obtain additional information about Star Ratings.
- Advise the consumer that no-cost translation services are available.
- Cancellation, withdrawal, and disenrollment processes and time frames.
- Appeals and grievance process.
- 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- If the enrollment application contains Name and ID fields for a Primary Care Physician (PCP), then a PCP is required and both fields must be populated. Otherwise, if there is not a PCP field on the enrollment application, PCP does not need to be designated.

- 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 will explain that the consumer will receive several mailings, including a letter confirming CMS approval into the plan, a copy of their enrollment application, a membership identification card, and a post-enrollment kit.

- You must explain the Outbound Enrollment and Verification (OEV) process for all plans.
  - ~ For applications taken on October 1, 2014 or after, a member-friendly letter will be sent to the member in place of conducting Outbound and Enrollment Verification (OEV) calls.

- 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 (e.g., Power of Attorney) signs the enrollment application, they must be able to provide proof that they have authority under state law to act on behalf of the consumer.

- You must provide contact information.

- You will sign and date the enrollment application after verifying all information provided by the consumer is correct and the enrollment application is signed by the consumer or authorized representative.
  - ~ You must provide your agent writing number on each enrollment application you write.
  - ~ Only the agent that explains the plan benefits and rules to the consumer may affix their writing number to the enrollment application. Note: An agent who is also an owner of an agency must use their individual writing number on the enrollment application rather than the writing number associated with the agency.
  - ~ If multiple agents attend a formal marketing/sales event, only the agent who assists the consumer in completing enrollment application may affix his/her writing number, sign, and date the enrollment application.
  - ~ 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.

- You must leave a receipt of the enrollment application, which confirms the enrollment application was submitted.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Section 7: How do I take an Enrollment Application?

All paper enrollment applications must be submitted via fax or overnight delivery to UnitedHealthcare within 24 hours of receipt. In Receipt is considered the date you take receipt and sign the enrollment application. Agents utilizing offline iEnroll must upload the enrollment application within 24 hours of receipt. External Distribution Channel (EDC) offices using eModel Office should process a paper enrollment application the same day it is received from the agent whenever possible, but no later than 24 hours after receipt. Medicare Advantage (MA) and Prescription Drug Plan (PDP) enrollment application received by the enrollment center more than three calendar days after the agent's signature are considered a late application and the agent may be subject to disciplinary action.

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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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 2014 for a January 2014 effective date, the agent must be certified for 2015 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 you commission for the sale.

Confirm Eligibility

- Consumers must be enrolled in Medicare Part A and Part B at the time of the plan effective date.
- Consumers must be residents of the state in which they are applying for coverage.
- The consumer must be an AARP member or a member's spouse or partner living in the same household in order to enroll in an AARP Medicare Supplement Insurance plan. If the consumer is not a member, you 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, you 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, unless the consumer is eligible for guaranteed acceptance or resides in a state that does not permit underwriting.

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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- 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 Payment Authorization form (where applicable)
- Additional state-specific documents may also need to be completed and submitted with the enrollment application, and/or copies left with the consumer. Directions are on the form. It is your responsibility to adhere to all federal and state regulations.

Replacement Business

- 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. Note: requirements may vary by state.
- 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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Pre-Enrollment Verification Process

Chronic Condition Special Needs Plan

Only enroll those consumers who have one of the qualifying conditions into the UnitedHealthcare Chronic Complete. Consumers are only enrolled in the plan ***after their chronic condition 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 condition plan and chooses to enroll, complete the enrollment application and submit it along with the required chronic condition 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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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).
- For applications taken on October 1, 2014 or after, a member-friendly letter will be sent to the member in place of conducting Outbound and Enrollment Verification (OEV) calls.

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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

General Medicare Advantage and Prescription Drug Plan Enrollment Application Elements

What to review prior to submitting an Enrollment Application

What should match the Medicare card?
- Name
- Medicare Number
- Part A/B/D Eligibility Date

Ensure the following is marked correctly:
- Plan Selection
- Election Period
- Effective Date
- Signature dates for agent and consumer

Other information
- Date of Birth
- Physical Address and mailing address (if applicable)
- Agent name and writing number
- Primary Care Physician (PCP)
- Method of payment for the premium

What can the consumer correct on an Enrollment Application?

Typographical/Data entry errors:
- Items that can be verified on the original paper enrollment application, but were keyed incorrectly via data entry
- Items that can be easily determined were typographical errors (e.g., transposed numbers/letters – i.e., Terrace vs. Terrcae)

Items that can be verified by Medicare System:
- HICN/Medicare Claim Number
- Name
- DOB (Date of Birth)
- DOD (Date of Death)
- Gender
- Part A Eligibility Date or Part B Eligibility Date or Part D Eligibility Date
- LIS (Low Income Subsidy) Status

Items not answered on the enrollment application:
- Plan not selected, consumer must attest to plan selection
- Multiple plan selection, consumer must attest to plan selection
- Address – physical or mailing
- Signature of consumer
- Phone number
- Email address
- Emergency contact

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- Election Period not provided/invalid election period
- Secondary Medical Coverage Values
- Medicaid Number
- Language Preference
- Materials Format
- SPAP Eligibility (State Pharmaceutical Assistance Plan)
- Proposed effective date (must meet requirements of election period)
- PCP (Primary Care Physician/Provider)
- ESRD- status not answered or answer differs from CMS/SMS

How does the consumer make a correction on an Enrollment Application?

- Monday through Friday 7am – 7 pm CST: Contact Pre enrollment at 866-479-0059
- Saturday, Sunday, and Holidays: Contact Member Services for the appropriate plan:
  - ~ MA/PD:
    - East Coast 800-643-4845
    - West Coast 800-950-9355
  - ~ PDP: 888-867-5575

What corrections can be made on an Enrollment Application?

Any corrections made on a paper enrollment application must be initialed by the consumer.

Typographical/Data entry errors:

- Items that can be verified on the original paper enrollment application, but were keyed incorrectly via data entry
- Items that can be easily determined were typographical errors (e.g., transposed numbers/letters – i.e., Terrace vs. Terrcae)

Items that can be verified by Medicare System:

- HICN/Medicare Claim Number
- Name
- DOB (Date of Birth)
- DOD (Date of Death)
- Gender
- Part A Eligibility Date or Part B Eligibility Date or Part D Eligibility Date
- LIS (Low Income Subsidy) Status

Items not answered on the enrollment application:

- Election Period not provided/invalid election period
- Medicaid Number
- SPAP Eligibility (State Pharmaceutical Assistance Plan)

How are corrections made on an Enrollment Application?

- Contact PHD Pre-Enrollment Monday through Friday 7 am – 7 pm CST at 888-381-8581
  - Option 1 [Pre-Enrollment]
  - Option 3 [UnitedHealthcare branded MA, SNP, PDP applications].

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Section 7: How do I take an Enrollment Application?

When is a new Enrollment Application required?

A new enrollment application is required in the following scenarios:

- Incorrect Plan Selection
- Plan selection not available in region
- Incorrect selection of county/region
- Missing information not provided within required time frame

When is a new Enrollment Application required?

The Additional Information Letter (AIL) is sent to the consumer for missing information or verification that is needed to complete processing of their application. The Additional Information Letter (AIL) will be sent to the consumer with date by which the missing information is needed.

If you are able to provide the missing information/verification needed for a pending enrollment application, please fill out the Missing/Incomplete Application Update Request form.

Pending Reason	Time frame to Supply Information
Blank	No action required
Missing Election Period	7 days from received date [agent's received date or submittal received date]
Pending Parts A/B Effective date	End of election period
Medicaid/Chronic Verification	21 days from the date of the letter or the end of the month [whichever is longer]
ESRD	30 days from the date of the letter
Intent to Enroll	30 days from the date of the letter
Other pending reasons	21 days from the date of the letter or the end of the month [whichever is longer]

Late Enrollment Penalty (LEP)

Who incurs a Late Enrollment Penalty?

- A consumer may incur an LEP if, at any time after they become eligible for Part D coverage, there is a period of 63 or more continuous days without creditable prescription drug coverage. Creditable prescription drug coverage is defined as coverage that meets Medicare's minimum standards or pays on average at least as much as Medicare's standard prescription drug coverage.

Who determines the Late Enrollment Penalty?

- UnitedHealthcare is responsible for determining, at the time of enrollment, whether a consumer was previously enrolled in a Medicare prescription drug plan or had other creditable coverage and whether there are any lapses in coverage of 63 days or more. UnitedHealthcare will then notify CMS of the lapses and CMS will determine the LEP amount to be applied to the consumer's account. Any consumer eligible for low income subsidy (LIS) are not subject to a Late Enrollment Penalty.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Once a Late Enrollment Penalty has been determined what are the next steps for the consumer?

- UnitedHealthcare will inform the consumer via letter about the LEP as well as what the next steps are. The consumer will receive an attestation form with instructions to either fill out the form and resubmit to UnitedHealthcare or the consumer can contact UnitedHealthcare's Customer Service department and attest to the creditable coverage. The consumer will need to attest to the exact dates they had creditable coverage as well as with whom they had creditable coverage (e.g., VA benefits). The consumer will have 30 days to respond to UnitedHealthcare with this information. UnitedHealthcare may send the consumer a reminder notice as the end of the 30 days are approaching.
  - ~ Example: I had coverage through my employer Boeing from August 1, 1995 – January 31, 2014
  - ~ Example: I had VA coverage from November 1,1997 – December 31, 2013
- If UnitedHealthcare receives an incomplete attestation (the start and end dates are missing or the type of coverage is missing) or an attestation is not received, UnitedHealthcare will follow up with the consumer via letter to obtain the missing information. The consumer will have up to 60 days after the 30 day deadline stated in the initial notice to provide UnitedHealthcare with an attestation.
- If UnitedHealthcare receives a response after 60 days from the initial deadline, UnitedHealthcare will be unable to accept the attestation and will inform the consumer of this via letter. UnitedHealthcare will inform the consumer of the LEP that will be placed on their household as well as the steps to take for reconsideration through Maximus. Maximus is CMS' independent review entity: they will notify UnitedHealthcare of the final decision upholding, reducing or eliminating the LEP amount. UnitedHealthcare will make the adjustments and send the notification to the consumer of the final outcome.

What causes a LEP Attestation to be deemed incomplete?

- Consumer does not state the full time period (start and end date of coverage)
- Consumer does not sign a submitted attestation form
- Consumer does not state what type of coverage they had (VA, Employer etc)

Primary Care Physician (PCP)

Who receives a Primary Care Physician assignment?

- Some plans require the member to have a designated Primary Care Physician (PCP) and it will be noted on their member ID card. If the enrollment application contains Name and ID fields for a PCP, then a PCP is required and both fields must be populated. Otherwise, if there is no PCP field on the enrollment application, PCP does not need to be designated.

What are the requirements for an accurate Primary Care Physician assignment?

- The Name and ID fields on the enrollment application must be populated exactly as the information appears in the Online Directory or Print Directory (see examples below).

What are the consequences if an incorrect/invalid Primary Care Physician is populated on the enrollment application?

- Auto assignment of a PCP has the potential to:
  - o Cause member dissatisfaction
  - o Delay member access to services due to inaccurate PCP assignment
  - o Lower Star Rating for the plan
  - o Lead to negative auto assignment for the writing agent

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Physician Status

The best practice is to look up every consumer's Primary Care Physician in the Provider Directory to determine network status **and the PCP's Physician Status**.

There are three types of physician statuses and it is important that you understand what each status means to the consumer you are enrolling.

- **Open** - Physician is accepting any UnitedHealthcare enrollees. Auto-assignment only occurs if there was an error when filling the application out and the PCP information was inaccurate or excluded.
- **Open to existing patients** - Physician is only accepting enrollees who are current patients. It is important to check the "existing patient" box on the application. Auto-assignment of a new physician will occur if the existing patient box is not checked or there is incorrect PCP information on the application.
- **Closed** - Physician is not accepting any UnitedHealthcare enrollees, new or existing patients. Consumers must pick a new physician when filling out the application. Auto-assignment will occur with the selection of a closed panel PCP on the application.

Medicare Advantage and Prescription Drug Plan 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. A Request to cancel an enrollment application occurs prior to the effective date, but after UnitedHealthcare has submitted the enrollment data to CMS.

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.

An External Distribution Channel (EDC), agency, or agent is 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. EDC agents 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. UnitedHealthcare Member Relations Department is authorized to contact disenrolling consumers within the guidelines provided under the privacy regulations and policies.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Withdrawal of Enrollment Application

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

- If the consumer signed a paper enrollment application and you have not submitted it to UnitedHealthcare, you are required to return the paper enrollment application to the consumer. Do not submit it to UnitedHealthcare
- Once the consumer requests to withdraw their paper enrollment application, you are prohibited from submitting the paper enrollment application to UnitedHealthcare, retaining, or destroying it.
- If the paper enrollment application has been submitted to UnitedHealthcare or if an electronic method of enrollment was used, the agent must direct the consumer to Customer Service to facilitate the withdrawal request. The Customer Service number is located in the Enrollment Guide.
- A consumer may verbally request to withdraw their enrollment application.

Cancellation of Enrollment Application

A consumer requests to cancel an enrollment application may occur prior to the effective date, but after UnitedHealthcare has submitted the enrollment data to the CMS. In this situation, you must direct the consumer to Customer Service to facilitate the cancellation request. The Customer Service number is located in the Enrollment Guide.

The consumer may verbally request a cancellation of an enrollment as long as it is received prior to the effective date of coverage.

Request to Disenroll

A voluntary disenrollment occurs after the effective date.

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

Denial

An enrollment application is denied if the consumer does not meet CMS eligibility guidelines (e.g., does not live in the plan's service area) or the consumer does not respond to the additional information letter within the required time frame.

Involuntary Disenrollments

UnitedHealthcare defines an involuntary disenrollment as a disenrollment based on CMS determination that the member is no longer eligible for the plan in which they enrolled.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Involuntary Disenrollment Reasons:

Special Needs Plans
- Move out of contracted skilled nursing facility (ISNP)
- Loss of Medicaid eligibility (DSNP)
- Loss of qualifying chronic condition (CSNP)

General Plans
- Non-payment of plan premium
- Death of member
- Termination of plan
- Incarcerated or moved out of plan's service area
- Fraud or abuse by member
- Disruptive behavior by member

See the Enrollment Handbook for additional details.

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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Section 8: How am I Paid?

Compensation Overview

Credential Validation Rules

Commission Payment Schedule and Payment Calculations

Agent of Record

Assignment of Commission

Electronic Funds Transfer (EFT)

Commission Payment Audit

Pended Commission Process

Plan Changes

Debt Repayment Plan

SecureHorizon Medicare Supplement

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Compensation Overview

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) a writing agent who submits an enrollment application is only eligible for a commission if he/she is properly credentialed (i.e. contracted, certified in the product in which the consumer enrolled, and licensed and appointed, if applicable, in the state in which the consumer resides) at the time of sale, irrespective of the credentialing status of any up-line entity.

For 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.

If the writing agent is eligible for a commission on the sale, then any up-line entity to the writing agent that is properly credentialed at the time of sale will be compensated. Entities that are not properly credentialed at the time of sale are not eligible to be compensated and their commission will be paid to their direct up-line, since the direct up-line is stepping into the shoes of the down-line who was not properly credentialed at the time of sale. If a writing agent is not properly credentialed, no commissions will be paid to the writing agent or their respective up-line. In the event the writing agent is a solicitor and their direct up-line is not properly credentialed at the time of the sale, the solicitor commission and the override commissions of their direct up-line will be paid to the level above the direct up-line. It is the responsibility of the level that receives payment to administer commissions to the solicitor who made the sale.

Agent Compensation

Compensation is defined by the Centers for Medicare & 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 of consumers in the plan that best meets such consumers' health care needs and membership renewals. Plan sponsors are not required to compensate agents or brokers for selling Medicare 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.
  - ~ Must be available upon CMS request for audits, investigations, and to resolve complaints.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- If plans pay commissions they must abide by CMS guidance by paying commissions for initial year (i.e. new to Medicare) enrollments as well as renewal compensation. For 2014 and prior effective dates, CMS established a six-year compensation cycle (initial year plus at least five subsequent renewal years. Starting with 2015 effective dates, CMS removed any limit to the number of years a plan sponsor pays renewal commission. CMS determines if an enrollment qualifies as an initial year or renewal year enrollment and directs the plan sponsor on which compensation level should be paid. Starting with enrollment 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 Medicare Advantage (MA) or Prescription Drug Plan (PDP) plan is as follows:
    - o After CMS publishes rate guidance for the upcoming plan benefit year, UnitedHealthcare will determine commission rates by contract-plan benefit package (PBP) and state based on market specific objectives.
    - o Upon receipt of a CMS-approved enrollment application and validation of the writing agent's credentials, commission for a new enrollment will be the renewal year rate.
    - o Beginning with 1/1/2014 effective dates, commission will be calculated based on the number of months the member is enrolled for the plan benefit year except any Plans, designated by UnitedHealthcare, where the member has no plan history per CMS, as these will be paid at the full initial rate regardless of date of enrollment. CMS guidelines state a plan year ends on December 31 regardless of effective date of the enrollment.
    - o 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. Beginning with 1/1/2014 effective dates, commission for enrollments designated as initial year by CMS will be paid the initial rate based on the number of months the member is enrolled during their initial plan year, except any Plans, designated by UnitedHealthcare, to be paid at the full initial rate regardless of date of enrollment. (Refer to UnitedHealthcare Products by Payment Methodology Master List section, for all available plans and their respective payment methodology.) CMS guidelines state a plan year ends on December 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 or plan exit.
    - o Renewal commission to the writing agent is paid so long as the writing 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 commissions will begin in January of the following plan benefit year. For example, renewal commissions for a July 2014 effective date will begin in January 2015 on a per member per month basis. In addition, starting in January 2015, CMS has changed the rules for determining the renewal rate. The new rules require the renewal rate to be an amount up to fifty percent of the current year initial rate. This guidance applies to all member effective dates in the renewal book of business.

  - ~ Exceptions to the rules above:
    - o Sales of Sierra-branded products are paid the initial or renewal year rate upon receiving notification from CMS of the cycle year.
    - o For 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- If the member leaves the plan:
  - Voluntarily within the first three months (i.e. a rapid disenrollment), the full amount of commission paid is charged back. In the event the new commission was paid at the annual rate (versus months on plan), even if the termination is in the second plan benefit year, the full amount of commission paid is charged back unless the enrollment effective date is October, November, or December, the termination date is 12/31 and the member reenrolls as of 1/1 (no gap in coverage) in which case CMS allows the producer to keep the entire commission.
  - 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 when the new commission was paid at the annual rate (versus months on plan) unless the termination is in the second plan benefit year in which case CMS allows the agent to keep the entire commission.
  - Effective 1/1/2014, if a member terminates coverage 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. Beginning with 1/1/2014 effective dates, if the commission was paid at the annual rate, no charge backs will apply if the termination is in the second plan benefit year.
  - 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 the 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

UnitedHealthcare Products by Payment Methodology Master List

HPBP	Product	State	Region	Status July 17, 2014
H2654-004	AARP MedicareComplete (HMO)	MO/IL	Central	1. Full
H2654-020	AARP MedicareComplete Essential (HMO)	MO/IL	Central	1. Full
H4590-027	AARP MedicareComplete SecureHorizons Essential (HMO)	TX	Central	1. Full
H4590-029	AARP MedicareComplete SecureHorizons Essential (HMO)	TX	Central	1. Full
H5253-021	AARP MedicareComplete Essential (HMO)	WI	Central	1. Full
H0084-001	Care Improvement Plus Medicare Advantage (PPO)	IA/IL/IN/NC/NE/NM/TX	Central	1. Full
H6528-030	Care Improvement Plus Medicare Advantage (PPO)	IL/IN	Central	1. Full
R6801-012	Care Improvement Plus Medicare Advantage (Regional PPO)	TX	Central	1. Full
H4527-002	AARP MedicareComplete Focus (HMO)	TX	Central	1. Full
H4527-013	AARP MedicareComplete Focus (HMO)	TX	Central	1. Full
H0294-004	Care Improvement Plus Medicare Advantage (PPO)	WI	Central	1. Full
H4590-025	AARP MedicareComplete SecureHorizons (HMO)	TX	Central	1. Full
H4527-001	AARP MedicareComplete Focus (HMO)	TX	Central	1. Full
H4527-005	AARP MedicareComplete Focus (HMO)	TX	Central	1. Full
H4522-001	AARP MedicareComplete Choice (PPO)	TX/NM	Central	1. Full
H0084-035	Care Improvement Plus Dual Advantage	NM	Central	1. Full
H0294-006	Care Improvement Plus Dual Advantage	WI	Central	1. Full
H2654-013	AARP MedicareComplete Plan 1 (HMO)	MO/IL	Central	1. Full
H2802-001	AARP MedicareComplete (HMO)	NE/IA	Central	1. Full
H3749-001	AARP MedicareComplete SecureHorizons Plan 1 (HMO)	OK	Central	1. Full
H4590-010	AARP MedicareComplete SecureHorizons (HMO)	TX	Central	1. Full
H4590-012	AARP MedicareComplete SecureHorizons (HMO)	TX	Central	1. Full
H5253-004	AARP MedicareComplete (HMO)	WI	Central	1. Full
H5253-011	AARP MedicareComplete (HMO)	WI	Central	1. Full
H5253-030	AARP MedicareComplete (HMO)	WI	Central	1. Full
H5507-001	AARP MedicareComplete Choice (PPO)	MO/IL	Central	1. Full
R6801-011	Care Improvement Plus Dual Advantage	TX	Central	1. Full
H3887-003	AARP MedicareComplete Plus (HMO-POS)	IL	Central	1. Full
H4514-007	AARP MedicareComplete (HMO)	TX	Central	1. Full
H4456-025	AARP MedicareComplete (HMO)	IA	Central	1. Full
H4456-010	AARP MedicareComplete (HMO)	IL	Central	1. Full
H1509-010	AARP MedicareComplete Choice (PPO)	IN	Central	1. Full
H1509-001	AARP MedicareComplete Choice Plan 1 (PPO)	IN	Central	1. Full
H1509-009	AARP MedicareComplete Choice (PPO)	IN	Central	1. Full
H2654-010	AARP MedicareComplete (HMO)	MO	Central	1. Full
H0084-004	Care Improvement Plus Gold Rx (PPO SNP)	TX, NM, IA, IN, IL, NC, NE	Central	1. Full
H0084-014	Care Improvement Plus Silver Rx (PPO SNP)	IN,IA	Central	1. Full
H0084-065	Care Improvement Plus Gold Rx (PPO SNP)	NM	Central	1. Full
H0294-002	Care Improvement Plus Gold Rx (PPO SNP)	WI	Central	1. Full
H6528-029	Care Improvement Plus Gold Rx (PPO SNP)	IL/IN	Central	1. Full
R6801-008	Care Improvement Plus Silver Rx (Regional PPO SNP)	TX	Central	1. Full
R6801-009	Care Improvement Plus Gold Rx (Regional PPO SNP)	TX	Central	1. Full
H0084-064	Care Improvement Plus Medicare Advantage (PPO) [Non-SNP]	NM	Central	1. Full
H5435-001	UnitedHealthcare MedicareDirect Essential (PFFS)	N/A	N/A	1. Full
H5435-014	UnitedHealthcare MedicareDirect Rx (PFFS)	N/A	N/A	1. Full
H5435-024	UnitedHealthcare MedicareDirect Rx (PFFS)	N/A	N/A	1. Full
H0755-032	UnitedHealthcare MedicareComplete Essential (HMO)	CT	NE	1. Full
H3307-018	AARP MedicareComplete Essential (HMO)	NY	NE	1. Full
H0755-030	UnitedHealthcare MedicareComplete Plan 1 (HMO)	CT	NE	1. Full
H0755-031	UnitedHealthcare MedicareComplete Plan 2 (HMO)	CT	NE	1. Full
H1944-001	AARP MedicareComplete Plan 1 (HMO)	MA	NE	1. Full
H1944-004	AARP MedicareComplete Plan 2 (HMO)	MA	NE	1. Full
H3307-002	AARP MedicareComplete Plan 1 (HMO)	NY	NE	1. Full
H3307-012	AARP MedicareComplete Plan 1 (HMO)	NY	NE	1. Full
H3307-015	AARP MedicareComplete Mosaic (HMO)	NY	NE	1. Full
H3379-001	AARP MedicareComplete Plan 2 (HMO)	NY	NE	1. Full
H3107-004	AARP MedicareComplete Plan 1 (HMO)	NJ	NE	1. Full
H3107-012	AARP MedicareComplete Plan 2 (HMO)	NJ	NE	1. Full
H2001-001	AARP MedicareComplete Choice (PPO)	ME	NE	1. Full
H5322-023	AARP MedicareComplete Plus (HMO-POS)	ME	NE	1. Full
H5322-024	AARP MedicareComplete (HMO)	NH	NE	1. Full
H4102-001	AARP MedicareComplete Plan 2 (HMO)	RI	NE	1. Full
H9011-019	AARP MedicareComplete Plus (HMO-POS)	FL	SE	1. Full
H9011-020	AARP MedicareComplete (HMO)	FL	SE	1. Full
R5287-002	AARP MedicareComplete Choice Essential (Regional PPO)	FL	SE	1. Full
H6528-006	Care Improvement Plus Medicare Advantage (PPO)	AR/GA/MO/SC	SE	1. Full
R3444-012	Care Improvement Plus Medicare Advantage (Regional PPO)	AR/MO	SE	1. Full
R9896-012	Care Improvement Plus Medicare Advantage (Regional PPO)	GA/SC	SE	1. Full

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

H1111-006	AARP MedicareComplete (HMO)	GA	SE	1. Full
H8748-002	AARP MedicareComplete (HMO)	SC	SE	1. Full
H0151-001	AARP MedicareComplete Plan 1 (HMO)	AL	SE	1. Full
H0151-025	AARP MedicareComplete Plan 2 (HMO)	AL	SE	1. Full
H1045-001	Preferred Choice Dade (HMO-POS)	FL	SE	1. Full
H1045-005	Preferred Choice Broward (HMO)	FL	SE	1. Full
H1045-016	Preferred Complete Care (HMO)	FL	SE	1. Full
H1045-025	UnitedHealthcare The Villages MedicareComplete (HMO)	FL	SE	1. Full
H1080-004	AARP MedicareComplete (HMO)	FL	SE	1. Full
H1080-042	AARP MedicareComplete (HMO)	FL	SE	1. Full
H1080-043	AARP MedicareComplete (HMO)	FL	SE	1. Full
H5420-001	Medica HealthCare Plans MedicareMax (HMO)	FL	SE	1. Full
H5532-001	AARP MedicareComplete Choice (PPO)	FL	SE	1. Full
R3444-011	Care Improvement Plus Dual Advantage	MO/AR	SE	1. Full
R5287-001	AARP MedicareComplete Choice Plan 2 (Regional PPO)	FL	SE	1. Full
R9896-021	Care Improvement Plus Dual Advantage	GA/GC	SE	1. Full
H3456-001	AARP MedicareComplete Plan 1 (HMO)	NC	SE	1. Full
H3456-023	AARP MedicareComplete (HMO)	NC	SE	1. Full
H5516-001	AARP MedicareComplete Choice (PPO)	NC	SE	1. Full
H4456-013	AARP MedicareComplete Plan 1 (HMO)	TN/VA	SE	1. Full
H4456-021	AARP MedicareComplete Plan 2 (HMO)	TN/VA	SE	1. Full
H7187-003	AARP MedicareComplete Plan 1 (HMO)	VA	SE	1. Full
H7187-009	AARP MedicareComplete Plan 1 (HMO)	VA	SE	1. Full
H1045-023	Preferred Secure Option (HMO)	FL	SE	1. Full
H6528-016	Care Improvement Plus Gold Rx (PPO SNP)	GA, SC, AR, MO	SE	1. Full
R3444-008	Care Improvement Plus Silver Rx (Regional PPO SNP)	AR/MO	SE	1. Full
R3444-009	Care Improvement Plus Gold Rx (Regional PPO SNP)	AR/MO	SE	1. Full
R9896-008	Care Improvement Plus Silver Rx (Regional PPO SNP)	GA/SC	SE	1. Full
R9896-009	Care Improvement Plus Gold Rx (Regional PPO SNP)	GA/SC	SE	1. Full
H0543-121	AARP MedicareComplete SecureHorizons Essential (HMO)	CA-S	West	1. Full
H0543-153	AARP MedicareComplete SecureHorizons Plan 3 (HMO)	CA-S	West	1. Full
H0609-015	AARP MedicareComplete SecureHorizons Essential (HMO)	CO	West	1. Full
H0609-018	AARP MedicareComplete SecureHorizons Essential (HMO)	CO	West	1. Full
H4604-005	AARP MedicareComplete Essential (HMO)	UT	West	1. Full
H0316-014	AARP MedicareComplete (HMO)	AZ	West	1. Full
H0303-013	AARP MedicareComplete Plan 1 (HMO)	AZ	West	1. Full
H0303-015	AARP MedicareComplete (HMO)	AZ	West	1. Full
H0316-002	AARP MedicareComplete Plus (HMO-POS)	AZ	West	1. Full
H0543-001	AARP MedicareComplete SecureHorizons Plan 1 (HMO)	CA-S	West	1. Full
H0543-004	AARP MedicareComplete SecureHorizons Premier (HMO)	CA-S	West	1. Full
H0543-007	AARP MedicareComplete SecureHorizons Plan 1 (HMO)	CA-S	West	1. Full
H0543-013	AARP MedicareComplete SecureHorizons Value (HMO)	CA-S	West	1. Full
H0543-022	AARP MedicareComplete SecureHorizons (HMO)	CA-S	West	1. Full
H0543-032	AARP MedicareComplete SecureHorizons (HMO)	CA-S	West	1. Full
H0543-060	AARP MedicareComplete SecureHorizons Premier (HMO)	CA-S	West	1. Full
H0543-138	AARP MedicareComplete SecureHorizons Plan 2 (HMO)	CA-S	West	1. Full
H0543-144	AARP MedicareComplete SecureHorizons Plan 2 (HMO)	CA-S	West	1. Full
H0543-145	Sharp SecureHorizons Plan by UnitedHealthcare (HMO)	CA-S	West	1. Full
H0543-151	AARP MedicareComplete SecureHorizons Plan 2 (HMO)	CA-S	West	1. Full
H0543-152	AARP MedicareComplete SecureHorizons Plan 4 (HMO)	CA-S	West	1. Full
H0609-002	AARP MedicareComplete SecureHorizons Plan 1 (HMO)	CO	West	1. Full
H0609-007	AARP MedicareComplete SecureHorizons Plan 1 (HMO)	CO	West	1. Full
H0609-012	AARP MedicareComplete SecureHorizons Plan 2 (HMO)	CO	West	1. Full
H0609-020	AARP MedicareComplete SecureHorizons Plan 2 (HMO)	CO	West	1. Full
H2931-002	Senior Dimensions Southern Nevada (HMO)	NV	West	1. Full
H3805-001	AARP MedicareComplete Plan 1 (HMO)	OR	West	1. Full
H3805-007	AARP MedicareComplete Plan 1 (HMO)	OR	West	1. Full
H3805-012	AARP MedicareComplete Plan 2 (HMO)	OR	West	1. Full
H3805-013	AARP MedicareComplete Plan 2 (HMO)	OR	West	1. Full
H3812-001	AARP MedicareComplete Choice (PPO)	OR	West	1. Full
H4604-003	AARP MedicareComplete Plan 1 (HMO)	UT	West	1. Full
H7949-001	UnitedHealthcare MedicareComplete (HMO)	NV	West	1. Full
H5424-001	AARP MedicareComplete Choice (PPO)	HI	West	1. Full
H1286-002	AARP MedicareComplete Plan 1 (HMO)	WA	West	1. Full
H1286-009	AARP MedicareComplete Plan 2 (HMO)	WA	West	1. Full
H0543-019	AARP MedicareComplete SecureHorizons (HMO)	CA-S	West	1. Full

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

R5342-002	UnitedHealthcare MedicareComplete Choice Essential	NY*	NE	1. & 3. Non-commissionable counties: Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester
R5342-001	UnitedHealthcare MedicareComplete Choice	NY*	NE	1. & 3. Non-commissionable counties: Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester
H1509-007	AARP MedicareComplete Choice (PPO)	IN	Central	2. Pro rata
H3659-001	AARP MedicareComplete Plan 3 (HMO)	OH	Central	2. Pro rata
H3659-054	AARP MedicareComplete Essential (HMO)	OH	Central	2. Pro rata
H4456-015	AARP MedicareComplete Plan 1 (HMO)	IL/IA	Central	2. Pro rata
H4527-024	AARP MedicareComplete Focus Essential (HMO)	TX	Central	2. Pro rata
H4590-037	UnitedHealthcare Chronic Complete (HMO SNP)	TX	Central	2. Pro rata
H3659-003	AARP MedicareComplete Plan 1 (HMO)	OH	Central	2. Pro rata
H3659-031	AARP MedicareComplete Plan 2 (HMO)	OH/KY	Central	2. Pro rata
H5749-001	AARP MedicareComplete Plus Plan 1 (HMO-POS)	KS/MO	Central	2. Pro rata
H3107-008	AARP MedicareComplete Essential (HMO)	NJ	NE	2. Pro rata
H4102-025	AARP MedicareComplete Essential (HMO)	RI	NE	2. Pro rata
H3921-001	UnitedHealthcare MedicareComplete Choice (PPO)	PA	NE	2. Pro rata
H3921-008	AARP MedicareComplete Choice Plan 1 (PPO)	PA	NE	2. Pro rata
H3921-009	AARP MedicareComplete Choice Plan 2 (PPO)	PA	NE	2. Pro rata
H5322-016	AARP MedicareComplete (HMO)	MA	NE	2. Pro rata
H1045-018	Preferred Special Care Miami-Dade (HMO SNP)	FL	SE	2. Pro rata
H1111-002	AARP MedicareComplete (HMO)	GA	SE	2. Pro rata
H3456-020	AARP MedicareComplete Essential (HMO)	NC	SE	2. Pro rata
H1286-003	AARP MedicareComplete Essential (HMO)	WA	West	2. Pro rata
H5424-003	AARP MedicareComplete Choice Essential (PPO)	HI	West	2. Pro rata
H0543-035	AARP MedicareComplete SecureHorizons (HMO)	CA-N	West	2. Pro rata
H0543-036	AARP MedicareComplete SecureHorizons Plan 1 (HMO)	CA-N	West	2. Pro rata
H0543-089	AARP MedicareComplete SecureHorizons Plan 1 (HMO)	CA-N	West	2. Pro rata
H0543-146	AARP MedicareComplete SecureHorizons Plan 2 (HMO)	CA-N	West	2. Pro rata
H0543-147	AARP MedicareComplete SecureHorizons Plan 2 (HMO)	CA-N	West	2. Pro rata
H1303-001	AARP MedicareComplete Choice (PPO)	ID	West	2. Pro rata
H1303-007	AARP MedicareComplete Choice Plan 2 (PPO)	ID	West	2. Pro rata
H5005-011	AARP MedicareComplete Plan 1 (HMO)	WA	West	2. Pro rata
H5005-019	AARP MedicareComplete Plan 3 (HMO)	WA	West	2. Pro rata
H4406-001	AARP MedicareComplete (HMO)	TN*	SE	2. Pro rata Non-commissionable counties: Tennessee: Davidson, DeKalb, Hickman, Rutherford
R7444-001	AARP MedicareComplete Choice (Regional PPO)	CT/MA/RI/VT	NE	2. and 3. VT: pro rata. MA: Berkshire, Bristol, Hampden, Middlesex, Norfolk and Suffolk: pro rata. Rest of MA service area: none. RI: pro rata. CT: none
H3749-004	AARP MedicareComplete SecureHorizons Plan 1 (HMO)	OK	Central	3. None
H3749-017	AARP MedicareComplete SecureHorizons (HMO)	OK	Central	3. None
H1537-001	UnitedHealthcare MedicareComplete Choice (PPO)	NY	NE	3. None
H5420-003	Medica HealthCare Plans MedicareMax (HMO)	FL	SE	3. None
H0543-149	AARP MedicareComplete SecureHorizons Plan 1 (HMO)	CA-N	West	3. None
H0543-028	AARP MedicareComplete SecureHorizons (HMO)	CA-N	West	3. None
H0543-029	AARP MedicareComplete SecureHorizons (HMO)	CA-N	West	3. None
H0543-070	AARP MedicareComplete SecureHorizons (HMO)	CA-N	West	3. None
H0543-086	AARP MedicareComplete SecureHorizons (HMO)	CA-N	West	3. None
H0543-140	AARP MedicareComplete SecureHorizons (HMO)	CA-N	West	3. None
H0543-148	AARP MedicareComplete SecureHorizons Plan 2 (HMO)	CA-N	West	3. None
H2905-001	Sierra Spectrum (PPO)	UT	West	3. None
H2931-004	Senior Dimensions Greater Nevada (HMO)	NV	West	3. None
* Certain counties are not commissionable for this plan				

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Credential Validation Rules

UnitedHealthcare/AARP Sierra Products as of 1/1/2012 Care Improvement Plus Products as of 1/1/2013 effectives Physicians Health Choice, Preferred Care Partners, and Medica HealthCare Plans Products as of 1/1/2014 effectives			
Writing Agent Credential Validation Rules *Includes applications written by a Solicitor*			
Writing Agent Validation	**New Transactions** (Submitted during or after the effective date of the status change) *Applies to writing agent and any up-line overrides* *Check done as of app sign date*	**Renewal/Premium Transactions** (Current 2013 and earlier effective dates and all premiums regardless of effective date) *Applies to writing agent and any up-line overrides* *Check done as of processing date*	**MA/PDP Renewal Transactions Only** (New rule for 2014 effectives onward) *Credential Validation for Solicitors will be done on the Solicitor if Solicitor status is Active or Suspended; on the immediate up-line of the Solicitor if Solicitor status is Servicing or Terminated (not for cause)*
Party Status = Active	Process	Process if New Processed	Process if New Processed
Party Status = In Process	Pend	Process if New Processed	Pend
Party Status = Suspended	Pend	Process if New Processed	Process if New Processed
Party Status = Term For Cause	Do Not Pay	Do Not Pay	Do Not Pay
Party Status = Term due to Death	Do Not Pay	Do Not Pay	Do Not Pay
Party Status = Term Not For cause	Pend	Process if New Processed	Do Not Pay
Party Status = Servicing (Renewal eligible)	Pend	Process if New Processed	Process if New Processed
Deauthorized for Product	Do Not Pay	Process if New Processed	Process if New Processed
Appointment not active as of app sign date (specific to state of app) for new or as of processing date for renewals)	Pend	Process if New Processed	If Status is Active or Suspended and if Appointment is not active with UHIC or UHIC NY as of processing date in **state of sale**, pend If Status is Servicing and if appointment is not active in UHIC or UHIC NY in **agent's resident state** as of processing date, pend
License not active as of app sign date specific to state of sale (resident or non-resident) (new) or processing date in resident/member state (renewal)	Pend	Process if New Processed	If Status is Active or Suspended and if license is not active as of processing date in **state of sale**, pend If Status is Servicing and if license is not active in **agent resident state** as of processing date, pend
License line not active as of app sign date (new) or processing date (renewal)	Pend	Process if New Processed	If Status is Active or Suspended and if license line is not active as of processing date in **state of sale**, pend If Status is Servicing and if license line is not active in **agent resident state** as of processing date, pend
Contract Version not valid as of app sign date	Pend	Process if New Processed	Process if New Processed
Certification for product	If not valid as of app sign date, pend	Process If New Processed	If Status is Active or Suspended and if **full product cert for product sold**** is not valid as of processing date, pend ** If a product is no longer valid/sold, a cross map will be created to identify the current-year product certification equivalent If Status is Servicing and if **course certification for the current renewal year** is not valid as of processing date, pend (Medicare Basics and Ethics and Compliance)

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Commission Payment Schedule and Payment Calculation

Commission Payment Schedule

- Medicare Advantage (MA) and Prescriptions Drug Plans (PDP)
  - ~ New Business – paid twice weekly, pro-rated based on months on plan, unless the member qualifies as in the initial year of enrollment and the plan is on the full payment list.
  - ~ 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 – process weekly*
  - ~ Premiums and Renewals – processed monthly**

* 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 by the member 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.

Exceptions to Commission Payment Schedule include:

- Sierra Medicare Advantage (MA) plans are paid once a month for New Business and Renewals
- Sierra pays Sierra Health and Life Medicare Supplement as follows:
  - ~ New business – once a week
  - ~ Renewals – once a month
- Care Improvement Plus Plans
  - ~ New Business - paid once a week
  - ~ Renewals – paid once a month
- Preferred Care Partners Plans
  - ~ Renewals for 2012 and earlier effective dates are paid once a month

Tax Information

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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Garnishment

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

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 referral/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 mileage to and from appointments with consumers.
- Reimbursement for actual costs associated with consumer sales appointments such as venue rent, materials, and snacks.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Agent of Record Retention

(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 AOR and associated entitlement to renewal payments will be retained 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 - Requirements for Members Impacted by a Service Area Reduction (SAR)/Plan Exit

All of the following qualifying enrollment requirements must be met in order for the current non-renewal eligible agent to retain AOR status:

- The impacted member's current plan is closing and they are able to choose a new plan during the Annual Election Period (AEP) or a Special Election Period (SEP); and
- The current member must switch from the current plan to a different UnitedHealthcare Medicare Advantage plan during AEP or a 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.); and
- The original AOR prior to the member's plan switch must be a renewal-eligible agent and appropriately licensed, appointed, and product certified for 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.

Eligibility Requirements - Requirements for Members Impacted by a Change in Plan Premium

All of the following qualifying enrollment requirements must be met in order for the current non-renewal eligible agent to retain AOR status:

- The impacted member's current UnitedHealthcare, non-special needs Medicare Advantage with integrated Part D benefits plan does not have a plan premium for 2014, but will have a plan premium effective January 1, 2015; and
- The current member must switch from the current plan to a $0 premium UnitedHealthcare, non-special needs Medicare Advantage with integrated Part D benefits plan during AEP. (Note: Any other type of plan switch does not qualify for AOR retention.); OR
- The current member must switch from the current plan to a UnitedHealthcare Dual Special Needs Plan with an October 1, 2014, effective date; and
- The original AOR prior to the member's plan switch must be a renewal-eligible agent and appropriately licensed, appointed, and product certified for the new plan year; and
- The agent enrolling the current member in the new $0 premium UnitedHealthcare, non-special needs Medicare Advantage with integrated Part D benefits 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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 also be actively contracted, licensed and appointed (if applicable) in the state in which the consumer resides, and certified. 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 ABC cannot assign to an agent that rolls up to XYZ
- Assignment to an estate, widow(er), or heir: Under the Agent Agreement, death of the agent is an automatic termination. 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 for cause or death 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Electronic Funds Transfer

(Does not apply to SecureHorizons Medicare Supplement products)

To submit an Electronic Funds Transfer (EFT) request:

- Access the "Contact Us" page on the Distribution Portal.
- Access the EFT Form link and complete and submit the form according to the instructions.
- An email confirmation is sent to email address on file.
- The updated EFT change may take up to two commission cycles to take effect.
- For any issues associated with self-service, email the PHD at phd@uhc.com.

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. Renewal payments audit requests are not reviewed if a corresponding new transaction was not paid. The request must be in writing and must detail the specific applications the agent is questioning. If an issue with the commission payment system is identified, it will be corrected and the commission will be processed systematically. A follow-up communication will be sent to the agent. 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, and PFFS; AARP MA/MA-PD, PDP, and Medicare Supplement; SecureHorizons Medicare Supplement; Care Improvement Plus, Medica and Sierra products.

- The agent must complete a Producer Help Desk (PHD) Service Request form located on Distribution Portal under Contact Us on the home page.
- The agent must email the completed Service Request form to the PHD at phd@uhc.com 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 the agent requesting the review, the Service Request will be escalated to the Commissions Audit department for additional research.
- Results of the audit of each enrollment application will be communicated to the agent 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 with reference to the Service Request provided.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Pended Commission Process

(Does not apply to Sierra, Care Improvement Plus, or SecureHorizons Medicare Supplement products)

Commissions are paid to eligible, non-employee agents for enrollment applications that are complete, legible, and accurate. A non-employee 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, if 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 an agent is not licensed at the time of sale, the agent will be terminated and the member will be notified of the sale involving an unqualified agent. (Refer to appointment and contract termination section for details 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.
    - o Communication is sent primarily via email.
    - o An exception process is in place for an instance where the agent has no email on file or the email is invalid.
    - o As part of this process, updated email information is gathered from the agent so the no pay communication can be sent to the agent.
    - o In cases where email communication is not possible, a letter will be sent to the agent via postal delivery.
    - o A summary of all weekly communications is provided to the following teams: EDC leadership.
- Pended Commission Status Reporting
  - ~ The agent and their up-line or manager/supervisor can 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 (Pended Activity Report): The Commissions Department generates a pended transaction report on a weekly basis and distributes it to EDC channel leadership and the impacted EDC agencies.

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. The agent and his/her up-line (EDC), can 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:

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Appeals Process:

- The communication outlines a clear appeal process that agents may use if they feel a transaction has been pended inappropriately.
  - ~ The agent has 30 days from receipt of the communication to submit an appeal to the PHD at PHD@uhc.com.
  - ~ The Agent On-Boarding, Certification, and/or Commissions team reviews the appeal and approves or denies it.
  - ~ For appeals that are specifically related to agent certification, the following requirements must be met:
    - o An agent may request exception process review under one of the following circumstances:
      - Agent knew, in good faith, that they were certified in the product and can provide documentary evidence, but UnitedHealthcare Medicare Solutions internal business process or technical error did not reflect that the agent had passed the test in that product.
      - Agent was told they were certified, and can provide evidence, but due to internal business process errors, was not provided with the appropriate certification requirements or online development plan.
    - o In order for an exception to apply, all of the following criteria must be met:
      - Agents must have taken the appropriate certification tests by the time the exception is being considered.
      - A UnitedHealthcare Medicare Solutions/UnitedHealth Group system or process created the certification error.
      - Agent was acting in good faith.
  - ~ For appeals that specifically relate to agent licensing, information available through the Department of Insurance or National Insurance Producer Registry (NIPR) will be used to validate licensing claims.

Analyst Review:

- Appeals are forwarded to an Agent On-Boarding and/or Certification analyst for review. Results of analyst review, on a per application basis, will fall into one of three categories:
  - ~ System(s) will be updated to reflect the necessary change(s) for the agent and the commission will be paid systematically.
  - ~ Commission payment remains ineligible due to reason(s) stated.
  - ~ Appeal could not be evaluated based on currently approved rules, i.e. guidelines or published rules do not exist for the scenario under evaluation.
- The transaction record and the Producer Contact Log (PCL) will be updated to reflect the final decision.
  - ~ Approved appeals: System records are corrected and payment will be systematically processed during the next commission cycle.
  - ~ Denied appeals: The transaction record will be updated to reflect a “permanent pend” status indicating no further appeal is available.
- The appeals process can take up to 14 business days, and the agent is contacted via email, phone, or letter with the final decision on the appeal.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Plan Changes

- 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 and Medica plans from January 1, 2014, 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 voluntary or 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 unless the member was enrolled in the prior plan through 12/31, in which case the commission is considered fully earned.
- If the effective date of the plan change is in benefit plan year two, 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 charge backs have been appropriately processed for members that rapidly disenroll or otherwise disenroll within the first plan benefit year or to validate agents no longer receive renewal commissions following a member's disenrollment from a Medicare Advantage or Prescription Drug Plan. When an audit process reveals an overpayment, the impacted agent is charged back accordingly. (See agent compensation section)

- In order to minimize the impact of large charge backs, 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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

SecureHorizon Medicare Supplement

SecureHorizons Medicare Supplement 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 Schedule:

- UnitedHealthcare pays all agents for all business either by check or through Electronic Funds Transfer into the agent's bank account. Commission 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 with funds available Friday (for most banks).
  - ~ Statements and checks, if 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 are wired to bank accounts Monday with funds available Tuesday (for most banks).
  - ~ Statements and checks, if applicable, for renewals are mailed on Monday.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Compliance and Ethics

Code of Conduct

Overview

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

Act with integrity

- Recognize and address conflicts of interest.

Be Accountable

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

Protect Privacy. Ensure Security

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

Your Role and Responsibilities

- To fulfill your Compliance Responsibilities.

Stop. Think. Ask.

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

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

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

Compliance Reporting Resources

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

The complete Code of Conduct can be accessed on 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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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.

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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- 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 suspected privacy or security incidents through:

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

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
  - ~ 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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

contractors – that are inconsistent with sound business, financial, or medical practices
- Practices or activities that cause unnecessary costs to the health care system

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

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

Ethics and Integrity

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

Merriam-Webster's Dictionary defines ethics as:
- The discipline dealing with what is good and bad and with moral duty and obligation.
- A theory or system of moral values
- A guiding philosophy.
- A set of moral issues or aspects.

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

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

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

Disclosure
- You must disclose to consumer all information needed to 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

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

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

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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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:

~ Agent Readiness Status
~ Call Monitoring
~ Cancelled applications
~ CMS Surveillance (Secret Shopper – CMS)
~ Complaints
~ Event Observation Program (Secret Shopper – Vendor)
~ Late enrollment application
~ PCP Auto-Assign
~ Rapid Disenrollments
~ Results

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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

programs to ensure you 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 A360 Compliance include:

- Call Monitoring
  - ~ Call monitoring is not reported at the agent level in A360 Compliance. Evaluations are set up in partner/site hierarchy, not by agent and requires the use of a non-production form.
- Complaints
- Late enrollment applications
- Rapid Disenrollment
- CMS Surveillance (Secret Shopper – CMS)
- Event Observation Program (Secret Shopper – Vendor)
- Cancelled Applications
- PCP Auto-Assign

Late event reporting and unqualified sales are two additional monitoring programs that are not reported through A360 Compliance. You may be monitored on late event reporting and unqualified sales.

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 you, your manager, and the 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 A360 Compliance are identified as Yellow and Red to correspond with results trending toward becoming unacceptable and unacceptable evaluation or results, respectively. Each of the monitoring programs, along with the calculation method and thresholds, are described later in this section.

For addition questions regarding the compliance monitoring thresholds, contact your manager.

Call Monitoring

Call monitoring evaluates telephonic enrollment conversations between a Telesales agent and the consumer to ensure compliance with the Centers for Medicare and Medicaid Services (CMS) guidelines. Monitoring may be conducted at the local level or by a UnitedHealthcare Quality Review Specialist (QRS). The infraction rates in A360 Compliance Dashboard only reflect QRS Quality Call Monitoring results. Quality evaluation data is not available in A360 Compliance for eAlliance.

Complaints

Complaints can be received from a variety of sources both external and internal to the company. All complaints are received by the Agent Complaint 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, 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 A360 Compliance 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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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.

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, you are reducing the risk of a rapid disenrollment.

CMS Surveillance (Secret Shopper – CMS)

CMS Surveillance (Secret Shopper - CMS) is a compliance program that identifies improper marketing and sales practices. The outcome of the secret shopper observations are only shared with UnitedHealthcare if you fail 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 your 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.

Event Observation Program (Secret Shopper – Vendor)

The Event Observation Program (Secret Shopper – Vendor) is a compliance program that evaluates your 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.

Cancelled Applications

The Cancelled Applications threshold monitors consumer cancellation of an enrollment application, prior to the effective date.

Note: The key difference between the Cancelled Application program and the Rapid Disenrollment program is that cancelled applications take place ***prior*** to the effective date, whereas rapid disenrollments take place ***after*** the effective date.

PCP Auto-Assign

PCP (Primary Care Physician) Auto-Assign is a compliance program that evaluates whether agents are selecting a valid PCP on Medicare Advantage enrollments. The main causes of auto-assignments include: no input into the PCP fields, PCP not found in the directory, PCP not participating in the network, and the "Existing Patient's Only" box was not checked on the application. The lack of a valid PCP selection leads to a higher rate of rapid disenrollments, member dissatisfaction and gaps in member care.

You should validate the PCP selection within the online provider directory prior to submitting any new enrollments that requires an assigned PCP. Some plans do not require an assigned PCP. The

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

PCP Auto-Assign compliance program does not include enrollments into plans that do not require a PCP assignment.

Unsuccessful Events (No Shows)

Unsuccessful Events (sometimes called "No Shows", but such issues are not all inclusive of Unsuccessful Events) are those Events in which the Secret Shopper contracted vendor is unable to complete the evaluation due to a number of potential factors. Examples of scenarios which will lead to the filing of an Unsuccessful Event, and subsequent corrective action, include: Agent not being present at the location; you are at the location, but is in an area that cannot normally be accessed, or signage giving directions to the area are not clear; filing the Event as "Formal", but you give an "Informal" style presentation.

Unqualified Sales

You must be appropriately licensed, appointed (if applicable), and certified at the time of the sale in order to be eligible for a commission on the sale. You will be terminated if at the time of sale you were not licensed in the state in which the consumer resides. If at the time of sale, you were appropriately licensed, but not appointed (if applicable) in the state in which the consumer resides and/or certified in the product in which the consumer enrolled, you will be assigned a Corrective Action Referral (CAR) and assessed two complaint points, and will receive outreach. Subsequent instances of sales in which you are not appointed or certified, which occur after previous CAR outreach within a rolling 12-month period, will result in you being terminated.

Event-Related Infraction and Corrective/Disciplinary Action

All events must be reported to UnitedHealthcare. The presenting agent must successfully complete the Events Basics module and assessment, with a passing score of 85% or better within three attempts prior to reporting and/or conducting an educational or marketing/sales event. The presenting agent is responsible for the timely entry, changing, and/or cancelling of the event in bConnected as well as the accuracy of the information reported.

- Late Reported, Changed, or Cancelled Event
  - ~ A report is generated that identifies events entered in bConnected less than 14 calendar days prior to the date of the event and events that are changed or cancelled in bConnected within three business days of the date of the event. The ACT team generates and assigns a Coaching Request to the manager/BDE of the presenting agent indicated in the report. The manager/BDE will conduct a coaching session and document the details of the outreach in PCL.
- Failure to Report
  - ~ A failure to report infraction, as reported by CMS through their clipping service audit or discovered during a complaint investigation, results in a formal Operational Behavior complaint against the presenting agent and a CAR. You will be assessed two complaint points and must complete assigned corrective action, which includes completing the on-line Operational Behavior remediation module and a second session of the Events Basics module, attending the Event Refresher WebEx training (if available), receiving manager coaching, and completing an attestation of understanding that a second offense may result in termination. Receiving two Operational Behavior complaints for an identical allegation in a rolling 12-month period results in a DAC referral.
- Failure to Complete Events Basics Module
  - ~ After secret shopper results are received, successful completion of the Events Basics module is validated based on the actual presenting agent at an event. Failure to successfully complete the Events Basics module prior to the event results in a formal Operational Behavior complaint against the presenting agent and a CAR. You will be assessed two complaint points and must complete

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

assigned corrective action, which includes completing the on-line Operational Behavior remediation module and Events Basics module and receiving manager coaching, which must include a formal event audition. The manager of the agent who conducted an event prior to successfully completing the Events Basics module will also receive corrective action that includes completion of the Event Refresher WebEx training (if available) and coaching by the Sales Director, which will include a written plan of how the manager will monitor and prevent any future event infractions. The Sales Director will document the coaching in the assigned PCL Coaching Request. Receiving two Operational Behavior complaints for an identical allegation in a rolling 12-month period results in a DAC referral.

- Presenting Agent is not Contract with UnitedHealthcare
  - ~ When it is determined that a non-contracted agent conducts a marketing/sales event on behalf of UnitedHealthcare, an investigation will be conducted to determine the presenting agent identified in bConnected, who made the decision for replacement, and what knowledge sales management had. Corrective and/or disciplinary action includes a no-show infraction against the presenting agent listed in bConnected, a Do Not Recontract flag against the non-contracted agent, and a Corrective Action Plan on the internal manager or external agency.
- Secret Shop Failures and Unsuccessful Event
  - ~ Unsuccessful Events infractions result when you did not show up for a reported event, the incorrect event type was reported, you arrived late and after the secret shopper arrived, the reported and actual addresses of the event are not the same, the event could not be located due to inadequate signage, the time of the event was changed, or the event was cancelled but not reported. You must complete assigned corrective action, which includes completing the on-line Operational Behavior remediation module and a second session of the Events Basics module, attending the Event Refresher WebEx training (if available), and receiving manager coaching that includes an event observation by the manager.
  - ~ ii. Agents failing a secret shop for a reason other than a No-Show must complete the Event Refresher WebEx training (if available), a second session of the Events Basics module, and will receive manager coaching that includes an event observation by the manager. An agent failing two consecutive secret shops will be removed from participating in any future events until retrained and approved by their Regional Sales Director to participate.
- Annual Election Period (AEP) Sales Leaders Event Observations
  - ~ Identified sales leaders must adhere to the requirements of the AEP Sales Leader Event Observation program, communicated annually prior to AEP. Managers who fail to comply with the requirements must complete the Event Refresher WebEx training (if available), will receiving coaching by their manager, and will be put on a Corrective Action Plan in HRDirect for repeated failure to comply. Note: Excluded are Optum sales leaders managing agents presenting the Institutional Special Needs Plans.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Section 9: What are Expected Performance Standards?

Agent Thresholds Matrix

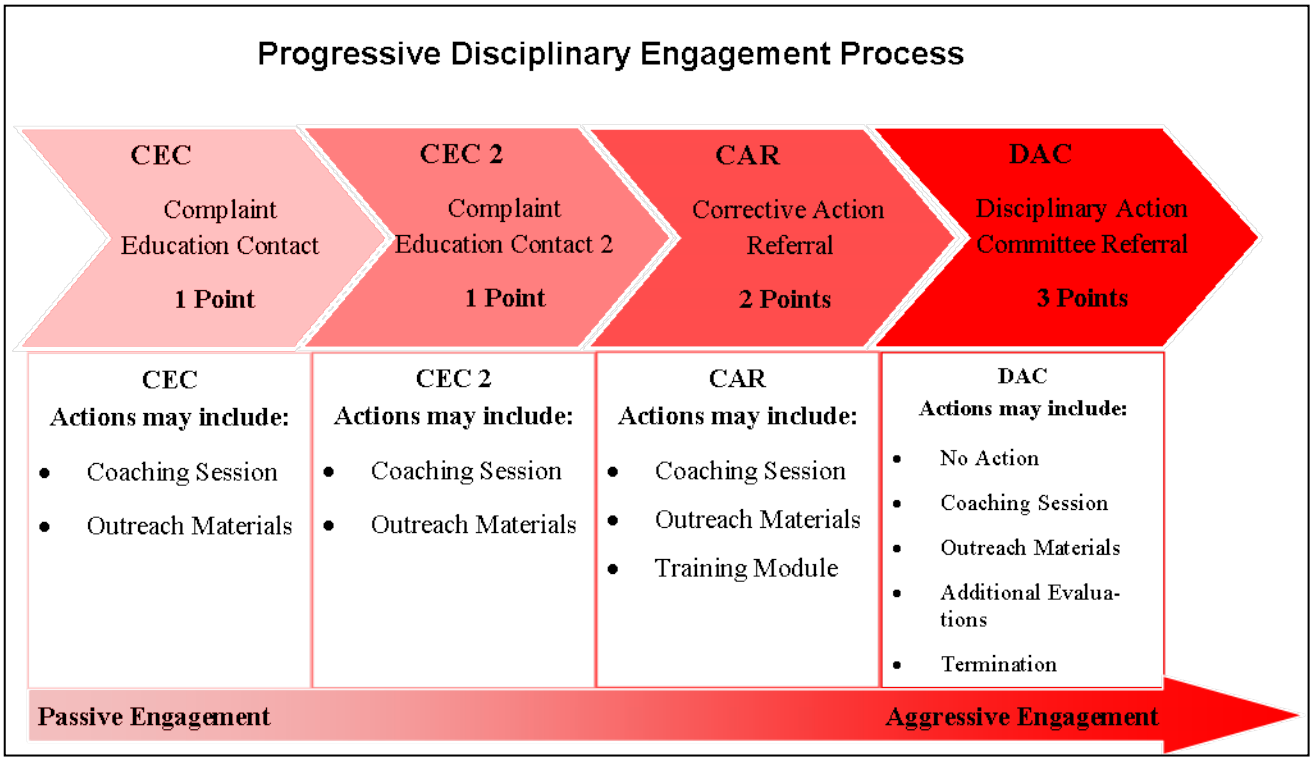
Program	Complaint	Cancelled Application	Rapid Disenrollment	Late Application
Infraction Definition	All closed complaints that are actionable. (Does not include those with final action of: No Current Action Required, Non-complaint, or Operational Issue/No Action Required) For DAC, all items referred to DAC.	An individual disenrolls from a plan before the effective date.	A member disenrolls from a plan within 3 months from the effective date.	The received date is greater than 3 calendar days from the agent signature date. For AARP Medicare supplement insurance plan enrollment applications, the received date is greater than 16 calendar days from the agent signature date.
Threshold	**Agent Threshold**	**Agent Threshold**	**Agent Threshold**	**Agent Threshold**
Minimum Requirement	N/A	Minimum of 20 enrollment applications	Minimum of 20 enrollment applications	N/A
Timeframe	Daily	Future 3 effective dates (Evaluated independently)	Most recent 6 effective dates (Evaluated independently)	Trailing time period
Limitations on CR Creation	N/A	Limit of 1 yellow and 1 red per effective date	Limit of 1 yellow and 1 red per effective date	7 days before creating another CR
Yellow CR	A closed complaint has been referred to CEC or CEC2.	N/A	Greater than 5% to less than or equal to 10%	Greater than or equal to 4 late enrollment applications in the last 14 days
Red CR	A closed complaint has been referred to the CAR or DAC	Greater than 25%	Greater than 10%	Greater than or equal to 4 late enrollment applications in the last 7 days
Threshold Calculations	Looks at complaints referred to CEC, CAR, or DAC.	Calculates % of Cancelled enrollment applications by effective date for the nearest 3 future effective months. Total # Cancels divided by Total Submitted enrollment applications for each effective date, independently.	Overall % of Rapid Disenrollments for an agent for the last 6 completed months. Total # of rapids divided by total accreted enrollment applications for each effective date, independently.	Looks at the number of late enrollment applications in a trailing time period.
Incident Date	Application Date; If not available, Receipt date	Application Date	Application Date	Agent Signature Date; If not available, Application Date
Infraction Date	For all programs, the date the infraction is identified and created in A360 Compliance			

Program	PCP Auto-Assign	Event Observation Program (Secret Shopper - Vendor)	CMS Surveillance (Secret Shopper - CMS)	Call Monitoring
Infraction Definition	For plans that require a PCP to be selected, a valid selection has not been made. Common errors include: No input, not in directory, not in-network, or the 'Existing Patient's Only' box was not checked.	An evaluation has a score that is less than 100%	An event has 1 or more valid findings where the finding is labeled as "Does Not Contest", "Agree", or "Dispute". If disputed, the CMS final outcome must state "Deficiency Stands".	Any call monitoring evaluation with a score that is less than 100%.
Threshold	**Agent Threshold**	**Agent Threshold**	**Agent Threshold**	**Agent Threshold**
Minimum Requirement	N/A	N/A	N/A	N/A
Timeframe	Trailing time period	Daily	Daily	Calendar Month
Limitations on CR Creation	7 days before creating another CR	N/A	N/A	1 per month
Yellow CR	Greater than or equal to 2 infractions in the last 14 days	Greater than or equal to 85% to 99.9% Vendor score	N/A	Greater than or equal to 90% to 95% average score
Red CR	Greater than or equal to 2 infractions in the last 7 days	Less than 85% Vendor score	1 or more Failed Events	Less than 90% average score
Threshold Calculations	Looks at the number of PCP Auto-Assign infractions in a trailing time period.	Overall composite score of the Secret Shopper event.	Number of Pass or Fail Infractions.	Calculates the average quality score (sum of scores of all calls divided by the number of calls evaluated).
Incident Date	Application Date	Event Date	Event Date	Call Date
Infraction Date	For all programs, the date the infraction is identified and created in A360 Compliance			

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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/Members
- Operational Behaviors
- Plan and Product Knowledge Issues
- Point of Sale Issues

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Point System

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 You will receive escalated disciplinary action.

The point breakdown 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 you 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, 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 consumer or member who filed the complaint regarding the allegations in the complaint during the investigative process.

Initial Review and Pre-Disposition

Review Process

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

- A complaint is closed, the case documented accordingly, and the submitter notified if the following conditions exist:
  - ~ No agent is involved in the complaint
  - ~ The product identified in the complaint is not a UnitedHealthcare Medicare Solutions product
  - ~ The basis for the complaint is due to an internal business operational issue
- If the complaint is in scope of the agent complaint process, it moves to the pre-disposition stage

Pre-Disposition

The ACT team reviews each complaint using the Complaint Education Contact (CEC) – Corrective Action Referral (CAR) – Disciplinary Action Committee Referral (DAC) criteria grid to determine if the complaint is referred to the CEC process or the Compliance Investigations Unit (CIU) for investigation. The status of the complaint is updated in the agent complaint tracking tool.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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, you 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 you.

- A Coaching Request (CR) is created in Producer Contact Log (PCL)
- The manager/coach is expected to meet in person or telephonically with you.
- The manager/coach is expected to engage you and discuss the complaint, review and reiterate any and all applicable rules and regulations.
- The manager/coach is expected to identify any gaps in understanding, tool usage, source of truth materials, or communication by you and address any gaps identified.
- 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 you demonstrated understanding, and what you will do to avoid repeating the mistake in the future in the "Document Coaching" section, for each identified allegation in PCL.
- If the requirements are not met within the allotted timeframe, you may be referred for administrative termination.

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 additionally investigated. If the complaint is assigned as a CAR you 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. Please note, it is not necessary that a complaint be investigated, in order to assign a CAR.

See the Corrective Action Referral process section.

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 you 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, you may be referred for administrative termination.

See the Disciplinary Action Committee Referral process section for additional details.

Investigation of Complaints, Allegations of Agent Misconduct by the Compliance Investigations Unit (CIU)

Complaints requiring additional investigation are forwarded to the Compliance Investigations Unit

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

(CIU). Upon completion of the investigation process, the ACT team dispositions the complaint.

Investigation Process

- Generally, a Request for Agent Response (RAR) is prepared and sent directly to you and to your sales or External Distribution Channel (EDC) management hierarchy. The RAR requests specific detailed responses to each allegation as well as other pertinent questions, facts, and circumstances. A response to the RAR is required within five business days. If a response is not received by the date requested, you, along with your sales or EDC management hierarchy, is sent a Non-Response Letter (NRL) stating that a response must be received within two business days. If no response is received within the prescribed timeframe, an administrative termination is initiated.
- Members or their authorized representatives may be interviewed during an investigation to gather required details regarding the complaint or to confirm identity of the agent and/or other pertinent facts. All contact with members is made in accordance with CMS guidance including use of a required script and recording of the conversation.
- The investigator may also conduct a telephone interview of the agent. These interviews may occur prior to or as a follow-up to the RAR or NRL when the investigator needs more information or clarification of details. Interviews of other witnesses relevant to the investigation are also conducted as determined appropriate.
- System research is conducted to obtain information regarding claims, customer service notes, lead generation, and other details as determined in reviewing the case (CIU investigator, CIU management) to assist investigators resolve allegation outcomes.
- When the complaint concerns a Telesales agent, a recording of the telephonic enrollment may also be obtained for review by the investigator.
- An Administrative Termination, termination considered not-for-cause, will be initiated if you fail to respond to the Request for Agent Response within the prescribed time. See Administrative Termination section for additional details.

Under no circumstance may the agent referenced in the complaint contact the consumer or member who filed the complaint regarding the allegations in the complaint during the investigative process.

Investigation Outcome

- The CIU will determine an allegation outcome of Substantiated, Unsubstantiated, Inconclusive, No Allegation, Non-Response, or Previously Terminated. The allegation outcome is considered in the recommendation for a final action which is assigned at the conclusion of the investigation.
- Substantiated: Based on the evidence and facts that existed at the time the investigation was conducted and applicable CMS Medicare Marketing Guidelines, internal policy, or other authority, a reasonable person would conclude that the allegation is true.
- Unsubstantiated: Based on the evidence and facts that existed at the time the investigation was conducted and applicable CMS Medicare Marketing Guidelines, internal policy, or other authority, a reasonable person would conclude that the allegation is unfounded.
- Inconclusive: There was insufficient evidence, facts, or corroborating evidence that existed at the time the investigation was conducted that would lead a reasonable person to conclude the allegation is substantiated or unsubstantiated.
- Insufficient Information: The complaint lacked the minimum amount of information necessary to determine the identity of the agent, member, or other information necessary to conduct a complex investigation.
- No Allegation: The complaint is determined not to have been a complaint against you for

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

sales or marketing misconduct in accordance with CMS guidelines and company policy.
- Non-Response: You failed to respond within the required timeframes to the RAR and NRL.

Refer for Disposition

Upon completion of the investigation, the Investigative Report, Investigative Findings, and Allegation Outcomes are generally documented in the agent complaint tracking tool. The case is updated as 'Refer for Disposition' in the tracking tool and is referred back to the ACT team. Supporting documentation, including exhibits, are provided to the ACT team within the tracking tool.

- Final action recommendations may include No Action Required, Training/Corrective Action, 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 you. The investigation and outcome documentation will be placed in the agent's performance file. The Agent Complaint Tracking (ACT) team will track completion of training and/or corrective action assigned to you as a result of the complaint investigation. Sales management will oversee your 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.

Assignment of Final Disposition

The ACT team considers each allegation outcome assigned by the CIU at the completion of an investigation to determine the final disposition of a complaint. The following final dispositions are available:

<u>No Action Required</u>

The following situations result in no required action and the case is closed in the agent complaint tracking tool:
- The allegation outcome is Insufficient Information, No Allegation, or Unsubstantiated.
- The allegation outcome is Inconclusive or Substantiated and you had outreach for this issue within the past twelve months, but the event/enrollment application for the current allegation took place before the outreach occurred. A Coaching Request is opened in PCL notifying your manager or BDE that no action is required.
- If the investigation results in unsubstantiated outcomes for all allegations, the Agent Closure Letter is emailed to you, thanking them for their cooperation and notifying them of the investigative results.

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

- You have not had outreach for the same allegation(s) within the past twelve months and the CEC-CAR-DAC Referral Criteria Grid recommends referral to the CAR process.
- You have had outreach through the CEC process for the same allegation(s) within the past twelve months and the event/enrollment application for the current allegation took place after the CEC outreach occurred.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Referral to the Disciplinary Action Committee
For allegation outcomes of Inconclusive or Substantiated, the ACT team will use the CEC-CAR-DAC Referral Criteria Grid to determine if a referral to the Disciplinary Action Committee (DAC) is appropriate. The following situations result in a DAC referral:

- You have not had outreach for the same allegation(s) in the past twelve-months and the CEC-CAR-DAC Referral Criteria Grid recommends referral to the DAC.
- You have had outreach through either the CAR or DAC process for the same allegation(s) within the past twelve months and the event/enrollment application for the current allegation took place after the CAR or DAC outreach occurred.
- You have repeated instances of lower severity complaints.

Corrective Action Referral Process

The Corrective Action Referral (CAR) process supports the progressive disciplinary process and is a proactive measure intended to address egregious agent behavior with retraining efforts delivered in a prompt manner intending to correct the underlying problem that resulted in program violation and to prevent future noncompliance. The following steps are taken when a referral is made to the CAR process:

- The ACT team uses the CEC Outreach Tool to determine appropriate outreach.
- For active agents, a Coaching Request is automatically generated in PCL and assigned to the appropriate BDE or agent manager/supervisor.
- For inactive agents, a Coaching Request is not created. The status of the complaint is updated in the agent complaint tracking tool and Agent On-Boarding is notified to flag you DNR in the event you re-contract. The outreach must be completed immediately after re-onboarding is completed. When an agent is re-appointed and active, they have access to the required tools and systems in order to complete coaching and begin marketing activities.
- The applicable Sales Remediation Web-Based Training Course(s) is assigned to you.
- You must successfully complete the course(s) within five days of availability. Successful completion is defined as completing the course in its entirety and passing the corresponding assessment with a minimum score of 80% within three attempts.
- The BDE or agent manager/supervisor has fourteen days from receipt to complete and document agent outreach and close the Coaching Request.
- The BDE or agent manager/supervisor is expected to meet in person or telephonically with you.
- The manager/coach is expected to engage you and discuss the complaint, review and reiterate any and all applicable rules and regulations.
- You 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 you demonstrated understanding, and what you will do to avoid repeating the mistake in the future in the “Document Coaching” section, for each identified allegation in PCL.
- The ACT team monitors the completion of CAR Coaching Requests and implements an escalation process for Coaching Requests not completed within the required fourteen days. See Escalation Process for details.
- The ACT team creates a monthly report that details key metrics of the CAR process including the percent of CAR outreaches completed.
- If the findings of the investigation relate to Substantiated outcomes for Unreported Sales Events or Unauthorized Marketing Materials, you are also required to review, complete, sign and return a mandatory CMS Attestation acknowledging understanding of the issue.
- The manager must include any related documentation (i.e. screen shots, Human

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Capital Corrective Action Plans (CAP), Attestations, etc.) that reflects your successful completion of the all the requirements.
- If the requirements are not met within the allotted timeframe, you may be referred for administrative termination.

Disciplinary Action Committee

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

Committee Membership and Mechanics

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

DAC Proceedings

- At the completion of a complaint investigation, the ACT team will refer an agent to the DAC if the allegation outcome, along with other defined criteria, indicates DAC Referral as the prescribed final disposition or if an agent has recurring instances of lower severity complaints.
- The DAC reviews the merits of the complaint and the investigation findings.
- If additional information is required, the DAC may request and consider other relevant information.
- The committee determines and votes on an outcome. Approval by a majority of voting members present is required.

DAC Outcomes

The following outcomes are available to the DAC:

- No Action Required
- The DAC determines you do not require additional training to address the issue presented.
- Corrective Action
- The DAC recommends appropriate corrective action tailored to address the complaint or issue of noncompliance and timelines for completion. In such cases, the ACT team opens a Coaching Request in PCL, in addition to drafting a formal corrective action letter that is sent to you and your applicable up-line notifying the appropriate manager to facilitate appropriate outreach and training to you. Typically, DAC recommended corrective action (e.g., training and/or manager ride-along/sit-beside) must be completed within 30 days.
- Decertification of Sales and Marketing Activity
- The DAC decertifies you from performing sales and marketing activity of a particular product until assigned corrective action is completed. The ACT manager is responsible for notifying your manager of the decertification and required training. Your manager is responsible for monitoring the completion of the assigned training.
- Termination
- The DAC terminates an EDC agent or Independent Career Agent (ICA) or recommends the termination of an employee agent (i.e. Internal Sales Representative (ISR) or Telesales agent). In addition to the decision to terminate you, the DAC must determine if the termination is for-cause or not-for-cause.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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.
- The suspension is effective immediately upon notice and continues until the investigation is complete and a final disposition is recommended and completed or as indicated in the notification.
- 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), UnitedHealthc are 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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 tests.

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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Termination Due to Unqualified (Unlicensed) Sale

An unqualified sale is a sale by an agent who is not appropriately licensed, or appointed (if applicable) in the state in which the consumer resides, or certified in the product in which the consumer is enrolling at the time of sale.

UnitedHealthcare will send a letter of notification to the member stating that the agent, at the time the enrollment application was completed, was not qualified to sell in the state in which the consumer resides or the product in which the consumer enrolled.

Commissions will not be paid on any unqualified sale.

You will be terminated not-for-cause if you complete a sale while you are not licensed in that state, including if your license has lapsed or expired, or if there are two separate incidents of unqualified sale due to certification or appointment in a rolling 12-month period.

Corrective action will be assigned if you complete a 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.

- Depending on the reason the termination is processed, you will either receive an evite that offers them the opportunity to enter into a “Servicing Status” with UnitedHealthcare or a standard letter stating your termination will be processed and effective on the given date. The evite needs to be accessed and completed by including an e-signature of the “Intent to Service” form.

- If you select “Servicing Status” and complete the “Intent to Service” form, you must maintain the following criteria to remain in “Servicing Status”

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

- ~ Maintain an active resident state license (depending on state requirements.
- ~ Be appointed to the appropriate UnitedHealthcare entity for your resident state.
- ~ Annually complete required certification with a minimum score of 85% in 3 attempts or less.

- Once Servicing Status is selected, your licensing, appointment and certification status is verified. If action is needed to meet the required criteria, you are notified and given a timeframe to complete the actions.

- If "Servicing Status is not selected, you will be terminated and notification will be sent to you and your EDC and uploaded in your agent record.

- If an appeal process is applicable, you will be notified.

- For UnitedHealthcare-initiated, non-disciplinary action (i.e., a business decision by leadership to terminate an agent's appointment), not-for-cause agent terminations, a not-for-cause termination letter, detailing the reason for termination, the termination effective date, and the appeal process (if applicable) is sent to you with a copy sent to your EDC or agent manager, uploaded to the agent's file, and submitted to Agent On-Boarding.

- For Disciplinary Action Committee (DAC) initiated, you will be mailed a termination notification letter that will identify the effective termination date.

- 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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.

Disciplinary or Administrative Termination 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.
- If the ninety day timeframe given after the termination effective date passes without a Reconsideration appeal being made by you, the Do Not Re-Contract status remains indefinitely.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Section 10: Glossary of Terms

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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 an 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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. Also referred to as Medicare Open Enrollment.
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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
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.
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.
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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
	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.
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)*
Coinsurance	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.
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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
	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.
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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
	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.
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 drug 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 drug 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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
	seeks covered medical services at each visit. 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.
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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
	management/reporting level of a specific agent/agency.
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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

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	
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.
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.
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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
	• 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.
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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
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.*
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 member has met their deductible and before their total medication expenses have reached a specific amount including amounts the member has paid

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
	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.
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 drugs 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.
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	An independent contractor with a direct contract with UnitedHealthcare at the MGA

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
(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.
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 drug 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 or Medicare Part C.
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.
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 will likely pay more • Members may 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 drugs. These plans are offered by insurance companies and other private companies approved by Medicare. Consumers can get Medicare Part D coverage as part of an MA plan (if offered where a consumer lives),

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
	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.
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 drug 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
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	
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;

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
	• 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 that accept Medicare. • 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.
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. All Medicare Advantage plans are required by CMS to have an out-of-pocket maximum.
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	A face-to-face, one-on-one marketing presentation that typically occurs in a

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
Marketing Appointment	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 members 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 drug coverage only.
Preventive Service	Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best.
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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
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.
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. There are 28 regions set by Medicare. A region is defined as one state or multiple states. 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.

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
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.)
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.
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

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
	addition to taking telephonic enrollments, the representative can set appointments, process sales event RSVPs, and provide basic benefits statements per CMS regulations.
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.
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	The agent website that provides access to product, commission, and resource

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Term	Definition
Distribution Portal (UDP)	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.*
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	

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Index

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.

Index

Confidential property of UnitedHealth Group. For Agent use only. Not intended for use as marketing material for the general public. Do not distribute, reproduce, edit or delete any portion without the express permission of UnitedHealth Group.