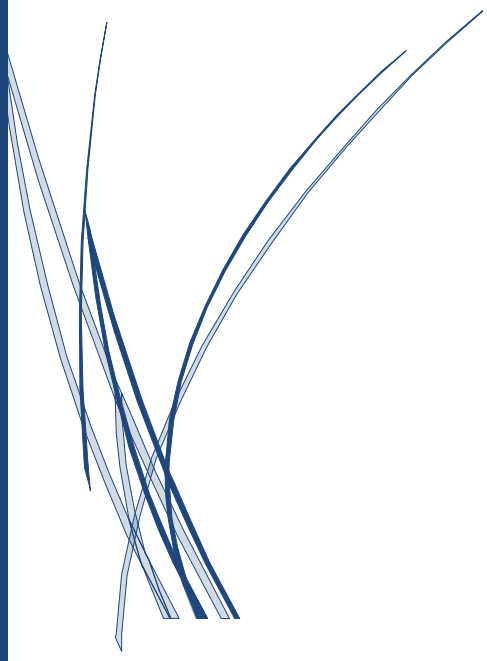
Texas Independence Health Plan, Inc.

2024

Compliance Program



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Commitment to a Culture of Compliance

Our Compliance Program establishes the framework for a culture of compliance. Our culture focuses on prevention, detection, and correction, including proactive monitoring, training, evaluation of violations of applicable federal and state laws and regulations. This is done to ensure business practices are conducted lawfully, ethically and in a manner conducive to the achievement of enterprise goals. Further, our culture of compliance encourages all employees and contracted business partners to perform duties in accordance with the Code of Conduct and published company policies and procedures.

Your executive leadership team fully supports all compliance efforts and expects that each employee (temporary, part-time, or full-time), providers and first tier, downstream and related entities will be active participants in this Compliance Program.

Everyone who contributes to our plan must foster and demonstrate compliance with the requirements and the spirit of this Compliance Program at all times. This includes the Board of Directors, executives, management, employees, and all contractors and vendors.

Our program is based on a continuing process of outreach, communication, education, and oversight. Ongoing efforts will be made at every level to foster this culture of compliance. Our Compliance Officer will lead these efforts to ensure that our Plan provides a fair, ethical and compliant environment in which our members will receive a superior level of service and quality.

I. INTRODUCTION

A. Our Mission and Purpose:

To connect our membership, through a fair, ethical and compliant environment, with coordinated healthcare delivered by professionals in the most appropriate setting possible.

B. Applicability and Oversight of the Compliance Program

The Compliance Plan applies to all Employees/Workforce Members of Texas Independence Health Plan, Inc. (TIHP). It also establishes expectations and requirements for First Tier, Downstream or Related Entities (FDRs) for maintaining, monitoring and reporting compliance activities. The Plan operates under the authority and oversight of the Board; and this Compliance Plan has been reviewed and adopted by the TIHP's Board of Directors.

C. Scope

This Compliance Plan applies to the Medicare Advantage program (Part C), the Medicare Prescription Drug Benefit program (Part D).

D. Purpose of the Compliance Program

TIHP operates in one of the most highly regulated industries in the world. The TIHP Compliance Plan was established to help ensure our Board of Directors, employees and business partners adhere to applicable laws and regulations that govern our business; regulate our internal processes and; reinforce our commitment to conduct our business and delivery of services in a fair, ethical, honest and transparent manner.

In addition to being required, another important reason for implementing a Compliance Program is simply because it is the right thing to do. The Board of Directors ("Board") and the Chief Executive Officer are committed to creating and supporting a culture of compliance to protect TIHP by avoiding fraud, waste, abuse, discrimination and other practices that disrupt operations or put our organization at risk. The Board and the Chief Executive Officer are fully knowledgeable and supportive of this Compliance Program. These individuals provide active oversight of the Compliance Program through the Compliance Officer. The Compliance Officer reports to the Chief Executive Officer but also has authority to communicate directly to the Board and applicable subcommittees, as necessary.

The objectives of our Compliance Plan are to:

(1) Cultivate a *Culture of Compliance* in which all stakeholders feel both empowered and obligated to do the right thing;
(2) *Make Compliance Meaningful* from the top-down by measuring and incentivizing performance against a system of defined compliance goals to demonstrate a shared responsibility for compliance and;
(3) *To Continuously Re-invent and Breathe New Life into the Compliance Program* by conducting ongoing risk assessments to keep pace with a rapidly changing regulatory environment; incorporating lessons learned and;
(4) Pre-prioritizing compliance projects, resources and activities that are most critical to the mission of TIHP.

The Compliance Program as presented in this document establishes a framework for effective compliance by the Company and its FDRs. It does not set forth all of the substantive programs and policies that are designed to achieve compliance. Established compliance policies, which will be updated through ongoing review, and future policies will be a part of overall compliance enforcement program.

Compliance is ever-changing…

As noted above, we operate in highly regulated and fast-paced industry. We must stay abreast of newly changed regulations. We are committed to ensuring that we dedicate the resources necessary to maintaining compliance in an ever-changing environment.

Compliance is everyone's business…

Ensuring that we remain in compliance requires a team effort. All employees and Board Members have a role to play in our Compliance Program. The Compliance Plan defines the responsibility of all workforce members to ensure honest and responsible performance of their duties, decreases the likelihood of unlawful or unethical behavior, and encourages all stakeholders to report potential problems for review and corrective action, if applicable.

The Compliance Plan applies to all employees/workforce members. The Plan operates under the authority and oversight of the Board.

E. Translating Essential Compliance Program Elements into Action

The Compliance Plan implements the seven compliance program elements set forth in the Centers for Medicare & Medicaid Services (CMS) regulatory requirements and federal guidelines in the following ways:

i. Developing organizational policies and procedures and a Code of Conduct that integrate compliance program elements into operations
ii. Assigning to individuals with authority, or who have a substantial role in creating or enforcing the policies of the Company, overall

responsibility to oversee compliance with those standards, policies and procedures

iii. Developing and maintaining effective internal controls to help assure compliance with Federal and State regulations and internal guidelines

iv. Establishing monitoring and auditing procedures to identify compliance risks and timely detect, prevent and correct compliance violations and evaluate the effectiveness of the Plan

v. Providing clarity on navigating various laws and regulations that govern TIHP operations

vi. Compliance education and training for TIHP workforce (i.e. employees, consultants, temporary workers and board members); communicating compliance and ethics standards, policies and procedures to all workforce members/employees by disseminating information appropriate to the duties of those individuals

vii. Encouraging and holding employees and business partners accountable for carrying out daily activities within appropriate ethical and lethal standards

viii. Ongoing assessment and identification of compliance risks

ix. Maintaining open lines of communication to allow for reporting of misconduct and violations of regulatory requirements and guidelines as well as seeking guidance regarding potential or actual compliance violations without fear of retaliation

x. Prompt response, investigation, escalation and reporting of identified compliance issues and Medicare Advantage and Medicare Prescription Drug Program violations

xi. Establishment and implementation of oversight mechanisms for our contracted First Tier, Downstream and Related Entities (FDRs)

xii. Identifying opportunities to improve quality of care and service in both clinical and non-clinical environments

xiii. Establish reasonable steps to respond promptly and appropriately to violations that have been detected and to prevent further violations

xiv. Prevention and detection of Fraud, Waste and Abuse and otherwise maximize compliance with applicable laws

F. Compliance Program Effectiveness

The Compliance Officer (CO) must regularly review the implementation and execution of the compliance program elements. The review will be conducted at least annually and include an assessment of each of the basic elements individually, as well as the overall success of the program. This review will help identify any weaknesses in the Compliance Program and implement appropriate changes. A copy of the completed review will be provided to the Chief Executive Officer, Compliance Committee and then to the Board as appropriate.

G. Key Regulatory Requirements

All employees and contracted service providers (e.g. practitioners, FDRs, business partners, etc.) must be knowledgeable about and ensure compliance with all laws and regulations that govern our business. While the listing is not inclusive of all laws and regulations, it does provide an overview of some important requirements that apply to our business.

Fraud, Waste & Abuse (FWA)	***False Claims Act:*** Aimed at preventing fraud against the government, including fraudulent billing and fraudulent submission of claims or statements to any Federal healthcare program. FCA applies when a false claim for reimbursement is submitted for payment to a government program and the provider knew or should have known that the information or certification of the claim was false. ***Anti-Kickback Statute:*** Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive bribes, kickbacks, or other renumeration (anything of value) in order to induce business reimbursed by Medicare, Medicaid and, other federal health care programs. ***Stark Law (Physician Self-Referral Law):*** Prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies and; Prohibits the designated health services entity from submitting claims to Medicare for those services resulting from a prohibited referral. ***Exclusion Law:*** Individuals or entities convicted for a program related crime, a criminal offense relating to patient abuse or neglect, a felony offense related to health care fraud, or a felony offense related to controlled substances must be excluded from Medicare and Medicaid for a minimum of 5 years. If there is one prior conviction, the exclusion will be for 10 years, and the exclusion will be permanent where there are two prior convictions. ***Civil Monetary Penalties (CMP) Law:*** CMPs may be imposed by the Office of Inspector General (OIG) for a variety of conduct, and different amounts of penalties and assessments may be imposed on the type of violation at issues. Penalties range from up to $15,000 to $70,000 per violation. Violators are also subject to 3x the amount of renumeration offered, paid solicited or received.
Privacy & Security	***Health Insurance Portability and Accountability Act (HIPAA):*** Protects the privacy and security of health care information and "mandates electronic and physical" safeguards "to prevent

	unauthorized access to protected health care information. ***Health Information Technology for Economic and Clinical Health Act (HITECH):*** Expanded the reach of HIPAA by extending certain obligations to business associates and imposed a nationwide security breach notification law.
Medicare Regulations & Guidelines	***Code of Federal Regulations 42 CFR Parts 422 and 423:*** Federal regulations that govern the Medicare Advantage Program (Medicare Part C) and the Prescription Drug Benefit (Medicare Part D). The Center for Medicare and Medicaid Services (CMS) is the federal agency that administers/oversees the Part C and Part D Programs. CMS maintains online manuals which provide guidance based on Medicare statutes and regulations and; maintains a web-enabled Health Plan Management System (HPMS) where health and drug plans, plan consultants, third-party vendors and pharmaceutical manufacturers can work with CMS to fulfill the plan enrollment and compliance requirements of the Medicare Advantage (MA) and Prescription Drug Programs.

II. COMPLIANCE PROGRAM

A. Element 1 – Code of Conduct and Written Policies and Procedures (P&Ps)

TIHP's written Code of Conduct (The Code) sets forth the TIHP's expectations and directives relative to corporate compliance, ethics, and conduct. It summarizes certain laws and standards applicable to TIHP, and states expectations for adherence to such regulations and guidelines. The Code is amended from time to time to incorporate changes in the laws.

TIHP has also established Compliance Program policies and procedures to further define its expectations relative to compliance with laws, regulations, and other standards. These policies and procedures are updated to reflect any relevant changes approved by senior executives and disseminated to workforce members. Because the Code as well as the Compliance policies and procedures cannot possibly encompass all legal duties of TIHP, the summaries should be viewed as minimum standards with company policies and procedures applicable to each area providing additional guidance and legal background.

All workforce members are expected to abide by the standards set forth in the Code and company policies and procedures.

Individuals who need additional guidance concerning their legal duties are encouraged to contact their supervisor or the Compliance Officer, who will consult with the company's Legal Counsel when appropriate.

The policies that articulate our Compliance Program are centrally located and are accessible to all employees. The Code, as well as policies and procedures, firmly establish our commitment to a culture of non-intimidation and non-retaliation for good faith participation in the compliance program.

B. Element 2 – The Compliance Officer (CO), The Compliance Committee & High Level Oversight

i. Compliance Officer (CO)

The CO is an employee of the Plan and is responsible for the development, implementation, and administration and oversight of the Compliance Plan. The duties of the CO include, but are not limited to:

- Ongoing assessment of compliance risks
- Development of annual compliance work plans
- Monitoring regulatory changes, industry trends and issues
- Overseeing the integration of the compliance program into operations
- Creating and coordinating, appropriate delegation, if desired, educational training programs to ensure employees and FDRs are knowledgeable about the compliance program, the Code of Conduct, compliance P&Ps, and all applicable statutory and regulatory requirements
- Development and implementation of methods that encourage employees to report noncompliance and potential FWA without fear of retaliation

- Promptly responding to reports of non-compliance and potential FWA coordination with the SIU or subject matter experts in relation to actual or potential instances of FWA as applicable
- Working with management and others to investigate non-compliant behaviors and processes; coordinating with Human Resources, Legal or other departments as appropriate regarding resulting disciplinary actions
- Overseeing the development, implementation and monitoring of corrective action plans (CAPs)
- Establishment of charge and composition of the Compliance Committee and coordinating operational aspects of the compliance program with the Committee
- Establishment of charge and composition of the First Tier, Downstream and Related Entities Committee (FDROC) and coordinating with the Committee to ensure FDR monitoring and oversight activities are performed in an efficient and systematic manner that promotes consistency in application of best practices.
- Maintaining direct access to the Chief Executive Officer (CEO), Senior Management and the Board
- Verifying the Board understands its responsibility as it relates to the compliance program and culture
- Independently investigating and acting on matters related to compliance and ethics. The CO possesses the authority to design and coordinate internal investigations and any resulting corrective action with the appropriate internal departments
- Collaboration with Legal Counsel regarding voluntary disclosures

The CO, at his/her discretion, need not await approval of the Board to implement needed compliance actions and activities, provided that those actions and activities are appropriate, and are reported to the Compliance Committee and the Board at their next scheduled meetings. Reports to the Compliance Committee, CEO and the Board should include, but not be limited to status updates on the compliance work plan; identification and resolution of suspected, detected or reported instances of noncompliance and; updates on FDR monitoring and oversight activities and FDR performance.

ii. Compliance Committee

The Compliance Committee supports the CO in the development, monitoring and assessment of the Compliance Plan. The CO serves as Chair of the Compliance Committee. The Compliance Committee will review reports and recommendations of the CO regarding Compliance Program activities, including data regarding compliance generated through audit, monitoring, and individual reporting. Based on these reports, the Compliance Committee will make recommendations regarding the effectiveness of the Compliance Program. The Compliance Committee is comprised of senior management from key

business areas:

- Executive Leadership
- Compliance
- Operations (Business & Clinical)
- Pharmacy
- Quality

iii. Senior Management

The Chief Executive Officer (CEO) and senior management should ensure that the CO is integrated into the organization and is given the credibility, authority and resources necessary to operate a robust and effective compliance program. The CEO will receive periodic reports from the CO, or his/her designee, of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies. The Chief Executive Officer will also be advised of all governmental compliance enforcement activity, from Notices of Noncompliance to formal enforcement actions.

iv. Board of Directors (The Board)

The Board will receive training and education to help foster the Board's knowledge and participation regarding the structure and operation of the compliance program and enable the Board to help advance our compliance program and the overall mission and values of the organization. The Board of Directors Oversight Bylaws clearly defines the respective roles, responsibilities and authorities of the Board in setting the direction, management and control of the organization. The Board's responsibilities include, but are not limited to:

- Overseeing the fiduciary assets and mission of the organization
- Approving and maintaining reasonable oversight of the organization's Compliance Program
- Ensuring there is an adequate reporting system in place to advise the Board of compliance risks and strategies in a timely and efficient manner
- Reviewing information and reports and to make informed strategic decisions regarding the compliance program, including matters that relate to funding and resource allocation and;
- To gauge the effectiveness of the compliance program

C. Element 3 – Effective Training and Education

The Compliance Department works collaboratively with Human Resources, and other business teams to support and reinforce compliance and ethics through ongoing training. Successful completion of mandatory training and attestations are placed in employee files for use during personnel evaluations. Training records are maintained for a period of ten years.

TIHP has developed a compliance and fraud, waste and abuse ("FWA") awareness, training, and education program that includes the effective communication of applicable compliance standards and procedures to its workforce members. Education and training programs involve basic education about compliance and FWA as required by CMS.

From time to time on an as-needed basis, TIHP may offer specialized education for certain groups of Workforce Members who have responsibilities which give rise to specialized issues. Specific attention is given to training concerning laws and regulations identified by government agencies as targets for enforcement actions against healthcare organizations including Code of Conduct, HIPAA, FWA, and General Compliance. Training is done within the first ninety (90) days of employment or appointment and repeated annually thereafter, unless otherwise noted.

The CO is responsible for coordinating the education and training process and ensures that appropriate documentation is maintained concerning participation in such training programs. The CO determines the appropriate content and method of educating particular groups of the TIHP's workforce.

Our contracted FDRs are required to ensure their employees, Board members, agents, temporary workers, consultants, volunteers, and employees of subcontractors or Downstream and Related Entities (collectively "Workforce Members") who have involvement in the administration or delivery of Medicare Advantage (Part C) or Medicare Prescription Drug Benefits (Part D) receive general compliance training and Fraud, Waste and Abuse (FWA) training within 90 days of hire and annually thereafter. FDR Training and Education requirements are addressed in our FDR Code of Conduct. The CO is responsible for ensuring FDRs complete a Compliance Attestation on an annual basis.

D. Element 4 – Effective Lines of Communication

We are committed to implementing and maintaining effective lines of communication to help reinforce the importance of compliance and; to ensure availability and confidentiality between the compliance officer, members of the Compliance Committee, employees, managers and the Board, as well as, first tier, downstream and related entities (FDRs). Methods of communication are accessible to our employees, members and business partners to allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified without fear of retaliation. The Compliance Department is required to respond to all reports in a timely fashion and must maintain management indicators recording receipt and response times as part of monthly compliance reporting.

i. Resources for Guidance and Reporting Violations

The Compliance Hotline 1-888-418-1566 is available 24 hours a day/7 days per week to our employees, members, providers and FDRs. The hotline allows for anonymous reporting of potential non-compliance and FWA matters. The following Compliance email address can also be used to ask questions or report

issues: tgifford@txihp.com

a. The compliance hotline number and email address are accessible to employees via the following:
   - Code of Conduct
   - Compliance Plan
   - TIHP website

b. The compliance hotline number and email address are accessible to our FDRs via the following
   - Code of Conduct for FDRs
   - TIHP website

c. The compliance hotline number and email address are accessible to members via the following:
   - Evidence of Coverage (EOC)
   - TIHP website

d. The compliance hotline number and email address are accessible to providers via the following:
   - Provider Manual
   - TIHP website

It is every employee's duty to report any potential or actual compliance concern. Failure to address and/or report such concerns may carry disciplinary consequences. Individuals shall not be disciplined for making a report in good faith or cooperating in any investigation or inquiry, or discriminated or retaliated against, even if the report is determined to be false.

ii. Compliance Messaging

To help encourage and maintain a culture of compliance and ethical behavior, the Compliance Department will establish various activities and communications to maintain compliance awareness.

E. Element 5 – Monitoring and Auditing

i. The Importance of Monitoring & Auditing.

One of the most important of the seven essential compliance program elements for managed care organizations is having an effective system in place for routine monitoring, auditing and identification of compliance risks. Ongoing monitoring and auditing demonstrate due diligence. We understand that we cannot assess the effectiveness of our compliance program or internal controls with a paper compliance program, meaning lots of well-intentioned policy pronouncements and descriptions of policies, but little follow through. A robust and sound monitoring and auditing plan is not only a way to ensure adherence to regulatory requirements; it enables us to assess quality and compliance over time; identify and categorize

risks; engage in planning to mitigate risks and; formulate/implement corrective actions plans.

The CO will regularly track and document compliance via a variety of resources which may include the use of dashboards, key performance indicators (KPIs) and, self-assessment tools that we create or purchase and; other mechanisms that show the extent to which operational areas and FDRs are meeting compliance goals. Compliance of operational areas will be tracked by management and publicized to employees. Issues of non-compliance identified in the aforementioned resources will be shared with senior management.

ii. Compliance Risk Assessment

One of the key steps in ensuring compliance is knowing and understanding the regulations with which the organization must comply and identifying systems and process weaknesses and areas of operational vulnerabilities. Risk assessments provide a mechanism for identifying which risks represent opportunities and which represent potential pitfalls. Further, risk assessments enable the organization to implement and maintain the appropriate controls to ensure effective and efficient operations and regulatory compliance. The Compliance Department works in collaboration with internal business department leads to identify and evaluate strategic, operational and compliance risks in a systematic manner. Risks are identified and measured in relation to organizational objectives and additional sources, including but not limited to the following:

- Office of Inspector General (OIG) Work Plan
- CMS Medicare Part C and D Requirements
- CMS Audit Protocols
- CMS STAR Ratings Performance Measures
- External Risk Assessments
- Compliance Key Performance Indicator (KPI) Results
- FDR Contract Provisions and Performance Results
- Substantiated reports from our Compliance Hotline

Once potential risks are identified, categorized and given a risk-rating in coordination with senior management; they are incorporated into the Annual Compliance Work Plan as a monitoring or audit item.

iii. Compliance Auditing & Monitoring Work Plan

We understand that we must continuously re-assess risk areas, re-prioritize compliance projects that are most critical to our mission and, report compliance developments to the Compliance Committee, our CEO and The Board. The Compliance Department's work plan is developed in coordination with senior management and overseen by the CO. The work plan briefly describes the various audit and monitoring areas we perceive as critical based on identified risk items and is organized into monthly and quarterly activities. The work plan includes but

is not limited to:

- Description of audit scope for audit items
- Targeted completion dates for audits
- Report due dates for monitoring items
- Responsible party for each work plan item

The CO may also include unannounced audits or "spot checks" when developing the work plan. Audits may be performed by the compliance department, a separate business department (e.g. SIU) or an external auditor (e.g. certified public accountant, health plan compliance consulting agency, pharmacist, etc.). The Board, with guidance from the CO and the Compliance Committee are responsible for understanding and overseeing the adequacy of resources that are devoted to carry out audit functions considering factors such as plan size, compliance history, current compliance risks, and the amount of resources necessary to meet the goals of the annual work plan. Operational staff that are designated to perform audit work are required to perform audits in an objective manner that is compatible with the independence of the audit.

The CO will submit the Compliance Work Plan to the CEO, Compliance Committee and then to the Board. Work plan status updates are reported to the Compliance Committee quarterly and to the Board semi-annually at a minimum.

iv. Exclusion Checks

We are prohibited from hiring, employing or making payments to any person or business excluded or debarred from federal or state health care programs. All workforce members and FDRs are screened against the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) List of Excluded Individuals and Entities (LEIE) and the contracting and the U.S. General Services Administration (GSA) System for Award Management prior to hiring or contracting with them and, on a monthly basis thereafter. Our Medicare Advantage and Prescription Drug network providers are also screened against the CMS Preclusion List prior to contracting and on a monthly basis thereafter.

v. Auditing and Monitoring of FDRs

We understand that we remain ultimately responsible for the quality, integrity and appropriateness of delegated functions. We are committed to establishing and maintaining auditing and monitoring mechanisms to ensure FDR oversight activities are performed in an efficient and systematic manner that promotes consistency in application of best practices. Our FDR Oversight Policy requires the establishment of clearly defined procedures and tools to help facilitate pre-delegation and post-delegation assessment activities; including, but not limited to the ongoing identification and assessment of performance and compliance of all FDRs. Our contracts with our FDRs include a Medicare Compliance Addendum and a Delegation Oversight Addendum.

In addition to FDR day-to-day monitoring and routine auditing activities performed by the vendor relationship owners and the appropriate business teams; The CO will coordinate with senior management to identify FDRs selected for audit in the compliance work plan. FDR audits may be performed independently by the Compliance Department; independently by individuals with subject matter expertise in the area/function selected for audit, or; collaboratively by compliance and designated subject matter experts (SMEs).

vi. Corrective Action Plans

A corrective action plan (CAP) must be established and implemented for adverse auditing and monitoring results. CAPs activities must be monitored routinely and tracked for progress to ensure remediation steps fully address the root cause. Where there is a significant regulatory failure, a summary of the issue and the corrective action plan will be reported to the appropriate authority in accordance with established self-disclosure protocols.

F. Element 6 – Enforcement and Discipline

Our Human Resources (HR) and Compliance policies and procedures (P&Ps), Code of Conduct and Code of Conduct for FDRs provide guidance for reporting misconduct and potential non-compliance and FWA violations and the disciplinary actions that may be taken for failing to adhere to the aforementioned documents, Medicare Parts C and D program requirements and health care laws and regulations that govern our business. Disciplinary actions may be taken for non-compliant business practices include, but are not limited to the following:

- Verbal or written consultations
- Corrective action plans
- Mandatory management action plans
- Notice of Noncompliance
- Notice to cure and contract termination for FDRs and network providers
- "Requires Improvement" rating on employee evaluations
- Disciplinary actions must be enforced timely and equitably and; documented in a consistent manner.

G. Element 7 – Response and Prevention

i. Timely and Reasonable Inquiry

The Compliance Officer (CO) will conduct timely and well-documented reasonable inquiries into any compliance incident or issue involving potential Medicare program noncompliance or potential FWA. The issue may be discovered through a hotline, a website, an enrollee complaint, during routine monitoring or self-evaluation, an audit, or by regulatory authorities. Reasonable inquiry includes a preliminary investigation of the matter by the CO, or if necessary, the use of the SIU. Regardless of how the noncompliance or FWA is identified, the CO will

initiate a reasonable inquiry as quickly as possible, but not later than 10 business days after the date the potential noncompliance or potential FWA incident was identified.

ii. Compliance Investigations

When an instance of non-compliance is suspected, detected, reported, or discovered internally or externally, a proper and thorough investigation will be commenced in accordance with established written protocols and action will be taken to cure the issue and prevent reoccurrence.

iii. Special Investigations Unit (SIU)

We are committed to ensuring that our network providers are reputable and provide quality care with transparency and integrity. The SIU is staffed with trained professionals with expertise in data analysis, health care claims auditing, and investigation of billing activities. The SIU employs various mechanisms geared towards the detection, prevention and correction of fraud, waste and abuse (FWA).

The CO will ensure there are effective communication methods in place to allow for appropriate coordination between the Compliance Department and the SIU. The SIU Investigator or the CO will investigate potential FWA activity to determine whether potential FWA has occurred and conclude investigations of potential FWA within a reasonable time period after the activity is discovered. If after conducting a reasonable inquiry, SIU or CO determine that potential FWA related to the Medicare Parts C or D programs has occurred, the matter may be referred to the National Beneficiary Integrity (NBI) – Medicare Drug Integrity Contractor (I-MEDIC) promptly via the Program Integrity (PI) Portal for Medicare Parts C & D Mandatory FWA Reporting. The CO will also work collaboratively with Vendor Relationship Owners (VROs) and the Special Investigations Unit (SIU) as appropriate to ensure the referral of potential FWA at the FDR levels via the PI so that I-MEDIC can help identify and address any scams or schemes.

iv. Provider-Related Complaints & Investigations

The CO will maintain files for a period of 10 years on both in-network and out-of-network providers who have been the subject of complaints, investigations, violations, and prosecutions. This includes enrollee complaints, NBI MEDIC investigations, OIG and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of Federal health care program requirements. The CO will also maintain files that contain documented warnings (e.g. fraud alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. We will comply as quickly as possible with requests by law enforcement, CMS and CMS' designee regarding monitoring of providers within the network that CMS has identified as potentially abusive or fraudulent.

v. Auditing by CMS or Designees

We understand that CMS has the discretionary authority to perform audits under 42 CFR 44 422.504(e)(2) and 423.505(e)(2), which specify the right to audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of sponsors or FDRs that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract or as the Secretary of the U.S. Health and Human Services may deem necessary to enforce the contract. The Plan and our contracted FDRs will facilitate access to any auditor acting on behalf of the federal government or CMS to conduct an on-site audit to complete a thorough review of required documentation. We will provide any information needed to determine compliance with the Medicare Parts C and D regulations and contracts. We will also facilitate interviews of the staff to allow auditors to gauge whether control activities are practiced as dictated by our policy and procedure and applicable Medicare Parts C and D requirements are being followed.

vi. Governmental Search Warrants

Compliance has written protocols for governmental search warrants which set forth the responsive steps that must be followed in the event that we are presented with a federal search warrant so to minimize disruption; protect the interests of the Plan and; ensure cooperation and compliance with agency officers executing the search warrant. In the event of attempted service of a subpoena, search warrant, garnishment, summons or other legal process, the CO or the CEO shall be notified immediately.

vii. Corrective Actions

Substantiated instances of non-compliance will result in the development of a corrective action plan (CAP). A root cause analysis will be completed to determine what caused or allowed the problem or deficiency to occur. Steps undertaken to resolve identified deficiencies will include timeframes for completion. Follow-up, monitoring and validation must be conducted to ensure the actions taken are effective and allow for ongoing compliance. Where there is a significant regulatory failure, a summary of the issue and the corrective action plan will be reported to the appropriate authority in accordance with established self-disclosure protocols.

viii. Voluntary Disclosures

We recognize the importance of voluntarily self-reporting substantiated cases of fraud, waste and abuse (FWA) and/or significant incidents of non-compliance to regulatory authorities (e.g. CMS, OIG, NBI MEDIC, etc.) and will maintain procedures to voluntarily self-report potential fraud or misconduct related to the Medicare program to CMS or its designee(s). The CO works collaboratively with the SIU, Legal and other business units as appropriate to ensure substantiated cases and the remediation actions undertaken in response to said cases are thoroughly documented, reported/disclosed to the appropriate authority based on the severity

and member impact of the issue identified and in accordance with established protocols. The CO also maintains an open relationship with our CMS Plan Manager and has established both a formal and informal process for reporting issues of non-compliance at the plan level or our FDRs to our CMS Plan Manager. Guidance provided by our CMS Plan Manager on mitigation of harm caused by an incident of non-compliance will be acted upon in timely manner.

ix. Conflicts of Interest

The purpose of the TIHP conflicts of interest policy is to protect the interests of TIHP when it is contemplating entering into a transaction or arrangement that might involve the interests of an entity that is represented by an officer or director of the Corporation or otherwise might benefit the private interest of an officer or director of the Corporation. Any director, principal officer, or member of a committee with board delegated powers who has a direct or indirect financial interest, as defined in the conflicts of interest policy, is an interested person. We do not allow actual, perceived or potential conflicts of interest to affect our operations. A conflict of interest may exist in a situation in which an interested person's personal interests actually or potentially conflict with company interests or, could be perceived to conflict company interests. We understand that conflicts of interests can interfere, influence or hinder an individual's ability to perform their job duties in a fair, objective and impartial manner or; cause him/her to use company resources for other than official purposes. All interested persons, as defined by the conflicts of interest policy, are required to assist us in evaluating compliance with our Compliance and Ethics Program by completing a Conflict of Interest Questionnaire upon hire and annually thereafter or more frequently as appropriate. Interested persons who fail to report a conflict of interest or comply with the actions required to resolve a conflict of interest are subject to disciplinary action up to, an including termination.

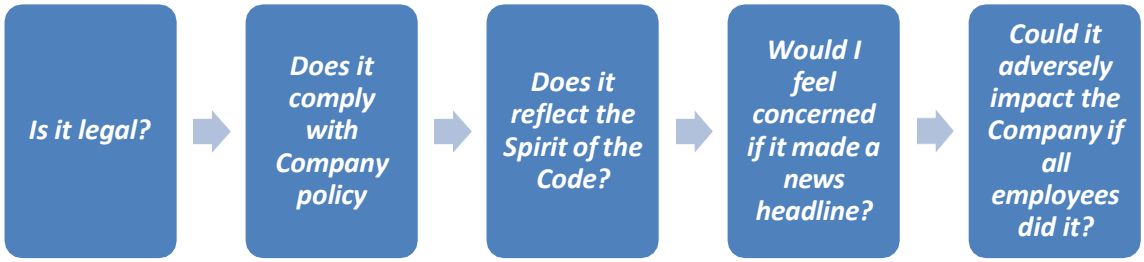
III. AMENDMENT OF THE COMPLIANCE PLAN

At a minimum, the CO and Compliance Committee will review this Plan annually to ensure completeness and accuracy. As regulations may change throughout the year, this plan may be revised according to any such regulatory changes or mandates. Changes to this Plan require approval of the Board.

IV. A MESSAGE FROM THE COMPLIANCE OFFICER (CO)

We are committed to providing the highest level of quality in a safe, cost-effective and compassionate manner to enhance the health, safety and well-being of the people and the communities we serve. Compliance with the laws and regulations that govern our business plays a significant role in helping us to achieve and maintain that commitment. Our Compliance Plan and our Code of Conduct reflect our core values and dedication to fostering ethical principles and behavior and a culture of compliance. However, it does not substitute for our own internal sense of fairness, honesty, and integrity. Doing the right thing at the right time and for the right reason requires balance, fairness and courage. When you run into a situation or are considering a course of action that does not feel right,

you should ask yourself the following questions:



If the answer to any of these questions is ***"No" or "Not Sure"***, then the action may have serious consequences and you should not do it. If you are uncertain of the answer, then please use available reporting procedures.

Any workforce member, who in good faith, believes that an activity may not comply with laws, regulations, Company policies and procedures, or our Code of Conduct shall report such activity by any of the following methods:

- Contacting the CO in person or via email at tgifford@txihp.com
- Filing a report, anonymously if desired through TIHP's Compliance Hotline at 1-888-418-1566 available 24 hours a day/7 days per week to our employees, members, providers and FDRs. The hotline allows for anonymous reporting of potential non-compliance and FWA matters.

You can also discuss your concerns with your immediate supervisor or Human Resources. It is your duty to report any potential or actual compliance concern. Failure to address and/or report such concerns may carry disciplinary consequences. Individuals shall not be disciplined for making the report in good faith or cooperating in any investigation or inquiry, or discriminated or retaliated against, even if the report is determined to be false.

Compliance is ever-changing…

A Compliance Program is never finished, it is always a work in progress. We are committed to evaluating and updating the Compliance Plan to incorporate process and regulatory changes whenever necessary to keep pace with a fast-changing regulatory environment.

Compliance is everyone's business…

Our Compliance Program cannot flourish and succeed without buy-in and participation from everyone in the organization. No matter one's standing in the organization, compliance is everyone's responsibility.

Tammy Gifford, JD, CHC
TIHP Compliance Officer

GLOSSARY

i. ***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 pay 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.

ii. ***Appeal (Part C)*** **-** Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 C.F.R. § 422.566(b). These procedures include reconsideration by the MA Plan and, if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

iii. ***Appeal (Part D Plan)*** **-** Any of the procedures that deal with the review of adverse coverage determinations made by the Part D plan sponsor on the benefits under a Part D plan the enrollee believes he or she is entitled to receive, including a delay in providing or approving the drug coverage (when a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for the drug coverage, as defined in 42 C.F.R. §423.566(b). These procedures include redeterminations by the Part D plan sponsor, reconsiderations by the independent review entity (IRE), Administrative Law Judge (ALJ) hearings, reviews by the Medicare Appeals Council (MAC), and judicial reviews.

iv. ***Audit*** is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures.

v. ***Cost Plan*** is a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) with a cost-reimbursement contract under section 1876(h) of the Act (See 42 C.F.R. §417.1, §423.4). Cost Plan sponsors may contract to offer prescription drug benefits under the Part D program. (See, 42 C.F.R. §423.4.).

vi. ***Data Analysis*** is a tool for identifying coverage and payment errors, and other indicators of potential FWA and noncompliance.

vii. ***Deemed Provider or Supplier*** means a provider or supplier that has been accredited by a national accreditation program (approved by CMS) as demonstrating compliance with certain conditions.

viii. ***DHHS*** is the Department of Health and Human Services. CMS is the agency within DHHS that administers the Medicare program.

ix. ***DOJ*** is the Department of Justice.

x. ***Downstream Entity*** is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between an MAO or applicant or a Part D plan sponsor or applicant and a first-tier entity. These

written arrangements continue down to the level of the ultimate provider of both health and administrative services. (See, 42 C.F.R. §, 423.501).

xi. ***Employee(s)*** or collectively "workforce members" refers to those persons (e.g. full and part-time employees, board members, temporary workers, consultants, volunteers, etc.) that are employed by the sponsor and provide health or administrative services for an enrollee.

xii. ***Enrollee*** means a Medicare beneficiary who is enrolled in a sponsor's Medicare Part C or Part D plan.

xiii. ***External Audit*** means an audit of the sponsor or its FDRs conducted by outside auditors, not employed by or affiliated with, and independent of, the sponsor.

xiv. **FDR** means First Tier, Downstream or Related Entity.

xv. ***First Tier Entity*** is any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program. (See, 42 C.F.R. § 423.501).

xvi. ***Formulary*** means the entire list of Part D drugs covered by a Part D plan and all associated requirements outlined in Pub. 100-18, Medicare Prescription Drug Benefit Manual, Chapter 6.

xvii. ***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.)

xviii. ***FWA*** means fraud, waste and abuse.

xix. ***Governing Body*** means that group of individuals at the highest level of governance of the sponsor, such as the Board of Directors or the Board of Trustees, who formulate policy and direct and control the sponsor in the best interest of the organization and its enrollees. As used in this chapter governing body does not include C-level management such as the Chief Executive Officer, Chief Operations Officer, Chief Financial Officer, etc., unless persons in those management positions also serve as directors or trustees or otherwise at the highest level of governance of the sponsor.

xx. ***GSA*** means General Services Administration.

xxi. ***Internal Audit*** means an audit of the sponsor or its FDRs conducted by auditors who are employed by or affiliated with the sponsor.

xxii. ***Monitoring Activities*** are regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

xxiii. ***NBI Medic*** means National Benefit Integrity Medicare Drug Integrity Contractor (MEDIC), an organization that CMS has contracted with to perform specific program integrity functions for Parts C and D under the Medicare Integrity Program. The NBI MEDIC's primary role is to identify potential FWA in Medicare Parts C and D.

xxiv. ***OIG*** is the Office of the Inspector General within DHHS. The Inspector General is responsible for audits, evaluations, investigations, and law enforcement efforts relating to DHHS programs and operations, including the Medicare program.

xxv. ***Pharmacy Benefit Manager (PBM)*** is an entity that provides pharmacy benefit management services, which may include contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; performing drug utilization review; and operating disease management programs. Some sponsors perform these functions in-house and do not use an outside entity as their PBM. Many PBMs also operate mail order pharmacies or have arrangements to include prescription availability through mail order pharmacies. A PBM is often a first-tier entity for the provision of Part D benefits.

xxvi. ***PDP*** means Prescription Drug Plan.

xxvii. ***Related entity*** means any entity that is related to an MAO or Part D sponsor by common ownership or control and performs some of the MAO or Part D plan sponsor's management functions under contract or delegation;

1. Furnishes services to Medicare enrollees under an oral or written agreement; or
2. Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than $2,500 during a contract period. (See, 42 C.F.R. §423.501).

xxviii. ***Special Investigations Unit (SIU)*** is an investigation unit responsible for conducting investigations of potential FWA; this unit will be staffed by appropriate subject matter experts (SMEs).

xxix. ***TrOOP (True Out of Pocket) Costs*** are costs that an enrollee must incur on Part D covered drugs to reach catastrophic coverage. (These incurred costs are defined in regulation at §423.100 and Pub. 100-18, Medicare Prescription Drug Benefit Manual, chapter 5, section 30). In general, payments counting toward TrOOP include payments by enrollee, family member or friend, Qualified State Pharmacy Assistance Program (SPAP), Medicare's Extra Help (low income subsidy), a charity, manufacturers participating in the Medicare coverage gap discount program, Indian Health Service, AIDS Drug Assistance Programs, or a personal health savings vehicle (flexible spending account, health savings account, medical savings account). Payments that do NOT count toward TrOOP include Part D premiums and coverage by other insurances, group health plans, government programs (non-SPAP), workers' compensation, Part D plans' supplemental or enhanced benefits, or other third parties, drugs purchased outside the United States, and over-the counter drugs and vitamins.

xxx. ***Vendor Relationship Owner*** means the individual primarily responsible for managing the relationship with a contracted vendor and management of day-to-day operational oversight, monitoring and auditing activities of a contracted vendor.

xxxi. ***We*** are the organization maintaining a contract with CMS to sponsor a Medicare Advantage plan. We may also be referred to as Us, Our, the Plan, the Employees, or the Company or similar phrases.

xxxii. ***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.

xxxiii. ***Workforce Members*** means those persons (e.g. full and part-time employees, board members, temporary workers, consultants, volunteers, etc.) that are employed by the sponsor and provide health or administrative services for an enrollee.

ACKNOWLEDGEMENT:
Texas Independence Health Plan Compliance Program

I hereby acknowledge that I have read, understand and will comply with the provisions of the Texas Independence Health Plan Compliance Program.

I will seek guidance from and raise concerns about possible violations of this Compliance Program with, my supervisor, senior management or through the Texas Independence Health Plan's Compliance Hotline.

I will attend all required training seminars provided by Texas Independence Health Plan throughout the course of the year.

_____
Printed Name

_____ _____
Signature Date