AGENT GUIDE

MEDICARE ADVANTAGE AND INDIVIDUAL FAMILY PLANS

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Please Note – Network Health is subject to regulation by the Office of the Commissioner of Insurance as well as other regulatory bodies. In no event will Network Health interpret any term of this guide that is against the recommendation of any regulatory agency.

All established practices and standards are subject to change at Network Health's sole discretion without prior notice.

MEET NETWORK HEALTH

We're a Wisconsin-based health plan, living in the communities we serve. We've been doing the right thing in Wisconsin for over 40 years, handling customer service, claims, billing, enrollment and more. With each passing year, our reputation for quality and personal service has grown stronger and stronger.

At Your Service

The Network Health member experience teams are based in Menasha and Brookfield, WI. We understand the landscape for local businesses and we're familiar with the providers and medical facilities in the area, so customers get personalized service from someone who understands them and their community.

CULTURE

BRAND POSITION

We do what's right because it's who we are. Health insurance is what we do. That's why we take the **extra steps** to make health insurance **affordable** and **understandable**, so you can make the most of your coverage.

MISSION

Our **mission** at Network Health is to create **healthy** and **strong Wisconsin communities**.

VISION

Your **local**, **reliable** partner delivering an **exceptional** health plan experience.

VALUES

INNOVATION

Bringing **ideas** to **life**

SERVICE EXCELLENCE

Providing **exceptional service** at the **right time**, **right place** and with the **right attitude**

INTEGRITY

Demonstrating **honesty** in **every** action

COLLABORATION

Working as **one team** toward a **common goal**

ACCOUNTABILITY

Honoring and **respecting** the **trust** people place in us

AGENT PORTAL

AGENT CONNECT - BOOK OF BUSINESS

Agents can view current members of Medicare Advantage, IFP/ACA and Commercial Groups within Agent Connect.

SECURE EMAIL MESSAGING

Agents can send secure messages to different Network Health departments by using the “Email Us” feature in the agent portal.

APPLICATION VERIFICATION

When writing new Medicare Advantage business or submitting short enrollment forms for existing business, agents will receive an email notification within 24-48 business hours. Notification emails will be sent from individualsalesteam@networkhealth.com and all application verifications will be securely housed in your agent portal. The email will direct you to log into the agent portal where you will have visibility to your application verifications for a seven-day time frame.

Once logged in, click on the Application Verifications card and this will take you to a page that will show your submitted applications and short enrollment forms that have been received by Network Health. If you have not received an email and do not find acknowledgment of receipt of application or short enrollment form in your agent portal, please contact our agent advisors at 920-720-1260 for assistance. **As a reminder the application verification is confirmation that Network Health has received an application, it is not confirmation of enrollment.** To see confirmed enrollments use the Agent Connect card in your agent portal. If there are questions about the enrollment, Network Health’s Agent Advisors will reach out.

RESOURCES

Forms

To find the most up to date forms visit the My Materials feature of the Agent Portal at login.networkhealth.com.

Contacts

NETWORK HEALTH RESOURCES – MEDICARE ADVANTAGE PLANS	
Member Experience Team (PPO and MSA)	800-378-5234 (TTY 800-947-3529) Monday–Friday, 8 a.m. to 8 p.m. Secure message via your agent portal
Member Experience Team (PPO D-SNP)	855-653-4636 (TTY 800-947-3529) Monday–Friday, 8 a.m. to 8 p.m.
Member Wellness	Network Health Coaches 800-236-0208
Care Management	Network Health Care Management Team 866-709-0019
Caregiver Support	Network Health Care Management Team 866-709-0019
Medication Therapy Management Program	To make an appointment to speak one-on-one with a pharmacist, members can call the Network Health Member Experience Team at 800-378-5234, Monday–Friday from 8 a.m. to 8 p.m.

NETWORK HEALTH RESOURCES – INDIVIDUAL AND FAMILY PLANS	
Member Experience Team	855-275-1400 Monday, Wednesday–Friday, 8 a.m. to 5 p.m., Tuesday: 8 a.m. to 4 p.m. Secure message via your agent portal

ADDITIONAL NETWORK HEALTH RESOURCES	
Agent Management	Secure message via your agent portal
Agent Advisors	920-720-1260 8:00 a.m. to 5:00 p.m. Monday–Friday Secure message via your agent portal
Network Health Compliance hotline	877-700-7020 or compliance@networkhealth.com
Pharmacy	920-720-1287 or 888-665-1246 or pharmacist@networkhealth.com Secure message via your agent portal
Locations	1570 Midway Place Menasha, WI 54952 16960 W. Greenfield Ave., Suite 5 Brookfield, WI 53005

AGENT LICENSING

Network Health establishes long-term relationships with our agents. We require new agents to participate in education and training to be appointed by Network Health. We require all agents to participate in yearly training to stay updated on Network Health's current benefits, policies and procedures.

To comply with Wisconsin Administrative Code Ins. 6.57 "Listing of Insurance Agents by Insurers," Network Health will require verification of licensure and Office of the Commissioner of Insurance (OCI) listing of all agents. Verification of licensure and OCI listings must be completed before Network Health accepts business from an agent. Network Health requires agents to comply with all state and federal regulations. For appointment with Network Health, an agent must agree to abide by the terms of Network Health's Agent Contract.

Network Health Contracting

Here are the steps for new and returning agents to become Network Health Ready to Sell.

NEW AGENTS FOLLOW THESE 5 STEPS

1. Contact a Network Health Sales Executive

2. Receive the onboarding email that contains the necessary training and testing for appointment

3. Once training is passed, receive an electronic onboarding invitation for the following

- Licensing
- Background check
- Active Errors and Omissions (E&O) insurance
- Certification documents (AHIP, NABIP, FFM, etc)

4. Onboarding approval or denial by Network Health

5. Appointed and Ready to Sell Network Health

EXISTING PRODUCERS – FOLLOW THESE 4 STEPS

Step 1: Active E&O

- You must maintain active Errors & Omissions (E&O) Insurance with a minimum of $1 million in coverage for each claim
- If you have any changes to your current E&O, upload in the Network Health Agent Portal using the secure messaging feature
- Agent to send a certificate of E&O insurance to Network Health via the Agent Portal secure messaging

Step 2: Annual Training Completed

- Complete training provided by your sales executive

Step 3: Submit Certifications, if applicable

- Provide copy of your America's Health Insurance Plan (AHIP) or National Association of Benefits and Insurance Professionals (NABIP) certificate
- Provide copy of your Federally Facilitated marketplace (FFM) certification and completion date (Typically this information is automatically received from the FFM, but may be requested)
- Upload certifications to Sales in the Network Health Agent Portal secure messaging feature

Step 4: Keep Your Info Current

- Changes such as name, address, SSN, health insurance license and Tax ID changes require that you complete a W-9 form through the Network Health Agent Portal secure messaging feature to agent management

IMPORTANT FOR ALL PRODUCERS

- Your information must be current in our system for tax and communication purposes.
- Producers are required to keep their electronic funds transfer current for commissions payments. **NO PAPER CHECKS ARE ISSUED**.
- It is your responsibility to upload your current E&O certificate each year via the Network Health Agent Portal secure messaging feature.
- Missing information will result in commissions not being paid. **NO EXCEPTIONS.**
- Be sure to add your NPN and Network Health Agent ID to all applications in order to receive proper commissions.

ANNUAL MEDICARE REQUIRED TRAINING

Network Health must ensure that all agents that sell Medicare products are trained and tested annually on Medicare rules and regulations and on the specific plan benefits their agents and brokers sell. All agents and brokers are required to test independently. Prior to representing plans annually, brokers must complete Network Health's Medicare Basics or the AHIP/NABIP certification. Brokers are also required to complete the product test annually.

ANNUAL INDIVIDUAL FAMILY PLAN REQUIRED TRAINING

Brokers who assist members with enrolling in Health Insurance Marketplace Plans are required to complete Federal Facilitated Marketplace (FFM) training, annually via the **CMS.gov** website.

ERRORS AND OMISSIONS (E&O) INSURANCE

All agents must obtain and maintain E&O Insurance coverage from a carrier satisfactory to Network Health, which will cover acts and omissions of you, and, if applicable, any of your employees or agents, with minimum amounts of $1,000,000 per incident and $1,000,000 in aggregate, or such higher amounts as may be required by law or as determined by Network Health. Upon the effective date of this agreement, annually thereafter, and at such other times as Network Health may request, you must provide Network Health with certificates of insurance evidencing such coverage. Agents will provide Network Health with thirty (30) days prior written notice of any modification, termination or cancellation of such coverage. Failure to do so may result in commission being held as well as termination of the agent contract and forfeiture of your commission.

COMMISSIONS

Commissions listed are for the 2026 calendar year. Commission schedules, rates and policies may be revised and changed annually by Network Health and will be reflected in subsequent versions of the Agent Guide.

I have updated information. How do I notify Network Health?

To update information such as address, name, banking information, please access the Network Health Agent Portal's secure messaging feature by selecting Agent Management - Commissions.

Can I get paid commissions without current Errors & Omissions coverage?

No. We cannot pay commissions to any producer without current Errors & Omissions coverage. Please be sure your latest E&O policy is on file with us in Agent Connect via the Network Health Agent Portal to confirm the expiration date of the E&O certificate on file.

When are commissions paid?

Network Health pays independent agents and agencies commission monthly for active members who are assigned to the agencies. Payment is typically paid by the 20th of the month and deposited via ACH into the designated bank account.

Note – Network Health does not share or split commission payments between agents. Agencies should review the statement and alert Network Health of any commission questions or disputes within 90 days of payment. **Any disputes after 90 days of payment will not be honored.**

I am a sub-agent who assigns my commissions to my agency. How will I know when commissions are paid?

If you are a sub-agent assigning your commissions to an agency, your payment will come from your agency. Please contact your agency.

How do I view my commission statement?

Commission statements are viewable in the Network Health Commission portal only by the agency owner or authorized representative. Visit the Network Health Commission Portal at **networkhealth.callidusinsurance.net/ICM**. Enter your credentials, user id (your six-digit agency code) and enter your password. Once logged in, select the **History** tab, then select **Statements**. Please see our **Network Health ICM Producer Portal Navigation Guide found here**. Agencies should review the statement and alert Network Health of any commission questions or disputes within 90 days of payment. Any disputes after 90 days of payment will not be honored.

I am having trouble accessing my commission statement, what do I do?

If you are having trouble accessing your commission statement or need your password reset, please use the **Forgot my Password** function. Make sure you have the correct producer number, be prepared to identify yourself as an authorized user and have proper identification for security verification purposes.

How do I download my commission statement in either PDF or Excel?

- Log into the Network Health Commission Portal.
- Click on the **History** tab.
- Click on **Statements** from the left-side menu to display the Statement screen.
- Click anywhere along the row for the appropriate process year/month and history statement type. The Statement Detail screen will display along with some additional menu options.
- Click on **Statement Extract** from the left-side menu. The Statement Extract screen will display.

- Click the **Save** button in the upper righthand corner of your screen. Your Save options will display.
- Click on the appropriate icon for the desired file format. The file download box will display.
- Click **Open** to view the exported file.

Who can I contact with commissions questions?
If you have any commission questions, contact our agent management specialists using the secure messaging feature in the Agent Portal using Agent Management - Commissions.

When will I get my 1099?
On an annual basis, Network Health will mail 1099 forms showing the annual commission amount for tax purposes. This statement will be sent during the month of January for the previous year.

Why are my commissions being held or forfeited?
Commission payment may be held or forfeited for several reasons, some of which include expired E&O coverage, expired Health Insurance license, incomplete training and certification requirements, if agent is part of a lawsuit, discrepancy between agent and agency or garnish of tax levy is received. Agents must be contracted with Network Health in-order to be paid commissions.

Individual Family Plans
On-Exchange, Off-Exchange and Grandmothered plans

What are the commission rates for Individual and Family Plans?
The commission for the first year is $18 per member per month (PMPM); commissions for each subsequent renewal year is $18 PMPM.

When are commissions paid?
Commissions are paid monthly following receipt of premium payment from the insured.

When can individual and family plan members pay their premiums?
Members may pay premiums monthly, quarterly, semi-annually or annually. If a member pays quarterly, semi-annually or annually, commissions will be paid monthly as they are earned.

Do agents need to do anything to receive commissions?
Agents must have completed the Federally Facilitated Marketplace (FFM) training, which must be done on an annual basis, to receive commissions for on-exchange members.

Individual Family Plan Bonus Program

Effective in 2026, Network Health will pay a bonus for new sales (not renewals) on our Individual and Family Plan.

The bonus program is calculated by the agency and is paid to the agency in March of 2027.

This program is in addition to the commissions paid, which are $18 per member per month.

# of Members	Bonus Per Member
0-24 Members	$0 bonus per member
25+ Members	$25 bonus per member

Individual Medicare Advantage Plans

Type of Agent Commission	2026 Rates
Initial – one time annual payment	$694
Renewal – monthly	$28.92 monthly payment for 11 months, final month is $28.88 for a total of $347 annual payment

How do I become eligible for commissions?

To be eligible for initial and renewal commissions, agents must pass yearly certifications and testing and follow all Network Health and Medicare Marketing Guidelines. No commission will be paid on any enrollment application written by an agent who was not fully certified and appointed at the time the enrollment application was written.

When do I get initial rate commissions?

During the month of the plan's effective date, you will receive one lump sum payment for the initial payment. You will not receive any other commissions on these new members for that plan year. The new member initial year rate comes to you all at once. Initial commission is paid in the following three scenarios.

1. When beneficiaries are in their first year of being enrolled in an Medicare Advantage Plan.
2. When a beneficiary enrolls in an "unlike plan type," during a renewal year.
3. When a beneficiary moves from an employer group plan to a non-employer group plan.

How will I get the renewal commission for these members?

You will receive monthly renewal commission for your retained membership. So, each month you will receive the renewal commission for your held book of business.

How are initial year and renewal commissions determined?

CMS determines if an enrollment qualifies for initial year or renewal year payment and Network Health pays commissions in accordance with Centers for Medicare & Medicaid Services (CMS) determination. In compliance with the CMS Medicare Manual Marketing Guidelines, Network Health may pay the full year initial compensation amount or a pro-rated amount based on the number of months the beneficiary is enrolled.

What happens if a member disenrolls?

Member disenrollment within the first 3 months of enrollment will result in full chargeback of commissions paid in accordance with CMS's requirements.

Please Note – Agents must comply with State of Wisconsin and CMS regulations related to compensation limits, commission splitting and/or payments to non-licensed or non-appointed agents.

AGENT OF RECORD (AOR) CHANGES

INDIVIDUAL FAMILY PLANS

On Exchange

Only members may request to change their AOR. All requests for a change of AOR status are subject to Network Health's review and approval, which approval will be granted in Network Health's sole discretion. Network Health will only accept member-initiated requests for change of AOR for on-exchange members when submitted via **HealthSherpa** or **healthcare.gov**.

Off Exchange and Grandmothered plans

Only members may request to change their AOR. All requests for a change of AOR status are subject to Network Health's review and approval, which approval will be granted in Network Health's sole discretion. A request to change an AOR may be initiated by sending a handwritten request including their member identification number, reason for change and signature to Network Health. Form letters and letters on agent letter head will not be accepted.

AOR requests must be mailed to - Network Health, Attn: Individual Sales, PO Box 120, Menasha, WI 54952.

Network Health reserves the right to contact the member in order to validate all AOR changes. If Network Health approved the request for AOR, so long as the request was received by the 10th of the month, it will be processed as effective the first of that month (month of receipt). For example, an AOR request received April 10 will be processed effective April 1. An AOR request received April 11 will be processed for May 1. AOR requests will not be backdated if received after the 10th of the month. AOR changes will only be changed after 13 months of enrollment or 12 months after any previous requests.

INDIVIDUAL MEDICARE ADVANTAGE

Only members may request to change their AOR. All requests for a change of AOR status are subject to Network Health's review and approval, which approval will be granted in Network Health's sole discretion. A request to change an AOR may be initiated by the member sending a handwritten request to Network Health. The request must include the member name, member identification number, reason for change and signature. Form letters and letters on agent letterhead will not be accepted.

AOR requests must be mailed to - Network Health, Attn: Individual Sales, PO Box 120, Menasha, WI 54952.

Network Health reserves the right to contact the member to validate all AOR changes. The AOR request may be denied due to lack of confirmation. If Network Health approves the request for AOR, so long as the request was received by the 10th of the month, it will be processed as effective the first of that month (month of receipt). For example, an AOR request received April 10 will be processed effective April 1. An AOR request received April 11 will be processed for May 1. AOR requests will not be backdated if received after the 10th of month. AOR changes will only be changed after 13 months of enrollment or 12 months after any previous requests.

HIERARCHY CHANGES

As a general rule, Network Health does not support hierarchy changes between FMO and/or Agencies. If a business case may necessitate change, the request for change may be submitted to the Network Health Vice President of Medicare and Individual products or the Director of Individual Sales for review and consideration. Approval is at the discretion of Network Health.

ASSIGNMENT AND TRANSFER OF BUSINESS

All requests for assignment or transfer of business are subject to Network Health's review and approval, which approval will be granted in Network Health's sole discretion.

Network Health will consider a number of factors in determining whether to grant a change in assignment and/or transfer of business, including the following.

1. Whether the Proposed Agent has a Producer Agreement or is affiliated with an agency that has a Producer Agreement with Network Health; and
2. Whether the Proposed Agent is in full compliance with all applicable provisions of the Agreement.

Any assignments or transfers of business must comply with the procedures and requirements outlined in the Producer Agreements of both the transferring and receiving entity. All requests for review and approval of an assignment or transfer of business must be submitted in writing for approval to Network Health not less than 90 days in advance of the requested transfer date. Failure to submit requests at least 90 days prior to the requested effective date may result in requests being effective beyond the date requested, if approved. For example, a request to transfer an agency effective November 1 would need to be received by August 1 to ensure we are able to review and process for the November 1 effective date.

To submit your request, reach out to the Vice President of Medicare and Individual Products or Director of Individual Sales. In most situations a Book of Business Transfer form will need to be completed.

PRODUCER TERMINATION

Annually in March, producers who have not written six applications over the span of two AEPs and rest-of-year periods will be termed. If a producer's book of business is greater than 50 members, we will not term based on lack of production.

ELITE PRODUCERS CLUB

The Elite Producers Club recognizes Network Health's top agents and agencies.

THE BENEFITS OF BEING IN THE ELITE PRODUCERS CLUB.

- **Annual Celebration**. Qualified agents are invited to a celebration event with members of the Network Health sales and executive teams.
- **Sales Summit Event**. An exclusive event where qualifying agents are invited to have a first look at the following year's benefits.
- **Elite Producers Club Round Table Luncheon**
- **Network Health Branded Promotional Items**

HOW DO I QUALIFY AS A MEDICARE ADVANTAGE ELITE PRODUCERS CLUB MEMBER?

You must meet at least one of the enrollment qualifications.

Enrollment Qualification	Sales Effective Dates
Medicare Advantage agent who writes 20+ (AEP) enrollments	January 1
Medicare Advantage agent who writes 44+ (ROY) enrollments	February 1 – December 1
Medicare Advantage agency owners 100+ enrollments AEP or ROY	January 1 or February 1 – December 1

HOW DO I QUALIFY AS AN ACA ELITE PRODUCER CLUB MEMBER?

You must meet at least one of the enrollment qualifications.

Enrollment Qualification	Sales Effective Dates
ACA agent who writes 20+ (OEP) members	January 1
ACA agent who writes 20+ (ROY) members	February 1 – December 1

ELITE PRESIDENTS CLUB

The Elite Presidents Club recognizes Network Health's Medicare Advantage largest book of business.

THE BENEFITS OF BEING IN THE ELITE PRESIDENTS CLUB.

- **Sales Summit Event**. An exclusive event where qualifying agents are invited to have a first look at the following year's Medicare Advantage benefits.
- **Elite Presidents Club Round Table Luncheon**
- **Personalized Book of Business Support**
- **Network Health Branded Promotional Items**

HOW DO I QUALIFY AS AN ELITE PRESIDENT?

Medicare Advantage agents with a book of business size of 500+

WHEN DO I KNOW IF I QUALIFY?

The Network Health sales team will notify agents that qualify on an annual basis.

APPEALS AND GRIEVANCES

Any appeals or grievances should be directed to the plan. Only members or their authorized representatives may initiate appeals or grievances.

To file an appeal, members may call us at 800-378-5234 (TTY 800 947-3529), Monday–Friday, 8 a.m. to 8 p.m. During October 1 to March 31 of each year, we're staffed Monday–Sunday 8 a.m. to 8 p.m., or appeals can be sent via fax to 920-720-1832. Appeals may also be mailed to

Network Health
Attn: Appeals and Grievance Department
P. O. Box 120
Menasha, WI 54952

COMPLIANCE AND OVERSIGHT RESPONSIBILITY

STAR RATING REQUIREMENT

The Star Rating system helps Medicare beneficiaries compare the quality of Medicare health and drug plans being offered. CMS requires that prospective members receive a copy of the health plan's Star Rating prior to enrollment into the plan.

SCOPE OF APPOINTMENT

All one-on-one appointments with beneficiaries are considered sales/marketing events regardless of the venue in which the meeting occurs.

- A **scope of appointment (SoA)** form must be completed by the beneficiary and in accordance with CMS guidance prior to the appointment and discussion of any topics. All sections of the SOA must be completed in order for it to be valid.
- Representatives can only discuss topics that were agreed upon within the scope of appointment. A new scope of appointment is required if the beneficiary requests information regarding a different plan type than previously agreed upon.
- Scope of appointments taken telephonically or virtually must be recorded.
- Representatives may not market non-health care related products (such as annuities or life insurance).
- A scope of appointment needs to be completed at least 48 hours in advance of a scheduled appointment. However, the 48-hour waiting period will not apply in two situations:
    - If the beneficiary is within the last four days of a valid election period (such as the Annual Election Period (AEP), the Open Enrollment Period (OEP), the Initial Coverage Election Period (ICEP) or valid Special Election Period (SEP)) and an SoA is completed at the appointment;
    - If the beneficiary initiates an in-person walk-in visit. Telephonic interactions must be recorded.
- Scope of appointments are valid for 12 months following the date of the beneficiary's signature.
- The most up to date scope of appointment is found in the agent portal.

Please Note

CMS does not allow agents to solicit or accept an enrollment request (application) for a January 1 effective date prior to the start of the Annual Enrollment Period (AEP) unless the beneficiary is entitled to another special election period.

REQUIRED DISCLAIMER FOR THIRD PARTY MARKETING ORGANIZATIONS (TPMOS)

TPMOs, which include independent agents and brokers are required to use a standardized disclaimer on their website and marketing materials, including all print materials and television advertising that meet the definition of marketing. The disclaimer must be provided verbally, electronically, or in writing, depending on how the TPMO is interacting with the beneficiary. Where the TPMO is providing information through telephonic means, the TPMO is required to provide the disclaimer within the first minute of the call. This disclaimer can be on an IVR if the scripting is made available and proof that the IVR is triggered with every call.

If a TPMO does not sell for all Medicare Advantage organizations in the service area the disclaimer consists of the following statement.

- We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1 -800 -MEDICARE, or your local State Health Insurance Program to get information on all of your options.

If the TPMO sells for all Medicare Advantage organizations in the service area the disclaimer consists of the following statement.

- Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact **Medicare.gov**, 1-800-MEDICARE, or your local State Health Insurance Program for help with plan choices.

AGENT OVERSIGHT PROGRAM

As part of Network Health Agent Oversight Program, Network Health may conduct random sampling of Scope of Appointment forms, telephonic enrollments and audio portions of calls via web-based technology, in their entirety. Network Health will also investigate agent complaints. Agents are expected to respond to requests from **salesoversight@networkhealth.com**.

MEDICARE MARKETING GUIDELINES

The Centers for Medicare and Medicaid Services (CMS) releases Medicare Marketing and Communication Guidelines which are designed to implement requirements and related provisions of Medicare Advantage (MA) and Medicare Prescription Drug Plans (PDP). Visit **CMS.gov** for a full overview of these guidelines.

Agents are prohibited from engaging in actives which mislead or confuse beneficiaries or misrepresent Network Health and its available plans. Network Health requires its agents and any other person or agency acting on its behalf, to submit print advertisements or website content that uses Network Health's name, logo, services provided or products, for approval prior to use. Agents are informed of this requirement by e-newsletter or letter from the sales department each year (see Policy n03563-NHP/NHIC-Communicating Changes in Wisconsin Insurance and Federal Law).

RECORD RETENTION POLICY

To ensure compliance with our contract with the Centers for Medicare and Medicaid Services (CMS) and federal regulations, all records pertaining to all Medicare and Qualified Health Plan (QHP) individuals you serve must be retained for at least ten (10) years. After the expiration of the required retention period, all records should be destroyed securely unless there is an exception made to store the record longer (i.e., active litigation or audit). Records include executed SOAs, telephonic recordings, completed applications, etc. Agents are responsible for retaining appropriate records and producing them at the request of Network Health.

CALL RECORDING REQUIREMENT

1. Do I have to record all my calls?
    a. You are required to record all sales, marketing and enrollment calls.
2. Do I have to record in person meetings?
    a. No. In-person meetings do not need to be recorded.
    b. Sales, marketing and enrollment telephone calls and virtual appointments (such as a Microsoft Teams meeting or Zoom call) must be recorded.
3. How long do I need to store the call recordings?
    a. CMS requires all calls and recordings relating to Medicare beneficiaries and QHP individuals be kept for 10 years.
4. What will the expectation be to reproduce calls?
    a. You will be required to reproduce calls in the event of an audit or for health plan monitoring activities.
5. Do I need to record service calls?
    a. No, service calls do not need to be recorded.
6. What about calls to review plan changes with a current client?
    a. No, not unless the client decides to make a change and the call transitions to a sales, marketing or enrollment call.
7. If I am setting an appointment with a prospect, do I need to record those calls?
    a. No, unless a scope of appointment is collected at the time of the call.

8. If I am using a cell phone for most of my business, is the expectation those calls also should be recorded?
    a. Yes, sales, marketing and enrollment calls must be recorded. You should make sure the system you are using has the ability to maintain Protected Health Information (PHI) in an encrypted way.
9. Are there recommendations on how to handle this call recording?
    a. Many options exist. We are aware of Connecture offering a recording option with their Broker Edge platform.
    b. Your agency phone system may have this option.
    c. You should make sure the system you are using has the ability to maintain PHI in an encrypted way.
10. For the disclaimer – if it is prerecorded and played prior to the call starting, how can you prove that the disclaimer was provided to the client?
    a. Brokers can use an Interactive Voice Response (IVR) to deliver the disclaimer if the scripting is made available and proof the IVR is triggered for every call
    b. Brokers must read the disclaimer to the individual within the first minute of a sales call.
    c. Disclaimer language should include that State Health Insurance Assistance Programs (SHIP) are available as a resource and should state the number of organizations represented by the TPMO and the number of plans available in the beneficiary's service area.

CODE OF CONDUCT

Why We Have a Code

Our Code of Conduct (Code) is the cornerstone on which our commitment to excellence is built. A workplace free of inappropriate, illegal or negative conduct and compliant with rules, laws and regulations is consistent with our Mission, Vision and Values, and provides information and answers to help us model our core Values. Network Health is committed to providing, and employees are responsible for ensuring a workplace free of inappropriate, disruptive and/or illegal behavior which inhibits effective communication, productivity and member/participant/employee sense of belonging and/or safety.

One of Network Health's strongest assets is our reputation for integrity and honesty. Network Health operates our business with sound ethical standards in full compliance with state and federal laws and regulations, including but not limited to the Centers for Medicare and Medicaid Services (CMS), Medicare Part C, Part D and Qualified Health Plan (QHP) requirements. Achieving business results by illegal acts and/or unethical conduct is not acceptable.

We are committed to open communication, and therefore encourage all employees and delegated entities to voluntarily contact Network Health's compliance officer, or designee, without fear of intimidation and/or retaliation if they seek clarification, have any questions or to report potential and/or actual noncompliance. Employees who have questions about the Code or its applicability to a particular situation should contact their direct leader or a member of the compliance department.

Who Has To Follow It

As an important component of Network Health's human resources and corporate integrity programs, our Code describes the basic principles all Network Health employees at every level of the organization, including contracted agents, must follow. This Code applies to all business units and reflects a commitment to detecting, preventing and correcting issues of noncompliance and fraud, waste and abuse in the administration or delivery of benefits for all lines of business including commercial, Medicare Part C &

Part D and Qualified Health Plan (QHP). All employees must conduct themselves in a manner consistent with this Code when they are acting on behalf of Network Health. Network Health strives to write the Code in an easy to read format and ensures it is accessible to all employees.

All Network Health employees and delegated entities are responsible for their own behavior and personal conduct in accordance with our Mission, Vision and Values. Failure to meet standards defined within the Code by demonstrating inappropriate/illegal/disruptive behaviors or conduct may result in corrective action, up to and including termination of employment. This Code is not intended to and shall not be deemed or construed to provide any rights, contractual or otherwise, to employees, delegated entities or other third parties.

To view Network Health's Code of Conduct in its entirety, **click here**.

Compliance Reporting
If you have compliance concerns, report them by the following.

1. Complete an Incident Form in Healthcare Compliance Core (**nh-hcc.com**)
2. Contact the compliance hotline (anonymous, 24/7) at 877-700-7020
3. Email an employee in the compliance department at **compliance@networkhealth.com**

INDIVIDUAL MEDICARE ENROLLMENT REQUEST TIMELINESS

Agents are required to submit an enrollment application, including short enrollment forms, to Network Health the same day they are received. Agents may submit new business:

- on our website **networkhealth.com**
- via fax to 920-720-1931, 920-720-1232 or 920-720-1933
- Scan and upload to the agent portal secure messaging
- drop off applications to Network Health.

After enrollments are submitted, agents will receive an email notification within 24-48 business hours, to check the Application Verifications feature of the Agent Portal. Please note this is confirmation that the application was received by Network Health. **It is not confirmation of enrollment.** Agents are expected to check their agent portal application verifications feature to ensure all business written was received by Network Health. Agents should also validate that the plan is correct.

If an agent receives an application via mail and the prospect has already signed and dated the application, the agent will note on the last page of the application why the signature date is not the same as when the agent is submitting the business.

Agents should complete short enrollment forms when current members would like to make a change to their plan.

Remember to add your name, 6-digit agent writing number and National Producer Number (NPN) to all enrollment forms in order to receive commissions and be listed as the Agent of Record.

network health

1533-21-0925