REGULATORY ADDENDUM

This Regulatory Addendum (this "Addendum") supplements and is made part of the Services Agreement between Medica Services Company, LLC (MSC), on behalf of itself and its Affiliates (collectively, "Medica") and Vendor. This Addendum is effective as of the Effective Date of the Agreement and applies to Medica's Medicare and Minnesota Health Care Programs products. In the event of a conflict between this Addendum and the Agreement, this Addendum shall govern with respect to the services related to Medica's participation in Medicare and Minnesota Health Care Programs.

SECTION I
Definitions

Capitalized terms used in this Addendum that are not otherwise defined herein shall have the meanings set forth in the Agreement.

1.1 Affiliate. "Affiliate" has the same meaning as in the Agreement.

1.2 Beneficiary. For purposes of Section 2.30 of this Addendum, "Beneficiary" means an individual who is eligible to elect a Medicare Advantage plan under 42 CFR 422.50, a Medicare Cost plan, or who is eligible for a Medicare Part D plan under 42 CFR 423.30.

1.3 CMS Contract. A contract between the Centers for Medicare and Medicaid Services ("CMS") and Medica Health Plans or an Affiliate of Medica Health Plans for the provision of Medicare benefits pursuant to the Medicare program.

1.4 DHS Contract. A contract between the Minnesota Department of Human Services ("DHS") and Medica Health Plans for the provision of government program benefits under state and/or federal law.

1.5 Downstream Entity. Any party that enters into an acceptable written agreement below the level of the arrangement between Medica and Vendor. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.

1.6 Managing Employee. An individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over Vendor, or part thereof, or who directly or indirectly conducts the day-to-day operations of Vendor, or part thereof.

1.7 Medica Member. An individual covered under the Agreement and eligible and enrolled for coverage of health benefits under a Medica Medicare and/or Minnesota Health Care Programs product.

1.8 Person with an Ownership or Control Interest. A person or corporation that: (a) has an ownership interest, directly or indirectly, totaling 5% or more in Vendor; (b) has a combination of direct and indirect ownership interests equal to 5% or more in Vendor; (c) owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by Vendor, if that interest equals at least 5% of the value of the property or assets of Vendor; or (d) is an officer or director of Vendor (if organized as a corporation) or is a partner in Vendor (if organized as a partnership).

1.9 Significant Business Transaction. Any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5% of Vendor's total operating expenses.

1.10 Subcontractor. For purposes of Sections 2.25 and 2.26 of this Addendum, an individual, agency or organization with which Vendor has contracted (or a person with an employment, consulting or other arrangement with Vendor) for the provision of items and services that are significant and material to Vendor's contract with Medica and Medica's obligations under the DHS Contract or the CMS Contract.

1.11 Third Party Marketing Organization ("TPMO"). TPMO means organizations and individuals, including independent agents and brokers, who are compensated to perform lead generation, marketing, sales, and enrollment related functions as a part of the chain of enrollment (the steps taken by a Beneficiary from becoming aware of Medicare Advantage, Medicare Cost plan, or Medicare Advantage Part D plan or plans to making an enrollment decision). TPMOs may be a first tier, downstream or related entity ("FDRs"), as defined under 42 CFR 423.4, but may also be entities that are not FDRs but provide services to Medica's FDR.

SECTION II
Requirements

2.1 Provision of Vendor Services. Vendor will provide Services in a manner consistent with professionally recognized standards of care and in accordance with the standard of practice in the community in which Vendor renders Services as required pursuant to each CMS Contract and the DHS Contract and all applicable Medicare and Minnesota Health Care Programs laws, regulations and sub-regulatory guidance and in a manner so as to assure quality of Services.

2.2 Access to Vendor Services. Vendor will provide Services in a culturally competent manner to all Medica members, including Medica members with limited English proficiency or reading skills and diverse cultural and ethnic backgrounds. Vendor will not discriminate against any person based on his or her race, color, creed, religion, national origin, sex, gender, health status including mental and physical medical conditions, marital status, familial status, status with regard to public assistance, disability, sexual orientation, age, political beliefs, membership or activity in a local commission, or any other classification protected by law.

2.3 Data Collection. Vendor will submit to Medica, within the timeframe specified by Medica, all data necessary to characterize the context and purpose of each encounter with a Medica member in the manner and to the extent required by CMS and DHS. Vendor will certify, in writing, the completeness and accuracy of all such data.

2.4 Prompt Payment for Services. Medica will pay Vendor for Services in accordance with the Agreement and applicable state and federal law as related to the prompt payment of claims.

2.5 Medica Member Grievances. Vendor will cooperate with Medicare and Minnesota Health Care Programs products grievance, appeals, and expedited appeals procedures.

2.6 Participation in Medicare; No Opting Out of Medicare. Vendor is certified for participation in Medicare and Minnesota Health Care Programs products, as applicable, to the extent Vendor is a Vendor type eligible to be certified for participation in Medicare and Minnesota Health Care Programs products. Vendor may not employ or contract with any individuals who have opted out of Medicare by filing with a Medicare carrier an affidavit promising to furnish Medicare covered services to Medicare beneficiaries only through private contracts with such beneficiaries.

2.7 Laws, Rules and Sub-Regulatory Guidance. In addition to informing all related entities, contractors and/or subcontractors that payments they receive are, in whole or in part, from federal funds, Vendor will, and will cause Downstream Entities to, comply with:

(a) all applicable state and federal laws, regulations and sub-regulatory guidance;

(b) all applicable Medicare laws, regulations, and CMS sub-regulatory guidance and all applicable Minnesota Health Care Programs laws, regulations, and DHS sub-regulatory guidance;

(c) all state and federal laws and regulations designed to prevent or ameliorate fraud, waste or abuse including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.) and the anti-kickback statute (§ 1128B(b) of the Social Security Act); and

(d) all applicable state and federal laws and regulations designed to protect Medica member privacy including, but not limited to: (i) the Health Insurance Portability and Accountability Act of 1996 and administrative simplification rules promulgated thereunder at 45 CFR Parts 160, 162, and 164, as amended ("HIPAA"); and (ii) the Health Care Administrative Simplification Act of 1994, Minnesota Statutes, § 62J.50 et. seq., as amended.

2.8 CMS Contract and DHS Contract; Compliance with Contractual Obligations. Vendor agrees to participate in Medicare and Minnesota Health Care Programs pursuant to the CMS Contract and the DHS Contract under the terms and conditions agreed to by the parties. Vendor understands that this Agreement involves receipt by the Vendor of payments that are, in whole or in part, from federal funds. Vendor, and all related entities, contractors and/or subcontractors are therefore subject to laws applicable to individuals and entities receiving federal funds. Any Services rendered to Medica members under the Agreement shall be consistent and comply with Medica's contractual obligations with CMS and DHS. Vendor acknowledges and agrees that Medica oversees and maintains ultimate responsibility for adhering to and otherwise fully complying with the terms and conditions of each CMS Contract and DHS Contract and for ensuring that Vendor satisfies its obligations in compliance with such contracts. In accordance with each CMS Contract and/or DHS Contract, payments to Vendor may be suspended by Medica for a determination of a credible allegation of fraud against Vendor.

2.9 Delegation of Activities.

(a) Medica has delegated certain obligations under the applicable CMS Contract and DHS Contract to Vendor. Vendor acknowledges and agrees that Medica may revoke such delegation of Services or sanction Vendor in instances where CMS, DHS or Medica determines that Vendor has not performed satisfactorily with respect to Services provided to Medica members. Vendor acknowledges and agrees that to the extent CMS or DHS directs revocation, Medica shall provide immediate written notice of such to Vendor, and such revocation shall become effective as directed by CMS or DHS. Vendor shall cooperate with Medica regarding the transition of any delegated activities or reporting requirements that have been revoked by Medica. No additional financial obligations shall accrue to Medica with respect to such revoked activities from and after the date of such revocation in accordance with this section.

(b) If Medica delegates any of its obligations under the applicable CMS Contract to Vendor, other than the activities described herein and in the Agreement, Medica and Vendor agree to

update the Agreement and this Addendum, as applicable, to reflect the newly delegated activities and to specify the reporting obligations of Vendor to Medica or its contractors.

(c) If Medica has delegated to Vendor any activities related to the credentialing of health care providers, Vendor must comply with all applicable CMS and DHS requirements for credentialing including, but not limited to, the requirement that the credentials of medical professionals must either by reviewed by Medica or its designee, or the credentialing process must be reviewed, pre-approved and audited on an ongoing basis by Medica or its designee.

(d) If Medica has delegated to Vendor the selection of health care providers, to be participating providers in Medica's Medicare provider network, or the selection of any other contractor, subcontractor, or other Downstream Entity, Medica retains the right to approve, suspend or terminate the participation status of such health care providers or arrangement with such contractors, subcontractors, or other Downstream Entities.

2.10 Subcontracting. If Vendor has any arrangements, in accordance with the terms of the Agreement, with Affiliates, subsidiaries, or any other subcontractors, directly or through another person or entity, to perform any of the Services Vendor is obligated to perform under the Agreement that are the subject of this Addendum, Vendor shall ensure that all such arrangements satisfy the requirements in the Agreement pertaining to subcontracting and are current, in writing, duly executed, contain a specific description of payment arrangements and duration, and include all the terms contained in this Addendum as may be interpreted, supplemented or amended in accordance with the terms and conditions of this Addendum. Vendor shall provide proof of such to Medica upon request. Vendor further agrees to promptly amend its agreements with such entities, in the manner requested by Medica, to meet any additional CMS and DHS requirements that may apply to the Services. Payment arrangements must be available for review by Medica, DHS and/or CMS. The Agreement is subject to DHS and CMS review and approval, upon request by DHS and/or CMS in accordance with the DHS Contract.

2.11 Monitoring and Oversight. Medica or its designee shall monitor Vendor's performance on an ongoing basis and Medica is ultimately responsible to CMS and DHS for performance of all Services that are provided to Medica members. Vendor agrees to cooperate with the monitoring and oversight activities of Medica.

2.12 Privacy and Accuracy of Records. Vendor agrees to comply with all applicable state and federal privacy and security requirements. Vendor will do the following in connection with any medical records or other health and enrollment information Vendor maintains with respect to Medica members:

(a) Safeguard Medica member privacy and confidentiality including, but not limited to, the privacy and confidentiality of any information that identifies a particular Medica member. Vendor shall abide by all applicable federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information of Medica members. With respect to information that identifies a particular Medica member, Vendor shall have procedures that specify: (i) for what purpose the information is used within Vendor's organization; and (ii) to whom and for what purposes Vendor discloses the information outside Vendor's organization;

(b) Ensure that medical information is released only in accordance with applicable federal and state laws, regulations, sub-regulatory guidance or under court orders or subpoenas;

(c) Maintain the records and information in an accurate and timely manner; and

(d) Ensure timely access by Medica members to the records and information that pertain to them in accordance with applicable laws, regulations, and sub-regulatory guidance.

2.13 Record Retention. Vendor shall maintain records arising out of or related to the Agreement and each CMS Contract and DHS Contract for at least ten (10) years from the date of termination or expiration of the Agreement or final audit, whichever is later, or such longer period required by law or regulation.

2.14 Government Access to Records. Vendor acknowledges and agrees that CMS, the Secretary of the U.S. Department of Health and Human Services ("HHS") Inspector General, the Comptroller General, and DHS, or their designees, shall have the right to audit, evaluate and inspect any premises, physical facilities, equipment, pertinent books, records and documents, financial records, claims history records, policies and procedures, provider review history, complaints, payment methodology, provider contracts and all other related agreements, computer or other electronic systems, including medical records and documentation related to the applicable CMS Contract or DHS Contract, consistent with 42 CFR § 438.3(h). If CMS, HHS Inspector General, the Comptroller General, or DHS, or their designees, determine that there is a reasonable probability of fraud or similar risk, CMS, HHS Inspector General, the Comptroller General, or DHS, or their designees, may audit the Vendor at any time. This right shall exist through ten (10) years from the later of the final date of the applicable CMS Contract or DHS Contract period in effect at the time the records were created or the date of completion of any audit, or longer in certain instances described in applicable laws or regulations.

2.15 Medica Access to Records. Vendor shall grant Medica or its designees such audit, evaluation, and inspection rights identified in Section 2.14 herein, as are necessary for Medica to comply with its obligations under the applicable CMS Contract and DHS Contract. Whenever possible, Medica will give Vendor reasonable notice of the need for such audit, evaluation or inspection, and will conduct such audit, evaluation or inspection at a reasonable time and place.

2.16 State Audits. Subject to Sections 2.13 and 2.14, with respect to Medica's Minnesota Health Care Programs products, Vendor acknowledges and agrees that under Minnesota Statutes, § 16C.05, Subd. 5, the books, records, documents, and accounting procedures and practices of the Vendor relevant to the DHS Contract shall be made available and subject to examination by the state, including DHS, the Legislative Auditor, and State Auditor for a minimum of six (6) years from the end of the final date of the applicable DHS Contract period in effect at the time the records were created.

2.17 Indian Health Services. Vendor will allow qualified Medica members to directly access any Indian Health Services facility operated by a tribe or tribunal organized under funding authorized by 25 U.S.C. §§ 450f through 450n or Title I of the Indian Self-Determination Act, Public Law Number 93-638, for Services that would otherwise be covered by the Medica member's benefit plan. No prior approval or prior authorization may be placed on such Services.

2.18 Accessibility for Disabled Members. Vendor will comply with applicable provisions of the Americans with Disabilities Act of 1990, 42 U.S.C. §12101. et. seq., and regulations promulgated pursuant to it. Vendor will also comply with 28 CFR §35.130(d), which requires that services, programs, and activities be provided in the most integrated setting appropriate to the needs of Medica members with disabilities. Vendor also will take reasonable steps to ensure meaningful access by Limited English Proficient ("LEP") persons. The following four factors should be

considered: (a) the number or proportion of LEP persons eligible to be served; (b) the frequency with which LEP individuals come in contact with Vendor; (c) the nature and importance of the program, activity, or service provided by the program to people's lives; and (d) the resources available to Vendor, and costs.

2.19 Medica Member Protection. Vendor agrees that in no event, shall Vendor, or any subcontractor of Vendor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Medica member or any other person(s) acting on a Medica member's behalf, for Services provided under the Agreement, or for any other fees that are the legal obligation of Medica under the applicable CMS Contract. This provision applies, but is not limited to, the following events: (a) nonpayment by Medica; (b) insolvency of Medica; or (c) breach of the Agreement by Medica.

Vendor will not hold Medica members that are eligible for both Medicare and Medicaid financially responsible for Medicare Part A and Part B copayments, coinsurance, or deductibles when Medicaid is responsible for payment of such amounts. Medica will not impose cost-sharing in excess of the cost-sharing permitted under Title XIX of the Social Security Act. Vendor will accept Medica's payment for Services as payment in full, or will bill the appropriate state source.

2.20 Medica Member Rights. Vendor will comply with any applicable state and federal laws that pertain to Medica member rights and, when providing Services to a Medica member, ensure the Medica member's right to:

(a) Receive information pursuant to 42 CFR §438.10;

(b) Be treated with respect and with due consideration for the Medica member's dignity and privacy;

(c) Receive information on available Services and alternatives, presented in a manner appropriate to the Medica member's condition and ability to understand;

(d) Participate in decisions regarding his or her health care, including the right to refuse treatment;

(e) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;

(f) Request and receive a copy of his or her medical records pursuant to state law and 45 CFR Parts 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR §§164.524 and 164.526;

(g) Be furnished services in accordance with 42 CFR §438.206 through §438.210; and

(h) Be free to exercise his or her rights and that the exercise of those rights will not adversely affect the way the Medica member is treated.

2.21 Reporting of Vulnerable Persons. To the extent Vendor is a mandated reporter, Vendor has a duty to report the suspected maltreatment of a vulnerable adult or child as required under Minnesota Statutes, § 626.557 or § 626.556. Web-based training is available at no cost to all

mandated reporters: http://registrations.dhs.state.mn.us/WebManRpt/ for adults and http://www.dhs.state.mn.us/id_000152 for children.

2.22 Lobbying Disclosure. Vendor shall, and shall require that its subcontractors, if any, certify that, to the best of their knowledge, understanding, and belief:

No federal appropriated funds have been paid or will be paid for salary, expenses or otherwise by or on behalf of Vendor, to any person influencing or attempting to influence an officer or employee of an agency, a member of Congress or state legislature, an officer or employee of Congress or state legislature, or an employee of a member of Congress or state legislature in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, the modification of any federal contract, grant, loan, or cooperative agreement, or in any activity designed to influence legislation or appropriations pending before Congress or state legislature.

If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with federal government health care program products, Vendor shall, and as applicable shall require that its subcontractors, complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

2.23 Compliance Training.

(a) Vendor certifies that it will annually provide compliance training that meets the guidelines set by CMS from time to time ("Compliance Training"), to its personnel and employees (as required by CMS) responsible for the administration or delivery of Services to Medica members. To the extent required by CMS, such Compliance Training will include such other applicable compliance and/or fraud, waste, and abuse training directed by CMS. Vendor further certifies that for Downstream Entities responsible for the administration or delivery of Services to Medica members, Vendor will within ninety (90) calendar days of contracting with its Downstream Entities and annually thereafter: (i) communicate general compliance information to its Downstream Entities; and (ii) provide fraud, waste and abuse training directly to its Downstream Entities or provide appropriate fraud, waste and abuse training materials to its Downstream Entities. Vendor will provide, at Medica's request, an attestation that Vendor has fulfilled the required Compliance Training hereunder for its personnel, employees, and Downstream Entities (to the extent required or instructed by CMS) in compliance with this section.

(b) Upon reasonable written notice from Medica to Vendor, Vendor shall permit Medica personnel to review Vendor's policies and procedures including, without limitation, Compliance Training program materials and methods of distribution to Downstream Entities related to Vendor's Compliance Training provided under this section.

2.24 Excluded Individuals and Entities.

(a) Vendor warrants that Vendor has not been: (i) convicted of a criminal offense related to Vendor's involvement in any federally funded government program; (ii) debarred, suspended or otherwise excluded from participation in any federally funded government program, as

required by applicable federal law; or (iii) sanctioned by the U.S. Department of Health and Human Services ("HHS") Office of Inspector General ("OIG"). In addition, Vendor does not appear on: (i) the OIG List of Excluded Individuals/Entities ("LEIE"); (ii) the General Service Administration's System for Award Management ("SAM"); or (iii) State Medicaid Excluded Vendor lists. Vendor agrees to search monthly, and upon contract execution or renewal, and credentialing, the LEIE, SAM, and State Medicaid Excluded Vendor lists to verify that Vendor's employees, officers, directors, agents, subcontractors and any Person with an Ownership or Control Interest: (i) are not debarred, suspended or otherwise excluded from participation in any federally funded government program; (ii) have not been convicted of a criminal offense related to that person's or entity's involvement in any federally funded government program; and (iii) have not been sanctioned by the OIG.

(b) Vendor further warrants that Vendor will not, during the term of the Agreement, employ, purchase products or services from, or contract with any subcontractor who: (i) has been convicted of a criminal offense related to the individual's or entity's involvement in any federally funded government program; (ii) is listed as debarred, suspended or otherwise excluded from participation in any federally funded government program as required by applicable federal law; or (iii) has been sanctioned by the OIG.

(c) Vendor shall provide written notice to Medica within five (5) calendar days of the date Vendor knows, or has reason to know, that Vendor or any subcontractor has been: (i) convicted of a criminal offense related to the individual's or entity's involvement in any federally funded government program; (ii) listed as debarred, suspended or otherwise excluded from participation in any federally funded government program as required by applicable federal law; or (iii) sanctioned by the OIG.

2.25 Disclosure of Ownership Information. On an annual basis and within thirty-five (35) calendar days of any request by Medica, Vendor shall provide written disclosure to Medica regarding the corporate ownership of Vendor and any Subcontractor as required by this section. In addition, Vendor shall notify Medica within ten (10) business days of the date Vendor knows, or has reason to know, of any update or change in such ownership. Vendor's disclosure to Medica shall include, but not be limited to, the following information:

(a) the name, address, date of birth and social security number of each Managing Employee, and Person with an Ownership or Control Interest in Vendor, or any Subcontractor in which Vendor has direct or indirect ownership of five percent (5%) or more;

(b) whether any Person with an Ownership or Control Interest identified in Section 2.25(a) is related to any other Person with an Ownership or Control Interest as spouse, parent, child or sibling; and

(c) the name of any other organization in which a Person with an Ownership or Control Interest in Vendor also has an ownership or control interest in that other organization.

2.26 Disclosure of Business Transactions. Within fifteen (15) calendar days of a request by CMS or DHS, Vendor shall disclose to Medica information related to business transactions in accordance with 42 CFR §455.105(b). Vendor's disclosure to Medica shall include the following information:

(a) the ownership of any Subcontractor with whom Vendor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(b) any Significant Business Transactions between Vendor and any wholly owned supplier, or between Vendor and any Subcontractor, during the 5-year period ending on the date of the request.

2.27 Offshore Services. Vendor represents that no subcontractor hereunder performs any Medicare-related work in any country that is not one of the fifty United States or one of the United States Territories (an "Offshore Subcontract"). In the event that Vendor desires to enter into an Offshore Subcontract, Vendor must get Medica's prior written consent, which may be conditioned upon the consent of Medica's regulators and Medica's review of applicable law. If Medica gives consent to Vendor to provide Offshore Services, Medica still reserves the right to later revoke that consent at Medica's sole discretion, or if Medica is compelled to do so due to any regulatory instruction or legal requirement. Vendor shall comply with all CMS and DHS requirements and instructions applicable to offshore subcontracting including, but not limited to, completing an "Offshore Subcontractor Information and Attestation Form."

2.28 BC/DR Plan. To the extent Vendor provides "priority services" (as defined by the DHS Contract), Vendor must ensure that it maintains a BC/DR Plan and that its BC/DR Plan: (a) includes the appointment and identification of an emergency preparedness response coordinator, and Vendor shall provide Medica with the name and contact information for such individual; (b) includes the procedures for activation of the BC/DR Plan upon the occurrence of an emergency performance interruption ("EPI"); (c) ensures that Vendor operations continue to provide Services under the Agreement for as long as is practicable; and (d) includes reversal procedures for re-entering normal operations after an EPI. In the event of an EPI, Vendor must implement its BC/DR Plan within two (2) calendar days and Vendor shall use best efforts to provide Medica with prompt notice of any EPI and the resulting effects of such on the delivery of Services under the Agreement. Vendor must maintain, review, and annually test the BC/DR Plan throughout the Agreement's term. Medica may review Vendor's BC/DR Plan upon request and Vendor will provide Medica a copy of its BC/DR Plan no later than ten (10) calendar days after Medica's request.

2.29 Termination Due to Government Action.

(a) In the event Medica ceases to offer a Medicare product and/or terminates (and does not replace) the applicable CMS Contract, the Agreement or portion thereof may be terminated by Medica effective as of the effective date of the termination of the applicable Medicare product or CMS Contract. Additionally, in the event Medica ceases to offer a state government programs product and/or terminates (and does not replace) the applicable DHS Contract, Medica may terminate the Agreement or portion thereof effective as of the effective date of the termination of the applicable state public programs product or DHS Contract.

(b) Medica shall be entitled to remove the applicable population served by the Agreement who are Medica members under dual eligible Medicare Advantage Special Needs Plan products, if the dual eligible Medicare Advantage Special Needs Plan contract between CMS and Medica is terminated or non-renewed, and the related dual eligible contract between DHS and Medica is terminated, unless CMS and DHS agree to the contrary.

To the extent applicable, termination of the Agreement shall be carried out in accordance with the termination requirements stated in 42 CFR § § 422.506 and 422.512.

2.30 Deficit Reduction Act. In accordance with § 1902(a) (68) of the Social Security Act, if Vendor receives or makes annual payments under Medicaid of at least $5,000,000, Vendor must:

(a) establish written policies for all employees, managers, officers, contractors, subcontractors and agents of Vendor which provide detailed information about the federal False Claims Act, administrative remedies for false claims and statements, any applicable state laws pertaining to civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in § 1902(a)(68)(A);

(b) include as part of such written policies detailed provisions regarding Vendor's policies and procedures for detecting and preventing fraud, waste and abuse; and

(c) include in any employee handbook a specific discussion of the laws described in § 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and Vendor's policies and procedures for detecting and preventing fraud, waste, and abuse.

2.31 Third-Party Marketing Organization Obligations and Activities. To the extent that Vendor is a Third-Party Marketing Organization under the Medicare Program, Vendor shall comply with the following requirements:

(a) Standard Disclaimers

1. Vendor, if it does not sell all commercially available Medicare Advantage and Medicare Cost plans in a given service area, or does not sell all commercially available Medicare Advantage Part D plans in a given service area, must use the following standard disclaimer:

> We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1- 800-MEDICARE, or your local State Health Insurance Program to get information on all of your options.

2. Vendor, if it sells all commercially available Medicare Advantage and Medicare Cost plans in a given service area, or sells all commercially available Medicare Advantage Part D plans in a given service area, must include the following standard disclaimer:

> Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. You can always contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program for help with plan choices.

3. Vendor shall ensure it uses the above standard disclaimer in the following circumstances:

   a. Verbally conveying the standard disclaimer within the first minute of a sales call;

   b. Electronically conveying the standard disclaimer when Vendor is communicating with a Beneficiary through e-mail, online chat, or other electronic means of communication;

   c. Prominently displaying the standard disclaimer on Vendor's website(s);

   d. Including the standard disclaimer in any Marketing materials, including print materials and television Advertisements, developed, used or distributed by Vendor.

(b) *Disclosure of Relationships*. Vendor shall disclose to Medica, in accordance with the Medica Compliance Reporting, Investigation and Prompt Response Policy on Medica.com, as may be

updated from time to time, any subcontracted relationships used for marketing, lead generation, and enrollment.

(c) *Recording of Marketing, Sales, and Enrollment Calls*: Vendor shall record all marketing, sales, and enrollment calls, including the audio portion of calls via web-based technology with Beneficiaries in their entirety, and must retain copies of the recording in accordance with the record retention requirements of the Agreement.

(d) *Marketing Material Review.* To the extent that TPMO has developed marketing materials, election forms, and certain designated communications materials for multiple MA organizations or plans, TPMO must submit such materials to the HPMS Marketing Module with prior review by Medica, in accordance with 42 CFR 422.2261(a)(2) and 42 CFR 423.2261(a)(2).

(e) *Reporting to Plan*. Vendor shall report to Medica on a monthly basis any staff disciplinary actions associated with Beneficiary interaction in accordance with the Medica Compliance Reporting, Investigation and Prompt Response Policy on Medica.com, as may be updated from time to time.

(f) *Lead Generation*. Vendor, when performing lead generating activities, shall inform the Beneficiary that the Beneficiary's information will be provided to a licensed agent for future contact, or that the Beneficiary is being transferred to a licensed agent who can enroll him or her into a new plan.

1. When Vendor is providing the Beneficiary's information to a licensed agent for future contact, Vendor shall inform the beneficiary of such activity in accordance with the following standards:

    a. Verbally when communicating with the Beneficiary through telephone;

    b. In writing when communicating with the Beneficiary through mail or other paper means; and

    c. Electronically when communicating with the Beneficiary through email, online chat, or other electronic messaging platform.

2. When Vendor is transferring the Beneficiary to a licensed agent, Vendor shall disclose to the Beneficiary that he or she is being transferred to a licensed agent who can enroll him or her into a new plan.