Summit Health Plan, Inc.
Medicare
Compliance Plan

Updated June 2023

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MEDICARE COMPLIANCE PLAN GOVERNANCE

The Medicare Compliance Plan ("Plan") is approved by the Board of Directors for Summit Health Plan, Inc. ("Summit Health" or "Company") that holds contracts with the Centers for Medicare & Medicaid Services ("CMS"). The Plan is reviewed at least annually by the Medicare Compliance Officer and updated as appropriate. Material changes are approved by the Board of Directors.

The Plan is a component of Summit Health's Medicare Compliance Program and reinforces the Company's commitment to comply with all applicable Federal and State regulations as well as ethical standards of conduct. Summit Health's Medicare Compliance Program includes the Code of Business Conduct ("Code"), which is endorsed by Summit Health's Chief Executive Officer ("CEO") and approved by the Board of Directors.

Summit Health makes this Medicare Compliance Plan available to any employees and Board of Directors, as well as contractors and delegated entities. The Medicare Compliance Officer reserves the right to amend and update components of the Medicare Compliance Program, including the material in this Medicare Compliance Plan, at any time in order to comply with regulatory guidance or make enhancements to improve the program's effectiveness.

The information contained in this Medicare Compliance Plan, including names and titles of any Summit Health employees, is correct as of the date of publication and may change without prior notice.

For the purposes of this Medicare Compliance Plan, the term "Medicare programs" includes the Medicare Advantage ("MA") and Part D Prescription Drug ("Part D") lines of business.

Any Summit Health employees, contractors, and delegated entities as well as the Summit Health Board of Directors must read and understand the content of this Medicare Compliance Plan and any associated policies and procedures.

Contractors and delegated entities have the option to:

1. Adopt Summit Health's Code of Conduct, Medicare Compliance Plan, and associated Medicare compliance and fraud, waste, and abuse policies and procedures; or
2. Develop and follow their own code of conduct, compliance plan, and/or equivalent policies and procedures that describe their commitment to comply with applicable laws and regulations.

If a contractor or delegated entity follows a code of conduct, compliance plan, and/or equivalent policies and procedures not developed by Summit Health, the Company reserves the right to review and approve these documents.

Please contact the Medicare Compliance Officer if you have questions regarding the Medicare Compliance Program or the information contained in the Medicare Compliance Plan.

MEDICARE COMPLIANCE PLAN

Summit Health recognizes the problems that both intentional and accidental misconduct in the health insurance industry can cause beneficiaries. To demonstrate its commitment to compliance and to ensure that it operates in accordance with all applicable State and Federal laws, Summit Health has developed this Medicare Compliance Plan applicable to its Medicare Advantage (Part C) and Medicare Prescription Drug (Part D) plans.

The Medicare Compliance Officer developed this Medicare Compliance Plan in accordance with guidance from applicable State and Federal regulations. As part of this plan, Summit Health promotes full compliance with all legal duties applicable to it, assures ethical conduct, and provides guidance to any Summit Health employee, Director, contractor and delegated entity regarding the appropriate standards of conduct. The procedures and the standard of conduct contained in this plan are intended to generally define the scope of conduct which the Plan is meant to cover and are not to be considered all inclusive.

This Plan is intended to prevent intentional and accidental noncompliance with applicable laws, to detect noncompliance if it occurs, to discipline those involved in noncompliant behavior, and to prevent future noncompliance. The Medicare Compliance Plan is an active document and will be updated periodically to keep employees and others (as applicable) informed of the most current information available pertaining to compliance requirements. The most recent version is made available on the Summit Health internet site, www.yoursummithealth.com.

This Medicare Compliance Plan is created with the knowledge and approval of Summit Health senior leadership and the Board of Directors.

DEFINITIONS

These terms have the following meaning throughout this plan:

1. **Abuse** - occurs when an individual unintentionally takes an action that may, directly or indirectly, result in unnecessary costs to the Medicare program by causing the individual or entity to receive a higher payment than he, she, or it is entitled to receive.
2. **Claim –** includes any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States Government provides any portion of the money or property which is requested or demanded, or if the Government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.
3. **Contractor** – means any entity that provides services to Summit Health pursuant to the terms of a written agreement. Additionally for the purposes of this plan, the term contractor includes subcontractors with whom the contractor subcontracts work relating to the Medicare Advantage (Part C) and/or Prescription Drug (Part D) plans. This term shall expressly include, but not be limited to first tier, downstream, and related entities.
4. **Delegated Entity** – means any entity that Summit Health determines meets the definition of a first tier, downstream, or related entity. See First Tier Entity, Downstream Entity, and Related Entity definitions for additional detail.
5. **Downstream Entity –** as defined by 42 C.F.R. §423.501, means any party that enters into an acceptable written arrangement below the level of the arrangement between Summit Health and a first tier entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
6. **Employee** – means any full time, part time, or temporary employee of Summit Health who works directly or indirectly on the Medicare Advantage and/or Prescription Drug (Part D) plans. Additionally for the purposes of this plan, the term employee includes Summit Health volunteers who work directly or indirectly on the Medicare Advantage and/or Prescription Drug (Part D) plans.
7. **Federal Health Care Offense** – means a violation of, or a criminal conspiracy to violate any of the provisions set forth under Section II.A. if the violation or conspiracy relates to a health care benefit program.
8. **Federal Health Care Program** – as defined at 18 U.S.C. §241320a-7b(f), includes any plan or program that provides health benefits to any individual, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or state health care program, including but not limited to, Medicare, Medicaid, CHAMPUS, Veterans Administration, Federal Bureau of Prisons, and Indian Health Service, but not excluding the Federal Employees Health Benefit Program.
9. **First Tier Entity** – as defined by 42 C.F.R. §423.501, means any party that enters into a written arrangement with Summit Health to provide administrative services or health care services for a Medicare eligible individual.

10. **Fraud** – means an intentional deception or misrepresentation that the person 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 herself, himself, or some other person.
11. **Health Care Benefit Program** – as defined at 18 U.S.C §24(a), includes any public or private plan or contract for the provision of any medical benefit, item, or service to any individual.
12. **Knowingly** – as defined in 31 U.S.C §3729(b), means that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.
13. **Related Entity** – as defined by 42 C.F.R. §423.501, means any entity that is related to Summit Health by common ownership or control and;
    a. Performs some of Summit Health's management functions under contract or delegation;
    b. Furnishes services to Medicare enrollees under an oral or written agreement; or
    c. Leases real property or sells materials to Summit Health at a cost of more than $2,500 during a contract period.
14. **Waste** – means the inappropriate or inefficient utilization of services or resources.

I. COMPLIANCE POLICIES AND PROCEDURES AND STANDARD OF CONDUCT

Summit Health employees, Directors, contractors, and delegated entities must comply with all applicable State and Federal laws and regulations and standards of conduct. In addition, any Summit Health employees and Directors must comply with internal policies and procedures, including but not limited to the Summit Health Code of Conduct.

A. Applicable Federal Laws and Regulations

Summit Health employees, Directors, contractors and delegated entities are expected to comply with the following laws and regulations. Failure to comply will be deemed noncompliance with such requirements.

1. **Social Security Act (42 U.S.C. §1395)**

   Summit Health, its employees, Directors, contractors, and delegated entities shall not violate the provisions governing the administration of the Medicare Choice (Part C) ("Medicare Advantage") and Medicare Prescription Drug (Part D) program.

2. **False Statements Relating to Healthcare Matters (18 U.S.C. §1035)**

   Summit Health, its employees, Directors, contractors, and delegated entities shall not knowingly and willfully make or use any false, fictitious, or fraudulent statements, representations, writings or documents, regarding a material fact in connection with the delivery of, or payment for, health care benefits, items or services. No Summit Health employee, Director, contractor, or delegated entity may knowingly falsify, conceal or cover up a material fact by a trick, scheme or device.

3. **False Claims Act (31 U.S.C §3729(a))**

   Summit Health, its employees, Directors, contractors, and delegated entities shall not:

   a. Knowingly file a false or fraudulent claim for payments to a governmental agency, or health care benefit program;
   b. Knowingly use a false record or statement to obtain payment on a false or fraudulent claim from a governmental agency or health care benefit program; or,
   c. Conspire to defraud a governmental agency or health care benefit program by attempting to have a false or fraudulent claim paid.

4. **Criminal False Claims Act (18 U.S.C §286, 287)**

   Summit Health, its employees, Directors, contractors, and delegated entities shall not knowingly make any false, fraudulent, or fictitious claim against a governmental agency or health care benefit program. Conspiring to defraud a governmental agency or health care benefit program is also prohibited.

5. **Criminal Wire and Mail Fraud (18 U.S.C. § 1341, 1434)**

   Summit Health, its employees, Directors, contractors, and delegated entities shall not devise a scheme to defraud a governmental agency or health care benefit program, which uses the U.S. Postal Service, private postal carriers, wire, radio, or television to perpetrate the fraud. This includes any writings, signs, signals, pictures, or sounds for the purpose of executing such scheme or artifice.

6. **Criminal False Statement Act (18 U.S.C. §1001)**

   Summit Health, its employees, Directors, contractors, and delegated entities shall not knowingly and willfully falsify or make any fraudulent, false or fictitious statement against a government agency or health care benefit program.

7. **Theft or Embezzlement in Connection with Health Care (18 U.S.C §669)**

   Summit Health, its employees, Directors, contractors, and delegated entities shall not embezzle, steal or otherwise, without authority, convert to the benefit of another person, or intentionally misapply money, funds, securities, premiums, credits, property, or other assets of a health care benefit program.

8. **Obstruction of Criminal Investigations of Health Care Offenses (18 U.S.C. §1518)**

   Summit Health, its employees, Directors, contractors, and delegated entities shall not willfully prevent, obstruct, mislead, delay, or attempt to prevent, obstruct, mislead or delay the communication of information or records relating to a violation of a federal health care offense to a criminal investigator.

9. **Criminal Conspiracy (18 U.S.C § 371)**

   Summit Health, its employees, Directors, contractors, and delegated entities shall not conspire to defraud any governmental agency or health care benefit program in any manner or for any purpose.

10. **Money Laundering Acts (18 U.S.C. §1956)**

    Summit Health, its employees, Directors, contractors, and delegated entities shall not use any income obtained from mail or wire fraud to operate any enterprise. In addition, its employees, Directors, contractors, and delegated entities shall not use the proceeds of wire or mail fraud in financial transactions, which promote the underlying fraud.

11. **Health Care Fraud (18 U.S.C. §1347)**

    Summit Health, its employees, Directors, contractors, and delegated entities shall not knowingly or willfully execute or attempt to execute, in connection with the delivery of, or payment for, health care benefits, items or services, a scheme or artifice to:

    - Defraud any health care benefit program; or
    - Obtain, by means of false or fraudulent pretense, representation, or promise any of the money or property owned by or under the custody or control of any health care benefit program.

12. **Law Applicable to Recipients of Federal Funds**

    Summit Health, its employees, Directors, contractors, and delegated entities will not knowingly or willfully fail to comply with laws that prohibit discrimination in programs, activities and facilities that receive federal funds. Summit Health will comply with the following laws:

    - Title VI of the Civil Rights Act of 1964 (and pertinent regulations at 45 CFR §84);
    - 504 of the Rehabilitation Act of 1973;
    - The Age Discrimination Act of 1975 (and pertinent regulations at 45 CFR § 91); and
    - The Americans with Disabilities Act.

B. Summit Health Policies and Procedures

Summit Health, any employees, its Directors, contractors, and delegated entities shall comply with the requirements and standards set forth by CMS and applicable to the Medicare Advantage (Part C) and/or Medicare Prescription Drug (Part D) products offered by Summit Health. Such requirements may be amended from time to time.

Summit Health may have in place additional policies and procedures which address compliance practices, including policies which govern the administration of the Medicare Compliance Program and related requirements specified in this plan. The Medicare Compliance Officer works with any operational areas or delegates to develop new or revise existing policies and procedures when any

changes are made to the applicable laws and regulations. All Medicare-related polices shall be subject to review annually.

Summit Health's makes Medicare compliance policies and procedures available to employees, Directors, contractors, and delegated entities.

C. Summit Health Code of Conduct

Summit Health has adopted a Code of Conduct, which is intended to serve as a guide by which Summit Health employees (if any) and Directors shall conduct themselves to protect and promote Company-wide integrity. The Code of Conduct is designed to assist all Summit Health employees and Directors in carrying out their daily responsibilities according to the appropriate legal and ethical standards. However, the Code of Conduct cannot encompass all legal and ethical standards, and is not a substitute for each employee or Director's good judgement and sense of honesty, integrity, and fairness.

The Code of Conduct is intended to be easily understood. In some instances, the Code of Conduct deals fully with the subject-matter in question. In many cases, however, the subject is sufficiently complex that additional guidance is necessary to provide adequate direction. Consequently, the Code of Conduct is designed to be supplemented by this Medicare Compliance Plan and any applicable corporate policies and procedures. The Code of Conduct is made available to any Summit Health employees.

The Code of Conduct is also available to all Directors, contractors, and delegated entities. The Summit Health Board of Directors reviews the Code of Conduct in the event that any material changes are proposed and annually. Summit Health provides a copy of the Code of Conduct annually to all contractors and delegated entities. It is also made available on the Summit Health internet site, www.yoursummithealth.com. Summit Health contractors and delegated entities may adopt Summit Health's Code of Conduct or demonstrate that they have a comparable corporate Code of Conduct that is available to all of the contractor's or delegate entity's employees.

II. COMPLIANCE OFFICER, COMPLIANCE COMMITTEE AND HIGH LEVEL OVERSIGHT

A. Medicare Compliance Program

Leadership of and responsibility for the Summit Health Medicare Compliance program consists of the Medicare Compliance Officer, Board of Directors and Compliance Committee. The program elements include education and training, routine auditing and monitoring to detect noncompliance, investigation into any allegations of noncompliance, and corrective steps and measures when any items of noncompliance are detected and reporting to the appropriate investigative or regulatory entities when noncompliance is found.

B. Medicare Compliance Officer

The Medicare Compliance Officer has a direct line of communication to the Board of Directors and CEO. The Medicare Compliance Officer is responsible for reporting any material issues of noncompliance to the Board and/or CEO. The Board will review and approve any proposed termination or material change in the duties of the Medicare Compliance Officer. The Medicare Compliance Officer must be an employee of Summit Health, a parent of Summit Health or a corporate affiliate. His or her responsibilities may not be delegated to a first tier or downstream entity.

The Medicare Compliance Officer is responsible for implementing the Medicare Compliance Plan, and has the authority to review all compliance records.

Consistent with CMS guidance, the role of the Medicare Compliance Officer shall include, but not be limited to, the following categories of activities:

- Providing regulatory interpretation and guidance regarding Federal regulations and CMS manuals;
- Creating and coordinating training programs to ensure the Summit Health Directors, employees, contractors, delegated entities, and other third parties are knowledgeable about the Medicare Compliance Program, Medicare compliance policies and procedures, and applicable statutory and regulatory requirements;
- Developing and implementing programs that encourage any employees to report Medicare program noncompliance or potential FWA;
- Coordinating with any Special Investigations Unit (SIU) to address reports of potential or identified issues of FWA;

- Promptly investigating and documenting each report of potential FWA or noncompliance received and reporting the same when appropriate to CMS or its designee;
- Implementing new or updated Medicare requirements, such as tracking HPMS memos from receipt to implementation and monitoring to confirm appropriate and timely implementation of such required changes;
- Overseeing the development, implementation and monitoring of corrective action plans; and
- Recommending policy, procedure, and process changes, as needed, to maintain compliance with CMS requirements.

Questions regarding the appropriateness or legality of certain conduct, as well as the nature of the Medicare Compliance Program should be directed to the Medicare Compliance Officer.

The Medicare Compliance Officer will prepare compliance reports for the Board and Summit Health senior leadership and will maintain records of compliance violations, except in those instances where compliance is specifically delegated to another individual or department. In addition, the Medicare Compliance Officer shall provide regular reports to Board on Medicare Compliance Program developments, initiatives, audits, risks, and corrective action measures.

C. Compliance Committee

The Compliance Committee is chaired by a member of the Summit Health Board of Directors or the Compliance Officer. The Medicare Compliance Officer reports to the Committee on the status of the Medicare Compliance Program, CMS audit results, CMS sanctions, warnings and penalties, reports of Medicare noncompliance, and risk determinations. Additionally, the Medicare Compliance Officer provides material changes to the Medicare Compliance Plan to the Committee for review and approval.

The Committee reviews the effectiveness of the Medicare Compliance Program through self-audits and monitoring metrics and key indicators and to ensure prompt and effective corrective actions are taken where deficiencies are noted. The Committee and Medicare Compliance Officer are responsible for escalating compliance deficiencies and ongoing issues of noncompliance to senior leadership, the CEO, and the Board of Directors.

The Medicare Compliance Officer reports regularly to senior management regarding any noncompliance issues including but not limited to failures to comply with CMS requirements, misconduct, and fraud brought before the Compliance Committee. If such issues require urgent action involving senior management, the Medicare Compliance Officer will notify senior management immediately. In addition, the Medicare Compliance Officer will regularly advise the Summit Health Board of Directors of ongoing developments relating to Medicare compliance matters, including audit findings and any identified noncompliance, with recommendations for dealing with such noncompliance if it warrants Board involvement.

D. High Level Oversight

The Summit Health Board of Directors is responsible for the oversight of the Medicare Compliance Program to ensure that Summit Health is upholding its commitment to compliant, lawful, and ethical conduct and to the Medicare Program. This oversight requires the Board of Directors to be knowledgeable about, and either approve or delegate approval, of the content and operation of the Medicare Compliance Program, Code of Conduct, Medicare compliance policies and procedures, and all applicable statutory and regulatory requirements.

The Directors, or their designees, are responsible for the review of quarterly reports provided by the Medicare Compliance Officer on the activities and status of the Medicare Compliance Program, including issues of noncompliance identified, investigated, and resolved; outcomes and effectiveness; results of internal and external audits; exclusion list matches; root cause analyses and corrective action plans; Notices of Non-Compliance, Warning Letters, and formal sanctions; fraud, waste, and abuse goals and actions; and risk assessment and reduction activities.

The Directors grant authority to the Medicare Compliance Officer to provide the Board and Summit Health Senior Leadership with in-person reports, depending upon the urgency and significance of the noncompliance. The Directors delegate authority to the Medicare Compliance Officer to implement corrective action plans and supplemental activities to ensure Summit Health maintains compliance with its contract with CMS and all applicable federal and state regulations without waiting for their approval.

The Board of Director meeting minutes and related documents provide evidence of its active engagement in the oversight of the Medicare Compliance Program and include documentation of the Board's questions, follow-up on issues, and actions taken to ensure an effective Medicare Compliance Program.

III. COMPLIANCE EDUCATION AND TRAINING

A. Overview

Summit Health reviews its Medicare Compliance Plan on an annual basis or more often as needed to ensure continued compliance with applicable regulations or to address specific concerns. In the event of a significant change to the Medicare Compliance Plan Summit Health shall ensure Company-wide notification of those changes. The notification will include the contact information for the Medicare Compliance Officer in the event of any employee or Director questions. Additionally, any significant change in the Medicare Compliance Plan will be communicated to all contractors and delegated entities if changes are made following the annual provision of the Medicare Compliance Plan to said parties.

B. General Training

Any new employees and newly appointed governing body members will receive training on the Summit Health Medicare Compliance Program, Code of Conduct, and Medicare compliance and fraud, waste, and abuse (FWA) policies. Such training shall be provided within thirty (90) days of hire and annually thereafter. The Summit Health Board of Directors and any existing employees receive training annually on the Medicare Compliance Program, Medicare Compliance Plan, Code of Conduct, and Medicare compliance and FWA policies. Summit Health's training incorporates both internal content and content from the CMS published training for compliance and FWA available through the Medicare Learning Network (MLN) website.

C. Specific Issue-Based Training

If Summit Health identifies specific issues of noncompliance within the organization, the Medicare Compliance Officer, or his or her designee, will provide training designed to prevent recurrence of such issues. Such training may be mandatory for a subset or all employees or Directors, as appropriate.

D. Training of Contracted Entities

With the exception of providers, contractors and delegated entities, including their respective office staff and other employed personnel, must complete fraud, waste, and abuse training within 90 days of entering into a contract with Summit Health, and annually thereafter. Contractors and delegated entities may administer internally developed training that includes content consistent with Summit Health published training. Summit Health reserves the right to review any internally developed compliance and/or FWA training to ensure it meets the minimum CMS requirements. Summit Health may request documentation evidencing that the training was completed by the contractor or delegated entity.

If a contractor or delegated entity chooses not to develop internal training, the contractor or delegated entity may provide available CMS compliance and FWA training or adapt Moda Health training.

IV. EFFECTIVE LINES OF COMMUNICATION

A. Effective Lines of Communication among the Medicare Compliance Officer, Compliance Committee, Employees, Governing Body, and Delegated Entities

Summit Health works diligently to foster a culture of compliance throughout the Company by regularly communicating the importance of performing in compliance with regulatory requirements and reinforcing the Company's expectation of ethical and lawful behavior. Consistent with this corporate culture, Summit Health's Code of Conduct and policies and procedures require any employees, Directors, contractors, and delegated entities to report compliance concerns and suspected or actual violations of State or Federal law and CMS regulations related to the Medicare Advantage (Part C) and Prescription Drug (Part D) program.

Summit Health has systems in place to receive, record, and respond to compliance questions or reports of potential or actual noncompliance from any employees, members, Directors, contractors, and delegated entities. The reporting mechanisms in place allow individuals to report issues in an anonymous manner (through EthicsPoint and a toll-free Compliance hotline) or directly to the Medicare Compliance Officer. The new hire and annual Medicare compliance and fraud, waste, and abuse training includes the reporting requirements and the available methods of reporting.

B. Reporting of Compliance Issues

Each Summit Health employee (if any), Director, contractor and delegated entity has an obligation to report compliance issues and assist Summit Health in any related investigation or corrective action. Any suspected or known violation of a Summit Health policy, Medicare regulation, and/or applicable State or Federal law should be reported. This reporting obligation applies equally to noncompliant actions taken by peers, supervisors, management, Directors, contractors, and delegated entities. Individuals may contact the Medicare Compliance Officer via any of the mechanisms set forth in this plan if a question exists as to whether or not certain actions or conduct is noncompliant.

Summit Health employees (if any), Directors, contractors, and delegated entities may report compliance issues directly to the Medicare Compliance Officer by phone at <855-801-2991> or by email to medicarecompliance@yoursummithealth.com. Individuals may receive follow-up communications from the Medicare Compliance Officer, or his or her designee, as needed to identify and research reports.

Summit Health will strive to maintain the anonymity of the individual who reports potential, suspected, and confirmed noncompliance using any of the methods listed above. However, in some circumstances,

Summit Health may not be able to maintain an individual's anonymity during the course of the investigation. Summit Health has a no tolerance policy for retaliation against individuals who make good faith reports of potential, suspected, or confirmed noncompliance. In the event that an individual's identity cannot be kept confidential, Summit Health will ensure that the individual does not experience retaliation as a result of the report. Any attempt to retaliate against an individual who makes a good faith report will be disciplined by Summit Health up to and including termination of the individual in violation of the anti-retaliation policy.

C. Anonymous Hotline for Reporting Compliance Issues

Summit Health employees (if any), members, Directors, contractors, delegated entities, and other parties may report suspected compliance violations anonymously through EthicsPoint (1-866-294-5591 or www.ethicspoint.com). This is staffed by non-Summit Health employees. EthicsPoint summarizes all reports and directs them to the appropriate individual(s) within Summit Health for investigation and resolution.

The use of EthicsPoint allows individuals to:

- Report violations without fear of retaliation;
- Report suspected violations on a confidential basis;
- Report violations anonymously, but with the understanding that anonymity is not always possible; and
- Communicate violations or compliance questions via phone call or email.

The use of EthicsPoint also creates a tracking system which documents the receipt of all suspected violations, and creates a system generated referral to Summit Health for full investigation and resolution.

V. DISCIPLINARY STANDARDS

A. Summit Health Handbook

Summit Health publishes a handbook annually that contains the Summit Health Code of Conduct, disciplinary standards, non-retaliation policy, and other applicable policies regarding the consequences for failure to comply with State and Federal Law, regulatory requirements, and Summit Health policies and procedures.

Summit Health disseminates this handbook to any new hires at the time of hire and to any existing employees annually thereafter. The Company requires any employees to read the handbook and confirm their understanding of the requirements contained therein annually through an attestation process.

The handbook, including the Summit Health Code of Conduct and all related disciplinary standards, as well as all policies and procedures related to Medicare Compliance and fraud, waste, and abuse (FWA) are available to any employees at any time.

Summit Health conducts annual training on the Medicare Compliance Program and the detection and prevention of FWA. This training reinforces Summit Health's expectation that any employees conduct themselves in an ethical and compliant manner at all times. The annual training includes the disciplinary measures that Summit Health will take up to, and including, termination of employment and/or contract.

VI. MONITORING, AUDITING, AND IDENTIFICATION OF COMPLIANCE RISKS

A. Risk Assessment and Monitoring

The Medicare Compliance Officer performs an annual risk assessment that includes an assessment of the various ways misconduct, noncompliance, fraud, waste and abuse can occur or has occurred by and against Summit Health. The risk assessment also considers Summit Health's ability to deter or remediate potential noncompliance that may have circumvented existing control activities. The results of the risk assessment are reported to the Compliance Committee, along with appropriate recommendations for additional education, delegate entity oversight, system edits or enhanced auditing and monitoring efforts.

Monitoring and auditing are critical elements in the Medicare Compliance Program. It allows Summit Health to identify areas that require corrective action in order to achieve compliance with specific Medicare regulatory requirements. This process of self-identification and corrective action, along with monitoring to ensure that such actions are effective, are crucial to the success of this Program.

The Medicare Compliance Officer, or designee(s), conducts regular auditing and monitoring to ensure adherence to Medicare regulations, Centers for Medicare and Medicaid Services (CMS) guidance, contractual provisions, applicable Federal and State laws, as well as internal policies and procedures. An audit work plan is developed annually based upon a formal risk assessment and sets forth the audits to be performed, audit schedules, and methodology. The Medicare Compliance Officer, or his or her designee, conducts corrective actions and follow up activities which may include reporting of such findings to CMS. The Medicare Compliance Officer also provides updates on monitoring and auditing to the Compliance Committee, Senior Leadership and the Board of Directors.

B. Audits of the Summit Health Compliance Program

Annually, Summit Health either (1) contracts with an independent third party or (2) employs an internal team that is independent of the Compliance department, to audit the effectiveness of the Medicare Compliance Program and adherence to CMS standards. The Medicare Compliance Officer reports the results of the audit to the Compliance Committee, senior leadership and the Board of the Directors.

C. Monitoring and Auditing Delegated Entities

Summit Health is responsible for the lawful and compliant administration of Medicare Advantage (Part C) and Prescription Drug (Part D) benefits under its contracts with CMS, regardless of whether Summit Health delegates some of this responsibility to another individual and/or entity. Summit Health shall monitor and audit its First Tier entities to ensure that they are in compliance with all applicable laws and regulations, and to ensure that the First Tier entities monitor the compliance of the entities with which they contract ("Downstream" entities). Summit Health performs a risk assessment to identify its high, medium, and low risk First Tier entities and selects a reasonable number of First Tier entities to audit annually. Monitoring of First Tier entities for Medicare Compliance Program requirements must include an evaluation to confirm that the First Tier Entity applies appropriate Medicare Compliance Program requirements to Downstream entities with which it contracts. If a First Tier entity performs its own audit, Summit Health shall obtain a summary of the audit results that relate to the services the First Tier entity performs.

When corrective action is needed as a result of either issues identified by Summit Health or the delegated entity in its internal process, Summit Health works with the delegated entity to ensure it takes appropriate corrective actions. Summit Health monitors the efficacy of corrective actions through continued monitoring and reporting from the delegated entity, as appropriate.

D. Tracking and Documenting Medicare Compliance Program Effectiveness

Summit Health tracks and documents Medicare compliance efforts to show the extent to which operational areas and delegated entities meet Medicare compliance goals. The Medicare Compliance Officer, or his or her designee, tracks the compliance of operational areas and reports any findings to the Compliance Committee and senior leadership. Identified issues of noncompliance identified are shared with the Compliance Committee and senior leadership.

E. OIG/SAM Exclusion

Summit Health reviews the Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the System for Award Management Exclusion List (formerly the GSA Excluded Parties Lists System) prior to the hiring or contracting of any new employee, temporary employee, volunteer, contractor, delegated entity, or Board member, and monthly thereafter, to ensure that no person or entity is excluded or becomes excluded from participation in federal programs. Summit Health may conduct initial background checks to review potential employees' and Directors' backgrounds for OFAC exclusions. Summit Health may examine additional screenings for criminal convictions, OIG and GSA exclusion lists, and other background records prior to employing an individual or appointing a Director.

For persons or entities determined to be delegated entities, Summit Health determines the appropriate party, Summit Health or the delegated entity, to conduct and track the monthly OIG and SAM screening. If the delegated entity maintains this responsibility, the Compliance Officer requires annual attestations from the delegated entity to confirm the completion of the screenings. Additionally, Summit Health conducts audits of delegated entities based on the annual Delegated Entity Risk Assessment to review the documentation evidencing the completion of the monthly screenings.

F. Audits of Summit Health by CMS or its Designee

Summit Health views regulatory audits as an opportunity to confirm the effectiveness of its ongoing Medicare compliance efforts and to identify areas for improvement. In cases where an audit outcome indicates Summit Health failed to meet regulatory requirements, the Medicare Compliance Officer works with the relevant operational areas to develop corrective action plans to address identified deficiencies.

Summit Health will fully cooperate with the Centers for Medicare and Medicaid Services (CMS) and any auditors acting on behalf of the Federal government in conducting audits, including onsite audits and audits of financial records. Summit Health requires its contractors and delegated entities to provide records to CMS upon request. Summit Health allows access to all documentation and records for audits and maintains all records for ten (10) years.

The Medicare Compliance Officer serves as the point of contact for all audits related to the Medicare Advantage (Part C) and Prescription Drug (Part D) program and will coordinate auditor requests with any internal operational areas and delegated entities as necessary.

VII. RESPONSE TO COMPLIANCE ISSUES AND ENFORCEMENT ACTIONS

A. Overview

Summit Health takes its commitment to the Code of Conduct and this Medicare Compliance Plan seriously. In the event of a violation of the Code of Conduct, Medicare Compliance Program, Summit Health policies and procedures, or any applicable State or Federal laws and regulations, Summit Health takes appropriate and immediate investigative and corrective action.

If Summit Health determines that unethical behavior or noncompliance with this Plan, the Code of Conduct, or any applicable law or regulation occurred, Summit Health provides for timely, consistent, and effective enforcement of the standards and promptly undertakes the development of a corrective action plan designed to correct the identified violation and prevent recurrence of similar violations.

Summit Health may identify the incident of noncompliance through a variety of sources, such as self-reporting channels, Centers for Medicare and Medicaid Services (CMS) audits, internal auditing and monitoring activities, hotline calls, external audits, and/or member complaints. Whenever Summit Health identifies an incident of potential or actual misconduct, noncompliance, or fraud, waste or abuse (FWA), the Company takes prompt action to reduce the potential for recurrence and ensure ongoing compliance with CMS requirements.

B. Investigations of Suspected Noncompliance

The Medicare Compliance Officer, or his or her designee, is responsible for reviewing cases of suspected or actual misconduct or noncompliance related to the Medicare Advantage (Part C) and Prescription Drug (Part D) programs and, when applicable, for disclosing such incidents to the Centers for Medicare and Medicaid Services (CMS). Due to the complex nature of some of the cases, particularly fraud investigations, the Medicare Compliance Officer may delegate all or a portion of this responsibility to the appropriate internal subject matter area expert(s).

The Medicare Compliance Officer, or his or her designee, promptly investigates any conduct that may be inconsistent with this Medicare Compliance Plan, Code of Conduct, Summit Health policy or procedure, or any applicable State or Federal law or regulation. After review and investigation, the Medicare Compliance Officer, or his or her designee, prepares a report of the findings and disseminates it to appropriate management, which may include members of the Compliance Committee, legal counsel, senior leadership, or the Board of Directors. Summit Health employees (if any), Directors, contractors

and delegated entities shall cooperate fully with any investigation of noncompliance undertaken by Summit Health compliance personnel and/or their designee(s).

C. Prompt Response to Compliance Issues

Any time any Summit Health employee, Director, contractor or delegated entity discovers an incident of noncompliance with Medicare regulatory requirements, including an instance of misconduct related to payment or delivery of items or services under the contract, the person or entity must report the issue to the Medicare Compliance Officer and provide its proposed corrective action plan. Compliance conducts a timely and reasonable inquiry into the conduct. Any time the Medicare Compliance Officer identifies an incident of noncompliance with regulatory requirements, it requests a corrective action plan from the applicable person, business unit(s), or entity. Corrective action plans represent a commitment from the person, business unit(s), or entity to correct the identified issue in a timely manner. Corrective actions include, but are not limited to, repayment of overpayments, disciplinary actions against responsible individuals, revising processes, updating policies and procedures, retraining staff, reviewing systems edits, and/or developing monitoring and reporting protocols. Corrective action plans must achieve sustained compliance with the overall CMS requirements for that specific operational area.

The status of open corrective plans is reported to the Medicare Compliance Officer and the Compliance Committee. The Medicare Compliance Officer tracks and monitors corrective action plan implementation and requires that the operational area regularly report the completion of all interim action steps. Once a corrective action plan is complete, the Medicare Compliance Officer may validate the corrective action plan by monitoring individual action items over a period of time to demonstrate sustained compliance was achieved and the corrective action plan was effective. The Compliance Committee may review ongoing activity to ensure that the corrective action plan undertaken is effective and to report ongoing noncompliance risks to senior leadership.

Summit Health requires contractors and delegated entities to submit corrective action plans when Summit Health, the contractor or the delegated entity identify deficiencies through oversight compliance audits, ongoing monitoring, or self-reporting. Summit Health tracks and monitors contractors' and delegated entities' corrective action plans through to completion and conducts monitoring activities, as appropriate, to ensure compliance is achieved and maintained. Summit Health takes appropriate action against any contractor or delegated entity that does not comply with a corrective action plan or does not meet its regulatory obligations, up to and including termination of its agreement.

D. Confidentiality

Summit Health shall always strive to maintain confidentiality of a reporter's identity, regardless of the method used to report suspected noncompliance. However, there are certain instances in which the identity of an individual reporting compliance concerns may need to be revealed, such as matters involving government or law enforcement authorities, or when it is necessary to further an internal investigation into the reported matter.

Subject to any requirements imposed by law, information identified, researched or obtained as part of any investigation into allegations of noncompliance may be considered confidential and shall be maintained solely for the purpose of determining compliance. Summit Health shall maintain confidentiality of such information in accordance with the terms of the Summit Health Confidentiality Policy.

E. Whistleblowing and Non-Retaliation

Summit Health will not terminate, demote, suspend or in any matter discriminate or retaliate against any employee with regard to promotion, compensation or other terms, conditions or privileges of employment for the reason that the employee has in good faith: (i) reported a compliance issue; (ii) caused a complainant's information or complaint to be filed against any person; (iii) cooperated with any law enforcement agency conducting a criminal investigation into allegations of noncompliance; (iv) brought a civil proceeding against an employer or has testified in good faith at a civil proceeding or criminal trial related to noncompliance with this plan.

Any individual found to have retaliated against a complainant shall face disciplinary action, up to and including termination of employment or failure to renew contracts if a delegated entity or contractor. If a complainant is found to be responsible for the noncompliance or to have acted in bad faith with respect to filing a report of noncompliance, the Human Resources department may be responsible for responding according to established disciplinary standards.

VIII. FRAUD, WASTE, AND ABUSE PREVENTION AND DETECTION

Summit Health is committed to the prevention and detection of fraud, waste and abuse (FWA). Upon hire, individuals must agree to comply with the Code of Conduct and complete all mandatory FWA training courses. Summit Health uses a number of internal system edits, an external delegated entity that applies medical edits, and further conducts programmatic reviews of data designed to detect claim coding errors as well as potential fraud, waste, and abuse.

Summit Health investigates all reports of potential fraud, waste or abuse. The Company maintains a FWA hotline for use by any Summit Health member, employee, Director, contractor and delegated entity to report potential fraud, waste, and abuse for investigation and resolution. Summit Health works with designated State and Federal agencies and law enforcement to pursue individuals or organizations who may be involved in activities that fall under the FWA umbrella and will pursue prosecution of health care fraud and abuse, as appropriate. Fraudulent activity may involve an employee, Director, contractor, delegated entity or member who engages in inappropriate schemes or behavior, or a health care provider who creates or provides false documentation, issues inappropriate prescriptions, falsifies a condition(s) in order to help an individual receive an otherwise uncovered service under the Medicare Advantage (Part C), Prescription Drug (Part D), or other Federal program or a combination of scenarios.

All Summit Health employees, Directors, contractors, and delegated entities play an important role in the prevention and detection of FWA and must report suspected fraud, waste, or abuse.

A. Special Investigations Unit (SIU)

A Special Investigations Unit (SIU) is responsible for conducting surveillance, interviews, and other methods of investigation relating to potential fraud, waste, or abuse (FWA). The SIU and Medicare Compliance Officer communicate and coordinate closely to ensure that Medicare Advantage (Part C) and Prescription Drug (Part D) benefits are protected from fraudulent, abusive and wasteful schemes. The Company monitors both the administration and the delivery of benefits of the Part C and Part D program at the plan and delegated entity level.

The SIU works with various business units to investigate suspected incidents of fraud and work with law enforcement and the MEDIC to pursue prosecution. The SIU maintains case related information in a dedicated database, which allows the SIU to track, profile, and accurately obtain qualitative and complete data concerning fraud investigations.

The SIU employs analytical data mining to identify referral patterns, possible payment errors, utilization trends, and other indicators of potential fraud, waste, and abuse. The SIU performs proactive and reactive data analysis of medical claims to detect outliers that may indicate potential

fraud, waste, and abuse. This process enhances Summit Health's investigations, highlights high risk areas, and improves the Company's ability to combat fraud, waste, and abuse.

The SIU works with the Medicare Compliance Officer to identify and resolve reports of potential fraudulent activity. The SIU may independently receive reports of FWA through other areas, such as the:

- Appeals and Grievances department;
- Billing and Eligibility department;
- Claims department;
- Customer Service department;
- Human Resources department;
- Legal department;
- Pharmacy department;
- Regulatory department;
- Contractors;
- Delegated Entities;
- Providers;
- Fraud, Waste and Abuse Hotline;
- the EthicsPoint website or Hotline;
- Law enforcement; or
- NBI MEDIC.

If the SIU determines that potential fraud or misconduct related to the Medicare program occurred within Summit Health or with a contractor and/or delegated entity, the SIU will promptly notify the Medicare Compliance Officer. Summit Health's overall FWA program is enhanced by partnering with the NBI MEDIC. The NBI MEDIC can help identify and address patterns across multiple sponsors and coordinate with the OIG, law enforcement or Department of Justice related to any scams or schemes.

In the event an investigation confirms FWA occurred, the SIU and the Medicare Compliance Officer work with applicable business units, contractors, or delegated entities to determine appropriate corrective action, which may include employment or contract termination.

B. Use of Data Analysis for Fraud, Waste, and Abuse Prevention and Detection

Summit Health or SIU perform monitoring and data analysis designed to prevent and detect fraud, waste, and abuse (FWA). Data analysis includes the comparison of claim information against other data (e.g., provider, drug, or medical service provided, diagnoses, or beneficiaries) to identify unusual patterns, potential errors, and/or potential fraud and abuse. Data analysis will factor in the particular prescribing and dispensing practices of providers who serve a particular population (e.g., long term care providers, assisted living facilities, etc.)

Data analysis which suggests inappropriate or questionable billing practices shall be reported to the Medicare Compliance Officer.

C. Fraud, Waste, and Abuse Training Program

Any new employee and newly appointed Board of Director member will receive training on the detection and prevention of fraud, waste, and abuse (FWA) and any Summit Health's FWA policies and procedures. Such training shall be provided within ninety (90) days of hire and annually thereafter.

D. Reporting of Suspected Fraud, Waste, or Abuse

Any Summit Health employee, Director, contractor and delegated entity has an obligation to report suspected fraud, waste, or abuse, regardless of whether such wrongful actions are undertaken by a peer, supervisor, contractor, delegated entity, provider, or member. When any employee, Director, contractor, or delegated entity suspects fraud, waste or abuse, he/she should complete and submit a Fraud & Abuse Investigations Referral Form to the SIU, send an email to stopfraud@yoursummithealth.com, send an email to the Medicare Compliance Officer, and/or submit a report through EthicsPoint at www.Ethicspoint.com or 1-866-294-5591. Any potential fraud, waste and abuse occurrence identified by any Summit Health employee during the course of performing Summit Health duties is initially reported to the employee's supervisor. The supervisor or the employee, with the supervisor's guidance, completes a Fraud & Abuse Investigations Referral Form, available on the intranet and in the Handbook, and sends the respective form to the Compliance Officer and SIU for review.

Summit Health contractors and delegated entities wishing to report suspected fraud, waste or abuse, may complete and submit a Fraud & Abuse Investigations Referral Form to the SIU, send an email to stopfraud@yoursummithealth.com, send an email to Medicare Compliance Officer at medicarecompliance@yoursummithealth.com and/or submit a report through EthicsPoint at www.Ethicspoint.com or 1-866-294-5591.