2026 Certification Study Guide - June 2025

UnitedHealthcare®

This study guide covers the topics that the Centers for Medicare & Medicaid Services (CMS) requires agents to be trained on annually. Read through the applicable section(s) in preparation for taking the corresponding assessment(s). Beyond certifications, use this study guide, along with the Agent Guide and other resources, to keep your knowledge current on the information you need to compliantly market and enroll consumers in 2026 UnitedHealthcare Medicare plans.

To begin, click the Open Study Guide button above or select a menu item below. After you open the study guide, you can use the menu to find a topic or **search for a topic** by clicking on the magnifying glass in the upper left corner of the menu above the title.

MEDICARE BASICS

- **Medicare defined**
- **Medicare Advantage (MA) Plans**
- **Prescription Drug Coverage**
- **Drug payment stages**

- Medicare Supplement Plans
- Other coverage options

ETHICS AND COMPLIANCE

- Introduction to ethics and compliance
- Educational events, marketing events and event activities
- Third party marketing organizations
- Marketing materials
- Appropriate contact
- Enrollment basics and plan changes for MA and PDP
- Enrollment details
- Disenrollment basics
- Compliance program
- Fraud, Waste and/or Abuse (FWA)
- Privacy and security
- Compliant sales practices summary

AARP

- Overview of AARP

- Essentials
- Relationship

EVENTS BASICS

- Types of events
- Venue selection
- Event reporting
- Conducting an educational event
- Marketing/sales events
- Marketing/sales events: presenting
- Giveaways
- Provider-based activities at events
- Event observation and oversight

SPECIAL NEEDS PLANS (SNP)

- Special Needs Plans (SNP)
- Dual Eligible and Chronic Condition SNPs
- Medicaid overview
- D-SNP overview

- D-SNP state specific agent requirements
- C-SNP overview
- I-SNP
- IE-SNP

2026 MASSACHUSETTS UNITEDHEALTHCARE SENIOR CARE OPTIONS

- UHC SCO
- PACE
- SCO model
- Enrollment

RESOURCES

- Helpful Resources

Medicare defined

What is Medicare?

Medicare, a federal health insurance program administered by the Centers for Medicare & Medicaid Services (CMS), provides coverage for consumers who:

- Are age 65 and older
- Are under 65 with certain disabilities
- Have End-Stage Renal Disease (ESRD/permanent kidney failure requiring dialysis or a kidney transplant) and meet other eligibility criteria
- Have Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's disease) and receiving Social Security Disability Insurance (SSDI) for ALS

Consumers who meet eligibility requirements are generally automatically enrolled in the Medicare program by the Social Security Administration (SSA) or the Railroad Retirement Board (RRB) when they are entitled to these benefits. Consumers who are not yet entitled to SSA or RRB benefits should contact their local SSA office to enroll in Medicare.

Click each tab to learn about the parts of Medicare. Additional details for Medicare Advantage and Prescription Drug Plans are also provided in the upcoming chapters.

ORIGINAL MEDICARE	PART A: HOSPITAL INSURANCE	PART B: MEDICAL INSURANCE	PART C: MEDICARE ADVANTAGE (MA)	PRI DRU

Medicare consists of 4 parts: A, B, C, and D. Parts A and B together are a federal health insurance program referred to as Original Medicare. All parts of Medicare have cost-sharing (such as deductibles, copayments or coinsurance) and specific eligibility qualifications.

What Original Medicare covers
Review the Part A and Part B tabs to learn what is covered by Original Medicare.

What Original Medicare does not cover
Original Medicare does not cover everything and does not offer an out-of-pocket maximum on costs for covered Part A and B services during the plan year. Below are some things not covered by Original Medicare.

- Prescription drugs
- Routine dental care – dental exams, cleanings and X-rays
- Routine eye exams, eyeglasses or contacts
- Hearing aids, related exams or services
- Most care while traveling outside the United States
- Custodial care – help with bathing, dressing, eating, etc.
- Comfort items such as a hospital phone, TV or private room
- Long-term care
- Cosmetic surgery
- Most chiropractic services
- Most acupuncture or other alternative treatments
- Routine foot care

Part A

- Helps with the cost of inpatient hospital stays and skilled nursing home costs
- Includes hospice care
- Provides limited home health benefits

Eligibility

- Individuals age 65 or older, who are citizens or permanent residents of the United States, are eligible for Medicare Part A at no cost if they or their spouse (living, deceased or divorced):
    - Are eligible for Social Security or Railroad Retirement Board benefits; OR
    - Worked long enough in a government job through which they paid Medicare taxes.
- Individuals under age 65 are eligible for Medicare Part A at no cost if they:
    - Are entitled to Social Security disability benefits or RRB disability pension and meet certain conditions for 24 months; OR
    - Have End Stage Renal Disease (ESRD) and meet other eligibility criteria; OR
    - Have Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's disease) and receiving Social Security Disability Insurance (SSDI) for ALS.

Enrollment

- Most individuals who qualify and already receive Social Security benefits are automatically enrolled in Part A. Otherwise, they can enroll at their local SSA office.
- Individuals who do not meet eligibility requirements may be able to purchase Medicare Part A during designated enrollment periods by paying a monthly premium.

Costs

- The Medicare beneficiary pays a Part A deductible before Medicare begins paying a share of the cost.
- After meeting the deductible, most cost-sharing is in the form of copayments.

Part B

Helps with the cost of medically necessary doctor visits and other medical services including:

- Outpatient care at hospitals and clinics
- Lab services
- Some diagnostic screenings
- Some skilled nursing care

Eligibility

- Individuals are eligible for Medicare Part B at age 65 if they:
  - Already receive retirement benefits from the SSA or the RRB; OR
  - Are eligible to receive Social Security or RRB benefits, but have not yet filed for them; OR
  - Had Medicare-covered government employment or their spouse did.
- Individuals under 65 are eligible for Medicare Part B if they:
  - Have received Social Security or RRB disability benefits for 24 months; OR
  - Have ESRD and meet other eligibility criteria; OR
  - Have ALS/Lou Gehrig's disease.
- In most cases, individuals 65 and older who do not qualify for Part A and purchase it must also enroll in Medicare Part B and pay monthly premiums for both.

Enrollment

- Most individuals who qualify and are already getting Social Security or RRB benefits are automatically enrolled in Part B.
- Individuals who are not receiving SSA or RRB benefits (e.g., they are still working) or they have ESRD must sign up for Part B with the SSA during a valid enrollment period.

Costs

- Medicare beneficiaries enrolled in Part B are assessed a monthly premium*, which is deducted from their Social Security or Railroad Retirement check. If the Medicare beneficiary does not receive any of the above payments, Medicare will mail them a bill for their Part B premium every 3 months.
- Most Medicare beneficiaries pay a Part B premium based on their yearly income. Before Medicare starts paying a share of the Part B costs, the Medicare beneficiary must first pay a deductible. After meeting the deductible for the year, the Medicare beneficiary typically pays 20% of the Medicare-approved amount.

** Some Medicare Advantage plans may offer a reduction or rebate in Part B premium.*

Part C

Medicare Advantage Plans (MA) are offered by private insurance companies like UnitedHealthcare. These MA plans are approved and contracted by the federal government, and the insurance companies must follow the rules and regulations set by CMS. Medicare pays a fixed amount for care every month to the insurance company offering the MA Plan. MA Plans:

- Must provide the same coverage as Original Medicare though many offer additional benefits such as Part D prescription drug coverage, routine dental coverage, hearing coverage, and

more.

- Are not Medicare Supplement Insurance Plans and MA Plan cost-sharing cannot be covered by a Medicare Supplement Insurance Plan.
- Do not manage hospice care, which is still administered under Medicare Part A.

Eligibility and enrollment

- To enroll in an MA Plan, consumers must be entitled* to Part A, enrolled in Part B, and live in the plan's service area. *(*There may be a few consumers who are not entitled to premium-free Part A and would have to purchase Part A.)*
- Enrollment is not denied based on pre-existing conditions; however, consumers must meet specific enrollment criteria if they want to enroll in a Special Needs Plan (SNP). SNPs are Medicare Advantage plans designed for specific Medicare consumer populations to provide focused and specialized cared.
- A valid election period is required to enroll in or disenroll from an MA Plan

Costs

- Plan structure and costs can vary widely by plan.
- Cost-sharing for some MA Plan benefits is in the form of a copayment – a set dollar amount, which provides the member with predictability when it comes to paying their share of the cost of covered services.
- Each MA Plan has an annual out-of-pocket maximum for Medicare-covered benefits, which must not exceed the limit set by CMS (see below for more information).
- The MA Plan may charge members a monthly plan premium in addition to the Part B premium members must continue to pay.

Out-of-Pocket (OOP) maximum

- All MA Plans have an OOP maximum that limits the total amount the member will spend on Medicare-covered Part A and B benefits during the plan year. Once the OOP maximum is met, the member will not pay cost-sharing for covered benefits for the remainder of the plan year.
- OOP maximums can vary by plan, but must not exceed the limit set annually by CMS.
- Cost-sharing for non-Medicare Part A and B covered benefits, such as hearing aids and prescription drugs, generally do not count toward the OOP maximum.
- The amounts paid for plan premium do not count toward the OOP maximum.

ORIGINAL MEDICARE	PART A: HOSPITAL INSURANCE	PART B: MEDICAL INSURANCE	PART C: MEDICARE ADVANTAGE (MA)	PR DRU

Part D

Medicare Part D is a government program that helps Medicare beneficiaries cover some of the cost of prescription drugs. To get Medicare prescription drug coverage, consumers must enroll individually in a plan offered by a private insurance company or other private company approved by Medicare. Benefits and costs can vary by plan and can change each year.

Eligibility

- To enroll in a standalone PDP, consumers must:
  - Be entitled to Part A and/or enrolled in Part B
  - Live in the plan's service area
- To enroll in a Medicare Advantage Prescription Drug (MAPD) plan, consumers must:
  - Be entitled to Part A and enrolled in Part B
  - Live in the plan's service area

Enrollment

- Consumers must have a valid election period to enroll in or disenroll from a standalone PDP or MAPD Plan.
- If a consumer does not sign up Medicare drug coverage when they become eligible, they may pay a late enrollment penalty if they enroll later.

Costs

- The federal government sets a standard of guidelines (costs and coverage) that must be met by private insurance companies. However, costs and the drugs covered can vary by plan depending on:
    - Member prescriptions and whether they are on your plan's list of covered drugs (formulary).
    - What "tier" the drug is in.
    - Which drug benefit phase the member is in (like whether they have met their deductible, or reached their out-of-pocket limit).
    - Which pharmacy the member uses (preferred in-network, in-network, mail order, or out of network). Member's out-of-pocket drug costs may be less at a preferred pharmacy because it has agreed with the plan to charge less.
    - Whether the member gets Extra Help paying for Medicare drug coverage costs. https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

Who is eligible for Medicare? (select all that apply)

- [ ] Age 65 and older
- [ ] Under 65 with certain disabilities
- [ ] Have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)
- [ ] Have Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's disease) and receives Social Security Disability Insurance (SSDI) for ALS

SUBMIT

Medicare Advantage (MA) Plans

Types of MA Plans

Some consumers may want a Primary Care Provider (PCP) to coordinate their care. Other consumers may want the flexibility to see specialists without needing a referral. There are different types of MA Plans and not all work the same way. Before consumers enroll, discuss the plan's rules, what the costs will be, and whether the plan will meet the consumer's needs. Here is a list of the different types of MA Plans:

- Health Maintenance Organization (HMO)
- Point-of-Service (POS)
- Preferred Provider Organization (PPO)
- Regional Preferred Provider Organization (RPPO)
- Private Fee-for-Service (PFFS)
- Special Needs Plans (SNP)*

**This module focuses on non-SNP MA Plans. To sell a Chronic Condition, Dual Eligible, and/or Institutional SNP, you must pass the associated assessment for the identified SNP product.*

Click each tab to review each of the different types of MA plans.

Health Maintenance Organization (HMO)
Point-of-Service (POS)

HMO and POS Plans are **network-based plans**. A provider network is a list of the doctors, other health care providers, and hospitals with whom a Plan has contracted to provide medical care to the Plan's members.

- In-network provider: A provider contracted with the Plan
- Out-of-network provider: A provider that is not contracted with the Plan

A Plan may require members to use only in-network providers for covered services. Providers that contract with the plan agree to accept the plan's payment and any plan cost sharing as payment in full. Some consumers may be willing to use in-network providers to limit out-of-pocket expenses.

Before enrolling a consumer, you must verify the network status of each provider the consumer currently uses or intends to use by checking the Plan's online Provider Directory. Advise the consumer to verify their provider's status prior to scheduling and seeking plan-covered services. (See the Provider Search Job Aid on Jarvis, UnitedHealthcare's agent portal.)

HMO
To receive covered services under the plan, the member generally must use in-network providers, except for emergency, urgent care, and renal dialysis services. Some plans require referrals for specialty care. HMO members select a PCP to help coordinate their care. (If a PCP is not selected on the enrollment application, the MA Plan may automatically assign a PCP to the member.) Members can change their PCP at any time for any reason.

POS (also referred to as HMO-POS)
A POS plan is an HMO plan that gives members the option to use out-of-network providers for certain benefits, generally at a higher cost. The benefits that are covered out-of-network vary by plan. Some plans may only provide out-of-network coverage for one or a few benefits (e.g., out-of-network dental care only), while others may provide out-of-network coverage for most or all of the benefits that are also covered in-network. Some plans require referrals for specialty care. POS members select a PCP to help coordinate their care. (If a PCP is not selected on the enrollment application, the MA Plan may automatically assign a PCP to the member.) Members can change their PCP at any time for any reason.

Important for POS:

- *Make sure to communicate to consumers that out-of-network providers are not required to accept the plan's terms and conditions of payment. In these cases, the member may be responsible for the full cost of out-of-network services, except in emergency services.*
- *If the service is covered and received from a qualified provider, the member can submit the claim to the Plan for reimbursements.*

Preferred Provider Organization (PPO)
Regional Preferred Provider Organization (RPPO)

PPO Plans are **network-based plans**. A provider network is a list of the doctors, other health care providers, and hospitals with whom a Plan has contracted to provide medical care to the Plan's members. In most cases, members select a PCP who can help coordinate their care with specialists and hospitals.

- In-network provider: A provider contracted with the Plan
- Out-of-network provider: A provider that is not contracted with the Plan

A PPO plan gives members flexibility to see providers outside of the plan's network nationwide for the same services that are covered in-network. Members who choose to see out-of-network providers will likely pay more out-of-pocket. ***Note:*** *In order for the coverage to apply, the out-of-network providers must accept Medicare and the PPO plan.*

Before enrolling a consumer, you must verify the network status of each provider the consumer currently uses or intends to use by checking the Plan's online Provider Directory. Advise the consumer to verify their provider's status prior to scheduling and seeking plan-covered services. (See the Provider Search Job Aid on Jarvis, UnitedHealthcare's agent portal.)

PPO (Local PPO)
A PPO plan has a contracted provider network. All benefits covered in-network are also available nationwide from out-of-network providers that accept Medicare and the plan, generally at a higher cost to the member. Members are encouraged to select a Primary Care Provider (PCP) who can help coordinate their care with specialists and hospitals. However, PPO plans do not require referrals for specialty care.

RPPO (Regional PPO)

An RPPO plan mirrors a local PPO in functionality and benefit structure. While a Local PPO plan's service area covers the particular set of counties chosen by the health plan, an RPPO plan's service area is one of 26 regions set by Medicare. A region is defined as one state or multiple states. An RPPO plan's regional service area expands provider access to members, including those who live in rural areas.

Important for PPO and RPPO:

- *Make sure to communicate to consumers that out-of-network providers are not required to accept the plan's terms and conditions of payment. In these cases, the member may be responsible for the full cost of out-of-network services, except in emergency situations.*
- *If the service is covered and received from a qualified provider, the member can submit the claim to the Plan for reimbursement.*

For more information about PPO and RPPO plans, refer to Learning Lab for more plan type overviews.

Private Fee-for-Service (PFFS)

PFFS Plans can be network-based or non-network based. Regardless of whether the PFFS Plan establishes a network of providers with signed contracts, any Medicare-eligible provider who does not have a contract with a PFFS Plan may continue to be deemed to have a contract with the plan if the deeming conditions are met. **(UnitedHealthcare does not offer network-based PFFS Plans. The focus of this section is on non-network PFFS Plans only.)**

A Primary Care Provider (PCP) does not need to be selected and there are no referral requirements for specialty care.

Note: Some consumers choose to enroll in an MA-Only plan, because they can obtain their Part D drug coverage through a separate plan. Only a Private Fee-for-Service (PFFS) MA-Only plan permits simultaneous enrollment in a standalone PDP.

What is deeming?
A key feature of a PFFS Plan is that the member can choose their health care provider both at home and when they travel within the United States. However, that provider must be a **deemed provider**. A deemed provider is one who meets all of the following:

- Is aware, before providing health care services, that the individual getting care is enrolled in a PFFS Plan
- Has reasonable access to the plan's terms and conditions of payment in advance of providing services
- Provides services that are covered by the plan

A member can seek treatment from any Medicare-eligible provider who agrees to accept the plan's terms, conditions and payment rates. Not all providers, even those that participate in Medicare, may agree to the plan's terms and conditions of payment. Providers who have agreed to see PFFS members in the past have the right to refuse to see PFFS members each time a PFFS member presents for services. Therefore, before providing services, a provider needs to know that the member has PFFS coverage in place of Original Medicare.

There are responsibilities for both the member and the provider when it comes to provider deeming. When you present a PFFS Plan to a consumer, make sure you explain to them their responsibilities once enrolled in the plan.

PFFS member responsibilities
The member must:

- Choose to use Medicare-eligible providers who agree to the PFFS Plan's terms and conditions of payment in order to receive coverage under the plan.
- Show their member ID card and tell the provider that they are a member of a PFFS Plan before each visit and before getting covered services.
- Confirm that the provider agrees to be deemed.
- Find another provider who agrees to be deemed if the current provider refuses to accept the PFFS Plan's terms and conditions of payment (except in emergencies).

PFFS provider responsibilities
A provider who gives health care services to a PFFS Plan member, except for emergency services, and does not have a signed contract or agreement with the plan is deemed to have a contract with the PFFS Plan if the following conditions are met:

- The provider is Medicare-eligible, meaning they are state licensed, have not opted out of Medicare, and have not been sanctioned by Medicare.
- The provider is aware that the patient is a PFFS member.
- The provider must have reasonable access to the plan's terms and conditions of payment. (UnitedHealthcare's PFFS Terms and Conditions are posted on UHCProvider.com.)

- As part of the UnitedHealthcare terms and conditions of payment, the provider must agree to bill the health plan directly for covered services and accept the rates as payment in full. The provider may collect only applicable plan cost-sharing amounts from members and may not otherwise charge or bill members.*

Note: CMS allows the PFFS Plan to decide if balance billing is permitted. Plans must disclose what is permitted in the terms and conditions of payment. UnitedHealthcare's PFFS plan's terms and conditions prohibit balance billing.

Dual eligible caution

UnitedHealthcare strongly discourages Dual Eligible (have both Medicare and Medicaid coverage) consumers, regardless of assistance level, from enrolling into a PFFS plan due to potential negative impacts to the consumer.

Before enrolling any consumer into a PFFS plan, ask if they are enrolled in a state Medicaid program. If they are, explain that enrolling in a PFFS plan may:

- Impact their ability to continue seeing their current providers if their providers do not agree to be deemed for the PFFS plan. (See additional information on Deeming in this course.)
- Create out-of-pocket expenses they are not currently responsible for and which they may not be able to afford. This can happen if a provider agrees to be deemed for the PFFS plan but does not accept Medicaid. In this case, the consumer may be responsible for any applicable cost-sharing under the PFFS plan.

Only enroll a dual-eligible consumer into a PFFS plan if the consumer insists on enrolling and you have disclosed the potential impacts of enrollment and explained that a PFFS plan might not be the best plan choice.

HMO & POS	PPO & RPPO	PFFS	SNP

Special Needs Plan (SNP)

Provides health care coverage for specific groups of people, such as people:

- with both Medicare and Medicaid (Dual Eligible SNP [D-SNP])
- living in a contracted skilled nursing facility (Institutional SNP [I-SNP])

- who live in the plan service area and require an institutional level of care (Institutional Equivalent SNP [IE-SNP])
- with certain qualifying chronic medical conditions (Chronic Condition SNP [C-SNP])

Enrollment details

When a member enrolls in an MA Plan, they:

- Keep their Medicare rights and protections as with Original Medicare.
- Must follow the MA Plan's coverage rules, which include:
    - Using contracted network providers if enrolled in a network-based plan. In some network-based plans, the member can get care from out-of-network providers, generally with higher cost-sharing.
    - Paying applicable plan premiums, deductibles, coinsurance, and/or copayments as their share of costs.
- Are automatically disenrolled from any other MA Plan or Prescription Drug Plan (PDP) in which they are enrolled as of the new plan's effective date. An exception exists for MA-only Private Fee-for-Service (PFFS) plans as a member can also be enrolled in a standalone PDP.
- Should cancel, generally in writing, their Medicare Supplement policy with the carrier after their request to enroll in the MA Plan has been approved. Medicare Supplement policies cannot be used in conjunction with an MA Plan. Medicare Supplement policies will not pay any cost sharing incurred under an MA Plan.

Make sure to use the correct Enrollment Guide and Enrollment Application based on the plan you present to the consumer. Enrolling a consumer in an MA-Only Plan when they want a Medicare Advantage Prescription Drug (MAPD) Plan (or vice versa) can lead to member dissatisfaction and complaints.

Prescription Drug Coverage

Medicare Part D is a federal program that helps Medicare consumers pay for prescription drugs (prescription drugs are not covered by Original Medicare).

How to enroll in Part D

Consumers can get Medicare Part D coverage by enrolling in a standalone Prescription Drug Plan (PDP) or a Medicare Advantage (MA) plan with Part D coverage (MAPD).

- Consumers enrolled in Original Medicare, with or without enrollment in a Medicare Supplement Plan, may enroll in a standalone PDP.
- Consumers enrolled in a PFFS MA-only plan may be simultaneously enrolled in a standalone PDP.
- Consumers enrolled in a non-PFFS MA-only plan or any MAPD plan will be disenrolled automatically from that plan upon enrollment in a standalone PDP.

Before presenting a plan to and enrolling a consumer, complete a thorough needs assessment to determine the consumer's current health care and prescription drug coverage. Explain to the consumer how their current coverage will be impacted by enrollment in a standalone PDP or MAPD. CMS-required elements that must be covered with the consumer prior to beginning the enrollment process are covered in the Ethics and Compliance section.

Benefit structure

A Part D Plan covers a wide range of both brand-name and generic prescription drugs. Members of a Part D Plan typically pay a monthly premium along with copayments or coinsurance. Costs, the drugs covered (formulary) and the drug tiers vary by plan. Plans have flexibility in how they design a Part D benefit structure as shown in this table.

Plan feature	Effect on Part D benefit
Plan premium	Plans may charge a monthly plan premium for prescription drug coverage. Not all plans will charge a premium.
Part D prescription drug deductible	Plans may charge a deductible up to the CMS limit on all covered drugs or just on certain tiers. Not all plans will charge a deductible.
Copayment and coinsurance levels	A copayment is a kind of cost sharing. Member pays a predictable, set amount for a covered drug each time you fill a prescription. The actual cost will depend on which tier the drug is in. In most situations, generic drugs will have a lower copay than brand-name drugs. Coinsurance is another kind of cost sharing the member may have. Member pays a percentage of the cost for a covered drug each time they fill a prescription. The Plan pays the remaining amount owed. The percentage will vary, depending on the plan.
Drugs on formulary	Plans may have different drugs on their formulary (drug list).
Tiers	All Medicare Prescription Drug Plans have a standard level of prescription drug coverage. This coverage is set by Medicare. However, plans differ in the specific drugs they cover and how they divide these drugs into tiers. The tiers determine what a member will pay. Usually, drugs in lower tiers will cost less and drugs in higher tiers will cost more.
Pharmacy network	Plans may include preferred pharmacies in their network, where members have access to lower drug costs because the pharmacy has agreed to charge less.

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

How can a consumer obtain prescription drug coverage? (Select all that apply)

- [ ] Enroll in Original Medicare which includes prescription drug coverage
- [ ] Enroll in Original Medicare and enroll in a standalone PDP

- [ ] Enroll in any MA plan and a standalone PDP
- [ ] Enroll in a PFFS MA-Only plan and a standalone PDP
- [ ] Enroll in any MAPD plan

SUBMIT

Cost considerations

There are several Medicare Part D cost considerations. Each item must be explained to the consumer when discussing Medicare Part D coverage.

Click each tab to learn about cost considerations.

COST-SHARING	LOW INCOME SUBSIDY (LIS)/EXTRA HELP	CREDITABLE COVERAGE & LATE ENROLLMENT PENALTY	PHARMACY NETWORKS

Each year, Medicare updates the standard Part D benefit parameters, around which each PDP and MAPD is structured. This includes the out-of-pocket maximum and maximum deductible amounts. Plans are able to customize details like monthly premiums, covered drugs, and pharmacy networks. It is important that you understand cost sharing elements and drug payment stages (see next section) and are able to clearly explain them to a consumer.

Plan premium

The plan premium is the member's monthly payment to the MAPD or PDP for coverage. Whether the consumer enrolls in an MAPD or PDP, they generally must continue to pay their Part B premium directly to Medicare. Consumers who have incomes over a certain amount may also have to pay the Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), which is a premium amount separate from the Part D Plan's monthly premium. The part D-IRMAA applies if consumers have a modified adjusted gross income, as reported on their federal tax return from 2 years ago, of more than $103,000 (individuals or married individuals filing separately) or $206,000 (married individuals filing jointly).

Deductible

The amount the member must pay for covered prescription medications before the MAPD Plan or PDP begins to pay. For example, if a plan has a $590 deductible, the member will need to pay $590 before the plan starts paying for covered drugs. Deductible amounts vary by plan and some plans may not have a deductible. ***Note:*** *A deductible can apply to the entire plan and/or individual drug tiers.*

Coinsurance

The amount the member may be required to pay as their share of the cost of prescription medications. Coinsurance is usually stated as a percentage, e.g., 25%.

Copayment

The amount the member may need to pay as their share of the cost of prescription medications. Copayments are a fixed amount, e.g., $10.

Consumers with limited income and resources may qualify for LIS from Medicare to cover their Part D premiums and Part D related out-of-pocket costs. The federal government refers to this program as Extra Help.

To qualify for Extra Help:

- A consumer's **income** must be at or below 150% of the Federal Poverty Level (FPL). The FPL varies by state and may change annually.
- A consumer's **resources** will also be considered for qualification.

A consumer may automatically qualify for Extra Help if they have Medicare and meet any of these conditions:

- Have full Medicaid coverage
- Get help from their state Medicaid program paying their Part B premiums (from a Medicare Savings Program)
- Qualify for Supplemental Security Income (SSI) benefits

Note: The state may check for additional low income assistance programs when a consumer applies for Part D help. Approved Extra Help begins the first day of the month the consumer becomes eligible.

Extra Help Part D coverage for 2025	
If income is*	**Less than 150% FPL:** Individuals: $29,325 or less Couples: $39,645 or less
And resources, with burial expenses, are	Individuals: $17,600 or less Couples: $35,130 or less
The monthly premium is	$0 *Note: only certain plans are available at no cost.*
The deductible is	None
The copayment will be	No more than $4.90 (for generic) or $12.15 (for name brand) out-of-pocket drug costs up to $2,000.
Catastrophic coverage will apply	After $2,000 in out-of-pocket drug costs, the beneficiary pays $0 for the rest of the calendar year.

*Income levels and assistance may vary for Alaska, Hawaii and the U.S. territories. Income levels in all areas may change each year.

Note: Refer consumers to Medicare (1-800-MEDICARE) for additional information and applications.

If the consumer does not automatically qualify for Extra Help, you can assist the consumer with the application by going to the Social Security Administration Website www.ssa.gov. Agents can refer MA-only or MAPD Plan members to UnitedHealthcare's Social and Government Referral (see phone numbers below) who will contact the member and assist with the LIS enrollment electronically.

SGRP Contact Summary				
	Plan Type	**Assistance**	**Hours**	**Number**
Member	MA/MAP D D-SNP	LIS, MSP & social needs	8 am - 8 pm local time Monday - Saturday	1-866-427-1873
Consumer – pre-effective	MA/MAP D D-SNP	LIS, MSP & social needs	8 am - 8 pm local time Monday - Saturday	1-833-214-1924

Applying for Extra Help does not automatically enroll a consumer in a prescription drug plan. The consumer must enroll in a prescription drug plan to use their Extra Help. If a consumer who automatically qualifies for Extra Help does not enroll in a Prescription Drug Plan, Medicare may automatically enroll them in one so they will be able to use the Extra Help.

What if the consumer loses their Extra Help?
At the time of enrollment, agents must clearly explain all costs related to prescription drug coverage in the event the consumer loses their Extra Help or their subsidy level changes.

Consumers are eligible to enroll in a Medicare Prescription Drug Plan when they become eligible for Medicare. If they do not enroll during their Initial Enrollment Period, a penalty may be applied.

What is creditable coverage?
Creditable coverage is prescription drug coverage (for example, from an employer, union, TRICARE, Indian Health Service, or the Department of Veterans Affairs) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Consumers with creditable coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

The organization providing the prescription drug coverage must inform the consumer annually (generally in a letter or organization newsletter) if the prescription drug coverage is creditable coverage. The consumer will need this information if they later enroll in a Medicare Plan that provides Part D prescription drug coverage.

What is the late enrollment penalty?

If a consumer does not enroll in Part D coverage when they are first eligible, or if they have a break in Part D coverage of 63 consecutive days or longer, they may be subject to a Part D late enrollment penalty (LEP). The Part D LEP is required by law and will be calculated by CMS and added to the consumer's monthly Part D premium for as long as they are enrolled Part D coverage, even if the consumer enrolls in a $0 premium plan. To help ensure a positive consumer experience, it is important that consumers understand what the LEP is and that it will apply regardless of which carrier or plan the consumer chooses.

Note: The LEP may be reduced or eliminated if the consumer qualifies for the Low-Income Subsidy Program (i.e., Extra Help).

Late enrollment penalty calculation (by CMS):

Multiply 1% of the National Base Beneficiary Premium (NBBP) times the number of months the member was eligible but did not join a Medicare drug plan (round to the nearest $.10).

1% x 34.70 (2024 NBBP) x # of months = penalty

For example, if a member waited 14 months after this member was eligible for Medicare to join a Medicare drug plan, and didn't have creditable drug coverage, this member will have to pay a 14% late enrollment penalty in addition to monthly plan premium.

.14 (14%) x 34.70 NBBP = .4858 or $4.90 penalty for 2024

(4.858 rounded to nearest $0.10 is $4.90)

This member would pay $4.90 each month in addition to the plan's premium.

Note: Agents should explain the penalty, but the amount of the penalty is computed by CMS.

A Preferred Pharmacy is a contracted network pharmacy that offers Medicare Part D members covered Part D drugs at negotiated prices. The cost sharing for Part D drugs obtained at preferred pharmacies is generally lower than for drugs obtained at non-preferred (standard) pharmacies.

Plan sponsors contract with a variety of retail pharmacies to support availability of covered prescription medications. Agents are responsible for reviewing pharmacy network information with the consumer to ensure a complete understanding of pharmacy networks, impact on out-of-pocket costs, and available benefits. Members can obtain their medications at contracted pharmacies (preferred or standard), called "in-network pharmacies," for the copayment or coinsurance identified within their plan benefit.

Occasionally, members may need to obtain their medications from non-contracted pharmacies called “out-of-network pharmacies.” Under the standard Part D benefit, drugs filled at an out-of-network pharmacy are covered only when the member cannot reasonablly be expected to obtain covered Part D drugs at an in-network pharmacy, for example, in medical emergencies or when traveling. However, some MAPD and PDPs offer additional coverage enabling members to use out-of-network pharmacies for covered medications, generally at a higher out-of-pocket cost.

Coverage considerations

Consumers must understand all the characteristics of the plan's prescription drug coverage including the formulary, drug tiers, and coverage rules specific to the plan. The following screens will review Medicare Part D coverage considerations. Each item must be explained to the consumer when discussing Medicare Part D coverage.

Click each tab to learn about cost considerations.

FORMULARY & DRUG TIERS	UTILZATION RULES: STEP THERAPY, QUANTITY LIMITS, PRIOR AUTHORIZATION, OPIOD SAFETY	MEDICATION THERAPY MANAGEMENT

Formulary (drug list)
A formulary is a list of the prescription drugs covered by a Part D Plan. Each Part D Plan develops its own formulary with the help of providers and pharmacists. CMS guidelines require Part D Plan formularies to cover at least 2 drugs in each of the most commonly prescribed drug categories and classes. CMS reviews and approves each Part D Plan’s formulary.

Tiers

Many Medicare Prescription Drug Plans group covered medications into tiers. The number of tiers may vary from plan to plan. Generally, the lower the tier, the lower the cost of the drugs in the tier. At the pharmacy, the member will pay the lower of the tier copay or the actual price of the medication. Some plans may apply a deductible to a specific tier(s). Here is an example:

Tier	Member pays	What is covered?
Tier 1: Preferred Generic	Lowest copayment	Lower cost, commonly used generic drugs
Tier 2: Generic	Low copayment	Many generic drugs
Tier 3: Preferred Brand*	Medium copayment or coinsurance	Many common brand-name drugs, called preferred brands, and some higher-cost generic drugs
Tier 3: Covered Insulin Drugs	No more than $35 for 1-month supply (retail and mail) and $105 for 3-months supply (retail and mail)	Covered insulin products
Tier 4: Non-Preferred Drug	Higher copayment or coinsurance	Non-preferred generic and non-preferred brand-name drugs
Tier 5: Specialty Tier	Coinsurance	Unique and/or very high-cost brand and generic drugs

**A preferred brand-name prescription medicaion is a drug that has been determined by the Plan to be as effective as other medications.*

Plans may have utilization management rules and exceptions that the member must follow.

Step therapy
Step therapy offers an effective, clinically proven, lower-cost alternative to some drugs that treat the same health condition. The Plan may require that a member try an alternate drug before covering the requested drug. If a member has already tried other drugs or a provider thinks other drugs are not right for the situation, a member or their provider can ask the Plan to cover these drugs.

Quantity limits
To ensure safe and efficient use of a drug, the Plan and/or Medicare sets a quantity limit that defines how much of a medication a member can receive at a time. Some drugs require approval from the Plan prior to the member filling their prescription. If a member is prescribed or requires more of a medication than allowed, the member or their provider can contact the Plan and ask for an exception.

Prior authorization
Some drugs require pre-approval by the Plan. A member or their provider can ask a Plan to cover the drug. The Plan may ask the provider for additional information to help ensure the drug is appropriate for Medicare-eligible health conditions. A member might be asked to try another drug on the formulary before the Plan will cover the drug they are requesting.

Opioid safety checks
Members may experience additional limits on opioid medications per federal guidance:

- 7-Day Limit – Members who have not filled an opioid prescription within the past 120 days, will be limited to a 7-day supply initially
- Dispensing Limit – If prescribed an opioid with a dispensing limit, will be limited to a one (1) month supply per prescription. This limitation is regardless of the pharmacy (including mail order).
- Limited Access – Limited Access means a member may only receive the medication from certain facilities or providers due to required extra handling, provider coordination or patient education.

Exception request process
The member or their provider may request an exception in order for the Plan to cover a drug that has a utilization management restriction (except for opioid-related utilization management rules). Members should contact Customer Service to learn how to submit an exception request. The Plan may or may not agree to waive the restriction.

Members enrolled in a Medicare Prescription Drug Plan who take medications for multiple medical conditions may qualify, at no additional cost, for a Medication Therapy Management (MTM) program. This program helps providers and members ensure their medications are working to help improve the member's health.

A UnitedHealthcare contracted pharmacist or other health professional will provide the member with a comprehensive medication review and discuss drug benefits, reactions, cost concerns, medication instructions, and other questions. The member receives a medication list, action plan, and information on safe disposal of medications.

The Plan may enroll a member into this program if they meet all of the following 3 requirements*:

1. **Member has more than one chronic health condition from 10 core conditions:**
    a. Alzheimer's disease
    b. Bone disease-arthritis (including osteoporosis, osteoarthritis, and rheumatoid arthritis)
    c. Chronic congestive heart failure (CHF)
    d. Diabetes
    e. Dyslipidemia
    f. End-stage renal disease (ESRD)
    g. Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
    h. Hypertension
    i. Mental health (including depression, schizophrenia, bipolar disorder, and other chronic/disabling mental health conditions)
    j. Respiratory disease (including asthma, chronic obstructive pulmonary disease (COPD), and other chronic lung disorders).
2. **Member takes several different medications.**
3. **Member's medications have a combined cost of more than $1,276 (2026) per year.**

- This dollar amount (which can change each year) is estimated based on out-of-pocket costs and the costs the plan pays for the medications each calendar year.

*Or members who are in a Drug Management Program to help better manage and safely use medications such as those for pain.

Consumers can visit www.medicare.gov/find-a-plan to get general information about program eligibility.

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

Medicare Prescription Drug plans may have utilization management (UM) rules that must be followed and explained to the consumer. Which of the following are true about UM rules? (Select all that apply)

- [ ] If there is a drug quantity limit in the Prescription Drug Plan, members (or their doctor) can contact the Plan and ask for an exception.

- [ ] All drugs require pre-approval by the Plan.

☐ Some Prescription Drug Plans may have step therapy which means they may require a member to try alternate drugs before covering a requested drug.

SUBMIT

Drug payment stages

Drug stages

The Inflation Reduction Act of 2022 made several significant updates to the Part D benefit aimed at reducing member's out-of-pocket costs. The updates included capping member out-of-pocket spending for covered Part D drugs at $2,000, eliminating member cost-sharing in the Catastrophic Coverage stage, and eliminating the Coverage Gap.

Accordingly, the Part D benefit has 3 stages instead of 4:

- Yearly deductible (***Note:*** *Some plans have a $0 deductible for prescription coverage.*)
- Initial coverage
- Catastrophic coverage

To determine when a member moves from one stage to the next, the plan keeps track of the member's True Out-of-Pocket (TrOOP) costs. Any money spent during the Deductible and Initial Coverage stages counts toward TrOOP costs. The monthly premium does not count toward TrOOP costs. Because member's out-of-pocket costs for covered Part D drugs will be capped at $2,100 in 2026 members may reach the Catastrophic Coverage stage sooner, at which point they will have $0 cost-sharing for Medicare covered Part D drugs.

Changes summary

Below is a summary of changes to Medicare Part D Standard Prescription Drug coverage for 2025.

	2024	2025
Annual deductible	Up to $545	Up to $590
Initial coverage limit	Ends at $5,030	Ends at $2,000

Medicare Supplement Plans

Definition and why enroll

What is a Medicare Supplement Plan?
Original Medicare pays for much, but not all, of the cost for covered health care services and supplies. Medicare Supplement policies, sold by private companies, can help pay some of the remaining health care costs for covered services and supplies, like copayments, coinsurance, and deductibles. **Medicare Supplement policies are also called Medigap policies.**

Medicare Supplement Plans must follow federal and state laws. Insurance companies can only sell a “standardized” policy identified in most states by letters A - D, F, G and K - N. Standardized policy benefits do not differ by insurance company but some policies have different plan benefits and payment levels.

Key reasons consumers choose Medicare Supplement Plans:

- To have more predictable out-of-pocket costs
- To have coverage when they travel throughout the United States and limited emergency coverage, with some plans, when traveling outside of the United States
- To have stability in knowing that coverage is guaranteed for life – plan features will never change and the plan cannot be canceled as long as the premium is paid when due
- No networks or referrals are needed. Clients have the option to keep their current providers as long as the providers accept Original Medicare patients.

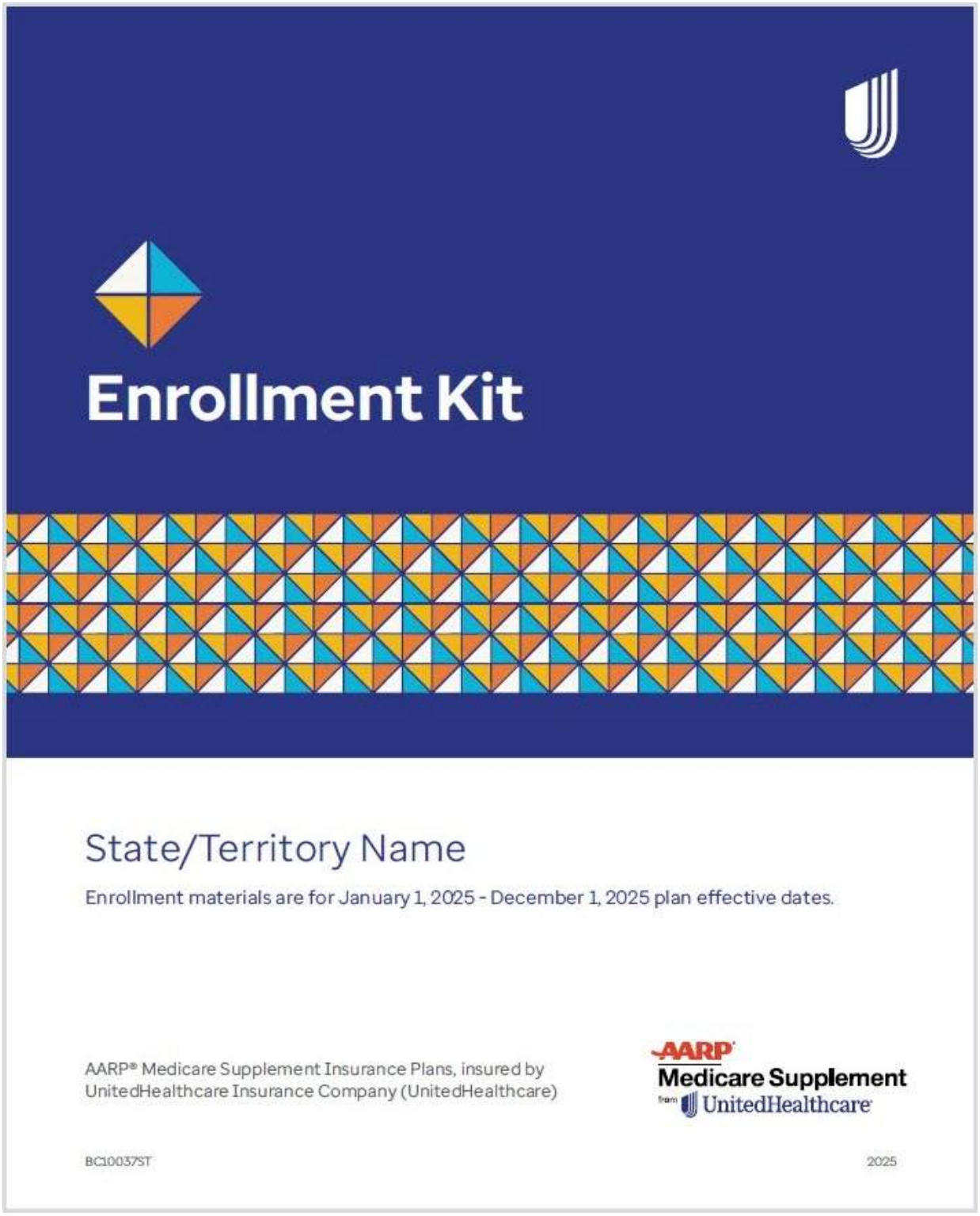
Producer tools

Two valuable tools available to producers are the Producer Handbook and the Enrollment Kit.

Producer Handbook

Producer Handbooks are agent facing, state-specific and updated yearly. Agents can download or order handbooks on the Sales Materials Portal, accessible via Jarvis. UnitedHealthcare will provide

newly-contracted agents with their resident state Handbook. Refer to the Producer Handbook when you or your members have questions. For rate information, please reference Medicare Supplement JarvisEnroll (the electronic enrollment application tool) or the state-specific Enrollment Kit.



Enrollment Kits

State-specific Enrollment Kits are consumer-facing and updated when changes are made to plan benefits, rates and enrollment information. Enrollment Kits can be found on the Sales Materials Portal, accessible via Jarvis. Refer to the Enrollment Kit to learn more about plan benefits and rates.

Eligibility

A consumer must meet eligibility requirements to enroll in a Medicare Supplement Plan.

Eligible

To be eligible for Medicare Supplement Plan, a consumer must:

- Be enrolled in Medicare Parts A and B at the time of the plan's effective date.
- Be a resident of the state in which they are applying for coverage. (***Note:*** *Usually, residency is defined as the location where the consumer files their federal tax return.*)
- Be age 65 or older (some states require insurers to offer coverage for Medicare beneficiaries under age 65).
    - Consumers who do not meet Medicare Supplement Open Enrollment or Guaranteed Issue requirements are underwritten to determine eligibility and rate in most states.

NOT eligible

A consumer may not be eligible for a Medicare Supplement Plan for various reasons, including, but not limited to, the following:

- Consumer does not qualify for Medicare Supplement Open Enrollment or Guaranteed Issue and does not pass medical underwriting, in applicable states.
- Consumer is enrolled in another Medicare Supplement Plan or a Medicare Advantage Plan, which they do not intend to replace.

Features

Consumers should understand the type of plan in which they are enrolling and how it differs from other options. Explain the features of a Medicare Supplement Plan to consumers to help them choose the coverage that best suits their needs and budgets.

Click each plus (+) to read more about the features of Medicare Supplement Plans.

Out-of-Pocket expenses —

Medicare Supplement Plans cover some out-of-pocket expenses for Medicare eligible care, such as:

- Coinsurance
- Copayments
- Deductibles

Explain all costs to the consumer
Ensure that the consumer understands all cost associated with the plan prior to enrollment. This includes any premiums, or any Medicare deductibles, coinsurances or copayments if not covered by the plan selected. Use the state-specific Enrollment Kit to help explain these items to the consumer.

Freedom to choose —

Insured members can choose any provider that accepts Original Medicare:

- No pre-authorization
- No referrals needed
- No provider networks (except Medicare Select Plans, which have a hospital network)

Coverage while traveling

Medicare Supplement Insurance covers the insured member anywhere they travel in the United States. Medicare Select insured members must use network hospitals, except for emergencies or when traveling more than 100 miles from their residence. Please see state-specific Enrollment Kits for additional information.

Foreign emergency coverage

Some plans have emergency coverage when traveling outside the United States.

Please see state-specific Enrollment Kits for additional information.

Guaranteed renewable coverage

Once enrolled, the plan is guaranteed renewable for life as long as the insured member pays the premium when due. The plan features will never change and the plan cannot be canceled.

Member must continue to pay premiums when due. Member must not make any material misrepresentations on the application when they apply for the plans.

State regulated

Medicare Supplement Insurance is regulated by each state's Department of Insurance.

Cost sharing and benefit amount updates

Plan benefits automatically update to match annual changes CMS makes to Original Medicare coinsurance, copayments and deductibles.

No enrollment period limitations

- Medicare Supplement Plans are available to enroll in year round.
- Medicare Supplement Plans may not be offered to Medicare Advantage (MA) members unless the member intends to replace the MA Plan with the Medicare Supplement Plan.
- Medicare Supplement Plans do not cover MA cost sharing expenses.

Note: If leaving a Medicare Advantage plan for a Medicare Supplement plan, disenrollment is not automatic. The consumer must be in a valid election period or disenrollment period. Once accepted in the Medicare Supplement Plan, the consumer should contact the Medicare Advantage carrier to disenroll or enroll in a Part D Plan (PDP).

30 day evaluation period

If the insured member cancels their plan within 30 days after coverage begins, premiums are refunded less any claims paid.

Standardized Medicare Supplement Plans

This plan chart provides a list of standard Medicare Supplement Plans carriers have the opportunity to offer.

Including a Prescription Drug Plan

Medicare Supplement Plans do not feature prescription drug benefits. Stand-alone Prescription Drug Plans are available to consumers who have Original Medicare and are enrolled in a Medicare Supplement Plan.

Plan Benefit Chart

Medicare Supplement Plans	A	B	D	G	K	L	M	N	F[4]	C[4]
Medicare Part A Coinsurance and Hospital Benefits	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part A Deductible	–	✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B Coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	Copay[1]	✓	✓
Medicare Part B Deductible	–	–	–	–	–	–	–	–	✓	✓
Medicare Part B Excess Charges	–	–	–	✓	–	–	–	–	✓	–
Blood (First Three Pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Foreign Travel Emergency (up to plan limit)[2]	–	–	✓	✓	–	–	✓	✓	✓	✓
Hospice Care Coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled Nursing Facility Coinsurance	–	–	✓	✓	50%	75%	✓	✓	✓	✓
2025 out-of-pocket limit (plans K and L only)[3]					$7,220	$3,610				

[1] Plan pays Part B coinsurance or copayment except for an insured copay of up to $20 for each doctor's office visit and up to $50 for each emergency room visit (emergency room copay waived if admitted as inpatient).

[2] Benefit is 80% after the $250 annual deductible with a $50,000 lifetime maximum for Foreign Emergency Care that begins during the first 60 days of a trip period.

[3] The plan pays 100 percent of covered services for the rest of the calendar year once beneficiaries have paid the out-of-pocket annual limit and annual Part B deductible ($257 in 2025).

[4] Plans C and F are only available to eligible applicants. Applicants (a) with a 65th birthday prior to 1/1/2020 or (b) who will be age 65 or older on or after 1/1/2020 with a Medicare Part A effective date prior to 1/1/2020.

All plans may not be available in all states or offered as AARP Medicare Supplement Insurance Plans.

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

Medicare Supplement Plans include many features. Which of the following are some of those features? (Select all that apply)

- [ ] Members can choose any provider that accepts Original Medicare
- [ ] Medicare Supplement is regulated by each state's Department of Insurance, not the federal government
- [ ] Members can only see a specialist if they are referred by their PCP

SUBMIT

MACRA

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation that went into effect January 1, 2020, affects a consumer's ability to enroll in Plans C and F. These are industry changes and apply to all carriers. Here are some important details to remember:

- Consumers eligible for Medicare Part A before January 1, 2020, can enroll in Plans C and F even after January 1, 2020, and can keep their plans as long as they choose.

- Consumers who are eligible for Medicare Part A on or after January 1, 2020, cannot purchase Medicare Supplement Plans C or F.
- Consumers already enrolled in Plans C or F do not need to take any action and they can keep the plan they have if they choose.

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

What is the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) which went into effect January 1, 2020?

- ○ Consumers eligible for Medicare Part A before January 1, 2020, can enroll in Plans C and F even after January 1, 2020, and can keep their plans as long as they choose.
- ○ Consumers newly eligible for Medicare Part A on or after January 1, 2020, can purchase Medicare Supplement Plans C or F.

SUBMIT

Open Enrollment

Under federal law, Medicare Supplement Open Enrollment is the first six months a consumer is 65 or older and enrolled in Medicare Part B. Most states permit consumers to apply for a supplement plan three months prior to their Medicare Initial Enrollment Period (IEP).

Medicare Supplement Open Enrollment

During the Medicare Supplement Open Enrollment, eligible consumers are guaranteed these rights:

- Ability to purchase any supplement plan offered by the carrier.
- Premium rates will not be adjusted based on health conditions.

After Medicare Supplement Open Enrollment

If the consumer does not apply during their Medicare Supplement Open Enrollment, they can apply later at any time, but they may be underwritten and charged a higher premium rate or denied coverage.

Guaranteed Issue

Some consumers losing or dropping other health insurance coverage have Guaranteed Issue rights under federal and state law. If a consumer qualifies for Guaranteed Issue, the insurance company cannot:

- Deny the consumer's application
- Apply pre-existing condition exclusions
- Charge the consumer more due to past or present health problems

The consumer must submit proper documentation with the enrollment application to prove Guaranteed Issue eligibility. An example of documentation would be the termination notice from prior coverage.

Guaranteed issue and plan availability vary by state; please review your state-specific Producer Handbook.

Important reminders:

- *Consumers who are voluntarily switching from one Medicare Supplement Plan to another are generally not entitled to Guaranteed Issue.*
- *Consumers who switch from a Medicare Advantage Plan to a Medicare Supplement Plan are sometimes, but not always, entitled to guaranteed issue.*

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

Which of the following statements are true about Medicare Supplement Open Enrollment and Guaranteed Issue? (Select all that apply)

- [ ] Medicare Supplement Open Enrollment is the first six months a consumer is 65 or older and enrolled in Medicare Part B.

- [ ] During Medicare Supplement Open Enrollment an insurer must offer the consumer any plan it sells.
- [ ] All consumers who lose or drop other health insurance coverage have Guaranteed Issue rights.
- [ ] Most states permit a consumer to apply for a plan three months prior to their Medicare Initial Enrollment Period.

SUBMIT

When is a consumer entitled to Guaranteed Issue rights for a Medicare Supplement plan?

(Select all that apply)

- [ ] When voluntarily switching from one Medicare Supplement Plan to another Medicare Supplement Insurance company.
- [ ] When they enroll in a Medicare Supplement Plan during their Medicare Supplement Open Enrollment.

☐ Whenever they first enroll in a Medicare Supplement Plan regardless of whether it is their Medicare Supplement Open Enrollment or not.

SUBMIT

AARP brand

AARP Medicare Supplement Insurance Plans are available nationwide.

Medicare Supplement Plan offerings are:

- AARP Medicare Supplement Plans
- AARP Medicare Select Plans
    - Alabama, Arizona, Arkansas, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Mississippi, North Carolina, Ohio, Oklahoma, Oregon, Tennessee, Texas, Utah, and Washington

- “Waiver” State Plans:
    - Massachusetts, Minnesota and Wisconsin are known as “waiver” states.
    - These states are permitted by statute to offer their own standardized Medicare Supplement Plans.

AARP Medicare Supplement Insurance Plans are insured by UnitedHealthcare Insurance Company or an affiliate

- Available nationwide, including Washington, D.C., and most United States territories
- 9 out of 10 insured members surveyed would recommend their AARP Medicare Supplement Insurance Plan to a friend or family member*
- 95% member satisfaction rate of those surveyed with AARP Medicare Supplement Insurance Plans*
- Discounts are available in most states

UnitedHealthcare was chosen as the only insurance company to have the AARP name on its Medicare Supplement Plans

- AARP membership is required (consumer can enroll in AARP at the time of application to meet this requirement)
- Available plans are A, B, C, D, F, G, K, L, N
    - Plan D is available in MI, NC and NJ
    - High Deductible Plan G is available in FL
- Medicare Select Plans are available in some states
    - AL, AZ, AR, FL, GA, IL, IN, KS, KY, LA, MS, NC, OH, OK, OR, TN, TX, UT, and WA

Note: If the consumer is already an AARP member, make sure the AARP membership number is included on the enrollment application. You can also use JarvisEnroll for AARP Medicare Supplement Plans to help the consumer apply for AARP membership.

Wellness Extras are available to insured members enrolled in most AARP Medicare Supplement Insurance Plans

- AARP® Staying Sharp®, AARP® Vision Discounts provided by LensCrafters, AARP® Hearing Solutions™ provided by UnitedHealthcare Hearing, 24/7 Nurse line, Dentegra Dental Discount from Dentegra, AARP® Smart Driver™, and Renew Active® by UnitedHealthcare (in most states).

Wellness Extras vary by state. Refer to state-specific Producer Handbooks for more details.
**Source: Access http://uhcmedsupstats.com for reports created for UnitedHealthcare Insurance Company.*

Rating and underwriting

Consumers Ages 65 and Older
Consumers who do not meet Medicare Supplement Open Enrollment or Guaranteed Issue requirements are underwritten to determine eligibility and rate in most states.

Eligibility, Rating and Underwriting
For details regarding rating and underwriting requirements, please see your state-specific Producer Handbook. Please note, plans eligible for Guaranteed Issue vary by state.

Consumers Ages 50 to 64
Many states require Medicare Supplement Plans be offered to consumers who:

- Are age 50-64 and eligible for Medicare, and
- Apply during an Open Enrollment or Guaranteed Issue period

In a limited number of states, consumers age 50-64 and eligible for Medicare:

- Who have ESRD are not eligible to apply (even during an Open Enrollment or Guaranteed Issue period), or
- Who apply outside of Open Enrollment or Guaranteed Issue periods:
    - Are underwritten to determine eligibility, or
    - Are accepted without underwriting

The consumer must be at least 50 years of age as required under the Group Master Policy.

Reminder: Consumers who meet Medicare Supplement Open Enrollment or Guaranteed Issue requirements do not have to answer underwriting questions.

Other coverage options

Group plans

Employer/union-sponsored Group MA and Part D Plans
Employers and unions may offer their retirees Group MA Plans (with or without Part D coverage). These customized plans may include additional benefits like vision, dental, and hearing. Stand-alone Part D plans may also be offered.

Employer/union sponsored Senior Supplement Group Retiree Plans
These medical Senior Supplement Plans, which are only available through employer groups and plan sponsors, help pay for some or all of the costs not covered by Original Medicare. Features of these plans include no provider network (enabling consumers to choose any provider that accepts Medicare), portable coverage for multiple residences, and may include additional benefits, such as fitness and caregiver support.

Before enrolling a consumer with group retiree coverage:

- Consumers must understand how employer/union-sponsored coverage (for them and/or their family member) may be impacted if they enroll in Original Medicare and/or a non-sponsored MA Plan or PDP.
- Enrolling in a non-sponsored MA Plan or PDP may limit or end coverage for the consumer and/or their family members enrolled in group coverage.
- Before making any coverage changes, the consumer should contact their former employer/union's benefits administrator, or the office that answers their coverage questions, to determine potential impacts.

Medicare-Medicaid Plans (MMP)

These plans, which are part of a CMS and state run demonstration program, are designed to manage and coordinate a member's Medicare, Medicaid, and Part D coverage through a single health plan. Qualified individuals must have Medicare Parts A and B and full Medicaid benefits and, generally, are passively enrolled into an MMP with the ability to opt-out and choose other Medicare options. MMP demonstrations and eligible populations vary by state.

Note: *UnitedHealthcare offers MMPs in some areas in Massachusetts, Ohio and Texas.*

Medicare Cost Plans

Medicare Cost Plans are a type of Medicare HMO health plan that works in much the same way, and has some of the same rules, as MA Plans.
While most HMO MA plans do not provide coverage when using an out-of-network provider (unless an exception applies), members of Medicare Cost Plans may visit a non-network provider and have the service covered under Original Medicare.

Note: *UnitedHealthcare does not offer Medicare Cost Plans.*

Medicare Savings Account Plans

These high-deductible MA-Only Plans include a bank account funded by the plan. Members are able to use the funds to pay for their health care expenses until their deductible is met.

Note: *UnitedHealthcare does not currently offer an MSA Plan.*

Programs of All-Inclusive Care for the elderly (PACE)

PACE is a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility. It combines medical, social, long-term care services, and prescription drug coverage for the frail, elderly, and/or disabled consumers who live at home.

PACE uses Medicare and Medicaid funds to cover all of the medically necessary care and services and Part D-covered drugs. Consumers can have Medicare and/or Medicaid to enroll in PACE.

PACE organizations:

- Provide caregiving training, support groups, and respite care to help members stay in the community.
- Provide care and services in the home, community, and PACE center.
- Contract with many specialists and other providers in the community to ensure that members get the care they need.
- Are provider sponsored health plans that treat members.
- Cover preventive care.

Note: *Enrolling a consumer in a Medicare Advantage plan or stand-alone PDP will automatically disenroll them from their PACE plan or vice versa. Agents should use special caution when disenrolling a consumer from a PACE plan due to all the additional benefits a PACE program provides.*

Note: *UnitedHealthcare does not offer any PACE plans.*

Veterans/TRICARE

Veterans may have the ability to get healthcare and prescription drug coverage through the Veterans Affairs (VA) program. Consumers, who are veterans, may also enroll in a Medicare Advantage plan with prescription drug coverage. Having coverage through the VA program and an MA Plan may be beneficial to veterans.

Keep in mind, all prescriptions written at a VA clinic, must be filled at a VA clinic. All prescriptions written by a UnitedHealthcare network doctor for an MAPD plan, must be filled at an MAPD network pharmacy.

Consumers enrolled in TRICARE For Life (TFL) have a prescription drug benefit, so they will most likely not need Medicare prescription drug coverage. It is best for a consumer with TFL to enroll in an MA-only plan. Some exceptions may be made; in this case, get on a three way call with TFL to ensure the consumer has proper coverage without jeopardizing their prescription drug coverage with TFL.

Introduction to ethics and compliance

Your responsibility

As an agent, you have a responsibility to treat consumers with respect and care while providing details about Medicare plans. In other words, you must be ethical and compliant. You are also responsible for ensuring that consumers are enrolled in the best plan based on their needs.

In this chapter you will learn about proper consumer contact, how to educate consumers and market plans to them, enrollment and disenrollment basics, and conducting thorough needs assessments. You must also ensure consumers comprehend their plan and assist when plan changes are requested. Further, you will learn about our compliance program and how you must be compliant in your sales practices, including keeping consumers' personal information safe and reporting suspected fraud, waste and abuse.

Who is CMS?

Centers for Medicare and Medicaid Services (CMS)

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that administers the Medicare program and contracts with private health care companies to offer Medicare Advantage (MA) plans and Prescription Drug Plans (PDP). CMS holds the authority to approve or disapprove plans that can be sold and is the regulating agency that also monitors our processes.

While CMS regulates the marketing of MA plans and PDPs, UnitedHealthcare's rules, policies, and procedures apply to the marketing of all products in its portfolio, including state-regulated Medicare Supplement products. Therefore, agents must consider the requirements in this module applicable to marketing all products in the UnitedHealthcare Medicare plans portfolio unless otherwise noted.

*Before selling any plan, **ensure you are currently certified** for that product by either checking on Jarvis* or calling the Producer Help Desk (PHD). Any product you sell without being certified is an unqualified sale. This is strictly prohibited by CMS. Unqualified sales are not compensated, and the selling agent will be subject to disciplinary action, which may include termination.*

Jarvis > Manage Profile > Certifications

Ethics overview

Promoting an ethical and honest environment involves all agents embracing the values of honesty and integrity. Take responsibility for your actions and remember the 3Bs of Ethics & Integrity:

Be informed

Be aware

Be vocal

Several reference materials will help you keep current with the compliance guidelines, rules, policies, and procedures:

- Agent Guide: ***Jarvis*** > Knowledge Center > Reference Guides > Agent Guide
- Compliance documents: ***Jarvis*** > Knowledge Center > Reference Guides > Compliance
- Other job aids: ***Jarvis*** > Knowledge Center > Agent Training > On-Demand Training tab > Learning Lab > Content library > search for topic (or use the Quick Access link on the *Jarvis* home page)

Disclosure, competency and suitability

Ethical issues can arise when marketing and selling Medicare plans and encompass three main components: disclosure, competency and suitability.

Click each tab to review examples of disclosure, competency and suitability.

DISCLOSURE | COMPETENCY | SUITABILITY

An example
Agent Lucy is presenting a plan to Mr. Spalding, a consumer. Along with presenting the benefits, network requirements, and costs of the plan, she also discloses all eligibility requirements and how enrolling in the plan presented might impact this.

When Mr. Spalding asks a question, Lucy takes the time to answer, ensuring that he understands and that she has answered his question completely.

Ethical practice
The ethics demonstrated in this example include, but are not limited to:

- Full disclosure of all information needed to make an informed decision, including all out-of-pocket costs, plan benefits and limitations, and provider network requirements.
- Disclosing enrollment eligibility requirements and how enrollment in a new plan might impact current coverage.

DISCLOSURE | COMPETENCY | SUITABILITY

An example

As an ethical agent, Lucy knows that it is important to keep up on any changes to the products she sells and how they differ. This ensures that she can help consumers choose the products that are most suited to fit a consumer's needs.

Ethical practice

- Agents have an ethical obligation to fully understand the products being sold.
- Product awareness will help agents identify the plans that meet a consumer's needs.

DISCLOSURE | COMPETENCY | SUITABILITY

When presenting MA or PDP to consumers, be certain you:

- Recommend/enroll consumers into a plan that fits their medical needs and personal preferences such as copay amounts, network doctors, formularies, etc.
- Advise the consumer of all their options, being especially clear about plans with and without prescription drug coverage.
- Verify consumer eligibility and service area for the plan.

- Accurately indicate on the Enrollment Application the plan in which the consumer wants to enroll.

Enrolling a consumer in an unsuitable plan is a common member complaint which can lead to disciplinary action against the agent.

What is compensation?

CMS requires you to understand the concept of compensation as provided in this module. **Refer to the Agent Guide for additional details (*Jarvis*>Knowledge Center>Reference Guides>Agent Guide).**

CMS defines compensation as monetary or non-monetary remuneration of any kind relating to the sale, renewal or services related to a plan or product offered by an MA organization or PDP Sponsor including, but not limited to the following:

- Commissions
- Bonuses
- Gifts
- Prizes or Awards
- Payment of fees to comply with state appointment laws, training, certification, and testing costs (beginning with contract year 2025)
- Reimbursement for mileage to, and from, appointments with beneficiaries (beginning with contract year 2025)
- Reimbursement for actual costs associated with beneficiary sales appointments such as venue rent, snacks, and materials (beginning with contract year 2025)

- Any other payments made to an agent or broker that are tied to enrollment, related to an enrollment in an MA or PDP plan or product, or for services conducted as a part of the relationship associated with the enrollment into an MA or PDP plan or product (beginning with contract year 2025)

You must review relevant information about compensation as it pertains to your agent type.

Click each plus (+) for the type of agent that applies to you.

Employed agents

Sales incentive plan
UnitedHealthcare pays employed agents and sales leaders 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.

Referral/finder's fees
UnitedHealthcare does not sponsor a lead referral program; therefore, no payment is made in exchange for a referral or as a result of a referred consumer's enrollment.

Marketing fees
Agents are prohibited from charging a consumer or member any type of fee for the marketing of a Medicare insurance product including, but not limited to: entrance fees to attend educational or marketing/sales events, fees to conduct a personal/individual marketing appointment (e.g., in-home), or to cover the cost of materials.

Compensation recovery (charge backs)
Incentive amounts are deducted from a SIP participant's incentive payment for previously paid advances on sales that are not earned. These are generally the result of a member's rapid disenrollment from their plan, but can occur for other reasons. Rapid disenrollment occurs when a member voluntarily disenrolls or moves from one UnitedHealthcare plan to another prior to the member's fourth month effective date following the original effective date. Some exceptions apply.

Contracted or independent agents

The compensation guidance contained in this section applies to non-employee contracted agents. UnitedHealthcare pays non-employee agents in the External Distribution Channel (EDC) and Independent Career Agent (ICA) channel a commission for enrollment of a consumer into a UnitedHealthcare Medicare Advantage Plan, Prescription Drug Plan, or Medicare Supplement insurance policy according to the terms of their Agent Agreement. Commission payments for sales written by a solicitor are paid to the solicitor's up-line. The remainder of this section only applies to Medicare plans regulated by CMS. Refer to your Agent Agreement and/or Agent Guide for details.

Compensation types and amounts
For each MA, MAPD, and PDP enrollment, CMS determines if the enrollment qualifies for initial or renewal compensation and the plan sponsor must comply with CMS' determination. Therefore, if a member disenrolls from one plan and enrolls in another, CMS determines the compensation type for the new enrollment.

Types of compensation:

Initial compensation is paid at the fair market value (FMV) amounts published by CMS annually for a member's first year of enrollment in a plan, regardless of the plan sponsor, or when the consumer enrolls in a different plan type (e.g., member makes a plan change from an MA/MAPD to a PDP or a PDP to an MA/MAPD).

- When a member enrolls in a plan and has no prior plan history, the plan sponsor may pay the full year initial compensation amount or a pro-rated amount based on the number of months the member is enrolled.
- When a member changes plans during the initial year, the plan sponsor must pay the agent at a pro-rated initial year rate based on the number of months the member is enrolled (unless the member makes a like plan change with the same carrier using the same agent in which case the agent will receive the full initial year compensation amount). Rapid disenrollment rules apply.

Renewal compensation (enrollments in a renewal year for contract years through 2024) is paid in any amount up to fifty (50) percent of the current FMV, published by CMS annually, for the member's second and subsequent enrollment years when they enroll in a new "like plan type" (a plan change from a PDP, MA, MAPD, MMP, or section 1876 cost plan to another PDP, MA, MAPD, MMP, or section 1876 cost plan respectively). Beginning with contract year 2025, renewal compensation is paid at fifty (50) percent of FMV. Renewal compensation must always be pro-rated for the actual months the member is enrolled in the plan. Rapid disenrollment rules apply.

Compensation cycle

Compensation paid for plan enrollment is based on the enrollment year, which runs from January 1 through December 31. Plan sponsors may only pay compensation for the current year enrollment. Payments must not be paid until January 1 and must be paid in full by December 31 of the enrollment year. Plan sponsors may pay compensation annually, quarterly, monthly, or utilizing other schedules.

Referral/finder's fees
UnitedHealthcare does not sponsor a lead referral program. However, CMS guidelines prohibit the payment of a referral/finder's fee to an individual in excess of $100 per referral or enrollment in an MA/MAPD plan or in excess of $25 per referral or enrollment in a stand-alone PDP. UnitedHealthcare recommends agents consult with local legal counsel to determine the compliance of any compensation arrangements they make with referrers.

Marketing fees
Agents are prohibited from charging a consumer or member any type of fee for the marketing of a Medicare insurance product including, but not limited to: entrance fees to attend educational or marketing/sales events, fees to conduct a personal/individual marketing appointment (e.g., in-home), or to cover the cost of materials.

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), some exceptions apply, and
2. Any other time a member is not enrolled in a plan.

Rapid disenrollment applies when a member moves from one plan sponsor to another or when the member moves from one plan to another plan offered by the same plan sponsor. It does not apply when the member enrolls in a plan effective October 1, November 1, or December 1, and subsequently changes plans effective January 1 of the following year. Rapid disenrollment compensation recovery does not apply in certain circumstances defined by CMS. In some cases, only a pro-rated amount of compensation must be recovered. When a member disenrolls after they have been enrolled in the plan at least three continuous months, only the amount the agent was paid for months the member was no longer enrolled in the plan is recovered.

Reporting misconduct

Did you know you are required to report instances of suspected misconduct?

Remember to “Speak up! Speak out!” and notify the plan of any suspected concerns.

Reporting misconduct

Report suspected illegal or unethical conduct by calling the Compliance & Ethics Help Center at 1-800-455-4521 or via Compliance & Ethics Help Center. Misconduct may include:

- Violations of law, contractual obligations and company policies (including the UnitedHealth Group Code of Conduct)
- Privacy issues
- Suspected fraud, waste and abuse

Not reporting suspected misconduct may lead to disciplinary action.

If you have questions about UnitedHealthcare rules, policies, procedures, CMS marketing requirements, or need assistance with privacy, security, or ethics, you can refer to the Agent Guide, contact your UnitedHealthcare sales leader, or send an email to: compliance_questions@uhc.com.

Educational events, marketing events and event activities

Event requirements

Conducting a successful and compliant event starts well before you greet the first consumer; it takes training, practice, and preparation. Events are covered in this certification Study Guide merely as an introduction to events for all agents. The Events Basics content can be found in this Study Guide by clicking on Events Basics in the menu on the left. However, prior to reporting and conducting marketing/sales events, you must complete the Events Basics module in Learning Lab or pass the Fast Track assessment (if eligible) for the applicable year.

For more in-depth information, please review the Agent Guide (Jarvis > Knowledge Center > Reference Guides > Agent Guides) or contact your sales leadership. Rules frequently change based on new information. Keep engaged and up to date by reading all communications and maintaining a relationship with your sales leaders.

Types of events

Educational events

An event designed to inform Medicare consumers about Original Medicare, Medicare

Advantage, Prescription Drug, or other Medicare programs. These events inform in an unbiased way that does not steer–or attempt to steer–consumers toward a specific plan or limited number of plans. Marketing of plans (including displaying or distributing marketing materials or collecting enrollment applications), scheduling appointments, or displaying, distributing, or collecting Scope of Appointment forms is prohibited. Lead generation activities, such as obtaining beneficiary contact information and Business Reply Cards (BRCs), are permitted at educational events. Educational events may be conducted in a public venue. Educational events are not reported to UnitedHealthcare.

Marketing/sales events

An event designed to steer, or attempt to steer, consumers toward a plan or limited set of plans. Agents may discuss plan specific information and collect applications. Marketing/sales events can be formal or informal. A formal event is conducted in a presenter-audience format. Informal events are passive in nature where the consumer approaches the agent to engage in conversation. A table, booth, or kiosk is typically used. A marketing/sales event must not begin within 12 hours of an educational event at the same location (i.e. same or adjacent building). All formal and informal marketing/sales events must be reported to UnitedHealthcare.

Marketing appointments

Marketing appointments, commonly called in-home, face-to-face, or one-on-one appointments, typically take place in the consumer's home. They can also take place in other venues such as a coffee shop, online, or even over the phone. Agents must obtain a completed Scope of Appointment no less than 48 hours before the start of the appointment, unless a 48-hour exception applies. Refer to the Scope of Appointment (SOA) section later in this module for details.

For more information related to events, refer to the Events Basics section in Learning Lab > Content Library > Certifications > Study Guide.

You will also find materials on Learning Lab > Content Library > Grow Your Business with UnitedHealthcare: Conducting a Successful Event.

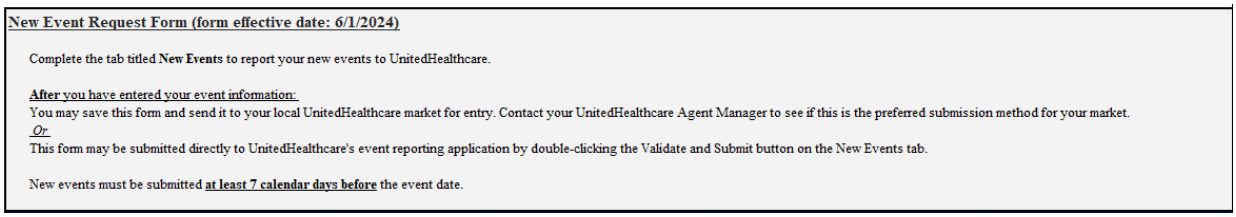
Event reporting

Event reporting rules

All marketing/sales events must be reported in UnitedHealthcare's event reporting application at least 7 calendar days prior to the date of the event. Agents use the New Event Request Form (available on ***Jarvis***) to submit their events. The agent is responsible for the timely reporting of events in the event reporting application. Therefore, we recommend agents submit the Event Request Form **14 calendar days prior** to the event date to allow time to process the New Event Request Form and resolve any issues that might occur.

UnitedHealthcare will not process new events reported less than 7 calendar days before the event date. Conducting an unreported marketing/sales event is prohibited.

Find the Event Request Form in Jarvis: Sales Tools > Meeting Resources > Events > NEW Event Request Form.



New Event Request Form (form effective date: 6/1/2024)

Complete the tab titled **New Events** to report your new events to UnitedHealthcare.

After you have entered your event information:
You may save this form and send it to your local UnitedHealthcare market for entry. Contact your UnitedHealthcare Agent Manager to see if this is the preferred submission method for your market.
Or
This form may be submitted directly to UnitedHealthcare's event reporting application by double-clicking the Validate and Submit button on the New Events tab.

New events must be submitted **at least 7 calendar days before** the event date.

Sensitivity to accommodations

Agents serving the Medicare-eligible population must be aware of and sensitive to the needs that might reasonably be expected within the defined population.

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

Hearing impairment and language translation

There are a number of services and aids available at no cost to the consumer to accommodate their needs. Consumers can request certain plan materials in alternate languages or formats, utilize TTY/TDD or State Relay Systems when calling Telesales or Member Services, and request alternate language translation services or a sign language interpreter at a formal marketing/sales event or personal/individual marketing appointment.

A consumer can request a sign language interpreter when calling Telesales to RSVP to a formal marketing/sales event or when scheduling a one-on-one marketing appointment with a field agent. Remember, agents are only permitted to use authorized individuals to serve as translators or interpreters. Using your family member or friend is not permitted. Consumers may elect to have family or friends available to assist; however, as an agent you need to accommodate reasonable requests for a sign language interpreter.

If you do not speak the consumer's non-English language fluently and the consumer is not accompanied by an individual who can competently perform translation services, you must either provide an authorized individual to provide translation services or refer the consumer to the phone number indicated in the Notice of Availability found in the Enrollment Guide for the plan you are presenting.

Requesting a Sign Language Interpreter

To schedule a sign language interpreter for a formal marketing/sales event or a personal/individual marketing appointment, enter the consumer's request directly in Mira at least 14 calendar days prior to the event or appointment.

If you do not have access to Mira or the request is within 14 calendar days of the date the interpreter is needed, you must submit a "Sign Language Interpreter Request" form (available on *Jarvis* > Contact Us > scroll to bottom, click Resources down arrow for ASL form) to the Producer Help Desk at PHD@uhc.com.

Promotional items and giveaways

Agents can offer consumers/members promotional items and giveaways provided they comply with the following guidelines:

- The combined retail cost of all giveaway items offered at an event or appointment, including food/refreshments, does not exceed $15 per person (maximum of $75 per person, per year).
- Giveaway items must not be a cash gift (or items convertible to cash, such as lottery tickets or other gambling devices), gift certificates or gift cards (unless approved by UnitedHealthcare), monetary rebates, or charitable contributions.
- Are offered to all Medicare eligibles in attendance without obligation to enroll. When a gift/giveaway is mentioned in event advertising, you must include a disclaimer indicating that there is no obligation to enroll.
- Must not be given in exchange for an enrollment or referral.

Refer to the Events Basics content in this Study Guide for information related to providing promotional items and giveaways at educational and formal/informal marketing/sales events.

Meals and refreshments

Meals may be offered at educational events only. Light food items and refreshments (which in combination could not reasonably be considered a meal) may be offered at educational events, marketing/sales events (formal and informal), and during in-person one-on-one marketing appointments. Alcoholic beverages are prohibited.

The cost of food items, in combination with all other giveaway items offered, may not exceed $15 per person ($75 per person per year maximum).

Food items not intended for consumption during the in-person event/appointment are prohibited from being offered as a giveaway, such as canned/boxed goods, eggs, milk, frozen turkeys, including vouchers for those kinds of items.

Refer to the Events Basics content in this Study Guide for information related to providing meals and/or refreshments at educational and formal/informal marketing/sales events.

Third party marketing organizations

Definition

Third-Party Marketing Organization (TPMO) Definition

- TPMOs include organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment-related functions as a part of the chain of enrollment (the steps taken by a beneficiary from becoming aware of a Medicare plan or plans to making an enrollment decision) into an MA plan or PDP.
- TPMOs may be a First tier, Downstream or Related entities (FDRs) to UnitedHealthcare or other entities that are not FDRs of UnitedHealthcare, but provide services to UnitedHealthcare or UnitedHealthcare's FDR.

What this means to UnitedHealthcare

- All entities and individuals contracted directly with UnitedHealthcare (EDC, ICA, IMO) are considered FDRs and, therefore, TPMOs, including National Marketing Alliances (NMA), eAlliance General Agents, Field Marketing Organizations (FMO), Strategic Marketing Organization (SMO), Independent Marketing Organization (IMO), Senior General Agents (SGA), IMO Master General Agents (MGA), IMO Regional Agents,

Master General Agents (MGA), General Agents (GA) and Agents (including EDC, Independent Career Agents (ICA), and IMO).

- TPMOs also include any entity contracted or subcontracted by an FDR that provides services to UnitedHealthcare or UnitedHealthcare's FDR. This includes Solicitors.

Requirements

TPMO requirements

- TPMOs must record, in their entirety, all marketing, sales, and enrollment calls, **including the audio portion of calls via web-based technology**. Entities and individuals are reminded of the requirement to protect consumer/member Protected Health Information (PHI) and Personally Identifiable Information (PII). The recording and storage of calls must meet UnitedHealthcare security requirements.
- All TPMOs are required to use, where appropriate, a standardized disclaimer. If the TPMO sells for all MA organizations or all Part D organizations in the service area (as applicable for the material), the disclaimer used is: "Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program for help with plan choices."
- If the TPMO does not sell for all MA organizations or all Part D organizations in the service area (as applicable for the material), the disclaimer used is: "We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program to get information on all of your options."
- The TPMO disclaimer must be:
    - Verbally conveyed within the first minute of a sales call.

    - Electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication.
    - Prominently displayed on TPMO websites.
    - Included in any marketing materials, including print materials and television advertisements, developed, used, or distributed by the TPMO.
- TPMOs, when conducting lead generating activities, either directly or indirectly for UnitedHealthcare, must, when applicable:
    - Disclose to the beneficiary that their information will be provided to a licensed agent for future contact. This disclosure must be provided as follows:
        - Verbally when communicating with a beneficiary through telephone.
        - In writing when communicating with a beneficiary through mail or other paper.
        - Electronically when communicating with a beneficiary through email, online chat, or other electronic messaging platform.
    - Disclose to the beneficiary that they are being transferred to a licensed agent who can enroll them into a new plan.
- Remember, Medicare beneficiaries must be aware of the role of the individual with whom they are interacting. Individuals interacting with beneficiaries are required to use a title that accurately describes their role in the “chain of enrollment." In some cases, a TPMO generates a lead and may or may not conduct eligibility screening activities. Regardless of the interaction, the beneficiary must be advised by the TPMO that their contact information is being provided or call is being transferred to a licensed agent who can enroll them in a Medicare Advantage or Prescription Drug plan. Refer to the Agent Guide for UnitedHealthcare-approved agent titles, for permission to contact and lead generation guidelines, and additional details related to TPMO recorded calls. (***Jarvis*** > Knowledge Center > Guides)

- TPMOs are required to disclose to UnitedHealthcare any subcontracted relationships used for marketing, lead generation, and enrollment.
- Beginning October 1, 2024, personal beneficiary data collected by a TPMO for marketing or enrolling them into an MA plan may only be shared with another TPMO when prior express written consent is given by the beneficiary. Prior express written consent from the beneficiary to share the data and be contacted for marketing or enrollment purposes must be obtained through a clear and conspicuous disclosure that lists each entity receiving the data and allows the beneficiary to consent or reject to the sharing of their data with each individual TPMO.
- TPMOs must report monthly to UnitedHealthcare any staff disciplinary actions or violations of any requirements that apply to UnitedHealthcare associated with beneficiary interaction.

Marketing materials

Marketing materials definition

Agents are required to comply with all applicable federal and state regulations and UnitedHealthcare rules, policies, and procedures when marketing and selling Medicare insurance products.

Marketing activity and materials, as defined by CMS, must meet both intent and content standards. In evaluating the intent of an activity or material, CMS will consider objective information including, but not limited to, the audience, timing, and other context of the activity or material, as well as other information communicated by the activity or material. The organization's stated intent will be reviewed, but not solely relied upon.

Intent

The activity or material intends to draw a consumer/member's attention to a plan or plans, influence a consumer/member's decision-making process when making a plan selection, or influence a consumer/member's decision to stay enrolled in a plan (retention-based marketing).

Content

Activity or material that includes or addresses content regarding the plan's benefits, benefits

structure, premiums, or cost sharing; measuring or ranking standards (such as Star Ratings); or rewards and incentives.

All agent/agency created material that meets the CMS definition of marketing must be reviewed and approved prospectively by UnitedHealthcare prior to filing in CMS' Health Plan Management System (HPMS).

Agent-created material that does not meet the CMS definition of marketing does not require UnitedHealthcare approval and must not contain any UnitedHealthcare brand element, including company or plan names or logos. Using "AARP" in any agent-created material is prohibited.

UnitedHealthcare provides agents with approved marketing materials in its UnitedHealthcare Agent Toolkit on Jarvis > Sales Tools > Sales Materials > UHC Agent Toolkit. Only materials for plans in which the agent is certified to sell will be displayed.

Examples

The method of communicating with the consumer or member does not determine if it is considered marketing material. Instead, it is the content of the material and the intent or purpose of the content. Any of the following communication methods may be considered marketing material based on content and intent:

- Newspaper, TV, Internet and radio advertisements
- Direct mail, postcards, flyers, brochures, magnets
- Pre-enrollment materials
- Websites and social media platforms

Important Note: Social media sites and websites can be considered communication or marketing material based on its content. Sites used to market UnitedHealthcare plans must be approved by UnitedHealthcare

and CMS prior to use. Refer to the Agent Website and Social Media Guidelines Job Aid on Jarvis > Knowledge Center > Reference Guides > Compliance > Key Compliance Resources.

Appropriate contact

Permission to contact

Agents are required to comply with all applicable federal and state regulations and UnitedHealthcare rules, policies, and procedures related to marketing and selling UnitedHealthcare Medicare products.

Permission to contact

Permission to Contact (PTC) is permission given by the consumer to be called or otherwise contacted by an agent for the purpose of marketing any UnitedHealthcare Medicare product, including Medicare Advantage, Prescription Drug or Medicare Supplement Plans. PTC must be documented, retained and available upon request by UnitedHealthcare or CMS for 10 years from the date PTC was received. The following elements must be contained within the PTC mechanism (online, paper, verbal, etc.):

- The name of the consumer requesting contact.
- The name or role of the entity that will be making the contact/outreach, such as Licensed Sales Agent or UnitedHealthcare.
- Requested contact method, such as phone call and telephone number or email and email address.

- Specific products or line of business, such as Medicare Advantage or Medicare Insurance Products.
- Required disclaimers, such as 'This is a solicitation of insurance' when the product scope includes Medicare Supplement Plans.

PTC only extends to:

- The person indicated in the PTC mechanism. For example, if another person answers the phone when the number on the PTC mechanism is dialed, you do not have permission to speak to that person - only the person that provided PTC.
- The phone number (and method) or email address provided on the PTC mechanism. If a consumer indicates they want to be called, using the phone number to text message is prohibited. If the phone number or email address is invalid, using other means to obtain valid contact information is not permitted. In addition, agents must comply with other regulations, such as the Telephone Consumer Protection Act (TCPA), to ensure it is compliant to use the contact information provided.
- The products indicated. Marketing products not indicated on the PTC mechanism is prohibited.
- The entity indicated in the PTC mechanism that will be contacting the consumer.

Permission to contact expires 12 months from consumer signature date or the date of their initial request unless one of the following occurs first:

- The consumer requests no future contact, in which case PTC expires upon request for no future contact.
- The consumer is on the Do-not-Call registry, is requesting information on Medicare Supplement Plans, or is on a Medicaid list, in which case PTC expires 90 days from the consumer signature date or the date of their initial request.

Click each plus (+) to read about types of contact.

BUSINESS REPLY CARDS | DIRECT CONTACT | ADDITIONAL REQUESTS | CONSUMER REFERRALS

- Agents who telephone a consumer in response to a Business Reply Card (BRC) that has specific products documented on the card may only discuss the products that were indicated within the BRC.
- BRCs are only intended to obtain permission to contact; it does not satisfy the SOA requirement.
- SOA does not secure permission to contact; it confirms permission to discuss product types during an individual appointment.
- If a BRC is returned by the consumer without a valid phone number, agents may not look-up or search for consumer information in order to contact the consumer either by telephone or an in-person visit. Valid PTC would not have been secured and agents may only contact the consumer via postal mail or email.

BUSINESS REPLY CARDS | DIRECT CONTACT | ADDITIONAL REQUESTS | CONSUMER REFERRALS

- Contact with consumers using postal mail and email is generally permitted. If a consumer requests no further contact, the agent must cease contact. For unsolicited email, an unsubscribe/opt-out process must be included in each email. Agents must comply with all applicable state and federal regulations related to communicating with consumers/members via telephone or email.
- Outside of postal mail and email, other forms of unsolicited direct contact are prohibited. Examples of prohibited unsolicited direct contact include door-to-door soliciting (including in congregate settings like assisted living or nursing homes), cold calling, direct messaging on social media platforms, text messaging, telemarketing, and approaching consumers during an informal marketing/sales event or in common spaces such as parking lots, retail stores, and lobbies.

BUSINESS REPLY CARDS | DIRECT CONTACT | ADDITIONAL REQUESTS | CONSUMER REFERRALS

- If during the course of an outbound call by a Medicare Supplement Plan the consumer requests additional information on an MA or PDP product, the agent can answer the consumer's questions related to the MA or PDP product. However, if the call proceeds to a plan discussion, the agent must observe SOA rules, obtain a new SOA, and wait 48 hours to discuss the MA or PDP plans (unless an exception applies).

BUSINESS REPLY CARDS | DIRECT CONTACT | ADDITIONAL REQUESTS | CONSUMER REFERRALS

- Agents may ask consumers/members to refer them to friends, neighbors and relatives and may provide business cards for that purpose. For example, an agent may choose to send a thank you card (available on the UnitedHealthcare Agent Toolkit) to newly enrolled members with extra business cards enclosed for the member to pass along to acquaintances.
- Agents are permitted to ask consumers/members for referrals (i.e. name and contact information) and are permitted to accept a referral offered by a consumer/member. However, the agent must comply with all permission to contact guidance, including the prohibition on cold calling. Agents may use postal mail and email to contact the referred individual, provided all state and federal regulations and UnitedHealthcare rules, policies, and procedures related to postal mail and email are followed. Prohibited methods of contacting the referred individual include door-to-door solicitation, calling, and texting. As a reminder, an agent may not offer or provide anything of value to a consumer/member in exchange for a referral.

Note: Agents are permitted to return phone calls or emails received from a referred individual.

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

Consumer John provides his cell phone number on agent Mark's Permission to Contact (PTC) mechanism and indicates he wants to be called as a means of contact. What does that mean? (select all that apply)

- [ ] Agent Mark may speak to anyone who answers the phone at the number provided on the PTC mechanism.
- [ ] Agent Mark may only call John, not text him.
- [ ] Agent Mark may only speak to John, the person who provided the PTC.
- [ ] Agent Mark may call or text John at the number provided.

SUBMIT

Agent Charlie receives a Business Reply Card from consumer Rebecca. Rebecca has provided her email address only and wants information about standalone Prescription Drug Plans. What can Charlie do?

- ○ Charlie may only email Rebecca marketing material related to Prescription Drug Plans.
- ○ Charlie may email Rebecca marketing material related to all Medicare plan types, including Medicare Advantage, Prescription Drug Plans, and Medicare Supplement Plans.

SUBMIT

Lead generation considerations

Lead generation and marketing activities are employed to generate consumer interest and often result in inbound calls. In some cases an agent is receiving a consumer inquiry based on activities conducted by another entity, such as the carrier or their agency.

Marketing activities may include:

- Direct mail pieces that consumers receive at their homes
- Television advertisements that consumers view while watching a program
- Websites operated by the call center agency or another third party

- Digital, billboard, and other types of advertisements

No matter the method of marketing and advertising, a consumer may rely on information that is provided in the advertisement and call the phone number presented in the advertisement.

Respect the reason the consumer gives for calling, but use caution so you do not jump to a plan recommendation prematurely.

Click each plus (+) to review the lead generation considerations.

Reason for the call —

There are risks in relying on what the consumer says is the reason for their call. Here are a few examples of what a consumer might say:

- “I saw an ad that says I can get money back in my Social Security each month.”
- “I want a plan that gives me a free gym membership.”
- “The TV ad says I can get over-the-counter items and food each month.”

These are just examples; what an agent hears from consumers as the reason for their call may vary widely. In some cases, the consumer may simply say they saw an advertisement.

If you rely only on what the consumer says is the reason for their call, you may be biased as to what type of plan to recommend, may overlook the importance of doing a thorough needs assessment, and/or enroll the consumer in an unsuitable plan.

Misleading / deceiving —

When speaking to a consumer, keep in mind that they may have misunderstood or been confused by what they read or heard in an advertisement. Make sure your interaction, from beginning to end, does not add to a consumer's misunderstanding or confusion.

For example, when you greet the consumer and throughout the interaction, make sure you are transparent in who you are, your role, and who you represent.

You are required to identify yourself by name, that you are a licensed insurance agent, and state the agency you represent. Do not indicate that you represent the carrier or any government agency (such as CMS). Remember, within the first minute of the call with the consumer, you are required to recite verbatim the standardized third-party marketing organization disclaimer.

As an agent, you are acting in the role of a trusted advisor. If you discover the consumer is not shopping for Medicare coverage, redirect them appropriately (e.g., to a carrier's customer service department) so they can get the help they need.

Scope of appointment

Consumers must agree to the scope of products that may be discussed at any face-to-face or telephonic marketing appointment. A Scope of Appointment (SOA) captures the consumer's permission to discuss certain products.

Click each tab to learn more.

RULES	DOCUMENTATION	MARKETING / SALES EVENTS

- SOA is required from each Medicare-eligible consumer present at any in-person, virtual or telephonic marketing appointment to discuss MA and/or PDP Plans, including authorized legal representatives and each spouse (if a married couple is present).
    - Inbound consumer-initiated calls require a SOA prior to a plan recommendation/presentation discussion, but the 48-hour rule is waived (similar to a

consumer-initiated walk-in to an agent's office). There is no SOA required when a consumer attends an event, talks to an agent at the event, or enrolls at the event. The SOA is only required for 1:1 appointments.

- SOA must be obtained from the consumer no less than 48 hours prior to the appointment, unless an exception to the 48-hour rule applies. Exceptions apply for unscheduled in-person meetings (e.g., walk-ins to an agent office or UnitedHealthcare MedicareStore) initiated by the consumer, inbound consumer-initiated calls, or appointments that are conducted during the last four calendar days of a valid election period for the consumer.

- When conducting in-person, virtual or telephonic appointments to present MA Plans and/or PDPs, the agent must:
    - Obtain a signed SOA from the consumer (including current members) no less than 48 hours prior to the start of the appointment unless an exception to the 48-hour rules applies.
    - When during an appointment, a consumer or agent requests to discuss a health-related product not identified on the original SOA, a new SOA that identifies the new product must be obtained and a future appointment scheduled no less than 48 hours from the time when the SOA is obtained. This includes appointments for Medicare Supplement Plans where the agent determines that an MA Plan and/or a PDP may be beneficial to the consumer, but was not identified in an SOA prior to the start of the appointment.

Note: While other health-related products, such as Medicare Supplement, do not in and of themselves require an SOA, any health-related product that will be discussed during an MA and/or PDP appointment must be indicated and agreed to by the consumer on the SOA.

RULES	DOCUMENTATION	MARKETING / SALES EVENTS

Agents are strongly encouraged to use JarvisEnroll electronic SOA (eSOA). eSOAs are retained in JarvisEnroll (for 10 years) and available to agents to view and download as a PDF. Agents are responsible for retaining for 10 years any SOA not obtained using JarvisEnroll eSOA and providing the SOA to UnitedHealthcare upon request.

Paper SOA forms are available in Enrollment Guides and as stand-alone documents on the Sales Materials Portal accessible on ***Jarvis*** > Sales Tools > Meeting Resources > Scope of Appointment.

RULES	DOCUMENTATION	MARKETING / SALES EVENTS

- In lieu of an SOA form, agents must announce the product(s) that will be presented at the formal or informal marketing/sales event.
- Agents may obtain an SOA for future in-person, virtual or telephonic appointments if the consumer requests the future appointment at the marketing/sales event.

PTC vs. SOA reminder

Permission to Contact (PTC) and Scope of Appointment (SOA), despite some similarities, are two distinct consumer protections provided by CMS and are not interchangeable. Permission to contact enables the agent to contact the consumer. Scope of appointment permits the agent to discuss with the consumer the products indicated on the SOA form during a one-on-one marketing appointment.

Cross-selling

CMS prohibits marketing non-health-related products (for example: annuities, life insurance and long-term disability/disability plans) when presenting an MA plan or PDP to a consumer. This activity is considered cross-selling and is prohibited. Presenting only MA and Part D Plans allows the consumer to focus on their Medicare options rather than cause confusion and a potentially misleading situation.

Agents may leave behind marketing materials describing other lines of business with a consumer when the appointment has concluded, but cannot discuss those other products during the appointment. The agent is responsible to ensure any such leave-behind

materials are in compliance with applicable state law governing the other lines of business.

Prohibited practices and sales tactics

Agents are prohibited from utilizing high pressure, aggressive, or scare tactics when marketing and/or selling to consumers.

Making worrisome or threatening statements or behaving in a way that can intimidate a consumer to cause them a feeling of undue urgency or pressure, can be considered a "scare tactic."

Potential consequences of engaging in any of these types or forms of activities may result in agent disciplinary action up to and/or including termination.

Here are a few examples of high pressure, aggressive or scare tactics:

- Advising a consumer that time is 'running out' and if they do not enroll now, they may not have health care coverage until next year.
- Advising a consumer that if they do not enroll now, they will not have medical coverage and any health-related condition could "wipe them out" financially.
- Using hypothetical health conditions to instill fear or scare consumers into purchasing coverage (for example: saying "Do you know someone who has recently had cancer? What if that happened to you?").

Power of attorney and/or legal representative

To enroll a Medicare beneficiary into a Medicare Advantage plan, Prescription Drug Plan, or Medicare Supplement Plan, an individual must have authority under state law to complete (i.e. sign) the enrollment application. The agent is not required to obtain proof of the individual's legal authority under state law, but must advise the individual that they must be

able to produce proof of their authority if requested by the plan. One common form of authorized legal representation* is to have durable Power of Attorney (POA). Note: some forms of POA do not include the authority to enter into contracts, such as enrollment into a health care plan.

Mental or physical ability

If a consumer appears to have either physical and/or mental challenges that may impede their ability to make an informed decision, you must ask if they have a POA or authorized legal representative.* If the consumer appears to be mentally incompetent, incoherent or unable to understand the product options and make an informed decision, it is recommended that the presentation be stopped. As a best practice, prior to the appointment ask the consumer if they have a POA. If they do, make arrangements to have that person present at the appointment.

If the consumer is mentally and physically capable of enrolling themselves, but needs some assistance, you can ask whether the consumer has a friend, clergy or family member who can assist. Note: A person assisting, including an agent, cannot sign the Enrollment Application on behalf of the consumer. Only the consumer, POA or authorized legal representative can sign the enrollment application.

A member may give another person permission to discuss their personal health information. A person granted this permission is referred to as an authorized legal representative or HIPAA authorized legal representative.

Enrollment basics and plan changes for MA and PDP

Needs assessment

Agents are required to conduct a thorough needs assessment with each consumer prior to plan recommendation and enrollment. A needs assessment is the act of asking questions, gathering information, and determining health plan coverage needs. Even if the consumer is currently enrolled in a Medicare insurance plan or calls stating a benefit or cost-share feature they want, do not omit conducting a thorough needs assessment.

Click each tab to learn more about a needs assessment.

PURPOSE OF A NEEDS ASSESSMENT | **NEEDS ASSESSMENT COMPONENTS**

The purpose of a needs assessment is to gather as much information about the consumer as possible to ensure you are recommending the plan that is the best fit for the consumer. Remember, the plan that best fits the consumer's needs may be the plan in which they are currently enrolled.

Failure to conduct a needs assessment, or conducting an incomplete assessment, may lead to an unnecessary plan change or enrollment in a plan that does not best fit the consumer's needs. The outcome often leads to a member complaint.

At minimum, a thorough needs assessment should include the following:

- **Type of plan:** Determine in what kind of health plan the consumer wants to enroll (e.g., low premium, high copay, etc.).
- **Eligibility:** Determine if the consumer is eligible to enroll (and disenroll if applicable), which includes knowing if they have Medicare Parts A and B and when each became or will be effective. In addition, determine if they have any recent or upcoming changes that may make them eligible for a special election period, such as a move to a new service area.
- **Current coverage:** Find out what the consumer has for current coverage. Coverage may include coverage through a current or former employer/union, state Medicaid program, Veterans Administration or TRICARE, PACE plan, Medicare Supplement Insurance, and/or Medicare (e.g., Original Medicare, Part C, and/or Part D). With Medicare Advantage and Medicare Supplement Insurance, it is also important to learn the plan type (e.g., HMO or Plan F) and the carrier. Ask if the consumer requires hearing, dental, and/or vision coverage.
- **Current providers:** Gather information about the consumer's current providers, including primary care, specialists, hospitals, and pharmacies. Look up providers, hospitals and pharmacies to determine if they are in network. If not, explain they could choose in-network providers, hospitals and/or pharmacies or pay out of pocket costs.
- **Current prescription medications:** Gather information about all medications taken on a regular basis or seasonally, including name (brand and/or generic), form (e. g., pill, extended-release capsule, liquid) and dosage. Check to see if the prescriptions are on the formulary. If not, explain they will have to pay the full price for the prescription.
- **Lifestyle and financial characteristics:** Ask what lifestyle or daily living considerations are important, such as transportation to and from provider appointments, fitness – mind and body, or network flexibility because they travel. Find out if the consumer needs durable medical equipment or physical therapy.
- **"Wish list":** Determine what healthcare coverage attributes are most important to the consumer and what tradeoffs might they be willing to make. For example, one customer might not want any network restrictions; whereas, another might be willing to enroll in a plan with a higher monthly plan premium if they can continue to see their current providers. Another consumer might be willing to change providers if it means paying a lower monthly plan premium. Alternatively, a consumer might be willing to pay more in cost-share to have access to

a national network of providers; whereas another consumer may be willing to enroll in a plan that has lower cost-share but a narrower network of providers and referral requirements.

Do not proceed with a plan recommendation until you have conducted a thorough needs assessment and have a complete picture of what the consumer has, wants and is willing to give up. You must also explain how to cancel the enrollment and any specific dates when the cancellation must occur.

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

From the list below, select the items that should be confirmed or obtained when conducting a thorough needs assessment. (select all that apply)

- [ ] Eligibility
- [ ] Current coverage
- [ ] Current providers

- [ ] Current prescription medications
- [ ] Current hygiene products
- [ ] Current grocery needs to determine allowance amount
- [ ] Daily living needs such as transportation, fitness, travel
- [ ] Other wish list items such as network restrictions, premium amounts, national network needs

SUBMIT

Plan comparison

Why is it important to compare plan options to the consumer's current plan?

When you recommend a plan that you have determined is the best fit, compare each plan side-by-side. Consumers often assume that the new plan recommended by the agent will have everything their current plan has and more. This assumption can lead to dissatisfaction and member complaints. It is your responsibility, prior to enrolling the consumer, to make sure that the consumer understands what they gain, what stays the same, and what they lose if they decide to enroll in the new plan.

- Compare benefits offered by the consumer's current plan with the coverage provided by the recommended plan. Review cost-share and benefit limitations of each plan.
- If the proposed plan has a network, look up all providers, including primary care, specialists, hospitals, and pharmacies and advise the consumer of each provider’s network status for their current and proposed plans. Look up each provider individually. Do not assume that an individual provider is in-network because the provider group they are affiliated with is in-network.
- In a similar manner, if the plan has drug coverage, look up all prescription medications and advise the consumer if the medication is in the plan’s formulary, tier, and any utilization management limitations.

Only proceed to enrollment in a new plan if the consumer understands that the plans are not the same and agrees to enroll. Make sure that the consumer knows to call customer service if they have any questions about using their new plan.

Plan changes

Anytime a consumer disenrolls from their current coverage by enrolling in a new plan, it is considered a plan change. For example, a plan change might be from a Medicare Supplement Plan to a Medicare Advantage plan or from Original Medicare and a stand-alone Part D plan to a Medicare Advantage with drug coverage plan.

A like plan change occurs when a consumer enrolls in a plan that is of the same product type as their current plan. For example, the consumer is enrolled in a Medicare Advantage (MA) plan and completes an enrollment application for a different MA plan. In some cases, the MA plans may even be of the same plan type: HMO to HMO, or HMO-POS to HMO-POS, or PPO to PPO.

During the needs assessment, if you discover the consumer is already in a Medicare health insurance plan, you need to compare any recommended plan to their current plan,

including benefits, costs, network, and drug coverage. Do not use phrases like “nothing will change” or “everything will be the same” because it is unlikely that two plans will be exactly the same. Similarly, do not say anything like, “I’m just adding some benefits to your coverage” or “I’m just upgrading your benefits” because it is inaccurate and misleading. The consumer must understand if they are changing plans, and if they are, what they get, what they give up, and what the effect is on their current coverage. Remember, the consumer’s current plan may be the best fit plan for them. Do not enroll the consumer in a new plan when it is not the best fit plan for them.

What are the pros and cons to changing plans?

Before recommending a plan change, follow these guidelines:

- Do not rely on and become biased by the consumer’s stated reason for calling. The consumer may have been enticed to call because of an advertisement they saw, but they must understand the pros and cons of enrolling in a different plan.
- Conduct a thorough needs assessment. The importance of this cannot be emphasized enough. You must gather comprehensive information related to the consumer’s situation and needs, including eligibility, current coverage, providers, medications, lifestyle, wish list items, and financial considerations.
- Only recommend a plan change when the new plan is determined to be the best fit for the consumer based on the needs assessment and after ensuring the consumer understands how the new plan compares to their current coverage.

Consumer comprehension

Agents must listen for signs of misunderstanding, confusion, and lack of comprehension at all stages of the meeting or call. Whenever you detect that the consumer may not be understanding, is confused, or is having difficulty comprehending what you are asking or telling them, STOP. Do not proceed until and unless you have cleared up the

misunderstanding, brought clarity to the confusion, and are sure they are comprehending the purpose of the conversation.

When you conduct selling and enrollment activities over the telephone, you don't have the benefit of seeing the consumer's facial expressions or body language in order to assess their comprehension. You must rely on what you hear, which includes the tone of the consumer's voice, the questions they ask, the responses they give, or even their pauses in the conversation.

A best practice is to ask each consumer if someone, such as a spouse, adult child, or other trusted individual, assists them with making decisions such as enrolling in healthcare coverage. It is especially important to ask them about assistance if you detect comprehension issues. If a consumer indicates someone assists them, do not proceed unless that individual can join the call. In situations when the person cannot join the call, advise the consumer to call back at another time when the individual that assists them can be on the call. ***See also the Power of Attorney section of the Appropriate Contact chapter.***

How must the agent respond when the consumer shows signs of confusion or lack of understanding?

- Follow the approved enrollment flow and sales and/or enrollment scripts precisely (if applicable). Do not use acronyms or technical terms that may not be familiar to a consumer.
- Speak clearly, at an appropriate volume, and at a moderate pace. Enunciate your words and do not mumble. Adjust your headset microphone and volume to ensure the consumer is able to hear, and if you hear a lot of background noise, ask the consumer if they can turn off the TV, for example, or go to a quieter location. Lastly, do not rush —instead, match your pace with the consumer's.
- Ask if someone assists them with making enrollment decisions and make sure that person is present. Do not proceed with the call or meeting if there is someone that assists the consumer and they cannot participate, or when the consumer says no one

assists them but the consumer is displaying signs of lacking comprehension to make an enrollment decision.

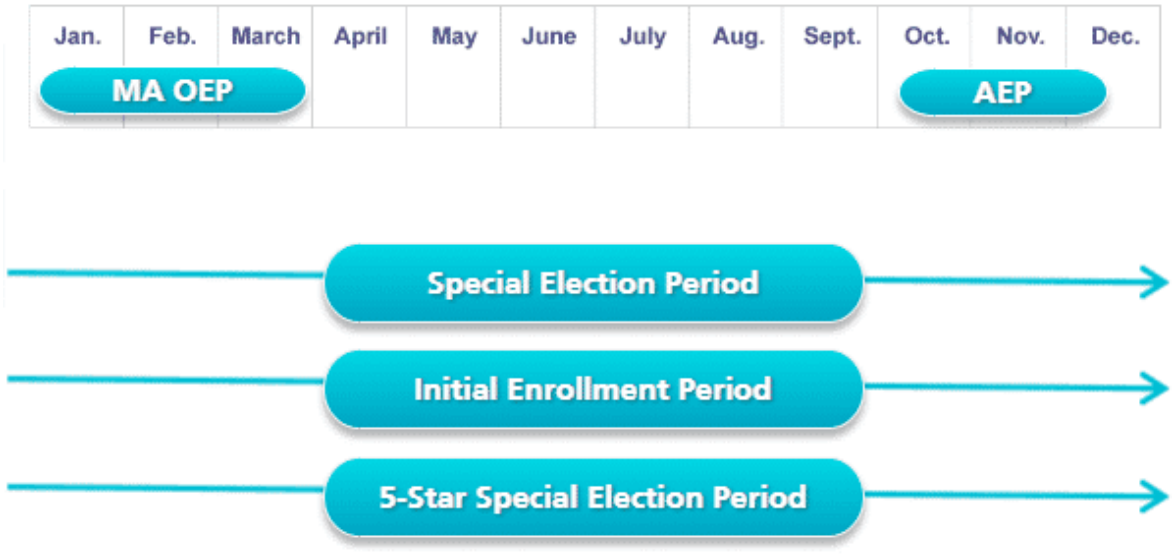
When consumers misunderstand, are confused by, or do not comprehend what you tell them, it may lead to dissatisfaction with the plan in which you enroll them. To help avoid member complaints, continually assess comprehension throughout the entire call.

What are election periods?

There are enrollment rules to follow and several items you must review with a consumer enrolling in an MA Plan or a PDP.

What are election periods? A consumer must have a valid election period in order to enroll in or disenroll from a Medicare Advantage or Prescription Drug Plan.

Review each election period time frame as shown below and click each tab to read the election period details.



January 1 to March 31

MA Plan members may have an opportunity from January 1 through March 31 to switch MA Plans (with or without drug coverage) or to disenroll from an MA Plan and obtain coverage through Original Medicare (with or without a standalone PDP). Newly eligible consumers who enroll in an MA Plan during their **Initial Enrollment Period (IEP)/Initial Coverage Election Period (ICEP)** can use OEP Newly Eligible, but only during the first three months in which they are **entitled** to Part A and Part B.

Members enrolled in stand-alone PDPs are not eligible for the Medicare Advantage Open Enrollment Period (MA OEP) election because the MA OEP is only available to those enrolled in an MA Plan.

Note: CMS prohibits plans or agents from marketing the MA OEP as a means to entice or encourage individuals to utilize their MA OEP opportunity to make a plan change.

MEDICARE ADVANTAGE OPEN ENROLLMENT PERIOD (MA OEP) | ENROLLMENT PERIOD (IEP) / INITIAL COVERAGE ELECTION | ANNUAL ELECTION PERIOD (AEP) | SPECIAL ELECTION PERIOD (SEP) | 5-ST

Qualifying members will have 3 months prior, the month of, and 3 months after their Parts A & B eligibility dates or the month they turn 65 (or date of disability, if prior to turning 65). If a qualifying member delays enrollment into Part B they will have only the 3 months prior to their Part B effective date. ***Note: Consumers born on the first day of the month would have 4 months prior, the month of, and 2 months after their birthday.***

- ICEP is for consumers newly eligible for Medicare Parts A and B who elect an MA-only Plan.
- IEP is for consumers newly eligible for Medicare Parts A and B who elect a stand alone-PDP or MAPD Plan.

The member's plan effective date will be:

- 1st day of month of Medicare eligibility, if the enrollment application is received prior to that date (often the month of the consumer's 65th birthday). If a member's birthday is on the first of the

month, their effective date is the first of the prior month.

- 1st day of month following receipt of the enrollment application, if the enrollment application is received in last four months of the IEP/ICEP.

MEDICARE ADVANTAGE OPEN ENROLLMENT PERIOD (MA OEP)	ENROLLMENT PERIOD (IEP) / INITIAL COVERAGE ELECTION	ANNUAL ELECTION PERIOD (AEP)	SPECIAL ELECTION PERIOD (SEP)	5-ST

October 15 to December 7

AEP is also called Medicare annual enrollment as it is the period each year when any Medicare consumer can enroll in or disenroll from a Medicare Advantage or Prescription Drug Plan. All AEP enrollment elections become effective January 1 and disenrollment elections become effective December 31.

Important! When agents may market for AEP

- Agents may not begin marketing until October 1.
- Agents may not accept or solicit submission of Enrollment Applications before October 15.
- If the Plan receives an unsolicited Enrollment Application prior to AEP, the Plan must retain the application and process the Enrollment Application beginning on the first day of the AEP with an application date of the same date.
- The consumer will receive an acknowledgment letter when the Plan receives an early Enrollment Application.

MEDICARE ADVANTAGE OPEN ENROLLMENT PERIOD (MA OEP)	ENROLLMENT PERIOD (IEP) / INITIAL COVERAGE ELECTION	ANNUAL ELECTION PERIOD (AEP)	SPECIAL ELECTION PERIOD (SEP)	5-ST

Qualifying members can make changes outside of the AEP in accordance with applicable requirements. There are various types of SEPs, including SEPs for dual-eligibles; consumers who move into, reside in, or move out of a nursing home; and those who have a qualifying chronic condition. Depending on the nature of the particular SEP:

- A member may disenroll from their MA Plan and return to Original Medicare

- A consumer with Original Medicare may enroll in an MA Plan
- A member of one MA Plan may enroll in a different MA Plan

Certain SEPs are limited to a single enrollment or disenrollment request within a particular time period; therefore, once the election is made, the SEP ends for the consumer even if the time frame for the SEP is still in effect. For example, an SEP is available for D-SNP members that lose their Medicaid eligibility. This SEP begins the month they are notified by the plan of the loss of Medicaid eligibility and ends when they enroll into a different Medicare Advantage/Part D plan or the last day of the third month after notification is received, whichever is earlier. For other SEPs, the consumer is not restricted by time periods or how often they may use the SEP. In these cases, consumers may enroll and disenroll using the particular SEP at any time throughout the year.

A member's plan effective date will be:

- 1st day of the month following receipt of an election
- For some SEPs, consumer may choose effective date of up to three months after the Plan receives their enrollment request
    - If the SEP is due to a move, the plan effective date cannot be earlier than the move date or receipt of the enrollment request.

At times, a consumer may be eligible for more than one election period. For example, during AEP a consumer may also be eligible for an SEP. Ensure the consumer understands the implications of choosing one election period over another and the resulting plan effective date.

For more information on Election Periods, review the Election Period Booklet found in the Enrollment Handbook in Jarvis > Knowledge Center > Learning Lab > Content Library > Enrollment and Election Periods.

MEDICARE ADVANTAGE OPEN ENROLLMENT PERIOD (MA OEP)	ENROLLMENT PERIOD (IEP) / INITIAL COVERAGE ELECTION	ANNUAL ELECTION PERIOD (AEP)	SPECIAL ELECTION PERIOD (SEP)	5-ST

October 15 to December 7

The 5-Star SEP is an election period available to consumers that allows them to enroll in a 5-Star rated plan. Consumers can use this SEP once from December 8 of the current year to November 30 of the next year and coverage will start the first of the month following receipt of the enrollment application. Consumers can only join a 5-Star Medicare Advantage Plan if one is available in their

area. Consumers who use this SEP to enroll in a 5-Star MA-Only Private Fee-for-Service (PFFS) Plan also have a coordinating SEP to enroll in a PDP even if it is not 5-Star rated.

Note: Consumers may lose their prescription drug coverage if they move from a Medicare Advantage Plan that has drug coverage to a Medicare Advantage Plan that does not. Unless that consumer has enrolled in a PFFS that permits them to also enroll in a stand alone PDP, the consumer will have to wait until AEP to obtain drug coverage. Additionally, the consumer may have to pay a Late Enrollment Penalty if their Part D coverage has lapsed.

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

Match the election period to the correct definition.

≡ 1 MA OEP	Consumers can switch or disenroll from their MA Plan & obtain Original Medicare
≡ 2 IEP	Newly eligible consumers can enroll 3 months prior, month of, & 3 months after turning 65

≡ 3 AEP	Annual period when any Medicare consumer can enroll in or disenroll from an MA or PDP
≡ 4 SEP	Opportunity to change plans for specific scenarios such as newly dual-eligible (Medicare and Medicaid) or new chronic condition
≡ 5 5-Star	One-time opportunity to enroll in a plan with a 5 star rating (if available)

SUBMIT

Medicare Supplement considerations

Medicare Supplement Plan sales are not restricted by election periods. Consumers with Original Medicare may enroll in and disenroll from Medicare Supplement Plans at any time, provided they meet the plan's eligibility criteria.

Consumers considering a Medicare Supplement Plan must have a valid election period if they are already enrolled in a Medicare Advantage Plan or want to enroll in a Prescription Drug Plan at the same time.

Enrolling in a Medicare Supplement Plan does not automatically disenroll a member from their Medicare Advantage Plan and vice versa.

Note: If a consumer has a Medicare Advantage Plan, it is non-compliant to sell them a Medicare Supplement Plan unless they are able to disenroll from their MA Plan and go to Original Medicare.

For additional guidance on enrollment and disenrollment, please see the Enrollment Handbook on Jarvis > Knowledge Center > Learning Lab > Content Library > Enrollment and Election Periods or use the Jarvis link in the resources tab above.

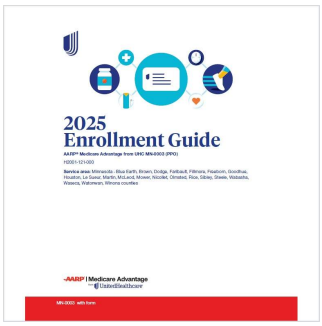
Important Medicare Supplement information

- A Medicare Supplement Plan helps to cover some of the out-of-pocket costs associated with Original Medicare.
- Consumers must be advised that:
    - A Medicare Supplement Plan does not pay any cost sharing incurred under a Medicare Advantage Plan,
    - A Medicare Supplement Plan will not automatically terminate when they are enrolled in a Medicare Advantage Plan, and
    - They should contact their Medicare Supplement insurer directly (generally in writing) in order to cancel their Medicare Supplement Plan. Furthermore, if they later leave the Medicare Advantage Plan, they may not be able to get the same Medicare Supplement Plan they were originally enrolled and/or may be subject to underwriting, which may increase the Medicare Supplement Plan’s premium amount.
    - If they remain enrolled in a Medicare Supplement Plan after their Medicare Advantage Plan has taken effect, plan premiums for the Medicare Supplement Plan will still be payable despite not being able to use the plan while enrolled in the Medicare Advantage Plan.

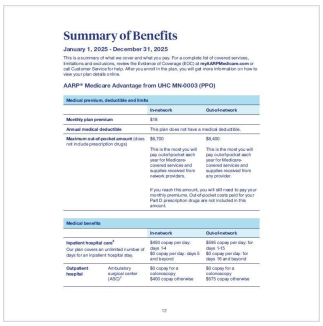
Materials required

UnitedHealthcare provides approved plan materials and resources for agents to use when conducting plan presentations. Materials are updated annually and are available at the beginning of a new plan year. Agents must provide the plan's complete Enrollment Guide (Enrollment Kit for Medicare Supplement) to the consumer at the time of enrollment. Enrollment materials may include:

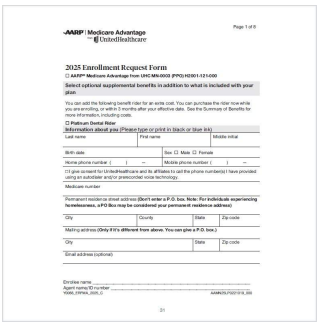
- **Summary of benefits:** Offers a detailed summary of the plan's benefits, explanation of cost sharing, and lists special features.
- **Pre-Enrollment Checklist (PECL):** A required document that helps the consumer understand the plan's benefits and rules (included with the Summary of Benefits).
- **Language interpreter disclaimer:** A required document that contains information explaining the consumer may request an interpreter (included in Summary of Benefits).
- **Plan ratings information ("Star Ratings"):** A required document that shows the Star Rating for the specific plan being sold, ranging from 1 to 5 stars.
- **Enrollment application:** A document used by individuals to request to enroll in a plan.



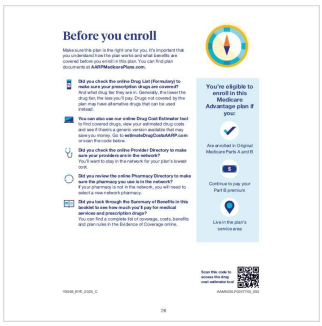
Enrollment guide



Summary of benefits



Enrollment request form



Before you enroll

Star Ratings

CMS rates plans annually in October based on performance in several key indicators, such as detecting and preventing illness, ratings from patients, patient safety and customer service. The ratings are displayed using a five star system. Five stars is the highest rating, one is the lowest. In addition to CMS publishing these ratings on Medicare.gov, CMS expects plans to inform consumers of the plan's overall rating at point of sale. Failure to do so is non-compliant with CMS requirements.

As plan representatives, agents must provide the most current star rating information to consumers at the time of enrollment. If the star rating changes in October after the Enrollment Guide has been published with the previous year's star rating, the agent must print a copy of current star rating (found on Medicare.gov or the Plan's website) to hand out with the Enrollment Guide and use that information during sales presentations until updated Enrollment Guides can be provided. Failure to disclose current and correct star rating information can result in a compliance infraction.

If a plan has received a Low Performing Icon (LPI) the agent must inform consumers of this as well. The LPI is assigned if the plan has 2.5 stars or less for three consecutive years in any combination of its Part C or D rating.

Star Ratings impact a Plan’s reputation and bottom line. There is also an impact on enrollments based on ratings. For more information about Star Ratings, see your Agent Guide, training materials or compliance information on ***Jarvis*** > Knowledge Center > Agent Training > Learning Lab > Content Library > Star Ratings > Star Ratings FAQ job aid.

Note: Star Ratings are issued at the individual contract level and are not an overall rating for the plan sponsor. Therefore, it is important that you are familiar with the Star Rating for each of the plans you sell.

Star Ratings do not apply to Medicare Supplement Plans.

Knowledge check

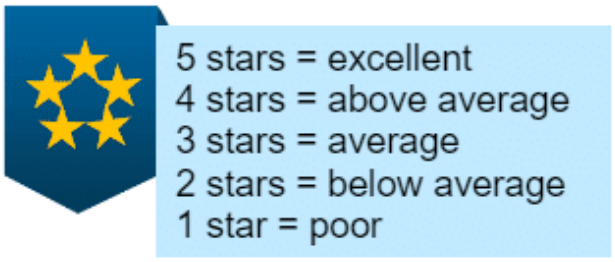
Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

What should you do if the consumer is interested in an MA Plan that has a 2-star rating?

- ◯ You should tell the consumer not to enroll in that plan.
- ◯ You should inform the consumer that the plan has received a "below average" rating.
- ◯ You only have to inform the consumer of a plan's star rating if it is a 3 or above.

SUBMIT

Affecting Star Ratings



How can I positively affect Star Ratings?

- Complaints are one element that CMS uses to determine a Plan's Star Rating. Here are two ways agents can help avoid complaints:
    - Conduct a thorough needs assessment to understand the consumer's current coverage and medical, prescription drug, and financial needs.
    - Ensure the consumer understands provider access and medication costs to prevent unpleasant surprises.

- CMS also measures how well the Plan is doing in getting members to obtain preventive care. Agents can help by:
    - Using materials on the UnitedHealthcare Agent Toolkit to encourage members to engage in healthy behaviors.
    - Encouraging members who have to choose a new PCP to set appointments as soon as possible after enrollment to prevent delays in care.

Statement of Understanding and disclosures

The Statement of Understanding (SOU) is a required element for enrollment and the agent must review it with the consumer at the point-of-sale. (It is called SOU on JarvisEnroll, but for paper applications, it is toward the end of the Enrollment Request Form.)

By signing the SOU, the consumer is acknowledging that they clearly understand the Enrollment Application (electronic or paper). This means they understand:

- They are actually enrolling in a plan
- The plan in which they are enrolling
- Several disclosure items*

**The SOU can vary between the different types of plans. The above items are among those a consumer can acknowledge on the SOU, depending on the plan type selected.*

Note: The SOU is not required for Medicare Supplement Plans.

Click the plus (+) below to read the disclosure items.

SOU disclosure items —

By completing this form, I agree to the following:

- This is a Medicare Advantage plan. It has a contract with the federal government. This is not a Medicare Supplement plan.
- I need to keep my Medicare Parts A and B. I must keep paying my Part B premium if I have one, unless Medicaid or someone else pays for it.
- I can only be in one Medicare health plan or Prescription Drug plan at a time. If I'm a member of another Medicare health plan or Prescription Drug plan and I join this plan, I will lose the other plan.
- If I have prescription drug coverage now or if I get it from somewhere else later, I will tell the plan.
- I may have to pay a late enrollment penalty (LEP). This would only happen if I didn't sign up for and keep creditable prescription drug coverage when I first qualified for Medicare. "Creditable" means the coverage is as good as a Medicare prescription drug plan. If I need to pay a LEP, the plan will tell me.

- I understand that I am joining the plan for the entire calendar year. If I want to change plans, I'll need to do so during the Open Enrollment Period for Medicare Advantage AND Medicare prescription drug coverage between October 15 and December 7. There may be special situations that would allow me to leave the plan at other times.
- This plan covers a specific area. If I plan to move out of the area, I will call my plan to switch to a plan in the new area. Medicare may not cover me when I'm out of the country. However, I have some limited coverage near the U.S. border.
- I will receive information on how to get an Evidence of Coverage (EOC). (The EOC is also known as a member contract or subscriber agreement.) The EOC will list services the plan covers, as well as the plan's terms and conditions. The plan will cover services it approves, as well as services listed in the EOC. If a service isn't listed in the EOC or approved by the plan, Medicare and the plan won't pay for it. If I disagree with how the plan covers my care, I have the right to make an appeal.
- I understand that I must get my health care coverage from doctors or providers that are in my plan's network. I can go to any doctor or hospital in an emergency or for urgently needed services or out-of-area dialysis services. If I happen to pay full price for any network services, this plan provides refunds for all medically necessary covered benefits.
- If I currently have Medicare Supplement Insurance (Medigap), I will cancel it in writing. I, not my agent, must cancel. I will cancel after my new plan tells me I've been accepted into the plan.
- My plan will give my information to Medicare and other plans when needed for treatment, payment and health care operations. This may include my prescription drug information. Medicare uses the information to understand how my care was handled or billed. Other plans may need my information when they help pay for my care. Medicare may also give my information for research and other purposes. All federal laws and rules protecting my privacy will be followed.
- If I get help from a sales agent, broker or someone who has a contract with the plan, the plan may pay that person for this help.
- The information on this form is correct, to the best of my knowledge. I understand that if I put information on this form that I know is not true, I will lose the plan.

Enrollment details

Enrollment Application guidelines

- Provide the Pre-Enrollment Checklist (PECL) to the consumer with the enrollment form. For telephonic enrollments, the contents of the PECL must be reviewed with the consumer prior to the completion of the enrollment.
- Ask each consumer if they are enrolled in Medicare Parts A and B.
- Be sure to include the Primary Care Provider (PCP) information if applicable.
- Remember that some plans have additional forms that are required to complete the enrollment. For example, the Chronic Condition Verification Form.
- Be sure to read and review the Statement of Understanding with each enrollment.
- Be sure the Enrollment Application is complete, accurate, clear and legible.
- Review the Before You Enroll document to ensure the consumer understands the plan.
- Provide the Summary of Benefits
- Provide the Star Ratings document with each enrollment. This document is available within the Enrollment Guide.

Note: These requirements apply specifically to CMS-regulated products. For information related to marketing non-CMS-regulated products, like Medicare Supplement Plans, please refer to the appropriate product module. See also the Jarvis link in the Resources tab above where you will find the Enrollment Handbook (Jarvis > Knowledge Center > Learning Lab > Content Library > Enrollment).

Risk awareness: innacurate provider information

Among the most common member complaints is the inability to see their established PCP, specialist or other care providers. To help you avoid this complaint, make sure you look up all providers the consumer currently uses to determine the provider's network status and whether their PCP (and any Specialists used) is "open," "open to existing patients" or "closed." Use the electronic directory because it will be the most up to date. Match the plan number to the directory you are using. Some providers are in network for specific plans/Plan Benefit Packages (PBPs) and not others. If the consumer's provider is not in network, ask if the consumer is willing to change providers.

If willing to change providers, help the consumer to look up suitable providers in the directory or direct them to member services for assistance. If changing a PCP or specialist, encourage the member to set up a new patient appointment as soon as reasonably possible to avoid delays in receiving care.

If the consumer is not willing to change providers, discuss out of network coverage and costs (if available), or seek another plan in which the required provider participates. Set expectations that out of network providers who don't accept the plan may require the consumer to pay up front and seek reimbursement from the plan on their own.

Whether for in or out of network benefits, be sure to discuss all referral requirements for providers.

See the user guide on Jarvis > Knowledge Center > Learning Lab > Content Library > Provider Search for additional information about provider search.

Enrollment signatures

Generally, the consumer is the only individual who may execute a valid enrollment or disenrollment request. As permitted by state laws where the consumer resides, CMS will allow an authorized legal representative to execute an enrollment application. Examples of an authorized legal representative include a court appointed guardian and/or a Power Of Attorney (POA).

Follow these guidelines for Enrollment Application signatures:

- Sign/complete and date the Enrollment Application and include your Agent ID Number.
    - If an agent indicates their agent writing number on the Enrollment Application prior to meeting with the consumer or assists the consumer in completing the MA or PDP Enrollment Application, the agent must clearly indicate this by checking the appropriate box on the Enrollment Application.
    - On the Enrollment Application, have the POA or authorized legal representative sign the application and print their name, contact information and relationship to the consumer.
    - The authorized legal representative or POA must sign an attestation on the application attesting that they have necessary legal authority to act on the consumer's behalf. Documentation of this authority must be available upon request by the Plan or by CMS, but you cannot require it for purposes of enrollment.
    - Someone who provides assistance to the consumer, but is not authorized to act on the consumer's behalf, cannot sign the Enrollment Application.

Note: Agents do not need to collect POA/authorized legal representation documentation. Medicare will request the documentation directly from the authorized legal representative if needed.

Non-discrimination requirements

Plan sponsors and agents working or contracted with Medicare may not discriminate against consumers or members based on race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of health care, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

Plan sponsors may not restrict enrollment into plans based on the criteria listed above except in cases where consumers must meet specific health requirements or income status in order to qualify for plan enrollment. This includes health conditions for Chronic Condition Special Needs Plans (C-SNPs) and Medicaid coverage for Dual Eligible Special Needs Plans (D-SNPs). This is not to imply if someone is eligible for Low Income Subsidy (LIS), they can only have a C-SNP or D-SNP plan.

Avoid shortcuts

- Do **not** take shortcuts when working with consumers to complete an enrollment application. The following guidelines should be followed when tempted with typical shortcuts:
- Do **not** sign the consumer's name. Never sign an application on the consumer's behalf, even with the consumer's knowledge and consent. Only the consumer or the authorized legal representative can provide the applicant signature.
- Do **not** misuse JarvisEnroll email address fields. Agents must only enter the consumer's email address in fields reserved for the consumer in the JarvisEnroll enrollment application, including when using JarvisEnroll remote signature functionality. The agent must leave the consumer email address field(s) blank if a consumer does not have an email address or does not want to provide an email address in order to receive plan related correspondence (including an enrollment

application receipt) electronically. Entering any email address (including that of an agent) in place of the consumer's is prohibited.

- Agent of Record only when you present. Never put your name on the enrollment application as the Agent of Record if you did not present the plan to the consumer. The signer of an application is responsible for ensuring that the consumer has been educated about the plan. That responsibility includes any mistakes or gaps in education provided to the consumer.

Taking shortcuts to avoid driving to an applicant's house or using agents that are not appointed to UnitedHealthcare to present plans will lead to disciplinary action, which may include termination of your agent agreement or even loss of renewal commissions.

Plan sponsor and agent requirements

The following is a basic outline of how applications are processed. Some enrollments may require additional steps based on added eligibility requirements.

AARP | Medicare Advantage from UnitedHealthcare

2024 Enrollment Request Form

☐ **AARP® Medicare Advantage from UHC CO-0004 (HMO-POS) H0609-036-002 - B3Q**

Information about you (Please type or print in black or blue ink)

Last name	First name	Middle initial

Birth date	Sex ☐ Male ☐ Female
Home phone number ( ) -	Mobile phone number ( ) -

Medicare number

Permanent residence street address **(P.O. box is not allowed)**

City	County	State	ZIP code

Mailing address **(Only if it's different from above. You can give a P.O. box.)**

City	State	ZIP code

Email address (optional)

Do you have other insurance that will cover your prescription drugs? ☐ Yes ☐ No

(Examples: Other private insurance, TRICARE, federal employee coverage, VA benefits or state programs.)

If yes, what is it?

Name of other insurance

Member number	Group number	RxBin	RxPCN (optional)

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

How do you want to pay?

Enrollee name _____

Agent name/ID number _____

Application submission: Agents must submit the Enrollment Application to UnitedHealthcare within 24 hours of receipt to avoid a "late application" infraction. Advise consumers that if they need to use the plan prior to receiving their confirmation letter and member ID card, they should contact

the customer service number to confirm enrollment. If the enrollment request is denied by CMS and depending on previous coverage, the consumer may have to pay the full cost for non-emergent or non-urgent care or fall back on Original Medicare cost sharing.

Enrollment Application receipt acknowledgment: Plans must acknowledge to the consumer that their application has been received. For paper applications, the plan sends a letter to the consumer within 10 days of receipt that acknowledges its receipt and states the effective date of coverage. Electronic enrollments are confirmed as received with a confirmation or tracking number. This must be provided to the consumer through an email or directly by the agent.

Plan validation: UnitedHealthcare will validate all information on the application, then submit the enrollment information to CMS for approval.

Confirmation letter and ID card: Once approved by CMS, the plan will send a letter confirming enrollment that also states the plan effective date along with the member's plan ID card.

Guaranteed rights

The following are guaranteed rights for all Medicare beneficiaries:

- Be treated with dignity and respect at all times
- Be protected from discrimination
- Have access to doctors, specialists, and hospitals
- Have questions answered about how doctors are paid
- Have questions about Medicare answered
- Have questions about contracted provider network limitations and requirements answered
- Learn about all of their treatment options and participate in the treatment decision

- Receive Medicare and health care provider/contractor information in a way the member understands
- Receive emergency care when and where a member may need it
- Receive a decision about health care payment of services or prescription coverage
- Have the right to appeal a decision about health care payment, coverage of services or prescription drug coverage
- File complaints (sometimes called grievances), including complaints about the quality of health care
- Have their personal and health information kept private

Appeals and grievances

What is an appeal? An appeal is a formal way of asking the plan to review and change a coverage decision the plan has made that the member believes should be made differently. Appeals may include requests to:

- Reconsider a denial of services or benefits
- Extend a hospital stay if the member thinks the planned discharge is too soon
- Continue services that the plan has medically determined to end at a particular point, including such services as physical therapy or skilled nursing stays

What is a grievance? A type of complaint consumers and members may make about the health plan, a health plan agent, one of its network providers or pharmacies, or quality of care. This type of complaint does not involve coverage or payment disputes. All consumers and members have the right to file a grievance with the health plan.

Note: Agents will find more information on Appeals and Grievances in the Evidence of Coverage or Statement of Understanding available on the Sales Materials Portal.

Disenrollment basics

Disenrollment defined

Disenrollment from a Medicare Advantage or Prescription Drug Plan can occur **voluntarily** by the member or **involuntarily** by the plan.

There are differences between disenrollment, withdrawal and cancellation requests.

- Requests to withdraw (before submission to CMS) or cancel (after submission to CMS) an enrollment application occur prior to the effective date.
- Voluntary disenrollments occur after the effective date.

See Enrollment Handbook/Table of Contents and click on Denial/Cancel/Withdrawal/Disenrollment section. (Jarvis > Knowledge Center > Learning Lab > Enrollment and Election Periods > Enrollment Handbook).

Click each tab to learn about disenrollment.

VOLUNTARY DISENROLLMENT | INVOLUNTARY DISENROLLMENT

Voluntary disenrollment basics

A member may request disenrollment from a Medicare Advantage or Prescription Drug Plan during a valid election period.

The member may disenroll by:

- Enrolling in another plan (during a valid election period).*
- Giving or faxing a signed written notice to the MA organization or through his/her employer or union, where applicable.
- Submitting a request via the Internet to the MA organization (if the MA organization offers such an option).
- Calling 1-800-MEDICARE.

When a member elects to enroll in another plan, the pending enrollment will cause an automatic voluntary disenrollment from the member's current plan.

Voluntary disenrollment options

MA OEP: An MA-Only or MAPD member may voluntarily disenroll from their MA Plan during the MA OEP by enrolling in another MA Plan or returning to Original Medicare. The disenrollment effective date for their existing enrollment is the last day of the month in which the new enrollment application or written disenrollment request is received.

AEP or SEP: When a member enrolls in an MA Plan or PDP during AEP or a qualifying SEP, they will be automatically disenrolled from their current MA Plan or PDP, even if it is offered by a different carrier. The effective date of the termination is the last day of the month prior to the effective date of the new enrollment. Exception: If the MA Plan is an MA-Only PFFS, the member will not be automatically disenrolled upon enrollment in a stand-alone PDP.

Note: Those disenrolling from a Medicare Supplement Plan should notify the Plan (generally in writing) of their wish to disenroll.

VOLUNTARY DISENROLLMENT | INVOLUNTARY DISENROLLMENT

Involuntary Disenrollment Basics

Disenrollment from a Medicare Advantage or Prescription Drug Plan can also occur involuntarily by the plan.

Required Involuntary Disenrollment
The plan must disenroll a member in the following cases:

- A change in residence to outside the plan's service area makes the individual ineligible to remain enrolled in the plan.
- The member loses entitlement to either Medicare Part A or Part B.
- The Special Needs Plan (SNP) member loses special needs status and does not reestablish SNP eligibility prior to the expiration of the grace period.
- The member dies.
- The MA organization contract is terminated or the MA organization reduces its service area.
- The member fails to pay his or her Part D - Income Related Monthly Adjustment Amounts (IRMAA) to the government.

Involuntary Disenrollment Options

Optional Involuntary Disenrollment: An MA organization may disenroll a member from its MA Plan if:

- Premiums are not paid on a timely basis.
- The member engages in disruptive behavior.
- The member provides fraudulent information on an enrollment application or if the member commits or permits fraudulent use of their plan member ID card.

Notice Requirements for Involuntary Disenrollments: In situations where the MA organization disenrolls the member involuntarily, the MA organization must notify the member in writing of the upcoming disenrollment that meets the following requirements:

- Advises the member the MA organization plans to disenroll them and the reason and effective date of termination.
- Includes an explanation of the member's right to a hearing under the MA organization's Grievance procedures.

Notices must be mailed to the member before submission of the disenrollment transaction to CMS.

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

A member can voluntarily disenroll from an MA Plan or PDP or they can be involuntarily disenrolled by the plan. Select the reasons below for **involuntary** disenrollment. (select all that apply)

- [ ] Member enrolls in another plan during a valid election period
- [ ] Member moves out of the plan's service area
- [ ] Member loses entitlement to either Part A or Part B
- [ ] During MA OEP, member switches from and an MA Plan to Original Medicare

SUBMIT

Can you identify these terms associated with enrollment and disenrollment basics? Read each statement and then drag the matching term to the statement.

≡ 1	Appeal	Action members take if they disagree with coverage or payment decision	⌄
≡ 2	Summary of Benefits	Detailed summary of plan's benefits, cost sharing and special features	⌄
≡ 3	Required Involuntary Disenrollment	Happens when member loses Part A or B entitlement	⌄
≡ 4	Statement of Understanding	Required to be read and acknowledged by the consumer at the enrollment	⌄
≡ 5	Star Rating	Medicare's measure of a plan's quality and performance	⌄

SUBMIT

Compliance program

Program elements

Federal law requires Medicare plan sponsors to implement and maintain an effective compliance program that incorporates measures to detect, prevent and correct non-compliance and fraud, waste and abuse. The program reflects our good faith effort to reduce non-compliance with legal, regulatory and business requirements.

There are seven key elements of a compliance program:

- Written policies, procedures, and standards or Code of Conduct
- High level oversight—accountable leaders, identified Compliance Officer and Compliance Oversight committees
- Effective training and education
- Effective lines of communication; reporting mechanisms
- Enforcement and disciplinary guidelines
- Effective and routine monitoring and auditing
- Prompt response to identified issues

What is compliance?

- Meeting and exceeding expectations
- Executing on our commitment to excellence, from beginning to end
- Getting it right the first time, every time
    - Take the time to do things right, even under pressure.
    - Have the right tools, know the policies and procedures, and understand how and when to ask for help.
    - Admit mistakes and take action when actions fall short of our commitment—especially when a consumer may be affected. We raise our hand and make it right.
    - Remember that the work we do is on behalf of someone's mother, father, child or loved one.

Your role and responsibilities

To fulfill your compliance responsibilities—Stop. Think. Ask.

- Ask for help if you are unclear or need guidance before you act.
- Speak up about your concerns.
- Address any mistakes, especially when a consumer may be affected.
- Do the right thing—the first time, and every time.

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

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

Compliance reporting resources

- Compliance questions: compliance_questions@uhc.com
- Privacy and security incidents: uhc_privacy_office@uhc.com
- The UnitedHealth Group Compliance & Ethics Help Center: 1-800-455-4521

Code of Conduct

Every UnitedHealth Group employee, director, and contractor must act with integrity in everything they do. Acting with integrity begins with understanding and abiding by the laws, regulations, Company policies, and contractual obligations that apply to our roles in the Company, our work, and our mission. The UnitedHealth Group Board of Directors has adopted a Code of Conduct, which applies to all employees, directors, and contractors, to provide guidelines for our decision-making and behavior. The Code is a core element of the Company's compliance program.

Conflict of Interest (COI)

Click each tab to learn about Conflict of Interest.

ATTESTATION, DISCLOSURE & MANAGEMENT	COI	CONFLICT CATEGORIES & TYPES

Agents and sales leaders representing UnitedHealthcare must annually complete a conflict-of-interest disclosure and attestation. An invitation to complete this action is sent to the individual on their Party ID anniversary date or, for newly onboarding individuals, shortly after their Party ID is issued. Failure to complete the conflict-of-interest disclosure and attestation within 90 calendar days of receiving the email invitation may result in corrective and/or disciplinary action up to and including termination.

When a conflict is disclosed, UnitedHealthcare will evaluate the disclosure and offer a management plan when applicable. An agent must acknowledge their compliance with the management plan. Failure to acknowledge and/or agree to a management plan may result in termination.

Conflicts of interest must be reported promptly as they arise. To request an invitation to disclose and attest to your conflict-of-interest status outside of the annual process, email Agent_COI@uhc.com and request a disclosure invitation.

Employees of UnitedHealth Group or its affiliates must also comply with the UnitedHealth Group corporate Conflict of Interest Policy and disclosure requirements. Employees should refer to the policy on Sparq/eGRC.

Individuals (employee and non-employee) representing UnitedHealthcare must disclose all conflicts, potential and real. UnitedHealthcare's goal is to work with the individuals to manage the conflict.

A conflict occurs when:

- Your interests or activities, or those of your immediate family*, could affect or appear to affect your decision-making on behalf of UnitedHealthcare, or
- Your objectivity could be questioned because of those interests or activities.

Immediate family includes: your spouse/domestic partner, your parents, step-parents and parents-in-law, your children, step-children and children-in-law, your siblings, step-siblings and siblings-in-law. Immediate family does not include aunts, uncles, or cousins.

UnitedHealthcare categorizes conflicts by type. Individuals may have more than one type of conflict and/or more than one conflict within a category.

Relationship with health care provider or UnitedHealthcare business partner:

You are (and/or your immediate family member is) an owner, employee, contractor, and/or consultant of and/or holds a position of influence with a health care provider or UnitedHealthcare business partner (e.g., equipment provider, vendor, supplier, and manufacturer).

What this might look like:

- You and/or a family member owns a medical clinic, an insurance agency, a durable medical equipment business
- You are and/or a family member is employed at a medical clinic, hospital, or other health care provider
- You are and/or a family member is contracted by a genetic/DNA testing company

Relationship with organization that interacts with Medicare beneficiaries:

You are an owner, employee, contractor, and/or consultant of and/or hold a position of influence with an organization that has any interaction with Medicare beneficiaries.

What this might look like:

- You work in the leasing office of a low-income housing development
- You rent a chair in a hair salon

UnitedHealthcare-appointed agent/agency has family member employed by UnitedHealth Group:

Note: Employment means your immediate family member receives a W2 from their UnitedHealth Group business at the end of the calendar year for tax purposes.

You are an agent/agency appointed with UnitedHealthcare AND have an immediate family member who is an employee of UnitedHealth Group or its affiliate.

What this might look like:

- Your mother is a UnitedHealthcare agent manager
- Your sister is an accountant with Optum

UnitedHealth Group employee has UnitedHealthcare-appointed family member:

Note: This category only applies to employees of UnitedHealth Group or its affiliate, meaning a UnitedHealth Group business provides a W2 at the end of the calendar year for tax purposes.

You are employed by UnitedHealth Group or its affiliate AND have an immediate family member who is an agent appointed with UnitedHealthcare.

What this might look like:

- You are a UnitedHealthcare agent manager and your father is a contracted agent (meaning he receives a 1099 from UnitedHealthcare at the end of the calendar year).

UnitedHealth Group Employee is Actively Contracted with UnitedHealthcare or Another Insurance Carrier:

Note: This category only applies to employees of UnitedHealth Group or its affiliate, meaning a UnitedHealth Group business provides a W2 at the end of the calendar year for tax purposes.

You are employed by UnitedHealth Group or its affiliate AND are actively contracted with UnitedHealthcare or another insurance carrier.

What this might look like:

- You are an underwriter with a UnitedHealthcare business and are simultaneously contracted in the Independent Career Agent (ICA) channel, actively writing new business.
- You are a UnitedHealthcare market manager and maintain an active contract with UnitedHealthcare to receive renewals for business written as an ICA prior to becoming a UnitedHealthcare employee.

Note: UnitedHealth Group employees are required to disclose any active contracts they have with UnitedHealthcare and/or another insurance carrier that offers Medicare insurance products even if it is because the employee must remain in a contracted status (e.g., servicing) with a carrier to receive renewals for business written prior to becoming a UnitedHealth Group employee.

UnitedHealth Group employee sells non-UnitedHealthcare products requiring a state license:

Note: This category only applies to employees of UnitedHealth Group or its affiliate, meaning a UnitedHealth Group business provides a W2 at the end of the calendar year for tax purposes.

You are employed by UnitedHealth Group or its affiliate AND actively sell non-UnitedHealthcare products that require a state license (e.g., health, life, property/casualty, financial services), which may or may not compete with UnitedHealthcare insurance products.

What this might look like:

- You are a UnitedHealthcare broker services representative and actively sell life insurance after hours and on weekends.

Progressive disciplinary engagement process

UnitedHealthcare regards complaints and allegations of agent misconduct and issues of noncompliance as serious matters requiring prompt attention. A progressive disciplinary engagement process provides the appropriate level of investigation, outreach, and remediation based on the severity of the allegation and/or the agent's complaint history.

The progressive disciplinary engagement process includes three levels of engagement and a point system:

Click each tab to learn more.

COMPLAINT EDUCATION CONTACT (CEC)	CORRECTIVE ACTION REFERRAL (CAR)	DISCIPLINARY ACTION COMMITTEE (DAC)	POINTS SYSTEM

The CEC process provides two levels of engagement, CEC1 and CEC2, and is used as an intermediary measure to address agent complaint behavior in a proactive manner through coaching and support materials. CEC1 coaching is specific to the allegation received from the consumer/member; whereas, CEC2 includes coaching on the specific allegation, but is expanded to cover the entire allegation family.

COMPLAINT EDUCATION CONTACT (CEC) | CORRECTIVE ACTION REFERRAL (CAR) | DISCIPLINARY ACTION COMMITTEE (DAC) | POINTS SYSTEM

The CAR process supports the progressive disciplinary process with retraining efforts delivered in a prompt manner intending to correct the underlying problem that resulted in a program violation and to prevent future noncompliance. Whether the outcome of an investigated allegation is Inconclusive or Substantiated, a CAR may be assigned to the agent. CAR coaching is specific to the allegation(s) received from the consumer/member and the agent is assigned a remediation course that covers the entire allegation family and must pass an assessment at the end of the course.

COMPLAINT EDUCATION CONTACT (CEC) | CORRECTIVE ACTION REFERRAL (CAR) | DISCIPLINARY ACTION COMMITTEE (DAC) | POINTS SYSTEM

An agent is referred to the DAC when the complaint investigation results in an Inconclusive or Substantiated outcome for an egregious allegation(s), previously coached higher-risk allegation(s), and/or is the result of repeated lower-level allegations within a 12-month period despite efforts to remediate. The DAC reviews the agent's case and assigns an outcome of No Action Required, Corrective Action, Deauthorization of Sales and Marketing Activity, or Termination.

COMPLAINT EDUCATION CONTACT (CEC) | CORRECTIVE ACTION REFERRAL (CAR) | DISCIPLINARY ACTION COMMITTEE (DAC) | POINTS SYSTEM

Each level of engagement is assigned a point value:

CEC/CEC2 - 1 point **CAR** - 2 points **DAC** - 3 points

Agents receive additional monthly coaching when complaint points exceed a defined threshold. For details, refer to Agent Guide on ***Jarvis*** > Knowledge Center.

Fraud, Waste and/or Abuse (FWA)

FWA overview

In the fiscal year ending September 30, 2024, the United States Department of Justice (DOJ) recovered over $2.9 billion[1] from settlements and judgments under the False Claims Act. All UnitedHealth Group employees, directors and contractors are required to report any and all suspicions of fraud, waste and abuse; violations of UnitedHealth Group policies or procedures and Federal or state laws; and illegal or unethical conduct. Under federal regulations, activities involving FWA may carry monetary penalties, federal imprisonment, and may be barred from future participation in any federal program. This section will cover Fraud, Waste, and Abuse (FWA) definitions and types: the laws and regulations that address FWA, and your role in identifying and reporting any suspected or real FWA incidents.

[1] *Department of Justice website*

Definitions

Click each tab to review each definition of Fraud, Waste and Abuse.

FRAUD | WASTE | ABUSE

Fraud is intentionally misrepresenting or concealing facts to obtain something of value. The complete definition has three primary components:

- Intentional dishonest action or misrepresentation of fact
- Committed by a person or entity
- With knowledge that the dishonest action or misrepresentation could result in an inappropriate gain or benefit for the person, entity, or other person

FRAUD | WASTE | ABUSE

Waste includes inaccurate payments for services, such as unintentional duplicate payments, and can include inappropriate utilization and/or inefficient use of resources.

FRAUD | WASTE | ABUSE

Abuse includes any practice that results in the provision of services that:

- Are inconsistent with sound fiscal, business or medical practices
- Result in unnecessary cost to the program
- Not medically necessary or fail to meet professionally recognized standards of health care

Examples of FWA

At UnitedHealth Group, we are all responsible for detecting, correcting and preventing fraud, waste and abuse. Within managed health care benefit programs like Medicare, fraud, waste and abuse comes in many forms. Some examples include:

- Completing applications for consumers without their knowledge or consent.
- Manipulating or falsifying information on an application to make eligible someone who is not actually eligible for enrollment.
- Entering into kickback schemes with providers or members.
- Charging consumers inappropriately for services (such as completion of applications).
- Enrolling a member by forging a signature on an application.
- Misrepresenting benefits to persuade an individual to join a health plan.
- Falsifying the location of a group in order to obtain insurance or lower premium rates.
- Conspiring with others to get a false or fraudulent claim paid by the federal government.
- Falsifying claims/encounters, services or credentials.

Federal and State laws

To combat the increasing problem of fraud, waste and abuse, federal fraud prevention laws have been established. Each of these federal laws has its own purpose in preventing fraud, waste and abuse. Some examples of the laws include:

Click each tab to review the examples.

Federal and State anti-kickback statutes

These statutes make it a crime to knowingly and willfully offer, pay, solicit, or receive–directly or indirectly–anything of value to induce or reward referrals of items or services reimbursable by a federal health care program. The intent of anti-kickback statutes is to ensure referrals for health care services are based on medical need or benefit and not based on financial or other types of incentives.

Citation: Anti-Kickback Statute (42 U.S.C. § 1320a-7b[b])

Examples of prohibited activities:

- Offering cash reimbursement in exchange for an enrollment or referrals (or potentially influence referrals) to health care providers or other health care programs for services paid for by the federal government.
- Offering gifts or services greater than the nominal amount permitted by federal guidelines.
- Offering gifts or services dependent on enrollment or referral.

Federal Health Insurance Portability and Accountability Act (HIPAA)

Title II of HIPAA

Title II includes multiple provisions including but not limited to the creation of a fraud, waste and abuse control program for coordination of state and federal health care fraud investigation and enforcement activities. It also created new criminal provisions that expanded which actions could be considered health care fraud and made it a federal crime to defraud health care benefit programs - any benefit program - not just Medicare or Medicaid.

Citation: Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104-191); 42 U.S. Code § 1320a-7c - Fraud and abuse control program; 42 U.S. Code § 1395ddd - Medicare Integrity Program

CMS data use agreement

As part of the Medicare Advantage and Part D contracts UnitedHealthcare has with CMS, the Company is required to attest annually that UnitedHealthcare will only use data it obtains from CMS systems and members for the administration of the Medicare Advantage and Part D plans.

What does this mean?

This means we can only use the data we obtain from CMS systems and members to administer our Medicare Advantage and Part D contracts. The data cannot be used for other purposes.

Federal and State False Claims Act

The Federal False Claims Act prohibits any person from knowingly presenting or causing the presentation of a fraudulent claim for payment. The Act also includes non-retaliation protections for persons who report potential misconduct to responsible authorities.

The proof of intent to defraud is not required and creates liability for anyone who knowingly submits, uses, or causes to be submitted or used a false record, statement, or claim for payment to the government.

In addition to the Federal False Claims Act, a number of states have also enacted False Claims Acts to discourage fraud against state government programs that also contain non-retaliation protections.

As of February 2025, violations can result in liability for repayment up to three times the original dollar amount and potential civil penalties of $13,946 - $27,894 for each claim.

Citation: False Claims Acts (31 U.S.C. §§ 3729-3733)

Reporting potential FWA

Speaking up is not only the right thing to do, it's required by company policy.

One of UnitedHealth Group's basic responsibilities is to create an environment that encourages and protects employees when there is a report of misconduct, policy violations or fraud, waste and abuse. UnitedHealth Group prohibits any form of retaliation against employees and directors who report good faith concerns of unethical conduct or violations of law, regulation or company policy. UnitedHealth Group provides many ways to report fraud, ethical, legal, regulatory and policy concerns.

Note: Questions related to fraud, waste and abuse should be submitted to either the Producer Help Desk or Distribution Compliance Mailbox at the contact information listed here.

Reporting options

- UnitedHealth Group Compliance & Ethics Help Center: 1-800-455-4521
- Producer Help Desk: Phone 1-888-381-8581 Monday-Friday, 7am-9pm CT
- Distribution Compliance Mailbox*: compliance_questions@uhc.com
- UnitedHealthcare Fraud Tip Line*: Phone 1-866-242-7727 Monday-Friday, 8am-6pm CT or via recorded message 24 hours a day, 7 days a week

**** For confidential reporting, utilize the Compliance Mailbox or Fraud Tip Line***

Privacy and security

HIPAA

Health Insurance Portability And Accountability Act (HIPAA)

HIPAA is a federal law that provides requirements for the protection of consumer health information. There are two pertinent provisions that guide the use of member/consumer information:

Privacy provisions	**Security provisions**
The HIPAA Privacy Rule outlines specific protections for the use and sharing of member PHI/PII*. **** Protected Health Information (PHI) and Personally Identifiable Information (PII)***	The HIPAA Security Rule defines how electronic PHI should be maintained, used, transmitted and disclosed.

The UnitedHealthcare Privacy Office is responsible for the investigation of all privacy and/or security incidents involving a potential or actual disclosure of member/consumer information. If consumer protected information is disclosed to an unintended recipient, the

Unitedhealthcare Privacy Office will investigate and provide any required notifications. Required notifications can include notifying:

- Federal and State regulatory agencies
- UnitedHealthcare members/subscribers
- UnitedHealthcare clients
- The media

In addition to possible civil fines and penalties, HIPAA violations could also result in criminal prosecution. If you become aware of a potential PHI/PII disclosure, it must be reported IMMEDIATELY to the UnitedHealthcare Privacy Office. Even if the disclosure involves only one consumer, you must report it.

What should you do?

All suspected privacy incidents must be reported to the UnitedHealthcare Privacy Office directly or by reporting the incident to the Compliance Mailbox or your UnitedHealthcare growth manager, who in turn must forward the report to the Privacy Office.

- Privacy Office: uhc_privacy_office@uhc.com
- Compliance Mailbox: compliance_questions@uhc.com

Security incidents (unauthorized access of UnitedHealth Group data/systems, laptop theft) must be immediately reported to the UnitedHealth Group Support Center at 888-848-3375, 24 hours/day, 7 days/week, 365 days/year.

Note: UnitedHealthcare prohibits retaliatory action against any individual for raising concerns or questions regarding ethics and compliance matters or for reporting suspected violations in good faith.

PHI and PII

Protected Health Information (PHI) and Personally Identifiable Information (PII)

What information must be protected?

PHI

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

- Identified individual + health information = PHI
- For example: Jon Doe + identifying Jon as a health plan member = PHI
- For example: Jon Doe + demographic information as a health plan member = PHI
- For example: Jon Doe + has diabetes = PHI
- The fact that someone is applying for coverage or is enrolled in a UnitedHealthcare plan is considered protected health information

PII

PII includes a person's first name or first initial and last name with one or more data elements which may include:

- Social Security number
- Driver’s license number or state identification card number
- Account number, credit card or debit card number in combination with any required security code, access code, or password that would permit access to a consumer's/member's financial account

Examples of inappropriate disclosures include:

- Accidentally or carelessly leaving documents with PHI or PII in a non-secured area.
- Allowing completed lead cards and/or enrollment applications to be viewed or handled by someone other than the consumer or plan representative at a marketing event.
- Faxing documents with PHI/PII to an incorrect fax number.
- Mailing documents with PHI/PII to an incorrect address.
- Lost or stolen hard copy documents (e.g., Enrollment Applications).
- Stolen, misplaced computers (unencrypted computers).
- Sending an unsecured email with PHI/PII to an incorrect email address (outside of UnitedHealthcare's firewall).

Risks and responsibilties

The use of personal information to commit medical identity theft or fraud is a fast growing issue. Access to and possession of protected consumer/member information requires that you be extremely focused on protecting it.

In an effort to protect consumer/member information and be compliant with applicable laws, agents and agencies (e.g., Field Marketing Organizations) must follow the rules pertaining to storage, retention and disposal of member/consumer PHI/PII.

Rules

The following are a few rules to keep in mind:

- When out of the office, keep all electronic devices and hard copy documents containing PHI/PII in your possession at all times.

- Do not leave electronic devices or hard copy documents containing PHI/PII unattended in your vehicle or in your office. Secure devices and materials to reduce the risk of unauthorized disclosure.
- Do not discuss member/consumer information in public spaces including restaurants or elevators, where your conversation could be overheard.
- Protect all electronic devices, such as laptops, tablets, and phones, with encryption software. See Agent Guide located on ***Jarvis*** > Knowledge Center.
- Safeguard your passwords and do not use the same password for multiple systems/accounts.
- Be cautious. UnitedHealthcare will not send you an email requesting your username and password and we will never call and request your password.
- Appropriately dispose of any device or document containing PHI/PII. For example, shred hard copy documents.

Scenario examples

Examples of Privacy and Security Issues that must be reported:

- An incorrect fax number was used to submit completed enrollment applications.
- Completed enrollment applications and/or an unencrypted laptop containing consumer PHI/PII were stolen from the agent's vehicle.
- An agent did not shred documents containing member PHI/PII prior to discarding.
- Accidentally leaving a completed application or copy with the wrong consumer.

Compliant sales practices summary

In each section below, click the tabs to review a summary of the rules to follow when selling Medicare Advantage and/or Prescription Drug Plans.

Plan details

MUST DO | **MUST NOT DO**

- Review the "Summary of Benefits" with the consumer, clearly pointing out both their benefits and what their costs will be related to the plan (such as premium, deductibles, copayments or coinsurance).
- Carefully explain the various aspects of Medicare Advantage Plans so that consumers understand their responsibilities and cost sharing. Be especially mindful of the differences with plans like SNP or PFFS.
- When discussing Value Added Items and Services (VAIS), make sure it is clear to the consumer that VAIS is not a plan benefit. VAIS are provided by a third party (not the plan), and the consumer is responsible for any costs associated with the services.
- Assess the consumer’s understanding and comprehension. Make sure the consumer understands what they gain, what stays the same, and what they lose by enrolling in a new plan.

MUST DO	MUST NOT DO
	• Lead with the plan's Value Added Items and Services (VAIS). Any discussion or promotion of VAIS prior to enrollment should take place only after the agent has presented a plan and discussed the plan's benefits. • Enroll consumers into plans that are not best suited to their circumstances without explaining potential challenges to obtaining benefits. • Recommend a plan before a needs assessment has been conducted. • Rely on the reason the consumer gives for the purpose of their inbound call. This may create a bias in your mind and lead you to a premature plan recommendation.

Marketing/sales activities

MUST DO	MUST NOT DO
• Ask if the consumer has a Power of Attorney, authorized legal representative, or other individual that assists them in making health care decisions. If so, make sure the person indicated is present when meeting with the consumer. • Market only health care related products during any Medicare Advantage (MA) or Prescription Drug Plan (PDP) sales activity or presentation. • Explain Medicare eligibility requirements, Election Periods, effective date selection, and conduct a thorough needs assessment prior to enrolling a consumer.	

- Provide the consumer with an Enrollment Guide and agent contact information at the time of enrollment.

MUST DO	MUST NOT DO
	• Solicit or accept an enrollment application outside of a valid Election Period. • Enroll a consumer in a plan if they have better benefits with their current health plan unless the consumer insists on enrolling. • Discuss plan options that were not agreed to by the consumer in advance on the Scope of Appointment (SOA).

Marketing materials

When offering UnitedHealthcare products, it is important to use approved and compliant materials, including advertisements, flyers, business cards, plan presentations, sign-in sheets, enrollment materials, and lead or business reply cards. Follow these basic guidelines when using materials:

MUST DO	MUST NOT DO
• Use marketing materials that are approved by UnitedHealthcare and the applicable regulator (e.g., CMS for federal products and the state/AARP for AARP Medicare Supplement Plans). • When using materials from the UnitedHealthcare Agent Toolkit, only personalize and customize to the extent permitted in the Toolkit.	

- Use materials approved for the current plan year and as they were approved to be used (e.g., a flyer must not be used as a newspaper ad).
- Agent-created communications materials must comply with all CMS regulations and UnitedHealthcare rules, policies, and procedures.

MUST DO	MUST NOT DO

- Modify approved materials in any way, including changing font size, reducing document size, adding your own company logo, highlighting, underlining, obscuring text, or affixing a sticker or label. Agents may attach a compliant business card to MA/PDP marketing materials provided it is not attached in a manner to obscure content. Agents are not permitted to attach a business card to Medicare Supplement marketing material.
- Create marketing materials that include any plan name, benefit or cost information.
- Ask consumers any health-related or health-screening questions on generic, agent-created materials intended to market Medicare Advantage or Prescription Drug Plans.
- Use colors schemes and/or words on a business card, business or website domain name, or agent-created materials that might lead a consumer to believe you represent Medicare or another government agency.

Network providers

MUST DO	MUST NOT DO	MAY DO

- Look up all providers from whom the consumer receives care in the online provider directory. (***Jarvis*** > home page > Quick Access > Find a Doctor; also find related training materials on Learning Lab.)
- Compare costs for in and out of network services.
- Review limitations and provider referral requirements.
- Explain what is meant when a Pharmacy is labeled as "preferred."

MUST DO	MUST NOT DO	MAY DO

- Assume that all providers are in the network without looking up providers in the online directory (if presenting a network-based plan).

MUST DO	MUST NOT DO	MAY DO

- Encourage members who change their PCP to set appointments with their new PCP to prevent delays with receiving healthcare.
- Encourage the member to contact you if they change their PCP or add a new specialist.

Provider settings

Agents must ensure that contracted providers are aware of their responsibility to remain neutral and not recommend specific plans or plan sponsors. These are a few of the guidelines you need to know.

MUST NOT DO

- Agents must not request providers to participate in marketing on behalf of the plan or an agent, such as:
  - Offer sales/appointment forms
  - Gather lead or business reply cards
  - Accept enrollment applications
- Agents must not use patient lists from providers for the purpose of solicitation.
- Providers must not mail marketing materials on the agent's behalf.
- Providers must not make telephone calls or steer their patients, in any way, to a limited number of plans.

MAY DO

MUST NOT DO

MAY DO

- Agents may schedule appointments with consumers residing in a residential health care facility upon request of the consumer.
- Agents may market (e.g., conduct a formal or informal marketing/sales event) in common areas of health care settings (such as hospital or clinic conference rooms, public and private waiting rooms, or community or recreational rooms).
- Providers may direct their patients to www.Medicare.gov to compare health plans.

Permission to Contact

MUST DO	MUST NOT DO	MAY DO

- Request and document permission to contact (in Mira if available to the agent) and PTC documentation (e.g., lead source/business reply card).
- Retain PTC documentation and make available to UnitedHealthcare upon request for ten years after the year of receipt.
- Understand that the prohibited activity of cold calling also applies to texting.
- Limit method of contact (e.g., phone, mail, etc.) to that which the consumer provided and gave permission.
- Comply with HIPAA.
- Comply with Federal Trade Commission (FTC) and Federal Communications Commission (FCC) requirements.
- Comply with federal and state "Do Not Call" lists and state calling hour rules.
- Always limit contact to the scope of the products provided in the PTC.

MUST DO	MUST NOT DO	MAY DO

- Approach a consumer in a common area such as a parking lot, hallway, lobby, or sidewalk.
- Deposit marketing material (e.g., flyer, door hanger, leaflet) outside a residence, under a door to a residence, on a vehicle, or similar.

- Telephone or text a consumer who has not provided PTC by these methods.
- Use contact information obtained from the sales lead management system for a consumer with whom the agent does not have a relationship unless UnitedHealthcare has delegated PTC and authorized an outbound call as part of a marketing campaign.
- Use contact information provided by UnitedHealthcare to market non-UnitedHealthcare products, including non-health related products.
- Engage in any “bait-and-switch” tactics, i.e., marketing a product that does not require PTC in order to convert the marketing effort to a product that does require PTC. For example, marketing a non-UnitedHealthcare Medicare Supplement Insurance plan through cold calling, text, or door-to-door and then converting the marketing effort to any UnitedHealthcare Medicare product including Medicare Supplement Insurance plans.
- Contact a former member who voluntarily disenrolled or a current member in the process of voluntarily disenrolling to market a product or plan or to dissuade them from disenrolling to retain their membership. In addition, an agent must not ask a disenrolling member for PTC to market plans in the future.

MUST DO	MUST NOT DO	MAY DO

- Telephone a consumer who requested a return call.
- Contact a consumer who submitted a compliant Business Reply Card (BRC) or on-line contact form using the means of contact permitted and provided by the consumer.
- Contact a consumer who scheduled a marketing appointment.
- Contact UnitedHealthcare members for whom they are the member's current Agent of Record (AOR) to discuss the member's current needs and schedule an appointment.
- Only call an existing UnitedHealthcare member, for whom the agent is not the member's current AOR, if UnitedHealthcare has specifically delegated PTC to the agent. Refer to the Agent Guide for details.
- Contact their current clients for whom they manage other services (e.g., the consumer is a current in-force life, homeowners, or dental insurance policy client of the agent). Agents should be prepared to provide proof of the consumer’s agent/client relationship.

Overview of AARP

Understanding AARP

In this section of the Study Guide, you will learn more about AARP. Let's begin by listening to a message from John Larew, President and CEO of AARP Services, Inc. **Click on the image to watch this short video.**

AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. With a nationwide presence, AARP strengthens communities and advocates for what matters most to the more than 100 million Americans 50-plus and their families: health security, financial stability and personal fulfillment. AARP also works for individuals in the marketplace by sparking new solutions and allowing carefully chosen, high-quality products and services to carry the AARP name. As a trusted source for news and information, AARP produces the nation's largest circulation publications, AARP The Magazine and AARP Bulletin.

UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP does not employ or endorse agents, producers or brokers. AARP and its affiliates are not insurers.

Learn More: There are more videos available on Learning Lab/Content Library/Medicare Supplement.

AARP entities

AARP is the parent organization, encompassing several distinct entities working toward the same mission. As an agent who is authorized to offer AARP branded Medicare products, we would like you to have a thorough understanding of who AARP is and what the organization stands for.

AARP

AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. With a nationwide presence, AARP strengthens communities and advocates for what matters most to the more than 100 million Americans 50-plus and their families: health security, financial stability and personal fulfillment.

AARP Services (ASI)

AARP Services, Inc., founded in 1999, is a wholly-owned taxable subsidiary of AARP. AARP Services manages the provider relationships for and performs quality control oversight of the wide range of products and services that carry the AARP name and are made available by independent providers as benefits to AARP's millions of members.

AARP Foundation

AARP Foundation works for and with vulnerable people over 50 to end senior poverty and reduce financial hardship by building economic opportunity. As a charitable affiliate of AARP, AARP Foundation serves AARP members and nonmembers alike through vigorous legal advocacy and evidence-based solutions, and by strengthening supportive community connections. AARP Foundation fosters resilience, advances equity and restores hope.

Wish of a Lifetime from AARP

Wish of a Lifetime from AARP grants wishes to people 65 and older in recognition of their special accomplishments, contributions and sacrifices. As one of AARP's charitable affiliates, Wish of a Lifetime helps people achieve long-held goals while also combating the negative effects of isolation and strengthening social ties and intergenerational connections. Connecting wish recipients with the people and passions that are important to them is central to the organization's work.

Older Adults Technology Services from AARP (OATS)

OATS from AARP helps older adults learn to use and leverage technology to transform their lives and their communities. Through its flagship program, Senior Planet, OATS works closely with older adults to create extraordinary experiences in-person and online. As one of AARP's charitable affiliates, the mission of OATS from AARP is "to harness the power of technology to change the way we age."

AARP consumer commitment standards

AARP is committed to meeting and exceeding consumers' expectations by helping them feel confident, in control, and secure as they age. The entire AARP organization must actively embrace this commitment so AARP consumers - people who are 50+, their families, and AARP members - see AARP as a trusted resource, a wise friend and fierce defender.

In consumers' lives, AARP is a Wise Friend: Honest, knowledgeable, helpful, relevant, realistic, and positive.

On consumers' behalf, AARP is a Fierce Defender: Leading the way, forthcoming, vigilant, powerful, timely and inclusive.

Authorized to Offer agents are encouraged to embrace this commitment. The following standards are your guide to achieving this:

- Do what is in the best interest of the customer. Always put your customer first. Be there to listen, provide support and help when needed. Protect their trust by putting the relationship ahead of short-term business interests.
- Be honest and straightforward. Provide the right information, be upfront about what it means, communicate clearly to alleviate any confusion and work to build the relationship over time.
- Serve the needs of the customer. Take time to get to know the customer, listen to their wants and needs and provide timely information.
- Keep it simple and easy. Don't make customers do extra work, take time to help step-by-step with product purchases, answer questions about AARP member benefits and help with information requests.
- Empower the customer. Always be a trusted advisor, provide usable and actionable insights that give them the power to act.

Essentials

AARP branded products

In this section, you will learn about properly identifying the relationship between UnitedHealthcare and AARP with respect to the products that carry the AARP name.

AARP has chosen to brand UnitedHealthcare Medicare Plans as the only Medicare plans with the AARP name. These plans stand for quality, value, and customer service.

UnitedHealthcare has an exclusive relationship to offer AARP-branded Medicare products and is proud to offer three AARP-branded Medicare products.

Scroll through the images below to review the three AARP-branded products offered.

MA & PDP products

UnitedHealthcare has a contract with the federal government to provide Medicare Advantage and Prescription Drug plans. Medicare approves our plans annually. UnitedHealthcare was chosen as the only insurance company to have the AARP name on its Medicare plans.

Note: Consumers do not need to be an AARP member to enroll in an AARP-branded MA or PDP.

Medicare Supplement Insurance Plans

AARP Medicare Supplement Insurance Plans insured by UnitedHealthcare Insurance Company or an affiliate (collectively "UnitedHealthcare")

UnitedHealthcare was chosen as the only insurance company to have the AARP name on its Medicare plans. Offering Medicare Supplement Insurance Plans helps UnitedHealthcare fulfill its mission of helping people live healthier lives for the millions of Medicare consumers

who rely on supplemental coverage as an important part of their healthcare coverage portfolio.

Note: The consumer must be an AARP member to enroll in an AARP Medicare Supplement Insurance Plan.

Endorsed by AARP

Does AARP endorse UnitedHealthcare's plans?

AARP has chosen to brand UnitedHealthcare Medicare Plans as the only Medicare plans with the AARP name. AARP does not "endorse" any UnitedHealthcare MA or PDP product. However, AARP "endorses" the AARP Medicare Supplement Insurance Plans. These plans stand for quality, value, and customer service.

Medicare Advantage and PDP = carry the AARP name

AARP Medicare Supplement = carry the AARP name and endorsed by AARP

Authorized to Offer (A2O) Program

The Authorized to Offer (A2O) AARP Medicare Plans Agent Program assures members and prospects that agents have completed stringent credentialing and training programs.

The A2O Program recognizes agents by providing exclusive opportunities to AARP-branded marketing materials and a UnitedHealthcare rewards program depending on the agent's status level. The A2O program is split into two status levels:

- Authorized to Offer status (formerly known as Level 1): Agents who are licensed, appointed and contracted with UnitedHealthcare, and have completed

UnitedHealthcare certification requirements.

- Authorized to Offer Elite status (formerly known as Level 2): Agents must meet requirements for the Authorized to Offer status level and must have 25 commission-eligible, accepted and paid sales of AARP Medicare Supplement Plans and/or Medicare Select Plans OR maintain a book of business of 150 or more active members each year.

For more information, see the Authorized to Offer Program Guidelines located on Jarvis>Knowledge Center>Ready to Sell>Authorized to Offer>A2O Program Guidelines.

AARP Services, Inc. agent visits

To maintain the Authorized to Offer (A2O) AARP Branded products distinction, all UnitedHealthcare agents who are Authorized to Offer or Authorized to Offer Elite are subject to visits from staff members of AARP Services, Inc. (ASI) Distribution (i.e., Field Director).

- The purpose of these visits is to ensure that agents are meeting all code of ethics and other obligations related to participation in the A2O program for the AARP-branded products.
- During the first three quarters of the year, an ASI Field Director will contact agents to schedule meetings or calls at a convenient date and time. Field visits may be in-person at a convenient location or completed virtually with video conferencing. During the meeting, which typically lasts about 30 minutes, the ASI Field Director will explain their role to help provide quality oversight and monitoring as it relates to AARP-branded products to help ensure a consistent and high-quality AARP member experience. In addition, the ASI Field Director will provide additional information and education about ASI, AARP and its member benefits.

- Agents are encouraged to accept the Field Directors meeting invite and be candid about their experiences and recommendations regarding the A2O program.
- Agents are encouraged to respond to an email from AARP Services that contains a survey called the Digital Agent Assessment (DAA). The DAA is a short survey taking about 5 minutes to complete. Agents have 2 weeks to complete it at their convenience.
- Agents should also remember to adhere to all privacy and related rules concerning consumers. Should an agent have questions regarding privacy or any related rules, they should contact their up-line or available UnitedHealthcare resources to address specific issues, as appropriate.
- **Agent feedback is vitally important.**

Relationship

Navigating conversations

What to say and what to avoid

When discussing AARP-branded products with consumers, it is important to ensure any information you provide is accurate and complete. Remember, AARP and its affiliates are not insurers and should never be positioned as the insurance carrier. UnitedHealthcare and its affiliates are the insurance carrier for AARP-branded Medicare products.

Below are some examples of statements that may most commonly occur in your conversations. The details below indicate what is not acceptable to say and what is acceptable to say when referring to the relationship between AARP and UnitedHealthcare.

Incorrect (do NOT say)	Correct (ok to say)
AARP is a healthcare expert. We're working together; we're teaming up. In partnership with AARP.	UnitedHealthcare has an exclusive relationship with AARP to offer Medicare plans with the AARP name. In a relationship with AARP.

AARP endorses the AARP-branded MA products. AARP endorses the AARP-branded PDP products.	AARP does not endorse AARP-branded MA and PDP Plans. AARP does endorse the AARP-branded Medicare Supplement Insurance Plans. (Do not use the term endorsed in any manner with MA or PDP.)
AARP providers (When referring to doctors and medical facilities).	UnitedHealthcare contracts with providers for MA and PDP Plans. (AARP and its affiliates do not contract with doctors or medical facilities to provide services for these plans. UnitedHealthcare contracts with providers and medical facilities for plan benefits.)
AARP provides the following services. AARP plans provide complete/comprehensive coverage.	UnitedHealthcare offers Medicare plans with benefits… UnitedHealthcare [insert plan name] provides coverage… (AARP and its affiliates do not contract with doctors or medical facilities to provide services for these plans. UnitedHealthcare contracts with providers and medical facilities for MA and PDP Plans.)
AARP plans provide medical care.	AARP is not the insurer. UnitedHealthcare is the insurer and provides the medical and/or prescription

	drug insurance coverage.(AARP does not have insurance plans. Do not say “AARP Plans.”)
AARP helps us set our Medicare Supplement rates.	UnitedHealthcare determines the rates for its Medicare Supplement products. Premiums are primarily affected by the level of deductibles and cost sharing, plan claims experience and increases in overall health care costs.

Types of events

Introduction

Welcome to Events Basics. Conducting a successful and compliant event starts well before you greet the first consumer; it takes training, practice, and preparation. Reviewing this guide is one step in your event preparation. Agents are not permitted to report or conduct a marketing/sales event representing UnitedHealthcare until they have passed the Fast Track assessment or completed the Events Basics module for the applicable year.

Throughout this section, you will learn about applicable Centers for Medicare & Medicaid Services (CMS) regulations and UnitedHealthcare business rules, policies, and procedures, including:

- Venues and event reporting
- Compliant activities
- Materials, giveaways, and refreshments

Event defined

Events are categorized first by type and then by how the information will be presented. The type of event determines its purpose, what can be discussed, and who can conduct it.

Educational events

Educational events are designed to inform consumers about Original Medicare, Medicare Advantage, Prescription Drug Plan, or other Medicare programs. These events inform in an unbiased way that does not steer, or attempt to steer, consumers toward a specific plan or limited number of plans.

The purpose is to provide objective information about the Medicare program and/or health improvement and wellness. Marketing plans, setting marketing appointments, displaying or distributing marketing materials, distributing and/or obtaining Scope of Appointment (SOA) forms or enrollment applications are prohibited.

Marketing/sales events

Marketing/sales events are designed to steer or attempt to steer Medicare consumers toward a specific plan or a limited set of plans. Details about specific plans (benefits and services) may be provided as well as enrollment applications accepted. In addition to Medicare Advantage and Part D plans, other health-related insurance products, such as Medicare Supplement Plan and dental policies, may be marketed.

Event format

After you decide to conduct an educational or marketing/sales event, determine if your event will be formal or informal. Marketing/sales events must be conducted as reported, except when only one consumer attends a formal event. In that situation, you may conduct the presentation less formally.

Click each plus (+) to see examples of event formats.

Formal

A formal event is typically structured in an audience-presenter style with the agent formally providing information via a presentation.

A formal marketing/sales event may be more commonly known as a Sales Meeting, Community Meeting or Neighborhood Meeting. Throughout this section, however, we will use the term formal marketing/sales event.

Informal

An informal event is conducted with a less structured presentation or in a less formal environment. Typically, an agent uses a table, booth or kiosk to conduct an informal event.

An informal event is a passive opportunity where the consumer must approach the agent to initiate a conversation. An example of an informal marketing/sales event is the staffing of a UnitedHealthcare kiosk at a retail program retailer.

Personal/individual marketing appointments

Personal/individual marketing appointments are one-on-one interactions that can occur in-person, online, or telephonically. Regardless if the appointment is scheduled or not, a Scope of Appointment (SOA) must be obtained from each Medicare beneficiary who will be present at the appointment. The SOA must be obtained at least 48 hours prior to the start of the appointment unless an exception to the 48-hour rule exists.

All individual appointments between an agent and a consumer/member are considered marketing/sales appointments regardless of the content discussed.

Venue selection

Venue selection considerations

Select a venue that is appropriate for the Medicare-eligible consumers attending and for the type of event you intend to conduct (educational and/or marketing/sales, formal or informal). Take these features into consideration when you select room or space accommodations:

1. Appropriate lighting levels so consumers can see your presentation and materials

   Best Practice: If you are projecting your presentation onto a screen or monitor, ensure the consumers have unobstructed views and the text is readable from where they are seated.

2. Appropriate noise levels or the availability of a microphone/speaker system.

   Best Practice: Will the consumer in the back corner of the room or under the air conditioning vent be able to hear your presentation? Will noise levels outside the meeting space vary depending on the time of day? You want each consumer to hear your entire presentation, so be sure to consider factors that might contribute to

them not being able to hear you. Ensure a microphone/speaker system is available.

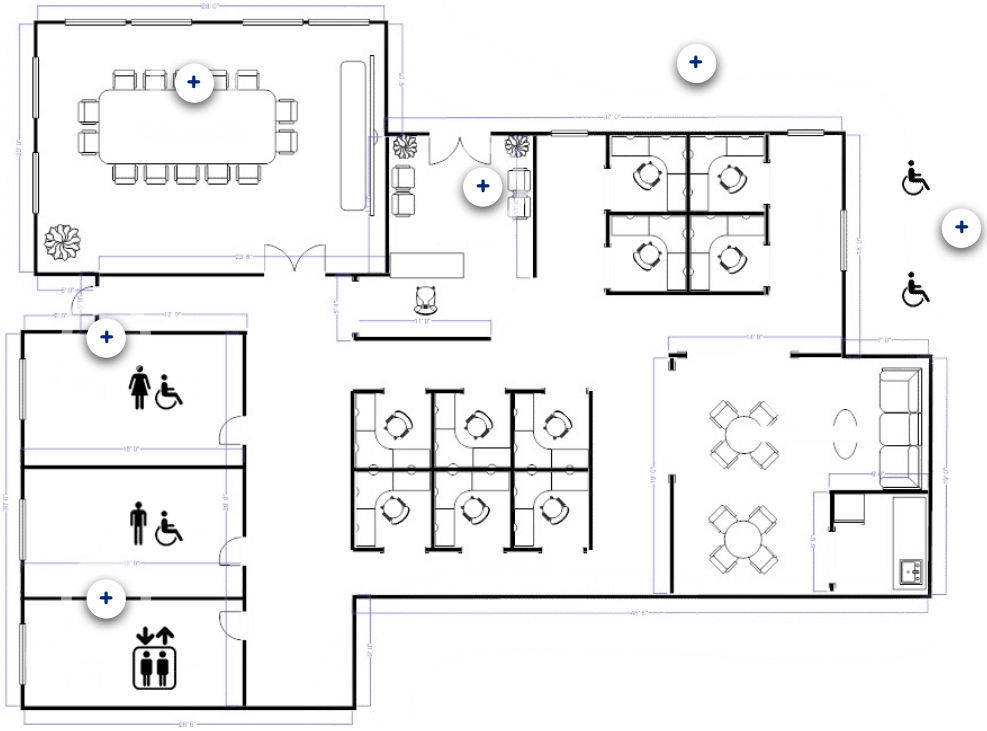
3 Comfortable and accessible seating options, especially for consumers who may utilize canes, walkers, or wheelchairs

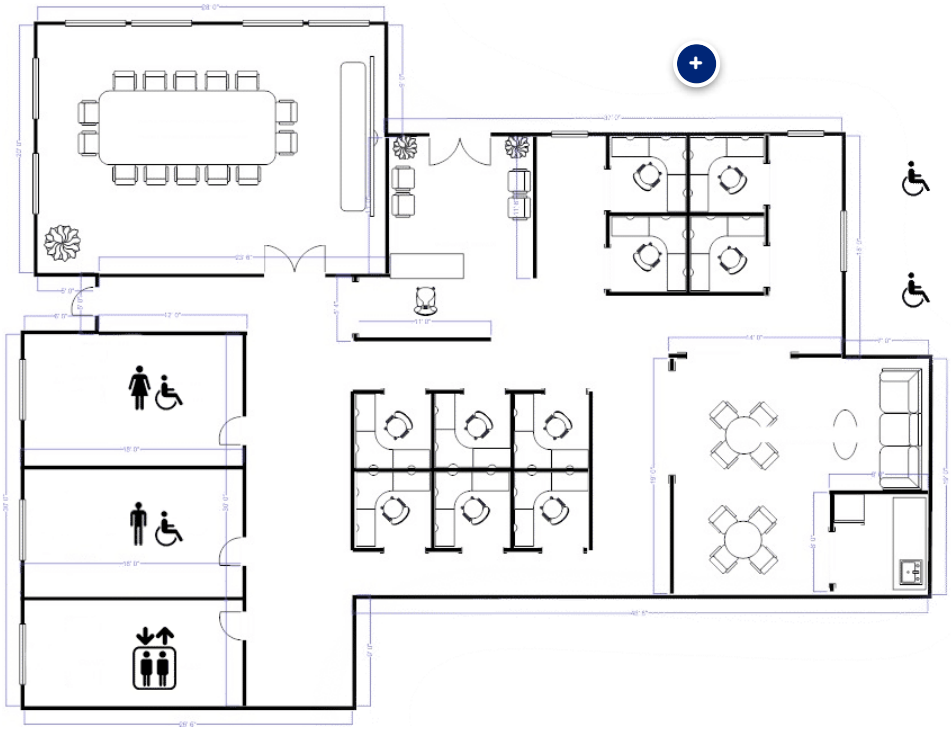
Best Practice: Consider visiting the venue on a day and time similar to your scheduled event to be aware of venue circumstances in advance (e.g., foot traffic, business activities, parking).

Venue characteristics

Choosing a site that is compliant with the Americans With Disabilities Act (ADA) is strongly recommended.

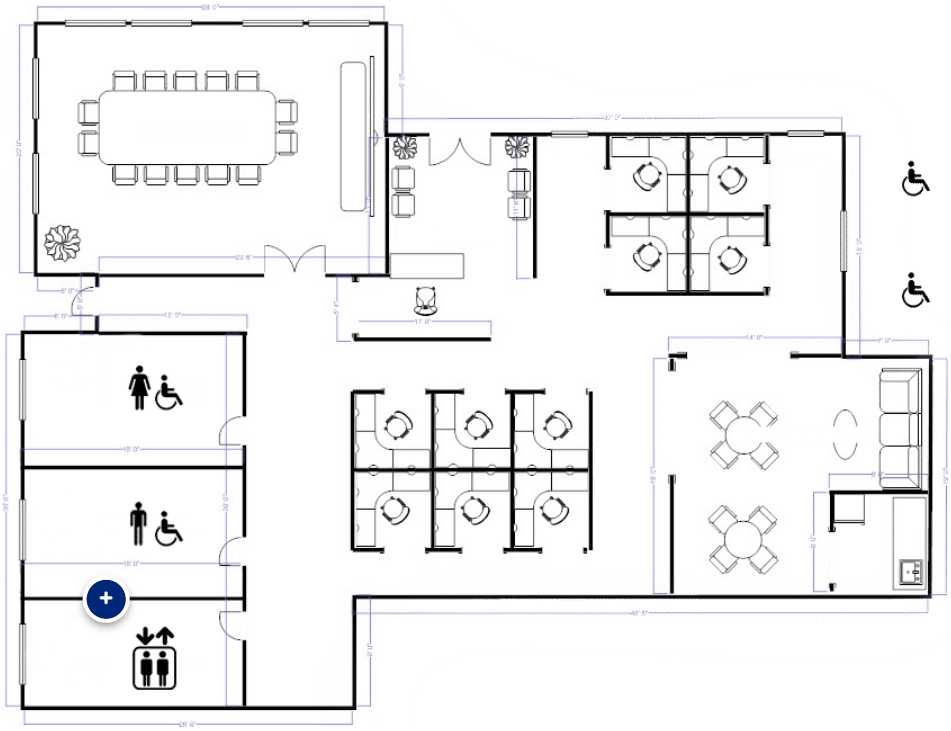
Click each marker on this diagram to see the venue characteristics you need to consider.





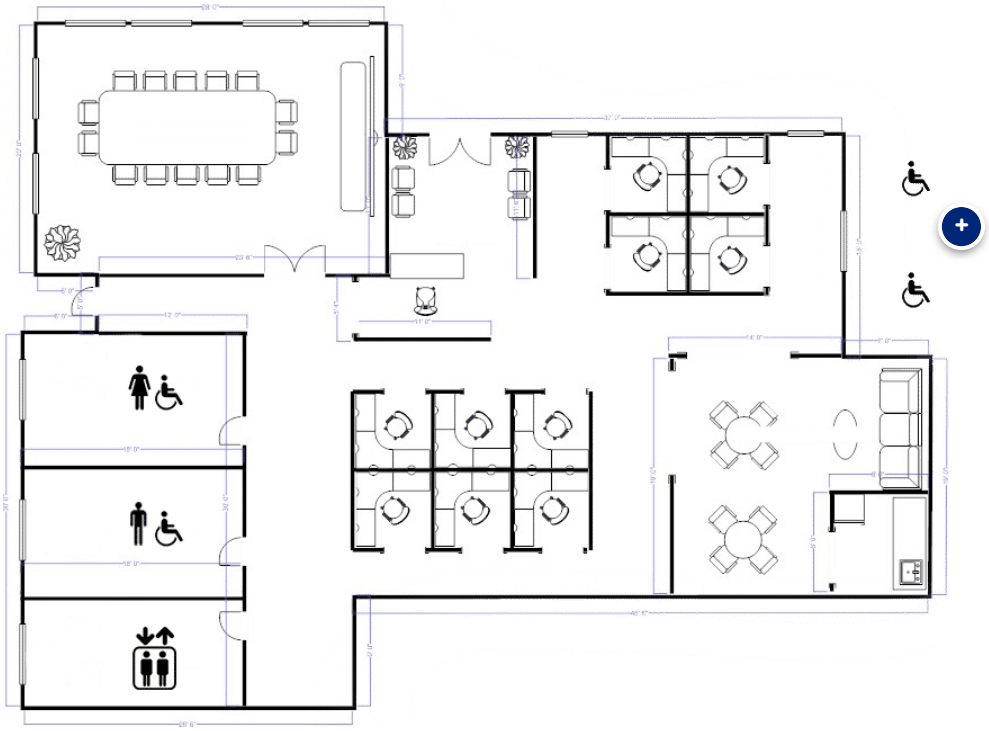
Venues should have...

Walkways, entrances, and hallways that are clear and dry, and handrails along stairways and/or ramps.



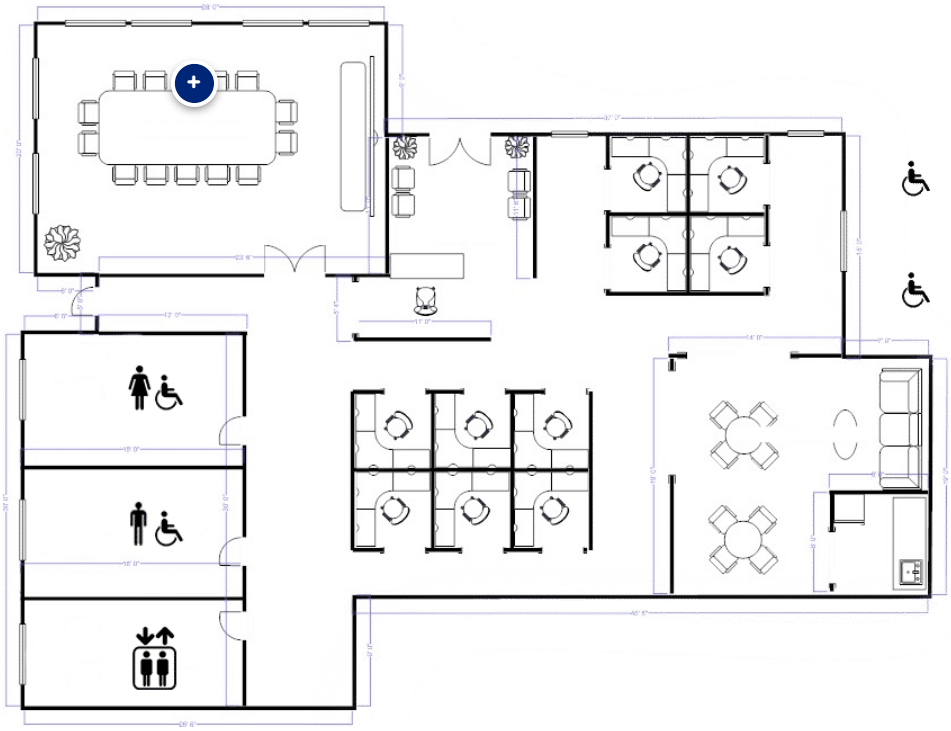
Venues should have...

Ramps and/or elevators as an alternative to stairs.



Venues should have...

Handicap and/or senior parking stalls close to entrances.



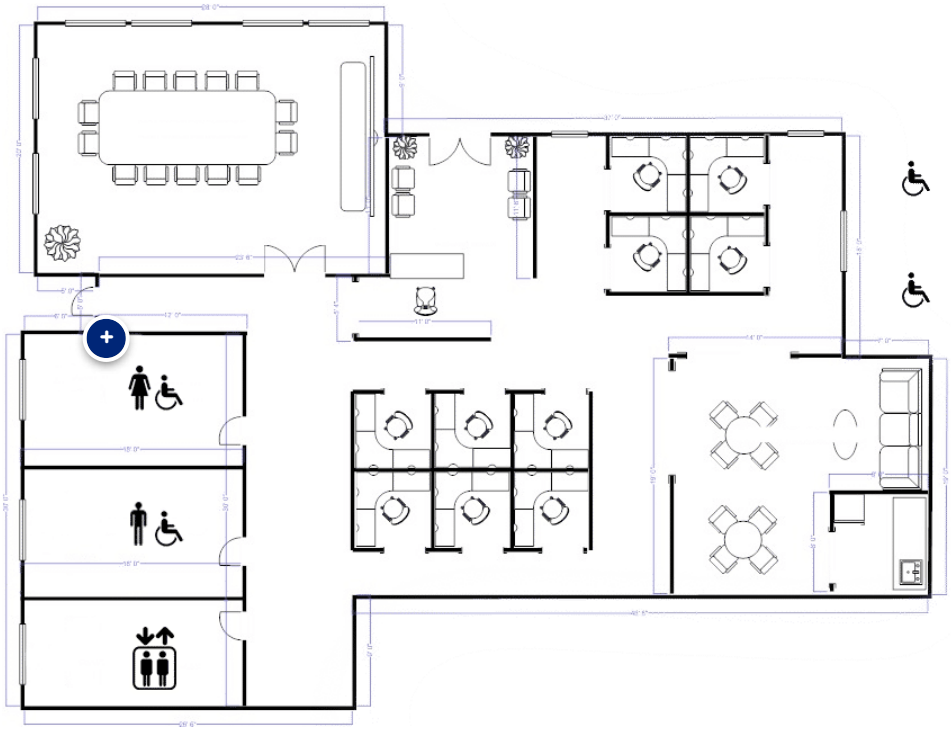
Be Aware...

Agents must be aware of and sensitive to the needs of the Medicare-eligible consumer, which may include planning for and/or accommodating language barriers and disabilities.

There are a number of services and aids available at no cost to the consumer, such as:

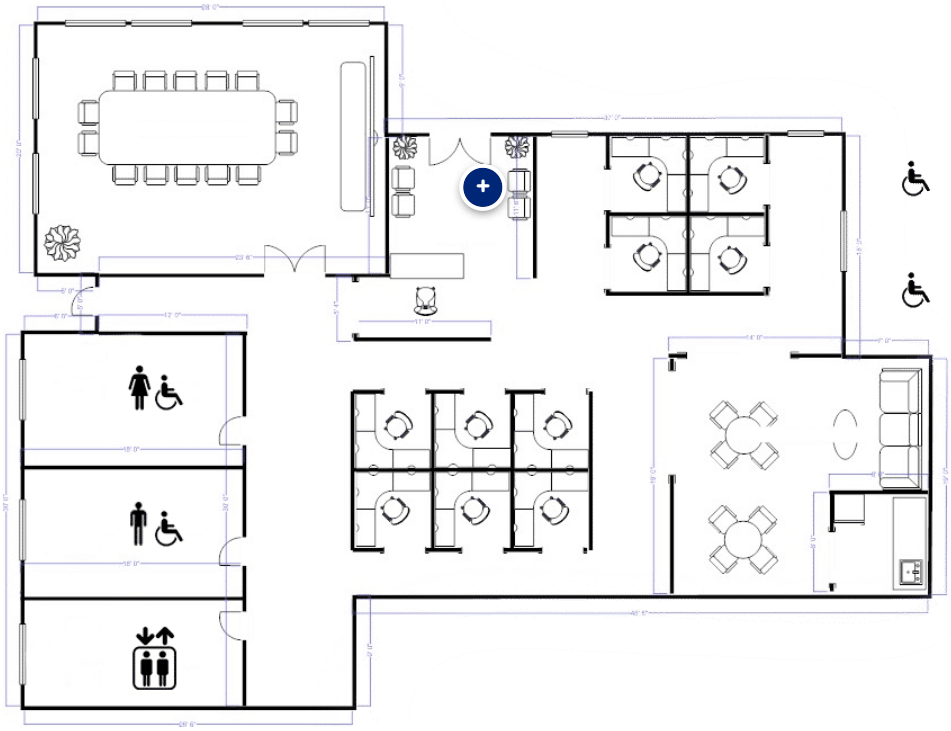
- Plan materials in alternate languages and formats
- TTY/TDD or state relay system when calling UnitedHealthcare's Direct to Consumer and Customer Service call centers
- Sign language interpreters (with advance notice) at formal marketing/sales events and face-to-face appointments, including online events and appointments
- Language translation services via conference call

Refer to the Agent Guide for additional guidelines related to accommodating the needs of a consumer.



Venues should have...

Handicap accessible restrooms.



Venues should have...

Entrance doors that open automatically or a resource available to welcome and assist the consumer.

Venue guidelines

Additional venue guidelines to follow when selecting a venue include the following:

Requirements:

- The event must be open to the public. Therefore, if the venue has a security entrance or is typically closed to non-members, agents should make arrangements with the venue to admit consumers that want to attend the event.
- Agents must not charge consumers a fee to attend an educational or marketing/sales event.
- Events must not be conducted in:
    - Any area of a health care facility where a patient receives care (e.g., exam room, dialysis treatment area). However, events may be conducted in common areas of healthcare facilities (e.g., conference and recreation rooms).

- Venues or areas of venues that may negatively impact UnitedHealthcare's reputation, such as where gambling activities takes place. However, it is acceptable to hold an event in an area completely separate from gambling activities, such as a conference room.

Best practices so consumers can find your event:

- Let appropriate venue personnel know that you are present; provide them with the event's location and time. Providing a copy of the event advertising can help them understand how a consumer might describe the event when seeking directions.
- Use approved signage to direct consumers, if allowed by the venue.

Did you know? You will receive an "Unsuccessful Event" infraction (i.e., No-Show) if an evaluator cannot locate your event. Ensure your consumers are able to locate you by accurately advertising the venue location, utilizing directional signage (if allowed by the venue), and/or asking venue staff to direct consumers.

Online guidelines

Field agents are permitted to conduct online formal educational and marketing/sales events. The following guidelines apply for online events:

Agents must not:

- Conduct an online informal event
- Complete an enrollment during an online event

Agents may:

- Use UnitedHealthcare-approved materials that are compliant based on the type of event conducted
- Allow consumers to utilize the online meeting chat function to ask questions or interact with the agent
- Provide their contact information via the online meeting service provider chat/survey/poll function so the consumer may contact the agent in the future

- Live-stream or record a live marketing/sales event for posting or distribution.
- Obtain Permission to Contact (PTC) in a compliant manner. For example, the agent may provide compliant call-to-action/PTC text in the online meeting chat. The agent must collect any PTC provided from the online meeting service provider. All PTC guidelines, including intent to share and retention, apply. Refer to Agent Guide for details.

Event reporting

UnitedHealthcare event reporting policy

UnitedHealthcare requires all marketing/sales events, formal and informal, in-person and online, be reported prior to advertising and no less than 7 calendar days prior to the event. At this time, educational events do not need to be reported to UnitedHealthcare.

Did you know? Even if the event is hosted by another entity, such as a provider or community group, you must report it to UnitedHealthcare as a marketing/sales event unless it meets and will be conducted according to the strict definition of an educational event.

All agents must use the NEW Event Request Form, located in Jarvis, to report their new marketing/sales events (Jarvis>Knowledge Center>Forms>Events).

To ensure that marketing/sales events are in UnitedHealthcare's event reporting application no less than 7 calendar days prior to the event date, we strongly recommend you submit the NEW Event Request Form at least 14 calendar days prior to the scheduled date of your event.

Note: NEW Event Request Forms submitted less than 7 calendar days before the date of the event will not be processed. Conducting

an unreported marketing/sales event is prohibited.

Event reporting basics

Accurate event reporting is important. You must also ensure the information reported matches any materials used to advertise your event. UnitedHealthcare requires the following information when reporting events:

Click each tab to see the required information.

WHERE WILL THE EVENT BE CONDUCTED? | WHEN WILL THE EVENT BE CONDUCTED? | WHO IS CONDUCTING THE EVENT? | WHAT TYPE AND FORMAT OF EVENT WILL BE CONDUCTED? | WHA... PR...

- List the venue street address, city, state, ZIP code, and phone number.
- For in-person events, use the "Address 2" field to indicate room or suite number, if applicable.
- For online events, enter the URL for the meeting in the "Address 2" field. Each online meeting will have its own venue due to the unique meeting ID (URL).
- List how many consumers the venue will accommodate.

WHERE WILL THE EVENT BE CONDUCTED? | WHEN WILL THE EVENT BE CONDUCTED? | WHO IS CONDUCTING THE EVENT? | WHAT TYPE AND FORMAT OF EVENT WILL BE CONDUCTED? | WHA... PR...

- Indicate the date of the event
- Report a start and end time.
- Remember for informal events, report each shift as a separate event. For example, Phil and Marco get permission to conduct an informal marketing/sales event every Tuesday from 10am-2pm at the public library. Phil will staff the table from 10am-noon and Marco from noon-2pm.

Therefore, two separate events must be reported - one for Phil's two-hour shift and one for Marco's.

Did you know? Marketing/sales events must not be conducted within 12 hours following an educational event at the same location, which CMS defines as the same building or adjacent buildings.

WHERE WILL THE EVENT BE CONDUCTED?	WHEN WILL THE EVENT BE CONDUCTED?	WHO IS CONDUCTING THE EVENT?	WHAT TYPE AND FORMAT OF EVENT WILL BE CONDUCTED?	WHA PR

- The presenting agent is the agent conducting the event.
- Use the actual presenting agent's name and information. Using "placeholder" names is prohibited and may result in corrective and/or disciplinary action.
- Presenting agents must be appropriately licensed and appointed, product certified, and have passed the Fast Track assessment or completed the Events Basics module as required.

WHERE WILL THE EVENT BE CONDUCTED?	WHEN WILL THE EVENT BE CONDUCTED?	WHO IS CONDUCTING THE EVENT?	WHAT TYPE AND FORMAT OF EVENT WILL BE CONDUCTED?	WHA PR

- Indicate the event type and whether it is informal or formal in the Event Category field on the NEW Event Request Form.
- For informal events, refer to the instructions on the NEW Event Request Form to determine the type of informal event to report, such as Kiosk or Resource Center.

WHERE WILL THE EVENT BE CONDUCTED?	WHEN WILL THE EVENT BE CONDUCTED?	WHO IS CONDUCTING THE EVENT?	WHAT TYPE AND FORMAT OF EVENT WILL BE CONDUCTED?	WHA PR

- For **formal marketing/sales events**, select the primary product you intend to present. For example, select "Dual" if you intend to present a Dual Eligible Special Needs Plan. Do not select a product that you are not certified to sell or is not available in your market.
- For **informal marketing/sales events**, select the primary product that you intend to market.

Remember: You may answer any plan specific question asked by a consumer (even if it is not related to the product you are presenting) provided you are certified in the applicable product. If you are not appropriately certified, refer the consumer to other resources, such as UnitedHealthcare's or Medicare's toll-free number or UnitedHealthcare's website or Medicare.gov.

Whether you report your events or another individual reports them on your behalf, you are ultimately responsible for the accurate and timely reporting of the events you host. It is recommended that you verify all elements of the event to ensure they were correctly reported.

Knowledge Check

Let's check what you just learned above on how to submit a new event! These are not scored and do not count toward your certification assessments.

Jared is planning a formal marketing/sales event for October 24. While it is strongly recommended that Jared reports his event at least 14 calendar days in advance, what is the last date the Event Request Form can be submitted to UnitedHealthcare?

- ○ October 23
- ○ October 17
- ○ October 10

SUBMIT

October						
SUN	MON	TUE	WED	THU	FRI	SAT
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Reporting changes to events

Avoid changing or canceling your reported events. If unavoidable, adhere to all reporting and procedure guidelines.

Click each tab to see the guidelines.

MAY I CANCEL AN EVENT SCHEDULED THE SAME DAY THAT IT IS SCHEDULED TO OCCUR?

MAY I CHANGE OR CANCEL MY EVENT THAT IS MORE THAN ONE (1) BUSINESS DAY FROM TODAY?

HOW DO I CHANGE THE VENUE, DATE, OR TIME OF A REPORTED EVENT?

Canceling an event less than one (1) business day of the date of the event is prohibited except in cases of inclement weather or other circumstances outside of the agent's control.
If canceling an event less than one (1) business day is unavoidable, contact your UnitedHealthcare sales leader immediately to decide on a course of action.

MAY I CANCEL AN EVENT SCHEDULED THE SAME DAY THAT IT IS SCHEDULED TO OCCUR?

MAY I CHANGE OR CANCEL MY EVENT THAT IS MORE THAN ONE (1) BUSINESS DAY FROM TODAY?

HOW DO I CHANGE THE VENUE, DATE, OR TIME OF A REPORTED EVENT?

First, work with your UnitedHealthcare sales leader to find a replacement agent. If cancellation or change is unavoidable, submit the CHANGE or CANCEL Event Request Form no less than one (1) business day prior to the event date.

A CHANGE or CANCEL Event Request Form (located on Jarvis) is required to report changes and cancellations respectively. We strongly recommend that the applicable form be submitted at least six business days before the event date to allow for processing time.

MAY I CANCEL AN EVENT SCHEDULED THE SAME DAY THAT IT IS SCHEDULED TO OCCUR?

MAY I CHANGE OR CANCEL MY EVENT THAT IS MORE THAN ONE (1) BUSINESS DAY FROM TODAY?

HOW DO I CHANGE THE VENUE, DATE, OR TIME OF A REPORTED EVENT?

Changing the venue, date, and/or start or end time of a reported event in effect cancels the existing event. This means that all applicable cancellation procedures for the existing event and new event reporting rules for the new event must be followed.

Remember, NEW Event Request Forms submitted less than 7 calendar days before the event will not be processed.

Changing and Cancelling Reported Events

Consider event changes and cancellations through the eyes of the consumer. When a reported event, in-person or online, is canceled, or the venue, date, or time of an event changes, consumers are no longer able to attend the event they saw advertised. In both scenarios, the original event was cancelled, and the following cancellation procedures must be followed to ensure a good consumer experience.

- If the event was advertised, take reasonable steps to advertise the cancellation. For example, if you posted an advertisement on a bulletin board at the venue, post a cancellation notice there as well.
- For advertised events (in-person or online) cancelled less than 7 calendar days before the event date (with the exception of last minute cancellations due to inclement weather or other extenuating circumstances beyond the agent's control), you or another plan representative must be at the venue at the advertised start time and remain there for at least 30 minutes for both online and in-person formal events and for the entire advertised time for an in-person informal event to redirect any consumer who arrives for the event.
- In cases of inclement weather or other extenuating circumstances that result in an unavoidable, last-minute cancellation, ask the venue to post a sign making consumers aware of the cancellation.

Knowledge Check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

Tori needs to cancel an event. To allow ample time for UnitedHealthcare to process the cancellation in the event reporting application, when should Tori submit a Cancel Event Request Form?

- ◯ At least 1 business day prior to the date of the event

- ◯ At least 6 business days prior to the date of the event
- ◯ At least 14 calendar days prior to the date of the event
- ◯ At least 7 calendar days prior to the date of the event

SUBMIT

Event reporting-related infractions

UnitedHealthcare monitors event reporting for timeliness and accuracy. When an agent fails to report a new event, change an existing event, or cancel an event in a timely manner, UnitedHealthcare assigns the agent corrective and/or disciplinary action. The following are infractions related to event reporting:

Click each plus (+) to learn more.

Unreported event —

An unreported event is one where the agent fails to report a marketing/sales event to UnitedHealthcare.

In some instances, events are not entered at all, but in others, there are discrepancies between the event details as advertised and those that were reported. For example, if you report an event with a 10:30 a.m. start time, but your advertisement indicates a start time of 10:00 a.m., it will flag an infraction.

How to avoid it

- Report all marketing/sales events to UnitedHealthcare according to event reporting rules
- Wait at least two (2) business days after submitting a NEW Event Request Form to advertise the event
- Make sure that the event details in the advertisement match those reported

Late reported event

A **late reported event** is one that was submitted on a NEW Event Request Form less than 7 calendar days before the scheduled event.

How to avoid it

- Report all marketing/sales events to UnitedHealthcare according to event reporting rules.
- When certain elements, like event date or time, change to an existing event, two event reporting actions are required, each with their respective reporting deadlines. A cancellation, using a CANCEL Event Request Form, is required for the existing event and the new event must be reported no less than 7 calendar days prior to the date of the event, using a NEW Event Request Form.

Late reported change/cancellation

A **late reported change or cancellation** occurs when a CHANGE or CANCEL Event Request Form reporting the change or cancellation is submitted less than one (1) business day before the date of the event.

How to avoid it

- Submit a CHANGE or CANCEL Event Request Form no less than 6 business days prior to the date of the event to ensure changes are entered into UnitedHealthcare's event reporting application no less than 1 business day prior to the date of the event.

- You must indicate a cancellation reason when submitting a CANCEL Event Request Form to cancel an event.

Conducting an educational event

Educational events

An educational event is designed to inform consumers about Original Medicare, Medicare Advantage, Prescription Drug, or other Medicare programs in an unbiased way that does not steer or attempt to steer consumers toward a specific plan or limited number of plans. The purpose is to provide objective information about the Medicare program and/or health improvement and wellness.

A plan sponsor, such as UnitedHealthcare, an agent, or another entity can host an educational event.

Advertising an educational event

If an in-person or online educational event is advertised or promoted, it must be done in a way that clearly communicates that the event is solely for educational purposes and also include the required accommodation disclaimer, which is "For accommodations of persons with special needs at meetings call <insert phone number and TTY number>".

Agents participating in an event sponsored by another entity must be aware how the event is being advertised or promoted by the sponsoring entity to ensure the agent properly reports and compliantly conducts the event. If the event does not meet the definition of an educational event, it must be reported and conducted as a marketing/sales event and all related rules would apply.

Materials and activities

Any material distributed, displayed, or provided at an educational event must be free of marketing content such as plan benefits, benefit structure, premium cost-sharing information, Star Ratings or plan comparison or rewards and incentives.

The following shows what an agent may and must not do at an educational event:

Materials and activities - permitted

When conducting an educational event, agents may:

1. Distribute, display, or provide:

   - Educational information, including UnitedHealthcare-branded Medicare Made Clear® materials, that is free of plan-specific information such as premiums or copayments.
   - Educational materials (not specific to any plan) on general health care related topics such as diabetes awareness and prevention and high blood pressure information.
   - Business reply or lead cards, sign-in sheets, or business cards free of marketing content.
   - Attach personal business cards and contact information to educational materials.
   - Have a banner or tablecloth with the plan name and logo displayed accessible via **Jarvis>Sales Tools>Sales Materials>UnitedHealthcare Agent Toolkit**.
   - Wear a shirt and/or name badge with approved plan names and logos (e.g., those purchased from the UnitedHealth Group Merchandise eStore accessible via **Jarvis>Sales Tools>Sales Materials>Promotional items**).

2. Answer consumer's plan related questions, provided your response does not go beyond the question asked and does not include the distribution of marketing materials.

   For example, a consumer asks: "Do any Medicare Advantage plans cover acupuncture?"

An agent may answer, “Yes, some do; however, I’m not permitted to discuss plan specific information in this setting. I’d be happy to talk to you at another time. I have lead cards and business cards here. If you would like to fill out a lead card, I can contact you."

3. Direct consumers to the plan’s website or toll-free number (see Medicare Made Clear brochure).

4. Accept completed Business Reply Card (BRC) and lead cards.

Materials and activities - prohibited

When conducting an educational event, agents must not:

1. Distribute, display or provide plan-specific materials such as Enrollment Applications, Enrollment Guides or Benefit Highlights brochure

2. Schedule future one-on-one marketing appointments

3. Display, distribute or collect scope of appointment forms

4. Promote or obtain RSVPs for future marketing/sales events

5. Engage in any activity that meets CMS' definition of marketing, including:

    - Steer consumers toward a specific plan
    - Discuss or present plan-specific cost - sharing and/or benefits information
    - Distribute or display marketing materials

- Complete or accept an Enrollment Application or conducting any other enrollment-related activities

Meals and refreshments at an educational event

When permitted by the venue, meals and refreshments may be offered at educational events as long as the retail value, when combined with any other permissible giveaway, does not exceed $15 on a per person basis (maximum of $75 per person, per year).

Providing alcoholic beverages is prohibited.

Marketing/sales events

Conducting a marketing/sales event

A marketing/sales event is designed to steer, or attempt to steer, Medicare consumers toward a specific plan or limited number of plans. Any agent conducting or participating at a marketing/sales event must be appropriately contracted, licensed, appointed, and certified in order to represent UnitedHealthcare during any marketing/sales activity and/or event.

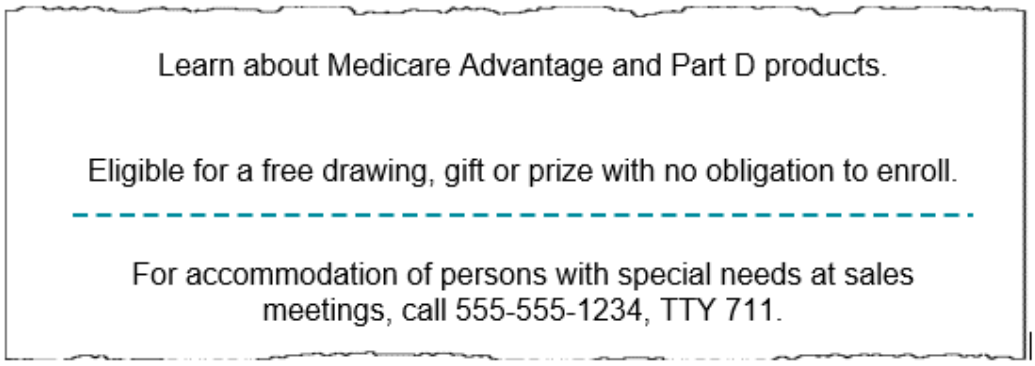
Advertising a marketing/sales event

If an agent decides to advertise and/or promote a marketing/sales event, there are several requirements that must be met. For example:

- All Medicare plan names and plan types that you will present during the event must be clearly stated.
- If the advertisement or marketing material promotes a drawing, prize, or any promise of a free gift, it must include a statement indicating that there is no obligation to enroll in the plan.
- In addition to an accommodation disclaimer (For accommodations of persons with special needs at meetings call <insert phone number and TTY number>), agents must make available a sign language interpreter at an in-person or online formal marketing/sales event upon reasonable request. A request form with instructions is

available on Jarvis (**Jarvis>Contact US>Resources>ASL Interpreter Request Form)**.

- Please note, ASL is just one type of sign language and, as requested, other sign language interpretation requests must be accommodated - such as Spanish or tactile.



Materials at a marketing/sales event

Various types of materials may be used during a marketing/sales event.

Click each plus (+) to learn more about each type of material.

Marketing materials —

You may display, distribute and provide UnitedHealthcare approved marketing materials at marketing/sales events. Marketing materials include those that provide:

- Information about the plan's benefits or benefit structure
- Information about the plan's premiums and cost-sharing
- Comparisons to other Plan(s)/Part D sponsor(s)
- Rankings or measurements in reference to other Plan(s)/Part D sponsor(s)
- Information about the plan's Star Ratings

Only use materials in the format and manner for which they have been approved. Alteration of approved materials is prohibited. Alteration includes, but is not limited to:

- Using a piece differently than the purpose for which it was approved. For example, using a piece approved for use as a free standing insert as a newspaper advertisement.
- Writing on or placing a label or sticker on materials.
- Removing or adding pages to the Enrollment Guide

Visual material

Agents may:

- Use a banner or tablecloth with the plan name and logo displayed accessible via Jarvis (Jarvis > Sales Tools> Sales Materials> UHC Agent Toolkit)
- Wear a shirt and/or name badge with approved plan names and/or logos (e.g., those purchased from the UnitedHealth Group Merchandise eStore (Jarvis > Sales Tools> Sales Materials> Promotional items)
- Display, distribute, and provide business reply cards, lead cards, sign-in sheets, and business cards.

Agent or third party created materials

Agents are strongly advised to only use materials currently available through the UnitedHealthcare Agent Toolkit or Sales Materials Portal when conducting marketing/sales events. By doing so, you will know that your materials have been approved by UnitedHealthcare and CMS (if applicable). Remember that materials must be used in the approved format and for the use intended.

Prior to use at a marketing/sales event, any material created by an agent or other third-party marketing organization (TPMO) that meets the CMS definition of marketing must be pre-approved by UnitedHealthcare, filed in Health Plan Management System (HPMS) according to CMS guidelines, approved or accepted by CMS, and opted into by UnitedHealthcare. Materials must be

compliant for the current election period regardless of UnitedHealthcare and/or CMS approval in HPMS. Agent and/or TPMO created materials that do not meet the CMS definition of marketing may be used at a marketing/sales event provided they are compliant with all applicable state and federal guidelines and UnitedHealthcare business rules, policies, and procedures.

Meals and refreshments at a marketing/sales event

Meals must not be provided or subsidized during any marketing/sales event or the performance of any marketing/sales activity, even if the meal is not sponsored by UnitedHealthcare. When a meal is served as part of the venue's normal daily activity (e.g., soup kitchens, senior centers, cafeterias, food banks, nursing homes, and shelters), the marketing/sales event must not be conducted inside or outside the venue during the serving time of the meal.

When permitted by the venue, agents may offer light refreshments or snacks, but must not bundle the food items in a manner that would constitute a meal. The retail value of food items, when combined with any other permissible giveaway, must not exceed $15 on a per-person basis (maximum of $75 per person, per year). The following are examples of acceptable snacks:

- Fruit or raw vegetables
- Pastries, cookies, or small dessert items
- Cheese, chips, yogurt, or nuts
- Crackers or muffins

Providing alcoholic beverages is prohibited.

Knowledge Check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

Janet is conducting an informal marketing/sales event at her local soup kitchen. When speaking to the Activities Director, Janet finds out that lunch is served daily from 11:00 AM-1:00 PM. Which of the following is a compliant time when Janet can host her event?

- ◯ 9 am to 11 am
- ◯ 11 am to 1 pm
- ◯ 10:30 am-1:30 pm, but only if the agent's table is set up outside of the room where the meal is served

SUBMIT

Prohibited activities at a marketing/sales event

- Conducting a marketing/sales event (formal or informal) within 12 hours of the completion of an educational event at the same location (i.e., same building or adjacent buildings).
- Requiring any contact information as a condition for consumers to attend an event (for example on BRCs, with RSVPs or on sign-in sheets).
- Using unsubstantiated qualified superlatives (e.g., the largest health plan in the state), unsubstantiated absolute statements (e.g., UnitedHealthcare is the best), disparaging statements, urgency statements, or scare tactics.
- Soliciting or accepting enrollment applications from consumers that do not have a valid election period.
- Engaging in discriminatory practices, such as marketing only to consumers from higher income areas or states, and/or implying that plans are available only to seniors and not all Medicare-eligible consumers.
- Conducting health screening or similar activities that could give the impression of "cherry picking" or selective marketing or enrollment based on health status.
- Steering consumers to specific providers or provider groups, practitioners, or suppliers.
- Presenting plan options not indicated in advertising/promotional material or announced at the beginning of the event or consumer interaction.
- Marketing non-health related products (e.g., annuities or life insurance) while marketing a Medicare-related product.
- Comparing one plan sponsor to another by name unless both plan sponsors have concurred or the agent is certified and appointed (if necessary) with both carriers.
- Using or displaying a roster or RSVP listing at the event for any purpose, including to verify attendance.

Permitted activities at a marketing/sales event

In addition to the permitted activities already mentioned, when conducting a marketing/sales event, you may:

- Accept and assist in the completion of enrollment applications during a valid marketing and election period.
- Schedule future personal marketing appointments and obtain completed Scope of Appointment forms.
- Provide plan-specific information when asked by consumers or members, such as what providers are in-network and drugs are on the formulary and the applicable costs for services and drugs.

Marketing/sales events: presenting

Introductory presentation of educational information

Informal marketing/sales event with an introductory presentation of educational information

Some marketing/sales events begin with an introductory presentation of educational information, followed by an opportunity for consumers to approach agents to receive plan information, schedule future personal marketing appointments, and ask plan-related questions. The educational information may be presented by licensed or non-licensed individuals (e.g., agent, sales leader, provider).

Report this type of event as an informal marketing/sales event. Refer to event reporting instructions on the NEW Event Request Form.

Guidelines for the **Introductory Presentation** include:

- Educational information may be presented, including the UnitedHealthcare-branded "Medicare Made Clear" booklet that is free of plan specific information.
- An agent introduction and the agent's location following the introductory presentation (consumers must approach the agent and initiate discussion).
- No plan-specific information can be presented, such as premiums, benefits and cost-sharing.

- No plan information should be attached to educational materials.
- If a provider is presenting, all provider guidelines apply.

After the introductory presentation, the agent must proceed by conducting the remainder of the event by observing all compliance regulations and UnitedHealthcare rules, policies, and procedures related to informal marketing/sales events.

Informal marketing/sales event

In addition to all other guidelines that pertain to marketing/sales events, the following guidelines apply to informal marketing/sales events and activities. Remember that an informal event is conducted with a less structured presentation or in a less formal environment. Typically, you would use a table, booth, or kiosk to conduct an informal event.

Prohibited activities

- Leaving the event unattended during the advertised or posted event time. Post a visible notice, indicating your time of return when leaving the event unattended for any reason (e.g., restroom break, assisting another consumer).
- Conducting an event in such a way as to obstruct the consumer's entrance or exit from the venue or to give any impression that attending the event is a requirement to visiting the venue.
- Proactively approaching consumers anywhere in the venue. Consumers must initiate contact with you; however, you may greet passersby (e.g., Good Morning, Hello).
- Locating a booth/table/kiosk anywhere the consumer receives care. Obtain provider permission prior to conducting an informal event at a provider location, and follow their instructions on placement of your booth/table/kiosk, making sure that you can reasonably protect consumer Protected Health Information (PHI) and Personally Identifiable Information (PII).

Permitted activities

- Waiting behind the booth/table for a consumer to request information.
- Answering questions about UnitedHealthcare plans and products, provided the agent is certified in those products/plans.
- Distributing and collecting enrollment applications.
- Providing non-alcoholic refreshments if permitted by the venue.
- Starting the event with a short introductory presentation consisting of educational (not plan-related) content.

Staffing a UnitedHealthcare MedicareStore

Generally speaking, all guidelines that pertain to marketing/sales events and activities apply to agents staffing a UnitedHealthcare MedicareStore. However, you must comply with some additional guidelines when staffing a UnitedHealthcare MedicareStore.

Prohibited activities

Prohibited activities at a UnitedHealthcare MedicareStore include:

- Proactively approaching consumers outside the entrance of the store.
- Discussing any Medicare Advantage and/or Prescription Drug Plan prior to obtaining a completed Scope of Appointment from the consumer.
- Distributing marketing materials outside of the store (e.g., walking through the mall handing out flyers or placing flyers on tables in the food court).

Permitted activities

Permitted activities at a UnitedHealthcare MedicareStore include:

- Meeting with a consumer who scheduled an appointment and completed a Scope of Appointment.

- Conducting a formal or informal marketing/sales event in the UnitedHealthcare MedicareStore provided all applicable rules are followed, including reporting of the event.

Required activities

Required activities at a UnitedHealthcare MedicareStore include:

- Days and hours of operation as a UnitedHealthcare office must be reported via the NEW Event Request Form. However, when operated as a UnitedHealthcare office, the activity is not considered a formal or informal marketing/sales event.
- A Scope of Appointment form must be obtained from the consumer prior to discussing any Medicare Advantage and/or Prescription Drug Plan.
- Complying with all health, safety, and security protocols established for the location.

Enrollment activities at a marketing/sales event

All guidelines related to enrolling consumers apply, but remember these rules when conducting in-person marketing/sales events (refer to the Ethics and Compliance Certification section for more detail):

- Only accept completed applications from consumers with a valid election period. Holding or offering to hold a completed application is prohibited. Enrollment applications using the Annual Election Period (AEP) must not be received until Oct. 15. Note: You are permitted to accept an enrollment application for the upcoming plan year Oct. 1-14 only if the election period used is IEP/ICEP.
- At the time of enrollment, provide all applicable CMS-required materials, such as Summary of Benefits, Pre-Enrollment Checklist, and current Star Rating. To ensure compliance, we strongly recommend providing the Enrollment Guide instead of standalone documents.
- Only the agent who last reviewed the plan and assisted the consumer in the completion of the enrollment application is permitted to sign, date, and affix their

writing number to the application. When multiple agents are working an event, it is the agent who assists in the completion of the enrollment application who signs, dates, and enters their writing number on the application. Agents are not permitted to divide up among themselves the enrollment applications completed during an event. Doing so would result in a compliance infraction and result in corrective and/or disciplinary action.

- If a consumer is not ready to enroll at the time of the event, agents may pre-fill their writing number (Agent ID), only on a paper enrollment application. Agents must not enter their name and/or sign/date the application until receiving the signed application from the consumer.

Giveaways

Giveaways

The following guidelines apply to giveaways offered at events (educational or marketing/sales):

- Gifts and giveaways offered by agents for attending marketing/sales activities must not be items or services that are considered drug or health benefits, including optional mandatory supplemental benefits (e.g., a free checkup, health screening, hearing test; blood pressure and/or cholesterol checks). Note: Agents are allowed to hold marketing/sales events at health fairs where health screenings are occurring as long as there is a separation between the agent's location and the health screening booth, and the agent is not providing, or does not appear to be providing, health screening services to the consumers.
- The offer of a giveaway cannot be conditional, such as in exchange for contact information or a referral or the completion of an enrollment application and should be given regardless of whether the consumer enrolls and without discrimination. The retail value of all giveaways, combined with the retail value of food items and refreshments, must not exceed $15 on a per-person basis (maximum of $75 per person, per year). Meals, or bundled food items constituting a meal, may not be provided at marketing/sales events.
- Regardless of dollar amount, the following items may not be used as giveaways: money, gift cards (unless previously approved by UnitedHealthcare), gift certificates,

gifts easily converted to cash, gambling associated items (e.g., lottery tickets, pull-tabs, meat raffles), charitable contributions on behalf of a consumer, coupons or certificates redeemable for meals or other consumables.

- If the giveaway provided is one large gift that is enjoyed by all in attendance (e.g., a movie), the total retail cost must be $15 or less when it is divided by the estimated attendance.
- Promotional items containing the plan sponsor's name, logo, toll-free customer service number, and/or website may be offered. Promotional items may contain agent contact information.

Contests, drawings and games

Event guidelines vary depending on whether the winner of a contest, drawing, or game is awarded a prize. Any prize awarded, regardless of value, creates a responsibility on the agent's part.

No Prize Awarded

Agents may conduct in-person or online BINGO games or conduct drawings without obtaining approval from UnitedHealthcare and completing Rules of Entry documentation requirements when **no prize will be awarded** to a contest winner. Examples of acceptable acknowledgement of a winner include applause or certificate.

Prize Awarded

Non-UnitedHealthcare-branded event

- External Distribution Channel (EDC) agents are responsible for ensuring compliance with all federal and state laws and regulations when conducting non-UnitedHealthcare-branded events during which a prize of any value will be awarded to a contest winner.

- Agents must obtain written approval from UnitedHealthcare prior to reporting and conducting an event when a drawing will be conducted with a prize worth more than $15 by submitting a detailed contest proposal to compliance_questions@uhc.com at least 30 days prior to the anticipated event date to ensure event reporting requirements can be met. UnitedHealthcare approval of the proposed contest and prize does not constitute a compliance approval. The agent remains responsible for ensuring compliance with all applicable federal and state laws and regulations.

UnitedHealthcare-branded event

- Agents and sales leaders must obtain written approval from UnitedHealthcare prior to reporting and conducting an event where a prize of any value will be awarded to the winner of a contest, drawing, or game by submitting a detailed proposal to compliance_questions@uhc.com at least 30 calendar days prior to the anticipated event date.
- If approved, the following requirements must be met:
    - The individual indicated as the “Presenting Agent” must complete, retain, and make available upon request a UnitedHealthcare Rules of Entry document (available via compliance_questions@uhc.com) for the applicable contest. AND
    - All requirements outlined in the Rules of Entry document must be met, including prize value limits, alternate means of entry option, posting the Rules of Entry document at in-person events and displayed or announced at online events, and limitation on use of consumer contact information.
    - If the awarded prize will be $30 or more in value, a liability waiver must be signed by the winner.

Provider-based activities at events

Provider-based activities at events

Providers are broadly defined to include health care professionals, service organizations, or suppliers that deliver health care or health-related services or manufacture and/or sell medical supplies or equipment. This can range from manufacturers of medical devices such as hearing aids, to those rendering professional services such as physicians or chiropractors, to representatives of facilities such as clinics, hospitals, or pharmacies.

Any provider or provider representative you invite to an event must follow these guidelines.

Note that these guidelines are the same for educational and marketing/sales events.

Providers must not...

- Use the event as an opportunity to promote their business or practice
- Sell products or offer sample items to consumers
- Provide gifts or giveaways
- Provide health screenings and/or tests
- Accept compensation for participating in or attending an event

- Attempt to steer consumers to plans based on the provider's financial or other interests
- Distribute marketing materials or distribute and/or collect scope of appointment forms, lead cards, or enrollment applications
- Discuss or answer questions about plan specific features (benefits, premiums, etc.)

Providers may...

- State their name, practice/business name and area of expertise in relation to any health information they are presenting
- Present topics around general health or product related information. Such as diabetes, hearing health, or how a medical device works
- Answer general questions about the topic presented or their area of expertise
- Display health education materials and business cards for consumer to pick up.

- Post event information on their website or other provider created material or in other provider-created material provided it does not meet the CMS definition of marketing material, does not include any mention of UnitedHealthcare or a UnitedHealthcare plan name, and includes all required disclaimers.

Event observation and oversight

Purpose of event observation and oversight

UnitedHealthcare is responsible for conducting oversight of agents who market and sell the UnitedHealthcare Medicare plans portfolio of products. In addition, CMS may perform surveillance activities to ensure Medicare beneficiaries receive accurate and compliant information from agents.

An agent must permit any individual evaluating the event to perform their evaluation without interference.

Special Needs Plans (SNP)

Overview

All SNPs are Medicare Advantage plans. These plans are designed for specific Medicare consumer populations to provide focused and specialized care. Generally, if a SNP is available in the service area and a consumer meets SNP eligibility requirements and has a valid election period, these plans are in the best interest of eligible consumers.

Who can enroll in a Medicare SNP?

To enroll in a SNP, consumers must be entitled to Medicare Part A, enrolled in Part B, reside in the plan's service area, and meet SNP specific eligibility requirements.

Here are the eligibility requirements for each type of SNP:

- Dual Eligible Special Needs Plan (D-SNP) – Both Medicare and Medicaid enrollment
- Chronic Condition-Special Needs Plan (C-SNP) – One or more qualifying chronic or disabling health conditions (like Diabetes Mellitus, cardiovascular disorders, and/or chronic heart failure)

- Institutional Special Needs Plan (I-SNP) – Consumer resides or is expected to reside in a contracted institution (like a nursing home) for 90 days or longer
- Institutional Equivalent Special Needs Plan (IIE-SNP) – Consumer resides in the plan service area and requires an institutional level of care

What do SNPs offer?

SNPs are required to offer benefits and a Model of Care (MOC) to address the unique needs of the population served by the plan. These differentiate the SNPs from non-SNP MA Plans.

SNPs must provide all benefits covered under Original Medicare (except Hospice). All SNPs also include Part D prescription drug coverage. Additional benefits not covered by Original Medicare may include:

- Routine vision and hearing
- Preventive/comprehensive dental
- Credits for over-the-counter products and healthy food in-store or online
- Non-emergency transportation
- Fitness membership
- Routine foot care

Benefits may vary by plan type and/or market.

How do SNPs address the unique needs of the

population served by the plan?

SNPs must develop and implement a Model of Care (MOC) for each type of SNP offered. The MOC is approved by CMS and provides the structure for care management and coordination for special needs individuals.

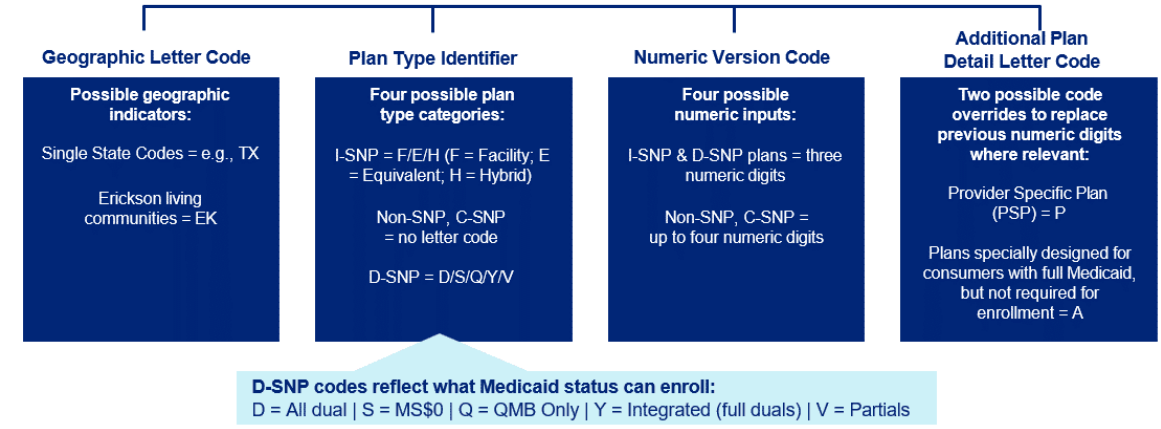
The MOC includes four elements:

1. Description of the SNP Population;
2. Care Coordination;
3. SNP Provider Network; and
4. MOC Quality Measurement & Performance Improvement.

The MOC is evaluated and approved by the National Committee for Quality Assurance (NCQA) according to CMS guidelines. CMS audits SNPs for compliance of MOC performance.

Special Needs Plans Identifiers*

2025 Plan Identifier breakdown



*D-SNP used for illustrative purposed only. Plans and plan names may vary by plan year. Refer to the Medicare Product Portal for plans available in your area for a specific plan year.

Dual Eligible and Chronic Condition SNPs

Key features

All Special Needs Plans have certain key features in common.

Click each plus (+) to learn the key features of SNPs.

Networks

All SNPs are network-based plans. SNPs may have the following plan types:

- Health Maintenance Organization (HMO): to receive coverage under the plan, the member must use contracted providers except for emergency, urgent care, and renal dialysis services.
- HMO Point-of-Service (POS), Preferred Provider Organization (PPO), and Regional Preferred Provider Organization (RPPO): the member may use out-of-network providers for covered services, but will likely incur higher cost-sharing if they do so. Therefore, to minimize cost-sharing obligations, members are encouraged to use in-network providers.

Agents must refer to the appropriate plan's online Provider Directory to confirm if the consumer's providers, specialists, and hospitals are in the contracted provider network.

Note: When working with a consumer with Medicaid, explain that providers in their Medicaid network may not be in the D-SNP network. They must use providers in the D-SNP network to receive in-network coverage under the plan.

Prescription drug coverage —

All SNPs include integrated prescription drug coverage. The coverage must comply with the Medicare Part D benefit as described in the Medicare Basics section. C-SNPs, however, have their own formulary.

Always review each of the consumer's current prescriptions to confirm:

- If it is on the formulary
- What cost-sharing applies, including LIS copays for eligible consumers
- Any applicable restrictions (such as Quantity Limits, Dispensing Limits, 7-Day Limits, Limited Access, Step Therapy or Prior Authorization)

Use the online drug look-up tool for the most current information.

Remember cost-sharing may vary by plan. Always review the potential cost-sharing with the consumer through all the coverage stages. Including:

- Plan premiums
- Deductibles
- Copayments
- Coinsurance

2025 Low-income cost sharing				
Drug Stage	**Drug Category**	**LIS 1**	**LIS 2**	**LIS 3**
Deductible	All	$0	$0	$0
Initial Coverage	Generic	$4.90	$1.60	$0
	Brand	$12.15	$4.80	$0
Catastrophic	All	$0	$0	$0

Note: Agents should use the Low Income Subsidy job aid for current cost sharing. *(Jarvis > Learning Lab > Content Library > Low Income Subsidy)*

Care coordination

Care coordination requirements for Special Needs Plans (SNP)

What is the requirement and when is it applicable?

All SNPs must provide a face-to-face encounter between each member and a member of the consumer's ~~s~~ Interdisciplinary Care Team (ICT) or the plan's case management and coordination staff on at least an annual basis "as feasible" and with the member's consent.

The SNP must honor any member's decision to not participate and should document that refusal. The "as feasible" regulation allows for compliance even if a member cannot be engaged so long as the SNP has made reasonable, documented efforts.

What type of encounters qualify and when must the encounter occur?

In person or by remote technology (including visual, real-time, interactive telehealth) encounters such as:

- Engaging with the consumer over their health care
- Annual wellness visit or physical
- Health Assessment (HA) completed in-person or via virtual telehealth except those completed by an agent

- Care plan review or care coordination activities
- Health related education
- Encounters that may address mental/behavioral health or overall health including functional status

Telephonic or other audio only encounters DO NOT qualify

The encounter must occur within the first 12 months of enrollment and annually thereafter

Health Assessment

Care management uses the Health Assessment (HA)* to determine each SNP member's risk level.

- The SNP is required to obtain an initial HA within 90 days of enrollment and annually within 365 days of the previous HA.
- An Individualized Care Plan (ICP) is created from the HA to address identified needs and is shared with the member and the PCP.
- The SNP member must have access to an Interdisciplinary Care Team (ICT), which at a minimum consists of the member and their PCP. When the member is in a clinical program the ICT also includes a case manager.

The HA asks questions about the member's **medical, functional, cognitive, psychosocial, mental health needs, any assistance needed with daily living activities and social determinants of health.** Authorized agents may be able to assist the consumer in completing the HA in JarvisEnroll at the time of enrollment or an authorized third-party enrollment platform is used. If the HA is not obtained by the agent at the time of enrollment, other methods will be used to obtain the HA, including during the HouseCalls visit offered by UnitedHealthcare.

***Be clear with consumers during the enrollment process that a Health Assessment call is not the same as the HouseCalls visit or UnitedHealthcare's Social and Government Referral Program outreach call. Explain the purpose of each call to consumers to help ensure they take advantage of important plan services.**

Click each tab for an example of how Care management can be implemented.

LOW-MODERATE RISK | HIGH- RISK

Based on the HA results, a member profile is created and an initial care management plan is developed. The low to moderate health risk member may be offered programs and services like those under "Services Included." Regular monitoring allows care management to adjust the programs and services as the member's needs change.

Member profile

- Lowest risk, stable
- Limited health care needs and gaps in care
- Generally doing well

Care management

- Initial HA
- Individualized care plan
- No care manager assignment
- Ongoing reassessment of risk level for status changes

Service included

- Primary prevention, health education, and reminders
- Telephonic access to a nurse
- Disease management programs

Note: HouseCalls is a service where licensed health care practitioners make in-home visits to members in select plans. HouseCalls is not available in some UnitedHealthcare C-SNPs or D-SNPs. For more information on HouseCalls, refer to HouseCalls job aid on Jarvis).

LOW-MODERATE RISK	HIGH- RISK

Member Profile

- Highest risk
- Disabled and/or unstable, multiple complex conditions

Care Management

- Initial HA
- Individualized care plan
- Care manager assignment
- Case management (telephonic, digital and/or face-to-face) according to individual needs
- Ongoing reassessment of risk level for status changes

Service Included

- Primary prevention, health education, and reminders
- Telephonic access to a nurse
- Disease management programs

(Same as Low-moderate risk level)

Care management

Based on unique medical need and health risk level, SNP members may receive care management support and services. These resources assist with answering health related questions, obtaining services and access to care. Care management seeks optimal outcomes for high-risk members by looking for ways to help improve care quality and efficiency and control costs.

- The Care Manager* helps coordinate medical care at the hospital and assists the member with post-hospitalization.
- The focus is on improving and maintaining the member's quality of life
- Provides information on how to access plan benefits, answers health related questions and provides education as needed
- Helps coordinate access to preventive care like flu shots or wellness visits

*The Care Manager will be a representative from either UnitedHealthcare or a contracted delegate.

Medicaid overview

The D-SNP is a Medicare Advantage product designed for the Medicare and Medicaid population; therefore, it is important to understand the basics of Medicaid, identify and verify Medicaid qualifications for enrollment, and determine a consumer's eligibility.

Click each tab to learn more.

Medicaid basics

Medicaid is a joint federal and state program that helps pay medical costs for certain groups of people with limited income and resources, such as pregnant women, children, and the aged, blind or disabled.

Medicaid programs vary from state-to-state as each state determines what programs are operated and funded, eligibility criteria, and benefits. Two programs that work with Medicare are Medicare Savings Programs and Medicaid Benefits.

A state's Medicaid program might be called by another name. For example, the Medicaid program in Wisconsin is called BadgerCare. Make sure you are aware of the name of the Medicaid program in the consumer’s state and be sensitive to consumers who might not recognize themselves as dual-eligible or enrolled in Medicaid.

Why understand Medicaid

Why Is it Important to Understand Medicaid?

It is important to understand Medicaid because a D-SNP consumer's Medicaid eligibility will determine if they are eligible for D-SNP, what is covered and if there is a cost share with their Medicare benefits.

There are several categories of Medicaid Eligibility, each determining whether a D-SNP consumer will receive full dual benefits or partial dual benefits.

Therefore, in order to direct the consumer to the best Medicare Advantage plan for their needs, agents should determine the consumer's level of Medicaid eligibility as they conduct a thorough needs assessment.

The Medicare Savings Program (MSP)

The Medicare Savings Program (MSP) is a federally funded program, administered and offered by every state through its Medicaid program. It helps low-income Medicare-eligible consumers access Medicare benefits by helping with some Medicare-related out-of-pocket costs. However, it does not provide health care coverage.

Agents should verify the consumer's eligibility by:

- Confirming the state of residence
- Confirming the Medicaid number, and
- Viewing the award letter that describes the type of benefits for which the consumer is eligible **OR** using the Medicare Medicaid Eligibility Tool on Jarvis to verify Medicaid

status

The different levels of Medicaid eligibility will be covered on the following slides.

Remember: Benefits vary by state and are based on the consumer's eligibility.

Full dual-eligible

For Medicare consumers who are eligible for full Medicaid coverage, **Full Benefit Dual Eligible (FBDE)**, **Qualified Medicare Beneficiary with full Medicaid (QMB+)** and **Specified Low Income Medicare Beneficiary with full Medicaid (SLMB+)**, Medicaid supplements the consumer's Medicare coverage with services and supplies that aren't typically covered by Medicare (For example, Nursing facility care beyond the 100-day limit covered by Medicare, non-Part D prescription drugs, eyeglasses, and hearing aids).

FBDE, QMB+ and SLMB+ members are Medicare consumers who are eligible for full Medicaid coverage. These members receive state assistance with Medicare cost-sharing and are collectively referred to as Full Duals.

UnitedHealthcare D-SNP Medicare-covered benefits are often filed to match Original Medicare cost-sharing. Generally, Full Duals receive assistance to cover their cost-sharing; however this may vary depending on the state's Medicaid program. Full Duals may or may not receive cost-sharing assistance. For example, Wisconsin does not recognize the SLMB+s as full duals, therefore, beneficiaries will have cost-sharing.

Remember, some UnitedHealthcare's D-SNPs are designed to best suit the Full dual-eligible Medicaid recipient while others are designed to service the Partial dual-eligible Medicaid recipient.

Note: Use the Medicare Medicaid Verification Lookup Tool to find the best plan for the consumer based on their Medicaid eligibility.

> *Note: Full Duals may have to pay a cost share if a benefit is not covered by Original Medicare or a Medicaid covered service. This varies by state.*

Partial dual-eligible

For Medicare consumers who are eligible for partial Medicaid coverage (Partial dual-eligible), the Medicaid program supplements only specific Medicare cost - sharing depending on their level of Medicaid coverage:

- **Qualified Medicare Beneficiary (QMB Only)**: for QMB Only consumer, Medicaid pays the consumer's Medicare Part A and B premiums and any other Part B costs, but does not receive Full Medicaid benefits.
- **Specified Low Income Medicare Beneficiary (SLMB Only)**: for SLMB Only consumer, Medicaid pays the consumer's Medicare Part B premium, but does not pay any other Part B costs.
- **Qualifying Individual (QI)**: These consumers are similar to a SLMB Only consumer where Medicaid pays the consumer's Medicare Part B premium, but does not pay any other Part B costs. The differences between a SLMB Only and QI consumer are the income and Federal Poverty Level (FPL) percentages that will qualify them for SLMB or QI program.

- **Qualified Disabled Working Individual (QDWI)**: Medicaid pays the consumer's Medicare Part A premium, but not the Part A deductible or copayments. Medicaid does not pay any costs related to Medicare Part B.

Note: Use the Medicare Medicaid Verification Lookup Tool to find the best plan for the consumer based on their Medicaid eligibility.

Click each tab to review each dual - eligible Category.

Dual-eligible categories

Types of dual-eligible consumers

FBDE —

Medicaid Benefits

- Full Medicaid benefits
- Cost - sharing varies by state

QMB+ —

Medicaid Benefits

- Full Medicaid benefits
- Medicare premiums and cost - sharing

SLMB+ —

Medicaid Benefits

- Full Medicaid benefits
- Cost - sharing varies by state

QMB ONLY —

Medicaid Benefits

Medicare premiums and any other Part B cost - sharing

SLMB ONLY —

Medicaid Benefits

Part B premium; must pay their own cost - sharing

QI —

Medicaid Benefits

Part B premium; must pay their own cost - sharing

QDWI —

Medicaid Benefits

Part A premium; must pay their own cost - sharing

Medicaid spend down explained

Some states provide a “spend down” process by which qualified consumers may use their excess income towards their out-of-pocket medical expenses to qualify for Medicaid coverage. Excess income is the amount of income the consumer has over the level established by the state as qualifying a consumer for Medicaid.

By “spending down” their income to the level set by the state’s Medicaid program the individual is considered “medically needy”.

After the spend down requirement is met (sometimes for particular types of expenses within a given time frame), Medicaid begins to provide benefits. Timeframes vary from state to state.

Consumers who want to know more should be encouraged to call their state Medicaid program to see if they qualify, learn how to apply, and their particular state’s requirement for spend down.

Medicaid eligibility

There are guidelines pertaining to Medicaid eligibility, which are determined by state Medicaid offices and may change month to month.

Click each plus (+) to learn about Medicaid eligibility.

Consumer must apply for Medicaid

- Must show proof of income and resources
- Meet any additional eligibility requirements (e.g., aged, blind, or disabled)

Dual status may not be permanent

- Consumers may have to “spend down” to trigger Medicaid eligibility, based on monthly income and medical expenses *(spend-down was explained previously)*
- Consumers may go on and off Dual status several times per year
- Consumers have to recertify periodically; at least once per year
- States may change eligibility criteria mid-year
- Full dual status varies by state; income, asset levels, and exclusions may vary

D-SNP overview

Types of D-SNPs

- Fully Integrated Dual Eligible SNP (FIDE) - A D-SNP that provides access to Medicare and Medicaid benefits managed under one health plan.
- Highly Integrated Dual Eligible SNP (HIDE) - A D-SNP that advances Medicare/Medicaid integration to align services with a focus on long-term support and services (LTSS) and/or behavioral health.
- Applicable Integrated Plans (AIPs) are D-SNPs that meet certain requirements. Note: Effective 1/1/25, FIDEs are now all AIPs.

Consumer characteristics

D-SNPs are designed for individuals who are eligible for both Medicare and Medicaid.

Earlier, features common to both C-SNP and D-SNP were covered. Now you will learn about **features unique to offering a D-SNP.** What are some characteristics of consumers who may benefit from a D-SNP? *(Examples are fictitious and do not reflect statements of a real plan member.)*

Click each plus (+) to learn why these individuals may most benefit from a D-SNP.

Prescription medication help

"I receive Extra Help with my prescription medication costs. I don't pay a premium for prescription drug coverage and I only pay a few dollars for my prescriptions."

Community services

"I live by myself and receive community services such as Meals on Wheels".

Low income

"I'm on a fixed income. I live in subsidized housing and receive help with my groceries."

State Medicaid assistance

"I have trouble keeping up with my Medicare bills. I also use some home health services that aren't covered by Medicare. My state helps with my Medicare cost-sharing and provides additional services not covered by Medicare."

Disabled —

"I have a permanent disability and receive Supplemental Security Income (SSI). I need assistance with daily activities such as bathing and dressing."

Special election periods

The Centers for Medicare & Medicaid Services (CMS) grants dual-eligible consumers that meet enrollment criteria a special election periods in addition to the Initial Enrollment Period (IEP)/Initial Coverage Election Period (ICEP), Annual Election Period (AEP), and Medicare Advantage Open Enrollment Period (MA OEP) election periods.

Dual-eligible consumers may uniquely qualify for the following election periods, some of which also depend on special eligibility and life events. Outside of those election periods, dual-eligible consumers enrolled in Original Medicare may enroll in a prescription drug plan (PDP) on a monthly basis. In addition, full benefit dual-eligible beneficiaries may make a monthly election into an integrated D-SNP (i.e., FIDE SNP, HIDE SNP or AIP) as eligible, to facilitate aligned enrollment, provided it is an aligned enrollment (i.e., the same organization, parent organization, or another entity owned by the same parent organization manages both Medicaid and Medicare coverage). Electing a non-integrated D-SNP or other MA plan is not permitted using the SEP-Integrated Care election period. ICEP/IEP, AEP, MA OEP and other SEPs continue to be available for enrollment into non-integrated D-SNPs.

Additionally, dual eligible or LIS eligible consumers who had a change in either their Medicaid Assistance (Medicare Savings Program) or LIS/Extra Help level or lost the assistance, will have the opportunity to change plans within 3 months of their notification of

change or from when the change went into effect, whichever is later. They can use the **SEP-DUAL/LIS (CHANGE IN STATUS).**

Note: The Dual/LIS Maintaining quarterly SEP is no longer available for D-SNP or MAPD for 1/1/2025 plan enrollments effective October 1, 2024.

For more information, please check the Election Period Booklet (available on Learning Lab).

Medicaid eligibility verification

A consumer's Medicare and Medicaid status can be verified during the sales process for most states. For eligible states, field sales agents should use the Medicare Medicaid Eligibility Lookup tool on Jarvis to determine Medicare and Medicaid eligibility for consumers and members. For states that are not available in the look up tool, the agent should call the Producer Help Desk (PHD).

Review the Medicare Medicaid Eligibility Lookup Tool job aid for instructions on how to use the tool. *(Jarvis>Knowledge Center>Learning Lab>Jarvis Course)*

Prior to using the lookup tool or calling the PHD, the agent must be prepared with the following information about the consumer:

- Date the consumer gave the agent permission to look up their Medicare and/or Medicaid status
- Consumer's first and last name, Medicare and Medicaid numbers (or Social Security number), and date of birth

After providing the required information, the agent will receive confirmation of the consumer's Medicaid eligibility status and level of benefits, if the consumer is eligible to use

a valid SEP and the UnitedHealthcare plans available to the consumer based on their Medicaid status.

> ***Note:*** *The Medicare Medicaid Eligibility Lookup Tool and PHD perform Medicaid verifications for states where UnitedHealthcare has either a D-SNP or plan designed for consumers with both Medicare and Medicaid (as identified by the A at the end of the plan identifier, e.g., UHC Complete Care AZ-001A).*

Loss of Medicaid eligibility

If a D-SNP member loses their Medicaid eligibility, the member can remain enrolled in the D-SNP for a period of continued eligibility, which is often called the "grace period." The length of the grace period can vary by state from one to six months, but is generally six months for most D-SNPs.

Loss of Medicaid eligibility generally means the member will have to pay premiums, deductibles, copayments, and coinsurance during the grace period.

The D-SNP member will be disenrolled at the end of the grace period if their Medicaid eligibility cannot be reestablished.

In addition, a Special Election Period (SEP) is available for D-SNP members that lose their Medicaid eligibility. This SEP begins the month they are notified by the plan of the loss of Medicaid eligibility or effective date of the loss, whichever is earlier and ends when they enroll into a different Medicare Advantage/Part D plan or the last day of the third month after notification is received, whichever is later.

Once a D-SNP member is enrolled in a D-SNP and later loses Medicaid eligibility, UnitedHealthcare offers assistance in most states to its members in re-establishing Medicaid eligibility through a third party vendor. This outreach by the vendor is often called Medicaid Recertification Assistance.

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

Bonnie, a D-SNP member, lost her Medicaid eligibility. She has a Special Election Period available to enroll in a new plan. When does that begin?

- ○ First Day of the month of notification of loss of Medicaid eligibility
- ○ Last day of the month of notification of loss of Medicaid eligibility
- ○ Upon notification or effective date of the loss, which ever is earlier

- ◯ Six months after they have been disenrolled from the D-SNP

SUBMIT

Harold lost his Medicaid eligibility. What is he responsible for paying? (select all that apply)

- ☐ Only his premiums
- ☐ Deductibles
- ☐ Copayments
- ☐ Coinsurance

SUBMIT

Cost-sharing: premiums

Part B premium:

The state may pay for the Medicare Part B premium on behalf of a dual-eligible consumer.

Part D premium:

The premium for the Part D benefit integrated in all D-SNPs is at or below the Low Income Subsidy (LIS) benchmark. Therefore, due to LIS eligibility, it is likely that a dual-eligible consumer enrolled in a D-SNP would not pay a Part D premium.

When working with consumers:

- Do **NOT** state that a D-SNP is a “free" plan.
- Make sure that the consumer understands that LIS eligibility does not mean Medicaid or D-SNP eligibility.

Cost-sharing: copayments and co-insurance

Take a moment to review the following important points about D-SNP cost-sharing. *Note: This information is general and may not reflect the actual coordination of benefits of all states.*

- If a consumer is **NOT** a Full Dual Eligible that receives full assistance from the state, then make it clear they are responsible for the D-SNP plan’s cost-sharing amounts. Other plan options may be more appropriate. NOTE: QMB Only receives cost-sharing but is not considered Full Dual Eligible.

- Full Dual Eligible consumers who receive full assistance from the state in which they reside are "zero cost-share" consumers. Explain that they should:
    - Use their D-SNP member ID card and Medicaid card (except in states, such as Florida where the Florida Medicaid Managed Medical Assistance Program requires the member only show the plan ID)
    - Use in-network providers to keep costs down. Review the difference between in and out of network costs and coverage. For PPO/RPPO/POS plans, the consumers may use out-of-network providers, as long as the services are covered benefits and medically necessary, but the share of costs for their covered services may be higher
    - Expect that their Medicaid eligibility to be verified monthly and any change in Medicaid level may affect their enrollment and cost-sharing (this includes spend down and grace period times)

What should agents tell consumers about cost-sharing?

Agents must inform the consumer of all types of cost-sharing that could be associated with the plan, whether or not they receive additional help in paying those costs. This way if their status should change, they can be aware of the potential out-of-pocket expense.

Medicare-Medicaid Plans (MMP)

In some states, CMS and the state run a demonstration program called a Medicare-Medicaid Plan (MMP) where individuals receive both Medicare Parts A and B and full Medicaid benefits. Generally, qualified individuals are passively enrolled into the state's coordinated care plan with the ability to opt-out and choose other Medicare options. Designed to manage and coordinate both Medicare and Medicaid and include Part D prescription drug coverage through one single health plan, MMP demonstrations and eligible populations vary by state.

NOTE: The MMP demonstration will end December 31, 2025.

These plans are **NOT** Dual-Eligible Special Needs plans.

Historically, there has been a financial and care coordination misalignment between Medicare and Medicaid for Medicare-Medicaid enrollees (fully dual-eligible beneficiaries). To begin to address this issue, CMS began testing models with select states to better align the financing of these two programs and integrate primary, acute, behavioral health and long-term services.

The MMP Demonstration seeks to provide Medicare-Medicaid enrollees with a better care experience.

- More person centered
- Integrated care program - easier navigation
- One member ID card
- One company paying claims

Click each plus (+) to read more about MMP.

Locations

Nine states signed a Memorandum of Understanding (MOU) with CMS establishing parameters of state demonstrations: CA, IL, MA, MI, NY, OH, RI, SC, and TX.

UnitedHealthcare is a participating MMP carrier in 12 counties in Northeast Ohio, Texas (Harris County only), and 9 Massachusetts counties.

There are specific eligibility requirements for each demonstration location.

MMP eligible consumers within these demonstration locations will be passively enrolled into these plans by the state. Passively enrolled consumers have the ability to opt out of these plans and choose other Medicare options.

- Consumers who choose to opt out, must do so themselves.
- Agents are not allowed to disenroll an individual from an MMP or market directly to MMP members.
- Enrollment in an MA/MAPD (including a D-SNP) will automatically disenroll the member from the Medicare portion of their MMP.

See the Agent Guide for additional details about marketing to dual eligible consumers in MMP areas in Ohio, Massachusetts, and Texas.

Marketing Medicare Advantage

When marketing Medicare Advantage (MA) plans in areas with an MMP:

Agents must:

- Support the state's efforts to enroll Full Dual Eligible consumers in an MMP where available
- Direct Full Dual Eligible consumers to the state Medicaid Consumer Hotline when a consumer has additional questions regarding the MMP program

Agents must not:

- Disparage the respective programs or make material misrepresentations about the program's possible impact
- Interfere with the state enrollment process
- Inappropriately promote/retain membership in an MA plan or steer dual-eligibles away from state plans when it is not the best fit for the consumer
- Call current MMP members to promote other Medicare plan types
- Use "scare tactics" about the program's possible impact on consumers

Massachusetts

Massachusetts One Care will transition to a Fully Integrated Dual Eligible Special Needs Plan FIDE SNP) for 2026.

For 2026, UnitedHealthcare will offer UHC One Care (HMO D-SNP) in Bristol, Essex Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester counties.

Members are enrolled in One Care through an authorized licensed sales agent. The agent must have completed the 2026 UHC One Care certification as well as the One Care training conducted by the health plan.

Eligible consumers include:

- Individuals aged 21 through 64 at the time of enrollment
- Eligible for Medicare and MassHealth Standard or MassHealth CommonHealth
- Not enrolled in a Home and Community-Based Services (HCBS) Waiver

Remember One Care and SCO eligibility is different for both programs because of the age requirement. One Care eligible members are not eligible for SCO unless they turn 65 and want to become part of SCO.

Unless there is a compelling reason, it is generally not appropriate to enroll SCO and One Care members into a non-SNP. It will change their integrated care plan.

Ohio

In accordance with CMS regulations, the Health and Human Services Commission (HHSC) is ending the MMP on Dec. 31, 2025 and will transition the MMP to an integrated FIDE-SNP model on Jan. 1, 2026.

When MMP members transition from an MMP, they have the option to enroll into:

- MA or non-integrated D-SNPs

- FIDE-SNP Next Generation MyCare plans
- Or fee-for-service Medicare for their Medicare services

MMP members must enroll in a Next Generation MyCare plan at a minimum for their Medicaid plan once Next Generation MyCare becomes available in their county.

For additional information on the transition of MMP to an integrated D-SNP, please reference the Transition section on MyCare-Ohio.

Texas

In accordance with CMS regulations, Health and Human Services Commission (HHSC) is ending the MMP on Dec. 31, 2025, and will transition the MMP to an integrated D-SNP model on Jan. 1, 2026.

When MMP members transition from an MMP, they must select:

- A Medicare Advantage (MA), D-SNP or fee-for-service Medicare for their **Medicare** services, and
- A STAR+PLUS MCO for their **Medicaid** services. MMP members are encouraged to choose companion D-SNPs operated by the same parent organization or that are the same entity as their STAR+PLUS MCOs for better coordination of their Medicare and Medicaid services.

For additional information on the transition of MMP to an integrated D-SNP, please reference the Transition section on the HHS Dual Eligible Integrated Care Demonstration Project site.

MMP waiver

CMS has approved a waiver to allow Dual eligible consumers to switch MMPs or disenroll from their MMP and enroll in any type of MA plan or return to Original Medicare with or without a PDP on a monthly basis. This waiver also includes monthly changes for November 1 and December 1 effective dates.

This applies to ALL 9 states that offer MMPs which means that members can make MMP-related elections on a monthly basis including those within UnitedHealthcare and competitors.

In order to meet the criteria to use the Dual/LIS SEP on a monthly basis, the consumer must:

- Be “full benefit dual - eligible” enrolled in an MMP
- Not be identified as “Potential At-Risk” or “At-Risk”. This limitation still applies to MMP enrollees as well. These individuals CANNOT use the SEP Dual/LIS

D-SNP state specific agent requirements

State D-SNP requirements

Some states have additional requirements for agents to sell D-SNPs. Read the information on each state's requirements.

Click each plus (+) to read more about the state specific requirements.

Virginia —

As Virginia moves to exclusively aligned enrollment for Medicaid members, there's a requirement for agents selling Dual Eligible Special Needs Plans (D-SNP) in Virginia.

What you need to do

Virginia agents wanting to sell D-SNPs are required to watch a video published by the Virginia Department of Medical Assistance Services (DMAS) on an annual basis and sign an attestation prior to completing a Virginia D-SNP enrollment. The signed attestation must be retained and provided upon request.

The video explains what exclusively aligned enrollment is and what it means for the member. The link to the video, slides and slide notes, as well as the attestation are all conveniently included in the information packet published by DMAS and linked below.

Click here to access the full packet, which includes a link to the video on YouTube.
If you cannot download the attestation from the full packet, **access it here.**

What you need to know

Full-benefit Virginia D-SNP members are being moved to exclusively aligned enrollment. This means the same carrier will provide a member's D-SNP and Medicaid plan. If a member's Medicaid plan is not offered by the same carrier that offers the member's D-SNP, the member's Medicaid carrier will automatically be changed to the member's D-SNP carrier and the member will receive notice.

With exclusively aligned enrollment, members should experience greater ease when using their benefits. They will receive one integrated ID card for their D-SNP and Medicaid plan and help avoid the confusion that comes with juggling benefits from two different carriers.

As you meet with clients, help ensure they understand what it means to have their Medicare and Medicaid plans exclusively aligned.

For questions Virginia agent requirements, contact the PHD:

- Live Chat via Jarvis
- English: 1-888-381-8581
- Español: 1-866-235-5990

C-SNP overview

Consumer characteristics

C-SNPs are designed to assist consumers who have one or more specific chronic or disabling conditions. While the plan restricts enrollment to consumers with specific conditions (such as Diabetes Mellitus, cardiovascular disorders, and/or chronic heart failure), it provides benefits for all Medicare covered conditions.

Earlier, features common to both C-SNP and D-SNP were covered. Now you will learn about **features unique to offering a C-SNP.** Let's first look at the following consumers who may benefit from a C-SNP.

Click each plus (+) to see consumer examples.

Want to reduce medical supply costs —

"I have diabetes and diabetic testing strips are expensive. I need a plan that will help me lower my costs."

Frustrated by multiple providers —

“I deal with a variety of health issues and it can be overwhelming to manage my illness with multiple providers. I'd like a plan where I can choose a provider that will help me coordinate my health care with my other providers.”

Benefit from additional coverage and more predictable costs —

“I have a cardiovascular disorder and I need a plan that will help me manage my illness and my health care costs. I'd also like my plan to have benefits in addition to what is covered under Original Medicare.”

Benefit from care management —

“I have complex medical conditions. I don't feel as if I have anyone with whom I can discuss my illness or treatment options. I still don't understand the health care system and wish there was someone who could provide me with the guidance that I need.”

Special election periods

A Special Election Period (SEP) can be used:

- When the consumer enrolls in any C-SNP for the first time based on a specific qualifying condition. Enrollment using SEP - Special Need/Chronic can occur any time during the year and ends once the consumer enrolls in the C-SNP.
- When the consumer has a different condition that their current C-SNP does not cover and changes from their current C-SNP to another C-SNP that serves that different condition. Enrollment using SEP - Special Need/Chronic can occur any time during the year and ends once the consumer enrolls in the new C-SNP.

Unless the consumer is eligible for a different SEP (e.g., change in residence out of the current plan's service area), the consumer is limited to the Annual Election Period (AEP) or the Medicare Advantage Open Enrollment Period (MA OEP) to enroll in another C-SNP that serves the same condition(s) as their current plan.

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

What are the reasons a consumer can use the Special Election Period- Special Need/Chronic? (select all that apply)

- [ ] Enrolling in a C-SNP first time
- [ ] Enrolling in a C-SNP to cover a different condition

☐ Enrolling in a different C-SNP to cover a condition covered by the current C-SNP for the same condition

SUBMIT

Primary care providers

Primary Care Providers (PCP) play an important part in managing the health of a member enrolled in a C-SNP because they are familiar with the member's medical history and can appropriately coordinate the member's care.

In addition to a PCP, consumers with a chronic condition often utilize one or more specialists to manage their complex health care needs and hospital services.

Upon enrollment in a C-SNP, the consumer may be required by the plan to select a PCP. To provide the best experience possible, encourage the consumer to select an in-network PCP to help manage their care. Use the online tool to look up providers and correctly enter the PCP's name and ID on the enrollment application and check "Existing Patient," if applicable.

Chronic condition verification process

In addition to all other eligibility requirements, CMS only permits continued enrollment in a C-SNP if a qualifying chronic condition is verified by the member's provider (including physician, physician assistant, or nurse practitioner). CMS permits C-SNPs to choose whether to verify the qualifying condition on a pre-enrollment or post-enrollment basis. The agent must understand and explain the chronic condition verification process to the consumer as it applies to the specific plan selected. **Note**: All UnitedHealthcare C-SNPs use the post-enrollment method.

Plans utilizing a pre-enrollment verification method

Enrollment will be denied if the chronic condition is not verified by a provider or their offices within 21 days of the request for additional information or the end of the month in which the enrollment request is made (whichever is longer).

Plans utilizing a post-enrollment method

The plan will attempt to verify the member's qualifying condition through the end of the second month of enrollment. However, if that verification does not occur by the end of the first month of enrollment, the plan must notify the member that they will be disenrolled at the end of the second month of enrollment if verification has not occurred by that time. In some circumstances, UnitedHealthcare may receive a denial of chronic condition prior to the plan's effective date. In this case, enrollment would be denied.

For example, the Plan effective date is April 1. As of April 30, the plan's attempts to verify the member's qualifying chronic condition have been unsuccessful. On May 1, the member is notified that their enrollment will be terminated effective May 31 if, as of May 31, the plan has not been able to verify a qualifying chronic condition.

Chronic condition verification process tips

Click each tab to learn more about chronic condition verification process.

AGENT RESPONSIBILITIES | CONSUMER ASSISTANCE WITH CHRONIC CONDITION VERIFICATION

- Explain the chronic condition verification process to the consumer
- Obtain a signed Chronic Condition Verification Authorization form from the consumer as authorization for the plan to contact the provider and submit it with the Enrollment Application. Ensure that the provider listed on the form is able to verify the condition. It could be someone other than the PCP. (Form is available in the Enrollment Guide and in JarvisEnroll in the Questionnaire)
- Ensure the consumer understands that if their chronic condition cannot be verified, they will not be enrolled into the plan or will be disenrolled from the plan and returned to Original Medicare, depending on the Plan's method of verification. The member is eligible for a Loss of SNP Status SEP to select a new plan.

AGENT RESPONSIBILITIES | CONSUMER ASSISTANCE WITH CHRONIC CONDITION VERIFICATION

Valid and accurate provider contact information is critical to verify a consumer's C-SNP eligibility. Here are some ways you can work with consumers to get the needed information:

- Ask for the name, address and telephone number of the PCP or specialist who would be able to verify the consumer’s chronic condition. Note: the PCP or specialist indicated does not need to be contracted with the plan.
- Here are some questions and ways that can help clarify contact information if the consumer is uncertain about details:

- *"Has the provider ever told you that you have X condition?"*

- *"Do you have an appointment scheduled with this doctor?" If yes, "Can you read me the information on the appointment or reminder card?"*

- *"Do you have a medicine bottle for a prescription given to you by this doctor?" If yes, "Can you read me the information on the bottle?"*

- Using the information provided by the consumer, use other resources to look up provider information, such as the provider directory or Internet.

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

Mrs. Murphy has recently been diagnosed with a cardiovascular disorder and wants to enroll in a C-SNP. Joshua asked her about a provider who can verify her condition. What is true about her provider?

- ○ She has to have an appointment with the provider the month the verification signed.
- ○ It has to be her Primary Care Provider

- [ ] The provider indicated on the form does not have to be contracted with the plan.

SUBMIT

Mrs. Murphy's effective date is February 1. She receives a letter on March 1 from the plan telling her the attempts to verify her qualifying chronic condition have been unsuccessful. What does this mean?

- [ ] She is disenrolled from the C-SNP
- [ ] Her enrollment will be terminated effective March 31 if, as of March 31, the plan has not been able to verify a qualifying chronic condition

SUBMIT

I-SNP

I-SNP eligibility

Individuals must meet eligibility requirements to enroll in an Institutional Special Needs Plan (I-SNP). Agents should carefully indicate the correct election period code on the enrollment application.

To enroll in an I-SNP, consumers must meet these requirements:

- Entitled to Medicare Part A and eligible for Part B
- Reside in the plan's service area
- Has resided in or expects to reside in a skilled nursing facility (SNF) contracted with the plan for at least 90 days

If, as of the date the enrollment application is completed, the enrollee has resided in the contracted SNF for 90 or more days, no documentation is required at the time of enrollment.

If, as of the date the enrollment application is completed, the enrollee has resided in the contracted SNF less than 90 days, the agent must obtain and submit a copy of the applicable pages of the Minimum Data Sets (MDS) assessment (Sections A0100 through A1100 and Q0300 through Q0400) or an approved letter of confirmation from the SNF that

indicates that the nursing facility expects the enrollee to require a stay of 90 days or more. The letter must be on SNF letterhead or an Optum-provided form and signed by the SNF administrator, MDS coordinator, director of admissions or nursing, or social services (director or social worker) or business manager. Documentation must be submitted to the enrollment department with the enrollment application or within two calendar days of submitting the enrollment application.

Individuals meeting eligibility requirements can enroll in an I-SNP anytime during the year using the OEPI (Open Enrollment Period for Institutionalized Individuals) election period option.

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

If the enrollee has not resided in the contracted SNF for 90 days at the time of enrollment, which documents qualify as additional proof to be submitted to the enrollment department? (select all that apply)

- [ ] MDS (Minimum Data Set) forms; Sections A0100 - A1100 and Section Q0300-Q0400
- [ ] An Optum-provided form letter signed by appropriate facility staff

- [ ] A notarized letter from the facility
- [ ] An approved letter on facility letterhead signed by appropriate facility staff

SUBMIT

Which election periods can be used at any time during the year to enroll an eligible consumer into an ISNP?

- [ ] Open Enrollment Period for Institutionalized Individuals (OEPI)
- [ ] General Election Period
- [ ] Annual Election Period

SUBMIT

Consumer characteristics

The consumer or the consumer's legal authorized representative may make the enrollment decision and complete the I-SNP enrollment application. Agents should work with the facility to identify if the consumer has a legal authorized representative to act on behalf of the consumer to make health insurance related decisions. In order to sign the enrollment application, the legal authorized representative must have authority in the state in which the consumer resides and must be able to provide documentation substantiating their authority upon request.

Click each plus (+) to learn about I-SNP consumer characteristics

Consumer/Self Decision Maker —

- Often relies on family and/or facility staff to learn about health plan options
- Generally frail with multiple health conditions
- May not be aware of the I-SNPs in which they can enroll based on residing in a contracted SNF

When working directly with the consumer, agents must:

- Prior to having any discussions with the consumer, confirm with a pre-determined staff member that the individual is listed as able to make their own healthcare decisions by the facility
- Offer the consumer the option of having a witness present at the marketing appointment
- NOT complete an enrollment application if the consumer is suspected of not having the mental capacity or competence to make an enrollment decision unless an authorized representative/responsible party is present at the marketing appointment

Legal Authorized Representative / Power of Attorney (POA)*

A large number of I-SNP consumers are not able to make their own healthcare-related decisions. These consumers may have someone with legal authority make health care decisions on their behalf.

- Most often the consumer's spouse or child, who often lives in a different city/state
- This could also be an appointed guardian or someone designated by the courts to make decisions on the individual's behalf
- Looking for better coordination of services for their loved one
- Desires more communication regarding loved one's medical care
- May not be aware of the I-SNPs in which their loved one can enroll
- Needs and appreciates help with understanding Medicare and MA Plans

An agent should work with the facility to identify whether there is someone authorized to act on behalf of the consumer related to decisions regarding the consumer's health insurance. A legal authorized representative or POA who enrolls a consumer in a plan must sign the attestation on the application, which says that they have the authority to act on behalf of the consumer. They also will have to produce valid documentation of legal authority upon request.

Important aspects of an I-SNP

As mentioned earlier, I-SNPs are required to offer benefits and Care Management models to address the unique needs of the populations they are designed to cover. While SNPs must provide all Original Medicare benefits, most provide additional benefits, which may vary by plan.

Click each tab to learn about important aspects of I-SNPs.

CARE MANAGEMENT	ADDITIONAL BENEFITS	NETWORKS	MEDICAID CONSIDERATIONS

CMS requires that all Special Needs Plans have a specific Model Of Care (MOC) delivery system based on the design of the needs of the members in that Special Needs Plan.

UnitedHealthcare contracts with Senior Community Care to provide Care Management for its I-SNP plans:

- Integrates coverage for primary care; specialists, such as cardiologists and urologists; behavioral health; and long-term care services into one member-centric, seamless model of care
- Provides an Advanced Practice Clinician (Nurse Practitioner or Physician's Assistant) to coordinate the member's care and conduct the new member health assessment
- Coordinates timely, medically necessary covered health care services in the least restrictive and appropriate setting
- Focuses on primary and preventive care that is intended to slow the progression of illness and disability
- Strives to optimize the health and well being of members
- Involves members, their responsible parties, and providers in the care planning process

Note: Model of Care delivery system is for medical need and does not include personal aide or housekeeping services.

CARE MANAGEMENT | ADDITIONAL BENEFITS | NETWORKS | MEDICAID CONSIDERATIONS

I-SNPs provide benefits beyond Original Medicare that may include:

- Transportation to and from medical appointments
- Routine eye exam and eyewear
- Routine hearing exam and hearing aids
- Preventive and/or comprehensive dental (to include dentures)
- Routine foot care
- Over-the-counter health benefits
- Waiver of the 3-day Medicare-covered hospital stay requirement for skilled nursing services, which allows members to be treated immediately

CARE MANAGEMENT | ADDITIONAL BENEFITS | NETWORKS | MEDICAID CONSIDERATIONS

I-SNPs are network-based Medicare Advantage (MA) Plans. Make sure the consumer or legal authorized representative understands any network limitations.

- I-SNP Members: Each facility has a list of accessible contracted Primary Care Providers (PCPs) who collaborate with the plan's nurse practitioners in delivering the plan's Model of Care. Having access to PCPs available within the nursing home and part of UnitedHealthcare's network is always the plan's goal, but there may not always be a network PCP available within a specific facility.
- Confirm the member's specialists are contracted with the I-SNP.

Use the online provider directory for the most up-to-date information and be sure to check each provider's status under the correct plan type. Provider information can be found on www.uhc.com or on **Jarvis**.

Note: Benefits, features and/or devices may vary by plan. Limitations, exclusions, and network restrictions may apply.

CARE MANAGEMENT	ADDITIONAL BENEFITS	NETWORKS	MEDICAID CONSIDERATIONS

Medicaid benefits and cost sharing vary by state and on the consumer's level of Medicaid benefit. If the Medicaid consumer currently pays copayments, they will likely continue to do so as a member of the UHC Nursing Home Plan (I-SNP).

Typically, Medicaid will pay Medicare cost-sharing amounts for QMBs (Qualified Medicare Beneficiary) and Full Dual-Eligibles. For these members, once UnitedHealthcare pays for the member's covered services, providers should bill the Medicaid program for any Medicare cost-sharing amounts.

You must advise the consumer or consumer's legal authorized representative what the plan premium is and costs are for plan benefits in case the consumer's Medicaid eligibility status changes.

Marketing and selling I-SNPs

Sales leads are obtained from a variety of sources. Leads from residents in skilled nursing facilities must comply with very strict requirements based upon:

- Health Insurance Portability and Accountability Act (HIPAA) privacy guidelines
- CMS Regulations and Medicare Communications and Marketing Guidelines (MCMG) requirements, particularly regarding unsolicited contact and marketing in a healthcare provider setting

- UnitedHealthcare rules, policies and procedures

Click each plus (+) to learn about each requirement and to make sure you understand these and other sales-related guidelines.

Permission to Contact —

Permission to contact must be obtained prior to any agent-initiated telephonic contact with a consumer or legal authorized representative, and the permission must follow the requirements learned in the Ethics and Compliance section of this guide.*

Permission to contact methods include:

- Receiving a completed business reply or lead card from the consumer or their legal authorized representative, or
- An approved authorization to contact form by the contracted institution to:
    - Document agreement for contact from the consumer or their legal authorized representative
    - Authorize the release of the consumer's name to the agent. Document the consumer or their legal authorized representative's agreement to be contacted and the consumer or their legal authorized representative's authorization to release the consumer's name to the agent.
- An inbound call to the plan or plan representative requesting a return phone call
- Agents of Record (AORs) may contact members in their active book of business to discuss existing plan details and benefits and other Medicare plans that may benefit the consumer

- Written Consent to Contact Form

All permission to contact documentation must be retained in the sales file for 10 years and must be available upon request.

- Unsolicited direct contact with a consumer or legal authorized representative in any public or common area such as a lobby, sidewalk, or parking lot is prohibited. You must not go door to door, place marketing items on doors, or ask the facility to do so
- You may not ask the facility to set up appointments with consumers on your behalf

In some cases UnitedHealthcare will delegate permission to contact to an agent for the purposes of marketing the I-SNP product to an existing UnitedHealthcare member (e.g., a member of a UnitedHealthcare commercial plan is aging in to Medicare).

Scope of Appointment (SOA)

All SOA guidelines apply when meeting with a consumer or legal authorized representative to market/sell an I-SNP, including the 48-hour rule, unless an exception applies.

Do not conduct a sales appointment within a consumer's room without a pre-scheduled appointment, the facility's permission, and documentation in the sales lead management system.

Documentation

Document all consumer contact and sales activity in the sales lead management system, such as appointment information and who was present. Due to the sensitivities surrounding marketing in a provider setting or at the consumer's residence, be sure to include notes on the discussion.

An agent may initiate contact if a compliant UnitedHealthcare provided Written Consent to Contact Form (WCCF) has been received from an employee of the contracted SNF. The WCCF must be completed in its entirety.

Documents used by Facilities for Permission to Contact

Contracted skilled nursing facilities can use UnitedHealthcare's form titled, "Authorization for Disclosure of Contact Information". Facilities may also use another form as long as it meets all UnitedHealthcare privacy requirements and includes the following disclosures:

- A description of the personal health information required (e.g., name, telephone number, and address)
- A description of entities to which the information is to be released (e.g., contracted health plan, UnitedHealthcare)
- An expiration date or expiration event
- A description of the purpose of the disclosure (i.e., marketing)
- Language indicating that the individual may revoke at any time
- Language indicating that the authorization is voluntary
- Language that the provision of health care services is not a condition of the signing of the Enrollment Application
- Authorization must have been signed within the previous twelve-month periods
- Language clearly informing the individual that someone will contact them
- Language clearly informing the individual that the information will be given to a health care plan contracted with the nursing home in which they reside

Provider Activities Guidelines

There are unique I-SNP marketing guidelines due to the setting where the consumer resides, which includes both residential and care/treatment areas. SNF staff members may be approached by the resident or the resident's responsible party/legal authorized representative with questions related to health plan options.

Click the download button to view what the SNF staff member may, must, or must not do relative to the I-SNP product.

PDF

Guidelines for Marketing ISNPs in a Skilled Nursing Facility 9-25-2023.pdf

194.2 KB

Knowledge Check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

Now that you read the Provider Activity Guidelines, which statement below is true?

- Skilled nursing facility staff members can contact the agent directly on behalf of the resident.
- The skilled nursing facility staff member cannot provide a completed BRC directly to an agent but may put it in a drop box or folder used to collect completed BRCs.

SUBMIT

Check your knowledge of the Authorization for Disclosure of Contact Information form. Any form used by a contracted skill nursing facilities for Permission to Contact must meet privacy requirements. Which statements below are requirements for that form?

Click and drag the required elements to the Required box and the elements that are not required to the Not Required box.

Required

A description of entities to which the information is to be released	Signed within the previous twelve-month period
Indicates someone will contact them	Information will be given to a health care plan

Not Required

No expiration date

Individual will be enrolled in an I-SNP

Anyone from the contracted skill nursing facility can sign

Materials

In addition to the Enrollment Guide and other plan related materials, such as the formulary and provider directory, the following resources are available on the UHC Agent Toolkit within Jarvis.

- IESNP Benefits Highlights brochure - a plan specific reference that describes the plan’s additional benefit

- The Heart of the Care Advantage Plan flyer - describes the role of the Optum Care Model

Refer to the Ethics and Compliance certification section for additional information about marketing and enrollment materials.

IE-SNP

Institutional equivalent-special needs plan Eligibility

Individuals must meet eligibility requirements to enroll in an Institutional Equivalent Special Needs Plan (IE-SNP).

- Entitled to Medicare Part A and eligible for Part B
- Reside in the plan's service area
- Require Institutional Level of Care (LOC) based on the state specific definition

The Institutional LOC Assessment must be completed, reviewed, and eligibility confirmed prior to the completion of an IE-SNP enrollment application.* The agent is required to document the level of care meets eligibility criteria within the sales lead management system. Agents have access to the following market specific resources:

- Instructions on how to request an Institutional LOC Assessment for a consumer.
- Support on how to review a completed Institutional LOC Assessment.
- Agents are not permitted to assist in the answering of questions during an Institutional LOC Assessment.

**State requirements might vary.*

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

Who cannot answer the questions for the Institutional Level of Care (LOC) assessment?

- ◯ Family member
- ◯ Responsible party
- ◯ Neighbor/friend
- ◯ Agent

SUBMIT

Consumer characteristics

The consumer or the consumer's legal authorized representative may make the enrollment decision and complete the IE-SNP enrollment application. If the consumer resides in a community setting such as an assisted living facility, agents should work with the facility to identify if the consumer has a legal authorized representative to act on behalf of the consumer to make health insurance related decisions. In order to sign the enrollment application, the legal authorized representative must have authority in the state in which the consumer resides and must be able to provide documentation substantiating their authority upon request.

Click each plus (+) to learn about I-SNP consumer characteristics.

Consumer/Self Decision Maker —

- Often relies on family and/or facility staff to learn about health plan options
- Generally has multiple health conditions
- May not be aware of the-IE-SNPs in which they can enroll based on residing in an assisted living residence

When working directly with the consumer, agents must:

- If the consumer resides in a community setting such as an assisted living facility, agents should work with the facility to identify if the consumer has a legal authorized representative to act on behalf of the consumer to make health insurance related decisions.
- Offer the consumer the option of having a witness present at the marketing appointment

- NOT complete an enrollment application if the consumer is suspected of not having the mental capacity or competence to make an enrollment decision unless an authorized representative/responsible party is present at the marketing appointment

Legal Authorized Representative/Power of Attorney (POA)*

A large number of IE-SNP consumers are not able to make their own healthcare-related decisions. These consumers may have someone with legal authority make health care decisions on their behalf.

- Most often the consumer's spouse or child, who often lives in a different city/state
- This could also be an appointed guardian or someone designated by the courts to make decisions on the individual's behalf
- Looking for better coordination of services for their loved one
- Desires more communication regarding loved one's medical care
- May not be aware of the IE-SNPs in which their loved one can enroll:
    - Resides in the plan service area and requires an institutional level of care (IE-SNP)
- Needs and appreciates help with understanding Medicare and MA Plans

Note: An agent should work with the facility to identify whether there is someone authorized to act on behalf of the consumer related to decisions regarding the consumer's health insurance. A legal authorized representative or POA who enrolls a consumer in a plan must sign the attestation on the application, which says that they have the authority to act on behalf of the consumer. They also will have to produce valid documentation of legal authority upon request.

Important aspects of an IE-SNP

As mentioned earlier, IE-SNPs are required to offer benefits and Care Management models to address the unique needs of the populations they are designed to cover. While IE-SNPs must provide all Original Medicare benefits, most provide additional benefits, which may vary by plan.

Click each tab to learn about important aspects of IE-SNPs.

CARE MANAGEMENT | ADDITIONAL BENEFITS | NETWORKS | MEDICAID CONSIDERATIONS

CMS requires that all Special Needs Plans have a specific Model Of Care (MOC) delivery system based on the design of the needs of the members in that Special Needs Plan.

UnitedHealthcare contracts with Senior Community Care to provide Care Management. Senior Community Care's Care Management model does the following:

- Integrates coverage for primary care; specialists, such as cardiologists and urologists; behavioral health; and long-term care services into one member-centric, seamless model of care
- Offers a dedicated care team that collaborate with providers and community staff to provide need care and address urgent issues
- Coordinates timely, medically necessary covered health care services in the least restrictive and appropriate setting
- Focuses on primary and preventive care that is intended to slow the progression of illness and disability
- Strives to optimize the health and well being of members
- Involves members, their responsible parties, and providers in the care planning process

Note: Model of Care is for medical need and does not include personal aid or house keeping services.

CARE MANAGEMENT | ADDITIONAL BENEFITS | NETWORKS | MEDICAID CONSIDERATIONS

IE-SNPs provide benefits beyond Original Medicare that may include:

- Transportation to and from medical appointments
- Routine eye exam and eyewear
- Routine hearing exam and hearing aids
- Preventive and/or comprehensive dental (to include dentures)
- Routine foot care
- Over-the-counter health benefits
- Waiver of the 3-day Medicare-covered hospital stay requirement for skilled nursing services, which allows members to be treated immediately

Note: Benefits, features and/or devices may vary by plan. Limitations, exclusions, and network restrictions may apply.

CARE MANAGEMENT | ADDITIONAL BENEFITS | NETWORKS | MEDICAID CONSIDERATIONS

IE-SNPs are network-based Medicare Advantage (MA) Plans. Make sure the consumer or legal authorized representative understands any network limitations.

- IE-SNP Members: Confirm the member's PCP and specialists are contracted with the plan.

Use the online provider directory for the most up-to-date information and be sure to check each provider's status under the correct plan type. Provider information can be found on www.uhc.com or on **Jarvis**.

CARE MANAGEMENT	ADDITIONAL BENEFITS	NETWORKS	MEDICAID CONSIDERATIONS

Medicaid benefits and cost sharing vary by state and on the consumer's level of Medicaid benefit. If the Medicaid consumer currently pays copayments, they will likely continue to do so as a member of the UHC Care Advantage Plan (IE-SNP).

Typically, Medicaid will pay Medicare cost-sharing amounts for QMBs (Qualified Medicare Beneficiary) and full dual-eligibles. For these members, once UnitedHealthcare pays for the member's covered services, providers should bill the Medicaid program for any Medicare cost-sharing amounts.

You must advise the consumer or consumer's legal authorized representative what the plan premium is and costs are for plan benefits in case the consumer's Medicaid eligibility status changes.

Marketing and selling IE-SNPs

In addition to the Enrollment Guide and other plan related materials, such as the formulary and provider directory, the following resources are available on the UHC Agent Toolkit within Jarvis:

- IESNP Benefits Highlights brochure - a plan specific reference that describes the plan's additional benefits
- The Heart of the Care Advantage Plan flyer - describes the role of the Optum Care Model

- Refer to the Ethics and Compliance certification section for additional information about marketing and enrollment materials

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Click each plus (+) to learn about each requirement and to make sure you understand these and other sales-related guidelines.

Permission to Contact

Permission to contact must be obtained prior to any agent-initiated telephonic contact with a consumer or legal authorized representative, and the permission must follow the requirements learned in the Ethics and Compliance section of this guide.*

Permission to contact methods include:

- Receiving a completed business reply or lead card from the consumer or their legal authorized representative, or
- An approved authorization to contact form by the contracted institution to:
  - Document agreement for contact from the consumer or their legal authorized representative and
  - Authorize the release of the consumer's name to the agent. Document the consumer or their legal authorized representative's agreement to be contacted and the consumer or their legal authorized representative's authorization to release the consumer's name to the agent
- An inbound call to the plan or plan representative requesting a return phone call
- Note: Agents of Record (AORs) may contact members in their active book of business to discuss existing plan details and benefits and other Medicare plans that may benefit the consumer

All permission to contact documentation must be retained in the sales file for 10 years and must be available upon request.

Note: In some cases, UnitedHealthcare will delegate permission to contact to an agent for the purposes of marketing the IE-SNP product to an existing UnitedHealthcare member (e.g., a member of a UnitedHealthcare commercial plan is aging in to Medicare).

Scope of Appointment (SOA)

All SOA guidelines apply when meeting with a consumer or legal authorized representative to market/sell an IE-SNP, including the 48-hour rule, unless an exception applies.

In an assisted living residence, many residents are living independently and do not require permission from residence staff.

Documentation

Document all consumer contact and sales activity in the sales lead management system, such as appointment information and who was present. Due to the sensitivities surrounding marketing in a provider setting or at the consumer's residence, be sure to include notes on the discussion.

Materials

In addition to the Enrollment Guide and other plan related materials, such as the formulary and provider directory, the following resources are available on Jarvis:

- The Consumer Presentation
- Benefits Highlights - a plan specific reference that describes the plan’s additional benefits

Refer to the Ethics and Compliance certification section for additional information about marketing and enrollment materials.

UHC SCO

DS Daniel Snelling

UHC Senior Care Options

- UHC Senior Care Options (SCO) is a Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) offered in Massachusetts. This plan covers services reimbursed under Medicare and MassHealth, Massachusetts' Medicaid program.
- The UHC SCO plan is a voluntary health plan that combines all the benefits and coverage of Original Medicare and MassHealth Standard under one plan. Additionally, the UHC SCO plan offers Long Term Support Services (LTSS) for elders and respite care for families and caregivers.

Authorized to sell SCO

To be authorized to sell the SCO plan, an agent must:

- Be licensed and appointed in Massachusetts
- Pass the Base Level assessments

- Pass the annual UHC SCO certification assessment
- Participate in any training assigned by the UHC SCO sales unit
- Be directly approved by the UHC SCO sales unit to offer the UnitedHealthcare SCO plan

This certification is for UHC SCO only.

SCO eligibility requirements

To qualify for the UHC SCO plan, consumers must:

- Be 65 years of age or older
- Be enrolled in MassHealth Standard or MassHealth CommonHealth
- Reside in service area
- Not have any other comprehensive health insurance, except Medicare

UHC SCO serves 10 counties in Massachusetts:

- Bristol
- Essex
- Franklin
- Hampden
- Hampshire

- Middlesex
- Norfolk
- Plymouth
- Suffolk
- Worcester

If a consumer is enrolled in a hospice and the consumer has MassHealth only (they do not have Medicare), the hospice must be part of the plan's network in order to enroll in UHC SCO. If the hospice provider is not in the network, the consumer may not join the plan.

The Frail Elder Waiver (FEW) allows people whose income is higher than that allowed by Medicaid to qualify for MassHealth Standard. A frail elder is a person who would need to reside in a nursing home if he or she did not receive additional care at home. A MassHealth application must be completed along with setting up a frail elder screening.

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

What are the eligibility requirements for the UHC SCO plan?

☐ Be 65 years of age or older

- [ ] Be enrolled in MassHealth Standard or MassHealth CommonHealth
- [ ] Has Original Medicare
- [ ] Reside in service area
- [ ] Not have any other comprehensive health insurance, except Medicare
- [ ] Can't have ESRD even if they meet the other requirements

SUBMIT

Key Medicare and Medicaid concepts

Consider for a moment what you already know about these two government programs.

Medicare is a federal health insurance program for consumers age 65 years or older, consumers under age 65 with certain disabilities, and consumers of all ages with End-Stage Renal Disease (ESRD) requiring dialysis or a kidney transplant.

The Medicare program includes four parts: Part A (hospital insurance), Part B (medical insurance), Part D (prescription drug coverage), and Part C (Medicare Advantage), which combines Parts A and B and can integrate Part D benefits. Part C and Part D are offered by private insurance companies that contract with Medicare.

Refer to the Medicare Basics certification section for additional information about Medicare.

Medicaid is a joint federal and state program administered by the state that helps pay medical costs for qualified individuals with limited income and resources.

In the state of Massachusetts, Medicaid is called MassHealth.

Refer to the C-SNP/D-SNP certification section for additional information about Medicaid.

MassHealth eligibility

MassHealth is a public health insurance program for eligible residents of Massachusetts.

MassHealth is a combination of Medicaid and the State Children's Health Insurance Plan (SCHIP).

To be eligible for MassHealth, the individual must live in Massachusetts, have low to medium income, and meet certain general and financial eligibility requirements.

MassHealth offers these coverage types to eligible individuals, families, and people with disabilities:

- MassHealth Standard,
- MassHealth CommonHealth
- MassHealth CarePlus
- MassHealth Family Assistance
- MassHealth Premium Assistance
- MassHealth Limited, and
- Children’s Medical Security Plan

For individuals with Medicare, two additional coverage types are available*:

- MassHealth Senior Buy-In
- MassHealth Buy-In

*Source:*https://www.mass.gov/info-details/masshealth-coverage-types-for-individuals-and-families-including-people-with-disabilities*

PACE

DS Daniel Snelling

Pace

PACE stands for “Program of All-Inclusive Care for the Elderly”.

- PACE is a unique benefit under Medicare and Medicaid that focuses on older adults and people over age 55 living with disabilities who meet their state's standards for nursing home care.
- PACE is administered by MassHealth and Medicare to provide a wide range of medical, social, recreational, and wellness services to eligible participants. The goal of PACE is to allow participants to live safely in their homes instead of in nursing homes. The PACE model is centered on the core belief that given a choice, most elders, the disabled, and their families would choose to receive care in their homes and communities rather than in a nursing home.
- A team of doctors, nurses and other health care professionals assess a participant's needs, develops care plans, and delivers all services under one integrated plan.
- A member of a PACE plan cannot be simultaneously enrolled in an MA plan (including SCO).

PACE is available in states like Massachusetts that have agreed to offer it through their Medicaid program.

Enrolling PACE members

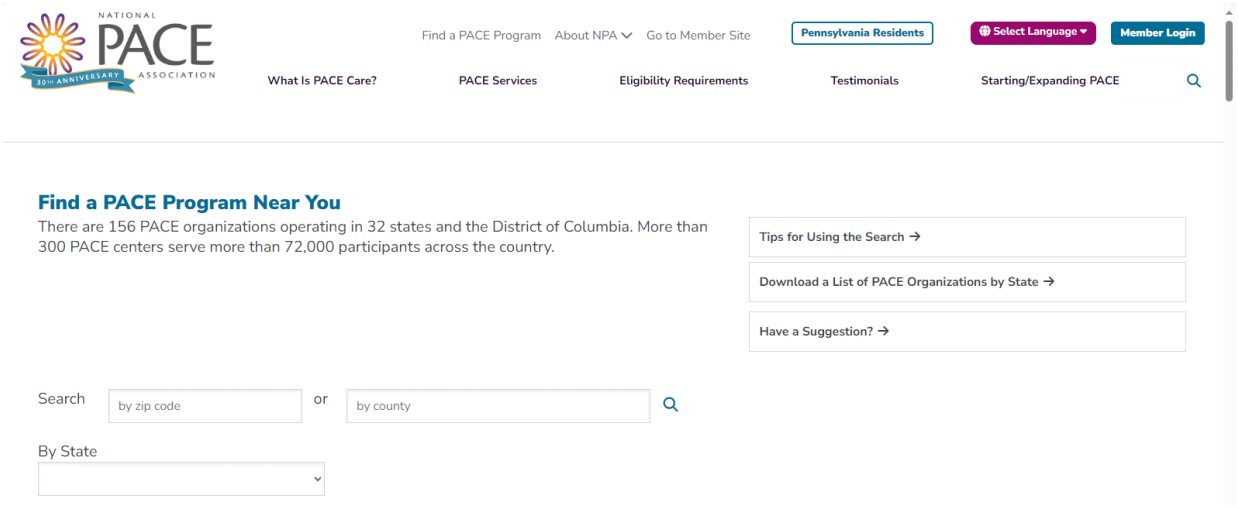
When considering enrolling consumers in UHC SCO, be sure to determine whether the consumer is enrolled in PACE. Unless there is a compelling reason, it is generally not appropriate to enroll PACE members into UnitedHealthcare SCO. These members are very frail and moving to SCO may require changing several providers.

Can you think of any appropriate reason for enrolling a PACE member? Here are some examples:

- John, a PACE participant, has moved out of the PACE service area.
- Anna no longer wants to use the PACE plan's PCP and prefers to use a PCP in the UHC SCO network.

A consumer enrolled in a PACE plan cannot be simultaneously enrolled in an MA plan (including SCO). Enrolling a PACE member in any MA plan (including SCO) will automatically disenroll them from their PACE plan.

PACE sites



Find a PACE Program | NPA | National PACE Association (npaonline.org)

There are a number of PACE sites available to eligible individuals throughout Massachusetts. For more information regarding PACE programs and locations, please visit the PACE website.

Identifying PACE or SCO plan consumers

Consumers who are members of other SCO Plans generally have comparable benefits and should not be enrolled unless they understand the implications of changing plans, including the possibility that their providers may change. There should be a reason for the change in plans, e.g., that they may be dissatisfied with the services of their current plan. Here are examples of some of the questions that you can ask.

Click each each box to review questioning options for identifying consumers who may be enrolled in PACE or a SCO Plan.

OPTION 1 | OPTION 2 | OPTION 3

Ask:
"Mr. Williams, thank you for your interest in the UHC Senior Care Options plan. May I see the insurance card that you currently show when you go to your doctor or pharmacy?"

Note:
Currently there are six SCO health plans Mass General Brigham Health Plan (MGBHP), Community Care Cooperative, Inc. (C3), NaviCare, Senior Whole Health (SWH), Point32Health (Tufts) and UHC Senior Care Options. If a consumer shows a card from one of these plans, the agent should remind the consumer that they already have a SCO plan.

OPTION 1 | OPTION 2 | OPTION 3

Ask:
"Mr. Williams, when you go to the pharmacy, do you pay any copayments for prescription drugs?"

Note:
If the consumer states that they do not pay any copayments for prescription medicines at the pharmacy, the agent must seek confirmation that they are not currently on a SCO plan or PACE program.

OPTION 1 | OPTION 2 | OPTION 3

Ask:
"Mr. Williams, do you regularly attend an Adult Day Health Center (ADHC) or a senior center?"

Note:
If the consumer attends an ADHC program, the agent should cross-reference with the list of PACE centers and ask the consumer if they attend one of those on the list. If the consumer does, the agent should remind them that they already have a comprehensive program that has comparable benefits to SCO.

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

Richard wants to determine if Jon is enrolled in PACE or another SCO plan. What questions could he ask?

Click and drag the correct questions to the Correct box and the incorrect questions to the Incorrect box.

Correct

Do you currently pay copayments for your prescription drugs?

May I see your current insurance card?

Do you attend an Adult Day Health Center (ADHC) on a regular basis?

Incorrect

May I see your Medicare card?

Do you go to fitness classes?

Do you see a specialist in addition to your Primary Care Provider?

SCO model

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Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

Which election periods apply to the UHC SCO? (select all that apply)

- [ ] Medicare Initial Enrollment Period

- [ ] Medicare Advantage Open Enrollment Period (MA OEP)
- [ ] SEP - Integrated Care once per month throughout the year
- [ ] Annual Election Period (AEP)
- [ ] PACE Only Enrollment Period

SUBMIT

Care management

A Care Management Team is responsible for care planning and service coordination of all Medicare and MassHealth Standard covered services.

A Health Risk Assessment Tool is used to assess the level of each member's health care needs. New members must be assessed within 30 days of becoming a member. All members are assessed at least twice a year, with more frail members being assessed more frequently.

Care Management proactively works to coordinate and integrate care and service into a seamless model of care. As a foundational aspect of UnitedHealthcare SCO, it is also a key selling point.

UnitedHealthcare SCO Care Management:

- Provides recommendations for timely, medically necessary covered health care services in an appropriate setting.
- Focuses on primary and preventive care. Care managers share service and care plan information with the member's Primary Care Provider (PCP). The Healthcare Service Coordinator, a UHC SCO clinical team member, assists new members with on-boarding and obtaining preventive services, such as flu and pneumonia vaccines.
- Provides 24/7 toll-free telephonic access to a health care professional where members can ask questions or discuss concerns about their health care.
- Seeks to optimize a member’s health and well-being by helping the member obtain the medical and home/community-based services they need, such as personal care assistance, home health, and adult day health.

SCO model

The purpose of a SCO plan is to keep members as independent as possible, whether they live in the community or in an institution.

To achieve this goal, the plan offers benefits in addition to those covered by Original Medicare or Medicaid alone.

As a fully integrated plan, members receive all of their Medicaid and Medicare benefits through UnitedHealthcare.

SCO plans are like Health Maintenance Organizations (HMO) and require each member to select and use an in-network Primary Care Provider (PCP).

Click each tab (+) to learn about the SCO Model.

Other benefits and services

- Drugs - No copayments or out-of-pocket costs for covered drugs or for over-the-counter medications prescribed by the member's primary care provider
- Dental - Covers routine exams, cleanings, fillings, dentures, implants
- Members receive a monthly allowance for food, OTC or utilities
- Vision (annual eyeglasses) and hearing benefits
- Transportation to all medical appointments
- Members with Medicare may receive care from any Medicare-certified hospice program.
- Fitness benefit which includes:
    - Free gym membership
    - Access to a large national network of gyms and fitness locations
    - On-demand workout videos and live streaming fitness classes
    - Online memory fitness activities

Community services

Community services, such as adult day care, housekeeping, home delivered meals, and transportation, are covered, if coverage guidelines are met.

Enrollment

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Enrollment period

Consumers must have a valid election period in order to enroll in or disenroll from the UnitedHealthcare SCO plan.

Consumers with Medicare and Medicaid can enroll in the UHC SCO plan during their Medicare Initial Enrollment Period (IEP), the Annual Election Period (AEP), the Medicare Advantage Open Enrollment Period (MA OEP), if eligible, or an available Special Election Period (SEP).

The Dual/LIS Maintaining quarterly SEP is no longer available for plan enrollments effective October 1, 2024. Beginning with plan year 2025, dual eligible consumers are permitted to use SEP - Dual/LIS status monthly to enroll in a standalone prescription drug plan (PDP) or use SEP - Integrated Care monthly to enroll in a fully integrated D-SNP (i.e., FIDE SNP, HIDE SNP, or AIP) provided they meet eligibility criteria and it is an aligned enrollment (meaning Medicaid and Medicare coverage are managed by an organization, parent organization, or another entity owned by the same parent organization). UHC SCO is a FIDE SNP and consumers who are eligible can enroll monthly using this election period.

When does a member's coverage begin?

The plan’s effective date depends on the election period used by the consumer. When SEP- Dual/LIS or SEP - Integrated Care is used, the plan effective date is the first day of the month following receipt of the enrollment application. The date the agent signs the enrollment application is considered the receipt date.

Refer to Election Period Booklet for details related to election periods and plan effective dates. *Jarvis > Learning Lab > Content Library > Enrollment and Election Periods (course)*.

Materials: mandatory enrollment guide

The UHC SCO Enrollment Guide contains the information, disclosures, and forms the consumer must receive at the time of enrollment, including:

- Summary of Benefits
- Free Language Interpreter Services Available
- Plan Star Rating
- Required Information
- Drug List
- Pre-enrollment Checklist
- Enrollment Application
- Enrollment Receipt

Agents must not alter the Enrollment Guide in any way prior to giving it to the consumer, including writing on or removing pages.

JarvisEnroll is preferred for submitting your SCO enrollment applications. Applications are received and uploaded in the enrollment system in hours with JarvisEnroll instead of days with paper applications. Enrollees get their ID cards faster, so they can have peace of mind

they are enrolled. Agents are alerted sooner if issues arise so they can be addressed quicker.

> ***At the time of enrollment, agents must review the Enrollment Guide in its entirety with the consumer, POA or responsible party/authorized representative prior to obtaining the consumer's, POA's or responsible party/authorized representative's signature on the Enrollment Application.***

SCO enrollment application requirements

An enrollment application is an offer of a contract between UHC SCO and a consumer. The enrollment application must contain statements disclosing to the consumer the nature of the plan offered for sale. The following are mandated by the Division of Insurance in the state of Massachusetts.

The enrollment application must:

- State in negative terms the nature and extent of any exclusions or limitations.
- State any waiting or exclusionary periods, including pre-existing conditions.
- Disclose whether or not and to what extent benefits are or are not contingent upon hospital confinement.
- Disclose the premium rate of the policy being solicited.
- Disclose any terms of renewability and premium guarantee.
- Have a space made for the consumer's signature acknowledging understanding of such disclosures.

Provider and formulary lists

Be sure to explain to the consumer that a Provider Directory* for their area, along with an updated Pharmacy Formulary, is not mailed in the Welcome Kit. If the member would like a complete Provider Directory and Formulary, they may request one and it will be mailed at no cost to the member.

*Agents should use the online directories to confirm providers are in network and drugs are in formulary. Agents should also encourage members to contact customer service to confirm the most up-to-date provider network status.

Why do I have to look up the consumer's provider?

Agents must help the consumer confirm whether their providers are in the network for this specific plan by looking up the provider in the online directory.

Also remind the consumer that a provider's status can change, so the consumer should be sure to call the plan or look online to see if the provider is still in the network before obtaining services.

Renewing, canceling or terminating coverage

Use the Enrollment Guide to explain to the consumer guidelines related to enrollment, cancellation, and disenrollment, such as:

- The plan effective date is the first day of the month following receipt of the enrollment application when using SEP - Integrated Care.

- Consumers may cancel the enrollment request prior to the plan effective date.
- Members may disenroll from the plan during a valid election period by providing written notice to UnitedHealthcare. The disenrollment is effective the last day of the month notice is received.
- Members remain enrolled in the plan as long as they remain eligible, e.g., live in the plan's service area and remain enrolled in MassHealth Standard or MassHealth CommonHealth.

Please refer to the Election Period Booklet for detailed information related to election periods.

Jarvis >Knowledge Center> Learning Lab, content library, Enrollment and Election Periods (course).

Outreach standards

In addition to complying with CMS regulations and UnitedHealthcare business rules, policies, and procedures when marketing the UHC SCO plan, agents must also comply with SCO state contractual marketing provisions.

To support the agreement between UnitedHealthcare and the state of Massachusetts, agents must:

- Use UHC SCO-created and approved marketing materials or submit agent-created materials to UHC SCO sales unit for review and approval by the state EOHHS and CMS prior to use.

- Refer members and consumers who inquire about MassHealth eligibility or enrollment to EOHHS or MassHealth Customer Service Center.
- Make available to UHC SCO, upon request, current schedules of all activities initiated or promoted to provide information or to encourage enrollment.

Have the following information available upon request by a consumer or member:

- A clear, comprehensive description of the UHC SCO plan including all enrollment requirements;
- Detailed information about the covered services;
- A description of the options members and consumers have to enroll, disenroll, and transfer;
- A directory of covered services, providers, and networks;
- Information on the member's right to file a complaint or appeal; and
- Information on the process of accessing primary and specialty care, including urgent care and emergency conditions.

Only UHC SCO approved materials may be used when written materials are presented to a consumer or member.

Additional sales support

- Jarvis at https://www.uhcjarvis.com
    - Sales materials and enrollment guides
    - UHC Agent Toolkit

    - UnitedHealthcare promotional materials
    - Search Tools for Plans, Providers, Pharmacies and Drug Cost Estimator
- UnitedHealthcare website - uhccp.com/MA
- Jarvis Wrap - newsletter sent via email
- Producer Help Desk (PHD): 888-381-8581 or Spanish phone number, 866-235-5990 (Monday - Friday 8 am - 10 pm ET)

UHC SCO is a specialized product. The SCO staff, based in Boston, MA, is available to respond to any product question. Agents will be given additional SCO service contact information in a follow up training.

Knowledge check

Check your knowledge of what you've studied so far. These are not scored and do not count toward your certification assessments.

What sales support tools are available to agents for questions about SCO related materials?

- [ ] UHC Agent Toolkit
- [ ] Provider directory
- [ ] Producer Help Desk
- [ ] JarvisWrap
- [ ] JarvisEnroll

SUBMIT

Helpful Resources

For more in-depth information, please review the resources noted below or contact your sales leadership.

JARVIS | LEARNING LAB | HELPFUL LINKS

- **Agent Guide** ***(Jarvis>Knowledge Center>Agent Guide)***
- **Sales Policy Job Aids:**
  - Agent Created and UnitedHealthcare Agent Toolkit Materials Guidelines *(Jarvis > Knowledge Center > Reference Guides > Compliance)*
  - Permission to Contact and Lead Generation *(Jarvis > Sales Tools > Meeting Resources)*
  - Scope of Appointment *(Jarvis > Sales Tools > Meeting Resources)*

Link to Jarvis

JARVIS	LEARNING LAB	HELPFUL LINKS

- Certification User Guide
- Enrollment Handbook, including the Election Period Booklet
- Provider Search Job Aids

To get to Learning Lab, go to Jarvis and click on the Training and Certification tab and then Learning Lab. From the content library, search for the document.

JARVIS	LEARNING LAB	HELPFUL LINKS

CMS.gov

Medicare.gov

MedicareMadeClear.com