Inter Valley Health Plan

Medicare Compliance Plan

And

Corporate Compliance Program

MAPD Contract# H0545

Inter Valley Health Plan
SERVICE TO SENIORS
For Health. Not for Profit.

Contents

Inter Valley Health Plan

Medicare Compliance Plan and Corporate Compliance Program

I. INTRODUCTION

MISSION

Inter Valley Health Plan is a non-profit, community based, Medicare Advantage organization focused on continuous improvement of health status and healthcare network support for its membership.

VALUES

Non-Profit

As a non-profit Medicare Advantage Organization, Inter Valley Health Plan can put the needs of its members, providers, and community ahead of the financial pressures that drive the decisions and policies of our investor owned for profit competitors. Inter Valley Health Plan puts member care ahead of profits, and we believe that in the end, our dedication to the superior service for our members and stakeholders is better served by that belief.

Community Based

At its core, Inter Valley Health Plan is an integrated and integral part of the regional delivery system for health care. The Plan maintains close relations with all community agencies, which support and promote the delivery of quality health care. It has a major commitment to community outreach activities and strong community representation on its Board of Directors. As a consequence of its community orientation, Inter Valley Health Plan enjoys significant community support.

Policy

Inter Valley Health Plan's policy is to conduct all of its business in a professional, ethical manner, with adherence to a high level of compliance with all state and federal laws and regulations governing the Medicare Compliance Plan and Corporate Compliance Program (the "Plan"). Inter Valley Health Plan expects

the same level of professional and ethical integrity from its employees and business partners. Part of our goal in daily interactions with our members is to ensure member rights are supported and respected.

Our program focuses awareness on the commitment to doing business the right way, and requires individuals to report activity that they believe is fraudulent or inconsistent with our overall program and standards of conduct. The program is reinforced with annual training programs, provisions in our Employee Manual and standards of conduct and through our corporate policies and specialized department policies.

Purpose

Inter Valley Health Plan's corporate-wide Compliance Program is designed to meet requirements as outlined in regulations at 42 CFR § 422.503(b)(3)(vi) and 42 CFR § 423.504(b)(4)(vi) and as otherwise clarified in the CMS Manuals. The Corporate Compliance Program is designed to establish a culture of compliance for Inter Valley Health Plan. The Compliance Program along with required training is supported by senior management and the Board of Directors to effectively articulate and demonstrate to employees, providers, business associates, delegated entities and the community, the company's strong commitment to honest, ethical and responsible corporate conduct at all levels. The responsibility for designing, implementing, maintaining, and monitoring this Corporate Compliance Program will reside with the Corporate Compliance Officer, and the Corporate Compliance Committee and the Board of Directors.

The purpose of Inter Valley Health Plan's Compliance Program is to establish a culture and programs to help prevent fraud, waste and abuse and to demonstrate the organizations commitment to compliance through training, policies and procedures, standards of conduct, monitoring and auditing, and periodic evaluation of areas of risk that may require focused attention.

The program supports ethical conduct with specific components that include -:

- preventing fraud, waste and abuse,
- improving operational quality,
- improving the quality of health care our members receive.

The Compliance Program includes requirements for both new hire training and annual refresher training designed to support the overall compliance program. Specialized training is provided in functional areas of the

Plan as regulations within the industry are changed and additional areas for improvement are noted through internal and external audits. This Compliance Program summarizes Inter Valley Health Plan's commitment to compliance, business ethics and prevention of fraud, waste and abuse. The Compliance Program provides for the following:

- Internal controls to assure compliance with state and federal regulations. Sub regulations, and CMS guidance;
- Training and internal and external communication channels;
- Increased likelihood of identification and prevention of unlawful and unethical conduct;
- Processes for prompt and thorough investigation of alleged misconduct by employees, and or agents; providers, business associates, and
- An environment that encourages employees to report potential problems anonymously and without fear of retaliation.

II. COMPLIANCE RULES AND PROCEDURES

Standards of Conduct

Inter Valley Health Plan is committed to conducting its business lawfully and ethically. This Compliance Program sets forth guidelines and standards established by the company and state and federal laws and regulations, which will guide the company and its employees and agents in the conduct of their daily activities. The program has been reviewed and accepted by the company's Senior Management Team and Board of Directors, and all are committed to meeting or exceeding all compliance goals and standards.

To protect Inter Valley Health Plan's reputation and to assure uniformity in the manner in which we conduct business, Inter Valley Health Plan has established Standards of Conduct. These Standards of Conduct are the framework for our employees and how we do business. The Standards of Conduct noted below in our Compliance Program and those standards of conduct separately outlined in the Employee Handbook represent the company's expectations for its employees. These standards are supported by our written policies and procedures that all employees must comply with as a condition of employment. Individuals who are sanctioned or excluded from receiving payment with government funds, have a felony or fraud related conviction, or loss of licensure, are not eligible to be employed or paid by Inter Valley Health Plan.

These policies and procedures are reviewed and updated as changes occur in regulations or CMS regulatory requirements, minimally once a year and at any time where Inter Valley Health Plan notices an opportunity to improve its policies and procedures. Any questions relating to the Corporate Compliance Program and the company's Standards of Conduct should be submitted either to an immediate supervisor or manager, or one of Inter Valley Health Plan's Corporate Compliance Committee members.

It is Inter Valley Health Plan's policy to comply with all applicable Federal and State rules, regulations, program guidance and to report any suspected violations of our Compliance Program, Standards of Conduct or possible Fraud, Waste, or Abuse. All employees must follow the Plan's policies adhere to procedures to detect instances of fraud which is defined in Vol. 42, Code of Federal Regulations, Section 455.2:

> "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law."

Inter Valley Health Plan, its officers, Board of Directors, employees, volunteers, and contracted agents have agreed to the company standards outlined in this Compliance Program, which prohibit engaging in any illegal or unethical conduct. Regulatory Compliance is the responsibility of all Board Members, employees, agents, contractors and subcontractors, acting as representatives on behalf of Inter Valley Health Plan. All such individuals must understand corporate policies and the ethical and regulatory standards to be followed by all representatives of the company.

Inter Valley Health Plan is committed to dealing honestly with employees, members, providers, and governmental agencies.

The following areas outline some, but not all areas in which the company is dedicated to maintaining a high standard of conduct.

Quality of Service

Inter Valley Health Plan is committed to providing services that meet all contractual obligations and Inter Valley Health Plan's quality standards. Policies and procedures are in place to support our commitment to do business

in compliance with federal and state regulations, including the requirements of the Medicare Modernization Act, the Affordable Care Act, and CMS regulations and guidance.

Our commitment to quality of service includes our initiatives for the company to meet all formulary requirements from CMS, supporting the Medicare Part D program regulations. Formulary composition ensures we provide appropriate access to Medicare Part D-covered drugs. Our Pharmaceutical and Therapeutic Committee is further committed to making ethical formulary decisions that support treatment and cost sharing that is non-discriminatory. Enrollees have access to the company's exceptions process for issues related to tiered cost-sharing and non-formulary drugs.

Inter Valley Health Plan maintains a Quality Assurance Program, that measures and has systems as specified under Part D regulations including components designed to mitigate fraud, waste or abuse of drugs and optimize care management. These include components to:

- Review potentially contraindicated medications and reduce adverse drug interactions
- Reduce medication errors
- Improve compliance with physician guidance on medication use.

The company additionally operates a cost-effective drug Utilization Management Program as indicated in its utilization management policies and procedures and a Medication Therapy Management Program to review therapeutic outcomes. . These Programs includes strategies for:

- reducing costs where medically appropriate
- preventing over and under-utilization of prescribed medications
- ensuring that drugs prescribed for enrollees are appropriately used to enhance therapeutic outcomes.
- Review of access reports from PBM to ensure transition coverage occurs and is timely and accurate.

Policies and procedures are also in place with staff on-call to ensure that all covered services are available and accessible to all enrollees and to ensure compliance with confidentiality of protected health information as required by the Health Insurance Portability and Accountability Act (HIPAA).

Data Collection & Submission

The company has established key performance indicators to ensure that all required submissions to governmental agencies are accurate, timely, and complete and that all appropriate reporting requirements are met. Key performance indicators are tracked and reviewed by the the Compliance Committee and Senior Management team. This includes data relating to both Part C and Part D. Validation audit contractors are in place to support the CMS requirements related to audits for the Part C and Part D data submissions.

Data Validation reviews will be enhanced through the data validations contractors that will be assessing data submissions according to the CMS requirements.

Accuracy of data and ability to review for trends in data that may be aberrant contribute to the plans ability to further assess risks of potential program fraud, waste and abuse.

All data collection and submission outcomes are also reported to the Quality Improvement Committee and to the Plan's Board of Directors on a quarterly basis and bi-annually as a performance outcome scorecard.

Grievance & Appeals

Grievances and Appeals are a window into the health plan and trends are reviewed as part of the oversight process in place. Inter Valley Health Plan's Grievance & Appeals Department has a grievance & appeals tracking system. This system allows for proper documentation and resolution of complaints, grievances, and appeals by enrollees and providers. The database and associated CMS Program Audit universe templates have the capability to separate Medicare Part C and Medicare Part D-related grievances and appeals. Ongoing review of patterns of cases occurs through the Quality Improvement Committee and Inter Valley has an ongoing audit program related to handling of Grievances and Appeals.

Anti-Kickback Issues & Conflict of Interest

As stipulated in our Human Resources Policies and Procedures, Employees and business partners alike are aware that they may not offer or accept anything of value to an entity or person in order to induce that customer or potential customer to purchase services from or to refer a customer to Inter Valley Health Plan.

Employees are also aware that conflicts of interest related to employment outside of the organization or other referrals must be reported to a supervisor or Human Resources. A separate policy exists for conflicts of interest relating to the Plan's governing body Board of Directors. Some examples of types of actions which violate state and federal laws governing anti-kickback actions include:

- Offering or paying anything of value to induce someone to refer a potential member to Inter Valley Health Plan;
- Offering or paying anything of value to anyone (member or referral source) in marketing Inter Valley Health Plan;
- Soliciting or receiving anything of value for the referral of Inter Valley Health Plan members to others; and
- Receiving free goods that are different than the goods purchased when purchasing products.

Examples of Conflict of Interest include:

- Second job or moonlighting job that may conflict with current employment
- Self-dealing

The Medicare Marketing Guidelines have exceptions for nominal, non-cash gifts. Sales staff and Broker contracts, agency agreements, or other marketing contracts shall follow the Medicare Marketing Guidelines related to allowable gifts and the payment or commission shall not exceed the amounts as stipulated in the contractual agreement for services rendered and CMS requirements for Broker Compensation.

The Medicare Marketing Guidelines can be found at:

http://www.cms.gov/managedcaremarketing/03_finalpartcmarketingguidelines.asp

Should employees have any questions regarding anti-kickback issues, they should promptly refer them to the company's Compliance Office. The Compliance Office will refer such questions to outside entities as necessary.

False Claims

State and federal law prohibit Inter Valley Health Plan, its employees, delegated medical groups, vendors, or anyone else involved in the provision of health care services from submitting a false claim for services or goods. Inter Valley contracts and subcontracts include specific contract language and obligations designed to prevent Medicare Program fraud. Further, state and federal laws require that Inter Valley Health Plan have a way of identifying false claims and to reduce costs to the Plan, providers, enrollees, and others through the timely detection, investigation and prosecution of any person or entity submitting a false claim.

Examples of the types of actions that could violate state and federal false claims laws include:

- Filing a claim for services that were not rendered at all or were not rendered as described on the claim form;
- Filing a claim for services that were rendered, but which the person knew were medically unnecessary;
- Submitting a claim containing information a person knows to be false;
- Submitting self-audit or Plan audit information regarding claims payment timeliness that is deliberately false or misleading; and/or
- Misusing any member or provider information made available in the course of lawful business activity to create or support a false claim.

Submitting requests for payment under the CMS risk adjustment model that are not supported / properly documented in the medical record.

Specific checks are in place to help prevent claims fraud in both the Part C and Part D program, including checks in the processing of claims related to member information, utilization and or authorization checks, monthly review of the OIG sanction and exclusion list, and opt out listing, and review that procedures were authorized or referred by the PCP, where required. Same said claims audit monitoring is performed on the Plan's delegated entities (FDRs) under the Delegation Oversight Compliance Committee.

Marketing and Advertising Activities

Use of Approved Materials:

All marketing and advertising materials must conform to the requirements outlined in the CMS marketing manual and guidelines. Materials must be filed and approved or meet the filing requirements under the file and use guidance.

Accurate and Complete Information:

The overall goal is for full disclosure to occur to the members and potential members in conducting all marketing and advertising activities. Inter Valley Health Plan employees may not use unapproved materials in sales and marketing activities – our goal is for all communications to offer only honest, straightforward, fully informative and non-deceptive information. Therefore, Inter Valley Health Plan employees and any marketing entity representing Inter Valley Health Plan, shall not distort the truth, make false claims, engage in unapproved comparative advertising, or attack or disparage another provider, physician group or health plan. Relevant materials also provide enrollees with a clear definition of enrollment periods and "lock-in", describe the provider network and sub networks, and the process of choosing primary care physician as the primary care coordinator for the enrollee.

Enrollee Rights:

CMS has detailed guidelines for marketing materials to support that all marketing materials contain clear descriptions of enrollees' rights along with procedures for accessing basic benefits and services.

Non discrimination:

Additionally, all marketing staff representing Inter Valley Health Plan will not selectively market to discriminate against the disabled, or otherwise screen out potential enrollees or otherwise perform any health screening on potential enrollees that might be viewed potentially as cherry-picking..

Nominal Gift Rule – Prohibition against cash or cash equivalent gifts

Similarly, no Inter Valley staff may have sales or marketing incentives that offer any cash gifts or cash equivalent payments of any kind. Anything that can be converted to cash is not allowed. Nominal non-cash gifts are allowable if they do not exceed the nominal amount allowed in the CMS marketing guidance ($15 dollars as of 2016 Medicare Marketing Guidelines), as this would be viewed as an inducement for individuals to enroll in the health plan. The company and its agents shall abide by all requirements contained in the Medicare Marketing

Guidelines, including those related to Part D regulations. No employees will provide gifts or meals to government employees.

Sales Issues and Sales Allegations:

All sales and marketing allegations are taken seriously, investigated, and formally reviewed and leveled for disciplinary action by the Executive Management Committee. Tracking and trending of cases by sales rep is part of the overall oversight process in place.

Training

Marketing and sales staff are expected to attend the CMS training and user group calls that have specific sales or marketing related presentations. If unable to attend, they will be requested to review the CMS recording posted from the training. Separately, annual training and testing is required for all sales representatives, brokers and agents. As new legislation is passed through CMS or Congress all sales and marketing staff are provided guidance and training. All policies and procedures are update accordingly. Compliance, Enrollment, PBM and/or Health Plan Operations staff attend all CMS User Calls.

Enrollment & Disenrollment

Inter Valley Health Plan has policies and procedures in place to effectively receive, control, and process enrollment and disenrollment forms. Specific procedures address issues related to processing and reconciliation for Low Income Subsidy (LIS) status members to ensure appropriate billing / cost sharing is in place for member benefits. The company's Reimbursement Department ensures that enrollment and disenrollment activities occur according to the CMS guidelines for election rules and monitors for any issues related to inappropriate sales and marketing activity, such as rapid disenrollment. The Plan's Customer Service staff is trained to identify Best Available Evidence from a prospective member. The Reimbursement Department also reports any potentially inappropriate disenrollment, such as disenrollment just prior to receiving costly health care services. Inter Valley Health Plan also maintains an Outbound Verification process to further ensure that enrollees of the Plan have not been misled by way of the sales process.

Contracting

Inter Valley Health Plan ensures that provider contracts and subcontracts contain the required CMS language provisions. This includes the requirements for credentialing and monitoring of the sanctioned and opt out provider reports monthly, as well as compliance with Inter Valley's policies and contract provisions related to its CMS contract. Either directly or through delegation agreements, Inter Valley Health Plan follows CMS requirements to protect members against balance billing, The Plan performs oversight audits to ensure that all of its providers have been credentialed and re-credentialed, as necessary, and that all required specialty services are part of a contracting network. Credentialing includes verification to ensure that a provider has a valid license to participate, that his/her clinical privileges are in good standing, and that he/she has appropriate educational qualifications and that there are no sanctions or exclusions from participation in Medicare or Federal programs. The Plan has a comprehensive audit process to ensure maximum oversight of delegated functions for claims payment, utilization management, credentialing, quality management and compliance program requirements and effectiveness.

Fraud Reporting:

As outlined in more detail in the Inter Valley Health Plan Policy and Procedure "Reporting Reporting Potential Issues or Areas of Noncompliance, Fraud and or Abuse (P202)", Inter Valley Health Plan employees, contracted provider groups and brokers and agents are expected to report potential Fraud, Waste or Abuse in a timely manner.

Individuals are expected to report any suspected fraud, violations of the Corporate Compliance Program, Standards of Conduct, or other irregularities to their supervisor, a Compliance Officer, and/or Vice President or Human Resources within 5 days, but no more than 45 days of the alleged incident. Inter Valley has a non – retaliation policy related to reporting potential violations, but if the individual wishes to remain completely anonymous, he/she may submit a report through the Corporate Compliance Fraud Alert contractor by:

- Placing a telephone call to 1-888-FRAUD ALERT (1-888-372-8325) and/or
- Mailing a report to "Fraud Alert" at P.O. Box 6002, Pomona, CA. 91769 and/or
- Submitting a report via the Fraud Alert website at www.reportlineweb.com/ivhp

Emergency Services

Inter Valley Health Plan understands that access to emergency services is crucial to a member in need of such services. We are further aware that hospitals routinely seek prior authorization from either the enrollee's primary care physician or the managed care organization when an enrollee requests emergency services. Inter Valley Health Plan does not seek prior authorization for these services regardless of the emergency room provider's contractual relationship with Inter Valley Health Plan. Additionally, payment for emergency and urgently needed services will be based on using the "prudent layperson standard".

Political/Lobbying Contributions

Political/Lobbying contributions if made by Inter Valley Health Plan follow all CMS guidelines and are not included in the Plan's annual bid submission. Employees may not contribute or donate Inter Valley Health Plan funds, products, services, purchase tickets to fundraising events, or contribute other company resources to any political cause, party or candidate with company funds without the advance written approval of a Compliance Officer or Legal Counsel. However, employees may make voluntary contributions from their own personal funds to any lawful political causes, parties or candidates as long as the individual does not represent that such contributions come from Inter Valley Health Plan and as long as the individual does not obtain the money for these contributions from Inter Valley Health Plan for the sole purpose of making such a contribution.

It is improper for an employee to use his or her position with Inter Valley Health Plan to solicit political contributions from another employee for the purpose of supporting a political candidate or influencing legislation. It is also improper for an employee to make a political contribution in the name of Inter Valley Health Plan.

Government Contract

Inter Valley Health Plan and its agents and providers in the Medicare Advantage program are parties to a government contracts with the Centers for Medicare & Medicaid Services (CMS). Inter Valley Health Plan is also subject to provisions in the State of California for licensure as a health care service plan under the jurisdiction of the Department of Managed Health Care (DMHC). It is essential that all employees are

knowledgeable of, and comply with, all of the applicable laws, rules and regulations of all such governmental agencies. Entities who contract with Inter Valley Health Plan, specifically those to whom Inter Valley Health Plan delegates any administrative or medical service responsibility of the Plan, are equally responsible for compliance with the applicable laws, rules and regulations of all such governmental agencies. It is incumbent upon company personnel to be sensitive to, and report to a Compliance Officer or through the Fraud Alert Hotline, any indicators of non-compliant or unlawful actions by any contracted entity with which they come in contact in the course of business.

Because Inter Valley Health Plan is paid with government funds, all employees, agents, contractors, and subcontractors must remain free and clear of federal sanctions or exclusions or specific felony convictions that prohibit payment to occur through government funds. Inter Valley Health Plan requires immediate disclosure of all sanctions and felonies. Sanctions and/or felonies are cause for termination and recoupment of payment.

Dealing with Government Employees

There are specific restrictions in working with government employees. Any Inter Valley Health Plan employee or party representing Inter Valley Health Plan in interactions with state of federal officials must maintain the highest level of conduct and no interactions can occur that may have any attempting to influence the federal official. The appearance of bribes, kickbacks, gifts or gratuities can be broadly interpreted, so where lodging expenses, dinner, or payment for a speaking engagement may otherwise seem innocent, this is not so in dealing with regulators or other federal or state officials. Employees may not provide or pay for any meal, entertainment, travel, or lodging expenses for government employees, auditors, or representatives, with limited exceptions for meetings or working sessions. Because the Federal Government and State and local governmental bodies have strict restrictions on the receipt of business courtesies, everyone must be aware that these include restrictions on meals and refreshments. Inter Valley Health Plan employees doing business with such governmental bodies are expected to know and respect all such restrictions.

Accurate Books and Accounts

All of Inter Valley Health Plan's payments and other transactions must be properly authorized by management and be recorded accurately and completely on Inter Valley Health Plan's books and records in accordance with established corporate accounting policies.

- No false, incomplete, or unrecorded corporate entries shall be made;
- No undisclosed or unrecorded corporate funds shall be established for any purpose;
- No Inter Valley Health Plan funds are to be placed in any personal or non-corporate account;
- No payments can be made in cash (currency) other than regular, approved petty cash expenses supported by signed receipts or other appropriate documentation. Further, business checks shall not be written to "cash", "bearer", or similar designations; and
- All corporate assets must be protected properly, and asset records must be compared regularly, with actual assets and with proper action taken to reconcile any variances.

All records pertaining to the Corporate Compliance Program shall be retained by the Compliance Officer. As changes are made and approved for the Corporate Compliance Program, the revised program information is approved through the Compliance Committee and will be distributed to heads of all operational departments and to all employees to ensure awareness and proper implementation of the program. Inter Valley Health Plan's Board of Directors will receive and approve updates to the program as required. First-tier, downstream, and delegated entities will receive updates through revisions to the Plan Manual and annually through an FDR attestation process for the Corporate Compliance Program.

Types of documents maintained as part of records retention of 10 (ten) years include documentation required by federal or state law, including records associated with the Medicare Compliance Committee, regulatory audits and filing, financial records, membership and grievance and appeals records, and any related operational records for the Part C and Part D Program. Records include documentation illustrating how Inter Valley Health Plan protects the integrity of the compliance process and how we confirm the effectiveness of the program.

The latter category of records retention includes information such as logs of employee training and all related relevant materials, reports from our Fraud Alert Hotline along with results of any investigation conducted as a result of a Hotline call, modifications to the Corporate Compliance Program, any notices to providers regarding compliance activities, sales & marketing allegations, and the results of any internal monitoring efforts. Additional information on records retention, including the types of records and the timeframes for maintaining such records, is outlined in Inter Valley Health Plan's policy and procedure, "Records Retention." All relevant records and documents are retained for a minimum of ten (10) years. All contract templates contain specific document retention language requiring records be maintained for a minimum of ten (10) years.

Confidentiality of Member Information

Inter Valley Health Plan has instituted training and awareness programs as well as safeguards related to data security in compliance with the Health Insurance Portability and Accountability Act. This includes standards for electronic transactions to occur in a secure manner for Inter Valley Health Plan members.

Employees, contracting providers, and business associates of Inter Valley Health Plan must safeguard all confidential information with which they are entrusted. Data use must be for the minimum required data set and must be guarded and kept securely and never used or disclosed outside the normal and necessary course of Inter Valley Health Plan's business.

Data Privacy, Security and Confidentiality are components of Inter Valley's program designed to meet all requirements under the Health Insurance Portability and Accountability Act (HIPAA), including the applicable modifications in the HITECH act provision of the American Recovery and Reinvestment Act (ARRA).

In particular, all employees, Board Members, P&T Committee members, volunteers, contracting providers, and business associates, must protect the confidentiality of all protected health information including, but not limited to patient records and the personal identifiable information and personal health information contained in such records. Confidentiality training is included in the general compliance training for all new employees and is a component in the annual compliance refresher training.

Inter Valley Health Plan has established Business Associate Requirements for maintaining confidentiality of information, for information security, and provisions for incident response and for mandatory notification should a data breach or security breach occur. ARRA provisions include notice to individuals when their health information is breached. Breaches impacting health information for 500 or more individuals include prompt notification to the secretary of HHS and the Media. The Plan's Compliance Office maintains a database of all breaches of less than 500 members and reports this annually to the CMS, OCR, and HHS.

Conflicts of Interest

The Directors, Officers, Senior Management and employees of Inter Valley Health Plan will exercise reasonable care and act in good faith to avoid any conflicts of interest. All Directors, Officers and Senior Management are required to avoid influencing or voting on decisions in the event that they have a conflict of interest involving

such decisions. An individual may not use his/her position with the company to serve interests, personal or otherwise, that are not the interests of Inter Valley Health Plan. Conflict of Interest Questionnaires are sent out annually to all Board Members and Senior Management.

If a Director or Officer has reason to believe that he/she may have a financial conflict of interest, the Director or Officer must bring the potential financial interest and all material facts to the attention of the Directors and member of committees with Board delegated powers considering the proposed transaction or arrangement. If any other individual has reason to believe a Director or Officer may have a financial interest that has not been disclosed, he/she is obligated to bring the potential financial interest and all material facts to the attention of the Chief Executive Officer of Inter Valley Health Plan. If any other individual has reason to believe that the Chief Executive Officer of Inter Valley Health Plan may have a financial interest that has not been disclosed, he/she is obligated to bring the potential financial interest and all material facts related to the attention of the Chairman of the Board of Inter Valley Health Plan.

All staff are trained upon initial hire and annually on avoidance and how to report Conflict of Interest.

Harassment

Harassment of any kind, whether verbal, physical, or visual, that is based upon race, pregnancy, marital status, medical condition, veteran status, ancestry, national origin, religion, age, disability, gender, or sexual orientation is prohibited. Inter Valley Health Plan will not tolerate harassing conduct that interferes with job performance, or that creates an intimidating, hostile, or offensive working environment for employees and any other entities conducting business with the company.

Sexual harassment is one specific prohibited type of harassment. Unwelcome sexual advances, requests for sexual favors, and other physical, verbal, or visual conduct of this nature constitutes sexual harassment when:

- Such conduct is between a manager, supervisor and his or her subordinate, where submission to the conduct is an explicit or implicit term or condition of employment;
- Such conduct is used related to hiring or promotions where submission to or rejection of the conduct is used as the basis for an employment or promotion decision; and/or
- The conduct has the purpose or effect of unreasonably interfering with your work performance or creating an intimidating, hostile, or offensive working environment.

All Inter Valley Health Plan personnel receive Harassment Training annually with (2) hours for management personnel and (1) hour for all other personnel.

III. OVERSIGHT OF COMPLIANCE PROGRAM

Corporate Compliance Officer

The Corporate Compliance Officer(s) reports directly to Senior Management and as necessary to the Board of Directors.

The Corporate Compliance Officer(s) and Compliance Committee have the responsibility to:

- Design, implement, operate, and monitor the Compliance Program;
- Chair the Corporate Compliance Committee;
- Establish and maintain an effective communications program to ensure that all employees and business partners are aware of the contents and requirements of the Compliance Program;
- Contract with an outside firm that provides specialized expertise in the investigation of suspected fraud, either internally by Inter Valley Health Plan personnel or externally by contracted providers, business associates, or members. The firm will maintain a toll-free Hotline telephone service for individuals to report instances of suspected fraud without fear of reprisal from the company;
- Monitor the Compliance Program to ensure it is being communicated and followed;
- Ensure that any potential violations are promptly investigated and addressed. This will include investigating all reports of wrongdoing, with the assistance of the firm that specializes in investigation of suspected fraud and outside counsel as necessary;
- Oversee appropriate disciplinary action for violations of law and/or corporate policies;
- Recommend modifications to the Compliance Program, as necessary;
- Monitor compliance indicators with the goal of reduction of identified areas of weakness through program changes, policy revisions or other corrective actions;
- Monitor that updates occur to company policies and procedures to ensure compliance with all applicable rules and regulations and regulatory changes;

- Monitor overall program effectiveness and escalate issues related to ongoing non compliance to the CEO and Senior Management, and
- Report to the Board of Directors, either directly, or via the Inter Valley Health Plan Quality Improvement Committee, at least quarterly, the activities of the Compliance Program.
- Obtain annual attestations from Business Associates/Administrative Services Contracts and Delegated entities annually.

Corporate Compliance Committee

The Corporate Compliance Committee is comprised of the heads of all departments in the company or their designee, including:

- Corporate Compliance Officer
- President/CEO
- Chief Medical Officer
- Vice President, Health Plan Operations
- VP, Finance/CFO
- Manager, Provider Services
- VP or Director, Sales & Marketing and Member Services
- VP, Human Resources
- Manager Medical Management
- Manager, Claims
- Director, Information Technology
- Director, Member Services
- Manager, Reimbursement
- Manager, Grievance & Appeals

Ad-Hoc Members may include

- Pharmacy Director or Pharmacy Consultant
- Regulatory Consultant
- Manager Decision Support

The Corporate Compliance Committee will advise the Corporate Compliance Officer and Compliance Team and consent to recommendations of both. The Committee will have the following responsibilities:

- Analyze Inter Valley Health Plan's regulatory environment and the legal requirements with which it must comply;
- Assess existing policies and procedures to address areas to be part of the Compliance Program;

- Recommend the development of internal systems and controls to carry out Inter Valley Health Plan standards;
- Develop a system to evaluate and respond to complaints and problems;
- Monitor, internally and externally, for the purpose of identifying troublesome issues and deficient areas and implement corrective actions;
- Review new legislation and / or regulations; and engage departments who need to act by updating policies, procedures or workflows, and provision of specialized training to ensure staff can implement changes effectively;
- Review and approve modifications of any aspects of the Compliance Program, as necessary.

IV. COMMUNICATION & EDUCATION

Employee Training

Training is one of the elements that is tracked to ensure that training occurs for new hires and includes overall compliance training, Human Resources Policies and Procedures and the foundational code of conduct for employment at Inter Valley Health Plan. Refresher training occurs on an annual basis, both in the form of direct compliance training and reminders on various topics or regulatory changes that occur throughout the year. Specialized training related to job functions is done in each respective department, supported by that department's policies, procedures and workflows. Annual Compliance Training is required to maintain employment.

The Compliance Officer & Compliance Committee will communicate the existence, purpose, contents, and expectations of the Compliance Program throughout the organization. These individuals will be responsible for monitoring, developing, and conducting general training and orientation sessions. The Compliance Officer will take attendance at all training sessions with a sign-in form to maintain a record of course attendance at any training session performed as part of the Corporate Compliance Program. Additional communication between the Compliance Officer and company employees occurs when employees seek clarification regarding company policies. The Compliance Officer or designee takes note of such inquiries and shares them, if appropriate, with other staff so that company practices and procedures may be updated and improved to reflect any needed modifications.

Training sessions will be held as the need arises to address changes in the Corporate Compliance Program, in federal and state laws and regulations, or any issues of interest. Department heads may conduct additional

training sessions for specific employees who have responsibilities with certain compliance issues such as employees responsible for billing governmental programs. Every Inter Valley Health Plan employee must attend at least one hour of Corporate Compliance Program Training on an annual basis. The company Corporate Compliance Officer and Team will provide such training to all employees, senior management and the Board of Directors, with a copy of the training required to be distributed to delegated entities and contractors, first-tier and downstream who work with or have access to confidential information. All delegated entities, contractors, first-tier and downstream will be required to provide the Plan with a signed attestation and will be audited at least annually to ensure compliance with CMS training requirements for FDRs. An employee who has missed a regularly scheduled training session, must complete the session, typically within thirty days of the originally scheduled training date.

Additionally, all new hires receive initial requirements with the Employee Handbook and receive supplemental training as part of their job orientations and will receive compliance training within fifteen (15) business days of their start date and no later than 90 days. The employee will be required to certify in writing that he/she has received, read, understood, and agrees to comply with the Standards of Conduct and Compliance Program. Any employee violating any provision of the Standards of Conduct will be subject to disciplinary action, up to and including discharge from employment.

Inter Valley Health Plan personnel whose job responsibilities include the oversight of auditing of operational functions performed by entities contracted or delegated to perform duties or provide services that would otherwise be performed by Inter Valley Health Plan will receive specialized training in their areas of expertise. Specialized training programs will be developed by the heads of Departments for, at a minimum:

- Claims auditors
- Claims processors
- Utilization Management auditors
- Medical Records auditors
- Quality Management auditors
- Provider Services Manager
- Financial Solvency Monitoring
- Compliance Program and Training including FWA
- Sanction Lists and Exclusions

Additionally, the heads of Inter Valley Health Plan's Sales and Marketing Department have developed training programs for their staff to ensure usage of correct marketing techniques and methods that include, but are not limited to, not discriminating among potential enrollees due to health status.

Broker, Agent, and Contractor Training

Brokers and Agents receive specific training on the Medicare Marketing requirements and must pass an exam in order to act as agents for Inter Valley Health Plan. In addition, the contract requirements tie to compliance with the Medicare Marketing Guidelines. Sales activity of Brokers and Agents is monitored through issues that arise from the Member Services and Grievance and Appeals staff, outbound verification, as well as through issues that the Reimbursement Department finds.

Specific Policies are in place related to:

- Sales Allegations
- Sales Rep Code of Conduct
- Sales Agent Training and Testing

Inter Valley Health Plan maintains a process and policies related to the appointment and termination of brokers and agents as required by MIPPA and as required by the State of California.

In addition to the Compliance Program requirements, Delegated provider groups have specific contract requirements that expand to downstream contracts they hold with individual physicians and other providers. The provider groups receive a Provider Plan Manual and training as well as ongoing training and education where corrective actions are required.

The Compliance Officer & Compliance Committee are involved in providing updates to information that may be needed to ensure new requirements are distributed to contractors and subcontractors as needed.

Fraud Alert Hotline

Employees, members and delegated providers may also avail themselves of a toll-free Hotline 24 hours a day for issues relating to fraud. Inter Valley Health Plan has contracted with an outside firm that provides specialized expertise in the investigation of suspected fraud, either internally by company personnel, or externally by contracted providers, business associates, vendors, or members. Inter Valley Health Plan publicizes the Hotline, which is entitled "FRAUD ALERT" by:

- Sending a flyer announcing the Hotline to all employees and contractors;
- Inclusion of Fraud Alert Hotline in Compliance Training and Corporate Compliance Program read, reviewed and attested to by all staff, contractors, vendors, and business associates;
- Publishing the Hotline number in the member newsletter, "InterView", providing reference desk cards to staff and inclusion in the Employee Handbook
- Providing the Hotline number in the Inter Valley Health Plan Provider Manual and; and posted on Plan website under provider resources;
- Placing posters about the fraud program including the FRAUD ALERT telephone number in the lunchrooms located on each floor of the Plan's offices.

All forms of education include assurances of anonymity of reporting with a non-retaliation clause. The Corporate Compliance Committee continually looks to promote the Standards of Conduct and the Corporate Compliance Plan in any way that will help to assure there is good faith participation in the program by all.

Reporting Potential Fraud Issues or Areas of Noncompliance

Violations of the provisions in the Compliance Plan, Inter Valley Health Plan policies and procedures, or CMS requirements may result in disciplinary action up to and including termination of employment, or for contractors, termination of their agreement with Inter Valley Health Plan. Remaining free and clear of any sanctions or exclusions is a condition of employment and a requirement for any contractors or subcontractors with Inter Valley Health Plan.

Employees, business associates, Board of Directors, contractors or members are expected to report any suspected violations of the Standards of Conduct, the Corporate Compliance Program, or other irregularities. Reporting can be made to an Inter Valley Health Plan Supervisor or Manager, the Compliance Officer, Compliance Team/Committee, or the Fraud Alert Hotline. Inter Valley Health Plan will protect, to the degree

possible, the identity of any person reporting suspected fraud or noncompliance. Individuals wishing to remain completely anonymous should submit their reports through 1 (888) FRAUD ALERT, the Fraud Alert Hotline, which is maintained by a contracted Certified Fraud Examiner. Individuals may also report suspected fraud via mail to "Fraud Alert Compliance Dept" at P.O. Box 6002 Pomona, California, 91769-6002, or via a website at www.reportlineweb.com/ivhp. Individuals who report incidences of fraud or abuse may do so without fear of retaliation.

Reporting of Fraud is also explained in Inter Valley Health Plan's Employee Handbook, a document that all employees receive upon employment and on a yearly basis or as updated by change in regulations.

All reports must contain sufficient information for the Compliance Officer and/or Compliance Team or Certified Fraud Examiner to investigate the concerns raised. No adverse action or retribution of any kind will be taken by Inter Valley Health Plan against an employee because he/she reports in good faith, a suspected violation of the Standards of Conduct, the Corporate Compliance Program, or other irregularity by any person other that the reporting employee. Inter Valley Health Plan will attempt to treat such reports confidentially and to protect the identity of the individual who has made a report to the maximum extent possible.

The Corporate Compliance Officer and Committee have been appointed to ensure compliance with the Corporate Compliance Program, to serve as the contacts for employees to report any potential violations of laws, regulations, or the Program, and to take appropriate action against violators of any such laws, regulations, or this Program. Under the direction of the Corporate Compliance Office, the Compliance Officer will coordinate any investigations in conjunction with the contracted Certified Fraud Examiners. If the investigation substantiates that fraudulent activities or willful non-compliance has occurred, the Compliance Officer will issue reports to appropriate designated personnel and, if appropriate, to the Board of Directors and/or law enforcement..

Individual department policies and procedures, delegation audits, along with Fraud Training programs are part of Inter Valley Health Plans overall program to deter and prevent Fraud, Waste and Abuse.

V. ENFORCEMENT OF DISCPLINARY ACTION

Response to Improper Conduct

Upon the knowledge that an alleged fraudulent activity has occurred, the Compliance Officer shall immediately or within 3 days begin an initial inquiry and take appropriate action. Upon receipt of an allegation of misconduct, the Compliance Officer will immediately conduct an investigation. The Corporate Compliance Officer, in consultation with the Compliance Team/or Executive Management Committee, or Certified Fraud Examiner, will determine the appropriate action to take, which may include corrective action, retraining or termination of employment. Compliance will complete investigation of misconduct, fraud, waste, and abuse or payment related and close case within 60 days unless an extension is required.

Enforcement of standards under the Corporate Compliance Program will be consistent and predictable. The Compliance Officer, with the advice of the Vice President of Human Resources, Legal Counsel, Executive Management Committee and/or the Corporate Compliance Committee, will determine appropriate discipline for various violations of the Standards of Conduct.

Discipline will include, where appropriate:

- Counseling, training and education;
- Verbal and/or written reprimand;
- Impair raises or promotions;
- Suspension without pay;
- Demotion; and/or
- Termination or suspension of contract
- Referral to Law Enforcement

Disciplinary action will be documented in an employee's personnel file. Determination of appropriate disciplinary action will be guided by:

- The severity of the offense – whether criminal or civil, whether and type of violation of corporate policies, and whether the type of harm done to the company, Inter Valley Health Plan members, and/or other employees;
- Repeat offenses;

- Maliciousness of the act;
- Innocence of the violation; and
- Cooperation with any investigation.

If the Compliance Officer discovers credible evidence of misconduct and, after reasonable inquiry, have reason to believe that the misconduct may violate criminal, civil, or administrative law, they will report such misconduct promptly to the appropriate governmental authorities within 2 weeks. In the case of fraudulent activity related to Part D regulations, the Compliance Officer shall report such activities to the Medicare Drug Integrity Contractors (MEDICs) for further investigation within 2 weeks. The company will coordinate and cooperate with the MEDICs, and state and federal agencies during the investigation. As necessary, the Compliance Department upon completion of investigation will implement corrective actions when violations are identified such as: repayment, disciplinary actions against responsible employees and delegated entities to establish greater internal controls that will further be monitored and audited.

VI. MONITORING

Internal Auditing Identified Risk Areas

An ongoing evaluation process is critical to the success of the Corporate Compliance Program. The Compliance Officer will maintain all reports of suspected noncompliance with the Program, which will be reviewed by Inter Valley Health Plan's Senior Management as well as by the Corporate Compliance Committee. The audit function of the company is the responsibility of the Corporate Compliance Committee under the direction of the Compliance Officer.

The Compliance Department under the direction of the Compliance Officer, will compile a list or provide a summary, of all new state and federal laws applicable to the company and will distribute this list and/or summary to the heads of all operational areas. This will be done in a timely manner so that the operational areas are able to perform any necessary modifications to current procedures to ensure compliance with the applicable laws and /or regulation.

The Compliance Officer will provide deadlines for compliance and will then follow-up with the appropriate department(s) as the deadline approaches. The Compliance Officer also chairs any necessary task forces and or committees to provide implementation guidelines to help operational areas in complying with applicable laws. Written proof of compliance is required when modifications to any processes are made.

If the Compliance Officer finds that written documentation does not meet with compliance with each applicable law, rule, or regulation, he/she will require a corrective action plan, with estimated timelines for completion. This plan will include:

- Actions being taken to bring the department into compliance;
- Individual(s) responsible for completing the plan;
- Documentation showing compliance, and
- The process used to continually monitor and assure compliance.

Inter Valley Health Plan monitors compliance through a series of key indicators and internal and external audits and self reporting. This data is tracked through the On-Line Management Tool.

VII. Delegation Oversight

Delegated entities have a detailed oversight program that includes monitoring and self reporting of compliance metrics for claims, UM and credentialing. Delegation standards include provider agreement to comply with Inter Valley Health Plans standards and policies, as well as required training, including Fraud, Waste and Abuse training components and compliance with policies in the Provider Manual.

Delegated entities that fail to maintain compliance with the standards are required to complete an appropriate corrective action plan and Inter Valley monitors that the plan has been effectively implemented to close out a given CAP.

Training occurs for the delegated entities as part of the initial contracting process with training material provided with an attestation required to ensure adherence to the Corporate Compliance Program and distribution of the program requirements to their staff and downstream entities. Annual refresher training includes a copy of updates to the Corporate Compliance Program and a signed attestation of completion of the ICE CMS approved webinar training or an equivalent.

The Delegation Oversight process focuses on any noted areas of non-compliance and related corrective actions to ensure that issues are effectively resolved. Joint Operations meetings that occur on a regular basis include discussions on CAP activity, re-education on specific topics may be part of required corrective actions with a delegated entity, or overall education to all providers related to patters or trends in compliance risks and fraud waste and abuse mitigation. All delegated provider information, Corrective Action Plans, and audit results are reviewed by the Delegation Oversight Committee to ensure compliance and continued/discontinued delegation efforts.

For Part D, the oversight program is in conjunctions with the PBM. The PBM works with Inter Valley Health Plan related to training programs and distribution of alerts to the network pharmacies and in overall oversight activities so that there is not a duplication of effort.

VIII. COMPLIANCE PROGRAM ASSESSMENT

The Compliance Program elements evolve based on risk assessment of program areas and vulnerabilities. The program assessment includes the following elements:

- Implementation of new CMS requirements or changes in CMS requirements through a work plan approach;
- Review of Policies and Procedures annually or as program requirements change
- Annual CMS readiness assessment review / Checklist
- Ongoing Review of metrics related to compliance
- Review and internal CAPS for all notices of non-compliance from CMS or other regulators.
- Ongoing review of grievances, appeals and CTM's for areas of improvement.
- Review the annual OIG work plan for potential areas of focus for compliance oversight
- Work plan to ensure new areas of review or oversight in the annual CMS call letter are integrated into the program.
- Incorporated into the overall Work Plan is the OIG Work Plan, Annual Call Letter Information, Policy Changes for Federal and State, and an Overall Risk Assessment for the organization

IX. CONCLUSION

Summary

Inter Valley Health Plan recognizes that compliance is driven by senior management and the Board of Directors, who oversee that the Company has an effective Compliance Program. The Compliance Officer is accountable for ensuring that the compliance program has sufficient oversight of the myriad of CMS and regulatory program requirements. Compliance is a dynamic process which helps to ensure that the company can fulfill its commitment to ethical behavior while also meeting the challenges imposed on it by Congress and private insurers. The company's Corporate Compliance Program has been tailored to meet the needs and resources of the company's corporate structure, mission, and employee composition. It has been designed to meet the goals of providing efficient and quality health care and at the same time, preventing fraud, waste, and abuse.