POLICY

Name:	Disciplinary Guidelines – Broker Agents	Number:	B0001
Department:	Compliance	Original Issue Date:	7/16/2013
Originator:	Marilyn Ferreira	Effective Date:	7/16/2013
Last Reviewed by:	Ryan Scully	Replaces:	M0001
Last Revised Date:	1/30/2014	Last Reviewed Date:	6/30/2016; 7/31/2017; 8/1/2018
Date of Approval:	11/21/2013		
Approved By:	Thomas Donegan Sr. VP & General Counsel	Signature:	

Guidance:
Medicare Managed Care Manual – Section 50.5.3 – Well-Publicized Disciplinary Standards

Policy

The Company establishes and maintains disciplinary standards that reflect clear and specific policies which encourage compliant behavior and awareness of and participation in the Compliance, Fraud, Waste and Abuse (FWA), and HIPAA training programs.

Our standards include policies that:

- Identify the Company's expectations for reporting compliance issues and assisting in the resolution of such issues;
- Identify noncompliance, FWA or HIPAA violations, including unethical or illegal behavior; and
- Provide for timely, consistent, and effective enforcement of standards and reporting when violations are determined to be founded.

Violation of the Company's Policies and/or CMS/DOI Regulations

Level I - if founded, will result in immediate termination of contract (CEO/President and/or principal of the marketing company makes the final determination in consultation with the Company's Legal/Compliance Department).

1. Dishonesty or theft.
2. Medicare Advantage door to door solicitation, improper outbound phone calls or sending unsolicited emails.
3. Misrepresentation of the product, the purpose of the sales agent's visit, or an implication that the visit is in any way connected with the government.
4. Discriminating against potential enrollees on the basis of health status, ethnicity, or personal needs.
5. Threatening, coercing, intimidating, or deceiving a member or prospective member, or the use of any other unethical sales tactics.
6. Blatant misrepresentation of plan benefits or plan premiums.
7. Marketing non-health care related products to prospective enrollees during any Medicare sales activity or presentation.
8. Negligent failure to provide full disclosure of any plan limitations and comparison to their current coverage to ensure the beneficiary understands any difference in benefits, costs and/or access to providers.
9. Forging or knowingly accepting a forged signature on an enrollment form.
10. Deliberate or negligent omission or falsification of significant information on any form, including carrier, state, and Company forms.
11. Enrollment of beneficiaries by an unlicensed individual or not licensed in a specific state.
12. Willfully enrolling an incompetent beneficiary.
13. Failure to maintain the privacy and security of all protected health information (PHI) in accordance with HIPAA guidelines and Company guidelines.
14. Offering or accepting inducements or favors to enroll.
15. Rebating or splitting commissions with another person who is not a licensed and contracted agent (i.e., payment of any kind or amount to a member or non-member as reimbursement for a referral name on the condition that the referred person purchases an insurance product).
16. Willful failure to assist a member with a disenrollment request (direct the member to call the carrier's member services division).

Level I Disciplinary Actions

Termination of contract

Level II: The following valid sales allegations are defined as egregious and subject to progressive discipline, up to and including termination of contract. (This list is a representative sample and is not all-inclusive.):

1. Requiring beneficiaries to provide any contact information as a prerequisite for attending an event.
2. Providing food/meals to potential enrollees that does not adhere to CMS Chapter 3 guidelines for Medicare Advantage and Prescription Drug Plan sales (snacks may only be provided).
3. Disparaging competitor plans, Medicare, or health care reform.
4. Incorrect enrollment paperwork/clerical error.
5. Marketing health care related products not identified or agreed upon on the telephonic or paper scope of appointment form.
6. Holding applications (when it impacts the member's effective date) or failing to submit applications within the carrier's specific time requirement.

Level II Disciplinary Actions
Valid: Level 2 Allegations – based on a rolling six (6) month period:

- First Occurrence – Coaching/Counseling
- Second Occurrence – First written warning
- Third Occurrence – Final written warning
- Fourth Occurrence – Termination of contract

Steps may be omitted at the discretion of the Company.

Invalid: Level 2 Allegations
Track and trend

Level III

Parameters of submitted vs. accreted sales (rapid disenrollment – defined as member cancellation/disenrollment during the first 90 days of enrollment) and rolling ninety (90) day cycle throughout the enrollment year. The expectation is a 5% or lower disenrollment rate.

Category 1: 0-10 enrollments
Category 2: 11-20 enrollments
Category 3: >21 enrollments

Level III

Category 1:	0-4%	disenrollment average – No Action
	5-10%	disenrollment average – Coaching
	11-20%	disenrollment average – First written warning
	> 20%	disenrollment average – Corrective action plan
Category 2:	0-4 %	disenrollment average – No Action
	5-10 %	disenrollment average – Coaching
	11-25%	disenrollment average – First written warning
	>26%	disenrollment average – Corrective action Plan
Category 3:	0-4%	disenrollment average – No Action
	5-15%	disenrollment average – First written warning
	21-25%	disenrollment average – Final Written Warning
	>26%	disenrollment average – Termination of contract

Steps may be added and/or omitted at the discretion of the Company.

POLICY

Title:	**Marketing Material Submission & Review**	Number:	B0002
Department(s):	Brokerage Companies & Legal	Original Issue Date:	11/21/2013
Originator:	Marilyn Ferreira	Effective Date:	1/1/2013
Reviewed by:	Ryan Scully, Legal	Replaces:	
Reviewed Date:	7/15/2015, 6/20/2016; 7/31/2017; 8/1/2018; 1/23/19	Last Revised Date:	1/23/19
Reference:	MMG Chapter 30		
Approved By:	Ryan Ramsey, Esq. Corporate Counsel	Signature:	

Guidance
2018 - Medicare Communication and Marketing Guidelines – 90 – Tracking, Submission and Review Process

Policy

Advertising and marketing material, in any form, must be approved by both the carrier, if applicable, and the Company's Legal/Compliance Department prior to submission for printing and distribution. Marketing material will be reviewed for compliance and applicable laws, with a view towards ensuring materials are complete and accurate and devoid of deception or the capacity to mislead or deceive.

1. Marketing company/brokers submits the desired generic marketing piece, written carrier approval of the marketing piece (if applicable), source of statistical material content, if applicable, and submits the documents to the Company's Legal/Compliance Department.
2. Legal/Compliance Department evaluates the marketing piece to include the following:
   a. Review of material content for accuracy including spelling and grammatical errors
   b. Ensures inclusion of all applicable guidelines, regulations and disclaimers
      a. Documents requiring revisions will be returned to the individual/department submitting the marketing piece.
      b. Revised document will be sent to the Compliance Department for final review and approval
   c. Final document will be reviewed, issued an approval code and returned to the submitting individual/department.

POLICY

Title:	**Agent/Agency Website Guidelines**	Number:	B0003
Department(s):	Brokerage Companies & Legal	Original Issue Date:	1/24/2014
Originator:	Marilyn Ferreira	Effective Date:	1/27/2014
Last Reviewed by:	Marilyn Ferreira Ryan Scully, Legal	Replaces:	
Last Revised Date:	7/18/2015; 6/20/2016; 7/31/2017; 8/1/2018	Last Revised Date:	8/1/2018
Date of Approval:	1/27/2014		
Approved By:	Thomas Donegan, Sr. VP & General Counsel	Signature:	

Guidance
2018 – Medicare Communication and Marketing Guidelines – 90.4 Submission of Websites and Webpages for Review

Policy

Plans/Part D sponsors must submit website marketing content for review, including contracted third-party websites. However, Plans/Part D sponsors do not need to submit webpages with or containing CMS required content (refer to sections 70.1.2, 70.1.3, and 70.2) for review.

Plans/Part D sponsors may submit website marketing content to CMS as either screen shots or a link to a test page. Website content submitted for review may not be viewable to the public prior to CMS approval. Plans/Part D sponsors must resubmit all updates to the marketing content.

POLICY

Title:	Background and Exclusion Verification Policy	Number:	B0004
Department:	Legal	Original Issue Date:	10/31/2014
Originator:	Marilyn Ferreira	Effective Date:	10/31/2014
Last Reviewed by:	Ryan Scully; M. Ferreira	Replaces:	
Last Reviewed Date:	7/18/2015; 6/20/2016; 7/31/2017; 8/1/2018	Last Revised Date:	
Date of Approval:	10/31/2014		
Approved By:	Ryan Scully, Esq.	Signature:	

Guidance

Medicare Managed Care Manual – Chapter 21; Section 50.6.8 – OIG/GSA Exclusion

Policy

The Department of Health and Human Services ("HHS") Office of the Inspector General ("OIG") provides information to the health care industry and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs. This information is set forth in the HHS-OIG list of excluded individuals/entities ("LEIE"). The LEIE includes mandatory exclusions (e.g., conviction of Medicare fraud) and permissive exclusions (e.g., misdemeanor convictions related to health care fraud other than Medicare) for which the OIG has the discretion to exclude individuals and entities on various grounds. The General Services Administration ("GSA) Excluded Parties List System and System for Award Management debarment list include exclusions taken by various federal agencies.

The Company does not hire or contract in the health care business with individuals and entities that are identified on the HHS-OIG LEIE or GSA exclusion lists. Accordingly, and as set forth more fully in the Company's background check guidelines, the Company checks potential new hires against the HHS-OIG LEIE and GSA exclusion lists prior to hire and verifies the status of associates on a monthly basis against the HHS-OIG LEIE and GSA exclusion lists. The Company screens vendors against the HHS-OIG and GSA excluded parties list. If a finding of a potential match against the HHS-OIG list or GSA exclusion list is made, the Human Resources Department and Legal Department will review the information to determine if the name on the list is a match to the applicant or employee and conduct a further identity verification using a social security number and/or other identifying information depending on the exclusion list being checked. Agents are also checked against the HHS-OIG LEIE and GSA exclusion list by the respective insurance companies at the time of appointment and monthly thereafter and they notify the Company of any HHS-OIG and GSA findings.

If a finding is made by the Company, the Human Resources Department and Legal Department will review the information to determine if the name on the list is a match and will take appropriate action

and make the required report of any findings to the contracted Field Marketing Organization (“FMO”). Thereafter, the
contracted FMO will alert any and all applicable contracted carriers. The Company’s records maintenance requirements must include, but are not limited to, a minimum of ten (10) years.

POLICY

Title:	**Thrivent Marketing Material Submission & Review**	Number:	B0005
Department(s):	Broker Sales and Distribution	Original Issue Date:	10/1/2016
Originator:	Marilyn Ferreira	Effective Date:	10/1/2016
Reviewed by:	Ryan Scully/Derek Richardson	Replaces:	
Reviewed Date:	10/1/2016; 7/31/2017; 8/1/2018		
Reference:	Thrivent Producer Compliance Guide	Last reviewed date:	
Approved By:	Nathan Hightower General Counsel	Signature:	

Guidance
Thrivent Producer Compliance Guide

Policy

Fraternal Status

To protect their fraternal heritage and maintain the fraternal status, Thrivent follows the federal and state requirements applicable to fraternal benefit societies. As a contracted partner, the Company will not inappropriately use the Thrivent fraternal status as a competitive advantage.

Material Approval

Advertising and marketing material in any form; e.g., agent-facing, consumer-facing, applicants and policyholders must be submitted to Thrivent's Compliance Department for review and written approval prior to distribution. Thrivent will review all marketing for compliance and applicable laws, with a view towards ensuring materials are complete, accurate and devoid of deception or the capacity to mislead or deceive.

Thrivent will provide an approval code for all approved marketing material.