

A close-up portrait of an elderly Black man with a white mustache, wearing a white fedora with a black band, a light blue dress shirt, a dark blue polka-dot bow tie, and a mustard yellow sweater. He is smiling and looking upwards and to the right, with his hands near his chest. The background is a solid dark blue with a purple geometric shape in the top left corner.

Rules of Engagement

2025 Agent and Agency Sales Handbook

10/01/2025

This version of the Rules of Engagement is effective 10/1/25. Health Care Service Corporation, a Mutual Legal Reserve Company, acquired the Cigna Group Medicare business in March 2025. All references in the ROE to HealthSpring are references to HealthSpring products and services provided exclusively by or through operating subsidiaries of Health Care Service Corporation. You will continue to market and sell products under the Cigna branding and product names for the remainder of the 2025 plan year effective sales. All commission payment schedules for 2025 plan year effective date sales remain the same and can be found in Producers University under 2025 commission schedule. Annual payment schedules with the new branding and HealthSpring product name changes for the 2026 plan year are included in this version of the Rules of Engagement.

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To open links within this document that are part of **Producers' University**, Agent/Agency must be logged into the system prior to opening.



Key Acronyms and Terminology



Key Acronyms and Terminology

AEP - Annual Enrollment Period

Agent - Independent Agents, Licensed Only Agents, or Brokers

AHIP - America's Health Insurance Plans

AOC - Agents Assignment of Commissions

AOR - Agent of Record

ASM - Agreement to Service the Member

ARC - Agent Resource Center

CMS - Centers for Medicare and Medicaid Services

CSV - Customer Service Violation

CTM - Medicare Complaints Tracking Module

D-SNP - Dual Eligible Special Needs Plan(s)

DOB - Date of Birth

Downline Agency - Agency underneath a Topline Agency

EFT - Electronic Funds Transfer

FDR - First Tier, Downstream and Related Entities

FMO - Field Marketing Organization

GA - General Agency

HPMS - Health Plan Management System

MAPD - Medicare Advantage and Prescription Drug

MAO - Medicare Advantage Organization

MBI - Medicare Beneficiary Identifier

MCMG - Medicare Communications and Marketing Guidelines

MGA - Managing General Agency

MIPPA - Medicare Improvements for Patients and Providers Act

NAHU - National Association of Health Underwriters

NFMO - National Field Marketing Organization

NPN - National Producer Number

PDP - Prescription Drug Plan

Personal Business Entity - Business entity commissions are assigned to but does not qualify as an Agency

PII - Personally Identifiable Information

PHI - Protected Health Information

RFI - Request For Information

RFMO - Regional Field Marketing Organization

ROE - Rules of Engagement

SDAP - Sales Development Action Program

SFTP - Secure File Transfer Protocol

SGA - Supervising General Agency

SOA - Scope of Appointment

SSA - Social Security Administration

SSN - Social Security Number

TIN - Tax Identification Number

Topline(s) - Directly contracted Agencies

TPMO - Third Party Marketing Organizations

Upline - Upstream Agency



Sales Distribution Management



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Sales Distribution Management

Levels and Engagement Criteria

Agencies

There are four different levels of Topline Agencies within the hierarchy structure at HealthSpring. To enter into an Agency Agreement, all Agency levels

MUST:

- Have a federal tax identification number.
- Possess all requisite permits, licenses and other approvals issued by the regulatory insurance Agency of the applicable state(s) in which the agency is appointed and in which HealthSpring operates.
- Meet all applicable laws, rules and regulations.
- Must have a licensed, certified, and active principal agent.

In addition, agencies should have a minimum number of active Agents and annually meet or exceed the hierarchy level requirements.

Note: Expansion market Agency targets may vary based on network and other factors at market launch.

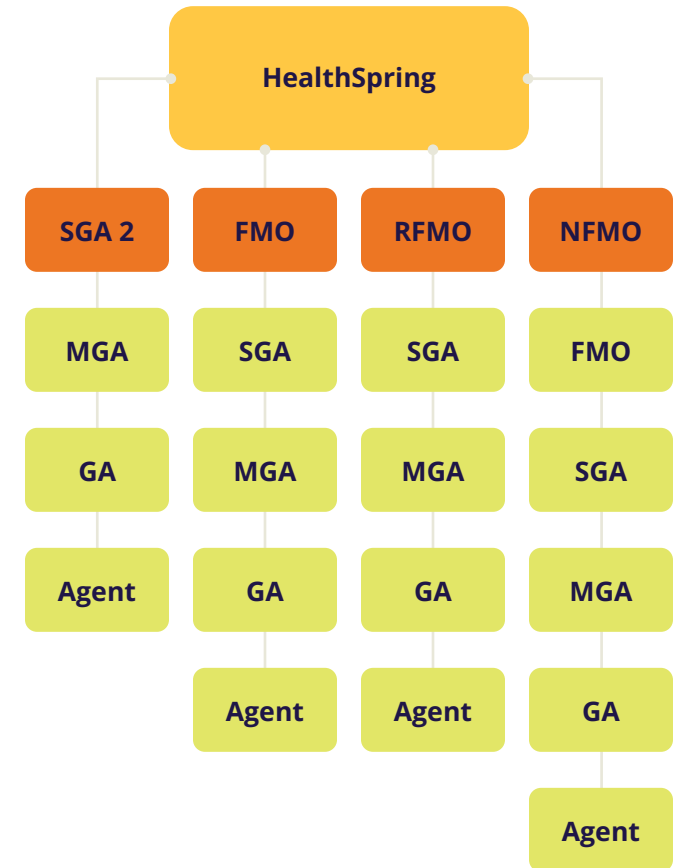
Independent Agents

Must contract directly with HealthSpring or contract through an Upline Agency.

- Agents directly contracted with HealthSpring are prohibited from contracting with an Upline Agency without HealthSpring approval.
- An Independent Agent can be a LOA, Direct Pay or may assign their commissions to a Personal Business Entity.

A Personal Business Entity:

- Must utilize an entity with a TIN to assign commissions to.
- Must possess all requisite permits, licenses and other approvals required by applicable law.
- Is not subject to engagement criteria.
- Does not qualify for non-enrollment service fees.
- May only have one broker assigning to a personal business entity.



Sales Distribution Management

Field Distribution Engagement Criteria

To enter and maintain an Agency Agreement, the Agency will need to meet or exceed the requirements as outlined in the table below.

Level	Agents RTS	Agents Writing	Agent States	CSB Contract	Book of Business
Topline Agency Level Requirements					
NFMO	1,000	500	20+	Yes	2,000
RFMO	500	250	10+	Yes	1,000
FMO	250	125	1+	Yes	500
SGA 2	25	12	1+	Yes	250
Downline Agency Level Requirements					
FMO	100	50	1+	No	500
SGA 1	25	12	1+	No	150
MGA	10	5	1+	No	50
GA	3	1	1+	No	20

Call Center Agency Engagement Criteria

Call Center Agencies are required to meet the minimum number of active Agents (during AEP) and meet or exceed the other requirements outlined in the table below.

Level	Agents RTS	Agents Writing	Agent States	CSB Contract	Book of Business
National Topline Agency Level Requirements					
NFMO	500	250	20+	Yes	2,000
RFMO	250	125	10+	Yes	1,000
FMO	125	75	1+	Yes	500
SGA 2	25	12	1+	Yes	250
Downline Agency Level Requirements					
FMO	50	25	1+	No	500
SGA 1	25	12	1+	No	150
MGA	10	5	1+	No	50
GA	3	1	1+	No	20



Sales Distribution Management

Engagement Criteria Additional Details

- New to HealthSpring Agencies have the following ramp-up periods:
 - 90 days for all Agency levels to get 3+ Agents RTS
 - 6 months for MGA/SGA/FMO levels to reach minimum Agents RTS for their level
 - 1 year for all Agency levels to reach minimum Agents writing and minimum Book of Business for their level
- To upgrade to a higher level, all requirements above must be met ahead of submission of the upgrade request and meet all other requirements in the recruitment and onboarding section of the ROE.
- Failure to meet Agency requirements may result in downgrade or termination of the contract with 30 days' notice.
- HealthSpring reserves the right to review all Agency-level contracts to ensure Agency requirements are being met at all times.
- New downline agencies contracting at the FMO-level must be pre-approved.
- Agencies operating as a downline call center are required to complete the Downline Call Center Profile and Requirements Document prior to being approved to onboard as a call center or upgraded to a higher agency level contract. For more information see the Call Center Guidelines section of the ROE.
- In order to receive sales and operational support, all Downline agencies operating as a Call Center must work with their Topline to ensure proper notification to HealthSpring. See page 35 for more detailed Call Center Guidelines.



Calendar Year at a Glance



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Calendar Year at a Glance

OEP	January	• OEP begins • AEP new application commissions distributed • Existing MA member renewal compensation paid the last Wednesday of the month
	February	• Full year advance for existing PDP member renewal compensation • Existing MA member renewal compensation paid the last Wednesday of the month
	March	• Agency annual measurement period begins • OEP ends 3/31 • Existing MA member renewal compensation paid the last Wednesday of the month
AEP Readiness	April	• Existing MA member renewal compensation paid the last Wednesday of the month
	May	• Existing MA member renewal compensation paid the last Wednesday of the month
	June	• Existing MA member renewal compensation paid the last Wednesday of the month
	July	• Annual certification release • Self-Release requests must be submitted no later than 7/15 and a new completed contract must be received by 10/15 or the request will not be processed. • Existing MA member renewal compensation paid the last Wednesday of the month
	August	• Existing MA member renewal compensation paid the last Wednesday of the month
	September	• Hierarchy changes are not accepted or permitted from September 15 to December 31 (see pg. 16 for specifics) • Existing MA member renewal compensation paid the last Wednesday of the month
AEP	October	• AEP Marketing period begins: 10/1 • AEP Sales period begins: 10/15 • Existing MA member renewal compensation paid the last Wednesday of the month
	November	• Last day for current plan year effective sales: 11/30 • Existing MA member renewal compensation paid the last Wednesday of the month
	December	• AEP ends: 12/7 • Last day to submit an HRA for AEP enrollments is: 12/24 • Agent certifications, recontracting and up-to-date licenses and appointments deadline: 12/31 Failure to complete, may result in forfeiture of commissions and contract termination. • Existing MA member renewal compensation paid the last Wednesday of the month



Recruitment and Onboarding



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Recruitment and Onboarding

Recruitment Ethics

- As an Agency grows through recruitment campaigns, it is common to come across existing HealthSpring Agents and Agencies. As a rule, Agencies cannot contract with any current directly contracted or employed HealthSpring Agent without written consent from HealthSpring.
- As a general guideline, HealthSpring requests the Agency respectfully walk away from any current HealthSpring Agent or Agency writing under an existing hierarchy. To assist Agencies in minimizing outreach, HealthSpring local markets can scrub its recruitment list to remove those actively contracted.
- Recruiting Agencies must ensure that they are not paying Agents more than Fair Market Value (FMV) compensation as set by CMS each year to recruit the agent away from another Agency. In addition, recruiting Agencies must not offer to pay current or potential downline Agencies more than FMV for non-enrollment service fees they are providing their hierarchy and must ensure they are not inducing Agents or Agencies to promote one health plan or carrier over another.

Qualifications

Action	Agent	Agency
Complete HealthSpring Credentialing.	✓	✓
Complete HealthSpring Training and Certification (prior to selling and annually thereafter) on Producers' University .	✓	
Complete any instructor-led virtual or in-person training that may be required by HealthSpring.	✓	✓
Hold appropriate active health insurance license in good standing within the state(s) Agency or Agent intends to market and submit HealthSpring applications.	✓	✓
Be appointed by HealthSpring in the states Agent/Agency sells and submits applications, either prior to selling or after the first sale as applicable, per state regulations.	✓	✓
Have an executed agreement with an NFMO, a RFMO, an FMO, an SGA2 (not a recruitable level), an SGA, an MGA, a GA or HealthSpring.	✓	✓
Comply with all legal, compliance and regulatory guidance in accordance with applicable state/ federal laws and HealthSpring policies.	✓	✓
Receive continuing education relative to the current MA/MAPD/PDP products and comply with any changes that occur relative to this program.	✓	✓
Attend all meetings required by HealthSpring to stay informed of compliance, regulatory, procedural and network changes.	✓	✓
Participate in integrity oversight evaluations and the HealthSpring SDAP as required by CMS and HealthSpring.	✓	✓
Have valid email address on file for receiving communications concerning immediate regulatory or network changes.	✓	✓
Maintain a proficiency in and knowledge of HealthSpring MA/MAPD/PDP products as well as all necessary compliance requirements.	✓	✓
Comply with HealthSpring sales performance and disciplinary standards as set forth in this <i>Rules of Engagement Handbook</i> and the <i>HealthSpring Policy Handbook</i> .	✓	✓
An active agent/agency must maintain Errors & Omissions insurance coverage with limits no less than what is required by HealthSpring or the state of domicile, if applicable.	✓	✓



Recruitment and Onboarding

Contracting

To sell HealthSpring MA/MAPD/PDP products, all Agents/Agencies must be properly credentialed and contracted. HealthSpring has chosen [Producer Express](#) (Sircon) as the data source for their eContracting system. To start the contracting process, **external Topline Agencies are responsible for initiating onboarding and maintenance requests for all Downline Agencies and Agents through the eContracting system.** Once the contracting information is completed by appropriate Downline and submitted to HealthSpring, a background check is initiated and HealthSpring will submit pre-appointments as applicable by state per the contract request. Following successful completion of the background check and appointment processing, as applicable, Agents will receive access to Producers' University to register for and complete Certification. Upon successful completion of the contracting process, background check and certification, Agents/Agencies must remain active and eligible to sell and continue to meet all validations (actively contracted, certified, licensed, appointed). In order to service members and maintain renewal commissions, Agents/ Agencies must remain in good standing and continue to meet all validations (actively contracted, certified, licensed, appointed). For further specific Telesales Agency-related onboarding, see the [Call Center Guidelines Section](#) of this document.

Additional contracting resources:

- [eContracting Guide for Recruiters](#)
- [eContracting Guide for Agents](#)

Note: All agencies doing business with HealthSpring must be onboarded with the appropriate agency-level contract, have an active credentialed principal (AOR) and have their downline agents reporting into their hierarchy. The principal agent for the Agency must also complete a separate Downline Agent contract to contract as an individual selling Agent or as AOR for the Agency and must maintain all applicable licenses, appointments, and certifications in order for the agency to be eligible for compensation. All other requirements for eligibility must be maintained. (Additional information can be found in the Compensation Rules section.)



Recruitment and Onboarding

Licensing and Appointments

All Agents, Agencies, and Agency Principals must be licensed and appointed in all states they market and sell HealthSpring products. Agents, Agencies, and Agency Principals are responsible for obtaining and keeping the appropriate licensure (Note: Rules vary by state) and must remain licensed and appointed to service members in order to continue receiving renewal commissions. Upon request, HealthSpring will only appoint in advance for *pre-appointment states where HealthSpring actively sells Medicare business, as required by state regulations.

Where state law permits, the appointment(s) will be requested after the first sale is received by HealthSpring. A valid license must be held regardless of appointment process used. For additional questions, contact applicable Topline or Local Market Manager for further details.

When an Agent/Agency intends to sell HealthSpring products in additional pre-appointment state(s), they must inform their recruiter, who will initiate the request. Agent/Agency is not approved to begin selling in additional pre-appointment state(s) until confirmation is received from HealthSpring of the specific state appointment(s). If an Agent or Agency has any additional questions or needs assistance with any part of the onboarding process, please contact [ARC](#).

Errors and Omissions Requirements

HealthSpring requires all active Agencies and independent agents to carry an Errors and Omissions (E&O) policy consistent with industry standards but at least \$1,000,000 per occurrence and \$3,000,000 aggregate limit with a reasonable deductible. The Agency is required to notify HealthSpring of any reduction, modification, cancellation or termination of the E&O insurance.

The Agency and their Topline (if applicable) are required to ensure all individuals employed by or contracted by the Agency (including Subordinate Agents) shall maintain E&O Insurance. E&O policies should be consistent with industry standards but at least \$1,000,000 per occurrence and \$1,000,000 aggregate limit with a reasonable deductible, or the applicable state required coverage amounts. The Agency and their Topline (if applicable) are required to provide evidence of such coverage upon request. Failure to maintain adequate E&O Insurance in accordance with the Sales Agreement and Rules of Engagement is considered a breach of the Agreement and may lead to disciplinary actions up to and including termination.

***Pre-appointment states for MA/MAPD include:** Alabama, Oklahoma, Oregon, Pennsylvania, and Washington

***Pre-appointment states for PDP include:** Alabama, Indiana, Louisiana, Montana, Oklahoma, Oregon, Pennsylvania, Washington, and Wisconsin



Recruitment and Onboarding

Hierarchy Change to a New Topline

When an Agency/Agent changes hierarchy, residual Service Fees are retained by the hierarchy structure and subject to the contract terms in place at the time of the original sale. Hierarchy changes are subject to the HealthSpring blackout period.

Hierarchy Blackout Period

New Hierarchy changes are not accepted or permitted from September 15 to December 31 except under the rules below.

Self-Release Blackout

In order to process your hierarchy change prior to the blackout, all agents and agencies must submit their request for self release to HealthSpring no later than 7/15. Contracting with your new Topline agency must be received by HealthSpring on or before 10/15 or your request will not be processed. Request for self-release should not be submitted and cannot be processed between 7/16 - 10/1.

On or after 10/2, new requests for self-releases can be submitted but they will not be effective until after the 90 day waiting period.

Topline Approved Release Blackout

Topline Approved Releases signed by 9/15 (blackout period start date) will be accepted as long as the new completed Topline contracting is received on or before 10/15. Topline approved releases are only valid for 60 days from the signature date. Therefore please be sure any releases submitted during the blackout period are signed and dated to meet the 60 day requirement or they will be rejected.



Recruitment and Onboarding

How to Obtain a Release

1. Obtain a release letter signed by the current Topline Agency.
2. If the Topline Agency is unwilling to grant a release, the Agent/Agency can submit a signed and dated **"Request for Release Form"** located on **Producers' University** to **ARC**. This will serve as the Agent's/Agency's notice of intent to change to a new sales hierarchy and will start a ninety (90) calendar day waiting period to be eligible to switch hierarchies without a release.
3. Once a release is received or the 90 day waiting period has ended, no change in hierarchy will occur until new contracting has been received and processed from the new Topline. **If new contracting is not received, the Agent will remain in their current hierarchy.**

Topline releases are valid for 60 days after the date of the release letter. HealthSpring Approved Call Center agents that can provide a termination letter from their employer showing proof of termination will have the ability to re- contract without obtaining a release.

Limitations

After the initial acknowledgment of the change request, no additional notices or reminders will be sent from HealthSpring regarding the eligibility date. At the end of the ninety (90) calendar- day waiting period, the Agent/Agency will be free to onboard with the Agency of their choosing.

The ninety (90) calendar day time frame for a release officially begins on the day the ARC email box receives the release form. For all move requests, changes are required to be processed within 60 days from the date the Agent/Agency is eligible to move (date of release letter or 90-day waiting period end date), or a new request, qualification check and waiting period are required. Agents may continue to sell during the ninety (90) calendar-days, but the business sold in that ninety (90) calendar-day time frame remains under the hierarchy in place at the time the business is written.

Agents/Agencies in the Topline hierarchy are permitted to change sales hierarchies no more than once per calendar-year under the ninety (90) calendar day notice scenario. When an Agency is released the contracted Downline Agents/Agencies are considered to be included in that release, unless other arrangements are requested by the Topline Agency and approved by HealthSpring.

An Agency must transfer to the same or lower contract level with the new Topline Agency. The Agency may only upgrade to a higher contract level after six (6) months from the change date if Downline Agent and all other level requirements are met and HealthSpring approval is granted.

When an Agency is terminated, and in the event of a broken hierarchy at the time of termination, all direct pay Downline Agents and Agencies will roll up to the next active Agency in the hierarchy. All LOA and AOC agents will be terminated with the terminated Agency. Please note – this policy also applies when HealthSpring terminates an Agency not meeting the minimum level requirements.



Recruitment and Onboarding

Hierarchy Change Within the Same Topline

The Topline Agency has discretion to move and change the level of Agents within their hierarchy structure at a reasonable frequency. However, the Topline may only move an Agency up one level of the hierarchy at a time unless Agency requirements are met, and HealthSpring approval is granted.

- The Topline Agency will initiate an agreement maintenance e-vite in producer express (Sircon) for any move or downgrade requests, which will be completed by the Agent/Agency and submitted to HealthSpring.
- All Agencies submitted for upgrade must meet the minimum agency engagement criteria as well as any contractual requirements including rapid disenrollment and other quality metrics.
- Agency level upgrade submissions will be sent for internal approval prior to processing.
- Agencies operating as a downline call center are required to complete the Downline Call Center Profile and Requirements Document prior to being upgraded to a higher level contract. For more information see the Call Center Guidelines section of the ROE.
- Residual non-enrollment service fees are retained by the hierarchy structure and are subject to the contract terms in place at the time of the original sale.

Annual Training and Certification

Overview

HealthSpring approaches training as a tool to help our Agents and Agencies become successful. We require agents to maintain a proficiency in the knowledge of HealthSpring MA/MAPD/PDP plans as well as all necessary compliance requirements. To this end, we offer a variety of performance-focused training and on-going learning opportunities for all our new and existing Agents and Agencies. Training and certification can be accessed at HealthSpring Producers' University available through Single Sign On at [CignaForBrokers](#).

Access to the site will be provided to the Agents/Agencies once the contract has been processed with HealthSpring and will remain active as long as the Agents/Agencies maintains an active agreement with HealthSpring. While many courses are self-paced eLearning, allowing Agents to learn at their own pace, several are also offered as virtual instructor-led training and webinars while others are offered as blended learning, incorporating both e-learning and instructor-led content.

You may not duplicate, record, take screenshot of or distribute our testing and training materials in any manner including digitally, online, on social media or physically. Testing/training materials are for our sales representatives and brokers individual use only.



Recruitment and Onboarding

Certification

Certification is required upon contracting as an Agent and annually thereafter by the date specified by HealthSpring. Certification includes:

1. Certain HealthSpring specific courses.
2. Medicare Basics and Fraud, Waste and Abuse training offered by certification vendors e.g. AHIP.

Requirements to Obtain/Maintain Active Status

- Complete certification (both 1 and 2 above) prior to selling any HealthSpring products.
- Pass each course with a minimum score of 85%.
- Pass each course in no more than three attempts.

Note: Agents will have the opportunity to test-out of each certification course by scoring at least 85% before reviewing course materials. Agents who do not pass the pre-test or chooses not to take it will be required to complete the course in its entirety.

Acceptable "Universal" Medicare and Fraud, Waste and Abuse Training

- AHIP
www.AHIPMedicareTraining.com
- Pinpoint Global
<https://medicareonlinecertification.com>
- NABIP
<https://nabip.org/professional-development/medicare-advantage-certification>

Both AHIP and Pinpoint Global certifications can be accessed directly from the Producers' University.

For reasons of emphasis, clarity or CMS directives, HealthSpring certification courses may repeat certain topics that Agents may have covered in the external certification administered by AHIP, Pinpoint or NABIP.

Training Steps

- Go to [CignaforBrokers](#)
- Log in with your NPN and password.
- Click the link for [Producers' University](#).
- Click "My Learning" to see your track/s.
- Select any course to start. You have three attempts to pass each course.
- Launch and complete AHIP or Pinpoint Medicare Training, or upload a valid certificate from AHIP, Pinpoint or NABIP.



Recruitment and Onboarding

HealthSpring training and testing programs are designed and implemented in a way that maintains the integrity of the training and testing and ensures that each individual is taking the test independently. Agents may not allow someone else to complete training on their behalf or share their logins to [CignaforBrokers](#) with anyone else. Doing so will violate the integrity of the training process and CMS Agent and Testing Guidelines. HealthSpring maintains evidence of the training exams and documentation demonstrating evidence of completion and can provide this information to CMS upon request.

Note: Agents and Agencies must have an active agreement with HealthSpring Business to access our Medicare Training. Bulk Agency Partners may have varied requirements regarding system access, but are required to adhere to all our Medicare Training Requirements.

Annual Attestation

Agents are required to agree to and abide by the HealthSpring Policies Handbook, ROE, and Social Media Policy through digital attestation prior to marketing or selling any of our products and annually thereafter by the deadlines communicated by HealthSpring.

Note: Failure to complete required attestations by the final deadline communicated by HealthSpring will result in forfeiture of Agent- level commissions and/or Agency non-enrollment service fee renewals. See [Calendar Year at a Glance](#) for deadlines.

Agencies are required to abide by the HealthSpring Policies Handbook, ROE, and Social Media Policy; which will be distributed to agencies on an annual basis and as needed if there are any updates throughout the year.

Changes can be made at anytime at the discretion of HealthSpring.



Recruitment and Onboarding

Certification Curriculum

Course Name	Key Focus
Selling with Integrity	• Our selling process • How to sell consultatively and compliantly telephonically and in one-on-one settings • Our value proposition
Products and Benefits Overview	• Line of products and features (includes PDP for agents in our MAPD states) • Model of Care • Eligibility • Snapshot of all plans and the key benefits
Our Compliance Program	• Key requirements of our Compliance Program • HIPAA and Compliance culture • Agent's role in our Compliance Program • Reporting violations
Attestations	Review and attestation of Rules of Engagement, Policies Handbook, and Social Media Communications and Marketing Policy
HealthSpring Rx (PDP)	Our stand-alone Part D product (required and only available for agents selling PDP who are only licensed in states that HealthSpring does not have MAPD plans)



Recruitment and Onboarding

Remediation Training

This training is focused on helping Agents improve compliance performance and satisfy violation requirements.

- Remediation courses are assigned as needed and Agents may be required to retake a previously completed course.
- Agents are required to complete in a timely manner to continue to be in good standing with HealthSpring.
- A coaching session with a HealthSpring employee may be a required component of the remediation training.

Invitation Only

Certain training courses and events are invitation only. When applicable, Agents will be invited to register for the training and attend online or in person. An example of this is our Sales Event Training for Agents who have been approved to conduct sales events on behalf of HealthSpring.

Ready to Sell

Welcome Email and Call

Upon successful completion of the credentialing and contracting process, a Welcome email that includes the following will be generated to the Agent/Agency:

- HealthSpring Writing Number/Agent ID
- The pre-appointment states the Agent is appointed in
- Direct Upline/Topline Name
- Link to this Rules of Engagement
- The **HealthSpring Broker Resource Guide** which provides a brief description of each HealthSpring tool available and important contacts



Upon successful completion of credentialing and contracting, HealthSpring, and its associates, will communicate with you via: CignaforBrokers; email; phone; and SMS text. Calls may be auto-dialed or prerecorded. Message and data rates may apply. You can opt-out at any time. Be sure to watch for important updates and helpful information that will assist you and advance your sales success.



FDR Oversight Guide



FDR Oversight Guide

First Tier, Downstream, or Related Entity Defined

HealthSpring partners with First Tier, Downstream and Related Entities (FDRs) to deliver administrative and health care services that support our Medicare and Medicaid Plans and CMS agreements. HealthSpring maintains the ultimate responsibility for fulfilling the terms and conditions of its contract with CMS, and for meeting the Medicare program requirements. CMS holds HealthSpring accountable for ensuring it's FDRs comply with Medicare program requirements.

Therefore, HealthSpring holds all FDRs accountable for complying with Medicare program requirements.

An FDR is any Agent/Agency contracted by HealthSpring to complete any administrative and/or health care related functions pertaining to HealthSpring and Medicaid contracts.

CMS defines First Tier Downstream and Related Entities as follows:

First Tier Entity is any Agency that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization (MAO) or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare-eligible individual under the MA program or Part D program.

Downstream Entity is any Agent/Agency that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA or Part D benefit, below the level of the arrangement between an MAO (or applicant) or a Part D plan sponsor (or applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Related Entity is any Agent/Agency that is related to an MAO or Part D plan sponsor by common ownership or control and meets one of the following parameters:

- Performs some of the MAO or Part D plan sponsor's management functions under contract or delegation
- Furnishes services to Medicare enrollees under an oral or written agreement

See 42 C.F.R. §§ 422.500 and 423.501 for more information.

HealthSpring FDRs are considered delegated entities. They fall into this category by performing Sales and Marketing on behalf of HealthSpring. HealthSpring is the brand name used for products and services provided exclusively by or through operating subsidiaries of Health Care Service Corporation.



FDR Oversight Guide

FDR Compliance Program Requirements

This guide summarizes the requirements of the HealthSpring FDR Compliance program that each FDR and their downstream entities must fulfill. FDR adherence to our compliance program also ensures compliance with applicable federal and state laws and regulations.

In addition to this guide, information can be found within the following documents or sets of documents:

- FDR Contract
- HealthSpring Policies and Procedures
- Compliance Program Guidelines in Chapter 21 of the *Medicare Managed Care Manual*
- Chapter 9 of the *Prescription Drug Benefit Manual*

If Agency/Agent fails to meet HealthSpring FDR compliance program requirements, it may lead to:

- Development of a corrective action plan
- Retraining
- Termination of FDR contract and relationship with HealthSpring



CMS Guidance	Best Practices to Ensure Compliance
Element I: Written Policies, Procedures and Standards of Conduct Chapter 21 § 50.1 Sponsors must have written policies, procedures and standards of conduct that: 1. Articulate the sponsor's commitment to comply with all applicable Federal and State standards; 2. Describe compliance expectations as embodied in the Standards of Conduct; 3. Implement the operation of the compliance program; 4. Provide guidance to employees and others on dealing with suspected, detected or reported compliance issues; 5. Identify how to communicate compliance issues to appropriate compliance personnel; 6. Describe how suspected, detected or reported compliance issues are investigated and resolved by the sponsor; and 7. Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including, but not limited to, reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.	• FDRs must have written Policies & Procedures and a Compliance Policy (Standards of Conduct, Code of Conduct or Code of Ethics), approved by HealthSpring, that are comparable to or exceed elements found in the HCSC Code of Ethics and Conduct. • Compliance policies should be distributed to employees within 90 days of hire, upon revision, and annually thereafter. You may choose your distribution method but you must maintain documentation. • The HealthSpring FDR Oversight team will review your compliance procedures and code of conduct annually. • Your code of conduct and policies and procedures must: – Articulate your commitment to comply with all applicable federal and state requirements – Describe compliance expectations as embodied in the Standards of Conduct – Describe ethical behaviors and compliance program operations – Explain how suspected, detected or reported compliance issues are investigated and remediated; and – Describe your non-retaliation protections for individuals that make good faith reports of suspected FWA
Element II: Compliance Officer, Compliance Committee and High Level Oversight Chapter 21 § 50.2 The sponsor must designate a compliance officer and a compliance committee who report directly and are accountable to the sponsor's chief executive or other senior management.	• A roster of the FDR's Compliance Committee, including the Compliance Officer, and contact information must be provided to HealthSpring • FDR Oversight should be notified of any future changes/updates to the Compliance Officer

FDR Oversight Guide

CMS Guidance	Best Practices to Ensure Compliance
Element III: Effective Training and Education Chapter 21 § 50.3 The sponsor must establish, implement and provide effective training and education for its employees, including the CEO, senior administrators or managers, and for the governing body members, and FDRs.	Training requirements: • Fraud, Waste, and Abuse and General compliance training must be completed within 90 days of hire (or contracting), when materials are updated, and annually thereafter • Certification is required within 90 days of initial hire or the effective date of contracting, and annually thereafter. • A record of employees requiring the training, completing the training, and the materials utilized for training must be retained for ten (10) years and be made available upon request by HealthSpring. • Annually, HealthSpring performs Compliance Program Effectiveness Monitoring and we will request evidence to support your training. Supporting Evidence must be in the form of a certificate of training or a sign in sheet of employees who completed the training on a particular day. If you use training logs or reports as evidence of completion, they must include: – Employee names or individual identification numbers – Dates of completion – Passing scores (if captured)
Element IV: Effective Lines of Communication Chapter 21 § 50.4 The sponsor must establish and implement effective lines of communication, ensuring confidentiality between the compliance officer, members of the compliance committee, the sponsor's employees, managers and governing body, and the sponsor's FDRs. Such lines of communication must be accessible to all and allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified.	• FDR employees must be aware of how to report suspected or detected non-compliance or potential Fraud, Waste, or Abuse, and that it is their obligation to report without fear of retaliation or intimidation against anyone who reports in good faith. • FDR Employees and other Downstream Entities may report concerns directly to HealthSpring, using the HealthSpring Corporate Integrity Hotline (1-800-838-2552 Confidential and Available 24/7) or FWA Hotline (1-800-543-0867 Confidential and Available 24/7). In addition, an FDR may maintain confidential and anonymous mechanisms for employees, Agents to report internally.



CMS Guidance	Best Practices to Ensure Compliance
Element V: Well-Publicized Disciplinary Standards Chapter 21 § 50.5 Sponsors must have well-publicized disciplinary standards through the implementation of procedures which encourage good faith participation in the compliance program by all affected individuals. These standards must include policies that: 1. Articulate expectations for reporting compliance issues and assist in their resolution; 2. Identify non-compliance or unethical behavior; and 3. Provide for timely, consistent, non-compliance and effective enforcement of the standards when or unethical behavior is determined.	• Policies and procedures must be in place for all employees or entities and their employees, to report any relationships external to the organization or HealthSpring that may present a potential conflict, at time of hire, within 90 days and annually thereafter. • HealthSpring should be notified immediately if any conflict exists. • FDRs must have written Policies & Procedures and a Compliance Policy (Standards of Conduct, Code of Conduct or Code of Ethics), approved by HealthSpring, that are comparable to or exceed elements found in the HCSC Code of Ethics and Conduct.



FDR Oversight Guide

CMS Guidance	Best Practices to Ensure Compliance
Element VI: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks Chapter 21 § 50.6 Sponsors must establish and implement an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the sponsor's, including FDRs', compliance with CMS requirements and the overall effectiveness of the compliance program.	- FDR should review Office of Inspector General (OIG), General Services Administration (GSA), and State exclusions, OFAC list prior to hire and monthly thereafter to ensure no employee, temporary employee, volunteer, consultant, vendor, agent, or governing body member responsible for administering or delivering Medicare and/or Medicaid benefits are excluded from the Federal/State health care programs. - FDR must document and retain evidence of the OIG and GSA/SAM exclusion checks/screenings Documentation must include: - The person/entity full name - Date when screening was conducted - Results of the screening conducted - Actions taken - FDR must take action if an issue is discovered; therefore, if any employee, vendor, agent or downstream entity is on one of the exclusion lists, they must immediately be removed from work directly or indirectly related to HealthSpring and PDP plans, and HealthSpring must be notified. - Conduct routine internal oversight of the services performed to ensure that activities within organization and downstream entities are in compliance with applicable laws, rules, and regulations including CMS regulatory/sub-regulatory guidance.



FDR Oversight Guide

CMS Guidance	Best Practices to Ensure Compliance
Element VII: Procedures and System for Prompt Response to Compliance Issues Chapter 21 § 50.7 Sponsors must establish and implement procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with CMS requirements.	• FDRs must conduct appropriate corrective actions (for example repayment of overpayments, disciplinary actions against responsible employees) in response to the potential violation. • If FDRs discover evidence of misconduct related to payment or delivery of items or services under the contract, the FDR must conduct a timely, reasonable inquiry into that conduct.



Offshore Operations

CMS requires HealthSpring to report specific offshore subcontractor information and complete an attestation regarding protection of member PHI. As a HealthSpring FDR, you must notify and request approval prior to entering into any contractual agreements with an offshore subcontractor, as there are state restrictions that may impact ability to offshore.



FDR Oversight Guide

Fraud, Waste and Abuse (FWA)

HealthSpring FDRs play an important role in protecting the integrity of the Medicare oversight program. To combat FWA, it is imperative to know what FWA is and how to protect against engaging in abusive practices and/or civil or criminal law violations.

FWA Defined

Fraud is intentionally misusing information to persuade another person or entity to part with something of value or to surrender a legal right. It could also be an act of planned deception or misrepresentation.

Waste is using, consuming, spending or expending resources thoughtlessly or carelessly.

Abuse is providing information or documentation for a health care claim in a manner that improperly uses program resources for personal gain or benefit but without sufficient evidence to prove criminal intent.

FWA Laws

Federal laws governing Medicare FWA include:

- Federal False Claims Act
- Anti-Kickback Statute
- Physician self-referral, or the “Stark law”
- Social Security Act
- United States criminal code

FWA and Compliance Concerns

There are a number of ways to confidentially report suspected or detected non-compliance or potential FWA regarding the sale of HealthSpring products:

- The FDR Oversight Team at FDROversight@healthspring.com
- Your HealthSpring broker account manager, who will then alert the FDR Oversight Team
- Our company **FWA Hotline** at **1-800-543-0867** or our **Corporate Integrity Hotline** at **1-800-838-2552**

Egregious policy violations that impact the member should be reported immediately (within 24 hours).

FDR Monitoring and Auditing

In accordance with CMS requirements, HealthSpring routinely monitors and periodically audits FDRs. This helps ensure compliant administration of CMS contracts and compliance with applicable laws and regulations. Each FDR must take part in these monitoring and auditing activities and be prepared to provide results upon request.



FDR Oversight Guide

Downstream Entity Monitoring

FDRs are responsible for monitoring any downstream entities with which they contract, ensuring subcontractors abide by all laws and regulations that apply to a First Tier Entity.

Examples of downstream monitoring include:

- Ensuring that contractual agreements contain all CMS-required provisions
- Ensuring adherence to Medicare compliance program requirements described in this guide
- Ensuring compliance with any applicable Medicare operational requirements

FDRs must:

- Conduct auditing and monitoring to test and ensure employees and Downstream Entities are compliant
- Retain evidence of auditing and monitoring results, as this may be requested at any time
- Ensure that root cause analysis is conducted for any deficiencies
- Implement corrective actions, including disciplinary actions, such as contract termination, to prevent recurrence of non-compliance

These requirements are found in:

- 42 CFR § 422.503(b)(4)(vi)(F) for MA
- 42 CFR § 423.504(b)(4)(vi)(F) for Part D
- Medicare Managed Care Manual, Chapter 21 § 50.6.6

FDRs may be subject to other federal and state laws, rules, and regulations that must also be fulfilled but are not covered in this guide. HealthSpring expects compliance with all applicable federal and state laws, rules, and regulations. Please contact your HealthSpring account manager or email FDROversight@healthspring.com with any questions about compliance obligations.

FDR Performance Tracking

HealthSpring has developed metrics and benchmarks for the monitoring of FDRs. This data is subject to change pursuant to CMS and HealthSpring rules and regulations. FDRs will receive monthly reports tracking metrics and benchmarks (in parentheses) including, but not limited to, the following:

- Founded % (**≤27%**)
- Timeliness of Applications (**≥ 97%**)
- Telephonic Evaluations (**>85%**)

FDRs are required to review reports and discuss any areas of non-compliance with their downstream entities. Upon request, FDRs must provide evidence they have met with the compliance contact of the downstream entities, have reviewed the data, have taken action as appropriate and have remediated any non-compliance. From time to time, specific action may be required by HealthSpring and/ or CMS. This action will be tracked pursuant to HealthSpring processes and documented accordingly.



FDR Oversight Guide

Reporting

Report Name	Frequency	Responsible Party
FDR Performance Dashboard	Monthly	FDR Oversight Team
TPMO Relationship Form	As Needed	All Agencies
Disciplinary Actions/Compliance Violations	Monthly	All Agencies

FDR Compliance Program and Attestation Requirements

Annual Compliance Attestation

HealthSpring FDRs are required to complete the Annual Compliance Attestation in support of the FDRs agreement to comply with the requirements. An authorized representative such as the Compliance Officer, Chief Medical Officer, Practice Manager/ Administrator or an Executive Officer must attest that the activities performed comply with CMS, State and Federal Requirements.

OIG/GSA Exclusion Screenings

HealthSpring will request a list of employees involved in the administration of MA and PDP services and review selected samples to confirm adherence to the OIG/GSA Exclusion Screening requirement annually. Upon sample selection, the HealthSpring FDR must submit evidence to support the activity.

The evidence and documentation will vary depending on how the OIG and GSA SAM screenings are completed. Regardless of how the screenings are completed, the documentation should show:

- Which exclusion list(s) were checked
- Date the check was completed
- Name of the individuals and entities that were checked
- Results of the check

General Compliance and Fraud Waste and Abuse (FWA) Training

HealthSpring performs Compliance Program Effectiveness Monitoring and will request evidence to support training. Supporting Evidence must be in the form of a certificate of training or a sign in sheet of employees who completed the training on a particular day. If you use training logs or reports as evidence of completion they must include:

- Employee names or individual identification numbers
- Dates of completion
- Passing scores (if captured)



Call Center Guidelines



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Call Center Guidelines

At HealthSpring, we believe in providing quality care and responsive service to our members when and where they need it. We are focused on putting our members at the center of all we do and welcome Agencies that share this focus. These guidelines provide additional details on how to operate a compliant and member-focused Call Center (CC) Agency on behalf of HealthSpring.

FDR Responsibilities for Call Centers

Call Center Monitoring and Oversight

As an FDR with Call Centers or Downline Call Center agencies, FDRs must work to ensure their Call Center and any Downline Call Center agency's activity and protocols adhere to CMS guidelines, the HealthSpring Rules of Engagement, and other applicable federal and state regulations. These FDRs must maintain and be able to provide the following for both their Call Center and any Downline Call Center agencies:

- A call center oversight program that includes, at minimum, a Comprehensive Call Monitoring and Quality Scorecard program
- Policies and procedures specific to routine Call Center agent and Downline Call Center agency monitoring, auditing and identification of compliance risks
- TPMO Relationship Form and Disciplinary Actions Compliance Violation Form for their Call Center and any Downline Call Center agency as outlined within the ROE

Sales Marketing Materials and Scripts

The FDR is also responsible for submitting for review and approval all Call Center and Downline Call Center agency sales and enrollment scripts via Wrike systems and HPMS. The FDR must provide HealthSpring with all approved Call Center and Downline Call Center agency sales and enrollment scripts. See Marketing Materials and Scripts section of the ROE for additional information.

Downline Call Center Contracting and Disclosure

It is the FDR's responsibility to understand the criteria outlined in the What is a Call Center (CC) section of the ROE and be able to identify any agent within their hierarchy that is conducting sales activities within a Call

Center as defined in the ROE. When an FDR has a downstream entity that is operating as a Downline Call Center the FDR must also:

- Onboard the Downline Call Center agency at the appropriate agency-level contract with an active, credentialed principal Agent of Record (AOR)
- Ensure all of the agency's Downline Call Center agents representing HealthSpring are contracted, appointed and reporting into the Downline Call Center agency's hierarchy
- Disclose when a downline agency is operating as a Call Center by notifying their assigned HealthSpring Strategist or Account Manager
- Work with their Account Manager to complete the Downline Call Center Profile Form and Downline Call Center Requirements Document

What is a Call Center (CC)?

To be considered a Call Center with HealthSpring, the agency must:

- Have a team of agents that either work at home or at the agency's physical location using the agency's call routing, recording and storage technology. See Telephonic System Requirements of the ROE for more information.
- Have CMS approved telephonic scripts that their agents are required to follow for both Marketing and Sales presentations
- Record and store every marketing and sales presentation for a minimum of 10 years, as per CMS guidelines
- Follow all state/federal and HealthSpring requirements

In order to receive sales and operational support, downline agencies meeting the above criteria must work with their Topline to ensure proper notification to HealthSpring.



Call Center Guidelines

Call Monitoring and Quality Score Cards

As an FDR with Call Centers or Downline Call Center agencies, the FDR's system for routine monitoring, auditing and identification of compliance risk must include a Call Center-specific oversight program. This includes, at a minimum, a Comprehensive Call Monitoring program for their Call Center agents as well as any Downline Call Center agencies. In addition to the FDR's oversight, HealthSpring may conduct call monitoring of the FDR and random quality audits of Downline Call Centers.

FDRs with Downline Call Center agencies must:

- Conduct auditing and monitoring to test and ensure employees and Downstream Entities are compliant
- Retain evidence of auditing and monitoring results, as this may be requested at any time
- Ensure that root cause analysis is conducted for any deficiencies
- Implement corrective actions, including disciplinary actions, such as contract termination, to prevent recurrence of non-compliance

Downline Call Center Agencies must:

- Perform live monitoring sessions
- Provide their FDR with completed Quality Scorecards when requested
- Respond to all requests for call recordings from their Topline FDR on a timely basis.

Additional details on the HealthSpring FDR Oversight and Downstream Entity Monitoring can be found in the FDR Oversight section of the ROE.



Call Center Guidelines

Call Center Guidelines

- All Call Center Agents must use the Agency's approved technology and call system.
- All Call Center Agents must perform a comprehensive needs assessment and review of health plan benefits in order for the shopper to make an educated decision on enrollment into the plan.
- All Call Center Agents must follow their Call Center CMS approved scripts for both Sales and Enrollment presentations.

- Call Center Enrollment requests are accepted only during an inbound telephone call from a shopper, exceptions apply as follows:

Enrollments may be accepted during an outbound shopper call, only in the following circumstances:

- When making an outbound call to an existing HealthSpring member regarding plan business and the member expresses a desire to enroll in a different or additional plan.
- When making an outbound call to a shopper who is not currently a member, in response to receipt of a business reply card or to return a message left by the shopper and the shopper expresses a desire to enroll in a HealthSpring plan.
- All portions of the call (needs assessment, pre-enrollment, enrollment, and any transfers between Agents or non-licensed reps) must be recorded and stored for 10 years (per CMS guidelines) by the Call Center Agency.
- Upon completing a telephonic enrollment request, Agent must provide a verbal, text, and/or email confirmation number for tracking purposes.

Enrollment Submission Methods

- Carrier platform
- HealthSpring approved Third-party enrollment vendors - FDRs only, please work with your HealthSpring Account Manager for more information. Prior approval required.
- Enrollment files via SFTP (OEC) - FDRs only, please work with your HealthSpring Account Manager for more information. Prior approval required.
- There will be separate and unique OEC files for both Medicare Advantage and Prescription Drug Plans (PDP).



Call Center Guidelines

Telephonic System Requirements

- An Agency must have a telephone system that can accurately route shoppers to trained and qualified individual Agents who can appropriately handle calls.
- The telephone system must be able to transfer calls to a particular Agent as requested or needed.
- The telephone system should have the capability to do either silent or side-by-side monitoring of live calls.
- The telephone system must also have voicemail capability or administrative support to answer calls when a licensed Agent is not available. Agency must return the call within one business day.
- An Agency must be able to record all telephonic needs assessments, discussions, sales presentations and enrollments for the duration of the call, including internal transfers.
- An Agency must successfully complete testing prior to going live. Testing will include recording calls and successfully retrieving the stored data.
- An Agency must be able to save recordings in a .WAV or .MP3 file.
- A functional demonstration may be required during the site/virtual visit for all of the above.



Call Center Guidelines

Recording Transfer and Storage Requirements

HealthSpring has the following option available for providing recorded Call Center calls. The Call Center call recording (“Recording”) must include the needs assessment, presale/sales presentation and the enrollment process. Failure to meet the outlined requirements may result in disciplinary or remediation actions.

- Agency is required to maintain all Recordings in accordance with the CMS records retention guidelines (minimum of 10 years).
- Agency is required to conduct self-audits to ensure 100% of Call Center enrollments have Recordings on file. Agency must immediately report any reconciliation discrepancies to HealthSpring.
- Agency is required to provide Recordings as requested by HealthSpring for quality audits. The HealthSpring Sales Integrity team will identify the number of Medicare Advantage and Part D Recordings to be provided monthly.
- Agency will receive an email from HealthSpring outlining the Recordings to be provided.
- Recordings are to be uploaded to the secure FTP site (or via the email address in the correspondence if unable to use the sFTP method) within five (5) business days of the request. Failure to provide the complete calls within the required time frame may result in Agency SDAP violation. Refer to the Downgrade, Suspension and Termination section for additional details and remediation requirements.
- For Agent complaints and CMS/Compliance requests, Agency is required to provide the Recording to HealthSpring via the sFTP within the following time frames.
 - Urgent/immediate need CMS requests within 24 hours.
 - Standard request within five (5) business days.
 - Agency must have and provide a contact that will provide Recordings, and respond to urgent/immediate need CMS requests, within 24 hours, seven days a week.
- Agencies must notify HealthSpring of any changes to their Internet Protocol (IP) address. Failure to provide Recordings, based on the above requirements, may result in disciplinary or remediation actions.



Call Center Guidelines

Remote Call Center Agency Requirements

- HealthSpring may allow approved Call Center Agencies to have remote Call Center Agents.
 - Remote Call Center Agents must meet the same requirements as stated in [Call Center Agency Requirements](#).
 - Agency must be able to provide documentation outlining their training program for remote Call Center Agents.

Remote Call Center Agents must only work from a secure location within the United States. Agency must maintain a list of addresses where Remote Call Center Agents are based and ensure such locations are safe and appropriate. Remote Call Center Agents are required to use approved scripts.

- Remote Call Center Agents must follow all PHI and PII security protocols and have a locking file cabinet for storage and a shredder for destruction of materials that include PHI/PII.
- Remote Call Center Agencies must create a separate remote workers' policy confirming adherence and compliant use, storage and disposal of PII and PHI as well as outlining how they track and monitor Agent compliance to this policy.
- Remote access to the Call Center Agency network must meet the same requirements outlined for in-house connectivity, including

but not limited to, data loss prevention measures, multi- factor authentication utilization, and encryption in transit and at rest.

Licensing, Certification, and Training

- All Agents and Agencies are required to comply with the rules outlined in the [Licensing and Appointments](#) section of this guide.
- Agents are required to follow the [Training Steps](#) section of this guide. Once all training is complete per the [Certification Curriculum](#) specific to Call Center Agents, the Agent will be made "Active". Agents will only be [Ready to Sell](#) after they receive their HealthSpring "Welcome Letter", as specified in the Ready to Sell section.
 - For agencies that submit via bulk it is the Top line Agency's responsibility to verify submissions and readiness status via the Agent Status report. Please report any errors or omissions as quickly as possible.
- All Agents must comply with any additional training requirements identified during the term of the agreement with HealthSpring.
- Call Center training will occur between September 1 and October 15 each year. Live, virtual or recorded trainings will be provided by HealthSpring at the time of initial onboarding and annually thereafter.

Call Center Agency Compliance Criteria

- Call Center Agencies are required to adhere to the Call Center onboarding criteria and all HealthSpring Policies and Procedures.
- If the organization does not adhere to the Call Center requirements, and if appropriate remediation action is not taken within 72 hours of written notice, the organization may be subject to immediate termination.
- The Call Center will be evaluated on an annual basis to ensure agency engagement criteria are met.
- The Agency must create and maintain all applicable policies and procedures to support the Call Center functions, which include both technical and administrative safeguards
- **Any violation of HealthSpring or state/ federal requirements may result in disciplinary action up to and including termination of the HealthSpring contract.**



Oversight



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Sales Development Action Program (SDAP)

The purpose of the SDAP is to address non-compliant incidents, as well as implement controls and evaluate marketing activities, quality improvement, and administrative aspects. The mission of the SDAP is to protect members (potential and/or existing) and the organization from non-compliant sales activities.

HealthSpring implemented a disciplinary action program, which is managed by the Sales Integrity Unit. The SDAP is composed of senior leadership within HealthSpring and meets regularly to review potential HealthSpring and CMS policy violations. Policy violations may trigger a remediation/corrective action plan that must be completed accurately and in a timely manner. These corrective action plans can be triggered by the number of issues associated with an Agent or Agency or by a single egregious event. Remediation/corrective action plans may include, but are not limited to:

- Retraining
- A meeting with a HealthSpring representative to review the violation(s) and discuss policy requirement(s)

- Mock telephonic evaluations
- Secret shops
- Coaching
- Formal audit
- Financial penalty
- Suspension of selling activity, which must be reported to state and federal agencies. (Will not receive compensation and may not sell.)
- Temporary hold of selling activities
 - If we determine an issue may threaten or damage our company's reputation or has the potential to harm our members or does not meet our standards, we may place selling activities on "hold" until a complete investigation is finalized.
 - Still receive compensation; however, may not sell.
 - Not reported to state or federal agencies.
- Termination of contract
 - For Cause = applicable state and federal agencies may be contacted.
 - Not for Cause = no state or federal agency is contacted.

How to Minimize Complaints

Preventing complaints positively impacts a health plan's Medicare Star Ratings performance, can help increase member retention, and enhances the member experience. As a broker you can help reduce complaints by:

- Ensuring shoppers are not enrolled without their consent.
 - Record the sales presentation
 - Complete a disclaimer disclosure
 - Deliver a complete presentation on SOB and plan requirements
 - Provide a confirmation number
 - Do not mislead shoppers with false information
- Provide accurate provider information:
 - Discuss PCP during the call
 - Assign the requested PCP
 - Do not assign Nurse Practitioner or Specialist as PCP
 - Use the provider lookup tool instead of calling the provider or searching their website to confirm plan coverage
 - Verify if provider covers PPO and not HMO, and vice versa
 - Verify if provider accepts Individual and not Group, or vice versa
 - Confirm if provider accepts Alliance plans, where applicable.



Decoding Member Complaint “Source”

Internally, HealthSpring uses two labels to assist with tracking complaints made to Medicare (CMS and CTM), while Medicare tracks complaints solely as CTMs. A third complaint type used internally comes from HealthSpring Customer Service (CSV).

CMS

Category: Marketing Misrepresentation

Agent driven - Agent involvement determined by CMS. Results in SEP for member/beneficiary.

CTM

Category: Claims, Provider, Plan Issue, Enrollment/ Disenrollment, Benefits, Access, Quality of Care.

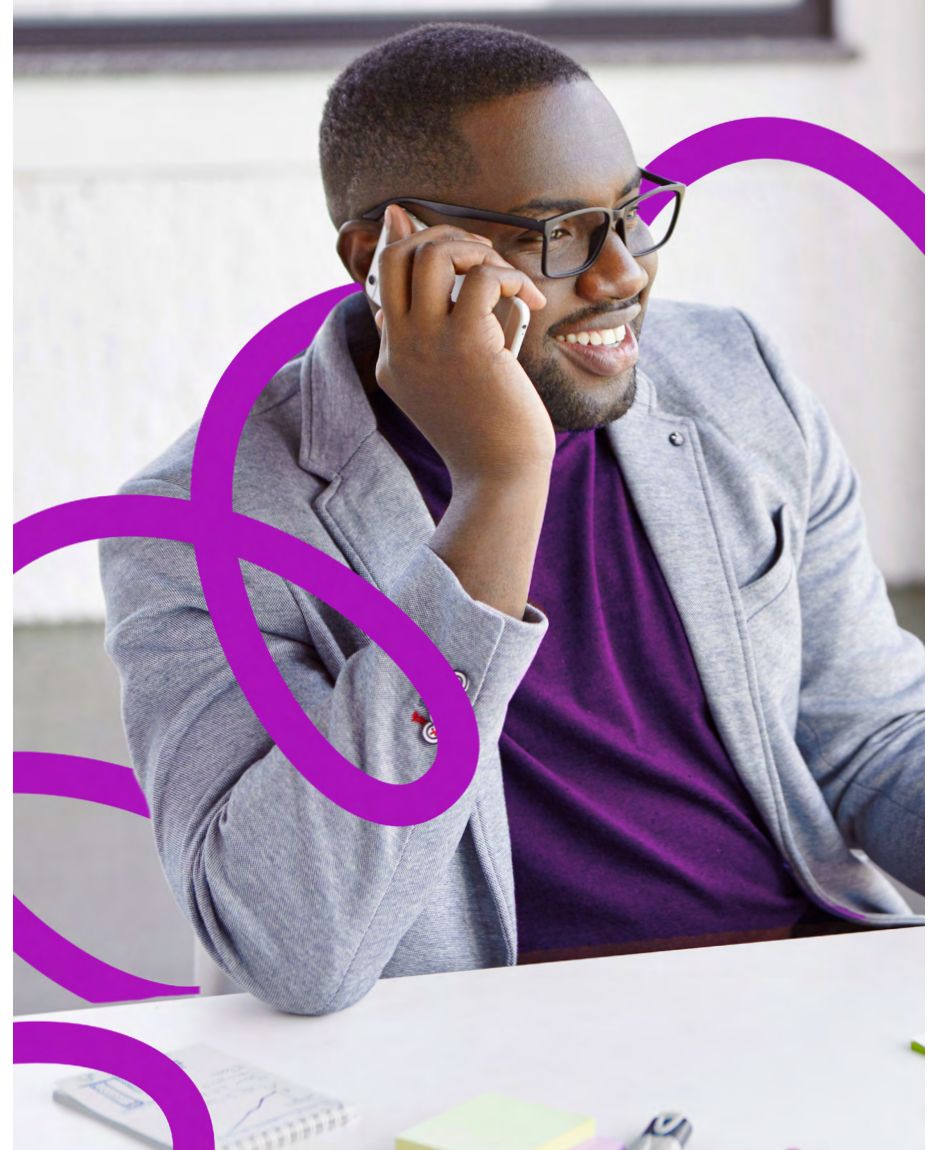
May be Agent driven-further research required for decision. May result in SEP for member/beneficiary as determined by CMS.

Note: Regardless of the internal source label, Compliance has 30 days to respond to Medicare regarding CTM's unless the issue has been deemed “urgent or immediate need”.

CSV

Category: Any complaint received by HealthSpring Customer Service.

May be Agent driven. May result in SEP for member/beneficiary if determination is founded.



Sales Integrity Quality Review and Audit

The Sales Integrity Unit has established a dedicated Quality Review and Audit team tasked to perform audit and monitoring reviews of HealthSpring External Field Sales Agent activity and Internal Medicare Sales Operations oversight business teams. This contributes to HealthSpring efforts to ensure internal and external business partners activity and protocols adhere to CMS guidelines, HealthSpring standards, and other applicable federal and state regulations. Audit and monitoring reviews occur throughout the calendar year and are managed through an annual work plan and in special circumstances tracked individually as ad hoc requests. As part of the audit and monitoring review process, selection of Agent/Broker activity to be reviewed is dependent on risk assessment, past performance, and recommendation.

When requested to participate in a Sales Integrity audit and monitoring review, FDRs or contracted agents and agencies can expect to:

- Receive advance notification of a review request and have a meeting scheduled to discuss the purpose and scope of the review.
- Address processes and potential areas of concern that may impact the outcome of the review.
- Provide supporting documentation and evidence for evaluation.
- Receive a summary of any found deficiencies, observations, and recommendations.
- If necessary, submit root cause analysis of acknowledged deficiencies and establish a remediation action plan for later retesting by the Sales Integrity Quality Review and Audit team.

At the conclusion of each audit and monitoring review, the Sales Integrity Quality Review and Audit team will share the review results with the appropriate Medicare Sales business team area owners. Any discovered activity determined to pose compliance concern or risk to HealthSpring businesses or members will be reported immediately to the appropriate business areas including but not limited to the SDAP team, HealthSpring Medicare Sales Senior Management, the Medicare Compliance department, or Ethics office for further evaluation and determination. Partners are expected to fully comply with audit requests and adhere to submission dates.



TPMO Responsibilities

All TPMOs must follow the guidelines defined in this section.

TPMO Defined

A **TPMO** is defined as organizations and individuals, **including independent agents and brokers**, who are compensated to perform lead generation, marketing sales, and enrollment related functions as a part of the chain of enrollment. TPMOs may be a first tier, downstream or related entity FDRs, as defined under [CFR 422.2260](#), but may also be entities that are not FDRs but provide services to an MA plan or an MA plan’s FDR.

HealthSpring TPMOs are obligated to understand and support the requirements related to the chain of enrollment. TPMOs are also required to have oversight of TPMOs that they may contract with directly in support of HealthSpring lead generation, marketing, sales and enrollment.

TPMO’s contracted directly with HealthSpring, as well as those contracted through a HealthSpring FDR must adhere to all CMS, State government and HealthSpring requirements. This includes but is not limited to the following guidance.

Plan Reporting Requirements

HealthSpring is required to report agents, brokers, and other TPMOs non-compliance with Marketing Regulations to our CMS account manager, at least monthly. This includes any violations of CMS requirements, in addition to repeat violations and those that have the potential to harm beneficiaries will be reported. §§422.2272(e) and 423.2272(e), §§422.2274(c) and (g) and 423.2274(c) and (g).

Reporting to the Plan

TPMOs are required to report the following to HealthSpring:

Requirement	When to Report	Link to Template
Disclose any subcontracted relationships used for marketing, lead generation, and enrollment.	New TPMO relationships to be reported immediately upon entering into a contract.	TPMO Relationship Form
Report staff disciplinary actions associated with a member interaction.	Report monthly	Disciplinary Actions Compliance Violations Form
Report any instances of non-compliance associated with a member interaction and/or any violations of requirements that apply to HealthSpring.	Report monthly	Disciplinary Actions Compliance Violations Form

Note: TPMO reports should only include new issues of non-compliance and all fields must be populated in its entirety. If there are fields that are not applicable, indicate N/A. TPMO reports are not required if there are no issues of non-compliance to report.



Sub-contracted TPMOs

HealthSpring TPMOs are required to update contracts or other agreements with the TPMOs that they contract with directly to include all applicable requirements as outlined in [§422.2267](#), [§422.2274](#), [§423.2267](#) and [§423.2274](#)

Sales Telephonic Recordings

TPMOs are required to record all marketing, sales, and enrollment calls with shoppers **in their entirety**. The requirement to record calls includes virtual connections such as Zoom and FaceTime, only the audio portion must be recorded for these types of calls.

Requirement	Applies to Telephonic Engagements	Applies to Virtual Engagements	Applies to Face to Face Engagements
Agents must record all calls to and from shoppers and potential shoppers if they are marketing plan options or enrolling them into a MA or Part D plan.	Yes	Yes	No
All calls are subject to Federal and State Telephone Communication Protection Act (TCPA) requirements and our US Telephone Communication policy.	Yes	Yes	N/A

Disclosures to Shopper

Requirement	When to Report/Disclose
When conducting lead generating activities, either directly or indirectly for an MA organization, disclose to the shopper that his or her information will be provided to a licensed agent for future contact.	This disclosure must be provided as follows: - Verbally when communicating with a shopper through telephone. - In writing when communicating with a shopper through mail or other written communications. - Electronically when communicating with a shopper through email, online chat or other digital messaging platforms.
Disclose to the shopper that he or she is being transferred to a licensed agent who can complete the enrollment.	When applicable, always disclose.

Marketing/Communications Materials Disclaimers and Disclosures

For TPMO marketing materials, CMS requires one of two disclaimers. The agency should select which version of the disclaimer is appropriate.

If the TPMO does not sell for all MA organizations in the service area, the following disclaimer should be used. “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 more information on all of your options.”

If the TPMO sells for all MA organizations in the service area the disclaimer should read: “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.”

Requirement	This Includes
Include on all marketing materials.	All materials that meet the definition of “marketing” including website, print and television.
Conveyed to a shopper during interactions.	Any verbal, digital or written interactions with a shopper, depending on how the TPMO is interacting with the shopper. If the TPMO is providing information to the shopper verbally, the disclaimer must be started within the first minute of the call.

Marketing Materials and Scripts

Multi-Plan Materials

Multi-plan marketing materials are materials that are used to market Medicare plans on behalf of multiple carriers. Directly Contracted Agents and Individuals within the FDR, authorized by HealthSpring, are required to submit all multi-plan materials that meet the CMS definition of “marketing” directly to CMS via HPMS for all Agencies, their Agents and or subcontractors. **Prior to submission in HPMS, all multi-plan marketing materials must be submitted to HealthSpring for review. In order for HealthSpring to opt in, all HealthSpring feedback should be incorporated into the material prior to submission in HPMS.**

Materials must also be approved, when applicable, by CMS prior to use.

Materials that Include the Medicare Card Image

CMS requires that all materials that include an image of the Medicare card be approved via a review process separate from the material review process. Below is CMS’ process that should be followed for the review of materials that include the Medicare card image. Only actual Medicare card images must follow this process. Graphic images of the card don’t need to be approved.

- Send an email to the CMS marketing mailbox at Marketing@cms.hhs.gov with a copy of the material that has the Medicare card image on it. An email must be sent for both Marketing and Communication materials.
- CMS will provide the approval or disapproval.
- When filing marketing materials in HPMS, the approval email must be included with the material when submitted (in a zipped file that includes the material ID of the marketing piece).

CMS also requires that agencies add a disclaimer in the vicinity of the Medicare card image that indicates they are not affiliated or endorsed by CMS, HHS, the Federal Government, etc. A missing disclaimer near the Medicare card image may indicate that the approval process was bypassed resulting in additional follow-up by the CMS reviewer.

HealthSpring Branded Materials

Materials created by third-party marketing organizations (TMPOs) to solely market HealthSpring plans must be submitted directly to HealthSpring for review and approval via the HealthSpring Co-Branded Marketing Material Review Wrike form. This applies to both CMS “Marketing” and “Communications” materials.

HealthSpring will provide a material ID and any necessary updates. “Marketing” materials will be reviewed by the HealthSpring compliance department and submitted directly to CMS by HealthSpring. “Communications” materials will be reviewed and filed internally with the HealthSpring compliance department.

Once approved for use, a notification will be sent by HealthSpring via email from Wrike.

Pre-Enrollment Checklist

Agents/brokers must explain the effect of an enrollee’s enrollment choice on their current coverage. The “effect on current coverage” is included in the pre-enrollment checklist (PECL) and must be reviewed with beneficiaries as part of all enrollments.

Agents/brokers must also cover a list of required elements prior to enrollment, including provider availability, costs and premiums for prescriptions and health care coverage, benefits, beneficiary-specific health care needs and the beneficiary’s current medications.

Inbound and Outbound Scripts

If contacting beneficiaries on behalf of HealthSpring, scripts used by certified Agents authorized to conduct telephonic sales and marketing activities must be forwarded to HealthSpring for review. Scripts should reflect the established guidance for each component of the enrollment. All telephonic presentations should include disclosure of the Pre-Enrollment Checklist; and any electronic enrollment portion(s) of a telephonic enrollment should include instruction to the shopper regarding completion of the enrollment form.

Upon HealthSpring approval, scripts are to be submitted in HPMS. Telephone sales and enrollment scripts are considered File and Use materials, so a 5-calendar day waiting period after HPMS submission is required.

During telephonic sales presentations, Agencies/Agents must verbally provide instruction to the shopper regarding how to locate the appropriate summary of benefits. It is important to provide this information regarding HealthSpring plans to all shoppers to ensure they understand the plan they are enrolling in and are making an informed decision. The elements noted in the Pre-enrollment Checklist must also be reviewed with the shopper. Failure to meet these requirements will result in an SDAP at the Agent level and potentially the Agency level.

In addition, when conducting outbound calls, scripts are to include a privacy statement notifying shoppers they are not required to provide any health-related information to HealthSpring or an Agent as part of the call, and the information provided will in no way affect the shopper's enrollment in the HealthSpring Advantage and Part D plans. Please refer to our Medicare Sales Policies Handbook and to CMS guidelines for additional guidance and requirements.



Operational Requirements



Operational Requirements

Business Reply Cards (BRC) and Scope of Appointment (SOA)

BRC Guidance

If benefits/cost share information or other “marketing” elements are included on a BRC, it must be filed with CMS. If the BRC is a “communications” material, it does not need to be filed with CMS. If the BRC is to be used as an agreement to be contacted, confirmation of a sales or marketing event, or a request for more information, it must include a statement informing the shopper that an Agent may call them as a result of returning the BRC. Please see [Marketing Materials and Scripts](#) section for specific details.

SOA Guidance

All Agents conducting one-on-one appointments with beneficiaries regardless of the venue (e.g., in home, by phone or at a library) must complete an SOA in advance when practicable and follow the SOA guidance including the following:

- Use a compliant SOA form.
- Clearly identify products before marketing to a shopper and the shopper must agree to the SOA and such agreement must be documented by the Agent.
- Provide adequate documentation, telephonic appointments must include a recorded SOA.
- Retain SOAs for a period of ten (10) years, in accordance with state and federal regulations. Evidence of the SOA, including the disclaimer language, must be submitted to HealthSpring upon request.
- Do not discuss additional products unless the shopper requests the information. Any additional lines of business that are not identified prior to the appointment will require a separate SOA.

- Collection of SOAs and/or setting up a future marketing appointment at educational events is prohibited.
- A marketing or sales event cannot occur within 12 hours of an educational event at the same location.
- Agents/brokers are not allowed to go to a beneficiary's home unless it was scheduled for that date/time. An agent or broker showing up unannounced is considered unsolicited contact.
- Beneficiary contact is limited to 12 months following the date that the enrollee first asked for information (e.g., SOA, BRC).
- A 48-hour window between the receipt of a SOA and an agent personal meeting with a beneficiary is required.
- Inbound calls do not need to have a 48-hour timeframe prior to discussion of products.
- Exceptions to the 48 hour rule include:
 - Beneficiary-initiated walk-ins
 - Beneficiary is within 4 days of the end of a valid election period (i.e., AEP, OEP, SEP, or ICEP)

For further guidance, please refer to our job aids available on Producers' University. Once signed in, search for keywords Scope of Appointment, SOA, or follow these direct links:

SOA

[Scope of Appointment Job Aid](#)

[SOA Scenarios – Internal FSRs](#)

[SOA Scenarios – External Brokers](#)

[Virtual Scope of Appointment](#)



Operational Requirements

SOA Compliance

While Independent Agents are no longer required to submit a paper SOA to HealthSpring, SOAs must be provided upon request for audits and investigation of complaints.

- Five non-compliant SOAs will incur a violation for non-compliant or inability to produce requested SOA's
- SOAs may also be requested by HealthSpring, and the Agent may incur a violation after five incidents of either a non-compliant SOA or inability to produce an SOA



Operational Requirements

Required Disclosure

Agents must provide the following disclosure, or a substantially similar disclosure, prior to enrollment or at the time of enrollment, in writing, to a shopper.

“The person that is discussing plan options with you is either employed by or contracted with HealthSpring and its applicable affiliates offering Medicare Advantage and/ or Medicare Part D plans. The person may be compensated based on your enrollment in a plan.”

Additional disclosures and disclaimers may be required. Please contact HealthSpring for assistance.

Distribution of Personal Beneficiary Data by TPMOs

Personal beneficiary data collected by TPMOs for the purpose of marketing or enrolling a beneficiary into an MA or Part D plan may not be shared with other TPMOs, unless prior written consent is given by the beneficiary. The disclosure to the beneficiary must be clear and consent must be obtained for each TPMO that will be receiving the beneficiary's data.

Individual Leads

HealthSpring may, at its sole discretion, supply overflow leads to Agency, Subordinate Agency or Agent. However, HealthSpring is not responsible for supporting the Agency with leads or financial support in their prospecting efforts. During a visit with the prospect, Agency, Subordinate Agency or Agent can present the HealthSpring Advantage products with full disclosure and enroll the prospect. Referrals may only be obtained in accordance with HealthSpring policy and CMS guidelines. Agency, Subordinate Agency or Agents must follow all guidelines and regulations that govern the proper procedure for prospecting and selling HealthSpring products, including all requirements set forth under MIPPA, TCPA, and the CMS MCMG.

Member Non-Payment Agent Outreach

HealthSpring may from time to time send member protected health information regarding potential terminations due to past due premium amounts. Agents receiving this information may use it to conduct outreach efforts with these members regarding such payment default and possible termination if left unpaid.

Submission of Enrollment Applications

It is important to fill out the enrollment

application completely and accurately in order to avoid processing delays and possible rejection of the enrollment. Utilizing the [USPS Address Lookup Tool](#) will assist in rejected applications due to invalid address. There are multiple methods Agents can use to submit enrollment requests to HealthSpring. Valid HealthSpring submission methods are as follows:

eEnrollment

The HealthSpring eEnrollment form is a paperless digital application accessible via <https://broker.hsconnectonline.com>.

The eEnrollment form:

- Is available via laptop and tablet browsers.
- Is an internet application accessed through a web browser.
- Creates a complete application that can be verified and signed before submission.
- Allows the Agent/shopper to submit a completed application immediately for processing.



Operational Requirements

Other Electronic/Paper Applications

Approved electronic submission of applications is preferred (Sunfire, ConnectureDRX, or your agency's approved electronic submission method). This is the most efficient way to submit an enrollment application.

HealthSpring will electronically deliver enrollment materials on your behalf when you complete an application online or over the phone and provide the shopper's email address on the enrollment application. You do not need to provide a printed kit when you complete these steps. You are required to provide a printed enrollment kit whenever the shopper completes a paper application.

For times when paper applications are necessary, each completed paper enrollment must be faxed to the appropriate HealthSpring enrollment fax number, using the appropriate [2024 MA/MAPD Enrollment Fax Cover Sheet English](#), [2024 MA/MAPD Enrollment Fax Cover Sheet Spanish](#), [2025 MA/MAPD Enrollment Fax Cover Sheet English](#), or [2025 MA/MAPD Enrollment Fax Cover Sheet Spanish](#), as the first page of each enrollment, within two (2) calendar days of the agent signature date. Please note that PDP applications do not require a fax Cover Sheet when submitting paper applications to the plan. The application receipt date for faxed paper applications is either the date the agent signs the application (agent sign date) or the date that the fax is received by the plan, whichever date is earlier.

The shopper may send the application directly to HealthSpring by mail or fax; the date received will be the office application receipt date. Applications sent by mail that do not meet the two calendar-day time frame may result in an SDAP violation for application timeliness.

For telephonic enrollments, the office application receipt date is the date of the call. To confirm receipt of faxed applications, an Agent can use [CignaforBrokers](#) or call [ARC](#).

All Standalone PDP Applications must be submitted via an approved electronic submission method (Connecture, Sunfire, or other approved external OEC) and also meet the two-day application submission timeframe.

When it is not possible to submit Standalone PDP applications electronically, PDP applications must be faxed or mailed to:

PDP Fax Number: 1-800-735-1469

**HealthSpring Prescription Drug Plans
PO Box 269005
Weston, FL 33326-9927**

We encourage Brokers to contact the IVR telephone number 24-48 hrs after fax submission to confirm receipt of the faxed application:

1. Call 1-800-222-6700
2. Follow the prompts to confirm the receipt of your application.
You will need shopper's Zip Code and Date of birth to confirm the application status.

If unable to verify all information the call will be transferred to Customer Service for further assistance.

If further assistance is needed, please call [ARC](#).

HealthSpring for Brokers

Contracted and approved telesales Agents may use the telephonic enrollment script on HealthSpring for Brokers via [CignaforBrokers](#) to submit enrollment requests.



Operational Requirements

In the event a telesales Agency/Agent does not use the telephonic enrollment script on [CignaforBrokers](#), enrollments over the phone must be recorded by approved telephonic enrollment mechanisms and follow the approved enrollment script. For more information on Agent resources; please refer to the following guide once logged into [Producers' University > Quick Guide](#).

Safeguard Information

Safeguard information when it is moved.

- Ensure HealthSpring information that is saved to non-HealthSpring equipment, such as a home PC, tablet or smartphone, is encrypted.
- Double-check for correct recipients and addresses before mailing and faxing information.

Protect paper documents.

- When away from the desk for an extended time, lock restricted information away and remove the keys. For highly sensitive information, lock it away any time the area is left.
- Discard paper documents in locked shred bins.
- Retrieve confidential documents at the printer or fax machine immediately.
- Files in any medium (paper, disk, CD) containing Highly Sensitive or Restricted information must be carried in a locked or secured pouch (such as a sealed envelope or closed briefcase) when transported between work locations.

Secure computer and passwords.

- Lock computer using Ctrl + Alt + Delete > Enter (or the Windows key + L) every time it will be left unattended.
- Passwords, PINs, or other security access codes will not be stored with or attached to the laptop or device.

Agencies must report incidents to HealthSpring when information has been misdirected.



Operational Requirements

Supporting Documentation

Power of Attorney

When applicable, a shopper may state on the election form that they have a Power of Attorney. In order to accept Power of Attorney for a shopper, copies of the executed legal document must be attached to the application. The Power of Attorney will state the person's name and may include relationship to shopper. The Power of Attorney will be able to act on their behalf should they become incapacitated. The Power of Attorney document should indicate that it is for medical reasons.

Required Documentation Includes:

- Name(s) of each Power of Attorney.
- Relationship to shopper if known.
- Initials of person entering the data.
- Department of person entering data.

Request for Information

RFI notification will be sent from HealthSpring when an application is received that is missing or requires additional information. The email will include the following information:

- Details regarding the specific issue.
- What is needed to continue processing the application.

- How to submit the information.
- Due date to receive the information to prevent the application from being denied.

There are many rules surrounding the deadlines for RFIs, but typically shoppers have **21** days from the date of their RFI to send the required information.

Application Submission Policies and Timeliness

CMS has strict regulations regarding the submission of enrollment applications. Per HealthSpring policy, Agents have two calendar days to submit the completed application form to HealthSpring. The two calendar-day window is applicable regardless of the day of the week the completed form was accepted from the shopper. The two-day rule applies for enrollments throughout the year, including AEP. **If the shopper insists on sending the application via mail, the Agent should not sign or date the Agent portion of the application. The Agent should also inform the shopper not to fill in this section at any time.** Enrollments accepted over the phone must be accepted by approved telephonic enrollment mechanisms and follow the approved enrollment script. Telephonic applications must list the date of the call as the application date.

Helpful Tips

- If an application is submitted and placed in RFI status (has missing information), agents should not submit a new application while an RFI is active. Submitting a second application will create a duplicate enrollment and the original application will remain in an RFI status. Please contact [ARC](#) to provide the RFI information.
- Please ensure to use your National Producer Number (NPN) as your agent identifier in all the fields that require it on PDP paper applications.
- To check the status of a PDP paper application, please call the IVR telephone number, 1-800-222-6700, 48 hours after submission and follow the prompts.
- If at any time an Agent has questions, they should reach out to [ARC](#).



Operational Requirements

Additional Application Requirements

Confirm eligibility requirements.

To join a Medicare Advantage plan (MA-Only), the shopper must have Medicare Part A and Medicare Part B. To join a Medicare Advantage Prescription Drug Plan (MAPD), the shopper must have Medicare Part A, Medicare Part B and Medicare Part D.

The criteria is different when joining a standalone PDP plan. To join a standalone PDP plan (PDP), the shopper must be enrolled in Medicare Part A and/or Medicare Part B.

If applying for a D-SNP plan, the shopper must have active Medicaid at the level required for the selected D-SNP plan, and the Agent should include proof of active Medicaid in the application submission when possible.

For any plan selected, the shopper must reside in the approved Service Area for their selected plan, and they must also have a valid election period.

Please ensure you are following the tips below for submitting enrollment applications.

- Ensure that applications are faxed to the correct line of business. Refer to the application coversheet for MA/MAPD contact information. The PDP fax number is: **1-800-735-1469**.
- Complete all required data fields on the application unless marked optional.
- SEP's that require a date, must have the date populated.
- Ensure that the plan, effective dates, election types and Member Beneficiary Identifier (MBI) are listed correctly on the application.
- **The MBI is unique to each individual member. The same MBI cannot be used on multiple applications (e.g. Spouses).**
- A PO Box is invalid and cannot be listed as a member's permanent address. It is only valid for a mailing address.
- Paper applications must be legible and submitted to HealthSpring within two days to avoid a 'timeliness of application' (TOA) violation.
- Enrollment applications must be signed and dated.
- Please ensure to use your National Producer Number (NPN) as your agent identifier in all the fields that require it on PDP applications (page six of the paper application).
- Scope of Appointment (SOA) forms must be completed 48 hours prior to enrollment. The box for each product discussed must be checked on the form. The SOA form must be signed and dated.



Operational Requirements

Late Enrollment Penalty (LEP)

When discussing enrollment with the shopper, ask the shopper if they had Prescription drug coverage through an employer or VA or other source since they became eligible for Medicare. If they did not, advise the shopper that they may have a late enrollment penalty (LEP).

A LEP will be assessed if the shopper is without Part D drug coverage, for any continuous period of 63 days or more since they became eligible for Medicare. If it is determined the enrollee may have a LEP, the shopper will receive an attestation form from the plan. It is important that the shopper completes and returns the form within 30 days of the date of the letter. Failing to do so might result in a LEP.

How to calculate the LEP?

Medicare calculates the penalty by multiplying 1% of the “national base beneficiary premium” (also called the “base beneficiary premium”) by the number of full, uncovered months the person didn’t have Part D or creditable coverage.

Once a LEP is assessed the LEP is permanent and will follow shoppers from plan to plan. Medicare Part D Late Enrollment Penalty (LEP) Job Aid can be accessed [here](#) or through Producers University.

Enrollment Application Cancellations, Withdrawals

Cancellation/Withdrawal

If a shopper wishes to cancel or withdraw an application, they must send a letter to HealthSpring or call Customer Service prior to the effective date.

Please note that cancellations must be completed before the effective date, and disenrollment requests must be completed after the effective date with a written and valid reason for disenrollment.



Compensation Rules



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Compensation Rules

Commission Department Services

The Commission Department exists to process new application, chargeback, CMS reconciliation and existing member compensation payments, as well as to provide service to the Agent and Agency partners surrounding these payments.

Any inquiries to the Commission Department should be sent from the partner through secure messaging. Inquiries are very important to the Commission Department, and all inquiries will receive a response within three business days of receipt, except during high-volume periods such as following the January 1 new sales pay cycle. All commission inquiries should be made to **ARC**.

All commission statements outline the activity which has occurred within the given pay period for each producer.



Compensation Rules

New Application Payments

Per CMS guidelines, HealthSpring defines a compensation year as January through December (a normal calendar year). HealthSpring is required to pay Agents at compensation rates within ranges filed and attested annually with CMS. More-specific compensation information can be found in the “2026 HealthSpring Compensation Rate Schedule”.

Enrollments must be a result of the direct contact between the Agent and the individual prospect. HealthSpring will pay a commission for each individual whom Agency or Subordinate Agency or Agents enroll in a HealthSpring MA/MAPD/PDP plan.

Agent-level commissions and Agency non-enrollment service fees for new applications are paid per the current schedule set forth annually (see “2026 HealthSpring Compensation Rate Schedule”). Payments will be made during the normal commission payment schedule as set forth by HealthSpring policy unless otherwise agreed between the parties.

To be eligible to receive Agent-level commission payments/Agency non-enrollment service fees from HealthSpring, both the writing Agent and Agency must be properly contracted, licensed and appointed (based on each state’s regulations) prior to making a sale.

Writing Agents are also required to complete annual training/certification requirements prior to making a sale, per CMS. If the writing Agent is noncompliant, payment will not be administered to any party, including the hierarchy, for the applicable enrollment.

In the event an Agency is noncompliant (i.e., is not properly contracted, licensed and appointed), that Agency will not receive a payment but all other compliant entities in the hierarchy may receive payment.

HealthSpring payments on new applications are made per the schedule

set forth in the 2026 HealthSpring Compensation Rate Schedule and also located on [Producers’ University](#). In addition, payments are made based on the contracting and hierarchy in place at the time of sale. HealthSpring endeavors to process payments for new applications within two or three weeks of submission. Payment may be delayed if the Agent’s correct HealthSpring writing ID is not included on the shopper’s enrollment application or if required information is missing from the application.

The above requirements must be maintained for all subsequent renewal years for the Agent and Agency to continue receiving compensation (see section entitled [Existing Member Compensation - Prior Effective Years](#) for more information).



Compensation Rules

HealthSpring identifies three potential compensation scenarios for new enrollments to HealthSpring.

1. Initial Year, No Prior Plan – A member identified by CMS via monthly CMS Compensation reporting to be in their Initial Compensation year in a MA, MAPD, or PDP plan with no reported prior plan. These enrollments are eligible for a full, initial compensation rate payment (12 months). This includes Agent-level commissions and Agency non-enrollment service fees.

2. Initial Year, Prior Plan – A member identified by CMS via monthly CMS Compensation reporting to be in their Initial Compensation year in a MA, MAPD, or PDP plan coming to HealthSpring from a like plan type or non-like plan. For example, a member ages into Medicare in March, enrolls with a different carrier, then moves out of the service area and subsequently enrolls with HealthSpring in September. These enrollments are eligible for payment at initial compensation rates.

Agent-level commissions will be prorated based on how many months the member is anticipated to be enrolled in a HealthSpring plan during the compensation year. For example, an enrollment effective January 1 will receive the full, initial compensation rate (12 months) as the member is expected to be enrolled for the full compensation year; however, an enrollment effective April 1 will receive 9/12 of the initial compensation rate as the member is expected to be enrolled for nine months of the compensation year.

Agency non-enrollment services fees will be paid at the full, renewal compensation rate (i.e. 12 months) regardless of the number of months the member is expected to be enrolled in the current plan year. However, if a plan change is submitted for an existing member, the Agency cannot receive more than 12 months of non-enrollment service fees for the current plan year.

3. Renewal Year Enrollment – A member identified by CMS via monthly CMS compensation reporting to be in a Renewal Compensation year. For example, a member coming from another carrier enrolls with HealthSpring during AEP for January 1, 2025, effective date.

These members have been enrolled in a plan for at least one full compensation year and thus are only eligible for payment at renewal compensation rates. Agent-level commissions will be prorated based on how many months the member is anticipated to be enrolled in a HealthSpring plan during the compensation year. For example, an enrollment effective January 1 will receive the full renewal compensation rate (12 months) as the member is expected to be enrolled for the full compensation year; however, an enrollment effective February 1 will receive 11/12 of the renewal compensation rate as the member is expected to be enrolled for 11 months of the compensation year.

Agency non-enrollment services fees will be paid at the full, renewal compensation rate (i.e. 12 months) regardless of the number of months the member is expected to be enrolled in the current plan year. However, if a plan change is submitted for an existing member, the Agency cannot receive more than 12 months of non-enrollment service fees for the current plan year.

New to HealthSpring Exception: HealthSpring will pay non-enrollment service fees for MA/MAPD members at the full initial compensation rates if the member meets “New to HealthSpring” criteria even if the member is identified by CMS as being in a Renewal Compensation year.

New to HealthSpring members are identified as:

An MA/MAPD member that has not been actively enrolled in an MA/MAPD plan for the previous 12+ months.

This policy **only** applies to non-enrollment service fees paid to properly contracted, licensed and appointed GA, MGA, SGA, SGA2 (not a recruitable level), FMO, RFMO, NFMO Agencies. This is a one-time payment to be made on the initial sale (normal chargeback rules apply), and HealthSpring may discontinue this policy at any time at its discretion.

Note: This payment policy does **not** apply to HealthSpring members enrolled in stand-alone PDP plans.



Compensation Rules

Initial Year Agent Commission Examples

MA/MAPD Initial Year Agent Commission Examples: Rates based on all markets except CT, DC/PA and NJ.

Enrollment Type	Effective Date	Prior Plan	First Payment	CMS Recon Payment	Total Paid
Initial Year	1/1/2026	NONE	\$347.00	\$347.00	\$694.00
Initial Year	1/1/2026	PDP, PACE, COST	\$347.00	\$347.00	\$694.00
Initial Year	4/1/2026	NONE	\$260.25	\$433.75	\$694.00
Initial Year	4/1/2026	MA/MAPD, PDP, PACE, COST	\$260.25	\$260.25	\$520.50
Initial Year	7/1/2026	NONE	\$173.50	\$520.50	\$694.00
Initial Year	7/1/2026	MA/MAPD, PDP, PACE, COST	\$173.50	\$173.50	\$347.00

PDP Initial Year Agent Commission Examples: Rates based on all markets, for HealthSpring PDP Extra Plans only

Enrollment Type	Effective Date	Prior Plan	First Payment	CMS Recon Payment	Total Paid
Initial Year	1/1/2026	NONE	\$57.00	\$57.00	\$114.00
Initial Year	1/1/2026	MA/MAPD, PACE, COST	\$57.00	\$57.00	\$114.00
Initial Year	4/1/2026	NONE	\$42.75	\$71.25	\$114.00
Initial Year	4/1/2026	MA/MAPD, PDP, PACE, COST	\$42.75	\$42.75	\$85.50
Initial Year	7/1/2026	NONE	\$28.50	\$85.50	\$114.00
Initial Year	7/1/2026	MA/MAPD, PDP, PACE, COST	\$28.50	\$28.50	\$57.00

Note: For 2026, HealthSpring Assurance PDP plans will be commissionable in most states excluding NH, ME, NY, MI, WI, AR, KS, NM, AZ, OR, WA, CA, AK. Please see Compensation Rate Schedule for full details.

Examples for illustrative purposes only. See the annual Compensation Rate Schedule for full details and rates for all markets/plans.

Due to the timing of the monthly CMS Compensation Reporting, all enrollments will be paid at the renewal compensation rate. The Agent-level renewal compensation rate will be prorated based on the number of months the member is anticipated to be enrolled with HealthSpring during the compensation year as stated in the section above. On receipt of the monthly CMS Compensation Report, HealthSpring will perform an audit and compensate Agents/Agencies for any additional payments owed on initial-year members. This payment is called the CMS Reconciliation (True Up) payment and it is made on a monthly basis. Please note: It may take six to eight weeks for Agents/Agencies to receive CMS Reconciliation (True Up) payments after an application has been submitted.



Compensation Rules

Service Fees for Digital Health Risk Assessment (HRA)

HealthSpring approaches the HRA as an opportunity to jump start the member journey, engagement and utilization of our services by collecting HRA data at the time of enrollment. Authorized agents may be eligible to receive a service fee for the successful and timely completion of a digital HRA.

Prerequisite

To be authorized to facilitate the HRA, Agent must:

- Complete HRA training via annual certification on Producers' University (HealthSpring Products and Benefits Overview)
- Qualify as "Ready to Sell" to complete a digital enrollment application with the shopper

HRA Process

- The Agent must be the AOR for the shopper.
- As a best practice, our defined talking points should be leveraged.
- The Agent must secure shopper's permission to complete the digital HRA survey with the shopper at the point of sale.
- The Agent must not pressure the shopper to complete the digital HRA survey.
- The Agent must complete the HRA with the member and submit the completed HRA within the HRA tool within ten (10) calendar days of the shopper's application sign date in order to ensure a positive member experience. As a best practice, the Agent should confirm the next appointment with the shopper with date and time details, prior to making the next outreach.

During AEP 2026, agents will have until 12/22/25 to facilitate the HRA

- If the Agent has a question about or issue related to the HRA survey they should call [ARC](#). These calls will be warm transferred to the HRA team if/as appropriate.

Service Fee for Facilitating HRA

HealthSpring ultimately owns the review and acceptance of any completed HRA, and it is not automatically assumed and counted. The Agent will be paid for administering the digital version of the HealthSpring HRA, and not the paper HRA version within the timeline set forth in this section.

- For PY2025 effective dates, the Agent will be paid \$125 for SNP shopper HRA submissions and \$75 for non-SNP shopper HRA submissions, when facilitating digital HRA and all requirements are met.
- For PY2026 effective dates, the Agent will be paid \$100 for SNP shopper HRA submissions and \$50 for non-SNP shopper HRA submissions, when facilitating digital HRA and all requirements are met.
- The Agent must be qualified as "Ready to Sell" in order to receive payout.

The Agent must be the AOR for the member.

- The HRA payment will be made for new Medicare Advantage members, and voluntary member plan changes that result in HealthSpring members.

If the Agent fails validations per the New Application Payments section of this document, HRA service fee will not be released.

- The HRA service fee is an Agent level payment only.
 - If Agent is direct pay they will receive the payment.
 - If an AOC is in place, the HRA payout will be made to the Agents Upline or Personal Business Entity, if applicable.
 - If an agent is LOA, the payment will be made to their Upline.



Compensation Rules

- Service fees for completed HRAs will be made on the first pay cycle of the month approximately 3-7 weeks after the HRA has been submitted. Timing of payments will be dependent on the time of the month the HRA was submitted to HealthSpring. HealthSpring does not pay HRA surveys until after the member is effective, meaning the HRA payout is released a month after the member goes live with HealthSpring. Example: 02/01/2026 effectives are paid 1st Friday in March.

Note: The HRA does not apply to stand-alone PDP. The program may be discontinued, and service fees may change at any time.

HRA Call Center Model

Select approved National call center agency partners are eligible to participate in the HRA program, allowing for non-licensed/member engagement representatives to facilitate the HRA with the member.

Qualified member engagement representatives must complete HealthSpring HRA training in order to participate in the program.

Note: For more information about the HRA Call Center Model, contact your Medicare Account Manager or Strategist.

Value Based Enrollment (VBE) Program

The VBE Program is a HealthSpring quality initiative that will improve our ability to service the member and keep the Agent in compliance with application timeliness. The VBE program is a partnership with the Agent to leverage the point of enrollment to capture important member information in a digitally submitted application.

Prerequisite

For members with an effective date in 2025, you must qualify as “Ready to Sell” to complete the enrollment application with the shopper.

Service Fees for VBE Program

HealthSpring ultimately owns the review and acceptance of any completed digital enrollment application, and it is not automatically assumed and counted. Agents can assist a member with the following administrative functions, and will be paid accordingly on digitally submitted applications only.

- Valid PCP - \$30 VBE service fee
- Valid member email address with consent to contact - \$20 VBE service fee
- The VBE program will be made for new Medicare Advantage members and voluntary member plan changes that result in HealthSpring members.
- If the Agent fails validations per the [Compensation Rules](#) section of this document, VBE service fee will not be released.
- The VBE service fee is an Agent level payment only.
 - If Agent is direct pay they will receive the payment.
 - If an AOC is in place, the VBE HRA payout will be made to the Agent’s Upline or Personal Business Entity, if applicable.
 - If an agent is LOA, the payment will be made to their Upline.

Note: The VBE program does not apply to stand-alone PDP.

Thanks to your help, our email & PCP capture rates have improved dramatically, and as such we will be discontinuing our VBE program. Starting with members effective 1/1/2026, we will no longer pay service fees for valid member email address or primary care physician selection.



Compensation Rules

Compensation Recovery – Chargebacks

Upon the termination of a member's continuous enrollment with HealthSpring, all payments (including Agent-level commissions and Agency non-enrollment service fees) made for 2026 effective applications will be subject to either a full or prorated chargeback based on the following.

A Full Chargeback Will Be Recovered If:

- The member makes any plan change within the first three months of enrollment, including disenrollment, that does not qualify for a rapid disenrollment exception as outlined by CMS. For example: The member becomes LIS or dual (Medicare and Medicaid) eligible and qualifies for another plan based on special needs.
- The member enrolls for October 1, November 1 or December 1 and disenrolls from the plan (unrelated to AEP).
- The member terminates prior to enrollment for any reason (cancellation).

A Prorated Chargeback Will Be Recovered If:

- The member makes any plan change within the first three months of enrollment, including disenrollment, that does qualify for a rapid disenrollment exception as outlined by CMS. For example: The member becomes LIS or dual (Medicare and Medicaid) eligible and qualifies for another plan based on special needs.
- The member enrolls in a new plan with a new Agent (external) after the rapid disenrollment period; the prior Agent will no longer continue to receive compensation and would incur a prorated chargeback for any unearned months.
- The member terminates after the rapid disenrollment period but prior to December 31 in the 2026 calendar year. This includes scenarios where a member might move from one carrier to another, or when a member moves from one plan to another within the same carrier.

Note: In the event an Agent is paid at the full, initial compensation rate for an enrollment with an effective date after January 1, HealthSpring would be required to chargeback compensation previously paid for all months that member is not on a HealthSpring plan. For example, if a member enrolls May 1 and disenrolls August 31, HealthSpring will chargeback commissions/non-enrollment service fees not only for September 1 through December 31 but also for January 1 through April 30, or the eight months that the member was not enrolled in a HealthSpring plan.

Retroactive Chargebacks

If HealthSpring is notified of a retroactive member disenrollment, full or prorated chargebacks will be issued accordingly, depending on the disenrollment scenario as outlined in the previous section. Retroactive chargebacks will also be issued in the event a member's disenrollment was not processed in a timely manner by the Commission Department. For example, a member disenrolls December 31, 2024, but the Commission Department is not notified of the change in enrollment status until after the 2025 plan year has already begun, resulting in the payment of 2024 renewals. In this scenario, all compensation paid for the 2025 plan year would be charged back.



Compensation Rules

Agent Change Scenarios

In the event of an Agent change, prorated chargebacks will be issued to the original Agent and hierarchy for unearned months. The new Agent will be paid commissions going forward based on the effective date of the change.

Valid Agent change scenarios include, but are not limited to, the following:

- An existing HealthSpring member is enrolled in a new plan by another Agent. For example, a member is enrolled in Plan 1 effective January 1, 2026, by Agent A and is then enrolled in Plan 2 effective July 1, 2026, by Agent B.

In this scenario, Agent A would no longer be the AOR effective July 1, 2026, and would incur chargebacks equal to six months of commissions (July through December). Agent B would be paid six months of commissions (July through December).

Note: If a plan change is performed by the HealthSpring Plan Change Unit, or an internal HealthSpring Agent, the current AOR will be retained, unless the Agent is currently in Terminated or Servicing status. Starting with 2026 effective enrollments, the current AOR will be retained in scenarios where the member moves from stand-alone PDP to MA/MAPD or vice versa when the plan change is completed by the HealthSpring Plan Change unit.

- A member terminates their enrollment with HealthSpring and then re-enrolls with another Agent at a later time. For example, a member disenrolls effective December 31, 2024, and then re-enrolls effective January 1, 2026, with a new Agent. In this scenario, there is a break in coverage, during which time the member was not enrolled with HealthSpring.
- A member voluntarily disenrolls with HealthSpring during AEP, enrolls with another carrier and then decides to return to HealthSpring without a break in coverage. For example, a HealthSpring member disenrolls effective December 31, 2025, and then chooses to re-enroll effective January 1, 2026, with a new Agent.
- A HealthSpring member converts from an MAPD plan to an MMP plan and then later re-enrolls in MAPD with a new Agent. For example, a member enrolls in an MAPD plan effective January 1, 2025, with Agent A, moves into an MMP plan effective April 1, 2025 and then re-enrolls in MAPD effective January 1, 2026, with Agent B.

Note: Effective 10/1/2024 HealthSpring does not allow an agent of record change for a current active member if they remain on the same plan. AOR and compensation remains with the AOR who wrote the original policy unless it falls under one of the approved plan change scenarios.

Plan Change Scenarios

In the event a plan change is submitted for an existing HealthSpring member and there is no break in coverage, compensation will be impacted as follows:

If an Agent submits a plan change for an actively enrolled HealthSpring member already in the Agent's own Book of Business (BOB), it will be treated like a new application. Since new application payments are made based on the contracting/hierarchy in place at the time of sale, Agent-level commissions and Agency non-enrollment service fees may be impacted if the Agent has experienced a contracting/hierarchy change. Please refer to the [New Application Payments](#) section of this document for more information, including Agent/Agency requirements for payment.



Compensation Rules

In the event a mid-year plan change is submitted, Agent-level commissions and Agency non-enrollment service fees will be charged back and subsequently repaid (where applicable) based on the new plan change effective date. For example, if an August 1 effective plan change is submitted for a January 1 effective member, chargebacks will be issued for August through December (five months). Agent-level commissions and Agency non-enrollment service fees would then be repaid (where applicable) based on the new plan change application submitted. If a CMS True Up is owed, the new application payment and the CMS Reconciliation (True Up) payment may be paid separately.

- If an existing HealthSpring member is enrolled in a new plan by a new external Agent, the AOR will change as of the new enrollment effective date. Please note, starting with 2026 effective enrollments, if the Agency is the same for both plans, only 12 months of non-enrollment service fees will be paid for the current plan year. For example, a member is enrolled in Plan 1 effective January 1, 2026, by Agent A and is then enrolled in Plan 2 effective July 1, 2026, by Agent B. In this scenario, Agent A will no longer be the AOR effective July 1, 2026, and will incur chargebacks equal to six months of commissions (July through December). Agent B will be paid six months of commissions (July through December).

Note: If a plan change is performed by the HealthSpring Plan Change Unit or internal HealthSpring Agent, the current AOR will be retained unless the Agent is currently in Terminated or Servicing status. Starting with 2026 effective enrollments, the current AOR will be retained in scenarios where the member moves from stand-alone PDP to MA/MAPD or vice versa.

- In the event a plan change is submitted for an existing HealthSpring member within the first three months of enrollment (rapid disenrollment period), Agent-level commissions and Agency non-enrollment service fees will be charged back in full. However, if the plan change qualifies for a rapid disenrollment exception as outlined by CMS, prorated chargebacks will be issued.



Compensation Rules

Existing Member Compensation – Prior Effectives

- All active member enrollments from prior effective years will begin the next renewal cycle in January 2026. Existing member compensation will be paid based on the contracting and hierarchy in place at the time of sale. Agent-level compensation for existing members will be paid at 2026 Fair Market Value (FMV). The FMV for 2026 renewals can be found in the Compensation Rate Schedule. Agency non-enrollment service fees will be paid based on historical renewal rates in place at the time the member was enrolled.

Note: Agency non-enrollment service fees for members originally enrolled under a HealthSpring Legacy Arizona contract will be paid based on 2026 renewal compensation rates.

- To be eligible to receive existing member compensation from HealthSpring, both the Agent and Agency must either be actively contracted or in a servicing status with HealthSpring. Actively contracted Agents/Agencies must be properly licensed and appointed (based on each state's regulations). Agents/Agencies in a servicing status must also be properly licensed; an active appointment is not required.
- In order to be eligible to remain active and receive existing member compensation, all Agents are required to complete the next year's training/certification prior to December 31 of the current plan year. For example 2026 training/certification must be completed by December 31, 2025 to receive Agent-level compensation for existing members. In the event an Agent/ Agency is noncompliant (i.e. is not actively contracted or in a servicing status, not actively licensed and appointed (where applicable) and/or the Agent has not completed required training by December 31), all current renewal compensation for existing members in their Book of Business (BOB) will be forfeited (i.e. a payment will not be received).
- Starting with Jan 2026 renewal payments, an Agent/Agency may be eligible for future renewal compensation in the event the Agent/Agency resolves outstanding current year renewal validation issues, as long as the New Application payment was successfully processed (i.e. Agent/ Agency was qualified for the sale) and renewals were not withheld prior to the 2026 plan year.
- All other compliant entities in the hierarchy will receive payment.
- Agencies that have been downgraded from an Agency level to a personal business entity are not eligible to receive Agency non-enrollment service fees. Therefore, compensation for existing members would not be received for the Agency's existing BOB written under their prior Agency level contract with HealthSpring.



Compensation Rules

- Existing member compensation for continuously enrolled MA/MAPD members will be paid monthly starting in January of the calendar year following the initial enrollment effective date providing all validation requirements are met (i.e., active HealthSpring contract or servicing status, license and appointment (where applicable), and completed certification).
 - For example, compensation for existing members that have a March 1 effective date will be paid beginning in January of the following calendar year.
- Monthly compensation for existing members will be based on 1/12 of the renewal year rate and will continue to be paid as long as the member remains continuously enrolled in the current MA/MAPD plan and the agent/agency continue to meet validation requirements. Compensation will cease upon termination of a member's continuous enrollment.
- Existing member compensation for continuously enrolled stand-alone PDP members will be paid on an up-front, lump-sum basis in February following the initial enrollment effective date. All renewal validation requirements must be met for payment to be received. Upon termination of a PDP member's continuous enrollment, all compensation made in 2026 will be subject to a full or prorated chargeback.
 - For example, a prior effective year member with a June 30, 2026 termination date will result in a chargeback of 6/12 of the February renewal payment, keeping the Agent/Agency whole for the six months (January through June) in which the member was enrolled in the plan.
- When a member enrolls in a new "like plan" with a new Agent (external), it will result in a change of the servicing Agent, therefore considered a commissionable event. A commissionable event is not initiated if a member calls the HealthSpring Plan Change Unit to make a plan change. In this situation, the original Agent will remain the servicing Agent and therefore retain commissions as long as the member remains enrolled (providing all required Agent validations are met).
- When an Agent/Principal retires or no longer wants to actively market and sell, they may elect to move into a servicing status if qualified. Otherwise they will become inactive and will no longer qualify to receive compensation of any type. See section entitled "Servicing Status."
- In the event an Agent moves to a HealthSpring employee contract, all future Agent- level compensation for existing members will be forfeited for their BOB written as an Independent Agent.



Compensation Rules

Reasons HealthSpring Will Not Compensate an Agent/Agency:

- When an application is rejected, denied, canceled or voided.
- When an application is incomplete or in RFI status and the request for additional information is not met within the required time frame.
- When an Agent is in terminated or suspended status.
- When an Agent/Agency is deemed unqualified due to lack of contract, license, appointment and/or certification.
- When fraud and/or intentional non-compliant activities are committed.
- When HealthSpring determines and communicates a plan to be non-commissionable.

Compensation Schedule Guidelines

All compensation for 2026 effective applications will be paid at the 2026 compensation rates indicated in the compensation rate schedule. Agent-level compensation for all eligible renewing members will also be paid based on the 2026 compensation rates, regardless of original effective year. Agency non-enrollment service fees for existing members will be paid based on historical renewal compensation rates in place at the time the member was originally enrolled; however, if the historical renewal compensation rates exceed the amounts allowable in the current year as published by CMS, compensation for existing members will be automatically adjusted to comply with applicable law.

Note: Agency non-enrollment service fees for members originally enrolled under a HealthSpring Legacy Arizona contract will be paid based on 2026 renewal compensation rates.

While HealthSpring intends to pay all Agents/ Agencies the highest compensation rate within the ranges filed with CMS, HealthSpring reserves the right to change an Agent/Agency's specific compensation rate to an amount within each range for any reason and at any time, at our sole discretion. HealthSpring will make best efforts to advise an Agent/Agency of any change to their compensation rate in advance of the effective date of such a change.

Per CMS, Initial Compensation is paid only when the member is a new enrollee to Medicare or MA/MAPD/PDP, as validated by the CMS Compensation Reports. All compensation will be paid as renewal compensation unless CMS Compensation Reports indicate the compensation should be Initial Compensation. In addition, compensation will not be received until CMS approves the member's enrollment.

All Agents will be compensated by HealthSpring at the rates indicated unless an alternative MIPPA-compliant compensation plan is submitted with the documented approval from HealthSpring. For enrollments with effective dates in the 2026 calendar year, Compensation Rate Schedules can be located on [Producers' University](#).



Compensation Rules

Payments

Per CMS Compensation Guidance, HealthSpring is required to compensate Independent Agents for all valid 2026 commissionable transactions, including those for 2026 effective enrollments and all renewing members, within the 2026 Plan Year (January 1, 2026, through December 31, 2026). HealthSpring cannot compensate an Independent Agent prior to January 1, 2026, for any 2026 enrollment and must complete compensation for all 2026 eligible enrollments by December 31, 2026.

HealthSpring will only release payment for new 2026 effective applications written during AEP to Agents/Agencies who are actively contracted with HealthSpring at the time of payment. Additional requirements for new application payments are outlined in the [New Application Payments](#) section of this document. In the event an Agent/Agency is not actively contracted with HealthSpring at the time of payment compensation will be forfeited (i.e., a payment will not be received).

After January 1, 2026, HealthSpring will begin to compensate all Agents on a weekly basis for all 2026 effective date applications submitted that result in HealthSpring members.

After January 1, 2026, HealthSpring will begin to compensate all Agents on a monthly basis for CMS Reconciliation payments on enrollments eligible to receive full or prorated initial compensation.

Regardless of original effective date, all active member enrollments from prior effective years (if applicable) will begin the next renewal cycle in January 2026. All Agent-level renewal compensation will be paid at current compensation plan year Fair Market Value (FMV). FMV for 2026 renewals can be found in the Compensation Rate Schedule.



Compensation Rules

Compensation Statements

During pay periods in which an Agent or Agency has transactions (new application, chargeback, CMS reconciliation or renewal records), a commission statement will be generated. HealthSpring statements for MA/MAPD business can be found on [CignaforBrokers](#). Please note, only statements dated February 2023 and forward will be found on [CignaforBrokers](#). Requests for older commission statements can be sent to [ARC](#).

Currently, HealthSpring uses Proofpoint as the secure email site. Registration to this site(login and password) is required to access HealthSpring statements. Agents or Agencies that have trouble opening emailed statements through the secured Proofpoint system should contact [ARC](#).

Statements for stand-alone PDP business with pay cycle dates prior to January 2026 are mailed out following bi-weekly pay cycle dates.

Commission Inquiries and Audits

Starting in January 2026, there will be a minimum check threshold of \$300 for all Agents/Agencies not setup for EFT. In the event this threshold is not reached, a check will be sent on the last pay cycle of the year for any compensation still owed. Agents/Agencies will have the ability to establish direct deposit via [CignaforBrokers](#).

All requests for commission related inquiries must be received within 2 plan years of the applicable member's enrollment effective date. For example, if an Agent/Agency is missing commissions for a member effective 1/1/2025, a request for a commission inquiry must be received by HealthSpring within the 2025 or 2026 plan years.

If the request is received after this point, the request will be denied. This policy also applies to requests for a commission audit (i.e. HealthSpring will only review membership enrolled within the current plan year or the prior plan year).

Outstanding Receivables

In the event HealthSpring makes an overpayment of compensation to an Agent/Agency for any reason, chargebacks will be issued.

All chargebacks will be identified on relevant commission statements and will be offset by new earnings. In the event an Agent/Agency does not have enough new earnings on a particular pay cycle to satisfy all chargebacks issued, no payment will be made and the commission statement will indicate a negative ending balance (also known as an outstanding receivable). Any new earnings on subsequent pay cycles will go toward satisfying the outstanding receivable.

HealthSpring also reserves the right to recover outstanding receivables from earnings across all HealthSpring.

On request, an Agent/Agency with an outstanding receivable shall remit payment to HealthSpring in full or establish an approved payment plan. If payment is not remitted in a timely manner, HealthSpring may engage a collection agency. The Agent/Agency will be responsible for reimbursing all expenses incurred by HealthSpring, including but not limited to, collection agency and/or legal fees. Agencies must also utilize best efforts to assist HealthSpring in recovering overpayments from any of its Subordinate Agents.



Compensation Rules

Assignment of Commissions

The AOC document defines how an Agent-level commission is paid at the time a member is enrolled, and for all future payments on that enrollee, should the member remain enrolled with HealthSpring. The AOC directs Agent-level commissions related to the specific member to the direct Upline Agency (Assignee). The AOC only pertains to business written as of the day the agreement is signed. If there is an AOC in place at the time of sale and the Agent is later released to be paid directly and/or to move under a new hierarchy, all payments for existing members will continue to be made under the AOC agreement in place at the time of sale. Similarly if an Agent moves from direct pay to an AOC, Agent-level payments for existing members will continue to be paid to the Agent directly.

Agreement to Service the Member*

An executed document between the Assignee Agency and HealthSpring whereby the Assignee agrees to properly service the HealthSpring member in the event of a Downline Agent becoming inactive with HealthSpring. A Downline Agent may become inactive as a result of the Agent's termination by HealthSpring, leaving our service area, or the Agent's participation in the Medicare Advantage Program. Termination may be due to a variety of reasons, including failure to certify by December 31 for the upcoming plan year, canceled/expired licensure, death, retirement, etc. When a Downline Agent becomes inactive with HealthSpring, they no longer qualify for compensation because CMS only allows HealthSpring to release Agent-level commission payments if an Agent is actively licensed and certified. In the case of an AOC, the Agreement to Service the Member (ASM) demonstrates that there is a new Agent within the Assignee Agency's organization dedicated to the service of that member (AOR). An AOC must be in place for the ASM to be valid.

*The ASM document does not apply to HealthSpring Legacy Arizona business.



Compensation Rules

ASM Policy

General requirements for the ASM are as follows:

- The ASM only applies to enrollments being paid under an AOC that are associated with the Assignee Agency. This includes new enrollments submitted by the Downline Agent during AEP for the upcoming plan year, in the event the Agent becomes inactive with HealthSpring prior to commissions being paid.
- The ASM only applies in scenarios where the Agent's entire book of business is impacted. It would not be applied in a scenario where only one state or product is impacted. For example, the ASM will not be applied in the event an Agent fails to maintain licensing requirements in one specific state and has existing HealthSpring MA/MAPD/PDP business in multiple states.
- The ASM does not apply to enrollments for which the original Agent was being paid directly, nor does it apply to enrollments the Agent previously submitted under a different hierarchy (i.e., business written independent of the Assignee Agency). The ASM also does not apply to enrollments where the original Agent has been deemed unqualified due to lack of contract, license, appointment and/or certification at the time of sale.
- The ASM is effective the day it is received, unless otherwise noted by HealthSpring.
- The ASM only applies to Agents who are inactivated after the document has been received and approved by HealthSpring.
- The designated AOR identified on the ASM document must have an AOC to the Assignee Agency on file and must pass all validations in order for the Assignee Agency to continue receiving the Agent-level commissions. If the designated Agent fails validations, Agent-level

commissions will be forfeited. Agent validations include having an active HealthSpring contract, relevant state licensure and appointment, and the completion of annual certification requirements. Agency non-enrollment service fees would not be impacted providing Agency validation requirements are met (i.e., active HealthSpring contract, license and appointment).

- If the original writing Agent fails validations and an ASM is not already in place, Agent-level commissions will be forfeited for the affected Book of Business; submitting an ASM at a later date will not restore Agent-level commissions. Agency non-enrollment service fees would not be impacted providing Agency validation requirements are met (i.e., active HealthSpring contract, license and appointment).
- The Assignee Agency will be required to notify all affected active members of the change in representation. The Assignee Agency will retain member notification documents and will provide to HealthSpring on request in the event of an audit.

Changes to Designated Agent on the ASM Document

In the event the designated AOR on the ASM is being terminated, or otherwise becoming inactive with HealthSpring, a new ASM document must be submitted prior to the Agent's termination date (i.e., within 30 days of the date on the termination letter). or Agent-level commissions will be forfeited. Similarly in the event of an Agent's death, notification** and a new ASM must be submitted within 30 days.

****HealthSpring will accept a signed letter from the principal of the Assignee Agency in lieu of a death certificate as notification to change the ASM.**



Compensation Rules

Assigning Commissions to a Personal Business Entity

Writing Agents may assign their commissions to a personal business entity that does not qualify to be contracted as an Agency. The entity must have its own tax ID and all applicable state licenses and appointments (based on each state's requirements). Only the Agent that owns the personal business entity may assign commissions to the entity. The personal business entity does not qualify for Agency non-enrollment service fees.

To assign commissions to a personal business entity, the Agent must submit an AOC form naming the entity and complete a W9 that includes the entity's business name, tax classification and tax ID. The AOC document defines how an Agent-level commission is paid at the time a member is enrolled, and for all future renewal payments on that enrollee, should the member remain enrolled with HealthSpring. The AOC only pertains to business written as of the day the agreement is signed. Agent-level commissions previously assigned to an Upline Agency (Assignee) would not be impacted. Similarly if an Agent moves from direct pay to an AOC, Agent-level payments for existing members will continue to be paid to the Agent directly.

In the event a personal business entity is upgraded to a to an Agency level contract, the Agency would only receive Agency non-enrollment service fees for new business written going forward. Business written while the Agency was contracted as a personal business entity would not be eligible for Agency non-enrollment service fees.

Agents on an AOC must similarly be paid by the Assignee unless a compliant compensation plan is submitted with documented approval from HealthSpring.

If a personal business entity fails to maintain applicable state licenses and appointments, all Agent-level commissions falling under the AOC will be forfeited.

Licensed Only Agent (LOA) Agreement

Definition

A Licensed Only Agent is a licensed insurance agent who is either employed by or under contract with a Sales Agency to sell Medicare business with HealthSpring. A Licensed Only Agent shall have no right to any compensation earned for business written under the LOA Agreement. All such compensation shall be paid to the Sales Agency.

In the event a Licensed Only Agent re-contracts as a direct pay Independent Agent, all future compensation for existing members written under the LOA agreement will continue to be paid to the Sales Agency.

To be eligible to receive Agent-level commission payments/Agency non-enrollment service fees from HealthSpring, both the writing Agent and the Sales Agency must be properly contracted, licensed and appointed (based on each state's regulations) prior to making a sale. Writing Agents are also required to complete annual training/ certification requirements prior to making a sale, per CMS (see the [New Application Payments](#) section of this document for more information).

To be eligible to receive existing member compensation from HealthSpring, both the current Agent of Record and the Sales Agency must be actively contracted, licensed and appointed (based on each state's regulations). Agents are also required to complete the next year's training/certification requirements prior to December 31 of the current plan year (see section entitled [Existing Member Compensation - Prior Effective Years](#) for more details).



Compensation Rules

Selling an Active Commissionable Book of Business

Subject to CMS rules and regulations, as amended from time to time, and when approved by HealthSpring Producer Commissions management, Agents and Agencies may be permitted to transfer their active commissionable Book of Business (BOB) to another Agent or Agency in good standing with HealthSpring. The transfer must be the result of an acquisition, merger, sale, consolidation or other legal transaction, and the transferring Agent/Agency must be terminating their contract with HealthSpring as a result of the sale/transfer.

To qualify for review, the transferring Agent/Agency must provide the following in writing to HealthSpring Producer Commissions at least 90 days prior to the effective date of the transfer:

- Current Owner name and writing number.
- New Owner name and writing number.
- Notarized documentation that demonstrates the legal transfer of the commissionable BOB.
- Proposed effective date of transfer.
- An attestation from the New Owner that the New Owner shall continue servicing the transferred BOB.
- Proof of New Owner's licensure and appointment in all states that the BOB transfer covers (based on each state's regulations).

If the Agent is changing as a result of the transfer, written demonstration that all members impacted by the BOB transfer have been notified of the change in representation will also be required. Member notification documents must be retained and provided to HealthSpring on request in the event of an audit.

Note: It is recommended to verify if a BOB transfer can be approved before completing the final purchase.

HealthSpring contracting policies state that existing member compensation must be paid to the hierarchy in place at the time of sale. Currently, we are unable to move an Agent's book of business when there has been a hierarchy change since the original time of sale. Since book of business transfers must be done for the entire book of business, we are unable to approve book of business transfers in this scenario due to an impact to the Upline hierarchy's compensation. For example, the commission payment hierarchy for Agent A's entire BOB does not exactly match Agent B's current hierarchy. In this scenario, the BOB transfer request cannot be approved.



Compensation Rules

Upon HealthSpring Receipt of Notification

On receipt of the request, HealthSpring Producer Commissions management will review the information provided and determine if any additional information is needed based on the type of transfer requested. HealthSpring will review all requests on a case-by-case basis and reserves the right to deny any request that does not meet current standards for approval.

HealthSpring also reserves the right to request any additional documentation not listed above and may designate additional requirements be met as a result of the review process.

If the request is approved, the effective date of the transfer can be no earlier than the first of the month following the date of initial notification indicated above. Please note that existing member compensation will not be impacted until the next applicable renewal pay cycle. Completion time varies depending on the BOB size. HealthSpring shall not be responsible for any payments made to the wrong Agent/Agency if HealthSpring does not receive at least 90 days' prior advance notice of the proposed transfer's effective date. All future debt for member terminations will be the responsibility of the Agent/Agency that was originally paid compensation for the relevant plan year.

In order for the new Agent or Agency to receive ongoing renewal compensation, all regular commissionable criteria must be met, including, but not limited to, an active HealthSpring contract, appropriate state licensure and appointment.



Compensation Rules

Servicing Status — Agents

HealthSpring has developed Servicing Status to allow retired from active selling Agents to continue to receive future renewal payments. To be eligible the below requirements must be met:

Servicing Status Requirements	Agent
Actively licensed in all Book of Business (BOB) states	✓
Current year certification modules completed	✓
Agent ready to sell at the time of Servicing request submission	✓
Servicing Module completion annually thereafter prior to the start of a new plan year	✓
In good compliance standing with HealthSpring	✓
Actively able to Service their BOB	✓

Once requirements have been met Agents may submit the [Agent Servicing Status Request Form](#) via email to ARCMAPD@healthspring.com. Once received, it may take 2-3 business days for the request to be processed. All requests will be effectuated the first day of the following month of receipt.

It is the Servicing Agents responsibility to ensure requirements are met on an annual basis prior to the beginning of each plan year or the servicing agreement will immediately terminate, and no future renewal payments will be made. Servicing Agents must continue to service their current BOB but are no longer authorized to actively sell HealthSpring Advantage or Part-D products. If at any time an Agent in Servicing Status should want to return to active selling status, they must initiate a new sales agreement with their Topline.

Only the Agent of Record (AOR) is eligible to service the active membership in the Agents BOB. Servicing the members requires but is not limited to, handling member inquiries, conducting periodic member outreach, and maintaining ongoing retention efforts with the active membership. Agent cannot sub delegate these services.

If the AOR is no longer able to maintain member relationships, remain qualified, outreach and be available to handle member inquiries, the Agents Servicing status will be immediately terminated, and no future renewal payments will be made. HealthSpring retains the right to audit the Agents activities, including but not limited to call recordings and member communications at any time.

Once in Servicing status, the Servicing Agent can't sell, move, or change AOR on any active membership within their book of business. As long as these requirements are met, and the members remain active on the same plan the AOR will be retained. If a member changes plans a new AOR will be assigned and renewal payments will cease. If a member terminates the plan no changes can be made, and renewal payments will cease. If the AOR was not eligible for renewals at the time of the original sale or due to failure to certify or retain proper licensing at any time after the sale they will not be eligible for renewal payments for that member.



Compensation Rules

Servicing Status — Agencies

HealthSpring has developed Servicing Status to allow Agencies with LOA and AOC agents who no longer want to retain an active selling Agreement to continue to receive future renewal payments. Please note: Since Agencies do not service members that were written by direct pay agents, Agencies with a commissionable book of business comprised of independent direct pay agents are not eligible for Servicing Status.

To be eligible to enter Servicing Status, the below requirements must be met by the Agency and its AOC Principal Agent:

Servicing Status Requirements	Agency	Principal
Actively licensed in all Book of Business (BOB) states	✓	✓
Current year certification modules completed	✓ (if required)	✓
Agent ready to sell at the time of Servicing request submission		✓
Servicing Module completion annually thereafter prior to the start of a new plan year	✓ (if required)	✓
In good compliance standing with HealthSpring	✓	✓
Dissolved all Downline Hierarchy	✓	
All Agency business was written by LOA or AOC agents and actively able to service the BOB	✓	✓

Once requirements have been met Agency must submit the [Agency Servicing Status Request Form](#) via email to ARCMAPD@healthspring.com. Once received, it may take 2-3 business days for the request to be processed. All requests will be effectuated the first day of the following month of receipt.

It is the Agency's responsibility to ensure requirements are met on an annual basis prior to the beginning of each new plan year or the servicing agreement will terminate, and no future renewal payments will be made. Agencies must continue to service active members within their BOB but will not have any downline agents and will no longer be authorized to actively sell HealthSpring Advantage or Part-D products. If at any time an Agency in Servicing Status wants to actively onboard and manage downline agents, they must initiate a new Agency sales agreement with their Topline.

If the Agency's commissionable book of business contains any direct pay agents therefore downline hierarchy is and was not 100% LOA and/or AOC Agents, the Agency is not eligible for servicing status.

Only the Agent of record (AOR) or the approved Agency member support (CS) staff for the Servicing Agency is eligible to service the Active membership in the Agency's book of business. Servicing the members requires, but is not limited to, handling member inquiries, conducting periodic member outreach, and maintaining ongoing retention efforts with the active membership.

If the AOR or CS staff is no longer able to maintain relationships, outreach and be available to service the members or remain qualified, Servicing status will be immediately terminated, and no future renewal payments will be made. HealthSpring retains the right to audit the Agency's activities at any time. Agency cannot sub delegate these services.

Once placed in Servicing Status the Servicing Agency or its Agents can't sell, move, or change AOR on any active membership within the Agency's BOB. As long as these requirements are met, and the member remains active on the same plan the AOR will be retained. If a member changes plans a new AOR will be assigned and renewal payments will cease. If a member terminates the plan no changes can be made, and renewal payments will cease. If the AOR and/or Agency was not eligible for renewals at the time of the original sale or due to failure to certify or retain proper licensing at any time after the sale they will not be eligible for renewals for that member.



Compensation Rules

Deceased Agent Active Commissionable Book of Business Transfer

HealthSpring may permit the transfer of a deceased Agent's active commissionable BOB to another eligible agent that meets the BOB transfer policy, providing he or she is actively contracted with HealthSpring, holds active state licenses and appointments in all relevant states, and has completed certification for the current plan year.

To qualify for review, the following must be provided to HealthSpring Producer Commissions in writing within 60 days of the deceased Agent's passing:

- Deceased Agent's name and writing number
- New Agent's name and writing number
- An attestation from the New Agent that he or she will continue servicing the transferred BOB
- Proof of New Agent's licensure and appointment in all states that the BOB transfer covers (based on each state's regulations)
- Proof of legal authority to act on behalf of the deceased agent

While we know this may be a difficult time, please note that our contracting policies state that existing member compensation must be paid to the hierarchy in place at the time of sale. Currently, we are unable to move an Agent's book of business when there has been a hierarchy change since the original time of sale. Since book of business transfers must be done for the entire book of business when the above applies, we are unable to approve book of business transfers in this scenario due to the impact to the Upline hierarchy's compensation.

In addition to these requirements, HealthSpring may also require the following in accordance with the standard BOB transfer requirements (outlined in the previous section):

Written demonstration that all members impacted by the BOB transfer have been notified of the change in representation.

On receipt of the request, HealthSpring Producer Commissions management will review the information provided and determine if the request will be approved. All requests will be reviewed on a case-by-case basis, and HealthSpring reserves the right to deny any request that does not meet current standards for approval. HealthSpring also reserves the right to request any additional documentation not listed above and may designate additional requirements be met as a result of the review process. If the request is approved, the effective date of the transfer can be no earlier than the first of the month following the date of initial notification.

In order for the new Agent to receive ongoing compensation for existing members, all regular commissionable criteria must be met, including, but not limited to, appropriate state licensure and appointment, and successful completion of plan-year certification.

Note: It is recommended to verify if a book of business transfer can be approved before completing the final purchase.



Downgrade, Suspension and Termination



Downgrade, Suspension and Termination

Agency Downgrade

Agencies should work with their Upline if there are questions or concerns related to meeting or maintaining the minimum Agent requirement. HealthSpring reserves the right to review all Agency-level contracts to ensure the specific requirements are being met. In the event an Agency is downgraded or terminated due to failure to meet engagement criteria, HealthSpring will notify the Agency's topline.

- **An Agency downgrade to a Personal Business Entity (PBE) level will result in forfeiture of Agency non-enrollment service fees (renewal compensation). A PBE may only retain its principal agent as a downline. All other downline agents will be dispersed as applicable.**

- An Agency downgrade to another Agency level (GA or above) will result in administrative fees being paid according to the Agency level in place as of the date of enrollment.

Example: Enrollments completed at SGA level will continue to be paid at the SGA level, while enrollments completed after the downgrade will be paid at the new administrative fee level (MGA/GA).

- When an Agency downgrades, Downline Agent/Agencies may be moved to the next direct Upline, as needed, based on the downgraded Agency's new level.

Downline Agent and Agency commissions will continue to be paid provided Agents and Agencies meet all required validations (contracted, certified/ attestation completed, licensed and appointed) and the member remains enrolled.

Suspension of Sales and Marketing

HealthSpring expects all Agencies/ Agents/Employees to comply with all CMS regulations, state and federal laws, guidelines, and HealthSpring rules, policies, and procedures.

If at any time individual performance or action damages or threatens to damage any Medicare beneficiaries or the reputation of HealthSpring or does not meet HealthSpring standards, HealthSpring can, at its discretion, suspend sales and marketing activities.

A determination to suspend can also be based on the severity of an allegation(s), the number of pending complaints or investigations, the nature and credibility of information initially provided, and/or the number of members or beneficiaries affected and can be based on other oversight criteria. In such cases, suspension is in effect till the investigation is completed, a final disciplinary recommendation has been made and any required remediation has been completed.

HealthSpring may be required to report the suspension to the applicable state or government Agency.



Downgrade, Suspension and Termination

Suspension Process

- When a determination to suspend sales and marketing activities is made, a suspension notification from HealthSpring Contracting will be sent, with a copy sent to applicable Topline.
- Agents cannot solicit or write new business while under suspension. If new business is written during the suspension period, Agents will not be eligible for commissions and/or renewals. Further disciplinary action may be levied.
- HealthSpring will satisfy suspension reporting requirements with notification to the appropriate state Agencies.
- HealthSpring is not obligated to report the status to a government agency unless further action is required.

Temporary Hold Status

Depending on the circumstances, an Agent may be placed on “temporary hold.” When a recommendation to place an Agent’s sales and marketing status on temporary hold is made, the Agent will be sent a temporary hold notification from HealthSpring Contracting, with a copy sent to the applicable Topline. The status of “temporary hold” means:

- Agent may not solicit or sell HealthSpring products while on a temporary hold status.
- Any outstanding commissions will continue to be paid during this period.
- HealthSpring is not obligated to report the status to a government agency unless further action is required.

Agent Termination: Not-For-Cause and For-Cause

All contract and appointment terminations are classified not-for-cause or for-cause. Termination of appointment may be recommended by HealthSpring, the Topline or immediate Upline, a regulatory Agency, or a state Department of Insurance; additionally, an Agent may request a voluntary termination.



Downgrade, Suspension and Termination

Not-For-Cause Termination (Agent/Agency)

A not-for-cause termination can be initiated by a Topline or immediate Upline, HealthSpring, or an Agent for any reason including, but not limited to, relocation, and expired license, and expired Errors and Omissions insurance coverage. Please review the following not-for-cause termination process:

- Termination requests must be submitted in writing via email or a termination form outlining the reason for termination. The termination form must be obtained from and returned to **ARC** via email.
- The terminated Agent/Agency will be sent a termination notification, which will identify the effective termination date.
- State-level appointments will be terminated in conjunction with the date the agreement is terminated.
- When an Agency is terminated, any Downline Agents/Agencies will be moved under the next highest entity in the hierarchy. Any LOA's will be terminated with their immediate upline.
- Termination will cease payment of commissions.

Not-For-Cause Termination – Agent

If an Agent is terminated by a Topline Agency or falls under a Topline Agency that will no longer hold a contract with HealthSpring but is in good standing with HealthSpring (i.e., not under investigation internally or externally, have acceptable compliance metrics, sufficient sales, not in debt to HealthSpring and/or current Upline, do not have third-party paper prohibiting a move in hierarchy), the Agent may re-contract under a new hierarchy or direct to HealthSpring. If recontracting, onboarding, certification and activation are complete within thirty (30) calendar days of the termination date, commissions and renewals may be restored.

Not-For-Cause Termination – Agency

If an Agency is terminated by its Topline or falls under a Topline Agency that will no longer hold a contract with HealthSpring and is in good standing with HealthSpring, the Agency may re-contract under a new hierarchy or direct to HealthSpring.

For-Cause Termination

A for-cause termination can be initiated by HealthSpring or by an external regulatory Agency.

- A for-cause termination notification letter, detailing the offense, termination effective date and the appeal process, is sent to the terminated party via certified U.S. mail.
- The applicable Topline or Upline is emailed a copy of the notification letter.
- State-level appointments will be terminated in conjunction with federal and state requirements.

Communication to any state in which the Agent/Agency is appointed will be made in accordance with all federal and state requirements.

- When an Agency is terminated, any active Downline Agents/Agencies will be moved under the next highest entity in the hierarchy.
- Termination will result in the Agent/Agency being ineligible to receive any further commission payments.
- In some cases, as directed by the HealthSpring SDAP, the Agent/Agency's profile in the contracting systems could also be marked as "Do Not Recontract."



Downgrade, Suspension and Termination

“Do Not Recontract” Reinstatement Process

If an Agent or Agency is flagged “Do Not Re-contract,” they may not contract with any HealthSpring company or its affiliates, including, but not limited to, all HealthSpring and commercial products. To request an appeal to the “Do Not Re- contract” status, use the following process:

- Upon receipt of the HealthSpring termination letter, an appeal must be submitted via email to request reinstatement of appointment within (10) business days to: [ARC](#).
- If there are no open violations against the Agent/Agency, the request will be considered at the SDAP meeting. If there are open violations, the Agent/Agency and the appropriate sales leader will be notified via email or telephone that the reinstatement request will not go to the committee until the open violations have been closed.
- The reinstatement request, along with any pertinent new information, is reviewed by the SDAP. When the committee has made a determination, the outcome will be documented in the Agent file and notification in writing will be sent via email with an digital copy to the applicable Topline.
- If Agent/Agency is approved for reinstatement, re-contracting is required and a new contracting packet must be submitted.
- If Agent/Agency is not approved for reinstatement, Agent/Agency must wait at least one year before submitting any additional requests for reconsideration.



Resources



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Resources

Helpful Links

[CignaforBrokers](#)

This is our portal that allows Agents to manage leads, appointments and applications. Through HealthSpring for Brokers, Agents are provided single sign on access to all HealthSpring resources listed below:

- [HealthSpring Producers' University \(Pinpoint\)](#)

Houses many HealthSpring resources, including training, forms, reporting and policies.

- [Producer Express \(Producer Onboarding\)](#)

Database of active producers used to house Agents' demographic information.

- [ConnectOne Storefront](#)

Our web-based tool allowing External Agents to customize and order Sales Kits and marketing collateral to better educate shoppers on plan information.

- [HealthSpring](#)

Our corporate public website.

- [Provider Lookup Tool](#)

With this online tool, Agents can locate network providers.

- [HealthSpring Quick Reference Guide](#)

These HealthSpring-created tools best support Agent success.

Key Contacts

Agent Resource Center (ARC)

Phone: **1-866-442-7516**

Email: ARCMAPD@HealthSpring.com

Hours of operation:

AEP

- October 1 – November 30
Monday – Saturday, 7 a.m. to 8 p.m. CST
Sunday, 11 a.m. to 4 p.m. CST
- December 1 – December 7
Monday – Saturday, 7 a.m. to 9 p.m. CST
Sunday, 11 a.m. to 6 p.m. CST

Lock-In

- December 8 – December 31
Monday – Friday, 7 a.m. to 6 p.m. CST
- April 1 – September 30
Monday – Friday, 7 a.m. to 6 p.m. CST

OEP

- January 1 – March 31
Monday – Saturday, 7 a.m. to 7 p.m. CST
- Medicaid Eligibility is an available option through **ARC**. Please have the Medicaid claim number and/or social security number and DOB of the member available prior to calling.



This version of the Rules of Engagement is effective 10/1/25. Health Care Service Corporation, a Mutual Legal Reserve Company, acquired the Cigna Group Medicare business in March 2025. All references in the ROE to HealthSpring are references to HealthSpring products and services provided exclusively by or through operating subsidiaries of Health Care Service Corporation. You will continue to market and sell products under the Cigna branding and product names for the remainder of the 2025 plan year effective sales. All commission payment schedules for 2025 plan year effective date sales remain the same and can be found in Producers University under 2025 commission schedule. Annual payment schedules with the new branding and HealthSpring product name changes for the 2026 plan year are included in this version of the Rules of Engagement.

