Contract #: 4600050981

STATE OF ARKANSAS
SERVICES CONTRACT

Contract #	4600050981	**Federal ID#**	2405306601
Service Type	Technical and General Services (TGS)	**Procurement Method**	Request for Proposals

1. **Contracting Parties**. State of Arkansas is hereinafter referred to as the Department and contractor is herein after referred to as the Contractor. This Agreement covers the services United Healthcare Services Incorporated (United) is providing to the Department, either directly or in conjunction with one of United's affiliates.

Department No. & Name	0914 - Statewide Shared Services
Division	Not Applicable

Contractor Name	United Healthcare Services, Inc.		
Contractor Address	9900 Bren Road East, Minnetonka, MN 55343		
Contractor Number	100161736	**Minority/Women Owned Business**	○ Yes ◉ No

2. **Objectives, Scope, and Performance.** Identify, in reasonable detail, the objectives and scope of the contractual agreement and the methods the Department will use to determine whether the objectives of the contract (Contract) have been achieved. If space below is insufficient it may be supplemented with Attachment 4.

See Attachment 4.

3. **Term Dates.** The original term **(Original Term)** of the Contract shall commence on 06/17/2022, and shall continue until 12/31/2025, unless earlier terminated or cancelled in accordance with the Contract or some other writing agreed to and signed by the parties, but in no event may the Original Term exceed a period of four (4) consecutive years from the effective date of the Original Term, unless exempt from Ark. Code Ann. § 19-11-238(c)(1). By written agreement of the parties, the term of the Contract may be extended or renewed for additional time beyond the Original Term. This allows for a total possible term **(Total Possible Term)** beyond the Contract's Original Term, as defined in the following paragraph.

The **Total Possible Term** of the Contract is a period comprised of the Original Term plus any extensions or renewals that may be agreed to by the parties in writing, but in no event longer than a period of seven (7) consecutive years from the effective date of the **Original Term**, unless otherwise provided by law. Subject to applicable law, the terms hereof, and an appropriation of necessary funding, the Total Possible Term of this Contract expires no later than 12/31/2029 (mm/dd/yyyy).

4. **Contractor's Performance Obligations.** Contractor, for the duration of the Contract and as consideration for the Department's payment as set forth below, shall provide the following to the Department:

See Attachment 5.

The parties agree that this paragraph 4 of the Contract, and any incorporated attachment, fully sets forth the Contractor's performance upon which the Department's obligation to pay the Contractor is conditioned. (if the space provided is not enough to fully specify the Contractor's duty to perform and to identify the standards of satisfactory performance, the Contractor's covenant to perform must be set forth in Attachment 5 hereto, Performance Details, the terms of which, if any, are incorporated herein by reference.)

5. **Department's Payment Obligations**. Department, as consideration for the Contractor's satisfactory performance of the Contractor's Performance Obligations, as set forth above, shall pay the Contractor as follows:

See Attachment 6.

The parties agree that this paragraph 5 of the Contract, and any incorporated attachment, fully sets forth all applicable rates, fees, charges, costs (transportation, per diem, subsistence, out-of-pocket allowances, and any other costs that may apply), and items for which the Contractor is entitled to payment under the Contract as consideration for Contractor's satisfactory performance of its obligations under the Contract. The Department shall not pay Contractor except as set forth. The parties also agree that the method(s) of determining the amount of payment corresponding to the Contractor's satisfactory performance is/are set forth in this paragraph 5 such that the total payment owed under the Contract can be determined by

reference thereto. (If the space provided is not enough to fully set forth the information needed to determine proper compensation owed by the Department for Contractor's satisfactory performance under the Contract, that information must be set forth in Attachment 2, Calculation of Compensation, the terms of which, if any, are incorporated herein by reference.)

Assuming: (a) Contractor's full and satisfactory performance under the Contract for the duration of the **Original Term**, and (b) the corresponding compensation identified in paragraph 5; the maximum number of dollars that the Department may be obligated to pay to the Contractor under the terms of the Contract for the Original Term is: $ 137,854,800.00 **(Initial Contract Amount)**.

Assuming: (a) Contractor's full and satisfactory performance under the Contract for the duration of its **Total Possible Term**, and (b) the corresponding compensation identified in paragraph 5, the maximum number of dollars that the Department may be obligated to pay to the Contractor under the terms of the Contract for the Total Possible Term is: $ 347,861,200.00 **(Total Projected Contract Amount)**.

If either the **Total Projected Contract Amount** or the amount the Department may be obligated to pay the Contractor in any given year of the **Original Term,** or the **Total Possible Term** of the Contract meets or exceeds the threshold of Ark. Code. Ann. § 19-11-265, the Contract shall be submitted for legislative review prior to its effective date.

6. **Terms and Conditions of Solicitation Incorporated and Order of Precedence.** The parties agree that the agreement in this Contract memorializes and incorporates by reference any and all written representations, warranties, terms, and conditions, set forth in the underlying solicitation document and the bid or proposal that became the basis of the Contract award, which representations, warranties, terms, and conditions continue in full force and effect unless expressly amended hereby.

   Accordingly, the provisions of this memorialization of the Contract should be read as being consistent therewith and supplementary thereto to the extent reasonably possible. However, in the event of a conflict between the provisions of this memorialization and the specific provisions of the bid or proposal that was the basis of award, such conflict shall be resolved by giving priority to the documents in the order listed below, including but not limited to conflicting order of precedence provisions.

   A. This Contract, as may be amended in writing by the parties;
   B. The solicitation S000000107 (Solicitation number) including all Addenda;
   C. Contractor's response to the solicitation.

7. **Termination & Cancellation Clauses.**
   A. Non-Appropriation Clause Pursuant to §19-11-1012(11). In the event the State of Arkansas fails to appropriate funds or make monies available for any biennial period covered by the term of this contract for the services to be provided by the Contractor, this Contract shall be terminated on the last day of the last biennial period for which funds were appropriated or monies made available for such purposes.

   This provision shall not be construed to abridge any other right of termination the agency may have.

   B. For Convenience. The Department may terminate this contract for any reason by giving the Contractor written notice of such termination no less than sixty (60) days prior to the date of termination.

   C. For Cause. The Department may cancel this Contract for cause when the Contractor fails to perform its obligations under it by giving the Contractor written notice of such cancellation at least thirty (30)

days prior to the date of proposed cancellation. In any written notice of cancellation for cause, the State will advise the Contractor in writing of the reasons why the State is considering cancelling the Contract and may provide the Contractor with an opportunity to avoid cancellation for cause by curing any deficiencies identified in the notice of cancellation for cause prior to the date of proposed cancellation. The parties may endeavor to agree to reasonable modifications in the Contract to accommodate the causes of the cancellation for cause and avoid the cancellation, to the extent permitted by law, and at the discretion of each party individually.

8. Non-negotiable **Governing Law and Venue.**
   - **A.** This contract shall be governed by and construed in accordance with the Laws of the State of Arkansas. Exclusive venue arising under this Contract is Pulaski County, Arkansas.
   - **B.** Any legislation that may be enacted subsequent to the date of this Contract, which may cause all or any part of the Contract to be in conflict with the laws of the State of Arkansas, will be given proper consideration if and when this contract is renewed or extended. At such time, the parties agree that the Contract shall be amended to comply with any applicable laws in effect.
   - **C.** Under Arkansas law, the release of public records is governed by the Arkansas Freedom of Information Act found at Section 25-19-101 et. seq. of the Arkansas Code Annotated.

9. Non-negotiable **Sovereign Immunity.** Nothing in this Contract shall be construed as a waiver of the State's sovereign immunity. Any claims Contractor wishes to assert against the State in connection with this Contract shall be brought in the Arkansas State Claims Commission.

10. Non-negotiable **Intergovernmental/Cooperative Use.** In accordance with Arkansas Code Annotated § 19-11-249, any State public procurement unit may participate in this Contract with a participating addendum signed by the Contractor and approved by the chief procurement officer of the procurement agency issuing the contract.

11. Non-negotiable **Disclosure Required by Executive Order 98-04.** Any contract or amendment to a contract executed by an agency which exceeds $10,000 shall require the Vendor to disclose information as required under the terms of Executive Order 98-04 and the Regulations pursuant thereto. The Vendor shall also require the subcontractor to disclose the same information. The Contract and Grant Disclosure and Certification Form shall be used for this purpose. Contracts with another government entity such as a state agency, public education institution, federal government entity, or body of a local government are exempt from disclosure requirements.

    The failure of any person or entity to disclose as required under any term of Executive Order 98-04, or the violation of any rule, regulation or policy promulgated by the Department of Finance and Administration pursuant to this Order, shall be considered a material breach of the terms of the contract, lease, purchase

    agreement, or grant and shall subject the party failing to disclose, or in violation, to all legal remedies available to the Agency under the provisions of existing law**.**

12. **Compliance.** The Contractor shall ensure, in cooperation with the Department, that the Contract adheres to the requirements of Arkansas procurement law, including without limitation the inclusion of any mandatory language and the submission of the contract for any required review. The signature of the Contractor on this Contract serves as an acknowledgement that the Contractor is:

    - **A.** Equally responsible with the Department for adhering to the requirements of Arkansas Procurement

Law related to the content and review of the Contract; and

B. Subject to the relevant ethical provisions of § 19-11-701 et seq.

13. **Indemnity.** The Contractor shall be fully liable for the actions of its agents, employees, partners, and assigns and shall fully indemnify, defend, and hold harmless the Department, and their officers, agents, and employees from third party suits, actions, damages, and costs of every name and description, including attorney's fees to the extent arising from or relating to personal injury and damage to real or personal property, caused in whole or in part by the negligence or willful misconduct of Contractor, its agents, employees, partners, or assigns.

14. **Assignment/Subcontracting.** Contractor shall not assign, sell, transfer, subcontract or sublet rights, or delegate responsibilities under this Contract, in whole or in part, without the prior written approval of the Department.

15. **Amendments.** The terms of this Contract shall not be waived, altered, modified, supplemented or amended in any manner whatsoever without written approval of both parties. Any amendment that increases compensation or represents a material substantive change may require review by Legislative Council or Joint Budget Committee pursuant to Ark. Code Ann. § 19-11-265.

16. **Records.** Financial and accounting records reasonably relevant to State of Arkansas transactions under this Contract shall be subject to examination by appropriate Arkansas government authorities for a period of five (5) years from the date of expiration, termination or cancellation and final payment under this Contract, provided, however, that such government authorities will provide thirty (30) days written notice to the Contractor of its intent to conduct such examination contemplated by this section; and provided that such examination occurs pursuant to a mutually agreed upon location, during normal business hours and subject to reasonable confidentiality obligations.

17. **Non-waiver.** The failure by one party to require performance of any provision shall not affect that party's right to require performance at any time thereafter, nor shall a waiver of any breach or default of this Contract constitute a waiver of any subsequent breach or default or a waiver of the provision itself.

18. **Severability.** If any provision of this contract is held unenforceable, all remaining provisions of this Contract shall remain in full force and effect.

19. **Attachments.**
    1. Certification of Contractor
    2. Calculation of Compensation, as applicable;
    3. Source of Funds
    4. Objectives, Scope, and Performance Standards, as applicable; and
    5. Performance Details, as applicable
    6. Financial Details

20. **Notices.**
    - **A. Method of Notice.** The parties shall give all notices and communications between the parties in writing by (i) personal delivery, (ii) a nationally-recognized, next-day courier service, (iii) first-class registered or certified mail, postage prepaid[, (iv) fax, or (v) electronic mail to the party's address specified in this Contract, or to the address that a party has notified to be that party's address for the purposes of this section.
    - **B. Receipt of Notice.** A notice given under this Contract will be effective on

i. the other party's receipt of it, or

ii. if mailed, the earlier of the other party's receipt of it and the fifth business day after mailing it.

C. Issuance of Notice. All notices and communications between the parties in writing shall be directed to the respective parties in accordance with the following:

Contact #1 – Department Representative submitting/tracking this contract

Jesse Jones	Research Analyst
Name	Title
(501) 682-6574	jesse.g.jones@arkansas.gov
Telephone#	Email

Contact #2 - Department Representative with knowledge of this project (for general questions and responses)

Shalada Toles	Deputy Director
Name	Title
(501) 682-5142	shalada.toles@arkansas.gov
Telephone#	Email

Contact #3 - Department Representative Director or Critical Contact (for time sensitive questions and responses)

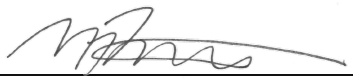
Jake Bleed	EBD Director
Name	Title
(501) 682-5502	jake.bleed@arkansas.gov
Telephone#	Email

21. Technology Access. If the Commodities are electronic information processing hardware or software, including telecommunications hardware or software ("Information Technology"), then the Contractor represents and warrants it shall comply with federal and state law relating to accessibility by persons with visual impairments and nonvisual access standards established by the Division of Information System, which standards can be found at https://www.dfa.arkansas.gov/images/uploads/procurementOffice/technologyAccessClause.pdf and are included herein by reference, as applicable.

22. SIGNATURES

DEPARTMENT SIGNATURE CERTIFIES NO OBLIGATIONS WILL BE INCURRED BY A STATE DEPARTMENT UNLESS SUFFICIENT FUNDS ARE AVAILABLE TO PAY THE OBLIGATIONS WHEN THEY BECOME DUE.

IN WITNESS WHEREOF, the Parties sign and cause this Contract to be executed. Notwithstanding verbal or other representations by the parties, the "Effective Date" of this Contract shall be the date provided in Section 3 above.

CONTRACTOR AUTHORIZED SIGNATURE	**DEPARTMENT AUTHORIZED SIGNATURE**
Michael Grossman	Jake Bleed
Printed Name	Printed Name
COO, URS	EBD Director
Title	Title
9800 Healthcare Ln, Minnetonka, MN 55343	501 Woodlane St Suite 500, Little Rock, AR 72201
Address	Address
	Jake Bleed
Signature	Signature
June 1, 2022	June 1,2022
Date	Date

Contract #: 4600050981

Attachment #1

CERTIFICATION OF CONTRACTOR

Sections A, B and C apply to all service contracts. Sections D and E apply to Professional and Consulting Services contracts only.

A. "I, Michael Grossman (Contractor) Chief Operating Officer, URS (Title)

certify under penalty of perjury that, to the best of my knowledge and belief, no regular full-time or part- time employee of the State of Arkansas will receive any personal, direct or indirect monetary benefits as a result of the execution of this contract that would violate the law." Where the Contractor is a widely-held public corporation, the term 'direct or indirect monetary benefits' "shall not apply to any regular corporate dividends paid to a stockholder of said corporation who is also a State employee and who owns less than ten percent (10%) of the total outstanding stock of the contracting corporation."

B. List any other contracts or subcontracts Contractor has with any other state government entities. (Not applicable to contracts between Arkansas state departments. If no contracts or subcontracts, please put "Not applicable" or "None.")

Contractor has contracts or subcontracts with other state government entities and does not believe they impact its ability to provide services under this contract with the State of Arkansas.

C. Is Contractor currently engaged in any legal controversies with any state agencies or representing any clients engaged in any controversy with any Arkansas state department? If no controversies, please put "Not applicable" or "None.")

Because of the nature of Contractor's business, we are routinely subject to lawsuits alleging various causes of action. Contractor is not aware of any legal controversies or litigation that would impact its ability to provide services to the State of Arkansas. Any material litigation or legal actions are disclosed in our financial statements available on the UnitedHealth Group Incorporated (UnitedHealth Group is Contractor's parent company) website: unitedhealthgroup.com.

D. Contractor shall list below, or on an attachment hereto, names, addresses, and relationship of those persons who will be supplying services to the State at the time of the execution of the contract. If the names are not known at the time of the execution of the contract, the Contractor shall submit the names along with the other information as they become known. Such persons shall, for all purposes, be employees or independent contractors operating under the control of the Contractor (sub- contractors), and nothing herein shall be construed to create an employment relationship between the departments and the persons listed below.

Name	Address	Relationship
See Attachment 4		

CERTIFICATION OF CONTRACTOR CONT'D

E. The State has no managerial responsibilities over the Contractor or Contractor's employees. In carrying out this contract, Contractor understands and represents that there is no employment relationship between the contracting parties.

F. By checking the box below, the Contractor certifies that Contractor: (1) does not boycott Israel and shall not boycott Israel during the aggregate term of the corresponding Contract.

☑ Contractor does not and shall not boycott Israel

Attachment #2

Calculation of Compensation

Calculation of Compensation (for Professional & Consulting Service Contracts Only):

A. In the table below, provide the various levels of expertise, the number of personnel for each level, the compensation rate, and total for each level, as applicable.

Level of Personnel	Number	Compensation Rate	Total for Level
TOTAL COMPENSATION EXCLUSIVE OF EXPENSE REIMBURSEMENT(S)			**$ 0.00**

B. In the table below, provide any allowable reimbursable expenses, estimated rates, and a total for each level.

Reimbursable Expense Items (Specify)	Estimated Rate of Reimbursement	Total
TOTAL REIMBURSABLE EXPENSES		**$ 0.00**

Total compensation inclusive of expense reimbursement: **$ 0.00**

Annual Contract Amount:

Calculation of Services and Commodities (for Technical & General Service Contracts Only):

A. In the table below, as applicable, provide the various services to be rendered, the quantity, cost per item, and total cost.

Services	Quantity	Cost Per Item	Total Cost
MAPD Services 23-24	1	$44,151,600	$ 44,151,600.00
MAPD Services 24-25	1	$45,951,600	$ 45,951,600.00
MAPD Services 25-26	1	$47,751,600	$ 47,751,600.00
		TOTAL SERVICES	**$ 137,854,800.00**

B. In the table below, as applicable, provide the various commodities, quantity, cost per item, and total cost

Commodities	Quantity	Cost Per Item	Total Cost
		TOTAL COMMODITIES	**$ 0.00**

Total services inclusive of commodities: **$ 137,854,800.00**

Annual Contract Amount: **$ 45,951,600.00**

Attachment #3

Source of Funds

Source of Funds the Department intends to draw on. This is provided for informational purposes only. It is required under Arkansas Procurement Law and is not a performance obligation of the Department or an unconditional promise to pay from the sources identified.

Fund Source	Identify Source of Funds *	Fund	Fund Center	Amount of Funding	% of Total Contract Cost
Trust	Arkansas State Emp Adr	383341	7006103	$ 85,836,240.00	62.3 %
Trust	Public Teachers Trust Fu	383353	700610B	$ 52,018,560.00	37.7 %
					%
					%
					%
					%
			TOTALS	**$ 137,854,800.00**	**100.00 %**

Identify whether State general revenue funds (GRF), special revenue funds (SRF), federal funds (FED), or other public funds (Other) are the source. Identify each specific source of SRF, such as special taxes or fees, in the “Identify Source of Funds” column. Similarly, if Other public funds, such as tobacco funds, general improvement funds, etc., are being used to pay the Contractor, these should be specified in the “Identify Source of Funds” column.

CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM

Failure to complete all of the following information may result in a delay in obtaining a contract, lease, purchase agreement, or grant award with any Arkansas State Agency.

SUBCONTRACTOR: ☐ **Yes** ☒ **No**

SUBCONTRACTOR NAME: United HealthCare Services, Inc.

TAXPAYER ID NAME: 41-1289245

IS THIS FOR: ☐ **Goods?** ☒ **Services?** ☐ **Both?**

YOUR LAST NAME: Grossman **FIRST NAME:** Michael **M.I.:**

ADDRESS: 9800 Healthcare Ln

CITY: Minnetonka **STATE:** MN **ZIP CODE:** 55343 **COUNTRY:** USA

AS A CONDITION OF OBTAINING, EXTENDING, AMENDING, OR RENEWING A CONTRACT, LEASE, PURCHASE AGREEMENT, OR GRANT AWARD WITH ANY ARKANSAS STATE AGENCY, THE FOLLOWING INFORMATION MUST BE DISCLOSED:

FOR INDIVIDUALS*

Indicate below if: you, your spouse or the brother, sister, parent, or child of you or your spouse *is* a current or former: member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee:

Position Held	Mark (√)		Name of Position of Job Held [senator, representative, name of board/ commission, data entry, etc.]	For How Long?		What is the person(s) name and how are they related to you? [i.e., Jane Q. Public, spouse, John Q. Public, Jr., child, etc.]	
	Current	Former		From MM/YY	To MM/YY	Person's Name(s)	Relation
General Assembly							
Constitutional Officer							
State Board or Commission Member							
State Employee							

☒* **None of the above applies**

FOR AN ENTITY (BUSINESS)*

Indicate below if any of the following persons, current or former, hold any position of control or hold any ownership interest of 10% or greater in the entity: member of the General Assembly, Constitutional Officer, State Board or Commission Member, State Employee, or the spouse, brother, sister, parent, or child of a member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee. Position of control means the power to direct the purchasing policies or influence the management of the entity.

Position Held	Mark (√)		Name of Position of Job Held [senator, representative, name of board/commission, data entry, etc.]	For How Long?		What is the person(s) name and what is his/her % of ownership interest and/or what is his/her position of control?		
	Current	Former		From MM/YY	To MM/YY	Person's Name(s)	Ownership Interest (%)	Position of Control
General Assembly								
Constitutional Officer								
State Board or Commission Member								
State Employee								

☒* **None of the above applies**

Contract and Grant Disclosure and Certification Form

Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this contract. Any contractor, whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the agency.

As an additional condition of obtaining, extending, amending, or renewing a contract with a *state agency* I agree as follows:

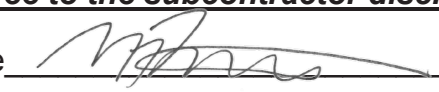
1. Prior to entering into any agreement with any subcontractor, prior or subsequent to the contract date, I will require the subcontractor to complete a **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM**. Subcontractor shall mean any person or entity with whom I enter an agreement whereby I assign or otherwise delegate to the person or entity, for consideration, all, or any part, of the performance required of me under the terms of my contract with the state agency.

2. I will include the following language as a part of any agreement with a subcontractor:

   Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this subcontract. The party who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the contractor.

3. No later than ten (10) days after entering into any agreement with a subcontractor, whether prior or subsequent to the contract date, I will mail a copy of the **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM** completed by the subcontractor and a statement containing the dollar amount of the subcontract to the state agency.

I certify under penalty of perjury, to the best of my knowledge and belief, all of the above information is true and correct and that I agree to the subcontractor disclosure conditions stated herein.

Signature  Title Chief Operating Officer, URS Date 06/02/2022

Vendor Contact Person John Thompson Title National Vice President Phone No. 763-283-2712

Agency use only

Agency Number_____ Agency Name_____ Agency Contact Person_____ Contact Phone No._____ Contract or Grant No._____

STATE OF ARKANSAS
DEPARTMENT OF TRANSFORMATION AND SHARED SERVICES
OFFICE OF STATE PROCUREMENT
501 Woodlane St., Ste. 220
Little Rock, Arkansas 72201-1023

ADDENDUM 1

TO: TSS-Employee Benefits Division and United Healthcare
FROM: Tanya Freeman
DATE: 5/31/2022
SUBJECT: S000000107 Medicare Advantage Prescription Drug Service

The following change(s) to the above-referenced IFB have been made as designated below:

X Change of specification(s)
_____ Additional specification(s)
_____ Change of bid opening time and date
_____ Cancellation of bid
_____ Other

CHANGE OF SPECIFICATIONS

Remove Section 12.A. of the *Services Contract* and replace with:

12. Compliance. The Contractor shall ensure, in cooperation with the Department, that the Contract adheres to the requirements of Arkansas procurement law, including without limitation the inclusion of any mandatory language and the submission of the contrct for any required review. The signature of the Contractor on this contract serves as an acknowledgement that the Contractor is:

A. Equally responsible with the Department for adhering to the requirements of Arkansas Procurement Law related to the content and review of the Contract, if applicable to Contractor; and

Remove 6TH bullet point United Healthcare *Services Official Solicitation Price Sheet* and replace with:

- UHC may request a modification to the 2023, 2024, or 2025 guaranteed rates in the event of changes to existing laws, regulations, or any new legislation, assessments, taxes, and/or marketplace changes to the Medicare Advantage and Part D programs that will have a significant impact to the program costs or revenue and occur through no fault of UHC. Significant impacts to the program costs or revenue may include, but are not limited to: (i) changes to the Part D program; (ii) changes in the methodology used to calculate CMS payments including any changes due to EGWP bid waiver; (iii) any plan design changes required by the applicable regulatory authority (i.e. mandated benefits); (iv) any Force Majeure event, including but not limited to national pandemic, act of God, acts of terrorism, or anything beyond United's reasonable control; or (v) as otherwise permitted in our contract. For the purpose of this section, impacts to program premium will be considered significant if the increase is twenty percent (20%) greater than the previous year. An increase requested under this section may not exceed five percent (5%) of UHC's Total Revenue (Including both CMS Direct Capitation + Employer Premium) as documented in the original proposed guaranteed rate exhibit. Any modifications to UHC's pricing will require approval of the Arkansas State Board of Finance and review by the Arkansas General Assembly. UHC's quote assumes that the Point-of Sale (POS) Rebate Rule will not be

effective as of January 1, 2023. If the POS Rebate Rule becomes effective as of January 1, 2023, United may seek a modification as described in this paragraph accordingly.

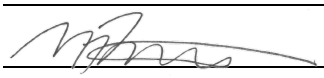
ADDITIONAL SPECIFICATIONS

Add the following language to Section 13 of the *Services Contract:*

The State and Contractor agree that Contractor does not render medical services to Members, that neither is responsible for the provision of health care by health care providers, that health care providers are not the agents of either, and that in no event shall the indemnification obligations under Section 13 apply to that portion of any loss, liability, damage, expense, settlement, cost or obligation caused by the acts or omissions of health care providers with respect to claimants.

The specifications by virtue of this addendum become a permanent addition to the above referenced RFP.

Company: United HealthCare Services, Inc.

Signature: 

Date: June 1, 2022

State Agency: Employee Benefits Division

Signature: Jake Bleed

Date: 06/01/2022

ATTACHMENT 4

TECHNICAL PROPOSAL PACKET
S000000107

PROPOSAL SIGNATURE PAGE

Type or print the following information.

PROSPECTIVE CONTRACTOR'S INFORMATION					
Company:	United HealthCare Services, Inc.				
Address:	9900 Bren Road East				
City:	Minnetonka	State:	MN	Zip Code:	55343
Business Designation:	☐ Individual ☐ Sole Proprietorship ☐ Public Service Corp ☐ Partnership ☒ Corporation ☐ Nonprofit				
Minority and Women-Owned Designation*:	☒ Not Applicable ☐ American Indian ☐ Service Disabled Veteran ☐ African American ☐ Hispanic American ☐ Women-Owned ☐ Asian American ☐ Pacific Islander American				
	AR Certification #: _____ * See *Minority and Women-Owned Business Policy*				

PROSPECTIVE CONTRACTOR CONTACT INFORMATION *Provide contact information to be used for solicitation related matters.*			
Contact Person:	John Thompson	Title:	National Vice President
Phone:	763-283-2712	Alternate Phone:	404-580-4502
Email:	john_c_thompson@uhc.com		

CONFIRMATION OF REDACTED COPY

☒ YES, a redacted copy of submission documents is enclosed.

☐ NO, a redacted copy of submission documents is not enclosed. I understand a full copy of non-redacted submission documents will be released if requested.

Note: If a redacted copy of the submission documents is not provided with Prospective Contractor's response packet, and neither box is checked, a copy of the non-redacted documents, with the exception of financial data (other than pricing), will be released in response to any request made under the Arkansas Freedom of Information Act (FOIA). See Solicitation Terms and Conditions for additional information.

ILLEGAL IMMIGRANT CONFIRMATION

By signing and submitting a response to this *Solicitation*, Prospective Contractor agrees and certifies that they do not employ or contract with illegal immigrants and **shall not** employ or contract with illegal immigrants during the term of a contract awarded as a result of this solicitation.

ISRAEL BOYCOTT RESTRICTION CONFIRMATION

By checking the box below, Prospective Contractor agrees and certifies that they do not boycott Israel and **shall not** boycott Israel during the term of a contract awarded as a result of this solicitation.

☒ Prospective Contractor does not and **shall not** boycott Israel.

An official authorized to bind the Prospective Contractor to a resultant contract shall sign below.

The signature below signifies agreement that any exception that conflicts with a Requirement of this *Solicitation* **may cause the Prospective Contractor's proposal to be rejected.**

Authorized Signature: Greta Redmond **Title:** Vice President, Actuarial and Underwriting

Printed/Typed Name: Greta Redmond, FSA, MAAA **Date:** April 25, 2022

SUBMISSION REQUIREMENTS CHECKLIST

The following items **must** be submitted with the Prospective Contractor's proposal*:*

- ☐ *Proposal Signature Page*
- ☐ *Information for Evaluation*
  - *Experience* (2 pages or less)
  - *Solution (10 pages or less)*
  - *Risk* (2 pages or less)
- ☐ Completed *Pricing Response*
- ☐ *Recommended Options Form*
- ☐ *Proposed Subcontractors Form*
- ☐ *Exceptions Form*, if applicable
- ☐ Copy of Prospective Contractor's *Equal Opportunity Policy*

The following items, which **must** be submitted prior to a contract award to the Prospective Contractor, may also be included with the Prospective Contractor's proposal:

- ☐ EO 98-04: *Contract and Grant Disclosure Form*
- ☐ *Voluntary Product Accessibility Template* (VPAT), if applicable (https://www.itic.org/policy/accessibility/vpat, use the VPAT 2.4Rev 508 version)

RECOMMENDED OPTIONS FORM

- Identify optional recommended services available to the State, along with the schedule impact and cost details of each item. Responses to this form *will not* be scored for evaluation purposes.
- Costs associated with the optional recommended services **must** be included on this form and **must not** be included in the completed *Pricing Response.*

PROSPECTIVE CONTRACTOR PROPOSES THE FOLLOWING OPTIONAL RECOMMENDED SERVICES UNDER A RESULTING CONTRACT.

Item Description:	Add routine acupuncture benefit (beyond Medicare covered services) 12 visits per year at $0 copay
How will this add value?	Our acupuncture benefits (beyond Medicare covered services) offer alternative treatment options for the relief of pain such as lower back pain, sprains, strains or headaches.
Schedule Impact:	No impact on schedule. Services can be added during discussions or implementation.
Cost Details:	$0.75 per retiree member per month (option must be selected for the entire group population)

Item Description:	Add routine dental care benefit (beyond Medicare covered services)
How will this add value?	Our routine dental benefits (beyond Medicare covered services) are supported by the largest national Medicare dental network. We offer a range of 5 standard plan options plus customization availability. The benefits include coverage for exams, cleanings, X-rays, and more to help maintain oral health.
Schedule Impact:	No impact on schedule. Services can be added during discussions or implementation.
Cost Details:	Costs for dental plans vary by benefit selection and one dental plan would be selected for the entire group population: $6 - $8 per retiree member per month for standard preventive & diagnostic plan. $17 - $24 per retiree member per month for standard comprehensive coverage plan

Item Description:	Personal Emergency Response System
How will this add value?	The personal emergency response system is a wearable monitoring device which provides quick access to a response center 24/7, 365 days a year. The system includes unique features such as fall detection, real-time monitoring, geo-fencing and more.
Schedule Impact:	No impact on schedule. Services can be added during discussions or implementation.
Cost Details:	$0.25 per retiree member per month (option must be selected for the entire group population)

Item Description:	Allowance for over-the-counter healthcare products ($40 allowance per quarter, allowance expires quarterly)
How will this add value?	Through our over-the-counter benefit, members have access to hundreds of brand name and generic health and personal care products from vitamins, medications, fall safety products and more. Items are available for members to order in the convenience of their homes through our catalog.
Schedule Impact:	No impact on schedule. Services can be added during discussions or implementation
Cost Details:	$2.40 per retiree member per month (option must be selected for the entire group population)

☐ **PROSPECTIVE CONTRACTOR DOES NOT OFFER OPTIONAL RECOMMENDED SERVICES.**

PROPOSED SUBCONTRACTORS FORM

- ***Do not*** *include additional information relating to subcontractors on this form or as an attachment to this form.*

PROSPECTIVE CONTRACTOR PROPOSES TO USE THE FOLLOWING SUBCONTRACTOR(S) TO PROVIDE SERVICES.

Please provide the following information

SUBCONTRACTOR'S COMPANY NAME	STREET ADDRESS	CITY, STATE, ZIP
ACTUALMEDS CORPORATION	222 Pitkin St	East Hartford, CT 06108
ALORICA	5161 California Ave	Irvine, CA 92617
AXION LLC	586 Valley Rd	Wayne, NJ 07474
BROADPATH HEALTHCARE SOLUTIONS INC	6400 E Grant Rd	Tucson, AZ 85715
C3 CUSTOMER CONTACT CHANNELS INC	600 N. Pine Island Rd	Plantation, FL 33324
CENVEO	200 First Stamford Pl	Stamford, CT 06902
CHANGE HEALTHCARE	100 Airpark Center E	Nashville, TN 37217
CLARITY SOFTWARE SOLUTIONS INC	1501 Broadway	New York, NY 10036
CONCENTRIX	44051 Nobel Dr	Fremont, CA 94538
CONDUENT	100 Campus Dr	Florham Park, NJ 07932
CONVEY HEALTH SOLUTIONS INC	1 Financial Plz	Fort Lauderdale, FL 33394
COVERMYMEDS LLC	2 Miranova Pl	Columbus, OH 43215
DIALAMERICA MARKETING INC	960 MacArthur Blvd	Mahwah, NJ 07430
ELIZA CORPORATION	75 Sylvan St	Danvers, MA 01923
FEDERAL EXPRESS	942 S Shady Grove Rd	Memphis, TN 38120
FIRSTSOURCE TRANSACTION SERVICES LLC	1661 Lyndon Farm Ct	Louisville, KY 40223
FIS	601 Riverside Ave	Jacksonville, FL 32204
FISERV INC	255 Fiserv Dr	Brookfield, WI 53045
HEALTH MANAGEMENT SYSTEMS INC	5615 High Point Dr	Irving, TX 75038
LANGUAGE LINE SERVICES INC	1 Lower Radsdale Dr	Monterey, CA 93940
MULTIPLAN INC	115 5th Ave	New York, NY 10003
NTT	5680 Greenwood Plaza Blvd	Greenwood Village, CO 80111
PERFORMANT RECOVERY INC	333 North Canyons Parkway	Livermore, CA 94551
R R DONNELLEY & SONS COMPANY INC	35 Wacker Dr	Chicago, IL 60601

REVEL HEALTH LLC	2421 Ingalls St	Edgewater, CO 80214.
SCIO INSPIRE CORP	433 South Main St	West Hartford, CT 06110
SEGERDAHL CORPORATION	385 Gilman Ave	Wheeling, IL 60090
SHUTTERFLY LLC	2800 Bridge Parkway	Redwood City, CA 94065
SILVERLINK COMMUNICATIONS LLC	67 S Bedford St	Burlington, MA 01803
SOURCEHOV HEALTHCARE INC	2701 East Grauwyler Rd	Irving, TX 75061
SURESCRIPTS LLC	2550 S Clark St	Arlington, VA 22202
TAYLOR CORPORATION	1725 Roe Crest Dr	North Mankato, MN 56003
TELEPERFORMANCE USA	176 N 2200 W	Salt Lake City, UT 84116
THE RAWLINGS COMPANY LLC	1 Eden Parkway	La Grange, KY 40031
TTEC HEALTHCARE SOLUTIONS INC	9197 South Peoria St	Englewood, CO 80112
UNITED PARCEL SERVICE	55 Glenlake Parkway NE	Atlanta, GA 30328
UNITED STATES PHARMACEUTICAL GROUP LLC	100 Southeast 3rd Ave	Fort Lauderdale, FL 33394
WELLTOK INC	3001 Brighton Blvd	Denver, CO 80216
WIPRO	140 Butterfield Rd	Oakbrook Terrace, IL 60181

☐ **PROSPECTIVE CONTRACTOR DOES NOT PROPOSE TO USE SUBCONTRACTORS TO PERFORM SERVICES.**

INFORMATION FOR EVALUATION – EXPERIENCE

Claim of Expertise:	We are the market leader for Group Medicare Advantage plans and services.
Documented Performance:	All Medicare Advantage plans (Medicare Part C) are assigned an annual Star Rating by the Centers for Medicare & Medicaid Services (CMS). A five-star rating system is used, with one Star being given to the lowest-rated plans, and five Stars being reserved for only the highest-rated plans. All plans are measured and issued a rating based on: • Screening tests and vaccines • Management of chronic conditions • Member experience with the Medicare Advantage plan • Member complaints and changes in plan performance • Customer service The most important service we can deliver to retirees is quality. For 2022, our Group Medicare Advantage plan, with more than 1.7 million members, is a 5-Star plan. We are the only major national carrier with a 5-Star rated Medicare Advantage plan from CMS. Prior to 2022, we were a 4.5-Star plan for the past 5 years and have been a 4-Star or greater plan for the last 10 years.

Claim of Expertise:	We have a fully dedicated line of business to Group Medicare Advantage to better serve our clients and members.
Documented Performance:	We understood early on that the Group Retiree market is significantly different from the individual market (or street plan you see on TV). To that end, we established an entire platform and organization with over 2,000 dedicated staff members 5,500 supporting employees dedicated to Group Medicare Advantage. This group engine encompasses 20 segments needed to support the Group Medicare Advantage business, including Stars, account management, network, operations, senior executive leadership, actuarial, clinical, product, marketing, implementation, reporting, and more. Our clinical team is led by a team of doctors that specialize in treating older patients. Their focus exclusively on the senior population has delivered a 5-Star rating - the only 5-Star rating amongst major national carriers.

Claim of Expertise:	Our Group Medicare Advantage plan provides ongoing rate stability and savings over time.
Documented Performance:	We have been able to deliver overall premium stability on our Group Medicare Advantage plans. On average, across our Group Medicare Advantage book of business, we have provided our clients with a $38 per member per month (PMPM) premium decrease over the past 5 years.

Claim of Expertise:	We have the proven experience to successfully transition the State of Arkansas to a Group Medicare Advantage solution.
Documented Performance:	We have successfully transitioned 20 State retirement systems to our Group Medicare Advantage plans. Most of these State clients were new to Group Medicare Advantage. We are also the nation's largest provider of Group Medicare Advantage plans with over 600 Group Medicare Advantage clients and over 1.7 million members.

Claim of Expertise:	We provide a best-in-class Group Medicare Advantage account management team service model that has extensive experience with proven results.
Documented Performance:	We pioneered providing an account management team service model that was dedicated to Group Medicare Advantage and includes subject matter experts in the Medicare space. For our clients, we provide a service team that includes a strategic account executive that has leadership responsibility. We also provide a client service manager who is a single client point of contact for day-to-day issues. Over 13 years ago, we introduced the concept of on-site service account managers to serve members for our State Group Medicare Advantage clients. Our Group Medicare Advantage account management team results for 2021: • 99% of Group Medicare Advantage clients likely to recommend our services • 99% Account Management satisfaction score on the annual client survey • 91- Account Management Net Promoter Score (Net Promoter Score or NPS is a measurement of customers rating their likelihood to recommend the prospective carrier's products and services to a colleague or peer. Based on the global NPS standards any score above 0 would be considered "good", with 50 and above classified as excellent, and 70 or higher as world class)

	• 27% reduction in the number of escalations to the client year-over-year with fewer than 1% of members reporting escalation of issues needing client intervention

Claim of Expertise:	We have an implementation team that delivers on its promises for our Group Medicare Advantage clients.
Documented Performance:	We have extensive experience in implementing Group Medicare Advantage plans. We have onboarded 308 Group Medicare Advantage clients over the past three years. Our 2021 implementation satisfaction survey results were 95% overall satisfaction based on 104 new Group Medicare Advantage client implementations. Our new clients provided us with a Net Promoter Score (NPS) of 85 for implementation.

Claim of Expertise:	Our innovative Group Medicare Advantage customer service model is designed to help retirees live healthier lives by improving healthcare outcomes.
Documented Performance:	Our dedicated Group Medicare Advantage customer service model supports our members and encourages access to their health and wellness benefits. Our Advocates delivered the following healthcare outcomes since 2018: • 5,700,000 health action reminders provided to members • 233,000 gaps in care addressed and closed with members • 240,000 appointments scheduled for members (i.e.: doctor visits) • 177,000 Group Medicare Advantage members were assigned a personal clinical advocate after being proactively identified of having a complex health event • 95%-member satisfaction (based on member surveys after a call) • 98% call quality rating (based on member surveys after a call) • 10 second average speed to answer with a dedicated toll-free number

Claim of Expertise:	We have the largest Group Medicare Advantage provider network with near universal access.
Documented Performance:	• Largest National Group Medicare Advantage PPO network with 889,000 providers, representing 80%+ of all Medicare providers that covers all U.S. counties and territories • Statewide Group Medicare Advantage PPO network in Arkansas covering all counties • Largest contracted Group Medicare Advantage network in Arkansas with 2,047 primary care physicians and 2,733 specialists Extensive and strategic provider education is a part of our onboarding process for our new Group Medicare Advantage clients. We leverage a broad and comprehensive communication campaign to out-of-network providers so that they will see our Group Medicare Advantage members. Under our Group Medicare Advantage plan, retirees can see any provider (at the in-network level of benefits) that accepts Medicare and accepts our plan.

Claim of Expertise:	We offer an innovative member rewards program to promote healthy behaviors.
Documented Performance:	We pioneered the member rewards program by demonstrating to CMS in 2014 the value of engaging with our Group Medicare Advantage members. Retirees will earn reward credits through a reloadable debt card for completing health care activities. The member rewards opportunities for eligible members are as follows: annual physical or wellness visit; completing a home visit by a licensed health care practitioner; closing a gap in care such as completing breast cancer screening, colon cancer screening, diabetic eye exam, rheumatoid arthritis visit and osteoporosis screening. Our member rewards program has the following 2021 results: 812,000 wellness visits; 602,000 rewards fulfilled; 2.8 million gaps in care closed.

Claim of Expertise:	Group Medicare formulary designed for Medicare retirees
Documented Performance:	• We are providing our broadest and most comprehensive Group Part D formulary • Our formulary covers over 99% of Part D eligible drugs • All covered generic drugs are in the lowest copay tier (tier 1) • Additional coverage for many non-Part D drugs • $0 copay for many preventive drugs, including shingles vaccine, statins for high cholesterol, breast cancer preventive medications, bowel prep products, tobacco cessation products, folic acid, and contraceptives • Flat dollar copays and no CMS donut hole • Over 68,000 pharmacies are in our Part D pharmacy network- includes all major chains and local pharmacies in Arkansas

INFORMATION FOR EVALUATION – SOLUTION

Experience in Group Medicare Advantage

As the market leader in Group Medicare Advantage, we have served the health care coverage needs of Medicare beneficiaries, navigating through multiple evolutions of the Medicare program and growing to become the preferred choice of more beneficiaries than any other company. We remain committed to providing our clients and members with a choice of innovative health and well-being solutions.

Our mission- we focus on achieving the “triple aim” of improved health, better health care quality and lower costs with our Group Medicare Advantage solutions. Our proven experience includes:

- We serve over 1.7 million Group Medicare Advantage members
- We have successfully transitioned 20 State retirement systems to our Group Medicare Advantage plans
- Over 600 Group Medicare Advantage clients
- We are the only 5-Star rated major national carrier
- We are the nation’s largest and most experienced provider of Group Medicare Advantage plans
- Our clinical, health and wellness programs have been created by our own team of doctors who specialize in serving the senior population

Engine for Group Medicare Advantage

We have a fully integrated infrastructure dedicated exclusively to our Group Medicare Advantage clients. In 2017, we implemented a fully dedicated operational focus to ensure we apply a Group Medicare Advantage perspective to all aspects of our operations. This distinctive approach has created high levels of client and member retention and satisfaction. We are the only carrier who has the proven experience to deliver 5-Star Rating care to a Group Medicare Advantage population which has materially grown year over year since 2014. Through our data, we know the longer a member stays on our plan, they will take action to improve their health and lead a healthier life.

With our fully dedicated business and an integrated operational focus, we have been able to improve the service we deliver to our Group Medicare Advantage clients and members. Since 2017, we have:

- Processed 153 million Group Medicare Advantage claims
- Supported over 8 million Group Medicare Advantage member calls
- Decreased the number of escalations back to our clients by 27% year-over-year

To provide comprehensive claim management services, our automated Medicare Advantage claim processing system handles all network and non-network claims throughout the country. This single platform combines all claim administration elements, including online eligibility, benefit design provisions, notification, physician and other health care professional data, discounts, negotiated rates, claim payment and claim history. Our entire claim adjudication process – with the exception of mail handling and imaging paper claims – is fully automated. Our knowledge of the Medicare program, coordination of benefits (COB) rules, and federal and state claims processing rules and regulations allow us to process claims, enrollment and billing information efficiently, dedicated solely to Group Medicare Advantage.

Group Medicare Advantage Member Service Model

Our Group Medicare Advantage member service team addresses a member's needs in one place, with one call. Members receive educational coaching and plan information, decision support, problem resolution, and can learn about their health and wellness programs. We are also especially committed to the use of plain language in both verbal and written communications. Our member service advocates only handle Group Medicare Advantage calls and are sensitive to the needs of older adults with special needs, hearing and visual impairments, non-English speakers, and those from a wide range of cultural backgrounds. All member service advocates reside in the United States. We simplify the member experience by connecting with members through a single toll-free number which will be dedicated to State of Arkansas Medicare retirees. Our advocates can provide assistance with both medical and pharmacy questions in one phone call with no transfers. Our goal with each call is to help members get the most out of their benefits, obtain the best care, avoid surprises and save time and money.

Client Service Model

We offer unparalleled experience with large public employers and government plan sponsors. We will provide an account management team who leverages the best practices we have learned by working with 20 other State Group Medicare Advantage clients. The strategic account executive (SAE) will have overall ownership and relationship management responsibilities to ensure all of our contractual and operational requirements are met. In addition, our team includes clinical, member service/issue resolution, data and analytics, billing and eligibility and executive sponsor leadership.

The account management team will make themselves available as often as needed to ensure the Group Medicare Advantage program is running optimally. The account management team will create, implement, and execute on all project plans necessary to accomplish the State's objectives – this is done by holding weekly meetings (or as needed) with thorough agendas and timelines with post call notes documenting all actionable items.

Implementation

Our priority in the implementation process is to ensure the State stays on the right track during the transition to the Group Medicare Advantage plan. Our entire implementation process is built on a foundation of best practices we have learned over the years.

Although we have vast Group Medicare Advantage experience, we fully recognize each implementation, each organization, and each retiree population have a unique set of very distinct needs. Our implementation team will utilize a project plan roadmap with clearly defined roles, responsibilities, and benchmarks. Collaboration and open lines of communication are key to success in building our partnership. Our project management of implementation includes five pillars we have developed as best practices:

- Regular meetings and communication with the State implementation team to ensure we are aligned and working on the right priorities; our implementation team carefully documents the State's specifications and utilizes a "living" project plan
- We have a Group Medicare Advantage open enrollment team who will handle all logistics of providing statewide education meetings include staffing, procurement of retiree friendly locations and making sure all communication materials are available to retirees at each meeting
- We will conduct extensive provider outreach and engagement strategies to ALL providers who are currently utilized by State Medicare retirees. Our proven provider outreach strategies about the Group Medicare Advantage PPO plan will ensure there is no disruption in care to members
- Enrollment file clean up includes a Medicare comparison file and additional review of the file to ensure accuracy and no delays
- Our Group Retiree Operations team is dedicated to the end-to-end client and retiree experience - onboarding and beyond. We will run several quality assurance claim tests prior to go-live including tests of the eligibility system, benefit system, and claims system to ensure the information is setup correctly

Clinical Programs

Our vast clinical and medical management experience comes from serving more than 1.7 million Group Medicare Advantage members. With access to the largest longitudinal database of Medicare beneficiaries outside of the federal government and access to an extensive workforce specialty trained in geriatrics and the care of older adults, we understand the challenges retirees face in the changing world of health care.

We achieve excellence by leveraging our experience and innovation:

- Health and wellness programs are specifically tailored and dedicated to serve our Group Medicare Advantage members, while also taking advantage of the learnings from our industry-leading Individual Medicare Advantage book of business
- Across our enterprise, we are continuously piloting new medical management interventions
- Our Group Medicare Advantage medical management programs have been developed specifically for the senior population and focuses on the needs of older adults including multi-morbid conditions, frailty, dementia, falls, incontinence, geriatric syndromes, and end-of-life care needs
- We offer a dedicated clinical and medical management infrastructure to support our Group Medicare Advantage clients
- We have a medical management team fully dedicated to Group Medicare Advantage clients, including board-certified geriatricians, hospice and palliative care providers, geriatric nurses and nurse practitioners and clinical Part D pharmacists
- Our Group Medicare Advantage clinical team brings over 200 collective years of geriatric medicine and nursing experience and expertise

Our Group Medicare Advantage plans provide a full spectrum of care and disease management programs including inpatient care management, care and condition management, specialty care management (e.g., transplant and End Stage Renal Disease management), behavioral health care management, and solutions for caregivers. All our clinical programs are encouraged but are voluntary to Medicare retirees.

Inpatient Care Management- Our inpatient care management activities focus on:

- Ensuring the physician's treatment plan is clinically appropriate, cost-effective and adheres to evidence-based medicine
- Identifying and preventing potential delays in care, tests and procedures
- Facilitating access to specialists as needed via consultation with the medical director
- Supporting discharge planning, including identifying members for post-discharge follow-up

Care and Chronic Condition Management- The hallmark of our focused care management approach is our innovative care and condition model. Our care and condition management programs are tailored to the member's disease acuity level and health care needs. In this model, a primary nurse is assigned to each member upon clinical program enrollment. Providing a member with one primary nurse who understands and manages all of their clinical needs increases engagement, eliminates redundancy, increases engagement by forming trusting relationships, minimizes handoffs and promotes the management of a "whole person" philosophy.

Our nurses are cross trained across all high-risk conditions such as chronic lung disease, coronary artery disease and diabetes. Each nurse is also supported by clinical specialists in other areas such as behavioral health, advanced illness, transplant, End Stage Renal Disease and social services. The nurses are especially attentive to transitions of care, a highly vulnerable situation commonly resulting in unnecessary hospital readmissions.

High Risk Care Management- Our high-risk care management program delivers high-touch, intensive services to members with complex illnesses and multiple comorbidities. High-risk care management provides telephonic care management services, designed to meet a member's medical, psychosocial and functional needs. A personal nurse offers support to each member to help them better manage their condition(s) and maintain their health. This proactive, holistic approach supports:

- Support for family caregivers
- Coordination of clinical care to address declining functional status
- Medication adherence and management

Our ability to have a single nurse address multiple conditions across disease and all phases of care management is enhanced by our technology platform, a single, unified clinical platform-to ensure smooth transitions and continuity of care.

Asthma Program- We address asthma in our chronic obstructive pulmonary disease (COPD) program. Our Asthma/COPD program began in 2015. COPD members, who are high risk due to the severity of their condition, are enrolled in our remote patient monitoring care management program, which helps members diagnosed with emphysema, chronic bronchitis, asthma, and other severe respiratory diseases avert acute episodes, reduce unnecessary hospitalizations and live as comfortably as possible. Engaged COPD members are contacted for routine check-ins.

Diabetes Support and Management Programs- We offer comprehensive programs that support and educate members with diabetes to help them understand and better manage their condition more effectively. Our diabetes programs are designed to improve each member's ability to self-manage not only their diabetes, but the other diagnoses frequently encountered with diabetes. The primary goal is to change behaviors in order to prevent unnecessary hospitalizations and further progression of the disease.

Our diabetes support program is designed to educate eligible members on the importance and relevance of achieving good diabetes control. Our diabetes management program addresses each member's clinical needs, helping them achieve optimal care by working closely with the member's physician. We use predictive modeling systems and a member's claims data to identify possible gaps in care such as missing lab tests, prescription medications and screenings.

One of our key initiatives is our diabetes outreach program. This program is designed to educate eligible low and moderate risk diabetic members on the importance and relevance of achieving good diabetes control. Engaged members receive diabetes education and strong encouragement to see their primary care physician; if needed, see an endocrinologist; and become engaged with a local diabetes educator for personalized care and diabetes self-management education. In addition, we provide one on one coaching that stresses the importance of medication management and/or reaching out to their doctor or pharmacist regarding specific concerns/instructions.

Chronic Obstructive Pulmonary Disease (COPD) Program- Members with COPD, who are high risk due to the severity of their condition, are eligible for our remote patient monitoring care management program, which helps members diagnosed with emphysema, chronic bronchitis, asthma, and other severe respiratory diseases to avert acute episodes, reduce unnecessary hospitalizations and live as comfortable as possible. Engaged COPD members use devices provided by our clinical team to track biometric readings and answer daily assessment-based questions about their health and condition.

Coronary Artery Disease (CAD), Congestive Heart Failure (CHF) program- Our heart failure program is a modernized digital first model powered by technology which enables resources to align with individual health needs. This program helps members manage their illness through home biometric monitoring and education. This program is a comprehensive solution, offering members a unique combination of daily at-home biometric monitoring, care coordination and patient education. This program also helps members better understand their illness, as well as how to keep up a healthy lifestyle, adhere to physician treatment plans and medications.

Low Back Pain or Musculoskeletal Pain- For members with low back pain or musculoskeletal pain, we provide a single point of contact to support and guide members when a request for a specific surgical procedure, such as a hip or knee replacement, is requested. Our service navigator will help the member with identifying issues like surgery and rehabilitation costs, transportation needs, durable medical equipment needs, medications and any service-related issues.

Weight Complications- We offer a proprietary, 52-week intensive lifestyle intervention program which focuses on helping members lose weight and maintain weight loss. The program is delivered live over the internet and combines entertaining and educational videos, live virtual coaching and online group participation. This program is customized to meet the preferences of each member to maximize outcomes and results.

Members receive access to all of the tools they need to succeed in the program. We provide a customized at home kit including electronic body weight scale, electronic food scale with bowl, resistance band, water bottle, measuring cups and spoons, portion plate, measuring tape, pedometer, session guide, nutrition guide, food blender and workout DVDs. We also provide an interactive app which provides online tools, popular nutrition and exercise tracking software. Our program also includes group sessions with a coach and one on one fitness coaching.

Hepatitis C- We have screening initiatives and guidance to identify members who are at highest risk for Hepatitis C. Chronic care management is offered to our members through our high-risk care management program which delivers high-touch, intensive services to retirees with complex illnesses and multiple comorbidities.

Fibromyalgia- Telephonic nurse support is available for members in need of a single point-of-contact 24 hours a day, seven days a week, and is integrated with our high-risk clinical programs. Our nurses can refer a member to the right health or well-being resource. This includes referrals to programs that will provide complex condition support for fibromyalgia.

Irritable Bowel Syndrome- Our telephonic nurse support provides a single-point of contact 24 hours a day, seven days a week for members who need clinical support for irritable bowel syndrome. Telephonic nurse support is also integrated with our high-risk clinical programs. Our nurses will refer a member to the right health or well-being resource.

End Stage Renal Disease- We have offered an end stage renal disease (ESRD) care management program since 2006 and have served over 40,000 Group Medicare Advantage members with ESRD. Our predictive model identifies members prior to starting dialysis. The foundations of our ESRD care management program are self-management, as well as communication and collaboration with the dialysis facilities and the treating nephrologist. Nutrition, treatment of co-morbid conditions (especially diabetes and hypertension), infection prevention (including flu and pneumonia vaccination), financial assistance, behavioral health (depression screening) and advanced care planning are all components of our ESRD care management program.

Transplant Case Management- Our transplant management program drives positive clinical outcomes by addressing the complex needs of older adults who are facing transplants. We cover all phases of transplant coordination, from evaluation, pre-transplant, transplant, post-transplant and 12-month follow-up health care Our unique clinical experience significantly reduces overall medical costs. Our Centers of Excellence network health care providers drive quality patient outcomes, with high patient one-year survival rates.

Chronic Kidney Disease- This evolutionary care coordination program is for participants with stage 3 chronic kidney disease. Our Specialty trained nurses focus on coaching the member on diet, lifestyle, medications and getting care from high quality nephrologists. The goals of the chronic kidney disease program are to delay the progression of kidney disease, avoid or delay ESRD and the need for dialysis by early intervention and prepare members for pre-emptive renal transplants.

Behavioral Health- We have a large, specialized network of licensed behavioral health professionals and facilities for the treatment of mental health and substance use conditions. Our behavioral health management team is integrated with our medical team. They work together to identify, engage and manage members' behavioral health concerns. Our integrated approach is industry-leading and uses clinically proven approaches to care including confidential access 24 hours a day to master's-level clinicians, guidelines, screeners, and other tools to appropriately identify behavioral health risk groups in older adults. Our behavioral health care program is led by experienced geriatric psychiatrists and licensed behavioral health clinicians with significant geriatric expertise.

Advanced Illness- We have offered an advanced illness care management program since 2006. The advanced illness care model is a comprehensive, evidenced-based approach facilitating appropriate, quality care focused on the last 12 months of life. We provide education and integration of palliative care, as desired by the member and family/caregiver, within a community health services delivery model which improves outcomes and assures appropriate care.

Stars expertise

We are the only 5-Star rated major national carrier from CMS (Centers for Medicare and Medicaid Services). We have a comprehensive plan in place to deliver continued Star Ratings improvements across our Group Medicare Advantage plans. We continue to analyze member, provider, employer, and demographics to identify areas of performance improvement. This analysis is used to develop and deploy targeted and timely Star improvement initiatives, such as customized engagement strategies with members, providers, and pharmacies to close gaps in care and improve medication adherence, which in turn, reduces overall claim costs. As a 5-Star Medicare Advantage plan, we receive the highest CMS payment since they reward for excellence which helps keep our costs low.

Our commitment to the Star Rating program includes a dedicated Group Medicare Advantage clinical quality team within our organization who focus exclusively on improving the Star performance and the quality of care for our members. Our focus will ensure maximization of CMS funding, reduction in claims cost and closing members gaps in care. Our overriding goal is to help our members live healthier lives.

Health and wellness programs

Our approach to health and wellness focuses on keeping members healthy and maintaining quality of life. To do this, we encourage annual wellness visits, reminders, screenings and other preventive activities including education and use of self-management tools. Our integrated member rewards programs promote healthy behaviors by providing financial incentives to members to encourage them to get an annual care visit or to complete wellness screenings in addition to other rewards incentives. 100% of our Group Medicare Advantage members are touched by at least one of our health and wellness programs with all these programs being available and accessible to our members on a voluntary basis.

Proprietary home visits program- Our fully integrated home visits program is the industry standard for improving the health and quality of life for our members by providing medical examinations in the comfort of their own homes.

Our program is unique as we employ our own licensed health care practitioners who visit Group Medicare Advantage members to assess medical history, conduct a physical exam, review medications, discuss health concerns and provide education on health-related issues. The program provides an opportunity to identify members who have gaps in care and refers members to their primary care physician as well as into our case and condition management clinical programs. Our nurse practitioners work closely with our social services team along with the primary care provider to ensure any medical or social needs are met. To address social needs, our health care practitioners connect members to community-based organizations, health plan resources, and federal/state programs.

Since 2012, we have conducted over 2,000,000 home visits to our Group Medicare Advantage members and are the largest employer of nongovernmental employer of nurses in the country.

Family support program- We offer a comprehensive program designed to support family caregivers in helping aging family members stay healthy, function as independently as possible, live with dignity and remain in the community for as long as possible. The program utilizes local resources to offer professional assessment, consultation and care management services to people who have long term or advanced illness, are older, or have disabilities, while providing support to their caregivers.

Fitness benefit- Our senior fitness program offers an innovative blend of physical activity, healthy lifestyle education and socially oriented programming which encourage members to take greater control of their health. Members receive a free fitness center membership at a nearby participating location with access to conditioning classes, exercise equipment, pool, sauna, and other available amenities.

Health risk assessment- Health risk assessments are used to assess the member's medical conditions, including chronic conditions, medications, general health, utilization, mental health, and the need for psychosocial services or help at home. Health risk assessments are tools used to meet the assessment requirement for CMS and also include medical and mental health history.

Wellness rewards- To incent participation in important health screenings and tests, which help identify health issues before they become problematic, members are eligible for rewards when they complete specified health activities.

Telephonic nurse support- We offer a telephonic resource available 24 hours a day, seven days a week. Our registered nurses use their medical and clinical expertise to provide members with appropriate care-seeking recommendations and a review of treatment options including scheduling a virtual visit, coordinating a visit with primary care provider, urgent care or emergency care.

Preventive care reminders- Our reminders program targets members who have missed preventive services. The program is designed to remind members to see their physician for specific screenings, including cancer screenings, and for conditions such as diabetes, high blood pressure, high cholesterol, and osteoporosis.

Online health and wellness planning- We offer a web-based program which allows members to create a personalized health and wellness plan from hundreds of two-week fitness, nutrition, and well-being programs to help them make positive changes and improve their health.

Hearing aid savings program- We provide our Group Medicare Advantage members with a full range of hearing health services and custom-programmed hearing aids exclusively from our hearing aid program. Through this program, members have access to premium name brand and private-labeled hearing aids from major manufacturers at discounted costs ranging from $699- $2,499, saving them thousands of dollars. We offer the option to purchase hearing aids in-person through a hearing provider or have the hearing aids delivered directly to their home.

Vision benefit- We provide our Group Medicare Advantage members with the following routine vision benefit: routine vision exam every year with $0 copay; $150 allowance for glasses or contacts, every 12 months

Tobacco cessation program- We will provide our Group Medicare Advantage members access to our tobacco cessation program. This program utilizes evidence-based combination of physical, psychological, and behavioral strategies to help members overcome their addiction to tobacco.

Routine podiatry – We will provide our Group Medicare Advantage members with a podiatry benefit of 6 visits per year.

Home programs- To help members transition back home after an inpatient admission or a convalescent stay, we provide our home program to help reduce the risk of hospital readmission and prevent new or worsening social determinants of health. Benefits of the program include post-discharge meal delivery which includes 28 home delivered meals; post-discharge transportation benefit includes 12 rides to and from medically related appointments and pharmacy; in-home personal care benefit includes up to 6 hours of personal care which may include grocery shopping, meal preparation, light housekeeping, personal care, and medication reminders. There are no limitations on the number of times members may access our home program benefits.

Social Determinants of Health (SDOH)

We have focused on addressing social determinants of health for many years. We identify social barriers to care through the various programs and services available to our Group Medicare Advantage members. Once barriers are identified, our advocates will connect members and their caregivers with resources specific to their needs and deliver them in a way preferred by the member. Our systems were also enhanced to link members and their caregivers so caregivers can be more easily identified when they call into our call center on behalf of a member to seek support.

Programs addressing Social Determinants of Health

- Our in-home visit includes a structured review of social barriers at each visit. SDOH assessment includes food security, transportation availability, ability to care for oneself, social isolation, and other common social risk factors. At the end of a home visit, while the nurse practitioner is still in the member's home, a warm transfer to an advocate can be initiated to begin the process of identifying appropriate social assistance either in the community or through available plan benefits.
- Through our customer service advocacy model, members with social risk factors are connected to experts who address social barriers and connect members to community- or state-based resources, as needed.
- Through our personalized health navigator program, we assign high risk members a concierge level navigator who provides support and guidance throughout a health episode, including screening and solving for social barriers

- Our clinical programs incorporate regular screening on social needs ranging from transportation to food insecurity. Our clinical nurses in these programs use a structured SDOH review to identify social risk factors and solve for those challenges.
- Health risk assessments, the annual self-reported health risk questionnaire members can take, helps to identify at risk members. We gather additional detail on the need for assistance at home and other factors.
- Our home program for Group Medicare Advantage members addresses several social determinants of health. The components include post-discharge meals delivered to the member's home; post-discharge transportation benefits for non-emergency rides to a health visit or pharmacy; personal in-home care to support activities of daily living and provide respite care.
- Our behavioral health programs take a whole person approach to care considering the medical, behavioral, and social factors influencing care. Social determinants of health screening and subsequent action steps to address those barriers are part of the behavioral health programs
- We provide resources to members which provide direct social work assistance to provide help with low-income subsidy support and connect members with financial resources to pay for healthcare
- We engage with local community resources to connect people to social services programs available at the city and state level which help with issues ranging from housing to social isolation to transportation to respite support
- Advocate and social work support, to support members with a point of contact to help solve for social barriers to care
- Our integrated national web-based social care network: this resource allows our advocates to connect and refer members to free or reduced cost need-based social services to proactively address member social determinants of health. This program allows us to track searches, referrals, responses and outcomes data to further impact the overall health and wellness of the community and our members

Medicare Advantage Network Approach

Network breadth and access to care are key differentiators of our Group Medicare Advantage PPO plans. Our Group Medicare Advantage PPO provides national coverage for all members regardless of where they live in the United States. Our plan travels with the retiree on a national basis with no primary care physician required and direct access to specialists and hospitals on a national basis. Members may access both our national network of contracted providers, as well as any Medicare provider that accepts the plan - enabling members to continue to use the doctors and hospitals they know and trust, backed by the largest Group Medicare Advantage national network of any carrier.

Provider education is a part of our onboarding process for all new Group Medicare Advantage PPO clients. With over 1 million retirees transitioned to our Group Medicare Advantage plans since 2014, we have solidified our provider outreach and education campaign for utilized providers who do not participate in our network. With our Group Medicare Advantage plan, retirees can see any provider who accepts Medicare and accepts our plan. We communicate with these providers to educate them on how to file a claim, how they are paid the same as Original Medicare (100% of the Medicare allowable), and the specifics of how the Group Medicare Advantage plan works. We have consistently refined and improved our provider outreach over the past few years based upon feedback from our members and clients.

We will deploy our industry-leading provider education and outreach strategy not only across Arkansas, but in every city where State of Arkansas retirees reside. We educate providers through in person or virtual meetings, telephonic and mailing campaigns, and provider expos and town halls- all geared towards ensuring our Group Medicare Advantage members have near universal access nationwide. Furthermore, we have a dedicated Provider call center whose sole focus is outreach and education to out-of-network providers to support access for our Group Medicare Advantage members.

Member communications and education

We understand the importance of helping educate retirees to understand how the Group Medicare Advantage plan works. We will work closely with the State to provide education, training and communications are customized to meet the State’s needs. For members, our communication and educational materials are written and designed to help alleviate concerns while motivating members to become informed and empowered health care consumers. To achieve this goal, our implementation approach includes several strategically timed communication touch points using a variety of communication methods throughout the process.

All of our communications will use language which is retiree-focused and easy to understand. We have extensive marketing expertise serving the 65-plus markets, and our materials were developed specifically to meet the needs of older adult readers. Color selection, font size, design and use of plain language are all incorporated to ensure our messages are clear and easy to understand. Prior to enrollment, we will work with the State to develop an announcement letter which provides members with introductory information about the upcoming change, plan, and the enrollment period.

After the initial program announcement, we will educate members so they can better understand the Group Medicare Advantage plan through various print materials which describe the plan's features and benefits. Following the announcement letter, the members will receive a pre-enrollment plan guide in the mail. The plan guide includes specific information about the plan and how it works, using out-of-network providers and how to contact our Group Medicare Advantage call center with any questions. This pre-enrollment guide is a key communication to help ensure the transition will go as smoothly as possible. We supplement these communications with materials such as postcards advising members of key enrollment activities and dates. Once members are officially enrolled into the Group Medicare Advantage plan, we send out a welcome packet includes the members' new ID card, a plan details booklet as well as a getting started guide and member/provider guide to care flier. The guide to care flier is a good resource for the member if they have questions about using a provider who part of our network. One side of the flier has information for the member; the other has information and resources for their provider.

Web resources

Our easy to navigate web portal provides information about our Group Medicare Advantage plan, both pre and post enrollment. Highlights of the portal include detailed information about the State's Group Medicare Advantage program and specific medical and pharmacy plan information, health and wellness information and other useful resources such as to help members manage their health care. Members can complete action items which include reading articles about a relevant health topic, watching videos, using online tools, completing recommended screenings for their age and gender, and visiting a doctor.

Education meetings and conference calls

While print and electronic materials are an important part of any communication strategy, we know retirees deeply value direct human interaction. As part of the implementation, we will hold state-wide education meetings. We have our own group retiree open enrollment team who will develop and coordinate the on-site educational meeting strategy in partnership with the State. Our team will review and analyze the location of State of Arkansas retirees to determine the best locations for meetings.

We will provide full support to the State for open enrollment meetings, on-site educational events, and health fairs. Our group retiree open enrollment team is dedicated exclusively to handling open enrollment and education meetings. This team will identify schedule locations for the State's education/open enrollment meetings in partnership with the State. We ensure these meetings are retiree friendly and include few or no steps, amps for wheelchairs, elevators to upper floors, and adequate parking at close distances.

Our Group Medicare Advantage account management team will partner with the State to coordinate on-site or off-site education/open enrollment meetings. Our team provides sensitive, knowledgeable guidance and information to members as they explore their health plan options. The State would have an opportunity to review content prior to the meetings. These meetings are a great way to support the transition and ensure the best member experience possible. Key meeting objectives include review the basics of Medicare Advantage, discuss the plan benefits, help retirees through the transition, answer all retiree questions, and provide varied meeting dates and times across the state of Arkansas.

To complement our open enrollment experience, we created a first-of-its-kind virtual open enrollment meeting experience. This an alternative to safely provide open enrollment support and educational meetings for our retirees. The website was designed to resemble an in-person open enrollment meeting; providing members direct access to information "booths" which will help members learn more about their benefits - just as they would at an on-site event.

Member website

Our retiree-focused website provides various tools to support shared healthcare decisions. These tools are specifically designed for the senior population to aid and educate them on the costs and quality of the Group Medicare Advantage plan services available to them, as well as access plan documents. Our web portal is designed with retirees in mind and provides easy-to-read access, including larger font and categories of topics to make researching options simple. A few of the documents and capabilities available include a summary of benefits, provider search tools, pharmacy locator search, drug look up tool, and who to contact for any additional questions.

Additionally, we have the ability to customize certain sections of our website for the State.

Once enrolled in the Group Medicare Advantage plan, members can easily access a wealth of additional and capabilities including updating contact information and mailing preferences, request replacement ID cards, view claim activity, view test results, prescriptions, and details about an office visit.

Provider search tool- Our provider search tool makes it easier for members to find providers. Members can search for doctors by name, specialty, and location.

Maximum accumulation tools- Members can view where their spend is in relationship to their out-of-pocket maximum via accumulator tools.

Drug pricing and alternatives tool- our drug pricing tool helps members make informed decisions about their prescriptions and pharmacy benefit. Through this tool, members can search for a medication, compare plan-specific costs at our mail order pharmacy and their preferred retail pharmacy, and view their out-of-pocket maximum balance. The tool also identifies:

- Lower-cost alternatives to member's prescriptions
- Plan-specific drug costs and member savings for the alternatives
- Reasons why lower-cost alternatives are clinically appropriate
- General drug information, such as dosage guidelines, potential side effects and related information regarding safe and appropriate use

Through this tool, members can request their prescription be switched to the lower-cost alternative. Members can also view messages about drug limitations such as prior authorization, quantity limits and drug-drug interactions. These messages inform members about clinical limitations associated with specific prescriptions as well as safety concerns regarding potential interactions between specific drugs.

Health & wellness tools- Our website provides health care information to help members achieve healthier lifestyles with senior-friendly information on topics such as aging, relationship building and dealing with life challenges. Members can complete engaging action items which include answering questions, reading articles about a relevant health topic, watching videos, using online tools, completing recommended screenings for their age and gender, visiting a doctor, tracking activity and more. The site also features valuable interactive programs, including symptom checkers, drug interactions monitor, nutrition and exercise planning programs.

Transparent and dedicated reporting

We offer a dedicated team of health care reporting and analytical experts who will provide innovative and customized reporting which has been specially created for Group Medicare Advantage plans. We have built and refined our reporting by working with our 20 State Group Medicare Advantage clients. They have challenged us to develop reporting metrics which focus on Medicare retirees in the public sector.

Our Group Medicare Advantage reporting team consists of a varied talent pool, from colleagues with advanced degrees in health policy, data science as well as actuaries and those previously employed in benefit consulting firms. We welcome analytic projects to utilize data and present results to help our clients make informed decisions regarding their Group Medicare Advantage plans. For example, our dedicated reporting team was an integral part in the develop of a Group Medicare Advantage client's diabetes task force. We provided detailed analysis for the task force based the client's Group Medicare Advantage membership; we then created displays and reporting which were utilized broadly within the task force. In addition, we were able to connect the task force director with another State director who led a similar task force to share ideas and results of outcomes. Our dedicated reporting team has engaged with other state plan sponsors on special analytic projects specific to their state's Medicare Advantage populations and more broadly impacting state health programs.

Our dedicated reporting team will conduct during quarterly and annual meetings which will include the following:

- Membership overview and demographics
- Risk adjustment overview
- Financial overview
- Medical utilization overview
- Medical high-cost claimants
- Top diagnosis and disease prevalence
- Clinical program engagement

- Readmission overview

In summary

We are a leader in the retiree health care field with 40 years of leadership and sustainability. Our experience helps us provide the service and support that our clients and members deserve. What makes us unique is our innovative ability to combine and customize our products and services to create solutions which are individually tailored to meet the needs of our clients.

From our earliest days, we have focused on the health needs of retirees. In 1979, we participated in early experimental programs offering private market alternatives for Medicare and developed the first policies designed specifically for retirees. This was a strong indicator of the future. Our first Group Medicare plan was offered in 1982 and we are now the nation’s leading provider of Medicare Advantage plans, Medicare Supplement plans and Medicare Part D Prescription Drug plans.

We have been offering Group Medicare Advantage plans with a national service area and Medicare Part D Employer Group Waiver Plans since 2006. We have an unmatched track record of sustainability and lead the industry as the number one carrier in market share for the Group Medicare Advantage and Individual Medicare Advantage markets.

Our business is built around making the health care system work better through the application of technology, information, and compassion. Our goal in everything we do is to help our members lead healthier lives.

INFORMATION FOR EVALUATION – RISK

Risk Description:	Long term clinical quality and overall financial stability of the Group Medicare Advantage solution depends on strong member engagement in health and wellness programs.
Solution:	Our health and wellness programs have been specifically designed and customized to serve Group Medicare Advantage retirees. These programs have been developed by our own team of doctors who solely focus on the care of older adults.
Documented Performance:	Our health and wellness incentive programs have resulted in a high engagement rate for our 1.7 million Group Medicare Advantage members, including completions of annual wellness visits, participating in preventive screenings, and receiving recommended follow up visits. Our Group Medicare Advantage results in 2021 include high rates of health care screenings: • 77% have had a colorectal screening • 82% have had a breast cancer screening • 75% have had a diabetic retinal eye exam screening

Risk Description:	The Centers for Medicare and Medicaid Services (CMS) provides federal funding for Medicare Advantage plans. Incomplete or nonspecific health care condition documentation could result in inaccurate CMS funding. This could also result in undetected health care conditions in Medicare retirees with fewer retirees receiving the clinical care and support they need.
Solution:	We use data from medical claims, pharmacy claims and lab results to identify retirees with conditions that should be documented in the medical record. An example would be a member who is filling a prescription for insulin but is not recorded as a diabetic in the medical record in the past year. This is important because the CMS payment system to the insurance company is based on the specific conditions in the Medicare retiree population. We have a comprehensive program to review medical records. For example, for members with a newly identified diagnosis, we review 100% of the medical record to ensure it supports the diagnosis. If diagnoses are not supported by the medical record, we do not submit the diagnosis to CMS.
Documented Performance:	In the past year, 2.6 million Group Medicare Advantage member charts were reviewed by our certified coding team, including a second level review and a quality assurance process prior to CMS submission. On average, we review two medical charts for every member on the Group Medical Advantage plan.

Risk Description:	Lack of understanding in how the Group Medicare Advantage program works could create member confusion and potential disruption resulting in member dissatisfaction.
Solution:	Medicare retirees need to be educated through multiple touch points that meet their needs. We take a multi-pronged approach to retiree education. We will provide multiple opportunities for retirees and their families and caregivers to learn about the Group Medicare Advantage plan. We will provide statewide education meetings so retirees can learn in person. For those that cannot make in-person meetings, we will set up retiree conference calls with the same content as the in-person retiree meetings. We will also provide clear, easy to understand communication materials that will help the retiree learn how the Group Medicare Advantage plan works for their own personal needs. Our Group Medicare Advantage call center will be up and running to answer retiree questions as soon as the program is officially announced by the State. In addition, we make an outgoing welcome call to all new members to check in and answer any questions.
Documented Performance:	• We conduct over 1,000 retiree meetings per year with an average retiree satisfaction of 97% • 99% of our current Group Medicare clients are likely to recommend our products and services to a colleague or peer • Over 360,000 live new member welcome calls were made in 2021

Risk Description:	Lack of operational readiness for plan administration can result in problems and delays in member materials, ID card accuracy, errors in claims set up, eligibility data accuracy, plan reporting and poor member service.

Solution:	Using our proven project management approach, we are able to deliver a successful installation of new Group Medicare Advantage clients. Our process begins with developing a detailed project plan with initial dates that will be updated based on agreed upon meetings the State. This project plan details all the steps and staff accountable for the implementation including benefit installation and testing, member materials development and mailing, ID card quality review, eligibility administration and secure data file transfer protocols, call center training on the benefits and testing to ensure readiness. Our implementation and account management teams will partner with the State and hold weekly implementation meetings working the project plan tasks and deliverables. We also will hold deep dive meetings as needed to review and discuss more complex topics. During the implementation we also provide Group Medicare Advantage training for appropriate State personnel.
Documented Performance:	For each new Group Medicare Advantage client we implement, we send our clients a customer satisfaction survey to gather their feedback on our performance. We have over 600 Group Medicare Advantage clients and year over year we have received consistently high scores. For 2021, our survey results of the 104 new Group Medicare Advantage clients we installed was 95%. In addition, we have enrolled 100% of our new members within the CMS timeline of 7 calendar days and mailed 100% of member ID cards on time. Our account management team has a customer satisfaction of 96% and Net Promoter Score of 91. Net Promoter Score is a measurement of customers rating their likelihood to recommend the carrier's products and services to a colleague or peer. Based on the global Net Promoter Score standards, any score above 0 would be considered "good", with 50 and above classified as excellent, and 70 or higher as world class.

Risk Description:	Moving from a traditional Medicare coordinated plan to a Group Medicare Advantage plan may uncover that the intended administration of the plan benefits is not consistent with the client's intent.
Solution:	To mitigate this risk, we have developed a best practice to ensure our clients' medical and pharmacy plan benefits are administered to their specifications. We will conduct a meeting with the State to walkthrough the intent of the benefit plan design. At this meeting, the benefit specialist will review in detail the State's existing plan design compared to the new Group Medicare Advantage plan design. We will obtain and review available claims data to uncover any potential differences in how the plan design is administered. Second, we run a benefit audit of the plan design set up in our claims administration system. This audit is comprised of the benefit setup and a review of claims processing to ensure the benefits are administered as intended.
Documented Performance:	This proven process has been used with all 20 of our State Group Medicare Advantage clients as well as other large complex clients. During the implementation process for one large State client, the benefit intent walkthrough uncovered benefits that required updating. For example, coverage on allergy shots and serum in the materials was different than how claims were being processed.

Risk Description:	Misunderstanding and confusion within the provider community of how a Group Medicare Advantage plan works vs. how Individual Medicare Advantage plans work.
Solution:	We will deploy our provider education team throughout the state of Arkansas and in every location where Medicare retirees reside. Our provider outreach education strategy includes in person or virtual provider meetings, telephonic and mailing campaigns, provider expos and town halls. Furthermore, we have a dedicated Group Medicare Advantage provider call center whose sole focus is outreach and education to out-of-network providers to support access for Medicare retirees. This breadth and depth of provider education minimizes both member and provider dissatisfaction and disruption.
Documented Performance:	Our Group Medicare Advantage provider outreach strategy provides Medicare retirees with near universal access nationwide. 99% of all Medicare providers nationwide accept our Group Medicare Advantage PPO plan.

EXCEPTIONS FORM

Prospective Contractor **shall** document all exceptions related to requirements in the Solicitation and terms in the *Services Contract (SRV-1) Fillable Form* and *Solicitation Terms and Conditions* located on the TSS OSP website. See Sections 1.9 and 1.10 of the Solicitation.

ITEM #	REFERENCE (SECTION, PAGE, PARAGRAPH)	DESCRIPTION	PROPOSED LANGUAGE
1.	Section 12, Page 5 of the Service Contract	Compliance	**A.** Equally responsible with the Department for adhering to the requirements of Arkansas Procurement Law related to the content and review of the Contract, if applicable to Contractor; and
2.	Section 13, page 6 of the Service Contract	Indemnification	Add the following: The State and Contractor agree that Contractor does not render medical services to Members, that neither is responsible for the provision of health care by health care providers, that health care providers are not the agents of either, and that in no event shall the indemnification obligations under Section 13 apply to that portion of any loss, liability, damage, expense, settlement, cost or obligation caused by the acts or omissions of health care providers with respect to claimants.

STATEMENT OF POLICY

UnitedHealth Group has a commitment to Equal Employment Opportunity (EEO) and to a work environment free of harassment. The policy of UnitedHealth Group is that people will be employed and promoted on the basis of their individual qualifications for the job and it is therefore the company's policy to prohibit discrimination and harassment against any applicant, employee, vendor, contractor, customer, or client on the basis of race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, pregnancy, veteran status, genetic information, citizenship status, or any other basis prohibited by federal, state or local laws.

UnitedHealth Group will provide:

1. freedom from abusive, intimidating or offensive behavior on the part of supervisors or other employees. In this regard it should be understood that harassment of any sort will not be tolerated, and that term includes derogatory ethnic, racial or sexist remarks;
2. freedom from sexual harassment. This refers to behavior which is not welcome, which is personally offensive, and which interferes with the work effectiveness of its victims and their co-workers. A separate communication on this subject further amplifies the Policy and is distributed to all employees;
3. freedom from any form of discrimination or intimidating or abusive behavior on the part of any supervisor or other employee as a result of a person's sexual orientation or gender identity;
4. benefits and services as outlined in Company publications; and

UnitedHealth Group is also a federal contractor subject to Executive Order 11246, Section 4212 of the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended ("Section 4212") and Section 503 of the Rehabilitation Act of 1973, as amended ("Section 503"). As such, UnitedHealth Group is committed to taking positive steps to implement the employment-related aspects of the company's equal opportunity policy. Accordingly, it is UnitedHealth Group's policy to take affirmative action to employ, advance in employment, and otherwise treat qualified minorities, women, protected veterans, and individuals with disabilities without regard to their race/ethnicity, sex/sexual orientation/gender identity, veteran status, or physical or mental disability. Under this policy, UnitedHealth Group will provide reasonable accommodation to the known physical or mental limitations of an otherwise qualified employee or applicant for employment, unless the accommodation would impose undue hardship on the operation of the company's business.

The company's affirmative action policy also prohibits employees and applicants from being subjected to harassment, intimidation, threats, coercion, or discrimination because they have engaged in or may engage in (1) filing a complaint; (2) assisting or participating in an investigation, compliance review, hearing, or any other activity related to the administration of Section 503, Section 4212, or any other Federal, state or local law requiring equal opportunity for disabled persons or covered veterans; (3) opposing any act or practice made unlawful by Section 503 or Section 4212 and their implementing regulations, or any other Federal, state or local law requiring equal opportunity for disabled persons or

covered veterans; or (4) exercising any other right protected by Section 503 or Section 4212 or their implementing regulations.

The non-confidential portions of the affirmative action program for individuals with disabilities and protected veterans shall be available for inspection upon request by any employee or applicant for employment by contacting HR direct.

Anyone with a question about UnitedHealth Group's Equal Employment Opportunity Policy should contact HRdirect at 1-800-561-0861. All concerns will be handled in confidence.

If you would like to review the Affirmative Action Plan, or need an accommodation, you may contact HR direct at 1-800-561-0861 between the hours of 7:00am and 7:00pm central time, Monday through Friday, or write HR direct Employee Relations at MN008-W210, 9900 Bren Road E., Minnetonka, MN 55343.

A person's race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, pregnancy, veteran status, genetic information, or citizenship status must not affect our estimation of their character if we are to achieve the objectives of our business, our society, and our country. These moral and economic reasons for supporting the Company policy of nondiscrimination are to be of primary concern to all employees.

Joy Fitzgerald, Chief Diversity Equity and Inclusion Officer

1/18/2022

Date

Detailed Scope of Work- Implementation Project Plan

Risk Management Plan

Financial Summary

- Pricing Response
- Gain Share Agreement
- Recommended Options Form
- Performance Standards
- Payment Schedule
- UnitedHealthcare's Billing Overview
- UnitedHealthcare's Sample Billing Invoice
- Proposed Group Medicare Advantage PPO Plan Design (MAPD)

Implementation Plan
Mangement Plan

- UnitedHealthcare's Account Management Team Organization Chart
- UnitedHealthcare's Account Management Scorecard

Administration Plan
Staffing Plan
Communications and Outreach Plan
Data Security and Disaster Recovery Plan

- UnitedHealthcare's Enterprise Resiliency and Response Program
- UnitedHealthcare's Policy Summary

Transition of Services Plan
Claims Processing Plan
Reporting Plan
Eligibility Plan
Medical Mangement Plan
Formulary and Clinical Program Management and Disruption Plan

DETAILED SCOPE OF WORK

At minimum, address how the Prospective Contractor will address each of the following under a resulting contract (include and expand upon the submitted Solution response):

UnitedHealthcare has provided a detailed project plan that addresses the scope of work for the following requirements. We have also provided written plans as separate attachments for the requirements below.

A. General Requirements

1. Describe how your company will meet the requirements outlined in 2.4 General Requirements.

B. Implementation Requirements

1. Describe how your company will meet the requirements outlined in 2.5 Implementation Requirements.

C. MA-PD PPO Plan Management

1. Describe how your company will meet the requirements outlined in 2.6 MA-PD PPO Plan Management.

D. Plan Administration

1. Describe how your company will meet the requirements outlined in 2.7 Plan Administration.

E. On-Site Staffing Requirements

1. Describe how your company will meet the requirements outlined in 2.8 On-Site Staffing Requirements.

F. Member Services

1. Describe how your company will meet the requirements outlined in 2.9 Member Services.

G. Communications and Outreach Requirements

1. Describe how your company will meet the requirements outlined in 2.10 Communications and Outreach Requirements.

H. Data Security and Disaster Recovery

1. Describe how your company will meet the requirements outlined in 2.11 Data Security and Disaster Recovery.

I. Transition Requirements

Describe how your company will meet the requirements outlined in 2.12 Transition Requirements.

J. Claims Processing Requirements

1. Describe how your company will meet the requirements outlined in 2.13 Claims Processing Requirements.

K. Reporting Requirements

1. Describe how your company will meet the requirements outlined in 2.14 Reporting Requirements.

L. Eligibility Requirements

1. Describe how your company will meet the requirements outlined in 2.15 Eligibility Requirements.

M. Coordination of Benefits (COB)

1. Describe how your company will meet the requirements outlined in 2.16 Coordination of Benefits (COB).

N. Revenue Maximization

1. Describe how your company will meet the requirements outlined in 2.17 Revenue Maximization.

O. Medical Management

1. Describe how your company will meet the requirements outlined in 2.18 Medical Management.

P. Network Access Management

1. Describe how your company will meet the requirements outlined in 2.19 Network Access Management.

Q. Formulary and Clinical Program Management

1. Describe how your company will meet the requirements outlined in 2.20 Formulary and clinical Program Management.

State of Arkansas Name	Product	Expected Lives	Effective Date
State of Arkansas	MAPD	30,000	1/1/2023

Task	Task Owner	Planned Date	Actual Date	Implementation Comments
	UHC IM/State of			
Determine subsidy arrangement (100% of premium billed to group, split bill,	UHC IM/State of			
	UHC IM/State of			
	UHC IM/State of			
Discuss group structure requirements (i.e. Subsidy levels, distinctions among	UHC IM/State of			
Discuss enrollment fallout strategy (i.e. members not able to be enrolled go	UHC IM/State of			
	UHC IM/State of			
	UHC IM/State of			
Facilitates the creation of the custom benefit and ensure all downstream	Benefit			
	UHC IM/State of			
	UHC IM/State of			
Discuss termination letter that will be sent by the previous UHC and potential				
Depending on agreement and outcome of above, either Add previous plan termination language into the Announcement letter OR Add previous UHC's termination letter mail date and a brief explanation of the letter into the				
Discuss suppressing the Individual Medicare Marketing efforts for the State of Arkansas's population (Individual Medicare Advantage and Individual				
Request Roster File in order to suppress Individual Medicare Marketing				
	UHC IM/State of			
Determine custom materials requirements and timeline (letters, brochures,				
Receive and provide group with updated announcement letter feedback	UHC Legal and			
	UHC/State of			
Review State of Arkansas comments and provide updated documents -				
State of Arkansas provides approval of custom documents - Marketing				
Provide documents to State of Arkansas for review - Required Materials	UHC IM/Required			
State of Arkansas provides comments/edits needed - Required Materials	UHC IM/Required			
	UHC IM/Required			
State of Arkansas provides approval of custom documents - Required				
Provide appropriate materials to build site	UHC SAE/VEC Development Consultant/UHC Marketing Specialist			
Develop promotional pieces	State of Arkansas/UHC Marketing Specialist			
Launch VEC	VEC Development			
Review website content document with State of Arkansas and receive State	UHC Digital/State of			
Final version of website content document provided to State of Arkansas for				
Post PDF of Open Enrollment Meetings on the Pre-Enrollment Website, if				
Submit final new sales Toolkit, final announcement letter, current benefit				
	UHC IM/UHC Pre Call Center/UHC			
Confirm how the following are handled: Permanent Address changes, temporary address changes, mailing address changes, telephone number changes, email changes, disenrollments, reinstatements and termination				
Identify if the Employer Group, Union, or Third Party Admin is in or out of scope for ADP Calls (Outbound calls for pending apps due to missing				
Ensure all Customer Service Exception Management Tool Requests http://emt.uhg.com requests are captured and included within post				
	UHC IM/UHC Pre Call Center/UHC			
	UHC SAE/State of			
	UHC SAE/State of			
	UHC SAE/State of			
Provide locations and/or telephonic information to include in materials to				
UHC provides invitation in email format so that State of Arkansas may email				
Determine if Employer Group is attesting pre-effective date with letter				
Determine if Employer Group is attesting post-effective date with no letter				
Review employer creditable coverage attestation, file layout, and xTool steps				
Remind State of Arkansas of LEP letter that will be going out and what the				
Request for LIPS report submitted to Operations for groups electing to receive				
Advise on the 30-month coordination period for members diagnosed with				
Complete initial high-level Electronic Eligibility Management System (EEMS)				
CMS Overview Presentation w/ Employer/TPA (EEA will present to State of				
Complete detailed EEMS review, eligibility file layout and Deployment				
Electronic Eligibility Questionnaire and Electronic Communication Gateway				
	UHC/State of			
	UHC/State of			
	UHC/State of			
Review Medicare comparison file results with State of Arkansas (Rx COB,				
	UHC/State of			
Determine day for the reconciliation file and report to be delivered to State				
Discuss reasons for fall out and options to manage retirees that do not get	UHC SAE/State of			
State of Arkansas reaches out to members to resolve missing				
Review State of Arkansas specific Medicare and retiree file Policies &				
Refresher review of the standard production reporting with group once				
Hold alignment meeting with State of Arkansas and prior UHC(s) to review all data requests and secure commitment to provide, including file layout, look	UHC/State of			
Add case information to the URS File Transfer Tracker via TEAMS , attach				
Open Refill Transfer File / Prior Authorizations (ORTF/PA) / Member Files				
Confirm agreement from State of Arkansas that they would like to move	UHC IM/State of			
	PBM/State of			
	PBM/State of			
	PBM/State of			
	PBM/State of			
	PBM/State of			
	PBM/State of			
Confirm agreement from State of Arkansas that they would like to move	UHC IM/State of			
	Current Medical UHC/State of			
UHC to bump file against enrollment data to remove anyone who is not				
Schedule meeting with UHC Clinical, House Visits, UHC Rx teams to discuss				
Review proposed file transmission method with UHC clinical team, UHC Rx &				
	UHC Rx Sr State of			
	UHC IM or UHC			
	UHC IM or UHC			
	UHC IM or UHC			
	UHC IM or UHC			
	UHC IM or UHC			
	UHC IM/Marketing/State			
Present ID Card mock up to State of Arkansas for review and approval, if				
Review State of Arkansas comments and provide updated documents, if				
Provide clean/final version of approved Quick Start Guide to State of				
	ID Card Fulfillment			
Hold internal meeting solution engineer and AMT to review the list of Custom	UHC IM/UHC Sr. Reporting			
Hold meeting with State of Arkansas to review the list of reports, formats,	UHC IM/UHC Sr. Reporting			
Review all reporting until State of Arkansas sign off on all reporting is	UHC IM/UHC Sr. Reporting			
	UHC IM/UHC Sr. Reporting			
Hold internal meeting solution engineer and AMT to review the list of Performance Guarantee reports, formats, timing, transmission method and	UHC IM/UHC Solutions			
Hold meeting with State of Arkansas to review the list of Performance	UHC IM/UHC Solutions			
Review all PG Reporting until State of Arkansas Sign off on all reporting is	UHC IM/UHC Solutions			
	UHC IM/UHC Audit			
Conduct billing meeting to review process with the group and introduce				
Confirm Group has received eServices access - test access and demonstrate				
Remind State of Arkansas that letters will be mailed for this in first quarter				
	UHC and State of			

<Client Name>			
Name	**Title/Role**	**Phone**	**Email**

<Broker/TPA>			
Name	**Title/Role**	**Phone**	**Email**

UnitedHealthcare			
Name	**Title/Role**	**Phone**	**Email**

IRAAD (Issues, Risks, Action Items, Assumptions, Decisions)

CONFIDENTIAL

Project:	
Date:	

#	Functional Area	Item Type	Item Description	Opened Date	Target Resolution Date	Assigned To	Status (Open / Closed)	Date Closed	Comments If Issue/Risk, Include Mitigation Plan

CONFIDENTIAL

Group Medicare Advantage with Prescription Drug Plan								
File Name	Size Thresholds	Purpose/Description	Lookback/Time Period	File Format Name	Data Source	File Transfer Method	Date(s)	Notes
Mail Roster File	None	Pre-enrollment Plan Guides Pre-enrollment call center toolkit Carrier Open Enrollment Meeting Invitations	N/A	Roster File Template - Excel Access the templates in our Share Drive. separate into a new line	State of Arkansas's eligibility system	Implementation Manager via ECG Quick Connect	TBD by the project plan	
Suppression File		Suppression from Carrier's Individual Medicare Campaigns	NA	Individual MA, MAPD, PDP Suppression File Layout and Individual Med Supp Suppression File Layout	State of Arkansas's eligibility system	Implementation Manager via ECG Quick Connect	6/1/2022	
Provider File (non-PHI)	None	Provider outreach data, a CMS requirement, with all providers to provide the most recent 12 months of providers utilized by the State of Arkansas retirees & dependents in order to complete a targeted provider education campaign prior to the 1/1/2023 effective date. If there are multiple carriers, data	1 year	External Carrier - Provider Outreach Data Template - Excel	Current Medical Carrier's claim system	SAE via ECG Quick Connect	At least 6 months prior to the effective date, but would prefer the data as early as possible	
Medicare Comparison File	None	File of planned enrollments to "bump" against CMS' systems to provide results back to State of Arkansas for any data issues to be updates prior to the enrollment file's arrival.	N/A	Medicare Comparison File	State of Arkansas's eligibility system	DA via Secure Email or ECG Quick Connect	TBD by the project plan	
LEP Attestation File, if desired	None	Opportunity for State of Arkansas to provide an attestation in order to suppress LEP letters and the LEP fee for newly issued LEPs.	N/A	LEP Attestation File	State of Arkansas's eligibility system	mplementation Manager via ECG Quick Connect	TBD by the project plan	
Medical Claim History File (Including Part B Rx and Durable Medical Equipment)	None	Clinical programs & engagement Historical claims data will enable Carrier to connect members to the proper care so: • Early outreach to members with complex medical conditions is done sooner to improve outcomes and manage ailments • Members receive necessary preventive screenings, tests and services • Members are more likely to fill and take their prescriptions as directed By receiving the HCD, our outcomes include: • Earlier outreach to chronically ill retirees • Close gaps in care • Prevent ER visits • Prevent unnecessary hospitalizations • Develop (earlier) stronger, supportive PCP relationships	3 years	File Layout Medical in .TXT or .CSV format (not Excel) Or Agreed upon file with Current Medical Carrier	Current Medical Carrier's claim system	Send via a connection (sFTP) currently set up with Current Medical Carrier or set up a new (sFTP) connection	Test: 10/3/2022 Production: 11/9/2022 (January 2019 - September 2022) (if EMF is approved for TFC), the production date will need to be 10/3) Lag: 1/31/2023 (October 2022 - December 2022)	
Rx Claims History & Ongoing File	None	Clinical programs & engagement Carrier Health and CarrierRx Claims uses it from a look back perspective for MAPD State of Arkansass	3 years	File Layout Drug in .TXT or .CSV format (not Excel) Or Agreed upon file with <Current PBM>	Current PBMs claim system	Send via a connection (sFTP) currently set up with Current PBM (sFTP) or set up a new (sFTP) connection	Production: 11/1/2022 Lag: 1/18/2023	
Member Crosswalk File	None	Used to complete data file transfers (Open Refill Transfers, PA)	N/A	Member Crosswalk File Template - Excel	Current PBMs eligibility system	Brian Horan via ECG Quick Connect	File: 11/1/2022 (generally, 60 days prior to effective date)	
Rx Prior Authorization (PA) Transfer	1,500 minimum	Prior Authorization (PA) Transfer refers to the process to move active PAs to United Healthcare (Carrier) from the previous Part D plan administered through an external PBM. This process includes clinical review for formulary and plan requirements. • Ineligible PA may include for example: high-risk medications, compounds, B drugs vs D drugs requirements, drugs with high off-label use	Open and Expired PAs from 7/1 of current plan year and forward	PA File Template - Excel	Current PBMs claim system	Brian Horan via ECG Quick Connect	Production: 11/1/2022 Lag: 1/16/2023	
Open Refill Transfer File (ORTF)	None	Open Refill Transfer File (ORTF) refers to the process to move mail service eligible prescriptions with open refills to Carrier Home Delivery from the previous Commercial or Part D plan administered through an external PBM. • Ineligible ORT include: expired scripts, scripts with no remaining refills, compounds & certain narcotics.	Only ORTFs that will extend into 2023 up to one year in length. Industry standard.	ORx HDP ORT Grid and ORTF 1600 file layout	Incumbent PBM to provide	Carrier Rx IT / via ECG Quick Connect / Confirm PBM has ECG (Carrier Rx IT contact will be listed on the Orx HDP ORT Grid)	Test: 11/15/22 optional file, not required, but recommended Production: 1/2/23 Lag: 1/16/23	
# CMDM Open Case Transition File (OCT)	For Groups greater than 10,000	CMDM Open Case Transition File refers to the transition of Case Management and Disease Management clinical programs so those who are eligible are enrolled into the appropriate Carrier clinical programs.	Current/open case and disease management cases	Open Case Transition File Template - Excel	Current Medical carrier's disease management system	Carrier Account Management via ECG Quick Connect	Production: 11/28/2022	
Medical Prior Authorizations		Medical Prior Authorization Transfer refers to the process to move active Medical Prior Authorizations that extend beyond 1/1/23 to United Healthcare (UHC) from the current Medical carrier. Only Medical Prior Authorizations from UHC in-network providers will transfer. Out of network providers are not included in this process. Note - No communication or letters are sent to the members or providers letting them know what Medical Prior Authorizations were accepted. The providers know they have a contractual requirement to notify UHC and obtain Prior Authorization and will likely duplicate this effort.	Current/open Medical PAs that extend beyond 1/1/23.	External Transition Auth Requirements Template File **Important** - The file layout doesn't include MBI; therefore, if the group would like to proceed with this process, the Social Security number will need to be provided on the enrollment file to be the key for matching the two files in order to perform the bump.	Current Medical carrier's Medical Prior Authorization system	Implementation Manager via ECG Quick Connect	The file is to be received one day after the enrollment file is received. UHC will bump this Medical PA file against those who were accepted by CMS and enrolled with a future effective date and only send those who matched to have the Medical PAs transferred.	

RISK MANAGEMENT PLAN

Risk Description:	Delayed operational readiness for plan administration can result in problems and delays in member materials, ID card accuracy, errors in claims set up, eligibility data accuracy, and poor plan reporting.		
Plan to Minimize:	Our process begins with developing a detailed project plan with initial dates that will be updated based on agreed upon meetings the EBD. EBD will provide implementation participants who have the authority to make decisions and agree on the meeting schedule and cadence.		
Solution:	The project plan details all the steps and staff accountable for the implementation including benefit installation and testing, member materials development and mailing, ID card quality review, eligibility administration and secure data file transfer protocols, call center training on the benefits and testing to ensure readiness. Our implementation and account management teams will partner with EBD and hold weekly implementation meetings working the project plan tasks and deliverables.		
Impact to Cost:	0	**Impact to Days:**	0

Risk Description:	Incomplete enrollment data could result in retirees not being able to enroll into the Medicare plan for various reasons, for example the file could include an incorrect date of birth, a missing Medicare Part B start date, or the MBI is not provided.		
Plan to Minimize:	EBD will send a Medicare comparison file with live production data so we can bump the file against CMS. At that time, we would be able to provide the EBD with the results, which will indicate if any retirees are missing critical information. (e.g., Missing MBI, no Part B, P.O. Box).		
Solution:	EBD will participate in the enrollment discussions to determine how the fallout process will be managed. At this time, we will work with the EBD to determine a missing information campaign.		
Impact to Cost:	0	**Impact to Days:**	0

Risk Description:	Lack of understanding when moving from a traditional Medicare coordinated plan to a Group Medicare Advantage plan may uncover that the intended administration of the plan benefits is not consistent with the EBD's intent.		
Plan to Minimize:	To mitigate this risk, we have developed a best practice to ensure our clients' medical and pharmacy plan benefits are administered to their specifications. We will conduct a meeting with the EBD to walkthrough the intent of the benefit plan design. At this meeting, the benefit specialist will review in detail EBDs existing plan design compared to the new Group Medicare Advantage plan design. EBD will engage and participate in discussions of the walkthrough and provide sign off on the benefits, or revisions as necessary.		
Solution:	In addition to the benefit intent walkthrough, we will request that EBD provide claims data to uncover any potential differences in how the plan design is administered. UnitedHealthcare will run a benefit audit of the plan design set up in our claims administration system. This audit is comprised of the benefit setup and a review of claims processing to ensure the benefits are administered as intended.		
Impact to Cost:	0	**Impact to Days:**	0

Risk Description:	Long term clinical quality and overall financial stability of the Group Medicare Advantage solution depends on strong member engagement in health and wellness programs.
Plan to Minimize:	Provide a health and wellness incentive programs to result in a high engagement rate for your members, including completions of annual wellness visits, participating in preventive screenings, and receiving recommended follow up visits.

Solution:	Our health and wellness programs have been specifically designed and customized to serve Group Medicare Advantage retirees. These programs have been developed by our own team of doctors who solely focus on the care of older adults.		
Impact to Cost:	0	**Impact to Days:**	0

Risk Description:	The Centers for Medicare and Medicaid Services (CMS) provides federal funding for Medicare Advantage plans. Incomplete or nonspecific health care condition documentation could result in inaccurate CMS funding. This could also result in undetected health care conditions in Medicare retirees with fewer retirees receiving the clinical care and support they need.		
Plan to Minimize:	UnitedHealthcare's certified chart coding team will review medical charts, including a second level review and a quality assurance process prior to CMS submission. On average, we review two medical charts for every member on the Group Medical Advantage plan.		
Solution:	We use data from medical claims, pharmacy claims and lab results to identify retirees with conditions that should be documented in the medical record. An example would be a member who is filling a prescription for insulin but is not recorded as a diabetic in the medical record in the past year. This is important because the CMS payment system to the insurance company is based on the specific conditions in the Medicare retiree population. We have a comprehensive program to review medical records. For example, for members with a newly identified diagnosis, we review 100% of the medical record to ensure it supports the diagnosis. If diagnoses are not supported by the medical record, we do not submit the diagnosis to CMS.		
Impact to Cost:	0	**Impact to Days:**	0

Risk Description:	Lack of understanding in how our Group Medicare Advantage program works could create member confusion and member dissatisfaction.		
Plan to Minimize:	We will provide multiple opportunities for retirees and their families and caregivers to learn about the Group Medicare Advantage plan. We will provide statewide education meetings so retirees can learn in person. For those that cannot make in-person meetings, we will set up retiree conference calls with the same content as the in-person retiree meetings. The EBD will participate in the review of materials, Web content, call center greeting development, and approve all materials as needed according to the agreed upon timeline in the Implementation project plan.		
Solution:	Medicare retirees need to be educated through multiple touch points that meet their needs. We take a multi-pronged approach to retiree education. We will provide clear, easy to understand communication materials that will help the retiree learn how the Group Medicare Advantage plan works for their own personal needs. Our Group Medicare Advantage call center will be up and running to answer retiree questions as soon as the program is officially announced by the EBD. In addition, we make an outgoing welcome call to all new members to check in and answer any questions.		
Impact to Cost:	0	**Impact to Days:**	0

Risk Description:	Misunderstanding and confusion within the provider community of how a Group Medicare Advantage plan works vs. how Individual Medicare Advantage plans work.
Plan to Minimize:	We will deploy our provider education team throughout the state of Arkansas and in every location where your Medicare retirees reside.
Solution:	Our provider outreach education strategy includes in person or virtual provider meetings, telephonic and mailing campaigns, provider expos and town halls. Furthermore, we have a

	dedicated Group Medicare Advantage provider call center whose sole focus is outreach and education to out-of-network providers to support access for Medicare retirees. This breadth and depth of provider education minimizes both member and provider dissatisfaction and disruption.		
Impact to Cost:	0	**Impact to Days:**	0

UnitedHealthcare Group Medicare Advantage (PPO)

State of Arkansas - Department of Finance and Administration Employee Benefits Division

Medical Coverage

Benefit Name	In Network Services	Out of Network Services
Annual Medical Deductible	None	None
Annual Medical Out-of-Pocket Maximum	$0	$0
Is Annual Medical Out-of-Pocket Maximum combined for IN and OUT of network?	Yes	
Physician Services		
Primary Care Physician Office Visit (includes Non-MD office visits)	$0	$0
Specialist Office Visit	$0	$0
Virtual Office Visit	$0	$0
- with Providers: **AmWell, Doctor on Demand,** or **Teladoc**	$0	
Telemedicine	$0	$0
Annual Routine Physical Exam	$0	$0
Inpatient Services		
Inpatient Hospital Stay	$0 Per Admit	$0 Per Admit
Skilled Nursing Facility Care - Prior hospital stay requirement waived	Yes	Yes
Skilled Nursing Facility Care - Benefit Period	100 Days	
Skilled Nursing Facility Care	$0 Per Day Days 1 - 100	$0 Per Day Days 1 - 100
Inpatient Mental Health Lifetime Maximum	Unlimited	
Inpatient Mental Health/ Substance Abuse in a Psychiatric Hospital	$0 Per Admit	$0 Per Admit
Outpatient Services		
Outpatient Surgery	$0	$0
Outpatient Hospital Services	$0	$0
Outpatient Mental Health/Substance Abuse - Individual Visit	$0	$0
Outpatient Mental Health/Substance Abuse - Group Visit	$0	$0
Partial Hospitalization (Mental Health Day Treatment) per day	$0	$0
Comprehensive Outpatient Rehabilitation Facility (CORF)	$0	$0
Occupational Therapy	$0	$0
Physical Therapy and Speech/Language Therapy	$0	$0
Cardiac/Intensive Cardiac/Pulmonary Rehabilitation/SET	$0	$0
Intensive Cardiac Rehabilitation	$0	$0
Pulmonary Rehabilitation	$0	$0
Supervised Exercise Therapy (SET) for Symptomatic peripheral artery disease (PAD)	$0	$0
Kidney Dialysis	$0	$0
Medicare Covered Services		
Chiropractic Visit	$0	$0
Podiatry Visit	$0	$0
Eye Exam	$0	$0
Eyewear (Frames and Lenses after cataract surgery)	$0	$0
Hearing Exam	$0	$0
Dental Services	$0	$0

Medical Coverage

Benefit Name	In Network Services	Out of Network Services
Ambulance/Emergency Room/Urgent Care		
Ambulance Services	$0	$0
Ambulance Copay Waived if Admitted	No	No
Emergency Room (includes Worldwide coverage)	$0	$0
Emergency Room Copay Waived if Admitted within 24 hours	Yes	Yes
Urgent Care (Includes Worldwide Coverage)	$0	$0
Urgent Care Copay Waived if Admitted within 24 hours	Yes	Yes
Part B Drugs And Blood		
Part B Drugs	$0	$0
Part B Chemotherapy Drugs	$0	$0
Blood (3 pint deductible waived)	$0	$0
Durable Medical Equipment (DME) And Supplies		
Durable Medical Equipment	$0	$0
Prosthetics	$0	$0
Orthotics	$0	$0
Diabetic Shoes and Inserts	$0	$0
Medical Supplies	$0	$0
Diabetic Monitoring Supplies	$0	$0
Insulin Pumps and Supplies	$0	$0
Home Healthcare Agency & Hospice		
Home Health Services	$0	$0
Hospice (Medicare-covered)	$0	$0
Procedures		
Clinical Laboratory Services	$0	$0
Outpatient X-ray Services	$0	$0
Diagnostic Procedure/Test (includes non-radiological diagnostic services)	$0	$0
Diagnostic Radiology Service	$0	$0
Therapeutic Radiology Service	$0	$0
Preventive Services (Medicare-Covered)		
Cardiovascular Screenings	$0	$0
Immunizations (Flu, Pneumococcal, Hepatitis B)	$0	$0
Pap Smears and Pelvic Exams	$0	$0
Prostate Cancer Screening	$0	$0
Colorectal Cancer Screenings	$0	$0
Bone Mass Measurement (Bone Density)	$0	$0
Mammography	$0	$0
Diabetes - Self-Management Training	$0	$0
Medical Nutrition Therapy and Counseling	$0	$0
Annual Wellness Exam and One-time Welcome-to-Medicare Exam	$0	$0
Smoking Cessation Visit	$0	$0
Abdominal Aortic Aneurysm (AAA) Screenings	$0	$0
Diabetes Screening	$0	$0

Medical Coverage

Benefit Name	In Network Services	Out of Network Services
HIV Screening	$0	$0
Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse	$0	$0
Screening for Depression in Adults	$0	$0
Screening for Sexually Transmitted Infections (STIs) and high intensity Behavioral Counseling to prevent STIs	$0	$0
Intensive Behavioral Therapy to reduce Cardiovascular Disease Risk	$0	$0
Screening and Counseling for Obesity	$0	$0
Glaucoma Screening	$0	$0
Kidney Disease Education	$0	$0
Dialysis Training	$0	$0
Hepatitis C Screening	$0	$0
Lung Cancer Screening	$0	$0
Additional Benefits/Non-Medicare Covered Services		
Routine Podiatry		
Routine Podiatry	$0	$0
Routine Podiatry - Number of visits per year	6 Visits	
Routine Chiropractic		
Routine Chiropractic	$0	$0
Routine Chiropractic - Number of Visits	15 Visits	
Routine Chiropractic - Benefit Period	1 Year	
Routine Vision		
Routine Eye Exam Refraction - every 12 months	$0	$0
Vision Hardware - Allowance for Eyeglasses - **OR** - Contact Lenses (in lieu of Eyeglasses)	$150	
Vision Hardware - Benefit Period	Every 12 Months	
Routine Hearing		
Routine Hearing Exam for Hearing Aids	$0	$0
Routine Hearing Exam - Number of Visits	1 Visit	
Routine Hearing Exam - Benefit Period	1 Year	
Routine Hearing Aid - Allowance Per Ear or Combined	Combined	
Routine Hearing Aid - Number of Devices	Unlimited	
Routine Hearing Aid - Benefit Period	3 Years	
Routine Hearing Aid - Device Allowance	$2,800	
TMJ Disorder Treatment		
Allowance per Calendar Year	$1,000	
Wellness/Clinical Programs		
UHC Healthy At Home - Post-Discharge Program, following each discharge: - 12 non-emergency medical rides - 28 home delivered meals - 6 hours in-home personal care	Included	
Fitness Program	Included	
Personal Emergency Response System - Benefit includes a lightweight device (worn on the wrist or as a pendant) that provides 24/7 access to emergency care.	Included	
HouseCalls Program	Included	
Preferred Diabetic Supply Program	Included	

Wellness/Clinical Programs	
Rally Coach: • **Wellness Coaching** blended model of personal coaching, self-paced online learning and digital support across a variety of wellbeing topics such as healthy eating, sleep management, and more. • **Quit For Life tobacco cessation program** using an evidence-based combination of physical, psychological and behavioral strategies to help members overcome their addiction to tobacco. • **Real Appeal:** two digital weight loss programs: Real Appeal Weight Loss Support and Real Appeal Diabetes Prevention.	Included
Case and Disease Management, including: - High Risk Members - Heart Failure - Respiratory Illness - Kidney Disease - Diabetes - Behavioral Health - Nurse Support - 24/7	Included
UHC Hearing Aid Discount Program - Note: Available services and offerings may be limited in the U.S. Territories	Included

Outpatient Prescription Drug Coverage	
Prescription Drug Plan	Custom
Part D Fund Type	Fully-insured
Formulary	Standard Formulary H (Group Select Formulary)
Bonus Drug List(s)	List U ACA Drug List
Formulary Edits (step therapy, quantity limits, prior authorization)	Standard: Edits On
Benefit Name	**In Network Services**
Part D Gap Coverage	
Part D Gap Coverage	Full Coverage
Custom OOP, ICL, Catastrophic	
Initial Coverage Limit	$4,430
True Out of Pocket Threshold (TrOOP)	$7,050
Catastrophic Coverage over TrOOP	Lesser of ICL Member's cost share is lesser of CMS Standard benefit (as shown below) or ICL cost shares
Copay for generics	$3.95
Copay for all other drugs	$9.85
- OR - Coinsurance	5%
Day Supply Information **Note: 90 day retail supply is available for 3x copay amount**	
Retail Day Supply (Tiers 1-4)	31
Mail Order Day Supply (Tiers 1-4)	93
Part D Retail Copay	
Tier 1: Generic	$15
Tier 2: Preferred Brand	$40
Tier 3: Non-Preferred Brand	$80
Tier 4: Specialty Tier	$100
Part D Mail Order Copay	
Tier 1: Generic	$30
Tier 2: Preferred Brand	$80
Tier 3: Non-Preferred Brand	$160
Tier 4: Specialty Tier	$200

UnitedHealthcare's standard premium billing and collection reconciliation processes are described below.

The State may pay premiums by check, automated clearing house (ACH) transfer or electronic funds transfer (EFT).

PAYMENT BY CHECK OR ACH

ACH transfer of funds is available from the State's account to UnitedHealthcare. We provide reporting on all funding transactions to serve as documentation of the funding as well as support for reconciliation of the account.

Plan sponsor invoices are generated by the 13th of the month prior to the month of coverage, and payment is due by the 1st of the invoiced month. For example, the State will receive the invoice for March premiums by February 13th, and the payment is due on March 1st.

Premiums are due in full each month by check or electronic transfer and should be paid directly by you, as applicable, to UnitedHealthcare.

PAYMENT BY EFT

To pay by EFT, the State first chooses a billing date. The dates are:

- The 23rd and 28th, which pull the premiums for the following month's benefits. For example, for Feb. 23 or 28 we would pull premiums for March, which are normally due on March 1.

- The 1st and the 5th, which pull for the current month. So, March 1st or 5th would pull premiums for March, which are normally due on March 1st

To complete the setup, the State fills out a form and sends it to us for processing. The State agrees to pay exactly the amount billed. UnitedHealthcare pulls the amount owed for the month on the date chosen, and the funds are transferred from the established checking or savings account to UnitedHealthcare. Any invoice discrepancies will be corrected within our eligibility system (if applicable), with the correction appearing on the following invoice.

LATE PAYMENTS

We have a 30-day grace period before premium payments are considered delinquent. Payment should be applied for the current month no later than the last day of the month. Failure to pay plan premiums on or before the due date may result in termination of the State's retirees from the Group Medicare Advantage PPO plan in accordance with the procedures set forth in the evidence of coverage (EOC) and CMS laws and regulations. Prior to terminating the State and their retirees, we would send notification to provide ample opportunity to address any concerns.

If payment is not received from the State, we reserve the right to assess the plan an administrative fee of 5% of the monthly premium prorated on a 30-day month for each day it is delinquent thereafter. This fee will be assessed solely at our discretion.

In the event we receive deposit of payments not made in a timely manner after termination of the plan, the depositing or applying of such funds does not constitute acceptance, and we will refund such funds within 20 business days of receipt.

To help plan sponsors avoid late payment penalties, we offer a one-time EFT that groups can arrange over the phone with their billing analyst. This option is available to any group and allows the transfer of funds from their account to UnitedHealthcare. This helps groups pay premiums before the end of the grace period when there isn't enough time to mail a check.

CHANGES AND ADJUSTMENTS

With respect to CMS guidelines, we have seven calendar days to process enrollment and dis-enrollments; therefore, we would need to receive any enrollment changes seven calendar days prior to the third of the month in order for changes to be reflected on the bill.

For adjustments to payments, the State must notify us in writing prior to the billing date of any known changes in member status or enrollment, voluntary or involuntary, by the end of the month following such change. Written notification must include the request for change, effective date and reason for change. Involuntary changes in member status require a 21-day notice to the retiree prior to effective date.

Should the State decide for any reason to make payment in any other amount than that listed on the monthly invoice, you must provide a detailed summary of payment listing the group number, full names, member identification numbers, month paid and payment amounts for each person for whom the plan is intending to pay.

We are able to reconcile premiums to group billing accounts at the individual retiree level. We require 30 days to complete the reconciliation and notify the State of any discrepancies.

The terms set forth in this Gain Sharing Agreement will only be effective upon Group's execution of a contract with United for a Medicare Advantage plan for 2023, 2024 and 2025.

GAIN SHARE
MEDICARE ADVANTAGE AND PRESCRIPTION DRUG GROUP AGREEMENT

UnitedHealthcare Insurance Company, a Connecticut corporation, on behalf of itself and its Affiliates, hereinafter collectively referred to as "UnitedHealthcare" agrees to provide State of Arkansas ("Group") with a gain share related to the Group Medicare Advantage and Prescription Drug plan purchased from UnitedHealthcare for Contract Year(s) 2023, 2024 and 2025, pursuant to the following terms and conditions:

A. Definitions.

1. "Benefit Cost Ratio" (hereinafter referred to as "BCR") is calculated by dividing Total Medical Costs by Total Revenues.

2. "Member" is defined in the Medicare Advantage Group Agreement between Group and UnitedHealthcare.

3. "Contract Year" is any one-year period during which the Group's UnitedHealthcare Group Medicare Advantage Plan is in effect.

4. "Plan" is defined as the Group Medicare Advantage and Prescription Drug plan between Group and UnitedHealthcare. And includes the following populations, effective January 1, 2023

    i. Total State of Arkansas population

5. "Total Medical Costs" consist of medical claims and prescription claims incurred by Members during the applicable Contract Year, irrespective of the date such claims are paid, and includes paid claims and claims incurred but not yet paid. Total Medical Costs shall also include the cost of care management, disease management, and any in-home assessment programs delivered to Members and quality improvement work that is considered a claim cost under the Patient Protection and Affordable Care Act (PPACA). Pharmacy Rebates, Manufacturer's Discounts and Reinsurance payments from CMS will be included in the calculation to offset Total Expenses.

6. "Total Revenues" consist of the payments UnitedHealthcare receives from the Centers for Medicare and Medicaid Services (CMS) on behalf of Members enrolled in the Plan during the applicable Contract Year and the premiums UnitedHealthcare receives from Group, on behalf of Members enrolled in the Plan during the applicable Contract Year.

The terms set forth in this Gain Sharing Agreement will only be effective upon Group's execution of a contract with United for a Medicare Advantage plan for 2023, 2024 and 2025.

B. UnitedHealthcare shall provide Group a gain share for the Contract Year(s) specified in the table below if the actual BCR for a Contract Year is less than the BCR stipulated in the table below for the respective Contract Year. Any gain share shall not exceed the amount of premiums paid by Group. If the actual BCR for a Contract Year is less than the BCR stipulated in the table below for that Contract Year, the gain share will be determined as fifty percent (50%) of the amount by which Total Medical Costs incurred are less than the applicable BCR percentage of Total Revenues for the respective Contract Year as set forth in the table below.

   Group Contract Year BCR
   2023 – 92%
   2024 – 92%
   2025 – 92%

C. UnitedHealthcare will complete a final reconciliation and provide it to Group within one (1) month following the final CMS payment. If Group does not dispute the amount of the gain share, if any, UnitedHealthcare will remit payment of the gain share within thirty (30) days of Group providing notice of acceptance of the gain share amount in writing.

D. The gain share cannot exceed Group paid premiums.

E. Group must have all premiums paid up to date at the time of the final reconciliation to receive the gain share pursuant to this agreement.

F. Any gain share UnitedHealthcare provides to Group is subject to compliance with Medicare Laws and Regulations. The gain share shall be used for the benefit of the retirees covered to the extent required by Medicare Laws and Regulations and to the extent Group is required to do so under any other State or Federal Law or Regulation.

G. This agreement terminates upon expiration of the initial contract term. Any extension of the initial contract term shall not extend this Agreement unless expressly agreed by the parties.

The terms set forth in this Gain Sharing Agreement will only be effective upon Group's execution of a contract with United for a Medicare Advantage plan for 2023, 2024 and 2025.

IN WITNESS WHEREOF, the parties have entered into this Agreement.

For: [GROUP FULL NAME]	For: UNITEDHEALTHCARE INSURANCE COMPANY INC., AND ITS AFFILIATES
By:	By:
[TITLE]	[TITLE]
Date:	Date:

UnitedHealth Group

Employer Number: Group Number
Bill Creation Date: 12/11/2021
Billing Period : January 2022

GROUP NAME
GROUP CONTACT
ADDRESS
ADDRESS 2
CITY, STATE ZIP CODE

Due Amount:	$XX,XXX,XXX.XX
Due Date:	January 01, 2022

Billing Summary:

Previously Billed / Not Paid:	$XX.XX
Payments On Account :	$XX.XX
Retroactive Charges And Credits :	$XX.XX
Current Charges :	$XX.XX
Total Balance Due :	$XX.XX

Please be sure to remit your payment exactly as billed by the due date. We cannot apply a partial payment to your retirees accounts.

Please do not submit any correspondence with your payment. Correspondence may be faxed to 1-855-322-0669 or mailed to:

UnitedHealth Group P.O. Box. 29675, Hot Springs, AR. 71903-0675

If you have any questions regarding your bill, please contact your dedicated Employer Account Specialist weekdays between 8:00 a.m. and 4:30 p.m., Central Time.

Please Detach and Return Coupon with Remittance

Employer Number: Group No	Billing Period Date: January 2022	Due Date: 01/01/2022	Due Amount: $

Employer Name: GROUP NAME

Make Check Payable to UnitedHealthCare Ins. Co. and Mail to :
UnitedHealthcare
PO BOX 5840
CAROL STREAMS, IL 60197-5840

Employer Name: GROUP NAME
Employer Number: Group No.
Product: Product Name
Bill Creation Date: 12/14/2021
Billing Period : January 2022

Bill Group Code	Bill Group Name	Retro-Active Charges And Credits	Current Charges	Current Month Total
X	Bill Group Name	$X.XX	$X.XX	$X.XX

Employer Name: GROUP NAME
Employer Number: Group No.
Product: Product Name
Bill Creation Date: 12/14/2021
Billing Period : January 2022
Bill Group # / Name X / Bill Group Name

Household Information	Retiree Information		Financial Information			
Member #	Retiree #	Name and Retiree Identifier	Branch	Coverage Month	Lep Amount	Total
000000001-1	001	LAST, FIRST	003	January 2016	$0.00	$0.00
000000001-2	001	LAST, FIRST	003	January 2016	$0.00	$0.00

R - Total Retirees : 2

< END OF EMPLOYER : XX >

MA-PD PPO Implementation Plan

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IMPLEMENTATION PLAN

UnitedHealthcare's implementation plan will include all components of the proposed plan, including, without limitation, the implementation team, complete implementation and project schedules, testing processes, deliverables, milestones, reporting, which party is responsible for which tasks, and issue escalation processes.

Our priority in the implementation process is to ensure the EBD Implementation stays on task according to the agreed upon timeline so that we can ensure a successful transition of the retirees into their new plan. Our implementation process is built on a foundation of best practices we have learned over the years as well as close partnerships with our clients to ensure we incorporate their voice in the transition.

Our implementation team will utilize a project plan roadmap with clearly defined roles, responsibilities, and benchmarks. Collaboration and open lines of communication are key to success in building our partnership. Our project management of implementation includes three pillars we have developed as best practices:

- Regular meetings and communication with the EBD implementation team ensures we are aligned and working on the right priorities as well as carefully documenting EBD's specifications;
- Enrollment file clean-up/testing includes a Medicare comparison file and additional review of the file to ensure accuracy and no delays in enrolling the retirees into their new coverage;
- Our Group Retiree Operations team is dedicated to the end-to-end client and retiree experience - onboarding and beyond. We will run several quality assurance tests prior to go-live including tests of the eligibility system, benefit system, and claims system to ensure the information is setup correctly

UnitedHealthcare has included detailed project plan with initial dates that will be updated based on meetings with EBD to ensure the timelines are agreeable and will achieve the desired goals. In addition, our project plans include a contact list of everyone involved in the implementation process, an IRAAD (Issues, Risks, Action Items, Assumptions and Decisions) where any outstanding items will be tracked and worked until resolved and finally a complete list of the file transfers that will be a part of the successful implementation.

The assigned implementation manager has least three (3) years of experience implementing similar plans with at least 25,000 group health members.

The Senior Implementation Manager has over 6 years of implementation experience handling multiple Group Medicare Advantage high complexity and complicated cases with excellent Net Promoter Scores on his performance. The Implementation Director who will participate as a resource to the Senior Implementation Manager has over 8 years of experience, including several State cases. A proven strength of our implementation process is that while the Implementation Manager shoulders the overall accountability, they are surrounded by a team of subject matter experts to oversee areas such as regulated and marketing materials, digital, call center, pharmacy, enrollment, benefits, audits, and many more. Our Implementation team has successfully delivered implementations for over 20 State cases, 8 of which have50,000 or more members.

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The UnitedHealthcare implementation team proposed for the State's account has been outlined below. This team consists of experienced professionals who are focused on the health care needs of the State's members. Our team will provide the State with a wide range of expertise in product specifications, communications, account management and operations.

COURTNEY JENNINGS, DIRECTOR OF IMPLEMENTATION

As Director of New Business Implementation, Courtney Jennings leads a team dedicated and focused on guiding our clients through the Implementation process. Courtney leads the Group Medicare Advantage Implementation team that continues to leverage our market-leading expertise and best practices to ensure a smooth implementation for EBD.

Courtney's role is to provide leadership, help manage the complexity and offer support. She focuses on building collaborative relationships, developing best practices and delivering upon client expectations.

Courtney has developed extensive project management and client management experience throughout in her career. Courtney brings firsthand experience to the director role for the Implementation team as she successful led some of the largest and most complex cases for UnitedHealthcare Retiree Solutions.

DERRICK OLSON, SENIOR IMPLEMENTATION MANAGER

Derrick Olson is a Senior Implementation Manager with UnitedHealthcare Retiree Solutions who specializes in serving the retiree health care needs of employer groups. Working closely with other account management team members, Derrick provides essential expertise and oversight in driving the successful implementation of new employer-group retiree offerings.

Derrick Olson has been an Implementation Manager with UnitedHealthcare since 2011. Derrick has led major implementations across several different lines of business and segments during his tenure with UnitedHealthcare, specializing in the Group Medicare, Medicaid, and reinsurance lines of business.

UnitedHealthcare will ensure the MA-PD PPO Plan is complete and fully implemented by January 1, 2023, unless otherwise specified by EBD. We will develop and track diligently a project plan that will guide the implementation process. This project plan is designed to ensure the implementation is successful and the benefits are fully implemented by the January 1, 2023 effective date. In addition, we also have an IRAAD (Issues, Risks, Action Items, Assumptions and Decisions) where we will track any open items to ensure they are properly closed out by all parties. By utilizing the project plan and our other tools we are able to ensure the implementation is successful.

UnitedHealthcare will develop and implement a member communication plan, including development and assistance to EBD, prior to Open Enrollment. In addition, UnitedHealthcare will bear the cost of printing communications to members as a part of the communication plan.

During Implementation, UnitedHealthcare will facilitate a communications deep dive to discuss EBD's communications objectives. UnitedHealthcare will partner with EBD to review and create an end-to-end communications plan designed to educate and engage EBD’s members through multiple touch points. We believe the key to engaging members is through multiple methods of communication as we understand that people learn and are motivated in different ways. Prior to enrollment, we will work closely with EBD on an announcement letter that provides members with introductory information about the plan and the upcoming enrollment period.

We will include in our project plan all the agreed upon timelines for the various communication pieces to ensure all communications are properly developed and executed. A summary of communication pieces is below:

MA-PD PPO Implementation Plan

Announcement Letter and FAQs:

- Written by EBD (with our support as needed), to reflect EBD culture, voice and brand.
- UnitedHealthcare can provide example language for the announcement letter to make sure important key messages are included and resonate with retirees.
- Introduces the upcoming change
- Describes UnitedHealthcare's role
- High level information about the new plan and lets retirees know what to expect in the coming months.

UnitedHealthcare Plan Guide: (can be co-branded with EBD, and with a custom toll-free number and URL) is a combination of educational content and regulatory documents that CMS requires to provide the Retiree with key information including:

- An introduction section with information from EBD on how to enroll
- Benefit plan information both on a general and detailed basis
- Information on how Medicare Advantage with Prescription Drug plans work
- Information on how the network works- you can see doctors and other health care providers that are in and out of our network at the same cost share as long as they participate in Medicare and accept the plan.
- Additional support, programs and resources
- Formulary information

UnitedHealthcare Quick Start Guide: (may be co-branded with the State, and with a custom TFN and URL). Our "Welcome" communication includes:

- Educational information to assist the member as they begin using the programs
- Services included in the plan with instructions on how to access plan materials online (such as the Evidence of Coverage or directories) and CMS required language.
- Member ID card is affixed to the front of the guide.

UnitedHealthcare will develop communications for, and implement, on-site Open Enrollment meetings and district and local retiree meetings.

UnitedHealthcare's extensive experience has provided us with valuable insights into the needs of seniors and helped us develop a comprehensive communication and education strategy. We think this strategy is the right one because it meets the member where they are through a variety of channels. If a member prefers face-to-face engagement or speaking to a person, we have in person open education and enrollment meetings. If a member prefers having information to read at their own pace, we have printed educational materials designed for retirees as well as a member web portal for members to research their plan and services.

EDUCATION MEETINGS/ OPEN ENROLLMENT/CONFERENCE CALLS

While print and electronic materials are an important part of any communication strategy, we know retirees deeply value direct human interaction. We will work with EBD benefits staff on member communications and education/open enrollment during Implementation. We will factor in details specific to EBD, such as summer education meetings, fall open enrollment meetings, the number of eligible members, retiree demographics, the number of meetings and the types of communications materials to ensure the best possible communication strategy.

We will provide full support to EBD for education meetings, open enrollment meetings, on-site educational events, and health fairs. Our Group Retiree open enrollment team is dedicated exclusively to handling open enrollment and education meetings. This team will schedule locations for EBD education/open enrollment meetings in partnership with EBD. We ensure these meetings are retiree friendly and include few or no steps, amps for wheelchairs, elevators to upper floors and adequate parking at close distances. UnitedHealthcare representatives will lead and conduct enrollment meetings with a formal presentation. Materials distributed at the meeting can include a description of the program, benefit summaries and instructions on how to enroll. We provide all of these services at no cost to EBD.

To complement our open enrollment experience, UnitedHealthcare created a first-of-its-kind Virtual Education Center (VEC). The VEC is an alternative to safely provide open enrollment support and educational meetings for our retirees. The VEC website, **uhcvirtualretiree.com**, was designed to resemble an in-person open enrollment meeting; providing members direct access to information “booths” that help members learn more about their benefits - just as they would at an on-site event.

Materials distributed at the meeting can include a description of the program, benefit summaries and instructions on how to enroll. Some examples of materials are:

UnitedHealthcare meeting invitation (can be co-branded with EBD, and with a custom toll-free number and URL)

- Provides details of available meetings both in person and virtual – dates and times

Meeting materials (signage, presentations and fliers/brochures (some materials available forco-branding with EBD, and with a custom toll-free number and URL). Examples of educational materials are:

- Plan Resources brochure provides an overview of key programs included in the plan such as:
  - Renew Active fitness benefit

- UnitedHealthcare hearing aid savings program
- Vision benefit
- HouseCalls
- Renew by UnitedHealthcare
- Virtual Visits
- New to Medicare Advantage brochure

Individual fliers may be selected if desired for:

- Medicare 101
- Diabetes Program
- Medical Management and clinical programs
- Flu Facts
- Using In and out of network providers

UnitedHealthcare will ensure transition of care and prior-authorization data is appropriately transferred from incumbent vendor. UnitedHealthcare will work collaboratively with EBD and the existing carrier to transfer existing prior authorizations.

Prior to the effective date, we proactively work with the existing carrier to develop a file layout agreed upon by both carriers to obtain member specific prior authorized information. Data elements include information such as complete and accurate member demographic data along with approved dates of services, approved type of services (and codes), and requesting provider details. During the pre-implementation phase, we provide the carrier with these necessary data elements required to build the prior authorization in our utilization management system.

UnitedHealthcare will test all systems and process to ensure they are fully functional prior to January 1, 2023, Including testing with an actual retail pharmacy from the Point-of-Sale transaction to a completed transaction where the pharmacy successfully processes the prescription drug claim for a successful fill of the medication.

UnitedHealthcare will run a number of quality assurance tests prior to go-live including tests of the eligibility system, benefit system, and claims system to ensure the information is setup correctly. Prior to the submission for system setup, EBD will review and approve the benefits through our formal benefit sign-off process. Additionally, we will run a 100% benefit audit to ensure the system set up is accurately and matches the Group Medicare Advantage Call Center reference documentation. We also conduct a test of the member service phone lines to ensure they are routing properly. UnitedHealthcare conducts a detailed review of all member materials including the announcement letter, benefit plan guide and evidence of coverage.

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UnitedHealthcare's benefit implementation audit team reviews/audits selected claims, in comparison to their benefit source of truth documents (evidence of coverage and plan guide), to ensure the full benefit package is aligned consistently and performing to the plan's expectation. We also submit and process claims through secure testing system, known as the Benefit Intent Certification tool. This tool is a secure test system that replicates how claims will process in live production environment and offers a comprehensive view and test of claims processing system from end-to-end. Once claims are processed and compared to source of truth documents, the benefit implementation audit team compiles findings for review with EBD. The UnitedHealthcare account management team will work with EBD to determine if any updates are needed and will work to resolve any issues or plan ambiguities.

EBD's involvement includes reviewing and signing off on the audit results. We are happy to discuss any additional testing needs that EBD requires.

UnitedHealthcare will complete and bear the cost of readiness assessments to the satisfaction of EBD. The UnitedHealthcare account management team in partnership with implementation/benefit configuration case installation and Benefit Implementation Audit operations has a comprehensive implementation project plan. As part of that plan, UnitedHealthcare will support a Benefit Implementation Audit conducted by a mutually agreeable designated authority to conduct a review of group structure and benefit plan configurations upon plan implementation.

Benefit Implementation Audits include claim scenarios to challenge the system as well as address silent or ambiguous plan provisions in the EBD's summary plan descriptions or benefit documentation. This is done intentionally to ensure that benefit intent is fully captured through the installation process with a process that does not utilize random selection.

A Benefit Implementation Audit is conducted after the case is considered fully configured and is therefore dependent on final benefit agreement and/or sign-off from EBD. The timeline for a Benefit Implementation Audit is fully dependent on the number of plans requested for testing and can only be conducted after configuration ready date.

The Benefit Implementation Audit process includes a comprehensive issue resolution process that will be employed to resolve all identified issues in a timely manner but is dependent upon the EBD's participation.

At EBD's request, UnitedHealthcare confirms it will allow EBD and its designees full access to test the functionality of all systems and processes during implementation.

STANDARD TESTS

The UnitedHealthcare internal Benefit Implementation Audit (BIA) standardly tests 450+ test claims in 70+ benefit categories. The BIA compares documented parameters (automated system calculations as well as manual claims processor instructions) and views system applications to:

- Verify copayments are computed correctly.
- Ensure benefit limitations (if applicable) are recorded accurately.
- Verify benefit calculation is correct for each sampled claim type.

At EBD's request, UnitedHealthcare confirms it will bear the cost of a third-party auditor selected by EBD to complete all pre-implementation audits required by EBD..

UnitedHealthcare will provide, via surface mail, valid, accurate member identification (ID) cards to all members prior to January 1, 2023. Valid, accurate member ID cards ("ID Cards") include, at minimum:

- **The member's name**
- **Contract number**
- **Contractor's twenty-four (24) hour, seven (7) day/week toll-free eligibility and pre-certification services telephone number**
- **Applicable co-payments for services**
- **Rx BIN**

UnitedHealthcare will mail, via surface mail, a member ID card to all members at least ten (10) business days before the "go-live" date based on the information confirmation from CMS.

MA-PD PPO PLAN MANAGEMENT

UnitedHealthcare has provided a detailed project plan that includes all components of the proposed plan, including, the plan management team, deliverables, milestones, which party is responsible for which tasks, and an issue escalation processes. The Implementation Kick-Off meeting is the official start to the implementation journey. Its purpose is to review the implementation steps, best practices, accountable parties, and the key milestones. During the kick-of meeting, we will review and explain the different topics areas, the data needed and the decisions that will need to be made to adhere to the mutually agreed upon overall timeline. We identify the key participants and decision makers by subject area , and we get to know the team at EBD and build the foundation of our collaborative relationship to deliver a successful implementation. Our overall goal is to ensure EBD is informed and comfortable with the decisions that have been made and the retirees are fully educated and ready to use their plan. The tools used during implementation will be introduced – project plan, contact list, IRAAD (Issues, Risks, Action Items, Assumptions and Decisions), file transfers, meeting agendas and notes.

UnitedHealthcare will assign a single, dedicated account manager for the MA-PD PPO Plan. Joe Larson is the UnitedHealthcare Retiree Solutions Strategic Account Executive for the MA-PD PPO plan dedicated to EBD.

UnitedHealthcare will provide an account management team focusing exclusively on the MA-PD PPO Plan. UnitedHealthcare is committed to providing EBD with day-to-day service that not only exceeds expectations, but also provides subject matter experts who focus on EBD's specific business needs. We have provided an UnitedHealthcare Retiree Solutions organization chart.

EBD will be supported by an experienced UnitedHealthcare account management (AMT). **This team will provide the following support:**

- **Overall account relationship, including strategic planning in relation to plan performance, consultative services, recommendations for benefit design and cost containment opportunities, overseeing contractual services under the contract with EBD, and managing all other Contractor staff**

  Confirmed.

- **Developing EBD's premiums for MA-PD PPO Plan options and projecting future claims costs and CMS reimbursements.**

  Confirmed.

- **Assisting EBD in determining the projected short- and long-term financial impact(s) of prospective programs**

  Confirmed.

- **Evaluating design and clinical effectiveness of medical management and wellness programs to manage the risk of EBD's membership and therefore control future cost/premium increases**

  Confirmed.

- **Assisting EBD in determining the projected short- and long-term clinical and health impact(s) of current and prospective programs**

  Confirmed.

- **Coordinating with CMS to ensure that all MA-PD PPO Plan filings are structured to properly and fully support EBD's requirements**

  Confirmed.

- **Developing processes and strategies to maximize CMS funding to minimize premiums**

  Confirmed.

- **Proactively assisting EBD in developing strategic considerations to maximize operational and cost efficiencies**

  Confirmed.

- **Managing the overall pharmacy operation, including all account services directly related to clinical pharmacy including formulary management, clinical plan rules and programs, medication therapy management, and specialty pharmacy**

  Confirmed.

- **Overseeing the file transfer process of eligibility data, interfaces between vendors, reporting, and data sharing**

  Confirmed.

- **Providing all member services and communications**

  Confirmed.

Having an account management teams that focus on State cases strengthens their awareness and ability to provide consultative and strategic direction that addresses the State of Arkansas's business needs. The AMT is available to provide support before and after the coverage effective date.

UnitedHealthcare will issue an annual account management scorecard to the State for assessment of our performance. We provide our customers with an annual Retiree Solutions Customer Survey. This survey provides an opportunity for the State to provide feedback on your assigned account management team (AMT) to ensure your satisfaction with the service and support you receive. The feedback will be shared with senior leadership and your team at UnitedHealthcare so they can facilitate appropriate action.

All applicable team members are appropriately licensed or certified in the state in which they are employed.

Our staffing structure is composed of a multi-disciplinary team of experienced clinical and non-clinical team members. Below are the licensing requirements for our team members.

Account Management Team

UnitedHealthcare understands the importance of having our account management team (AMT) be current and well-versed on local, state and federal legislative policies, guidelines and compliance changes. The AMT includes the Strategic Account Executive, Client Service Manager, and Service Account Managers. This is reinforced through various trainings including:

Local and State Training

UnitedHealthcare requires all AMT members to maintain a license in good standing and pass all required continuing education courses, which helps the team to stay up to date on state laws and compliance related to the renewal of his/her license. Team members go through a series of training sessions to better understand the operations of the various government agencies, the political environment, various legislative actions that may possibly impact the EBD, state statutes related to EBD , etc. Regular monthly meetings are also held with our UnitedHealth Group Government Affairs team to make the AMT aware of any proposed legislation and newly enacted changes to laws and regulations that could impact the State of Arkansas's health plan.

Federal Training

UnitedHealthcare requires all AMT members to complete a comprehensive training curriculum and receive their Medicare Certification on an annual basis. Annual training focuses on changes to federal rules, regulations and policies impacting Medicare and the Medicare program.

This training includes:

- CMS Medicare Program administrative guidance
- Annual Open Enrollment Certification as required by CMS
- Medicare product training – A comprehensive series of courses on the federal CMS Medicare program designed to ensure employees across the entire organization, including account management, are experts in all of the Medicare products, guidelines and services

Legislative and Compliance Support

Partnered with the ongoing training listed above, the AMT and our operational areas have access to two large resource departments designed and dedicated to providing ongoing monitoring, support and regulatory guidance on local, state and federal laws.

Additional Training

Annually, our AMT completes training and is required to pass an exam on the following compliance trainings

- Fraud, Waste and Abuse Training
- Safe and Secure with Me – Privacy and Security (PHI and HIPAA)
- ERM – Electronic Records Management
- ESRD- End Stage Renal Disease

- EOC – Evidence of Coverage
- Each employee signs an annual attestation for the UnitedHealth Group Code of Conduct which includes:
  - Anti-Corruption
  - Antitrust Compliance
  - Conflicts of Interest
  - False Claims Act Compliance
  - Federal Contracting, Insider Trading
  - Interactions with Pharmaceutical
  - Medical Device or Biologic Manufacturers
  - Wholesalers or Distributors
  - Reporting Misconduct

MEMBER SERVICES REPRESENTATIVES

Our Group Medicare Advantage pre-enrollment service center is staffed by licensed advisors who help retirees understand their new Group Medicare Advantage plan offering. All Group Medicare Advantage pre-enrollment advisors are licensed and appointed in all 50 states. This is done so that the advisor will be able to speak to members no matter what state they reside in. Every two years, the advisors are required to complete 24 credits (including three credits of ethics) of continuing education to keep their license current. In addition to licensing and appointments, the advisors must also complete a number of CMS-required certification courses that include Medicare basics, ethics and compliance, Medicare Advantage and Medicare Part D. These certification courses are completed on an annual basis.

Our Group Medicare Advantage post-enrollment member service center is staffed by advocates dedicated to serving Group Medicare Advantage members. Advocates are not required to be licensed. However, they focus on exclusively serving Group Retiree members and receive extensive training on Medicare products as well as senior sensitivity training to assist members with the physical, emotional and psychosocial issues associated with aging.

CARE AND CONDITION MANAGEMENT NURSES

Condition management nurses are registered nurses (RNs) with condition-specific clinical/social work experience in an acute inpatient hospital or community setting and a working knowledge of the management of any comorbidity related to a member's primary condition. Each nurse undergoes an extensive and rigorous experiential training program before they move on to mentor with an experienced condition or case management nurse. All training is in compliance with state, federal, URAC and NCQA requirements.

At a minimum, RNs must have a nursing diploma or Associate of Arts degree in nursing, including a current, unrestricted RN license in good standing, in the state where the position is located and eligibility in other states as required.

Nurses must have a deep expertise and training in the diseases they manage as well as expertise in clinical review and evaluation of patients, with an emphasis on cardiac disease, diabetes, respiratory (as applicable to job position) and multiple comorbidities. We encourage the nurses to acquire certified case manager certification within one year of employment.

Advanced Illness nurses hold complex case management certification. They also have a high level of training in collaboration with the Optum Center for Palliative Care and with our medical director on end-of-life care and our Advanced Illness model of care.

Engagement Specialists

Engagement specialists are non-clinical staff members whose responsibilities include enrolling members into condition management/health coaching programs, counseling and scheduling. They must have a high school diploma or equivalent, and a B.S. or Associate degree in a health care field is preferred. We require at least two years of experience in a telephonic customer service role and one or more years in a patient care setting (e.g., hospital, physician's office, assisted living facility, nursing home). Proficiency with medical terminology is also required.

Wellness Coordinators

Our wellness coordinators are non-clinical staff members providing follow up to consumers stratified as non-intensive. Their activities are specific to ensuring ambulatory follow up and connection to outpatient services.

Behavioral Health Specialists

Behavioral health specialists are licensed clinicians with at least three years of post-licensure clinical experience and hold a master's-level clinical degree with independent licensure (e.g., Licensed Professional Counselor, Licensed Social Worker, Psychologist or Advance Practice Registered Nurse). Our specialists have significant advocacy experience across a number of treatment settings, as well as knowledge of behavioral health treatment modalities and their effectiveness. Prevalent senior behavioral health disorders, such as major depressive and bipolar disorders, co-occurring and co-morbid conditions, eating disorders, substance abuse and dementia are all specializations of our licensed, behavioral health specialists.

Telephonic Nurse Support

Telephonic Nurse Support registered nurses have an average of 15 years of experience and must have a minimum of three years of recent clinical experience in areas such as emergency room, geriatrics, obstetrics, critical care, urgent care or medical/surgical environment. All nurses must be registered nurses with current active licensure and must maintain 30 hours of continuing education credits every two years, which exceeds the requirements of many state nursing boards. Additionally, nurses must be clinically competent, effective listeners, good communicators and good problem-solvers who can empathize with a member's needs.

Social Workers

We have an experienced staff of social workers, specifically dedicated to our Medicare Advantage programs. Our clinical social workers are master's or doctorate level therapists with three to five years of experience. They also hold degrees in counseling, psychology, social work, or are registered nurses (RN) with a specialty in advance practice. A valid clinical license, such as a marriage and family therapist or a licensed clinical social worker (LCSW), is required. Prior experience with older adults is highly desirable, along with an understanding of community supports and services. Our social workers receive ongoing training to fully address members' behavioral and co-morbid needs.

Medicare Pharmacist

As part of our interdisciplinary care approach, we include a pharmacist, along with our nurse care managers and social workers, to support members' plans of care. The pharmacist is a vital component of our Medicare Advantage care teams as the prevalence of multi-morbidity and polypharmacy increases with age. Older adults often have to manage multiple prescriptions for several conditions at one time.

Based on our engagement guidelines, our nurses consult with and refer active cases to the pharmacist on the care team. The pharmacist reviews the case and posts a medication review with guidance for the nurse to discuss with the engaged member. The information provided by the pharmacist may address topics such as medication adherence; drug/drug or drug/condition interactions; lower cost alternatives or medication adverse effect education. The pharmacist can also address specific questions from the care manager or member. The pharmacist is always available to our staff by email or instant message.

In addition to case referrals, the pharmacist collaborates with our medical directors in global education of nurse teams. The forums for education include medical director case reviews informal Q & A sessions and presentations on health care and condition specific topics.

Medical Director

Our medical directors are licensed, board-certified physicians, hold an active unrestricted license with a minimum of five years of clinical practice experience, as well as experience in managed care, employee benefits and medical policy development.

Medical directors' training includes online and instructor-led courses on models of care, Medicare, plan design, clinical guidelines, medical policy, risk management, compliance, coverage determination guidelines, grand rounds, coding and operational processes and systems. The average tenure of our medical directors is six years.

UnitedHealthcare will maintain an escalation process for member satisfaction and complaints. We have a detailed escalation process for member satisfactions and complaints. The two dedicated on-site service account managers (SAM's) are a single point of contact assigned to EBD to resolve complex or escalated member-level operational or service issues or questions. UnitedHealthcare will provide two full time on-site SAMs to assist EBD and its members with escalates issues.

The SAM's primary objectives are to:

- Handle end-to-end member level issue resolution by identifying root cause and subsequently routing service matters to appropriate support areas and tracking through to resolution

- Report on an issue trend to appropriate service areas

The most common reasons for escalations to the SAM include:

- Medical and prescription claim explanation inquiries
- Provider outreach/education – These are typically proactive requests prior to enrollment where members ask if their current providers will accept their new plan
- Enrollment/eligibility verifications – These can potentially include enrollment/eligibility errors; however, not all escalations are a result of errors

GROUP MEDICARE ADVANTAGE MEMBER SERVICE ESCALATION

The escalation process begins immediately if the member service advocate is unable to assist the caller. The advocates fully document the case and warm transfer the call with all necessary information to an escalation line staffed by a Senior Service Advocate or Supervisor. If the issue is resolved, the escalation specialist documents the issue and advises the caller of the resolution. If the issue cannot be resolved within the call, the escalation specialist notifies the caller the issue requires additional research and provides a callback timeframe for status of the review. All actions taken on the call as well as any further follow-up actions are documented. The member is notified of final resolution by a phone call providing the status and/or an answer to the member's issue.

All complaints are tracked and reviewed immediately to ensure all steps have been taken to resolve the member's questions. Specifics of UnitedHealthcare's complaint resolution procedures are listed below:

We assign a project manager who leads a designated group of customer service subject matter experts who complete a thorough review of complaint codes where there is an increase in the number of complaints for specific complaint categories. We use standard deviation methodology in the reporting to identify the focused review for the quarter.

- Findings are then analyzed for any trends or significant issues requiring further actions.
- This analysis is presented to the appointed internal committees with recommendations.
- Our reporting team has a verbal complaint dashboard, which provides leadership with improved snapshots of verbal complaints by code, trending charted quarter-over-quarter and year-over-year, and automatically identifies items requiring additional research.

The UnitedHealthcare account management team will notify EBD of any emerging issues. If a trend is identified, the member service team works directly with you to identify both a short-and long-term solution for the situation.

UnitedHealthcare will maintain an escalation process for urgent drug claim issues where claims are rejecting at the pharmacy and members need immediate assistance and resolution. Below is the escalation process for urgent drug claim issues where claims are rejecting at the pharmacy and members need immediate assistance and resolution, (before the member leaves the pharmacy).

UnitedHealthcare's network pharmacies are equipped with instructions on how to communicate and assist members with a rejected claim as follows:

- We provide claim level messaging to pharmacies to guide them in next steps, for example, refill too soon, prior authorization required, and preferred alternatives.
- Pharmacy may contact help desk for an override or claim submission assistance.
- Pharmacy may contact the prescriber to relay the messaging or to initiate a prior authorization, which can be expedited.
- Pharmacy may give member a short supply of medication until the prescriber submits a prior authorization request.
- Pharmacy will give the member the printed appeal rights to seek a prior authorization.

Members may call member service to seek assistance. Our member service advocates can provide the member formulary alternatives or facilitate a prior authorization request, which can be expedited. Expedited prior authorizations are resolved within 24 hours of receipt of the complete information.

In addition, EBD's dedicated on-site Service Account Managers (SAM) will provide immediate assistance and resolution for all member needs, including urgent drug claim issues.

UnitedHealthcare will handle all initial internal and external appeals in accordance with CMS requirements and guidelines. UnitedHealthcare's appeals policies and procedures comply with CMS regulations. Our policies and procedures prohibit staff from discriminating against a member or the member's authorized representative for filing an appeal.

A member has the right to appeal any adverse organization determination regarding disputed health care services and coverage decisions, whether the decision is adverse in whole or in part.

The first level of appeal is considered a reconsideration which must be submitted in writing within 60 calendar days from the date of the adverse determination. The 60-calendar-day limit may be extended for good cause. Our appeals and grievances department tracks and records all appeals in accordance with CMS reporting requirements.

We send written notification of the reconsideration determination within 30 calendar days from receipt of the request or no later than the expiration of the 14-calendar-day extension for standard service reconsideration or 60 calendar days from the date of the request for reconsideration of a standard claim.

Based on the outcome of this review (to either uphold or overturn the denial), the member and/or care provider is notified via a written notice that the services will be paid, or a detailed explanation is provided to justify the continued denial.

During the appeal process, the member or the member's authorized representative has the right to submit additional information to support their appeal.

If the determination is fully favorable to the member, we must authorize or provide coverage as expeditiously as the member's health requires but no later than 30 calendar days of the date of receipt of the initial request for standard pre-service reconsideration, or if an extension was granted, no later than the expiration of the 14-calendar day extension. The claim will be paid within 60 calendar days for standard reconsiderations.

If the determination is in whole or in part unfavorable to the member, they are notified, and the case is prepared and submitted to MAXIMUS Federal Services, the external review vendor contracted with CMS.

Reconsiderations not completed within the mandatory timeframes constitute an adverse decision, and the case will be submitted to MAXIMUS Federal Services.

If the member believes that handling the appeal through the standard 30-day appeal process could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum function, the member, member's representative or physician may request an expedited reconsideration (appeal) either orally or in writing regarding a denial, reduction or discontinuation of coverage for a service.

UnitedHealthcare will handle all grievances in accordance with CMS requirements and guidelines. UnitedHealthcare's grievance policies and procedures comply with CMS laws and regulations. Our policies and procedures prohibit staff from discriminating against a member or the member's authorized representative for filing a complaint or grievance.

We are committed to addressing all member concerns in a timely and consistent manner.

A member or the member's authorized representative has the right to file and communicate a grievance/complaint verbally or in writing. For quality-of-care issues, a grievance can be filed within 60 calendar days of the date the dissatisfaction occurred.

When UnitedHealthcare advocates receive a verbal grievance, they immediately document it and attempt to resolve the grievance during the initial telephone call. If a resolution is reached, the grievance and the resolution are documented in our management information system according to internal policies and procedures. If the grievance is not resolved to the member's satisfaction, the member will be provided with our appeal and grievance address to submit their grievance in writing.

Once received, all verbal or written grievances are date stamped by UnitedHealthcare.

Members receive written notification of the proposed resolution of their written grievance no more than 30 calendar days from the date stamped receipt of the grievance. We respond to all grievances regarding quality-of-care issues in writing, whether the member relayed the issue to us telephonically or in writing. Verbal quality of service grievances only results in a written resolution if the member requests a written response. If the member submitted a grievance in writing, a written resolution is provided regardless of grievance type.

UnitedHealthcare Retiree Solutions Account Management Team
State of Arkansas

Craig Condon
CEO/Executive Sponsor

Linda Jones
Chief Client Officer

John Thompson
National Vice President
National Practice Leader
Public Sector

Implementation

Jeffrey Harr
VP, New Business Implementation

Courtney Jennings
Director Implementation

Derrick Olson
Implementation Manager

Network

Joy White
Vice President National Network

Nicole Dincecco
Director Network Manager

Paul Burnett
VP Network Contracting Arkansas

Clinical

Joe Agostini, MD
Chief Medical Officer

Linda May, MD
Senior Medical Director

Keith Murbach
Clinical Director

Linda Kobilarcsik
Vice President, Group Part D

Brock Howard
Clinical Account Pharmacist

Michael Mark
Director Pharmacy Operations

Client Management

Geoff Rensi
Vice President Client Management

Joseph Larson
Strategic Account Executive

Yesenia Labrada
Sr. Client Service Manager

Onsite Service Account Manager

Onsite Service Account Manager

Operations

Lynn Mueller
Director of Client Services

Sasha Morrison
Client Delivery Operations Manager

Susan Nevers
Marketing/Associate Director

Tessa Boettner
Marketing/Client Manager

Seth Westerlund
Billing Manager

David Denoyer
Business Manager, Enrollment

Roxanne Anderson
Electronic Eligibility Analyst

Breannaa Morton
Deployment Manager

Michael Chandler
Associate Director, Customer Service

Joseph Fleming
Customer Service Manager

30 Customer Service Advocates

Underwriting, Reporting, and Legal

Debbie Donaldson
Vice President, Actuarial Services

Ryan Kuehn
Director Underwriting

Jessica Zuba
Legal Counsel

Lynn Freese
Compliance Specialist

Key

Staff Dedicated to State of Arkansas

UnitedHealthcare

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2022 UnitedHealthcare Retiree Solutions Account Management Client Survey

Opening

Welcome to the annual URS Account Management Client Survey. Your feedback is highly valued as UnitedHealthcare strives to exceed your expectations and earn your satisfaction. Thank you for your participation.

Your name and feedback will be shared with senior leadership and your team at UnitedHealthcare so they can facilitate appropriate action.

ACCOUNT TEAM MEMBER EVALUATION FOR:
Senior Strategic Account Executive (SAE)
Senior Client Service Manager (CSM)
Service Account Managers (SAM)

Please enter your first and last name in the box below.

Scoring: Dissatisfied (1), Satisfied (2), Extremely Satisfied (3)

Account Management – General

How would you rate your UnitedHealthcare Account Management Team on the following:	1 DISSATISFIED	2 SATISFIED	3 EXTREMELY SATISFIED
1. Understanding your business needs and expectations (SAE)			
2. Serving as a thought leader and strategic partner to the client (SAE)			
3. Maintaining an effective relationship with your leadership team (SAE)			
4. Being a trusted advisor to the client (SAE)			
5. Responding in a timely manner (SAE/CSM/SAM)			
6. Communicating clearly and effectively (SAE/CSM/SAM)			
7. Effectively supports your day-to-day operational needs (SAE/CSM)			
8. Keeps the client staff involved in projects and informed about developments and plans (SAE/CSM)			
9. Ensures that regular communication takes place (SAE/CSM)			
10. Behaves in an honest and trustworthy manner (SAE/CSM/SAM)			

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Please enter any additional comments or feedback in the box below:

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MA-PD PPO Administration Plan

UnitedHealthcare will support EBD in handling split-family contracts in which some members are Medicare eligible and some members are not.

The eligibility and billing systems UnitedHealthcare utilizes to administer our Group Medicare Advantage business has significant flexibility to meet our client's needs regarding split families. As part of the implementation process, we will meet with the appropriate staff from EBD and our subject matter experts to understand your split family definitions and processing needs and then work to configure, to the extent possible, a solution. We have found that we can accommodate most split family administration requirements.

UnitedHealthcare will develop and manage the following processes:. During implementation, our Implementation and Eligibility Analyst will work with the EBD to complete eligibility questionnaires and data collection documents which provide the information we need to complete the setup process. These documents help to determine the enrollment file frequency, reporting frequency as well as who the contacts are at EBD. Once EBD's plan is operational, your Eligibility Analyst will be your day to day contact and is accountable for the on-going oversite of EBD's eligibility files.

- **Initial enrollment process for January 1, 2023**

  UnitedHealthcare accepts eligibility data in various file formats, including the industry standard 834, electronic file format. All file interactions with our clients are managed via secure file transport protocols (SFTP)

  For all new enrollments, within 48 hours, clean and complete records are transmitted to CMS's pre-eligibility application for initial validation. This validation quickly confirms that the member meets basic Medicare eligibility requirements prior to submitting the transaction file to CMS. Once the record returns from this initial validation, if the validation is successful, the member's record is then passed to CMS for final eligibility and enrollment processing. If the initial validation is unsuccessful, discrepancies are distributed to various work queues where processors review and resolve the errors. Teams will also work any records that may have fallen out from the original file load. The processors work closely with your assigned team, EBD or third-party administrator; whoever is deemed the appropriate resource. Once issues are resolved, the process will continue, and the application will result in either an approval or denial.

  Upon receipt of the initial retiree enrollment file, the account management team and Eligibility Analyst works closely with EBD to establish a normal file transfer schedule and discrepancy resolution process. Once we receive complete and accurate eligibility data, we enter the data into our eligibility system, within seven calendar days. We also process enrollment additions, changes and termination within seven calendar days of the receipt date of the file.

  We will work with EBD to define the requirements and processes to smoothly enroll and transition their retirees to our Medicare Advantage plan while being fully compliant with CMS guidelines.

- **Opt in and opt out processes**

  Under CMS rules, a plan sponsor offering an Employer Group Prescription Drug Plan, Medicare Advantage, or Medicare Advantage Prescription Drug Plan, can use electronic enrollment with a 21-day opt-out process for retirees.

In our typical process, the plan sponsor sends an announcement letter to the retirees who are going to be auto-enrolled into the plan. Contained in the announcement letter is the statement that the retiree has an option to opt out of the plan by a certain date and the instructions on how to opt out if that is the retiree's choice.

UnitedHealthcare prefers that the plan sponsor manage their own opt-out if feasible. However, for initial enrollment, if EBD prefers, we will facilitate the opt-out. The announcement letter will direct the member to contact either EBD or UnitedHealthcare to perform the opt-out. The opt-out member information is collected, and EBD would have those who will not be enrolled removed from the production file.

- **Age in process**

  Information for aging-in retirees is typically provided 90 days prior to the individual turning 65. Most retirees are eligible to enroll in a Medicare plan when they turn 65, first become eligible for Medicare, retire, and/or lose their employer sponsored coverage. Upon receipt of a file of Medicare-eligible retirees, we send the retiree a personalized packet of information that includes an introductory letter and Medicare education materials.

- **The 21-day rule and retro enrollments/cancellations**

  Once the 21-day opt-out period is over, we submit an electronic enrollment file to CMS to enroll all retirees who have chosen to stay in the plan. Once enrolled, we send retirees their identification cards and welcome kits.

  Additions and terminations can be made up to 90 days retroactively if EBD is responsible for the delay in the receipt of the requested transaction. CMS, however, has no time limit on the adjustments they can make to membership.

  Disenrollments processed based on group notification do not result in any notification to the group; however, disenrollment at a member level is reflected on the next monthly premium statement. If an internal process results in disenrollment of a dependent, a disenrollment letter will be sent to the member.

  In order for a retiree to disenroll from the plan, we must have written documentation from the retiree requesting disenrollment. This can be provided in the form of a written request received directly from the retiree or supporting documentation from EBD that the request to disenroll was received timely through the group.

- **Members with Part A coverage but not Part B coverage**

  When retirees are applying for UnitedHealthcare coverage, we verify their coverage status in Medicare Parts A and B. For those applicants that do not have Medicare Part B, the application drops to a work queue in our eligibility system. An “additional information needed” letter is then mailed to the retiree requesting more information around their Part B coverage. If the retiree does not respond to the letter in the requested timeframe, their application will be denied. If the retiree does respond within the requested timeframe but responds that it is accurate that they do not have Part B, their application is denied. A denial of enrollment letter is mailed out in both scenarios.

For existing members who lose Part B coverage, CMS sends a disenrollment transaction to UnitedHealthcare notifying us that the member has dropped their Part B coverage. UnitedHealthcare processes the disenrollment and notifies the member via a disenrollment letter.

For members who do not have Part B coverage, our suggestion would be to allow EBD to move that member to their commercial plan until the member's Part B goes into effect or is re-instated.

- **Members with Part B coverage only**

  Medicare Advantage plans require that members be enrolled in both Medicare Parts A and B. Failure to do so results in disenrollment per CMS guidelines. Members are notified by letter and can request reinstatement if an error occurred.

- **Members who drop Part B after enrollment in the MA-PD PPO Plan**

  UnitedHealthcare receives a daily Transaction Reply Report (TRR) from CMS that lists a specific Transaction Reply Code (TRC) to identify any enrollee that has lost Part B coverage. Medicare Advantage plans require that members be enrolled in both Medicare Parts A and B. Failure to do so results in disenrollment per CMS guidelines. Members are notified by letter and can request reinstatement if an error occurred.

- **Members who enroll in another Part D plan**

  CMS sends a disenrollment transaction for any member who enrolls in a standalone Medicare Part D plan or another Medicare Advantage Part D plan as members can only have one Part D plan at a time. UnitedHealthcare must process the disenrollment and will notify the member via a disenrollment letter and can request reinstatement.

  In addition, your electronic eligibility analyst will review the disenrollment file and work with EBD and the member to correct enrollment if necessary.

- **Members who enroll in Medicare late and fail to enroll when he/she turns 65.**

  UnitedHealthcare administers the Medicare Part D late enrollment penalty (LEP) per CMS regulations. The late enrollment penalty is defined as:

  "An amount added to the Part D plan premium of an individual who did not obtain creditable prescription drug coverage when s/he was first eligible for Part D or who had a break in creditable prescription drug coverage of at least 63 consecutive days. The LEP is considered a part of the plan premium."

  Any Medicare beneficiary who is already paying a higher Medicare Part D premium for late enrollment prior to the effective date of our plan continues to pay that penalty under our Medicare Part D plans. During the enrollment process, CMS notifies us directly if a retiree is currently paying the penalty.

  For first-time enrollment transactions, EBD may attest for the late enrollment penalty on the member's behalf, as long as EBD can attest for their entire population and can provide us with all applicable data. Having complete data enables us to respond appropriately to CMS requests. To attest for an entire enrolling retiree population, the following conditions must be met:

  - Available for initial implementation only

- EBD must be able to attest for entire membership
- Attestation must be for continuous coverage back to the 65th birthday or June 1, 2006, whichever is most recent
- Enrollment staff must receive a file of attested membership that includes first and last name, date of birth, Medicare number, ZIP code, coverage start and stop dates, and name of prior coverage(s)
- Signed attestation must be received prior to enrollment applications/file process

We suppress late enrollment penalty attestation letters for members enrolling during the initial implementation; however, this attestation does not apply to future retirees or "age-ins" who will receive late enrollment penalty attestation letters.

- **Applying a member's Late Enrollment Penalty (LEP)**

Retirees that did not enroll in Medicare Part B when they first became eligible for Medicare (due to age) may fall into different paths to enroll in Part B:

- If an individual delayed enrollment in Medicare Part B due to having coverage through current employment or coverage through a spouse's employment, the individual may qualify for a Special Enrollment Period (SEP) for Part B:
  - The individual must enroll in Part B during the 8-month period that begins the month after employment ends or the group health coverage ends, whichever happens first.
  - The individual will need to complete the appropriate Medicare form(s) in order to enroll.
  - Coverage under Part B will be different based on when the individual applies during the 8-month SEP.
  - If the application is submitted within the SEP, a Part B premium penalty should not apply.
- If the individual does not qualify for the SEP for Part B described above:
  - The individual can enroll in Part B during Medicare's "general enrollment period" from January 1 through March 31.
  - Coverage under Part B will begin on July 1 of the year enrollment occurs.
  - The individual may be subject to a Late Enrollment Penalty (LEP) for Part B.
  - Monthly Part B LEP is assessed at 10% for each 12-month period the individual was eligible for Part B but didn't sign up.

Note: *Individuals that are eligible for premium-free Part A who did not get automatically enrolled can enroll any time after first eligibility for Medicare. Those who have to buy Part A would follow the same process / timeline as individuals enrolling in Part B without a SEP.*

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- **Qualifying life events (QLE) for Medicare-eligible retirees and their Medicare-eligible dependents when the QLE happens after EBD's Open Enrollment period has ended**

  For individuals making an enrollment request into or out of an employer group health plan (EGHP), a more flexible "open season" is available through a special enrollment period (SEP). This is commonly referred to as a SEP EGHP. The SEP EGHP may be used when the EGHP allows the individual to make changes in their health coverage choices, such as during the employer's "open season," or at other times the employer permits. The SEP ends two months after the month the employer or union coverage ends. The individual may choose an effective date of up to three months after the month in which they completed an enrollment or disenrollment request; however, the effective date may not be earlier than the first of the month following the month in which the request was made.

  Another common SEP exists for the working aged or working disabled who did not enroll in Medicare Part B or Premium-Medicare Part A when first eligible because they were covered under a group health plan. Whether that coverage was based on their own, or a spouse's current employment (or the current employment of a family member, if disabled), they may enroll during the SEP. The individual can enroll at any time while covered under the group health plan, based on current employment, or during the 8-month period that begins the month the employment ends or the group health plan coverage ends, whichever comes first.

  On a monthly basis, we provide the employer with a group billing invoice that includes summary data containing additions, terminations or changes to the group's membership. For ongoing enrollment, we expect customers to send files in one of the standard formats (834-5010 HIPAA or UnitedHealthcare proprietary flat file), and we prefer the changes-only file. Initially, the employer's membership volume and activity level will be assessed to determine the best frequency for member or employer group updates. We prefer to receive the files weekly and accept Secure File Transfer Protocol (SFTP), HTTPS or FTP with PGP encryption as valid transmission methods. The employer can enroll/disenroll their members at any time as long as they fall within a valid election period. Election periods are expected be placed on the enrollment file sent to UnitedHealthcare. UnitedHealthcare will partner with the employer during the implementation process to identify the appropriate election period for members who fall within the described scenario.

  We offer a toll-free number for member enrollment-specific questions and a toll-free member number for any customer service questions throughout the year.

- **Low-income subsidies and their impact on copayments, deductibles, and premiums, and calculating amounts owed to EBD**

  Medicare beneficiaries who have limited income and resources may qualify for extra help to pay for prescription drug costs. Recipients of the low income premium subsidy will get help paying for some of the following: their monthly premium, yearly deductible, prescription coinsurance, and copayments with no gap in coverage.

Eligibility for the Low Income Subsidy (LIS) is determined and verified by the Social Security Administration (SSA) for all Medicare Part D members. Beneficiaries may fall into two potential LIS categories: full subsidy eligible and partial subsidy eligible. Full subsidy eligible beneficiaries have income below 135% of the federal poverty level based on family size and fit under an asset guideline. These beneficiaries automatically qualify and are enrolled in LIS. Partial subsidy eligible beneficiaries have an income below 150% of the federal poverty level based on family size, and also fit under an asset guideline. Partial subsidy eligible beneficiaries must apply to SSA or their state of residence to determine LIS qualification and entitlement level. All beneficiaries must continue to apply separately to us for their Medicare Part D coverage.

Some individuals automatically qualify for the low-income premium subsidy; those individuals include:

- Full benefit dual-eligible (Medicare / Medicaid)
- Supplemental Security Income (SSI) recipients with Medicare
- Medicare Savings Programs members.

As a condition of offering Employer Sponsored Group Health Plans (EGHP), CMS requires that we meet the following requirements for the pass-through of low income premium subsidies:

- Ensure that the premium contributions of retirees eligible for LIS are reduced prior to monies being applied to any premium paid by the employer
- Ensure that enrollee receive credits within 45 days of receiving payment from CMS
- Obtain/retain evidence that the low income premium subsidy has reached the enrollee within the guidelines above.

REIMBURSEMENT PROCESS

At the time of enrollment or change, CMS sends Low Income Subsidy (LIS) eligibility information along with other information on the Transaction Reply Report. This information is updated in our eligibility system. Following enrollment and/or notification of eligibility change, UnitedHealthcare receives a Monthly Membership Report that contains payment information for members. One type of payment received on the report is the Low Income Premium Subsidy (LIPS). The LIPS analyst utilizes the Monthly Membership Report to complete the LIPS reconciliation with the eligibility system and to issue the LIPS refund to the appropriate recipient within the required 45 days allowed by CMS.

The following determines who receives additional monies if any credits are identified:

- Any credit that CMS passed through that is beyond the Medicare Part D premium is refunded back to CMS.
- If the credit on the Monthly Membership Report belongs to a member enrolled in a zero premium plan, the monies are refunded back to CMS.
- If EBD fully subsidizes their population's Medicare Part D premiums, and UnitedHealthcare confirms this via their written attestation, the monies can be distributed to EBD, or in some cases to the member. The amount due to the member is determined

by comparing the rate billed, the low- income premium subsidy credit provided on the rate prior to billing and the credit amount indicated on the monthly membership report.

EBD can complete the UnitedHealthcare LIPS attestation stating that they are paying the full premium (no member collections of premiums from EBD) and they are passing the LIPS payments onto the member. If EBD is group invoiced by our eligibility system, you may request that the monthly invoice reflect the LIS reduction. Alternately, a check will be issued to EBD.

PAYMENT DISTRIBUTION

Checks are released from UnitedHealthcare within 45 days of the Monthly Membership Report. Letters are sent separately from the checks only to the member explaining what check's intent. If EBD is the recipient of the LIPS on behalf of the member, the member would need to inquire about their LIPS refunds with EBD.

The process starts with distribution of a letter containing detailed instructions. Included with the letter is a form listing the following available attestation responses, depending on the payment setup EBD chooses:

- **Fully subsidized plans:** EBD is billed by UnitedHealthcare for the entire premium and does not charge its employees for the premium or for plan administrative costs.
- **Partially subsidized plans:** EBD is billed by UnitedHealthcare for the entire premium and bills their employees for part of the premium or plan administrative costs.
- **Split subsidy plans:** EBD and members are both billed by UnitedHealthcare.
- **Non-subsidized/endorsed plans:** EBD is not financially funding the plan premium (in part or in whole) for anyone in the group.

LIPS ASSISTANCE TO EBD

Based on the payment setup selected, UnitedHealthcare can provide a plan to assist with the LIPS refund process.

EBD REQUIREMENTS

Employer attestation is a critical component toward satisfying regulatory requirements regarding the issuing of credits. Employers need to return attestation forms to us that attest to their subsidy practices. The process starts with distribution of a letter containing detailed

UnitedHealthcare will plan and facilitate on- or off-site meetings and work with the State benefits staff to ensure the best possible communication strategy is presented. This includes in-person meetings in each county in Arkansas. While print and electronic materials are an important part of any communication strategy, we know retirees deeply value direct human interaction. We will work with EBD staff on member communications and summer education meetings and fall open enrollment meetings during the kick-off meeting. We will factor in details specific to EBD, such as the open enrollment period, the number of eligible members, retiree demographics, the number of meetings and the types of communications materials to ensure the best possible communication strategy.

We will provide full support to EBD for summer education meetings, fall open enrollment meetings, on-site educational events, and health fairs. Our Group Retiree open enrollment team is dedicated exclusively to handling open enrollment and education meetings. This team will schedule locations for the State education/open enrollment meetings in partnership with the State. We ensure these meetings are retiree friendly and include few or no steps, amps for wheelchairs, elevators to upper floors and adequate parking at close distances. UnitedHealthcare representatives will lead and conduct enrollment meetings with a formal presentation. Materials distributed at the meeting can include a description of the program, benefit summaries and instructions on how to enroll. These services are all provided at no additional cost to EBD.

UnitedHealthcare will mail, via surface mail, a member ID card to all members at least ten (10) business days before the ”go-live” date based on the information confirmation from CMS. Confirmed. We meet CMS guidelines and ensure that members have received their ID cards at their home mailing address within 10 days of receiving CMS approval Transaction Reply Report (TRR).

UnitedHealthcare will re-issue, at no additional cost, the member ID card within five (5) business days of notice if a member reports a lost card or for any reason that results in a change to the information disclosed on the member ID card. In addition, we will issue new valid, accurate ID cards as required by EBD. Confirmed.

MA-PD PPO Staffing Plan

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STAFFING PLAN

ON SITE MEMBER SERVICE REPRESENTATIVES

UnitedHealthcare will provide two (2) full-time, dedicated employees to work onsite at the EBD office in Little Rock to serve as member service representatives. The on-site Service Account Managers (SAMs) will work as Member Service representatives for medical and pharmacy issues during open enrollment, implementation and post enrollment. The SAMs will be experts on EBD Group Medicare Advantage plan offering and UnitedHealthcare processes, serving as a direct line for questions from the EBD management staff as well as providing coaching for member questions or escalated issues. Our SAMs become a true extension of the EBD staff providing invaluable and valued support.

The UnitedHealthcare member service representatives will provide, at minimum, the following services:

- **Answer member service calls (consistent with the responsibilities of other member service representatives not on-site)**

  Confirmed.

- **Respond to member walk-in inquiries**

  Confirmed.

- **Work with EBD staff to resolve claim and member issues**

  Confirmed

The SAM's have detailed knowledge of the plan benefits and will have expertise in timely resolving complex pharmacy and medical claims issues.

The on-site SAMs will be subject to a background check at EBD's discretion and will pass the background check prior to performing services under a resulting contract.

UnitedHealthcare has extensive experience providing service account managers (SAMs) to support our public sector customers. We select them from a pool of candidates that possess strong knowledge of insurance as a whole and the skillset needed to meet the expectations of both members and customers.

UnitedHealthcare Retiree Solutions provides a training curriculum to our Service Account Managers (SAMs) so that they are knowledgeable about all facets of EBD's benefits and are prepared to service EBD according to our best practices and overall organizational mission. The SAM training curriculum consists of several instructor led courses and self-guided courses related to Medicare products offered by UnitedHealthcare and related to operational areas within the organization that are relevant to inquiry resolution. In addition, we incorporate customer care training, sensitivity training and State of Arkansas -specific training (including culture training). The training takes place over a course of six to nine weeks. During and after training, a tenured SAM is assigned as a mentor. Our mentorship program is designed to provide an ongoing, one-on-one training experience tailored to the individual SAM's needs.

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Member Services

UnitedHealthcare will provide an Arkansas-specific website and mobile application for members to access plan specific information. The website will include provider and pharmacy directories (or look-up functions) and the drug formulary, as well as plan documents sent to all members such as Evidence of Coverage documents and Annual Notice of Change documents. In addition, the website will comply with all state, federal, HIPAA, and CMS laws, rules, and regulations.

Our retiree-focused website, **retiree.uhc.com,** provides various tools to support shared healthcare decisions. These tools are specifically designed to aid seniors and educate them on the costs and quality of plan services available to them. Our website is designed with retirees in mind and provides easy-to-read access, including larger font and logical categories of topics to make researching options simple.

Member Website Capabilities

- Provider directory and provider search (physician, hospital, pharmacy, and ancillary providers) for Providers that accept Medicare assignment)
- Directions to provider's office provided by Google Maps or other mapping/direction applications
- Ability to make a doctor's appointment online
- Ability to review claims payment status online
- Ability to review a history of claims payments (medical and pharmacy), including deductible status, and out-of-pocket maximum status
- Ability to see a summary of EBD's plan design and review the EOC
- Ability to print ID cards and request replacement cards
- Ability to contact Member Services online
- Star Ratings
- Information about diseases and conditions
- Contact information for EBD, its other vendors, and links to their websites
- Online access to forms
- Up to date EBD-specific formularies with tier rankings
- Ability to review/select incentives (i.e., gift cards) when they are available to the member.
- Access to Wellness Resources

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Health Risk Assessment Tool

The Health Risk Assessment is a proprietary tool used to assess the member's medical conditions, including chronic conditions, medications, general health, utilization, mental health, and the need for psychosocial services or help at home. The Health Risk Assessment is a tool used to meet the initial assessment requirement for CMS. Health Risk Assessment responses are evaluated electronically, and a score is assigned. Data from the Health Risk Assessment, in combination with our predictive model scoring, identifies those at highest risk for hospital admission and places them in the case management queue for outreach.

Health and wellness/Health Promotion & Health Education Tools

The member website provides health care information to help members make better health care choices and assist in self-management of chronic conditions. Topics include: heart disease, heart failure, COPD, kidney dialysis, diabetes, depression, prescription drugs, falls, use of cane/walker, caregiver needs, engaging a care manager, hospitalization and memory loss. On the website, we also provide physical, behavioral health and wellness information.

Through extensive online resources, we help members achieve healthier lifestyles with senior-friendly information on topics such as aging, relationship building and dealing with life challenges. Members can complete engaging action items that include answering questions, reading articles about a relevant health topic, watching videos, using online tools, completing recommended screenings for their age and gender, visiting a doctor, tracking activity and more. The site also features valuable interactive programs, including:

- Symptom checkers
- Tools, quizzes and calculators
- Drug interactions monitor
- Nutrition and exercise planning programs

Examples of tools include:

- Healthy Weight Tools
- Find Your Body Mass Index (BMI)
- Self-care Tools
- Headache Log
- Sleep Log
- Symptom Checker
- Health Quizzes
- Prescription Drug Tools
- Drug Interaction Checker

- Drug Comparison Tool
- Reading articles and viewing images on diseases, conditions, symptoms, injuries, nutrition and other preventative health topics on the Health and Wellness section of our site
- Accessing patient education write-ups about prescriptions, over-the-counter medications, vitamins and supplements via the Drug Guide

UnitedHealthcare will provide dedicated information support via email, toll-free telephone help line, and direct chat to members from 8:00 am to 5:00 pm, Central Time.

- **Member service staff will be English-speaking and fully trained to answer questions from EBD's members.**
- **Toll-free telephone help line will provide features for the hearing impaired and resources to assist non-English speaking callers**.

UnitedHealthcare's Group Medicare Advantage member service team addresses a member's needs in one place, with one call. Members can receive sensitive educational coaching and plan information, seek decision support, request problem resolution, and gain access to the full breadth of plan benefits, programs and services. We are also especially committed to the use of plain language in both verbal and written communications. Our member service advocates are sensitive to the needs of adults with special needs, hearing and visual impairments, non-English speakers, and those from a wide range of cultural backgrounds.

In addition, the Advocate4Me member services program is designed to create a better member experience, help members take charge of, and make better decisions about, their health care.

In order to accomplish this, our Advocate4Me program does the following:

- Simplify the Member Experience. Connect members through a single toll-free number to a trusted advocate who helps them get the most out of their benefits, obtain the best care, avoid surprises and save time and money.
- Personalize the Member Experience. Use our position as a member's health insurer to provide information relevant to each member's unique health situation, anticipate the member's health care needs, and respond to benefits or claims issues using the data and history unique to each individual.
- Demonstrate Care for Members. Three tiers of advocates are accountable for compassionately connecting consumers with the resources they need to reach optimal health and save money.
- All member service advocates reside in the United States.

UnitedHealthcare advocates for State of Arkansas are available via a dedicated toll-free number from 8 a.m. to 8 p.m. in all U.S. time zones, Monday through Friday with the exception of the following holidays:

- New Year's Day
- Memorial Day

- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

All of our lines are available to take a Telecommunication Device for the Deaf (TDD) hearing impaired call.

UnitedHealthcare will provide a twenty-four (24) hour, seven (7) day/week toll-free eligibility and pre- certification services telephone number.

- **Member service staff will be English-speaking and fully trained to answer questions from EBD's members.**
- **Toll-free telephone help line will provide features for the hearing impaired and resources to assist non-English speaking callers.**

We provide a toll-free number exclusively for physicians and other health care professionals. With this number, they can quickly obtain authorization of services, network information, contract information, news about our health plans, claim status, claim filing and eligibility information. The provider resolution specialists will work with providers and internal resources to answer claims questions and concerns. Providers can obtain benefits and eligibility, claims status, care notifications and a variety of other professional services using our automated toll-free United Voice Portal. In addition, providers may use the self-service options via the IVR to access and verify eligibility, or they can access information online via the provider web portal at **www.uhcprovider.com.**

UnitedHealthcare will provide a warm or soft transfer members to other service areas, including EBD, as needed. Members will be able to opt out of the Interactive Voice Response (IVR) to speak with a live member service representative. Our advocates are able to complete warm transfers to a customer's group benefits center or to a benefits/enrollment/eligibility vendor representing a customer.

Warm transfers allow us to create a positive member experience when callers are in need of speaking to another department or third-party. To create this experience, our advocates complete the following:

- Proactively offer to assist the caller with any other questions prior to the warm transfer
- Provide the caller with the third-party party or internal department's telephone number for future use, when applicable.
- The member and third-party party or internal department are introduced by the advocate
- We take ownership of clearly defining the issue and ensure the member is in the right place
- Should we need to remain on the line to further assist, the advocate will do so

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UnitedHealth will provide designated clinical managers to EBD for both medical and pharmacy programs, who will have full knowledge of all clinical programs in effect as well as all clinical programs offered. Our clinical and medical management team grows in proportion to our membership and in 2022 our dedicated Arkansas team currently includes.

- Market medical director dedicated to Arkansas.
- For our proprietary HouseCalls program team we have 20 full time nurse practitioners located in Arkansas.
- In-home Palliative Care program: There are 14 staff members who reside in Arkansas.
- There are 14 registered nurses who provide remote coverage of inpatient care management for the Medicare Advantage members across Arkansas.
- There are 11 care coordinators consisting of registered nurses, physical therapists, occupational therapists and cross-market telephonic support, who coordinate care for Medicare Advantage members in skilled nursing facilities across Arkansas. Additionally, we have 6 pre-certification coordinators who support Arkansas members.

We have 43 nurses that provide case and disease management support for members in Arkansas and have the proper endorsements through Nurse License Compact.

- A national medical management team fully dedicated to Group Medicare Advantage retiree groups, which consists of board-certified geriatricians, hospice and palliative care providers, geriatric nurses and nurse practitioners and clinical Part D pharmacists
- Over 200 collective years of geriatric medicine and nursing experience

MA-PD Communications and Outreach Plan

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COMMUNICATIONS AND OUTREACH PLAN

UnitedHealthcare will develop and implement communication plans and materials for the MA-PD PPO Plan that include, at minimum:

- **Open Enrollment campaigns to assist members in learning about their benefit options**

  Confirmed.

- **Notification letters to members and their prescribing physicians of drug formulary changes or other changes where there is a negative impact on the member at no additional fee.**

  Confirmed.

- **Letters must be sent at least sixty (60) days prior to effective date of change**

  Confirmed.

- **On-site, Statewide educational sessions for EBD's Medicare-eligible retirees and Medicare-eligible dependents of retirees prior to and throughout Open Enrollment**

  Confirmed.

- **All other items required by CMS**

  Confirmed.

UnitedHealthcare will provide an opportunity for EBD to review and approve all communication materials (including letters, brochures, electronic, website, etc.) prior to being sent to members and providers. Communication materials will include all CMS-related communications, even if edits are not allowed by CMS. We can accommodate review and approval of all materials. All communications are reviewed by UnitedHealthcare subject matter experts to ensure that they meet UnitedHealthcare legal and CMS requirements.

UnitedHealthcare will effectively communicate with and educate EBD's retirees about programs and services available to them. UnitedHealthcare has been educating retirees and assisting them in selecting Medicare Advantage plans since 1982. We have a robust communication cycle that uses a blend of non-required, educational and regulatory-required materials to educate, engage and help retirees make the most out of their benefits. The Centers for Medicare and Medicaid Services (CMS) regulates the information that can be sent to retirees/members and requires the use of model documents for many communications.

To supplement these required regulatory communications, UnitedHealthcare has created educational content and materials that are provided along with the required communications to help ensure prospective members understand their new plan. Each year we evaluate the content design, font size, images and icons, color and use of plain language to ensure our messages are clear and easy to understand. We can accommodate client review and approval of all annual (pre-enrollment- Plan Guide and the post- enrollment-Quick Start Guide) materials.

The UnitedHealthcare team (Communications, Implementation and Account Management) will work with EBD to define a communication plan and review process. We will leverage our best practices, developed through our work with other state clients, but will refine the strategy to meet EBD retirees needs.

MA-PD Communications and Outreach Plan

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Our retiree experience approach includes both pre-enrollment and post-enrollment communication. Listed below are Group Medicare Advantage PPO communication touchpoints:

PRE-ENROLLMENT

During this phase, the focus is to ensure retirees have a smooth transition from their previous plan to their new UnitedHealthcare plan. This begins with an announcement letter from EBD that introduces the change to Group Medicare Advantage PPO, describes UnitedHealthcare's role and notifies retirees on what to expect in the coming months. We will partner with EBD to make sure key messages are included and resonate with EBD retirees.

We will coordinate with EBD to make certain the UnitedHealthcare pre-enrollment website and UnitedHealthcare Group Medicare Advantage Call Center are ready to support Arkansas State Employees (ASE) and Public School Employees (PSE) prior to the plan details being communicated to them.
Next, retirees will receive a pre-enrollment Plan Guide from UnitedHealthcare that provides information about the new Group Medicare Advantage PPO plan. This Plan Guide is a combination of educational content, as well as regulatory documents that CMS requires, we provide prior to the retiree's enrollment in the plan.

The UnitedHealthcare team will work to define and establish a Summer Education meeting schedule and a fall Open Enrollment meeting schedule with the EBD's collaboration and approval. We will support in-person meetings by creating meeting invitations, open enrollment presentations and ensuring that appropriate support materials (signage, brochures, fliers etc.) are available. We also offer virtual meetings via teleconference or webinar to support retirees in that prefer to engage and learn about the plan from the comfort of their home. Virtual meetings are an effective way to deliver information about the plan and provide an opportunity for retirees to ask general questions.

Throughout the transition, retirees will have access to our Virtual Education Center (VEC) This is a good resource for retirees and for those that are helping them with their health care to learn more about the new plan. The VEC will continue to be available to retirees after enrolling in the plan. Examples of the virtual booths are:

- How the Plan Works
- Telephonic and Virtual Visits
- HouseCalls (In-home visits)
- Health and Wellness
- Clinical Resources Support

UnitedHealthcare is prepared to send out notification letters of formulary changes or other changes.

In addition, to ensure retirees have a smooth transition, we will also be reaching out to the providers EBD retirees currently see to make sure they understand how the UnitedHealthcare Group Medicare (PPO) plan works. We will deploy our industry-leading provider education and outreach strategy not only in the State of Arkansas, but in every city where your retirees reside. This five-pillar strategy is inclusive of in person or virtual provider meetings, telephonic and mailing campaigns, and provider expos and town halls- all geared towards ensuring that members have near universal access nationwide. This education outreach strategy is contractual status agnostic; with a strategic focus on out-of-network providers. Further, we have a dedicated call center whose sole focus is outreach and education to out-of-network providers to support access for your retirees. This breadth and depth of provider education minimizes both member and provider abrasion and disruption.

We base our out-of-network strategy on your retirees' experience as evidenced in the provider claims data provided by EBD. We will provide status updates on a cadenced basis that we mutually determine during the Implementation phase.

POST-ENROLLMENT

Once retirees are enrolled into the new plan, we send out our "Welcome" communication; the UnitedHealthcare Quick Start Guide. This guide contains educational information to assist the member as they begin using the programs and services included in the plan and instructs them on how to access plan materials online (such as the Evidence of Coverage or directories) and CMS required language. Their new member ID card is affixed to the front of the guide.

To ensure new members understand their plan, the programs and services included and to answer any questions they may have, we reach out to them with a "New Member Just Checking In" call. This call is an opportunity to establish a positive and partnering relationship with the new member. As part of the call, we:

- Thank them for being a part of the plan and ask if they have any questions or concerns.
- Discuss plan/provider network information.
- Assist with scheduling annual wellness/physicals and/or HouseCalls visits.
- Identify individuals who would benefit from our clinical programs.

Throughout the year, members will receive communications designed to help them understand and take full advantage of their plan. For example, we send health and wellness reminders to encourage all members to schedule an Annual Wellness Visit with their physician as well as other important preventive screenings.

In the autumn, all Medicare Advantage members receive an Annual Notice of Changes (ANOC.) This is a CMS-required document that informs retirees of any changes that are happening within Medicare and/or their plan for the upcoming plan year.

Our member website is a great resource for health and wellness information. The website includes practical and personalized tools to help members manage and budget for their health care expenses. It also provides members with access to claims and health information. Members are able to register prior to their effective date, once they have received their member ID card.

Data Security and Disaster Recovery Plan

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DATA SECURITY AND DISASTER RECOVERY PLAN

UnitedHealthcare recognizes and acknowledges that the protection of assets and business operations is a major responsibility to its employees, customers and other communities that we service. Therefore, it is company policy that business continuity and disaster recovery plans must be developed, tested, and maintained in order to limit losses caused by disruptions to critical business operations and to enable efficient and effective recovery. Our Enterprise Resiliency & Response Plan minimizes customer impact from disrupted service in a significant event or disaster, while aiding compliance to published regulatory guidelines. Our plans are developed to address cyber security protection and includes policies and procedures related to any work performed under this contract.

Our policies include the following:

- **Information on privacy policies, terms of use protections and any other terms related to cyber security protection, that applies to how UnitedHealthcare uses and transfers data, including via websites and online portals.**
- **Information security policies and procedures related to the systems, processes, and personnel directly related to the work included in this contract.**
- **Operational and system redundancy and disaster recovery procedures to ensure disruption-free services under a resulting contract.**

SUPPORTING DOCUMENTATION:

- Enterprise Resiliency & Response Program Overview
- Information Security Policy Summary

Our plans details may be viewed in a controlled environment with our subject matter experts, who will be made available to answer questions. This policy is in place to protect not only our operations and our employees, but also the security, integrity and confidentiality of protected information.

UNITEDHEALTH GROUP®

Enterprise Resiliency & Response Program Customer Overview

January 1, 2022

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Section I – Enterprise Resiliency & Response Overview

Background

The purpose of this document is to demonstrate how the Enterprise Resiliency & Response Program, with the interrelated services of event management, site emergency planning, business continuity planning, disaster recovery planning, and response to events impacting public health and pandemics, are designed to ensure we can react quickly to all forms of disasters, minimizing potential negative impacts to our operations and vital services.

The company has an Enterprise Resiliency & Response Program (the Program) that minimizes customer impact from disrupted service in a significant event or disaster, while aiding compliance to published regulatory guidelines.

The Program helps prevent and/or mitigate the impact of events that could disrupt our business by containing the impact within a predictable and predetermined period of time. Effective business continuity planning establishes the basis from which business processes and operations, including service to customers, are resumed.

We have business contingency planning preventative controls, contingency resources, and procedures administered by a formal internal management organization. In addition, we have developed a contingency process that minimizes customer impact from disrupted service during an event while aiding compliance to published regulatory guidelines.

Mission Statement

The mission of the Program is to:

- Provide for the safety of our employees in the event of a business disruption or disaster
- Demonstrate our consumer-focus and service excellence when our customers and members are vulnerable after an event
- Minimize service disruptions
- Meet customer and other stakeholder expectations
- Preserve customer information
- Protect and preserve organizational assets, including people, process, technology and information
- Comply with laws and regulations regarding the continuity of operations
- Enhance our competitive position, market share and reputation

This mission can only be achieved through management and control of business impact and risk; therefore, the program focuses on designated critical operations and sites. The level of business continuity safeguards is based on the business impact of the business segment's critical operations, sites, assets, and their inherent vulnerabilities.

Policy

The company recognizes and acknowledges that the protection of its assets and business operations is a major responsibility to its employees, shareholders, business associations, customers and other communities that it services. Therefore, it is company policy that business continuity and disaster recovery plans must be developed, tested, and maintained in order to limit losses caused by disruptions to critical business operations and to enable efficient and effective recovery. The Program includes

processes and controls to protect the company's businesses, the life and safety of workforce members, as well as to protect the image, reputation, assets, and resources of the organization.

Objective

The objectives of the Program are to continue to serve customers, minimize financial loss to the organization, and minimize the negative effects disruptions can have on strategic plans, reputation, operations, liquidity, credit quality, market position and ability to remain in compliance with applicable laws and regulations. Changing business processes, internally to the organization and externally among interdependent vendors and partners, and new threat scenarios require updated and viable business continuity plans.

In order to carry out the Program mission, the company has adopted a business continuity strategy to address the key business interruption risks that stem from the deployment and use of our people, processes, technology and financial assets in carrying out the day-to-day business operations. This strategy focuses on our critical business functions and planning for the worst-case scenario so that we can react quickly and efficiently, adding value to our business and customers through effective risk reduction, compliance with industry, contractual or regulatory standards, and safeguarding of our operations and assets. This worst-case scenario covers all forms of events, both natural and human-caused (e.g., hurricane, flood, fire, terrorism, public health emergencies, pandemics, etc.).

Program Strategy

The Program strategy requires that the ownership, responsibility and accountability for business continuity planning reside at the segment business operations level while providing for governance, standardization, and oversight at the enterprise level. This program encompasses a “layered” approach to continuity planning, which recognizes that risks to our business operations are inherent individually and to the environment as a whole due to the interdependent nature of our operations. Therefore, the continuity strategy is an appropriate combination of safeguards within our operations that work together to address inter-segment dependencies and meet the business continuity requirements of the segments individually, as well as the enterprise as a whole. Risk assessment, organizational accountabilities, governance and metrics are the foundational components of the Program and layered approach.

The Program integrates the appropriate levels of skills and required activities across all business operations. The level of business continuity safeguards required is based on the business impact of the critical operations, sites, assets and their inherent vulnerabilities.

Internal and external factors continually change business processes as well as risks, so the Program also includes lifecycle maintenance, testing and third-party validation.

The Program strategy integrates core planning assumptions in plan development. They are:

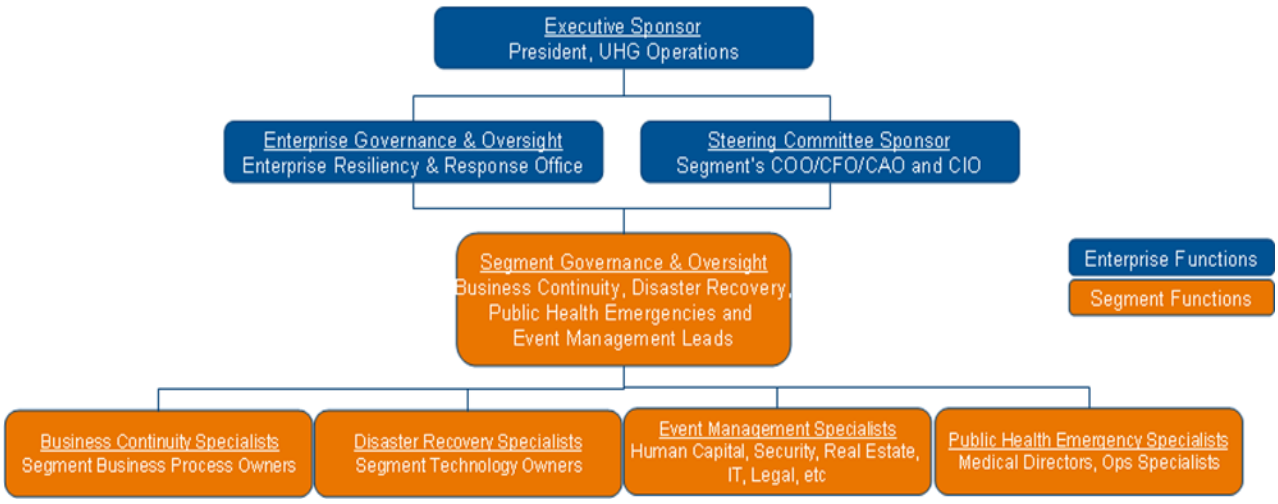
- The event which prompted the recovery process affects only internal business function(s) and/or site(s). Certain other public services infrastructure (fire, ambulance, police, etc.) remain intact.
- Worst-case scenario is total disruption. If the actual event is not worse-case scenario, procedures will be modified within the appropriate strategies to only cover the critical business function(s) and processes affected by an event.
- Up to 50% of the function’s staff at a particular site may be unavailable for work following an event. The event may affect multiple sites within a regional area.
- The off-site storage location is unaffected by the event since geographical proximity and accessibility were considered in site selection which minimizes the potential for the same event impacting both locations.
- Operating efficiency will be reduced during the recovery and stabilization periods. Processing will take longer and/or there may be greater instances of human error during survival-mode operation of the business function(s).

The Layered Program Model

The layered Program model is focused on ensuring consistency between the organization's event management, site emergency response, corporate security, business continuity, disaster recovery and public health emergency planning efforts. These layers are interrelated and work together to provide maximum protection and risk mitigation. The model is built upon the following key components:

Organizational Accountabilities and Governance

The Program is implemented through an organization structure that requires active participation among all business stakeholders; including technology and business operations. The Enterprise Resiliency & Response Office together with the Enterprise Disaster Recovery organization and the Enterprise Resiliency & Response Steering Committee, comprised of corporate and segment executives, have the responsibility for defining the recovery project initiatives, oversight and support of the program which is in compliance with regulatory guidelines and customer expectations. Through the Program, the segments have responsibility and accountability to sustain the organization's capacity and readiness to manage an event through to resolution.



Section II - Event Management Plan

Event Management Strategy

Effectively managing a disruptive situation through to resolution in a large organization requires more rapid decision-making and communication process than is used for normal day-to-day business operations. As a result, the Event Management Plan outlines the management organization (Event Management Team) and communication process to be utilized to facilitate a timely response to events affecting our personnel, business operations, and site locations, with the goal of avoiding or minimizing damage to the organization's ability to serve patients, members, customers and key stakeholders.

This plan identifies the Event Management Team (EMT) and outlines their key roles and responsibilities. The EMT is collectively responsible for managing the situation and making the critical decisions that drive remediation and coordination with various internal and external stakeholders as determined by the nature of the event and the short- and long-term impact on the organization. The EMT also supports execution of the event management decisions and provides central coordination of communications, resources, personnel, issues, and other information through the notification and response phases of event management.

The event management plan has been established to provide a framework to facilitate the effective response and recovery of an event. This plan provides the structure for:

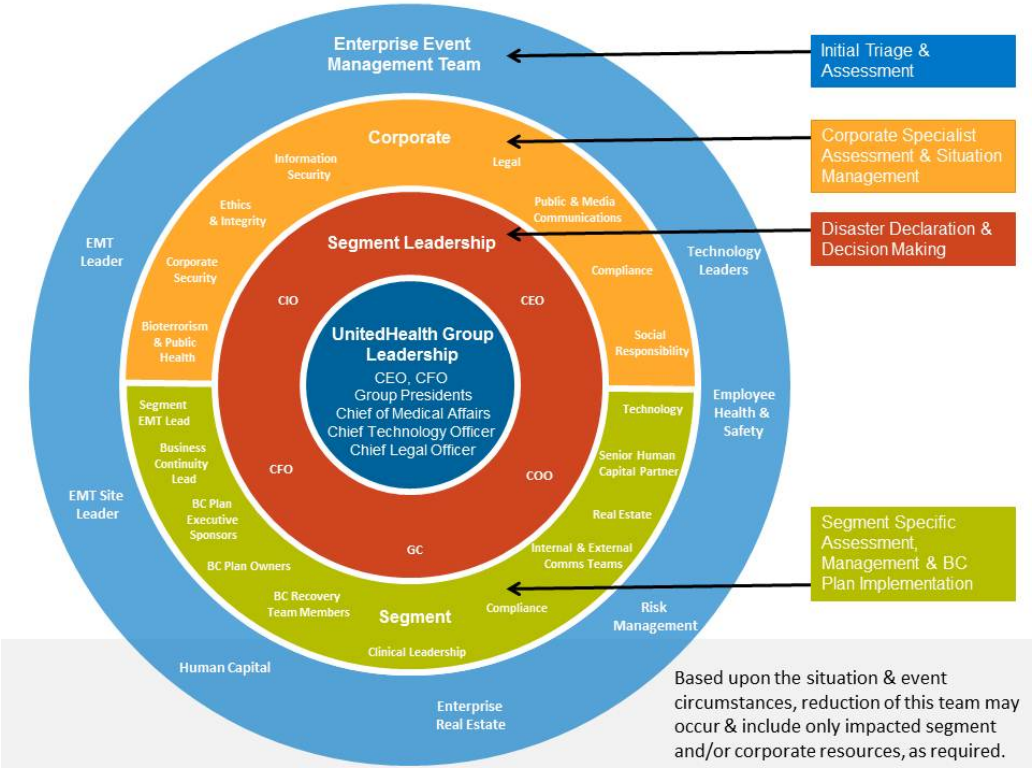
- the Event Management Team.
- Event Management process, including identification, escalation, notification and response channels as well as roles and responsibilities of the EMT.
- Established standards and checklist for the Event Management Team, including, but not limited to: command center activation; damage assessment of people, information and property; risk management and safety; technology impact and response; and, employee, media and customer communications.
- Disaster declaration standards.

Event Management Team

The primary purpose of the Event Management Team is to provide a consistent and reliable approach for communication and engagement between all required parties necessary to manage an event. Subject

matter experts, both at the corporate and segment level, continue to manage actions within their functional teams, however, will leverage the Event Management Team as a forum to more quickly and reliably engage, communicate and make decisions between teams. The Event Management Team:

- Consists of corporate and segment leadership with responsibility for event communication and response execution.
- Engages required executive leadership necessary to respond to the event.
- Executes on the decisions made by executive leadership and provides central coordination of communications, resources, personnel, issues, and other information through the notification and response phases of event management.
- Determines the strategy for how an event will be managed effectively and efficiently through to resolution.
- Responsible for facilitating the critical decisions that drive the remediation and coordination efforts with various internal and external stakeholders as determined by the nature of the event and the short- and long-term impact on the organization.
- Comprised of the following functional leaders or appropriate alternatives, as required:



Section III – Site Emergency Response

Site Emergency Response Strategy

To support and facilitate a coordinated and controlled building occupant response in an emergency, company policy requires all offices with over 11 employees (over 10 in the State of California) have a site Emergency Action Plan (EAP). These plans focus on the immediate site needs during an emergency, such as employee evacuation and public services engagement. The company's emergency response team is often the first responder to a situation and help ensure that employees remain safe, sheltered and their basic life/safety needs are met.

Emergency action plans are used in conjunction with the event management process.

Site Emergency Planning Standards

To help ensure consistency and effectiveness, the site Emergency Action Plans are developed using standard tools and templates. The following provides a high-level description of each of the sections contained within the individual site plans:

- Purpose – The purpose of the Emergency Action Plan.
- Location Information – Information pertaining to the physical location including building address and primary contact phone numbers.
- Emergency Contact Information – A list of key phone numbers including emergency services, Facilities Management and Security, where applicable.
- Site Emergency Response Team Roles and Responsibilities – Specific roles and responsibilities as defined including Event Management Team Site Lead, Emergency Response Team Site Lead, Security Crisis Response Team Lead, Floor Marshals, and Facilities Management.
- Evacuation Maps: Information pertaining to evacuation routes, exits, emergency shelter areas, designated areas for employees that need assistance to evacuate, location of first aid kits, etc.
- Facility Emergency Information: Includes site specific information such as location of evacuation assembly areas, how employees get notified on emergencies, etc.
- Emergencies that may Result in Business Interruption or Office Closing – Procedures to engage the Event Management Team with communication procedures for domestic and international locations.
- Reporting Procedures:
    - Fire
    - One Breath Situations (Human Capital)
    - Workplace Fraud, Theft or Violence etc. (Corporate Security)
    - Utility Outages, Water leaks, Property Damage etc. (Facility Management/Facility Service Center)
- General high-level guidelines on hazard specific procedures such as medical emergencies, severe weather, fire, hazardous materials exposures, or release etc.

Lifecycle Maintenance

Change Management and Update Process

In order to maintain an effective Program, site Emergency Action Plans are reviewed and updated, as needed or at least annually by the Emergency Response Team (ERT) Site Lead and monitored for compliance by the Environmental Health & Safety Department.

Testing

The site Emergency Action Plans are tested at a minimum annually through drill techniques including fire, severe weather and/or earthquake. Drills may include tabletop (practical or simulated exercise), structured walk-through (functional), and/or large or full-scale (live or real-life exercise).

Section IV - Business Continuity Planning

Risk Assessment & Management

Business continuity planning requirements are driven by a business impact analysis, supporting the company's Enterprise Risk Management discipline as an integral part of our culture, decision-making processes, and governance processes. The business impact analysis, combined with threat and risk assessments, helps assure that business continuity risks are appropriately prioritized and remediated by applying cost effective strategies and mechanisms to reduce risk to a tolerable level. The enterprise business impact analysis process:

- Identifies potential impact of uncontrolled, nonspecific events on business processes and customers;
- Considers all business segment functions; and
- Provides an estimation of maximum allowable downtime and acceptable levels of data and operational loss.

Each critical function is required to perform a risk assessment utilizing the business impact analysis, threat and vulnerability assessment, and gap analysis of business continuity mechanisms currently in place. The result of this risk assessment is a segment commitment to reduce risk to an acceptable level within reasonable resource and budgetary constraints.

This risk-based approach further optimizes business continuity planning by creating common definitions, defining standards and best practices and using common recovery strategies to meet the business requirements.

Business Continuity Plan Strategy

The business continuity plans are part of the overall program designed and structured to respond to disaster events, restore critical business function processes, and resume normal business function operations in a prioritized manner. The plans focus on critical business functions and planning for the worst-case scenarios so that we can react quickly and efficiently. These worst-case scenarios cover impacts from all types of events, both natural and human-caused.

The following scenarios are provided as planning recovery objectives:

- Loss of Facility - Complete interruption of facilities without access to its equipment, local data and content. The interruption may impact a single site or multiple sites in a geographic region. Recovery from anything less than complete interruption will be achieved by using appropriate portions of the Plan.
- Loss of Critical People - Complete interruption with 100% loss of personnel within the first 24 hours and 50% loss of personnel long-term. The interruption may impact a single site or multiple sites in a geographic area. Recovery from anything less than complete interruption will be achieved by using appropriate portions of the Plan.
- Loss of Critical Systems - Complete interruption and/or access of critical systems and data located at the various Data Centers for an extended period of time. Recovery from anything less than complete interruption will be achieved by using appropriate portions of the Plan.

- Loss of Critical Vendors - Complete interruption in a service or supply provided by a third-party vendor(s). Recovery from anything less than complete interruption will be achieved by using appropriate portions of the plan.

Having clearly defined the business recovery objectives, our teams developed recovery strategies needed to meet these objectives. These recovery strategies vary between Business Segment and the overall criticality rating of the business function or process, which in turn provides guidance on a minimum recovery time objective.

Business functions which are classified as critical generally provide for near immediate failover of core services by leveraging geographically dispersed redundant operations and maintain a recovery time objective of 72 hours or less. Critical business functions include, but not limited to, healthcare delivery, customer and provider call services, claims processing services, clinical and pharmaceutical services, banking operations and core corporate functions.

A variety of business continuity strategies are deployed depending on the business function, criticality ranking and established recovery time objectives. These strategies include:

- Resilient operations - include dual site operations and continuous availability solutions. In the event of an interruption at one site the business function is transferred to one or more alternate locations at which staff and facilities are already prepared to handle it.
- Remote working - includes the concept of “working from home or telecommuting” and working from other non-corporate locations through secured connections.
- Multiple shifts – makes alternate space available to greater number of staff by dividing staff into two shifts (e.g., morning and evening).
- Buddy up - makes use of existing in-company accommodation such as a training facility or lunchrooms to provide recovery space or increasing the office density.
- Off-loading – consists of off-loading additional critical tasks to staff at available sites or staff cross-trained to perform that function.
- Displacement - involves displacing workspace used by staff performing less urgent business processes with staff performing a higher priority activity.
- A “do nothing” strategy may be acceptable for certain non-urgent functions identified in the business impact assessment.

Business Continuity Program Development Standards

To help ensure consistency and effectiveness, the business continuity plans are developed using standard tools and templates. The following provides a high-level description of each of the sections contained within the individual business continuity plans:

Plan Intro, Plan Overview and Plan Scenarios

- Standards for document use, intended audience, plan availability and distribution.
- Life-cycle maintenance, review and updated procedures and budget guidelines.
- Plan Scenarios used in writing the plan and internal and external communication standards

Business Recovery Overview

- Business overview, plan objectives, regulatory timeframes, performance guarantees, service level agreements
- Defines the recovery checklist, chain of events, critical tasks and detailed steps that need to be taken to stabilize operations in survival-mode and restore the business function processes in order of their criticality.
- Establishes the process for plan evaluation and defines the detailed steps for evaluating the business continuity plan performance to learn from the experience and enhance our business function preparedness and capabilities to respond and recover more effectively and efficiently.

Remaining BC Plan Sections

- Process Details – Provides key impact metrics utilized during prioritization analysis.

- Worst Case Scenario/Recovery Strategies - Uses the results of the business impact analysis to define the business process criticality and prioritization, recovery time objectives, and overall business function recovery strategy. Defines the recovery analysis for loss of critical facility, loss of critical resources, loss of critical system and loss of critical vendor.
- Segment Interdependencies – Defines the business function's critical dependencies on other business functions/processes.
- Critical Applications – Defines the business function's critical dependencies on our systems/applications.
- Recovery Teams – Identifies team members with responsibility to execute and coordinate recovery activities defined in the BC Plan.
- Employee Rosters – Identifies additional team members outside of the recovery team who assist with recovery activities. Rosters also provide a list of individuals with emergency contact information to be notified of an event.
- Locations – Defines the main locations, alternate recovery and command center locations used by the business operations.
- Critical Customers, Regulators and Other Third Parties – Identifies the critical external stakeholders and/or communication process to be used at the time of the event.
- Critical Vendors – Identifies the critical vendors and/or suppliers the business requires to sustain operations.
- Critical Resources – Defines the business function's minimum equipment configuration needed to sustain operations.
- Essential Records – Defines the specific essential records stored offsite, as well as their storage location and contact information to use to retrieve them during a disaster.

Lifecycle Maintenance

Change Management and Update Process

Change is inevitable in any organization. Applications, infrastructure, function alignments, customer, vendors, site and contacts must continually be monitored and updated. In order to maintain an effective Program, business continuity plans are updated a minimum of twice annually and monitored for compliance by the Enterprise Resiliency & Response office.

Metrics and Measurements

The Program metrics and reporting provide status and information necessary to manage current and future efforts. Key performance indicators are used to derive the "health" of the business continuity plans. Annually, each segment is required to provide executive sign-off on the certification of the plans. This reporting is delivered and reviewed by the Program Steering Committee and the Executive Sponsor to help ensure compliance with the Program strategy.

Testing and Certification

The business continuity plans must be tested at a minimum annually through a variety of exercises formats, using scenarios that vary annually. Exercises may include structured walk-throughs, call tree validation, tabletop event simulation, and large or full-scale simulations. The Program uses an exercise roadmap to track what scenarios have been exercised in the past to ensure each exercise introduces a new situation that challenges the recovery team. A formal test exercise report, identifying any gaps, issues and/or enhancements identified through testing, is published and monitored for remediation. When the remediation plan is complete, the plan is certified by the appropriate Executive Leadership. This certification process is monitored by the Program Steering Committee.

Section V - Disaster Recovery Planning

Disaster Recovery Objectives

The company relies on a diverse array of interconnected information systems to meet the needs of its clients. The goal of disaster recovery (DR) planning is to protect the organization in the event that all or key aspects of operations are rendered unusable. Preparedness is the key. The company has instituted an Enterprise Disaster Recovery Program (the Program) to first eliminate or reduce disaster risk in critical technology areas, and then plan for facilitation and the timely and predictable restoration of key applications, data, and supporting critical infrastructure.

The mission of the Program is to minimize the aggregate risk and impact to the company from the occurrence of disaster events, focused on the overall viability of the company to survive an event.

Following are the objectives of the Program that are in support of the mission:

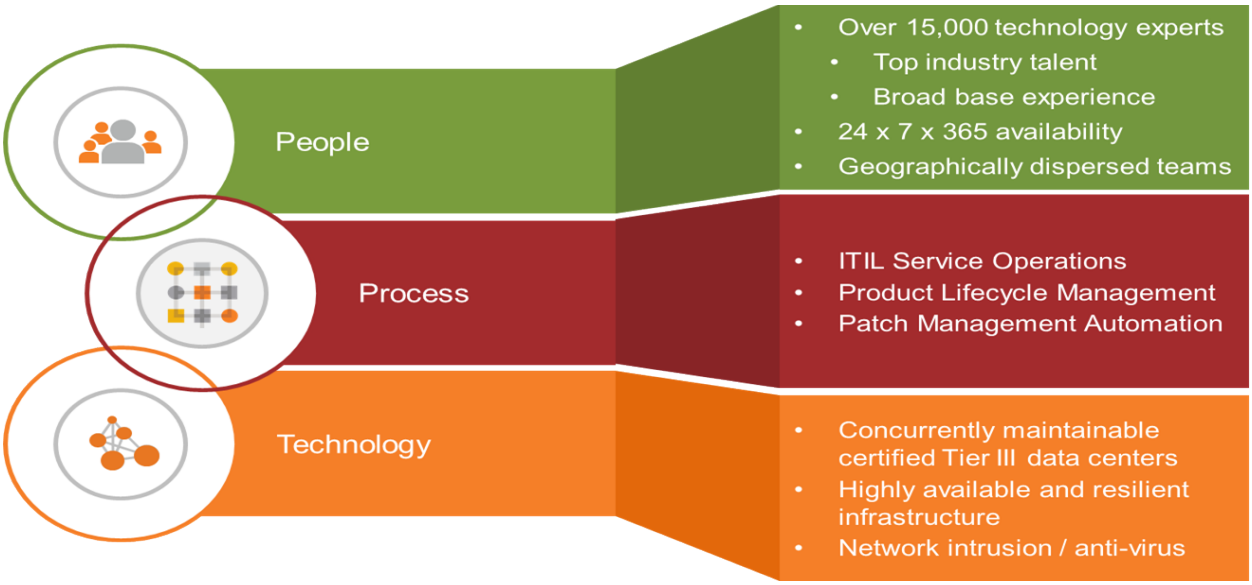
- Provide a “systems solution” that accommodates the interdependencies between business processes and applications (i.e., recover the entire business transaction)
- Drive systemic and measurable improvements in DR capability (e.g., business process Recovery Time Objective (RTO))
- Recognizing funding and time constraints, evolve and improve the DR capability in a manner that provides greatest good for greatest number
- Establish DR requirements as part of our systems architecture, delivery and operations as opposed to an after-thought once a new application goes into production
- Develop and deploy a modular, adaptive set of capabilities rather than one size fits all
- Deal with the most probable DR scenarios in addition to worst case “smoking hole”
- In addition to protecting the company's on-going viability, make the DR capability a competitive strength that can be leveraged in the market.

Disaster Recovery Strategies

The company's approach to DR is based on the two fundamentals: Prevention and Protection. A focus on balancing the combination of disaster prevention and protection results in reducing both the probability and impact of a disaster. The Program first eliminates or reduces disaster risk in critical areas, and then plans for the most probable disaster scenarios.

Prevention

For many companies, disaster recovery means minimizing downtime as they try to restore systems and get them back online. Our strategy includes focusing on items that would assist in preventing a disaster from taking down systems in the first place. The corporation has invested in creating an effective combination of people, process and technology that provides the fundamentals for a proven production method resulting in a stable, scalable environment for our applications to perform at operational excellence. This investment creates the “prevention” which is fundamental to the Program. Prevention is the proactive remediation of known technology exposures. Prevention includes removing the “accidents just waiting to happen”.



Protection

Completely avoiding a technology disaster is impossible. However, the Program is based on anticipating and planning for the common types of disasters and designing solutions to address them. Disaster Protection addresses recovery from the most probable disaster scenarios and a worst case “smoking hole” scenario.

The Program utilizes a variety of recovery strategies which align to the defined criticality of the application. Business critical applications, as defined by the Business Impact Analysis (BIA) and subsequent Business Continuity Plan (BCP), are given the highest priority and generally have a 72 hour or less Recovery Time Objective (RTO).

Highlights of the disaster recovery protection components include:

- Our data centers can operate in a “Lights out” mode for up to 3 days. If the data center continues to get fuel to run the generators, they are designed to run in this mode indefinitely.
- Operational backups are designed to use high performance disk-to-disk primary copy with physical offsite second copy to virtual tape libraries.
- Active-Active recovery designs which utilize two geographically separate data centers with global load balancing where both sites are fully supporting the production application. In the event of the loss of a single datacenter, the application continues to function with no intervention required.
- Active-Standby recovery designs which utilize two geographically separate with one site fully supporting the production application. In the event of the loss of the Active site datacenter, manual intervention is required before the application is returned to service.
- Native Database replication technologies can be utilized depending on the related database technology in either an Active-Standby or Active-Active methodology.
- Mainframe SAN Replication recovery utilizes full asynchronous data replication between the production mainframe and a geographically dispersed hot standby DR mainframe.
- Distributed SAN Replication recovery utilizes full asynchronous data replication of production storage pools for distributed systems (UNIX and Wintel) and failover of production processing to geographically dispersed non-production systems for processing.
- Other storage replication technologies are utilized in specialized areas such as with VMware Site Recovery Manager (SRM) or IBM iSeries replication.
- Some distributed systems employ a Cold recovery solution with failover of production to geographically separate non-production systems utilizing data restoration from virtual tape.

- Each application identified as critical within corporate business continuity plans has a DR Plan that is refreshed at least once each year and tested annually.
- Metrics in the form of Key Risk Indicators (KRIs) are used to derive the "health" of application DR plans.

Our enterprise DR strategy involves identifying critical business processes and transitioning these critical applications, data, and supporting infrastructure to an alternate recovery location in a timely manner, thereby reducing the impact of a technology event to our critical business clients.

Lifecycle Maintenance

Existing DR Plans follow standard lifecycle maintenance and are refreshed at least annually and as changes occur. It is the responsibility of Application Owners and the Enterprise DR Team to ensure Plans are reviewed to identify:

- Equipment updates
- Employee changes (resignations and terminations)
- Changes in business requirements not reflected in specific plans
- Third party preparedness to validate against contractual obligations
- Inaccurate assumptions or oversights

Application DR Plans are approved and certified annually by the appropriate Application Owner with the organization. Failure to complete a new DR Plan on time or complete an annual update of a DR Plan requires that a policy exception be submitted in Optum's Enterprise Governance Risk Compliance system (EGRC) by the Application Owner.

Section VI – Public Health and Pandemic Planning

Objectives

As a health and well-being company, we believe it is critical to plan for events that impact public health, including pandemics and the potential impact to our customers, members, providers and our own operations. Natural disasters such as hurricanes, wildfires and pandemics can expand very quickly and arrive with little or no warning; therefore, companies need to be vigilant and prepared. We recognize the need to provide ongoing access to health care for our members and customers who may be impacted by these events. Pandemics can spread very quickly, so understanding what we need to address in advance, and being prepared to readily implement these actions will help sustain our operations and minimize impact to our customers during a pandemic or other public health event.

The company plans for such public health events within the Enterprise Resiliency & Response Program to ensure the availability of critical services for our customers. Individual business continuity plans require planning for a loss of 50% of personnel, loss of facilities, critical vendors and loss of or disruption to our technology. The Event Management Plan provides the command and control structure to ensure effective monitoring, communication and decision making during the emergency. Information technology Disaster Recovery Plans are in place to manage any impact to technology infrastructure and applications that could negatively affect our ability to serve customers, physicians, members, and others. As a national company with vast local resources, we have geographically dispersed computing, customer service facilities and health care networks that can support and supplement the work of compromised localities.

Where a pandemic involves a virulent strain, we may experience a surge in the need for our services but may simultaneously see a reduction in our ability to provide these services. Therefore, pre-planning is critical to address any adverse impact to our services and systems from anticipated demands. During a pandemic, health services access will likely be altered from the services that are provided now. For example, demand for elective medical and surgical procedures will probably decrease; demand for acute

care services in emergency departments and hospitals will likely increase. Public health officials will have the responsibility of triaging and prioritizing where, when and how health services will be provided.

We work in collaboration with local and state health department officials to disseminate information on the availability of health services and will adhere to the public health direction on prioritization efforts for the provision of such services during public health emergencies. We will use our communication vehicles, including print and electronic media, to make information on provisions and availability of services widely accessible to our members, as well as members of the broader community where we operate.

We are committed to providing our customers, physicians who contract with us, members and others with timely clinical information. We will work to ensure that benefit designs and their interpretation will facilitate socially and medically appropriate access to clinical care, medical supplies, vaccines and pharmaceuticals. For example, we will assure that quantity limits for antiviral medications used to prevent and treat influenza are consistent with recommendations of the Centers for Disease Control and Prevention (CDC).

Clinical Resources

Approach

Established procedures for handling emergency management situations include: initial assessment of the severity of the situation; prioritization of actions needed to resolve the immediate care needs of our members; development of an action plan, which includes assigning resources for implementation; implementation of action plan, including continuous monitoring; documenting successful interventions; and validation of successful intervention.

Our Event Management Team monitors for impending disasters such as those caused by hurricanes and flooding and proactively mobilizes the appropriate planning and response resources to address the needs of our business, members and providers

The Public Health Event Management Team assesses the risk and engages both enterprise-level executives and local Health Plan leadership to mobilize a complete response. Leaders engaged in the response may include Healthplan CEO's, Medical Directors, Provider Services, Member Services, Communication Specialists, Compliance Officers, and others as appropriate. The Public Health Event Management Team convenes to discuss the current situation and defines actions to be taken, resources to be deployed, and specific timeframes and touch points for monitoring to ensure continuous communication and care continuity for members and providers.

Each event is unique, and our response is customized based on need and based on the services provided to members in the impacted area. The following activities may be included as part of our overall efforts:

- Medical benefits may be temporarily modified to assist members preparing for, or responding to, the disaster in order to ease access to healthcare. These actions may include: removing prior authorization/notification requirements, allowing early refills of prescription medication, easing restrictions on use of out-of-network providers and providing early replacement of Durable Medical Equipment (DME).
- The Optum Crisis Counseling line may be made available to the community as a whole to provide mental health support to those who may need it. This service is free of charge and open to anyone impacted by the event.
- Our local clinical directors collaborate to identify members currently hospitalized or at long-term care facilities, evaluate the provider capacity within the geographic area, and where appropriate, identify reassignments and communicate this information to members and providers.
- Our Medical Directors review case management and disease management files to identify members at most risk due to disease severity or fragility. These members are a priority to contact to arrange for care continuity and determine if they need evacuation assistance.

- Post-acute care patients are identified and our care managers ensure adequate supplies and prescriptions medication are available. In the event the member is to be evacuated, appropriate sites and resources are identified that will meet the transportation and ongoing needs of individual.
- We often provide financial support, both proactively to strengthen communities, and as part of our post-disaster community response.
- Employees and local leaders often participate in community recovery and rebuilding efforts as part of our social responsibility efforts to support the communities in which we work.
- Our compliance team proactively searches for any regulatory orders related to the event, such as state-level Executive Orders, Department of Insurance Orders or federal-level HHS or CMS orders, to ensure we are addressing all regulatory requirements.

Section VII - Conclusion

In support of our mission to help people live healthier lives and help the healthcare system work better for everyone, we are committed to providing vital services to our members and community during times of calm as well as crisis. The Enterprise Resiliency & Response Program, with the interrelated services of event management, site emergency planning, business continuity planning, disaster recovery planning, and response to events impacting public health and pandemics , are designed to ensure we can react quickly to all forms as disasters, minimizing potential negative impacts to our operations and vital services.

If additional information is required regarding any component of this program, please direct questions to your account executive team, or regulatory officer.

UnitedHealth Group Policy Summary

UNITEDHEALTH GROUP®

Policy Information			
Policy Title	Enterprise Information Security Policy	**Current Version Publish Date**	01/05/2022
Version	1.0	**Original Effective Date**	12/31/2015
Policy ID	ID-6047		

Policy Applicability			
Country	All UHG Countries	**State/Territory**	All UHG States/Territories
Employee Applicability	All Employees	**UHG Business Applicability**	Enterprise Wide
Contingent Worker (Contractor) Applicability	Contingent Workers (Contractors)	**Market Group**	Corporate
Products Impacted			

Policy Statement and Purpose

Introduction

UnitedHealth Group and Business Organizations, also referred to as ("the Company") requires that appropriate security controls are maintained to protect the confidentiality, integrity, and availability of Company Information, including all non-public information and data about our Workforce, people we serve, and our Company (hereafter referred to as "Company Information"); our Company Information technology systems (including, but not limited to our IT systems, websites, applications, infrastructure, equipment such as telephone, voicemail, pagers, hardware, software, as well as usage of Company Information technology systems and electronic communications such as email, intranet, Internet, and networks, such as topology, protocol, and architecture (hereafter referred jointly as "Company Information technology systems"). This Enterprise Information Security Policy, in conjunction with the Enterprise Information Security Standards, defines the required security controls (collectively the ("Information Security Policy" or "Policy").

Scope

The Policy applies to Company employees and other non-employee workers (such as third-party contractors, service professionals, and temporary staff). For purpose of this Policy, the Company employees and non-employee workers will be collectively referred to as "Workforce" or "Workforce Member" although the use of the term does not establish a labor relationship with the Company. Any reference to "we", "our" "us", or "Company" in this Policy means UnitedHealth Group or the Company with which you work. Specific control requirements are documented in the respective Information Security Standards.

Definitions for key terms used in this Policy are found in the Enterprise Information Security Glossary.

Enforcement

If the Company or a Business Organization determines that a Workforce Member has violated this Policy, the employee may be subject to discipline. Discipline may include warnings, suspension with or without pay, and/or termination of employees. Factors to be considered in assessing disciplinary actions include, but are not limited to: the extent of the violation, the nature of the violation (accidental, inadvertent, or purposeful misconduct), the potential harm or risk created by the disclosure for the individuals whose information was released, the client company or other data source, or the Company, whether the employee self-reported and was forthcoming in the investigation and whether there has been repeated or purposeful misconduct or violations of Company policies and procedures by the employee.

Workforce Members are responsible for promptly raising any concerns about possible violations of this Policy. If a Workforce Member is aware of a situation that he or she believes may be in violation of this Policy or otherwise unlawful, he or she must immediately contact any of the following resources: his or her Company Data Protection Office, Manager, legal representative or Compliance Officer, or the Ethics & Compliance Help Center.

Actual or suspected instances of potential security incidents must be reported to the appropriate Company Security Incident Response function for investigation and follow-up. Contact the Technology Support Center at the appropriate country-specific phone number.

01. Security Program Management

1.1. The Enterprise Information Security Organization has accountability for developing, documenting, maintaining, and communicating a comprehensive Enterprise Information Security Program. The authority and responsibility for managing the Enterprise Information Security Program is delegated to the Company Chief Information Security Officer.

1.2. The mission of the Enterprise Information Security Organization is to protect the confidentiality, integrity, and availability of Company Information. This includes creating, administering, communicating, and overseeing the Policy.

02. Risk Management and Assessment

2.1. The Enterprise Information Security Risk Management Program provides accurate and relevant risk analysis information that facilitates consistent risk management decisions. Risk Management decisions will be made in partnership with Legal, Business, Information Technology, and Enterprise Information Security leadership to optimize the balance between business operational needs and legal, regulatory, customer, and security requirements.

2.2. Risk assessments are performed to determine the security controls required based on the use and risk, as well as the applicable legal, regulatory, customer, and Information Security Policy.

03. Personnel Security

3.1. The security responsibilities of Workforce Members must be appropriately defined, communicated, evaluated, and monitored to minimize the risk of error, theft, fraud, loss, or misuse of Company Information and Company Information technology systems.
3.2. Workforce Members must comply with the Information Security Policies, including requirements for acceptable use of Company Information technology systems.
3.3. On a regular basis, Workforce Members must acknowledge their security responsibilities, as defined in the Information Security Policy.
3.4. We monitor, in accordance with applicable laws, all activities on Company Information technology systems.

04. Physical Security

4.1. Company Information, Company Information technology systems, and secure areas must be protected against unauthorized physical access.
4.2. Controls must exist to safeguard against reasonable environmental hazards, and to preserve the health and safety of Workforce Members.
4.3. Appropriate environmental controls must be implemented for the proper operation and availability of Company Information and Company Information technology systems.

05. Operations Security

5.1. Company Information technology systems must be configured, operated, and managed in a controlled manner to protect the confidentiality, integrity, and availability of Company Information.
5.2. Hardware and software must be approved prior to use within the Company. Hardware and software must be formally supported, including regular maintenance and periodic upgrades.

06. Logging, Monitoring, and Incident Management

6.1. Company Information technology systems must be monitored to detect system, security, and operational events that may

impact the confidentiality, integrity, and availability of Company Information.
6.2. Security incidents must be managed by a documented response capability, which includes procedures for reporting, analyzing, escalating, investigating, and resolving security incidents in a timely manner.

07. Communications Security

7.1. The confidentiality, integrity, and availability of Company Information must be protected when being communicated.
7.2. The transmission of Company Information must be performed in accordance with applicable regulatory and contractual requirements, and the Information Security Policy.

08. Access Control, Access Management, and Incident Response

8.1. Access to Company Information and Company Information technology systems must be controlled. Access must be limited to the minimum amount needed to perform assigned duties.

09. Network Security

9.1. The Company networks, and the ability to connect to Company Information technology systems, must be managed and controlled.
9.2. All connections to non-Company Information technology systems must be approved and meet applicable security requirements.

10. External Party Security

10.1. The Company Business Organizations must manage the risks presented by allowing outside entities that are not affiliates of the Company ("External Parties" or "External Party") to access Company Information or Company Information technology systems.
10.2. External Parties are permitted to access Company Information or Company Information technology systems within the context of a formal contractual agreement which documents the appropriate security requirements and responsibilities of the External Party.
10.3. Devices in use by External Parties must be reviewed and approved prior to being connected to Company Information technology systems.

11. Application Development Security

11.1 Company applications must be designed, implemented, and managed to protect the confidentiality, integrity, and availability of Company Information technology systems and Company Information.
11.2. Application software and code must be protected against unauthorized modification.

12. Business Continuity and Disaster Recovery

12.1. Company Business Organizations must develop, test, and maintain Business Continuity and Disaster Recovery Plans in order to limit losses caused by disruptions to critical business operations, and to enable efficient and effective recovery. The Business Continuity and Disaster Recovery Plans will include processes and controls to protect the business of the Company, the life and safety of Workforce Members, as well as to protect the image, reputation, assets, and resources of the organization.
12.2. Business Continuity and Disaster Recovery requirements are determined by the business risks, legal, regulatory and contractual obligations, and potential business impacts of service disruptions.

13. Data Classification and Protection

13.1. Information used or maintained by the Company must be collected, used, maintained, and disclosed only as permitted under, and in accordance with, all applicable laws and regulations, Company Policies and, if also applicable, more stringent individual authorizations or customer contracts.
13.2. Information used or maintained by the Company must be classified in accordance with Company data classification level definitions. These definitions provide guidance as to the appropriate ways to handle and protect Company Information in order to protect their confidentiality, integrity, and availability.

Policy Definitions

Definitions for key terms used in this Policy are found in the Enterprise Information Security Glossary.

MA-PD PPO Transition of Services Plan

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TRANSITION OF SERVICES PLAN

Upon contract termination, cancellation, and/or expiration, UnitedHealthcare will:

- **Assist EBD and the new Contractor, to the extent EBD determines necessary, to ensure an orderly transfer of responsibility and the continuity of those services required under the terms of the contract to another organization designated by EBD.**

- **Ensure that no covered Medicare-eligible retirees and covered Medicare- eligible dependents of a retiree loss or gain coverage as a result of transfer of responsibility.**

We will provide EBD or EBD's designee with requested elements assuming it meets CMS Minimum Necessary requirements, complies with HIPAA protection and other data guidelines and entities in receipt of such information has a signed non-disclosure agreement (NDA). No Loss/No Gain provisions apply to non-retired members who are covered by plans that do not have Medicare as the primary benefit. Therefore, this does not apply to our Medicare Advantage retiree plan

All transition-of-care-related issues and non-confinement provisions will be expressly waived for the initial enrollment for covered retirees and covered dependents that have already satisfied the limitations under the existing plan, unless otherwise specified in the eligibility rules established by EBD and/or CMS.

Confirmed.

During enrollment, we help the retiree to know if their provider is in network or accepts our plan and explain the transition of care process:

- Transition of care incorporates policies and procedures that span across our entire company, including customer service, intake, concurrent review and care management.

- Requests for transition of care services can be initiated by the treating physician after enrollment through a customer service professional by calling our toll-free customer service telephone number.

- We obtain documentation provided by the physician and assist the member in coordinating care as appropriate to their individual circumstance.

MEMBERS CONFINED IN HOSPITAL

Members can remain wherever they are as long as the hospital is Medicare approved. For members who are confined to a hospital as of midnight on January 1, and coverage begins during an inpatient hospital stay, the following applies:

- Under such circumstances, we abide by CMS rules for claims adjudication.

- If the member is hospitalized at the time of a plan change, the payer of record upon admission is financially responsible until the member is discharged from the acute setting. Thereafter, the liability changes to our plan.

- If a member terminates coverage, he or she is covered through the end of the month in which coverage terminated. After the end of the month, coverage is limited to original Medicare coverage.

- The member's previous health plan will continue to pay Medicare Part A inpatient services until the date of the member's discharge.
- The new plan effective 1/1/23, is not responsible for Medicare Part A inpatient services until after the date of the member's discharge.
- The new plan effective 1/1/23, is responsible for Medicare Part B charges beginning on the date the member becomes eligible with the new plan.

PRE- AND POST-SURGICAL CARE

- We identify members who need assistance for surgical care by the providers request for a pre-authorization.
- We then make medically necessary determinations based on clinical records, peer-to-peer discussions and externally recognized evidence-based guidelines.
- Based on individual needs, we may offer transitional programs to help the member successfully transition from intensive surgical services.
- Members who are seeking elective surgery also have access to our 24/7 Telephonic Nurse Support health information line. Here, our registered nurses educate members on their diagnosis and treatment options and help them carefully weigh the risks, benefits and alternatives of an elective surgical procedure.

SKILLED NURSING FACILITY SHORT- TERM STAYS

The Post-acute Transition Program and Secondary Level of Care Program provides targeted interventions for individuals who transition from hospitals to short-term stays at a skilled nursing facility (SNF).

The goal of this individualized, whole-person approach is to reduce the length of stay at the SNF by removing any barriers to discharge so the member can safely return to the east restrictive setting that is safely possible.

Care managers collaborate with members' facilities, physicians, families and caregivers after their hospital stay and throughout their care at a skilled nursing facility.

The care manager participates in care conferences, family meetings, and discharge planning as appropriate to communicate with members/families and discuss benefits, progress, goals of care, discharge plans, etc.

TRANSITIONA L PROGRAMS (RELATED TO CLINICAL OFFERINGS)

MEMBERS IN CASE MANAGEMENT WITH CURRENT CARRIER

Members are not routinely placed in case or disease management when transitioning from Medicare. CMS does not allow Medicare Advantage plans to proactively outreach to new enrollees who are receiving benefits and services from Medicare or other Medicare Advantage plans prior to their effective date into the new Medicare Advantage plan. We do, however, provide new members with information on how to contact our Advocate4Me member services team and Telephonic Nurse Support to receive help with transitioning into our clinical programs.

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Open Case Transition for Members with Chronic or Terminal Illness

- To identify new members with chronic or terminal illness, we will work with the client during account implementation to obtain an open case file. Particular focus is put on those members currently enrolled in case management or condition management programs.

- Our care management staff will review each existing case based on our clinical risk stratification to determine if the member qualifies for our case and/or disease management programs. Note that some lower risk members may require temporary or short-term clinical support and/or assistance versus high-risk management.

- The risk stratification process also identifies those members who can benefit from complex care such as our Advanced Illness program for members with life-limiting illness, end stage renal disease (ESRD) management or transplant services.

UnitedHealthcare will provide at no charge to EBD, all records, documentation, reports, data, recommendations, and/or printing elements, etc., produced under a resulting contract to EBD or to EBD's designee, within ninety (90) days of EBD's request, contract termination, or contract cancellation. In addition, UnitedHealthcare will follow the method of delivery determined by EBD and include all raw, primary data from all research and analysis completed under a resulting contract. As noted in the RFP, this requirement does not refer to the UnitedHealthcare's intellectual property. Upon termination, we will transfer all necessary information to the succeeding carrier or third-party administrator, within a reasonable time frame, in accordance with applicable state and federal law. If the customer desires more data, particularly historical claim files, we are willing to try to reach an agreement with the customer and would require a hold harmless for the release of such information. We are happy to discuss specific time frames for the delivery of information and are confident that we can reach a mutually satisfactory result.

UnitedHealthcare confirms it will provide all services to execute the successful transition of services data.

UnitedHealthcare confirms all data, records, files, and other information relating to the EBD account will remain the property of EBD and will be returned to EBD in the event the contract is ended.

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UnitedHealthcare will not share, release, or otherwise use EBD's data without the prior and express written consent from EBD.

UnitedHealthcare will allow EBD, or an entity chosen by EBD, to review and audit our operations, including the internal control procedures and records, at any point during the life of the resulting contract. In addition, UnitedHealthcare will:

- **Cooperate with an outside audit firm EBD selects to perform the audit.**
- **Allow EBD or its designated agent to annually audit our performance under the contract, at no cost to EBD, including, but not limited to, claims processing and payment, customer service, and banking and billing records to assure that claims subject to MA-PD coverage are evaluated in accordance with the plan provision.**
- **If an audit identifies performance guarantees are not being met, UnitedHealthcare will pay for follow-up audits to confirm resolution of any problem(s) uncovered during the initial audit.**
- **Allow EBD the right to audit for the duration of the agreement and for a period of three (3) years following expiration or termination thereof.**

  UnitedHealthcare is required to follow CMS standards and procedures regarding billing, enrollment and claim processing. To ensure a comprehensive process, our administrative service centers have quality management teams dedicated to providing ongoing monitoring of billing, enrollment and claim processing functions. Our policies and procedures and our performance reporting are developed for consistency in administering quality review criteria protocols. In addition to ongoing monitoring, our internal compliance department performs periodic audits to meet CMS standards and oversight.

  These audits are done with proper notification of time frames, audit review content and universal samples. Formal corrective action plans are developed and monitored for implementation and sustainability, as applicable.

MA-PD PPO Claims Processing Plan

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MA-PD PPO Claims Processing Plan

UnitedHealthcare will provide claims processing in accordance with EBD and CMS policies.

UnitedHealthcare's proprietary system, COSMOS, is the claims adjudication platform for our Group Medicare Advantage PPO business. This highly sophisticated system leverages state-of-the-art artificial intelligence to facilitate efficient claims administrative processes and provide significant automation for our adjudication process. The following is a description of the end-to-end clean claim's payment process for both network and non-network claims:

- Electronic claims submitted by providers automatically flow into COSMOS. The few paper claims we receive via mail are converted into electronic format where they are assigned claim numbers and added to the electronic processing flow.
- The majority of claims flow through COSMOS using automated processing to administer benefits.
- Claims are processed and reviewed according to policies in place to comply with relevant regulations and contract language. To process claims correctly, we rigorously apply various coding systems and internal guidelines. 93% of claims are automatically adjudicated.
- Claims that cannot be automatically adjudicated are suspended for processor review and intervention. Our claims processors focus exclusively on processing Medicare claims. Claims processors apply standard policies and procedures to pay or deny claims, resulting in their release from COSMOS.
- COSMOS applies the appropriate pricing, benefit rules are applied, and the system releases the claim.
- Once the claim is released, payment is dispersed along with a remittance advice letter to the provider and a monthly explanation of benefits (EOB) to the member.
- Turnaround time is measured from the received date of the claim to the paid date of the claim and is continuously monitored.
- While the process for network and non-network providers is the same, UnitedHealthcare follows CMS guidelines that states 95% of clean claims from non-network providers be paid within 30 calendar days of the request.

Our claims, eligibility and member services systems are integrated to reflect changes in real time. UnitedHealthcare has a single claims platform that combines all claim administration elements, including online eligibility, benefit design provisions, notification, physician and other health care professional data, discounts, negotiated rates, claim payment and claim history.

Our Member Interaction and Issue Management proprietary customer service system provides our advocates with access to service notes, claims and claims history, utilization management and provider contracting information.

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UnitedHealthcare will ensure that medical and prescription drug benefits or program changes that have the potential to create member disruption and provider payment issues are made timely and accurately. UnitedHealthcare has robust testing and quality processes that are completed and signed off on by operations and IT staff prior to deployment into our claims system. Based on our experience and to help prevent errors, we have increased dedication to do deeper validation upstream on all CMS updates, payment integrity, affordability and clinical changes that are proposed to ensure the impact is understood and the proposed solution for the change is validated before implementing. This team will provide sign-off to any proposed changes.

In addition, processes including additional business controls and quality assurance have been added or enhanced based on escalations. Our goal is to ensure that our protocols and processes support both a good experience for members and providers.

UnitedHealthcare will provide proper quality control testing for medical and prescription drug benefits and/or program changes. UnitedHealthcare conducts an audit of the benefit set-up and a Benefit Implementation Audit (BIA) to ensure member benefits are correctly applying benefits such as copayment, deductible, and out-of-pocket limits. We have established protocols to ensure that benefits or program changes are thoroughly tested in a timely and accurate manner before live release to our members and providers. All protocols are signed off by operations and IT staff prior to deployment into our claims system.

Based on escalations, our processes include additional business controls and quality assurance. We have proactive analytical claims tools that continuously analyze claims to find and prevent errors before an issue may occur.

Standard Tests

The UnitedHealthcare internal Benefit Implementation Audit (BIA) standardly tests 450+ test claims in 70+ benefit categories. The BIA compares documented parameters (automated system calculations as well as manual claims processor instructions) and views system applications to:

- Verify copayments are computed correctly.
- Ensure benefit limitations (if applicable) are recorded accurately.
- Verify benefit calculation is correct for each sampled claim type.

UnitedHealthcare will provide medical Prior Authorization (PA) and medical pre-certification processes, including appeals process for denied PAs and medical pre-certifications. Medical prior authorization and advanced notification is a pre-certification review process that establishes if a requested service is both clinically appropriate and a covered benefit.

Intake coordinators receive requests from providers and members and transfer the request to the appropriate area. If approval is not forthcoming at the initial clinical review, secondary review is performed by a medical director. Pre-service review also provides an expedited review as a part of the appeals and grievance process.

When adverse determinations are necessary for clinical reasons, those determinations are made by medical directors or supporting physician specialists, using national, externally licensed clinical care guidelines, state and federal regulations when applicable, (as well as Medicare Coverage Guidelines and Durable Medical Equipment Regional Carriers Regional and Local Coverage Guidelines) and/or internally developed medical policies. Nurses may issue administrative denials of coverage without physician input for explicit benefit coverage reasons only. We deny less than 1% of services.

Our network providers are contractually obligated to notify us of all inpatient admissions and to obtain prior authorization for services and procedures on our prior authorization list, whether performed in an inpatient or outpatient setting. Providers can access the current prior authorization list on the provider portal, **www.uhcprovider.com.** Please note that our prior authorization list may change at any time as it is constantly reviewed and updated per CMS guidance and regulation.

Whenever we make an adverse determination, the member and/or his or her physician or other health care professional has the right to appeal the determination. If a Medicare health plan denies a member's request (issues an adverse organization determination) for an item or service, in whole or in part, the member may appeal the decision to the plan by requesting a reconsideration. Reconsideration requests must be filed with the health plan within 60 calendar days from the date of the notice of the organization determination. Once the plan receives the request, it must make its decision and notify the member of its decision as quickly as the member's health requires, but no later 72 hours for expedited requests, 30 calendar days for standard requests, or 60 calendar days for payment requests. There are 4 additional external levels of appeal available for members in a Medicare Advantage plan: Independent Review Entity, Office of Medicare Hearings and Appeals, Medicare Appeals Council, and Federal Court.

Reporting and Valuation

Our prior authorization list is reviewed regularly and subject to change based on evidence-based medicine and CMS guidelines. We perform a thorough financial and non-financial analysis of services and procedures prior to adding to our prior authorization list. We consider cost-effectiveness and quality of care when recommending prior authorization of services.

We can provide prior authorization and appeals reporting in a data file that contains fields including date of request/service, place of service, provider type, determination status (e.g., approved, denied), and appeal status.

UnitedHealthcare will honor existing medical PAs and pre-certifications and will ensure member care is not disrupted. UnitedHealthcare will work with the existing carrier to transfer data and minimize member disruption. We are able to transfer the member-level data from the existing carrier, along with the prior authorization request and approval. During the implementation process, we will convey the data elements that are required from the existing carrier and the preferred file layout.

We have found to have the most timely and accurate transition process, the file feed with member-level data should begin approximately 6 weeks prior to the membership's new effective date with UnitedHealthcare. Prior to this date, we request a test file exchange to ensure the data format and file feeds are working correctly. The transition authorizations that the previous carrier has documented as approved in their system would be sent to UnitedHealthcare through a secure interface in the requested file layout.

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UnitedHealthcare will provide results of internal claims audit to EBD. Below are the current standards for internal claim audits:

- Claims are randomly sampled and included in quality reviews. There are no criteria at the business or processor level to include or exclude claims based on modifiers, duplicates, dates of service, etc.
- Our universal master sample is stratified based on paid dollars and distributed by claim population within those strata. Therefore, all claims can potentially fall into the sample pool.
- The percentage of post-disbursement claims are subject to internal operational audit is variable, based on the volume of claims processed. Generally, about 0.01% of processed claims are reviewed monthly.
- Claim processors are audited weekly.
- When an error is found, all corrections are completed within three weeks.
- There is a closed loop process in place for corrections. Claim feedback initiated by the quality team remains open until claim operations corrects the item as appropriate and returns the feedback to the quality team. Once returned, the quality team reviews the correction made, determines whether it was completed appropriately and returns for appropriate corrections or closes the item as complete.
- Performance and remediation reports are provided weekly, monthly, quarterly and/or annually.
- High dollar claims are Physician claims with billed charges of $10,000 or greater and hospital claims with billed charges of $7,000 or greater. All high dollar claims go through an additional review by an internal processing team dedicated to high dollar claims.
- Criteria determined for internal audits: Claims are randomly sampled and included in quality reviews. There are no criteria at the business or processor level to include or exclude claims based on modifiers, duplicates, dates of service, etc.
- Percent of claims audited internally: The percentage of post-disbursement claims are subject to internal operational audit is variable, based on the volume of claims processed. Generally, about 0.01% of processed claims are reviewed monthly.

MA- PD PPO Reporting Plan

UnitedHealthcare will create and generate standard utilization and cost reports through a secure file transfer that is approved by EBD. We offer a dedicated team of health care reporting and analytical experts who will provide innovative and customized reporting which has been specifically created for Group Medicare Advantage plans. We have built and refined our reporting by working with our 20 State Group Medicare Advantage clients. They have challenged us to develop reporting metrics which focus on Medicare retirees in the public sector.

Our Group Medicare Advantage reporting team consists of a varied talent pool, from colleagues with advanced degrees in health policy, data science as well as actuaries and those previously employed in benefit consulting firms. We welcome analytic projects to utilize data and present results to help our clients make informed decisions regarding their Group Medicare Advantage plans. For example, our dedicated reporting team was an integral part in the development of a Group Medicare Advantage client's diabetes task force. We provided detailed analysis for the task force based the client's Group Medicare Advantage membership; we then created displays and reporting which were utilized broadly within the task force. In addition, we were able to connect the task force director with another State director who led a similar task force to share ideas and results of outcomes. Our dedicated reporting team has engaged with other state plan sponsors on special analytic projects specific to their state's Medicare Advantage populations and more broadly impacting state health programs.

UnitedHealthcare's proposed comprehensive standard utilization and cost reporting package is below:

UnitedHealthcare's account management team will deliver a quarterly Executive Performance Reporting package to EBD. We utilize the following analytics to build our reporting package:

- Key indicators
- Trend drivers
- Benchmarking
- Key strategies
- Recommendations for managing cost and utilization
- Custom reporting to support key program initiatives as defined by EBD.

We offer a best-in-class suite of reports. The Executive Performance Report, available quarterly, includes the following reports:

Membership Overview

The membership overview reports provide data on where EBD's members reside across the country for our Group Medicare Advantage PPO plan.

- Demographics (number of members, % female, average member age)
- Membership by geography (state / county)

Financial Overview

The financial overview report provides financial performance results of current year compared to previous for both medical and pharmacy. It compares the costs to our Group Medicare Advantage book of business. Reports include:

- Percent of Claims (Inpatient/Outpatient/Physician/Pharmacy/Ancillary)

Medical Utilization Overview

For the utilization metrics measured and presented, the report will compare EBD plan metrics for current to prior year to review performance and engagement with members and compares to our Group Medicare Advantage book of business results. Reports include:

- Acute: Admissions, days, ALSO
- Observations
- Outpatient Surgeries
- Emergency Room Visits and Urgent Care Visits
- Physician Visits
- Home Health Visits

High- Cost Claimants

- Top 5 High-Cost Claimants
- Primary Diagnosis
- High-Cost Claimant Distribution

Medicare Advantage Diagnosis Overview

- Diagnosis Description
- Top 10 Diagnosis
- Cost & Claimant Review
- Disease Prevalence
- Telehealth Trends

Clinical Activity Highlights

The clinical activity highlights provide information on clinical engagement. We present the performance of membership on Star Ratings and engagement of members in clinical programs and HouseCalls. Reports include:

- Stars Scorecard
- HouseCalls Participation and Referral Generation

- Identify Top 5 Social Determinants of Health
- Clinical Program Engagement; Diabetes, Heart Failure, Care Management, ESRD and Transplant
- High-Cost Claimants
- Telephonic Nurse Support Utilization
- Identifying Member Health Needs
- Program Case Study
- Remote Patient Monitoring
- Inpatient and Transitional Care
- UnitedHealthcare Healthy at Home

MEDICARE ADVANTAGE PRESCRIPTION DRUG REPORTS

We provide details on the pharmacy spend, tier information, top pharmacy spend, condition categories and specialty drug costs, including changes year over year as well for the population. Reports include:

- Pharmacy Utilization
- Generic vs. Brand
- Retail vs. Mail
- Utilizations - Scripts PMPM
- Gap and Catastrophic Claimants
- Drug Breakdown (Generic/Brand/Specialty)
- Top 10 Therapeutic Classes (PMPM cost by therapeutic class)
- Top 10 Drugs (PMPM cost by drug)
- Specialty Drug Classes

UnitedHealthcare will provide claim line detail for all claims, medical and pharmacy, including, but not limited to, financial and diagnoses information. In addition, UnitedHealthcare will provide reporting by the 15th day of the month following the subject month, in the *Attachment C: Claims File Layouts* format.

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UnitedHealthcare will submit the Part C and Part D Medicare Membership Reports (MMR) monthly via secure email, including all CMS fields. The monthly MMR will be submitted by the end of the corresponding month. In addition, we will submit the MORs upon request annually via secure email, including all CMS fields. The MOR will be submitted within 30 days of request.

UnitedHealthcare will provide Transaction Reply Report (TRR) file on a weekly basis. The TRR includes the daily transaction reply codes from CMS and contains details of rejected and accepted enrollment and disenrollment transactions.

UnitedHealthcare will work with EBD daily to resolve any discrepancies that may arise from the nightly 834 file. Your dedicated Electronic Eligibility Analyst will work to ensure files are received and that any missing files do not go undetected, we will establish a regular and predictable file transfer schedule and discrepancy resolution process with EBD during implementation.

UnitedHealthcare will provide a denied claims report, including number of denials by reason on a quarterly basis. In addition, we will submit monthly, quarterly, and annual appeals reports to EBD, and provide ad hoc reports as requested. UnitedHealthcare's account management team (AMT) will meet with EBD on a quarterly basis to present quarterly Executive Performance Review reports. Our AMT is also available to meet on a more frequent basis to review ongoing trends and current topics.

As part of our ongoing management process, the UnitedHealthcare AMT collaborates with EBD to discuss and recommend additional programs or services that make sense within the framework of emerging challenges or objectives. We also share detailed analyses of benefit plan performance, including cost and outcomes forecasting and trend evaluations.

UnitedHealthcare will submit web portal and member services utilization reports to EBD. Our web utilization reporting includes the following data:

- Number of members registered
- Total members in plan
- Percentage of members registered on the website
- The part of the site EBD members use
- The documents EBD members download
- Online trends

We will also provide member service utilization report scorecards which include the following:

- Year to date review of claims and customer service metrics
- Performance guarantees (if applicable)

- Call center contact reasons
- Member trust, satisfaction scores, and feedback
- Service account manager trends
- Newly added services

UnitedHealthcare will report to the State and the State designated health care consultant rebates received associated with the reimbursement of Medicare Part B drugs at least quarterly.

UnitedHealthcare ensures that all data can be received and accepted by CMS in a timely fashion, in compliance with submission timelines established by CMS. We comply with the requirement to submit all data, and we have controls in place to ensure data is submitted to CMS for each collection period.

UnitedHealthcare's system generates files for submission to CMS in the appropriate EDS (Encounter Data System) format. Our controls include quality checks to validate the integrity of the EDS format and reconcile record totals to ensure both data submissions are complete. The controls in place to ensure all required data is sent to CMS for each data collection period are as follows:

- All finalized claim data from our claim source platforms is extracted, configured in CMS required format and submitted to CMS daily. Medicare Advantage organizations no longer apply risk adjustment filtering criteria as all claims need to be submitted to CMS.
- Controls and audits in our centralized EDS ensure files are correctly formatted and populated. An error correction team resolves claim format discrepancies and makes needed adjustments to records prior to submission to CMS.

UnitedHealthcare monitors quality and completeness of claims by maintaining a centralized system that processes risk adjustment data submissions to CMS. This system applies duplicate checking and claim filtering through a configurable rules engine.

In addition, we perform chart reviews to supplement the completeness of diagnosis data that is received via claims. During chart review, diagnosis codes supported in the medical chart are submitted to CMS. We also perform chart reviews targeted at certain outlier providers to confirm that diagnosis codes submitted through claims are supported by a medical record. We engage in a vigorous quality assurance program which includes a second level review of approximately 70% of all charts to ensure that we submit only valid diagnosis codes to CMS. UnitedHealthcare's centralized system that processes risk adjustment data submissions, Encounter Data System (EDS), applies duplicate checking logic. Once identified, claims that meet the current CMS definition of a duplicate claim are removed.

UnitedHealthcare will submit data elements and additional documentation as requested by EBD prior to contract renewal.

MA-PD PPO Eligibility Plan

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ELIGIBILITY PLAN

UnitedHealthcare will provide a comprehensive online enrollment system that includes the following components:

- **Ability to handle more than one (1) 834 eligibility file each day**

  Confirmed

- **Member data repository**

  Confirmed

- **Accommodate confidential mailing addresses as required by Title II of HIPAA.**

  Confirmed

- **Maintain historical eligibility information on an individual's file, including accessible online, real time and archived information.**

  Confirmed

The Generation Policy System (GPS) is UnitedHealthcare's strategic front-end platform for policy administration of Medicare Advantage and Medicare Part D products. The system provides a common platform to support enrollment/eligibility, premium billing and collections, fulfillment material. GPS is a distributed application running on WebSphere Application Server, Oracle 10g, and MQ Series. GPS has been in production for enrollment and billing since 2006. There are no plans to use a new system in the next three years.

GPS helps us be more customer-centric by presenting a seamless face to the customer. Having a single, comprehensive view of our members, for example, means that we can simultaneously track an application - start-to-finish - through the enrollment process; see billing information and know the order and delivery status of fulfillment material.

The overall benefits of GPS are substantial: improved service to CMS, reduced handle time for enrollment and greater standardization. The following examples illustrate several of the advanced features:

- Enrollment: Only invalid applications (that is, applications with missing information or written comments) need to be viewed or touched by a processor.

- Eligibility: Eligibility status can be efficiently tracked by storing detailed enrollee information, including eligibility segments, addresses, primary physicians and a record of CMS enrollment transactions.

- Fulfillment: Advanced business rules create dynamic mailing scenarios; the majority of enrollment letters are triggered by the system rather than having to be manually generated.

- Billing: Monthly invoices and multiple payment methods are supported at a product level. For Group Retiree business, GPS provides the ability to send a bill to the customer and also to the individual member.

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UnitedHealthcare will update eligibility data within 24 hours from receipt of data.

UnitedHealthcare will load the file within 24 hours into our Electronic Eligibility Management System (EEMS). CMS provides the Transaction Reply Report (TRR) on a nightly basis, confirming member enrollment/eligibility updates back to UnitedHealthcare.

UnitedHealthcare will accept and process the 834 eligibility file sent by EBD and confirm receipt within 24 hours.

UnitedHealthcare will load the file within 24 hours into our Electronic Eligibility Management System (EEMS). EEMS is an automated file review and pre-processor program that systematically loads membership files sent by EBD via the file transfer connection to our eligibility and enrollment system, GPS. After the file has been processed via EEMS, the enrollment records are fed into GPS. The record is then transmitted to CMS's pre-eligibility query application. This validation quickly ensures the member meets basic Medicare eligibility requirements, prior to submitting the transaction file to CMS. Once the record returns from this initial successful validation, the member's record is then passed to CMS for final eligibility processing.

UnitedHealthcare will not enroll or cancel EBD members without EBD's approval unless there is a conflict from CMS. If a conflict from CMS is found, UnitedHealthcare will confirm conflicted information and report back to EBD within twenty-four (24) hours so EBD can correct and retransmit records. An electronic eligibility analyst (EEA) will work with EBD to identify the conflicting information, its correction, and ensure EBD is able to correct and retransmit.

UnitedHealthcare will validate participant eligibility through CMS. We have unparalleled experience coordinating eligibility and enrollment processes in conjunction with CMS, vendors, our customers and their retirees. UnitedHealthcare will be responsible for validating member eligibility through CMS using the following process:

UnitedHealthcare will load the file into our Electronic Eligibility Management System (EEMS). EEMS is an automated file review and pre-processor program that systematically loads membership files sent by the State via the file transfer connection to our eligibility and enrollment system, GPS. After the file has been processed via EEMS, the enrollment records are fed into GPS. The record is then transmitted to CMS's pre-eligibility application. This validation quickly ensures the member meets basic Medicare eligibility requirements, prior to submitting the transaction file to CMS. Once the record returns from this initial successful validation, the member's record is then passed to CMS for final eligibility processing.

If the initial validation is not successful, our operations team attempts to remove any errors. This often requires working with either the employer or the member to clarify or supplement any of the required data elements. The process can take up to seven calendar days.

UnitedHealthcare will generate a monthly reconciliation file that will contain, the member's social security number, the contract number, demographics, enrollment date, and cancel date. This report provides discrepancies between the full membership file provided by the State and the UnitedHealthcare enrollment and eligibility system (GPS). The discrepancy types that are included in this report are MBI, Unmatched Enrollment, Zip, State, Daytime Phone and Address. This report contains PHI and is provided either monthly or quarterly.

UnitedHealthcare will implement processes for working error reports generated from file loads. Eligibility transactions are sent to our enrollment system, Generation Policy System (GPS). If discrepancies are identified, our GPS system distributes to various work queues where processors review and resolve the errors. These teams will also work any records that may have fallen out from the original file load. If any issues or errors require the EBD action for resolution, UnitedHealthcare will work closely with the EBD If a member's application falls to one of these work queues due to additional information being needed in order to process the application, we send the member an additional information letter requesting the necessary information. We also send a work queue report which assists the EBD in gathering the missing information. The work queue report captures any relevant member applications that are pending within our enrollment system, whether due to additional information being needed, or if the application required manual processing. Once issues are resolved, the process will continue, and the application will result in either an approval or denial.

UnitedHealthcare is also able to provide an add, term, change and denied report on a weekly or monthly basis. This report captures any additions, changes or terminations that occur from the last time the report has been run.

We will also provide the EBD with monthly full audit file results. We will schedule meetings to discuss the results of the full file reconciliation. It is the expectation that UnitedHealthcare and EBD will work together to ensure all respective enrollment and eligibility systems are in sync.

UnitedHealthcare will confirm member physical address and other necessary enrollment information if the information is not initially provided on an enrollment file. If we require additional information for a member, we send the member an additional information letter requesting the necessary information. If any issues or errors require the EBD's action for resolution, EBD electronic eligibility analyst (EEA) will work closely with you to resolve any issues which we are not able to resolve on our own.

UnitedHealthcare also sends a work queue report which assists the EBD in gathering the missing information. The work queue report captures any relevant member applications that are pending within our enrollment system, whether due to additional information being needed, or if the application required manual processing. EBD can add the member's address to their file or the member can respond to UnitedHealthcare's letter. Once issues are resolved, the process will continue, and the application will result in either an approval or denial.

We are also able to provide an add, term, change and denied report on a weekly or monthly basis. This report captures any additions, changes or terminations that occur from the last time the report has been run.

UnitedHealthcare will handle CMS eligibility issues for members that only have a P.O. Box address. If a P.O. Box is presented on an enrollment without a physical address, UnitedHealthcare sends a letter to the member requesting the physical permanent address. If the member does not respond to the letter within 21 days, a denial of enrollment letter is sent to the member along with a notification denial to EBD via reporting. Members are only submitted to CMS upon receipt of all CMS required data (i.e., valid, permanent address).

Alternatively, prior to sending the initial enrollment file, EBD can attest that members with a P.O. Box permanently reside in the valid service area for the Group Medicare Advantage Plan. After the initial enrollment file, members that age into the plan can call member service to attest they live in the service area.

UnitedHealthcare will manage and coordinate with EBD regarding CMS eligibility issues. We will receive a monthly membership report (MMR) from CMS, typically around the 20th of each month. At that time, we will load the MMR into our system which compares 36 months' worth of CMS eligibility data with the data in our eligibility system. We then work on all discrepancies identified by this reconciliation process within the CMS-required deadline of 45 days after receipt of the MMR and attest to CMS that we have reconciled the two files. The historical percentage of matches between UnitedHealthcare's eligibility information and CMS's is 99.9%. Any changes that are made to a member's account through this process will be reported back to EBD on the monthly reconciliation report.

In the event a member's status changes, the member will be reported back to EBD by way of the Adds, Terms, Changes and Denied Report. In addition, it is expected that a monthly reconciliation between UnitedHealthcare and EBD will be performed. This will ensure any outstanding discrepancies are identified and reviewed for remediation.

MA-PD Medical Management Plan

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MEDICAL MANAGEMENT PLAN

UnitedHealthcare will maintain program design that enhances quality of care, including engaging targeted individuals and improving health status and clinical outcomes. We utilize complex analytics to engage the right member at the right time with the right program to ensure improved health and wellness, and long-term stability. In order to engage members, we first consider their risk acuity and that informs our enrollment approach and program offering.

UnitedHealthcare's initiatives to increase engagement begin with educating members on how they can become more involved in their health care. In 2021, UnitedHealthcare clinicians worked directly on care plans with approximately 48% of our Group Medicare members through our clinical programs. These programs range from wellness and prevention to serious illness care. We utilize multiple direct and indirect outreach channels to engage individuals to participate in our programs including telephone (inbound and outbound), digital (tablet or smart phone), mail, email, interactive voice response and web-based resources.

UnitedHealthcare will offer case management programs that include the following components:

- **Pre-admission review/Pre-determination**
- **In-patient admission/concurrent review**
- **Discharge planning**
- **High-risk post-discharge outreach**
- **Retrospective review**
- **Outpatient review**
- **Catastrophic/long-term case management**
- **Episodic/short-term case management**
- **End-of-life program identification and transition**

UnitedHealthcare will provide the following clinical and disease management programs:

- **Asthma**
- **Diabetes**
- **Chronic Obstructive Pulmonary Disease**
- **Heart conditions, including coronary artery disease and congestive heart failure**
- **Low back pain and musculoskeletal pain**
- **Weight complications**
- **Hepatitis C**
- **Fibromyalgia**
- **Irritable bowel syndrome**

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Our Group Medicare Advantage plans provide a full spectrum of care and disease management programs including inpatient care management, care and condition management, specialty care management (e.g., transplant and End Stage Renal Disease management), behavioral health care management, and solutions for caregivers. All our clinical programs are encouraged but are voluntary to Medicare retirees.

Our clinical programs include the following:

Inpatient Care Management- Our inpatient care management activities focus on:
• Ensuring the physician's treatment plan is clinically appropriate, cost-effective and adheres to evidence-based medicine
• Identifying and preventing potential delays in care, tests, and procedures
• Facilitating access to specialists as needed via consultation with the medical director
• Supporting discharge planning, including identifying members for post-discharge follow-up

Care and Chronic Condition Management- The hallmark of our focused care management approach is our innovative care and condition model. Our care and condition management programs are tailored to the member's disease acuity level and health care needs. In this model, a primary nurse is assigned to each member upon clinical program enrollment. Providing a member with one primary nurse who understands and manages all their clinical needs increases engagement, eliminates redundancy, increases engagement by forming trusting relationships, minimizes handoffs and promotes the management of a "whole person" philosophy.
Our nurses are cross trained across all high-risk conditions such as chronic lung disease, coronary artery disease and diabetes. Each nurse is also supported by clinical specialists in other areas such as behavioral health, advanced illness, transplant, End Stage Renal Disease, and social services. The nurses are especially attentive to transitions of care, a highly vulnerable situation commonly resulting in unnecessary hospital readmissions.

High Risk Care Management- Our high-risk care management program delivers high-touch, intensive services to members with complex illnesses and multiple comorbidities. High-risk care management provides telephonic care management services, designed to meet a member's medical, psychosocial, and functional needs. A personal nurse offers support to each member to help them better manage their condition(s) and maintain their health. This proactive, holistic approach supports:
• Support for family caregivers
• Coordination of clinical care to address declining functional status
• Medication adherence and management

Our ability to have a single nurse address multiple conditions across disease and all phases of care management is enhanced by our technology platform, a single, unified clinical platform-to ensure smooth transitions and continuity of care.

Asthma Program- We address asthma in our chronic obstructive pulmonary disease (COPD) program. Our Asthma/COPD program began in 2015. COPD members, who are high risk due to the severity of their condition, are enrolled in our remote patient monitoring care management program, which helps members diagnosed with emphysema, chronic bronchitis, asthma, and other severe respiratory diseases avert acute episodes, reduce unnecessary hospitalizations, and live as comfortably as possible. Engaged COPD members are contacted for routine check-ins.

Diabetes Support and Management Programs- We offer comprehensive programs that support and educate members with diabetes to help them understand and better manage their condition more effectively. Our diabetes programs are designed to improve each member's ability to self-manage not

only their diabetes, but the other diagnoses frequently encountered with diabetes. The primary goal is to change behaviors to prevent unnecessary hospitalizations and further progression of the disease.

Our diabetes support program is designed to educate eligible members on the importance and relevance of achieving good diabetes control. Our diabetes management program addresses each member's clinical needs, helping them achieve optimal care by working closely with the member's physician. We use predictive modeling systems and a member's claims data to identify possible gaps in care such as missing lab tests, prescription medications and screenings.

One of our key initiatives is our diabetes outreach program. This program is designed to educate eligible low and moderate risk diabetic members on the importance and relevance of achieving good diabetes control. Engaged members receive diabetes education and strong encouragement to see their primary care physician; if needed, see an endocrinologist; and become engaged with a local diabetes educator for personalized care and diabetes self-management education. In addition, we provide one on one coaching that stresses the importance of medication management and/or reaching out to their doctor or pharmacist regarding specific concerns/instructions.

Chronic Obstructive Pulmonary Disease (COPD) Program- Members with COPD, who are high risk due to the severity of their condition, are eligible for our remote patient monitoring care management program, which helps members diagnosed with emphysema, chronic bronchitis, asthma, and other severe respiratory diseases to avert acute episodes, reduce unnecessary hospitalizations, and live as comfortable as possible. Engaged COPD members use devices provided by our clinical team to track biometric readings and answer daily assessment-based questions about their health and condition.

Coronary Artery Disease (CAD), Congestive Heart Failure (CHF) program- Our heart failure program is a modernized digital first model powered by technology which enables resources to align with individual health needs. This program helps members manage their illness through home biometric monitoring and education. This program is a comprehensive solution, offering members a unique combination of daily at-home biometric monitoring, care coordination and patient education. This program also helps members better understand their illness, as well as how to keep up a healthy lifestyle, adhere to physician treatment plans and medications.

Low Back Pain or Musculoskeletal Pain- For members with low back pain or musculoskeletal pain, we provide a single point of contact to support and guide members when a request for a specific surgical procedure, such as a hip or knee replacement, is requested. Our service navigator will help the member with identifying issues like surgery and rehabilitation costs, transportation needs, durable medical equipment needs, medications and any service-related issues.

Weight Complications- We offer a proprietary, 52-week intensive lifestyle intervention program which focuses on helping members lose weight and maintain weight loss. The program is delivered live over the internet and combines entertaining and educational videos, live virtual coaching and online group participation. This program is customized to meet the preferences of each member to maximize outcomes and results.
Members receive access to all of the tools they need to succeed in the program. We provide a customized at home kit including electronic body weight scale, electronic food scale with bowl, resistance band, water bottle, measuring cups and spoons, portion plate, measuring tape, pedometer, session guide, nutrition guide, food blender and workout DVDs. We also provide an interactive app which provides online tools, popular nutrition, and exercise tracking software. Our program also includes group sessions with a coach and one on one fitness coaching.

Hepatitis C- We have screening initiatives and guidance to identify members who are at highest risk for Hepatitis C. Chronic care management is offered to our members through our high-risk care

management program which delivers high-touch, intensive services to retirees with complex illnesses and multiple comorbidities.

Fibromyalgia- Telephonic nurse support is available for members in need of a single point-of-contact 24 hours a day, seven days a week, and is integrated with our high-risk clinical programs. Our nurses can refer a member to the right health or well-being resource. This includes referrals to programs that will provide complex condition support for fibromyalgia.

Irritable Bowel Syndrome- Our telephonic nurse support provides a single-point of contact 24 hours a day, seven days a week for members who need clinical support for irritable bowel syndrome. Telephonic nurse support is also integrated with our high-risk clinical programs. Our nurses will refer a member to the right health or well-being resource.

End Stage Renal Disease- We have offered an end stage renal disease (ESRD) care management program since 2006 and have served over 40,000 Group Medicare Advantage members with ESRD. Our predictive model identifies members prior to starting dialysis. The foundations of our ESRD care management program are self-management, as well as communication and collaboration with the dialysis facilities and the treating nephrologist. Nutrition, treatment of co-morbid conditions (especially diabetes and hypertension), infection prevention (including flu and pneumonia vaccination), financial assistance, behavioral health (depression screening) and advanced care planning are all components of our ESRD care management program.

Transplant Case Management- Our transplant management program drives positive clinical outcomes by addressing the complex needs of older adults who are facing transplants. We cover all phases of transplant coordination, from evaluation, pre-transplant, transplant, post-transplant and 12-month follow-up health care Our unique clinical experience significantly reduces overall medical costs. Our Centers of Excellence network health care providers drive quality patient outcomes, with high patient one-year survival rates.

Chronic Kidney Disease- This evolutionary care coordination program is for participants with stage 3 chronic kidney disease. Our Specialty trained nurses focus on coaching the member on diet, lifestyle, medications and getting care from high quality nephrologists. The goals of the chronic kidney disease program are to delay the progression of kidney disease, avoid or delay ESRD and the need for dialysis by early intervention and prepare members for pre-emptive renal transplants.

Behavioral Health- We have a large, specialized network of licensed behavioral health professionals and facilities for the treatment of mental health and substance use conditions. Our behavioral health management team is integrated with our medical team. They work together to identify, engage, and manage members' behavioral health concerns. Our integrated approach is industry-leading and uses clinically proven approaches to care including confidential access 24 hours a day to master's-level clinicians, guidelines, screeners, and other tools to appropriately identify behavioral health risk groups in older adults. Our behavioral health care program is led by experienced geriatric psychiatrists and licensed behavioral health clinicians with significant geriatric expertise.

Advanced Illness- We have offered an advanced illness care management program since 2006. The advanced illness care model is a comprehensive, evidenced-based approach facilitating appropriate, quality care focused on the last 12 months of life. We provide education and integration of palliative care, as desired by the member and family/caregiver, within a community health services delivery model which improves outcomes and assures appropriate care.

QUALITY OF CARE

Quality of care is the primary focus of our clinical programs and services, with markers of success being measurable improvements in members' health status and clinical outcomes. Our high Star ratings reflect how we are improving member health outcomes, closing gaps in care and helping members take the right action at the right time. We offer the only 5 Star rated national PPO plan in the Group Medicare Advantage market.

Over the past four years, we have closed more than 8 million quality gaps in care for our Group Medicare Advantage members. This includes activities such as colon cancer screenings, medication adherence, and controlling blood pressure.

Examples of how we improve health status and care outcomes include:

- UnitedHealthcare's Diabetes Support Program provides telephonic outreach conducted by a registered dietitian working in collaboration with registered nurses. Engaged members receive diabetes education and strong encouragement to see their primary care physician, and if needed, an endocrinologist. In 2021, our Diabetes Support Program engaged 77% of diabetics across the country. For outcomes, all CMS Star ratings related to diabetes care (e.g., blood sugar control, retinal eye exams, etc.) scored 5 Stars in our 2022 Group Medicare Advantage contract rating.
- Our proprietary HouseCalls program lowers the rate of hospitalization, decreases emergency room visits and increases PCP visits, based on peer-reviewed data. We completed more than 330,000 HouseCalls visits across our Group Medicare Advantage book of business in 2021.Over the past decade, HouseCalls has performed more than 2.1 million visits to Group Medicare Advantage members.
- As a result of our Prediabetes screening efforts, our HouseCalls practitioners have screened more than 82,000 members across our Book of Business in 2021 and have identified 24% as being prediabetic and 3% as being undiagnosed diabetics. In Arkansas, we found that 26% of the screened members identified as prediabetic and 4% identified as undiagnosed diabetics in 2021.

Our comprehensive breadth of custom Medicare population-focused clinical programs provides:

- Dedicated clinical leadership oversight of clinical programs and direct clinical support to members and their physicians.

- Interdisciplinary clinical staff dedicated to Group Medicare Advantage members.

Medicare-specific engagement and outcomes reporting. We measure our impact on quality of care, health status and clinical outcomes through pre-and-post evaluations, trends in utilization, as well as through more rigorous matched cohort studies.

UnitedHealthcare will provide members access to behavioral health services in a primary care setting, during chronic condition case management, during an acute inpatient episode, and during post- discharge follow up. Our behavioral health management program has an integrated approach with our medical team to identify, engage and manage members' behavioral health concerns. A referral is not required to obtain services from a behavioral health practitioner. Our behavioral health program includes:

- Confidential access 24 hours a day to master's-level clinicians, who are qualified to handle behavioral health crises and who routinely screen for depression and substance use-issues
- Case management for members who are experiencing co-morbid conditions such as depression, end of life issues, dementia, and other related illness.

Primary Care and Chronic Condition Management

For members in primary care and in chronic condition case management, we coordinate referrals from medical management to behavioral health. Expedited referrals are warm-transferred to a behavioral health care manager on our assessment and triage team for medical-behavioral care coordination. Referrals are generated through our clinical care platform and routed to the behavioral case management program.

Each health risk assessment, including HouseCalls visits, includes the Patient Health Questionnaire-2 (PHQ-2). Members who score positively are referred for more comprehensive screening for depression. If the member scores positively on the PHQ-9 a referral is generated to a behavioral health care manager.

Following identification, a clinician will contact the member to perform a comprehensive assessment and work with the member's health care provider to ensure the appropriateness of the treatment plan.

Outpatient

For members in the outpatient setting, we have enhanced our ability to provide support to members with comorbid medical/behavioral issues via our Virtual Behavioral Health Counseling. This program engages members experiencing depression, anxiety or stress as a comorbidity with a medical condition. When enrolled, members receive eight weeks of telephonic or video-enabled behavioral health services.

We also monitor outpatient care through our proprietary model. This program emphasizes early identification and monitoring of high-risk cases among those members in outpatient behavioral health treatment, allowing us to deliver tailored interventions based upon health risk categories and member need, using two key methodologies: wellness assessment and claims data.

Inpatient and Discharge

For behavioral health and substance abuse members, inpatient care advocates use care guidelines to conduct concurrent reviews between admission and discharge.

The discharge planning process begins at the time of admission. Our experienced care advocates assist our members with discharge planning and obtain timely outpatient follow-up appointments and other services.

Within two business days of discharge, a care management nurse or behavioral health care advocate contacts the member to conduct an assessment and, if needed, talks with the attending physician to identify any gaps in health care services and in the member's ability to self-care.

UnitedHealthcare will provide after-hours behavioral health and crisis call support. There are specific procedures to handle emergency calls during and after hours and specific procedures to handle threats of violence. Licensed clinicians are available 24 hours each day of the year to triage crisis callers including members who present with threats of violence, such as suicidal or homicidal ideation.

UnitedHealthcare will educate members and medical providers and facilities of available behavioral health services. Communication about behavioral health services starts before enrollment and continues throughout the retiree's tenure as a member. Member education is provided through telephonic outreach, mailers, and emails. We provide education on available follow-up resources, such as referral to a provider, behavioral health virtual care options, and enrollment in a behavioral health support program. Our case managers provide real-time education when interacting with members who have anxiety, depression, or other behavioral health symptoms.

We educate our members about behavioral health services through the following methods:

- Member materials focusing on new retirees pre-and post-enrollment, e.g., open enrollment materials.
- Messaging is nested within several multi-message outreaches via mail and email throughout the year to both new and tenured members, e.g., our monthly email newsletter, new member onboarding calls, and email.
- Health and Wellness articles on **retiree.uhc.com**. Our helpful educational materials, as well as interactive programs and videos, provide physical, behavioral health and wellness information to help members get involved in their care.
- Live and Work Well (**liveandworkwell.com**) provides our members with content on multiple behavioral health challenges and provides navigation to behavioral health resources, programs, and providers. This site provides information on the following programs:
- Self-Guided Mindfulness Program provides self-guided education, tools and activities for members.
- Virtual Behavioral Counseling provides cognitive behavioral therapy to help members improve their health.
- Virtual Education Center (**uhcvirtualretiree.com**) is a website with educational materials about behavioral health and other clinical programs available to members.

Referrals from Providers and Facilities and Educational Resources for Providers

UnitedHealthcare coordinates referrals from medical management to behavioral health, including from outside providers. Expedited referrals are warm-transferred to a behavioral health care manager on our assessment and triage team for medical-behavioral care coordination. Non-urgent referrals are directed to the behavioral health team through a secure mailbox and are prioritized by their urgent/non-urgent classification.

Our behavioral health care team has specific experience and training to coordinate our retirees' needs. Our behavioral health specialists make the initial attempt to contact the member at the date/time indicated on the internal or external provider referral. Timeframes for referrals are:

- Expedited Referrals: by the end of the business day following the day of the assignment (or sooner).
- Routine Referrals: by the end of the third business day following the day of the assignment (or sooner).

Our provider outreach teams provide education to clinicians and facilities in the community about UnitedHealthcare behavioral health services. The provider website has a specific behavioral health subsection (**uhcprovider.com/behavioralhealth**). Here providers can find information on:

- Screening tools: Validated and downloadable depression screeners in several languages.
- Behavioral health information library: A library of articles to support prevention and recovery for each behavioral condition, co-morbid conditions, and web links to nationally recognized practice guidelines. A self-appraisal tool is available for members and providers to use for referrals.

Information on behavioral health referrals: Instructions on the provider website for referring a member to a United Behavioral Health network practitioner for assessment and/or treatment.

UnitedHealthcare will give medical providers access to clinical documentation of behavioral health case management notes. While we do not provide medical providers direct access to our clinical documentation system, interaction with providers is a vital component of UnitedHealthcare's medical management programs and ensures important information regarding our members is available to the physician at the right time. We collaborate closely with care providers to support improved population and member health through data-sharing, year-round electronic chart collection, performance incentives and field-based practice resources. Our staff shares information over the phone as part of standard intervention and care coordination outreach. Clinical data more broadly may also be faxed at the discretion of the nurse or taken to provider visits by the members themselves for review.

Providers can also use our web portal to receive additional information such as:

- Emergency room visits
- Daily inpatient census
- Risk scores
- Patient medication profile
- View care by other providers
- Member level medication adherence data
- Member participation in UnitedHealthcare programs
- Social needs

We also partner with providers to encourage care coordination by sending reminders for preventive services and lab tests.

Providers are also notified of member participation in condition management programs. Participating members are encouraged to make and keep provider appointments, discuss a plan for potential exacerbated symptom management, and supported in following their treatment plan. Remote biometric monitoring alerts and notifications are sent to our internal care teams and to providers when intervention may be needed.

UnitedHealthcare will minimize member disruption during the discharge or transition of care processes. On-site (in facility) and remote case managers will be available for members at facilities statewide.

UnitedHealthcare will ensure provider advocates are available via telephone and physically in Arkansas. We currently have 108 provider advocates who live in Arkansas. In addition to the provider advocates, UnitedHealthcare has a clinical management team supporting the provider advocates, providers and retirees. Our clinical and medical management team grows in proportion to our membership and in 2022 our dedicated Arkansas team currently includes.

- Market medical director dedicated to Arkansas.
- For our proprietary HouseCalls program team we have 20 full time nurse practitioners located in Arkansas.
- In-home Palliative Care program: There are 14 staff members who reside in Arkansas.
- There are 14 registered nurses who provide remote coverage of inpatient care management for the Medicare Advantage members across Arkansas.
- There are 11 care coordinators consisting of registered nurses, physical therapists, occupational therapists and cross-market telephonic support, who coordinate care for Medicare Advantage members in skilled nursing facilities across Arkansas. Additionally, we have 6 pre-certification coordinators who support Arkansas members.

We have 43 nurses that provide case and disease management support for members in Arkansas and have the proper endorsements through Nurse License Compact.

- A national medical management team fully dedicated to Group Medicare Advantage retiree groups, which consists of board-certified geriatricians, hospice and palliative care providers, geriatric nurses and nurse practitioners and clinical Part D pharmacists
- Over 200 collective years of geriatric medicine and nursing experience

UnitedHealthcare will review medical management and utilization management. We review 75% of acute cases and 78% of post-acute cases. Most acute stays are reimbursed under diagnosis-related group (DRG) methodology and these inpatient cases are only reviewed for admission. For a small number of hospitals, inpatient cases are reviewed daily. Skilled nursing facility cases are reviewed on day 3 and then every 7 days.

UnitedHealthcare will implement medical necessity guidelines that align with EBD's benefit intent and will evaluate and update/revise guidelines as needed. Our Utilization Management programs use a medical necessity review process that focuses members receiving the right care in the right setting at the right time by evaluating the quality, continuity, timeliness and outcomes of health services. Our medical directors and nursing staff work closely with providers to ensure treatment plans are consistent with evidence-based guidelines, are clinically appropriate, cost-effective and optimize health care outcomes. Our executive medical policy committee reviews and updates local clinical guidelines at least every two years to ensure continued consistency with scientific knowledge and that they reflect current standards of clinical practice.

Medical Necessity Review

Based upon a foundation of evidence-based medicine, medical necessity review is a process for determining benefit coverage and/or provider payment for services, tests or procedures that are medically appropriate and cost-effective for the member. The process:

- Provides an opportunity to address covered services at the individual level to support enhanced access to quality care for the member
- Uses generally accepted standards of good medical practice in the medical community
- Offers timely communication between health plans, members and providers to allow for prospective, concurrent, and retrospective review as well as appeal rights for adverse determinations

Standards For Medical Necessity

CMS reviews clinical evidence in the development of its medical policies. UnitedHealthcare follows all applicable local and/or national coverage determinations (LCD/NCDs) as required by CMS for its Medicare Advantage programs. Where CMS has not provided guidance, we have developed a hierarchy of clinical evidence to use in evaluating the scientific literature and developing medical policy. Input from appropriate external clinicians and specialty societies are sought during the development of our medical policies. Medical policies are approved via a committee structure that incorporates external Medical Advisory Committees, internal physician medical directors, our National Quality Oversight Committee, and executive oversight.

Each policy is then evaluated for application to our Medicare programs. UnitedHealthcare has developed Medicare Advantage Coverage Summaries to assist our reviewers in correctly applying CMS coverage determinations and internal medical policies. Our approved medical policy, practice guidelines, and coverage summaries are published to providers via our provider portal. Our provider advocates maintain a communications channel with our network clinicians to allow ongoing feedback regarding our policies and guidelines and have incorporated use of guidelines into our provider contracts and provider administrative guides. Additionally, we have standardized internal communication processes to ensure appropriate and consistent administration of these policies.

We will work collaboratively with EBD to ensure alignment between benefit intent and medical necessity guidelines. As part of implementation for the new calendar year, we propose to review the list of services that require medical necessity authorization. This discussion would be part of a "benefit intent" meeting prior to the January 1st go-live date of the plan.

Providers in the Medicare network and their staff have online access to the services requiring medical notification and prior authorization. This service list is described in the Medicare Advantage policy guide and available on **www.uhcprovider.com.**

CONFIDENTIAL

UnitedHealthcare will implement a referral process that includes communication between all parties (PCP, specialist, and medical management) prior to the issuance of a referral, timelines for communication, and after-hours processes. Our referral process includes the following services which may need a referral authorization:

- Outpatient services
- Laboratory and diagnostic testing
- Specialty consultation/treatment
- Facility admissions
- Out-of-network services

The referral process verifies eligibility and participating health care provider listings on all referral authorization requests. This helps ensure members are referred to the appropriate network provider, including the following procedures:

- When a member requests specific health care provider services, treatment or referral, the PCP or treating health care provider reviews the request for medical necessity.
- If there is no medical indication for the requested treatment, the health care provider discusses an alternative treatment plan with the member.
- If the member's treatment option requires referral or prior authorization, the PCP or treating health care provider submits the member's request for a decision. The PCP or treating health care provider includes appropriate medical information and referral notes about why the requested service is medically necessary. Information should include results of previous treatment.
- If the request is not approved in whole a denial letter will be issued to the member. It states the requested services, treatment or referral and complies with applicable state and federal requirements.

Our prior authorization turn-around time includes the following:

- 14 days for standard requests
- 72 hours for urgent requests

Requests for care after-hours are handled in several ways:

- Telephonic Nurse Support is an inbound and outbound call model providing members with services such as telephonic triage and support by registered nurses 24 hours a day, seven days a week.
- In our behavioral health management program, members have confidential access 24 hours a day, seven days a week to masters-level clinicians, who are qualified to handle behavioral health crises and screen for depression and substance use issues.

- Virtual visits are available 24 hours a day, 7 days a week. Members can experience a live video chat (synchronous communication) with a doctor using their computer, tablet or smartphone. Members can ask questions, get a diagnosis, and get medication prescribed and have it sent to their pharmacy. The telehealth physicians will alert patients if they need to see an in-person doctor for treatment.

- Our Advanced Illness and Palliative Care Program helps our most vulnerable members in locations that do not have in-home palliative care. Specially trained nurses routinely contact these members on an ongoing basis. We provide 24 hours a day, seven days a week member and caregiver telephonic support. Our nurses help the member connect with their doctors and establish a contingency plan for urgent issues to protect them from avoidable hospital admissions.

UnitedHealthcare will provide training for providers regarding utilization management issues and shall identify, educate, and/or sanction non-compliant providers. We provide education and training to physicians in multiple ways, starting with the initial contracting and credentialing process on through their subsequent recredentialing which takes place every three years. Below we describe in more detail the various methods we use to engage and reach out to providers as well as monitor and evaluate performance with regard to utilization management issues:

PHYSICIAN EDUCATION/ENGAGEMENT

We offer physicians written documentation of clinical review criteria used in making utilization management determinations. Providers may initiate requests through our customer service, intake or account management departments. Copies of Coverage Determination Guidelines (CDG) and Medical Policies are available on our physician website, **www.uhcprovider.com**. We also share the applicable CMS Local Coverage Determination, CMS National Coverage Determination, or CMS Medicare Manual.

From a clinical perspective, we involve the providers during utilization management functions, which are geared to facilitate the member's health care in coordination with the provider. This includes inpatient utilization management and secondary level of care (skilled nursing facilities) management.

We have physician advisory councils around the country that are led by local medical directors and include community-based physicians. These councils serve UnitedHealthcare in both an information distribution role and an active listening role so that we can engage providers in a timely and ongoing manner.

BEHAVIORAL HEALTH NETWORK

Providers receive training regarding our utilization management expectations as part of their orientation materials. Additionally, our provider manual which is incorporated by reference in our provider contracts requires our providers to participate and comply with our utilization management and quality management policy and procedures.

Our educational materials include:

- Administrative protocols, including our policies and procedures for credentialing and privileging, obtaining treatment authorizations and submitting claims and appeals. Our Network Manual, which is sent to every clinician upon joining our network, is also available online. The manual documents our administrative protocols and provides details on both regulatory requirements and our expectations for treatment.

- Clinical reference material and resources, including our Clinical Criteria used to make level of care decisions. These references help promote clinical best practices and consistency within our network.
- Frequently used forms, which can be downloaded for use. These include applications to join our network, Outpatient Treatment Reports for continuing certifications and claim forms.

PROVIDER NON-COMPLIANCE

UnitedHealthcare records and investigates issues or complaints about providers and conducts on-site inspections when necessary to make certain that our members receive quality care. We also perform reporting on a semiannual basis to monitor site deficiencies and activities.

We take multiple steps when a provider is not in compliance with our network agreements, including our utilization management requirements. The process for managing complaints is consistent with CMS regulations. We monitor the issue or complaint and give the provider feedback and opportunities to make corrections. If corrective actions are not made, the process is escalated, and providers are terminated if they do not comply. UnitedHealthcare follows required state and federal requirements for handling the change in participation status.

UnitedHealthcare will utilize value-based contracting practices both nationally and in Arkansas (to the extent permitted by CMS) whenever possible. We plan a significant expansion of value-based contracting over the next three to four years that will benefit members in Arkansas and we will be carefully evaluating all opportunities to collaborate with providers who are aligned with our strategy. Expanding the contracted network not only gives members the “peace of mind” of seeing their doctor or hospital's name in the directory, but it also gives us the best opportunity to collaborate with the medical community on shared-risk arrangements that better identify and close gaps in patient care, drive higher-quality health outcomes, and establish incentives to lower the total cost of care for attributed health plan members. As of 3rd quarter 2021, 56% of all UnitedHealthcare Medicare Advantage spending focuses on value-based arrangements as 5.8 million Medicare Advantage members are impacted by value-based programs. Specifically in the state of Arkansas 23% of Medicare spend are in value-based arrangements.

Value-based care improves member health as evidenced by the following:

- Medicare seniors in Accountable Care Organizations (ACOs) see their primary care providers nearly 70% more often for annual care visits, and receive critical tests and screenings more frequently, at a rate of approximately 14% higher for colorectal cancer and 53% higher for A1c testing to diagnose and manage prediabetes and diabetes.
- Star ratings for Medicare ACOs are approximately 35% higher.
- Acute admissions per 1,000 members decreased 3.8% from 2020 into 2021.
- In 2021, Value-based care arrangements closed 5,829,723 gaps in care.
- There are 193 providers in Arkansas in a Medicare Advantage value-based contract.
- 185 participating groups with 57,646 lives
- 8 out-of-network groups with 3,885 lives

Like health care reform, the goal of our value-based contracting strategy is to move toward increased collaboration among providers through clinical integration within the health care community and greater emphasis on shared-risk accountability for improved outcomes. Our Group Medicare Advantage plans are focused on increased collaboration with providers including our collaborative data sharing with Accountable Care Organizations (ACOs). This program shares data between providers and UnitedHealthcare for both clinical and stars performance improvements. Our collaborative data sharing with providers has the following benefits:

- Identifies gaps in care that physicians can use to effectively care for patients
- Physician and health plan performance information can be used by UnitedHealthcare members to make informed decisions about their health care options

UnitedHealthcare will utilize "total cost of care" reduction programs whenever possible. UnitedHealthcare Group Medicare Advantage works to control costs, improve quality and access to care, and enhance clinical outcomes for our members. Examples of "total cost of care" reduction programs include:

- Bundled payments. The UnitedHealthcare Care Bundles Program offers care providers in more than 21 states the opportunity to participate in bundled payment models for their patients enrolled in UnitedHealthcare Medicare Advantage plans for certain procedures, including hip and knee replacements, spinal fusions and coronary bypasses. These episodes of care bundled models contribute to total cost of care reduction by sharing more risk between providers and UnitedHealthcare.
- Value-based provider contracts. UnitedHealthcare collaborates with high-performing physicians and health systems throughout the country that have a proven record of working towards offering high quality, lower costs and a better patient experience. The plan pulls the triple aim focus-improving health care affordability, outcomes and the patient experience - together to provide the member with direct access to care from these established providers. These alternative payment models include Accountable Care Organizations (ACOs) and delegated arrangements with provider practices.
- OptumCare provider relationships. Optum Care (part of UnitedHealth Group) is a family of more than 53,000 doctors and 1,450 neighborhood clinics across the country, including MedExpress in Arkansas. OptumCare's major focus is primary care, with a goal to deliver high-quality care at lower cost. These efforts toward value-based care are making a meaningful impact in Medicare Advantage, with a 30% lower cost of care in mature markets, compared to traditional Medicare fee-for-service.
- Medical and pharmacy utilization management. Utilization review activities are a component of total cost of care through their focus on objective, evidence-based, nationally recognized Medicare medical policies, clinical guidelines and criteria. These policies, guidelines and criteria promote delivery of appropriate care to members in the most appropriate setting at the appropriate time, which contribute to total cost of care improvements. The program includes end-to-end processes such as prior authorization, prospective/pre-service review, inpatient care management, concurrent review, discharge planning, post-service review, and pharmacy management.

- Point of Care Assist. Point of Care Assist adds real-time patient information —including clinical, pharmacy, labs, prior authorization, eligibility and cost transparency — to existing electronic medical records (EMRs) to make it easier for physicians to understand what patients need at the point of care. This contributes to total cost of care by highlighting estimated care costs and by incorporating evidence-based prior authorization criteria during the prescribing process. Our year-end 2021 enterprise report shows that we currently have 661,000 active providers utilizing our Point of Care Assist system. These providers have processed 120 million transactions and addressed 1.5 million gaps in care.

UnitedHealthcare will provide criteria and processes for case management referrals to the Medical Director, specialty programs, and community resources including addressing social determinates of health. Successful population management begins with the identification of those individuals who are most likely to benefit from the services we offer. All of our primary programs stratify based on predictive modeling, which considers priority of disease interventions, and utilization of resources.

We identify potential members for our care management programs in the following ways:

- Predictive modeling
- Health Assessment
- Claims data analysis
- Referrals from providers/health care practitioners
- Inpatient and outpatient notification of services
- Self-referrals
- Through triage from our integrated programs

Through the health assessment members are asked a series of questions that measure their health needs. From this, some members are targeted for specific interventions such as referrals to condition management programs or one-on-one consultation with care management services.

CRITERIA AND PROCESS FOR REFERRAL TO MEDICAL DIRECTOR

UnitedHealthcare has local, regional, and national medical directors who support utilization management, care and condition management programs, quality of care and star rating initiatives, provider performance and education, and innovation.

The medical director works with our case managers and when opportunities for improving a member's care or health are identified, the case managers discuss these with the medical director and alterations to the member's care plan are established and initiated. In addition, the medical director interfaces with the member's treating physician(s).

The medical director also receives routine case review referrals from care management staff and reviews approximately 5% of cases over the course of a year.

Criteria and Process for Referral to Specialty Programs and Community Resources

UnitedHealthcare connects members to community resources to address non-clinical aspects known as social determinants of health (SDOH). Any member identified with an unmet social risk factor after being screened by a HouseCalls clinician, a case/disease manager, or a UnitedHealthcare advocate can be referred to our social support team.

Our support team then connect members with local and federally available resources. UnitedHealthcare partners with a robust national network of on-the-ground community experts that will help the member enroll into federal assistance programs and the member may also be referred to one of thousands of community-based programs at no cost to the member.

Clinicians routinely address food insecurity, transportation needs, medication adherence and in-home safety. We continue to expand non-medical services, including incorporating several support programs for post-discharge meals, transportation, and in-home personal care into the Group Medicare Advantage health plan.

All our clinical programs provide telephonic support to the chronically ill members and three of our clinical programs provide in-home visits and support (HouseCalls, palliative care, and serious illness support).

UnitedHealthcare Social Determinants of Health Interventions for our Group Medicare Advantage members in 2021 included:

- Over 330,000 social needs assessments were completed through our HouseCalls programs, with over 557 completed for members in the state of Arkansas.
- Over 604,661 post-discharge meals delivered to Group Medicare Advantage members across the country.
- Provided in-home personal care to over 15,0000 members assisting them with activities of daily living, household tasks, fall prevention, medication adherence resulting in 92.5 caregiver tasks completed for every engaged member

UnitedHealthcare will provide support to members that reside in lower income zip codes to access/link to community-based services, including tools to help members access and use virtual health care services. We provide support to members wherever they reside. Our telephone support programs have nurses that screen for social needs regardless of zip code. Our UnitedHealthcare HouseCalls nurse practitioners in Arkansas and throughout the country travel throughout low and higher income zip codes to provide in home support, and similarly screen every member for needs that can be solved through community- or plan-based services. To support our efforts to address social barriers to care, we have integrated the national web-based social care network, FindHelp. This resource allows our clinical and advocacy staff to connect and refer members to free or reduced cost, need-based social services in order to proactively address member Social Determinants of Health factors. FindHelp allows us to track searches, referrals, responses and outcomes data to further impact the overall health and wellness of the community and our members.

All members in our proprietary HouseCalls program or those working with an UnitedHealthcare case or disease manager are identified for support services through a proactive screening process. Tools like FindHelp are integrated into the UnitedHealthcare staff's workflow as noted above. In addition, our customer service advocates and clinicians educate members on the availability of virtual health care services and assist members with step-by-step instructions on how to access virtual care through either a national provider partner (e.g., Teladoc, Amwell, Doctors on Demand) or other virtual care available through their own community provider. Referrals to a specialized team called Resources for Members are made when the HouseCall practitioner identifies a social barrier that cannot be resolved during the visit and requires follow-up.

In 2021, across our book of business, UnitedHealthcare supported our members by delivering the following:

- Over 330,000 members screened for social needs through our HouseCalls program, with 557 members screened in the state of Arkansas.
- Over 604,661 post discharge meals delivered to Group Medicare Advantage members across the country.

Referral is also generated when a UnitedHealthcare employee identified a member with one of the issues below, which require a link to state or community-based resources:

- Medicare Savings Program (MSP): Assists members with payment of Medicare Part B premium and enrollment into Medicaid if eligible.
- Low Income Subsidy (LIS) “Extra Help”: Assists with prescription drug expenses. This could include monthly plan premiums, co-pays, and deductibles.
- Supplemental Nutrition Assistance Program (SNAP): Assist with paying for food to supplement their current food budget.
- Low Income Home Energy Assistance Program (LIHEAP): Assists members with their heating and cooling costs, bill payment assistance, energy crisis assistance, weatherization or energy-related home repairs.
- Community Assistance: Assists members to connect to community-based programs that help with food, utilities, housing, transportation, etc.

UnitedHealthcare will support senior membership with respect to issues such as anxiety/depression, substance use disorder, social isolation, food insecurity, etc. that came to light or were exacerbated as a result of the COVID-19 pandemic. The emergence of the COVID-19 pandemic caused significant changes in the provision of healthcare in Arkansas and throughout the country. There has been notable disruption to traditional patterns of care and related downstream clinical disruption that has the potential to exacerbate disparities across the nation's health care delivery and coverage systems. As a company that serves 137 million people, UnitedHealth Group has a distinct commitment to ensure that our products and services are accessible to everyone and meet the needs of a senior population. We quickly pivoted our systems, processes and people to address the changing needs of the members we serve.

Increasing Member Access to Care and Support for Vulnerable Members

- During the pandemic, member care delivery changed significantly and quickly. The opportunities below reflect how we have been able to innovate our programs and services to meet these changing needs. Opportunities include:

- Ensuring Access to Care - By using live video and other technologies, telehealth is sparking innovation that benefits members, care providers, and plan sponsors through expanded access to care, a superior care experience and greater efficiency. The result is improved health for members and a health care system that works better for everyone.

- Telehealth has allowed patients with varying needs to access quality care from established, local providers for a variety of use cases while avoiding in-person visit pain points. Updated coverage policies for telemedicine/telehealth services including consultation, office visits, individual psychotherapy and pharmacologic management. Examples include:

  - Electronic visits
  - Virtual Check-Ins
  - Remote Physiologic Monitoring
  - Interprofessional Telephone/Internet/Electronic Health Record Consultations
  - Added additional providers to keep volume and wait times down for telehealth visits. Based on our contractual agreement with each national telehealth provider group, wait times are less than 30 minutes.
  - Reduced cost-share for COVID-19 testing-related telehealth testing and treatment visits ($0 copayments) during the public health emergency.

- Addressing Social Determinants of Health - We have introduced a new benefit offering to our Group Medicare Advantage plans: UnitedHealthcare Healthy at Home. This benefit combines our market leading In-Home Personal Care, Meal Delivery, and Transportation offerings into an easy to use, comprehensive program that delivers needed support, care, and measurable results to our members. We can identify members through our HouseCalls and case management programs who have social risk factors. In 2021, our HouseCalls program screened over 330,000 members for social risk factors. We refer members to our UnitedHealthcare Resources for Retirees experts who can help to address these social factors. This resource connects members to community-based organizations, health plan resources, and federal/state programs.

- Virtual Behavioral Health Counseling - We have enhanced our ability to provide support to members with comorbid medical/behavioral issues via our Virtual Behavioral Health Counseling. This program engages members experiencing depression, anxiety or stress as a comorbidity with a medical condition offering behavioral therapy and cognitive skill coaching.

- Building on Clinical Innovation - We introduced additional remote patient monitoring, a digital care management capability that enables members to communicate and share biometric and symptom information with UnitedHealthcare Care Management staff. Through remote monitoring devices and tablet apps, real-time data is utilized to connect the member to care resources and engage their provider as needed.

- Advocating for Members - Navigate4Me offers personalized concierge services to support and guide members with complex chronic health challenges or a sudden health event. A personalized member navigation plan is developed using member data, taking into consideration the member's clinical and service needs, and ensuring it works with the member's lifestyle, while proactively removing obstacles.

VACCINE EQUITY

We have been working as part of a broad health care industry effort with the White House's Coronavirus Task Force to provide data to develop a COVID-19 vaccine equity strategy.

The COVID-19 cross-enterprise task force partnered with multiple technology teams to pull various data streams from several sources including:

- COVID-19 vaccination information from medical and pharmacy claims as well as members' self-reported data. This information is provided in monthly reporting to clients.
- COVID-19 vaccination information from CMS and state registries.
- Census Tract Records from census.gov, which focus on the subdivisions of every county that the Census Bureau collects statistical data on, including social and economic factors of the social determinants of health.
- Social Vulnerability Index (SVI) scores from the CDC which ranks the resilience of communities when confronted by external stresses such as natural or human made disasters, and disease outbreaks.

OUTREACH

UnitedHealthcare continues to be committed to providing helpful information to our clients, members and providers. Through the pandemic we have focused on:

- Regular client newsletters and webinars highlighting key information about benefits and available resources
- Client reporting examining changing patterns of healthcare screening and prevention visits as the pandemic has evolved
- Member vaccine reminder campaign both email and telephonic, along with messaging about self-guided behavioral health resources available to members at no cost, such as the Sanvello app promoting mindfulness, stress reduction, and meditation
- Vaccine tracking information highlighted in the member's electronic health record
- Updates to call center technology allowing Advocates to remind members about vaccine adherence and new services available to support the Medicare population.

UnitedHealthcare will provide our Renew Active fitness program at no additional cost. Our senior fitness program, Renew Active will be provided at no additional cost. Renew Active offers an innovative blend of physical activity, healthy lifestyle education and socially oriented programming that encourage members to take greater control of their health. Renew Active is the gold standard in Medicare fitness programs for body and mind with a larger network of facilities than Silver Sneakers. In 2021, UnitedHealthcare Group Medicare Advantage members had over 5.5 million gym visits. Members engaging in the program receive:

- A free gym membership at a nearby participating location
- Access to our nationwide network of gyms and fitness locations—the largest of all Medicare fitness programs
- Access to a wide variety of fitness classes
- Virtual resources, including access to thousands of digital on-demand workout videos and live streaming exercise classes
- Access to any participating fitness center while traveling
- An annual personalized fitness plan
- Access to social activities at local health and wellness classes and events.

MA-PD PPO Formulary and Clinical Program Management and Disruption Plan

Confidential

Formulary and Clinical Program Management and Disruption Plan

UnitedHealthcare provided a detailed formulary disruption report with our proposal response.

UnitedHealthcare will propose a Part D formulary that minimizes disruption to members while maximizing savings to members and to the Plan. Our formulary is designed for Medicare retirees. Our goal in developing our UnitedHealthcare Group Select (H) formulary is to minimize disruption to members when transitioning to our plan and provide formulary stability for members while they remain on the Plan all while maximizing savings for members and the Plan. Our Group Select formulary covers all Medicare Part D eligible drugs (in brand or generic form) and places all covered generic drugs on the lowest copay tier (tier 1).

During the first 90 days of plan membership, for many of the drugs the member is taking that are non-formulary or subject to utilization management controls (prior authorization, quantity limit, or step therapy), the plan will cover at least a one-month temporary supply. This transition supply provides the member time to discuss alternative treatments with their doctor or to pursue a formulary exception.

We use formulary tier structure and benefit design to encourage utilization of lower cost brand and generic drugs. Partnering with our wholly owned PBM, OptumRx, we negotiate with pharmaceutical companies to secure best-in-class rebates for many preferred brand products. Utilization of lower cost generic and preferred products results in lower net plan cost for EBD.

UnitedHealthcare will propose a Part D formulary that minimizes disruption to members while maximizing savings to members and to the Plan. We are offering the UnitedHealthcare Group Select (H) formulary. This formulary provides comprehensive coverage of Medicare Part D eligible drugs. Our formulary covers all Medicare Part D eligible drugs (in brand or generic form). Tier descriptions are below.

Group Select - 4 Tiers

- Tier 1 Generic: All covered generic drugs.
- Tier 2 Preferred Brand: Many common brand name drugs (called preferred brands).
- Tier 3 Non-Preferred Brand: Non-preferred brand name drugs. Also includes Medicare Part D eligible compound medications.
- Tier 4 Specialty Tier: Unique and/or very high-cost brand name drugs

UnitedHealthcare will provide formulary management support services. Our Group Medicare Part D formulary management strategy is to provide access to high quality, clinically appropriate, cost-effective therapies. Our formularies are actively managed throughout the plan year using information from industry experts within the organization to navigate the dynamic landscape. Tier and utilization management for new and existing drugs are determined by formulary design, clinical value, net plan cost and formulary stability. We strive to implement optimal formulary strategies to encourage utilization of lower cost products. Our clinical guidelines are continually updated as the market evolves and new drugs are approved by the Food and Drug Administration (FDA). As new information becomes available, positive changes can be introduced to the formulary during the plan year. Negative changes to clinical guidelines and the formulary would only occur during the plan year where CMS permits, e.g. preferring a newly launched generic over the originator brand or, in limited situations, updating prior authorization criteria to account for new clinical information like a new black-box warning.

CMS requires Medicare Part D plan sponsors to make a reasonable effort to review a new FDA approved drug within 90 days and to make a formulary decision within 180 days of its release onto the market. UnitedHealthcare's National Pharmacy & Therapeutics (NP&T) Committee supports this process by reviewing new drug approvals and making recommendations on formulary placement accordingly.

UnitedHealthcare's Part D formularies are reviewed annually, and revised as appropriate, to provide ongoing access to high quality, clinically appropriate, cost-effective therapies while aiming to provide formulary stability for members.

On an annual basis, physicians and members are notified of negative formulary changes such as new utilization management requirements. In addition, we will provide EBD with a report of annual formulary changes prior to the new year. The report will list the drugs with a formulary change categorized by the type of change, e.g. prior authorization added, along with the count of current utilizers.

UnitedHealthcare will propose supplemental coverage that wraps around the basic Medicare Part D benefits and are not covered under Part D (i.e., bonus drug list). To meet the needs of the State retirees, we are offering coverage for many non-Part D eligible drugs through a wrap named Bonus Drug List U. Unlike payments for Part D eligible drugs, payments for bonus drugs do not count toward the initial coverage allowance or true out-of-pocket (TrOOP) costs, and these payments do not help the member move into, or out of, the coverage gap. Discounts follow our network contracted rates and member cost-share is based on plan design and the drug tier.

Select prescription drugs in the following categories are covered on Bonus Drug List U:

- Drugs used for cough and cold relief
- Drugs for erectile dysfunction
- Drugs for anorexia, weight-loss, or weight-gain
- Fertility drugs
- Topical medications
- Oral vitamins
- Thyroid medications

Changes to Contractor formulary, from one year to another, must not impact more than two percent (2%) of members unless explicitly requesting in writing by EBD.

UnitedHealthcare understands the importance of formulary stability and strives to make as few formulary changes as possible from one year to the next. These formulary changes are anticipated to impact no more than two percent (2%) of members when you take into consideration access to a transition supply. To lessen the impact of annual formulary changes on members, during the first 90-days of the new plan year, for many of the drugs the member is taking that are non-formulary or subject to new utilization management controls (prior authorization, quantity limit, or step therapy), the plan will cover at least a one-month temporary supply. This transition supply provides the member time to discuss alternative treatments with their doctor or to pursue a formulary exception.

We will provide you with a report of annual formulary changes prior to the new year. The report will list the drugs with a formulary change categorized by the type of change, e.g. prior authorization added, along with the count of current utilizers.

UnitedHealthcare will work closely with EBD on the drug formulary to ensure the least amount of member disruption as members transition from the active/non-Medicare plan to the MA-PD plan. Our formulary design is one of the greatest strengths associated with our Employer Group Waiver Plan (EGWP) plans. With the guidance of our National Pharmacy & Therapeutics Committee, we developed a comprehensive Part D formulary that meets the needs of retirees while minimizing disruption for those individuals that are switching from an active/non-Medicare plan to an EGWP plan

We are offering the UnitedHealthcare Group Select (H) formulary. This formulary provides comprehensive coverage of Medicare Part D eligible drugs. Our offered formulary covers all Medicare Part D eligible drugs (in brand or generic form) with all covered generic drugs in the lowest copayment tier (tier 1). In addition, we are offering Bonus Drug List U (non-Part D drugs) and our $0 ACA Preventive List.

UnitedHealthcare will allow members to obtain an excluded prescription through a prior authorization for medical necessity. Consistent with Medicare Part D regulations, should a member require access to a Part D drug that is not covered on the formulary, the member or their physician can request a formulary exception.

UnitedHealthcare will provide Rx utilization management programs (prior authorizations, quantity level limitations, age and gender restrictions, medication therapy management, high-risk drug for the elderly, etc.) that include enrollment, targeting, reporting, and outcomes reporting. A number of embedded programs work together to make up our Rx utilization management approach. These programs together guide members to safe, appropriate and cost-effective medication therapies and help provide a sustainable benefit.

Prior Authorization

Prior authorization manages the appropriate use of high-cost and/or highly utilized therapeutic drug categories that have potential for inappropriate or unsafe use in the elderly. We develop our prior authorization criteria based on nationally recognized clinical practice guidelines, Food and Drug Administration (FDA) labeling, published clinical literature, and input from practicing medical experts. Our goal is to increase formulary awareness, promote positive clinical outcomes, minimize the use of high-risk drugs in the elderly, and reduce drug costs.

Drugs may require prior authorization if there are coverage, efficacy, or safety concerns. For example, in certain circumstances, some drugs are covered by Medicare Part B, and in other circumstances, covered by Medicare Part D. Prior authorization is also to so the plan collects the necessary information to make the appropriate coverage determination.

Use of prior authorization has been successful in reducing utilization of drugs with safety concerns in those aged 65 and over (high-risk drugs in the elderly), as well as other age-related safety edits, such as certain vaccine requirements. We no longer have gender edits in our guidelines. Applying prior authorization encourages providers to prescribe safer alternatives covered by the plan.

Quantity Limits

Quantity limits identify appropriate maximum drug quantities for either a defined period of time or per prescription fill. A quantity limit is placed on a drug for three primary reasons:

- Ensure safety where well-established dosing limits exist. For example, prevent unsafe acetaminophen dosing by evaluating the total amount of drug available to the member across all acetaminophen-containing analgesics.
- Prevent fraud, waste, and abuse. For example, validate that the claim's days' supply is consistent with the quantity submitted.

- Encourage dose-optimization to maximize cost-effective dosing. For example, when a drug is available in multiple strengths (e.g., 10mg and 20mg), quantity limits can encourage the use of one 20mg tablet rather than two 10mg tablets. This results in no clinical difference to the member and reduces plan drug cost.

Quantity limits are determined by UnitedHealthcare's National Pharmacy and Therapeutics Committee based on dosages defined by the FDA, nationally recognized clinical practice guidelines, or other published clinical literature.

Described below is the process for enrollment, targeting, reporting and outcomes reporting for our Rx Utilization Management programs that are available to 100% of qualified members.

MEDICATION THERAPY MANAGEMENT PROGRAM

We manage an integrated Medication Therapy Management (MTM) program designed for our Medicare Part D population. The program promotes safe, appropriate and affordable medication use by providing education and consultation to targeted members, their caregivers and their prescribing physicians. Our program offers a holistic approach to improving medication use by addressing all types of drug-related problems to manage utilization and improve quality of care.

Services include, but are not limited to:

- Providing member and physician education
- Detecting clinically significant drug interactions
- Detecting medications that are considered inappropriate in older individuals
- Detecting patterns of over- and under-utilization of prescribed medications
- Maximizing effectiveness of medication therapy

ENROLLMENT AND TARGETING

Members meeting specific criteria are identified for the program. The targeting criteria are as follows:

- Members have at least three of the following five chronic conditions:
  - Diabetes
  - Dyslipidemia
  - Heart Failure
  - COPD
  - Osteoporosis
- Member takes eight or more chronic Medicare Part D medications
- Member is projected to reach a Medicare Part D cost threshold of $4,696 in 2022

Key components include:

Comprehensive Medication Review

The UnitedHealthcare Medication Therapy Management Program (MTM) communicates interventions to prescribers and members to optimize therapeutic drug management by improving medication use while reducing adverse events. Members meet criteria for inclusion if they have certain conditions, have a high number of prescribed medications, and they meet projected drug spend thresholds. Members identified for this program are eligible for individualized member counseling by our Comprehensive Medication Review (CMR) provider to address drug therapy concerns. Following the medication review and clinical assessment, an individualized plan is communicated to the member outlining the identified medication-related issues and corresponding recommendations.

Members are identified for the program each quarter and receive an MTM welcome letter offering a CMR within 60 days. We take a proactive approach to encourage all MTM-eligible members to participate in an annual CMR. Our outreach campaign consists of mailings, phone calls, emails, and text messages.

Members receive consultation that includes assessment of medication use and medication-related problems. A written summary of the interactive consultation, including a personal medication list, is provided to the member. The medication list will include all active medications including prescriptions, over-the-counter medications, herbal products and supplements. The consultation is intended to identify and address drug-related problems including:

- Adverse drug reactions
- Drug-drug interactions
- Drug-disease interactions
- Duplicate therapy
- Medication adherence
- Gaps in care

Gaps in Care

In addition to Medication Therapy Management and retrospective Drug Utilization Review (DUR), we provide Drug Therapy Management programs to address gaps in care.

These programs work to identify and close potential medication therapy gaps in key disease categories via targeted provider fax/mailings. Our programs improve member care, reduce pharmacy and/or medical costs, and optimize the appropriate use of medications in the following disease states:

- Asthma
- Cardiovascular disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- HIV
- Migraine
- Osteoporosis
- Rheumatoid arthritis

REPORTING

We develop monitoring reports and review outcomes to evaluate program effectiveness and ensure consistency with industry standards. We continue to evolve and implement enhancements to our clinical programs based on a changing clinical landscape such as changes in nationally recognized clinical guidelines, input from practicing medical experts, and CMS regulatory updates to ensure ongoing positive outcomes.

UnitedHealthcare will ensure Rx utilization management criteria are transferred properly to our system during implementation. Through our Prior Authorization transfer process, we will transfer prior authorizations, including step therapy and quantity limit authorizations, from the existing carrier through the individual expiration date, as permitted by CMS.

We will also load historical pharmacy claims so that our utilization management programs, including Drug Utilization Review (DUR), step therapy, quantity limits, etc., are effective immediately upon transition to promote safety, ensure the drug is eligible for coverage under Part D, or to reduce fraud, waste, or abuse. As an example, for drugs with a step therapy requirement, historical claims are used to verify prior use of the targeted drug and alternatives, thereby easing member transition.

UnitedHealthcare will limit member disruption for those members currently using prescription drugs requiring Rx utilization management criteria during implementation. We have a robust program to limit disruption for those members currently using prescription drugs requiring Rx utilization management. First, through our Prior Authorization transfer process, we will transfer prior authorizations, including step therapy and quantity limit authorizations, from the existing carrier through the individual expiration date as permitted by CMS.

Second, we will load historical pharmacy claims, so that our utilization management programs, including Drug Utilization Review (DUR), step therapy, quantity limits, etc., are effective immediately upon transition to promote safety, ensure the drug is eligible for coverage under Part D, or to reduce fraud, waste, or abuse. As an example, for drugs with a step therapy requirement, historical claims are used to verify prior use of the targeted drug and alternatives, thereby easing member transition.

In addition, new or existing members who experience a formulary change in the coming year may be eligible for a transition supply. During the first 90 days of plan membership, for many of the drugs the member is taking that are non-formulary or subject to utilization management controls (prior authorization, quantity limit, or step therapy), the plan will cover at least a one-month temporary supply. This transition supply provides the member time to discuss alternative treatment with their doctor or to pursue an exception for the plan to cover the drug.

Certain drugs with a prior authorization and/or quantity limit requirement are not eligible for a transition supply. Utilization management is in place for these drugs to promote safety, ensure the drug is eligible for coverage under Part D, or to reduce fraud, waste, or abuse.

When a transition supply has been filled, a letter explaining the options available is sent to the retiree and their doctor.

The processes described above, as well as our robust drug coverage, ensure a high level of continuation of care for members.

UnitedHealthcare will mine data from the incumbent vendor for either existing UM rules or new UM rules to identify members that will need UM criteria under the proposed MA-PD PPO Plan and will use incumbent data to identify better clinical management. We have extensive experience working with PBMs, vendors and clients to transition claims information to our systems. During the implementation process, we will work closely with EBD and current vendors to secure claims data and maintain the integrity of member history in our systems. This process may include the transition of:

- Open mail service refills
- Prior authorization records
- Up to 36 months of claims history

Through our Prior Authorization transfer process, we will transfer prior authorizations, including step therapy and quantity limit authorizations, from the existing carrier through the individual expiration date as permitted by CMS.

We will also load historical pharmacy claims, so that our utilization management programs, including Drug Utilization Review (DUR), step therapy, quantity limits, etc., are effective immediately upon transition to promote safety, ensure the drug is eligible for coverage under Part D, or to reduce fraud, waste, or abuse. As an example, for drugs with a step therapy requirement, historical claims are used to verify prior use of the targeted drug and alternatives, thereby easing member transition.

Managing both the medical and pharmacy components of the plan enables our clinicians to intervene with the member and facilitate appropriate discussions with their providers to ensure the member is on the correct medications.

The integration of medical and pharmacy data leads to better clinical management by providing for the following:

- Robust and timely data analysis identifying and stratifying the severity of illness of members with chronic and complex diseases
- Clinical outcomes for members resulting in reduced burden of illness, improved quality of life and improved member and caregiver satisfaction
- Reduction of health care costs (unnecessary hospitalizations and emergency room visits)
- Closure of potential medication therapy gaps in key disease categories, including bone health, diabetes and rheumatoid arthritis.

In addition, we request up to 36 months' of pharmacy data from the current carrier to be used for predictive modeling and risk stratification as another method to identify candidates for our clinical management programs. Our predictive modeling tool analyzes data based on diagnosis, care-seeking behavior, prescriptions, hospitalizations, doctor visits and tests ordered among other factors.

Our predictive modeling tool ranks each member's risk relative to other members. This clinical profile is augmented with criteria that considers risk scores in concert with other claims and non-claims-based data, enabling us to identify members who are likely to need intensive health care services in the next 12 to 18 months.

UnitedHealthcare will provide a detailed disruption report with the proposed formulary exclusions.

Except as they relate to FDA recalls or other safety issues, UnitedHealthcare will not remove drug products, brand or generic, from EBD's non-specialty and specialty formulary or non-specialty and specialty preferred drug listings without sixty-day advance notice to EBD.

UnitedHealthcare will notify EBD as soon as reasonably possible about removals due to FDA recalls and other safety issues. We will notify EBD as soon as reasonably possible about removals from the formulary due to FDA recalls or other safety issues, and 60-days in advance for other drug removals.

UnitedHealthcare will provide sixty-day advance, written notification to physicians of affected members for negative formulary changes (drug moving to non-preferred or non-covered) or when new prior authorization or step therapy rules are implemented. Physicians of affected members are notified 60-days in advance of annual negative formulary changes such as drug removals from the formulary or when new prior authorization or step therapy requirements are being implemented.

Mid-year negative formulary changes are uncommon. Our mid-year negative formulary change notification timeframes are aligned with CMS requirements. Accordingly, physicians of affected members are notified at least 30 days in advance for mid-year negative changes and may be notified retrospectively when a brand drug is moved to a higher formulary tier when a new generic is added to the formulary. CMS calls this later change, an immediate generic substitution. We notify physicians within 30 days of an immediate generic substitution.

UnitedHealthcare will provide sixty-day advance, written notification to affected members for negative formulary changes (drug moving to non-preferred or non-covered) or when new prior authorization rules are implemented. Affected members are notified 60-days in advance of annual negative formulary changes such as drug removals from the formulary or when new prior authorization or step therapy requirements are being implemented.

Mid-year negative formulary changes are uncommon. Our mid-year negative formulary change notification timeframes are aligned with CMS requirements. Accordingly, affected members are notified at least 30 days in advance for mid-year negative changes and may be notified retrospectively when a brand drug is moved to a higher formulary tier when a new generic is added to the formulary. CMS calls this later change, an immediate generic substitution. We notify members within 30 days of an immediate generic substitution.

UnitedHealthcare will use pharmacy data to identify high risk, high need populations. We use pharmacy claims data to populate a variety of predictive modeling tools to identify high risk, high need populations. Our predictive modeling tools help identify members who may have new conditions and/or special needs. We review the data and then reach out to members, or providers of members, who may be eligible for one or more of our pharmacy, clinical or condition management programs.

We identify potentially harmful drug-drug and drug-disease interactions such as those involving non-steroidal anti-inflammatory drugs (NSAID); prescribing a NSAID for a patient with renal impairment could accelerate kidney deterioration. We identify quality opportunities where known interventions have proven benefits. For example, prescribing beta blockers for individuals diagnosed with an acute myocardial infarction.

We also leverage medical and pharmacy claims to address gaps in care. This program works to identify and close potential medication therapy gaps in key disease states such as asthma, cardiovascular disease, COPD, diabetes, and migraine via targeted provider fax or mailings. Closing the gaps in care improves member care, reduces pharmacy and/or medical costs, and optimizes the appropriate use of medications in these disease states.

Pharmacy utilization data is integrated into the tools used by our UnitedHealthcare clinical staff thereby improving the overall management of members. In addition, having access to medication data enables us to identify members who are likely to need intensive health care services in the next 12 to 18 months. Members who are engaged in our clinical programs receive care and condition management interventions specific to their individualized care plan.

Medication review and reconciliation is a standard intervention initiated to ensure members are taking their medications properly. Medication review and reconciliation is the process of comparing a member's medication orders to all of the medications that the member is currently taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors or drug interactions. Often these errors can lead to hospitalizations or re-admissions and can be prevented through the medication review and reconciliation process. For members engaged in our clinical programs, this process is done at every transition of care in which new medications are ordered or existing orders are rewritten.

Also, as part of our Medicare Part D pharmacy management program, we review medication usage regularly to identify members who might benefit from our programs. Some areas of focus include polypharmacy, medication adherence and high utilization of opioid medications. We evaluate this information and communicate our recommendations to members, prescribers and/or dispensing pharmacists. For example, we use pharmacy data to identify members who are potentially abusing opioids and other high-risk medications. Members filling prescriptions for opioids, benzodiazepines, and muscle relaxants who may benefit from having their medication regimens re-evaluated by their provider, are targeted for intervention. In 2019, CMS finalized new opioid guidance permitting Part D plans to better manage access to opioids. With this new guidance, we are now able to limit opioid coverage for at-risk individuals to certain prescribers and/or pharmacies. Providers are often unaware of members receiving multiple narcotic prescriptions from other prescribers and/or pharmacies.

UnitedHealthcare will remind members regarding refills and medication adherence. We are committed to helping our members live healthier lives and has a multi-faceted approach to help our members achieve adherence to their medication regimens.

- Refill reminder calls - These are live outbound calls that are made to members at risk for medication non-adherence who are due or past due for their medications for diabetes, hypertension, and high cholesterol. Our agents help members facilitate a 3-way call to the pharmacy to assist with a medication refill, enroll members into medication refill reminder programs at the pharmacy, and help member refill extended day supplies of a medication.

- Refill reminder emails/text messages - This program provides refill reminders through email or text messages to members who are due or past due for their medications that have a preference for email or text message for communication purposes

- Retail pharmacy partnerships - We notify participating pharmacies of their patients who are at risk for medication non-adherence for their diabetes, hypertension, and cholesterol medications in real time. These pharmacists are then incentivized to work with the members through one-on-one consultations to help address their individual barriers to medication adherence.

- New to therapy mailings - When a member is new to taking a prescribed medication for their diabetes, hypertension, or high cholesterol they are less likely to be adherent. These mailings provide education on the new medication and tips on building strong medication adherence behaviors, and well as directions on how to get their next medication refill

The star ratings released by CMS in October 2021 showed 100% of UnitedHealthcare's Group Medicare Advantage PPO membership (contract H2001 and H1537) is enrolled in a 5-star plan. Our medication adherence performance continued to outpace the prior year, with the contract earning its highest total performance to-date on these Star measures.

Additionally, our disease management programs such as the Diabetes and Hypertension Support programs have built in timely “nudges” to remind our members engaged in the program to refill their medications to help manage these disease conditions.

Lastly, through our innovative HouseCalls and Medication Therapy Management program, a licensed health care professional reviews the member's entire medication history and educates on the importance of medication adherence.

UnitedHealthcare will provide e-Prescribing, allowing the member's physician access to the formulary status of a drug and ability to enter the prior authorization criteria into the e-Prescribing tool. PreCheck MyScript, within Point of Care Assist, is our e-prescribing solution that provides real-time prescription cost and coverage information before the member leaves the provider’s office, and, when needed, facilitates prior authorization requests. The tool displays the member's coverage, member cost-share, and preferred alternatives, including cost-share of alternatives. Prescribers can also submit a prior authorization request for drugs within the tool if alternatives are not clinically appropriate, which enables prescribers to make treatment decisions at point of care.

UnitedHealthcare will monitor individual physician prescribing patterns and will have processes in place to address physicians with high degrees of non-compliance. We offer a variety of clinical programs to address physician prescribing patterns that can be influenced to improve quality of care, cost savings and clinical outcomes.

Drug Utilization Review

Drug utilization review (DUR) programs help control drug spending and overuse by identifying physician-prescribing patterns, pharmacy fraud or abuse, and inappropriate or potentially dangerous member utilization patterns.

By evaluating member drug utilization against evidence-based prescribing standards and applying system edits, our specialized DUR programs promote safe prescription dispensing and cost savings while aiming to optimize drug therapy and patient health outcomes.

Our drug utilization programs include the following three types:

- **Prospective Drug Utilization Review** promotes utilization of appropriate and cost-effective medications by steering members and prescribers to medications that are considered safe and effective within the member's demographic. Prospective DUR includes drug coverage limitations, generic utilization, tiering, quantity limits, step therapy, and prior authorization.
- **Concurrent Drug Utilization Review** is applied at the point of service or before a prescription is dispensed and evaluates the prescription based on established clinical criteria. Prescriptions determined as potentially unsafe or inappropriate may be subject to drug utilization management programs.
- **Retrospective Drug Utilization** Review augments our concurrent DUR program, providing a safety net for our Medicare members. Pharmacy claims data are reviewed to identify members who may benefit from clinical interventions.

Utilization Management

Prior Authorization

Prior authorization manages the appropriate use of high-cost and/or highly utilized therapeutic drug categories that have potential for inappropriate or unsafe use. We develop our prior authorization criteria based on nationally recognized clinical practice guidelines, Food and Drug Administration (FDA) labeling, published clinical literature, and input from practicing medical experts. Our goal is to increase formulary awareness, promote positive clinical outcomes, and reduce drug costs.

Quantity Limits

Quantity limits identify appropriate maximum drug quantities for either a defined period of time or per prescription fill. A quantity limit is placed on a drug for three primary reasons:

- Ensure safety where well-established dosing limits exist. For example, prevent unsafe acetaminophen dosing by evaluating the total amount of drug available to the member across all acetaminophen-containing analgesics.
- Prevent fraud, waste, and abuse. For example, validate that the claim's days' supply is consistent with the quantity submitted.
- Encourage dose-optimization to maximize cost-effective dosing. For example, when a drug is available in multiple strengths (e.g., 10mg and 20mg), quantity limits can encourage the use of one 20mg tablet rather than two 10mg tablets. This results in no clinical difference to the member and reduces plan drug cost.

Step Therapy

Step Therapy focuses on specific drugs and drug classes to promote utilization of safe, effective, and less costly first-line medications. The program ultimately improves member behavior patterns and influences physician prescribing patterns.

Medication Therapy Management

Our integrated Medication Therapy Management (MTM) program is designed specifically for our Medicare Part D population. The program promotes safe, appropriate and affordable medication use by providing education and consultation to targeted members, their caregivers and their prescribing physicians. Key components of our MTM program include:

- **Comprehensive Medication Review** - Individualized member counseling by pharmacists or other qualified providers helps to address drug therapy concerns. Members who have multiple chronic conditions and are taking multiple medications may be identified for the program. Following the medication review and clinical assessment, an individualized Medication Action Plan is sent to the member outlining the identified medication-related issues and corresponding recommendations. Providers are also contacted when clinically significant issues arise, such as when dose or therapy adjustments are needed.
- **Polypharmacy** - In addition to the member-facing interventions outlined above, we also deploy provider-based interventions designed to identify and address drug-drug interactions, drug-disease interactions, and duplicate therapy. Provider communications are sent via fax to expedite the receipt of the pertinent clinical information.

Opioid Management

In compliance with new Federal CMS requirements as well as to promote better opioid prescribing and prevent opioid misuse/abuse by reducing opioid exposure, our opioid management program includes the following:

- Quantity limits

- One-month supply limit at both retail and mail order
- First-fill 7-day supply limit for individuals new to opioid therapy
- Cumulative opioid safety edit threshold of 200 morphine milligram equivalents (MME) per day when opioids are prescribed by two or more providers
- Lock-in capability to limit opioid coverage for at-risk individuals to certain prescribers and/or pharmacies
- Broad coverage of drugs to treat opioid use disorder on the Part D formulary. These drugs minimize withdrawal symptoms, reduce opioid cravings, prevent relapse and restore normal physiological function.

In addition, we have two clinical programs in place to provide a safety net for our Medicare members:

- Abused Medications Program promotes optimal pharmacologic therapy in the management of patients with pain while minimizing the occurrence of drug abuse, diversion, and inappropriate use of opioids, benzodiazepines, and muscle relaxants.
  - Historical claims are analyzed to identify members on opioids, benzodiazepines, and muscle relaxants who may benefit from having their medication regimens re-evaluated by their provider
  - Providers of targeted members receive reports with pertinent claims information to use in evaluating their patients' medication regimen
- Drug Management Program minimizes the occurrence of drug abuse, diversion, and inappropriate use in members utilizing potentially unsafe dosages/quantities of opioids and other frequently abused drugs, e.g., benzodiazepines
  - Historical claims are analyzed to identify potential opioid overuse and initiate clinical case management
  - Case management outreaches to providers of members that exceed the MED threshold of 90mg/day and obtain opioid prescriptions from ≥3 prescribers and ≥3 pharmacies, or ≥5 prescribers regardless of the number of pharmacies
  - Restrictions (point-of-sale edits) may be implemented to limit access to opioids or other frequently abused drugs based on provider engagement or at the discretion of the plan, e.g., edits can limit coverage to a single opioid or prevent coverage of all opioid claims
  - A lock-in capability to limit coverage of opioids or other frequently abused drugs for at-risk individuals to certain prescribers and/or pharmacies is also available

UnitedHealthcare will administer a Medicare B vs. D program at point of sale, at no additional cost.

ATTACHMENT 5

PERFORMANCE GUARANTEE METRICS

Service/Task	Service Level Target	Reporting & Assessment Intervals	Dollars at Risk
All metrics offered for membership over 20,000. For membership under 20,000, metrics highlighted in red will not be applicable			
Implementation/Annual Service Ready	100% of MA-PD services shall take effect/ go live and be fully operational on the annual 'go-live' date as specified in the Contract.	Reported annually, no later than one month after the initial 'go-live' date	$100,000
Annual Service Ready	100% of MA-PD services will take effect and be fully operational on the 'go live' date(s) as specified in the Contract for each plan year.	Reported annually, no later than one month after the annual effective date	$100,000
ID Card Delivery	UHC will guarantee 100% of ID cards will be mailed no later than one week prior to effective date on the annual distribution of ID Cards dependent upon an annual enrollment file being received by a mutually agreed upon date	Reported and assessed annually	$10,000 for each percentage point below the threshold; $500,000 annual max

Service/Task	Service Level Target	Reporting & Assessment Intervals	Dollars at Risk
Member Services			
Service Level	87% of answered member calls that are answered within 30 seconds.	Reported monthly, assessed quarterly	$10,000 for each percentage point below the threshold, measured on a quarterly basis; $85,000 annual max
Telephone Abandonment Rate	Average call abandonment rate will be less than 3%.	Reported monthly, assessed quarterly	$10,000 for each percentage point above the threshold, measured on a quarterly basis; $50,000 annual max
First Call Resolution	Calls that are completed or adequately resolved on first call. 90% of calls completed without need for referral or follow-up actions, divided by total calls received.	Reported monthly, assessed quarterly	$15,000 for each percentage point below the threshold, measured on a quarterly basis; $60,000 annual max
Post Call Survey	Post call satisfaction results are based on the United Experience Survey. The survey is designed to capture member experience and satisfaction results based on their recent interaction with our service organization. Goal 90%	Reported monthly, assessed quarterly	$10,000 for each percentage point below the threshold, measured on a quarterly basis; $50,000 annual max
Call Issue Resolution	95% of member calls are resolved within 7 calendar days of the initial call. Timeliness of resolving calls that require follow up or research. Measured by the number of calls that are resolved within 7 calendar days, divided by total number of calls received	Reported monthly, assessed quarterly	$15,000 for each percentage point below the threshold measured on a quarterly basis; $60,000 annual max
Contractor's website for the Clients Members will offer online, real-time access, except for scheduled maintenance.	The amount of time that UHC's website for Members will offer online, real-time access, except for scheduled maintenance. The UHC website for Members will be available and fully operational except for scheduled maintenance for this percentage of time. Total 'live' operational and accessibility time, divided by the difference of total time less maintenance time.. Goal 99.5% **Based on book-of-business reporting only**	Reported monthly, assessed quarterly	$10,000 for each percentage point below the threshold measured on a quarterly basis; $100,000 annual max

Service/Task	Service Level Target	Reporting & Assessment Intervals	Dollars at Risk
Claims Processing			
Medical Claims Procedural Accuracy (PAR).	97% of sampled claims without procedural errors. (Number of Sampled Claims - Number of Sampled Claims with Procedural Defects) / Number of Sampled Claims	Reported monthly, assessed quarterly	$10,000 for each percentage point below the threshold measured on a quarterly basis; $50,000 annual max
Medical Claims Processing TAT	95% of clean claims processed within 30 calendar days.	Reported monthly, assessed quarterly	$10,000 for each percentage point below the threshold measured on a quarterly basis; $50,000 annual max

Service/Task	Service Level Target	Reporting & Assessment Intervals	Dollars at Risk
Eligibility			
Eligibility updates (daily)	Daily update eligibility files will be loaded within 2 business days Files must be received by 12:00 midnight CST; otherwise, written notification of the file delivery (off schedule) must be provided and receipt confirmed by Contractor. If the file is received after 12:00 midnight CST the guarantee period commences upon file receipt.	Reported monthly, assessed quarterly	$15,000 per day for each day the standard is not met; $125,000 annual max
Clinical			
Overall H2001 Contract Star Rating	Achieve 4.0 Overall H2001 Contract Star Rating	Reported and assessed annually	$250,000
Member Satisfaction with Clinical Programs	Measurement is based off a random sampling of members. In the event that less than 200 survey responses are returned, the measure may be reported at the book of business level. Margin of error is added to the actual results in measuring against the target Year 1 - set baseline Year 2 - 80% threshold or YOY improvement Year 3 - 80% threshold or YOY improvement	Reported and assessed annually	Year 1 - baseline $0 Year 2 - $50,000 Year 3 - $50,000
Clinical Program Engagement	75% of Employer Group's population enrolled in a disease management program will receive a minimum of two completed call attempts within the first six months of program enrollment Members without valid phone numbers will be removed from denominator	Reported and assessed annually	$100,000
PHARMACY METRICS			
Annual Formulary Disruption	Changes to Contractor formulary, from one plan year to another, must not impact more than two percent (2%) of members unless explicitly requesting in writing by EBD.	Reported and assessed annually, beginning in 2024, with year 2023 as an established baseline.	2% or less: $0 >2%-3%: $50,000 >3%-4%: $100,000 >4%-5%: $150,000 >5%-6%: $200,000 >6%: $250,000
Pharmacy Mail Service Dispensing Accuracy	99.99% of mail service prescriptions that are fulfilled accurately and without error	Reported monthly, assessed quarterly	$10,000 for each percentage point below the threshold measured on a quarterly basis; $50,000 annual max

Service/Task	Service Level Target	Reporting & Assessment Intervals	Dollars at Risk
Pharmacy Mail Service Turnaround	Clean mail order prescription orders will be shipped within an average of two (2) business days following receipt. For mail order prescription orders requiring intervention, prescriptions will be shipped with an average of five (5) business days following receipt	Reported monthly, assessed quarterly	$10,000 for each day that is above the standard, measured on a quarterly basis, $25,0000 annual max
Pharmacy Processing Accuracy Rate - Paper (Direct Member Reimbursement) and electronic	99% of all prescription drug claims paid with no errors. Direct Member Reimbursement Claims only, Paper and Electronic)	Reported monthly, assessed quarterly	$10,000 for each percentage point below the threshold measured on a quarterly basis; $50,000 annual max
Pharmacy Processing Turnaround Time - Paper claims and Direct Member Reimbursement Claims (Prompt Pay DMR Claims)	Clean Claims: 99% of Part D clean claims paid to members within fourteen (14) calendar days after receipt. Paper Claims and requests for direct Member reimbursements shall be paid or denied within fourteen (14) calendar days following receipt.	Reported monthly, assessed quarterly	$10,000 for each percentage point below the threshold measured on a quarterly basis; $50,000 annual max
Bold PGs			
Customer Care Test Calls Completed	Customer Care test calls will be made prior to effective date and include calls to Customer Care Advocates to address the group's anticipated member questions . Percent of targeted calls completed; applicable coaching information provided to Customer Care Advocates. Service Account Management Leadership will determine the number of test calls required and questions to be asked. Measurement will be client specific Service Goal is 100% of calls completed in years 1, 2, 3 Reporting is client specific Reported and Assessed Annually	Reported and assessed annually	$50,000
Service Account Management Issue Resolution Turnaround Time	Percentage of issues received by the Service Account Management team that are resolved in 2 business days. Measurement is reported with Group Retiree Book of Business results Service Goals: 85% in year 1, 90% in year 2 Reporting is book of business unless actual enrollment is over 25,000	Reported quarterly, assessed annually	$10,000 for each percentage point below the threshold; $50,000 annual max

Service/Task	Service Level Target	Reporting & Assessment Intervals	Dollars at Risk
Escalations to employer under target	Requested Escalations (Issues) to employer will decrease year over year during years 2 and 3 with year 1 setting the base line. Measured as the total number of issues that the Service Account Management team receives from the employer group divided by 1000 (members). Escalations do not include value added or pro-active measures taken on behalf of a member Service Goals: 5% decrease year over year for years 2 and 3 after year 1 sets the baseline **Reporting is book of business unless actual enrollment is over 25,000**	Reported quarterly, assessed annually	$50,000
Account Management/ Client Services			
Annual Score Card for Account Management	UnitedHealthcare will achieve a satisfactory NPS satisfaction score of 7. Within the annual client satisfaction survey, UnitedHealthcare will guarantee that the client will recommend UnitedHealthcare' s retiree benefit offerings to a colleague. A score of 9-10 will be considered a promoter score, a score of 7-8 will be considered neutral, and a score of 6 or below will be considered as the metric not being met.	Reported and assessed annually	$25, 000
Member Satisfaction Survey	The Carrier agrees to have a mutually agreed upon external vendor conduct a Member Satisfaction Survey for each contract year and that the Satisfaction Rate will be 85% or greater. A penalty per Contract Year may be assessed against the Carrier for failure to meet this standard. "Member Satisfaction Rate" means (i) the number of Eligible Persons responding to Carriers annual standard Patient Satisfaction Survey as being satisfied with the overall performance under the Integrated Program divided by (ii) the number of Eligible Persons responding to such annual Patient Satisfaction Survey; the TRB must provide timely approvals and responses, and a minimum of 10% of surveys must be returned for the Performance standard to be applicable.	Reported and assessed annually	$25,000
Reporting			
Delivery of Standard Reports	The standard reporting will be delivered within 90 days after the end of the quarter. This is measured as the time from the last day of the end of a reporting cycle to the day standard reports are sent. This excludes custom/consultative reporting requests	Reported and assessed quarterly.	$25,000

Service/Task	Service Level Target	Reporting & Assessment Intervals	Dollars at Risk
Contractor must provide MMR reports monthly **Applicable to MAPD plan only**	Contractor will provide accurate MMR reports monthly by the end of the corresponding month, as appropriate.	Reported monthly, assessed quarterly	$25,000
Contractor must provide MOR reports upon request, no more often than annually **Applicable to MAPD plan only**	Contractor will provide accurate MOR reports upon request, no more often than annually, including all fields as received from CMS. The latest MOR will be submitted within 30 days of request.	Reported and Assessed Annually	$25,000

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ATTACHMENT 6

Official Solicitation Price Sheet
S000000107 Medicare Advantage Prescription Drug Services

Prospective Contractor Name:	**United HealthCare Services, Inc.**
Prospective Contractor CMS Contract #:	**H-2001**

· Prospective Contractors shall complete all yellow-highlighted cells on each tab. Cells not shaded in yellow will calculate.

· Prospective Contractors shall break out the price between the medical (MA) and the drug (PD) components. Price must be broken out between the claims and non-claims components, with a further breakdown of each component. Do not enter $0 in any field unless that is truly accurate (e.g., do not enter $0 in the profit field

· Submitted rates on Tables 1 and 2 of the PMPM Costs tab must be guaranteed for the first year of a resulting contract, Calendar Year 2023.

· Submitted annual cap rates on Table 3 of the Totals tab must be guaranteed for corresponding Calendar Years 2024 and 2025.

· The plan design to be used for pricing is outlined in the RFP.

· Provide all rates on a per member per month (PMPM) basis.

· Exclude commissions from premium rates submissions.

Official Solicitation Price Sheet
S0000000107 Medicare Advantage Prescription Drug Services
United HealthCare Services, Inc.

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TABLE 3: TOTALS (to be used in determining low-cost)

The ASE and PSE 2023 Guarantee PMPM rate will automatically populate from the 2023 PMPM Rates tab and extend to reflect the initial term total. Enter 2024 and 2025 Cap PMPM rates in the yellow-shaded cells. The Annual PMPM costs will total in the Estimated Annual Contract Term PMPM Cost cells and will automatically populate in the Estimated Total Cost of Initial Contract Term cell. **Do not alter** this table.

ASE PMPM Rate		Members	Estimated Annual Contract Term PMPM Cost (x 12 months)
2023 Guarantee	$ 155.00	14,000	$ 26,039,836.28
2024 Cap	$ 160.00		$ 26,880,000.00
2025 Cap	$ 165.00		$ 27,720,000.00
PSE PMPM Rate		**Members**	**Estimated Initial Contract Term PMPM Cost (x 12 months)**
2023 Guarantee	$ 75.00	16,000	$ 14,399,352.09
2024 Cap	$ 80.00		$ 15,360,000.00
2025 Cap	$ 85.00		$ 16,320,000.00
Estimated Total Cost of Initial Contract Term			**$ 126,719,188.36**

Please see our attached gainshare "State of Arkansas Gainshare" for the details around our proposed Gainshare offer.

Stipulations applying to our 2023, 2024, 2025 rates:

- This is a quote effective 1/1/2023 - 12/31/2025. The situs state is Arkansas.
- To ensure proper claim adjudication effective 1/1/2023, it is imperative that we have final 1/1/2023 plan design decisions from employers as soon as possible. Final decisions received after 11/1/2022 could be problematic in terms of claim adjudication on 1/1/2023.
- These rates assume Auto-Enrollment into the MAPD plan.
- This quote assumes that the current employer contribution structure remains in place.
- Please note the following with regard to the drug coverage on these MAPD products: (i) We reserve the right to change our Part D formulary for calendar year 2023 , 2024, 2025 . We also reserve the right to change our pharmacy benefit manager and/or our pharmacy network for calendar year 2023, 2024, 2025. (ii) There is a specific, Part D drug formulary that applies to all of our MAPD plan offerings. (iii) All Part D prescription drug coverage is considered to be creditable, therefore Creditable Coverage Notices are not required.
- United reserves the right to modify its 2023, 2024, 2025 rates in the event of changes to existing laws, regulations, or any new legislation, assessments, taxes, and/or marketplace changes to the Medicare Advantage and Part D programs that will have an impact to the program costs or revenue, including but not limited to: (i) any proposed changes to the Part D program; (ii) changes in the methodology used to calculate CMS payments including any changes due to EGWP bid waiver; (iii) any plan design changes required by the applicable regulatory authority (i.e. mandated benefits); (iv) any Force Majeure event, including but not limited to national pandemic, act of God, acts of terrorism, or anything beyond United's reasonable control; or (v) as otherwise permitted in our contract. This quote assumes that the Point-of Sale (POS) Rebate Rule will not be effective as of January 1, 2023. If the POS Rebate Rule becomes effective as of January 1, 2023, United will modify the 2023, 2024, 2025 rates accordingly.
- Quote assumes $0.00 PMPM commission level.
- 1,505 Pre-65 Medicare eligible retirees are included.
- The premium rate quoted herein assumes that premiums are due in full on a monthly basis on or before the last business day of the month.

OFFICIAL SOLICITATION PRICE SHEET
S000000107 Medicare Advantage Prescription Drug Services
United HealthCare Services, Inc.

TABLE 1: 2023 MA COMPONENT OF PREMIUM PMPM

	ASE	PSE
MA Star Rating	5	5
Aggregate Benchmark (based on Star Rating)	$1,055.38	$1,056.10
MA Risk Score	0.951	0.905
Claims Component	$16.90	-$64.07
Projected Gross Medical Claims	$1,020.52	$891.48
QIA Expenses	$0.00	$0.00
Total Medical Claims Cost	$1,020.52	$891.48
Member Cost Sharing	$0.00	$0.00
Direct Capitation (Risk Adjusted)	$1,003.62	$955.54
Non-Claims Component	$40.49	$40.04
Administration	$50.49	$50.49
Risk Charges	$10.41	$9.55
Profit	-$20.41	-$20.00
TOTAL	$57.39	-$24.02

TABLE 2: 2023 PD COMPONENT OF PREMIUM PMPM

	ASE	PSE
Part D Risk Score	0.844	0.844
Claims Component	$102.52	$102.52
Projected Gross Pharmacy Claims	$434.69	$434.69
Other (describe below)	-$274.45	-$274.45
Total Drug Claims Cost	$160.24	$160.24
Member Cost Sharing	$60.65	$60.65
Projected 70% Manufacturer Discounts	$0.00	$0.00
Direct Capitation (Risk Adjusted)	-$2.92	-$2.92
Federal Reinsurance Payment	$0.00	$0.00
Non-Claims Component	-$4.91	-$3.50
Administration	$13.13	$13.13
Risk Charges	$1.14	$1.14
Profit	-$19.18	-$17.77
TOTAL	$97.61	$99.02
2023 Total Price	**$155.00**	**$75.00**

First year Implementation Credit: $500,000

Please see POS Rebate description on the Totals tab.

Claims Component "other" includes rebates, manufacturer discounts and federal reinsurance. Detailed splits will be provided upon contract award. Non-Claims component "risk charges" accounts for the premium tax.

FINANCIAL SUMMARY

Recommended Options

Item Description:	Routine acupuncture benefit (beyond Medicare covered services) 12 visits per year at $0 copay		
Additional Cost (if any):	Included at no additional cost (for the entire group population)	**Agency Acceptance: (Y/N)**	Y

Item Description:	Routine dental care benefit Plan 2 (beyond Medicare covered services)		
Additional Cost (if any):	$7.91 per retiree member per month (for the entire group population)	**Agency Acceptance: (Y/N)**	Y

Item Description:	Personal Emergency Response System		
Additional Cost (if any):	Included at no additional cost (for the entire group population)	**Agency Acceptance: (Y/N)**	Y

Item Description:	Allowance for over-the-counter healthcare products ($40 allowance per quarter, allowance expires quarterly)		
Additional Cost (if any):	$2.40 per retiree member per month (for the entire group population)	**Agency Acceptance: (Y/N)**	Y

➢ Routine Dental Care (beyond Medicare covered services)

What does the benefit offer members?

- All plans include 100% coverage for routine cleanings, exams, x-rays, and periodontal maintenance, when utilizing an in-network provider
- Plans may cover comprehensive dental services which may include some combination of fillings, crowns, bridges, root canals, extractions, periodontal services, or dentures
- Choice from a large nationwide network with over 101,000 dentists and 365,000 access points

	Plan 2
Class 1 Preventive & Diagnostic (P&D)	**100%**
Class 2 Minor	**100%**
Class 3 Major	**Not Covered**
Class 4 Ortho	**Not Covered**
Deductible (P&D not included)	**$0**
Annual Calendar Maximum	**$500**
Reimbursement Schedule In/Out-of-Network	**MAC / MAC**

Maximum Allowable Charge (MAC) – The negotiated fee the in-network provider has agreed to accept for each covered ADA code. In network discounts off UCR typically range between 20% and 50%.
Usual, Customary and Reasonable (UCR) – The usual and customary fee for the area which providers charge for each ADA code.

➢ Routine Acupuncture (beyond Medicare covered services)

What does the benefit offer members?

Acupuncture benefit covers services for diagnosis and treatment to correct body imbalances and conditions such as: Lower back pain, sprains and strains (such as tennis elbow or sprained ankle), nausea and headaches, and carpal tunnel syndrome

Benefit Details: 12 visits per year at $0 copay

➢ Personal Emergency Response System

What does the benefit offer members?

- With the Personal Emergency Response System, help is a button push away. The system provides quick access to help in any emergency 24 hours a day
    - Provides member confidence and independence, while providing peace of mind to family members, friends and caregivers knowing that help is only a button press away
- Various features may be available including:
    - AutoAlert fall detection feature can automatically provide access to help when a fall is detected—even when disoriented, immobilized or unconscious and unable to push a button for help button. Detects >95% of falls. Most widely adopted fall detection technology in the US market today
    - Go Safe Mobile GPS pendant allows for monitoring in and out of the home
    - Lightweight, waterproof help button can be worn on the wrist or as a pendant

Benefit Details:

- **Monitoring device with quick access to help 24/7/365.**
- **Members chooses the model that best fits their needs**

➢ Over-The-Counter Healthcare Products Allowance

What does the benefit offer members?

250+ products are offered through the catalog under this benefit. FirstLine Medical manages and ensures all items are CMS approved and adds products as allowed each year. Categories include:

- Pain Management
- OTC Medications
- Medicine Chest Items
- Stomach Remedies
- Incontinence
- Home Medical
- Bath Safety
- Vitamin and Supplements

Benefit Details: $40 allowance per quarter, allowance expires quarterly

Members may purchase over-the-counter products by web, mobile app or mail
Orders require a minimum of $30 per order and can be placed once per quarter
Products are delivered to the member within 2-3 days

STATEMENT OF POLICY

UnitedHealth Group has a commitment to Equal Employment Opportunity (EEO) and to a work environment free of harassment. The policy of UnitedHealth Group is that people will be employed and promoted on the basis of their individual qualifications for the job and it is therefore the company's policy to prohibit discrimination and harassment against any applicant, employee, vendor, contractor, customer, or client on the basis of race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, pregnancy, veteran status, genetic information, citizenship status, or any other basis prohibited by federal, state or local laws.

UnitedHealth Group will provide:

1. freedom from abusive, intimidating or offensive behavior on the part of supervisors or other employees. In this regard it should be understood that harassment of any sort will not be tolerated, and that term includes derogatory ethnic, racial or sexist remarks;
2. freedom from sexual harassment. This refers to behavior which is not welcome, which is personally offensive, and which interferes with the work effectiveness of its victims and their co-workers. A separate communication on this subject further amplifies the Policy and is distributed to all employees;
3. freedom from any form of discrimination or intimidating or abusive behavior on the part of any supervisor or other employee as a result of a person's sexual orientation or gender identity;
4. benefits and services as outlined in Company publications; and

UnitedHealth Group is also a federal contractor subject to Executive Order 11246, Section 4212 of the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended ("Section 4212") and Section 503 of the Rehabilitation Act of 1973, as amended ("Section 503"). As such, UnitedHealth Group is committed to taking positive steps to implement the employment-related aspects of the company's equal opportunity policy. Accordingly, it is UnitedHealth Group's policy to take affirmative action to employ, advance in employment, and otherwise treat qualified minorities, women, protected veterans, and individuals with disabilities without regard to their race/ethnicity, sex/sexual orientation/gender identity, veteran status, or physical or mental disability. Under this policy, UnitedHealth Group will provide reasonable accommodation to the known physical or mental limitations of an otherwise qualified employee or applicant for employment, unless the accommodation would impose undue hardship on the operation of the company's business.

The company's affirmative action policy also prohibits employees and applicants from being subjected to harassment, intimidation, threats, coercion, or discrimination because they have engaged in or may engage in (1) filing a complaint; (2) assisting or participating in an investigation, compliance review, hearing, or any other activity related to the administration of Section 503, Section 4212, or any other Federal, state or local law requiring equal opportunity for disabled persons or covered veterans; (3) opposing any act or practice made unlawful by Section 503 or Section 4212 and their implementing regulations, or any other Federal, state or local law requiring equal opportunity for disabled persons or

covered veterans; or (4) exercising any other right protected by Section 503 or Section 4212 or their implementing regulations.

The non-confidential portions of the affirmative action program for individuals with disabilities and protected veterans shall be available for inspection upon request by any employee or applicant for employment by contacting HR direct.

Anyone with a question about UnitedHealth Group's Equal Employment Opportunity Policy should contact HRdirect at 1-800-561-0861. All concerns will be handled in confidence.

If you would like to review the Affirmative Action Plan, or need an accommodation, you may contact HR direct at 1-800-561-0861 between the hours of 7:00am and 7:00pm central time, Monday through Friday, or write HR direct Employee Relations at MN008-W210, 9900 Bren Road E., Minnetonka, MN 55343.

A person's race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, pregnancy, veteran status, genetic information, or citizenship status must not affect our estimation of their character if we are to achieve the objectives of our business, our society, and our country. These moral and economic reasons for supporting the Company policy of nondiscrimination are to be of primary concern to all employees.

Joy Fitzgerald, Chief Diversity Equity and Inclusion Officer

1/18/2022

Date