QUALCHOICE Health

2017 AGENT HANDBOOK

Soundpath HEALTH | HeartlandPlains HEALTH | QualChoice® ADVANTAGE | RiverLink HEALTH

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Section 1 Introduction

We are committed to providing you with the tools to be successful at selling any or all of our brands and products. This handbook provides you an overview of our company, products, and an outline of how we c partner together.

Our expectation is that our agents share our commitment to be compliant and act with integrity at all times by putting the best interest of the Medicare beneficiary first. You will find compliance and administrative guidelines throughout this handbook and we expect that you will learn and abide by them.

Our Broker Relations team continues to build powerful, collaborative relationships with our Agents. We strive to provide superior service, education and support to help achieve mutually beneficial defined goals.

Your comments, suggestions, questions and recommendations are encouraged. We are here to assist you with helping your clients. Please email us anytime at BrokerRelations@QualChoiceHealth.com.

Welcome to our team and we look forward to a successful partnership serving the Medicare eligible population in our communities.

Sincerely,

Jim Moses
Senior Director of Sales and Business Development

1.1 How to use the Guide

This handbook consists of answers to Agents most frequently asked questions about doing business with us. It provides the business procedures on how to get you started with the company, how to conduct business and interact with us, and administrative guidelines and expectations.

1.2 Company History

Owner Organization

QualChoice Health Plan Services, is a subsidiary of Catholic Health Initiatives (CHI). QualChoice Health Plan Services subsidiaries, CHI is developing, operating and marketing health program administration capabilities and innovative market products, including commercial and Medicare Advantage health plans, in a number of CHI markets. CHI is one of the nation's largest Catholic health care systems in the United States.

1.3 Our Mission

To provide health insurance in a way that inspires and guides members towards better health with a well-orchestrated experience at every step of the way.
To do this we will:

1. Offer health insurance and services that are easy to use, affordable and create value.
2. Establish community partnerships to deliver a seamless, high quality care experience.
3. Give exceptional and personalized customer service.

To partner with our members and communities to improve their health and their health care experience in every stage of life. We pledge to provide:

- Easy-to-use, affordable products
- Access to quality health care providers
- Caring, personalized service

1.4 Our Values

Respect	Care deeply about those we serve, always showing respect.
Trust	Act with integrity. We provide stable products and networks our members can count on.
Collaboration	Work together to exceed the expected. We act as valued partners for our members, providers and brokers.
Innovation	Work together to exceed the expected. We act as valued partners for our members, providers and brokers.
Service	Identify with the customer (member) letting them know you understand, care and are on their side. Find the inconveniences or injustices that stand in the way of a positive health experience and fix it.
Excellence	Hold ourselves and our partners to the highest standards for products, clinical care and the customer experience.

Section 2 Getting Started

2.1 Contracting

We do not contract directly with Agents. We partner with select Sales Organizations throughout the nation that help with recruitment, support and training, and administrative functions that we believe help to deliver the best experience for our Agents.

Agents will receive a link from their Sales Organization to initiate and complete the following steps in order to represent the plan(s).

2.2 Licensing and Appointment(s)

Agents must have an active insurance license in Life, Accident and Health lines of authority (as determined by each state's Department of Insurance) and be appointed, where applicable, in your state of residence and in any state where you perform regulated activity (i.e., sales, educational event, etc.).

In addition, you must complete annual training and certification as required by the Center for Medicaid and Medicare Services (CMS) in order to obtain an appointment for the plan(s) through Gorman/Sentential Elite.

2.3 Errors and Omissions (E&O)

Agents must agree to maintain an E&O policy limit of at least one million dollars. The declaration page for the E&O policy must contain the name of the insured, termination date and amount of coverage.

2.4 Background Checks

A background check acknowledgment and authorization for consumer reports must be completed. Consumer reports or investigative consumer reports may be requested about you including information about your character, and general reputation. A background investigation collects information regarding an Agent's history of criminal charges, credit history, insurance licensing history, Office of Inspector General records, and General Service Administration excluded party records.

2.5 Training and Certification

Training is a business process that begins during the on-boarding of an Agent and is repeated annually, prior to the start of a new selling season, to ensure that plan benefit and regulatory changes are appropriately communicated to you in a consistent manner. To ensure you have a fundamental understanding of the QualChoice Health organization, products, and enrollment process, as well as applicable regulations, a foundational course and certification process is required. Ongoing training and development is required on an annual basis, upon significant benefit or regulatory changes, or as the need is identified for individual Agents. You must become certified as part of your initial on-boarding process and remain certified on an on-going basis in order to market and sell QualChoice Health plans.

Under no circumstance may you market or sell our plans until you are fully certified in the products you are authorized to sell. You must be certified for the plan year for which an Enrollment application is written. For example, if in December 2016, you write an Enrollment application with a January 1, 2017 effective date, you must have completed your 2017 product certification.

Each year, CMS provides Agent and Broker requirements for training and testing. The training you are provided meets the following requirements as set forth in the *Agent and Broker Training & Testing Guidelines:*

- All Agents and Brokers (including employed) that sell Medicare products are trained and tested annually on Medicare rules and regulations, and details specific to the Plan products they are selling. This includes employees, contractors, downstream entities, and/or delegated entities.
- That training and testing procedures are put in place to ensure each individual is taking the test independently, maintaining the integrity of the training and testing program.
- That information on training and testing programs can be provided to CMS upon request. CMS may request information that includes, but is not limited to, training tools, training exams, policies and procedures, and documentation demonstrating evidence of completion.

In addition, Agents and Brokers must obtain a passing score of at least 90% on the test(s) to be certified.

No commissions will be paid on any enrollment application written by an Agent who was not fully licensed and credentialed at the time the enrollment application was written.

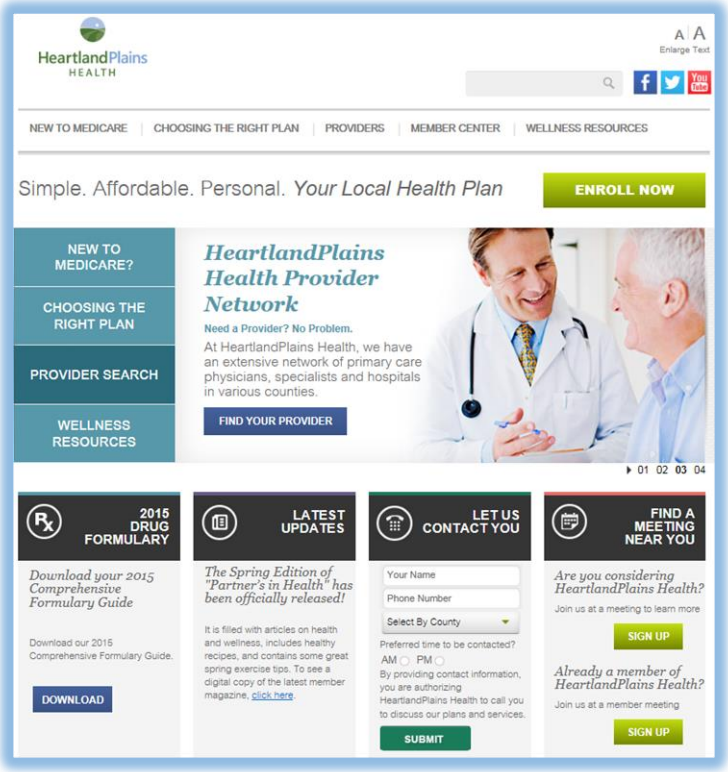
2.6 Writing Number

We use the National Producer Number (NPN) for your writing number. This number is required to be used on all applications in order for the Agent to be paid.

Section 3 Tools and Resources Available

3.1 Plan Websites

Each of our plans have their own website that include plan benefits, enrollment and member information. Every month they are updated with the most current formulary, and have a provider search tool for finding network primary care physicians, specialists and hospitals.



From our forms page to wellness prevention; our websites are a great resource not only for our members, but also for Agents selling our products.

Visit any of our sites:

HeartlandPlains Health:	www.HeartlandPlainsHealth.com
QualChoice Advantage:	www.QualChoiceAdvantage.com
RiverLink Health:	www.RiverLinkHealth.com
Soundpath Health:	www.SoundpathHealth.com

3.2 Broker Relations Support

The Resource Portal (https://qualchoicehealth.evolvespm.com), is available 24 hours a day, seven days a week, providing you access to enrollment applications and commission status, plan information, marketing materials, and much more. If, however, you are unable to locate what you need on the Portal, need assistance with a pending enrollment application, or have a commission inquiry, our Broker Relations Team is here to help.

You can reach us by email, and usually get a response same day but no later than 24 hours.
BrokerRelations@QualChoiceHealth.com or 1-866-513-6125

Team Members:
Jim Moses – Senior Director of Sales and Business Development
Kim Hunke – Broker and Sales Operations Manager
Blanca Garza – Broker Relations Assistant

If you are inquiring about a member please remember not to include any personal health information (PHI) or the member number in the email unless you send it secure.

3.3 Medicare Marketing Guidelines

At any time you can access the CMS Medicare Marketing Guidelines for reference on what is allowed and what isn't at the link below. The guidelines are updated often so be sure you are referencing the most recent version.

The 2016 Medicare Marketing Guidelines are posted at:

www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html

Section 4 We Are Member Centric

4.1 Partners in Health (SPH only)

Partners in Health – our award winning magazine – delivers information and helpful tips your clients can use to maintain their health and get the most from their plan. *Partners in Health* will be mailed to your clients mailing address, and is available online as well.
* Currently only offered in Soundpath Health

4.2 Bi-Monthly e-Newsletter: *Member Matters*

Every other month, members who provide their email address are sent an e-newsletter that is packed with information on wellness, healthy living, dates and times for orientation meetings and events, health recipes and much more.

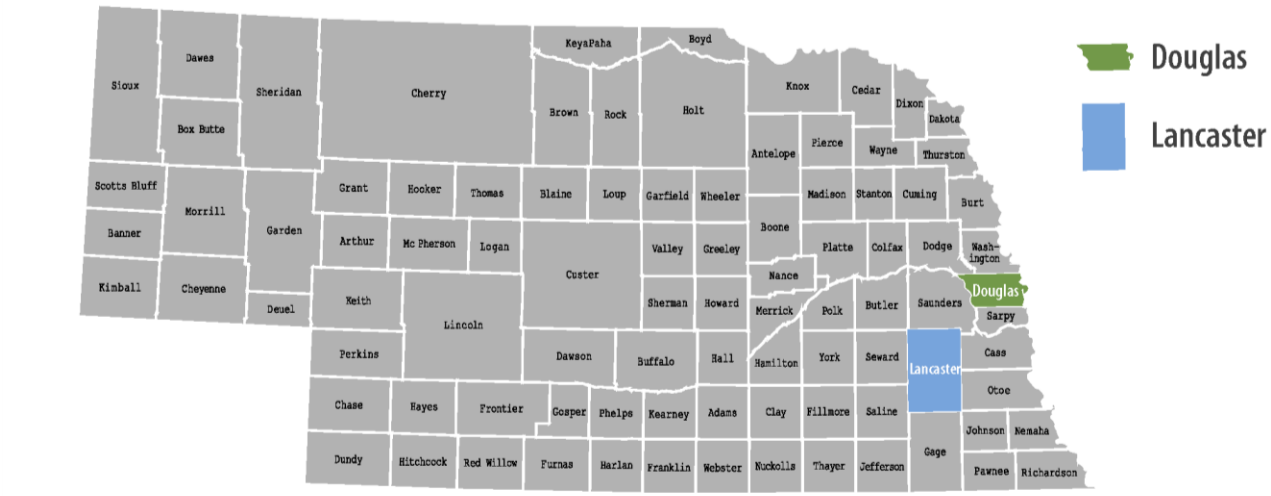
4.3 Online Tools

Each of our plans websites are designed to help our members have access to all the tools they need. They can access current forms, register for meetings, and so much more!

Section 5 Service Areas

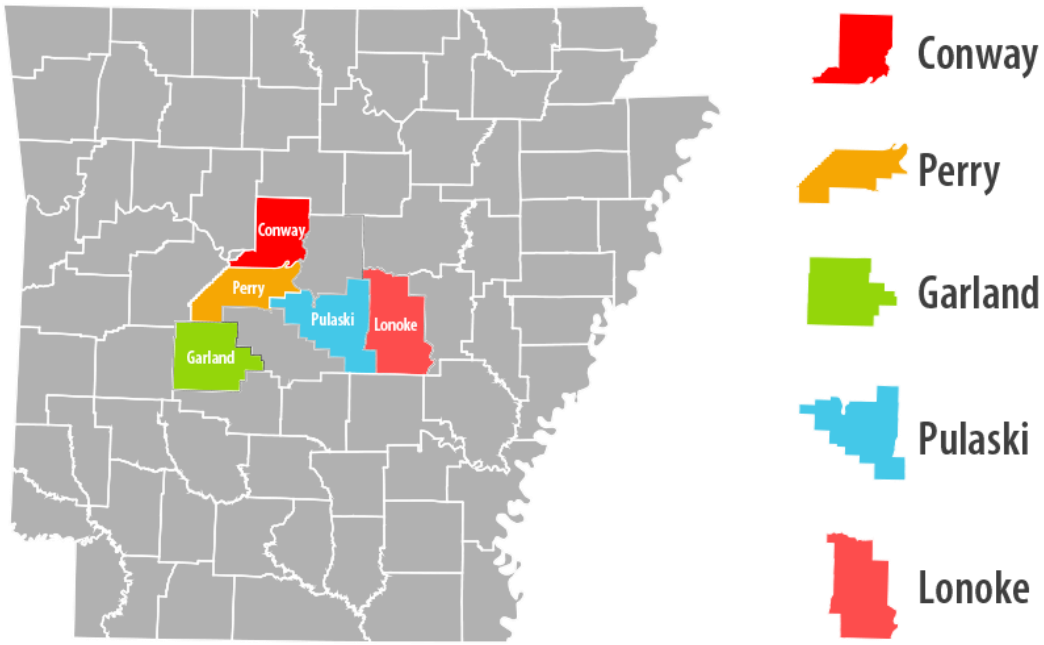
HeartlandPlains Health in Nebraska

Based in Omaha, our service area is Douglas and Lancaster counties.



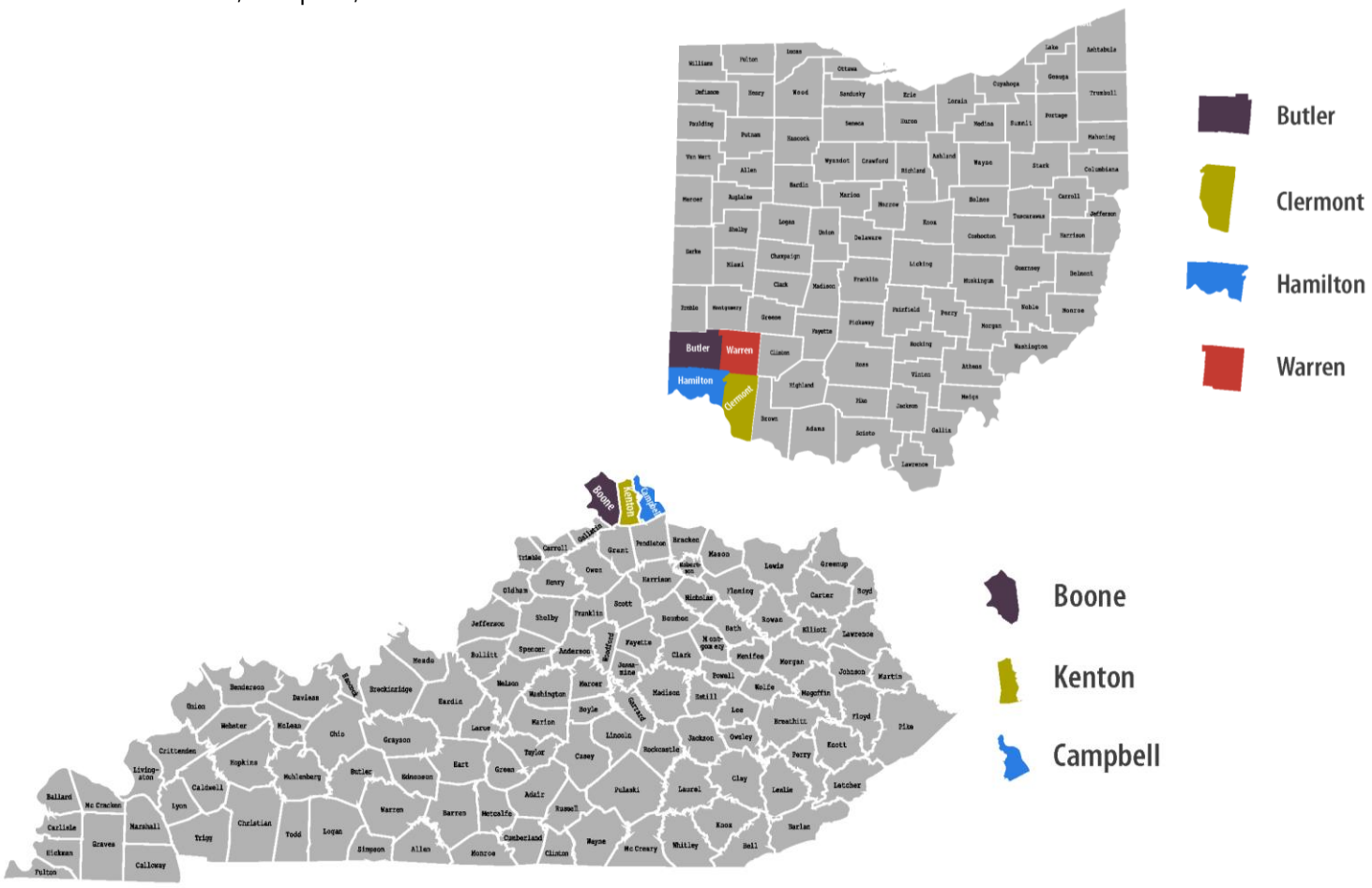
QualChoice Advantage in Arkansas

Based in Little Rock, our service area is Conway, Garland, Lonoke, Perry, and Pulaski counties.



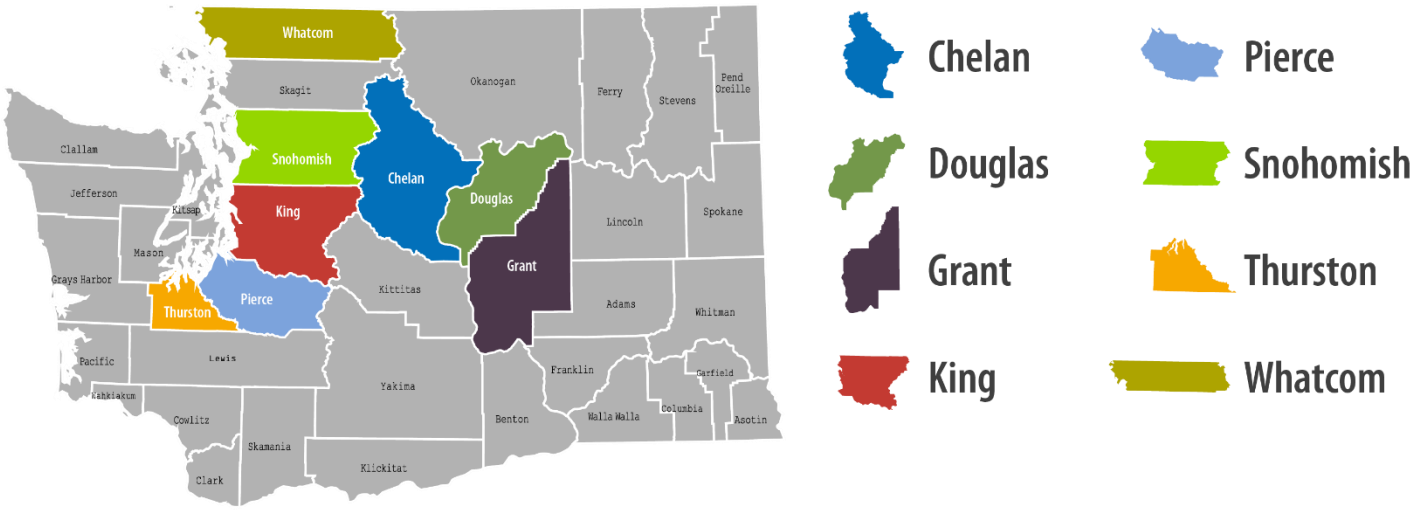
RiverLink Health in Ohio and Kentucky

Based in Cincinnati, our service area is Butler, Clermont, Hamilton, and Warren counties in Ohio. We are also in Boone, Campbell, and Kenton counties in Kentuckv.



Soundpath Health in Washington

Based in Federal Way, our service area is Chelan, Douglas, Grant, King, Pierce, Snohomish, Thurston, and Whatcom counties.



Section 6 Taking an Enrollment Application

6.1 Enrollment Methods

Enrollment applications cannot be solicited or accepted outside of a valid election period. Marketing and/or selling outside of eligible periods is prohibited and subject to corrective and/or disciplinary action up to and including termination. You must be contracted, licensed, appointed and certified in the product in which the consumer is enrolling at the time the enrollment application is completed.

An enrollment application should only be completed after you have thoroughly explained all plan benefits, rules, confirmed eligibility, disclosed Agent and product specific information (e.g., Star Rating), disclaimers, and the consumer has agreed to proceed with the enrollment.

All paper enrollment applications must be entered through the Health Plan Customer Relationship Management (HPCRM) Portal within 48 hours of the signature date. The enrollment application is considered in receipt the date you take receipt and sign the enrollment application.

6.2 Election Periods

There are specified election periods available for Medicare eligible consumers. The election periods include an Annual Election Period (AEP), Medicare Advantage Disenrollment Period (MADP), an Initial Coverage Election Period (ICEP), Initial Election Period (IEP), or a Special Election Period (SEP) based on specific eligibility criteria. Note: Medicare Supplement products are not restricted to the Centers for Medicare & Medicaid Services (CMS) election periods and may be enrolled throughout the year.

Annual Election Period (AEP)

AEP, which runs from October 15 through December 7, enables consumers to change or add Prescription Drug Plans (PDPs), change Medicare Advantage plans, return to Original Medicare, or enroll in a Medicare Advantage plan for the first time even if they did not enroll during their Initial Election Period.

Medicare Advantage Disenrollment Period (MADP)

MADP, which occurs January 1 through February 14, gives consumers an annual opportunity to disenroll from their Medicare Advantage plan and return to Original Medicare. Regardless of whether the Medicare Advantage plan included Part D drug coverage, consumers using the MADP to disenroll from their plan are eligible for a coordinating Part D SEP which allows them to enroll in a PDP during the same timeframe.

Initial Coverage Election Period (ICEP) and Initial Election Period (IEP)

ICEP and IEP occur when consumers first become eligible for Medicare. These periods are for all consumers becoming eligible for Medicare whether it is due to turning 65 or by becoming eligible due to a qualifying disability. Eligible consumers can enroll into a Medicare Advantage plan (MA) of their choosing, including a Medicare Advantage Prescription Drug Plan (MAPD). Those already enrolled into Medicare due to disability have a second IEP upon turning 65. Note: based upon specific eligibility criteria and election choices, ICEP and IEP may occur together or may occur separately.

Special Election Period (SEP)

A SEP allows consumers to make an election change in accordance with applicable requirements anytime during the year, including during the period outside of the OEP. The SEPs vary in the qualifications to use them as well as the types of elections allowed. Situations such as dual-eligible status and institutionalization provide the ability to switch plans at any time during the year. All SEPs are determined and announced by CMS.

5-Star Special Election Period (SEP)

The 5-Star SEP is an election period available to consumers/members that allows them to enroll in a 5-Star rated plan. Consumers/members can use the 5-Star SEP to enroll in a 5-Star plan one time during the benefit year when changing from a plan that does not have a 5-Star rating. Consumers/members can only join a 5-Star Medicare Advantage (MA) plan if one is available in their area.

6.3 Enrollment Process and Using HPCRM

After your client has signed their enrollment application, you will need to either log into HPCRM Portal and enter the application or send the application to your Sales Organization to be processed. If you don't enter applications yourself, you can skip the rest of this section. If you enter your own applications, read on.

When you have completed the on-boarding process you will receive an email with your username, password, link to the program and a PDF of our user guide. All applications must be entered into the system within 48 hours of signature date. If you are not able to enter them into the system within that time, please contact our Broker Relations Team because you will be out of compliance.

Once the application has been entered, the sales status will change to 'Application Received by Agent'. Be sure to upload your enrollment documents for the member as well. These include the enrollment form, Scope of Appointment, agent checklist, and any other supporting documents you have.

You will need to log back in daily until you see the sales status changed to 'Processed by Enrollment' because if there is any information that was entered incorrectly or any missing, our enrollment department will change the sales status to 'Incomplete Application' and it is your responsibility to correct the application in the system. (More information on this and other processes in the *HPCRM Agent User Guide*.)

6.4 Scope of Appointment

A Scope of Appointment (SOA) form is not required at marketing/sales events since the scope of products has been defined through advertisement and announced at the beginning of the event. Any follow-up or secondary personal/individual appointments with the consumer after an event requires a SOA form. A SOA is required for personal/individual sales appointments where you intend to present plan Products.

The completed SOA is required to be obtained 48 hours prior to the appointment. A SOA may be sent to a consumer via postal mail, fax, or email (permission to email must be obtained and documented). Situations that require a completed SOA include but are not limited to:

- A completed SOA form is required for any face-to-face marketing appointment for any plan product.
- A completed SOA form is required from each attending Medicare-eligible consumer.
    - If your appointment is with a husband and wife, you must obtain a SOA form from both consumers.

- A new SOA form is required for any and all subsequent face-to-face personal/individual marketing appointments; even to discuss previously discussed products.
- If setting a future or second appointment, you must fill in all required fields on an approved SOA form, identify all products that might be discussed with the consumer at the future appointment, and secure the consumer's agreement to discuss the identified products.
    - Send the consumer the SOA form to the consumer for signature and receive it back from the consumer prior to the appointment.
    - The future or second appointment cannot occur within 48 hours of the initial appointment.

- In certain circumstances, an exception can be made when obtaining the consumer's signature. If you are unable to obtain the SOA in advance of the meeting, you may secure the consumer's signature in-person immediately prior to the start of the appointment and indicate on the form the reason why the signature could not be obtained in advance.

- An SOA is valid until used or until the end of the applicable election period. For example, on October 1 an Agent schedules an appointment for October 16 and mails an SOA to the consumer. The consumer signs the SOA and the Agent receives it back on October 8. On October 15, the consumer calls and reschedules the appointment for October 17. On October 17, the Agent and consumer meet. The SOA sent out October 1 and received October 8 is valid for the October 17 appointment.

- All SOA forms must be retained, including those for cancelled or rescheduled appointments, consumer no-shows, or appointments that do not result in a consumer enrollment, and made available upon request. You are required to retain and store a copy of the SOA forms for a minimum of ten years from the date of the appointment. You must be able to provide an SOA within 48 hours of request.

6.5 Telephonic Enrollments

Telephonic enrollment requests must be approved by Health Plan prior to use. Agents will ensure that any and all telephone enrollments are conducted in compliance with CMS's Guidance, including the Medicare Marketing Guidelines currently in effect at the time of any telephone enrollment, and our standards and policies. Agents must use a CMS and company-approved script. The Agent must maintain documentation of recorded calls for ten years and upon request, make available to QualChoice Health documentation of the recorded calls. The Agent agrees that they will not participate in any prohibited telephonic activities as set forth in the guidance. Agents will assist QualChoice Health in meeting any and all outbound enrollment and verification requirements as set forth in the regulations and the guidance. The Agent understands that all scripts require CMS approval, and if the Agent seeks to use a script other than the QualChoice Health and CMS-approved script, it may take up to 60 days for notice of approval or denial.

6.6 Application Process

When the consumer completes the enrollment application, confirm that every required section is thoroughly completed prior to submission.

Risk of non-compliance: Submitting an incomplete enrollment application puts the consumer at risk for not having coverage when they expect to, because their enrollment may be delayed in processing or denied. Signing the enrollment application for the consumer is considered forgery and is subject to disciplinary action.

Agents Must

- Help the consumer enroll in the most appropriate plan based on his/her needs.
- Ensure the consumer understands and agrees with the plan effective date, premium (when applicable) and benefits.
- Ensure the consumer understands how to access a provider; explaining any network or provider limitations including referrals as applicable.
- Ensure the enrollment application is complete (e.g., PCP selection, Medicare effective dates) prior to having the consumer sign the application.
- Provide the physical address in the residential address portion and the P.O. Box in the billing address portion of the enrollment application, if applicable.
- Explain that upon request the authorized legal Agent must provide documentation of their authorization under state law to the plan or CMS.
- Review withdrawal, cancellation, and disenrollment processes with the consumer.
- Review the Outbound Enrollment Verification (OEV) process with the consumer.

Agents Must Not

- Sign the enrollment application or have anyone else, who is not an authorized legal representative, sign on behalf of the client, even with the client's permission.
- Sign or add your writing number to an application when you did not assist with the enrollment.
- Be physically present with a consumer who is completing a web-based enrollment.

6.7 Disenrollments

A client or legal representative may request, for any reason, to cancel, after submission to the Centers for Medicare & Medicaid Services (CMS), or withdraw, prior to submission to CMS, their enrollment application prior to the effective date of coverage. A client's enrollment can only be cancelled or withdrawn if the request is made (based on the date the telephone call or written notification is received by the plan or Agent) prior to the effective date of the enrollment. A request to cancel an enrollment application occurs prior to the effective date, but after the plan has submitted the enrollment data to CMS.

In addition, the client or legal representative may request to terminate their enrollment in a plan after the effective date.

You may neither verbally nor in writing, nor by any action or inaction, request or encourage any member to disenroll. Furthermore, you are not permitted to make additional contact with a member or legal representative who requests to cancel or withdraw their enrollment application or disenroll from the plan.

Withdrawal of Application

Requests to withdraw an enrollment application occur prior to the effective date and prior to submission of the enrollment data to CMS.

- If the client signed a paper enrollment application and you have not entered it into HPCRM, you are required to return the paper enrollment application to the consumer.

- Once the consumer requests to withdraw their paper enrollment application, you are prohibited from submitting the paper enrollment application, retaining, or destroying it.
- If the application has been entered into HPCRM, the Agent must direct the client to Customer Service to facilitate the withdrawal request.
- A consumer may verbally request to withdraw their enrollment application.

Cancelation

A client's request to cancel an enrollment application may occur prior to the effective date, but after the plan has submitted the enrollment data to CMS. In this situation, you must direct the client to Customer Service to facilitate the cancellation request. The Customer Service number is located in the Enrollment Guide. The client may verbally request a cancellation of an enrollment as long as it is received prior to the effective date of coverage.

Request to Disenroll

A voluntary disenrollment occurs after the effective date.

- A member may request disenrollment only during a valid election period.
- The member may disenroll by:
  - Enrolling in another plan (during a valid election period)
  - Providing a written (signed) notice to the plan
  - Calling 1-800-MEDICARE.

If the member verbally request disenrollment, you must instruct the member to make the request in one of the ways described above.

6.8 What your client can expect once enrolled

After confirmation from CMS of enrollment, our client will receive an Outbound Enrollment Verification (OEV) call to verify they wanted to sign up for the plan. If the client cannot be reached an OEV letter will be sent. This is proof of enrollment and may be used for provider access and pharmacy prescriptions.

Member kits are mailed within 30 days of CMS approval. Included in the member kit:

- Welcome letter
- Evidence of Coverage (EOC)
- Abridged formulary
- Provider/Pharmacy directory card
- Authorization to disclose information form

The member ID cards are mailed at approximately the same time as the member kit, but will arrive separately.

Section 7 Commissions

7.1 Compensation Overview

Commission is a form of compensation given to an agent for new enrollments of clients in the plan and annual renewals. Compensation must comply with CMS and other regulatory guidance.

Plans must establish a compensation structure for new enrollments and renewals effective in a given plan year. The compensation structure:

- Must be reasonable and reflect fair market value for services performed.
- Must comply with fraud and abuse laws, including the anti-kickback statute.
- Must be in place by the beginning of the plan year marketing period, October 1.
- Must be available upon CMS request for audits, investigations, and to resolve complaints.

Commissions are paid monthly (on the 25th) to the Sales Organization. The Sales Organization is responsible to then pay their agents within 10 working days of receiving funds. Compensation is subject to chargeback for enrollees who terminate for any reason.

Agents who have not completed the QualChoice Health Plan Services credentialing process will not be appointed and will not receive commissions, in accordance with CMS guidelines.

If you have any questions on your commissions, contact your Sales Organization.

7.2 AOR Changes

Enrollees may select an agent to provide them education and support on plan and enrollment information and facilitate the enrollment process. Enrollees may also choose to:

- **Change Agent by Notice** – Once an enrollee has been provided services from an agent they may choose to change agents or use a plan agent. To change agents the enrollee must select another QualChoice Health appointed agent. This request must be documented on the AOR change form with the client's signature and occur during an approved CMS enrollment period. Any AOR change form which is received either outside the open enrollment period or after 30 days from the date of signature will not be recognized. The Commission and Compensation payment is made to the Sales Organization managing the Agent at the time of payment.

- **Change of Agent by Application (During AEP)** – The Agent on the latest application will be considered the AOR replacing the previous Agent. There will be no retroactive commission, compensation or take-backs due to change of AOR on a new application except in the event of a QualChoice Health Plan Services error, as determined by QualChoice Health Plan Services. Depending on when notice is given, the change may not be visible in the QualChoice Health online systems for up to 60 days. Plan Changes will require an AOR form from the member.

- **Sale or Assignment of an Agent's Book of Business (BOB)** – Agents who retire or move may assign or sell their BOB to assure a continuation of a high level of service for those clients. Thirty days' notice is required to make this change. Based on when that notice is given during the month, change may not be visible for 60 days in the QualChoice Health Plan Services online system. Commissions and

compensation will be determined based on the date of the notification. The commission and compensation payment is made to the sales organization managing the agent at the time of payment. If compensation and commission has been paid to another sales organization, any new compensation and commission will begin to the sales organization and its agent at the next annual renewal. If commission and compensation has already been paid QualChoice Health Plan Services will not retroactively adjust for commissions and compensation. QualChoice Health Plan Services will not adjust or pay sales organization for any business it has already paid another sales organization unless QualChoice Health determines it made an error in such payment.

- **Agents Changing Sales Organizations/FMOs -** FMO and Agents shall comply with QualChoice Health policies and procedures with respect to Agents changing or moving from FMO. Such policies may be amended by QualChoice Health from time to time by written notice to FMO and without amendment to this Agreement. Starting with the 2017 Contract year, the Health Plan will require a release from the current Agency in order to transition to another contracted Agency. The Agency can release the Agent immediately or retain the Agent for a period of time not to exceed 12 months. Once the release is signed, the book of business will be moved within 30-60 days.

7.3 Commission Audits or Inquiries

In the event compensation and/or commission are not paid or paid in error, each party agrees it shall correct the error. Sales organization shall reconcile payments each month and provide written notice of any discrepancy to QualChoice Health Plan Services. Sales organization will evaluate monthly application reports it receives from QualChoice Health Plan Services. Sales organization will file discrepancies within 90 days from the effective date or in the case of renewal notification by March 31st. If QualChoice Health is not notified within 90 days of the enrollment effective date, the agent won't be paid until next renewal. Discrepancies will be submitted once-a-month on a QualChoice Health Plan Services discrepancy form. Discrepancies turned in by the third Wednesday of the month will be reflected in the next month's deposit unless further investigations are required. Sales organization waives any and all rights to request additional payment for requests that are not made within the required timeframe.

7.4 Plan Changes verse Initial

In the event that client changes plans without a break in coverage, such changes by the client shall not be considered a new sale.

7.5 Chargebacks

Chargebacks will occur for months where the member was not enrolled but the rep was previously paid for those months. We will not go back further than January 1st of the previous year. If your member has a rapid disenrollment, there will always be a chargeback for the full amount unless it qualifies for a CMS exception.

If a client disenrolls after four months with the plan, the agent will be charged back the full value of the months the client is not enrolled but agent was paid for.

Section 8 Compliance and Standards

8.1 Compliance and Ethics

Sales organization and any related contractor or subcontractor, including, but not limited to Agents, will comply with all state and federal law and regulations, including all applicable State, Federal, including all Medicare and CMS, laws, guidance, regulations and instructions related to Part C and Part D.

8.2 Standards of Conduct

In accordance with Medicare Managed Care Manual Chapter 21 – Compliance Program Guidelines and Prescription Drug Benefit Manual, Chapter 9 - Compliance Program Guidelines 50.1 – Element I: Written Policies, Procedures and Standards of Conduct, the plan's board and committee members, officers, employees (to include temporary, volunteers or independent contractors), and contracted vendors defined by CMS as FDRs, are responsible for complying with all laws, regulations, rules and/or guidance applying to our business as a plan sponsor, as defined by CMS and as a Health Care Services Contractor, by the State Department of Insurance.

It is also the expectation of the plan that the aforementioned parties are responsible for complying with the requirements of ethical behavior and standards of conduct as delineated below:

- Exercise good faith and honesty in all dealings and transactions.
- Create a work place that fosters community, honors and cares for the dignity, safety and wellbeing of all persons in mind, body and spirit.
- Maintain a high level of knowledge and skill among all who serve in order to provide high quality service.
- Observe all laws, regulations and policies that govern what we do.
- Maintain the integrity and protect the confidentiality of member, employee and organizational information.
- Avoid conflicts of interest and/or the appearance of conflicts.
- Use our resources responsibly.

The plan promotes an environment that encourages all of us to seek clarification of issues and ask questions and report concerns. It is everyone's duty and responsibility to report possible violations of our standards, guidelines or policies. Reporters of suspected compliance issues will be protected from retaliation if the reporter makes a good-faith report, complaint or inquiry. A person who retaliates against a good-faith reporter is subject to discipline, up to and including termination from employment or termination of a business relationship with the plan.

Non-retaliation policies do not protect individuals whose actions violate the plan sponsor's policies or applicable laws.

Failure to comply with the Standards of Conduct or failure to report any potential violation may result in disciplinary action, up to and including, termination of employment or business relationship with the Plan, as applicable.

8.3 Policies and Procedures

Sales organization and its Agents shall strictly comply with all QualChoice Health Plan Services written policies and procedures as outlined herein or communicated independently to sales organization, as amended and updated from time to time throughout the term, upon notice but without need to amend this agreement. Sales organization shall create and maintain a policy and procedure manual that it will use as a guide to train Agents and other sales organization employees or independent contractors. This manual is to be maintained and up to date at all times.

8.4 Complaints and Allegations of Agent Misconduct

Sales organizations and Agents shall report to QualChoice Health Plan Services within 24 hours of receipt any complaints or inquiries which may indicate non-compliance on behalf of the sales organization, its Agents, QualChoice Health Plan Services, or a plan by any prospective enrollee, client, Agent, or any governmental agency related to the sale or servicing plans or in connection with an enrollee. The sales organization is required to have a mechanism in place to receive and record complaints on Agents and contracted entities functions. If an Agent or Agent's behavior is found to be non-compliant, contracted entities shall put such Agent immediately on a Corrective Action Plan (CAP) and monitor regularly to ensure continued compliance. Failure to comply with the CAP will result in immediate termination of the Agent. Sales organization and its Agents and other employees or contractors of sales organization are encouraged to report compliance concerns and any suspected or actual misconduct. The QualChoice Health Plan Services compliance hotline number is 877-864-2028.8.5 Termination of Non-Producing Agent

8.5 Termination of Non-Producing Agent

An Agent, who is terminated, will cease to be an appointed Agent recognized by QualChoice Health Plan Services and as such no longer eligible to receive commission. A terminated Agent's BOB will be reassigned at QualChoice Health Plan Services sole discretion.