RITTER
Insurance Marketing

Anthem, CICI & AICI

Agent/Agency Application for Appointment

**** Attention Agents: Once this information has been received and processed by Ritter, Ritter Insurance Marketing will email you the link to complete your contracting electronically on No More Forms. You will need to complete contracting electronically, there is no paper contract option.**

**** You must choose the following code "26RI97" from a dropdown list in section 3 of the Producer Appointment Data Sheet. (This is the only way the carrier will be able to tie your appointment back to Ritter Insurance Marketing.) Regardless if you have an immediate upline other than Ritter, you must select the "26RI97" code. Ritter will maintain the rest of the hierarchy internally.**

**** When you are completing the contracting electronically on NMF, please be sure to only list your individual information. DO NOT LIST ANY AGENCY INFORMATION. If you wish to have commissions pay to your agency, please complete the Ritter ACH and W9 accordingly.**

Agent Full Name: _____

Primary Email Address: _____

Primary Phone Number: _____

National Producer Number: _____

Agent Social Security Number: _____

Date of Birth: _____

Resident State: _____

Immediate Upline's Name: _____

Do you want commissions to pay to your own personal Agency: ◯ YES or ◯ NO

If YES, list your Agency's name: _____

If YES, list your Agency's TaxID Number: _____

If YES, list your Agency's NPN Number: _____

Required Supporting Documents:

1. Completed W9 (Complete with Agency information if applicable).
2. Completed Ritter Insurance Marketing ACH form.
3. Voided check to accompany your ACH form.
4. Signed copy of commission schedule.

Please select the state(s) below that you are requesting to be appointed in:

If you are requesting multiple state appointments, you will need to complete contracting using the NMF links for each state listed below. (You are only eligible to sell products in the state(s) you select below upon completion of the No More Forms contract(s)).

Requesting Appointment (Select all that apply)	Contract Name	Available State(s)	Available Products
	Anthem	GA	Medicare Advantage, Prescription Drug Plans, Medicare Supplement
	Anthem	CA	Medicare Advantage, Prescription Drug Plans, Medicare Supplement
	Anthem	ME	Medicare Advantage, Prescription Drug Plans, Medicare Supplement
	Anthem	NH	Medicare Advantage, Prescription Drug Plans, Medicare Supplement
	Anthem	CT	Medicare Advantage, Prescription Drug Plans, Medicare Supplement
	Empire BC	NY	Medicare Advantage ONLY
	Anthem Insurance Company "AICI"	OH, MO, WI	Medicare Supplement ONLY
(List states requesting appointment in)	Anthem Multi State	CO, IN, MO, NV, OH, VA, WI, KY	Medicare Advantage, Prescription Drug Plans, Medicare Supplement
(List states requesting appointment in)	Community Insurance Company "CICI"	IN	Medicare Supplement ONLY

Agents will be required to pay all applicable State Appointment Fee(s) online through No More Forms while completing your contracting.

State	Agent Resident Fee	Agent Non-Resident Fee
California	$30.53	$30.53
Connecticut	$101.53	$101.53
Colorado	$0.00	$0.00
Georgia	$49.11	$49.11
Indiana	$0.00	$0.00
Kentucky	$41.53	$51.53
Maine	$31.53	$46.53
Missouri	$0.00	$0.00
Nevada	$0.00	$0.00
New Hampshire	$53.06	$53.06
New York	$0.00	$0.00
Ohio	$49.59	$49.59
Virginia	$34.59	$34.59
Wisconsin	$52.59	$124.59

Attention Agents- Now through 6/29/18 there are NO APPOINTMENT FEES for the AICI and CIC contracts. Contract now to avoid the fees.

Please return contracting paperwork with all Required Supporting Documents to:

Ritter Insurance Marketing 2600 Commerce Drive, Harrisburg, PA 17110

Fax: 888-509-7058 or Email: license@ritterim.com Thank you!

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 2014)
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.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

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

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 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 line 1 to avoid backup withholding. For individuals, this is generally 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 instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

or

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); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 3.

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

General Instructions

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

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

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, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

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 one-on-one sales meeting in advance in accordance with the guidelines set forth in the Medicare Marketing Guidelines or Insurance Company's policy, when applicable.
   (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.

   In the event that an error is made in the calculation and/or payment of compensation under this Agreement, regardless of who made the error or the reason for the error, the parties agree that the correction of the error requiring payments to Agent or recovery of payments from Agent shall be made retroactively for a maximum of twelve (12) months from the date the error was discovered by Ritter and/or Insurance Company. This section shall not limit in any way Ritter's right to collect any indebtedness of Agent to Ritter, through offset of compensation or otherwise, for reasons other than an error in calculations or payments.

   Notwithstanding the foregoing or anything else contained in this Agreement or in the commission schedule, in the case of retroactive beneficiary changes (i.e., retroactive enrollment or disenrollment) for Medicare Advantage and/or Part D product Members, Insurance Company shall and in turn Ritter shall (1) be obligated to pay Agent any additional compensation that may be owing as the result of retroactive enrollment of a member during the current calendar year or immediately preceding calendar year, and (2) be entitled to recoup from Agent any compensation paid to Agent with respect to a member who was retroactively disenrolled during the current calendar year or immediately preceding calendar year.

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 Subcontractor 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, Subcontractor 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 Subcontractor 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 health care 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 Scope of Appointment is required to discuss additional products;

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.

26. Choice of Law, Forum. This Agreement shall be governed by the law of the Commonwealth of Pennsylvania, without reference to or use of any conflicts of laws provisions. The Parties hereto agree that with respect to any disputes, actions, suits or proceedings arising in connection with this Agreement, venue will be in the State of Commonwealth of Pennsylvania and in such event, the Parties hereby consent to the exclusive jurisdiction of the federal and state courts located in Dauphin County, Pennsylvania.

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

2018 Commission Schedule

I. Medicare Advantage/Prescription Drug Plans

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. This schedule is applicable to Medicare Advantage (MA), Medicare Advantage Prescription Drug (MA-PD), and Prescription Drug (Part D) plans that are offered by Anthem Blue Cross (Anthem BC) and sold in select counties within California.

Anthem Value Plus (HMO), Anthem Diabetes (HMO SNP), Anthem StartSmart Plus (HMO), Anthem Heart (HMO SNP), Anthem Breathe (HMO SNP), Anthem Connect Plus (HMO), and Anthem ESRD (HMO SNP)

4	GA4	$567.00	$284.00	$284.00	Carrier Rate + $ 0.00	Carrier Rate + $ 0.00
3	GA3	$517.00	$259.00	$259.00	Carrier Rate - $ 25.00	Carrier Rate - $ 25.00
2	GA2	$467.00	$234.00	$234.00	Carrier Rate - $ 50.00	Carrier Rate - $ 50.00
1	GA1	$417.00	$209.00	$209.00	Carrier Rate - $ 75.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

Anthem Connect (HMO)

Level	Title	2018 Initial Year 1 New to Medicare	2018 Year 1 External Replacement	2018 Year 1 Internal Replacement	Renewal Yr 2 (Paid Monthly)	Renewal Yr 3+ (Paid Monthly)
4	GA4	$0.00	$0.00	$0.00	$0.00	$0.00
3	GA3	$0.00	$0.00	$0.00	$0.00	$0.00
2	GA2	$0.00	$0.00	$0.00	$0.00	$0.00
1	GA1	$0.00	$0.00	$0.00	$0.00	$0.00
0	LOA	$0.00	$0.00	$0.00	$0.00	$0.00

Anthem MediBlue Access (PPO)

Level	Title	2018 Initial Year 1 New to Medicare	2018 Year 1 External Replacement	2018 Year 1 Internal Replacement	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$503.00	$252.00	$252.00	Carrier Rate + $ 0.00
3	GA3	$453.00	$227.00	$227.00	Carrier Rate - $ 25.00
2	GA2	$403.00	$202.00	$202.00	Carrier Rate - $ 50.00
1	GA1	$353.00	$177.00	$177.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 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	2018 Initial Year 1 New to Medicare	2018 Year 1 External Replacement	2018 Year 1 Internal Replacement	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$567.00	$284.00	$284.00	Carrier Rate + $ 0.00
3	GA3	$517.00	$259.00	$259.00	Carrier Rate - $ 25.00
2	GA2	$467.00	$234.00	$234.00	Carrier Rate - $ 50.00
1	GA1	$417.00	$209.00	$209.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00	$ 0.00

Standalone Prescription Drug Plans (PDP) – Where available

Level	Title	2018 Initial Year 1	2018 Year 1 Renewal	Renewal Yr 2 - Yr 6 (Paid Monthly)
4	GA4	$72.00	$36.00	Carrier Rate + $ 0.00
3	GA3	$66.00	$33.00	Carrier Rate - $ 3.00
2	GA2	$56.00	$28.00	Carrier Rate - $ 8.00
1	GA1	$46.00	$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. This schedule is applicable to Medicare Advantage (MA), Medicare Advantage Prescription Drug (MA-PD), and Prescription Drug (Part D) plans that are offered by Anthem Blue Cross and Blue Shield (Anthem) and sold in select counties within Colorado, Nevada, Virginia, Indiana, Kentucky, Ohio, Missouri, Wisconsin, New Hampshire, Maine and Connecticut.

Anthem Value Plus (HMO) Nevada, Anthem StartSmart Plus (HMO) Nevada, Anthem Heart (HMO SNP) Nevada, Anthem Breathe (HMO SNP) Nevada, and Anthem Connect Plus (HMO) Nevada

Level	Title	2018 Initial Year 1 New to Medicare	2018 Year 1 External Replacement	2018 Year 1 Internal Replacement	Renewal Yr 2 (Paid Monthly)	Renewal Yr 3+ (Paid Monthly)
4	GA4	$455.00	$228.00	$228.00	Carrier Rate + $ 0.00	Carrier Rate + $ 0.00
3	GA3	$405.00	$203.00	$203.00	Carrier Rate - $ 25.00	Carrier Rate - $ 25.00
2	GA2	$355.00	$178.00	$178.00	Carrier Rate - $ 50.00	Carrier Rate - $ 50.00
1	GA1	$305.00	$153.00	$153.00	Carrier Rate - $ 75.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

Anthem Touch (HMO SNP) Nevada and Anthem Connect (HMO) Nevada

Level	Title	2018 Initial Year 1 New to Medicare	2018 Year 1 External Replacement	2018 Year 1 Internal Replacement	Renewal Yr 2 (Paid Monthly)	Renewal Yr 3+ (Paid Monthly)
4	GA4	$0.00	$0.00	$0.00	$0.00	$0.00
3	GA3	$0.00	$0.00	$0.00	$0.00	$0.00
2	GA2	$0.00	$0.00	$0.00	$0.00	$0.00
1	GA1	$0.00	$0.00	$0.00	$0.00	$0.00
0	LOA	$0.00	$0.00	$0.00	$0.00	$0.00

Anthem MediBlue Plus (HMO), Anthem MediBlue Choice (HMO), Anthem MediBlue Dual Advantage (HMO SNP), Anthem MediBlue Prime Select (HMO), 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), Anthem MediBlue Touch (HMO), Anthem MediBlue Access (PPO), Anthem MediBlue Access Plus (PPO), Anthem MediBlue Access Basic (Regional PPO), and Anthem MediBlue Access Core (PPO)

Level	Title	2018 Initial Year 1 New to Medicare	2018 Year 1 External Replacement	2018 Year 1 Internal Replacement	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$455.00	$228.00	$228.00	Carrier Rate + $ 0.00
3	GA3	$405.00	$203.00	$203.00	Carrier Rate - $ 25.00
2	GA2	$355.00	$178.00	$178.00	Carrier Rate - $ 50.00
1	GA1	$305.00	$153.00	$153.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00	$ 0.00

Anthem MediBlue Access (PPO) CO, ME, NH and VA

Level	Title	2018 Initial Year 1 New to Medicare	2018 Year 1 External Replacement	2018 Year 1 Internal Replacement	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$402.00	$201.00	$201.00	Carrier Rate + $ 0.00
3	GA3	$352.00	$176.00	$176.00	Carrier Rate - $ 25.00
2	GA2	$302.00	$151.00	$151.00	Carrier Rate - $ 50.00
1	GA1	$252.00	$126.00	$126.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 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	2018 Initial Year 1 New to Medicare	2018 Year 1 External Replacement	2018 Year 1 Internal Replacement	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$511.00	$256.00	$256.00	Carrier Rate + $ 0.00
3	GA3	$461.00	$231.00	$231.00	Carrier Rate - $ 25.00
2	GA2	$411.00	$206.00	$206.00	Carrier Rate - $ 50.00
1	GA1	$361.00	$181.00	$181.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00	$ 0.00

Standalone Prescription Drug Plans (PDP) – Where available

Level	Title	2018 Initial Year 1	2018 Year 1 Renewal	Renewal Yr 2 - Yr 6 (Paid Monthly)
4	GA4	$72.00	$36.00	Carrier Rate + $ 0.00
3	GA3	$66.00	$33.00	Carrier Rate - $ 3.00
2	GA2	$56.00	$28.00	Carrier Rate - $ 8.00
1	GA1	$46.00	$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. This schedule is applicable to Medicare Advantage (MA), Medicare Advantage Prescription Drug (MA-PD), and Prescription Drug (Part D) plans that are offered by Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (BCBS GA) and sold in select counties.

BCBSHP MediBlue Dual Advantage (HMO SNP), BCBSHP MediBlue Plus (HMO), BCBSHP MediBlue Essential (HMO) and BCBSGA MediBlue Access (PPO)

Level	Title	2018 Initial Year 1 New to Medicare	2018 Year 1 External Replacement	2018 Year 1 Internal Replacement	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$455.00	$228.00	$228.00	Carrier Rate + $ 0.00
3	GA3	$405.00	$203.00	$203.00	Carrier Rate - $ 25.00
2	GA2	$355.00	$178.00	$178.00	Carrier Rate - $ 50.00
1	GA1	$305.00	$153.00	$153.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00	$ 0.00

Standalone Prescription Drug Plans (PDP) – Where available

Level	Title	2018 Initial Year 1	2018 Year 1 Renewal	Renewal Yr 2 - Yr 6 (Paid Monthly)
4	GA4	$72.00	$36.00	Carrier Rate + $ 0.00
3	GA3	$66.00	$33.00	Carrier Rate - $ 3.00
2	GA2	$56.00	$28.00	Carrier Rate - $ 8.00
1	GA1	$46.00	$23.00	Carrier Rate - $ 13.00
0	LOA	$ 0.00	$ 0.00	$ 0.00

Empire BlueCross

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. This schedule is applicable to Medicare Advantage (MA), Medicare Advantage Prescription Drug (MA-PD), and Prescription Drug (Part D) plans that are offered by Empire BlueCross (Empire BC) and sold in select counties within New York.

Empire MediBlue Plus (HMO), Empire MediBlue Core (HMO), and Empire MediBlue Dual Advantage (HMO SNP)

Level	Title	2018 Initial Year 1 New to Medicare	2018 Year 1 External Replacement	2018 Year 1 Internal Replacement	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$455.00	$228.00	$228.00	Carrier Rate + $ 0.00
3	GA3	$405.00	$203.00	$203.00	Carrier Rate - $ 25.00
2	GA2	$355.00	$178.00	$178.00	Carrier Rate - $ 50.00
1	GA1	$305.00	$153.00	$153.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00	$ 0.00

Empire MediBlue Access (PPO)

Level	Title	2018 Initial Year 1 New to Medicare	2018 Year 1 External Replacement	2018 Year 1 Internal Replacement	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$402.00	$201.00	$201.00	Carrier Rate + $ 0.00
3	GA3	$352.00	$176.00	$176.00	Carrier Rate - $ 25.00
2	GA2	$302.00	$151.00	$151.00	Carrier Rate - $ 50.00
1	GA1	$252.00	$126.00	$126.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00	$ 0.00

Empire BlueCross 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. This schedule is applicable to Medicare Advantage (MA), Medicare Advantage Prescription Drug (MA-PD), and Prescription Drug (Part D) plans that are offered by Empire BlueCross and BlueShield (Empire BCBS) and sold in select counties within New York.

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

Level	Title	2018 Initial Year 1 New to Medicare	2018 Year 1 External Replacement	2018 Year 1 Internal Replacement	Renewal Yr 2 – Yr 10 (Paid Monthly)
4	GA4	$455.00	$228.00	$228.00	Carrier Rate + $ 0.00
3	GA3	$405.00	$203.00	$203.00	Carrier Rate - $ 25.00
2	GA2	$355.00	$178.00	$178.00	Carrier Rate - $ 50.00
1	GA1	$305.00	$153.00	$153.00	Carrier Rate - $ 75.00
0	LOA	$ 0.00	$ 0.00	$ 0.00	$ 0.00

II. Anthem -Medicare Supplement

		Colorado			
		All Plans			
		Override	Commission (Eff 1/1/18 – 12/31/18)		
Level		Yr 1 - 6	Yr 1	Yr 2 - 6	Yr 7+
4	GA4	0.00%	26.00%	13.00%	2.00%
3	GA3	0.00%	23.40%	11.70%	1.80%
2	GA2	0.00%	18.20%	9.10%	1.40%
1	GA1	0.00%	13.00%	6.50%	1.00%
0	LOA	0.00%	0.00%	0.00%	0.00%

		California			
		65 and Over Plans Plan A, Plan F, Plan N			Pre-65 Plans A, F, N
		Override	Commission Effective 1/1/16 (Per Month)		Yearly Admin Fee
Level		Yr 1 - 6	Yr 1	Yr 2 +	Yr 1 - 6
4	GA4	0.00%	20.00%	10.00%	$5.00
3	GA3	0.00%	18.00%	9.00%	$4.50
2	GA2	0.00%	14.00%	7.00%	$3.50
1	GA1	0.00%	10.00%	5.00%	$2.50
0	LOA	0.00%	0.00%	0.00%	$0.00

		Wisconsin			
		All Plans			
		Override Effective 10/1/17 – 9/30/18		Commission (Effective 2/1/18)	
Level		Yr 1 - 6	Yr 7-10	Yr 1 - 6	Yr 7-10
4	GA4	0.00%	0.00%	18.00%	4.00%
3	GA3	0.00%	0.00%	16.20%	3.60%
2	GA2	0.00%	0.00%	12.60%	2.80%
1	GA1	0.00%	0.00%	9.00%	2.00%
0	LOA	0.00%	0.00%	0.00%	0.00%

		Indiana			
		All Plans			
		Override Effective 10/1/17 – 9/30/18		Commission (Effective 1/1/18)	
Level		Yr 1 - 6	Yr 7 +	Yr 1 - 6	Yr 7 +
4	GA4	0.00%	0.00%	18.00%	0.00%
3	GA3	0.00%	0.00%	16.20%	0.00%
2	GA2	0.00%	0.00%	12.60%	0.00%
1	GA1	0.00%	0.00%	9.00%	0.00%
0	LOA	0.00%	0.00%	0.00%	0.00%

		Kentucky			
		All Plans			
		Override Effective 10/1/17 – 9/30/18		Commission (Effective 2/1/18)	
Level		Yr 1 - 6	Yr 7 -10	Yr 1 - 6	Yr 7 - 10
4	GA4	0.00%	0.00%	18.00%	4.00%
3	GA3	0.00%	0.00%	16.20%	3.60%
2	GA2	0.00%	0.00%	12.60%	2.80%
1	GA1	0.00%	0.00%	9.00%	2.00%
0	LOA	0.00%	0.00%	0.00%	0.00%

		Ohio			
		All Plans			
		Override Effective 10/1/17 – 9/30/18		Commission (Effective 5/1/18)	
Level		Yr 1 - 6	Yr 7 -10	Yr 1 - 6	Yr 7-10
4	GA4	0.00%	0.00%	18.00%	4.00%
3	GA3	0.00%	0.00%	16.20%	3.60%
2	GA2	0.00%	0.00%	12.60%	2.80%
1	GA1	0.00%	0.00%	9.00%	2.00%
0	LOA	0.00%	0.00%	0.00%	0.00%

		Missouri			
		All Plans			
		Override Effective 6/1/18 - 9/30/18		Commission Effective 5/1/18	
Level		Yr 1 - 6	Yr 7-10	Yr 1 - 6	Yr 7-10
4	GA4	0.00%	0.00%	18.00%	4.00%
3	GA3	0.00%	0.00%	16.20%	3.60%
2	GA2	0.00%	0.00%	12.60%	2.80%
1	GA1	0.00%	0.00%	9.00%	2.00%
0	LOA	0.00%	0.00%	0.00%	0.00%

		Georgia				
		65 and Over Plans				Pre-65 Plans
		Override Effective 6/1/18 - 9/30/18		Commission Effective 2/1/18		Yearly Admin Fee
Level		Yr 1 - 6	Yr 7-10	Yr 1 - 6	Yr 7-10	Yr 1 - 6
4	GA4	0.00%	0.00%	18.00%	4.00%	$5.00
3	GA3	0.00%	0.00%	16.20%	3.60%	$4.50
2	GA2	0.00%	0.00%	12.60%	2.80%	$3.50
1	GA1	0.00%	0.00%	9.00%	2.00%	$2.50
0	LOA	0.00%	0.00%	0.00%	0.00%	$0.00

		Virginia					
		Medicare Over 65 All Plans				Dental	
		Override		Commission		Commission	
Level		Yr 1 - 6	Yr 7 +	Yr 1 - 6	Yr 7 +	Yr 1 - 6	Yr 7 +
4	GA4	0.00%	0.00%	12.00%	4.00%	10.00%	10.00%
3	GA3	0.00%	0.00%	10.80%	3.60%	9.00%	9.00%
2	GA2	0.00%	0.00%	8.40%	2.80%	7.00%	7.00%
1	GA1	0.00%	0.00%	6.00%	2.00%	5.00%	5.00%
0	LOA	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

		Maine - Effective January 1, 2018 through December 31, 2018											
		Plan F, G *				Plan N				Plan A			
		Override (Annual Amt)		Commission (Annual Amt)		Override (Annual Amt)		Commission (Annual Amt)		Override (Annual Amt)		Commission (Annual Amt)	
Level		Yr 1	Yr 2 - 6	Yr 1	Yr 2 - 6	Yr 1	Yr 2 - 6	Yr 1	Yr 2 - 6	Yr 1	Yr 2 - 6	Yr 1	Yr 2 - 6
4	GA4	$0.00	$0.00	$225.00	$225.00	$0.00	$0.00	$210.00	$210.00	$0.00	$0.00	$204.00	$120.00
3	GA3	$0.00	$0.00	$202.50	$202.50	$0.00	$0.00	$189.00	$189.00	$0.00	$0.00	$183.60	$108.00
2	GA2	$0.00	$0.00	$157.50	$157.50	$0.00	$0.00	$147.00	$147.00	$0.00	$0.00	$142.80	$84.00
1	GA1	$0.00	$0.00	$112.50	$112.50	$0.00	$0.00	$105.00	$105.00	$0.00	$0.00	$102.00	$60.00
0	LOA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

* Plan G effective 2/1/2018

		New Hampshire and Connecticut - Medicare Supplement Over 65 Effective January 1, 2018 through December 31, 2018)												MS - Pre 65 (Medicare Disabled)			
		Plan F, Plan G				Plan N				Plan A				All Plans			
		Override (Annual Amt)		Commission (Annual Amt)		Override (Annual Amt)		Commission (Annual Amt)		Override (Annual Amt)		Commission (Annual Amt)		Override (Annual Amt)		Commission (Annual Amt)	
Level		Yr 1	Yr 2 - 6	Yr 1	Yr 2 - 6	Yr 1	Yr 2 - 6	Yr 1	Yr 2 - 6	Yr 1	Yr 2 - 6	Yr 1	Yr 2 - 6	Yr 1	Yr 2 - 6	Yr 1	Yr 2 - 6
4	GA4	$0.00	$0.00	$225.00	$225.00	$0.00	$0.00	$210.00	$210.00	$0.00	$0.00	$204.00	$120.00	$0.00	$0.00	$24.00	$24.00
3	GA3	$0.00	$0.00	$202.50	$202.50	$0.00	$0.00	$189.00	$189.00	$0.00	$0.00	$183.60	$108.00	$0.00	$0.00	$21.60	$21.60
2	GA2	$0.00	$0.00	$157.50	$157.50	$0.00	$0.00	$147.00	$147.00	$0.00	$0.00	$142.80	$84.00	$0.00	$0.00	$16.80	$16.80
1	GA1	$0.00	$0.00	$112.50	$112.50	$0.00	$0.00	$105.00	$105.00	$0.00	$0.00	$102.00	$60.00	$0.00	$0.00	$12.00	$12.00
0	LOA	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

		Nevada							
		Medicare Supplement- Classic Plan A, N, and F				Medicare Supplement- Innovative Plan F, G & N			
		Override	Commission (Effective January 1, 2017)			Override	Commission (Effective January 1, 2017)		
Level		Yr 1 - 6	1-3 policies	4 - 8 policies	9+ policies	Yr 1 - 6	Yr 1	Yr 2-6	Yr 7+
4	GA4	0.00%	11.00%	12.00%	14.00%	0.00%	26.00%	13.00%	2.00%
3	GA3	0.00%	9.90%	10.80%	12.60%	0.00%	23.40%	11.70%	1.80%
2	GA2	0.00%	7.70%	8.40%	9.80%	0.00%	18.20%	9.10%	1.40%
1	GA1	0.00%	5.50%	6.00%	7.00%	0.00%	13.00%	6.50%	1.00%
0	LOA	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

III. Anthem Insurance Company Inc. (AICI) -Medicare Supplement

Level		Wisconsin				Missouri				Ohio			
		Basic Plan and Optional Riders				Plan F				Plan F			
		Override Effective 5/1/18		Commission Effective 5/1/18		Override Effective 10/1/17 – 9/30/18		Commission (Effective 2/1/18)		Override Effective (Effective 5/1/18)		Commission (Effective 5/1/18)	
		Yr 1 - 6	Yr 7-10	Yr 1 - 6	Yr 7-10	Yr 1 - 6	Yr 7 -10	Yr 1 - 6	Yr 7 - 10	Yr 1 - 6	Yr 7 -10	Yr 1 - 6	Yr 7-10
4	GA4	0.00%	0.00%	18.00%	4.00%	0.00%	0.00%	18.00%	4.00%	0.00%	0.00%	18.00%	4.00%
3	GA3	0.00%	0.00%	16.20%	3.60%	0.00%	0.00%	16.20%	3.60%	0.00%	0.00%	16.20%	3.60%
2	GA2	0.00%	0.00%	12.60%	2.80%	0.00%	0.00%	12.60%	2.80%	0.00%	0.00%	12.60%	2.80%
1	GA1	0.00%	0.00%	9.00%	2.00%	0.00%	0.00%	9.00%	2.00%	0.00%	0.00%	9.00%	2.00%
0	LOA	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

IV. Community Insurance Company Inc. (CICI) - Medicare Supplement

Level		Indiana			
		Plan F			
		Override		Commission	
		Yr 1-6	Yr 7+	Yr 1-6	Yr 7+
4	GA4	0.00%	0.00%	18.00%	0.00%
3	GA3	0.00%	0.00%	16.20%	0.00%
2	GA2	0.00%	0.00%	12.60%	0.00%
1	GA1	0.00%	0.00%	9.00%	0.00%
0	LOA	0.00%	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.