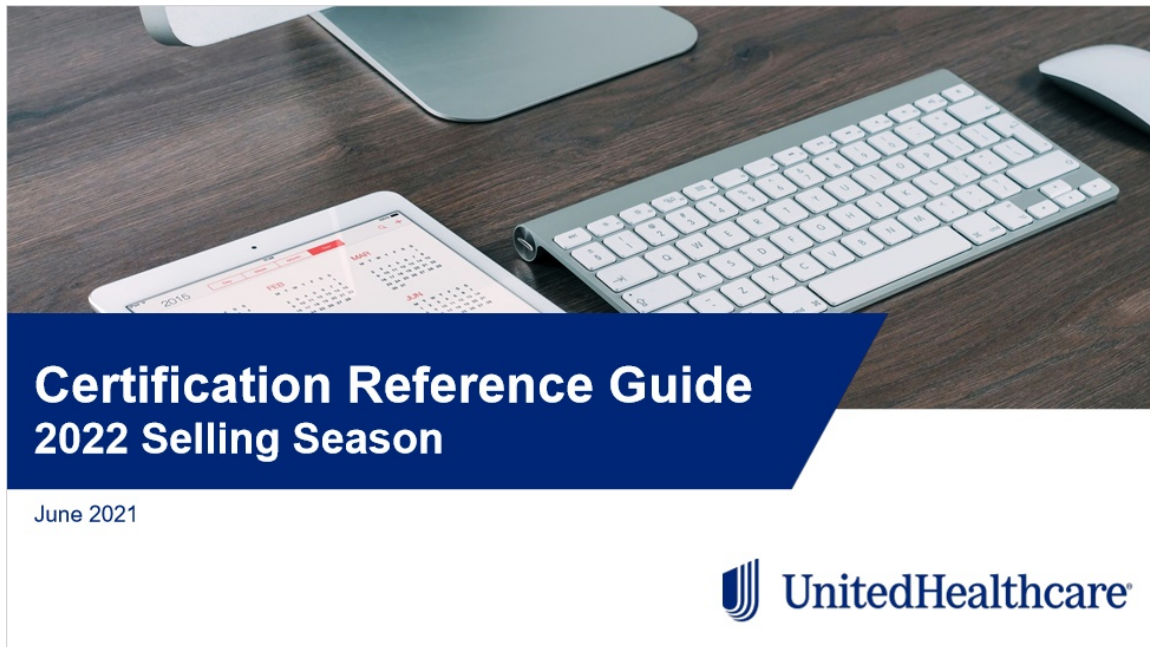


1.1 Cover Page



1.2 Disclaimer



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June 26, 2021

2. Medicare Basics

2.1 Medicare Defined



What is Medicare? (Slide Layer)

Medicare Defined

What is Medicare?

Original Medicare

Part A

Part B

Part C

Part D

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
- Under 65 with certain disabilities
- Any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)
- Any age with Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's disease)

Individuals who meet eligibility requirements are generally automatically enrolled in the Medicare program by the Social Security Administration (SSA) or the Railroad Retirement Board (RRB).

Original Medicare (Slide Layer)

Medicare Defined

- What is Medicare?
- Original Medicare
- Part A
- Part B
- Part C
- Part D

Medicare consists of four parts: A, B, C and D. **Parts A and B** are a federal health insurance program **referred to as Original Medicare**. All parts of Medicare include cost sharing, such as deductibles, copayments or coinsurance, and specific eligibility qualifications.


What Original Medicare Doesn't Cover
Here are some things not covered by Original Medicare:

- Prescription Drugs
- Dental exams, most dental care or dentures
- Routine eye exams, eyeglasses or contacts
- Hearing aids or related exams or services
- Most care while traveling outside the United States
- Help with bathing, dressing, eating, etc. (custodial care)
- 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 (Slide Layer)

Medicare Defined

- What is Medicare?
- Original Medicare
- Part A
- Part B
- Part C
- Part D



Part A: Hospital Insurance

- 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 or deceased, including divorced spouses):
 - Is eligible to receive 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 under certain conditions that include:
 - Being entitled to Social Security disability benefits (or railroad board disability pension and meet certain conditions) for 24 months; OR
- Individuals at any age having End Stage Renal Disease (ESRD) and meet other eligibility criteria; OR
- Individuals at any age with Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's disease).

Enrollment

- Most individuals who qualify and already receive Social Security benefits automatically enroll in Part A; otherwise, they can enroll at the local Social Security 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.

Medicare Defined

- Part C
- Part D


Costs

- The 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 (Slide Layer)

Medicare Defined

- What is Medicare?
- Original Medicare
- Part A
- Part B
- Part C
- Part D



Part B: Medical Insurance

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

- Outpatient care at hospitals and clinics
- Laboratory tests
- 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 Social Security Administration or the Railroad Retirement Board, OR
 - They are eligible to receive Social Security or Railroad benefits, but have not yet filed for them, OR
 - They or their spouse had Medicare-covered government employment.
- Individuals under 65 are eligible for Medicare Part B if:
 - They have received Social Security or Railroad Retirement Board disability benefits for 24 months, OR
- Individuals at any age having End Stage Renal Disease (ESRD) and meet other eligibility criteria, OR
- Individuals at any age with Amyotrophic Lateral Sclerosis (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

For most individuals who qualify and are already getting Social Security or Railroad Retirement Board benefits, enrollment in Part B is automatic. Individuals who are not receiving Social Security or Railroad Retirement Board benefits (e.g., they are still working) or they qualify because they have ESRD must sign up for Part B during a valid enrollment period.

Costs

- Medicare beneficiaries enrolled in Part B are assessed a monthly premium*, which is deducted from their Social Security, Railroad Retirement or Civil Service 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.

**A reduction or rebate in Medicare Part B premium is an additional benefit where a Medicare Advantage (MA) organization may elect to receive a reduction in its payments.*

Medicare Defined


- Part A
- Part B
- Part C
- Part D

Costs

- Medicare beneficiaries enrolled in Part B are assessed a monthly premium*, which is deducted from their Social Security, Railroad Retirement or Civil Service 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.

**A reduction or rebate in Medicare Part B premium is an additional benefit where a Medicare Advantage (MA) organization may elect to receive a reduction in its payments.*

Part C (Slide Layer)


Medicare Defined	
What is Medicare?	 <p>Part C: Medicare Advantage (MA) MA Plans are Medicare health plans offered by private insurance companies, like UnitedHealthcare, that are contracted by the federal government and follow their rules. MA Plans provide Medicare Part A (hospital) and Part B (medical) coverage, and most plans include Medicare Part D (prescription drug) coverage. MA Plans:</p> <ul style="list-style-type: none">• Must provide the same coverage as Original Medicare (most plans also offer additional benefits, which may vary by plan).• Are part of the Medicare program, where Medicare pays a fixed amount for care every month to the companies offering MA Plans and the companies must follow rules and regulations set by the Centers for Medicare & Medicaid Services (CMS) who administers the Medicare program.• Are not Medicare Supplement Insurance Plans, and MA Plan cost sharing cannot be covered by a Medicare Supplement Insurance Plan.• May have a monthly premium, payable to the plan, in addition to the Part B premium the member must continue to pay.• Do not administer hospice care, which is still administered under Medicare Part A. <p>Eligibility Consumers may generally enroll in a Medicare Advantage Plan if they meet these eligibility criteria:</p> <ul style="list-style-type: none">• Must be entitled to Medicare Part A and enrolled in Medicare Part B• Must live in the plan's service area• Can have pre-existing conditions, including End Stage Renal Disease
Original Medicare	
Part A	
Part B	
Part C	
Part D	

Medicare	
Part B	<ul style="list-style-type: none">• Can have pre-existing conditions, including End Stage Renal Disease (ESRD) beginning with the 2021 plan year <p>Note: For plan years 2020 and prior, consumers with ESRD were not permitted to enroll in an MA plan unless they had an exception allowed by CMS.</p> <p>Enrollment</p> <ul style="list-style-type: none">• Consumers must have a valid election period in order to enroll in and/or disenroll from an MA Plan. Agents should refer consumers who do not have a valid election period back to Original Medicare. <p>Costs</p> <ul style="list-style-type: none">• Plan structure and costs can vary widely by plan; however, all plans limit the amount a consumer must spend out-of-pocket each year.
Part C	
Part D	

Part D (Slide Layer)

Medicare Defined

- What is Medicare?
- Original Medicare
- Part A
- Part B
- Part C
- Part D



Part D: Prescription Drug Plans (PDP)

Medicare Part D is a government program that helps Medicare beneficiaries cover some of the cost of prescription drugs. To obtain 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, such as the drugs covered, and costs can vary by plan and can change from year to year. Prescription drug coverage should not be confused with pharmacy discount card programs.

Eligibility

- Consumers can enroll in a stand-alone PDP if each of the following conditions are met:
 - They are entitled to Part A and/or enrolled in Part B
 - They permanently reside in the service area of the plan
- Generally, consumers can enroll in a Medicare Advantage Prescription Drug Plan (MA-PD) if all of the following conditions are met:
 - They are entitled to Part A and enrolled in Part B
 - They permanently reside in the service area of the plan
 - Can have pre-existing conditions, including End Stage Renal Disease (ESRD) beginning with the 2021 plan year

Note: For plan years 2020 and prior, consumers with ESRD were not permitted to enroll in an MA plan unless they had an exception allowed by CMS.

Enrollment

- Consumers must have a valid election period in order to enroll in and/or disenroll from a stand-alone PDP or MA-PD Plan. Agents should refer

Medicare

- Part C
- Part D

disenroll from a stand-alone PDP or MA-PD Plan. Agents should refer consumers who do not have a valid election period back to Original Medicare.

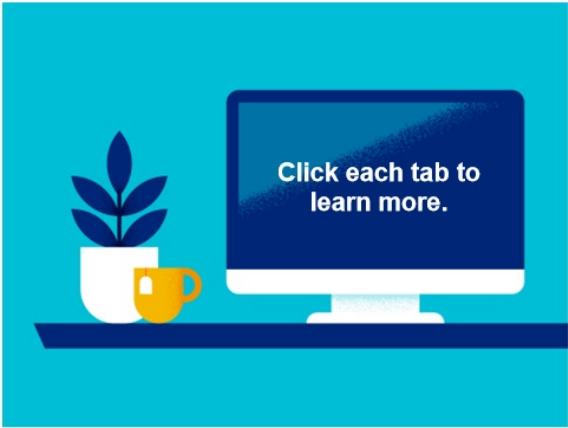
Costs

- 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. If a consumer does not sign up when they become eligible, they may pay a late enrollment

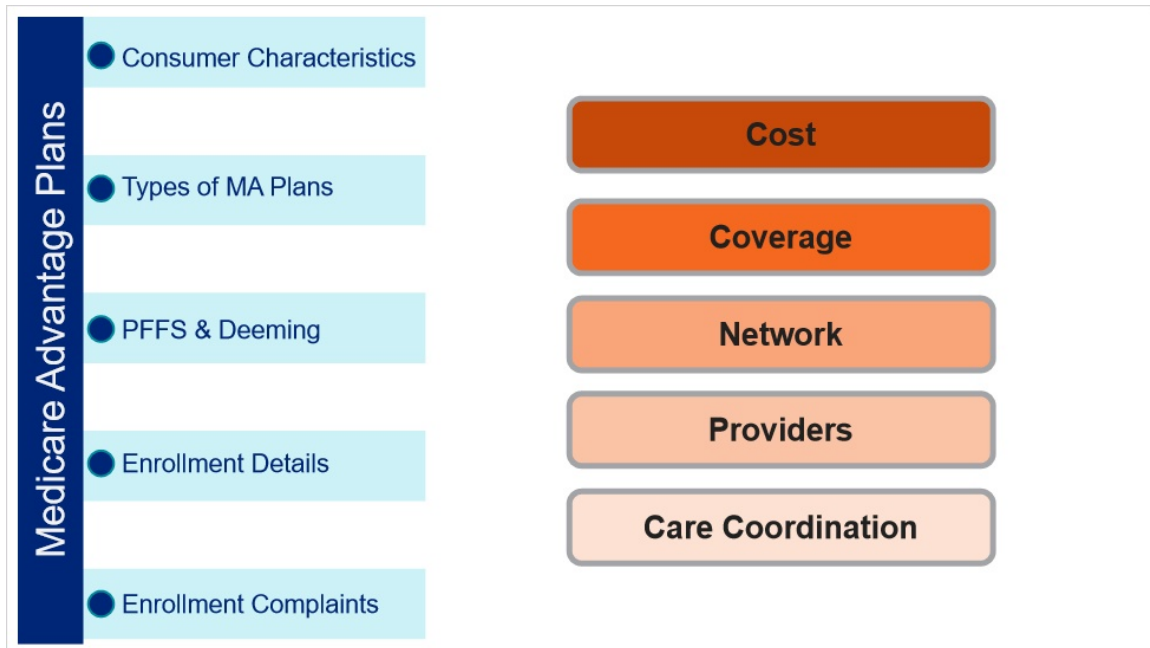
2.2 Medicare Advantage Plans

Medicare Advantage Plans

- Consumer Characteristics
- Types of MA Plans
- PFFS & Deeming
- Enrollment Details
- Enrollment Complaints



Consumer Characteristics (Slide Layer)




Medicare Advantage Plans

Cost

Monthly plan premiums
When compared to Medicare Supplement Insurance Plans and other health plan coverage, Medicare Advantage Plans may offer lower monthly plan premiums. Some MA Plans may have a \$0 monthly plan premium.

Predictable cost sharing
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.

Out of Pocket (OOP) Maximum 
An Out-of-Pocket Maximum is a feature that limits the amount of money the member will have to spend on certain health care services throughout the year. Once members reach the OOP maximum for covered services, they do not have cost sharing for any additional services that are included in the OOP maximum for the remainder of the year.

- All MA Plans have an OOP maximum for covered services.
- MA Plans with an out-of-network component may or may not have an OOP maximum for the out-of-network services, depending on the plan.
- All Medicare-covered (Part A and Part B) services count toward the OOP maximum.
 - Services and features that do not count toward the OOP maximum include plan premium, Part D prescription drugs and any non-Medicare-covered services, such as eyewear and hearing aids.
- The OOP maximum amount can be different between MA Plans and can change each year.

Close

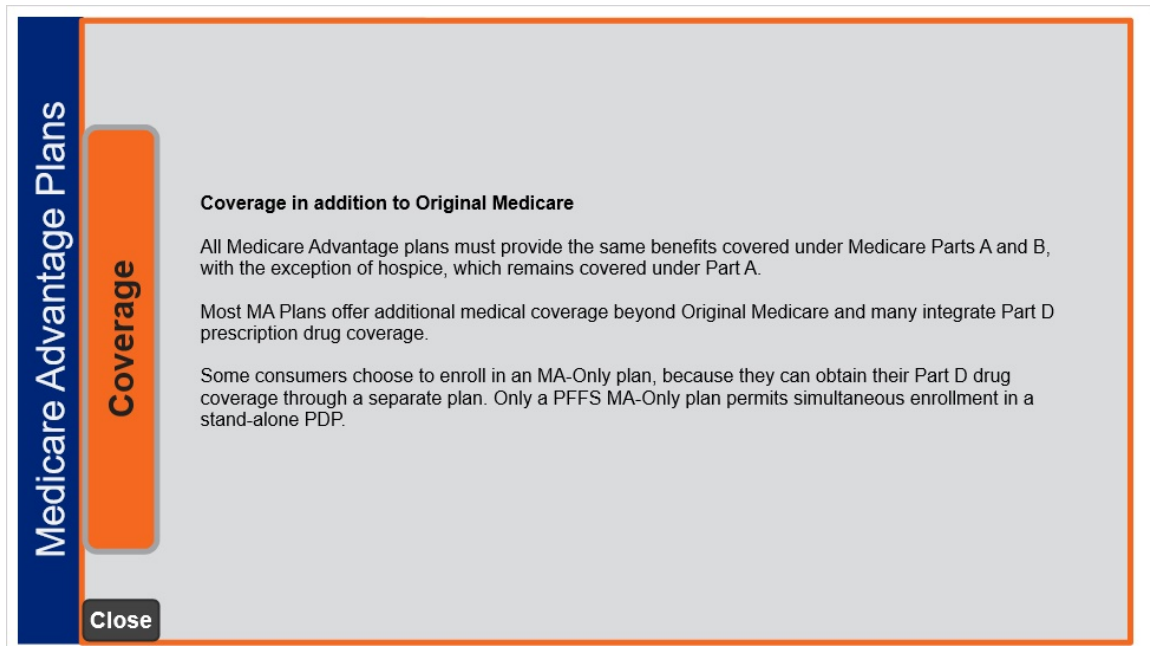
Transferring Accumulated Out-of-Pocket Costs

When a member enrolls in a different MA Plan offered by the same MA organization, their year-to-date contribution toward the annual OOP maximum in the previous plan is counted toward their OOP maximum in the new MA Plan in the following scenarios:

- The new plan is the same type as the previous plan (e.g., HMO to HMO) and both plans are **on the same contract and/or have the same legal entity**.
- The new plan is a different type than the previous plan (e.g., HMO to PPO) and both plans **have the same legal entity**.
Note: While the two plans in this scenario must have the same legal entity, they will not be on the same contract because a contract only covers one plan type. For example, one contract is only made up of HMO plans while another contract is only made up of PPO plans.

If a member comes to us from a different insurance carrier, we do not apply the OOP maximum they accumulated at the previous carrier.

Coverage (Slide Layer)



This slide, titled 'Coverage', is part of a presentation on Medicare Advantage Plans. It features a blue sidebar with the text 'Medicare Advantage Plans' and an orange tab labeled 'Coverage'. The main content area is light gray and contains text about Medicare Advantage coverage. A 'Close' button is located at the bottom left of the slide.

Coverage in addition to Original Medicare

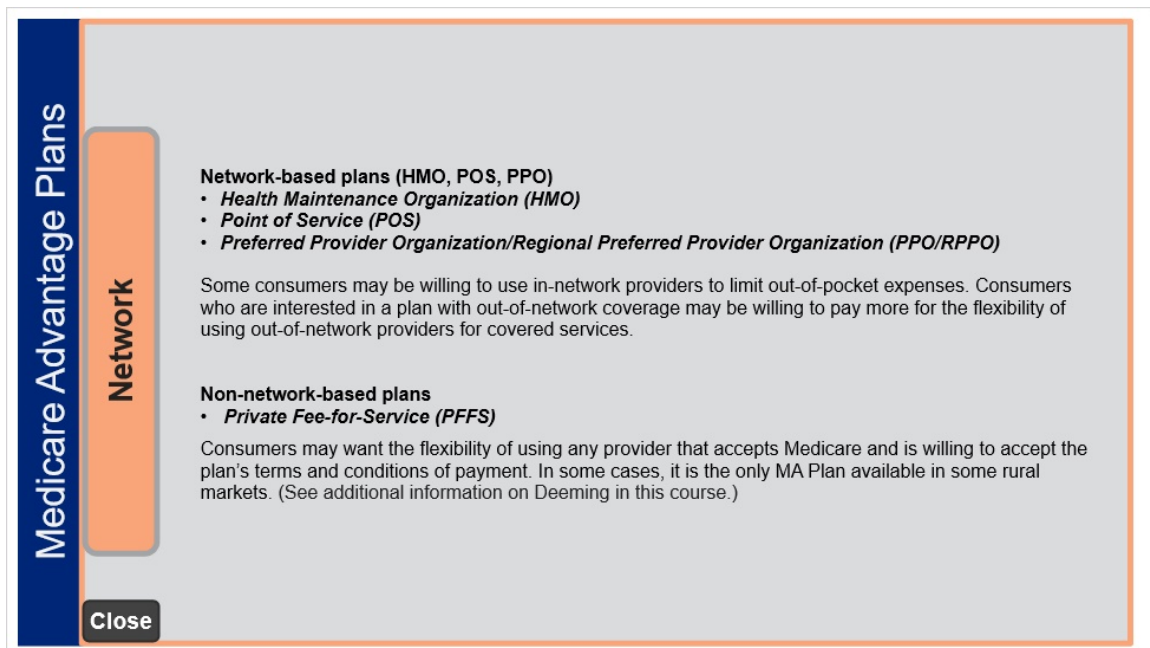
All Medicare Advantage plans must provide the same benefits covered under Medicare Parts A and B, with the exception of hospice, which remains covered under Part A.

Most MA Plans offer additional medical coverage beyond Original Medicare and many integrate Part D prescription drug coverage.

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 PFFS MA-Only plan permits simultaneous enrollment in a stand-alone PDP.

Close

Network (Slide Layer)



This slide, titled 'Network', is part of a presentation on Medicare Advantage Plans. It features a blue sidebar with the text 'Medicare Advantage Plans' and an orange tab labeled 'Network'. The main content area is light gray and contains text about network-based and non-network-based plans. A 'Close' button is located at the bottom left of the slide.

Network-based plans (HMO, POS, PPO)

- *Health Maintenance Organization (HMO)*
- *Point of Service (POS)*
- *Preferred Provider Organization/Regional Preferred Provider Organization (PPO/RPPO)*

Some consumers may be willing to use in-network providers to limit out-of-pocket expenses. Consumers who are interested in a plan with out-of-network coverage may be willing to pay more for the flexibility of using out-of-network providers for covered services.

Non-network-based plans

- *Private Fee-for-Service (PFFS)*

Consumers may want the flexibility of using any provider that accepts Medicare and is willing to accept the plan's terms and conditions of payment. In some cases, it is the only MA Plan available in some rural markets. (See additional information on Deeming in this course.)

Close

Providers (Slide Layer)

Medicare Advantage Plans

Providers

HMO, POS and 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-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. Members who use out-of-network providers may incur higher cost sharing or may be responsible for the entire cost of care out-of-pocket, depending on the 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 or by contacting the Plan. 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.)


Close

Care Coordination (Slide Layer)

Medicare Advantage Plans

Care Coordination

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.



Close

Types of MA (Slide Layer)

Medicare Advantage Plans

- Consumer Characteristics
- Types of MA Plans
- PFFS & Deeming
- Enrollment Details
- Enrollment Complaints

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, Dual, and/or Institutional SNP, you must complete the applicable module and pass the associated assessment for the identified SNP product.

Click each brochure to learn about the different types of MA Plans.

- HMO & POS
- PPO & RPPO
- PFFS
- SNP

HMO & POS (Slide Layer)

Medicare Advantage Plans

HMO & POS

HMO
To receive covered services under the plan, the member must use in-network providers, except for emergency, urgent care, and renal dialysis services. The member must select a Primary Care Provider (PCP) and in some plans, a referral from their PCP is required to see a specialist. (If a PCP is not selected on the enrollment application, the MA Plan may automatically assign a PCP to the member.)

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 cover one or a few benefits out-of-network. Some plans may also have coverage limits for certain benefits. Some of these plans do not require referrals for specialty care.

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. If the service is covered and received by a qualified provider, the member can submit the claim to the Plan for reimbursements.

Close

PPO & RPPO (Slide Layer)

Medicare Advantage Plans

PPO & RPPO

PPO (Local PPO)
A PPO plan has a contracted provider network. All benefits covered in-network are also available nationwide from out-of-network doctors that accept Medicare, generally at a higher cost to the member. In most cases, members 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
An RPPO plan is a PPO plan that offers the same premiums, benefits, and cost-sharing to all consumers in a region. 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 reside 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 by a qualified provider, the member can submit the claim to the Plan for reimbursements.*

Close

PFFS (Slide Layer)

Medicare Advantage Plans

PFFS

PFFS
With PFFS plans, a member can seek treatment from any Medicare-eligible provider who agrees to accept the plan's terms, conditions and payment rates. A Primary Care Provider (PCP) does not need to be selected and there are no referral requirements for specialty care. PFFS plans may or may not use provider networks to provide care, but UnitedHealthcare only offers non-network PFFS plans.

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.
- Create out-of-pocket expenses they do not currently incur and which they may not be able to afford. This is because with a PFFS Plan, the consumer may be responsible for cost sharing.

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.


Close

SNP (Slide Layer)

Medicare Advantage Plans

SNP

Special Needs Plan (SNP)
Provides health care for specific groups of people, such as those who have both Medicare and Medicaid (Dual SNP), or those who reside in a contracted skilled nursing facility or assisted living facility (Institutional/Institutional-Equivalent SNP), or those who have certain chronic medical conditions (Chronic Condition SNP).



Close

PFFS & Deeming (Slide Layer)

Medicare Advantage Plans

● Consumer Characteristics

● Types of MA Plans

● PFFS & Deeming

● Enrollment Details

● Enrollment Complaints

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. Therefore, the focus of this section is on non-network PFFS Plans only.

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.

Click each tab to learn about deeming and the responsibilities of PFFS members and providers.

Definition

Member

Provider

Enrollment Complaints (Slide Layer)

Medicare Advantage Plans

- Consumer Characteristics
- Types of MA Plans
- PFFS & Deeming
- Enrollment Details
- Enrollment Complaints

There are three common member complaints related to enrollment:

- 1. Enrollment in an MA Plan by a Medicare Supplement Insurance Member.**

Confusion often drives member complaints when moving from a Medicare Supplement Insurance Plan to an MA Plan. When a Medicare Supplement Insurance Plan member is enrolling in an MA Plan, try to limit confusion by explaining:

 - How each plan type works differently. The member's current Medicare Supplement Plan fills in the gaps in their Original Medicare coverage, but cannot be used with the new MA Plan as it will not pay their MA Plan cost sharing.
 - That their Medicare Supplement Insurance Plan will not cancel automatically upon enrollment in the MA Plan. After receiving confirmation of enrollment in the MA Plan, the member must notify their Medicare Supplement carrier (even if it is UnitedHealthcare), according to the plan's rules, to cancel their policy.
 - Do **not** refer to an MA Plan as a supplement replacement, supplement, replacement, no cost, free plan, or zero cost plan.
 - Do **not** describe a \$0 premium plan as "free."
- 2. Benefits Coverage Information**

Providing inaccurate or incomplete information about plan benefits is a common driver of member complaints. Complaints are generally related to the member not knowing or understanding the benefits of their plan or thinking the plan covers benefits not actually covered. Review the plan's benefits using the Summary of Benefits to ensure the consumer understands what medical coverage is provided. For plans with drug coverage, make sure to review and explain to the consumer what medications are covered by the plan and if there are any utilization management restrictions.
- 3. PCP Auto Assignment**

When assisting a consumer to enroll in an MA Plan, the agent is responsible for ensuring a valid PCP is accurately noted on the enrollment application if the MA Plan requires one. Failure to enter a valid PCP on the enrollment application may result in one being assigned to the member by the MA Plan.

 - To help avoid member complaints, encourage consumers to select a PCP and make sure the PCP is accepting new patients; otherwise, the consumer must select one who is in the network.
 - Carefully enter the selected PCP's name and provider number on the enrollment application. Check "Existing Patient" if applicable.
 - As a best practice, encourage the member to set up appointments with newly selected PCP as soon as possible.

Deeming Definition (Slide Layer)

Medicare Advantage Plans

Deeming Definition

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, in advance of furnishing health care services, that the individual receiving the services is enrolled in a PFFS Plan
- Has reasonable access to the plan's terms and conditions of payment in advance of furnishing services
- Furnishes services that are covered by the plan

Not all providers, even those that participate in Medicare, may agree to the plan's terms and conditions of payment. Moreover, 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.

Close

PFFS Member (Slide Layer)

Medicare Advantage Plans

Member

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.
- Present their member ID card and inform the provider of PFFS Plan membership prior to each visit and prior to receiving 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).

Note: Emergency care is covered for the member whether the provider agrees to accept the plan's payment terms or not.

Close

PFFS Provider (Slide Layer)

Medicare Advantage Plans

Provider

PFFS Provider Responsibilities

A provider that furnishes 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.
- 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; they must not require prepayment for services from the consumer.* (UnitedHealthcare's PFFS Terms and Conditions are posted on UHCProvider.com.)

***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.

Close

Enrollment Details (Slide Layer)

Medicare Advantage Plans

- Consumer Characteristics
- Types of MA Plans
- PFFS & Deeming
- Enrollment Details
- Enrollment Complaints

When a member enrolls in an MA Plan, they:

- Retain their Medicare rights and protections as with Original Medicare,
- Must abide by 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 seek care from non-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 stand-alone PDP.
- Must cancel, generally in writing, their Medicare Supplement Insurance policy with the carrier after their request to enroll in the MA Plan has been approved. Medicare Supplement Insurance policies cannot be used in conjunction with an MA Plan. Medicare Supplement Insurance 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 wanted an MAPD Plan (or vice versa) can lead to member dissatisfaction and complaints.

2.3 Prescription Drug Coverage

Prescription Drug Coverage

- Benefit Structure
- Consumer Characteristics
- How to Obtain Part D
- Unsuitable Plan
- Cost Considerations
- Extra Help
- Coverage Considerations



Benefit Structure (Slide Layer)

Prescription Drug Coverage	Plans have flexibility in how they design a Part D benefit structure as shown in this table.	
	Plan Feature	Effect on Part D Benefit
	Premium	Plan sponsors set plan premiums that members pay monthly throughout the year.
	No deductible	Plans may eliminate the Medicare Part D deductible.
	Part D deductible	A certain dollar amount that applies to some or all tiers that must be met before drug coverage begins.
	Different copayment/coinsurance levels	Many plans have moved to flat copayments rather than coinsurance for the member cost sharing.
	Coverage gap	Some plans provide benefits in the coverage gap.
	Different drugs on formulary	Plans may have different drugs on their formulary or drug list.
Close	Drugs at different copayment tiers	Plans typically charge different copayments for drugs at different tiers (rather than charge the same cost sharing for all drugs obtained during the initial coverage level).
	Plans may include different pharmacies in their network	CMS approves a plan's pharmacy network to ensure appropriate member access.

Consumer Characteristics (Slide Layer)

Prescription Drug Coverage

- Benefit Structure
- Consumer Characteristics
- How to Obtain Part D
- Unsuitable Plan
- Cost Considerations
- Extra Help
- Coverage Considerations

Consumers have options when it comes to obtaining prescription drug coverage, so it is important to understand their needs based on prescribed medications, preferred pharmacies, drug costs, and other coverage they may have.

[Click each box to see examples of consumers explaining why they are interested in prescription drug coverage. \(Examples are fictitious and do not reflect statements of a real plan member.\)](#)

Enrolled in Original Medicare	I am only enrolled in Original Medicare and need prescription drug coverage.
Wants Additional Drug Coverage	I am only enrolled in Original Medicare and need prescription drug coverage.
Medicare Supplement Plan Member	I am enrolled in Original Medicare and Medicare Supplement and need prescription drug coverage.
MA-Only PFFS Member	I am only enrolled in Original Medicare and need prescription drug coverage.


How to Obtain Part D (Slide Layer)

Prescription Drug Coverage


- Benefit Structure
- Consumer Characteristics
- How to Obtain Part D
- Unsuitable Plan
- Cost Considerations
- Extra Help
- Coverage Considerations

There are two ways for consumers to obtain Medicare prescription drug coverage:

1. Stand-alone Prescription Drug Plans
These plans (called "PDPs") add prescription drug coverage to Original Medicare, Medical Savings Account, some Medicare Cost Plans, and some Medicare Private Fee-for-Service (PFFS) Plans.




2. Medicare Advantage Plans or other Medicare health plans that include Medicare prescription drug coverage
In addition to their Part A and Part B coverage, consumers may also receive prescription drug coverage (Part D) through these plans.



When a consumer has Original Medicare and a Prescription Drug Plan, they can also have a Medicare Supplement Insurance Plan.

Prescription Drug

- Unsuitable Plan
- Cost Considerations
- Extra Help
- Coverage Considerations



Other consumers may receive Part D benefits through an Employer-Sponsored Group Retiree Plan.

Remember, you must be clear on which plans the consumer may already have before helping them enroll in a new coverage. You must be sure whether you can combine a Medicare Part D Plan with their existing coverages.

Unsuitable Plan Enrollment (Slide Layer)

Prescription Drug Coverage

- Benefit Structure
- Consumer Characteristics
- How to Obtain Part D
- Unsuitable Plan
- Cost Considerations
- Extra Help
- Coverage Considerations

Enrolling in a PDP may affect the consumer's membership in other insurance plans. For example:

1. A consumer enrolled in a Medicare Advantage plan (with or without prescription drug coverage) will be automatically disenrolled from that plan and returned to Original Medicare upon enrolling in a PDP (except for MA-only PFFS plans).
2. A consumer enrolled in an employer or union-sponsored health plan may lose coverage for themselves and their dependents upon enrollment in a PDP and may not be able to re-enroll in the employer or union plan at a later date.

Enrolled in Wrong Plan

A common member complaint is enrollment in an unsuitable plan. Do the following to avoid enrolling the consumer in an unsuitable plan:

- Conduct a thorough needs assessment to understand the consumer's current medical and prescription drug coverage, current prescription medications, and financial considerations and personal preferences.
- After advising the consumer of their options, present and/or recommend a plan that is equal to or better than their current coverage.
- Make sure the consumer understands what the plan covers, such as medical coverage, prescription drug coverage, and cost sharing, such as premium, deductible, coinsurance or copayment.

F

- Coverage Considerations

- Carefully indicate on the Enrollment Application the plan selected by the consumer.

Cost Considerations (Slide Layer)

Prescription Drug Coverage

- Benefit Structure
- Consumer Characteristics
- How to Obtain Part D
- Unsuitable Plan
- Cost Considerations
- Extra Help
- Coverage 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 button to learn about cost considerations.](#)

Cost Sharing

Low Income Subsidy (LIS)

Creditable Coverage & Late Enrollment Penalty

Pharmacy Networks

Cost Sharing (Slide Layer)

Prescription Drug Coverage

Cost Sharing

Medicare defines the standard Part D benefit, around which each PDP and MAPD is structured, and adjusts Part D benefit levels annually, including drug payment stage cost limits, which each plan must meet.

While the standard Part D benefit is established by Medicare, MAPD and PDP plan features, such as monthly plan premium, drugs covered, and network, can vary from plan to plan.

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.

Close

Plan Premium

The monthly payment to the plan for prescription drug coverage. In addition to the monthly plan premium for prescription drug coverage, the member may have to pay a Part B, MA Plan, and/or a Medicare Supplement Insurance Plan premium. Some members may have to pay a Part D Late Enrollment Penalty (refer to the applicable section in this module) and/or a Part D IRMAA (Income Related Monthly Adjustment Amount), which is an amount paid to Medicare (not the plan) if their modified adjusted gross income, as reported on their federal tax return from two years ago, is more than \$88,000 (individuals and married individuals filing separately) and \$176,000 (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, in 2022, the member may pay a deductible up to \$480 (may vary by plan) before the plan starts paying benefits. 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 be required to pay as their share of the cost of prescription medications. Copayments are usually stated as a fixed amount, e.g., \$2.00.

LIS (Slide Layer)

Prescription Drug Coverage

Low Income Subsidy (LIS)



Consumers with limited income and resources may qualify for LIS/Extra Help from Medicare to cover their Part D premiums and Part D related out-of-pocket costs.

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

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.

Click each picture for an example from a consumer describing why they qualify for Low Income Subsidy.

Close




Single (Slide Layer)

Prescription Drug Coverage

Single person earning less than \$19,320 per year* with resources less than \$14,790 (2021)

Consumer Eligibility Requirements	Benefit Summary
<ul style="list-style-type: none">• Incomes below 135% of the FPL• Assets that do not exceed FPL-defined levels	<ul style="list-style-type: none">• No monthly premium**• No deductible• Minimal cost sharing
<ul style="list-style-type: none">• Incomes between 135% and 150% of the FPL• Assets that do not exceed FPL-defined levels	<ul style="list-style-type: none">• Sliding scale premiums• Lower deductible***• Reduced cost sharing



"I have a small pension, but it doesn't add up to more than \$15,000 per year. My needs are pretty simple, but every little bit helps."

* Income levels and assistance may vary for Alaska, Hawaii and the U.S. territories. Income levels in all areas may change each year.
** Only certain plans are available at no cost.
*** The lower deductible has a \$99 deductible for 2022, if the plan has a deductible.
Note: Refer consumers to Medicare (1-800-MEDICARE) for additional information and applications.

Close


The quote above is a fictitious example and does not reflect the statements of a real plan member.

Couple (Slide Layer)

Prescription Drug Coverage

Married couple (and living together) earning less than \$26,130 per year* with resources less than \$29,520 (2021)

Consumer Eligibility Requirements	Benefit Summary
The consumer is eligible for Medicare and Medicaid, i.e., full-benefit Dual-eligible.	<ul style="list-style-type: none">• No monthly premium**• No deductible• Minimal cost sharing



"We qualify for Low-Income Subsidy because our household income is less than \$20,000 per year and our assets are less than \$10,000. When money is tight, subsidies sure do help to keep our health care on track."

* Income levels and assistance may vary for Alaska, Hawaii and the U.S. territories. Income levels in all areas may change each year.
** Only certain plans are available at no cost.

Close

The quote above is a fictitious example and does not reflect the statements of a real plan member.

Creditable Coverage & LEP (Slide Layer)

Prescription Drug Coverage

Creditable Coverage & Late Enrollment Penalty

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. [Click each box below to learn more about Creditable Coverage and Late Enrollment Penalty.](#)

Creditable Coverage

Late Enrollment Penalty

Penalty Calculation

Close

Pharmacy Networks (Slide Layer)

Prescription Drug Coverage

Pharmacy Networks

Agents must review pharmacy network information with consumers to ensure the consumer understands how the pharmacy used can impact their out-of-pocket costs for covered drugs.

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 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 is not able to use 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.

Preferred Pharmacy
A contracted network pharmacy that offers Medicare Part D members covered Part D drugs at negotiated prices.

The prices are lower levels of cost-sharing than apply at a non-preferred (standard) pharmacy.

Close

Extra Help (Slide Layer)

Prescription Drug Coverage

- Benefit Structure
- Consumer Characteristics
- How to Obtain Part D
- Unsuitable Plan
- Cost Considerations
- Extra Help
- Coverage Considerations

A consumer automatically qualifies 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)
- Get Supplemental Security Income (SSI) benefits

If the consumer does not automatically qualify for LIS, 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 (1-866-865-3851) who will contact the member and assist with the LIS enrollment electronically.

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.


Coverage Considerations (Slide Layer)

Prescription Drug Coverage


- Benefit Structure
- Consumer Characteristics
- How to Obtain Part D
- Unsuitable Plan
- Cost Considerations
- Extra Help
- 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 button to learn about coverage considerations.](#)



**Formularies
& Drug Tiers**



**Utilization
Rules:
Step Therapy,
Quantity
Limits, Prior
Authorization,
Opioid Safety**



**Medication
Therapy
Management**

Formulary & Drug Tiers (Slide Layer)

Prescription Drug Coverage

Formulary & Drug Tiers

Formulary (Drug List)

- A list of covered drugs selected by the Plan with the help of a team of doctors and pharmacists.
- The drug list often represents the level of cost-sharing associated with various groupings of medications (Preferred Generics, Generics, Preferred Brands, Non-Preferred Drugs).
- The list must meet requirements set by Medicare (CMS).
- Medicare approves the plan's drug list.

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. It's true that the plan cost sharing amounts is the same for all drugs on a specific tier, however, if the price at the pharmacy is lower, the member will not pay the plan copay. 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	Many common brand-name drugs and some higher-cost generic drugs
Tier 4: Non-Preferred Drug	Copayment (MAPD) Coinsurance (PDP)	Non-preferred generic and non-preferred brand-name drugs
Tier 5: Specialty Tier	Coinsurance	Unique and/or very high cost drugs

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

Close

Utilization Management (Slide Layer)

Prescription Drug Coverage

Utilization Management Rules

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 member or 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 – If prescribed an opioid within the last 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.

Close

Medication Therapy Management (Slide Layer)

Prescription Drug Coverage

Medication Therapy Management Program

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 a written summary of details to offer their health care providers.

The drug plan may enroll a member into this program if they meet all of the following:

1. Member has more than one chronic health condition.
2. Member takes several different medications.
3. Member's medications have a combined cost of more than \$4,696 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. The plan can help members determine if they may reach this dollar limit.

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

Close

2.4 Drug Payment Stages

Drug Payment Stages

- Drug Stages
- Who Pays What?
- PDP Changes Summary
- The Coverage Gap
- Coverage Gap Step-by-Step



Drug Stages (Slide Layer)


Drug Payment Stages

- Drug Stages
- Who Pays What?
- PDP Changes Summary
- The Coverage Gap
- Coverage Gap Step-by-Step

In addition to cost considerations covered in the previous section, there are four stages to Medicare Part D Standard Prescription Drug Coverage:

- Yearly Deductible (Note: Some plans have a \$0 deductible for prescription coverage.)
- Initial Coverage
- Coverage Gap
- Catastrophic Coverage

To determine when a member moves from one stage to the next, the plan keeps track of the member's TrOOP (True Out-of-Pocket) costs. Any money spent during the Deductible, Initial Coverage, and Coverage Gap stages counts toward TrOOP costs. The monthly premium does not count toward TrOOP costs.



Who Pays What? (Slide Layer)

Drug Payment Stages

- Drug Stages
- Who Pays What?
- PDP Changes Summary
- The Coverage Gap
- Coverage Gap Step-by-Step

Who pays what in each drug payment stage?

Click and drag the dollar bill over each number to learn about the drug payment stages.

1

2

3

4

Yearly Deductible \$0 - \$480	Initial Coverage \$4,430	Coverage Gap \$7,050	Catastrophic Coverage
Member pays 100% Plan pays nothing	Member pays 25%* Plan pays 75%	Member pays 25% Plan/manufacture pays 75%	\$3.95 - \$9.85 - 5% Member pays ~5% Plan pays 15% Government pays 80%
Member starts in this coverage stage when they fill their first prescription of the year. If plan or drug tier has a deductible, member pays the total cost of drugs until they reach the deductible amount. (Many plans have no deductible.)	Drug costs are shared by member and plan until total drug costs paid by both, including the deductible, reaches \$4,430.	Member pays 25% for brand-name drugs and generic drugs. (For non-LIS members only.) Once member's out-of-pocket costs reach \$7,050 they move to Catastrophic Coverage.	Member pays a small copay or coinsurance for drugs (the greater of generic [\$3.95] and brand-name drugs [\$9.85] or 5% of total drug cost). Plan pays the rest of the drug costs until end of the year.

*coinsurance or copays
(LIS=Low Income Subsidy)

PDP Changes Summary (Slide Layer)

Drug Payment Stages

- Drug Stages
- Who Pays What?
- PDP Changes Summary
- The Coverage Gap
- Coverage Gap Step-by-Step

Below is a summary of the PDP changes for 2022

	2022	2021
Annual Deductible	\$480 if applicable	\$445 if applicable
Initial Coverage Limit	Ends at \$4,430	Ends at \$4,130
OOP Max	\$7,050	\$6,550

A detailed example of "What The Consumer Pays" is provided in the coverage gap section of this module.


The Coverage Gap (Slide Layer)

Drug Payment Stages

- Drug Stages
- Who Pays What?
- PDP Changes Summary
- The Coverage Gap
- Coverage Gap Step-by-Step

- The coverage gap is a temporary limit on what the Medicare Prescription Drug Plan will cover for drugs.
- Not every member will enter the coverage gap.
- The coverage gap begins when the combined amount the member and plan have spent on covered drugs reaches \$4,430 (for 2022), which includes the deductible, but not plan premiums.
- Once a consumer reaches the coverage gap in 2022, they will pay 25% for both brand-name drugs and generic drugs.
- Consumers who get LIS/Extra Help paying Part D costs will not enter the coverage gap.

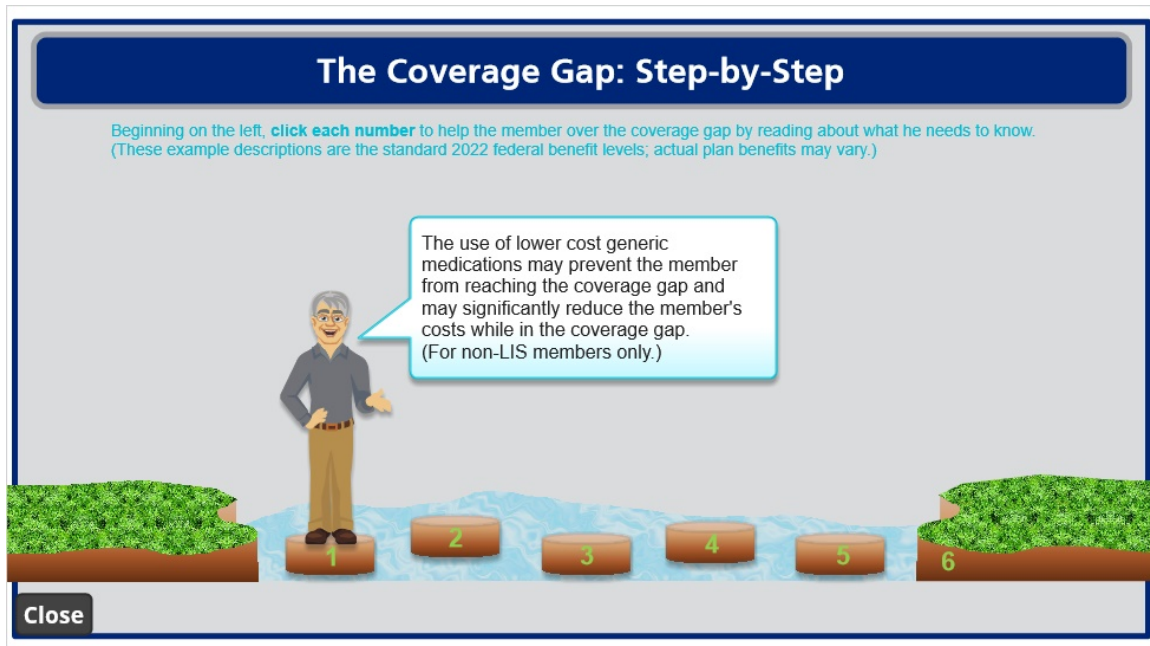
Some plans offer some coverage to a member in the coverage gap, but may charge a higher plan premium. Check with the plan first to see if the consumer's drugs would be covered during the gap.



Coverage Gap Steps (Slide Layer)



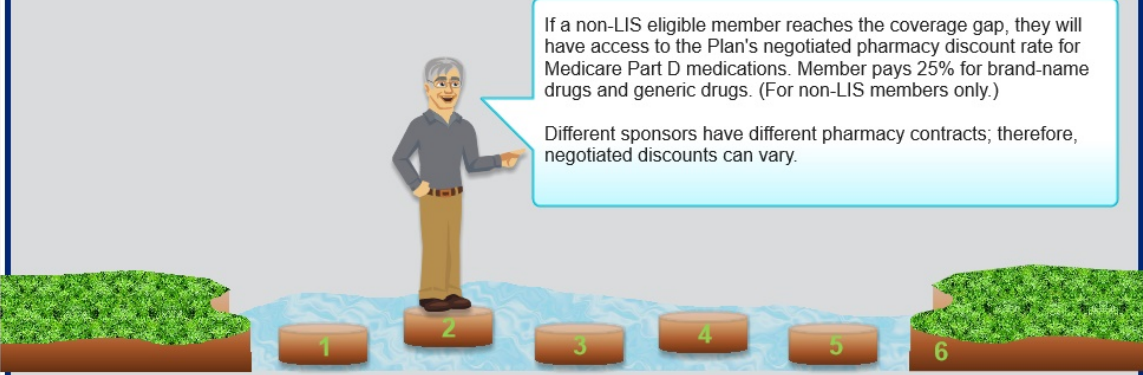
Step 1 (Slide Layer)



Step 2 (Slide Layer)

The Coverage Gap: Step-by-Step

Beginning on the left, **click each number** to help the member over the coverage gap by reading about what he needs to know.
(These example descriptions are the standard 2022 federal benefit levels; actual plan benefits may vary.)



If a non-LIS eligible member reaches the coverage gap, they will have access to the Plan's negotiated pharmacy discount rate for Medicare Part D medications. Member pays 25% for brand-name drugs and generic drugs. (For non-LIS members only.)

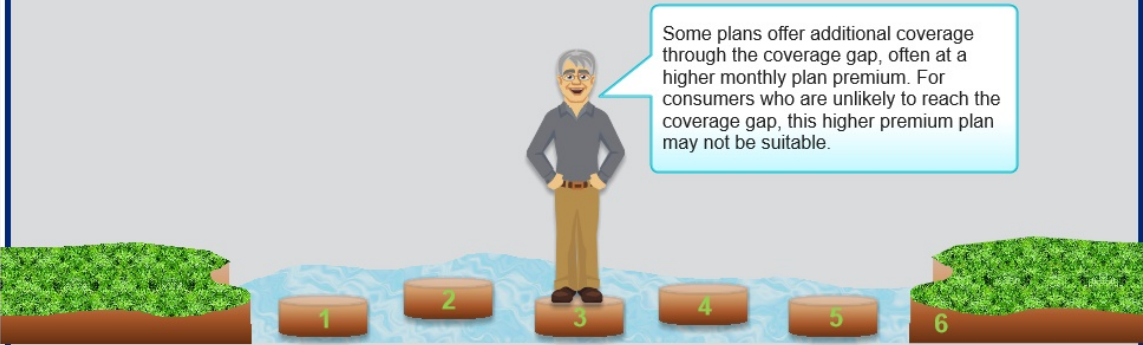
Different sponsors have different pharmacy contracts; therefore, negotiated discounts can vary.

Close

Step 3 (Slide Layer)

The Coverage Gap: Step-by-Step

Beginning on the left, **click each number** to help the member over the coverage gap by reading about what he needs to know.
(These example descriptions are the standard 2022 federal benefit levels; actual plan benefits may vary.)



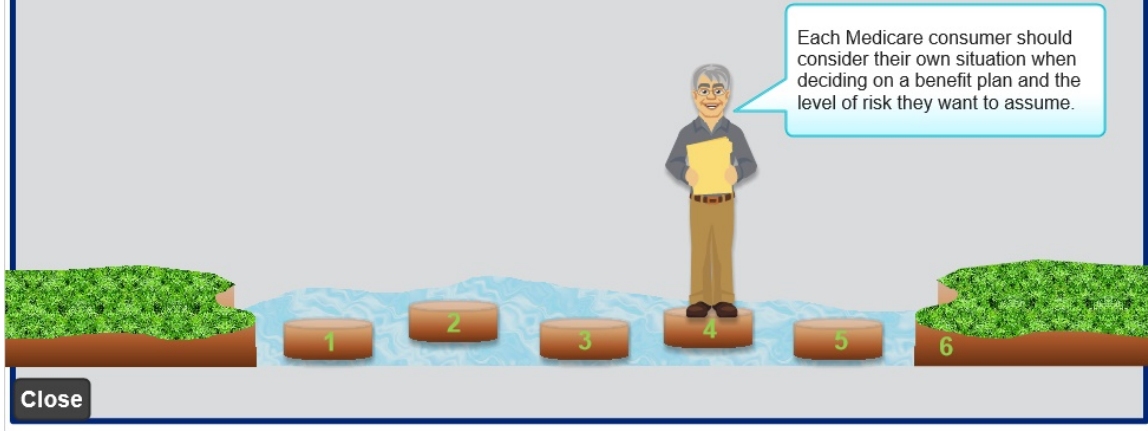
Some plans offer additional coverage through the coverage gap, often at a higher monthly plan premium. For consumers who are unlikely to reach the coverage gap, this higher premium plan may not be suitable.

Close

Step 4 (Slide Layer)

The Coverage Gap: Step-by-Step

Beginning on the left, **click each number** to help the member over the coverage gap by reading about what he needs to know.
(These example descriptions are the standard 2022 federal benefit levels; actual plan benefits may vary.)




Each Medicare consumer should consider their own situation when deciding on a benefit plan and the level of risk they want to assume.

Close

Step 5 (Slide Layer)

The Coverage Gap: Step-by-Step

Beginning on the left, **click each number** to help the member over the coverage gap by reading about what he needs to know.
(These example descriptions are the standard 2022 federal benefit levels; actual plan benefits may vary.)



Not every Medicare consumer enrolled in a plan with Part D benefits will reach the coverage gap. Many plans have a coverage gap that starts after a member incurs \$4,430 in medication spending for 2022.

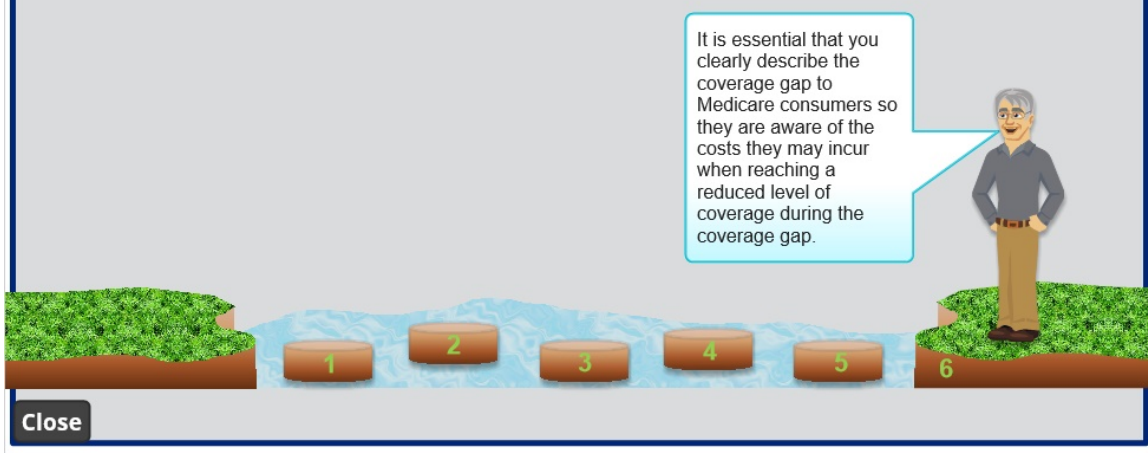
Close

Step 6 (Slide Layer)

The Coverage Gap: Step-by-Step

Beginning on the left, click **each number** to help the member over the coverage gap by reading about what he needs to know. (These example descriptions are the standard 2022 federal benefit levels; actual plan benefits may vary.)

It is essential that you clearly describe the coverage gap to Medicare consumers so they are aware of the costs they may incur when reaching a reduced level of coverage during the coverage gap.

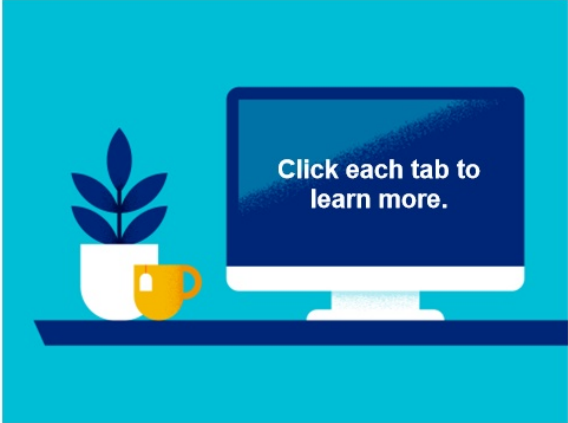


Close

2.5 Medicare Supplement Plans

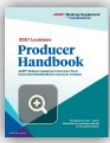
Medicare Supplement Plans

- Definition & Why Enroll
- Eligibility
- Features
- MACRA
- Open Enrollment
- Guaranteed Issue
- AARP Brand
- Rating & Underwriting




Click each tab to learn more.

Definition & Why Enroll (Slide Layer)

Medicare Supplement Plans	Definition & 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 Insurance 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 Insurance 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 through D, F through G, and K through N. All policies offer the same basic benefits, but some offer additional benefits.	 <p>Producer Handbooks are state specific and are mailed to all agents when they become certified. Each year, the handbooks are updated and can be found on the Sales Material Portal that is accessed via Jarvis. Refer to the Producer Handbook when you or your members have questions. You will see this Producer Handbook image throughout the guide. When you do, refer to the Producer Handbook for additional information. For rate information, please reference Jarvis, LEAN and/or the Enrollment Kit.</p>
	Eligibility		
	Features		
	MACRA		
	Open Enrollment		
	Guaranteed Issue	Key reasons consumers choose Medicare Supplement Insurance include: <ul style="list-style-type: none"> To be able to choose any doctor that accepts Original Medicare To have predictable out-of-pocket costs Some plans have limited emergency coverage when traveling outside the United States To have stability in knowing that coverage is guaranteed renewable as long as the premium is paid 	
	AARP Brand		
	Rating & Underwriting		

Eligibility (Slide Layer)

Medicare Supplement Plans	Definition & Why Enroll	Eligibility A consumer must meet eligibility requirements to enroll in a Medicare Supplement Insurance Plan.		
	Eligibility			
	Features			
	MACRA			
	Open Enrollment			
	Guaranteed Issue	Eligible To be eligible for Medicare Supplement Insurance, a consumer must: <ul style="list-style-type: none"> 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. <i>(Note: Usually, residency is defined as the location where the consumer files their tax return.)</i> Be age 65 or older (some states require insurers to offer coverage for Medicare beneficiaries under age 65). 	Eligible A consumer may not be eligible for Medicare Supplement Insurance for various reasons, including, but not limited to, the following: <ul style="list-style-type: none"> Consumer does not qualify for Medicare Supplement Open Enrollment or Guaranteed Issue and does not pass medical underwriting, where applicable. Consumer is enrolled in another Medicare Supplement Plan or a Medicare Advantage Plan, which they do not intend to replace. 	
	AARP Brand			
	Rating & Underwriting			

Features (Slide Layer)

Medicare Supplement Plans	Definition & Why Enroll	Medicare Supplement Features <p>Consumers should understand the type of plan in which they are enrolling and how it differs from other options. Explain the features of Medicare Supplement Insurance to consumers to help them choose the coverage that best suits their needs.</p> <p>Click each image to learn more about these features.</p> <div> </div>
	Eligibility	
	Features	
	MACRA	
	Open Enrollment	
	Guaranteed Issue	
	AARP Brand	
	Rating & Underwriting	

1 Feature-Expenses (Slide Layer)

Medicare Supplement Plans	Definition & Why Enroll	Medicare Supplement Features <p>Consumers should understand the type of plan in which they are enrolling and how it differs from other options. Explain the features of Medicare Supplement Insurance to consumers to help them choose the coverage that best suits their needs.</p> <p>Click each image to learn more about these features.</p> <div> </div>
	Eligibility	
	Features	
	MACRA	
	Open Enrollment	
	Guaranteed Issue	
	AARP Brand	
	Rating & Underwriting	

Out-of-pocket Expenses











Medicare Supplement Insurance Plans cover some or all 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.

2 Features-Choose Drs & Hospitals (Slide Layer)

Medicare Supplement Plans	Definition & Why Enroll	Medicare Supplement Features Consumers should understand the type of plan in which they are enrolling and how it differs from other options. Explain the features of Medicare Supplement Insurance to consumers to help them choose the coverage that best suits their needs. Click each image to learn more about these features.      Freedom to Choose Insured members can choose any provider that accepts Medicare: <ul style="list-style-type: none">• No pre-authorization• No referrals• No provider networks (except Medicare Select Plans, which have a hospital network)     
	Eligibility	
	Features	
	MACRA	
	Open Enrollment	
	Guaranteed Issue	
	AARP Brand	
	Rating & Underwriting	

3 Features-Coverage (Slide Layer)

Medicare Supplement Plans	Definition & Why Enroll	Medicare Supplement Features Consumers should understand the type of plan in which they are enrolling and how it differs from other options. Explain the features of Medicare Supplement Insurance to consumers to help them choose the coverage that best suits their needs. Click each image to learn more about these features.      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.     
	Eligibility	
	Features	
	MACRA	
	Open Enrollment	
	Guaranteed Issue	
	AARP Brand	
	Rating & Underwriting	

4 Features-Foreign ER (Slide Layer)





Medicare Supplement Plans

- Definition & Why Enroll
- Eligibility
- Features
- MACRA
- Open Enrollment
- Guaranteed Issue
- AARP Brand
- Rating & Underwriting






Medicare Supplement Features

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

[Click each image to learn more about these features.](#)



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



5 Features-Guaranteed Renewable (Slide Layer)






Medicare Supplement Plans

- Definition & Why Enroll
- Eligibility
- Features
- MACRA
- Open Enrollment
- Guaranteed Issue
- AARP Brand
- Rating & Underwriting






Medicare Supplement Features

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






[Click each image to learn more about these features.](#)



Guaranteed Renewable Coverage
Guaranteed Renewable – once enrolled, plan automatically continues as long as the insured member pays the premium.








6 Features-State Regulated (Slide Layer)






Medicare Supplement Plans	Definition & Why Enroll	Medicare Supplement Features <p>Consumers should understand the type of plan in which they are enrolling and how it differs from other options. Explain the features of Medicare Supplement Insurance to consumers to help them choose the coverage that best suits their needs.</p> <p>Click each image to learn more about these features.</p> <div>      </div>
	Eligibility	
	Features	
	MACRA	
	Open Enrollment	
	Guaranteed Issue	
	AARP Brand	
	Rating & Underwriting	

State Regulated

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












7 Features-Cost Sharing Updates (Slide Layer)






Medicare Supplement Plans	Definition & Why Enroll	Medicare Supplement Features <p>Consumers should understand the type of plan in which they are enrolling and how it differs from other options. Explain the features of Medicare Supplement Insurance to consumers to help them choose the coverage that best suits their needs.</p> <p>Click each image to learn more about these features.</p> <div>      </div>
	Eligibility	
	Features	
	MACRA	
	Open Enrollment	
	Guaranteed Issue	
	AARP Brand	
	Rating & Underwriting	

Cost Sharing and Benefit Amount Updates

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






8 Features-No Enrollment Period Limitation (Slide Layer)

Medicare Supplement Plans	Definition & Why Enroll	Medicare Supplement Features <p>Consumers should understand the type of plan in which they are enrolling and how it differs from other options. Explain the features of Medicare Supplement Insurance to consumers to help them choose the coverage that best suits their needs.</p> <p>Click each image to learn more about these features.</p>     
	Eligibility	
	Features	
	MACRA	
	Open Enrollment	
	Guaranteed Issue	
	AARP Brand	
	Rating & Underwriting	


No Enrollment Period Limitations

- Medicare Supplement Insurance Plans are available year round.
- Medicare Supplement Insurance 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 Insurance Plans do not cover MA cost sharing expenses.

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










9 Features-30 Day Evaluation (Slide Layer)

Medicare Supplement Plans	Definition & Why Enroll	Medicare Supplement Features <p>Consumers should understand the type of plan in which they are enrolling and how it differs from other options. Explain the features of Medicare Supplement Insurance to consumers to help them choose the coverage that best suits their needs.</p> <p>Click each image to learn more about these features.</p>     
	Eligibility	
	Features	
	MACRA	
	Open Enrollment	
	Guaranteed Issue	
	AARP Brand	
	Rating & Underwriting	

30 Day Evaluation Period

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

10 Features-Standardized Medicare Supplement Plan (Slide Layer)

Medicare Supplement Plans

● Definition & Why Enroll

Medicare Supplement Features

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

[Click each image to learn more about these features.](#)







● Eligibility

2021 Standardized Medicare Supplement Insurance Plans

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

[Click to enlarge and view the plan chart.](#)



● Features







● MACRA







● Open Enrollment







● Guaranteed Issue







● AARP Brand







● Rating & Underwriting








MACRA (Slide Layer)

Medicare Supplement Plans

● Definition & Why Enroll






Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

The 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 know:








- 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 Insurance 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.






● Eligibility






● Features






● MACRA






● Open Enrollment






● Guaranteed Issue

● AARP Brand

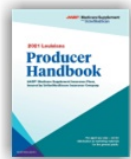
● Rating & Underwriting

Open Enrollment (Slide Layer)

Medicare Supplement Plans	Definition & Why Enroll	<h3>Medicare Supplement Open Enrollment</h3> <p>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).</p> <div> <h4>Medicare Supplement Open Enrollment</h4> <p>During the Medicare Supplement Open Enrollment, eligible consumers are guaranteed these rights:</p> <ul style="list-style-type: none"> • Ability to purchase any supplement plan offered by the carrier. • Premium rates will not be adjusted based on health conditions. </div> <div> <h4>After Medicare Supplement Open Enrollment</h4> <p>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.</p> </div>
	Eligibility	
	Features	
	MACRA	
	Open Enrollment	
	Guaranteed Issue	
	AARP Brand	
	Rating & Underwriting	

Guaranteed Issue (Slide Layer)

Medicare Supplement Plans	Definition & Why Enroll	<h3>Guaranteed Issue Rights</h3> <p>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 <u>cannot</u>:</p> <ul style="list-style-type: none"> • Deny the consumer's application • Apply pre-existing condition exclusions • Charge the consumer more due to past or present health problems <p>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.</p> <p>Guaranteed Issue and plan availability vary by state; please review your Producer Handbook.</p> <div> <h4>Important reminders:</h4> <ul style="list-style-type: none"> • Consumers who are voluntarily switching from one Medicare Supplement insurance company to another are generally not entitled to Guaranteed Issue. • Consumers who switch from a Medicare Advantage Plan to a Medicare Supplement Insurance Plan are sometimes, but not always, entitled to Guaranteed Issue. <p><i>Guaranteed Issue and plan availability vary by state; please review your Producer Handbook.</i></p> </div>	
	Eligibility		
	Features		
	MACRA		
	Open Enrollment		
	Guaranteed Issue		
	AARP Brand		
	Rating & Underwriting		

AARP Brand (Slide Layer)

Medicare Supplement Plans

● Definition & Why Enroll

● Eligibility

● Features

● MACRA

● Open Enrollment

● Guaranteed Issue

● AARP Brand


● Rating & Underwriting

AARP Medicare Supplement Insurance Plans

The AARP Medicare Supplement Insurance Plans are available nationwide. For a list of plans offered, please see your state specific Enrollment Kit or Producer Handbook. **Medicare Supplement Plan Offerings are:**

- AARP Medicare Supplement Plans
- AARP Medicare Select Plans
- "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.

Click logo below to learn some important things about the AARP branded plans.



AARP Details (Slide Layer)

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
- 95% of insured members currently renew their AARP Medicare Supplement Insurance Plan, and on average, hold their plan for 11 years*
- 9 out of 10 insured members surveyed would recommend their AARP Medicare Supplement Plan to a friend or family member*
- 95% member satisfaction rate of those surveyed with AARP Medicare Supplement Insurance Plans²
- Discounts are available in most states

The only Medicare Supplement Insurance Plans that carry the AARP name.

- 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
- Medicare Select Plans are available in some states

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 the online enrollment tool, LEAN, for AARP Medicare Supplement Plans to help the consumer apply for AARP membership.

Value added services are available to insured members in most AARP Medicare Supplement Plans.


AARP® Staying Sharp, AARP® Vision Discounts provided by EyeMed, Hearing Care Program by HearUSA, 24/7 Nurse line Fitness program memberships in some states, Dental Discount, Driver Safety, and more!

Availability of these services varies by state and may be discontinued at any time. Refer to your Producer Handbook for more details.

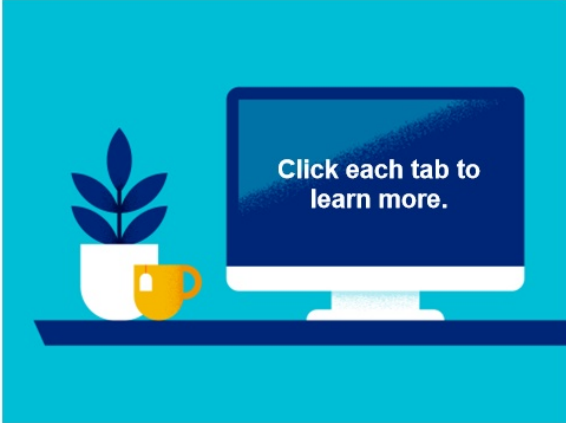
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*Source: Access <http://uhcmcdsupstats.com> for 2019/2020 reports created for UnitedHealthcare Insurance Company.

Rating & Underwriting (Slide Layer)

Medicare Supplement Plans	● Definition & Why Enroll	Rating & 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: <ul style="list-style-type: none">• 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: <ul style="list-style-type: none">• 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:<ul style="list-style-type: none">○ 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. <i>Reminder, consumers who meet Medicare Supplement Open Enrollment or Guaranteed Issue requirements do not have to answer underwriting questions.</i>	
	● Eligibility		
	● Features		
	● MACRA		
	● Open Enrollment		
	● Guaranteed Issue		
	● AARP Brand		
	● Rating & Underwriting		


2.6 Other Coverage Options

Other Coverage Options	● Group Retiree	
	● Medicare-Medicaid Plans (MMP)	
	● Medicare Cost Plans	
	● Medicare Savings Account (MSA)	
	● PACE	
	● VA/TRICARE	

Group Retiree (Slide Layer)

Other Coverage Options	● Group Retiree	Group Retiree Employer/Union-Sponsored Group Retiree Plans Group Retiree consumers are Medicare eligible, retired from their previous employer, and are looking to continue coverage with their previous employer. Employer Groups contract with health plans that allow them to offer products and administer benefits through contractual agreements and arrangements. With subsidized plans, the employer contributes to the premium, but with endorsed plans the employer does not.	
	● Medicare-Medicaid Plans (MMP)	Employer Senior Supplement Group Retiree Plans These medical plans, which are only available through employer groups, help pay for some or all of the costs not covered by Original Medicare. They have similar coverage as Medicare Supplement Insurance Plans and members can go to any provider that accepts Medicare.	
	● Medicare Cost Plans	There are two important considerations about Group Retirees:	
	● Medicare Savings Account (MSA)	Understanding the consumer's existing coverage It is important for the consumer to understand how their employer or union coverage will work with Original Medicare before a decision is made about whether to enroll into a Medicare Advantage Plan.	Effects on other types of coverage Enrolling in a Medicare Advantage Plan may limit or end the consumer's employer or union coverage for both the consumer and/or family members covered by his/her group coverage (medical and/or prescription) plan. The consumer should contact their former employer's benefits administrator or the office that answers their coverage questions before they make any changes.
	● PACE		
	● VA/TRICARE		

MMP (Slide Layer)

Other Coverage Options	● Group Retiree	Medicare-Medicaid Plans (MMP) Many consumers qualify for additional coverage through Medicaid due to low income status or certain health conditions.	
	● 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.	
	● Medicare Cost Plans	Generally, qualified individuals are passively enrolled into the state's coordinated care plan with the ability to opt-out and choose other Medicare options.	
	● Medicare Savings Account (MSA)	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.	
	● PACE	UnitedHealthcare offers MMPs in some areas in Massachusetts, Ohio and Texas.	
	● VA/TRICARE		

Medicare Cost Plans (Slide Layer)

Other Coverage Options	● Group Retiree	Medicare Cost Plans Medicare Cost Plans are a type of Medicare HMO health plan available in certain areas of the country.
	● Medicare-Medicaid Plans (MMP)	These plans may work in much the same way, and have some of the same rules, as Medicare Advantage Plans.
	● Medicare Cost Plans	Although in most cases HMO Plan members must use providers in the contracted network for care to be covered, members of Medicare Cost Plans may visit a non-network provider and have the services covered under Original Medicare.
	● Medicare Savings Account (MSA)	
	● PACE	
	● VA/TRICARE	




MSA (Slide Layer)


Other Coverage Options	● Group Retiree	Medicare Savings Account (MSA) Combines a high deductible Medicare Advantage Plan and a bank account. The plan deposits money from Medicare in the account. Members can use it to pay their medical expenses until their deductible is met.
	● Medicare-Medicaid Plans (MMP)	Note: UnitedHealthcare currently does not offer an MSA Plan.
	● Medicare Cost Plans	
	● Medicare Savings Account (MSA)	
	● PACE	
	● VA/TRICARE	



PACE (Slide Layer)

Other Coverage Options	● Group Retiree	Programs of All-Inclusive Care for the Elderly (PACE) Note: UnitedHealthcare does not offer any PACE plans. 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, and long-term care services and prescription drug coverage for the frail, elderly, and/or disabled consumers who reside 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: <ul style="list-style-type: none"> • 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 sponsored by 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.	
	● Medicare-Medicaid Plans (MMP)		
	● Medicare Cost Plans		
	● Medicare Savings Account (MSA)		
	● PACE		
	● VA/TRICARE		

VA-Tricare (Slide Layer)

Other Coverage Options	● Group Retiree	Veterans and TRICARE Veterans may have the ability to get healthcare and prescription drug coverage through the VA program. Consumers, who are veterans, may also enroll in a Medicare Advantage plan with prescription drug coverage. Having both is 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 they have proper coverage without jeopardizing their prescription drug coverage with TFL.	
	● Medicare-Medicaid Plans (MMP)		
	● Medicare Cost Plans		
	● Medicare Savings Account (MSA)		
	● PACE		
	● VA/TRICARE		

3. Ethics & Compliance

3.1 Educational & Marketing/Sales Activities

Educational & Marketing Events

- Who is CMS?
- Event Requirements
- Types of Events
- Event Reporting
- Accommodations
- Sensitivity to Accommodations

Ethics & Compliance



Click each tab to learn more.

Who is CMS? (Slide Layer)

Educational & Marketing Events

- Who is CMS?
- Event Requirements
- Types of Events
- Event Reporting
- Accommodations
- Sensitivity to Accommodations

Centers for Medicare and Medicaid Services (CMS)

The Centers for Medicare and 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 Medicare Solutions' rules, policies, and procedures apply to the marketing of all products in its portfolio, including Medicare Supplement products. Therefore, agents must consider the requirements in this module applicable to marketing all products in the UnitedHealthcare Medicare Solutions 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 > Profile > Certifications

Event Requirements (Slide Layer)

Educational & Marketing Events	Who is CMS?	Events Requirement <p>Events are covered in this certification reference guide merely as an introduction to events for all agents. Prior to reporting and conducting marketing/sales events, the agent must complete the <u>Events Basics</u> assessment with a minimum score of 85% within six attempts.</p> <p>The Events Basics module is located in Learning Lab. Go to Jarvis > Knowledge Center > Learning Lab > Content Library > Events Basics.</p> <p><i>For more in-depth information, please review the Agent Guide noted in the resources tab above (Jarvis > Knowledge Center) 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.</i></p>
	Event Requirements	
	Types of Events	
	Event Reporting	
	Accommodations	
	Sensitivity to Accommodations	

Types of Events (Slide Layer)

Educational & Marketing Events	Who is CMS?	<p>It's important to understand the differences between an educational event and a marketing/sales event as defined by the Medicare Communications and Marketing Guidelines. Events are classified by type and how the information will be presented to the consumer.</p> <p>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 is prohibited. Educational events may be conducted in a public venue.</p> <p>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 full plan presentation, given in a presenter-audience format, describes a formal event. Informal events are passive in nature where the consumer approaches the agent to engage in conversation. A table, booth, or kiosk is typically used. All formal and informal marketing/sales events must be reported to UnitedHealthcare.</p> <p>Marketing Appointments  Marketing appointments, commonly called in-home, face-to-face, or one-on-one appointments, typically take place in the</p>
	Event Requirements	
	Types of Events	
	Event Reporting	
	Accommodations	
	Sensitivity to Accommodations	
Education	Accommodations	<p>consumer's home. They can also take place in other venues such as a coffee shop or even over the phone. Agents must obtain a completed Scope of Appointment no later than the start of the appointment. Refer to the Scope of Appointment (SOA) section later in this module for details.</p> <p><i>For more information related to events, refer to the Events Basics module in Learning Lab > Content Library > Events Basics.</i></p>
	Sensitivity to Accommodations	

Event Reporting (Slide Layer)

Educational & Marketing Events

Who is CMS?

Event Requirements

Types of Events

Event Reporting

Accommodations

Sensitivity to Accommodations

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.

Find the Event Request Form in **Jarvis**: Sales and Marketing Tools > Sales Materials (scroll to the bottom) > Compliance Documents > Events > NEW Event Request Form.



UnitedHealthcare will not process new events reported within 7 calendar days of the event date.

Conducting an unreported marketing/sales event is prohibited.

Accommodations (Slide Layer)

Educational & Marketing Events

Who is CMS?

Event Requirements

Types of Events

Event Reporting

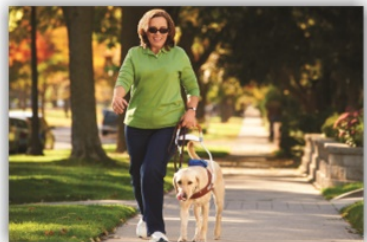
Accommodations

Sensitivity to Accommodations

Accommodating Consumers with Special Needs

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.



Sensitivity to Accommodations (Slide Layer)

Educational & Marketing Events	● Who is CMS?	Sensitivity to Consumer Accommodations <u>Hearing Impairment and Language Translation</u> 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.	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 the sales lead management system at least 14 calendar days prior to the event or appointment. If you do not have access to the sales lead management system 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 for ASL form) to the Producer Help Desk at PHD@uhc.com .
	● Event Requirements		
	● Types of Events	A consumer can request a sign language interpreter when calling Telesales to RSVP for an event or when scheduling a formal marketing/sales in-home appointment with the 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.	
	● Event Reporting		
	● Accommodations	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 Language Interpreter Disclaimer found in the front of the Enrollment Guide for the plan you are presenting.	
	● Sensitivity to Accommodations		

3.2 Marketing Materials

Marketing Materials	● Definition	
	● Examples	

Definition (Slide Layer)

Marketing Materials

Definition

Examples

Agents are required to comply with all UnitedHealthcare rules, policies, and procedures when marketing and selling Medicare insurance plans.

Marketing Materials Definition

Marketing Materials are used to:

- Draw attention to a plan sponsor or their plan(s), and
- Influence a consumer's decision when selecting a plan in which to enroll or a member's decision to remain enrolled in their current plan.

Marketing Materials contain or address information about a plan or plans:

- Benefits or benefit structure
- Cost sharing (including premiums, copayments and deductibles)
- Measurements or ranking standards (such as Star ratings, comparison to other plans, or statistical studies or surveys)

Approval is Required for:

- All Medicare marketing materials, including AARP® Medicare Supplement, or
- Any material that mentions a plan sponsor (such as "UnitedHealthcare"), one of its affiliated plans, or displays any plan logos.

Materials that do not meet the marketing materials criteria, and do not carry any plan sponsor information or logos, are considered "generic". Generic materials do not require prior approval, but must be provided upon request and may be reviewed on a retrospective basis.

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

Examples (Slide Layer)

Marketing Materials


Definition

Examples

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 these 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 generic 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 > Sales & Marketing > Sales Materials > scroll down to Compliance Documents** for information on agent-created websites and use of social media.

3.3 Appropriate Contact With Consumers

Appropriate Contact

- Permission to Contact
- Types of Contact
- Scope of Appointment
- Cross Selling
- Proper Marketing
- Power of Attorney and/or Legal Representative



Permission to Contact (Slide Layer)

Appropriate Contact

- Permission to Contact
- Types of Contact
- Scope of Appointment
- Cross Selling
- Proper Marketing
- Power of Attorney and/or Legal Representative

When marketing Medicare insurance products, agents must comply with all CMS regulations and UnitedHealthcare rules, policies, and procedures related to contacting the consumer and discussing plan options.

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 Solutions product, including Medicare Advantage, Prescription Drug or Medicare Supplement Insurance Plans. PTC must be documented, retained and available upon request by UnitedHealthcare or CMS for 10 years from the date PTC was received.

PTC must be considered:

- **Method-specific** - Contact can only be made by the method permitted by the consumer. Permission to telephone only enables the agent to dial the number provided. An agent must receive explicit permission to text or email the consumer. Simply having access to a phone number or email address (e.g., a purchased lead list) does not imply permission from the consumer.
- **Short-term** - PTC expires once the agent has made contact with the consumer or nine months after the date the PTC was received, whichever comes first. PTC expires 90 days after receipt for consumers requesting information on Medicare Supplement insurance or who are on the federal Do Not Call list. PTC is not open-ended permission for future contacts. Agents must renew PTC by asking the consumer to be contacted again in the future.
- **Event-specific** - The agent can only contact the consumer to discuss the products indicated in the PTC mechanism.

Types of Contact (Slide Layer)

Appropriate Contact

● Permission to Contact

● Types of Contact

● Scope of Appointment

● Cross Selling

● Proper Marketing

● Power of Attorney and/or Legal Representative

Permission To Contact – Types of Contact

Click the images for information on types of contact.



Business Reply Cards



Unsolicited Contact



Additional Requests



Consumer Referrals

Business Reply Cards (Slide Layer)

Appropriate Contact

Business Reply Cards

- 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 a visit. Valid PTC would not have been secured and agents may only contact the consumer via postal mail.

Close

Unsolicited Contact (Slide Layer)

Appropriate Contact

Unsolicited Contact

Marketing to consumers through direct, unsolicited contact is prohibited. Without documented permission, the following forms of outreach are considered to be unsolicited contact:

- door-to-door soliciting
- text messaging
- emailing
- telemarketing
- cold calling

Direct mail is permitted.

During contact with the consumer, agents must update the lead status or permission to call within the company sales lead management system with the consumer's preference.

If an agent does not have access to the sales lead management system, they must have a system that enables them to document and retain PTC for a minimum of 10 years and provide documentation upon request. Refer to the Privacy section of this module for guidance on secure storage and disposal of consumer information.

Close

Additional Requests (Slide Layer)

Appropriate Contact

Additional Requests

If during the course of an outbound call by a Medicare Supplement issuer the consumer requests additional information on a MA or PDP product, a discussion can be held (at that time) on the MA or PDP product.



The image shows an older man and woman sitting at a table covered with a floral tablecloth. They are both looking down at a document or brochure that the man is holding. There are some small items on the table, including what looks like a small bowl or container. The background shows a window and some indoor plants, suggesting a home setting.

Close

Consumer Referrals (Slide Layer)

Appropriate Contact

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 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 are only permitted to use conventional postal mail to contact the referred individual. Prohibited methods of contacting the referred individual include door-to-door solicitation, calling, texting, and emailing. 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.

Close

Scope of Appointment (Slide Layer)


Appropriate Contact

- Permission to Contact
- Types of Contact
- Scope of Appointment
- Cross Selling
- Proper Marketing
- Power of Attorney and/or Legal Representative


Scope of Appointment

Consumers must agree to the scope of products that may be discussed at any face-to-face or telephonic marketing appointment any time before the appointment. A Scope of Appointment (SOA) captures the consumer's permission to discuss certain products. SOA forms are available in Enrollment Guides and as stand-alone documents on the Sales Material Portal accessible on **Jarvis > Sales & Marketing Tools > Sales Materials > Compliance Documents > Scope of Appointment**.


[Click the images to learn more about Scope of Appointment.](#)




Marketing Appointments



Marketing/Sales Events



Rules



Documentation

2022 Certification Reference Guide 06212021 original

Page 53 of 182

Marketing Appointments (Slide Layer)

Appropriate Contact

Marketing Appointments



- An 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).
- When a consumer walks into an agent's office or a UnitedHealthcare MedicareStore, the agent must obtain an SOA prior to the discussion.

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.

Close

Marketing/Sales Events (Slide Layer)

Appropriate Contact

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.

Close

Rules (Slide Layer)

Appropriate Contact

Rules



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) any time prior to the start of the appointment.
- Obtain a new SOA when the consumer or agent requests to discuss a health-related product not identified on the original SOA. Once obtained, the new product may be discussed.
- Obtain a new SOA when the agent determines a product not identified on the original SOA may benefit the consumer. This includes appointments for Medicare Supplement Insurance 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.

Close

Documentation of SOA (Slide Layer)

Appropriate Contact

Documentation of SOA



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

Close

Cross-Selling (Slide Layer)

Appropriate Contact	● Permission to Contact	Cross-Selling Medicare Communications and Marketing Guidelines prohibit 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. 
	● Types of Contact	
	● Scope of Appointment	
	● Cross Selling	
	● Proper Marketing	
	● Power of Attorney and/or Legal Representative	

Proper Marketing & Sales Tactics (Slide Layer)

Appropriate Contact	● Permission to Contact	Other Required Practices: Proper Marketing & 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?").
	● Types of Contact		
	● Scope of Appointment		
	● Cross Selling		
	● Proper Marketing		
	● Power of Attorney and/or Legal Representative		

POA or Legal Representative (Slide Layer)

Appropriate Contact	● Permission to Contact	Other Required Practices: Is a Power of Attorney or Authorized Legal Representative Needed? An authorized legal representative is a person who is authorized under state law to complete the Enrollment Application, make health care decisions on behalf of the consumer and is authorized to receive health care related information on his/her behalf. The authorized legal representative (or Power of Attorney/POA) must have documentation to prove their authority which must be produced if requested by the 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. <small>* 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.</small>
	● Types of Contact	
	● Scope of Appointment	
	● Cross Selling	
	● Proper Marketing	
	● Power of Attorney and/or Legal Representative	

3.4 Event Practices

Event Practices	● Promotional Items & Giveaways	
	● Meals & Refreshments	

Promotional Items & Giveaways (Slide Layer)

Event Practices

Promotional Items & Giveaways


Meals & Refreshments

Promotional Items & Giveaways

Agents can offer promotional gifts to attendees of any event type as long as such gifts are of nominal retail value. Nominal value is currently defined as an item worth \$15 fair market value (retail value) or less.

The following rules must be followed when providing nominal gifts:

- The combined value of all giveaway items, including food, must not exceed \$15 per consumer.
- Cash gifts (or items convertible to cash such as lottery tickets or pull tabs), gift certificates, gift cards, monetary rebates, and charitable contributions made on behalf of consumers/members are prohibited regardless of amount.
- You must state that accepting a gift or prize does not obligate a consumer to enroll.
- When providing gifts, you must offer to all Medicare eligible attendees.
- Giving gifts in order to solicit referrals is prohibited.



*Refer to the Events Basics module for information related to providing promotional items and giveaways at educational and formal/informal marketing/sales events. (Events Basics is located in **Jarvis > Knowledge Center > Learning Lab > Content Library > Events Basics**.)*

Meals & Refreshments (Slide Layer)

Event Practices

Promotional Items & Giveaways


Meals & Refreshments

Meals & Refreshments

Meals must not be provided at any sales/marketing event, including personal/individual marketing appointments.

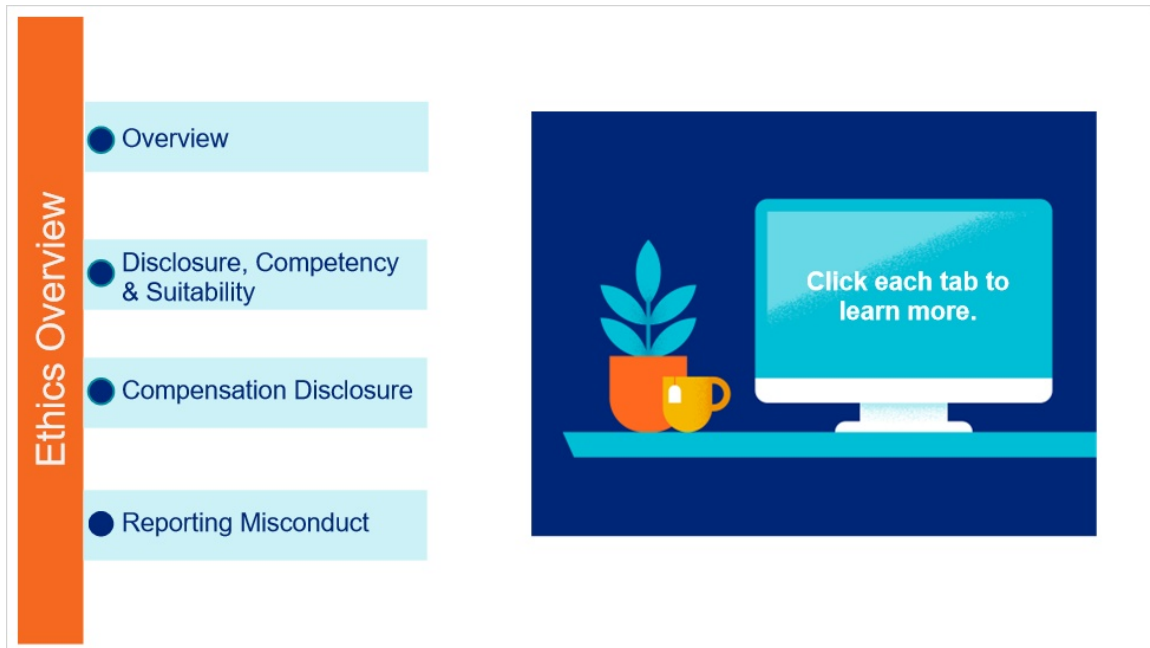
Agents may serve light refreshments (e.g., cookie and coffee), provided the items cannot be combined to equal a meal (alcoholic beverages are prohibited).

The combined value of giveaways and refreshments must not exceed \$15 per person.



Refer to the Events Basics module for information related to providing meals and/or refreshments at educational and formal/informal marketing/sales events.

3.5 Ethics Overview



Ethics Overview (Slide Layer)

Ethics Overview

- Overview
- Disclosure, Competency & Suitability
- Compensation Disclosure
- Reporting Misconduct

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 > Agent Guides
- Compliance documents: Sales & Marketing Tool > Sales Materials (scroll down to Compliance documents)
- Other job aids: Jarvis > Knowledge Center > Learning Lab > Content library > search for topic

Disclosure, Competency & Suitability (Slide Layer)

Ethics Overview

Overview

Disclosure, Competency & Suitability

Compensation Disclosure

Reporting Misconduct

Disclosure, Competency & Suitability

Ethical issues can arise when marketing and selling Medicare plans.

Click each drawer label to explore three main components of ethical sales and marketing practices.

Disclosure

Competency

Suitability

Refer to the Events Basics module for information related to providing meals and/or refreshments at educational and formal/informal marketing/sales events.

Disclosure (Slide Layer)

Ethics Overview

Overview

Disclosure, Competency & Suitability

Compensation Disclosure

Reporting Misconduct

Disclosure, Competency & Suitability

Ethical issues can arise when marketing and selling Medicare plans.

Click each drawer label to explore three main components of ethical sales and marketing practices.

Disclosure

Competency

Suitability

Refer to the Events Basics module for information related to providing meals and/or refreshments at educational and formal/informal marketing/sales events.

Disclosure: An Example

Agent Lucy is presenting a plan to Mr. Spalding, a consumer. Along with presenting the benefits and costs of the plan, she also discloses that she may receive compensation for his enrollment in the plan.

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.
- Disclosure that compensation may be received based on the consumer's enrollment in the plan (more in the next slide).

Competency (Slide Layer)

Ethics Overview

Overview

Disclosure, Competency & Suitability

Compensation Disclosure

Reporting Misconduct

Disclosure, Competency & Suitability

Ethical issues can arise when marketing and selling Medicare plans.

Click each drawer label to explore three main components of ethical sales and marketing practices.

Disclosure

Competency

Suitability

Refer to the Events Basics module for information related to providing meals and/or refreshments at educational and formal/informal marketing/sales events.

Competency: 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 understand fully the products being sold.
- Product awareness will help agents identify the plans that meet a consumer's needs.

Suitability (Slide Layer)

Ethics Overview

Overview

Disclosure, Competency & Suitability

Compensation Disclosure

Reporting Misconduct

Disclosure, Competency & Suitability

Ethical issues can arise when marketing and selling Medicare plans.

Click each drawer label to explore three main components of ethical sales and marketing practices.

Disclosure

Competency

Suitability

Refer to the Events Basics module for information related to providing meals and/or refreshments at educational and formal/informal marketing/sales events.

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.

Compensation Disclosure (Slide Layer)

Ethics Overview

Overview

Disclosure, Competency & Suitability

Compensation Disclosure

Reporting Misconduct

Compensation Disclosure

While you are not required to disclose to consumers the amount and/or type of compensation you may receive based on their enrollment, **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 > Agent Guides*).

CMS defines compensation as monetary or non-monetary remuneration of any kind relating to the sale or renewal of a policy including, but not limited to, commission, bonuses, gifts, prizes, and awards.

Compensation does not include the payment of fees to comply with state appointment laws; costs related to training, certification, and testing requirements; reimbursement for mileage to and from educational and marketing/sales events or marketing appointments with consumers; and reimbursement for actual costs associated with educational and marketing/sales events and marketing appointments such as venue rent, snacks, and materials.

You must review relevant information about compensation as they pertain to your agent type. Click the "Agent" button that applies to you.

Employed Agents

Contracted or Independent Agents

Employed Agents (Slide Layer)

Ethics Overview

Compensation: Internal Sales Representative (ISR)

Sales Incentive Plan
Employed agents are paid an incentive when specific sales goals have been met. In order to be paid an incentive, the agent must meet all conditions set forth within their Sales Incentive Plan (SIP) in effect at the time. Employed agents should refer to their SIP for details.

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.

Close

Compensation: EDC and ICA Non-Employee 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 an amount at or below the fair market value (FMV) cut-off 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 (i.e., 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

Close

Compensation: EDC and ICA Non-Employee Agents

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).

Renewal Compensation 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, MA-PD, MMP, or section 1876 cost plan to another PDP, MA, MA-PD, MMP, or section 1876 cost plan respectively). Renewal compensations must always be pro-rated for the actual months the member is enrolled in the plan.

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 agent in excess of \$100 per referral or enrollment in an MA/MA-PD 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.

Close

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.

Close

Reporting Misconduct (Slide Layer)

Ethics Overview

- Overview
- Disclosure, Competency & Suitability
- Compensation Disclosure
- 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, including violations of law, contractual obligations and company policies (including the UnitedHealth Group Code of Conduct); privacy issues; or suspected fraud, waste and abuse by calling the Compliance & Ethics HelpCenter at 800-455-4521 or via **Compliance & Ethics Help Center** (ethicsoffice@uhg.com).

Failure to report an instance of suspected misconduct could result in disciplinary action.

For answers to questions about UnitedHealthcare rules, policies and procedures; Medicare Communications and Marketing Guidelines; and privacy, security or ethics, refer to the Agent Guide, contact your UnitedHealthcare sales leader or send an email to: compliance_questions@uhc.com

3.6 Enrollment Details

Enrollment Details

- Enrollment Application Guidelines
- Enrollment Signatures
- Non-Discrimination Requirements
- Avoid Shortcuts
- Plan Sponsor & Agent Requirements
- Guaranteed Rights
- Appeals & Grievances



Enrollment Application Guidelines (Slide Layer)

Enrollment Details

- Enrollment Application Guidelines
- Enrollment Signatures
- Non-Discrimination Requirements
- Avoid Shortcuts
- Plan Sponsor & Agent Requirements
- Guaranteed Rights
- Appeals & Grievances

Enrollment Application Guidelines

- Ask each consumer if they are enrolled in Medicare Parts A and B.
- Be sure to include the primary care physician (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.
- Complete the Plan Recap with the consumer to ensure the consumer understands the plan.

Risk Ahead

Click the sign to read tips to avoid inaccurate provider information complaints.

Note: These requirements apply specifically to CMS-regulated products. For information related to marketing non-CMS-regulated products, like Medicare Supplement Insurance 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 (Slide Layer)

Enrollment Details

Inaccurate Provider Information

Risk

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.)

Close

Enrollment Signatures (Slide Layer)

Enrollment Details	● Enrollment Application Guidelines	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 a Power Of Attorney (POA). Follow these guidelines for Enrollment Application signatures: <ul style="list-style-type: none">• Sign and date the Enrollment Application and include your Agent ID Number.<ul style="list-style-type: none">– 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.
	● Enrollment Signatures	
	● Non-Discrimination Requirements	
	● Avoid Shortcuts	
	● Plan Sponsor & Agent Requirements	
	● Guaranteed Rights	
	● Appeals & Grievances	

Non-Discrimination Requirements (Slide Layer)

Enrollment Details	● Enrollment Application Guidelines	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 Special Needs Plans (CSNPs) and Medicaid coverage for Dual Special Needs Plans (DSNPs). This is not to imply if someone is eligible for LIS, they can only have a CSNP or DSNP plan.	
	● Enrollment Signatures		
	● Non-Discrimination Requirements		
	● Avoid Shortcuts		
	● Plan Sponsor & Agent Requirements		
	● Guaranteed Rights		
	● Appeals & Grievances		

Avoid Shortcuts (Slide Layer)

Enrollment Details	Enrollment Application Guidelines	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: <ul style="list-style-type: none"> • Don't 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. • Don't misuse LEAN email address fields. Agents must only enter the consumer's email address in fields reserved for the consumer in the LEAN enrollment application, including when using LEAN 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. <p><i>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.</i></p>
	Enrollment Signatures	
	Non-Discrimination Requirements	
	Avoid Shortcuts	
	Plan Sponsor & Agent Requirements	
	Guaranteed Rights	
	Appeals & Grievances	

Plan Sponsor and Agent Requirements (Slide Layer)

Enrollment Details	Enrollment Application Guidelines	Plan Sponsor & Agent Requirements The following is a basic outline of how applications are processed. Some enrollments may require additional steps based on added eligibility requirements. Application Submission: Agents must submit the Enrollment Application to UnitedHealthcare <u>within 24 hours of receipt</u> 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.
	Enrollment Signatures	
	Non-Discrimination Requirements	
	Avoid Shortcuts	
	Plan Sponsor & Agent Requirements	
	Guaranteed Rights	
	Appeals & Grievances	



[Click the image to enlarge.](#)

Guaranteed Rights (Slide Layer)

Enrollment Details	● Enrollment Application Guidelines	Guaranteed Rights The following are guaranteed rights for all Medicare beneficiaries: <ul style="list-style-type: none">• 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
	● Enrollment Signatures	
	● Non-Discrimination Requirements	
	● Avoid Shortcuts	
	● Plan Sponsor & Agent Requirements	
	● Guaranteed Rights	
	● Appeals & Grievances	

Appeals and Grievances (Slide Layer)

Enrollment Details	● Enrollment Application Guidelines	Appeals & 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: <ul style="list-style-type: none">• 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 Material Portal.
	● Enrollment Signatures	
	● Non-Discrimination Requirements	
	● Avoid Shortcuts	
	● Plan Sponsor & Agent Requirements	
	● Guaranteed Rights	
	● Appeals & Grievances	

3.7 Enrollment Basics

Enrollment Basics for MA and PDP

● What are Election Periods?


● Election Period Restrictions

● Materials Required

● Star Ratings

● Affecting Star Ratings

● Statement of Understanding



What are Election Periods? (Slide Layer)

Enrollment Basics for MA and PDP

● What are Election Periods?

● Election Period Restrictions

● Materials Required

● Star Ratings

● Affecting Star Ratings

● Statement of Understanding

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.

Click each highlighted section of the image to learn more about election periods.

Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
MA OEP									AEP		

Special Election Period

 →

Initial Enrollment Period

 →

5-Star Special Election Period

 →

MA OEP (Slide Layer)

Enrollment Basics for MA and PDP

Medicare Advantage Open Enrollment Period (MA OEP)

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 stand-alone 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 Open Enrollment Period election because the OEP is only available to those enrolled in an MA Plan.

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

Close

AEP (Slide Layer)

Enrollment Basics for MA and PDP

Annual Election Period (AEP)

October 15 to December 7

AEP is also called Medicare open 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.

Close

SEP (Slide Layer)

Enrollment Basics for MA and PDP

Special Election Period (SEP)

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, Dual-eligible or LIS-eligible consumers who are maintaining their status have a quarterly (not monthly) opportunity to change plans within the first nine months of the calendar year. The change cannot be made during calendar quarter four. 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 election
- For some SEPs, consumer may choose effective date of up to three months after Plan receives 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.

Close 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.

IEP (Slide Layer)

Enrollment Basics for MA and PDP

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

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.

- 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 MA-PD 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.

Close

5 Star SEP (Slide Layer)

Enrollment Basics for MA and PDP

5-Star Special Election Period

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 during the benefit year. 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.

Close

Election Period Restrictions (Slide Layer)

Enrollment Basics for MA and PDP

●
What are Election Periods?

●
Election Period Restrictions

●
Materials Required

●
Star Ratings

●
Affecting Star Ratings

●
Statement of Understanding

Election Period Restrictions


Medicare Supplement Insurance 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.

Click the info button to review important Medicare Supplement information



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

- What are Election Periods?
- Election Period Restrictions
- Materials Required
- Star Ratings
- Affecting Star Ratings
- Statement of Understanding

Election Period Restrictions

Medicare Supplement Insurance Plan sales are

Important Medicare Supplement Information

- A Medicare Supplement Insurance Plan helps to cover some of the out-of-pocket costs associated with Original Medicare. A Medicare Supplement Insurance Plan does not pay the cost sharing of a Medicare Advantage Plan.
- Consumers enrolled in a Medicare Supplement Insurance Plan at the time they are enrolling in a Medicare Advantage Plan must be advised that:
 - A Medicare Supplement Insurance Plan does not pay any cost sharing incurred under a Medicare Advantage Plan.
 - A Medicare Supplement Insurance Plan will not automatically terminate when they are enrolled in a Medicare Advantage Plan, and
 - They must contact their Medicare Supplement insurer directly (in writing) in order to cancel their Medicare Supplement Insurance Plan. *(Note: This applies even if UnitedHealthcare is the Medicare Supplement insurer.)* Furthermore, if they later leave the Medicare Advantage Plan, they may not be able to get the same Medicare Supplement Plan back and/or may be subject to underwriting, which may increase the Medicare Supplement Insurance Plan's premium amount.

Click the info button to review important Medicare Supplement information

Materials Required (Slide Layer)

- What are Election Periods?
- Election Period Restrictions
- Materials Required
- Star Ratings
- Affecting Star Ratings
- Statement of Understanding

Materials Required During A Sales Presentation

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 to the consumer at the time of enrollment.** Enrollment Guide includes:

- Summary of Benefits: Offers a detailed summary of the plan's benefits, explanation of cost sharing, and lists special features.
- Enrollment Checklist: 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.




Click on the Table of Contents image to see what is included in the Enrollment Guide.

Star Ratings (Slide Layer)

Enrollment Basics for MA and PDP	What are Election Periods?	Star Ratings  <p>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.</p> <p>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 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.</p> <p>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.</p> <p>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 > Learning Lab > Content Library > Star Ratings > Star Ratings FAQ job aid</p> <p><i>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.</i></p>
	Election Period Restrictions	
	Materials Required	
	Star Ratings	
	Affecting Star Ratings	
	Statement of Understanding	

Affecting Star Ratings (Slide Layer)

Enrollment Basics for MA and PDP	What are Election Periods?	How can I positively affect Star Ratings <ul style="list-style-type: none"> Complaints are one element that CMS uses to determine a Plan's Star Rating. Here are two ways agents can help avoid complaints: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Using materials on the UnitedHealthcare 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. <div style="text-align: right;">  <p>5 stars = excellent 4 stars = above average 3 stars = average 2 stars = below average 1 star = poor</p> </div>
	Election Period Restrictions	
	Materials Required	
	Star Ratings	
	Affecting Star Ratings	
	Statement of Understanding	

SOU and Disclosures (Slide Layer)

Enrollment Basics for MA and PDP

● What are Election Periods?

● Election Period Restrictions

● Materials Required

● Star Ratings

● Affecting Star Ratings

● Statement of Understanding

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 LEAN, 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.

Click the image to review the disclosure items from the SOU.



SOU (Slide Layer)

Enrollment Basics for MA and PDP

Statement of Understanding (SOU)

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. (The EOC is also known as a member contract or a member agreement.) (The EOC will contain the plan's rules, rates, and benefits.)

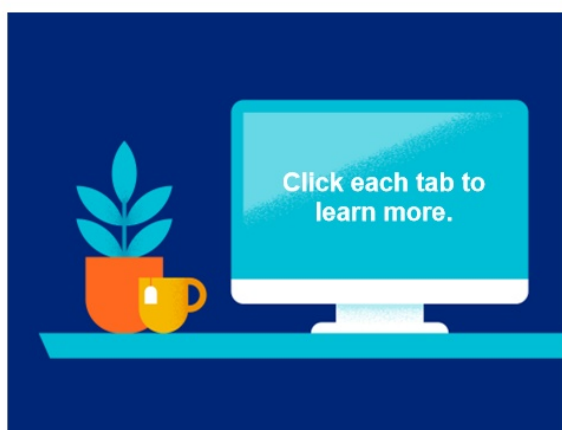
Close
✕

- 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.

Close

3.8 Disenrollment Basics

- Disenrollment Defined
- Voluntary Disenrollment
- Involuntary Disenrollment



Disenrollment Defined (Slide Layer)

Disenrollment Basics

Disenrollment Defined

Voluntary Disenrollment

Involuntary Disenrollment

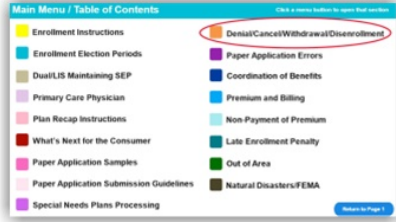
Disenrollment Defined

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 Handbook)



Voluntary Disenrollment (Slide Layer)

Disenrollment Basics

Disenrollment Defined

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:

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

** 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 MA-PD 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 Insurance Plan, must notify the Plan in writing of their wish to disenroll.

Involuntary Disenrollment (Slide Layer)

Disenrollment Basics	● Disenrollment Defined	Involuntary Disenrollment Basics Disenrollment from a Medicare Advantage or Prescription Drug Plan can also occur involuntarily by the plan.	Involuntary Disenrollment Options
	● Voluntary Disenrollment	Required Involuntary Disenrollment The plan must disenroll a member in the following cases: <ol style="list-style-type: none">1. A change in residence to outside the plan's service area makes the individual ineligible to remain enrolled in the plan.2. The member loses entitlement to either Medicare Part A or Part B.3. The Special Needs Plan (SNP) member loses special needs status and does not reestablish SNP eligibility prior to the expiration of the grace period.4. The member dies.5. The MA organization contract is terminated or the MA organization reduces its service area.6. The member fails to pay his or her Part D - Income Related Monthly Adjustment Amounts (IRMAA) to the government.	Optional Involuntary Disenrollment: An MA organization may disenroll a member from its MA Plan if: <ol style="list-style-type: none">1. Premiums are not paid on a timely basis.2. The member engages in disruptive behavior.3. 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: <ul style="list-style-type: none">• 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.
	● Involuntary Disenrollment		

3.9 Compliance Program

Compliance Program	● Program Elements	
	● Your Role & Responsibilities	
	● Code of Conduct	
	● Progressive Disciplinary Process	

Program Elements (Slide Layer)

Compliance Program

● Program Elements

● Your Role & Responsibilities

● Code of Conduct

● Progressive Disciplinary Process


Compliance 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

[Click on the Compliance emblem to review the definition of compliance.](#)



What is compliance? (Slide Layer)

Compliance Program

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.

Close

Your Role and Responsibilities (Slide Layer)

Compliance Program

● Program Elements

● Your Role & Responsibilities

● Code of Conduct

● Progressive Disciplinary Process

Your Role & 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 & Security Incidents - uhc_privacy_office@uhc.com
- The UnitedHealth Group Compliance & Ethics HelpCenter - 1-800-455-4521

Code of Conduct (Slide Layer)

Compliance Program

● Program Elements

● Your Role & Responsibilities

● Code of Conduct

● Progressive Disciplinary Process

UnitedHealth Group 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.

Code of Conduct

Act with Integrity

Recognize and address conflicts of interest. Learn what a conflict of interest** is, common scenarios, disclosure requirements, and possible measures to manage disclosed conflicts.

Be Accountable

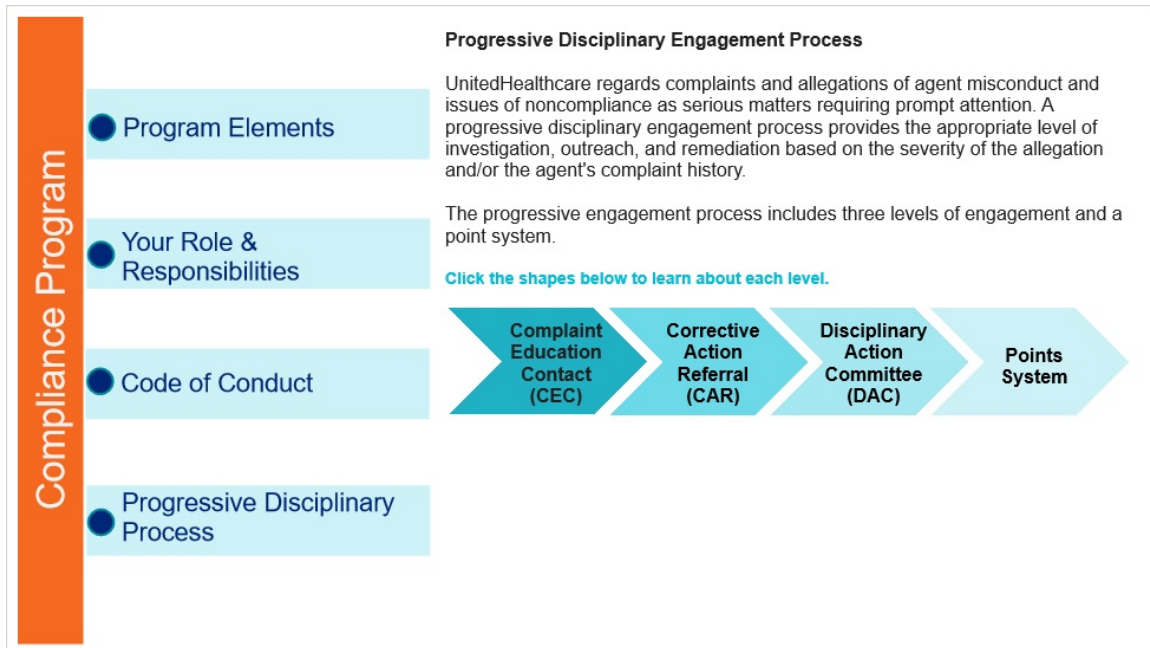
Hold yourself accountable for your decisions and actions. Remember, we are all responsible for compliance.

Protect Privacy - Ensure Security

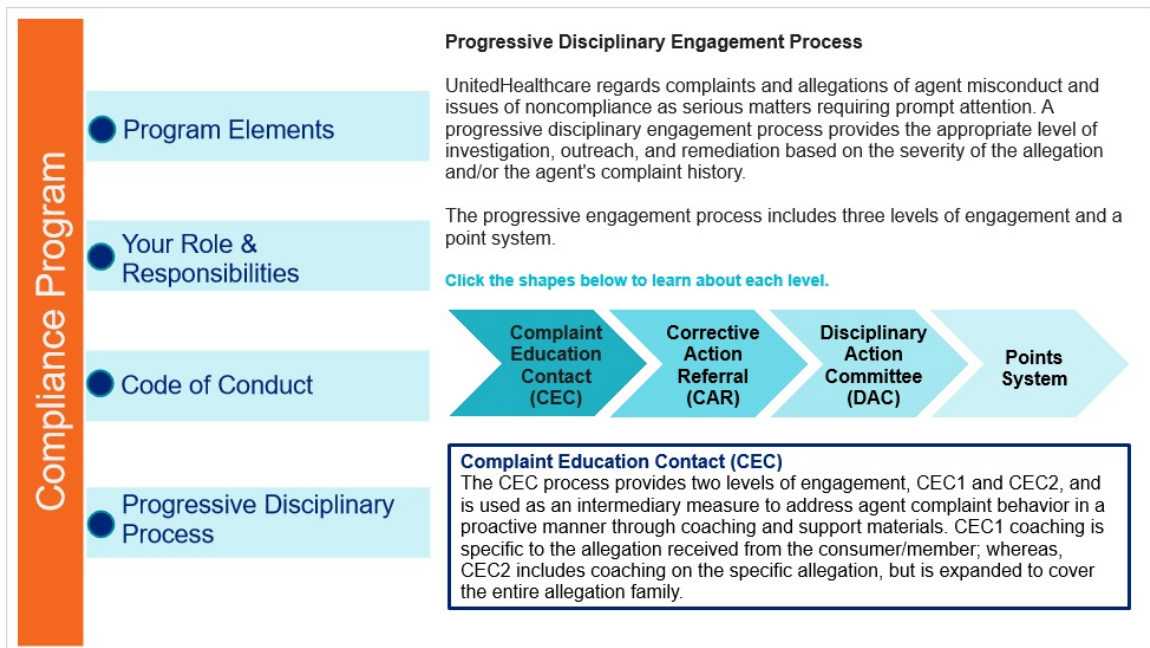
Fulfill the privacy and security obligations of your role. When accessing or using protected information, take care of it!

**Details about Conflict of Interest are provided in a separate Certification module on Learning Lab.

Progressive Disciplinary Process (Slide Layer)



CEC (Slide Layer)



CAR (Slide Layer)

Compliance Program

- Program Elements
- Your Role & Responsibilities
- Code of Conduct
- Progressive Disciplinary Process

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 engagement process includes three levels of engagement and a point system.

[Click the shapes below to learn about each level.](#)

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graph LR; CEC[Complaint Education Contact (CEC)] --> CAR[Corrective Action Referral (CAR)]; CAR --> DAC[Disciplinary Action Committee (DAC)]; DAC --> PS[Points System];
```

Corrective Action Referral (CAR)

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. When 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.

DAC (Slide Layer)

Compliance Program

- Program Elements
- Your Role & Responsibilities
- Code of Conduct
- Progressive Disciplinary Process

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 engagement process includes three levels of engagement and a point system.

[Click the shapes below to learn about each level.](#)

```
graph LR; CEC[Complaint Education Contact (CEC)] --> CAR[Corrective Action Referral (CAR)]; CAR --> DAC[Disciplinary Action Committee (DAC)]; DAC --> PS[Points System];
```

Disciplinary Action Committee (DAC)

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.

Points System (Slide Layer)

Compliance Program

● Program Elements

● Your Role & Responsibilities

● Code of Conduct

● Progressive Disciplinary Process

Progressive Disciplinary Engagement Process

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

[Click the shapes below to learn about each level.](#)

Complaint Education Contact (CEC)

Corrective Action Referral (CAR)

Disciplinary Action Committee (DAC)

Points System

Points System

Each level of engagement is assigned a point value:

CEC/CEC2 - 1 point	CAR - 2 points	DAC - 3 points
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Agents receive additional monthly coaching when complaint points exceed a defined threshold. For details, refer to Agent Guide on *Jarvis* > Knowledge Center.

3.10 Privacy & Security

Privacy & Security

● HIPAA

● PHI and PII

● Risks & Responsibilities

● Rules

● Scenario Examples

HIPAA (Slide Layer)

Privacy & Security

- HIPAA
- PHI and PII
- Risks & Responsibilities
- Rules
- Scenario Examples

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
The HIPAA Privacy Rule outlines specific protections for the use and sharing of member PHI/PII*.

Security Provisions
The HIPAA Security Rule defines how electronic PHI should be maintained, used, transmitted and disclosed.

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

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

Privacy & Security

- Risks & Responsibilities
- Rules
- Scenario Examples

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.

[Click the button to learn what to do if you learn of a potential incident.](#)

What should you do?

What Should I Do? (Slide Layer)

Privacy & Security

What Should I 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 agent 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.

Close

PHI and PII (Slide Layer)

Privacy & Security

HIPAA

PHI and PII

Risks & Responsibilities

Rules

Scenario Examples

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 + 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 is 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 unencrypted computers.
- Sending an unsecured email with PHI/PII to an incorrect email address (outside of UnitedHealthcare's firewall).

Risks and Responsibilities (Slide Layer)

Privacy & Security


HIPAA

PHI and PII

Risks & Responsibilities

Rules

Scenario Examples




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 (Slide Layer)

Privacy & Security

- HIPAA
- PHI and PII
- Risks & Responsibilities
- Rules
- Scenario Examples



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 (Slide Layer)

Privacy & Security

- HIPAA
- PHI and PII
- Risks & Responsibilities
- Rules
- Scenario Examples



Scenarios

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.

3.11 Fraud, Waste & Abuse

Fraud, Waste and/or Abuse (FWA)

Overview

Definitions

Examples of FWA

Federal & State Laws

Reporting Potential FWA



Overview (Slide Layer)

Fraud, Waste and/or Abuse (FWA)

Overview

Definitions

Examples of FWA

Federal & State Laws

Reporting Potential FWA

Fraud, Waste and Abuse (FWA) Overview

In 2020, The United States Department of Justice (DOJ) recovered about \$2.2 billion¹ from cases involving fraud and false claims against the government.

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 (Slide Layer)

Fraud, Waste and/or Abuse (FWA)

Overview

Definitions

Examples of FWA

Federal & State Laws

Reporting Potential FWA

Definitions of Fraud, Waste and Abuse

Click the images to view the definitions of Fraud, Waste and Abuse.

Fraud

Waste

Abuse

Fraud (Slide Layer)

Fraud, Waste and/or Abuse (FWA)

Overview

Definitions

Examples of FWA

Federal & State Laws

Reporting Potential FWA

Definitions of Fraud, Waste and Abuse

Click the images to view the definitions of Fraud, Waste and 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

Waste

Abuse

Waste (Slide Layer)

Fraud, Waste and/or Abuse (FWA)

Overview

Definitions

Examples of FWA

Federal & State Laws

Reporting Potential FWA

Definitions of Fraud, Waste and Abuse

Click the images to view the definitions of Fraud, Waste and Abuse.

Fraud

Waste

Abuse

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- 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

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

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

Abuse (Slide Layer)

Fraud, Waste and/or Abuse (FWA)

Overview

Definitions

Examples of FWA

Federal & State Laws

Reporting Potential FWA

Definitions of Fraud, Waste and Abuse

Click the images to view the definitions of Fraud, Waste and Abuse.

Fraud

Waste

Abuse

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Examples of FWA (Slide Layer)

Fraud, Waste and/or Abuse (FWA)

- Overview
- Definitions
- Examples of FWA
- Federal & State Laws
- Reporting Potential FWA

Examples of Fraud, Waste and Abuse

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.
- Enrolling a group of individuals to form a nonexistent company.
- 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 (Slide Layer)


Fraud, Waste and/or Abuse (FWA)


- Overview
- Definitions
- Examples of FWA
- Federal & State Laws
- Reporting Potential FWA


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 image to learn more about these laws.](#)

**Federal and State Anti-Kickback Statutes**

**Federal Health Insurance Portability and Accountability Act (HIPAA)**

**CMS Data Use Agreement**

**Federal and State False Claims Act**

Anti-Kickback (Slide Layer)

Fraud, Waste and/or Abuse (FWA)


Federal & 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.



Close

HIPAA 1996 (Slide Layer)


Fraud, Waste and/or Abuse (FWA)

Federal Health Insurance Portability & Accountability Act of 1996 (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



Close

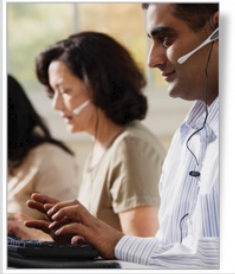
Fraud, Waste and/or Abuse (FWA)

The CMS Data Use Agreement

As part of the Medicare contracts UnitedHealthcare maintains with CMS, the Company is required to attest annually that UnitedHealthcare will only use CMS data and their systems for the administration of the Medicare managed care and/or outpatient prescription drug benefit programs.

What does this mean?

Simply stated, our data use agreement with CMS means that we have committed to following UnitedHealth Group privacy and security policies such as not sharing passwords, using the minimum necessary information to complete our jobs, and ensuring confidential data is protected and secure at all times.



Close

False Claims Act (Slide Layer)

Fraud, Waste and/or Abuse (FWA)

Federal & State False Claims Acts


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.

Violations can result in liability for repayment up to three times the original dollar amount and potential civil penalties of \$5,500-\$11,000 for each claim.

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



Close

Reporting FWA (Slide Layer)

Fraud, Waste and/or Abuse (FWA)	● Overview	Reporting Fraud, Waste and Abuse 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.	Reporting Options UnitedHealth Group Compliance & Ethics Help Center <ul style="list-style-type: none">• 1-800-455-4521 Producer Help Desk <ul style="list-style-type: none">• Phone 1-888-381-8581 Monday-Friday, 7am-9pm CT• Email PHD@uhc.com Distribution Compliance Mailbox* <ul style="list-style-type: none">• compliance_questions@uhc.com UnitedHealthcare Fraud Tip Line* <ul style="list-style-type: none">• Phone 1-866-242-7727 Monday-Friday, 8am-6pm CT or via recorded message 24 hours a day, 7 days a week <p><i>* For confidential reporting, utilize the Compliance Mailbox or Fraud Tip Line</i></p>
	● Definitions		
	● Examples of FWA		
	● Federal & State Laws		
	● Reporting Potential FWA	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.	

3.12 Compliant Sales Practices

Compliant Sales Practices	● Plan Details	 <p>Click each tab to learn more.</p>
	● Marketing/Sales Activities	
	● Marketing Materials	
	● Network/Providers	
	● Provider Settings	
	● Permission to Contact	

Refer to the Agent Guide for a complete list and to stay abreast of current guidelines. (Jarvis > Knowledge Center > Agent Guides)

Plan Details (Slide Layer)

Compliant Sales Practices	Plan Details	Below is a summary of the Plan Detail rules to follow when selling Medicare Advantage and/or Prescription Drug Plans.
	Marketing/Sales Activities	<p>Must Do:</p> <ul style="list-style-type: none"> 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.
	Marketing Materials	
	Network/Providers	<p>Must NOT Do:</p> <ul style="list-style-type: none"> Present the Plan's Value Added Items and Services (VAIS) prior to enrollment in the plan. Only filed benefits may be presented to the consumer prior to enrollment. Enroll consumers into plans that are not best suited to their circumstances without explaining potential challenges to obtaining benefits.
	Provider Settings	
	Permission to Contact	

Marketing-Sales Activities (Slide Layer)

Compliant Sales Practices	Plan Details	Below is a summary of the Marketing/Sales Activities rules to follow when selling Medicare Advantage and/or Prescription Drug Plans.
	Marketing/Sales Activities	<p>Must Do:</p> <ul style="list-style-type: none"> 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. Look up all the consumer's current providers in the online provider directory; review network limitations and provider referral requirements.
	Marketing Materials	
	Network/Providers	
	Provider Settings	<p>Must NOT Do:</p> <ul style="list-style-type: none"> Solicit or accept an enrollment application outside of a valid Election Period. Enroll a consumer in a plan if he/she has 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).
	Permission to Contact	

Marketing Materials (Slide Layer)

Compliant Sales Practices	Plan Details	<p>Below is a summary of the Marketing Material rules to follow when selling Medicare Advantage and/or Prescription Drug Plans.</p> <p>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:</p> <p>Must Do:</p> <ul style="list-style-type: none">• 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 Insurance Plans).• When using materials from the UnitedHealthcare 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 materials must be generic and must include any required disclaimers. <p>Must NOT Do:</p> <ul style="list-style-type: none">• 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.• 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.
	Marketing/Sales Activities	
	Marketing Materials	
	Network/Providers	
	Provider Settings	
	Permission to Contact	

Network/Providers (Slide Layer)

Compliant Sales Practices	Plan Details	<p>Below is a summary of the Network/Provider rules to follow when selling Medicare Advantage and/or Prescription Drug Plans.</p> <p>May Do:</p> <ul style="list-style-type: none">• Encourage members who change their PCP to set appointments with their new PCP to prevent delays with receiving healthcare. <p>Must Do:</p> <ul style="list-style-type: none">• Look up all providers from whom the consumer receives care in the online provider directory.• 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." <p>Must NOT Do:</p> <ul style="list-style-type: none">• Assume that all providers are in the network without looking up providers in the online directory (if presenting a network-based plan).
	Marketing/Sales Activities	
	Marketing Materials	
	Network/Providers	
	Provider Settings	
	Permission to Contact	

Provider Settings (Slide Layer)

Compliant Sales Practices

- Plan Details
- Marketing/Sales Activities
- Marketing Materials
- Network/Providers
- Provider Settings
- Permission to Contact

Below is a summary of the **Provider Setting** rules to follow when selling Medicare Advantage and/or Prescription Drug Plans.

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.

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.

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.

Permission to Contact (Slide Layer)

Compliant Sales Practices

- Plan Details
- Marketing/Sales Activities
- Marketing Materials
- Network/Providers
- Provider Settings
- Permission to Contact

Below is a summary of the **Permission to Contact** rules to follow when selling Medicare Advantage and/or Prescription Drug Plans.

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.

Must Do:

- Request and document permission to contact (in the sales lead management system if available to the agent) and PTC documentation (e.g., lead source/ business reply card).

Compliant Sales Practices

- Plan Details
- Marketing/Sales Activities
- Marketing Materials
- Network/Providers
- Provider Settings
- Permission to Contact

- 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 emails and 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 NOT 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, text or email 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.

Compliance

- Provider Settings
- Permission to Contact

- 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, email, or door-to-door and then converting the marketing effort to any UnitedHealthcare Medicare Solutions 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.

4. Events Basics

4.1 Types of Events

Types of Events

- Introduction
- Events Defined
- Event Format

Events Basics

Click each tab to learn more.


Introduction (Slide Layer)

Types of Events

● Introduction

● Events Defined

● Event Format



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 training and preparation, and it will prepare you for the Events Basics test, which you must pass each selling season (with a minimum score of 85% within six attempts). Agents are not permitted to report or conduct a marketing/sales event representing UnitedHealthcare if they have not passed the Events Basics assessment 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

Events Defined (Slide Layer)

Types of Events

● Introduction

● Events Defined

● Event Format

Types of Events

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 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. The purpose is to provide objective information about the Medicare program and/or health improvement and wellness. Marketing of plans and distribution of marketing materials 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, any other health-related insurance product, such as Medicare Supplement Insurance and dental policies, may be marketed.

Agents may conduct formal online (virtual) educational or marketing/sales events provided all requirements are met. Refer to the Agent Guide (Jarvis> Knowledge Center> Agent Guide) for guidelines.

Event Format (Slide Layer)

Types of Events

● Introduction

● Events Defined

● Event Format

After you decide whether to conduct an **Educational** or **Marketing/Sales** event, then determine if your event will be **formal** or **informal**. 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.

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.

Personalized/Individual Marketing Appointments

Type

● Event Format

You may wonder where individual marketing appointments fit into these event categories. These appointments may occur in-person (e.g., in the consumer's home or public places like a coffee shop), online (i.e. virtually) and telephonically.

These appointments are always considered marketing/sales events, but unlike formal or informal marketing/sales events, they are not reported to UnitedHealthcare. Instead, agents must obtain a completed Scope of Appointment form no later than the start of the appointment.

4.2 Venue Selection


Venue Selection

● Venue Selection Considerations

● ADA Venue Considerations

● Venue Guidelines

● Online Guidelines



Venue Selection

Considerations (Slide Layer)

Venue Selection




Venue Selection Considerations

ADA Venue Considerations

Venue Guidelines

Online Guidelines

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:

-  Appropriate lighting levels so consumers can see your presentation and materials
-  Appropriate noise levels or the availability of a microphone/speaker system
-  Comfortable and accessible seating options, especially for consumers who may utilize canes, walkers, or wheelchairs

[Click each marker on the right to review best practices tips.](#)

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.

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 your presentation. Ensure a microphone/speaker system is available.

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).

ADA Venue Considerations (Slide Layer)

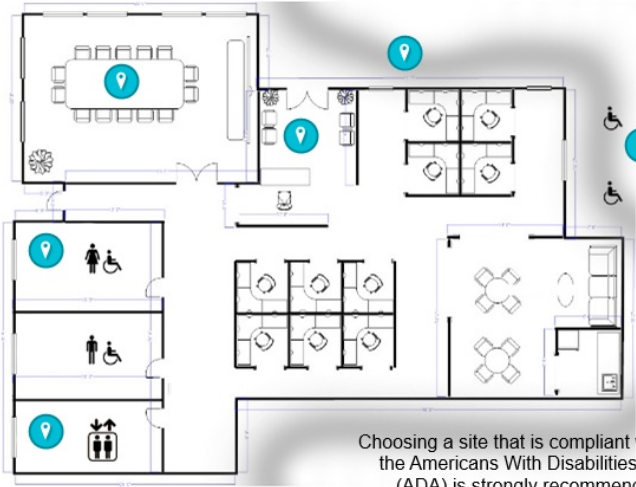
Venue Selection

Venue Selection Considerations

ADA Venue Considerations

Venue Guidelines

Online Guidelines



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 accessibility features you need to consider.

The diagram shows a floor plan of a venue with several rooms. Blue location markers are placed in various areas: a large conference room, a smaller meeting room, a reception area, and a restroom. Each marker is accompanied by a small icon representing a specific accessibility feature, such as a wheelchair, a person with a cane, or a person with a hearing aid.

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 Telesales 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...

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

Venues should have...

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

Venues should have...

Handicap and/or senior parking stalls close to entrances.

Venues should have...

Handicap accessible restrooms.

Venues should have...

Ramps and/or elevators as an alternative to stairs.

Venue Guidelines (Slide Layer)

Venue Selection

Venue Selection Considerations

ADA Venue Considerations

Venue Guidelines

Online 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).
 - Venues or areas of venues that may negatively impact UnitedHealthcare's reputation, such as where gambling activities takes place.

Best Practices of helping people find you:

- Make a reasonable attempt to notify the venue front desk staff, manager, or other appropriate employees of the event, room number/location, and time of your event so staff can direct consumers appropriately to your location. Use approved signage to direct consumers, if allowed by the venue.

Remember to use discretion when selecting a venue to ensure the reputation of UnitedHealthcare is not compromised.

Did you know...?

Events may be conducted in common areas of healthcare facilities (e.g., conference and recreation rooms).

Did you know...?

It is acceptable to hold an event in an area completely separate from gambling activities, such as a conference room.

Did you know...?

It is acceptable to hold an event in an area completely separate from gambling activities, such as a conference room.

Online Guidelines (Slide Layer)

Venue Selection

Venue Selection Considerations

ADA Venue Considerations

Venue Guidelines

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.
- Create a resource by recording a live online event. A recorded online event is considered a marketing material and is subject to all rules, including required submission to CMS.

Agents may:

- Use the Medicare Made Clear® presentation.
- 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 and advise the consumer may contact the agent to schedule a future appointment.
- Obtain PTC in a compliant manner. For example, the agent may provide compliant call-to-action - Permission to Contact text in the online meeting chat. The agent must collect any PTC provided from the online meeting service provider. All PTC guidelines including retention apply.

4.3 Event Reporting

Event Reporting

- UnitedHealthcare Reporting Policy
- Reporting Basics
- Reporting Changes
- Cancellations of Events
- Related Infractions



UnitedHealthcare Reporting Policy (Slide Layer)

Event Reporting

- UnitedHealthcare Reporting Policy
- Reporting Basics
- Reporting Changes
- Cancellations of Events
- Related Infractions

After you have determined the type and format of the event you want to conduct, and selected an appropriate venue, it's time to report your event to UnitedHealthcare. Marketing/sales events must be in UnitedHealthcare's event reporting application, according to its event reporting rules, prior to advertising and no less than **7 calendar days** prior to the event.

All agents must use the NEW Event Request Form, located in **Jarvis**, to report their marketing/sales events (**Jarvis**> Sales & Marketing Tools> Sales Materials (header)> scroll down to Compliance documents> 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: UnitedHealthcare only requires agents to report formal and informal marketing/sales events, including online events.


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


Did you know?

New Event Request Forms submitted within 7 calendar days of the date of the event will not be processed. Conducting an unreported marketing/sales event is prohibited.
Note: Educational events are not reported to UnitedHealthcare.

Reporting Basics (Slide Layer)

Event Reporting	UnitedHealthcare Reporting Policy	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:
	Reporting Basics	Where will the event be conducted? <ul style="list-style-type: none">List the venue street address, city, state, ZIP code, and phone number. 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.
	Reporting Changes	When will the event be conducted? <ul style="list-style-type: none">Indicate the date of the event.Report a start and end time.
	Cancellations of Events	<ul style="list-style-type: none">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.
	Related Infractions	Who is conducting the event? <ul style="list-style-type: none">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 licensed and appointed, product certified, and have passed the Events Basics test as required.

Event Reporting	UnitedHealthcare Reporting Policy	
	Reporting Basics	What type and format of event will be conducted? <ul style="list-style-type: none">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.
	Reporting Changes	What products will be presented?  <ul style="list-style-type: none">For formal marketing/sales events, select the primary product you intend to present. For example, select "Dual" if you intend to present a Dual 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.
	Cancellations of Events	
	Related Infractions	

Related Infractions	 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.
---------------------	--

Did you know?

Report your event as an informal marketing/sales if it will consist of a short introductory presentation, that does not include plan specific information, immediately followed by an opportunity for consumers to approach you (at a booth or table) to ask questions, receive plan information, obtain your business card/contact information, schedule a future appointment, or any other marketing activity. All compliance rules for an informal marketing/sales event would apply and you must make sure any event advertising is consistent with a marketing/sales event.

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.

Reporting Changes (Slide Layer)

Event Reporting

- UnitedHealthcare Reporting Policy
- Reporting Basics
- Reporting Changes
- Cancellations of Events
- Related Infractions

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

I have an event scheduled this afternoon that I want to cancel because I have a consumer who wants to meet with me at their home. Can I do that?

Canceling an event within 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 within one (1) business day is unavoidable, contact your UnitedHealthcare sales leader immediately to decide on a course of action.

Can I change or cancel my event that is more than one (1) business day from today?

First, work with your UnitedHealthcare sales leader to find a replacement agent. If cancellation or change is unavoidable, submit the 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.**

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 must be followed. Remember, NEW Event Request Forms submitted within 7 calendar days of the event will not be processed.

Cancellations of Events (Slide Layer)

Event Reporting


- UnitedHealthcare Reporting Policy
- Reporting Basics
- Reporting Changes
- Cancellations of Events
- Related Infractions

Cancellation Procedures

When a reported event is canceled, or a change to the venue, date, or time of an event in effect cancels the original event, follow these cancellation procedures:

- * Notify all consumers who RSVP'd to your event that the event was canceled or, if applicable, the date, time, or venue was changed.
- * 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 canceled within 7 calendar days of 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 a formal event and for the entire advertised time for an informal event to redirect any consumer who arrives for the event.

Note: Cancellation procedures also apply to online events.



Note!

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.

Related Infractions (Slide Layer)

Event Reporting

- UnitedHealthcare Reporting Policy
- Reporting Basics
- Reporting Changes
- Cancellations of Events
- Related Infractions

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:

Select each type of reported information button to learn more.

Unreported Event

Late Reported Event

Late Reported Change/Cancellation

Unreported Event (Slide Layer)

Event Reporting

Unreported Events

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:

An **unreported event** is one where the agent simply fails to report an event to UnitedHealthcare.

In some instances, events are simply 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.

Close

Late Reported Event (Slide Layer)

Event Reporting

Unreported Events

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:

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.
- Depending on the nature of the change, make sure to submit changes to previously reported events no less than 7 calendar days prior to the date of the event, as some changes may require a new event to be reported.

Close

Late Reported Change / Cancellation (Slide Layer)

Event Reporting

Unreported Events

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:

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.

Close

4.4 Educational Events

Conducting an Educational Event

- Educational Events
- Advertising an Educational Event
- Materials and Activities
- Meals and Refreshments



Educational Events (Slide Layer)

Conducting an Educational Event

● Educational Events

● Advertising an Educational Event

● Materials and Activities

● Meals and Refreshments

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 (Slide Layer)

Conducting an Educational Event

● Educational Events

● Advertising an Educational Event

● Materials and Activities

● Meals and Refreshments

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 include the required 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 (Slide Layer)

Conducting an Educational Event

Materials and Activities

Any material distributed, displayed, or provided at an educational event must be free of marketing content such as plan/product names, plan benefits, or cost-sharing information. The following shows what an agent may and must not do at an educational event.

Click each icon below to review the may and must not compliance rules.

Agents May Do

Agents Must Not Do

● Educational Events

● Advertising an Educational Event

● Materials and Activities

● Meals and Refreshments

Materials and Activities - Permitted (Slide Layer)

Conducting an Educational Event

Materials and Activities - Permitted

Any material distributed, displayed, or provided at an educational event must be free of marketing content such as plan/product names, plan benefits, or cost-sharing information. The following shows what an agent may do at an educational event.

Agents may:

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, business cards free of marketing content, or Scope of Appointment forms.
- Attach personal business cards and contact information to educational materials.
- Have a banner or table skirt with the plan name and logo displayed.
- 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 & Marketing tools>Sales Materials>Promotional items**).
- 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?"

● Educational Events

● Advertising an Educational Event

● Materials and Activities

● Meals and Refreshments

Conducting an Educational Event

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 or if you prefer, we can set up an appointment to discuss your needs and plan options."

- Direct consumers to the plan's website or toll-free number (see Medicare Made Clear brochure).
- Accept completed BRCs and lead cards.
- Schedule future one-on-one marketing appointments and obtain Scope of Appointment forms.
- Promote future marketing/sales events and accept RSVPs.

● Educational Events

● Advertising an Educational Event

● Materials and Activities

● Meals and Refreshments

Materials and Activities - Prohibited (Slide Layer)

Conducting an Educational Event

Close

Materials and Activities - Prohibited

Any material distributed, displayed, or provided at an educational event must be free of marketing content such as plan/product names, plan benefits, or cost-sharing information. The following shows what an agent must not do at an educational event.

Agents must not:

Distribute, display, provide, or collect:

- Plan-specific materials such as Enrollment Guides or brochures.

Agents must not engage in any activity that meets CMS' definition of marketing, including:

- * Steering consumers toward a specific plan
- * Discussing or presenting plan-specific cost-sharing and/or benefits information
- * Distributing or displaying marketing materials
- * Completing or accepting an Enrollment Application or conducting any other enrollment-related activities.

Meals and Refreshments at an Educational Event (Slide Layer)

Conducting an Educational Event

● Educational Events

● Advertising an Educational Event

● Materials and Activities

● Meals and Refreshments

Meals and Refreshments at an Educational Event

When permitted by the venue, meals and refreshments may be offered as long as the retail value, when combined with any other giveaway, does not exceed \$15 on a per person basis.

Providing alcoholic beverages is prohibited.



4.5 Marketing/Sales Events

Marketing/Sales Events

- Advertising a Marketing/Sales Event
- Materials at a Marketing/Sales Event
- Meals and Refreshments
- Prohibited Activities
- Permitted Activities

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 properly contracted, licensed, appointed, and certified in order to represent UnitedHealthcare during any marketing/sales activity and/or event.



Advertising a Marketing/Sales Event (Slide Layer)

Marketing/Sales Events

- Advertising a Marketing/Sales Event
- Materials at a Marketing/Sales Event
- Meals and Refreshments
- Prohibited Activities
- Permitted Activities

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.

[Click on phrases from this advertising flyer to learn about the required information.](#)

?

 Learn about Medicare Advantage and Part D products.

?

 Eligible for a **free drawing** and prizes with no obligation!

?

 For accommodation of persons with special needs at sales meetings call 555-555-1234, TTY 711.

Note

All plan names and plan types that you will present during the event must be clearly stated

Note





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.

Note

In addition to this disclaimer, 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>Contact US*, scroll down to locate Interpreter Request form.

Materials at a Marketing/Sales Event (Slide Layer)

Marketing/Sales Events





Various types of materials may be used during a marketing/sales event.

Select the buttons to learn more about each type of material shown.

Close

Marketing Materials (Slide Layer)

Marketing/Sales Events

Various types of materials may be used during a marketing/sales event.

Select the buttons to learn more about each type of material shown.

Close

Marketing Material

You may display, distribute and provide marketing materials at marketing/sales events that are current and pre-approved by a plan sponsor (such as UnitedHealthcare) and/or CMS. Marketing materials include those that:

- Promote a plan sponsor, Medicare Advantage plan, or Prescription Drug plan.
- Inform Medicare members that they may enroll or remain enrolled in these plans.
- Explain the benefits of enrollment and/or the rules applicable to these plans.
- Explain how services are covered and/or conditions of coverage.





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.

Close

Visual Materials (Slide Layer)

Marketing/Sales Events

Various types of materials may be used during a marketing/sales event.

Select the buttons to learn more about each type of material shown.

Visual Material

Agents may:

- Use a banner or table skirt with the plan name and logo displayed.
- Wear a shirt and/or name badge with approved plan names and/or logos (e.g., those purchased from the UnitedHealthcare Group Merchandise eStore (**Jarvis > Sales & Marketing tools > Sales Materials > Promotional items**)).
- Display, distribute, and provide business reply cards, lead cards, sign-in sheets, and business cards.





Agents must:

- Post a disclaimer outlining non-discrimination requirements on the basis of race, color, national origin, sex, age or disability according to Section 1557 of the Affordable Care Act (ACA) at all events where UnitedHealthcare Medicare Advantage and Part D health plans are exclusively marketed and sold.

Close

Educational Materials (Slide Layer)

Marketing/Sales Events

Various types of materials may be used during a marketing/sales event.

Select the buttons to learn more about each type of material shown.

Educational Material


Although distinct from educational events, marketing/sales events may include educational content. Agents may distribute, display, or provide:

- Educational information, including UnitedHealthcare-branded Medicare Made Clear materials that are free of plan-specific information such as premiums, copayments, or agent contact information.
- Educational materials (not specific to any plan) on general health care related topics, such as diabetes awareness and prevention, and high blood pressure information.

Close

Generic Materials (Slide Layer)

Marketing/Sales Events



Various types of materials may be used during a marketing/sales event.

Select the buttons to learn more about each type of material shown.

Generic Material

Agents are strongly advised to only use materials currently available through the UnitedHealthcare Toolkit or Sales Material Portal when conducting marketing/sales events rather than agent-created, generic material. By doing so, you will know that your materials have been approved by UnitedHealthcare and CMS. Remember that materials must be used in the approved format and for the use intended.

Agents may display, distribute, and provide agent-created generic material at a marketing/sales event provided the material is current and meets all the requirements pertaining to generic material.

Agent-created generic materials do not require UnitedHealthcare and/or CMS approval prior to use. To be considered generic, the material must:

- Be free of plan-specific information, such as plan names, benefits, and premiums.
- Not meet CMS' definition of marketing material.
- Not contain any UnitedHealthcare product or plan name or logo.
- Include any appropriate disclaimers.
- Comply with the applicable Medicare Communications and Marketing Guidelines and UnitedHealthcare rules, policies, and procedures.

Meals and Refreshments at an Educational Event (Slide Layer)

Marketing/Sales Events

● Advertising a Marketing/Sales Event

● Materials at a Marketing/Sales Event

● Meals and Refreshments

● Prohibited Activities

● Permitted Activities

Meals and Refreshments at a Marketing/Sales Event

Meals may 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 may not be conducted during the serving time of the meal.

When permitted by the venue, agents may offer light refreshments or snacks, but cannot bundle the food items in a manner that would constitute a meal. The retail value of food items, when combined with any other giveaway, must not exceed \$15 on a per-person basis. 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.



Prohibited Materials at a Marketing/Sales Event (Slide Layer)

Marketing/Sales Events	
● Advertising a Marketing/Sales Event	<p>Prohibited Activities at a Marketing/Sales Event:</p> <p><u>Prohibited activities</u> at a marketing/sales event include, but are not limited to:</p> <ul style="list-style-type: none">• 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 an unsubstantiated absolute or qualified superlative that is not already contained in approved materials. Nor may such information be used out of context or in a way that is misleading. Superlatives are words like "the best" or "one of the best." Consider instead using specific information about the plan that demonstrates actual value, such as giving a closely approximate number of in network physicians.• Soliciting or accepting enrollment applications from consumers who are not eligible for a qualifying election period (e.g., Annual Election Period or Special Election Period) as set by CMS. <p>Additional prohibited activities at a marketing/sales event include:</p> <ul style="list-style-type: none">• 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.
● Materials at a Marketing/Sales Event	
● Meals and Refreshments	
● Prohibited Activities	
● Permitted Activities	

Marketing/Sales Events	
● Materials at a Marketing/Sales Event	<ul style="list-style-type: none">• 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 agreed in writing to the comparison and/or the material has been approved by CMS.• Employing scare tactics or what could be perceived as one and/or interjecting personal opinion regarding the plan sponsor, government programs or entities, a competitor's plans or financial situation, political environment/elections, etc.• Using or displaying a roster or RSVP listing at the event for any purpose, including to verify attendance.
● Meals and Refreshments	
● Prohibited Activities	
● Permitted Activities	

Permitted Materials at a Marketing/ Sales Event (Slide Layer)

Marketing/Sales Events	● Advertising a Marketing/Sales Event	Permitted Activities at a Marketing/Sales Event: In addition to the permitted activities already mentioned, when conducting a marketing/sales event, you may: <ul style="list-style-type: none">• Use a CMS-approved presentation, handouts, and other approved marketing material.• Accept and assist in the completion of enrollment applications during a valid marketing and election period.• Provide and obtain a Scope of Appointment form for a subsequent personal/individual marketing appointment.• Provide the names and contact information of providers contracted with a particular plan when asked by a consumer.• Conduct a marketing/sales event immediately following an educational event at the same venue provided that both events are conducted separately and according to applicable guidelines. For example, agents must advise consumers attending the educational event that the event is shifting to a marketing/sales event and provide any consumer present the opportunity to leave. No marketing materials may be displayed or distributed at the educational event and no meal may be served during the marketing/sales event. Event advertising must include details related to both the educational event and marketing/sales event.
	● Materials at a Marketing/Sales Event	
	● Meals and Refreshments	
	● Prohibited Activities	
	● Permitted Activities	

4.6 Marketing/Sales Events Presenting

Marketing/Sales Events: Presenting	● Presenting a Plan at a Marketing/Sales Event	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 properly contracted, licensed, appointed, and certified in order to represent UnitedHealthcare during any marketing/sales activity and/or event.
	● Introductory Presentation of Educational Information	
	● Conducting an Informal Marketing/Sales Event	
	● UnitedHealthcare MedicareStore	
	● Enrollment Activities	



Presenting a Plan at a Marketing/Sales Event (Slide Layer)

Presenter Conduct

Sign In

Marketing Materials

Enrollment Forms

Election Periods

Rx: Coverage/Cost Sharing Stages

Rx: Formularies, Tiers and Step Therapy

Pharmacy Networks

MA Plans

Dual SNP

Chronic Condition SNP

Star Ratings

Health Care Reform


Presenting a Plan at a Marketing/Sales Event

You are required to provide a lot of information to consumers when presenting a plan during a marketing/sales event. There are a number of tools and resources available to help you prepare for and give a compliant presentation, including the Agents Events Job Aid, Agent Marketing Sales Event Checklist, Clarity Guide, and Clarity Video. These resources are available on **Jarvis**. Go to **Jarvis**>Sales & Marketing tools>Sales Materials (header)> scroll to Compliance documents>Events for the Events Job Aid and Agent Checklist. The Clarity Guide and Clarity Video are located on the UnitedHealthcare Toolkit.

Click each topic on the left to see the statements Phil makes during a marketing/sales event, as well as the guidance Marco provides behind the scenes.

Click the close button after you have reviewed each tab and want to return to the main page.

Close



Did you know?

If you have reported a formal marketing/sales event, but only one consumer attends, you may conduct the event in a less formal manner, such as by sitting at a table with the consumer. However, you must still provide the consumer with the entire presentation just as if there were several consumers present.

Presenter (Slide Layer)

Presenter Conduct

Sign In

Marketing Materials

Enrollment Forms

Election Periods

Rx: Coverage/Cost Sharing Stages

Rx: Formularies, Tiers and Step Therapy

Pharmacy Networks

MA Plans

Dual SNP

Chronic Condition SNP

Star Ratings

Health Care Reform

Close


Hello and welcome. I am Phil Mortenson, a UnitedHealthcare representative. Today I will present a Medicare Advantage...

I'm going to cover several slides in my presentation, but feel free to stop me if you have a question or if my pace is too fast.

Introduce yourself, the plan sponsor you represent, the plan, and plan type you are presenting. Contracted agents may also include their affiliation with an agency.

Don't rush your presentation or skip any portion of the presentation. You want your attendees to be well-informed so they can make the best possible plan choice.

GUIDANCE





Sign In (Slide Layer)

- Presenter Conduct
- Sign In
- Marketing Materials
- Enrollment Forms
- Election Periods
- Rx: Coverage/Cost Sharing Stages
- Rx: Formularies, Tiers and Step Therapy
- Pharmacy Networks
- MA Plans
- Dual SNP
- Chronic Condition SNP
- Star Ratings
- Health Care Reform

Close

Hi. Welcome to our Medicare Advantage presentation. If you'd like, please sign in on this sheet, but it is completely optional.

If you choose to use a sign-in sheet, it is recommended that you download the one available on the **UnitedHealthcare Toolkit** to ensure compliance. In addition, when inviting consumers to sign-in, you must verbally state that providing any information is completely optional. It is not compliant to give any indication that signing-in is required. Do not use any type of roster, such as an RSVP list, as a sign-in sheet. Remember, a sign-in sheet does not provide permission to contact.

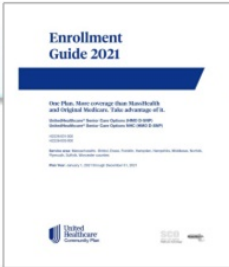

GUIDANCE

Marketing (Slide Layer)

- Presenter Conduct
- Sign In
- Marketing Materials
- Enrollment Forms
- Election Periods
- Rx: Coverage/Cost Sharing Stages
- Rx: Formularies, Tiers and Step Therapy
- Pharmacy Networks
- MA Plans
- Dual SNP
- Chronic Condition SNP
- Star Ratings
- Health Care Reform

Close

I'd like to review the Summary of Benefits with you. Let's open our Enrollment Guide to page X where the Summary of Benefits begins.

When referring to materials during presentations, verbally state the name of the document and where it is located.

GUIDANCE

Enrollment (Slide Layer)

Presenter Conduct

Sign In

Marketing Materials

Enrollment Forms

Election Periods

Rx: Coverage/Cost Sharing Stages

Rx: Formularies, Tiers and Step Therapy

Pharmacy Networks

MA Plans


Dual SNP

Chronic Condition SNP

Star Ratings

Health Care Reform


In the Enrollment Guide, we have the details you need about this plan, including the enrollment application. If you choose to enroll, the application is simple and we can fill it out together when the time is right.



When referring to materials during presentations, verbally state the name of the document and where it is located.

Close

GUIDANCE



Election Periods (Slide Layer)

Presenter Conduct

Sign In

Marketing Materials

Enrollment Forms

Election Periods

Rx: Coverage/Cost Sharing Stages

Rx: Formularies, Tiers and Step Therapy

Pharmacy Networks

MA Plans

Dual SNP

Chronic Condition SNP

Star Ratings

Health Care Reform

Medicare provides election periods when you can enroll in or leave a Medicare Advantage or Prescription Drug plan. The Annual Election Period, which runs from October 15 through December 7, is the time when any Medicare beneficiary can enroll in a Medicare Advantage or Prescription Drug plan for the first time, switch to a different plan, or disenroll from their Medicare Advantage plan and return to Original Medicare.


Individuals enrolled in any Medicare Advantage plan have an Open Enrollment Period from January 1 through March 31 to make a one-time election to enroll in another Medicare Advantage plan or return to Original Medicare, with or without a stand-alone Prescription Drug Plan. If you are new to Medicare, you have a similar Open Enrollment Period, but only during the first three months in which you have Medicare Parts A and B.

If you have a special circumstance, for example you move out of the plan's service area, you might be eligible for a Special Election Period. A Special Election Period allows you to enroll in or disenroll from a Medicare Advantage or Prescription Drug plan outside of the Annual Election Period or Open Enrollment Period. A Special Election Period is available for a number of circumstances. Together we can figure out what is best for your situation.

You must explain that a valid election period is required to enroll in or disenroll from a plan. More details are available in the Ethics and Compliance certification section or Election Period booklet (**Jarvis** >Knowledge Center> Learning Lab, content library, Enrollment (course)). You may want to carry the Election Period booklet with you as a handy reference.

Close

GUIDANCE



RX-Coverage (Slide Layer)

Presenter Conduct

Sign In

Marketing Materials

Enrollment Forms

Election Periods

Rx: Coverage/Cost Sharing Stages

Rx: Formularies, Tiers and Step Therapy

Pharmacy Networks

MA Plans

Dual SNP

Chronic Condition SNP

Star Ratings

Health Care Reform

We've covered how you can obtain prescription drug coverage, now let's go over the costs that are shared between you and the plan.

You pay a **premium** to the Plan to receive coverage, and if you have had gaps in prescription drug coverage since you first became eligible, you may incur a late enrollment penalty. We'll cover that penalty in detail a little later.

If the plan has a **deductible**, you will pay all drug costs until you reach that amount. Once you meet the deductible, you will enter the **Initial Coverage** stage. In this stage, you and the Plan share costs. You pay copays or coinsurance and the Plan pays the rest. Once the total drug costs paid by you and the Plan reach \$4,430 for the plan year, you move to the Coverage Gap.


In the **Coverage Gap**, you pay 25% for brand-name drugs and generic drugs. Once True Out-of-Pocket (TrOOP) costs reach \$7,050, you move to the last stage.

When you are in the **Catastrophic Coverage** stage, you only pay a small copay or coinsurance for drugs and the Plan pays the rest of the cost until the end of the year. In this stage, you pay the greater of \$3.95 for generic drugs and \$9.85 for brand-name drugs or 5% of total drug costs.

Note: Dollar amounts, including copayments/coinsurance, are adjusted annually by CMS. Always refer to cost sharing amounts for the plan year you are presenting.

You must explain what the cost-sharing will be for the plans you are presenting, including all the details and costs in each drug coverage stage. It can be complicated to understand all of this, so use slides or other handouts to explain drug costs. The Enrollment Guide and the Clarity Guide have good examples to share with consumers.

Close



GUIDANCE

RX Formularies (Slide Layer)

Presenter Conduct

Sign In

Marketing Materials

Enrollment Forms

Election Periods

Rx: Coverage/Cost Sharing Stages

Rx: Formularies, Tiers and Step Therapy

Pharmacy Networks

MA Plans

Dual SNP

Chronic Condition SNP

Star Ratings

Health Care Reform

With drug coverage, you also need to understand formularies and tiers. A formulary is a list of drugs covered by the plan. The medications are grouped by tiers, which indicate different levels of coverage and costs. Medications within a specific tier have the same cost. To look at this plan's formulary, let's turn to page X in your Enrollment Guide.

There are other aspects of drug coverage to understand including Step Therapy, Quantity Limits, and Prior Authorization. With Step Therapy, you may be required to first try an effective, clinically proven, lower-cost alternative to the drug prescribed. You may also have to request that a particular medication be covered prior to the pharmacist filling the prescription. This is called Prior Authorization. For some medications, the Plan may limit the quantity of the drug that can be dispensed at one time by the pharmacist.

You or your provider may ask the Plan to make an exception to the formulary, tiering, and utilization restrictions. The process is explained in your "Evidence of Coverage" and on the plan website. In brief, you can make the request by calling UnitedHealthcare Customer Service at 1-555-555-5555. Your prescriber or physician should submit a statement supporting your request. You will receive a coverage decision within 72 hours after receiving your prescribing physician's statement.


I know we've covered a lot about prescription drug coverage. You can read more about it on the Plan's website or [medicare.gov](https://www.medicare.gov).

You must help the consumer understand all the components of drug coverage, what a formulary is, drug tiers, network pharmacies, step therapy, and the drug exception process.

Provide websites where consumers can do more research on their own.

www.aarpmedicareplans.com and www.medicare.gov

Close



GUIDANCE

Disclaimer

Phone number is for illustrative purposes only. Consult plan materials for the phone number for the plan you are presenting.

Pharmacy Networks (Slide Layer)

Presenter Conduct

Sign In

Marketing Materials

Enrollment Forms

Election Periods

Rx: Coverage/Cost Sharing Stages

Rx: Formularies, Tiers and Step Therapy

Pharmacy Networks

MA Plans

Dual SNP

Chronic Condition SNP

Star Ratings

Health Care Reform

Now, let's look at where you can obtain your prescription drugs. We work with a variety of national, regional and local pharmacies to provide you with plenty of availability and convenience. In addition, some of these pharmacies are contracted with us as "preferred" pharmacies and they offer discounts on certain medications. Of course, you can choose to go to a pharmacy that is not in our network, but your prescriptions may cost you more.

Risk Ahead Click the sign to read tips to avoid Complaints

Tools to help you choose a plan
Get a Plan Recommendation
Drug Cost Estimator
Pharmacy Search
Provider Search

Be sure to review the pharmacy networks available with the consumer. Go to the website at aarpmedicareplans.com to show them the list.

Close

GUIDANCE

Pharmacy Network Risk (Slide Layer)

Risk

Confused About Prescription Drug Coverage Costs

A common member complaint is that they didn't understand the costs associated with prescription drug coverage. If the consumer submits an enrollment application after attending your event, call them upon receiving the application to review each of their prescription medications to ensure they understand if the drug is on the formulary, what tier it is in, if there are any utilization management restrictions, and how much it will cost. In addition, make sure their pharmacy is in the network and explain the cost associated with using an out-of-network pharmacy.

Continue

MA (Slide Layer)

Presenter Conduct

Sign In

Marketing Materials

Enrollment Forms

Election Periods

Rx: Coverage/Cost Sharing Stages

Rx: Formularies, Tiers and Step Therapy

Pharmacy Networks

MA Plans

Dual SNP

Chronic Condition SNP

Star Ratings

Health Care Reform


To get the most cost effective coverage, you should see providers that are in network. Of course, you can always see a doctor that is not in network, but you will probably pay more for services. One way to see if your provider is in-network is to use the plan's online provider directory. Also, some plans require referrals from your primary care doctor for specialist and hospital visits. The HMO plan I am presenting today has a referral requirement.

Some of the services may not be covered at all or at a reduced level. If you are in an emergency situation you may use non-network providers.

Risk Ahead

Click the sign to read tips to avoid Complaints

Close



GUIDANCE

You must explain networks and costs associated with going out of network. You must also explain consumers/members may use a non-network provider in an emergency situation. Also discuss if there is a provider referral requirement for the plan.

MA- Out of Network Costs (Slide Layer)

Risk

Out-of-Network Costs

A common member complaint is that they didn't understand the provider network and the costs associated with using an out-of-network provider. If the consumer submits an enrollment application after attending your event, call them upon receiving the application to review each of their providers, including their primary care physician (PCP), specialists, and hospitals. To avoid a PCP auto-assignment infraction, make sure their PCP is in-network. Correctly enter the PCP's name and ID on the enrollment application and check "Existing Patient", if applicable.

Make sure the consumer understands that for HMO plans there is no coverage when using an out-of-network provider (except in an emergency) and that for POS and PPO plans, an out-of-network provider does not have to accept the Plan's terms and conditions of payment; therefore, the consumer may be responsible for the entire cost of services provided.

Continue

Dual SNP (Slide Layer)


Presenter Conduct
Sign In
Marketing Materials
Enrollment Forms
Election Periods
Rx: Coverage/Cost Sharing Stages
Rx: Formularies, Tiers and Step Therapy
Pharmacy Networks
MA Plans
Dual SNP
Chronic Condition SNP
Star Ratings
Health Care Reform

We talked about the enrollment periods earlier, but because we're talking about a Dual Special Needs Plan, I'd like to focus on some enrollment details that pertain to this plan. Completing the enrollment application isn't a guarantee that you'll be enrolled into this Dual Special Needs Plan.

First, the Plan has to confirm your Medicaid status. Once that is confirmed, you will be enrolled. In the future, if you want to enroll in a different Dual Special Needs Plan, you have a special election period where you can enroll in a new plan once per quarter every January through September.

Drug coverage cost sharing is the same as what you pay with Medicaid -- the drug costs will be the same, if the drug is in the formulary. You just show both your member ID and Medicaid cards when you go to the pharmacy.

If you lose your Medicaid status, you will be notified that you will be disenrolled from the Plan and the effective date of the disenrollment.

Close

When presenting a Dual Special Needs Plan, you must explain the Special Election Period, dual status verification, drug cost sharing, changes in Medicaid status, and the impact of changes in Medicaid status.

Remember, you can always open the certification guide that covers Dual Special Needs Plans to review the content.


GUIDANCE

Chronic Condition (Slide Layer)

Presenter Conduct
Sign In
Marketing Materials
Enrollment Forms
Election Periods
Rx: Coverage/Cost Sharing Stages
Rx: Formularies, Tiers and Step Therapy
Pharmacy Networks
MA Plans
Dual SNP
Chronic Condition SNP
Star Ratings
Health Care Reform

We talked about the enrollment periods earlier, but because we're talking about a Chronic Condition Special Needs Plan, I'd like to focus on some enrollment details that pertain to this plan. If you have been diagnosed with a qualifying chronic condition, such as diabetes, you are entitled to what is called a Special Election Period. That means you can enroll any time of the year, but once you enroll in a plan that covers that condition, you can no longer use that election and would have to wait until the Annual Election Period, which starts October 15, to enroll in a different plan that covers that same condition.

Completing the enrollment application isn't a guarantee that you'll be enrolled into this Chronic Condition Special Needs Plan. We can complete the enrollment application, but the Plan has to confirm your chronic condition with your physician. If the Plan can't verify you have a qualifying condition, you will be notified that you will be disenrolled from the plan and the effective date of the disenrollment.

Close

When presenting a Chronic Condition Special Needs Plan, you must explain the election period and chronic condition verification.

Remember, you can always open the certification section that covers Chronic Special Needs Plans to review the content.

GUIDANCE

Star Ratings (Slide Layer)

Presenter Conduct
Sign In
Marketing Materials
Enrollment Forms
Election Periods
Rx: Coverage/Cost Sharing Stages
Rx: Formularies, Tiers and Step Therapy
Pharmacy Networks
MA Plans
Dual SNP
Chronic Condition SNP
Star Ratings
Health Care Reform

The Centers for Medicare & Medicaid Services (CMS) uses Star Ratings to rate the quality of Medicare Advantage Plans and Part D Prescription Drug Plans. The ratings for all plans are published publicly on www.Medicare.gov.


This Medicare Advantage Plan has a Star Rating of X out of 5 stars. Let's open our Enrollment Guide to page X so you can see the rating noted. You can also go to medicare.gov for even more information.

Some of the things used to rate a plan include:

- How our members rate our plan's service and care
- How well our doctors detect illnesses and keep members healthy
- How well our plan helps our members use recommended and safe prescription medications

During your presentation, refer directly to the page in the Enrollment Guide where the Star Rating is listed. Explain a couple of the measures used to calculate the rating.

You will find tools in Learning Lab (Learning Lab/Content Library/Star Ratings) that offer ideas for discussion points on Star Ratings. Consumers can visit www.medicare.gov to find more information on Star Ratings.



Close


GUIDANCE

Healthcare Reform (Slide Layer)

Presenter Conduct
Sign In
Marketing Materials
Enrollment Forms
Election Periods
Rx: Coverage/Cost Sharing Stages
Rx: Formularies, Tiers and Step Therapy
Pharmacy Networks
MA Plans
Dual SNP
Chronic Condition SNP
Star Ratings
Health Care Reform

Thanks for the question about health care reform. I'm not an expert on that topic, but you can read more about health care reform at <https://www.unitedhealthgroup.com>.

Agents should focus on the plan presentation and refer consumers with questions related to health insurance news items, the political landscape and legislation, etc. to other sources.



Close

GUIDANCE

Introductory Presentation of Educational Information (Slide Layer)

Marketing/Sales Events: Presenting

- Presenting a Plan at a Marketing/Sales Event
- Introductory Presentation of Educational Information
- Conducting an Informal Marketing/Sales Event
- UnitedHealthcare MedicareStore
- Enrollment Activities

Introductory Presentation of Educational Information

Informal Marketing/Sales Event with an Introductory Presentation of Educational Information

This event format begins with an introductory presentation of educational information by an agent, a non-licensed UnitedHealthcare representative (e.g., market manager), or a non-UnitedHealthcare representative (e.g., a provider) to the attendees.

Report this type of event as an informal marketing/sales event. Refer to event reporting instructions on the 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 (consumer's must approach the agent and initiate discussion).
- No plan-specific information can be presented, such as 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.

Prohibited Informal Marketing/Sales Event (Slide Layer)


Marketing/Sales Events: Presenting

Informal Marketing/Sales Event - Prohibited

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 PHI/PII.



Continue

Permitted Informal Marketing/Sales Event (Slide Layer)

Marketing/Sales Events: Presenting

Informal Marketing/Sales Event - Permitted

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.

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 refreshments if permitted by the venue.
- Starting the event with a short introductory presentation consisting of educational (not plan-related) content.



Close

UnitedHealthcare MedicareStore (Slide Layer)

Marketing/Sales Events: Presenting

- Presenting a Plan at a Marketing/Sales Event
- Introductory Presentation of Educational Information
- Conducting an Informal Marketing/Sales Event
- UnitedHealthcare MedicareStore
- Enrollment Activities

Staffing a UnitedHealthcare MedicareStore

Generally speaking, all other 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.
- Enrolling consumers provided the consumer has a valid election period.

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.
- If a formal or informal marketing/sales event takes place within a UnitedHealthcare MedicareStore, all guidelines, regulations, rules, policies, and procedures related to marketing/sales events apply. As an example, formal marketing/sales meetings must be reported separately when using space inside the store for the meeting.
- Complying with all health, safety, and security protocols established for the location.

Marketing/Sales Events: Presenting

- Conducting an Informal Marketing/Sales Event
- UnitedHealthcare MedicareStore
- Enrollment 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.
- If a formal or informal marketing/sales event takes place within a UnitedHealthcare MedicareStore, all guidelines, regulations, rules, policies, and procedures related to marketing/sales events apply. As an example, formal marketing/sales meetings must be reported separately when using space inside the store for the meeting.
- Complying with all health, safety, and security protocols established for the location.

Enrollment Activities (Slide Layer)

Marketing/Sales Events: Presenting

- Presenting a Plan at a Marketing/Sales Event
- Introductory Presentation of Educational Information
- Conducting an Informal Marketing/Sales Event
- UnitedHealthcare MedicareStore
- Enrollment Activities

Enrollment Activities at a Marketing/Sales Event

All guidelines related to enrolling consumers apply, but remember these rules when conducting 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. Without a valid election period, enrollments are not accepted by CMS.
- Never offer or give the perception that you are offering to hold an enrollment application and submit it at a later date.
- At the time of enrollment, the consumer must have CMS-required documents, which include the Summary of Benefits, Pre-Enrollment Checklist, and Star Ratings. To ensure consumer's have the correct required information, we strongly recommend providing the Enrollment Guide to the consumer instead of individual required 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.
- You may enter your writing number (Agent ID) on the paper enrollment application in advance. But you must not enter your name, sign, or date the enrollment application until the consumer is prepared to enroll and completed their portions of the application.

For example...

During a marketing/sales event conducted on October 10, do not solicit and/or accept a completed enrollment application with an election period of AEP (Annual Election Period). However, if a consumer is enrolling in the current year's plan using an SEP (Special Election Period), you could accept their enrollment application.

For example...

During a marketing/sales event conducted on October 10, do not solicit and/or accept a completed enrollment application with an election period of AEP (Annual Election Period). However, if a consumer is enrolling in the current year's plan using an SEP (Special Election Period), you could accept their enrollment application.

4.7 Provider-Based Activities at Events


Provider-Based Activities

- Providers Must Not
- Providers May

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 (Slide Layer)

Provider-Based Activities

Providers Must Not

Providers May



Activities at Events

Providers must not...

Related to their Practice or Business:

- Use the event as an opportunity to promote their business or practice
- Actively hand out materials about their practice, business or service
- Sell products or offer sample items to consumers
- Provide health screenings and/or tests
- Accept compensation for participating in or attending an event

Related to the Plan:

- Attempt to steer consumers to plans based on the provider's financial or other interests
- Distribute marketing materials (including Scope of Appointment forms) or accept enrollment applications
- Discuss or answer questions about plan specific features (benefits, premiums, etc.)

Providers May (Slide Layer)

Provider-Based Activities

Providers Must Not

Providers May



Activities at Events

Providers may...

Related to their Practice or Business:

- 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, at educational or marketing/sales events. Such as diabetes, hearing health, or how a medical device works
- Answer general questions about the topic presented or their area of expertise

Related to the Plan:

Post generic event information on their website or other provider created material. Note: the agent and provider must have contracts (benefits, premiums, etc.)

4.8 Giveaways

Giveaways



Giveaways

Agents may provide a giveaway to consumers at an event as long as the giveaway is of nominal value and is provided whether or not the consumer enrolls in the plan. **Note that these guidelines are the same for educational and marketing/sales events.**

The following guidelines apply to giveaway items:

- The retail value of all giveaways, combined with the retail value of meals and refreshments, must not exceed \$15 on a per-person basis.
- Regardless of dollar amount, the following items may not be used as giveaways: money, gift cards, 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.

The following are additional guidelines that apply to giveaway items:

- 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 and Drawings

When no prize, regardless of value, is to be awarded to a contest winner, agents may conduct in-person or online games of chance (e.g., BINGO) or games of skill (e.g., trivia) without obtaining approval from

games of skill (e.g., trivia) without obtaining approval, from UnitedHealthcare and completing Rules of Entry documentation requirements. Examples of acceptable acknowledgement of a winner include applause or certificate.

- When a nominal prize (does not exceed \$15 in combination with all other giveaways, including refreshments) is to be awarded to a contest winner, 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 on Jarvis) 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.
- Agents must obtain written approval from UnitedHealthcare prior to reporting and conducting an event where a drawing will be conducted with a prize worth more than \$15. A detailed contest proposal must be submitted to compliance_questions@uhc.com at least 30 days prior to the anticipated event date to ensure event reporting requirements can be met. When approved, requirements outlined above must be met except for the nominal value limit and includes the additional requirement that winners awarded a prize of \$30 or more must sign a liability waiver.

Giveaways



4.9 Event Observation and Oversight

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 Solutions 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.



5. Special Needs Plans

5.1 Special Needs Plans (SNP)

Special Needs Plans Overview

- Overview
- Who
- What
- How
- SNP Plan List

Special Needs Plans (SNP)



[Click each tab to learn more.](#)

Overview (Slide Layer)

Special Needs Plans Overview

Overview

Who

What

How

SNP Plan List

All SNPs are MA Plans. These plans are designed for specific Medicare consumer populations to provide focused and specialized care. Generally, if a SNP is available, these plans are in the best interest of eligible consumers.

The Centers for Medicare & Medicaid Services (CMS) allows plan sponsors to offer these types of SNPs:

- **Chronic Condition** SNP (CSNP)
- **Dual Eligible** SNP (DSNP)
- **Institutional** SNP (ISNP)
- **Institutional Equivalent** SNP (IESNP)

Who (Slide Layer)

Special Needs Plans Overview

Overview

Who

What

How

SNP Plan List

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:

- **DSNP** – Both Medicare and Medicaid enrollment
- **CSNP** – One or more qualifying chronic or disabling health conditions (like Diabetes Mellitus, cardiovascular disorders, and/or chronic heart failure)
- **ISNP** – Consumer resides or is expected to reside in a contracted institution (like a nursing home) for 90 days or longer
- **IESNP** – Consumer resides in a contracted assisted living facility and requires an institutional level of care

What (Slide Layer)

Special Needs Plans Overview	Overview	What Do SNPs Offer? SNPs are required to offer benefits and care management models to address the unique needs of the population served by the plan. These differentiate the SNPs from regular MA Plans. Like MA Plans, SNPs must provide all benefits covered under Original Medicare (except Hospice). Additional benefits may include: <ul style="list-style-type: none">• Routine vision and hearing• Preventive/comprehensive dental• Over-the-counter credits• Personal Emergency Response System (PERS)• 24-hour Nurseline• Non-emergency transportation• Fitness membership• Routine foot care Benefits may vary by plan type and/or market.
	Who	
	What	
	How	
	SNP Plan List	

How (Slide Layer)

Special Needs Plans Overview	Overview	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: <ol style="list-style-type: none">1. Description of the SNP Population;2. Care Coordination;3. SNP Provider Network; and4. MOC Quality Measurement & Performance Improvement. The MOC is evaluated and approved by National Committee for Quality Assurance (NCQA) according to CMS guidelines. CMS audits SNPs for compliance of MOC performance.
	Who	
	What	
	How	
	SNP Plan List	

SNP Plans (Slide Layer)

Special Needs Plans Overview

Overview

Who

What

How

SNP Plan List

CSNP

- Erickson Advantage® Champion
- Preferred Special Care Miami-Dade
- UnitedHealthcare® Chronic Complete
- UnitedHealthcare® Chronic Complete Focus
- UnitedHealthcare® Medicare Advantage Ally
- UnitedHealthcare® Medicare Advantage Assist
- UnitedHealthcare® Medicare Gold or Silver
- UnitedHealthcare® Medicare Advantage Walgreens

DSNP

- Medica HealthCare Plans MedicareMax Plus
- Peoples Health Secure Health®
- Peoples Health Secure Choice®
- Peoples Health Secure Complete®
- Preferred Medicare Assist
- Rocky Mountain Health Plans DualCare Plus
- UnitedHealthcare Dual Complete®

ISNP and IESNP

- Erickson Advantage® Guardian (ISNP)
- UnitedHealthcare® Nursing Home Plan (ISNP)
- UnitedHealthcare® Assisted Living Plan (IESNP)

5.2 CSNP DSNP Common Features

Chronic Condition and Dual Eligible SNP

Key Features

Care Management

Health Assessment

HouseCalls



Key Features (Slide Layer)

Chronic Condition and Dual Eligible SNP

● Key Features

● Care Management

● Health Assessment

● HouseCalls

All Special Needs Plans have certain key features in common.

Click each button to learn the key features of SNPs

Networks

Prescription Drug Coverage

Networks (Slide Layer)

Chronic Condition and Dual Eligible SNP

● Key Features

● Care Management

● Health Assessment

● HouseCalls

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 RPPO (Regional Preferred Provider Organization): 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 should use in-network providers.

Agents must refer to the appropriate plan's online provider directory to confirm if the consumer's physicians, specialists, and hospital are in the contracted provider network. If a provider is not in the online provider directory, contact the Producer Help Desk.

Note: When working with a consumer with Medicaid, explain that providers in their Medicaid network may not be in the DSNP network. They must use providers in the DSNP network to receive in-network coverage under the plan.

Close

Prescription Drug Coverage (Slide Layer)

Chronic Condition and Dual Eligible SNP

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. Each SNP, however, has its own formulary.

Always review each of the consumer's current prescriptions to confirm:

- If it is on the formulary
- What cost-sharing applies
- 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

Close


Care Management (Slide Layer)

Chronic Condition and Dual Eligible SNP


Care Management

Based on medical need, 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.


Click each image to learn how Care Management key components all work together.




Care Manager* helps coordinate medical care at the hospital.




Care Manager* 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 vendor.

Close

Health Assessment (Slide Layer)

Chronic Condition and Dual Eligible SNP

Health Assessment

Care management uses the Health Assessment (HA), also known as a Health Risk Assessment* 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 health status and any assistance needed with daily living activities. Authorized agents may be able to assist the consumer in completing the HA in LEAN at the time of enrollment. 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 program call 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 on each risk level button for an example of how care management can be implemented.

Low-Moderate

High Risk

Close

Chronic Condition

Click on each risk level button for an example of how care management can be implemented.

Low-Moderate

High Risk

Close

Low- Moderate Risk (Slide Layer)

Chronic Condition and Dual Eligible SNP

Health Assessment

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***Be clear with consumers during the enrollment process that a Health Assessment**

Care Management: Low-Moderate

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 Plan

- Initial HA
- Individualized care plan
- No care manager assignment
- Ongoing reassessment of risk level for status changes

Services Included

- Primary prevention, health education, and reminders
- Telephonic access to a nurse
- Disease management programs

Low-Moderate

High-Risk

Close

High Risk (Slide Layer)

Chronic Condition and Dual Eligible SNP

Health Assessment

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The HA asks questions about the member's health status and any assistance needed with daily living activities. Authorized agents may be able to assist the consumer in completing the HA in LEAN at the time of enrollment. 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

Care Management: High-Risk

Member Profile

- **Highest risk**
- **Disabled and/or unstable, multiple complex conditions**

Care Management Plan

- 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

Services Included

- Primary prevention, health education, and reminders
- Telephonic access to a nurse
- Disease management programs

(Same as Low-Moderate risk level)

Low-Moderate

High Risk

Close

House Calls (Slide Layer)

Chronic Condition and Dual Eligible SNP

HouseCalls

In addition to the care management model previously described, most* UnitedHealthcare CSNPs and DSNPs provide members with access to a model of care that includes the HouseCalls program.

*** Note: HouseCalls is not available in some UnitedHealthcare CSNPs or DSNPs. Please check your local market for availability.**

With the HouseCalls program, members receive an in-home clinical visit from a licensed health care practitioner that includes the following:

- A thorough medical, family, and social history review
- A physical exam

The purpose of the visit is to:

- Gather information to help the plan provide additional health education and care coordination
- Identify urgent health problems or related risks
- Provide advice on health related topics to discuss at the member's next appointment with their regular doctor
- Develop a plan of care and provide the results of the HouseCalls visit with the member's regular doctor
- Determine the member's health risk assessment level

HouseCalls is available at no additional cost to eligible members and all eligible members can receive the HouseCalls visit once annually.

Note: A HouseCalls visit does not replace the consumer's regular doctor visits or annual wellness visit.

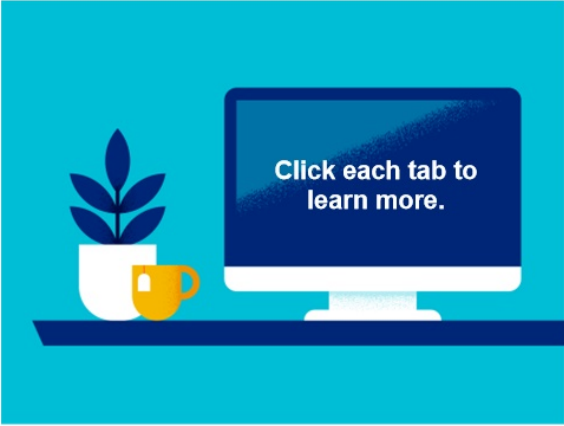
Chronic

HouseCalls

5.3 DSNP Overview

DSNP Overview

- Medicaid Overview
- Medicare Savings Program (MSP)
- Full Dual Eligible
- Partial Dual Eligible
- Dual Eligible Categories
- Medicaid Spend Down
- Medicaid Eligibility




Click each tab to learn more.

Medicaid Overview (Slide Layer)

DSNP Overview

- Medicaid Overview
- Medicare Savings Program (MSP)
- Full Dual Eligible
- Partial Dual Eligible
- Dual Eligible Categories
- Medicaid Spend Down
- Medicaid Eligibility

The DSNP is a Medicare Advantage product designed for the Medicaid population; therefore, it is important for you to understand the basics of Medicaid, identify and verify Medicaid qualifications for enrollment, and determine a consumer's eligibility.



Click the buttons to learn more.

Medicaid 101

Why Understand Medicaid

Medicaid 101 (Slide Layer)

DSNP Overview

- Medicaid Overview
- Medicare Savings Program (MSP)
- Full Dual Eligible
- Partial Dual Eligible
- Dual Eligible Categories
- Medicaid Spend Down
- Medicaid Eligibility

Medicaid 101

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.

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.

Medicaid 101

Why Understand Medicaid

Why Is it Important to Understand Medicaid (Slide Layer)

DSNP Overview

- Medicaid Overview
- Medicare Savings Program (MSP)
- Full Dual Eligible
- Partial Dual Eligible
- Dual Eligible Categories
- Medicaid Spend Down
- Medicaid Eligibility

Why Is it Important to Understand Medicaid?

It is important to understand Medicaid because a DSNP consumer's Medicaid eligibility will determine if they are eligible for DSNP, what is covered and if there is a cost share with their Medicare benefits.

There are several categories with Medicaid Eligibility, each determining whether a DSNP 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.

Medicaid 101

Why Understand Medicaid

Medicare Savings Program (Slide Layer)

DSNP Overview

- Medicaid Overview
- Medicare Savings Program (MSP)
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- Partial Dual Eligible
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- Medicaid Eligibility

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 (Slide Layer)

DSNP Overview

- Medicaid Overview
- Medicare Savings Program (MSP)
- Full Dual Eligible
- Partial Dual Eligible
- Dual Eligible Categories
- Medicaid Spend Down
- Medicaid 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.

Examples
Nursing facility care beyond the 100-day limit covered by Medicare, non-Part D prescription drugs, eyeglasses, and hearing aids.

FBDE, QMB+ and SLMB+ who receive state assistance with Medicare cost sharing are collectively referred to as Full Duals.

UnitedHealthcare DSNP Medicare-covered benefits are often filed to match Original Medicare cost sharing. Generally, Full Duals receive coverage of their cost-sharing assistance. **Depending on the individual state's Medicaid program**, Full Duals may or may not receive cost-sharing assistance.

Remember, UnitedHealthcare's DSNPs were designed to best suit the Full Dual-eligible Medicaid recipient.

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 (Slide Layer)

DSNP Overview

- Medicaid Overview
- Medicare Savings Program (MSP)
- Full Dual Eligible
- Partial Dual Eligible
- Dual Eligible Categories
- Medicaid Spend Down
- Medicaid Eligibility

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: The needs of the Partial Dual Eligible consumer may be met better by a plan other than a DSNP.

Dual-Eligible Categories (Slide Layer)

DSNP Overview

- Medicaid Overview
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- Partial Dual Eligible
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- Medicaid Spend Down
- Medicaid Eligibility

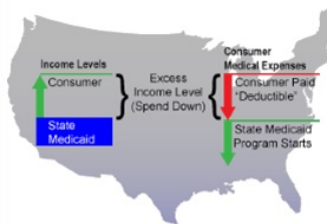
Dual Eligible Categories

Type of Dual Eligible	Medicaid Benefits
SNP Target Population	
FBDE	<ul style="list-style-type: none"> • Full Medicaid benefits • Cost sharing varies by state
QMB+	<ul style="list-style-type: none"> • Full Medicaid benefits • Medicare premiums and cost sharing
SLMB+	<ul style="list-style-type: none"> • Full Medicaid benefits • Cost sharing varies by state
Must Pay Plan Cost Sharing	
QMB Only	<ul style="list-style-type: none"> • Medicare premiums and cost sharing
SLMB Only	<ul style="list-style-type: none"> • Part B premium
QI	<ul style="list-style-type: none"> • Part B premium
QDWI	<ul style="list-style-type: none"> • Part A premium

Note: Please see <http://kff.org/statedata/> for state health facts and specific details.

Medicaid Spend Down Explained (Slide Layer)

DSNP Overview



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. For these consumers, usually the spend-down requirement has to be met annually.

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.

Close

Medicaid Eligibility (Slide Layer)

DSNP Overview

- Medicaid Overview
- Medicare Savings Program (MSP)
- Full Dual Eligible
- Partial Dual Eligible
- Dual Eligible Categories
- Medicaid Spend Down
- Medicaid Eligibility

Medicaid Eligibility

There are guidelines pertaining to Medicaid eligibility, which are determined by state Medicaid offices and may change month to month.

Click each button to learn about Medicaid eligibility.

Consumer Must Apply for Medicaid

Dual Status May Not Be Permanent

Medicaid Eligibility - Consumer Must (Slide Layer)

DSNP Overview

- Medicaid Overview
- Medicare Savings Program (MSP)
- Full Dual Eligible
- Partial Dual Eligible
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- Medicaid Spend Down
- Medicaid Eligibility

Medicaid Eligibility

There are guidelines pertaining to Medicaid eligibility, which are determined by state Medicaid offices and may change month to month.

[Click each button 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

Medicaid Eligibility - Dual Status (Slide Layer)

DSNP Overview

- Medicaid Overview
- Medicare Savings Program (MSP)
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- Medicaid Eligibility

Medicaid Eligibility

There are guidelines pertaining to Medicaid eligibility, which are determined by state Medicaid offices and may change month to month.

[Click each button to learn about Medicaid eligibility.](#)

Consumer Must Apply for Medicaid

- 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

Dual Status May Not Be Permanent

5.4 Medicaid

Medicaid

- Consumer Characteristics
- Special Election Periods
- Medicaid Eligibility Verification
- Loss of Medicaid Eligibility
- Cost Sharing - Premiums
- Cost Sharing
- Medicare-Medicaid Plans (MMP)



Consumer Characteristics (Slide Layer)

Medicaid

- Consumer Characteristics
- Special Election Periods
- Medicaid Eligibility Verification
- Loss of Medicaid Eligibility
- Cost Sharing - Premiums
- Cost Sharing
- Medicare-Medicaid Plans (MMP)

Consumer Characteristics
What are some characteristics of consumers who may benefit from a DSNP?
(Examples are fictitious and do not reflect statements of a real plan member.)

Click each box to learn why these individuals may most benefit from a DSNP.

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 heating bills.
State Medical 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 (Slide Layer)

Medicaid	Consumer Characteristics	Special Election Periods
	Special Election Periods	The Center for Medicare and Medicaid Services (CMS) grants Dual Eligible consumers a special election period in addition to the IEP, AEP, and OEP election periods.
	Medicaid Eligibility Verification	DSNP consumers are permitted to enroll or disenroll once per calendar quarter from January 1 through September 30 using the Dual/LIS Maintaining SEP.
	Loss of Medicaid Eligibility	During AEP, DSNP consumers may not switch plans, but may elect a new plan for a January 1 effective date.
	Cost Sharing - Premiums	<i>For more information, please check the Election Period Booklet (available on Learning Lab). Also, the Medicare and You Handbook available at Medicare.gov will provide additional information. Consumers may incur penalties if they do not enroll for either Medicare Part B or Medicare Part D during their initial eligibility period.</i>
	Cost Sharing	<i>For more information on Medicare Part B penalties, see the Medicare and You Handbook.</i>
	Medicare-Medicaid Plans (MMP)	<i>For more information on Medicare Part D penalties, see the Late Enrollment Penalties topic in the Medicare Prescription Drug Plans section.</i>

Medicaid Eligibility Verification (Slide Layer)

Medicaid	Consumer Characteristics	Medicaid Eligibility Verification
	Special Election Periods	A consumer's 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 <i>Jarvis</i> 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).
	Medicaid Eligibility Verification	Review the Medicare Medicaid Eligibility Lookup Tool job aid for instructions on how to use the tool. (<i>Jarvis</i> > Knowledge Center> Learning Lab> Content Library> <i>Jarvis</i> > Additional References)
	Loss of Medicaid Eligibility	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.
	Cost Sharing - Premiums	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 the Dual/LIS Maintaining SEP, and the UnitedHealthcare plans available to the consumer based on their Medicaid status.
	Cost Sharing	Note: The Medicare Medicaid Eligibility Lookup Tool and PHD performs Medicaid verifications for states where UnitedHealthcare has either a DSNP or UnitedHealthcare® Medicare Advantage Assure plan.
	Medicare-Medicaid Plans (MMP)	

Loss of Medicaid Eligibility (Slide Layer)

Medicaid	Consumer Characteristics	Loss of Medicaid Eligibility If a Dual Eligible consumer loses his or her Medicaid eligibility, the consumer can remain enrolled in the DSNP 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 DSNPs. In addition, a Special Election Period (SEP) is available for Dual Eligible consumers 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. Once a Dual Eligible consumer is enrolled in a DSNP and later loses Medicaid eligibility, UnitedHealthcare offers assistance to its members in re-establishing Medicaid eligibility through a third party vendor. This outreach by the vendor is often called Medicaid Recertification Assistance. Loss of Medicaid eligibility means the consumer will have to pay premiums, deductibles, copayments, and coinsurance during the grace period.
	Special Election Periods	
	Medicaid Eligibility Verification	
	Loss of Medicaid Eligibility	
	Cost Sharing - Premiums	
	Cost Sharing	
	Medicare-Medicaid Plans (MMP)	

Cost Sharing - Premiums (Slide Layer)

Medicaid	Consumer Characteristics	Cost Sharing - Premiums Part B Premium: The state may pay the Medicare Part B premium on behalf of the zero cost share Dual Eligible, the targeted consumer for the DSNP. Part D Premium: The premium for the Part D benefit integrated in all DSNPs 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 DSNP would not pay a Part D premium. When working with consumers: <ul style="list-style-type: none">• Do NOT state that a DSNP is a "zero premium or free" plan.• Make sure that the consumer understands that LIS eligibility does not mean Medicaid or DSNP eligibility.
	Special Election Periods	
	Medicaid Eligibility Verification	
	Loss of Medicaid Eligibility	
	Cost Sharing - Premiums	
	Cost Sharing	
	Medicare-Medicaid Plans (MMP)	

Cost Sharing (Slide Layer)

Medicaid

- Consumer Characteristics
- Special Election Periods
- Medicaid Eligibility Verification
- Loss of Medicaid Eligibility
- Cost Sharing - Premiums
- Cost Sharing
- Medicare-Medicaid Plans (MMP)

Cost Sharing

Take a moment to review the following important points about DSNP 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 DSNP plan's cost sharing amounts. Other plan options may be more appropriate.
- Full Dual Eligible consumers who receive full assistance from the state are "zero cost share" consumers. Explain that they should:
 - Use their DSNP member ID card and Medicaid card (except in 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).

5.5 CSNP Overview

CSNP Overview

- Consumer Characteristics
- Special Election Periods
- Primary Care Providers
- Chronic Condition Verification Process
- Chronic Condition Verification Process Tips



Consumer Characteristics (Slide Layer)

CSNP Overview

Consumer Characteristics

Special Election Periods

Primary Care Providers

Chronic Condition Verification Process

Chronic Condition Verification Process Tips

CSNPs 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 CSNP and DSNP were covered. Now you will learn about **features unique to offering a CSNP**. Let's first look at the following consumers who may benefit from a CSNP:

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."

Verification Process

Chronic Condition Verification Process Tips

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 (Slide Layer)

CSNP Overview

Consumer Characteristics

Special Election Periods

Primary Care Providers

Chronic Condition Verification Process

Chronic Condition Verification Process Tips

Special Election Periods

A Special Election Period (SEP) can be used:

- When the consumer enrolls in any CSNP 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 CSNP.
- When the consumer has a different condition that their current CSNP does not cover and changes from their current CSNP to another CSNP that serves that different condition. Enrollment using this SEP can occur any time during the year and ends once the consumer enrolls in the new CSNP.

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 Open Enrollment Period (OEP) to enroll in another CSNP that serves the same condition(s) as their current plan.

Primary Care Providers (Slide Layer)

CSNP Overview

- Consumer Characteristics
- Special Election Periods
- Primary Care Providers
- Chronic Condition Verification Process
- Chronic Condition Verification Process Tips

Primary Care Providers

Primary Care Providers (PCP) play an important part in managing the health of a member enrolled in a CSNP 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.

To enroll in a CSNP, plans may require the consumer to select a PCP. To provide the best experience possible, encourage the consumer to select an in-network PCP to help them 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 (Slide Layer)

CSNP Overview

- Consumer Characteristics
- Special Election Periods
- Primary Care Providers
- Chronic Condition Verification Process
- Chronic Condition Verification Process Tips

Chronic Condition Verification Process

In addition to all other eligibility requirements, CMS only permits enrollment in a CSNP if a qualifying chronic condition is verified by the consumer's provider. CMS permits CSNPs 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 CSNPs 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 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 (Slide Layer)

CSNP Overview

Consumer Characteristics

Special Election Periods

Primary Care Providers

Chronic Condition Verification Process

Chronic Condition Verification Process Tips

Chronic Condition Verification Process Tips

Agent Responsibilities

- Explain the chronic condition verification process to the consumer.
- Obtain a signed Chronic Condition Verification Authorization form from the consumer and submit it with the Enrollment Application. (Form is available in the Enrollment Guide and in LEAN™.)
- 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, depending on the Plan's method of verification.

Consumer Assistance with Chronic Condition Verification

Valid and accurate provider contact information is critical to verify a consumer's CSNP 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:

CSNP

Chronic Condition Verification Process

Chronic Condition Verification Process Tips

- "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.

5.6

Medicare—Medicaid Plans (MMP)

DSNP

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.

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 is 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 membership card
- One company paying claims



Click and drag the blue box to the right to learn about MMP Details.

Close

Location (Slide Layer)

DSNP

Medicare—Medicaid Plans (MMP)

Locations:

- There are 9 states that 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 and Texas (Harris county only). In 2022, UnitedHealthcare will also be a participating MMP carrier in up to 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 DSNP) will automatically disenroll the member from their MMP.

See the Agent Guide for additional details about marketing to Dual eligible consumers in MMP areas in Ohio and Texas.



Click and drag the blue box to the right to learn about MMP Details.

Close

Marketing MA (Slide Layer)

DSNP

Medicare—Medicaid Plans (MMP)

Marketing MA:

When marketing 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 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



Click and drag the blue box to the right to learn about MMP Details.

Close

Ohio (Slide Layer)

DSNP

Medicare—Medicaid Plans (MMP)

Ohio: UnitedHealthcare participates in MyCareOhio, Ohio's MMP, in Columbiana, Cuyahoga, Geauga, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit, Trumbull and Wayne counties. Agents must know if there is an MMP in the state, the service area of the MMP, what to do if UnitedHealthcare is participating, and what to do if UnitedHealthcare is not participating.

If an MMP-eligible consumer resides in a county where UnitedHealthcare does not have an MMP, the agent is permitted to market to and enroll the consumer in any plan offered by UnitedHealthcare. If the consumer is not full dual -eligible, the agent may market a UnitedHealthcare plan.

If there is a UnitedHealthcare MMP available and the consumer is a full dual eligible, the agent must contact the Producer Help Desk to determine if the consumer is a possible MyCareOhio member. If the consumer is enrolled in a UnitedHealthcare MMP, the UnitedHealthcare Members Matter team will contact the consumer.

Agents must not present a plan or discuss any MA or DSNP plan options until the consumer has been contacted by the Members Matter team.

If a warm transfer cannot be done because the call is after hours, the PHD representative will leave a voice message with the service request number for the Members Matter team to follow up with the consumer.

The UnitedHealthcare Member Matters team will reach out to the UnitedHealthcare MMP member to provide education, clarify benefits, and/or resolve any issues that may have motivated the consumer's request for a change in enrollment. If the member is satisfied with the MyCareOhio MMP plan, they will be invited to rescind their marketing request. If the member is not satisfied with their MMP plan, the member will be invited to move forward with their marketing request.



Click and drag the blue box to the right to learn about MMP Details.

Close

Texas (Slide Layer)

DSNP

Medicare—Medicaid Plans (MMP)

Texas:

Texas MMP (STAR+PLUS) is available in Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant counties. UnitedHealthcare only participates in Harris County. There are no specific procedures that must be followed prior to marketing a DSNP to a Texas consumer residing in a county where an MMP is available.



Click and drag the blue box to the right to learn about MMP Details.

Close

MMP Waiver (Slide Layer)

DSNP

Medicare—Medicaid Plans (MMP)

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 instead of quarterly. 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 **CAN NOT** use the SEP Dual/LIS Maintaining.



Click and drag the blue box to the right to learn about MMP Details.

Close

5.7 ISNP IESNP

Institutional/ Institutional-Equivalent
Special Needs Plans

- ISNP and IESNP Eligibility
- Consumer Characteristics
- Care Management Model
- Marketing and Selling
- Materials

ISNP and IESNP Eligibility (Slide Layer)

Institutional/ Institutional-Equivalent
Special Needs Plans

● ISNP and IESNP Eligibility

● Consumer Characteristics

● Care Management Model

● Marketing and Selling

● Materials

ISNP and IESNP Eligibility

Individuals meeting eligibility requirements can enroll in an ISNP or IESNP anytime during the year using the OEPI (Open Enrollment Period for Institutionalized Individuals) election period option. Agents should carefully indicate the correct election period code on the enrollment application.

Click each button to learn specific ISNP and IESNP eligibility requirements.

ISNP Eligibility

IESNP Eligibility

ISNP Eligibility (Slide Layer)

Institutional/ Institutional-Equivalent
Special Needs Plans

To enroll in an ISNP, consumers must meet these requirements:

- Reside in the plan's service area; and
- 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 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.

Close

IESNP Eligibility (Slide Layer)

Institutional/ Institutional-Equivalent
Special Needs Plans

To enroll in an IESNP, consumers must meet these requirements:

- Reside in the plan's service area;
- Reside in an assisted living facility contracted with the plan; and
- Require Nursing Home Level of Care (LOC) based on the state specific definition.

The Nursing Home LOC Assessment must be completed, reviewed, and eligibility confirmed prior to the completion of an IESNP enrollment application.* The agent is required to document and attest that 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 LOC assessment for a consumer
- Support on how to review a completed LOC assessment

*State requirements might vary.

Close

Consumer Characteristics (Slide Layer)

Institutional/ Institutional-Equivalent
Special Needs Plans

● ISNP and IESNP Eligibility

● **Consumer Characteristics**

● Care Management Model

● Marketing and Selling

● Materials

Consumer Characteristics

The consumer or the consumer's legal authorized representative may make the enrollment decision and complete the ISNP or IESNP 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 picture to learn about consumer and authorized representative characteristics.

Consumer
Self Decision Maker

Authorized Representative
Power of Attorney POA)

Consumer (Slide Layer)

Institutional/ Institutional-Equivalent
Special Needs Plans

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 have Medicaid (85-90% of ISNP consumers have Medicaid, but about 70% of IESNP consumers do not (i.e., are private pay))*
- May not be aware of the ISNP/IESNPs in which they can enroll based on residing in a contracted SNF or assisted living facility

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

*Internal UHG data

Close

POA (Slide Layer)

Institutional/ Institutional-Equivalent
Special Needs Plans

Legal Authorized Representative / Power of Attorney (POA)*

A large number of ISNP and IESNP 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 ISNP/IESNPs in which their loved one can enroll based on residing in a contracted SNF or assisted living facility
- 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 POA documentation upon request.*

Close

Care Management Model (Slide Layer)

Institutional/ Institutional-Equivalent
Special Needs Plans

● ISNP and IESNP Eligibility

● Consumer Characteristics

● Care Management Model

● Marketing and Selling

● Materials

Important Aspects of an ISNP/IESNP

As mentioned earlier, the ISNP and IESNP 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 title to learn about important aspects of ISNPs and IESNPs.](#)

Care Management Model

Benefits in addition to those covered
by Original Medicare

Networks

Medicaid Considerations

Care Management (Slide Layer)

Institutional/ Institutional-Equivalent
Special Needs Plans

● ISNP and IESNP Eligibility

● Consumer Characteristics

● Care Management Model

● Marketing and Selling

● Materials

Care Management

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 OptumCare to provide Care Management. OptumCare'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
- 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

Close

Additional Benefits (Slide Layer)

Institutional/ Institutional-Equivalent
Special Needs Plans

● ISNP and IESNP Eligibility

● Consumer Characteristics

● Care Management Model

● Marketing and Selling

● Materials

Additional Benefits

ISNPs and IESNPs 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 podiatry services
- 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

Availability and level of benefits may vary by plan. See plan Summary of Benefits for specifics.

Close

Networks (Slide Layer)

Institutional/ Institutional-Equivalent
Special Needs Plans

● ISNP and IESNP Eligibility

● Consumer Characteristics

● Care Management Model

● Marketing and Selling

● Materials

Networks

ISNPs and IESNPs are network-based MA Plans. Make sure the consumer or legal authorized representative understands any network limitations.

- ISNP Members: Each facility has a list of accessible contracted 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 for a specific facility. Confirm the member's specialists are contracted with the ISNP.
- IESNP 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 UHCMedicareSolutions.com or on *Jarvis*.

Close

Medicaid Considerations (Slide Layer)

Institutional/ Institutional-Equivalent
Special Needs Plans

● ISNP and IESNP Eligibility

● Consumer Characteristics

● Care Management Model

● Marketing and Selling

● Materials

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 UnitedHealthcare Nursing Home Plan (ISNP).

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.

Close

Marketing and Selling ISNPs and IESNPs (Slide Layer)

Institutional/ Institutional-Equivalent
Special Needs Plans

● ISNP and IESNP Eligibility

● Consumer Characteristics

● Care Management Model

● Marketing and Selling


● Materials

Marketing and Selling ISNPs and IESNPs

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 Medicare Communications and Marketing Guidelines (MCMG) requirements, particularly regarding unsolicited contact and marketing in a provider setting
- UnitedHealthcare rules, policies and procedures

Click the images below to learn about each requirement and to make sure you understand these and other sales-related guidelines.



PTC (Slide Layer)

Institutional/ Institutional-Equivalent
Special Needs Plans

Permission to Call

- Permission to call 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 call 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:
 1. document agreement for contact from the consumer or their legal authorized representative and,
 2. 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.
- All permission to call 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 call to an agent for the purposes of marketing the ISNP/IESNP product to an existing UnitedHealthcare member (e.g., a member of a UnitedHealthcare commercial plan is aging in to Medicare).*

Close

SOA (Slide Layer)

Institutional/ Institutional-Equivalent
Special Needs Plans

Scope of Appointment (SOA)

All SOA guidelines apply when meeting with a consumer or legal authorized representative to market/sell an ISNP/ IESNP.

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.

Close

Provider Activities Guidelines (Slide Layer)

Institutional/ Institutional-Equivalent
Special Needs Plans

Provider Activities Guidelines

There are unique ISNP 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 button to view what the SNF staff member may, must, or must not do relative to the ISNP product.

Provider Activities Guidelines

Close

Documentation (Slide Layer)

Institutional/ Institutional-Equivalent
Special Needs Plans

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.

Documents used by Facilities for Permission to Call
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 HIPAA privacy and CMS requirements and includes the following disclosures:

- Director of Sales Operations signature prior to use,
- 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, **and**
- 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.


Close

Materials (Slide Layer)

Institutional/ Institutional-Equivalent Special Needs Plans	● ISNP and IESNP Eligibility	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 CCM portal or on Jarvis . <ul style="list-style-type: none">• The Consumer Presentation• Benefits Highlights - a plan specific reference that describes the plan's additional benefits• The Heart of the UnitedHealthcare Nursing Home Plan flyer - describes the role of the advanced practice clinician Refer to the Ethics and Compliance certification section for additional information about marketing and enrollment materials.
	● Consumer Characteristics	
	● Care Management Model	
	● Marketing and Selling	
	● Materials	

6. UnitedHealthcare SCO

6.1 Senior Care Options

UnitedHealthcare SCO	● SCO Overview	 <h1>Senior Care Options</h1> <p>Click each tab to learn more.</p>
	● Authorized to Sell SCO	
	● SCO Eligibility	
	● Key Concepts	
	● MassHealth Eligibility	
	● PACE	

SCO Overview (Slide Layer)

UnitedHealthcare SCO	● SCO Overview	UnitedHealthcare SCO UnitedHealthcare 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 UnitedHealthcare SCO plan is a voluntary health plan that combines all the benefits and coverage of Original Medicare and MassHealth under one plan. Additionally the SCO plan offers Long Term Support Services (LTSS) for elders and respite care for families and caregivers.
	● Authorized to Sell SCO	
	● SCO Eligibility	
	● Key Concepts	
	● MassHealth Eligibility	
	● PACE	

Authorized to Sell SCO (Slide Layer)

UnitedHealthcare SCO	● SCO Overview	Authorized to Sell SCO To be authorized to sell the SCO plan, an agent must: *Be licensed and appointed in Massachusetts; *Pass the prerequisite assessments; *Pass the annual UnitedHealthcare SCO certification assessment; *Participate in any training assigned by the UnitedHealthcare SCO sales unit; <i>and</i> *Be directly approved by the UnitedHealthcare SCO sales unit to offer the UnitedHealthcare SCO plan.
	● Authorized to Sell SCO	
	● SCO Eligibility	
	● Key Concepts	<i>This certification is for UnitedHealthcare SCO only.</i> <i>*This Product is not yet available to sell via telesales.</i>
	● MassHealth Eligibility	
	● PACE	

Key Concepts (Slide Layer)

UnitedHealthcare SCO	● SCO Overview	Key Medicare and Medicaid Concepts Consider for a moment what you already know about these two government programs.
	● Authorized to Sell SCO	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.
	● SCO Eligibility	The Medicare program includes four parts: Part A (hospital insurance), Part B (medical insurance), Part D (prescription drug coverage), and Part C, 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.
	● Key Concepts	Refer to the Medicare Basics certification section for additional information about Medicare.
	● MassHealth Eligibility	Medicaid is a joint federal and state program that helps pay medical costs for qualified individuals with limited income and resources. In the state of Massachusetts, Medicaid is called MassHealth.
	● PACE	Refer to the CSNP/DSNP content for additional information about Medicaid.

MassHealth Eligibility (Slide Layer)

UnitedHealthcare SCO	● SCO Overview	MassHealth Eligibility MassHealth is a public health insurance program for eligible residents of Massachusetts.
	● Authorized to Sell SCO	MassHealth is a combination of Medicaid and the State Children's Health Insurance Plan (SCHIP).
	● SCO Eligibility	To be eligible for MassHealth, the individual must live in Massachusetts, have low to medium income, and meet certain general and financial eligibility requirements.
	● Key Concepts	MassHealth offers these coverage types to eligible individuals, families, and people with disabilities: <ul style="list-style-type: none">• MassHealth Standard,• MassHealth Common Health,• MassHealth CarePlus,• MassHealth Family Assistance,• MassHealth Premium Assistance,• MassHealth Limited, and• Children's Medical Security Plan
	● MassHealth Eligibility	For individuals with Medicare, two additional coverage types are available*: <ul style="list-style-type: none">• MassHealth Senior Buy-In• MassHealth Buy-In
	● PACE	* Source: MassHealth

PACE (Slide Layer)

UnitedHealthcare SCO

- SCO Overview
- Authorized to Sell SCO
- SCO Eligibility
- Key Concepts
- MassHealth Eligibility
- PACE

PACE

PACE stands for "Program for All-Inclusive Care for the Elderly".

- PACE is a unique benefit under Medicare and Medicaid that focuses on frail seniors who meet their state's standards for nursing home care.
- It features comprehensive medical and social services at an Adult Day Health Center, in-home, and/or in-patient facility. For most participants, the comprehensive care allows them to remain in their homes while receiving care, rather than be institutionalized.
- 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.

SCO Eligibility (Slide Layer)

UnitedHealthcare SCO

- SCO Overview
- Authorized to Sell SCO
- SCO Eligibility
- Key Concepts
- MassHealth Eligibility
- PACE

Eligibility Requirements

To qualify for the UnitedHealthcare SCO plan, consumers must:

- Be 65 years of age or older
- Be enrolled in MassHealth Standard
- Reside in service area

Note: Consumers can, but are not required to have Medicare Parts A and B to enroll.

UnitedHealthcare SCO now serves 10 counties in Massachusetts.

- Bristol
- Essex
- Franklin
- Hampden
- Hampshire
- Middlesex
- Norfolk
- Plymouth
- Suffolk
- Worcester

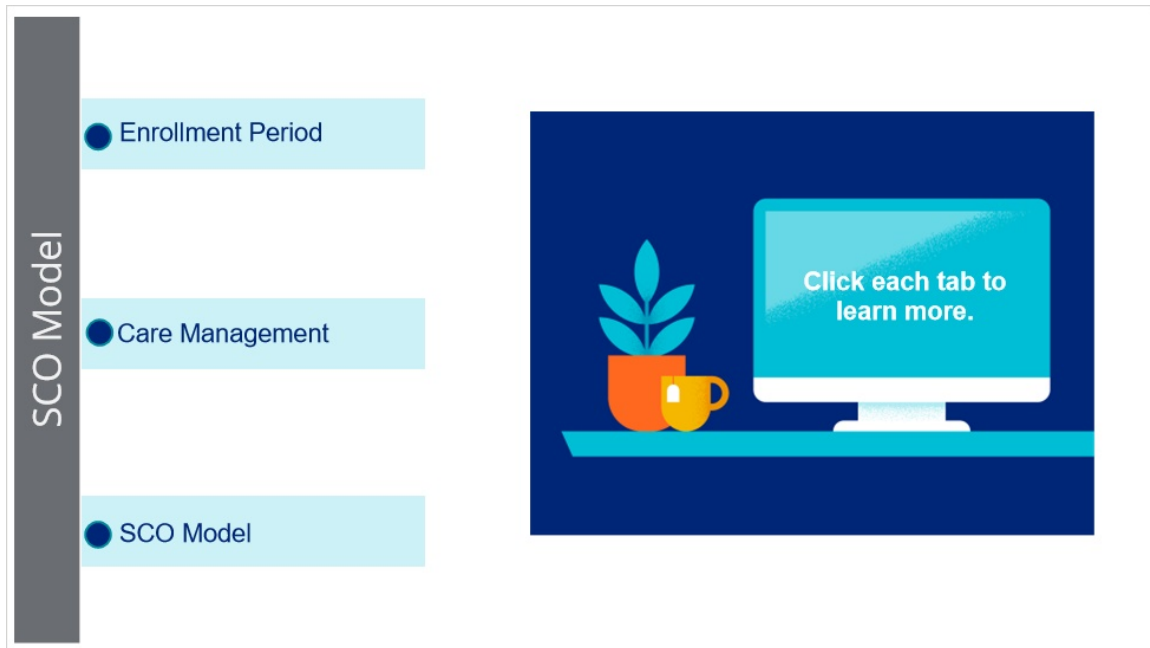
If a consumer is enrolled in a hospice and the consumer has MassHealth only (they do not have Medicare), the hospice must be part of the plan's network in order to enroll in UnitedHealthcare SCO. If the hospice provider is not in the network, the consumer may not join the plan.

Un

- MassHealth Eligibility
- PACE

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.

6.2 SCO Model



Enrollment Period (Slide Layer)

SCO Model

● Enrollment Period

● Care Management

● SCO Model

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 UnitedHealthcare SCO plan during their Medicare Initial Enrollment Period (IEP), the Annual Election Period (AEP), the Medicare Advantage Open Enrollment Period (OEP), or an available Special Election Period (SEP).

Consumers with Medicare **and** Medicaid can use the Special Election Period (SEP) for Dual/LIS Maintaining once per calendar quarter from January through September.

Medicaid-only consumers are not restricted by CMS election period rules and are permitted to enroll or disenroll on a monthly basis.

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 Maintaining 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 >Knowledge Center> Learning Lab, content library, Enrollment (course)].

Care Management (Slide Layer)

SCO Model

Enrollment Period

Care Management

SCO Model

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 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 UnitedHealthcare 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 (Slide Layer)

SCO Model

Enrollment Period

Care Management

SCO Model

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).

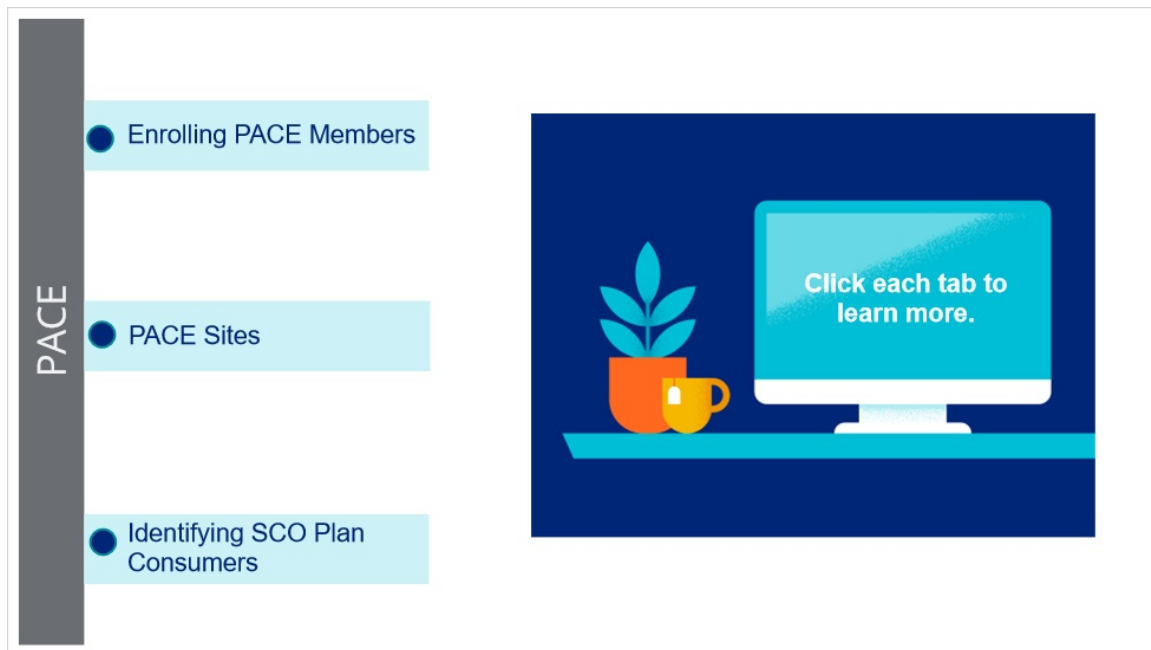
Other Benefits and Services

- 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
- Vision (annual eyeglasses) and hearing benefits
- Transportation to all medical appointments
- Members with MassHealth standard only can get Hospice care at in-network providers. Members with Medicare and MassHealth Standard are covered under Medicare.

Community Services

Community Services, such as adult day care, housekeeping, home delivered meals, and transportation, are covered, if coverage guidelines are met.

6.3 PACE



PACE and other SCO Plans (Slide Layer)

PACE

- Enrolling PACE Members
- PACE Sites
- Identifying SCO Plan Consumers

Enrolling PACE Members

When considering enrolling consumers in UnitedHealthcare 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 UnitedHealthcare 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 (Slide Layer)

PACE

● Enrolling PACE Members

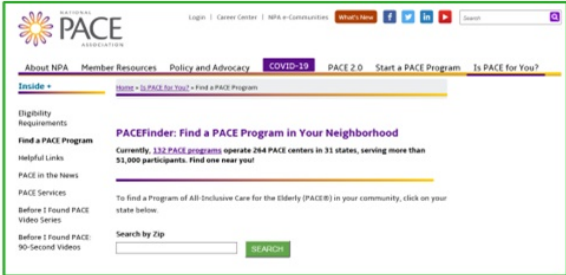
● PACE Sites

● Identifying SCO Plan Consumers

PACE Sites

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:

[PACEfinder: Find a PACE Program in Your Neighborhood](#)



Identifying SCO Plan Consumers (Slide Layer)

PACE

● Enrolling PACE Members

● PACE Sites

● Identifying SCO Plan Consumers

Identifying 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.

[Click each button to review questioning options for identifying consumers who may be enrolled in PACE or a SCO Plan.](#)

Option 1

Option 2

Option 3

Identifying SCO Plan Consumers - Option1 (Slide Layer)

PACE

● Enrolling PACE Members

● PACE Sites

● Identifying SCO Plan Consumers

Identifying 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.

[Click each button to review questioning options for identifying consumers who may be enrolled in PACE or a SCO Plan.](#)

Option 1

Option 2

Option 3

Question Option 1

Ask:
"Mr. Dickson, thank you for your interest in the UnitedHealthcare 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: Boston Medical Center HealthNet Plan, Commonwealth Care Alliance (CCA), NaviCare, Senior Whole Health (SWH), Tufts Health Plan and UnitedHealthcare 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.

Identifying SCO Plan Consumers - Options 2 (Slide Layer)

PACE

● Enrolling PACE Members

● PACE Sites

● Identifying SCO Plan Consumers

Identifying 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.

[Click each button to review questioning options for identifying consumers who may be enrolled in PACE or a SCO Plan.](#)

Option 1

Option 2

Option 3

Question Option 2

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 an SCO plan or PACE program.

Identifying SCO Plan Consumers - Options 3 (Slide Layer)

PACE

- Enrolling PACE Members
- PACE Sites
- Identifying SCO Plan Consumers

Identifying 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.

[Click each button to review questioning options for identifying consumers who may be enrolled in PACE or a SCO Plan.](#)

[Option 1](#)[Option 2](#)[Option 3](#)

Question Option 3

Ask:
"Mr. Williams, do you regularly attend an Adult Day Health (ADH) program or a senior center?"

Note:
If the consumer attends an ADH 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.

6.4 Selling and Marketing

Selling and Marketing

- Understanding Consumer Needs
- Compliant Marketing Methods
- Must and Must Nots
- State of MA Marketing



Understanding Consumer Needs (Slide Layer)

Selling and Marketing

● Understanding Consumer Needs

● Compliant Marketing Methods

● Must and Must Notes

● State of MA Marketing

Understanding Consumer Needs

It is important to become familiar with the types of consumers that might benefit from a Senior Care Options plan. You need to understand their needs and how to sell the SCO plan.

Keep My Doctors

"With all the coverage choices I have to make, I get confused and frustrated. All I really want is a plan that doesn't make me change my doctor or clinic and someone who can help me arrange the care that I need."

New to MassHealth

"I'm new to the whole process of Medicaid. I don't have Medicare but just received notice that I am with MassHealth."

Copayments

"I'm on a fixed income and live in subsidized housing. I'm currently paying copayments for my medications and would like a plan that would assist with those copayments."

Care Management

"I have challenges living on my own and could benefit from long term support services and care managers who can help me get the care I need to continue living in my home."

Compliant Marketing Methods (Slide Layer)

Selling and Marketing

● Understanding Consumer Needs

● Compliant Marketing Methods

● Must and Must Notes

● State of MA Marketing

Compliant Marketing Methods

Marketing of this plan type must follow appropriate marketing guidelines as learned in the Medicare Basics and Ethics and Compliance section of this guide. Exercising compliance in your marketing efforts supports a positive experience for all parties and helps you avoid complaints or misunderstandings during the sales experience.

Before conducting a marketing/sales event, the agent must take and pass the Events Basics assessment. The assessment covers elements the agent is required to state and cover when conducting a plan presentation. Agents conducting personal/individual marketing appointments, for example, an in-home appointment, are encouraged to review the Events Basics section of this guide as well.

Must and Must Nots (Slide Layer)

Selling and Marketing

● Understanding Consumer Needs

● Compliant Marketing Methods

● Must and Must Nots

● State of MA Marketing

Regulations and Guidelines: Must and Must Nots

UnitedHealthcare SCO is a Medicare Advantage (MA) Plan; therefore, all CMS regulations and UnitedHealthcare rules, policies, and procedures related to the marketing and selling of MA plans apply. In addition, state guidelines apply because of the contract with the state of Massachusetts. In order to successfully represent the UnitedHealthcare SCO plan, an agent must be knowledgeable, thorough in their needs assessment, and compliant throughout the sales process.

Click each button to review the must and must not compliance rules.

✓

Agents Must Do

✗

Agents Must Not Do

Remember, this is not a complete list; please refer to your Agent Guide available on Jarvis. For more detailed MA requirements, please refer to the Medicare Basics and Ethics & Compliance section of the guide or speak to your sales leadership.

Must Do (Slide Layer)

Selling and Marketing

Understanding Consumer Needs

Compliant Marketing Methods

Must and Must Nots

State of MA Marketing

SCO Must Do - Before The Sale

- Know about Massachusetts Medicaid eligibility requirements and MassHealth benefits. Find information at www.mass.gov/masshealth.
- Obtain a Scope of Appointment from each consumer present at a personal/individual marketing appointment (in-person or over the phone).
- Ask the consumer if they have a legal authorized representative or Power of Attorney (POA). If not, ask if they would like someone to be present to help them at the appointment.

SCO Must Do - During The Sale

- Review consumer's current health plan coverage.
- Verify consumer's enrollment in MassHealth Standard.
- Look up all of the consumer's providers, including their PCP, to determine if they are in network. The consumer must be willing to change to a contracted provider if their current provider is not in the network.
- Explain how to access providers and any network or provider limitations.
- Confirm understanding and agreement with all the plan's terms and conditions (reference Evidence of Coverage).

Selling and Marketing

Understanding Consumer Needs

Compliant Marketing Methods

Must and Must Nots

State of MA Marketing

- Provide and review the entire SCO Enrollment Guide.
- Explain to the consumer all costs related to the plan, including any Medicare Part B premiums, if members are already paying such premiums, and any cost sharing, which would be limited to non-covered drugs, benefits or services, or out-of-network drugs, benefits, or services.

SCO Must Do - After The Sale

- Go through the Plan Recap found in the SCO Enrollment Guide. Fill out the Enrollment Receipt and your contact information.
- Review the Enrollment Application for completeness, including:
 - Medicare number (if applicable)
 - MassHealth number and status
 - PCP name and ID
 - Current plan name
 - Agent ID

Continue

Must Not (Slide Layer)

Selling and Marketing

Understanding Consumer Needs

Compliant Marketing Methods

Must and Must Not

State of MA Marketing

SCO Must Not Do - Before The Sale

- Do not use unapproved marketing materials or make your own materials.
- Do not conduct one-on-one marketing appointments (in-person or telephonic) without:
 - a previously scheduled appointment with the consumer and
 - a completed Scope of Appointment obtained from the consumer prior to presenting the plan.

Note: Agents must have permission to call and document that permission in the sales lead management system.

SCO Must Not Do - During The Sale

- Do not introduce yourself as a Medicare/Medicaid representative or agent.
- Do not claim the plan is recommended or endorsed by Medicare and/or Medicaid.
- Do not coerce or intimidate a consumer to enroll.
- Do not enroll consumers if they have better benefits with their current health plans.
- Do not enroll consumers who may not be fully competent to make health care decisions on their own – be sure to ask if they have a legal authorized representative or POA and do not conduct a sales appointment without that person present.

Continue

State of MA Marketing (Slide Layer)

Selling and Marketing

Understanding Consumer Needs

Compliant Marketing Methods

Must and Must Not


State of MA Marketing

State of Massachusetts – Regulatory and Contractual Requirements

In this section, we will review a paraphrasing of the applicable and most relevant state regulations and state contractual requirements.

For a full set of the regulations, please see the link in Resources. For the relevant portions of the SCO contract, please contact your manager.

Click on the map of Massachusetts to review the relevant regulations and requirements.



Regulations (Slide Layer)

Selling and Marketing

Understanding Consumer Needs

Compliant Marketing Methods

Must and Must Not

State of MA Marketing

Marketing SCO

State regulations apply to any insured health plan that presents, disseminates or distributes marketing information in Massachusetts (MA). As such, UnitedHealthcare SCO is required to establish and maintain a system for controlling all marketing materials and the methods used to market the SCO plan. Agents representing this product are expected to comply with all regulatory requirements.

The goals of state regulations include:

- ensuring truthful and adequate disclosure of marketing and sales materials used by UnitedHealthcare SCO and its sales agents
- educating agents on misleading or misrepresentative practices that must be avoided
- establishing the minimum standards and guidelines of conduct
- preventing unfair competition
- ensuring all information presented is accurate to the intended audience

[Click the buttons for additional information.](#)

MassHealth for Seniors

Senior Care Options

Close

6.5 Enrollment

Enrollment

Enrollment Guide

SCO Enrollment Application Requirements

Provider and Formulary Lists

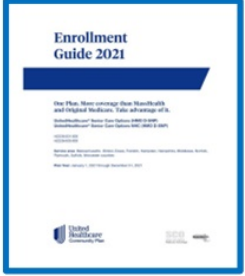
Renewing, Canceling or Terminating Coverage

Outreach Standards

Additional Sales Support

Click each tab to learn more.

Enrollment Guide (Slide Layer)

Enrollment	● Enrollment Guide	Materials: Mandatory Enrollment Guide The UnitedHealthcare SCO Enrollment Guide contains the information, disclosures, and forms the consumer must receive at the time of enrollment, including:	
	● SCO Enrollment Application Requirements	<ul style="list-style-type: none">• Summary of Benefits• Multi-Language Interpreter Services• Plan Star Rating• Required Information• Drug List• Enrollment Application• Enrollment Receipt	
	● Provider and Formulary Lists		
	● Renewing, Canceling or Terminating Coverage	Agents must not alter the Enrollment Guide in any way prior to giving it to the consumer, including writing on or removing pages.	
	● Outreach Standards	Use LEAN for submitting your SCO enrollment applications. Applications are received and uploaded in the enrollment system in hours with LEAN 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.	
	● Additional Sales Support	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 (Slide Layer)

Enrollment	● Enrollment Guide	An enrollment application is an offer of a contract between UnitedHealthcare 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.
	● SCO Enrollment Application Requirements	The enrollment application must:
	● Provider and Formulary Lists	<ul style="list-style-type: none">• 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.
	● Renewing, Canceling or Terminating Coverage	
	● Outreach Standards	
	● Additional Sales Support	

Provider and Formulary Lists (Slide Layer)

Enrollment

● Enrollment Guide

● SCO Enrollment Application Requirements

● Provider and Formulary Lists


● Renewing, Canceling or Terminating Coverage

● Outreach Standards

● Additional Sales Support

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.



Click the stars icon to read an important reminder

For 2021, our UnitedHealthcare® Senior Care Options (HMO D-SNP) is a Five-star plan. It means consumers get the highest-rated plan that combines doctor, hospital and prescription drug coverage – all for a \$0 monthly premium. Consumers may enroll only once during the Special Enrollment Period (SEP) for 5-star plans December 8 - November 30.

Note: Every year Medicare evaluates plans based on a 5 star rating system.

Provider Lookup (Slide Layer)

Enrollment

● Enrollment Guide


● SCO Enrollment Application Requirements

● Provider and Formulary Lists

● Renewing, Canceling or Terminating Coverage

● Outreach Standards

● Additional Sales Support



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.

Close

Renewing, Cancelling or Terminating Coverage (Slide Layer)

Enrollment	● Enrollment Guide	Use the Enrollment Guide to explain to the consumer guidelines related to enrollment, cancellation, and disenrollment, such as:
	● SCO Enrollment Application Requirements	<ul style="list-style-type: none"> • The plan effective date is the first day of the month following receipt of the enrollment application when using SEP - Dual/LIS Maintaining SEP. • Consumers may cancel the enrollment request prior to the plan effective date.
	● Provider and Formulary Lists	<ul style="list-style-type: none"> • 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.
	● Renewing, Canceling or Terminating Coverage	<ul style="list-style-type: none"> • 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.
	● Outreach Standards	<p>Please refer to the Election Period Booklet for detailed information related to election periods.</p> <p>[Jarvis >Knowledge Center> Learning Lab, content library, Enrollment (course)].</p>
	● Additional Sales Support	

Outreach Standards (Slide Layer)

Enrollment	● Enrollment Guide	In addition to complying with CMS regulations and UnitedHealthcare business rules, policies, and procedures when marketing the UnitedHealthcare SCO plan, agents must also comply with SCO state contractual marketing provisions.
	● SCO Enrollment Application Requirements	<p>To support the agreement between UnitedHealthcare and the state of Massachusetts, agents must:</p> <ul style="list-style-type: none"> • Use UnitedHealthcare SCO-created and approved marketing materials or submit agent-created materials to UnitedHealthcare 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 UnitedHealthcare SCO, upon request, current schedules of all activities initiated or promoted to provide information or to encourage enrollment.
	● Provider and Formulary Lists	
	● Renewing, Canceling or Terminating Coverage	<p>Have the following information available upon request by a consumer or member:</p> <ul style="list-style-type: none"> • A clear, comprehensive description of the UnitedHealthcare 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.
	● Outreach Standards	Only UnitedHealthcare SCO approved materials may be used when written materials are presented to a consumer or member.
	● Additional Sales Support	

Additional Sales Support (Slide Layer)

Enrollment

● Enrollment Guide

● SCO Enrollment Application Requirements

● Provider and Formulary Lists

● Renewing, Canceling or Terminating Coverage

● Outreach Standards

● Additional Sales Support

Additional Sales Support

- **Jarvis** at <https://www.uhcjarvis.com>
 - Sales materials and enrollment guides
 - UnitedHealthcare Toolkit
 - UnitedHealthcare SCO promotional materials
 - Search Tools for Plans, Providers, Pharmacies, and Drug Cost Estimator
- UnitedHealthcare website - www.UHCommunityPlan.com
- **Jarvis** Wrap - newsletter sent via email
- Producer Help Desk (PHD): 888-381-8581 or phd@uhc.com (Monday - Friday 8 a.m. - 10 p.m. ET)

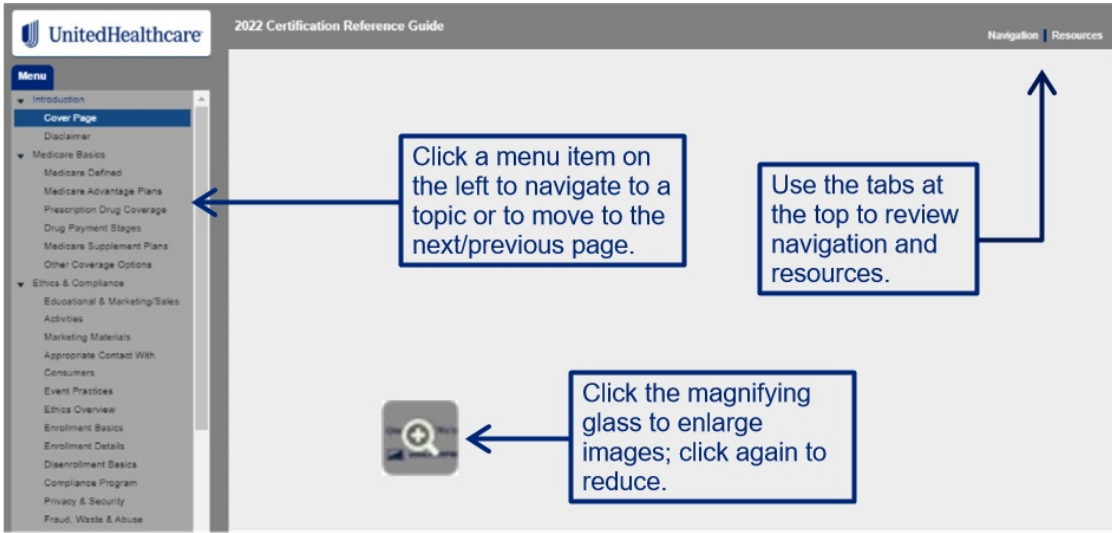


UnitedHealthcare SCO is a specialized product. SCO staff, based in Waltham, MA, is available to respond to any product question. Agents will be given additional SCO service contact information in a follow up training.

7. Navigation

7.1 Navigation

Navigation



Click a menu item on the left to navigate to a topic or to move to the next/previous page.

Use the tabs at the top to review navigation and resources.

Click the magnifying glass to enlarge images; click again to reduce.

8. Resources

8.1 Resources

Resources and References

For more in-depth information, please review the resources noted below or contact your sales leadership.

- Agent Guide
- Agent Hosted Events
- Sales Policy Job Aids:
 - Formal Marketing/Sales Events
 - Marketing and Generic Materials
 - Scope of Appointment
- AARP Medicare Supplement Producer Handbook

Click here to access these resources on **Jarvis**.

Jarvis

- Enrollment Handbook, including the Election Period Booklet
- Provider Search Job Aids
- Certification User Guide

Access the above resources on **Learning Lab**.
Go to Jarvis > Knowledge Center > Learning Lab > Content Library > type the name of the resource into the search field.

In addition, you may find the following links helpful:

CMS.gov

Medicare.gov

MedicareMadeClear.com