Dear Broker/Producer,

Re: Hometown Health/Senior Care Plus Producer Agreement Medicare Letter Agreement, Exclusive to Senior Care Plus Value Rx Complete Plan (019)

We are pleased to confirm our understanding of the services you are providing to Hometown Health/Senior Care Plus ("SCP") for enrollment in the Senior Care Plus Value Rx Complete Plan ("SCP Plan 019").

As a result of regulatory guidelines and increased monitoring activities, SCP has developed a Medicare Letter Agreement for brokers/producers who sell our Medicare Advantage or Part D plans. This Letter Agreement provides specific required processes to follow when marketing SCP Plan 019 to Medicare Beneficiaries, scheduling an appointment with the beneficiary, presenting Medicare Advantage or Part D plans, assisting the beneficiary with the enrollment form, and other important sales activity.

License

Broker/Producer represents and warrants that he/she is licensed by the State of Nevada to sell the SCP Plan 019, will maintain appropriate licenses at all times, and will provide SCP with written proof of such licensure, if not previously provided. Pursuant to Nevada state law, SCP may not pay any commission or other remuneration to Broker/Producer unless Broker/Producer's current and valid license is on file with SCP. Continued solicitation for SCP Plan 019 shall be contingent upon the continuing qualification of Broker/Producer by possession of the required licenses, appointments, and certifications.

Broker/Producer shall promptly notify SCP of any disciplinary proceedings related to such licenses, including notice of any investigatory proceedings instituted by CMS and/or the State of Nevada's licensing authority.

AHIP Certification

A broker/producer is required to complete the certification before they can sell Senior Care Plus Medicare Advantage or Part D plans.

Brokers are required to complete the AHIP Medicare Advantage and Part D certification course and pass that course with a minimum score of 90%.

In addition, Brokers must complete the Southern Nevada Broker Test and pass that course with a minimum score of 85%.

OIG Exclusion Screening

The Office of Inspector General (OIG) for Health and Human Services (HHS) is charged with identifying and combating health care and Medicaid fraud. OIG maintains an exclusion list known as the List of Excluded Individuals and Entities (LEIE) that provides information to the health care industry, patients, and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs. LEIE is owned and administered by the OIG.

Any individual or entity listed on the LEIE (e.g., excluded by OIG from participation in the Federal health care programs) cannot participate as an Agent and/or Broker in any healthcare program funded by the Federal government.

No Engagement in Activities which Mislead, Confuse or Misrepresent Policy and Procedure

SCP ensures all marketing related complaints are reviewed and appropriately investigated. SCP also ensures the marketing activities of its Brokers, Agents, Brokers and Associations are monitored. SCP ensures that the following activities are prohibited.

Discriminatory Activities: These include attempts to discourage participation on the basis of actual or perceived health status, such as:

- Attempts to enroll beneficiaries from a high income area if you are not making a comparable effort to enroll beneficiaries from lower income areas in your service area; or
- Attempts to give enrollment priority to those in your service area who are newly eligible for Medicare over other beneficiaries, unless those newly eligible are 'age-ins', *e.g.*, members of your plan prior to Medicare entitlement.

Activities Which Mislead, Confuse, or Misrepresent: Activities that could mislead or confuse beneficiaries or activities that misrepresent the organization, its Brokers, or CMS are prohibited. The following are examples of activities considered to fall within these categories:

- Claiming recommendation or endorsement by CMS of the plan or claiming that CMS recommends that beneficiaries enroll in the plan;
- Using terms such as 'official U.S. Government' or 'Medicare' on envelopes or in other marketing materials in ways likely to result in beneficiary confusion;
- Using terms such as 'Medicare substitute' or 'instead of Medicare' which imply that Medicare entitlement does not continue once a beneficiary is enrolled in the plan;
- Using coupons or cards seemingly intended for requesting additional information for enrollment and/or enrollment screening;
- Identifying your representative as an agent of Medicare or the Federal government;
- You may, however, explain that your organization has a contract with CMS or the Medicare program;
- Omitting information necessary for the beneficiary to make an informed choice, whether or not the beneficiary specifically requests the information;
- Making inaccurate statements about fee-for-service Medicare;
- Making overstatements about the plan's coverage;
- Giving implications of perpetual coverage;
- Using enrollment forms which are not accompanied by sufficient other information to allow for an informed choice;
- Incorrectly describing Medicare covered services; and
- Not offering benefits approved by CMS as part of the bid submission.

Gifts or Payments to Induce Enrollment: Offers of gifts or payments as an inducement to enroll in your organization are prohibited. However, CMS does allow plans to give Medicare beneficiaries nominal value gifts, provided that the plan offers these gifts whether or not the beneficiary enrolls in the plan. For example, HMOs may give nominal value gifts to all beneficiaries who attend a marketing presentation. We define nominal value as an item having little or no resale value and which cannot be readily converted to cash. Generally, nominal value gifts are worth less than $15.00.

Although you may describe legitimate benefits the beneficiary might obtain as a managed care enrollee, you are prohibited from offering or giving rebates, dividends or any other incentives, especially those that in any way compensate for lowered utilization of health services by beneficiaries. You may not tie lowered or reduced premium costs for the beneficiary to the beneficiary's decreased utilization of health services.

Door-to-Door Solicitation: Door-to-door solicitation of beneficiaries who have not now extends to other instances of unsolicited contact that may occur outside of advertised sales or educational events. Prohibited activities include, but are not limited to, the following:

- Outbound marketing calls, unless the beneficiary requested the call. This includes contacting existing members to market other Medicare products, except as permitted below;
- Calls to former members who have disenrolled, or to current members that are in the process of voluntarily disenrolling, to market plans or products, except as permitted below;
- Calls to beneficiaries to confirm receipt of mailed information, except as permitted below;
- Calls to beneficiaries to confirm acceptance of appointments made by third parties or independent agents;
- Approaching beneficiaries in common areas (i.e. parking lots, hallways, lobbies, etc.); and
- Calls or visits to beneficiaries who attended a sales event, unless the beneficiary gave express permission at the event for a follow-up call or visit.

Distribution of Unapproved Marketing Materials: You are prohibited from distributing marketing materials which have not been approved by SCP's Compliance and Legal departments and CMS. Similarly, you are prohibited from distributing marketing materials which CMS has disapproved in writing within 45 days after your submission of them.

You will have the right to use sales and marketing brochures, applications and various other forms provided by SCP. You will not alter the materials provided by SCP in any way.

National Do-Not-Call Registry Rules: In 2003, the Consumer and Government Affairs Bureau of the Federal Communications Commission (FCC) implemented rules that enhanced the Telephone Consumer Protection Act (TCPA). These enhancements included the establishment of a National Do-Not-Call Registry, in coordination with the Federal Trade Commission (FTC). On October 1, 2003, the National Do-Not-Call Registry went into effect. It is nationwide in scope, includes all telemarketers, and covers both inter- and intra-state telemarketing calls (the rules are outlined in 47 CFR 64.1200).

The changes to the FCC's telemarketing regulations apply to all companies subject to its jurisdiction; this includes health insurance companies, which contract with CMS. However, there are exceptions such as:

- Calls from non-profit tax-exempt companies may continue;

- If a business relationship has been established, then that firm may continue calling its existing customers (i.e., you may continue to call your members);
- Prior customers (members) are allowed to be called up to 18 months (i.e., up to 18 months after the effective date of disenrollment);
- Calls which are not commercial or do not include unsolicited advertisements may continue; and
- Calls where prior written consent was given may also continue for a period up to 3-months (for example, a participant in a sales presentation who releases his/her phone number to a sales person can be contacted for a period of up to 3-months after the date of the presentation).

CMS recognizes that the National Do-Not-Call Registry ruling may require Medicare managed care organizations to revise their marketing activities. All contractors should make any changes necessary in order to comply with the FCC ruling. If you have concerns and issues regarding the National Do-Not-Call Registry, please visit the FCC website at www.fcc.gov/cgb/donotcall for further information.

Allowable Actions for Medicare Advantage/Medicare Part D Organizations:

Medicare Advantage/Medicare Part D Organizations may do the following:

- Assist in the planning of local Health Fairs;
- Distribute health plan brochures and application forms, while at the Health Fair. They may also include in their handouts a reply card which may be given to interested beneficiaries for return to the organization via mail;
- Have a booth at the Health Fair;
- Distribute items with a total retail value of no more than $15.00. These items MUST be offered to everyone, (*e.g.*., organizations cannot give gifts to only those individuals who show interest).
- Have any personnel present (*e.g.*, marketing personnel, customer service personnel) as long as they adhere to these guidelines;
- Contribute funding for any Health Fair costs (*e.g.*, purchasing of food, drawings, raffles or door prizes for attendees which exceed $15.00 nominal value requirement) as long as the recognition of the donation is to a number of entities (not just one particular Medicare Advantage/Medicare Part D organization); and
- Market multiple lines of business in Medicare Advantage/Medicare Part D.

Medicare Advantage/Medicare Part D Organizations may not do the following:

- Give sales presentations;
- Collect enrollment applications (although application forms may be distributed, they may not be collected during CMS - sponsored Health Fairs);
- Collect names/addresses of potential enrollees. However, as noted above, they may distribute application forms and reply cards;
- Compare their benefits against other health plans. However, they may use comparative information which has been created by CMS (*i.e.*, information from CMS' Web site) or information/materials which have been approved by CMS (*e.g.*, the standardized Summary of Benefits);

- Third party created materials may not be used, unless they have been approved by CMS in advance;
- Give individuals gifts with a retail value of more than $15.00;
- Cross-sell non-health care related products (*i.e.*, annuities and life insurance) to prospective enrollees during any MA or Part D sales activity or presentation;
- Conduct sales activities in health care settings except in common areas; and
- Conduct sales activities at Educational Events.

Prohibition on the Provision of Meals

- Medicare Advantage and Medicare Prescription Drug Plans may not allow prospective enrollees to be provided meals, or have meals subsidized, at any event or meeting at which plan benefits are being discussed and/or plan materials are being distributed.
    - While CMS does not intend to define the term "meal" or create a comprehensive list of food products that qualify as light snacks, items similar to the following could generally be considered acceptable:

• Fruit	• Raw vegetables	• Pastries	• Cookies or other small dessert items	• Crackers
• Muffins	• Cheese	• Chips	• Yogurt	• Nuts

Rapid Disenrollment / Chargebacks

Any MA, MAPD, or Part D only member disenrollment of three months or less of coverage will result in rescinding the annualized 1st year commission of the broker from the date of disenrollment. For brokers with higher than average rapid disenrollment, corrective action will be implemented.

- A Rapid Disenrollment Report will be produced each month with a count of Rapid Disenrollment by broker, as well as the average Disenrollment Rate and Disenrollment Rate by broker.
- The Broker Sales Director will review the Rapid Disenrollment Report and identify brokers that have Rapid Disenrollment more than 1% greater than the monthly average.
    - The Broker Sales Director will notify broker(s) that they must reduce Rapid Member Disenrollment to no more than 1% greater than the monthly average or they will be required to repeat the online certification course.
    - If the Broker continues to have Rapid Disenrollment of more than 1% greater than the monthly average Rapid Disenrollment, the Broker Sales Director will notify the broker they have two months to reduce this rate to no more than 1% greater than the monthly average or they will revoke the Broker's privilege to sell Medicare Advantage and Part D plans.
- If the Rapid Member Disenrollment rate has not been reduced to no more than 1% greater than the monthly average within two months of second contact, Broker Sales Director will revoke the Broker's privilege to sell Medicare Advantage and Part D plans.

Enrollment Form Submission Policy and Procedure

The Broker/Producer must submit completed Enrollment Forms for Medicare Advantage and Part D immediately upon receipt from the beneficiary ensuring that SCP is positioned to comply with CMS guidelines for timely handling of beneficiary enrollment applications. In addition, the Broker must ensure that the Enrollment Form is complete and all of the information is accurate.

- The Broker must review the Enrollment Form, including online Enrollment Forms, with the applicant to ensure that the form is complete and the information provided is accurate before the applicant signs the form.
- All Enrollment Forms received by home visits, mail, seminar, walk-ins or other means are submitted within two days following receipt of the Enrollment Form. This can be accomplished by overnight mail, faxing the Enrollment Form, or utilizing the VUE portal.

Immediately upon receipt of the completed Enrollment Form from the Medicare beneficiary, the Broker provides the date received in the Agent /Broker use only section of the Enrollment Form.

Holding Enrollment Forms

An Enrollment Form cannot be held for any period of time that results in the plan not receiving by the next day. If the beneficiary wants a Broker to hold an Enrollment Form, the Broker must explain that he/she can either submit or cancel the Enrollment Form following established procedures.

Books, Records and Monitoring

Maintenance. The Broker shall maintain complete and accurate business records concerning its activities pursuant to this Letter Agreement, consistent with CMS guidelines and appropriate retention schedules. SCP shall have the right to review and copy records directly related to the Broker's activities pursuant to this Letter Agreement, at its expense upon reasonable advance notice, at the Broker's offices, during its normal business hours. This section shall survive the termination of this Agreement.

Record Ownership. In the event this Agreement is terminated, the Broker's records shall remain the property of the Broker and left in the Broker's undisputed possession. In the event this Letter Agreement is terminated, then SCP may continue to service SCPs customers directly.

Monitoring. Broker understands that SCP shall monitor its adherences to the compliance requirements related to the Medicare Products and any required periodic reports or evaluations of the Broker's performance as it relates to the products.

Access to Books and Records. Broker agrees that as it relates to SCP's Medicare Products, CMS and its agents shall have audit evaluation or review rights related to any materials or activities generated in support of these Medicare Products.

Independent Contractor Relationship

No Employer-Employee Relationship. The Broker/Producer and its Representatives are independent contractors of SCP. This Letter Agreement shall not be construed to create an employer-employee or joint venture relationship among those parties.

Insurance Coverage. The Broker/Producer shall obtain and maintain all insurance coverages, including but not limited to errors and omissions, workers' compensation and comprehensive general liability coverages, in amounts that are reasonably acceptable to SCP, and that are necessary or appropriate to insure the Broker/Producer against liability or to comply with applicable Laws. The Broker/Producer agrees to submit evidence of such coverages to SCP upon request. The Broker/Producer shall also be responsible for paying all wages, benefits, license fees and taxes for itself and its Representatives related to the provision of services to SCP pursuant to this Letter Agreement.

No Liability for Acts of Other Party. Neither party shall have imputed, constructive or vicarious liability for any loss or expense, including attorneys' fees, incurred in the settlement or satisfaction of any claim, action or judgment proximately resulting from any action or failure to act by the other party, its directors, officers, employees, agents or contractors. The responsible party shall indemnify and hold the other party harmless against any and all vicarious losses or expenses related to such claims, actions or judgments; provided the indemnifying party has received timely notice of and been given the opportunity to defend against such actions.

Broker/Producer may be liable to SCP for fines and or penalties caused by its non-compliance with requirements related to the Medicare Products.

Survival. This section shall survive the termination of this Agreement.

Distribution of Compliance Policies and Procedures and Standards of Conduct

In order to communicate compliance expectations to our Brokers, Hometown Health is required to ensure that the Renown Health Compliance Program and Code of Conduct, Compliance Policies, and delegated specific policies are distributed. The Code of Conduct and Compliance policies are available here: https://www.hometownhealth.com/compliance-program/important-compliance-links/.

Brokers represents and warrants that distribution of the Code of Conduct, Compliance policies, and delegated specific policies have been distributed to its employees assigned to the performance of the Delegated Activities, within ninety (90) days of hire or contract, and/or when there are updates to the policies, and on an annual, ongoing basis for all new and existing Employees.

Miscellaneous

Governing Law. This Agreement will be governed by, and construed in accordance with the laws of Nevada Laws.

Broker, any related agent, and its employees will comply with all applicable Medicare laws, regulations and CMS instructions.