

**EXHIBIT A**  
**CLEVER CARE OF GOLDEN STATE INC. MEDICARE ADVANTAGE PRODUCER  
AGREEMENT**

THIS MEDICARE ADVANTAGE PRODUCER AGREEMENT (“Agreement”) by and between Clever Care of Golden State Inc., on behalf of itself and/or its affiliates (“Company”), 8990 Westminster Blvd., 3<sup>rd</sup> Floor, Westminster, CA 92683 and the undersigned individual agent, broker, producer or agency (“Producer”), is effective as of \_\_\_\_\_ (the “Effective Date”).

WHEREAS, Company offers Medicare Advantage plans pursuant to one or more contracts with the Centers for Medicare and Medicaid Services (“CMS”).

WHEREAS, Company and Producer desire to enter into this Agreement, whereby, among other things, Producer shall present Medicare Products (as defined below) to Medicare eligible individuals in return for compensation paid by Company.

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

Producer has read and fully understands the terms and conditions of this Agreement, and its exhibits. Producer certifies that it is duly licensed and authorized to lawfully market Medicare Products, as set forth herein.

This Agreement shall be effective on the Effective Date and shall automatically renew on January 1 of each year following the Effective Date unless otherwise terminated as set forth in this Agreement.

**1. DEFINITIONS**

- a) “Enrollee” means an eligible Medicare beneficiary who has enrolled in a Medicare Product as confirmed by CMS through the efforts of Producer.
- b) “Medicare Product(s)” means those Medicare Advantage and Medicare Advantage with Part D prescription drug coverage products that are offered by Company and set forth on Exhibit 1, which is hereby made a part of this Agreement.

**2. RESPONSIBILITIES AND AUTHORITY OF PRODUCER**

- a) Producer shall solicit from eligible Medicare beneficiaries' applications for the Medicare Products. Producer is only authorized to solicit business for, and this Agreement only applies to, the Medicare Products included in Exhibit 1. Producer's authority under this Agreement is non-exclusive. Producer agrees to make no representation with respect to the benefits offered by Company beyond the material prepared and furnished to Producer for that purpose by Company.
- b) Producer agrees to secure and maintain such licenses and appointments by Company as are necessary to conduct business on behalf of Company and as required by any state where Producer solicits sales of the Medicare Products, including but not limited to the California Department of Managed Health Care. Producer shall provide Company copies of all required licenses.
- c) Producer agrees that Producer shall not commence soliciting or accepting applications for Medicare Products prior to their successful completion of training and testing on Medicare

**IN WITNESS WHEREOF**, the parties, wishing to be bound by the terms and conditions of this Agreement, have affixed their signatures below effective as of the Effective Date.

**CLEVER CARE OF GOLDEN STATE INC.  
COMPANY**

By: \_\_\_\_\_

Name: Britt Travis

Title: Vice President of Sales

Date: \_\_\_\_\_

**PRODUCER (all information must be filled in)**

By: \_\_\_\_\_

Name: \_\_\_\_\_

Phone No.: \_\_\_\_\_

License No.: \_\_\_\_\_

TIN or SSN: \_\_\_\_\_

Email: \_\_\_\_\_

Date: \_\_\_\_\_

**Producer Address:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**EXHIBIT 2**

**2022 COMPENSATION SCHEDULE**

1. **Definitions**

- a. **Initial Enrollment**: an enrollment into a Company MA/MA-PD, as defined by CMS.
- b. **Like Plan Type Change**: a change in enrollment as defined by CMS, including from any MA or MA-PD to another MA or MA-PD.
- c. **MA or MA-PD**: a Medicare Advantage or Medicare Advantage – Prescription Drug Plan.
- d. **Renewal Enrollment**: Occurs where the Member: (i) remains continuously enrolled in the same MA/MA-PD plan in which he/she enrolled as an Initial Enrollment; (ii) makes a Like Plan Type Change; or (iii) as otherwise defined by CMS.

2. **Compensation Amounts**. Effective October 15, 2021, Company shall pay to Producer the following compensation for each enrollment that is effective on or after January 1, 2022, of an Enrollee in a Medicare Product by Producer, subject to the conditions for payment set forth in the Agreement, this Exhibit 2 and pursuant to CMS regulations and guidance. Enrollee enrollment is determined by Company’s and CMS’ records.

<b>COMPENSATION TYPE</b>	<b>2022 COMPENSATION RATE</b>
<b>New-to-Medicare/Age-in member</b>	
- Initial Year	\$715 (2022)
- Following the First Year Anniversary: Renewal Compensation	\$29.83 per month
<b>Existing-to-Medicare member</b>	
- Initial Year	See schedule below
- Renewal Year Compensation	\$29.83 per month

Existing-to-Medicare Compensation Schedule for Initial Year:

Effective Date	Enrollment Months	Initial Year
01/01/2022	12 Months	\$358.00
02/01/2022	11 Months	\$328.17
03/01/2022	10 Months	\$298.34
04/01/2022	9 Months	\$268.51
05/01/2022	8 Months	\$238.68
06/01/2022	7 Months	\$208.85
07/01/2022	6 Months	\$179.02
08/01/2022	5 Months	\$149.19
09/01/2022	4 Months	\$119.36
10/01/2022	3 months	\$89.53
11/01/2022	2 Months	\$59.70
12/01/2022	1 Month	\$29.83

Producer compensation quoted above is for Initial and Renewal Enrollments of Enrollees beginning January 1, 2022, and supersedes all compensation set out in any prior exhibits. Initial and Renewal Enrollment compensation for each subsequent year may change and will be based upon the fair market values as published by CMS for each subsequent year. Initial and Renewal Enrollment compensation will be provided to Producer on Exhibit 2 issued in writing prior to each subsequent calendar year.

3. Conditions for Payment. Subject to the terms and conditions of the Agreement and this Exhibit 2, Company shall make payments to Producer as follows:
  - a. Payment to Producer. Company will pay to Producer compensation due within thirty (30) days following the end of each calendar month based on payments actually received by Company from CMS. However, Company reserves the right to accumulate compensation until compensation due equal at least twenty-five dollars. Producer agrees that to the extent of any indebtedness of Producer to Company, Company may at any time offset any compensation, fees or bonuses accrued or to accrue to Producer against any debt or debts due Company from Producer.

**EXHIBIT 5**

**FMO/BROKER AGENT BINDING AGREEMENT**

\_\_\_\_\_ (“Agent”), hereby agrees to be bound by all of the provisions of the Field Marketing Organization (FMO) Independent Broker Agreement dated as of by and between Applied General Agency, Inc. (“FMO”) and Clever Care Health Plan, Inc. (“Clever Care”) as it has been and may be amended, supplemented, or otherwise modified from time to time, the “Agreement”. Unless otherwise indicated all capitalized terms used but not defined shall have the meaning given to such terms in the Agreement. In connection with the foregoing, all references to “Agent(s)” or “Broker(s)” in the Agreement shall include Agent.

Agent, by executing this Binding Agreement, hereby acknowledges that Agent has read the terms and conditions of the Agreement and agrees to, and shall, be bound, and abide, by all terms, conditions, covenants and obligations applicable to Broker and Agents under the Agreement as of the date set forth below.

Agent, by executing this Binding Agreement also certifies that Agent currently satisfies all of the requirements to be an Agent/Broker as set forth in the Agreement and affirms that Agent will immediately notify FMO and/or Clever Care in the event that Agent no longer satisfies all of the requirements to be an Agent/Broker, or if the representations and warranties set forth in the Agreement that are applicable to Agent are no longer true.

Agent hereby acknowledges that Clever Care shall have the right, at its sole discretion, to remove Agent from providing services under the Agreement if Agent fails to continue to meet the requirements to be an Agent/Broker or if the representations and warranties set forth in the Agreement that are applicable to Agent are no longer true. Agent acknowledges that in the event of such removal, Clever Care will provide written notice of the termination of the Agreement with respect to Agent to both FMO and Agent and that the effect of such termination on any Compensation payable to Agent shall be as described in the Agreement.

FMO Name: Applied General Agency, Inc.

Address: 1040 N Tustin Ave. Anaheim CA 92807

**AGENT**

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Agent License Number: \_\_\_\_\_

Issuing State: \_\_\_\_\_ Expiration Date \_\_\_\_\_

**EXHIBIT 6**  
**INDEPENDENT PRODUCER INFORMATION FORM**

Applied General Agency, Inc.

\_\_\_\_\_

Date		FMO Name
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\_\_\_\_\_

Agent Name	Date of Birth
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\_\_\_\_\_

Tax ID Number/Social Security Number

**General Information**

\_\_\_\_\_

Office Phone	Cell Phone	National Producer No.
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\_\_\_\_\_

Business Address

\_\_\_\_\_

City	State	ZIP Code
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\_\_\_\_\_

Email Address

\_\_\_\_\_

Agent License Number (CA License#)	Additional Language
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**Commission Payout:**       **Pay to FMO**       **Pay to Agent**

I confirm the information provided is accurate to the best of my knowledge.

\_\_\_\_\_

Signature of Applicant/Authorized Officer	Date
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**EXHIBIT 7**

**INDEPENDENT PRODUCER COMMISSION DIRECT DEPOSIT AUTHORIZATION FORM**

**INSTRUCTIONS: Please use only black or blue ink. Initial any corrections.**

**Part I: TYPE OF ACTION** (Please select one of the options)

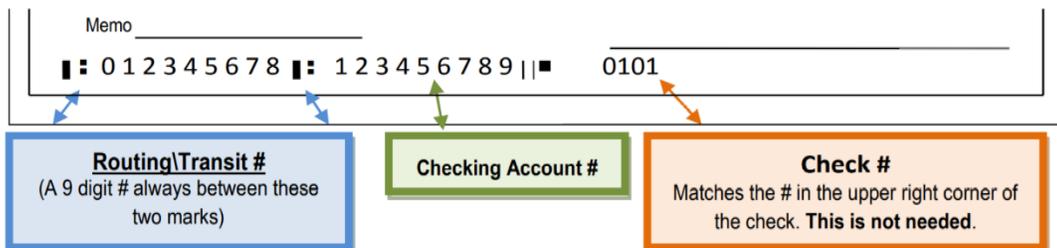
	New direct deposit authorization (Complete part II, III & IV)
	Change financial institution and/or bank account (Complete part II, III & IV)
	Cancellation of direct deposit (Complete part II and V)

**Part II: PAYEE INFORMATION**

Name	
Mailing Address	
City, State & Zip	
Phone number	

**PART III: FINANCIAL INSTITUTION INFORMATION**

Financial Institution Name	
City and state	
Type of Account	<input type="checkbox"/> <b>Checking</b> <input type="checkbox"/> <b>Savings</b>
Routing/Transit #	
Account Number	



**Please include voided check with this form**

**PART IV: AUTHORIZATION FOR NEW OF CHANGED ACCOUNTS**

I authorized Clever Care Health Plan (CCHP) and my financial institution indicated above to make deposits to my account. If funds to which I am not entitled are deposited to my account, I authorize CCHP to direct the financial institution to return such funds and notify me. This authorization will remain in effect until CCHP receives a new authorization from me either changing or cancelling this authorization.

Authorization Signature	
Printed name	
Date	



**PART V: AUTHORIZATION FOR NEW OF CHANGED ACCOUNTS**

I request that Clever Care Health Plan (CCHP) and my financial institution indicated above terminate direct deposits to my account. I understand that it may take 30 days for the cancellation to take effect.

Authorization Signature	
Printed name	
Date	

## EXHIBIT B

### BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (“BA Agreement”) is entered into by and between \_\_\_\_\_, a California \_\_\_\_\_ (“Business Associate”), and **Clever Care of Golden State Inc.**, a Delaware corporation (“Company”). Company and Business Associate are entering into this BA Agreement to address the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, including the changes mandated by the Health Information Technology for Economics and Clinical Health Act (“HIPAA” and “HITECH Act” respectively). Any capitalized term used, but not defined, in this BA Agreement shall have the meaning set forth in the HIPAA Rules. The HIPAA Rules include the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Part 160 and Part 164. The “HIPAA Privacy Rule” is at 45 C.F.R., Part 160 and Part 164, Subparts A and E. The “HIPAA Security Rule” is at 45 C.F.R. Parts 160 and 164. The “HIPAA Breach Notification Rule” is at 45 C.F.R. Part 164, Subpart D.

The parties agree that this BA Agreement supersedes any business associate agreement, addendum, attachment, or other business associate contract terms previously entered by the parties.

Business Associate represents and warrants that it is a duly formed organization and has the full right and legal authority to enter into and fully perform this BA Agreement.

#### A. **Privacy of Protected Health Information.**

1. **Permitted Uses and Disclosures.** Business Associate is permitted to use or disclose Protected Health Information (“PHI”) it creates or receives for or from Company or to request PHI on Company’s behalf only as follows:

- a) **Functions and Activities on Company’s Behalf.** Business Associate is permitted to use and disclose PHI in connection with the performance of services to Company and on Company’s behalf, including provision of tools for Company to conduct a survey to measure the physical and mental conditions of plan members, as specified in an agreement entered into between the parties (“the Agreement(s)”). Business Associate’s use, disclosure or request of Protected Health Information shall utilize a Limited Data Set if practicable. Otherwise, Business Associate will, in its performance of these services, make reasonable efforts to use, to disclose, and to request of a Covered Entity only the minimum amount of Company’s Protected Health Information reasonably necessary to accomplish the intended purpose of the use, disclosure or request. In addition, Business Associate agrees to implement and follow appropriate minimum necessary policies in the performance of its obligations under this BA Agreement and any other Agreement(s) entered by the parties.
- b) **Business Associate’s Operations.** Business Associate may use the Minimum Necessary PHI it creates or receives for or from Company for Business

4. **Indemnity.** Business Associate will indemnify and hold harmless Company and any Company affiliate, officer, director, employee or agent from and against any claim, cause of action, liability, damage, cost or expense, including attorneys' fees and court or proceeding costs, arising out of or in connection with any non-permitted or violating use or disclosure of PHI or other breach of this BA Agreement by Business Associate or any subcontractor, agent, person or entity under Business Associate's control.

G. **Confidentiality.** Business Associate acknowledges that, in the course of providing services to Company, it may have access to Confidential Information of Company. The term Confidential Information shall include, without limitation, provider information, processes, know-how, intellectual property, pricing policies, financial information, or other information, owned by or relating to Company, or which has been acquired by Company under terms limiting or protecting the disclosure thereof. Business Associate acknowledges that Company's Confidential Information is confidential and proprietary and Business Associate shall not disclose the Confidential Information to any third party without the prior written consent of Company. Additionally, Business Associate shall not utilize the Confidential Information for any purpose other than as may be necessary to perform the services for Company which Business Associate was retained to perform. Business Associate shall adopt policies and procedures as may be reasonably necessary to assure the confidentiality and safekeeping of the Confidential Information in its possession. Business Associate will monitor each employee or agent who has access to the Confidential Information and will take all appropriate action to maintain strict security with respect to the Confidential Information.

H. **Amendment to Agreement.** Upon the effective date of any final regulation or amendment to final regulations promulgated by the U.S. Department of Health and Human Services with respect to PHI, this BA Agreement and the Agreement(s) to which it refers will automatically amend such that the obligations they impose on Business Associate remain in compliance with these regulations.

**IN WITNESS WHEREOF,** Company and Business Associate execute this BA Agreement in multiple originals to be effective on the last date written below.

**[Business associate]**

**Clever Care of Golden State Inc.**

By: \_\_\_\_\_

By: \_\_\_\_\_

Print Name: \_\_\_\_\_

Print Name: Britt Travis

Title: \_\_\_\_\_

Title: Vice President of Sales

Date: \_\_\_\_\_

Date: \_\_\_\_\_



**Acknowledgment of Receipt**

**Clever Care Health Plan, Code of Conduct**

I hereby acknowledge that I have received, read and understand the Clever Care Health Plan Code of Conduct. I agree to abide by the Code of Conduct at all times during my relationship with Clever Care Health Plan. I understand that I have a duty to promptly report any known or suspected violation of the Code of Conduct to the Clever Care Health Plan Audit and Compliance Officer. I understand that any violation of the Code of Conduct or any other corporate compliance policy or procedure is grounds for disciplinary action, up to and including termination of my relationship with Clever Care Health Plan. Unless specified below, I am not currently aware of any violation of the Code of Conduct or Compliance Program:

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I certify that I am not aware of any other situation that could represent a potential violation of the Compliance Program or the Code of Conduct.

I hereby certify that I have not been convicted of, or charged with, a criminal offense related to health care, nor have I been listed by a Federal agency as debarred, excluded or otherwise ineligible for participation in any federally funded health care program.

Signature

Date

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Printed Name: \_\_\_\_\_