PrimeTime Compliance Program (including Fraud, Waste, and Abuse)

PrimeTime Health Plan (PrimeTime) is committed to ethical and legal conduct in the operation of our business, the provision of health care services, and the participation in government health care plans. As part of PrimeTime's commitment to legal and ethical conduct and regulatory compliant business practices, we have adopted standards to uphold these principles. These standards are the basis for the PrimeTime Compliance Program. This Program is comprised of the PrimeTime Code of Business Conduct and Ethics, compliance components consistent with applicable Federal and State standards and measures to prevent, detect and correct Part C or Part D Plan non-compliance as well as fraud, waste and abuse.

PrimeTime's Compliance Program strives to improve operational quality by fulfilling four primary goals:

- Demonstrate a commitment to compliance and ethical and legal business conduct.
- Prevent, identify and correct non-compliant behavior and fraud, waste, and abuse.
- Develop and implement internal controls, processes and a culture to promote compliance with all applicable State and Federal laws and regulations.
- Establish an environment of open communication that encourages employees, including contractors, first tier, downstream, and related entities, directors and company leadership and to identify and report potential non-compliant practices and behavior.

To achieve these goals, PrimeTime has established a PrimeTime Compliance Program, which is comprised of the following key components:

1. The PrimeTime Code of Business Conduct and Ethics describes the guiding principles of business conduct applicable to all activities conducted by PrimeTime employees, directors, company leadership, contractors, and first tier, downstream, and related entities who provide health or administrative services for PrimeTime or its enrollees. Please review, download, and be familiar with this Code of Business Conduct and Ethics.

2. The PrimeTime Compliance Program establishes and implements procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensures ongoing compliance with CMS requirements.

3. The PrimeTime Fraud, Waste and Abuse Plan describe the processes used by PrimeTime to implement a comprehensive plan to detect, correct and prevent fraud, waste and abuse.

Code of Business Conduct and Ethics

The reputation and integrity of AultCare Insurance Company, AultCare Health Insuring Corporation dba PrimeTime Health Plan, AultCare Corporation, Aultra Administrative Group, and AultComp MCO, Inc. (the "Company") are valuable assets critical to the Company's success in delivering high quality services to our members. Each employee, including contractors, first tier, downstream, and related entities, directors and company leadership that provide health or administrative services for PrimeTime is responsible for conducting PrimeTime's business in a manner that is consistent with a commitment to the highest standards of integrity and professionalism. This Code of Business Conduct and Ethics ("the Code") is intended to help employees, contractors, first tier, downstream, and related entities, directors and company leadership recognize areas of ethical risk, and to deal appropriately with ethical

issues in all areas of company operations. It is also intended as a means of fostering a culture of honesty and accountability.

PrimeTime's continued success is directly related to our ability to deliver quality services and the ability of our employees to conduct themselves in accordance with the highest standards of business ethics and the law.

General Compliance

Employees, including contractors, first tier, downstream, and related entities, directors and company leadership who provide health or administrative services for PrimeTime or its enrollees must report any activity or conduct believed to be in violation of the Code of Conduct or any Federal, State or local law, regulation or ethical standard. Any employee, including contractors, first tier, downstream, and related entities, directors and company leadership found to have known of such allegation activity or conduct, but failed to report it, may be subject to disciplinary action, up to and including termination. Reports of non-compliance or suspected non-compliance should be based on facts and objective information only, and will be treated with complete anonymity.

Legal Compliance

PrimeTime is required to comply with many laws and regulations at the Federal, State and local level. Employees, directors, company leadership, contractors, and first tier, downstream, and related entities who provide health or administrative services for PrimeTime or its enrollees are under a continuing obligation to familiarize themselves with any and all legal requirements that affect the performance of their job duties and to keep abreast of changes and revisions to legal requirements and regulatory policy. Employees including contractors, first tier, downstream, and related entities, directors and company leadership shall take all steps necessary to ensure that all activities undertaken by or on behalf of PrimeTime are in compliance with all applicable Federal, State and local laws and regulations.

Some of the laws and regulatory requirements that pertain to Company's products include, but are not limited to:

- Federal False Claims Act
- Federal Anti-Kickback Statute
- Health Insurance Portability and Accountability Act (HIPAA)
- Code of Federal Regulations, specifically 42 C.F.R. § 400 (Medicare Program), § 403 (Medicare Supplemental Policies), § 411 (Stark Regulations), § 417 (Qualified HMO Plans), § 422 (Medicare Advantage Plans), § 423 (Medicare Prescription Drug Benefit), § 1001 (Anti-Kickback Regulations) and 1003 (Civil Monetary Penalties and Exclusions).
- Regulatory guidance produced by the Centers for Medicare and Medicaid Services (CMS), including requirements in the Medicare Managed Care Manual (MMCM) and the Prescription Drug Benefit Manual (PDBM), as well as all other policy guidance.
- Applicable State laws, including Ohio Revised Code Title 39, Insurance, Chapter 17, Health Insuring Corporations, and Chapter 4123, Workers' Compensation, and the corresponding regulations in the Ohio Administrative Code. Contractual obligations and commitments Health Care Consumer Bill of Rights and

Responsibilities ("Patients' Bill of Rights") in accordance with the U.S. Office of Personnel Management (OPM) guidance.

General Compliance and Fraud, Waste and Abuse (FWA) Training:

PrimeTime must establish, implement, and provide effective training and education programs for its employees, including the Chief Executive Officer, senior administrators or managers, governing body members, and first tier, downstream, and related entities.

In order to ensure consistency and reduce burden on providers, suppliers, contractors and Sponsors, CMS has established a web-based training to satisfy General Compliance and Parts C and D Fraud, Waste and Abuse (FWA) training and education requirements.

The Medicare Parts C and D General Compliance Training and Combating Medicare Parts C and D Fraud, Waste and Abuse training courses provide separate content for compliance and FWA, and provide web-based versions that are printable and PDF versions that are downloadable. The training content is generic since various entities (e.g., health plans, labs, hospitals, providers, etc.) complete the training. A certificate of completion (which includes contact hours) is generated upon passing a short test with a score of 70% or higher at the end of each web-based training (WBT). To get your certificate you must go through the WBT itself.

To access the most up-to-date CMS training information, log onto the below website and follow the instructions:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf

Note: First tier, downstream, and related entities who have met the FWA certification through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of DMEPOS are deemed to have met the FWA training and education requirements.

PrimeTime is accountable for maintaining records for a period of 10 years of the time, attendance, topic, certificates of completion (if applicable), and test scores of any tests administered to its employees and also require our first tier, downstream, and related entities to maintain records of the training of their employees for 10 years.

Reporting Concerns:

PrimeTime encourages anyone with knowledge of suspected instances of Part C and Part D non-compliance and/or fraud, waste and abuse to report this information to the Compliance Department and/or the FWA Department. This information can be reported confidentially or anonymously and without fear of retaliation. PrimeTime has and enforces a policy of non-retaliation and non-retribution toward any party reporting suspected instances of non-compliance or FWA. PrimeTime

will not discriminate or retaliate against anyone for reporting a compliance concern or for cooperating in any government or law enforcement investigation or prosecution.

Call our toll-free anonymous hotline, email us, or send us a letter via fax or mail.

Compliance/FWA Reporting:

Phone: 1.866.307.3528
Email: https://aultcarepthp.alertline.com
Fax: 330.363.3066
Mail: PrimeTime Health Plan
Compliance Department
214 Dartmouth Ave SW
Canton, Ohio 44710
-or- PrimeTime Health Plan
FWA Department
PO Box 6029
Canton, Ohio 44706

Reporting to the MEDIC and other Law Enforcement

Parties may also choose to report suspected instances of non-compliance or FWA directly to the MEDIC and/or other Law Enforcement. Reports to the MEDIC can be made as follows:

- Telephone - 1-877-7SafeRx (1-877-772-3379)
- Fax - (410) 819-8698
- Website - www.healthintegrity.org

Prompt Response and Corrective Action

All reports of suspected improper conduct, Part C and Part D non-compliance, and/or fraud, waste or abuse are investigated promptly and thoroughly by the PrimeTime Compliance and/or the FWA Department, under the direction of the PrimeTime Compliance Officer. Every effort is made to maintain the confidentiality of reports of potential violations and concerns about fraudulent, illegal or non-compliant behavior.

As determined by the respective area, cases of confirmed non-compliance and/or fraud, waste and abuse by a first-tier, downstream or related entities, will result in a corrective action plan documented in writing. The agreement will provide details of the required corrective action, timeframes for completion of the corrective action, a description of the methods of evaluation to ensure the corrective action plan has been implemented and effective in correcting the violation, and a description of the ramifications to the first-tier, downstream or related entity up to and including contract termination, should the entity fail to implement the corrective action according to the plan, or should the corrective action fail to correct the violation.

PrimeTime maintains complete and thorough documentation of all investigations per CMS record retention requirements, including a description of the suspected non-compliance or fraud, waste or abuse, a description of the investigation, copies of relevant documents and notes from staff and other interviews, findings from the investigation, and disciplinary and/or corrective actions taken as a result of the investigation.

Identification of Fraud, Waste and Abuse

Listed below are examples of Medicare Part C and Part D fraud, waste or abuse:

Fraud: Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. 18 U.S.C. § 1347.

Examples of fraud by employees include but are not limited to:

- Paying claims that are known to be false
- Altering/destroying member materials, medical records, physician referrals, etc.
- Back-dating enrollment forms or suggesting that a member do so, and
- Submitting false information to a government agency

Examples of fraud by sales agents include but are not limited to:

- Altering or destroying enrollment forms, member materials, medical records, or physician referrals, etc.
- Back-dating enrollment forms or suggesting that a member do so
- Submitting false information to a government agency
- Reviewing the obituaries and enrolling a Medicare beneficiary that has died

Examples of fraud by providers include but are not limited to:

- Billing for care of a patient who was never seen or for services not performed
- Billing for unnecessary services that were performed
- Billing for more extensive or complicated services than were actually delivered
- Prescription drug shorting, which is not filling the prescription with all of the appropriate number of pills
- Duplicate billing

Examples of fraud by members include but are not limited to:

- Submitting false information or omitting material information on an enrollment form
- Forging or altering enrollment forms or prescriptions, etc.
- Filing false claims
- Misusing a member ID card

Waste: Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Examples of waste include, but are not limited to:

- Unnecessary spending to purchase supplies or equipment
- Failure to reuse or recycle major resources or reduce waste generation

Abuse: Abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or

services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Examples of abuse include, but are not limited to:

- A Provider billing for services or items in excess of those needed bythe patient
- A Provider routinely filing duplicate claims, even if it does not result in duplicate payment
- A Provider filing a claim for the same member, date of service, procedure, etc., several times
- A Beneficiary doctor shopping for the purpose of inappropriately obtaining multiple prescriptions.

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