ApexHealth

Medicare Compliance Plan

Adopted: 04/25/2022

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Medicare Compliance Plan Governance

This Medicare Compliance Plan ("Plan") is created with the knowledge and approval of the Apex Health, Inc. ("ApexHealth", "Our", "Company") Board of Directors ("Board") and applies to the Medicare Parts C and D lines of business ("Medicare Programs"). At least annually, this Plan is reviewed by the Medicare Compliance Officer ("Compliance Officer") before being approved by the Company's Board. More frequent updates may also be made to comply with regulatory or sub-regulatory guidance, to improve the effectiveness of the Compliance Program ("Program"), or for any other reason. Material changes to this Plan are approved by the Company's Board.

This Plan is one component of the Program and serves to reinforce our Company's commitment to comply with all applicable Federal and State standards (see Appendix A for a summary of relevant regulations) and the highest ethical standards of conduct. Another component of the Program is the Code of Conduct ("Code") which includes ApexHealth's standards of conduct and is endorsed by the Company's Compliance Officer and CEO and approved by the Board.

ApexHealth makes this Plan available to all employees, board members, and first tier, downstream, and related entities (FDRs). Employees and board members must read and understand the content of this Compliance Plan and the associated policies and procedures. FDRs have the option to:

1. Adopt the Company's Code, Plan, and associated policies and procedures

2. Create and comply with their own standards of conduct, compliance plan and/or equivalent policies and procedures that describe their commitment to comply with applicable Federal and State standards

3. Adopt the standards of conduct, compliance plan and/or equivalent policies and procedures of another entity contracted with the Centers for Medicare and Medicaid Services (CMS) for Medicare Programs

ApexHealth reserves the right to review and approve the standards of conduct, compliance plan, and/or policies and procedures adopted by an FDR.

Our Compliance Officer is available to answer any questions or provide additional information about this Plan or the Program.

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Compliance Program

Intentional and accidental misconduct in the health insurance industry can cause significant harm to beneficiaries. The Program is an essential tool that aims to prevent, detect, and resolve such non-compliant and illegal conduct, including fraud, waste, and abuse (FWA) and further promote regulatory compliance and ethical conduct. Organizational integrity is of utmost importance at ApexHealth and begins with everyone observing the spirit and letter of all applicable laws and regulations and demonstrating the highest standards of personal integrity.

Modeled after the *Compliance Program Guidelines* published by CMS, the Program consists of seven core elements:

1. Written policies, procedures, and standards of conduct
2. Compliance officer, compliance committee, and high-level oversight
3. Effective training and education
4. Effective lines of communication
5. Well-publicized disciplinary standards
6. Effective system for routine monitoring and identification of compliance risk
7. Procedures and system for prompt response to compliance issues

ApexHealth takes seriously its responsibility to maintain an effective compliance program that sufficiently:

- Promotes and enforces the Code
- Promotes and enforces the Program
- Effectively trains and educates employees, board members, and FDRs
- Effectively establishes lines of communication within the organization and between our organization and FDRs
- Oversees FDRs' compliance with Medicare Program requirements
- Establishes and implements an effective system for routine auditing and monitoring
- Identifies and promptly responds to risks and findings

Policies and Procedures and Standards of Conduct

ApexHealth is firmly committed to complying with, and expects its employees, board members, and FDRs to comply with, all applicable Federal and State standards. Employees and board members must also comply with all internal policies and procedures, the Code, and the ApexHealth Employee Handbook.

Policies & Procedures

ApexHealth is committed to operating its Medicare Programs in a compliant manner. The specific Medicare Program requirements applicable to each operational area are set forth in policies and procedures maintained by each such department and are subject to review by the Medicare Compliance department. The Compliance department is also available to assist operational areas in interpreting regulations or answering questions about regulations.

ApexHealth has in place policies and procedures which address both compliance practices and operational area processes, including policies that govern the administration of the Program and related requirements specified in this Plan. The Compliance department works with the operational areas to develop new or revise existing policies and procedures when any changes are made to the applicable laws and regulations. All Medicare-related policies shall be subject to review annually and as part of department-specific audit processes.

Compliance policies and procedures support the Code and this Plan. Aside from helping reduce the prospect of fraudulent, wasteful, abusive, or non-compliant activity through the identification and response to risk areas, Compliance policies:

- Articulate the Company's commitment to comply with all applicable Federal and State standards
- Describe compliance expectations as embodied in the Code
- Implement the operation of the Program
- Provide guidance to employees and others on dealing with potential compliance issues
- Identify how to communicate compliance issues to appropriate compliance personnel
- Describe how potential compliance issues will be investigated and resolved by the Company

- Include a policy of non-intimidation and non-retaliation for good-faith participation in the Program, including, but not limited to:
    - Reporting potential issues
    - Investigating issues
    - Conducting self-evaluations, audits, and remedial actions
    - Reporting to appropriate officials

All policies and procedures are stored on ApexHealth's compliance platform for access by all employees and board members. In addition, all such polices are made available to FDRs.

Standards of Conduct

The standards of conduct are included in the Code which articulates the Company's commitment to conduct business in a lawful and ethical manner in compliance with Federal and State requirements and defines the underlying framework for the Compliance policies and procedures. The Code describes the Company's expectations that all employees, board members, and FDRs ethically conduct themselves, that issues of suspected or actual non-compliance and FWA are reported through appropriate mechanisms, and that reported issues will be addressed and corrected.

The Code directs employees, board members, and FDRs on how to act in a variety of situations to uphold the highest standards of ethics and promote a culture of compliance. In the event the Code does not fully address the situation at hand, employees, board members, and FDRs are encouraged to use the Code as a guiding principle, exercise good judgment, and ask questions, as appropriate.

Simply stated, the standards of conduct embodied in the Code set the expectation that persons working for or on behalf of ApexHealth:

1. Promote honest and ethical conduct
2. Ask questions and raise concerns
3. Comply with the spirit and letter of the law
4. Avoid bribery, kickbacks, and corruption
5. Avoid conflicts of interest
6. Maintain accurate books and records
7. Safeguard the quality of products and services
8. Protect and properly use company information and assets

Compliance Officer, Compliance Committee, and High-Level Oversight

Compliance Officer

ApexHealth employs a full-time Compliance Officer who is independent and free to raise compliance issues without fear of retaliation. The Compliance Officer must be an employee of ApexHealth, and his/her responsibilities may not be delegated to a third party. The Compliance Officer reports in a supervisory capacity to the Vice President of Legal Affairs and has the authority to provide unfiltered, in-person reports directly to the President & CEO, when deemed appropriate. The Compliance Officer makes to the Compliance Committee periodic (e.g., quarterly) reports on the activities and status of the Program, including issues identified, investigated, and resolved by the Program.

Vested with the day-to-day operations of the Program, the Compliance Officer is responsible for:

- Providing regulatory interpretation and guidance regarding Federal regulations and CMS manuals
- Creating and coordinating training to ensure employees, board members, and FDRs are knowledgeable about the Program, Medicare Program guidelines, and relevant regulatory requirements
- Developing and implementing programs that encourage good-faith reporting of noncompliance and potential FWA without fear of retaliation
- Designing and coordinating internal investigations in response to reports of noncompliance/FWA
- Ensuring ApexHealth does not hire, appoint, or contract with individuals or entities that are excluded from participating in Medicare
- Overseeing the development and monitoring of the implementation of corrective action plans

To be successful, the Compliance Officer needs a certain level of authority and the necessary resources. As such, the Company authorizes the Compliance Officer to:

- Provide unfiltered, in-person reports to the CEO, Board of Directors, and/or Compliance Committee
- Interview employees and other relevant individuals regarding compliance issues
- Review company contracts and other documents pertinent to the Medicare Programs
- Review the submission of data to the CMS to ensure that it is accurate and in compliance with CMS reporting requirements
- Independently seek advice from legal counsel
- Report potential FWA to CMS, its designee, or law enforcement
- Conduct and/or direct audits and investigations of any FDR
- Conduct and/or direct audits of any area or function involved with Medicare Programs
- Recommend policy, procedure, and process changes
- Enforce compliance program requirements at all levels of the organization

Compliance Committee

Our Compliance Committee oversees the Compliance Program and advises the Compliance Officer. The Compliance Committee is accountable to and provides regular compliance reports to, the CEO and Board. Members of senior management and individuals with a variety of backgrounds who have decision-making authority in their areas of expertise are represented on the Compliance Committee.

The Compliance Committee is responsible for:

- Meeting at least quarterly, or as necessary, to enable reasonable oversight of the Compliance Program
- Ensuring that training is effective and complete
- Assisting with the creation and implementation of the compliance risk assessment and the compliance monitoring and auditing work plan(s)
- Assisting in the creation, implementation, and monitoring of effective corrective actions
- Reviewing the effectiveness of the system of internal controls designed to ensure compliance with Medicare regulations in daily operations
- Supporting the Compliance Officer's needs for sufficient staff and resources to carry out their duties
- Ensuring Compliance policies and procedures are appropriate and up-to-date
- Ensuring there is a system for employees and FDRs to ask compliance questions and report potential instances of noncompliance and FWA confidentially or anonymously without fear of retaliation

- Reviewing and addressing reports of monitoring and auditing of areas at risk for program noncompliance or potential FWA and ensuring corrective action plans are implemented and monitoring for effectiveness
- Providing regular and ad-hoc reports on the status of compliance with recommendations to the Board

High-Level Oversight

The Board of Directors oversees the implementation and effectiveness of and is accountable for reviewing the status of, the Compliance Program. The Board of Directors is knowledgeable about compliance risks and strategies, understands the measurements of the outcome, and gauges the effectiveness of the Compliance Program. Further, when issues are presented to the Board, it makes a further inquiry and takes appropriate actions to ensure the issues are resolved. The Board of Directors' active engagement in overseeing the Compliance Program may be demonstrated through a review of Board meeting minutes or other documentation.

The Board shall exercise reasonable oversight by, at a minimum:

- Approving the Code
- Understanding the structure of the Compliance Program
- Remaining informed about the Compliance Program outcomes, including results of internal and external audits
- Remaining informed about governmental compliance enforcement activity (e.g., Notices of Non-Compliance, Warning Letters, and/or more formal sanctions)
- Receiving regularly scheduled, periodic updates from the Compliance Officer and Compliance Committee
- Reviewing the results of performance and effectiveness assessments of the Compliance Program

The Board collects and reviews measurable evidence that the Compliance Program is detecting and correcting Medicare program noncompliance on a timely basis. Indicators of an effective Compliance Program include, but are not limited to:

- Use of measurement tools (e.g., scorecards, dashboard reports) to report, and track and trend, compliance with key Medicare Parts C and D operations such as enrollment; appeals and grievances; prescription drug benefit administration
- Use of monitoring to track and review open/closed corrective action plans, FDR compliance, Notices of Non-Compliance, Warning Letters, CMS sanctions, marketing material approval rates, training completion/pass rates

- Implementation of new or updated Medicare requirements (e.g., tracking HPMS memo from receipt to implementation) including monitoring or auditing and quality control measures to confirm appropriate and timely implementation
- Increase or decrease in number and/or severity of complaints from employees, FDRs, providers, beneficiaries through the customer service calls or the Complaint Tracking Module (CTM), marketing misrepresentations, Parts A and B issues
- Timely response to reported noncompliance and potential FWA, and effective resolution
- Consistent, timely, and appropriate disciplinary action
- Whether root cause was determined, and corrective action appropriately and timely implemented and tested for effectiveness
- Actions taken in response to compliance reports submitted by FDRs

The CEO promotes and recognizes the importance of compliance and gives the Compliance Officer the authority and resources needed to operate a best-in-class Compliance Program. The CEO receives from the Compliance officer:

- Periodic reports of risk areas facing the organization, the strategies being implemented to address them, and the results of those strategies
- Information regarding all governmental compliance enforcement activity, from Notices of Non-Compliance to formal enforcement actions

Training and Education

ApexHealth reviews this Plan on at least an annual basis to ensure compliance with applicable regulations or to address specific concerns. If a material change is made after the annual distribution, a description of the change is sent via a Company-wide notice. Such notice includes the contact information for the Compliance Officer to address any questions/concerns. Material changes are also communicated to FDRs.

General Training

Employees and board members receive general Compliance and FWA training as part of their orientation process. Such training occurs within 90 days of hire/appointment and at least annually thereafter. Training incorporates internal content such as this Plan, the Code, and Compliance policies and procedures, as well as external content (e.g., CMS-published content). Topics covered in general training include:

- An overview of how to ask compliance questions, request compliance clarification, or report suspected or detected non-compliance (with an emphasis on confidentiality, anonymity, and non-retaliation/non-intimidation for good-faith participation in the Program)
- The requirement to report to ApexHealth actual or suspected Medicare Program non-compliance or FWA
- Examples of reportable noncompliance that employees may observe
- A review of the disciplinary guidelines for non-compliant or fraudulent behavior
- A review of policies related to contracting with the government (e.g., gifts and gratuities for government employees)
- A review of potential conflicts of interest and the Company's system to disclose conflicts of interest
- An overview of HIPAA/HITECH and the importance of maintaining the confidentiality of personal health information
- An overview of the monitoring and auditing process
- A review of laws that govern employee conduct in the Medicare Program

Training is delivered in different ways including through a learning management system (LMS) that provides course content and may have an associated test, sessions hosted by the Compliance Officer, and/or the distribution of materials that

employees/board members attest to receiving and understanding. Regardless of how training was conducted, proof of completion is recorded and retained for no less than 10 years.

Specific Issue-Based Training

Training that addresses a specific subject matter may be developed by, or at the direction of, the Compliance Officer. Training of this nature may be a result of repeated instances of noncompliance, by employee request, or in response to significant regulatory changes. Such training may be mandatory for an individual, one or more departments, or offered to employees throughout the company, as appropriate.

FDR Training

General Compliance and FWA[1] training must be completed by FDRs within 90 days of contracting with ApexHealth and annually thereafter. Training may be administered using internally developed materials that include content consistent with previously published CMS training for Compliance (and FWA). When the FDR does not have training that meets this requirement, ApexHealth provides its training materials for the FDR to use.

ApexHealth reserves the right to review any training materials that are created by an FDR and are used to fulfill this requirement.

[1] An entity who has met the FWA certifications requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and supplies (DMEPOS) is deemed to have met the training and educational requirements for FWA

Effective Lines of Communication

Open Lines of Communication between the Compliance Officer, Employees, Board, and FDRs

ApexHealth strives to foster a culture of compliance throughout the organization. This is, in part, achieved by regularly communicating the importance of complying with applicable regulations and reinforcing our expectation of ethical and lawful behavior as described in the Code. Consistent with this culture, ApexHealth's Code and policies and procedures require all employees, board members, and FDRs to report compliance concerns and suspected or actual violations of State or Federal law and CMS regulations pertaining to the Medicare Programs.

ApexHealth has systems in place to receive, record, and respond to compliance questions or reports of potential/actual non-compliance from employees, members, board members, and FDRs. Reporting channels allow issues to be reported anonymously if desired, or directly to the Compliance Officer.

Reporting Mechanisms

Employees, board members, and FDRs must report compliance concerns and actual or suspected FWA to ApexHealth using one of the mechanisms below.

1. **Direct Reporting** – Compliance concerns may be reported either directly to management or the Compliance Officer/department.

2. **Compliance Hotline** – Compliance concerns may be reported anonymously by using EthicsPoint, a third-party vendor that accepts phone, website, and mobile reports. Report to EthicsPoint by:
    a. Visiting www.apexhealth.ethicspoint.com
    b. Calling 844-634-1167
    c. Scanning the QR code below

Non-Intimidation and Non-Retaliation

We strive to maintain, to the greatest extent possible, the confidentiality of individuals' identities; however, there may be a point where the identity may become known or may have to be revealed.

ApexHealth enforces a strict non-retaliation and non-intimidation policy. This means that good faith participation in the Program (including reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials) offers protection from intimidation, retaliation, or retribution.

This protection includes retaliation from False Claims Act complaints, as well as any other applicable anti-retaliation protections.

Well-Publicized Disciplinary Standards

As part of the Company's Program, ApexHealth has published the Code which establishes standards of conduct that all employees and board members are expected to follow. Among these is the expectation that individuals report suspected or known non-compliant, unethical, or illegal conduct. Standards of conduct adopted by FDRs must articulate a similar expectation.

Below are examples of types of conduct that may constitute grounds for disciplinary action; the absence of an item on this list does not mean it is not grounds for disciplinary action. Employees, board members, and FDRs are encouraged to use their best judgment to determine whether an action is in line with the values and culture of ApexHealth.

- Submitting claims to the government for services that were never rendered, failure to pay providers at the correct rate, paying providers who are on the Medicare opt-out or OIG/GSA exclusion list
- Improperly enrolling beneficiaries to obtain increased reimbursement from the government, improperly disenrolling beneficiaries due to increased medical expenses or other medically related reasons
- Not approving members for medically necessary services
- Failing to approve medically necessary services
- Misleading beneficiaries, violating a CMS marketing rule, allowing agents and brokers to conduct illegal marketing activities
- Not credentialing providers in accordance with credentialing laws and regulations, contracting with providers who are on the Medicare opt-out or OIG exclusion list
- Denying beneficiaries their transition supply, applying utilization management rules that have not been approved, inappropriately denying drugs that should be covered
- Billing beneficiaries an incorrect premium amount and/or not providing beneficiaries with the required grace period to pay their bills

Not reporting the above activities is inconsistent with the Company's culture of compliance and subjects an employee, board member, or FDR to disciplinary actions up to and including termination of employment, board appointment, or

contract, as applicable. The severity of disciplinary action depends on several factors and follows the Company's progressive disciplinary policy.

Serious or severe performance or conduct issues may result in immediate written notice or termination of employment, board appointment, or contract. For less serious or severe issues, ApexHealth uses a progressive coaching and performance improvement process, which offers a fair, equitable, and consistent method of addressing the improper performance and conduct.

The Compliance Officer is responsible for implementing procedures that encourage good-faith participation in the Program. One of these procedures provides for timely, consistent, and effective enforcement of the disciplinary standards when noncompliance or unethical conduct is determined. The Compliance Officer periodically meets with the Human Resources department to review the records of discipline to ensure that actions are appropriate to the seriousness of the violation, fairly and consistently administered, and imposed within a reasonable timeframe.

ApexHealth makes clear to employees, board members, and FDRs that violations of the standards of conduct in the Code and other illegal and unethical conduct will result in disciplinary action. This message is stated, and re-stated, in this Plan, the Code, each policy and procedure, training materials, the employee handbook, and other materials published by or at the direction of the Compliance Officer.

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Effective System for Routine Monitoring, Auditing, and Identification of Compliance Risks

Risk Assessment & Monitoring

The Compliance Officer, or his/her designee, performs an annual risk assessment that includes an assessment of the ways misconduct, noncompliance, and FWA can occur or have occurred by and against ApexHealth. The likelihood of realizing a risk is weighed against the anticipated consequence of realizing a risk to generate a risk score. At a minimum, the following factors are considered to generate a risk score:

- Results of audit/program evaluations
- Operational metric trends
- Organization/health plan changes
- Previously identified program issues and concerns
- Regulatory guidance & work plans
- Current controls

The risk assessment ensures that Compliance resources are devoted to areas that pose the greatest risk to ApexHealth and formalizes a protocol by which ApexHealth responds to the identified risk. The risk assessment is routinely reviewed and updated by the Compliance Officer to ensure that it adequately reflects the landscape at any given moment. Results of and updates to the risk assessment are reported to the Compliance Committee, along with recommendations for additional education, delegate entity oversight, system edits, or enhanced auditing and monitoring efforts.

In addition to the risk assessment to review functional areas, the Compliance Officer, or his/her designee, conducts a risk assessment of its first-tier entities to identify its high, medium, and low-risk entities.

Monitoring & Auditing

Monitoring and auditing are critical elements of the Program. It allows ApexHealth to identify areas that require corrective actions to achieve compliance with specific Medicare Program 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 the Program.

The monitoring and auditing work plan is a product of the annual risk assessment. Areas with higher risk scores generally call for formal audit engagements whereas an area with a lower risk score may be sufficiently managed by routine monitoring efforts. The Compliance Officer provides updates on monitoring efforts and results to the Compliance Committee and Board.

ApexHealth monitors and audits its first-tier entities to ensure that they follow all applicable laws and regulations, and to ensure that the first-tier entities monitor the compliance of the entities with which they contract. A reasonable number of first-tier entities with increased risk scores from the risk assessment are selected to be audited annually. If a first-tier entity performs its own audit, ApexHealth shall obtain a summary of the audit results that relate to the services the first-tier entity performs. Monitoring of first-tier entities for Medicare Compliance Program requirements includes an evaluation to confirm that the first-tier entity applies appropriate compliance program requirements to downstream entities with which it contracts.

Annually, ApexHealth either contracts with an independent third party or employs an internal team that is independent of the Compliance department to audit the effectiveness of the Program and adherence to CMS standards. The Compliance Officer reports the results of the audit to the Compliance Committee, CEO, and Board.

OIG/SAM Exclusion Screening

ApexHealth reviews the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) List of Excluded Individuals (LEIE) and the System for Award Management Exclusion List before hiring, appointing, or contracting with an employee (full-time, part-time, or temporary), volunteer, consultant, board member, or FDR, and monthly thereafter, to ensure that no person or entity working with our Medicare Programs is excluded or becomes excluded from participation in Federal programs.

For FDRs, ApexHealth determines the appropriate party, ApexHealth or the FDR, to conduct and track the monthly OIG and SAM screening. If the FDR maintains this

responsibility, the Medicare Compliance department requires annual attestations from the delegated entity to confirm the completion of the screenings. Additionally, ApexHealth conducts audits of selected delegated entities based on the annual risk assessment to review the documentation evidencing the completion of the monthly screenings.

Audits of Apex by CMS or its Designee

Audits by CMS or its designee allow ApexHealth to confirm the effectiveness of its Medicare compliance efforts and to identify areas for improvement. If deficiencies are noted in an audit, the Compliance Officer works with the relevant operational areas to develop corrective action plans to address the shortcomings.

ApexHealth fully cooperates with the CMS and any auditors acting on behalf of the Federal government in conducting audits, including onsite audits and audits of financial records. ApexHealth requires its FDRs to provide records to CMS upon request. ApexHealth allows access to all documentation and records for audits and maintains all records for 10 years.

The Compliance Officer, or his/her designee, is the point of contact for all audits related to the Medicare Programs.

Response to Compliance Issues and Enforcement Actions

ApexHealth takes seriously our commitment to compliance. Reported/identified violations of this Plan, our Code of Conduct, policies and procedures, or applicable laws/regulations are met with appropriate and immediate investigative action. If it is determined that unethical behavior or noncompliance has occurred, we take timely, consistent, and effective actions to enforce our disciplinary standards and develop corrective action plans to prevent the recurrence of similar violations and ensure ongoing compliance with CMS requirements.

We learn of and identify potential non-compliance through several sources, including:

- Exit interviews & questionnaires
- CMS audits
- Internal audits/monitoring
- Member complaints
- External audits
- Hotline tips
- Regulatory agencies
- Reports from other entities

Timely & Reasonable Inquiry

The Compliance Officer, or his/her designee, is responsible for making a timely and reasonable inquiry into cases of suspected or actual misconduct/noncompliance related to the Medicare programs. Reasonable inquiries are made as quickly as possible, but no later than 2 weeks after the date the potential noncompliance or potential FWA was identified/reported. This does not, however, mean that cases are resolved within 2 weeks; rather, a preliminary investigation of the matter is conducted in this timeframe. The time required to close out a case is largely dependent on its level of complexity. As a rule of thumb, we attempt to close out cases as shown below.

Complexity	Timeframe to close
1 – Simple	Within 2 months
2 – Complex	Within 6 months
3 – Highly complex	Within 6-12 months
4 – Exceptionally complex	Over 12 months
The level of complexity is subject to change	

Cases involving fraud, for example, may be complex and resource/time constraints may challenge ApexHealth's ability to timely investigate the matter. In this case, the Compliance Officer may either delegate the investigation to the appropriate subject matter expert or, within 30 days of the fraud being identified, refer the matter to the NBI MEDIC.

Depending on the severity of the suspected wrongdoing, an investigation may include:

- Interviews by internal personnel
- Review of systems and processes
- Review of policies and procedures
- Interviews by outside counsel, auditors, or other experts

Records of investigation contain documentation of the violation, a description of the investigative process, copies of interview notes and relevant documents, a list of interviewees, and the results of the investigation. Reasonable measures are in place to prevent the disposal/loss of such records for 10 years.

We expect all employees, board members, and delegated entities to cooperate fully in all compliance investigations. Failure to do so is grounds for disciplinary action up to and including termination of employment.

Corrective Actions

ApexHealth uses corrective action plans (CAP) to correct confirmed instances of noncompliance. CAPs represent the affected business area(s) commitment to correct the underlying issue that caused or allowed the non-compliance to occur. Corrective actions to correct non-compliance generally include creating/revising policies and procedures, retraining employees, reviewing system processes, developing monitoring and reporting protocols, and, in severe cases, termination of employment/contract. CAPs must achieve sustained compliance with the overall CMS requirements for that specific operational area. In the case of overpayments, corrective action includes repaying the overpaid amount.

The status of CAPs is reported to the Compliance Officer and Compliance Committee. The Compliance department tracks and monitors CAP implementation and requires that the operational area regularly report the completion of all interim action steps. Once a CAP is complete, the Compliance department may validate the CAP monitoring action items over some time to demonstrate sustained compliance was achieved and the CAP was effective. The Compliance Committee may review ongoing activity to ensure that the CAP undertaken is effective and to report ongoing noncompliance risks to the Board.

Self-Disclosure

ApexHealth views the self-disclosure of suspected or known FWA or instances of noncompliance as evidence that the Program is working, indicating that while some noncompliance occurred, the systems and people are in place to identify and respond to it. Depending on the type of misconduct, ApexHealth may refer matters to the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC), the OIG, the Department of Justice (DOJ), and/or CMS. Examples of misconduct that are subject to each entity, include:

NBI MEDIC

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond the Parts C and D plans, involving multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of fraud;
- Pattern of fraud or abuse threatening the life or well-being of beneficiaries; and
- Scheme with large financial risk to the Medicare program or beneficiaries.

OIG and DOJ

- Conduct involving false billing (e.g., the submission of improper claims to Federal health care programs);
- Conduct involving excluded persons (e.g., the employment of, or contracting with, individuals or entities on OIG's List of Excluded Individuals (LEIE)); and
- Conduct involving the anti-kick state and physician self-referral law

CMS

- Significant Medicare Program non-compliance
- Other matters deemed appropriate by the Compliance Officer

Fraud, Waste, & Abuse Detection and Prevention

ApexHealth is committed to the prevention and detection of FWA. Upon hire, employees and board members must agree to comply with the Code and complete all mandatory FWA training courses. Unless an FDR is deemed to have met the training and educational requirements for FWA, similar courses must be completed by FDRs within 90 days of the contract with ApexHealth and annually thereafter. Suspected and known instances of FWA must be reported to Compliance by using the reporting mechanisms described under the *Effective Lines of Communication* section.

Special Investigations Unit

The Compliance department functions as the Special Investigations Unit (SIU) for ApexHealth. In this capacity, they are responsible for investigating issues of possible Medicare FWA and developing and implementing training and awareness programs to promote the Company's commitment to combating FWA.

The SIU employs analytical data mining to identify referral patterns, possible payment errors, utilization trends, and other indicators of potential FWA. The SIU performs proactive and retroactive data analysis of medical and prescription drug claims to detect outliers that may indicate potential FWA. This process enhances ApexHealth's investigations, highlights risk areas, and improves the Company's ability to combat FWA.

If the SIU determines that potential fraud or misconduct related to the Medicare program occurred internally at ApexHealth or externally with an FDR, the SIU will promptly notify the Medicare Compliance Officer. ApexHealth'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 works with applicable business units, and FDRs to determine appropriate corrective action, which may include employment or contract termination.

Data Analysis for Prevention and Detection of FWA

ApexHealth performs monitoring and data analysis designed to prevent and detect 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 prescribing and dispensing practices of providers who serve a particular population (e.g., long-term care providers, assisted living facilities, etc.)

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

ApexHealth also relies on the Analytics and Investigations Collaboration Environment for Fraud, Waste, and Abuse (AICE-FWA) module in HPMS to support its FWA efforts and to generate reports on and target high-risk providers and pharmacies for investigation.

Appendix A: Applicable Federal & State Regulations

ApexHealth, its employees, board members, and FDRs must comply with applicable Federal and State standards. Summaries of several of them are listed below. Questions regarding the applicability of regulation in a given situation may be submitted to the Compliance Officer.

Anti-Kickback Statute

ApexHealth, its employees, board members, and FDRs shall not knowingly and willfully participate in the exchange of remuneration to induce or reward patient referrals or for the generation of business involving any item or service payable by a Federal health care program.

Beneficiary Inducement Statute

ApexHealth, its employees, board members, and FDRs shall not provide remuneration to enrollees who are eligible for Medicare or Medicaid benefits if they know (or should know) that doing so is likely to induce the enrollee's decision to order or receive items or services from a particular provider or to enroll in a particular plan or organization.

Criminal False Statement Act

ApexHealth, its employees, board members, and FDRs shall not knowingly and willfully falsify or make any fraudulent, false, or fictitious statement against a government agency or health care benefit program.

Criminal Wire and Mail Fraud

ApexHealth, its employees, board members, and FDRs 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 perpetuate the fraud. This includes any writings, signals, pictures, or sounds to execute such scheme or artifice.

Exclusion Statutes

ApexHealth, its employees, board members, and FDRs shall not employ or contract with persons or entities that have been excluded from doing business with the Federal Government.

False Statements Relating to Healthcare Matters

ApexHealth, its employees, board members, and FDRs shall not knowingly and willfully make or use any false, fictitious, or fraudulent statement, representations, writings, or documents, regarding a material fact in connection with the delivery of, or payment for, health care benefits, items, or services. No ApexHealth employee, board member, or FDR may knowingly falsify, conceal, or cover up a material fact by a trick, scheme, or device.

Federal Criminal False Claims Statute

ApexHealth, its employees, board members, and FDRs 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.

Federal False Claims Act

ApexHealth, its employees, board members, and FDRs shall not:

- Knowingly file a false or fraudulent claim for payment to the United States Government;
- Knowingly make a false record or statement to get a false or fraudulent claim paid or approved by the Government;
- Conspire to defraud the government by getting a false or fraudulent claim paid or approved by the Government; or
- Knowingly make a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government

Health Insurance Portability and Accountability Act (HIPAA)

ApexHealth, its employees, board members, and FDRs shall not violate the provisions that govern the privacy and security of individually identifiable information or protected health information.

Healthcare Fraud

ApexHealth, its employees, board members, and FDRs shall not knowingly or willfully execute or attempt to execute, in connection with the delivery of, or payment for, healthcare benefits, items, or services, a scheme or artifice to:

- Defraud any healthcare benefit program; or
- Obtain, using 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

Law Applicable to Recipients of Federal Funds

ApexHealth, its employees, board members, and FDRs shall not knowingly or willfully fail to comply with laws that prohibit discrimination in programs, activities, and facilities that received federal funds. ApexHealth will comply with the following laws:

- Title VI of the Civil Rights Act of 1964;
- § 504 of the Rehabilitation Act of 1973;
- The Age Discrimination Act of 1975; and
- The Americans with Disabilities Act

Money Laundering Acts

ApexHealth, its employees, board members, and FDRs shall not:

- Use any income obtained from mail or wire fraud to operate any enterprise
- Use the proceeds of wire or mail fraud in financial transactions, which promote the underlying fraud

Obstruction of Criminal Investigation

ApexHealth, its employees, board members, and FDRs 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.

Physician Self-Referral ("Stark") Statute

Physicians shall not make referrals for certain designated health services paid for by Medicare to any entity in which the physician has a financial relationship (e.g., any direct or indirect ownership or investment interest by the referring physician or the referring physician's immediate family members).

Title XVIII of the Social Security Act

ApexHealth, its employees, board members, and FDRs shall not violate the provisions that govern the administration of the Medicare Programs.

Theft or Embezzlement in Connection with Health Care

ApexHealth, its employees, board members, and FDRs 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 health care benefit program.

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