Individual and Family Plans (IFP) Agent Guide

United Healthcare®

Proprietary and confidential to UnitedHealth Group.

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

This Guide is intended for agent use only.

Version 2.81 Release Date – May 01, 2023

Table of Contents

Section 1: Introduction

Welcome to UnitedHealthcare

Using this Guide

Welcome to UnitedHealthcare

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

Here to help you succeed

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

Compliance and integrity

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

Easy access

An electronic version of this guide is available on ***Jarvis*** and is updated regularly. We welcome your comments, suggestions and recommendations for additional content.

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

Sincerely,

Marcus Robinson
President of Markets
UnitedHealthcare Individual and Family Plans

Using this Guide

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

The Agent Guide has been developed for use by Individual and Family Plans (IFP) agents. Throughout the guide, the words “agent” and “you” are used to refer to any IFP agent unless otherwise indicated.

Section 2: On-Boarding and Readiness

On-Boarding

Agent/Solicitor Level, Alignment, or Channel Change Requests

On-Boarding

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

Active Non-Employee Agents and Agencies

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

On-Boarding

Contracting

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

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

- Agreement (not applicable for solicitor) – First and signature pages, at a minimum, must be submitted. Note: The signature date must be within 30 days of the date received by Agent Lifecycle Management (ALM).
- Appointment Application – signed and dated. Note: The signature date must be within 30 days of the date received by ALM.
- Background Check Authorization Form – signed and dated. Note: The signature date must be within 30 days of the date received by ALM.
- Errors and Omissions Attestation of Coverage within the Appointment Application – signed and dated. Note: The signature date must be within 30 days of the date received by ALM.
- W-9 Form (not applicable for solicitor) – signed and dated. Note: The signature date must be within 30 days of the date received by ALM.

Direct Entity

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

Section 2: On-Boarding and Readiness

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

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

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

Email
Effective April 15, 2023, all entities with an active Party ID must provide and maintain a unique email address on file with UnitedHealthcare Agent Lifecycle Management (ALM). Use of a shared email address is prohibited. Email addresses can be updated in Jarvis or by email at exchangecontracting@uhc.com.

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

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

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

Periodic Investigation

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

- A notification letter is sent to you informing you of the upcoming background investigation. The notification letter provides instructions on how to notify ALM if you do not authorize the investigation.
- If you do not authorize the background investigation, you will receive a 30-day termination notice. Refer to the Termination Section for details.
- The periodic background investigation review follows the same process outlined in the Initial On-Boarding Section above (except credit history information is not collected). If you fail the periodic background process, you will receive a 30-day termination notice, regardless of channel or level (solicitors included). Refer to the Termination Section for details.
- Proactive Background Review
  To expedite the periodic background investigation process, an investigation may be paused temporarily in order to obtain clarification of data reported by the background investigation vendor.
  - A communication is sent to you requesting the necessary documentation for you to pass the review. You must respond to the request within ten days to complete the background review process.
  - If you miss the deadline or choose not to participate in the process, the background review will proceed as usual, which may result in a failed background review.
  - If you do not pass the review, you are entitled to the standard two-tiered appeal process. (Refer to the Agent Appeal of Decline Due to Background Investigation section below.)
- On a monthly basis, ALM accesses the Office of Inspector General (OIG) –U.S. Department of State Health & Human Services website (www.oig.hhs.gov/exclusions) and downloads the list of excluded individuals/entities. The list is analyzed against the active agent population to ensure active agents have not appeared on the list since the previous month. Any agent or agency appearing on the list is terminated in accordance with their agreement.
- On a monthly basis, ALM accesses the US General Services Administration (GSA) housed in the System for Award Management (SAM) website to download a list of excluded individuals/entities. The list is analyzed against the active agent population to ensure active agents have not appeared on the list since the previous month. Any agent or agency appearing on the list is terminated in accordance with their agreement.

Agent Appeal of Decline Due to Background Investigation

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

- First-Level Appeal – Tier I

Initial, Tier I appeals are reviewed and determinations made by designated ALM staff specifically trained to review background investigation results. If the ALM analyst who made the original decision to decline the agent based on the background investigation results also conducts the Tier I appeal review, in order to obtain an impartial decision the analyst will solicit input from other analysts trained in background investigation reviews or a review by leadership will be requested.

- The ALM specialist reviews the background investigation results, appeal letter and attachments, and other pertinent documents and makes a determination to approve or deny the appeal.
- If the appeal is approved, the contracting process resumes. New documents may be required if they no longer meet signature date requirements.
- If the appeal is denied, a denial notification letter is sent via email and postal mail to you that describes your right to a second appeal and the process. Your up-line receives a copy of the notification letter.

- Second-Level Appeal – Tier II

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

Waiting Period to Submit a New Contract Packet

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

Errors and Omissions (E&O)/Professional Liability Insurance

Each non-employee agent representing UnitedHealthcare must carry and maintain continuous E&O/Professional Liability insurance coverage and provide proof of coverage (e.g., carrier's

declaration page) upon request. Failure to carry and maintain proof of E&O/Professional Liability coverage is grounds for termination. The following guidelines apply:

- The policy must specifically state "Errors and Omissions" or Insurance Agent/Broker Professional Liability.
- The declaration page or certificate of insurance must state the policy number, policy limits, policy period (issue and expiration dates), and carrier.
- Minimum insurance is required. E&O/Professional Liability insurance is required at a minimum of $1,000,000 per claim and/or $1,000,000 aggregate.
- E&O/Professional Liability for a corporation should state who is covered by the policy (e.g., the corporation, principal, and/or its employees or subcontractors).
- Blanket E&O/Professional Liability coverage must explicitly state who the policy covers:
    - Entities that have blanket E&O coverage for their down-line agents may provide a non-carrier produced listing of those covered, as long as the down-line is classified as an agent or solicitor level. The listing must be on the entity's letterhead, provide the agent's or solicitor's full legal name and be signed by the entity's principal. Agents or solicitors can be added by providing either an update to the original listing or a separate letter.
    - General Agent level and above producers must have their own E&O coverage or their name must appear as the certificate holder (or similar) on the confirmation of insurance of a blanket policy.
    - Contracted entities may provide E&O/Professional Liability coverage by submitting a non-carrier produced listing of covered individuals. The listing must be on the business entity's letterhead, provide covered individual's full legal name and signed by the entity's principal. IFP entities may provide coverage for their down-line employees, affiliated producers, agents, and/or subcontractors who are contracted at the individual agent level.
- E&O/Professional Liability for a principal covers the corporation, but not specifically the employees or subcontractors of the corporation.
- If you are not insured by a corporate policy, you may have individual E&O/Professional Liability insurance. The policy should be in your name.
- Submission of E&O/Professional Liability coverage documentation is not required unless specifically requested and may be sent to exchangescontracting@uhc.com. See the Contracting section above regarding the attestation requirement.

Appointment

You must be appointed (as required by the state) in the state in which the consumer resides and each state in which you represent UnitedHealthcare in the marketing and/or sale of UnitedHealthcare products. Note: Just-in-Time (JIT) appointment may apply in select states.

When all contracting and licensing requirements have been met, ALM will submit state appointment requests to each state requested during on-boarding or at the time a sale (e.g., Just-in-Time) is made (as required by the state). For solicitors, the up-line must also be appointed in the requested state(s).

In order to be eligible for a commission, you must be appointed (as required by the state) in the state in which the consumer resides at the time of the enrollment application received date. In addition to

requesting appointment during on-boarding, UnitedHealthcare may use Just-in-Time appointing (including back-dating appointments when available), or current appointment in another UnitedHealthcare product to satisfy the appointment requirement. If the appointment is not verifiable at the required time, an enrollment application and any future renewals will not be commission eligible.

Writing Number (Agent ID) Notification

You receive a writing number (Agent ID) as part of your on-boarding process. An active writing number allows you to access marketing and sales materials on Jarvis. Once the appointment request is submitted to the state, you are set to active status in the contracting system, a writing number is issued, and your Agent Agreement is in force executed with the Chief Sales Distribution Officer's signature. A Welcome Letter, which contains your writing number and a copy of the executed signature page of your Agent Agreement, if applicable, is available in your agent performance file. A copy of the Welcome Letter sent to your up-line or to UnitedHealthcare sales leadership. You are expected to confirm state appointment approval via Jarvis prior to marketing/selling any product unless the state is indicated as a "Just in Time" appointment and the appointment will be submitted after the first enrollment.

UnitedHealthcare Telesales Sales Agents

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

UnitedHealthcare Telesales Sales Agents must:

- Have an active insurance license in Life, Accident, and Health (or similar as determined by the state) with appropriate lines of authority for their state of residence, plus non-resident licenses for any other states where they will market or sell UnitedHealthcare products. Telesales agents are responsible for all educational requirements to maintain an active state license.
- Be appointed (as required by the state) in their resident state and any other state where they will market or sell UnitedHealthcare products.
- Complete all applicable FFM and/or SBM exchange training, certification, and registration requirements prior to marketing/selling for the applicable selling season. Telesales agents must complete all trainings/certifications themselves.

Agent/Solicitor Level, Alignment, or Channel Change Requests

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

Release and Notice of Intent to Move Requirements

When an agent/solicitor contracted with UnitedHealthcare wants to align under a new hierarchy a Letter of Release or Notice of Intent to Move is required unless the change results in an employment relationship with UnitedHealth Group or its affiliate or a telesales vendor contracted with UnitedHealthcare.

Release Process

- For an agent/solicitor, only the highest contracted entity (e.g., FMO, Key FMO, Key GA, GA, or eAlliance) in the agent/solicitor's current hierarchy (or UnitedHealthcare if applicable) may, at its discretion, provide the agent/solicitor with a full release to leave the hierarchy (even if the agent/solicitor self-terminated within six months of submitting new contract paperwork).
- Upon receipt of the release, you may move to a new hierarchy. While there is no waiting period to contract under a new hierarchy, ALM does not process contracting change requests during a blackout period that runs annually October 1 through January 31. The new contracting packet, which must include the Letter of Release, must be received by ALM no later than September 30 in order to align under the new hierarchy by the start of the Open Enrollment Period (OEP).
- You may only move to a contracting level equal to or lower than your current contract level and must stay at that level for a minimum of one year.
- If your current FMO, Key FMO, Key GA, GA, or eAlliance (or highest upline agency or UnitedHealthcare, if applicable) will not provide a release, you may terminate your agreement with UnitedHealthcare and contract under a different FMO, Key FMO, Key GA, GA, eAlliance, or as a direct agent, at the same or lower contract level no less than six months after your termination effective date or you may use the Notice of Intent to Move process. Normal contracting rules apply.

Notice of Intent to Move Process

- Agencies (GA and above) are not permitted to use the Notice of Intent to Move Process.
- You must be under your current Agency and/or in your current hierarchy level for at least six months prior to submitting a Notice of Intent to Move and can only change agency hierarchy once every 12 months from the effective date of your current agreement or hierarchy change, whichever occurred most recently.
- You must email your Notice of Intent to Move to UnitedHealthcare at exchangescontracting@uhc.com and the top level of your current hierarchy, indicating the name of the hierarchy under which you intend to move.
- Upon receipt of the Notice of Intent to Move, UnitedHealthcare will send a reply letter to you, with a copy to the current hierarchy and intended hierarchy or applicable UnitedHealthcare sales leader, indicating the date when the 6-month waiting period expires.
- A 6-month waiting period begins on the date UnitedHealthcare receives the email. During the waiting period, you and your down-line, if applicable, may continue to write UnitedHealthcare business. If, during the 6-month waiting period, you decide to move to a different hierarchy than indicated in the Notice of Intent to Move, you must submit a new Notice of Intent to Move, which begins a new 6-month waiting period.

- Once the Notice of Intent to Move is submitted to the current up-line, the current up-line may not make changes to the transferring agent/solicitor's hierarchy unless the transferring agent/solicitor provides written notice to make changes.
- ALM must receive required contracting paperwork (i.e. Appointment Application and only if moving level a new contract agreement) within 30 days of the expiration of the waiting period except as noted below:
    - ALM does not process contracting change requests during the Blackout Period (October 1 through January 31). Therefore, in order to move to a new hierarchy by the start of an Open Enrollment Period, the new contracting packet must be received by ALM before the blackout period begins October 1.
    - If ALM does not receive required paperwork within the required timeframe, you must submit a new Notice of Intent to Move, which begins a new 6-month waiting period.

Servicing Status and Successor Programs

- Servicing Status – Non-Active Renewable Eligible Non-Employee Agent
  Non-employee agents terminated not-for-cause must enter servicing status prior to the effective date of their termination in order to receive renewal commission for IFP plans. You may receive in your not-for-cause termination notification letter an invitation from UnitedHealthcare to enter into a Servicing Status agreement. Servicing Status is determined at the Party ID level and will be the status of all lines of business.
    - To enter servicing status, prior to your not-for-cause termination, you must:
        - ~ Sign and return the Intent to Service form.
        - ~ Hold and maintain thereafter an active resident state license.
        - ~ Have and maintain thereafter an active resident state [UHIC] appointment.
        - ~ Complete registration and training required by UnitedHealthcare or the applicable exchange (FFM or SBM).
        - ~ Complete the Servicing Attestation.
    - Servicing status agents <u>are not</u> required to carry/maintain E&O/Professional Liability insurance coverage and are not subject to periodic background investigations.
    - Servicing status agents are not active and must not market UnitedHealthcare IFP plans or write new business. You may return to active status by re-contracting and meeting all active agent requirements, including FFM and/or SBM exchange training and registration requirements.
    - While in servicing status, you are expected to continue providing service to the member.
    - Servicing status will terminate effective the date you fail to meet servicing status requirements (e.g., no longer has an active license or fails to meet FFM and/or SBM exchange training and registration requirements). Renewal commissions for IFP plans will permanently cease as of the servicing status termination date.
- Successor Agent Program – Renewal Eligible Non-Employee
  When all eligibility requirements are met, contracted non-employee agents may request UnitedHealthcare transfer their entire UnitedHealthcare book of business to a successor agent, who agrees to accept and service the original agent's book of business and oversee down-line agents, where applicable.
    - Eligible products include all UnitedHealthcare IFP plans.

Section 2: On-Boarding and Readiness

- Original Agent Eligibility and Terms of Agreement requirements:
  - ~ Original Agent must be in active or servicing status with UnitedHealthcare.
  - ~ Original Agent must not be the subject of an open complaint investigation. Open complaint investigations must be closed prior to requesting a successor Agent Agreement.
  - ~ Original Agent must be in the FMO (solicitors are ineligible) or Direct Agent channel.
  - ~ Original Agent must sign the "UnitedHealthcare Exchange/Qualified Health Plans Successor Agent Agreement" which includes without limitation the following terms:
    - Original Agent's current Agent Agreement and Writing ID(s) will be terminated.
    - Original Agent acknowledges that the transfer of their book of business is contingent on their down-line hierarchy, if any, also being transferred to the successor agent. Standard release rules apply.
    - Original Agent's rights related to their entire current UnitedHealthcare business, including renewal commissions and up-line payments, if any, will cease upon the effective date of the transfer.
    - Original Agent's liabilities and obligations related to their business that is not eligible to be transferred will continue and survive the termination of their Agent Agreement.
    - Original Agent's current debt related to the transferred business is to be paid in full or transferred to the Successor Agent upon transfer of the book of business. Debt repayment plans are not allowed.
    - If Original Agent is the assignee of another agent's commission, the assignment of commissions agreement will be terminated.
    - Original Agent agrees to comply with applicable state and federal rules and requirements related to the transfer of their book of business, including, but not limited to, member notice and consent requirements.
- Successor Agent Minimum Eligibility and Terms of Agreement
  - ~ Successor Agent must have an active contract (i.e. Successor Agent must not be in servicing status at the time they enter the successor agent agreement) with UnitedHealthcare. Standard release rules apply.
  - ~ Successor Agent must be licensed and appointed (as required by the state) in each state in which a currently enrolled IFP plan member resides and complete registration and training required by UnitedHealthcare or the applicable exchange (FFM or SBM).
  - ~ Successor Agent must be of an equal or higher level than the highest level at which the original agent had been contracted to receive the original agent's full book of business.
  - ~ Successor Agent must not be the subject of an open complaint investigation. Open complaint investigations must be closed (refer to policy IFP-112 for details) prior to requesting a successor agent agreement.
  - ~ Successor Agent must sign the "UnitedHealthcare Exchange/Qualified Health Plans Successor Agent Agreement" and agree to the following terms:

- Successor Agent agrees to accept and service Original Agent's entire eligible book of business and oversee, where applicable, down-line agents transferred to Successor Agent's hierarchy to receive renewal commission/up-line payments.
- Successor Agent will take on any future charge back debt related to the transferred book of business.
- Successor Agent agrees to comply with applicable state and federal rules and requirements related to working with new clients, including, but not limited to, member notice and consent requirements.

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

- Successor Agent Program Approval Process
  - All requests to transfer Original Agent's UnitedHealthcare book of business to Successor Agent are subject to prior review and approval by UnitedHealthcare.
  - UnitedHealthcare approves or disapproves a request to transfer within approximately 30 days of receipt of the signed Successor Agent Interest Form. If approved, a "UnitedHealthcare Exchange/Qualified Health Plans Successor Agent Agreement" between Original Agent and Successor Agent may be executed.
  - Successor Agent Agreements are effective immediately upon full execution (i.e. the date UnitedHealthcare signs the agreement).
  - UnitedHealthcare reserves sole discretion to deny any agreement up until it is a fully executed contract.
  - UnitedHealthcare reserves sole discretion to remove Successor Agent as Agent of Record (AOR) and to discontinue paying the agent if it determines that Successor Agent is not servicing the members or overseeing down-line agents, if any, as required by the Agent Agreement.
  - UnitedHealthcare, at its sole discretion, reserves the right to rescind the Successor Agent Program at any time without notice.
- Deceased Agent Successor Program – Renewal Eligible Non-Employee
  When all eligibility requirements are met, UnitedHealthcare will work with a deceased contracted non-employee agent's next of kin, estate, and/or up-line to establish a successor agent, who agrees to accept and service the members within the deceased agent's book of business and oversee down-line agents, as applicable. In all cases, transfer of a deceased agent's book of business is subject to UnitedHealthcare's prior review and approval.
  - Eligible products include all IFP plans.
  - Deceased Agent Successor Program Qualifications and General Considerations
    - ~ Deceased Agent must have been a renewal eligible agent (solicitors are ineligible) in active or servicing status with UnitedHealthcare at the time of death.
    - ~ Deceased Agent must have been in the FMO or Direct Agent channel at the time of death.
    - ~ Under normal operations, the following occurs upon notification of an agent death:
      - Deceased Agent's Writing ID(s) will be termed for death.

- If Deceased Agent's book is the assignee of another agent's commission, the assignment of commissions agreement will be terminated.

- Successor Agent Eligibility and Terms of Agreement
  - Successor Agent must have an active contract (i.e. Successor Agent must not be in servicing status at the time they enter the successor Agent Agreement). Standard release rules apply.
  - Successor Agent must be licensed and appointed (as required by the state) in each state in which a currently enrolled IFP plan member resides and complete registration and training required by UnitedHealthcare or the applicable exchange (FFM or SBM).
  - Successor Agent must be of an equal or higher level than the highest level at which the Deceased Agent was contracted to receive the Deceased Agent's full book of business,
  - Successor Agent must not be the subject of an open complaint investigation. Open complaint investigations must be closed (refer to policy IFP-112 for details) prior to proceeding with a successor agent agreement.
  - Successor Agent must sign the "UnitedHealthcare Exchange/Qualified Health Plans Successor Agent Agreement" and agree to the following terms:
    - ~ Successor Agent agrees to accept and service Deceased Agent's entire eligible book of business and accept and oversee, where applicable, down-line agents transferred to the Successor Agent's hierarchy to receive a renewal commission/up-line payments. UnitedHealthcare reserves sole discretion to remove Successor Agent as AOR and to discontinue paying Successor Agent if it is determined that Successor Agent is not servicing the member.
    - ~ Successor Agent agrees that outstanding debt related to the transferred business will also be transferred to the Successor Agent. They also will take on any future charge back debt related to the transferred book of business.
    - ~ Successor Agent agrees to comply with applicable state and federal rules and requirements related to working with new clients, including, but not limited to, member notice and consent requirements.
  - Upon transfer, Successor Agent's Agent Agreement with UnitedHealthcare will govern the book of business.
- Deceased Agent Successor Program Approval Process
  - UnitedHealthcare must approve all requests to transfer a Deceased Agent's UnitedHealthcare book of business to a successor agent.
  - UnitedHealthcare must receive notification, including a death certificate and/or obituary, within 6 months of Deceased Agent's death. If UnitedHealthcare is not properly notified within 6 months of Deceased Agent's death, UnitedHealthcare may take on the role of servicing Deceased Agent's book of business or find a successor agent.
  - Upon notification of death, next of kin/estate/up-line has 7 months from the date of death to identify a potential Successor Agent who agrees to the terms of and submits the "UnitedHealthcare Exchange/Qualified Health Plans Successor Agent Agreement."

- UnitedHealthcare will work first with Deceased Agent's next of kin/estate to identify a Successor Agent.
- If next of kin/estate does not wish to help identify a Successor Agent, UnitedHealthcare will next work with Deceased Agent's up-line to identify a successor agent.
- If no Successor Agent is established and/or no Successor Agent Agreement is signed within 7 months from the date of death, UnitedHealthcare may take on the role of servicing Deceased Agent's book of business or find an alternate Successor Agent.
- UnitedHealthcare will approve or disapprove the request to transfer within approximately 30 days of receipt of the signed Successor Agent Interest Form. If approved, a "UnitedHealthcare Exchange/Qualified Health Plans Successor Agent Agreement" may be executed with the Successor Agent and the original agent's estate representative.
- Successor Agent Agreements are fully executed as of the date UnitedHealthcare signs the Agreement and effective the date noted on the Agreement. UnitedHealthcare, at its sole discretion, reserves the right to deny any agreement up until it is a fully executed contract.
- UnitedHealthcare, at its sole discretion, reserves the right to rescind the Deceased Agent Successor Program at any time without notice.

- Successor Agent Program Appeal Process
  An appeal process is offered to agents who are declined for the Successor Agent program.
  - Appeals must be in writing, include the agent's name and address, and provide detailed information explaining the rationale for appeal, including information on how the members will be serviced by engaging in the Successor Agent program. Appeals may be mailed, faxed, or emailed to Commissions:
    UnitedHealthcare Attention: Commissions – Successor Agent
    MN006-E800 9800
    Health Care Lane
    Minnetonka, MN 55343
    Fax: 1-866-761-9162
    Email: sh_commissions_administration@uhc.com (preferred method)
  - Appeals are forwarded for consideration to the Successor Agent Approval Board (SAAB), which includes senior-level distribution operations and field sales representatives.
    - ~ The SAAB reviews the appeal and pertinent documents, renders a decision, and forwards the appeal documentation with noted decision to Commissions.
    - ~ Commissions facilitates processing and documenting the appeal, including the communication of the final decision to the applicable agent(s).
    - ~ If the appeal is approved, the Successor Agent process resumes. New documents may be required if they no longer meet signature date requirements per the Successor Agent process.
    - ~ If the appeal is denied, a denial notification letter is sent via email to the agent(s).
    - ~ The decision of the SAAB is final and may not be appealed again.

Section 3: Marketing Activities and Materials

Marketing Activities and Materials

UnitedHealthcare Agent Toolkit Facebook Assets

Book of Business

Marketing/Sales Activities and Materials

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

You must not:

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

You must:

- Use a title or designation that accurately reflects your role as a licensed insurance agent/producer marketing/selling health insurance. Using a title or designation that has the potential to confuse or mislead a consumer is prohibited.
- When using UnitedHealthcare approved materials, you must use the most current version. You must not modify approved materials beyond approved customization options.
- Provide required materials to the consumer at the time of enrollment.
- Be aware of and sensitive to the needs of the consumer related to language barriers and physical or cognitive impairments/disabilities and must comply with all applicable accessibility requirements.
- Protect consumer/member Protected Health Information (PHI) and Personally Identifiable Information (PII) and report any potential incidents to UnitedHealthcare immediately upon discovery.
- Comply with UnitedHealthcare guidelines related to the use of any UnitedHealthcare or affiliated third-party logo, company or plan name, or brand element, including on agent websites and social media sites.

- Provide consumers with correct information, without omission of material fact, regarding the Federally-facilitated Exchanges, QHPs offered through the Federally-facilitated Exchanges, and insurance affordability programs.
- When providing information to Federally-facilitated Exchanges that may result in a determination of eligibility for a special enrollment period in accordance with regulations, you must obtain authorization from the consumer to submit the request for a determination of eligibility for a special enrollment period and make the consumer aware of the specific triggering event and special enrollment period for which you will be submitting an eligibility determination request on the consumer's behalf.

UnitedHealthcare Agent Toolkit Facebook Assets

Agent/Agency use of Facebook as a communications or marketing tool is subject to federal and state regulations and UnitedHealthcare rules, policies, and procedures. In order to feature Facebook assets available on the UnitedHealthcare Agent Toolkit on a registered business Facebook account, the following guidelines apply:

You must:

- Be active, licensed, appointed (as required by the state), and completed registration and training required by UnitedHealthcare or the applicable exchange (FFM or SBM) in order to feature the Facebook assets. Agents in a non-active status must remove all Facebook assets no later than their termination date.
- Use a business Facebook account, not a personal or multi-purpose (i.e. personal and business) account to conduct business on behalf of UnitedHealthcare.
- Register your Facebook account. Registration requests must be submitted to compliance_questions@uhc.com and must minimally include:
    - First Name
    - Last Name
    - Email address
    - Phone Number
    - National Producer Number (NPN)
    - Facebook account URL
- Access the Facebook assets through the UnitedHealthcare Agent Toolkit. You must use your own log on credentials.
- Only use the Facebook assets during the approved timeframe (e.g., open enrollment period).
- Use the Facebook assets in the format provided. If the Facebook assets are ordered in both PDF and an image file, the assets must be used together.

You must not:

- Use any form or derivative of the UnitedHealthcare brand name, abbreviation (e.g., UHC), or plan names in a Facebook URL.
- Feature UnitedHealthcare brand elements (e.g., brand name, logo, or plan information), including but not limited to any reference to UnitedHealthcare, on a Facebook account, except as allowed with approved Facebook assets.
- Share log on credentials with or provide materials to an agent/agency that is not appropriately active, licensed, appointed (as required by the state), or completed registration and training required by UnitedHealthcare or the applicable exchange (FFM or SBM).

- Modify Facebook assets (beyond the customization options available in the UnitedHealthcare Agent Toolkit).
- Use a social media's interactive functionality (e.g., direct messaging, writing on a consumer's Facebook wall) to engage in unsolicited contact.

Book of Business

UnitedHealthcare at its discretion may provide an agent access to their Book of Business member information. Provided member information must only be used to the extent necessary to conduct business (e.g., servicing members and member retention activities) on behalf of UnitedHealthcare. Any other use of provided member information is prohibited. Book of Business reports are confidential and proprietary information of UnitedHealth Group. Do not distribute or reproduce any portion without the express permission of UnitedHealth Group. All other rules, regulations, policies, and procedures apply. Please note that provided member information may not be reflective of all Book of Business or AOR information and does not impact commissions/incentives or renewal payments.

Section 4: Enrollment Process

Enrollment

Enrollment

You must comply with all federal and state laws and regulations and all UnitedHealthcare policies, procedures, and rules related to enrollments and disenrollments. Failure to comply with any laws, regulations, rules, policies, or procedures may result in corrective and/or disciplinary action up to and including contract termination.

You must not:

- Submit enrollment applications that contain inaccurate information provided by either the consumer or yourself, e.g., inaccurate household income.
- Alter the enrollment application without consumer authorization or falsify business documents.
- Enter their own personal, professional, or company telephone number, email address, or mailing address on a consumer's application or an application for advance payments of the premium tax credit and cost-sharing reductions for QHPs.
- Create or use a dummy telephone number or address in place of the consumer's telephone number, email address, or mailing address.

You must:

- Be licensed, appointed (as required by the state), and have completed the registration and training required by UnitedHealthcare or the applicable exchange (FFM or SBM) at the time of the enrollment application received date. To receive commissions or renewals on an eligible enrollment, in addition to being licensed, appointed (as required by the state), and appropriately trained as of the enrollment application received date, agents must be contracted with UnitedHealthcare. Agents not contracted at the time of the enrollment application received date must be contracted with UnitedHealthcare no later than the member's plan effective date.
- Obtain and document consumer consent prior to assisting with Marketplace coverage, including but not limited to, prior to searching for a current application using an approved Classic Direct Enrollment (DE)/Enhanced Direct Enrollment (EDE) website.
- Conduct a thorough needs analysis, prior to enrolling the consumer, to determine the plan that will best meet the consumer's needs.
- Provide complete and accurate information related to the consumer's plan options and the plan in which the consumer enrolls.
- When submitting household income projections used by the exchange to determine a consumer's eligibility for advance payments of the premium tax credit or cost-sharing reductions in accordance with regulations, you must only enter consumer's household income projections that the consumer or authorized legal representative has designated is compliant with regulations, knowingly authorized, and confirmed is accurate. Household income must be calculated and attested to by the consumer.
- Comply with all applicable state and federal laws and regulations and all UnitedHealthcare policies related to the disclosure of compensation to consumers at the time of plan selection. Newly contracted agents/brokers (Effective 12/27/2021) and all agents/brokers (effective 01/24/2022), must disclose the total amount of direct (e.g., commissions payment) and indirect compensation (e.g., bonus contests) the agent/broker and/or agency may receive associated with the enrollment. Compensation must be disclosed before the consumer

makes a final plan selection and can be provided verbally. UnitedHealthcare has talking points available with the required compensation information on the Jarvis agent portal for agent/broker use. Failure to disclosure compensation is subject to corrective and disciplinary actions.

- Explain that subsidy calculations are based off household income for the entire year and inform consumers of the importance of reporting any changes to household income to the exchange as soon as possible so that any subsidy can be adjusted accordingly.
- Use your own exchange login credentials.
- Enroll only those consumers who request to be enrolled and understand the purpose of the enrollment application.
- Accurately and completely fill in the enrollment application.
- Submit the enrollment application timely (i.e. immediately) to ensure the consumer obtains the desired effective date.

You may:
Answer questions posed by the consumer related to household income projection, such as helping the consumer determine what qualifies as income.

Section 5: Compensation

Non-Employee Commissions

Employee Incentives

Non-Employee Commissions

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

Non-Employee Commissions

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

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

Note: Enrollments in the state of Colorado are excluded from the compensation procedures outlined below.

Agent Compensation Eligibility Requirements

Credential Validation Rules for the Writing Agent

- First-year commissions
  To be eligible to receive first-year commissions, the writing agent (including solicitors) must be appropriately credentialed as of the enrollment application received date. To be appropriately credentialed to be eligible for commission, you must be licensed and appointed (as required by the state) in the state in which the consumer resides; completed registration and training required by UnitedHealthcare or the applicable exchange (FFM or SBM) as of the enrollment application received date; and contracted no later than the member's plan effective date.
- Monthly Renewals (Year Two and Subsequent Years)
  To be eligible to receive monthly renewal commissions for year two and beyond, the writing agent (or immediate up-line if writing agent was a solicitor level) must have been licensed, appointed (as required by the state), and completed registration and training requirements as of the enrollment application received date and as of the first of each renewal month, be actively contracted (including servicing status contract), actively licensed and appointed (as required by the state) in the state in which the consumer resides, and completed the

registration and training required by UnitedHealthcare or the applicable exchange (FFM or SBM).

Compensation Structure

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

Commission Payment Schedule

- New Business – processed twice weekly, Per Member Per Month, upon effectuation (i.e. the member has made their binder payment or first month premium payment).
- Renewals - paid monthly, Per Member Per Month, the fourth weekend of the month.

Direct Deposit

You may follow the instructions below to request direct deposit.

- Access Jarvis
- Under “Knowledge Center” tab, access “Account Info”.
- Under “Profile”, access “Edit Direct Deposit Info”.
- Enter the direct deposit information.
- An email confirmation is sent to the email address on file.
- The updated direct deposit change is effective immediately for the next commission cycle.
- For any issues, email the Producer Help Desk (PHD) at acabrokersupport@uhc.com.

Commission Sharing

Commission payments may not be shared within a hierarchy. For example, an FMO may not share or split its commission payments with a GA or agent/broker in its hierarchy. For each enrollment, an entity/agent within a hierarchy is entitled only to the appropriate amount listed on the UnitedHealthcare commission schedule.

Tax Information

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

Section 5: Compensation

Assignment of Commission

- Agent Assignment to an Individual or Entity
  - The assignee, an individual or an entity represented by a principal, must be actively contracted.
  - The assignor and the assignee must belong to the same line of business. For example, an IFP Writing ID (WID) cannot assign to a Medicare & Retirement WID or an IFP agent cannot assign to an agent only selling Medicare products.
  - The assignor and the assignee must belong to the same IFP channel. For example, an eAlliance agent cannot assign commissions to a direct or FMO/GA agent and a direct or FMO/GA agent cannot assign to an eAlliance agent.
  - Assignment to an estate, widow(er), or heir: under the Agent Agreement, death of the agent is an automatic termination. UnitedHealthcare shall cease paying compensation to the agent and no further payment shall be due.
  - Assignment of commissions can only occur to one individual or entity at 100%.

Assignment of Commission Process

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

Termination of Authorization to Assign Commissions

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

- Termination of the assignee.
- Termination for cause or death of the assignor.
- Assignor's failure to maintain appropriate 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.

Held Commission Process

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

Agent of Record (AOR)

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

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

AOR Change or Removal

- Federal Marketplace Exchange Members
  Members must log into the federal exchange to request an AOR change or removal.
- State-Based Marketplace Exchange Members
  - Members may call the plan's customer service or;
  - Log in to the State specific Member Portal to request an AOR change or removal.
- Off Exchange Enrolled Members
  Members must call UnitedHealthcare Customer Service to request an AOR change or removal.

Commission Payments

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

Reporting and Communication Process

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

Review and Resolution Process

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

- Appeals Process: The communication outlines a clear appeal process that you may use if you feel a transaction has been held inappropriately.
  - You have 30 days from receipt of the communication to submit an appeal to the PHD at acabrokersupport@uhc.com.
  - The Agent Lifecycle Management (ALM) and/or Commissions team reviews the appeal and approves or denies it.
  - For appeals that specifically relate to agent licensing, information available through the Department of Insurance or National Insurance Producer Registry (NIPR) will be used to validate licensing claims.
- Analyst Review
  - Appeals are forwarded to an ALM analyst for review. Results of analyst review, on a per application basis, will fall into one of three categories:
    - System(s) will be updated to reflect the necessary change(s) for you and the commission will be paid systematically.
    - Commission payment remains ineligible due to reason(s) stated.
    - Appeal could not be evaluated based on currently approved rules (i.e. guidelines or published rules do not exist for the scenario under evaluation).

- The transaction record and the Producer Contact Log (PCL) will be updated to reflect the final decision.
  - Approved appeals: System records are corrected and payment will be systematically processed during the next commission cycle.
  - Denied appeals: The transaction record will be updated to reflect a "forfeit" status indicating no further appeal is available.
- The appeals process can take up to 14 business days, and you are contacted via email, phone, or letter with the final decision on the appeal.

Plan Changes

Plan changes within the IFP product, result in a new effective date with new commissions processed for the plan change effective date.

Commission Payment Audit/Appeal

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

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

Debt Repayment Process

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

- When an audit process reveals an overpayment, the impacted agent is charged back accordingly. Charge backs may be applied against future payments to you or may be recovered by any other means allowed by law.
- To minimize the impact of large charge backs, you may request a debt repayment plan by submitting an appeal to the PHD via email at acabrokersupport@uhc.com. Debt repayment options are only available for charge backs in situations where large debt is created due to

audits of commission payments. Debt repayment options are not available for charge back debt created as a result of day-to-day commissions processing. To request a debt repayment plan:

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

Garnishment

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

Employee Incentives

Employee agents are paid an incentive on a commissionable enrollment based on the terms of their Sales Incentive Plan (SIP).

Incentive Eligibility Requirements

- To be eligible for an incentive:
  - You must meet all requirements set forth within your Sales Incentive Plan (SIP) in effect at the time.
  - You must be a participant in a SIP and satisfy any signature requirements. Note: incentive payments may be held until signature requirements have been met.
  - You must be appropriately credentialed (i.e. licensed, appointed (as required by the state) in the consumer's resident state, and completed testing required by UnitedHealthcare and/or Federally-Facilitated Marketplace (FFM)/State Based Marketplace (SBM) Exchange) at the time of sale.
  - Inter-Segment Telesales agents must meet all requirements set forth within their agreement with their Inter-Segment Telesales organization.
- For an enrollment application to be eligible:
  - It must have been written by an active agent, who at the time of sale was appropriately credentialed.
  - The enrollment must be effectuated (e.g., the premium has been paid by the enrollee).
  - The company must receive revenue for the enrollment from the applicable entity (e.g., member premium).
  - The consumer must be enrolling in a product covered by this policy.
  - The member must be actively enrolled in the plan on the fourth month effective date following the original effective date (e.g., if the original effective date is 1/1, the member must be actively enrolled on 4/1), unless an exception applies.

Incentive Payment Calculation

Incentive payments are calculated monthly, and, if earned, are processed for payment in the employee's last paycheck of the month. Payments are withheld if you did not meet eligibility

requirements at the time the enrollment application was written. Enrollments eligible for incentive payment may vary by plan year and sales role. You should refer to your SIP for eligibility specifics.

UnitedHealthcare Government Programs Employee Agent (Field)

- The enrollment application is validated for eligibility.
- You are validated for eligibility. If you do not pass credential validation, the enrollment is not incentive-eligible.
- If the enrollment application and you are eligible, incentive payment is calculated based on information reported in DART.
- The Sales Employee Incentive Compensation team will make available to you and your sales director/supervisor a monthly enrollment data report.
    - You and your sales leader are responsible for reviewing your enrollment data report each month on a timely basis.
    - If you find a discrepancy, you must submit an adjustment request using the Agent Enrollment Tracker (AET) tool. Sales leaders must submit an adjustment request to GP_employeeincentive@uhc.com. Adjustment requests submitted after the deadline will be processed during the next incentive payment cycle.
    - The adjustment request is reviewed by the Sales Employee Incentive Compensation team and the requestor is notified of the request's approval or denial (with explanation).

Inter-Segment Telesales Organization (UHOne)

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

Chargeback Calculation

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

- Amounts are deducted from your incentive payment for previously paid advances on sales that are not earned.
- Chargebacks due to rapid disenrollment are calculated and processed as they occur against available incentive payments the month it is determined and on a go-forward basis until it is recouped. For example, if in February it is determined that a member with a January 1 effective date voluntarily disenrolled in January, the chargeback is calculated and taken in February.

Section 6: Compliance

Compliance and Expectations

Complaints

Compliance and Expectations

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

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

Complaints

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

Sources of Complaints

Complaints and allegations of misconduct can originate from both internal and external sources. All complaints against agents must be forwarded to the Agent Issue Management (AIM) team via the agent complaint tracking tool within five business days of initial receipt.

Sources of Complaints and Allegations of Misconduct:

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

Initial Review and Pre-Disposition

Review Process

The AIM team will complete the entry of each complaint as needed into the agent 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 and the case documented accordingly if any of the following conditions exist:
    - No UnitedHealthcare sales agent is involved in the complaint
    - The product identified in the complaint is not a UnitedHealthcare product
    - The issue in question is not a violation of UnitedHealthcare policies, CMS guidelines, or federal or state rules or laws
    - The basis for the complaint is due to an internal business operational issue and submitted through the agent complaint tracking tool

- If the complaint is in scope of the agent complaint process, it moves to the pre-disposition stage

Pre-Disposition

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

Complaint Education Contact Process

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

- The AIM team uses the applicable Referral Criteria Grid to determine appropriate outreach.
- For active agents, the AIM team creates a Coaching Request (CR) in PCL and assigns it to the appropriate Agent Coaching & Policy Specialist (ACPS) or UnitedHealthcare agent manager/supervisor.
- For inactive agents, a CR is not created. The AIM team updates the complaint status in the agent complaint tracking tool and notifies ALM to put a Review Before Contracting (RBC) flag on the agent, which serves as an alert in the event the agent attempts to re-contract. When an agent re-contracts and becomes active, any outstanding coaching must be completed prior to conducting any marketing/selling activities.

Agent Complaint Investigation Process

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

Initial Review and Assignment of Case

Upon receipt of a complaint referral from the AIM team, the CIU makes a preliminary assessment of the case and assigns the case to an investigator who initiates an investigation as quickly as possible.

Investigation

The investigation process consists of obtaining information, documenting findings, and determining allegation outcomes.

Obtaining Information and Documenting Findings

- Generally, a Request for Agent Response (RAR) is prepared and sent directly to you and to your up-line or UnitedHealthcare sales leadership. The RAR requests that you provide specific detailed responses to each allegation as well as other pertinent questions, facts, and circumstances. You must submit your own RAR statements with an Agent Attestation of Signature. A written response to the RAR is required within five business days. If a response is not received by the date requested, you, along with your up-line UnitedHealthcare sales leadership, is sent a Non-Response Letter (NRL) stating that a response must be received within two business days. If no response is received within the prescribed timeframe, an administrative termination is initiated.
- Members or their authorized representatives may be interviewed during an investigation to gather required details regarding the complaint or to confirm identity of the agent and/or other pertinent facts. All contact with members is made in accordance with CMS guidance.
- The investigator may also conduct a telephone interview of the agent. These interviews may occur prior to or as a follow-up to the RAR or NRL when the investigator needs more information or clarification of details.
- Interviews of other witnesses relevant to the investigation are also conducted as determined appropriate.
- System research is conducted to obtain information regarding claims, customer service notes, lead generation, and other details as determined in reviewing the case (CIU investigator, CIU management) to assist investigators resolve allegation outcomes.

Allegation Outcomes

A complaint may contain one or more separate allegations as determined by the investigation. Each allegation is investigated and an outcome determined on its own merits. Therefore, different allegation outcomes may result from one complaint. Following the review of an allegation, investigation, and consideration of the findings, one of the following allegation outcomes is assigned:

- Substantiated: Based on the evidence and facts that existed at the time the investigation was conducted and applicable state regulations, CMS Medicare Communications and Marketing Guidelines (MCMGs), 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 MCMGs, 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 neither substantiated nor unsubstantiated.
- Insufficient Information: The complaint lacked the minimum amount of information necessary to determine the identity of the agent, member, or other information necessary to conduct a complex investigation.
- No Allegation: The complaint is determined not to have been a complaint against the agent for sales or marketing misconduct in accordance with MCMGs and company policy.
- Non-Response: You failed to respond within the required timeframes to the RAR and NRL.

Refer for Disposition
Upon completion of the investigation, the Investigative Report, Investigative Findings, and Allegation Outcomes are generally documented in the agent complaint tracking tool. The case is updated as 'Refer for Disposition' in the tracking tool and is referred back to the AIM team. Supporting documentation, including exhibits, are provided to the AIM team within the tracking tool. Effective 05/05/2021, the CIU may refer for disposition, cases that no longer meet the requirement for CIU investigation back to the AIM team.

Assignment of Final Disposition
The AIM team considers each allegation outcome to determine the final disposition. The following final dispositions are available:

No Action Required
The following situations result in no required action and the case is closed in the agent complaint tracking tool:

- The allegation outcome is Insufficient Information, No Allegation, or Unsubstantiated. If the investigation results in unsubstantiated outcomes for all allegations, the Agent Closure Letter is emailed to you, thanking them for their cooperation and notifying them of the investigative results.
- The allegation outcome is Inconclusive or Substantiated, you had received outreach for the same allegation or the same allegation family within the past twelve months, and the event/enrollment application for the current allegation took place before the outreach occurred.

Referral to the Corrective Action Referral Process
For allegation outcomes of Inconclusive or Substantiated, the AIM team uses the CEC-CEC 2-CAR-DAC Referral Criteria Grid to determine if a referral to the Corrective Action Referral (CAR) process is appropriate. The following situations result in a CAR process referral:

- You **have not** had outreach for the same allegation(s) within the past twelve months and the CEC-CEC 2-CAR-DAC Referral Criteria Grid recommends referral to the CAR process.
- You **have** exhausted all CEC/CEC2 opportunities for the same allegation family (-ies) within the past twelve months and the event/enrollment application for the current allegation took place after those previous CEC/CEC 2 outreaches occurred.

Referral to the Disciplinary Action Committee
For allegation outcomes of Inconclusive or Substantiated, the AIM team will use the CEC-CEC 2-CAR-DAC Referral Criteria Grid to determine if a referral to the Disciplinary Action Committee (DAC) is appropriate. The following situations result in a DAC referral:

- You **have not** had outreach for the same allegation(s) in the past twelve-months and the CEC-CEC 2-CAR-DAC Referral Criteria Grid recommends referral to the DAC.
- You **have** had outreach for a non-CEC eligible allegation (i.e. high-risk) through either the CAR or DAC process within the past twelve months and the event/enrollment application for the current allegation took place after that previous CAR or DAC outreach occurred.
- You **have** repeated instances of lower severity complaints.
- Your behavior posed a continuing risk to company reputation or harm to members.

- You **have** been terminated for cause from another UnitedHealth Group line of business (e.g., Employer and Individual (E&I)).

Corrective Action Referral Process

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

- For active agents, the AIM team creates a Coaching Request (CR) in PCL and assigns it to the appropriate Agent Coaching & Policy Specialist (ACPS) or UnitedHealthcare agent manager/supervisor.
- For inactive agents, a CR is not created. The AIM team updates the complaint status in the agent complaint tracking tool and notifies ALM to put a RBC flag on the agent, which serves as an alert in the event the agent attempts to re-contract. When an agent re-contracts and becomes active, any outstanding coaching must be completed prior to conducting any marketing/selling activities.

Disciplinary Action Committee

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

Committee Membership and Mechanics

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

DAC Proceedings

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

DAC Outcomes

The following outcomes are available to the DAC:

- No Action Required

    - The DAC determines the agent does not require additional training to address the issue presented.
- Corrective Action
    - The DAC recommends appropriate corrective action tailored to address the complaint or issue of noncompliance and timelines for completion. In such cases, the AIM team opens a Coaching Request in PCL, in addition to drafting and sending a formal corrective action letter that is sent to the agent and the agent's manager/supervisor notifying the appropriate manager to facilitate appropriate outreach and training to the agent or the agency if the issue is best addressed at the agency level.
- Deauthorization of Sales and Marketing Activity
    - The DAC deauthorizes the agent from performing sales and marketing activity of a particular product until assigned corrective action is completed. The DAC chairperson is responsible for notifying the agent's manager of the deauthorization and required training. The agent's manager is responsible for monitoring the completion of the assigned training.
- Termination
    - The DAC terminates an agent or recommends the termination of an employee agent. In addition to the decision to terminate the agent, the DAC must determine if the termination is for-cause or not-for-cause. ALM is notified to flag the agent RBC. (Refer to the Agent Termination Process section for termination process details.)

Complaint point System

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

Section 7: Termination

Suspension of Marketing/Sales Activities

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

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

Revocation of Authority to Market or Sell UnitedHealthcare IFP Products

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

Revocation of Authority Process

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

Revocation of Authority Appeal Process

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

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

Disciplinary Action Termination

Refer to the Complaints section for termination determinations made by the DAC.

Administrative Termination – Contracted and Appointed Non-Employee Individual
Administrative terminations are disciplinary, not-for-cause terminations initiated by the (AIM) team in certain circumstances including:

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

- **Administrative Termination – Agent Coaching and Policy Specialist (ACPS)**
  If you fail to complete required training/coaching resulting from a Complaint Education Contact (CEC/CEC2), Corrective Action Referral (CAR), or DAC referral or any required compliance monitoring program coaching. (Refer to the Complaint section for details.)
  - The AIM team sends you a notification of termination letter detailing the reason for termination, the termination effective date, and the appeal process via email, with a read receipt, to your email address in ICM. A copy of the notification is sent your up-line or UnitedHealthcare sales leader and to ALM.
  - ALM will process the termination 30 days from the termination notification letter and add a RBC flag to your file.
    - If within 30 days from the date of the letter, your UnitedHealthcare manager or ACPS provides notice that you have completed all coaching or corrective action requirements, your UnitedHealthcare manager or ACPS will alert the AIM team and a retraction to the notification of termination letter will be sent via email with a read receipt. A copy is sent to your up-line or UnitedHealthcare manager/supervisor and to ALM.
    - If the termination becomes effective, the individual may request a reconsideration of an administrative termination. (See the Request for Reconsideration section.)

Discretionary Termination Without Cause

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

Termination Process

Terminations

All terminations must be classified for-cause or not-for-cause. If an individual's IFP contract is terminated, UnitedHealthcare will review the individual's contract in other UnitedHealthcare products (e.g., Medicare Advantage (MA) plan, Prescription Drug Plan (PDP), or Medicare Supplement Insurance plan) to determine if a contract termination is necessary for those products and vice versa.

For-Cause

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

Not-for-Cause

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

- **Non-Employee Individual**
  - For-Cause Termination Process
    - A for-cause termination letter, detailing the reason for termination, the termination effective date, and the appeal process, is sent to you via email, with a read receipt, to your email address in ICM. A copy of the letter is sent to your up-line or UnitedHealthcare sales leader and is uploaded to your file.
    - ALM is notified of the termination request by the AIM team via a database referral to PCL.
    - ALM processes the for-cause state appointment termination with the same termination date as indicated in the individual's termination notification letter.
    - If you have down-line agents, the entire down-line is reassigned to the next hierarchy as of your termination effective date. Any solicitors in the down-line are terminated as of the terminated individual's termination effective date.
    - You are flagged RBC in the contracting system.
    - If you are terminated for disciplinary or administrative termination, you may request a reconsideration of a termination. (See the Request for Reconsideration section.)
  - Not-for-Cause Termination Process
    - When UnitedHealthcare initiates a not-for-cause termination, a not-for-cause termination letter, detailing the reason for termination, the termination effective

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

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

- **Employee**
  When your appointment is terminated, it may necessitate a termination of your employment as well. Therefore, when the termination of your appointment is under consideration, the following steps must be followed:
  - If the DAC makes a recommendation to terminate your appointment, your UnitedHealthcare management will confer with Human Capital to discuss the next steps when a recommendation to terminate your appointment necessitates the need to terminate employment.
  - You will be sent a written notification of employment termination if requested by you through HRDirect, unless required by state law, in which case your notification is automatic. It is the responsibility of your UnitedHealthcare management to notify ALM of your termination. You will be flagged RBC in the contracting system.
  - A written notification of appointment termination will be sent to you when the appointment is terminated for-cause.

- ALM processes the employee not-for-cause or for-cause appointment termination and appropriate state Department(s) of Insurance notification. (See the State and CMS Notification Process section.)
- UnitedHealthcare reserves the right to suspend you from marketing and sales activities until the termination becomes effective.
- You may request a reconsideration of termination. (See the Request for Reconsideration section.)

State and CMS Notification Process

UnitedHealthcare will comply with all regulatory requirements regarding state and CMS notification of appointment termination of individuals. Contact your up-line or UnitedHealthcare Sales Leader for details.

Request for Reconsideration – Employee Individual

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

Request for Reconsideration – Non-Employee Individual

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

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

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

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

DAC For-Cause Termination

- A minimum waiting period of 36 months from your termination effective date is required before your re-contract request is considered.

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

DAC Not-for-Cause Termination

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

Administrative Termination – CIU

- A minimum waiting period of 12 months from your termination effective date is required.

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

Administrative Termination – ACPS

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

Section 8: Glossary of Terms

Glossary of Terms

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

Term	Definition
A	
Agent Issue Management (AIM) Team	The team that manages the intake, review, and disposition of agent related complaints.
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 within 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.
Agent	A global term to refer to any licensed, appointed (as required by the state), and certified individual soliciting and selling UnitedHealthcare products, including, but not limited to, NMA, FMO, MGA, GA, ICA, IMO, ISR, IFP Broker, Solicitor, or Telesales agent. See also Solicitor and Producer.
Agent ID	*See Writing Number.*
Agent Manager	A UnitedHealthcare employee responsible for the relationship between a field 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 Lifecycle Management	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 federal or state regulations, Company policy, or engaged in other inappropriate sales activities.
Americas Health Insurance Plans (AHIP)	A national trade association whose agents sell health insurance coverage and provide health-related services.
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.
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 Personal/Individual Marketing Appointment*
B	
Background Investigation	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. Also known as background check.
Book of Business	The collection of leads, contacts, and/or members assigned to a particular agent.
Brand	A name that identifies and distinguishes a product and Company and any associated logos, service marks, images, etc. Brand elements are defined for each of the UnitedHealthcare brands, via a set of brand guidelines that address logos, legal marks and requirements, brand colors, typography, layout requirements and other topics in detail. Complete graphics usage guidelines may also be included.
C	
Call Monitoring	A quality assurance function used to evaluate inbound and outbound calls either side-by-side or remotely for the purposes 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 product or products.

Section 8: Glossary of Terms

Certified/Certification	The process required by that all agents selling UnitedHealthcare products are annually trained and tested on 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 Services (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 Agent Coaching & Policy Specialist (ACPS) and an agent/agency. *See also Service Request*.
Cognitive Impairment/ Cognitive Ability	The consumer's capacity to understand, assemble and reason based on the information provided including a decline in memory and thinking skills.
Commission	*Refer to Compensation*.
Compensation	CMS defines compensation as monetary or non-monetary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commissions, bonuses, gifts, prizes, awards, and referral/finder's fees. Compensation does not include the payment of fees to comply with state appointment laws; costs related to training, certification, and testing requirements; reimbursement for mileage to and from appointments with consumers; and reimbursement for actual costs associated with sales appointments such as venue rent, snacks, and materials.
Compensation Recovery (Charge-backs)	Compensation Recovery (Charge Backs) Plan sponsors must recover compensation payments from agents under two circumstances: 1. The member disenrolls from the plan within the first three months of enrollment (rapid disenrollment), and Any other time a member is not enrolled in a plan but the plan sponsor had been paid compensation for that time period.
Complaint	A grievance received from a consumer or member, or any person or organization acting on a consumer or member's behalf, including written grievances from any Department of Insurance or other regulatory or governmental agency.
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 products. Complaints referred to the CIU are severe allegations of misconduct or repeated complaints of lower severity.

Section 8: Glossary of Terms

Conflict of Interest	A situation in which an individual's personal, financial, social, or political interests or activities, or those of their immediate family, could affect or appear to affect their decision making on behalf of UnitedHealthcare or where their objectivity could be questioned because of these interests or activities.
Consumer	The customer, lead, or prospect for all products who is not currently enrolled in particular a UnitedHealthcare plan.
Corrective Action Plan (CAP)	When it is determined that an organization or business area is not complying with 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 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.
Credentialing	Process of contracting, appointment, certification, and approval for an agent to sell any UnitedHealthcare products.
D	
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 the Company's products.
Down-Line	A term used to describe agents within an NMA hierarchy that are below the management/reporting level of a specific entity/agency.
E	
Enrollment Application	Refers to the form used by consumers to request to enroll in a UnitedHealthcare product.
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.
F	
Finder's Fee	*See Referral/Finder's Fee.*
For-Cause Termination	A termination of an agent's contract and/or appointment that is the result of specified misconduct that violates the agreement.
G	
Geographic Area	A specific region, state, county, or zip code.
H	
Hierarchy	The structure of an NMA down-line that is defined as part of the NMA agent contracting process.

HIPAA	Health Insurance Portability and Accountability Act (HIPAA) 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: *CONFIDENTIALITY NOTICE: Information accompanying this facsimile is considered to be UnitedHealthcare's confidential and/or proprietary business information. Consequently, this information may be used only by the person or entity to which it is addressed. Such recipient shall be liable for using and protecting UnitedHealthcare's information from further disclosure or misuse, consistent with applicable contract and/or law. The information you have received may contain protected health information (PHI) and must be handled according to applicable state and federal laws, including, but not limited to HIPAA. Individuals who misuse such information may be subject to both civil and criminal penalties. If you believe you received this information in error, please contact the sender immediately.*
I	
Incentive	*Refer to Compensation: ISR, sales management, Telesales.*
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).
In-Home Appointment	A personal/individual marketing appointment that takes place in a consumer's residence. Includes a nursing home/facility resident's room.
J	
Jarvis	The agent website that provides access to product, commission, and resource information. The agent's central point of communication and sales distribution resources.
K	
L	
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 MIRA.
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,

Section 8: Glossary of Terms

	product, and/or brand.
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 enrollees in an organization, explains how services are covered under an organization (including conditions that apply to such coverage), and/or communicates with the individual on the various membership operational policies, rules, and procedures.
Member	The enrollee or customer who is currently enrolled in a UnitedHealthcare plan.
N	
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.
National Insurance Producer Registry (NIPR)	NIPR developed and implemented the Producer Database (PDB), which provides: financial/time savings, reduction in paperwork, real time information, verification of license and status in all participating states, ease of access via the internet, and single source of data versus multiple web sites.
Non-Complaint	A member's withdrawal or nullification (verbal or in writing) of an allegation against an agent or broker. Also includes circumstances where, upon review, a complaint fails to state an allegation of agent or broker misconduct.
Non-Resident License	An agent who is licensed and appointed (as required by the state) to sell in a state outside of the state where that agent holds their primary residency.
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.
P	
Party ID	A number assigned by ALM 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.
Personally Identifiable Information (PII)	PII is a person's first name or first initial and last name in combination with one or more of the following: • Social Security Number

	• Driver's License Number or State Identification Card Number • Credit card number or debit card number • Unique biometric data (e.g., fingerprint, retina, or iris image) • Tax information • Account Number in combination with any required security code, access code or password that would permit access to an individual's financial account.
Personal/Individual Marketing Appointment	A scheduled face-to-face marketing presentation that typically occurs in a consumer's residence, but may also be conducted in a coffee shop, library, or other public setting. Includes a nursing home/facility resident's room.
Premium	The amount paid by a member to participate in a plan or program. Includes LEP, LIS reductions, Employer Subsidy reductions, and rider premiums.
Producer	A global term introduced in 2007 to refer to any licensed, certified, and appointed individual soliciting and selling UnitedHealthcare Products, including, but not limited to NMA, FMO, MGA, GA, ICA, ISR, IFP, 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 Agent Coaching & Policy Specialist (ACPS).
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)	PHI is individually identifiable information (including demographics) that relates to health condition, the provision of care, or payment of such care.
Q	
Quality Call Monitoring	A monitoring program evaluating telephonic enrollment conversations between a Telesales agent and the consumer to ensure compliance with CMS guidelines.
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.
Ready to Sell	An agent has met the certification requirements for their channel in order to market/sell for the plan year.
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/broker directly.
Resident License	An agent who is licensed and appointed (as required by the state) to sell in their state of residence.

Section 8: Glossary of Terms

S	
Sales Distribution	An organization comprised of various distribution channels that market and sell UnitedHealthcare portfolio of products.
Sales Incentive Plan	Employed agents are paid an incentive when specific sales goals have been met. In order to be paid an incentive, the agent must meet all conditions set forth within their Sales Incentive Plan (SIP) in effect at the time. Employed agents should refer to their SIP for details.
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 who is responsible for the management of a sales agent, agency, channel, or geography.
Service Request	The documentation in PCL of all inbound and outbound contacts between the PHD and an agent. *See also Coaching Request*.
SMRT Agent Onboarding	A tool that resides on the QlikView portal that provides licensing, appointment, and certification status information on agents and sales management.
SMRT Compliance	A tool that resides on the QlikView portal that provides a holistic view of each agent, NMA, or manager. The compliance programs reporting tool is refreshed daily and manager threshold evaluation data is refreshed monthly
Solicitor	A licensed, certified, and appointed agent who sells designated UnitedHealthcare products through a contract with an agency (NMA, FMO, MGA and GA), but does not have a direct contract with UnitedHealth Group.
Substantiated Allegation	Following review of the allegations against an agent, appropriate investigation, consideration of the evidence and pertinent circumstances, there is sufficient information to conclude that the allegations are true.
Successor Agent	The active agent who becomes the Agent of Record (AOR) for the original agent's book of business.
Suspension	Temporary removal of an agent's ability to market and sell products. Suspension 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	
Telemarketing	A firm or individual employed by a firm who telephonically contacts consumers on behalf of UnitedHealthcare for the purpose of soliciting or selling designated UnitedHealthcare 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 designated UnitedHealthcare products in a call center environment. May be an employee of UnitedHealthcare or an employee of a delegated vendor.

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.
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	
UnitedHealthcare Government Programs	A term used internally within the Company to collectively refer to the benefit businesses of UnitedHealthcare Medicare & Retirement, UnitedHealthcare Community & State, and UnitedHealthcare Military & Veterans.
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.
Up-Line	The contracted entities within an NMA 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 UnitedHealth Group under mutual agreement.
W	
Writing Number	A UnitedHealthcare generated number, assigned to a contracted, licensed, and appointed agent used for submitting business, to track commissions, and other agent-specific sales statistics. *Also known as Writing ID. See Agent ID.*

Index