RITTER
Insurance Marketing

Anthem Blue Cross California

Must Complete Certification Prior to Submitting Business!

Agent Application For Appointment

Please follow the instructions listed below so we can quickly and accurately process your appointment paperwork.

1. Sign the No More Forms consent form.
2. Complete the Producer Appointment Data Sheet.
3. Complete the Medicare Advantage and Medicare Part D Broker Contract Addendum.
4. Complete the Ritter ACH form.
5. Complete the W9.

Required Supporting Documents:

1. Ritter ACH form (Required to pay commissions).
2. Void check.
3. Copy of your California Agent State License (CA State license must include the Life line of business).
4. Make a check payable to Anthem Blue Cross for $30.53 for your state appointment fee. Or you can complete the Credit Card Form included and Ritter will charge your card and cut a check internally.
5. Agent Compensation Agreement must be signed and returned with the contracting.

Please return contracting paperwork with all Required Supporting documents to:

Ritter Insurance Marketing
2600 Commerce Drive, Harrisburg, PA 17110 Fax: 888-509-7058
Email: license@ritterim.com

Ritter Insurance Marketing, LLC

Date: _____

Name on card: _____
(exactly as it appears on card)

Card Number: _____

CVC2#: _____ Card Type (circle one): Mastercard; Visa;

Billing Address:
_____
City, State, Zip:
_____
Expiration date:
_____
Transaction amount:
_____
Cell Phone:
_____
By signing below, I authorize Ritter Insurance Marketing to electronically charge my credit card account as specified
above to pay the appropriate license fees/appointment fees/renewal fees.

Signature:
_____

I (Agent Name)_____ give Ritter Insurance Marketing LLC, 2600 Commerce Drive, Harrisburg PA 17110 permission to submit contracting on my behalf to Anthem. I understand that my contracting will be submitted electronically through the No More Forms system.

_____

Agent Signature

_____

Date

Producer Appointment
Data Sheet

Red border indicates required field.

SECTION 1: PRODUCER INFORMATION

First name	M.I.	Last name	Suffix	Social Security no./Government ID no.

Date of birth (MM/DD/YYYY)	National producer no. (NPN optional)	Home phone no.	Home fax no. (optional)

Producer business phone no. Ext.	Producer business fax no.

Residence mailing address (no PO Box)	City	State	ZIP code	County

Business mailing address (if PO Box, please provide physical address below)	City	State	ZIP code	County

Physical location business mailing address (if different from business address)	City	State	ZIP code	County

I prefer to receive mailings at: ☐ Residence mailing address ☐ Business mailing address ☐ Physical location business mailing address

Business email address

Are you bilingual? ☐ Yes ☐ No If Yes, what language(s) do you speak? _____

Previous names or aliases

Have you used any other names or aliases in the last seven (7) years? ☐ Yes ☐ No If Yes, please list any/all such names.

Different first and/or last name?	Previous name
☐ First ☐ Last	
☐ First ☐ Last	
☐ First ☐ Last	

SECTION 2: APPOINTMENT INFORMATION

Type of appointment
☐ Subagent ☐ Firm/agency ☐ Agent

Is firm/agency incorporated? ☐ Yes ☐ No
If Yes, type of corporation: ☐ Sole proprietor ☐ LLC ☐ LLP ☐ S-Corporation

All Exchange business must be submitted under the same assignment. If this is your only assignment, this will be your Exchange relationship. CA, CO, NV, GA and NY allow more than one assignment at a time. CT, IN, KY, ME, MO, NH, OH, VA and WI allow only one assignment at a time. Do you authorize for this to be your Exchange relationship on this new assignment?
☐ Yes ☐ No

SECTION 3: COMMISSION ASSIGNMENT — Complete this section if commissions are to be assigned to an agency or corporation

Agency name	Agency tax ID no.	Agency principal name		

Agency business address	City	State	ZIP code	County

Agency physical location address (no PO box)	City	State	ZIP code	County

County	Agency fax no.

SECTION 4: COMMISSION HIERARCHY — If applicable

Brokerage general agency (BGA) name	BGA broker ID no. or BGA broker code

SECTION 5: PREVIOUS ADDRESSES

Have you lived anywhere other than the above mentioned legal residence in the last two (2) years? ☐ Yes ☐ No
If Yes, please list any/all such addresses. Please enter any additional information in the Remarks (section 10).

Previous address	City	State	ZIP code	County
Previous address	City	State	ZIP code	County

SECTION 6: EMPLOYMENT HISTORY

Have you been employed anywhere other than with your current employer in the last two (2) years? ☐ Yes ☐ No
If Yes, please list any/all such employment history. Please enter any additional information in the Remarks section (section 10).

Previous employer name	Start date	End date		
Previous employer address	City		State	ZIP code
Previous employer name	Start date	End date		
Previous employer address	City		State	ZIP code

SECTION 7: LICENSE INFORMATION

Residence license state	Residence license no.

SECTION 8: E&O POLICY INFORMATION — Please include a copy of your declaration page or certificate with application

Policy amount	Policy no.	Policy carrier	Effective date	Expiration date

SECTION 9: BUSINESS PRACTICES

If you answer "Yes" to any questions, attach a signed written explanation with all relevant information and supporting documents.

a. Have you ever had an insurance license or appointment, or a securities registration, or an application for such, denied, suspended, canceled or revoked?	☐ Yes ☐ No	g. Have you individually, or has a company you exercised control over, filed a bankruptcy petition or been the subject of an involuntary bankruptcy petition?	☐ Yes ☐ No
b. Has any legal or regulatory body ever sanctioned, censured, penalized or otherwise disciplined you?	☐ Yes ☐ No	h. Are there any unsatisfied judgments, garnishments, or liens against you?	☐ Yes ☐ No
c. Has any state or federal regulatory agency or self-regulatory authority ever filed a complaint against you?	☐ Yes ☐ No	i. Are you in debt to any insurance company?	☐ Yes ☐ No
d. Have you ever been subjected to an insurance or investment related, consumer initiated complaint or proceeding?	☐ Yes ☐ No	j. Have you ever been indicted for, convicted of, or pled guilty or nolo contendere to any felony or misdemeanor other than a minor traffic offense?	☐ Yes ☐ No
e. Has a bonding or surety company denied, ever paid out on, or revoked a bond for you?	☐ Yes ☐ No	k. Are you currently party to any litigation or the subject of any investigations?	☐ Yes ☐ No
f. Has an E&O carrier ever denied claims, paid claims, or canceled your coverage?	☐ Yes ☐ No	l. Has any employer, insurance company, or securities, broker-dealer ever terminated your employment or contract, or permitted you to resign for any other reason than lack of sales?	☐ Yes ☐ No

SECTION 10: REMARKS — Enter any remarks or additional information from sections 5, 6 and/or 7. Attach additional sheets, if necessary.

SECTION 11: AUTHORIZATION — Signature required

This notice is being provided to you by the Company pursuant to the Fair Credit Reporting Act ("FCRA"). As used herein, "the Company" means the identified insurer (the insurer identified on this form) and its subsidiaries, affiliates, officers, employees, agents, and representatives.

In connection with determining your eligibility for an insurance agent or producer license and/or your eligibility to be appointed or sponsored as an agent of the Company, and to maintain such license and appointment, in one or more states, the Company will from time to time conduct background checks. Such background checks may include the ordering of "consumer reports" from a "consumer reporting agency" containing information on your criminal and credit history. These terms are defined in the FCRA.

I acknowledge and agree that this Producer Appointment Data Sheet does not constitute a contract of any kind. I hereby authorize the Company and its authorized agents to investigate my background, references, character, past employment, education, criminal or police reports, including those mandated by both public and private organizations and all public records for the purpose of qualifications for my appointment, I hereby consent to the Producer Appointment Form and background information to government or regulatory agencies.

I hereby release the Company, its authorized agents and any person or entity which provides information pursuant to this authorization, from any and all liabilities, claims or lawsuits relating to the information obtained from any and all of the above referenced sources, or from the furnishing of the same. This is a continuing authorization.

I understand that I am obligated to immediately report any event that changes any of the information, in any manner, which I have provided on this application.

I hereby certify that all of the information herein is accurate and complete. Finally, I acknowledge and agree that my appointment will, in part, be based on this Producer Appointment Data Sheet and background information, and any falsification, misrepresentation or omission of information from this form may result in the withholding or withdrawal of any offer of appointment or the revocation of appointment by the Company whenever discovered.

For Maine Applicants Only
Upon request, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, the name and address of the consumer reporting agency furnishing the report. You may request and receive from us, within five business days of our receipt of your request, the name, address and telephone number of the nearest unit designated to handle inquiries for the consumer reporting agency issuing an investigative consumer report concerning you. You also have the right, under Maine law, to request and promptly receive from all such agencies copies of any reports.

For New York Applicants Only
You have the right, upon written request, to be informed of whether or not a consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report.

I understand that I may sign this Acknowledgement and Authorization for Appointment manually or by electronic signature. Further, I understand that whether I sign manually or by electronic signature, the signature will have a legally binding effect on me or the agency on whose behalf I am signing.

I certify that I have read and understand the above information.

Signature	Date (MM/DD/YYYY)
X	

Privacy Policy: Your privacy is important to us. We do not sell or share any personal information contained in this document with any third parties, with exception of providing information to state or government agencies for the express use of obtaining licenses or licensing information. We reserve the right to disclose your personally identifiable information as required by law and/or to comply with a judicial proceeding, court order, or legal process served on our company. We shall not be held responsible for any personal information obtained illegally by a third party via fax, email, or other online transmittal.

Medicare Advantage and Part D Producer Contract Addendum

The following Medicare Advantage and Medicare Part D terms and conditions shall be incorporated into the agreement between Anthem Blue Cross and its applicable affiliates offering Medicare Advantage and/or Medicare Part D plans (herein referred to as "Customer") and the party signing as "Producer" on the signature page hereof (herein referred to as "Producer.") These provisions shall only apply to services provided by Producer, as a First Tier Entity, to or for Customer's Medicare Advantage and/or Medicare Part D plans, including those plans for members dually eligible for Medicare and Medicaid in accordance with and pursuant to title XVIII of the Social Security Act (Act) (specifically, but not limited to, Social Security Act Parts C and Part D), and any subsequent amendments or relevant provision in the Act and applicable regulations. In the event that there is a conflict between the attached agreement and these Medicare Advantage and Medicare Part D terms and conditions, the Medicare Advantage and Medicare Part D terms and conditions shall control, but only as they relate to services provided to or on behalf of Covered Individuals enrolled in Customer's Medicare Advantage and/or Medicare Part D plans.

A. Definitions:

1. **Downstream Entity**: Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between Customer and Producer, a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

2. **First Tier Entity**: Any party that enters into a written agreement, acceptable to CMS, with Customer or applicant to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage program.

3. **Related Entity**: Any entity that is related to Customer by common ownership or control and (1) performs some of the Customer's management functions under contract or delegation, (2) furnishes services to Medicare Advantage enrollees under an oral or written agreement, or (3) leases real property or sells materials to Customer at a cost of more than $2,500 during the contract period. Hereinafter any reference to Subcontractors shall include the terms Downstream Entity and Related Entity.

B. Terms:

1. **Federal Funds.** Producer acknowledges that payments Producer receives from the Customer to provide services to Medicare Advantage and/or Medicare Part D enrollees are, in whole or part, from Federal funds. Therefore, Producer and any of its Downstream and/or Related Entities may be subject to certain laws that are applicable to individuals and entities receiving Federal funds, including but not limited to, 42 C.F.R. 423.100, 42 C.F.R. Part 422, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Americans With Disabilities Act; the Rehabilitation Act of 1973 and other regulations applicable to recipients of Federal Funds.

2. **Confidential Information.** Producer recognizes that in the performance of its obligations under this Agreement it may be party to the Customer's proprietary, confidential, or privileged information, including, but not limited to, information concerning the Customer's members. Producer agrees that, among other items of information, the identity of, and all other information regarding or relating to any of the Customer's customers is confidential. Producer agrees to treat such information as confidential and proprietary information of the Customer, and all such information shall be used by Producer only as authorized and directed by the Customer pursuant to this Agreement, and, unless required by law, shall not be released to any other person or entity under any circumstances without express written approval of the Customer. During and after the term of this Agreement, Producer shall not disclose or use any of the information described in this Section for a purpose unrelated to the terms and obligations of this Agreement. Further, Producer agrees to abide by all Federal and State laws regarding confidentiality and disclosure of Medicare Advantage and/or Medicare Part D enrollee information. In addition, Producer agrees to abide by the confidentiality requirements established by the Customer and CMS for the Medicare Advantage and/or Medicare Part D program.

    a. To the extent applicable, Producer will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal and State law or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§422.504(a)(13) and 422.118.]

3. **Inspection of Books and Records.** In accordance with, but not limited to, 42 C.F.R. 422.504(i) and/or 42 C.F.R. 423.505(i), Producer acknowledges that Customer, Health and Human Services department (HHS), the Comptroller General, or their designees have the right to timely access to inspect, evaluate and audit any books, contracts, medical records, patient care documentation, and other records of Producer, or its First tier, Downstream and Related entities, including but not limited to Subcontractors or transferees involving transactions related to Customer's Medicare Advantage contract through ten (10) years from the final date of the contract period or from the date of the completion of any audit, or for such longer period provided for in 42 CFR §422.504(e)(4) or other applicable law, whichever is later. For the purposes specified in this provision, Producer agrees to make available Producer's premises, physical facilities and equipment, records relating to Customer's Covered Individuals, including access to Producer's computer and electronic systems and any additional relevant information that CMS may require. Producer acknowledges that failure to allow HHS, the Comptroller General or their designees the right to timely access under this section can subject Facility to a $15,000 penalty for each day of failure to comply.

4. **Independent Status**. Producer is an independent contractor and nothing contained in this Agreement shall be construed or implied to create an agency, partnership, joint venture, or employer and employee relationship between Producer and the Customer. At no time shall either party make commitments or incur any charges or expenses for or in the name of the other party except as otherwise permitted by this Agreement.

5. **Subcontractors.** In accordance with, but not limited to, 42 C.F.R. 422.504(i)(3)(ii) and/or 42 C.F.R. 423.505(i)(3), Producer agrees that it will obtain from Customer prior written consent should Producer desire to subcontract any services delegated to Producer under this Agreement. Should Customer agree to Producer's subcontractor selection, Producer will cooperate with Customer in validating the compliance of the sub-delegation with the terms and conditions of this Exhibit. In addition, if Producer enters into subcontracts to perform services under the terms of the Agreement, Producer's subcontracts shall include an agreement by the subcontractor to comply with all of the Producer obligations in this Medicare Advantage and Medicare Part D Regulatory Exhibit and applicable terms in the attached Agreement. In addition, any and all contracts Producer enters into with such Subcontractors must name Customer in the contract and clearly delineate that Customer retains the necessary control and oversight over Producer and all downstream subcontractors.

6. **Federal and State Laws**. Consistent with, but not limited to, 42 C.F.R. 422.504(i)(4) and 422.504(i)(3)(iii) and/or 423.505(i)(4) and 423.505(i)(3)(iii) Producer agrees to comply, and to require any of its subcontractors to comply, with all applicable Federal and State laws, regulations, CMS instructions, and policies relevant to the activities to be performed under the Agreement, including but not limited to, the Medicare Marketing Guidelines for Medicare Managed Care Clients, and any requirements for CMS prior approval of materials. Further, Producer agrees that any services provided by the Producer or its subcontractors to or on behalf of Customer's Medicare Advantage and/or Medicare Part D plans will be consistent with and will comply with the Customer's Medicare Advantage and/or Medicare Part D contractual obligations.

7. **Compliance.** The Customer maintains an effective Compliance Program and Standards of Business Conduct, and requires its employees and First Tier, Downstream and Related entities to act in accordance therewith. The Customer will provide a copy of its then current Standards of Business Conduct to Producer annually or more frequently if required by law.

    a. Compliance Requirements. Consistent with the preceding paragraph and to the extent applicable, Customer and its Downstream and Related Entities are required to comply with all CMS regulations relevant to Medicare Advantage and/or Part D First Tier, Downstream and Related Entities. In addition, Producer agrees to comply with Customer's FDR Policies and Procedures, including the Annual Monitoring Report, which are incorporated herein by reference and can be amended from time to time by Customer with advance notice. In addition, Customer and its First Tier, Downstream and Related entities are required to complete all training required by CMS and Customer and to monitor for Fraud, Waste and Abuse consistent with CMS guidance. To the extent applicable,

Producer acknowledges that certain CMS guidance on Fraud, Waste and Abuse may be implicated by the Agreement and agrees to take appropriate actions to identify and/or monitor for such activities, including but not limited to producing Producer's plan to monitor for Fraud, Waste and Abuse.

b. Validation of Compliance. Producer agrees to provide documentation at least annually, to Customer, demonstrating compliance with the CMS guidance as outlined in part in this Exhibit. An example of the required monitoring form is attached hereto as Attachment 1. The parties acknowledge that Attachment 1 may be amended by Customer upon notice, from time to time, on an annual basis or as needed to comply with CMS oversight and monitoring requirements. In addition, Producer agrees to maintain documentation demonstrating compliance on an ongoing basis with all applicable CMS requirements.

c. Reporting of Identified Compliance Issues. Producer shall report all identified compliance issues affecting the services being performed hereunder to Customer immediately, but in no event greater than three (3) business days of identifying the issue. Customer has a non retaliation policy for all compliance issues reported in good faith. Upon identification of a compliance issue, Producer agrees to cooperate with Customer by providing any and all documentation required to evaluate, correct and monitor the identified issue.

d. Adherence to New CMS Requirements. Should CMS enact new requirements that impact the services being provided by Producer or its Subcontractors, Producer will provide written evidence of their or their Subcontractors compliance prior to the implementation date of the new requirement.

8. Hold Harmless. In accordance with, but not limited to, 42 C.F.R. 422.504(i) and 422.504(g)(1) and (2) and/or 423.505(i) and 423.505(g), Producer agrees that in no event, including but not limited to non-payment by Plan, insolvency of Plan or breach of the Agreement, shall Producer bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Medicare Advantage and/or Medicare Part D enrollee for covered services provided pursuant to the Agreement. This provision does not prohibit the collection of supplemental charges or Copayments made in accordance with the terms of the Medicare Advantage and/or Medicare Part D enrollee's benefits.

9. Ineligible Persons. Producer warrants and represents that at the time of entering into this Agreement and at least monthly thereafter when providing services to or for the benefit of Medicare Advantage and/or Medicare Part D members under this Agreement, Producer will review the applicable sources to insure that neither he/she/it nor any of his/her/its employees, contractors, subcontractors or agents are ineligible persons identified on the General Services Administrations' List of Parties Excluded from Federal Programs (available through the internet at https://www.sam.gov/) and the HHS/OIG List of Excluded Individuals/Entities (available through the internet at http://exclusions.oig.hhs.gov/). Producer agrees to maintain

documentation evidencing compliance with this requirement and agrees to sign a certification consistent with the meaning and requirements of this provision as required by Customer

In the event Producer or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose his/her/its ineligible person status, Producer shall have an obligation to (1) immediately notify the Customer of such ineligible person status and (2) immediately remove such individual from responsibility for, or involvement with, the Customer's business operations related to this Medicare Advantage and Medicare Part D attachment.

The Customer retains the right to provide notice of immediate termination of the Agreement to Producer in the event it receives notice of Producer's ineligible person status.

10. **Conflict of Interest.** The parties agree that the provision of services under this Agreement is free from any conflicts of interest. Customer requires and Producer agrees to certify that it will require its managers, officers and directors responsible for the administration or delivery of Medicare Advantage and/or Part D benefits to sign a conflict of interest statement, attestation, or certification at the time of hire and annually thereafter certifying that the manager, officer or director is free from any conflict of interest in administering or delivering Medicare Advantage and/or Part D benefits.

11. **Illegal Remunerations**. Producer specifically represents and warrants that activities to be performed under the Agreement are not considered illegal remunerations (including kickbacks, bribes or rebates) as defined in § 1128B(b) of the Social Security Act.

12. **Indemnification for Non-compliance**. Producer agrees to indemnify and hold the Customer harmless from and against any and all liabilities, claims and expenses connected therewith, including reasonable attorneys fees, arising from any acts or omissions of Producer, not specifically authorized or directed by the Customer, violating or resulting in an investigation under § 1128B(b) of the Social Security Act or any other Federal or State law or regulation.

13. **Termination-Regulatory Issues.** In accordance with, but not limited to, 42 C.F.R. 422.504(i)(5) and/or 423.505(i)(5), if during the term of the Agreement, the Customer concludes that it is necessary to cancel any of the activities to be performed under this Agreement in order to comply with Federal or State laws, regulations, policies, or for any other purpose to comply with applicable CMS regulations or instructions, the Customer may, at its discretion, cancel the activity and be relieved of any related obligations under the terms of the Agreement. If the Customer or Producer concludes that it is necessary to reorganize or restructure any of the activities to be performed under this Agreement in order to comply with Federal or State laws, regulations, or policies, the Customer or Producer may request to renegotiate such terms. If the parties are not able to reorganize or restructure the activities to meet the changes in Federal or State laws, regulations or policies, the parties may cancel or terminate the services being rendered pursuant to this Exhibit without being subject to any breach of contract penalties.

14. **Oversight Responsibility.** Producer acknowledges that the Customer shall oversee and monitor Producer's and all of Producer's Subcontractors' providing Services under this Agreement. Accordingly, Customer will regularly review the performance of Producer and, if applicable, Producer's Subcontractors, as part of its normal operations to confirm ongoing compliance and to ensure any identified corrective actions are undertaken and effective. Producer further acknowledges that the Customer is ultimately responsible to CMS for the performance of such services and that the Customer shall oversee and is accountable to CMS for the functions and responsibilities described in the Medicare Advantage and Medicare Part D regulatory standards and ultimately responsible to CMS for the performance of all services.

15. **Revocatio**n. Producer agrees that the Customer has the right to revoke this agreement if CMS or the Customer determines that Producer or any of its Downstream or Related Entities has not performed the services satisfactorily and/or if requisite reporting and disclosure requirements are not otherwise fully met in a timely manner. Such revocation shall be consistent with the termination provisions of the Agreement.

16. **Approval of Materials.** Any printed materials, including but not limited to letters to the Customer's members, brochures, advertisements, telemarketing scripts, packaging prepared or produced by Producer or any of its subcontractors pursuant to this Agreement must be submitted to the Customer for review and approval at each planning stage (*i.e.,* creative, copy, mechanicals, blue lines, etc.) to assure compliance with Federal, state, and Blue Cross/Blue Shield Association guidelines. The Customer agrees its approval will not be unreasonably withheld or delayed.

17. **Medicare Advantage and Medicare Prescription Drug Plan - Compliance Training, Education and Communications.** In accordance with, but not limited to 42 C.F.R. 422.503(b)(4)(vi)(C)&(D) and 42 C.F.R. 423.504(b)(4)(vi)(C)&(D) Producer agrees and certifies that it, as well as its employees, subcontractors, downstream entities, related entities and agents who provide services to or for Customer's Medicare Advantage and/or Part D Covered Individuals or to or for the Customer itself shall participate in applicable compliance training, education and/or communications as reasonably requested by the Customer or its designee annually or as otherwise required by applicable law, and must be made a part of the orientation and completed within the first ninety (90) days of hire for a new employee, new first tier, downstream or related entity and for all new appointments of a chief executive, manager, or governing body member. Both parties agree that the Customer or its designee may make such compliance training materials available to Producer in either electronic, paper or other reasonable medium upon request. Producer shall be responsible for documenting applicable employee's, Subcontractor's, Downstream Entity's, Related Entity's and/or agent's attendance and completion of such training on an annual basis. Producer shall provide such documentation to Customer annually and as required to support a Customer or CMS audit. In addition, the training requirement set forth herein is not required for providers or suppliers who have met the fraud, waste and abuse certification requirements through enrollment into the Medicare program, as those providers and/or

suppliers are deemed to have met that portion of the fraud waste and abuse training required by CMS.

18. Audit. Producer agrees to comply with any and all requests for Compliance documentation, as set forth in section 7 above, in order to support a Customer audit request or a CMS audit request. Producer must provide all requested documentation demonstrating compliance with all CMS regulations and/or Anthem requirements for first tier, downstream and/or related entities.

19. Delegated Activities. If Customer has delegated activities to Producer, then the Customer will provide the following information to Producer and Producer shall provide such information to any of its subcontracted entities:

a. A list of delegated activities and reporting responsibilities;
b. Arrangements for the revocation of delegated activities;
c. Notification that the performance of the contracted and subcontracted entities will be monitored by the Customer;
d. Notification that the credentialing process, if applicable, must be approved and monitored by the Customer; and
e. Notification that all contracted and subcontracted entities must comply with all applicable Medicare laws, regulations and CMS instructions.

20. Prohibition of Payment/Gifts/Incentives to Beneficiaries. Producer shall not provide or offer gifts or payments to a Medicare Advantage and/or Part D enrollee as an inducement to enroll in a Customer Medicare Advantage and/or Part D Product. Notwithstanding this section, Producer may provide an individual eligible for Medicare Advantage and/or Part D a gift of nominal value, so long as the gift is provided whether or not the individual enrolls in the plan. For purposes of this Agreement, nominal value is defined as an item having little or no resale value and which cannot be readily converted into cash. Generally nominal value gifts are worth less than fifteen dollars ($15.00). Cash gifts or gifts readily converted into cash are prohibited in any amount, as are charitable contributions in the name of potential enrollees. In addition, while Producer may describe legitimate benefits the individual eligible for Medicare Advantage and/or Part D may receive, Producer is prohibited from offering or giving rebates, dividends or any other incentives, especially those that in any way compensate for lowered utilization of health services by such eligible individual. This includes, but is not limited to the fact the Producer may not tie lowered or reduced premium costs for the Medicare Advantage and/or Part D enrollee to their decreased utilization of health services.

21. Unsolicited Contacts.

a. Producer may not do any of the following:

1. Place any outbound marketing calls to Members or to beneficiaries unless the beneficiary requested the call;

2. Place calls to former Members who have disenrolled or to current Members who are in the process of voluntarily disenrolling, to market plans or products. Members who are voluntarily disenrolling from a plan should not be contacted for sales purposes or be asked to consent in any format to further sales contacts;
3. Place calls to Members or beneficiaries to confirm receipt of mailed information, unless otherwise set forth herein;
4. Place calls to Members or beneficiaries to confirm acceptance of appointments made by third parties or independent agents;
5. Approach Members or beneficiaries in common areas (i.e. parking lots, hallways, lobbies, etc.)
6. Place calls or visit Members or beneficiaries who attended a sales event, unless the Member or beneficiary gave express permission at the event for a follow-up visit or call. Any such permission must be event specific and shall not be treated as open-ended permission for future calls. Any such permission must be documented.
7. Place calls based on referrals. If an individual would like to refer a friend or relative to an agent or plan sponsor, the agent or plan sponsor may provide contact information such as a business card that the individual may give to the friend or family member. In all cases, a referred individual needs to contact the plan or agent/broker directly.

b. Producer may do the following:

1. Place a call to a Member or beneficiary that Producer enrolled into an Customer Medicare Advantage and/or Part D plan as long as the Member remains enrolled with the Customer plan; or
2. Place a call to a beneficiary who has expressly given permission for Producer to contact them, for example by filling out a business reply card or asking a Customer Service Representative of Customer to have an Producer contact them. This permission by the beneficiary applies only to Customer Medicare Advantage and/or Part D plans for the duration of that transaction or as otherwise indicated by the beneficiary.
3. Return phone calls and messages, so long as they were unsolicited.

c. Outbound Scripts. Any and all outbound scripts utilized by Producer to contact beneficiaries on behalf of Customer must be submitted to Customer and to ultimately to CMS for review and approval prior to use in the marketplace. In addition, when conducting outbound calls, Producer must ensure the scripts include a privacy statement clarifying that the beneficiary is not required to provide any health related information to Customer or Producer and that the information provided will in no way affect the beneficiary's membership in the Medicare Advantage and/or Part D Plan.

22. **Cross Selling Prohibited**. Producer understands and agrees that marketing non-health care related products (such as annuities and life insurance) to prospective enrollees during any Medicare Advantage and/or Part D sales activity or presentation is considered cross selling and is strictly prohibited.

23. **Scope of Producer Appointments with Beneficiaries**. Producer must clearly identify the types of products that will be discussed before marketing to a potential enrollee beneficiary and the beneficiary must agree to the scope of the appointment (48-hours in advance when practicable) and such agreement must be documented by Producer. For example, if a beneficiary attends a sales presentation and schedules an appointment, the Producer must obtain written documentation signed by the beneficiary agreeing to the products that will be discussed during the appointment. In addition, appointments that are made by Producer over the phone must be recorded in order to provide adequate documentation. Producer will maintain the required documentation providing the scope of the appointment and will provide such documentation to Customer upon request. Producer further agrees that additional products may not be discussed unless the beneficiary requests the information and any additional lines of business that are not identified prior to the in-home appointment will require a separate appointment. Separate appointments cannot be re-scheduled until forty-eight (48) hours after the initial appointment. Producer may, however, leave Customer materials during the initial appointment so long as enrollment applications are not left with potential enrollees.

24. **Marketing in Health Care Settings.** Producer is prohibited from conducting sales presentations and distributing and/or accepting enrollment applications in areas where patients primarily intend to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis centers, and pharmacy counter areas (where patients wait for services or interact with pharmacy providers and obtain medication). Producer may, however, conduct sales and marketing activities only in common areas of health care settings. Common areas include areas such as hospital or nursing home cafeterias, community or recreational rooms, conference rooms and space in a pharmacy outside of the area where patients wait for services or interact with pharmacy providers and obtain medication. For beneficiaries residing in long term care facilities, Producer may only schedule an appointment if the beneficiary requested it.

25. **Sales/Marketing Prohibited at Educational Events.** Producer may not include sales activities, including but not limited to distribution of marketing materials or distribution or collection of Customer Medicare Advantage and/or Part D enrollment applications at educational events. Moreover, Producer must include the following disclaimer on all materials advertising an educational event: "educational only and information regarding a Medicare Advantage and/or Part D plan will not be available." Materials distributed or made available at an educational event must be free of plan-specific information, (including plan-specific premiums, co-payments, or contact information), and any bias toward one plan type over another. An educational event is one that is sponsored by a health insurance plan or by outside entities and are promoted to be educational in nature and have multiple Producers,

such as health information fairs, conference expositions, state-or community-sponsored events.

Without limiting the generality of the foregoing, Producer may not:

a. Discuss plan-specific premiums and/or benefits.

b. Distribute plan specific materials.

c. Distribute or display business reply cards, scope of appointment forms, enrollment forms, or sign-up sheets.

d. Set up individual sales appointments or get permission for an outbound call to the beneficiary.

e. Attach business cards or plan/agent contact information to educational materials, unless requested by the beneficiary.

f. Advertise an educational event and then have a marketing/sales event immediately following in the same general location, (e.g., same hotel).

26. Prohibition on the Provision of Meals. Producer may not provide meals or subsidize meals for any prospective enrollee of a Medicare Advantage or Part D plan at any event or meeting at which plan benefits are being discussed and/or plan materials are being distributed. Producer may provide refreshments and light snacks so long as the items provided could not be reasonably considered a meal and/or that multiple items are not being bundled and provided as if a meal. The following light snacks could generally be considered acceptable: fruit, raw vegetables, pastries, cookies or other small dessert items, crackers, muffins, cheese, chips, yogurt or nuts.

27. **Required Disclosure**. Producer must provide the following disclosure or a substantially similar disclosure, prior to enrollment or at the time of enrollment, in writing, to a potential enrollee:

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

28. License, etc. Producer warrants and represents that it is properly licensed, certified, and/or registered under applicable state laws to sell and/or market Medicare Advantage and/or Medicare Part D products in the state(s) where Producer intends to sell and/or market.

29. Discrimination Prohibited. Producer is prohibited from employing discriminatory practices that preferentially enroll healthier beneficiaries, mislead beneficiaries or churn beneficiaries

between Medicare Advantage and/or Medicare Part D plans. Producer shall not discriminate based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability or geographic location. Producer shall not target beneficiaries from higher income areas or state or otherwise imply that plans are available only to seniors rather than to all Medicare beneficiaries. Producer agrees to implement policies, procedures and monitoring activities that are consistent with the concepts noted in this provision.

30. Restrictions on Payments. Irrespective of any conflicting term or provision, Customer shall not pay Producer a Medicare Advantage and/or Medicare Part D commission rate that is based upon the value of the Medicare Advantage and/or Medicare Part D business generated for Customer (i.e., profitability of the book of business). Producer reimbursement for Medicare Advantage and/or Medicare Part D business shall not be tied or linked to a beneficiary's health risk profile. Under no circumstances may Producer charge a marketing fee or any other fee to a beneficiary.

31. Rapid Disenrollment. Consistent with CMS guidance, Producer agrees that Customer may withhold, withdraw or recoup compensation payment made to Producer if (i) a Medicare Advantage and/or Medicare Part D beneficiary disenrolls less than three (3) months after enrollment (i.e., rapid disenrollment), except as otherwise provided in CMS guidance; or (ii) any other time a beneficiary is not enrolled in a plan.

32. Contracting Authority. Each party to this Agreement warrants that it has full power and authority to enter into this Agreement and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective for the term set forth herein.

"PRODUCER"

_____
(Print Full Name of Producer)

Date Signed:_____

By:_____
(Signature of Authorized Signatory)

Name:_____
(Print Name of Signatory)

Title:_____
(Print Title of Signatory)

"CUSTOMER"
Anthem Blue Cross

By:_____
Erin Ackenheil
Vice President
Medicare Sales

_____ _____ _____
Producer Writing # (Tax ID#) Agency tax ID# (if appl) Social Security #

_____ _____
Business Address (Street, City, State, Zip) Email Address

_____ _____
Producer Phone # Producer Fax #

RITTER
Insurance Marketing

ACH Authorization Form

Add ☐ Delete ☐ Change ☐
Company Name:_____
Name:_____
Address:_____
City:_____State:_____Zip:_____
Phone:_____
Agent NPN:_____

Funds Settlement Information

Checking ☐ Savings ☐
Bank Name:_____
Account Owner:_____
Account Name:_____
Address:_____
City:_____State:_____Zip:_____
Routing # (9 digits) _____
Account #_____

_____(hereinafter referred to as Agent) authorizes Ritter Insurance Marketing (hereinafter referred to as Ritter) to initiate ACH transfer entries and to credit the account identified herein for business relating to contracts with Ritter. This authorization shall remain in effect unless and until Ritter has received written notification from the Agent that this authorization has been terminated in such time and manner to allow Ritter to act. Undersigned represents and warrants to Ritter that the person executing this Release is an authorized signatory on the Account referenced above and all information regarding the Account and Account Owner is true and correct.

_____ / / _____
Account Owner Signature Date

_____
Print Name and Title

ATTACH PRE-PRINTED VOIDED CHECK
OR
BANK LETTER
SEND TO

FAX: 1-888-509-7058
EMAIL: LICENSE@RITTERIM.COM
MAIL: 2600 Commerce Drive, Harrisburg, PA 17110

This form **MUST** be accompanied by a **Printed Voided Check or Bank Letter**

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

Employer identification number

–

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

Ritter Insurance Marketing LLC
Compensation Agreement – Anthem, Inc. – Level 4 (GA4)

This Agent Compensation Agreement ("Agreement"), effective _____ ("Effective Date") is for the payment of commissions for Anthem, Inc. and applicable Affiliates that provide Medicare Advantage and/or Medicare Part D Plans, hereinafter referred to as ("Insurance Company"). This Agreement is between Ritter Insurance Marketing LLC, hereinafter referred to as ("Ritter") and _____ _____, hereinafter referred to as ("Agent"). Ritter and Agent are referred to herein individually as a Party or party and collectively as the Parties or parties.

WHEREAS, Insurance Company is contracted with the Centers for Medicare & Medicaid Services ("CMS") to offer Medicare Advantage Benefit Plans (collectively, the "Plans") to Eligible Medicare Beneficiaries;

WHEREAS, Ritter is contracted with Insurance Company to facilitate the enrollment of Eligible Medicare Beneficiaries into Insurance Company's Plans; and,

WHEREAS, Agent desires to solicit, and Ritter desires that Agent so solicit, applications from Eligible Medicare Beneficiaries to enroll in the Insurance Company's Plans.

NOW THEREFORE, in consideration of the mutual covenants herein contained and intending to be legally bound hereby, the Parties hereto agree as follows:

General Conditions:

1. By accepting commission payments from Ritter, Agent agrees to all conditions of this contract.

2. Agent agrees to submit a copy of the Scope of Appointment ("SOA") form and other required materials along with the Enrollment form for all self-generated enrollments. Failure to submit SOA and other required materials will result in loss of commission for that enrollment. Additionally, failure to properly collect and submit a SOA is a violation of the Center for Medicare & Medicaid Services ("CMS") guidelines that may result in disciplinary action up to, and including, termination. As such, Agent agrees to:

   (a) Obtain the SOA for any face-to-face sales meeting 48-hours in advance, when applicable. If it is not practicable to obtain the SOA in advance, Agent must document the reason following the applicable Insurance Company and/or CMS guidelines.
   (b) Ensure the SOA, enrollment application, and all such related materials are complete, accurate, and appropriately signed by the eligible Medicare beneficiaries or his/her authorized representative.
   (c) Submit SOAs and enrollment applications to Ritter immediately but no later than 24 hours upon completion.

3. Agent agrees to allow Ritter and Insurance Company to conduct monitoring activities including Ride Alongs and Secret Shopping activities.

4. Agent agrees to assign any and all commissions related to the enrollment of Eligible Medicare Beneficiaries into Insurance Company's plans to Ritter. Ritter shall pay commissions to Agent according to the terms of this Agreement, however, nothing in this Agreement shall be construed to violate the CMS Marketing Guidelines nor shall this Agreement violate the terms and conditions of the Field Marketing Organization Agreement between Ritter and Insurance Company. If there is any conflict between this Agreement and the aforementioned, this Agreement shall be amended to adhere to CMS regulations and to the Field Marketing Organization Agreement terms and conditions.

   Assigned Commission to General Agency. Licensed Only Agent ("LOA") agrees to assign any and all commissions to the General Agency who employs or contracts with the LOA. General Agency will provide Ritter with written documentation that each General Agency's agent has assigned any and all commission related to the enrollment of eligible Medicare Beneficiaries into Insurance Company to General Agency. For the LOAs who have assigned their commission to General Agency, Ritter shall pay General Agency and General Agency's downline agents shall be compensated by General Agency according to the Commission schedules in the Agreement, unless the downline agent has agreed with General Agency in writing to an alternative compensation

methodology or amount in compliance with applicable law. Ritter reserves the right to pay the LOA directly if the General Agency fails to compensate the LOA.

5. Ritter shall not be responsible to pay any commissions to Agent for any commissions where Ritter does not receive compensation from the Insurance Company. This includes circumstances where Ritter's actions or in action result in the loss of commissions.

6. Ritter will pay Agent commissions based on the Commission Schedule in Exhibit A below. To the extent any sales level is not involved in the sale of Insurance Company product, the Commission payable to such sales level shall roll-up and be payable to the next higher sales level. Ritter shall pay Agent the net amount of commission payable on this schedule less any commissions paid at a lower level for the sale of an Insurance Company product.

7. "Initial" First Year Commissions and "Replacement" First year commissions are determined by the "Insurance Company" in accordance with CMS Marketing Guidelines. Ritter will pay the "Initial" first year commission or "Replacement" first year commission in accordance with the Insurance Company payment. Ritter is not responsible for any dispute involving determining whether a first year commission is "Initial" or "Replacement".

8. Ritter will pay Commissions within fourteen (14) days of receipt of payment from Insurance Company. Commission payments from Insurance Company to Ritter are processed after confirmation of accretion by CMS and effective date of coverage on the plan. Commissions of less than $100.00 will accrue to the next statement.

9. The Insurance Company may charge back commissions to Ritter for a variety of reasons including but not limited to: Rapid Disenrollment of the member, Early Termination of the member, Corrections of Commissions paid to Ritter in error, etc. In cases where Insurance Company charges back commissions to Ritter, Ritter will charge back all or a portion of commissions previously paid to Agent. Agent agrees to promptly repay any debit balances which may accrue due to charge backs to the Agent account by Ritter.

10. If Agent does not promptly repay any debit balances, Ritter may off set such balances against any commissions due the Agent from any contracts with any insurance company.

11. Agent shall not engage in any prohibited marketing activities and all marketing activities shall be conducted in accordance with Medicare Laws and Regulations and will be pre-approved, in writing by Insurance Company. Agent agrees to strictly comply with Insurance Company's policies and procedures and all applicable federal and state laws, rules and regulations (including but not limited to anti-kickback statues, false claims acts and fraud and abuse statutes and/or regulations) relating to promoting the Medicare Products to Eligible Medicare Beneficiaries. Agent will complete the training required by Insurance Company for the promotion and marketing of the Medicare Products and read and understand the Marketing Guidelines (as defined below) and will comply with all policies therein. Agent shall not make representations with respect to the nature or scope of the benefits of enrollment in the Medicare Products except in conformity with the written guidelines and marketing materials furnished by Insurance Company to Ritter and its Agents for that purpose. These written guidelines specifically include, but are not limited to (i) Title 42 of the Code of Federal Regulations Parts 417, 422 and 423 Medicare Program; Revisions to the Medicare Advantage and Prescription Drug Benefit Programs; Final Rule; (ii) CMS' Medicare Marketing Guidelines for Medicare Advantage Plans, Prescription Plans and 1876 Cost Plans and any and all updates, revisions and additional thereto and (iii) such other written guidelines and marketing materials that may be issued by CMS or other applicable regulatory agencies or otherwise be established by Insurance Company and, in the case of those established by Insurance Company, provided to Ritter and Agent directly (collectively, the "Marketing Guidelines"). By entering into this Agreement, Agent is acknowledging he/she has received, read and understands the Marketing Guidelines and will comply with said Marketing Guidelines.

    Agent shall comply with all applicable provisions of Insurance Company's Corporate Compliance Program including but not limited to the Insurance Company's Code of Ethics.

12. At all times that this Agreement is in effect, Agent shall not:

    (a) Bind coverage;
    (b) Accept an applicant into an Insurance Company Plan;
    (c) Misrepresent or omit facts in any application;
    (d) Modify or waive any Insurance Company Plan provisions or any terms regarding enrollment, coverage or benefits;

(e) Distribute any advertising, circular or promotional literature without prior approval by Insurance Company;
(f) Represent that Agent has authority on behalf of Insurance Company or has any authority except as explicitly provided in this Agreement;
(g) Represent or imply that an employer and employee relationship exists between Agent and Insurance Company; or
(h) Create or disseminate any communication or materials, hard copy or electronic, using the Insurance Company name or logo, trademark, symbol, and service mark except upon prior written agreement and written approval of all such communications or materials by Insurance Company.

Furthermore, Agent shall not and cannot guarantee an effective date of coverage for an Eligible Medicare Beneficiary and shall only advise Eligible Medicare Beneficiaries that a proposed effective date will be submitted to CMS who will approve the effective date of coverage. Agent agrees to only utilize CMS-approved marketing materials that are obtained directly from Insurance Company, which Agent is not permitted to change or modify in any manner whatsoever.

13. Agent shall deliver and explain to Eligible Medicare Beneficiaries the initial administrative forms, such as billing and enrollment materials as approved in advance by Insurance Company. Agent shall ensure Eligible Medicare Beneficiaries sign forms and Agent returns complete and accurate forms in a timely manner in accordance with Insurance Company procedures and CMS' requirements. Agent shall comply with all Insurance Company and CMS requirements regarding the timely submission of enrollment materials and all such related materials and shall submit all enrollment forms and, if applicable, scope of appointment forms, set forth in Section #2 above.

14. Agents shall maintain adequate books and records and comply with all other Medicare requirements set forth in Exhibit B, as attached hereto. Insurance Company, during regular business hours and upon reasonable notice or demand, shall have access to and the right to audit all information and records related to services rendered by Agent pursuant to this Agreement. This right shall survive the termination of this Agreement and shall continue so long as Agent has a legal obligation to maintain such records.

15. Agent acknowledges that pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the United States Department of Health and Human Services has promulgated regulations relating to the privacy of individually identifiable health information, protected health information ("PHI") and the security of such information when transmitted by electronic means and further that such regulations may require that contracts contemplating the collection of individually identifiable health information and/or the transmission of such information electronically include certain provisions.

Agent, its sub-agents and employees (collectively, "Subcontractor") acknowledge that as a result of its relationship with Ritter and Insurance Company, it may create, have access to or receive confidential PHI including, but not limited to, social security numbers, medical records and other individual member identifying information. Subcontractor agrees to comply with the terms included in the HIPAA Subcontractor Business Associate Addendum set forth in Exhibit C and requirements included in this Section 15 listed below:

(a) Will not use or further disclose PHI other than as permitted or required by law;
(b) Will use or disclose PHI to perform functions, activities, or services for, or on behalf of, Ritter and/or Insurance Company, provided that such use or disclosure would not violate the minimum necessary and/or Limited Data Set requirements of HIPAA or the minimum necessary policies and procedures of Insurance Company;
(c) Will protect and safeguard from any oral and written disclosures of all confidential information, both medical and financial, regardless of how such information is stored, with which it may come into contact;
(d) Use appropriate safeguards to prevent use or disclosure of PHI other than as permitted by this Agreement or required by law;
(e) Will document such disclosures of PHI and information related to such disclosures as would be required for Ritter or Insurance Company to respond to a request by an Individual for an accounting of Disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528 and will shall make such documentation available to upon request;
(f) Will agree to comply with the determination of a request for restriction to the Use or Disclosure of Protected Health Information and/or determination of a request for alternative methods of confidential communication pursuant to 45 C.F.R § 164.522 at the request of Ritter or Insurance Company, and in the time and manner mutually agreed to by the parties, but no later than ten (10) business days. If Business Associate receives a request for restriction to the Use or Disclosure of Protected Health Information and/or request for alternative

methods of confidential communication directly from an Individual, Business Associate shall forward such request to Ritter within five (5) business days;

(g) Will ensure that all of its subcontractors, subagents and employees, which may have contact with PHI, agree to all of the same restrictions and conditions to which Business Associate is bound;

(h) Will report to Ritter and Insurance Company any unauthorized use or disclosure of PHI immediately upon becoming aware of it; and

(i) Will comply with all applicable laws and regulations specifically including the privacy and security standards of HIPAA (45 C.F.R. Parts 160-164), Title V of the Gramm-Leach-Bliley Act (15 U.S.C.§ 6801 et seq.), applicable provisions of the Health Information Technology for Economic and Clinical Health Act as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act"), and any applicable state legislation and regulations, as amended from time to time.

Agent further agrees to cooperate and successfully complete any required HIPAA training requested and offered by Insurance Company or its designated vendor.

16. Agent acknowledges and agrees to cooperate with Insurance Company on the submission of all licensure and background information in a timely and accurate manner. This includes but is not limited to the submission of all information by agent via a web based implementation and monitoring tool. Agent further agrees to comply and cooperate with Insurance Company in the timely investigation and response to any complaints received by Ritter, Insurance Company or CMS from any Medicare beneficiary, enrollee or prospective enrollee.

Agent authorizes Insurance Company, in its sole discretion, to (a) conduct an investigation relating to Agent's background and qualifications including but not limited to, reviewing criminal, education, and state insurance records; and (b) monitor Agent's performance through (i) outbound verification calls, (ii) examination of Agent's rapid disenrollment and cancellation frequencies, and (iii) any other lawful means chosen by Insurance Company.

Agent further agrees to notify Ritter immediately but no later than three (3) days of any and all actions regarding Agent's non-compliance with any of the policies and procedures of Insurance Company, and/or non-compliance with Medicare Marketing Guidelines, and/or non-compliance with the applicable laws.

17. Term of Agreement. The term of this Agreement shall begin on the date first written above (the "Effective Date") and shall continue until terminated in accordance with the provision of Section 17.

17.1 Termination without Cause. This Agreement may be terminated without cause by either Ritter or Agent upon sixty (60) days prior written notice or such minimum number of days as required by applicable law, but in no event less than one hundred twenty (120) days prior to the date the Annual Open Enrollment ("AEP") begins as determined by CMS. Termination received by Ritter during AEP shall be postponed until January 1st of the following year. Upon termination of this Agreement without cause, any compensation due to Agent as set forth in this Agreement in effect as of the effective termination date of this Agreement (subject to the conditions specified in Section 17.3) shall be vested in Agent and payable to Agent by Ritter regardless of whether this Agreement is still in force at the time such compensation becomes due for as long as each such applicable Eligible Medicare Beneficiary remains enrolled in the product with Insurance Company, commissions continue to be paid by Insurance Company, and Agent remains licensed and appointed in good standing with Insurance Company.

17.2 Termination with Cause. This Agreement may be terminated immediately upon the occurrence of any of the following:

(a) Such termination is required by state or federal law or regulation, or by an order of any state or federal agency or court with authority to issue such an order;

(b) The failure of Agent to comply with (i) the policies, procedures, rules and regulations of Insurance Company, (ii) the Marketing Guidelines, (iii) the Medicare Laws and Regulations or (iv) the laws or regulations of the states in which Agent is licensed to conduct business or any federal or state regulatory authority having jurisdiction over the Parties;

(c) The failure of Agent to perform any material obligations imposed upon Agent under the terms and conditions of this Agreement;

(d) The conviction of Agent or any of its principals, shareholders, directors or officers of a felony crime or any other crime involving moral turpitude;

(e) The exclusion of Agent or any of its principals, directors or officers from participation in Medicare,

Medicaid or any federal health care program;

(f) The failure of Agent to provide Insurance Company with certificates of insurance and to maintain the insurance coverages as required by Insurance Company; or

(g) The promotion and marketing of the products by Agent or any of its principals, shareholders, directors or officers or any representative when a suspension is in effect.

17.3 Agent of Record (AOR) and Vesting of Commission Following Termination. Agent will be the Agent of Record (AOR) on all policies the Agent submits and commissions are vested with the Agent subject to the following terms:

(a) Agent remains in "Good Standing" with Insurance Company according to CMS Marketing Guidelines and Insurance Company continues to pay commission to Ritter for agent business. "Good Standing" shall mean licensed and appointed to sell in the appropriate state(s), annually trained and tested with passing score. To guarantee staying AOR for a given calendar year, Agent must be in "Good Standing" with Insurance Company no later than December 7th of the previous calendar year.

(b) Full Year Commissions earned by Agent total at least $250 in the prior Calendar Year.

(c) Agent is not terminated for cause as specifies in Section 17.2.

(d) With approval from immediate Upline, Agent may voluntarily cede AOR for any or all cases they are currently AOR of to any other agent in "Good Standing" with Insurance Company, subject to Ritter and Insurance Company approval.

(e) In scenarios (a) and (c), the Agent's immediate Upline will have the right to choose and assign new AOR to any and all cases the previous AOR had. The new AOR must be in "Good Standing" with Insurance Company.

(f) Ritter reserves the right to pass through any and all applicable financial penalties assessed by Insurance Company when Agent fails comply with any provision of this Agreement.

18. Agent conduct. Agent agrees to disclose to any prospective Eligible Medicare Beneficiary prior to or at time of enrollment that the Agent is compensated based on the prospective Eligible Medicare Beneficiary's enrollment in a plan.

Agent further agrees to not engage in the following prohibited sales practices.

a. Making unsolicited home visits;
b. Soliciting Beneficiaries door-to-door prior to receiving an invitation from the Eligible Medicare Beneficiary;
c. Placing outbound calls to prospective or former members, unless the Eligible Medicare Beneficiary requested the call and their solicitation for information is documented;
d. Sending unsolicited emails to a Eligible Medicare Beneficiary unless the Eligible Medicare Beneficiary agrees to receive emails and has provided his/her address to the Agent;
e. Misrepresenting, intimidating, or using high-pressure sales tactics. If Eligible Medicare Beneficiary says he or she is not interested, the conversation must end;
f. Offering Eligible Medicare Beneficiaries a cash payment as an inducement to enroll in a Medicare Advantage Part C or Medicare Advantage Prescription Drug (Part D) plan;
g. Stating that the Agent works for or is contracted with the Social Security Administration (SSA) or the Centers for Medicare & Medicaid Services (CMS);
h. Misrepresenting a product being marketed as an approved Medicare Advantage Prescription (Part D) plan when it is actually a Medigap policy or non-Medicare drug plan;
i. Using an unapproved presentation or material. Agent shall use only those subscription forms, insurance applications, printed materials, and any other sales or marketing materials as are provided by Insurance Company, except as Insurance Company may otherwise approve in writing;
j. Marketing or enrolling other lines of business. Additional products that were not identified, agreed upon, and documented in the Scope of Appointment cannot be discussed unless the Eligible Medicare Beneficiary requests this information. A separate appointment is required to discuss additional products and a 48 hour "cool off" period must be observed before a second appointment can be scheduled;
k. Requesting Eligible Medicare Beneficiary identification information such as bank account number, credit card number;
l. Conducting outbound telephone enrollment, which also includes transferring outbound calls to inbound lines for telephone enrollment;

m. Engaging in forgery, including manually assisting Eligible Medicare Beneficiary with the signing of the enrollment application;
n. Engaging in unauthorized language interpretation;
o. Dissemination of inaccurate or false enrollment materials;
p. Enrolling Eligible Medicare Beneficiary(s) at educational events, or in healthcare settings (waiting rooms, exam rooms, hospital patient rooms, dialysis center, etc.);
q. Scheduling unauthorized group presentations. Agent must obtain approval from Insurance Company prior to organizing or advertising a group presentation (30) days in advance; and
r. Any other conduct that CMS prohibits in the future, or which Ritter deems prohibited in the future, based on interpretation of current or new CMS guidance.

19. Each Party agrees to indemnify and hold the other party harmless from and against any and all claims, demands or causes of action whatsoever to the extent resulting from or arising out of any act, error or omission on the part of the indemnifying party's officers, agents, representatives or employees in breach of this Agreement. Agent further agrees to indemnify and hold harmless Insurance Company from any claim, suit, cost or expense, of any kind, including but not limited to the costs of defense incurred by Insurance Company as a result of any actions or omissions by Ritter or Agent in connection with its performance of the terms and conditions of any compensation agreement among and between Ritter and/or Agent, including but not limited to (i) breach of Ritter obligations under the applicable compensation agreement, and/or (ii) allegations, judgments, findings or determinations that Insurance Company is vicariously liable for such actions or omissions by Ritter and/or Agent, (iii) allegations, judgments, findings or determinations that Insurance Company is liable, directly or vicariously, for failure to oversee Ritter's and/or Agent's compliance with the terms, conditions and obligations under the applicable compensation agreement or the law, (iv) allegations that Ritter has not paid any commissions or other amounts due or allegedly due, and/or (v) allegations that Insurance Company is responsible for any commission payments or other payments to any third parties under any applicable compensation agreement.

20. Insurance Company is required to comply with the provisions of the Violent Crime Control and Law Enforcement Act of 1994 ("VCCA"), 18 U.S.C. §§ 1033 et seq., and the related state Insurance Department guidelines. The VCCA prohibits companies and individuals from engaging in the business of insurance if the company or individual has ever (1) pled guilty to, (2) pled no contest to, or (3) been convicted of (a) any criminal felony involving dishonesty or a breach of trust, or (b) of an offense defined within the VCCA, unless that company or individual has obtained written consent from the appropriate state insurance department. Agents are "engaged in the business of insurance" for purposes of the VCCA. Agent certifies that he/she and each of the employees, agents, and/or other representative of Agent who perform work or services described in this Agreement has not (1) pled guilty to, (2) pled no contest to, or (3) been convicted of (a) any criminal felony involving dishonesty or a breach of trust, or (b) of an offense defined within the VCCA. Agent understands that if Agent learns that any person who is performing work or services on behalf of Agent as described in this Agreement may not be in compliance with the VCCA, Agent is obligated to immediately notify Ritter, in writing, of this information and remove the subject person from performing the work or services under this Agreement.

21. Training. Agent agrees to provide and document Compliance / Fraud, Waste and Abuse (FWA) training for all non-agent employees, management, temporary workers or subcontractors, if applicable. Agent agrees to utilize the training content located on the CMS Medicare Learning Network (MLN) to satisfy the general compliance and FWA training requirements. CMS' trainings are titled – "Medicare Parts C and D General Compliance Training" and "Combating Medicare Parts C and D FWA Training". If applicable, such training must be provided within 90-days of hiring and annually after. Documentation on completion of training (i.e., training certificate) must be retained in accordance with the CMS record retention guidelines as defined in Exhibit B Medicare Administrative Addendum.

22. Excluded Persons. Agent agrees to review the DHHS OIG List of Excluded Individual and Entities (LEIE List) and the GSA Excluded Parties Lists System (EPLS) for all non-agent employees, management, temporary workers or subcontractors, if applicable. These databases must be checked prior to hiring and during the term thereafter not less than monthly. Agent agrees to document the date of the review and retain all such document in accordance with the CMS record retention guidelines as defined in Exhibit B Medicare Administrative Addendum.

23. Amendment.

(a) Unilateral Amendments. Any amendment to this Agreement proposed by Ritter**,** shall be effective thirty (30) days after Ritter has given written notice to Agent of the amendment, and Agent has failed, within fifteen (15) days of Agent receiving written notice, to notify Ritter in writing of Agent's rejection of the requested amendment.

(b) Amendments to Comply with Laws and Regulations. Amendments required because of legislative, regulatory or legal requirements do not require the consent of Agent or Ritter and will be effective immediately on the effective date thereof.

(c) Prior Agreements. Agent and Ritter agree that this Agreement, including all exhibits, appendices and addenda attached hereto or incorporated into this Agreement by reference, constitutes the entire agreement between Ritter and Agent and will, upon execution by the Parties, supersede any prior agreement, oral or written, between the Parties concerning the subject matter of this Agreement. If any such agreements are in existence, they are, upon execution of this Agreement by the Parties, hereby cancelled, except with respect to any compensation or commission payable thereunder, which compensation or commission shall continue to be paid in accordance with the terms thereof.

IN WITNESS WHEREOF, the Parties have executed this Agreement to be signed by their duly authorized representatives as of the Effective Date.

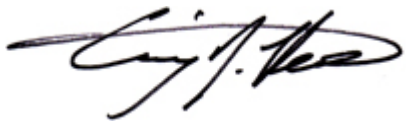
Ritter Insurance Marketing, LLC	_____
	
By:_____	By:_____
Name: Craig J. Ritter	Name:_____
Title: President	Title:_____
Date:_____	Date:_____

Exhibit A

2017 Commission Schedule

Empire BlueCross and BlueShield

Initial (From Original Medicare or New to Medicare, determined by CMS). First payment will be made at the Replacement level until Insurance Company is notified by CMS to release the initial compensation and Insurance Company pays this to Ritter. (New York – MA, and MAPD that are underwritten by Empire BlueCross and BluesShield and sold in select counties within New York)

Empire MediBlue Plus HMO Select Counties, Empire MediBlue Choice (HMO), Empire MediBlue Core (HMO) MA Only, and Empire MediBlue Dual Advantage (HMO SNP)

Level	Title	2017 Initial Year 1	2017 Year 1 Renewal	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$443.00	$222.00	Carrier Rate + $ 0.00
3	GA3	$393.00	$197.00	Carrier Rate - $ 25.00
2	GA2	$343.00	$172.00	Carrier Rate - $ 50.00
1	GA1	$293.00	$147.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00

Empire MediBlue Access (PPO) Select Counties in NY

Level	Title	2017 Initial Year 1	2017 Year 1 Renewal	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$402.00	$201.00	Carrier Rate + $ 0.00
3	GA3	$352.00	$176.00	Carrier Rate - $ 25.00
2	GA2	$302.00	$151.00	Carrier Rate - $ 50.00
1	GA1	$252.00	$126.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00

Anthem Blue Cross

Initial (From Original Medicare or New to Medicare, determined by CMS). First payment will be made at the Replacement level until Insurance Company is notified by CMS to release the initial compensation and Insurance Company pays this to Ritter. (California – MA, MAPD, and Part D Plans that are underwritten by Anthem Blue Cross and sold in select counties within California)

Anthem MediBlue Access (PPO)

Level	Title	2017 Initial Year 1	2017 Year 1 Renewal	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$503.00	$252.00	Carrier Rate + $ 0.00
3	GA3	$453.00	$227.00	Carrier Rate - $ 25.00
2	GA2	$403.00	$202.00	Carrier Rate - $ 50.00
1	GA1	$353.00	$177.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00

Anthem MediBlue Select (HMO), Anthem MediBlue Dual Advantage (HMO SNP), Anthem MediBlue Plus (HMO), and Anthem MediBlue Coordination Plus (HMO)

Level	Title	2017 Initial Year 1	2017 Year 1 Renewal	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$553.00	$277.00	Carrier Rate + $ 0.00
3	GA3	$503.00	$252.00	Carrier Rate - $ 25.00
2	GA2	$453.00	$227.00	Carrier Rate - $ 50.00
1	GA1	$403.00	$202.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00

Anthem MediBlue Dual Advantage (HMO SNP) Sacramento County, Anthem MediBlue Plus (HMO) Sacramento County, and Anthem MediBlue Plus (HMO) Yolo County (Non-Commissionable)

Level	Title	2017 Initial Year 1	2017 Year 1 Renewal	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$0.00	$0.00	$0.00
3	GA3	$0.00	$0.00	$0.00
2	GA2	$0.00	$0.00	$0.00
1	GA1	$0.00	$0.00	$0.00
0	LOA	$0.00	$0.00	$0.00

Standalone Prescription Drug Plans (PDP) – Where available

Level	Title	2017 Initial Year 1	2017 Year 1 Renewal	Renewal Yr 2 - Yr 6 (Paid Monthly)
4	GA4	$71.00	$36.00	Carrier Rate + $ 0.00
3	GA3	$65.00	$33.00	Carrier Rate - $ 3.00
2	GA2	$55.00	$28.00	Carrier Rate - $ 8.00
1	GA1	$45.00	$23.00	Carrier Rate - $ 13.00
0	LOA	$ 0.00	$ 0.00	$ 0.00

Anthem Blue Cross and Blue Shield

Initial (From Original Medicare or New to Medicare, determined by CMS). First payment will be made at the Replacement level until Insurance Company is notified by CMS to release the initial compensation and Insurance Company pays this to Ritter. (MA, MAPD, and Part D Plans that are underwritten by Anthem Blue Cross and Blue Shield and sold in select counties within Colorado, Nevada, Virginia, Indiana, Kentucky, Ohio, Missouri, Wisconsin, New Hampshire, Maine and Connecticut.)

Anthem MediBlue Plus (HMO), Anthem MediBlue Dual Advantage (HMO SNP), Anthem MediBlue Coordination Plus (HMO), Anthem MediBlue Essential (HMO), Anthem MediBlue Local (HMO), Anthem MediBlue COPD (HMO SNP), Anthem MediBlue Diabetes (HMO SNP), Anthem MediBlue Smartfit (HMO), and Anthem MediBlue Care to You (HMO).

Level	Title	2017 Initial Year 1	2017 Year 1 Renewal	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$443.00	$222.00	Carrier Rate + $ 0.00
3	GA3	$393.00	$197.00	Carrier Rate - $ 25.00
2	GA2	$343.00	$172.00	Carrier Rate - $ 50.00
1	GA1	$293.00	$147.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00

Anthem MediBlue Access (PPO), Anthem MediBlue Access (Regional PPO), Anthem MediBlue Access Enhanced (PPO), and Anthem MediBlue Access Core (Regional PPO)

Level	Title	2017 Initial Year 1	2017 Year 1 Renewal	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$402.00	$201.00	Carrier Rate + $ 0.00
3	GA3	$352.00	$176.00	Carrier Rate - $ 25.00
2	GA2	$302.00	$151.00	Carrier Rate - $ 50.00
1	GA1	$252.00	$126.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00

Anthem MediBlue Select (HMO) Connecticut, Anthem MediBlue Dual Advantage (HMO SNP) Connecticut, and Anthem MediBlue Plus (HMO) Connecticut

Level	Title	2017 Initial Year 1	2017 Year 1 Renewal	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$498.00	$249.00	Carrier Rate + $ 0.00
3	GA3	$448.00	$224.00	Carrier Rate - $ 25.00
2	GA2	$398.00	$199.00	Carrier Rate - $ 50.00
1	GA1	$348.00	$174.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00

Standalone Prescription Drug Plans (PDP) – Where available

Level	Title	2017 Initial Year 1	2017 Year 1 Renewal	Renewal Yr 2 - Yr 6 (Paid Monthly)
4	GA4	$71.00	$36.00	Carrier Rate + $ 0.00
3	GA3	$65.00	$33.00	Carrier Rate - $ 3.00
2	GA2	$55.00	$28.00	Carrier Rate - $ 8.00
1	GA1	$45.00	$23.00	Carrier Rate - $ 13.00
0	LOA	$ 0.00	$ 0.00	$ 0.00

Blue Cross Blue Shield of Georgia

Initial (From Original Medicare or New to Medicare, determined by CMS). First payment will be made at the Replacement level until Insurance Company is notified by CMS to release the initial compensation and Insurance Company pays this to Ritter. (Georgia – MA, MAPD, and Part D Plans that are underwritten by Blue Cross and Blue Shield of Georgia and sold in select counties within Georgia)

BCBSGA MediBlue Access (PPO)

Level	Title	2017 Initial Year 1	2017 Year 1 Renewal	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$402.00	$201.00	Carrier Rate + $ 0.00
3	GA3	$352.00	$176.00	Carrier Rate - $ 25.00
2	GA2	$302.00	$151.00	Carrier Rate - $ 50.00
1	GA1	$252.00	$126.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00

BCBSHP MediBlue Dual Advantage (HMO SNP), BCBSHP MediBlue Plus (HMO), and BCBSHP MediBlue Prime Select (HMO)

Level	Title	2017 Initial Year 1	2017 Year 1 Renewal	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$443.00	$222.00	Carrier Rate + $ 0.00
3	GA3	$393.00	$197.00	Carrier Rate - $ 25.00
2	GA2	$343.00	$172.00	Carrier Rate - $ 50.00
1	GA1	$293.00	$147.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00

For Standalone Prescription Drug Plans (PDP) – Where available

Level	Title	2017 Initial Year 1	2017 Year 1 Renewal	Renewal Yr 2 - Yr 6 (Paid Monthly)
4	GA4	$71.00	$36.00	Carrier Rate + $ 0.00
3	GA3	$65.00	$33.00	Carrier Rate - $ 3.00
2	GA2	$55.00	$28.00	Carrier Rate - $ 8.00
1	GA1	$45.00	$23.00	Carrier Rate - $ 13.00
0	LOA	$ 0.00	$ 0.00	$ 0.00

Exhibit B

Medicare Administrative Services Addendum

WHEREAS the parties adopt this Medicare Administrative Services Addendum ("Medicare Addendum") to the Agreement to comply with the requirements of the Medicare regulations at 42 C.F.R. Parts 422 ("Part C") and 423 ("Part D"), to the extent that Agent performs Medicare administrative services on behalf a Medicare Advantage Plan or a Prescription Drug Plan **("Plan")**.

Delegated Activities. Plan delegates to Agent and Agent shall provide Medicare administrative services, as listed in the Agreement. Agent acknowledges and agrees that Plan may only delegate activities or functions to Agent in a manner consistent with the requirements set forth as applicable in 42 C.F.R. §§ 422.504(i)(4) and 423.505(i)(4); 42 C.F.R. §§ 422.504(i)(3)(ii), 423.505(i)(3)(ii). Agent agrees that (i) the performance of the Delegated Activities and responsibilities thereof shall be subject to monitoring on an ongoing basis by Insurance Company; and (ii) in the event that Insurance Company or CMS determine that Agent has not satisfactorily performed any Delegated Activity or responsibility thereof in accordance with the CMS Contract, applicable laws and regulations and CMS instructions, then Insurance Company shall have the right, at any time, to revoke the Delegated Activities by terminating the Agreement in whole or in part, and shall have the right to institute corrective action plans or seek other remedies or curative measures as contemplated by the Agreement. Agent shall not further delegate any activities or requirements without prior written consent of Insurance Company.

1. **Consistency with CMS Contract.** Agent shall perform the services in a manner that complies with and is consistent with Plan's contractual obligations relating to performance of Medicare administrative services. 42 C.F.R. §§ 422.504(i)(3)(iii), 423.505(i)(3)(iii).

2. **Accountability**. Agent acknowledges and agrees that the Plan is required to monitor the performance of Agent on an ongoing basis and that the Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the CMS Contract. 42 C.F.R. §§ 422.504(i)(1), 422.504(i)(4)(iii), 423.505(i)(4)(iii), 423.505(i)(1).

3. **Laws, Regulations and CMS Requirements**. Agent represents and agrees that, throughout the term of the Agreement, Agent shall comply with the following Laws and requirements, in each case to the extent applicable to Agent's performance of the Services: (i) all applicable Medicare statutes and regulations and CMS guidance, instructions and requirements; (ii) HIPAA and the HITECH Act, to the extent provided in the HIPAA Addendum attached to the Agreement; (iii) all other applicable Federal Laws. 42 C.F.R. §§ 422.504(i)(4)(v), 423.505(i)(4)(iv).

   (a) Fraud and Abuse. Agent shall comply with Federal Laws designed to prevent fraud, waste, and abuse, including applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. § 3729 et seq.), and the Anti-Kickback statute (42 U.S.C. § 1320a-7b(b)). 42 C.F.R. §§ 422.504(h)(1), 423.505(h)(1).

   (b) Excluded Persons. Agent represents as of the effective date of the Agreement that neither it, nor any of its employees, members of its board of directors, officers, or Medicare subcontractors have been excluded from participation in the Medicare program or any other Federal Health Care Program or criminally convicted or has a civil judgment entered against it for fraudulent activities.

   Agent shall contractually require its Medicare subcontractors to ensure that their employees are not excluded from participation in the Medicare program or any other Federal Health Care Program.

   Agent must check appropriate databases to determine whether any of its employees, members of its board of directors, or officers or Medicare subcontractors has been excluded from participation in the Medicare program or any other Federal Health Care Program. These databases must be checked during the Term not less than monthly. Agent shall also check appropriate databases prior to when any of its employee, members of its board of directors, or officers commence their employment, directorship or ownership of Agent. Databases include the General Services Administration's Excluded Parties List System and the OIG Exclusion List. Agent shall notify Plan immediately in writing if Agent determines that any of its employees, members of its board of directors, or officers are suspended or excluded from the Medicare program or any other Federal Health Care Program or if criminally convicted or has a civil judgment entered against it for fraudulent activities.

Agent shall notify Ritter immediately in writing if Agent determines that any of its employees, temporary employees, volunteers, consultants and members of its board of directors, officers or Medicare subcontractors are suspended or excluded from the Medicare program or any other Federal Health Care Program. Agent agrees that it is subject to 45 C.F.R. Part 76 and shall require its employees, members of its board of directors, or officers to agree that they are subject to 45 C.F.R. Part 76. 42 C.F.R. §§ 422.752(a)(8), 423.752(a)(6).

Agent shall comply with all applicable provisions of Insurance Company's Corporate Compliance Program and Standards of Business Conduct.

(c) Compliance with Insurance Company's Obligations, Policies and Procedures. Agent agrees to comply with the Insurance Company policies and procedures applicable to its Products, to the extent applicable to the Services Agent is providing under the Agreement.

4. Confidentiality and Accuracy of Records. Agent agrees to abide by all Federal and state Laws regarding confidentiality and disclosure and shall treat all enrollees' health and enrollment information, including any medical records or mental health records as confidential in accordance with the provisions of the Agreement, and comply with all applicable Laws regarding the confidentiality and disclosure of such health and enrollment information. Agent shall maintain such health and enrollment information in an accurate and timely manner and ensure timely access to such records and information by enrollees, all as set forth in the Agreement. 42 C.F.R. §§ 422.118, 422.504(a)(13), 423.136, 423.505(b)(14).

5. Inspection and Audit. Agent shall permit CMS, HHS, the Comptroller General, or their designees, to inspect, evaluate, and audit any of Agent's books, contracts, medical records, patient care documentation, documents, papers, and other records pertaining to any services provided under the Agreement. This right to inspect, evaluate, and audit shall extend ten (10) years from the expiration or termination of the Agreement or completion of final audit, whichever is later, unless otherwise required by applicable Law. 42 CFR §§ 422.504(i)(2)(i) 423.505(i)(2) 423,505(e)(2)

6. Contracts with Downstream Entities. The following provisions also apply to Agent's delivery of the services:

(a) Agent shall contractually obligate any providers, contractors and subcontractors Agent utilizes in the delivery of the services to comply with all applicable Laws, for which Agent has a compliance obligation under this Medicare Addendum. 42 C.F.R. §§ 422.504(i)(4)(v), 423.505(i)(4)(iv).

(b) Agent shall not hold enrollees liable for any amounts that are the legal obligation of the Plan. 42 C.F.R. §§ 422.504(i)(3)(i), 423.505(i)(3)(i).

(c) Agent shall contractually obligate any providers, contractors, and subcontractors Agent utilizes in the delivery of the services to comply with the same conditions and restrictions that are applicable to Agent under this Medicare Addendum. 42 C.F.R. §§ 422.504(i)(3)(iii), 423.505(i)(3)(iii).

(d) Agent shall not subcontract for Part C and/or Part D activities outside the jurisdiction of the United States ("offshore subcontractor"), without Plan's prior written approval. In the event that Agent intends to contract for any Medicare Part C and/or Part D activities with an offshore subcontractor that relates to Member PHI, Agent must obtain the prior written approval of the Plan. Failure to do so may result in the immediate termination of the Agreement.

7. Training. Agent shall ensure that its employees, downstream and related entities conduct compliance and fraud, waste and abuse training ("**FWA**"). Such training and education must occur at a minimum annually and must be made a part of the orientation for a new employee, within 90-days of hiring, and new appointment to a chief executive, manager, or governing body member. 42 C.F.R. §§ 422.503(b)(4)(vi)(C),423.504(b)(4)(vi)(C).

Agents who have met the FWA certification requirements through enrollment into the Medicare program are deemed to have met the training and educational requirements for fraud, waste, and abuse.

8. Termination of Agreement for Breach. Agent acknowledges and agrees that a breach of this Medicare Addendum shall be considered a breach of the Agreement. For purposes of the Medicare Addendum, a determination by CMS or Plan that Agent has not satisfactorily performed its delegated obligations under the Agreement constitutes a breach. 42 C.F.R. §§ 422.504(i)(4)(ii), 423.505(i)(4)(ii).

9. Additional Contract Terms Required by CMS. This Medicare Addendum shall automatically amend to include terms and conditions necessary to address additional contract terms required by CMS. 42 C.F.R. §§ 422.504(j), 423.505(j).

Exhibit C

Ritter Insurance Marketing LLC.
HIPAA Subcontractor Business Associate Addendum

This Subcontractor Business Associate Addendum ("SubBAA ") adds to and is made a part of the Ritter Agent Compensation Agreement ("Agreement") by and between Ritter Insurance Marketing, LLC., hereinafter referred to as "Business Associate" and Agent (hereinafter referred to as "Subcontractor"). This SubBAA is an integral part of the Agreement as if fully set forth therein (each a "Party" and collectively the "Parties").

Business Associate performs services under contracts with certain covered entities (each such covered entity a "Covered Entity" and collectively "Covered Entities") offering Medicare Advantage and Part D Plans, and in the course of satisfying its obligations will have access to and/or use of Protected Health Information that is subject to protection under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Business Associate has agreed to provide such services in compliance with privacy, information security, and breach notification regulations, including the regulations contained in 45 C.F.R. Parts 160 and 164, promulgated under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and the HITECH Act, and as otherwise amended from time to time ("HIPAA Rules").

Under the HIPAA Rules and the agreement referenced in the paragraph directly above, Business Associate is required to obtain contractual assurances from its subcontractors to the extent that they receive or obtain PHI in the course of providing services to Business Associate that they will safeguard the PHI in accordance with applicable requirements under the HIPAA Rules.

The Parties agree that Subcontractor may have access to Protected Health Information ("PHI") (as defined below) in order to perform Subcontractor's obligations and services to Business Associate. Both Parties also desire to comply with the HIPAA Rules and GLB Rules that are applicable to Subcontractor's relationship with Business Associate.

1. **Definitions.** For purposes of this SubBAA, the terms below shall have the meanings given to them in this Section.

(a) **Breach** shall mean the acquisition, access, use, or disclosure of PHI in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of the PHI, as defined in 45 C.F.R. §164.402.

(b) **Breach Notification Rule** shall mean that portion of the HIPAA Rules set forth at 45 C.F.R. Part 160 and in Subparts A and D of 45 C.F.R. Part 164.

(c) **Covered Entity** shall mean covered entities that meet the definition given to that term in 45 C.F.R. § 160.103, and as described in the second paragraph of this SubBAA.

(d) **Data Aggregation** shall mean, with respect to PHI created or received by Subcontractor in its capacity as the subcontractor of Business Associate, the combining of such PHI by Subcontractor with the PHI received by Subcontractor in its capacity as a subcontractor of another business associate or business associate of another covered entity, to permit data analyses that relate to the Health Care Operations (defined below) of the respective Covered Entities. The meaning of "data aggregation" in this SubBAA shall be consistent with the meaning given to that term in the HIPAA Rules.

(e) **Designated Record Set** shall mean a group of Records maintained by or for a Covered Entity that: (a) consists of medical records and billing records about individuals maintained by or for the Covered Entity; (b) consists of the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (c) consists of Records used, in whole or part, by or for the Covered Entity to make decisions about individual patients. As used herein, the term "Record" shall mean any item, collection or grouping of information that includes PHI and is maintained, collected, used or disseminated by or for a provider. The term "designated record set", however, shall not include any information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, including but not limited to, any information subject to the attorney-client privilege, trial

preparation immunity, attorney work product, peer review privilege or other privilege under applicable law, nor shall it include any information that constitutes "psychotherapy notes" as defined in 45 C.F.R. § 164.501.

(f) **De-Identify** shall mean to alter the PHI such that the resulting information meets the requirements described in 45 C.F.R. § 164.514(a) and (b).

(g) **Effective Date** shall mean the date first written above.

(h) **Electronic PHI** shall mean any PHI maintained in or transmitted by "electronic media" as defined in 45 C.F.R. § 160.103.

(i) **GLB Rules** shall mean the requirements of all insurance commissioner regulations implementing Title V of the Gramm-Leach-Bliley Act (15 USC § 6801 et seq.).

(j) **Health Care Operations** shall have the meaning given to that term at 45 C.F.R. § 164.501.

(k) **HHS** shall mean the U.S. Department of Health and Human Services.

(l) **HITECH Act** shall mean the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, Public Law 111-5.

(m) **Privacy Rule** shall mean that portion of the HIPAA Rules set forth in 45 C.F.R. Part 160 and in Subparts A and E of 45 C.F.R. Part 164.

(n) **Protected Health Information** or **PHI** shall mean information transmitted or maintained in any form or medium, received by Subcontractor from, or created by Subcontractor on behalf of, Business Associate or any of Business Associate's Covered Entity clients, including demographic information collected from an individual, that

(i) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
(ii) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual, and (a) identifies the individual or (b) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

The meaning of "protected health information" or "PHI" in this SubBAA shall be consistent with the meaning given to that term in the HIPAA Rules.

(o) **Security Incident** shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. This term shall not include trivial incidents that occur on a daily basis, such as scans, "pings", or unsuccessful attempts to penetrate computer networks or servers maintained by Subcontractor. The term shall be limited to such incidents involving PHI or information systems containing electronic PHI.

(p) **Security Rule** shall mean that portion of the HIPAA Rules set forth in 45 C.F.R. Part 160 and in Subparts A and C of 45 C.F.R. Part 164.

(q) **Unsecured PHI** shall mean PHI that is not secured in accordance with standards promulgated by the Secretary of HHS in guidance issued by HHS or Office of Civil Rights (OCR) under Section 13402(h)(2) of the HITECH Act and as defined in 45 C.F.R. §164.402.

2. <u>Use and Disclosure of PHI</u>.

(a) Except as otherwise provided in this SubBAA, Subcontractor may use or disclose PHI only as reasonably necessary to provide the services described in the Agreement or other activities of Subcontractor permitted or required of Subcontractor by this SubBAA or as required by law.

(b) Except as otherwise limited by this SubBAA, Business Associate authorizes Subcontractor to use and disclose PHI in its possession for the proper management and administration of Subcontractor's business and to carry out its legal responsibilities. Subcontractor may disclose PHI for such purposes, provided that (i) such disclosures are required by law; or (ii) Subcontractor obtains, in writing, prior to making any disclosure to a third party (a) reasonable assurances from such third party that the PHI will be held confidential as provided under this SubBAA and used or further disclosed only as required by law or for the purpose for which it was disclosed to such third party; and (b) an agreement from such third party to notify Subcontractor immediately of any breaches of the confidentiality of the PHI, to the extent it has knowledge of such breach.

(c) Business Associate does not authorize Subcontractor to provide Data Aggregation services with respect to the PHI or to De-Identify the PHI.

(d) Subcontractor shall not transfer PHI outside the United States without the prior written consent of Business Associate. In this context, a "transfer" outside the United States occurs if Subcontractor's workforce members, agents, or subcontractors physically located outside the fifty United States and United States territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands) are able to access, use, or disclose PHI which was received from or on behalf of Business Associate.

(e) Subcontractor shall not use or disclose PHI in a manner other than as provided in this SubBAA, as permitted under the HIPAA Rules, or as required by law. Except as permitted under paragraphs (a-b) of this section, Subcontractor will not use or disclose PHI in any manner that would violate applicable laws or regulations, including, without limitation, the HIPAA Rules, if done by Business Associate or Business Associate's Covered Entity clients. Subcontractor shall use or disclose only the minimum necessary amount of PHI for each use or disclosure it makes of PHI in accordance with the provisions of Section 13405(b) of the HITECH Act and any implementing regulations.

(f) Upon request, Subcontractor shall make available to Business Associate any of Business Associate's PHI that Subcontractor, or any of its subcontractors or agents, have in their possession.

3. **Safeguards Against Misuse of PHI.** Subcontractor shall use appropriate safeguards, and comply with the applicable provisions of the Security Rule with respect to the Electronic PHI that it creates, receives, maintains, or transmits on behalf of Business Associate or its Covered Entity clients, to prevent the use or disclosure of PHI other than as provided by the Agreement or this SubBAA. Subcontractor agrees to take reasonable steps to ensure that the actions or omissions of its employees or agents do not cause Subcontractor to breach the terms of this SubBAA.

4. **Reporting Impermissible Disclosures of PHI and Security Incidents.** Subcontractor shall report to Business Associate in writing (1) any use or disclosure of PHI not provided for by this SubBAA of which it becomes aware, or (2) any Security Incident affecting Electronic PHI that it creates, receives, maintains, or transmits on behalf of Business Associate or its Covered Entity clients of which it becomes aware. Subcontractor agrees to report any such unauthorized use or disclosure or Security Incident promptly and in no case later than three (3) business days of becoming aware of its occurrence.

5. **Reporting Breaches of PHI**. Subcontractor shall notify Business Associate in writing promptly upon the discovery of any Breach of Unsecured PHI in the manner prescribed in 45 C.F.R. §164.410, but in no case later than two (2) business days after discovery. Subcontractor shall provide information regarding such Breach (including, to the extent possible, identification of each individual whose Unsecured PHI has been or is reasonably believed by Subcontractor to have been accessed, acquired, used, or disclosed during the Breach). Thereafter, the information shall be timely supplemented with additional information as may be obtained by Subcontractor. Subcontractor shall reimburse Business Associate for any and all costs and expenses incurred by Business Associate as a result of any such Breach caused by Subcontractor or any of its agents or subcontractors.

6. **Mitigation of Disclosures of PHI; Indemnification.** Subcontractor shall mitigate, to the extent practicable, any harmful effect that is known to Subcontractor of any use or disclosure of PHI by Subcontractor or its agents or subcontractors in violation of the requirements of this SubBAA, or of any Security Incident. Additionally, Subcontractor shall indemnify, defend and hold Covered Entity and its affiliates, officers, directors, agents and employees harmless from and against any and all losses, claims, actions, demands, liabilities, damages, costs and expenses (including costs of judgments, settlements, and reasonable attorneys' fees actually incurred) arising

from or related to: (i) the use or disclosure of PHI in violation of the terms of the Agreement; (ii) a Security Incident; (iii) a Breach of Unsecured PHI; or (iv) a "breach" as defined by applicable state law regarding a Covered Entity applicant's or insured's information.

7. **Agreements with Agents or Subcontractors.** In accordance with 45 C.F.R. §§ 164.502(e)(1)(i) and 164.308(b)(2), Subcontractor shall ensure that any agent or subcontractor that has access to, or to which Subcontractor provides PHI (a) agrees in writing to the same restrictions, conditions, and requirements concerning the uses and disclosures of PHI as apply to Business Associate with respect to PHI and as contained herein; and (b) agrees in writing to comply with the applicable provisions of the Security Rule with respect to any Electronic PHI that it creates, receives, maintains, or transmits on behalf of Business Associate or Covered Entity.

8. **Access to PHI by Individuals.**

(a) Upon request, Subcontractor agrees to furnish Business Associate with copies of the PHI maintained by Subcontractor in a Designated Record Set in the time and manner designated by Business Associate.

(b) In the event any individual or personal representative requests access to the individual's PHI directly from Subcontractor, Subcontractor shall forward that request to Business Associate within the same day it is received.

(c) Any disclosure of, or decision not to disclose, the PHI requested by an individual or a personal representative and compliance with the requirements applicable to an individual's right to obtain access to PHI shall be the sole responsibility of the Covered Entity contracting with Business Associate.

9. **Amendment of PHI.**

(a) Upon request, Subcontractor shall make available for amendment and/or shall amend PHI or a Record about an individual in a Designated Record Set that is maintained by, or otherwise within the possession of, Subcontractor as directed by Business Associate in accordance with procedures established by 45 C.F.R. § 164.526. Any request by Business Associate to amend such information shall be completed by Subcontractor within fifteen (15) business days of Business Associate's request.

(b) In the event that any individual requests that Subcontractor amend such individual's PHI or Record in a Designated Record Set, Subcontractor within five (5) business days shall forward such request to Business Associate.

(c) Any amendment of, or decision not to amend, the PHI or Record as requested by an individual and compliance with the requirements applicable to an individual's right to request an amendment of PHI shall be the sole responsibility of the Covered Entity contracting with Business Associate.

10. **Accounting of Disclosures.**

(a) Subcontractor shall document any disclosures of PHI made by it, to the extent that a Covered Entity would have an obligation to account for such disclosures under 45 C.F.R. § 164.528. Subcontractor also shall make available information related to such disclosures as would be required for a Covered Entity to respond to a request for an accounting of disclosures in accordance with 45 C.F.R. § 164.528 and any amendments thereto, promulgated under the HITECH Act. At a minimum, Subcontractor shall furnish Business Associate the following with respect to any covered disclosures by Subcontractor: (i) the date of disclosure of PHI; (ii) the name of the entity or person who received PHI, and, if known, the address of such entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure which includes the basis for such disclosure.

(b) Subcontractor hereby agrees to implement an appropriate recordkeeping system to enable it to comply with the requirements of this Section. Subcontractor agrees to retain such records for a minimum of six (6) years.

(c) Upon request, Subcontractor shall furnish to Business Associate information collected in accordance with this Section, in the time and manner designated by the Business Associate, to permit the Covered Entity contracting with Business Associate to make an accounting of disclosures as required by 45 C.F.R. §

164.528, and Subcontractor shall otherwise furnish Business Associate with the information necessary to enable Business Associate to comply with the applicable provisions of Section 13405(c) of the HITECH Act and any implementing regulations.

(d) In the event that an individual delivers the request for an accounting directly to Subcontractor, Subcontractor shall forward such request to Business Associate the same day it is received.

(e) The Covered Entity contracting with Business Associate shall maintain sole responsibility for preparing and delivering any accounting requested and for complying with the requirements applicable to an individual's right to obtain an accounting of disclosures of PHI.

11. **Equitable Relief**. Subcontractor understands and acknowledges that any disclosure or misappropriation of PHI in violation of the Agreement will cause Business Associate irreparable harm, the amount of which may be difficult to ascertain, and therefore agrees that Business Associate shall have the right to apply to a court of competent jurisdiction for an order restraining and enjoining any such further disclosure or breach and for such other relief as Business Associate shall deem appropriate. Such right of Business Associate is in addition to the remedies otherwise available to Business Associate at law or in equity.

12. **Availability of Books and Records.** Subcontractor shall make available its internal practices, books, agreements, records, and policies and procedures relating to the use and disclosure of PHI to Business Associate and, upon request, to the Secretary of HHS for purposes of determining compliance with the HIPAA Rules and this SubBAA. Notwithstanding the foregoing, prior to any such disclosure to the Secretary of HHS or any other federal or state agency, Subcontractor shall notify Business Associate in writing immediately of such request and shall furnish Business Associate with copies of such request. Business Associate and Subcontractor agree to work together in responding to any such request, including but not limited to engaging in an effort to obtain a confidentiality agreement, protective order, injunction or court order, if necessary, to preserve any applicable privilege.

13. **Covered Entity/ Business Associate Obligations.**

(a) Business Associate shall not request Subcontractor to use or disclose PHI in any manner that would not be permissible under, or that would violate, the Privacy Rule if done by the Business Associate (or its Covered Entity client).

(b) To the extent that such limitations, changes, or restrictions may affect Subcontractor's ability to use or disclose PHI to provide services under the Agreement and this SubBAA, Business Associate will notify Subcontractor of

(i) any known limitations on the use or disclosure of PHI contained in its Covered Entity client's Notice of Privacy Practices;
(ii) any known changes in, or revocation of, any authorizations by an individual to use or disclose his or her PHI; and/or
(iii) any known restrictions on the uses or disclosures of PHI that its Covered Entity client has agreed to or is required to comply with under 45 C.F.R. § 164.522.

14. **Term and Termination.**

(a) This SubBAA shall become effective on the date first written above, and shall continue in effect until all obligations of the Parties have been met under the Agreement and under this SubBAA.

(b) Business Associate may terminate immediately this SubBAA, the Agreement, and any other related agreements, if feasible, if/when the Business Associate makes a determination that the Subcontractor has breached a material term of this SubBAA and Subcontractor has failed to cure that material breach, to Business Associate's reasonable satisfaction, within thirty (30) days after written notice from Business Associate.

(c) Upon termination of the Agreement or this SubBAA for any reason, all PHI maintained by Subcontractor shall be returned to Business Associate or destroyed by Subcontractor. Subcontractor shall not retain any copies of such information. This provision shall apply to PHI in the possession of Subcontractor's agents

and subcontractors. If return or destruction of the PHI is not feasible in Subcontractor's reasonable judgment, Subcontractor shall furnish Business Associate notification, in writing, of the conditions that make return or destruction infeasible. Upon Subcontractor's determination that return or destruction of the PHI is infeasible, Subcontractor will extend the protections of this SubBAA to such information for as long as Subcontractor retains such information and will limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible. This Section 14(c) shall survive any termination of this SubBAA.

15. **Effect of SubBAA.** This SubBAA is a part of and subject to the terms of the Agreement, except that to the extent any terms of this SubBAA conflict with any term of the Agreement regarding the use, disclosure, protection, reporting or obligations as to PHI, the terms of this SubBAA shall govern. In the event of inconsistency between the provisions of this SubBAA and mandatory provisions of the HIPAA Rules, as amended by the HITECH Act or otherwise, or their interpretation by any court or regulatory agency of competent authority and jurisdiction over either Party hereto, the HIPAA Rules, as interpreted by such court or agency, shall control. Where the provisions of this SubBAA are different from those mandated in the HIPAA Rules, but are nonetheless permitted by such rules as interpreted by courts or agencies, the provisions of this SubBAA shall control.

16. **Regulatory References.** A reference in this SubBAA to a section in the HIPAA Rules means the section as in effect or as amended from time to time.

17. **Notices.** All notices and notifications under this Agreement shall be sent in writing to the listed persons on behalf of Business Associate and Subcontractor identified in the Arrangements.

18. **Amendments; Waiver; Interpretation.** This SubBAA may not be modified, nor shall any provision be waived or amended, except in writing duly signed by authorized representatives of the Parties. The Parties agree to take action as is necessary to amend this SubBAA from time to time as may be necessary for Business Associate to comply with the HIPAA Rules. A waiver with respect to one event shall not be construed as continuing, or as a bar to or waiver of any right or remedy as to subsequent events. To the extent they are unclear, the terms of this SubBAA shall be construed to allow for compliance by Business Associate and Subcontractor with the HIPAA Rules.

19. **HITECH Act Compliance.** The Parties acknowledge that the HITECH Act includes provisions that require significant changes and additions to the HIPAA Rules. The Privacy Subtitle of the HITECH Act sets forth provisions that significantly change the requirements for business associates and the agreements between business associates and their agents and subcontractors under the HIPAA Rules. Many of these changes may be further clarified in forthcoming regulations and/or guidance issued by HHS or OCR. Each Party agrees to comply with the applicable provisions of the HITECH Act and any implementing regulations issued thereunder.

20. **No Third Party Beneficiaries.** Business Associate and Subcontractor do not intend to confer, nor does anything express or implied in this SubBAA confer, upon any person other than Business Associate and Subcontractor, and their respective successors or assigns, any rights, remedies or obligations or liabilities whatsoever.

21. **Independent Contractor**. Subcontractor is performing services pursuant to the Agreement and for all purposes hereunder, Subcontractor's status shall be that of an independent contractor.