

1. Introduction

Cambia Health Solutions, Inc. (Cambia) is strongly committed to compliance and ethics. This includes compliance with all laws, regulations, and sub-regulatory guidance that apply to our Medicare Advantage and Part D contracts. To support this commitment for our Medicare line of business, Cambia has established a Medicare Compliance Program, which is implemented and administered by the Medicare Compliance Department. The Medicare Compliance Department reports directly to senior leadership of Cambia and the Board of Directors.

In this document you will find information regarding what you can expect from the Medicare Compliance Program and the role you take to ensure we continually strive for Medicare Compliance; compliance is everyone's responsibility. These Medicare Compliance Principles can be used as a guide and would apply to all individuals who have job duties related to Cambia's Medicare Advantage and Part D plans.

Please note that you will not be retaliated or discriminated against for good faith compliance with our Medicare Compliance Program. However, failure to comply with all laws, regulations, and sub-regulatory guidance that apply to our Medicare Advantage and Part D contracts could subject you to disciplinary action, up to and including termination of your employment.

2. Medicare Compliance Program Description

2.1. Goals and Activities

The purpose of the Medicare Compliance Program is to provide a framework that enables Cambia to continually assess and maintain compliance with the Centers for Medicare & Medicaid Services (CMS) rules and regulations. The Medicare Compliance Program is specifically designed to prevent, detect, and correct noncompliance as well as fraud, waste, and abuse.

The following are some examples of how we try to meet these goals:

- Publicizing standards of conduct and other Medicare compliance policies;
- Providing annual FWA and compliance training and utilizing the other mandated Corporate Compliance focused departmental trainings (HIPAA/Security, Ethics, and fraud, waste, and abuse);
- Communicating CMS regulations and serving as a front-line resource to foster implementations;
- Monitoring and auditing Medicare related operational areas and any functional area with a responsibility for Medicare related business to ensure compliance;
- Providing hotlines and other resources for individuals to report concerns or ask questions regarding Medicare compliance or fraud, waste, and abuse;
- Promptly investigating reported concerns; and
- Reporting on Medicare compliance and fraud, waste, and abuse issues to senior management and the Board of Directors.

2.2. Defining Compliance and Fraud, Waste, and Abuse

It is important to know the definitions for compliance and fraud, waste, and abuse.

- **Compliance**, as it is used in this document, means complying with all Medicare regulations, including guidance through the code of federal regulations (CFR) 42.422 and 42.423, the Managed Care Manual (Part C) and the Medicare Prescription Drug Benefit Manual chapters, Health Plan Maintenance System (HPMS) memos, and other guidance, that CMS instructs us to follow.
- **Fraud** means an intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and that the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or to some other person;
- **Waste** is the inappropriate utilization and/or inefficient use of resources;
- **Abuse** occurs when an individual or entity unintentionally provides information to Medicare which results in higher payments than the individual or entity is entitled to receive.

2.3. Cooperation with Other Departments

The Medicare Compliance Department cannot ensure compliance and prevent fraud, waste, and abuse on its own. Individual engagement in the Medicare Compliance Program is critical. The Medicare Compliance Department works regularly with operational areas and partners with other departments to implement the Medicare Compliance Program. Some of those departments are the following:

- Ethics and Compliance, which develops and administers Cambia's Code of Business Conduct and Conflict of Interest disclosure process.
- The External Audit and Investigations Department, which is primarily responsible for detecting, preventing and correcting external fraud.
- Human Resources, which enforces disciplinary standards internally.
- Privacy and Security Departments, which develop and administer both non-electronic and electronic personal health information;
- Internal Audit, which audits operations to ensure compliance.

2.4. Non-Intimidation and Non-Retaliation for Good Faith Reporting of Compliance or Fraud, Waste, and Abuse Issues

A key part of Cambia's Medicare compliance program is our policy of non-retaliation and non-intimidation for individuals who report a compliance or fraud, waste, or abuse concern. You can rely on our commitment of non-retaliation and non-intimidation when you report a potential issue. Any individual who retaliates against or intimidates an individual who, in good faith, reports a compliance or fraud, waste, or abuse concern is subject to disciplinary action up to, and including, termination.

2.5. Responding to Reported Compliance or Fraud, Waste, or Abuse Issues

Cambia provides several different options for reporting compliance and fraud, waste, and abuse issues. The Medicare Compliance Department, Ethics & Compliance Department, and External Audit and Investigations Department all provide anonymous and confidential reporting hotlines and other resources. Please see the *Report Compliance and Fraud, Waste, and Abuse Issues*, section 3.5, for details.

These departments promptly respond to compliance and fraud, waste, and abuse issues as they are raised or discovered and ensure that the resulting issues, investigations and resolutions are documented. Specific issues and/or trends are reported to senior leaders, the Board of Directors, and/or law enforcement as appropriate.

2.6. Examples of Compliance and Fraud, Waste, and Abuse Issues

Examples of unethical and illegal behavior can be found in the Code of Business Conduct. The following are some examples of non-compliant or fraudulent, wasteful, or abusive behavior:

- Intentionally failing to report unresolved member complaints to the Appeals and Grievances Department.
- Ignoring requests for urgent appeals and processing them as standard appeals.
- Manipulating date stamps on enrollment applications or other documents subject to timeliness standards to improve personal performance.
- Intentionally providing misleading information to prospective members to secure their applications.
- Assisting with the manipulation of claims to wrongfully increase reimbursement.
- Advising members who permanently move out of a service area on methods to inappropriately retain coverage.

3. What We Expect From You

In order to be effective, Cambia's Medicare Compliance Program requires participation and commitment from all levels of the organization.

3.1. Follow Policies and Procedures

Know where to find your departmental policies and procedures and read the ones that apply to your job duties. Look for accurate descriptions of your workflow; they should be updated at least annually or when there are changes in CMS regulations.

3.2. Engage in Training

FDRs and FDR employees involved in the administration or delivery of benefits for Medicare Advantage and Part D plans, are required to take compliance and FWA training within 90 days of hire and annually thereafter, as well as Ethics and Code of Business Conduct compliance. You are also required to take specialized training on issues posing compliance risks based on your job functions.

3.3. Know your Resources

Familiarize yourself with appropriate resources, such as the CMS manuals, your departmental policies and procedures, and the Medicare Compliance Department. Ask your supervisor or the Compliance Department for clarification or if you have a question.

3.4. Cooperate Fully

Monitoring and auditing of operational areas are constant and necessary to maintain an effective compliance program. Your commitment to supporting these activities is essential.

3.5. Report Compliance, Privacy/Security, Ethical and Fraud, Waste, and Abuse Issues

You are required by CMS to report compliance or fraud, waste, or abuse issues as well as to assist in the resolution of reported issues. If you identify any issue involving compliance or fraud, waste, or abuse, please report it through one of the following ways:

For questions or concerns related to Government Programs compliance, please call the Compliance Department anonymous and confidential line at 877-878-2273 or send an email to Regence_MedicareCompliance@Regence.com.

Ethics can be reached via an anonymous resource line: (888) 384-3577 or send an email to eco@cambiahealth.com.

Privacy concerns may be sent to privacy_office@cambiahealth.com or call 503-225-6994.

For potential fraud, waste, and abuse questions or concerns, call the External Audit & Investigations Department at 800-323-1693.

For suspected security incidents contact the Cambia IT Enterprise Support Center (ESC) at 877- 372-8223.