# Policy

| | | | |
|---|---|---|---|
| **Title:** | Effective Lines of Communication | **Number:** | L0001 |
| **Department:** | Compliance | **Original Issue Date:** | 11/21/2013 |

| **Guidance** |
|---|
| Medicare Managed Care Manual 50.1- Written Policies, Procedures and Standards of Conduct |

## Policy

The Company has established and implemented effective lines of communication regarding compliance matters. This is designed to ensure that Company associates have open access to the Legal/Compliance Department to discuss Compliance, Fraud, Waste and Abuse (FWA), and HIPAA matters. Such open lines of communication ensure that associates have access to the Legal/Compliance Department to allow compliance issues to be reported as they are identified.

All information is conveyed by the Company in a timely manner and to all appropriate parties. The Company's written standards of conduct and policies and procedures require all associates to report compliance concerns and suspected or actual violations (e.g., Compliance, FWA, and HIPAA) through one of the available reporting methods.

The Company does not tolerate retaliation or retribution against anyone who provides a good faith report of potential or suspected violations. The Company will keep reports confidential to the extent reasonably practicable within the legitimate needs of the Company and as permitted under applicable law.

When a suspected issue is reported, the Company provides the complainant with information regarding expectations of a timely response, non-retaliation, and a certain degree of confidentiality, along with progress reports, as warranted.

On a regular basis, typically monthly, the Compliance Department will send out Compliance Bulletins relating to topics that include Compliance, HIPAA and/or FWA.

# Policy

| Title: | Agent/Broker Compensation | Number: | L0002 |
|---|---|---|---|
| Department: | Legal/Commissions | Original Issue Date: | 11/21/2013 |

| Guidance |
|---|
| Medicare Marketing Guidelines Section 120.4 – Agent/Broker Compensation; 42 CFR 422.2274(a); 423.2274 |

## Policy

Compensation from the sale of insurance products is generally determined by state or federal regulation to include monetary or non-monetary remuneration of any kind relating to the sale or renewal of a policy. Depending on the type of insurance product or the state, compensation may include, but not be limited to, commissions, bonuses, gifts, prizes, awards, and finder's fees.

**First Year Commission Payments**

Commissions are paid on an earned basis and are based upon a 12-month enrollment beginning January and ending in December. Subject to carrier contract requirements and agent agreements, commissions are generally earned as the carrier receives premium from the Centers for Medicare and Medicaid Services (CMS) on a monthly basis (i.e., 1/12 per month).

**Initial Sales and Sales of Unlike Plans**

For sales of Medicare Advantage products, confirmed by CMS to be payable as initial year of enrollment or enrollment in an unlike plan type, subject to the terms of applicable agreements, the carrier will generally pay the full "Initial Rate" set forth in the contract, regardless of the effective date of the policy.

**Other Sales**

For sales of Medicare Advantage products which will not be paid at an initial commission rate, the carrier will advance a pro-rated amount of the replacement rate as determined in the contract based upon the number of months the beneficiary will be enrolled in such Medicare product within the initial calendar year.

**CMS and Carrier Contract Requirements**

All commission payments remain subject to appropriate chargebacks and other adjustments in accordance with CMS and carrier requirements as well as specified in the terms of the applicable agreement.

**Renewal Commission Payments**

Renewal commissions are typically paid on a monthly basis, as specified by the carrier contract and subject to contractual requirements.

# Policy

| Title: | Agent/Marketing Oversight Policy | Number: | L0003 |
|---|---|---|---|
| Department: | Compliance | Original Issue Date: | 11/21/2013 |

| Guidance |
|---|
| 50.3.1 – General Compliance Training |

## Policy

The Company has developed a Marketing Oversight Policy to promote adherence to standards of business conduct throughout all aspects of our marketing and sales divisions. The purpose of this policy is to ensure conformity with all applicable federal, state, and local laws, rules, and regulations by our organization that includes all associates.

The Compliance Department maintains the Marketing Oversight Policy that includes:

- The review of the agent/broker appointment governed by regulatory requirements
- The review of agent/broker training
    - New agent training
    - Supplemental agent/broker training
    - Review of generic marketing material
    - Process for overseeing and responding to agent and broker complaints
    - Implementation of corrective action

Corrective Action may include but is not limited to, the following:

- Coaching/monitoring session
- Verbal/written warning
- Retraining
- Suspension with or without commissions
- Contract termination
- Reporting to the department of insurance and insurance company

Monitoring activities may include, but are not limited to, the following:

- Cancellation rates
- Disenrollment rates
- Rapid disenrollment rates
- Submission of enrollment applications per carrier guidelines
- Scope of Appointment forms
- Third party secret shopper surveillance
- Complaints and marketing incidents
- Marketing/sales seminars cancellations and event updates

# Policy

| Title: | Enrollment/Disenrollment Requests | Number: | L0004 |
|---|---|---|---|
| | | Original Issue Date: | 11/21/2013 |

| Guidance |
|---|
| Medicare Enrollment/Disenrollment Chapter 2 – 40.1 Eligibility, Enrollment and Disenrollment |

## Policy

The Medicare beneficiary is generally the only individual who may execute a valid election for an enrollment/disenrollment from a Medicare-related plan. However, another individual may be the legal representative or appropriate party to execute an enrollment request as the applicable law of the state in which the beneficiary resides may allow. The Centers for Medicare and Medicaid Services (CMS) will recognize state laws that authorize certain persons to make an election for Medicare beneficiaries.

**Enrollment**
Sales agents must:

- Review the enrollment information for accuracy
- Request the beneficiary to sign/notate the application, as applicable, per carrier and application type.
- Submit enrollment documentation/e-application per carrier guidelines.

**Disenrollment**
Requests must be made in writing and submitted to the carrier.

# POLICY

| | | | |
|---|---|---|---|
| **Title:** | Background and Exclusion Verification Policy | **Number:** | L0005 |
| **Department:** | Legal | **Original Issue Date:** | 11/21/2013 |

| **Guidance** |
|---|
| Medicare Managed Care Manual – Chapter 21; Section 50.6.8 – OIG/GSA Exclusion |

## Policy

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

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

It is the Company's policy to screen all vendors and business partners against the General Services Administration's excluded parties list system or system for award management. The Company conducts this search on a monthly basis. If a finding is made, the Human Resources Department and Legal Department will review the information to determine if the name on the list is a match and will take appropriate action and make the required report of any findings.

# Policy

| | | | |
|---|---|---|---|
| **Title:** | **Charge-backs - Rapid Disenrollment and Unearned Commission** | **Number:** | L0006 |
| **Department:** | Commissions/Career/ Brokers/Legal | **Original Issue Date:** | 11/21/2013 |

| **Guidance** |
|---|
| Medicare Marketing Guidelines Section 120.4.6. – Recovering Compensation Payments (Charge-backs) |

## Policy

Medicare Advantage (MA) and Prescription Drug Plan (Part D) carriers are required to recover compensation payments from agents under two circumstances:

a. When a beneficiary disenrolls from a plan within the first three months of enrollment (rapid disenrollment)
b. Any other time a beneficiary is not enrolled in a plan.

Note: An enrollment that is effective October, November, or December for a beneficiary who subsequently changes plans effective January 1 of the following year is not considered a rapid disenrollment. Therefore, a carrier chargeback will generally not be applied. If the member returns to traditional Medicare effective January 1, a rapid disenrollment chargeback will be applied.

- All carrier charge-back data will be processed through the Company's Commissions Department for commissions processed by the Commissions Department.
- Individual charge-back information is added to the commission statement and includes:
  - Consumer's name
  - Amount of the charge-back
  - Reason, if provided by the carrier

Compensation may also be charged back to the agent as permitted by applicable law, carrier contracts, and agent agreements.

# Policy

| Title: | Compliance Committee | Number: | L0007 |
|---|---|---|---|
| | | Original Issue Date: | 11/21/2013 |
| Originator: | Marilyn Ferreira | Effective Date: | 1/1/2013 |

| Guidance |
|---|
| Medicare Marketing Manual – Chapter 21 - 50.2.2 – Compliance Committee |

## Policy

The Company maintains a Compliance Committee to oversee, among other things, compliance and Medicare-related matters that may impact the business of the Company. The Committee is chaired by our Company's regulatory and compliance counsel. The Committee is comprised of representatives from the following departments:

- Compliance
- Career Sales
- Broker Sales
- Licensing
- TPA and New Business

The Compliance Committee's obligations include:

- Meeting on a monthly basis (subject to change)
- Developing strategies to promote compliance
- Reviewing and approving the Compliance and FWA training materials
- Reviewing policies and procedures

Committee meeting notes are distributed to members of senior management and pertinent updates are included in board reports.

# Policy

| Title: | Outbound Enrollment and Verification Requirements | Number: | L0008 |
|---|---|---|---|
| | | Original Issue Date: | 11/21/2013 |

| Guidance |
|---|
| Medicare Marketing Guidelines Section 70.7 – Outbound Enrollment and Verification Requirements |

## Policy

All Medicare Part C (Medicare Advantage) and D (Prescription Drug) plans are required to maintain a system to ensure that individuals requesting enrollment understand the plan rules. As part of that system, Plans/Part D Sponsors are expected to conduct outbound enrollment and verification (OEV) calls for enrollment requests in which an independent or employed agent/broker provided plan-specific information to the individual, thus influencing the individual's plan choice and/or assisting in a subsequent enrollment request.

It is important for all sales agents to obtain from the beneficiary their best phone number to be used for a verification call and to provide a description of the enrollment verification process to the applicant during the enrollment request process.

Additionally, if a carrier supplies an "OEV checklist" for agents to complete during the time of the enrollment, the agent is obligated to complete this OEV checklist.

OEV calls are expected to be made to the applicant after the sale has occurred; they are not permitted to be made at the point of sale. The Part C and D plans are expected to ensure that the verification calls are not conducted by sales agents and that the sales agents are not physically present with the applicant at the time of the verification call. Carriers may not use automated calling technologies to conduct these outbound calls; CMS expects OEV calls to be interactive. The Company's agents are expected to comply with these requirements.

# Policy

| Title: | Records Retention | Number: | L0009 |
|---|---|---|---|
| Department: | Legal/Compliance | Original Issue Date: | 11/21/2013 |

| Guidance |
|---|
| Medicare Managed Care Manual, Chapter 11; 42 CFR 422.504 (d)(e) |

## Policy

This policy is designed to supplement the Company's record retention manual. The Company maintains books, records, documents and other evidence of accounting procedures and practices related to Medicare Advantage for ten (10) years.

At a minimum, the records maintenance must be sufficient to do the following:

1. Accommodate periodic auditing of financial records;
2. Enable CMS to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the contract, and the facilities of the organization; and
3. Enable CMS to audit and inspect any books and records of the MA organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract, if applicable.

The Company's records maintenance requirements must include, but are not limited to, maintenance of the following:

4. Financial statements
5. Federal income tax or information returns for the current year and 10 years prior
6. Agreements, contracts, and subcontracts
7. Marketing and management agreements
8. Financial reports filed with other federal programs or state authorities
9. Documents demonstrating compliance with CMS requirements for maintaining privacy and security of protected health information and other personally identifiable information of Medicare enrollees
10. Computer and other electronic systems
11. Enrollment and disenrollment records

CMS may inspect, evaluate and/or audit a company if it determines that there is a reasonable possibility of fraud or similar level of fault.

# Policy

| Title: | Personal/Individual Marketing Appointments | Number: | L0010 |
|---|---|---|---|
| | | Original Issue Date: | 11/21/2013 |

| Guidance |
|---|
| Medicare Marketing Guidelines - 70.9.2 – Personal/Individual Marketing Appointments |

## Policy

Personal/individual marketing appointments for the sale of Part C (Medicare Advantage) and Part D (Prescription Drug) plans typically take place in the beneficiary's home; however, these appointments can also take place in other venues such as a library or coffee shop that may be permitted by applicable law and CMS guidelines. Appointments must follow the scope of appointment guidance and must take place only in permitted areas.

All one-on-one appointments with beneficiaries wherein Medicare Advantage and Part D plan options are discussed are considered sales/marketing events. The sales agent may not do the following at these appointments:

- Discuss plan options that were not agreed to by the beneficiary in advance.
- Market non-health care related products (such as annuities or life insurance).
- Ask a beneficiary for referrals.
- Solicit/accept an enrollment request (application) for a January 1st effective date prior to the start of the Annual Enrollment Period (AEP) unless the beneficiary is entitled to another enrollment period.

For Medicare Advantage and Part D sales, the agent must:

- Complete a Scope of Appointment
- Use carrier sales presentation material, as applicable
- Review all benefits and exclusions
- Complete the enrollment material in its entirety
- Review enrollment material for accuracy (paper or electronic enrollment)
- Prepare the beneficiary for the outbound enrollment and verification (OEV) call
- Leave CMS/carrier mandated enrollment material with the beneficiary
- Comply with all applicable Company and insurance carrier requirements

# Policy

| | | | |
|---|---|---|---|
| **Title:** | Effective Training and Education – Written Policies and Procedures | **Number:** | L0011 |
| **Department:** | Compliance | **Original Issue Date:** | 11/21/2013 |

| **Guidance** |
|---|
| Medicare Managed Manual – Chapter 21 – 50.1.2 – Policies and Procedures; 50.3.1 and 50.3.2 – Effective Training and Education |

## Policy

The Company has established and implemented effective General Compliance; Fraud, Waste and Abuse (FWA); and HIPAA training and education for associates, including first tier, downstream and related entities (FDRs). Training occurs annually and is a part of the orientation for new associates.

General Compliance, HIPAA, and FWA training:

- General Compliance, HIPAA and FWA training are provided within 90 days of initial hire or contracting and annually thereafter.
- Training may be tracked for completion via website, sign in sheets, and attestations.

The Compliance Program consists of:

- Compliance program elements
- Standards of conduct
- Compliance policies and procedures
- FWA
- HIPAA
- Pertinent laws and suspected violation reporting process

The FWA Training includes:

- Laws and regulations related to Medicare Advantage and Part D fraud, waste, and abuse (i.e., False Claims Act, Anti-Kickback statute, etc.)
- The obligation to have policies and procedures that address FWA
- Protection for those who report suspected FWA
- Situations that demonstrate the common types of FWA

# Policy

| | | | |
|---|---|---|---|
| **Title:** | Distribution of Compliance Procedures Standards of Conduct | **Number:** | L0012 |
| **Department:** | Compliance | **Original Issue Date:** | 11/21/2013 |

| **Guidance** |
|---|
| Medicare Managed Care Manual – Chapter 21 - 50.1.1 – Standards of Conduct |

## Policy

The Company's code of conduct states the Company's principles and values by which the Company operates. The Company's policies and procedures, along with the standards of conduct, are distributed or made available to associates within ninety (90) days of hire or contracting, as updates occur, and annually thereafter.

The Company offers a code of conduct in its employee handbook, along with a separate agent code of conduct and ethics that is reviewed annually by the Compliance Committee. Agents may be required to sign the agent code of conduct at the time of their initial contracting and annually thereafter.

The code of conduct will be posted on the Company's intranet and/or websites.

# Policy

| Title: | Scope of Appointment Procedure (SOA) – 2013-2014 MMG | Number: | L0013 |
|---|---|---|---|
| Department: | Sales | Original Issue Date: | 7/2/2013 |

| Guidance |
|---|
| Medicare Marketing Guidelines – Chapter 70.9.3 – Scope of Appointment (SOA) |

## Policy

When conducting marketing activities of Medicare Advantage (MA) and Medicare Prescription Drug Plans (PDP), a sales agent may not market any health care related product during a marketing appointment beyond the scope that the beneficiary agreed before the meeting with that individual. The sales agent must document the scope of the agreement before the appointment via a scope of appointment (SOA).

- Distinct lines of plan business include MA, PDP and Cost Plan products. If a sales agent would like to discuss additional products during the appointment that the beneficiary did not agree to discuss in advance, they must document it 48 hours in advance, when practical.
- If it is not practical and the beneficiary requests to discuss other products, the sales agent must document a second scope of appointment for the additional product type to continue the marketing appointment.

An agent should not educate, discuss, or request any information (Discovery/Needs Analysis) that would pre-determine the carrier(s) to be presented at the subsequent meeting. This includes, but is not limited to:

a) Special Needs Plan (SNP) qualifications
b) Current providers
c) Current prescriptions

<u>Scope of Appointment Documentation</u>

a) In writing (a form reviewed and approved by the Centers for Medicare and Medicaid Services (CMS), in the form of a signed agreement by the beneficiary, or
b) A call can be made to the carrier's recorded Scope of Appointment line.
c) A paper SOA must accompany the enrollment application, if applicable.

If a prospect attends a sales presentation and subsequently schedules an in-home sales appointment, the agent must obtain an SOA from the prospect agreeing to the products that will be discussed.

- A follow up appointment may be held at the same venue immediately after the sales presentation or at the prospect's home following the sales presentation (it does not need to be scheduled 48 hours later).
- Permission given by a prospect is considered to be short-term, event specific and may not be treated as an open-ended permission for future contacts.
  Note: Although CMS does not define "short-term, event specific," a number of carriers will not allow the initial timeframe of the beneficiary's signature for an SOA to last beyond thirty (30) days for additional contact. If the agent will be contacting the prospect after thirty (30) days, it is recommended

that the agent have the prospect sign a second SOA and that the agent include both forms with the enrollment application submission. Agents are expected to comply with carrier requirements.

- If additional sales prospects are present for a scheduled in-home appointment, the sales agent must request that the additional prospects complete the scope of appointment process.

"Walk-in" Beneficiaries to an Agent/Broker Office

In instances where a beneficiary visits an agent/broker office on his/her own accord, the agent/broker must document the scope of appointment prior to discussing Medicare Advantage or a Prescription Drug Plan. The agent must note the "walk-in" appointment on the SOA form or the oral agreement to the carrier's recorded Scope of Appointment line.

Carriers will track and notate SOAs signed less than 48 hours prior to the appointment and where there is no documentation demonstrating why the agent did not wait 48 hours prior to presenting a health plan, agents may be subject to disciplinary action by the carrier and the Company.

Update/Review

This guidance is subject to change by the Company and is not intended to be exhaustive in nature. Agents are expected to comply with all carrier requirements. In the event of any conflict between this guidance and applicable law, including the CMS Medicare Marketing Guidelines then in effect, applicable law controls and this guidance is modified to comply with applicable law.

# Policy

| Title: | Annual Sales Training and Testing Documentation | Number: | L0014 |
|---|---|---|---|
| Department: | Sales - Career | Original Issue Date: | 6/28/2013 |

| Guidance |
|---|
| Medicare Marketing Guidelines – Section 120.3 - Agent/Broker Training and Testing |

## Procedure

Specifications for training/testing criteria and documentation requirements are provided annually by the Centers for Medicare and Medicaid Services (CMS).

Plan sponsors must ensure that their training and testing programs are designed and implemented in a way that maintains the integrity of the training and testing and must have the ability to provide this information to CMS upon request.

Agents must complete all required training, successfully pass testing with a score of 90% or better (per carrier guidelines) and obtain a distinct carrier writing number prior to presenting or selling their plan.

Upon completion of America's Health Insurance Plans (AHIP) and/or carrier certification:

- Agents will submit a copy of their passing certification to their general manager and/or broker upline and the administrative assistant.
- The administrative assistant will forward a copy to the Company's Licensing Department.
- The Licensing Department will:
  - Save certifications in the Company's database and key the data into the database for reporting.
  - Reports are generated and distributed within the following timelines:
    - Medicare Advantage Certifications – minimum of weekly during training season (July – October), monthly thereafter
    - Annuity Product Certifications – Monthly
    - Long Term Care Certifications – Monthly
- In addition to a copy being maintained by the Licensing Department, the career entity will also be required to maintain a copy of the agent's certifications in either a paper file or e-file (at the discretion of the general manager on the file storage method).
- If required, a sales agent must fulfill face to face carrier education.

Under no circumstances will an agent be permitted to represent a carrier or enroll a beneficiary in a plan without carrier approval.

If a sales agent presents and/or enrolls a beneficiary without meeting the carrier's certification requirements, the agent may not be compensated for the enrollment and disciplinary action will take place up to and including termination of an agent's contractual relationship.

# Policy

| Title: | Lead Generation | Number: | L0015 |
|---|---|---|---|
| | | Original Issue Date: | 11/21/2013 |

| Guidance |
|---|
| Medicare Marketing Guide - Section 70.5 – Marketing through Unsolicited Contacts; Lead Generation |

## Policy

In general, Medicare Advantage Plans and Prescription Drug Plan (Part D) Sponsors may not market through unsolicited direct contact, including but not limited to:

- Door-to-door solicitation, including leaving information such as a leaflet or flyer at a residence or car.
- Approaching beneficiaries in common areas, (e.g., parking lots, hallways, lobbies, sidewalks, etc.).
- Telephonic or electronic solicitation, including leaving electronic voicemail messages or text messaging.

NOTE: Agents/brokers who have a pre-scheduled appointment which becomes a "no-show" may leave information at the no-show beneficiary/individual's residence.

The prohibition on marketing through unsolicited contacts for Medicare Advantage and Part D plans does not extend to mail and other print media (e.g., advertisements, direct mail). In addition, permission given to be called or otherwise contacted must be short-term, event-specific, and may not be treated as open-ended permission for future contacts.

What lead sources does the Company use?
The Company uses various sources to generate consumer leads including the following:

- Direct Mail
- Workshops
- Print Advertising
- Television Advertising

**How does the Company manage leads?**
The Company's offices may use the Microsoft® Customer Relationship Management (CRM) software for effective lead management. CRM is a web-based application that enables each office to access their lead database, while allowing general managers to also assign and monitor leads at the agent level.

# Policy

| | | | |
|---|---|---|---|
| **Title:** | Monitoring Implementation of Corrective Action | **Number:** | L0016 |
| **Department:** | Legal/Compliance | **Original Issue Date:** | 11/25/2013 |

| **Guidance** |
|---|
| Medicare Managed Care Manual – Chapter 21 and Prescription Drug Benefit Manual Chapter 9, Section 50.7.2 |

## Policy

The Company's Compliance Department will establish, manage, and evaluate a standard process for timely implementation of corrective actions for agents who are the subject of corrective action regarding the sale of Medicare Advantage and Part D (Prescription Drug Plan) plans and other sales as warranted by the Compliance Department. This core function assures compliance with established and distributed disciplinary procedures in order to achieve and maintain operational compliance.

The Company's Compliance Department monitors the submission and receipt of inquiries, conducts investigations and agent coaching, implements corrective action plans (CAP), and/or notifies agents of the termination of agent appointments. When warranted, the Compliance Department will implement corrective action for the Company's agents. All agent correspondence regarding corrective action is documented in the compliance database. The agent cases will be considered closed after any necessary investigation, if any.

# CONFLICT OF INTEREST POLICY ATTESTATION

I have received and read the Company's Conflict of Interest Policy. I understand the policy, my duties and responsibilities to comply with its provisions, and the consequences of non-compliance. I certify that I am in compliance with the policy, know of no violation or potential violation of or deviations from the policy, and have raised all issues concerning actual or potential conflicts of interest in writing with the Company's Director of Human Resources Director or Legal Department, as appropriate.

I agree that if I become aware of any information that might indicate that this attestation is inaccurate or that I have not complied with this Conflict of Interest Policy, I will notify the appropriate Company representative immediately.

Alternatively, if I am aware of a conflict or potential conflict of interest, instead of completing this attestation, I will instead complete and sign the Company's Conflict of Interest Disclosure Form that identifies any conflict or potential conflict of interest.

My attestation hereto is complete and correct to the best of my knowledge.

# CONFLICT OF INTEREST DISCLOSURE FORM

To be completed by employees, agents, contractors, directors, officers and first tier, downstream, and related entities of the Company (collectively "Associates"). If the answer to each question below is "None," please indicate as much.

(Please print)
Name of Associate: _____

Job Title: _____

Department: _____

Definitions:

*Conflict of Interest:* when an Associate's personal interest or activities may influence his/her judgment in the performance of his/her duties to the Company or the Company's subsidiaries or affiliates.
*Immediate Family Members:* an Associate's spouse, parents, children, siblings, and anyone who share his/her home.
*Affiliated Organization:* any organization of which an Associate is a board member, officer, partner, manager, or employee, or in which an Associate is, directly or indirectly, a debt holder or the beneficial owner of any class of equity securities.
*Financial Interest:* when a person has, directly or indirectly, through business, investment, or immediate family member, an ownership or potential investment interest in an entity with which the Company has a business dealing.

1. List all Affiliated Organizations with which you are engaged and/or business enterprises in which you, or any Immediate Family Member, holds a direct or indirect Financial Interest:

| Name of Affiliated Organization/Business Enterprise | Primary Business Address | Brief Description of the Business | Nature of Conflict |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

2. List all personal interests or outside engagements which may pose or result in a Conflict of Interest to the Company:

| Personal Interest/Outside Engagement | Nature of Conflict or Potential Conflict |
|---|---|
| | |
| | |

3. List all commissions, fees, gifts, and hospitality, including meals, and entertainment (other than customary gifts of token value) that you or an Immediate Family Member receives from suppliers, competitors, or customers of the Company, or become entitled to receive, directly or indirectly, as a result of your relationship or position with the Company, that is not or will not be compensation directly related to your duties to the Company:

| **Date Received** | **Value of the Item** | **Item Received (e.g., cash, gift certificate, restaurant dinner)** | **Name and Primary Address of the Individual or Company who provided the Item** |
|---|---|---|---|
| | | | |
| | | | |

4. List all Immediate Family Members who are employed, contracted, or affiliated with the Company or Affiliated Organizations:

| **Name and Relationship of Immediate Family Member** | **Nature of Conflict** | **Date of Employment, Contracting, or Affiliation** |
|---|---|---|
| | | |
| | | |

***I acknowledge and agree that the information provided in this form is true and accurate.***

Signature: _____

Printed Name: _____

Date: _____

# Policy

| Title: | Conflict of Interest Policy | Number: | L0017 |
|---|---|---|---|
| Department: | Legal/Compliance | Original Issue Date: | 11/25/2013 |

## Guidance

Medicare Marketing Manual Section 50.3.1 – General Compliance Training

## Policy

A conflict of interest exists when a person's private or personal interest interferes in any way, or gives the appearance that it interferes, with the interests of the Company. A conflict situation can arise when an associate takes actions or has interests that may make it difficult to perform his or her work for the Company objectively and effectively. Conflicts of interest may also arise when an associate, or member of his or her family, receives improper personal benefits as a result of his or her position or relationship with the Company.

It is generally a conflict of interest for a Company associate to work simultaneously for a competitor, customer, or supplier. Associates are not permitted to work for a competitor, consultant, or supplier as a consultant or board member. The best policy is to avoid any direct or indirect business connection with the Company's customers, suppliers, or competitors, except on the Company's behalf. A conflict of interest situation may include, without limitation, ownership of a competitor (other than ownership of one percent or less of a publicly-traded entity) and receipt of gifts of more than a nominal value from actual or potential competitors, consultants, or suppliers.

Conflict of interest attestations are distributed on an annual basis and conflicts or potential conflicts are identified on conflict of interest disclosure forms. Copies of the current versions of these forms are attached hereto as Exhibit "A." These forms may be modified by the Company. Any associate who becomes aware of a conflict or potential conflict should immediately bring it to the attention of a supervisor, manager or other appropriate personnel or follow the procedure for reporting Compliance issues. Potential conflicts will be reviewed by the Compliance Department, Human Resources Department, and/or the Legal Department, as applicable. Associates may also be required to complete other documentation related to the disclosure a potential conflict of interest. If a conflict is found to be valid, the Company will take appropriate action and notify the applicable parties (if any) and will document the action taken. The Company's Human Resources Department will maintain the attestations.

# Policy

| | | | |
|---|---|---|---|
| **Title:** | Conducting a Timely Inquiry of Alleged Detected Offenses | **Number:** | L0018 |
| **Department:** | Legal/Compliance | **Original Issue Date:** | 1/2/2014 |

| **Guidance** |
|---|
| Medicare Marketing Manual Chapter 50.7.1 – Conducting a Timely and Reasonable Inquiry of Detected Offenses |

## Policy

The Company's compliance procedures call for the Company to be able to inform the applicable carrier that the Company's agent has been duly notified a response is required to either a carrier complaint or outreach. That means that the Company will engage in the following steps regarding carrier complaints and outreach:

1. Notification to the agent of the existence of a complaint/corrective action within the first twenty-four (24) hours of receipt.
2. Providing a copy of the complaint/corrective action to the agent.
3. Advising the agent of the requirement of a response and the deadline by which he/she must respond to the allegation.
4. Informing the agent that following the carrier's review of the agent statement, corrective action my follow, as determined by the carrier and/or the Company.
5. Notifying the agent that in some cases, corrective action may be initiated by the Company's Compliance Department, individual agency and/or marketing company, as applicable, per individual contracting relationship.

All complaint and outreach documentation that the Company receives is maintained in the compliance database.

| Name: | Disciplinary Guidelines – Broker Agents | Number: | B0001 |
|---|---|---|---|
| Department: | Broker Agents/Legal | Original Issue Date: | 7/16/2013 |

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

## Policy

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

Our standards include policies that:

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

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

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

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

**Level I Disciplinary Actions**

Termination of contract

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

1. Requiring beneficiaries to provide any contact information as a prerequisite for attending an event.
2. Providing food/meals to potential enrollees that does not adhere to CMS Chapter 3 guidelines for Medicare Advantage and Prescription Drug Plan sales (snacks may only be provided).
3. Disparaging competitor plans, Medicare, or health care reform.
4. Incorrect enrollment paperwork/clerical error.
5. Marketing health care related products not identified or agreed upon on the telephonic or paper scope of

appointment form.

6. Holding applications (when it impacts the member's effective date) or failing to submit applications within the carrier's specific time requirement.

**Level II Disciplinary Actions**

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

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

Steps may be omitted at the discretion of the Company.

**Invalid: Level 2 Allegations**

Track and trend

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**Level III**

Parameters of submitted vs. accreted sales (rapid disenrollment – defined as member cancellation/disenrollment during the first 90 days of enrollment) and rolling ninety (90) day cycle throughout the enrollment year. The expectation is a 10% or lower disenrollment rate.

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

**Level III**

Category 1: 0-10% disenrollment average – No Action
11-20% disenrollment average – Coaching
> 50% disenrollment average – Corrective action plan

Category 2: 0-14 % disenrollment average – No Action
15-25 % disenrollment average- Coaching
26-35% disenrollment average – Coaching
>36% disenrollment average – Corrective action Plan

Category 3: 0-14% disenrollment average – No Action
15-20% disenrollment average- First Written Warning
21-25% disenrollment average – Final Written Warning
>26% disenrollment average – Termination of contract

Steps may be omitted at the discretion of the Company.

# POLICY

| Title: | **Marketing Material Submission & Review** | Number: | B0002 |
|---|---|---|---|
| Department(s): | Brokerage Companies & Legal | Original Issue Date: | 11/21/2013 |

## Guidance

Medicare Marketing Guidelines - 30.3 Plan/Part D Sponsor for Subcontractor Activities and Submission of Materials for CMS Review

## Policy

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

1. Marketing company/broker completes the advertising review checklist, attaches the marketing piece, written carrier approval of the marketing piece (if applicable), and source material, and submits these documents to the Company's Legal/Compliance Department.
2. Legal/Compliance Department evaluates the marketing piece for the following:
   a. Review of material content.
   b. Ensures all applicable guidelines and regulations are satisfied.
   c. Documents and submits changes, if any.
   d. Final review, sign off, and issuance of approval code.
   e. Approved pieces are filed in the Legal/Compliance Department.
3. Approved marketing pieces are returned to the marketing company/broker.