Subject: STANDARDS OF CONDUCT

Introduction. Clarion Health ("Company") is committed to conducting its activities in compliance with all federal, state and local laws and regulations and with the highest professional and ethical standards. This includes a commitment to promoting evidence-based medicine; effective beneficiary engagement; and cost-effective, high quality beneficiary-centered care. All Company board and committee members, employees, contractors, participating and preferred providers, Sales Agents and Brokers ("Affiliated Parties") play an integral role in helping achieve these goals.

This Standards of Conduct has been adopted by the Company board of directors in support of Company's Compliance Plan. The Standards of Conduct describes standards by which all Affiliated Parties are expected to conduct themselves when working for or on behalf of Company. All Affiliated Parties are required to adhere to both the spirit and letter of the Standards of Conduct. In addition to the Standards of Conduct, all Affiliated Parties are expected to follow all policies and procedures affecting their activities in Company.

All Affiliated Parties remain subject to the requirements of their own organization's compliance programs and Standards of Conduct, in addition to the requirements of Company's Compliance Plan and this Standards of Conduct.

Standards of Conduct:

a. **Honest and Lawful Conduct:** Company and Affiliated Parties will abide by all applicable laws and regulations. All Affiliated Parties must maintain a high level of integrity and honesty in their conduct relating to the operations and performance of the Company and will be held accountable for behaviors and actions inconsistent with this Standards of Conduct.

b. **Quality of Care:** Company treats all beneficiaries with respect and dignity, providing care that is both necessary and appropriate. Company is committed to providing high-quality health care to its beneficiaries and to delivering health care services in an ethical, professional and effective manner. Company and Affiliated Parties are committed to delivering people-centered, high-quality health care services with compassion, dignity and respect for each individual.

c. **No Reduction in Medically Necessary Services:** Company and Affiliated Parties are committed to improving health, enhancing quality of care and lowering the costs of health

care services. Company and Affiliated Parties will not deny, reduce or limit the provision of medically necessary services to any beneficiary.

d. No Discrimination: Company prohibits any form of discrimination in the provision of services, marketing or enrollment practices. Company and Affiliated Parties will not deny, limit or condition services to beneficiaries on the basis of race, color, religion, gender, sexual orientation, marital status, national origin, citizenship, age, disability or any other characteristic protected by law or any factor that is related to health status, such as nature and extent of medical condition, medical history or genetic information. Company prohibits any practice that would reasonably be expected to have the effect of denying or discouraging the provision of medically necessary services to eligible individuals.

e. Licensure: All individuals and entities providing care to Company beneficiaries will be properly licensed and possess the necessary experience and expertise to deliver high-quality, effective care. Only qualified Affiliated Parties with proper licensure or certification will be permitted to make clinical assessments or to develop plans of treatment for beneficiaries. Affiliated Parties will confirm licensure of all employees, agents and contractors rendering services to Company beneficiaries. Complying with licensure requirements is an important component of Company's commitment to ensuring that beneficiaries receive high-quality, effective care.

f. Quality Data, Certifications and Other Information Reporting: Company must periodically submit quality data, certifications and other information as required by payer contracts. All Affiliated Parties will cooperate in the gathering, recording and submitting of such data and information in a timely, accurate and complete manner in accordance with all Medicare and other regulatory requirements. All certifications and other reports submitted to government agencies will be made by an individual with authority to legally bind Company and will be filed in a timely manner, accurately and in accordance with applicable requirements.

g. Marketing Activities: Company will adhere to all federal and state laws and Medicare program and other performance-based plan requirements governing marketing activities. Company will not use incorrect or misleading information in marketing materials. All marketing materials used in connection with the Medicare Advantage program must be submitted to the CMS for approval prior to use. Marketing materials and activities include, but are not limited to, general audience materials such as brochures, advertisements,

outreach events, letters to beneficiaries, web pages, data sharing opt-out letters, mailings, social media or other activities conducted by or on behalf of Company or by Affiliated Parties when used to educate, solicit, notify or contact beneficiaries or providers and suppliers.

The following beneficiary communications are not considered marketing materials and activities: certain informational materials customized or limited to a subset of beneficiaries; materials that do not include information about the Company or Affiliated Parties, materials that cover beneficiary-specific billing and claims issues or other specific individual health-related issues, educational information on specific medical conditions (for example, flu shot reminders), written referrals for health care items and services, and materials or activities that do not constitute ‘‘marketing’’ under the HIPAA Privacy Rule.

h. Beneficiary Choice: Within the Medicare program, Company and Affiliated Parties are prohibited from engaging in practices or adopting policies that restrict or diminish the right of beneficiaries aligned with Company to exercise their basic freedom of choice to obtain health care services from practitioners who are not Company providers and suppliers. Under section 1902(a)(23) of the Social Security Act, Medicaid beneficiaries generally have the right to obtain medical services “from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide . . . such services.” This provision is often referred to as the “any willing provider” or “free choice of provider” provision. Implementing regulations at 42 C.F.R. § 431.51(b)(1) require a state plan to allow a beneficiary to obtain Medicaid services from any institution, agency, pharmacy, person or organization that is (i) qualified to furnish services and (ii) willing to furnish them to that particular beneficiary. There is an exception for beneficiaries enrolled in certain managed care plans (to permit such plans to restrict beneficiaries to providers in the managed care plan network), except that such plans cannot restrict free choice of family planning providers. 1902(a)(23)(B); 42 C.F.R. § 431.51(b)(1); 42 C.F.R. Part 438.

i. Beneficiary Notices: Under Medicare, Company and Affiliated Parties shall comply with applicable requirements established by the CMS relating to the provision of notices to Medicaid beneficiaries aligned with Company, including notifications of provider and supplier participation in Company, collection and use of beneficiary data for purposes of care coordination and quality improvement work, and the right of beneficiaries to opt out of sharing of such data.

j. **Eligibility to Participate in Federal and State Health Care Programs:** Company and Affiliated Parties will not knowingly hire, employ, contract or do business with any individual or entity excluded, debarred or otherwise ineligible to participate in federal or state health care programs, such as Medicare and Medicaid, or whose officers, directors or employees are excluded from participating in federal or state health care programs. Affiliated Parties are responsible for taking all necessary steps to ensure employees involved in providing goods or services to Company, directly or indirectly, remain eligible to participate in federal and state health care programs.

k. **Documentation, Coding and Billing:** All Affiliated Parties will adhere to federal and state laws and regulations governing billing, coding and documentation requirements for medical services billed to Medicare, Medicaid and other payers. All billing, coding and documentation must be accurate and truthful. Only medically necessary services that are consistent with accepted standards of medical care may be billed. Billing and coding are to be based on adequate documentation of the medical justification for the service provided and for the claim submitted, and medical documentation must comply with applicable payer requirements. Only codes that correspond to the service rendered and documented are to be used.

l. **Mandatory Reporting:** Company will ensure that all incidents that are required to be reported under applicable federal and state mandatory reporting laws, rules and regulations are reported in a timely manner. This includes, but is not limited to, the reporting of probable violations of law to an appropriate law enforcement agency and the disclosure and repayment of identified overpayments from Medicare or other third-party payers as required by law.

m. **Accuracy and Integrity of Records:** Company and Affiliated Parties shall maintain accurate and complete records relating to all business activities, claim submissions, arrangements or transactions relating to the operations of Company and Medicare, and any other contract.

n. **Privacy and Security of Patient Information:** Federal and state laws require Company and Affiliated Parties to maintain the privacy and security of beneficiary health information ("PHI") in all forms – paper, electronic records, films and images, and verbal discussions. All Affiliated Parties will keep PHI confidential, except when disclosure is authorized by the beneficiary or permitted by law. Personnel:

- Will not access or use PHI except as necessary to perform their jobs;
- Will access, use and disclose only the minimum amount of PHI necessary to perform their jobs;
- Will not discuss PHI with others who do not have a job-related need to know such information, including co-workers, family and friends;
- Will not leave PHI unattended, unsecured or otherwise available to the public;
- Will not store PHI on laptops, tablets, storage media or other portable devices unless authorized and approved for use by Company or their employer organization;
- Will immediately notify their supervisor or their organization's Privacy Officer if PHI has been lost, stolen or accessed inappropriately.

o. **Cooperation With Company Compliance Program:** All Affiliated Parties will cooperate with and support Company's Integrity and Compliance Program through adherence to the standards described herein and participation in activities such as:

- Periodic internal audits, including allowing Company staff or agents to conduct audits of Affiliated Parties' medical records documentation, quality data collection and claims submission, as applicable to the Affiliated Parties participation in the Medicare Advantage and any other contract;
- Compliance and other training of Affiliated Parties as required by CMS regulations, including distribution of compliance communication and training materials such as this Standards of Conduct;
- Implementation of procedures to ensure the accurate collection, submission or transmission of quality data required by participation in Medicare and any other contract; and
- Responding to compliance audits, investigations, reviews and inquiries, and implementation of corrective actions, as needed.

p. **Compliance With Fraud and Abuse Laws:** Federal and state laws prohibit the exchange of anything of value in order to induce or reward beneficiary referrals for business payable by a federal or state health care program, except as permitted by law. In accordance with these laws, Company and Affiliated Parties will not offer, solicit, pay or receive anything of value, directly or indirectly, for referring a beneficiary or furnishing or arranging for a good or service payable by a federal, state or other third-party payer. All referral decisions will be based solely on the health care needs of Company beneficiaries.

q. Conflicts of Interest: A conflict of interest exists whenever an individual's outside personal or financial interests influence, or appear to influence, decisions made involving Company. Affiliated Parties are expected to exercise good judgment, maintain objective business relationships with external parties conducting business with Company, and avoid conflicts of interest. Company decisions are to be made fairly and objectively, without favor or preference based on personal considerations. Affiliated Parties may not use their positions or knowledge gained through their relationship with Company for personal advantage. Personnel may occasionally find that their duties to Company are in conflict, or may appear to be in conflict, with other relationships and responsibilities. Such matters should be disclosed to the individual's supervisor, a higher-level manager or Company's Compliance Officer to ensure appropriate actions are taken to manage any conflicts of interest.

r. Reporting Requirement: Company promotes an environment that encourages all Affiliated Parties to seek answers to questions and report issues and concerns. Affiliated Parties are expected to report, in good faith, any actual or suspected fraud, waste and abuse or violations of law, regulation, professional standards or Company policies. Affiliated Parties may choose one or more of the following methods for reporting:

- Participant Organization Management: Affiliated Parties are encouraged, but not required, to report compliance matters directly to their direct supervisor, to other management of their organization or to their own organization's compliance officer;
- Company Compliance Officer: Affiliated Parties may at any time report compliance matters directly to Company's Compliance Officer as follows:

Compliance Hotline: Company has established a Compliance Hotline that is available to all Affiliated Parties to confidentially report any issues or concerns or to seek advice or clarification on compliance and other issues. You have the option to remain anonymous when reporting if you so choose. The Compliance Hotline is available 24 hours a day, 365 days a year, and is supported by an outside organization. You may file a report online at www.LeeHealth.ethicspoint.com.

s. No Retaliation: Company prohibits retaliation, in any form, against any individual reporting issues and concerns in good faith. Retaliation is subject to discipline up to, and including, termination of employment or termination of participation in or business relationships with Company. Company will attempt to maintain, within limits of the law, the confidentiality and identity of individuals reporting issues and concerns.

t. Investigation of Alleged Fraud, Waste and Abuse: Company will promptly investigate any reports of alleged violations of law, regulations or policies related to Company activities. Affiliated Parties are expected to fully cooperate in such investigations and, where appropriate, take corrective actions in response to matters identified, as needed. The Federal False Claims Act and similar state laws make it a crime to present a false claim to the government for payment. These laws also protect "whistleblowers" (people who report noncompliance or fraud, or who assist in investigations) from retaliation. Company strictly prohibits retaliation or reprisal against individuals exercising their rights under the Federal False Claims Act or similar state laws.

u. Affiliated Parties Compliance Program Obligations: The Affordable Care Act of 2010 mandated the establishment of compliance programs for all health care providers enrolled in the Medicare and Medicaid programs. Florida also implemented mandatory compliance program requirements. All Affiliated Parties are subject to the requirements of their own organization's compliance programs, in addition those of Company's Compliance Program, including any periodic reporting or certification requirements that may be applicable.

ACKNOWLEDGEMENT

Standards of Conduct

I, _____, have read and understand the Clarion Health Standards of Conduct and agree to abide by the rules and regulations as stated herein. And if applicable, I also agree to abide by the Standards of Conduct and Compliance Policies of my own organization.

_____

Print Name

_____

Signature

_____

Date

_____

Home Organization (if applicable)