



PROGRAM INTEGRITY PLAN

FOR

COVENTRY HEALTH CARE OF LOUISIANA, INC.

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In compliance with the contract between Coventry Health Care of Louisiana, Inc. (“Coventry”) and the Louisiana Department of Health and Hospitals (“DHH”), Coventry adopts the following Program Integrity Plan. The Program Integrity Plan meets those requirements of applicable state and federal law, including but not limited to 42 CFR § 438.600 to 438.610 and additional requirements as described in Subtitle F, Section 6501 through 6507, of the Patient Protection and Affordable Care Act (PPACA) of 2010. As a subsidiary of Coventry Health Care, Inc., Coventry receives support for many elements of the Program Integrity Plan. However, Coventry retains responsibility for ensuring implementation of this Program Integrity Plan, and Coventry will provide oversight of all activities related to Program Integrity. Coventry works closely with Coventry Health Care, Inc.’s Customer Service Operations (“CSO”) unit, including the Special Investigative Unit (“SIU”) for health care fraud prevention, detection, and investigation.

A clearly articulated anti-fraud and abuse plan is a core requirement of program integrity. Coventry’s Compliance Officer, Medicaid staff and the Corporate Medicaid Compliance Officer are responsible for the Program Integrity Plan. Coventry’s staff are accountable to Senior Management and responsible to coordinate with the Agency and any other state/federal authorities on any fraud or abuse case.

I. Program Integrity -- General Obligations for Coventry

As a condition of payment from DHH, Coventry must comply with applicable certifications, program integrity and prohibited affiliation requirements.

A. Certifications

All statements, reports and claims, financial or otherwise submitted by Coventry and its subcontractors must be certified for all documents specified by the state in the contract. Any data that Coventry submits to the Agency must be certified by one of the following: Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority and reports directly to the CEO or CFO. The certification must attest to the data’s accuracy, completeness and truthfulness and be submitted concurrently with the certified data. Coventry shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, contract requirements, and DHH requirements.

B. Program Integrity

Coventry will maintain a mandatory compliance plan in effect that guards against fraud and abuse. Written policies, procedures, and standards of conduct shall be conveyed to all employees through a mandatory Compliance and Ethics program that clearly demonstrates Coventry's and Coventry Health Care, Inc.'s commitments to compliance with all applicable federal and state laws and regulations. This commitment is demonstrated, in part, by the Coventry's designation of a Compliance Officer and a Compliance Committee accountable to senior management. The Compliance Officer and Compliance Committee assure that there is (a) effective training and education for all employees; (b) effective lines of communication between the Compliance Officer and all employees; (c) enforcement of standards through well-publicized disciplinary guidelines; (d) internal monitoring and auditing; (e) prompt response to offenses; and (f) development of corrective action initiatives when warranted.

C. Prohibited Affiliations

Prohibited affiliations with individuals, owners and managing employees is a key component of assuring that Coventry makes no payments for Medicaid services to any individual or entity debarred by any federal agency. Coventry assures compliance with this requirement through its credentialing policies and procedures, as well as through requiring that all providers and subcontractors submit an ownership disclosure so such individuals with ownership and/or controlling interest can be checked in the appropriate federal sanctions databases (EPLS, LEIE, HIPDB, etc.). Coventry requires all subcontractors and delegated entities to apply the same due diligence.

Coventry will terminate the participation of any individual or entity found to be excluded, debarred, suspended or terminated by a federal health care program (Medicare, Medicaid, Tricare, FEHB) or any other state plan, or affiliated with someone who is, or if such individual has delinquent unpaid overpayments.

Further, pursuant to applicable federal law, Coventry shall make no payments to institutions or entities outside of the United States.

D. Verification of Services for Members

Coventry is required to verify whether services reimbursed to providers were actually furnished to Members. Coventry utilizes a survey (telephonic or mail) or explanation of benefits (EOB) mailing to meet this requirement. Coventry's verification method, EOB or member survey, assures a statistically valid sample of members based upon a percentage of paid claims. Coventry excludes certain 'sensitive' services from these verification activities to protect member confidentiality.

II. *Program Integrity – Fraud, Waste and Abuse*

In compliance with one or more contracts Coventry may have with federal and/or state government agencies and because it is a good business practice for managed care organizations, such as Coventry , to have a general fraud, waste and abuse detection program, the plan adopts the following Anti-Fraud, Waste and Abuse program plan (“Anti-Fraud Plan”). This Anti-Fraud Plan sets forth specific procedures to prevent health care fraud, including, but not limited to, claims fraud, employee fraud, and internal and external fraud. Except as where specifically noted, Coventry adopts this plan with respect to all lines of business, including any insurance or health benefit plan business administered on behalf of Coventry Health and Life Insurance Company.

- A. Anti-fraud, Waste and Abuse Policy
- B. Education/Training
- C. Detection/Prevention
- D. Investigations
- E. Reporting Fraud and Abuse
- F. Review and Revision
- G. Auditing
- H. Exhibits

A. ANTI-FRAUD WASTE AND ABUSE POLICY

Coventry will not tolerate health care fraud, waste, or abuse in any of its relationships with internal and external parties. Coventry will identify, report, monitor, and when appropriate, refer for prosecution, situations in which suspected fraud or abuse occurs in accordance with applicable state and federal law, and Coventry ’s contract with DHH.

The anti-fraud, waste and abuse goals of Coventry will be pursued by the plan, and relevant employees including those from the SIU and CSO, and where appropriate, vendors with whom the plan or Coventry Health Care, Inc. has contracted to provide such services. Coventry and Coventry Health Care, Inc. employees as well as vendors performing services on behalf of Coventry , are responsible for:

- Financial Responsibility, Accountability and Savings;
- Civic Responsibility;
- Customer Acquisition and Retention;

- Regulatory Compliance;
- Deterrence;
- Investigation of Fraud Waste and Abuse; and
- Anti-Fraud Training

B. EDUCATION/TRAINING

Coventry Health Care, Inc. and Coventry recognize that health care fraud may be reduced once potential perpetrators realize that Coventry's personnel and associated stakeholders have the skills and commitment to detect and investigate fraudulent activity directed against Coventry. This is achieved through comprehensive and ongoing education and training activities.

Employee Education/Training

Anti-fraud, waste and abuse training is provided to all Coventry Health Care, Inc. employees upon hire and as part of the annual Compliance and Ethics Program training distributed through an on-line learning tool. Successful completion of the training, including the fraud, waste and abuse sections, is a condition of employment. The Coventry Health Care, Inc. corporate Chief Compliance Officer is responsible for assuring that all employees receive Compliance and Ethics Program training. The fraud, waste and abuse training aims to increase employee awareness of suspicious claims or ineligible beneficiaries and to assist in deterring the payment of fraudulent claims or claims for ineligible beneficiaries. It also reinforces Coventry Health Care, Inc.'s commitment to integrate anti-fraud detection, prevention and reporting as a routine business practice. In addition to the annual training, the SIU issues a quarterly anti-fraud newsletter with the latest fraud news and awareness reinforcement articles. Coventry Health Care, Inc. and the Coventry would also provide supplemental and specialized training as needs are identified.

The fraud, waste and abuse portion of the annual corporate Compliance and Ethics Program Training is designed to elicit an awareness, reaction and proper response to indicators of health care fraud. Increasing early detection is a primary goal of the training and will be a benchmark of its effectiveness. The fraud, waste and abuse training will include, but is not limited to, the detection of fraud in the following areas:

- Overcharging and overpayment detection;
- Claims processing guidelines;
- Medical coding;
- Duplicate bills;
- Excessive charges;
- Unnecessary services or supplies;
- Over utilization;

- Services not rendered or drugs not dispensed;
- Miscoded or misleading claim information;
- Drug switching;
- Hospital inpatient or outpatient billing abuse or inappropriate commitment or confinement;
- Addressing fraud, waste, abuse and neglect referrals;
- The SIU referral process;
- Ineligible groups or members of groups; and
- Statutory requirements dealing with fraud referrals.

The fraud, waste and abuse training will be augmented over time by modules which will be delivered through a variety of media formats and distribution channels. Advanced training topics may include, but are not limited to, the following:

- The impact of fraud, waste and abuse;
- Current health care/pharmacy/insurance fraud trends, schemes and those committing fraud, waste and abuse;
- Historically relevant SIU case studies; and
- Health care and pharmacy fraud, waste and abuse risk detection.

In support of training and awareness efforts, all Coventry Health Care, Inc. employees have access to the Health Care & Pharmacy Anti-Fraud, Waste and Abuse Guide (Exhibit 2) (the “Guide”) for their use in detecting fraud and referring claims to the SIU for investigation. The Guide includes, but is not limited to, the following:

- Information regarding the process to be employed when a suspicious claim is identified;
- Law enforcement relations;
- Possible indicators for health care and pharmacy fraud;
- The duties and functions of the SIU and vendors;
- The procedure for referral of a claim to the SIU;
- The post referral procedure for communication;
- Information regarding reporting of employee and member fraud;
- The Coventry Health Care Comply Line phone number: **1-877-242-5463 (1-877-CHC-LINE)**; and
- The Coventry Health Care, Inc. SIU Hotline: **1-866-806-7020**

The Guide as well as anti-fraud policies and procedures are available to employees on the company intranet site for the SIU. Anti-fraud training and reference material are continuously updated and published. The Corporate Compliance Officer conducts a scheduled review of the annual training at least once every two years.

SIU Investigator Education/Training

Coventry Health Care, Inc. will conduct training for SIU Investigators that will include, but is not limited to:

- The duties and functions of the SIU;
- Information for SIU Investigators regarding general investigation guidelines, conducting interviews, report writing, information disclosure, and law enforcement relations;
- Potential health care and pharmacy fraud indicators;
- The process to be employed when a suspicious claim is identified;
- The procedure for referral of a claim to the SIU;
- The procedure for referral of a claim to the pharmacy benefit vendor and coordinating investigations with the pharmacy benefit vendor;
- The investigation process for suspected member fraud;
- The post-referral procedure for communication between Coventry and the SIU; and
- The procedure for recommending referral of suspected fraud to the appropriate authorities.

Provider Education

Fraud, waste and abuse information and updates may be communicated to providers through one or more sources, such as provider manuals, newsletters and Coventry Health Care, Inc. web sites.

Member Education

Fraud, waste and abuse information and updates may be communicated to members through one or more sources, such as new member materials, explanation of benefits, plan newsletters, member handbooks, Coventry Health Care, Inc. web sites and member identification cards.

Third Party Vendor Education

If Coventry utilizes one or more third parties to process some of its members' claims and provide customer service, Coventry Health Care, Inc. will review such third party's fraud, waste and abuse program to ensure the third party provides proper fraud and abuse training to its employees assigned to Coventry's account, to the extent such third parties are not Coventry Health Care, Inc. entities and incorporated or included in this training process. Coventry will also follow any specific requirements or protocols for such third party delegation as may be required by its contract with DHH.

Third party companies contracted to provide services for Coventry must

complete compliance education, including fraud, waste and abuse, at the time of initial contracting and annually thereafter. This function is overseen by the CHC Compliance and Ethics Program Office.

C. DETECTION/PREVENTION

Identifying Persons and Organizations Involved in Suspicious Claims or Eligibility Activity

Coventry recognizes that early detection of fraud, waste and abuse limits its financial consequences on the health care system. Coventry understands that fraud may have either an internal or external origin. Coventry, Coventry Health Care, Inc.'s SIU and designated vendors will work together to ensure that the proper fraud detection guides are prepared, published and maintained to assist employees in the identification, detection, and handling of suspicious claims according to any applicable federal or state law (including, but not limited to, the requirements of 42 C.F.R. §§422.503(b)(4)(vi) & 423.504(b)(4)(vi)) contractual requirements, guidance issued by the Centers for Medicare and Medicaid Services ("CMS"); and this Anti-Fraud Plan.

Medical Claims (i.e., claims processed through IDX)

The SIU is responsible for detecting and investigating suspected fraudulent activity or abuse by providers when the provider claims are processed through the Coventry Health Care, Inc. claims processing system (currently IDX). Additionally, the SIU is responsible for detecting and investigating suspected employee and member medical claim fraud. Suspect claims are identified from a variety of sources including, but not limited to the following:

- Tips from members, providers and customer service personnel;
- Referrals from claims personnel or provider relations personnel;
- Information obtained through Coventry Health Care, Inc.'s involvement in the National Health Care Anti-Fraud Association;
- Information obtained through contact with other insurers and managed care plans;
- Information obtained in conjunction with studies or queries conducted by Coventry or other Coventry Health Care, Inc. entities;
- Information developed by the SIU through data mining, claims queries and anti-fraud software;
- Referrals from federal and state regulatory and law enforcement agencies such as the State Departments of Insurance, the FBI, State and local police departments, Medicaid Fraud Control Units, State Medicaid Agencies, or any other agency; and

- Provider and/or member claims flagged in Coventry’s claims processing system.¹ (Depending on the nature or extent of the problem and the type of service, an individual provider may be placed on prepayment review to avoid unnecessary expenditures during the review process.)

Role of Pharmacy Vendor (Vendor Audit Function/Vendor SIU)*

Coventry Health Care, Inc., on behalf of its subsidiaries, has contracted with one or more pharmacy benefit vendors to administer pharmacy benefits for all pharmacy claims including Part D. The pharmacy benefit vendors, through their audit and special investigations unit are responsible for the detection of fraud, waste and abuse involving pharmacy claims. For purposes of this Anti-Fraud Plan, the term “pharmacy claims” means those Coventry pharmacy benefit claims processed through the third party pharmacy claims administrator’s system(s).

The pharmacy benefit vendor will analyze Coventry’s various pharmacy claims, both pre- and post-payment and will conduct on- and off-site post-payment audits. The audits are designed to:

- verify the accuracy of pharmacy claims submitted through observation of original records including, among other things, prescription hard copies and patient signature logs; and
- identify erroneous billings through review of reports based on utilization and cost data.

The pharmacy benefit vendor will identify pharmacies to audit based on such areas that include but are not limited to the following:

- statistical review of the pharmacy claims submitted by pharmacies and auditing those pharmacies with claim activities indicating unusual or improper behavior and possible noncompliance to program parameters;
- high dollar and abnormally submitted pharmacy claims (i.e., reasonableness of quantity and dosage form); and
- tips from outside sources such as boards of pharmacy, law enforcement agencies, National Health Care Anti-Fraud

¹ Information regarding providers who are flagged in Coventry’s claims processing system may originate from the National Health Care Anti-Fraud Association (“NHCAA”) Database, the SIU Case Tracking Database, the OIG/OPM excluded/sanctioned provider database, and SIU’s use of retrospective analysis tools. These sources are further explained in Section IV(A)(2)(c).

* Coventry recognizes that Pharmacy Services are the responsibility of DHH, but provide this service in other Medicaid markets and is prepared to implement if the service becomes a managed care responsibility.

Association, National Association of Drug Diversion Investigators, and other pharmacy organizations.

The pharmacy benefit vendor, through their audit function, meets regularly with the Coventry Health Care, Inc. SIU to review findings, collaborate on cases and share information. The vendor, thorough its auditing identifies recovery opportunities which are realized through the recovery functions of the contract. The vendor also has the capacity to flag prescribers excluded by the state and the federal government to prevent their scripts from being filled at the point of sale. The Coventry Health Care, Inc. SIU evaluates the vendor's performance and offers feedback to both the vendor and Coventry Health Care, Inc. Pharmacy Operations on how to improve the relationship and processes. The relationship between the pharmacy benefit vendor and the Coventry Health Care, Inc. SIU and the work that is done between the two is essential to fulfilling Coventry Health Care, Inc.'s' anti-fraud commitment. See Exhibit 6 for an overview of this service.

Embezzlement/Internal Theft and Other Forms of Employee Fraud

Coventry Health Care, Inc. has several corporate policies that are designed to ensure employees conduct Coventry Health Care, Inc. business in a legal and ethical manner. These policies are designed in part to detect, prevent and investigate embezzlement, internal theft and other forms of employee fraud. Attached hereto, as Exhibit 1, is Coventry Health Care, Inc.'s relevant corporate Compliance and Ethics Program Policies and the Code of Business Conduct and Ethics.

All employees receive yearly education and training on these policies and the Code of Business Conduct and Ethics. Employees are required to report any suspected violations of this Code of Business Conduct and Ethics and Compliance and Ethics Program to their supervisor, manager, a Compliance Officer or others as specified in the Code of Business Conduct and Ethics. If the employee wishes to remain anonymous, the employee may report his/her suspicions via the CHC Compliance Program Comply Line: 1-877-242-5463 (1-877-CHC-LINE). No individual who reports compliance plan violations or suspected fraud and/or abuse will be retaliated against by anyone who is employed by or contracts with Coventry.

Reporting by Providers or Members

Providers or members may report suspected fraud, waste and abuse by calling the CSO, as instructed on the member identification card, member explanation of benefits or provider remittance advice.

Through member and provider handbooks, Coventry has and will continue to direct members and providers to report suspected fraud, waste and abuse to Coventry . Additional details on identifying and reporting fraud, waste and abuse are made available to members and providers on Coventry Health Care, Inc.'s public websites.

Reporting by Vendors

Vendors can report suspected fraud, waste and abuse by contacting the SIU according to the instructions in their Coventry Health Care, Inc. fraud, waste and abuse training materials.

D. INVESTIGATIONS

Medical Provider Claim Investigations (i.e., Claims Processed Through IDX)

Overview

The investigation process begins with a referral. There are multiple sources for referrals and there are well publicized channels for directing referrals to the SIU. Generally speaking, there are four channels by which referrals originate:

- Internally, from Coventry Health Care, Inc. employees such as claims personnel, enrollment staff, and compliance and medical areas.
- Externally, from sources such as member complaints and tips, law enforcement, government agencies and anti-fraud workgroups and trade associations.
- Proactive and reactive efforts of the SIU including the SIU's routine examination of claims data. The SIU utilizes anti-fraud software that scrubs the data which identifies outliers that require investigation.
- Pharmacy Benefit Manager (PBM) audit function. Coventry Health Care, Inc. contracts with the PBM for their pharmacy audit services. The Coventry Health Care, Inc. SIU and the PBM's audit team routinely meet to discuss audit outcomes, data analysis results, external leads and other intelligence about potential pharmacy fraud.

Hereinafter all detection methods to be called a "referral".

The well publicized channels for directing referrals to the SIU include an internal form available on the SIU's intranet site. A link to the SIU Referral Form is attached hereto as Exhibit 3. Coventry Health Care, Inc. staff may also send referrals via SIU's e-mail address. This e-mail address may also be used to ask questions of the SIU. The SIU uses e-mail exchanges to gather additional information from the referring party. The SIU also promotes a hotline number as well as direct contact with SIU staff members.

The Coventry Health Care, Inc. SIU is also responsible for establishing contacts with external parties, including other SIUs and law enforcement personnel to obtain referrals.

Investigative Process

Upon receipt of the referral or detection by the SIU, the SIU staff, which includes registered nurses, professional Investigators, and data technicians, initiates the investigative process described below. Claims shall be investigated and adjudicated within the applicable claims processing time frames.

Initial Handling of Referral

Upon receipt or detection of the referral, all relevant information is loaded into the SIU Case Tracking Database. The loading process includes preliminary investigative steps, such as the validation or verification of the provider's tax identification number ("TIN") and patient name.

Evaluating the Referral

The Investigator must evaluate the referral to determine the merits or substance of the referral. The following steps should be taken to evaluate the referral as it applicable given the fact and circumstances of the particular referral:

- A review of all submitted documents for potential fraud indicators (see Exhibit 2).
- A review of the provider claims history, provider pre-authorization history, and/or member grievances records, as appropriate.

- Identification of additional information needed to properly evaluate the referral, i.e., medical records for billed charges for specific dates of services.
- Determination of whether additional investigation of the referral is warranted depending upon findings after initial evaluation.
 - If during the initial evaluation the possibility of fraud is eliminated, the referral should be closed. The referral is then returned to Coventry's Customer Service Operations for completion of claims processing.
 - If fraud cannot be definitively eliminated, an investigation is initiated.
- The referral in the SIU Case Tracking Database will be updated to reflect it is an open case. Additionally, an electronic case file is also created on the SIU's secure drive to store documentation. The SIU Case Tracking Database allows easy access to all case files and contains pre-programmed reporting to track and manage the investigations being performed by the SIU staff.

Case Development

The Investigator utilizes the following sources of information to plan and develop the course and strategy of the investigation:

- **NHCAA Database.** Coventry Health Care, Inc., as a corporate member of the National Health Care Anti-Fraud Association ("NHCAA"), has access to tools developed by the Association for the dissemination of anti-fraud intelligence. Specifically, the NHCAA has developed a database that includes a listing of providers that have demonstrated that they are or were involved in questionable billing practices. Accessing this database assists the Investigator in identifying questionable billing patterns and/or potential provider schemes.
- **Software Tools.** Coventry Health Care, Inc. utilizes an anti-fraud software tool, the StarSentinel software. The

rules- based software analyzes claim data on a post payment basis and identifies outliers for investigation. The tool, which is administered by the SIU, is capable of generating several reports that afford varied looks at the data. The SIU utilizes the tool to review providers who were not necessarily identified by the rules as an outlier. The information is helpful with comparing providers by peer group, specialty and region, in order to identify those with irregular billing and/or high or low utilization.

- **Medical Records and Supporting Documentation.**

All providers contracted with Coventry are required to collect, process, maintain, store, retrieve and distribute member medical records in accordance with applicable state and federal laws and regulations and CMS, NCQA/URAC/AAHC and JCAHO standards. If obtained, medical records are reviewed by the SIU nurses who assess the validity of the claim through an examination of variances between what is documented in the medical record and what has been submitted on the claim(s).
- **Review of Excluded Persons**

The Federal Government maintains various lists of excluded, debarred and sanctioned individuals and companies who are precluded from participating in government health care delivery. Coventry, through the credentialing process and through ongoing monthly monitoring, ensures that individuals and companies who are excluded from participation in Federal programs are identified and flagged in the claim systems. This includes actual health care providers, as well as those individuals with ownership or controlling interest of providers and companies with which Coventry contracts. Additionally, the pharmacy vendor follows a similar process to flag and prevent payment to any provider in its claim system which is excluded. The SIU reviews the contents of these databases to ensure that any provider in Coventry Health Care, Inc.'s claim system or under investigation is not already excluded by the government. The databases reviewed are:

- Ø **OIG Exclusion Database:** The Department of Health and Human Services, Office of Inspector General (“OIG”), under a Congressional mandate to protect the integrity of federally-funded government health care programs, has established a process to exclude certain individuals and entities, for among other reasons, fraudulent activities, and maintains a list of all currently excluded parties under its “List of Excluded Individuals/Entities.”
- Ø **OPM Debarment List.** Under the authority of the Federal Employees Health Benefits Amendments Act of 1988 (5 USC § 8902a) and the Government-wide Non-procurement Debarment and Suspension Common Rule (Executive Order 12549 and 5 CFR Part 970), the Administrative Sanctions Branch debars from participation in the Federal Employees Health Benefits Program (FEHBP) health care providers who have 1) lost professional licensure; 2) been convicted of a crime related to delivery of or payment for health care services; 3) violated provisions of a federal program; or 4) are debarred by another federal agency.
- Ø **GSA Excluded Parties List.** Using a web based database, the General Service Administration maintains an Excluded Parties Listing System (EPLS), which identifies those parties excluded throughout the U.S. government (unless otherwise noted) from receiving federal contracts or certain subcontracts and from certain types of federal financial and non-financial assistance and benefits.
- Ø **Health Care Integrity and Protection Databank (HIPDB).** The Program Integrity Section will update HIPDB to reflect all permissive and mandatory provider exclusions
- Ø Based upon the Investigator’s review of investigative sources, the Investigator will establish an investigative plan.

Conducting the Investigation

Depending upon the investigative plan, the Investigator may investigate the case by performing one or more of the

following investigative measures:

- **Member Information.** Interviewing members, via telephone contact, enables the Investigator to confirm or refute whether the services charged were actually rendered.
- **Provider/Billing Entity Information.** Researching the provider's license and disciplinary actions to evaluate past history and behavior. Contacting the provider's office to confirm the listed phone number and address assists in determining the legitimacy of the provider and/or claim. Searching for mail-drop listings may also result in discovery of a nonexistent provider or billing entity.
- **Clinical Review.** Medical records are reviewed to confirm if the services rendered were medically necessary. Investigators who perform this level of review must be qualified as required by applicable law, possessing such qualifications as nursing degrees or other mandated clinical background or experience. Cases may contain charges that represent not generally accepted medical practices (i.e., application of experimental and investigational procedures or therapies.) Additionally, the SIU has, as a resource, the Coventry Medical Director(s) who evaluate(s) claims where the medical necessity or appropriateness of the services are in question. The SIU nurses coordinate the Medical Director review and incorporate the findings into the case.

Closing the Investigation

After the Investigator has concluded the investigation of the case, the Investigator completes an investigation report. The Investigator includes in the report the allegation, an executive summary, case notes and recommendations. The Investigator's recommendations may include recovery figures and suggested corrective actions. The SIU will then present the report to Coventry and their established Fraud, Waste and Abuse Committee. The committee, which is made up of compliance, medical, provider relations, financial and legal representatives reviews the case and determines the appropriate actions. Such actions will be based upon Coventry's analysis of the report findings, its

interpretation of applicable law, the provisions of Coventry's contractual requirements and its provider contracts, if applicable. Possible actions include, but are not limited to, a determination that:

- ✓ the claim or claims should be paid, denied in part, or denied completely (if the claims are already paid, then a decision to deny, in whole or in part, would result in a recovery action against the provider);
- ✓ any provider or member activity should be reported to appropriate state and federal agencies;
- ✓ action should be taken with respect to a member's eligibility status; and/or
- ✓ employee action needs to be taken (see section IV.D, below).

If the claims involve a network provider, the Coventry Medical Director and/or Compliance Officer will also determine whether to submit the case to Coventry's credentialing committee for review and possible action.

Pharmacy Claim Investigations

Overview

As with medical claims, there are multiple sources of pharmacy referrals as described above in the medical claims section. The well publicized channels for directing referrals to the SIU as described in this section also apply to pharmacy referrals.

Pharmacy referrals are also generated from the pharmacy benefit vendor as described above. It should be noted that the pharmacy benefit vendor will take charge of all referrals and investigations related to the behavior of the pharmacy, including the pharmacy employees, except in the case of interest conflict where the Coventry Health Care, Inc. SIU would assume jurisdiction. Pharmacy referrals and investigations involving a member or provider will be led by the SIU as described above. However, in both situations the pharmacy benefit vendor and the SIU will work closely to investigate and resolve the allegation. Further, Coventry Health Care, Inc. reserves the right to object to any PBM decision that involves referring cases to law enforcement and the Medic or when a pharmacy contract is terminated.

Upon receipt of the referral, the SIU will facilitate the

communication and coordination of the referral to the pharmacy benefit vendor. Likewise, if the pharmacy benefit vendor is the developer of the referral, they will communicate and coordinate the process with the SIU.

Investigative Process

Upon receipt or detection of the referral, the pharmacy benefit vendor will handle, evaluate, plan and conduct the investigation in accordance with the pharmacy benefit vendor's policies which have been provided to and reviewed by the SIU.

If the pharmacy benefit vendor refers a case that involves suspected member or provider fraud, the SIU may take the following steps to investigate:

- Review all filled prescriptions to determine suspicious utilization patterns that include:
 - drugs considered recreational or having high resell (street) value
 - multiple pharmacy utilization, including pharmacies more than 25 miles from work or residence
 - comparison to medical services to determine if prior history is appropriate for prescribed medication
 - determine if multiple physicians (doctor shopping) prescribed the medication
- Request related medical records or pharmacy records from health care providers, if appropriate.
- Review medical records to determine if the prescriptions were written by licensed health care professionals for the purpose of the member's medical treatment.
- Review appropriate records to determine if the drugs were dispensed for use by the member, or were obtained through improper use of a member's health plan prescription drug card.
- Review the records with Coventry's Medical and/or Pharmacy Director(s), to obtain their clinical opinion and expertise on issues such as appropriate dosage and utilization for the member's medical condition.

Closing the Investigation

After the Investigator (either the pharmacy benefit vendor or SIU, depending on the type of case) has concluded the investigation of the case, an investigation report will be completed. This report summarizes the results of the investigation and may include

reimbursement recommendations.

If the report is completed by the pharmacy benefit vendor, upon receipt of the investigative report, the SIU will evaluate the report and supporting documentation and if necessary, conduct any additional investigation and/or supplement the report with any additional SIU findings or recommendations.

The final Investigator's report contains the allegation, an executive summary, case notes and recommendations. The Investigator's recommendations may include recovery figures and suggested corrective actions. The SIU will then present the report to Coventry and their established Fraud, Waste and Abuse Committee. The committee, which is made up of compliance, medical, provider relations, financial and legal representatives reviews the case and determines the appropriate actions. Such actions will be based upon Coventry's analysis of the report findings, its interpretation of applicable law, the provisions of Coventry's contractual requirements and its provider contracts, if applicable. Possible actions include, but are not limited to, a determination that:

- ✓ the claim or claims should be paid, denied in part, or denied completely (if the claims are already paid, then a decision to deny, in whole or in part, would result in a recovery action against the provider or member);
- ✓ any provider or member activity should be reported to appropriate state and federal agencies;
- ✓ action should be taken with respect to a member's eligibility status; and/or
- ✓ member action needs to be taken (see section IV-D, below).

If the claims involve a pharmacy contracted directly with Coventry Health Care, Inc. (rather than through the pharmacy benefits vendor), the Pharmacy Director and/or Compliance Officer will also determine whether to submit the case to Coventry's Credentialing Committee and/or the Coventry Health Care, Inc. Pharmacy Department for review and possible action. Corrective actions involving pharmacies contracted through the pharmacy benefit vendor are carried out by the vendor. The SIU is notified of the corrective actions and communicates them as necessary to Coventry.

Member Medical Claim Investigations (i.e., Claims Processed Through IDX)

The investigation process begins with a referral and, as noted in medical claims section, there are multiple sources for referrals and there are well publicized channels for directing referrals to the SIU. Sources include, but are not limited to, a member or provider inquiry, complaint, grievance or appeal. Generally speaking, member medical claim investigations are forwarded to the SIU by Coventry or Coventry Health Care, Inc. personnel. Upon receipt, the SIU Investigator will log the information into the SIU Case Tracking Database and initiate an investigation. During the course of the investigation the SIU may consult with the health plan Compliance Officer and involve as necessary other health plan disciplines such as medical and claims personnel.

The SIU and/or any of the personnel described above will evaluate the referral to determine the merits or substance of the referral. The following steps should be taken to evaluate the referral:

- Review all submitted documents for potential fraud indicators (see Exhibit 2).
- Identify additional information needed to properly evaluate the referral, i.e., medical records for billed charges for specific dates of services and obtain and review such information, if possible.
- Interview the provider of services to determine if the member actually received the services.

If during the evaluation the possibility of fraud or abuse is eliminated, the case should be closed. If the issue involved pended claims, the SIU shall instruct Customer Service Operations to process the claims according to plan guidelines.

After the Investigator has concluded the investigation of the case, the Investigator completes an investigation report. The Investigator's report contains the allegation, an executive summary, case notes and recommendations. The Investigator's recommendations may include recovery figures and suggested corrective actions. The SIU will then present the report to Coventry and their established Fraud, Waste and Abuse Committee. The committee, which is made up of compliance, medical, provider relations, financial and legal representatives reviews the case and determines the appropriate actions. Such actions will be based upon Coventry's analysis of the report findings, its interpretation of applicable law, the provisions of Coventry's benefit documents and contract with the state agency. Possible actions include, but are not

limited to, a determination that:

- ✓ the claim or claims should be paid, denied in part, or denied completely;
- ✓ any member activity should be reported to appropriate state and federal agencies;
- ✓ action should be taken with respect to a member's eligibility status; and/or
- ✓ member action needs to be taken

Employee Investigations

Cases involving suspected employee fraud will be reviewed and investigated in accordance with Coventry Health Care, Inc.'s compliance policies and procedures attached as Exhibit 1.

Member Safety (Abuse)

If at any time during an investigation, the SIU, pharmacy benefit vendor, Coventry Health Care, Inc. or Coventry personnel reasonably believe a member's health or safety may be in jeopardy or has been jeopardized as a result of the suspected fraud, the person investigating the case shall immediately report such concerns to the Coventry Medical Director. The Coventry Medical Director will review the case, or have the case reviewed, in accordance with Coventry's quality improvement and/or peer review procedures.

E. REPORTING FRAUD AND ABUSE

When Coventry reasonably suspects fraud and abuse has occurred/is occurring and the suspected fraud and abuse involves a Medicaid member, a plan or Coventry Health Care, Inc. employees actions that relate to a Medicaid member or the Medicaid program (such as reasonably suspected fraud and abuse in marketing/outreach services), or services allegedly rendered to a Medicaid member, the Medicaid compliance staff shall report such incidents DHH within three (3) business days upon discovery of such suspected fraud and abuse.

Coventry will notify DHH within three (3) business days of the time it receives notice that action is being taken against the Coventry, a Coventry employee, network providers contractor or contractor employee or any contractor which could result in exclusion, debarment, or suspension of Coventry or a contractor from the Medicaid to CHIP program, or any program listed in Executive Order 12549.

Coventry will notify MFCU and DHH within three (3) business days of suspected fraud, abuse, waste and neglect, taking prompt corrective actions and cooperating

with DHH in its investigation of the matter(s).

All reports shall be sent to DHH in writing and shall include a detailed account of the incident, including names, dates, places, and reasonably suspected fraudulent activities.

For any investigations relating to Medicaid members, Coventry will notify DHH in writing of any action taken as a result of its investigation, including, but not limited to, suspension or termination (voluntary or involuntary) of a provider or subcontractor contract, or recovery of improper payments made to network providers.

The plan will report quality issues to the Quality Improvement Department for further investigation. Quality issues are those which, on an individual basis, affect the Medicaid members' health (e.g. poor quality services, inappropriate treatment, aberrant and/or abusive prescribing patterns, and withholding of medically necessary services from enrollees).

F. REVIEW AND REVISION

Coventry will routinely evaluate the effectiveness of the Anti-Fraud Plan. As part of the review, Coventry will also determine if it has modified the training protocols and procedures it follows for instances or suspected instances of health care and pharmacy fraud. Coventry will also determine if there was a change in the person or persons responsible for the anti-fraud program. If so, Coventry will modify this Plan accordingly. Additionally, Coventry Health Care, Inc. corporate will evaluate the Anti-Fraud Plan on an annual basis. A policy on this review process is enclosed as Exhibit 8.

G. AUDITING

To the extent permitted by law, Coventry will cooperate fully with governmental agencies responsible for fraud, waste and abuse detection and prosecution activities in arranging for or participating in, any audit or review of Coventry to determine if Coventry is complying with this plan. Such agencies may include, but are not limited to State Departments of Insurance, State Medicaid Agencies, Medicaid Fraud Control Unit, the U.S. Department of Health and Human Services Office of Inspector General, and United States Justice Department. This cooperation shall include allowing access, in accordance with applicable law, to relevant SIU and Coventry offices upon reasonable notice and at reasonable hours to conduct on-site reviews of Coventry's compliance with the Anti-Fraud Plan. Coventry and the SIU will also cooperate fully in all reviews, investigations and in any resulting subsequent legal action brought by appropriate governmental agencies against providers or members relating to fraud, waste and abuse issues. Coventry will maintain complete claims data that are accessible and retrievable

for examination. All records shall be retained in accordance with applicable law and Coventry 's and Coventry Health Care, Inc.'s policies.

H. EXHIBITS

Coventry Health Care Corporate Compliance Policies Exhibit 1

Exhibit 1a- CHC Policy of Reporting of Potential Issues or Areas of Noncompliance

Exhibit 1b- CHC Policy on Federal and State Government Agency Requests for Information, Audits, Interviews, Searches, and Other Contacts with CHC

Exhibit 1c- CHC Policy on Employee Training

Exhibit 1d- Code of Business Conduct and Ethics

Coventry Health Care & Pharmacy Fraud, Waste & Abuse GuideExhibit 2

Sample SIU Referral Form.....Exhibit 3

Policy For Identifying, Reporting, And Addressing Abusive/Fraudulent Behavior By ProvidersExhibit 4

MEDCO Pharmacy Audit Overview.....Exhibit 6

Fraud Plan Revision PolicyExhibit 8

**COVENTRY HEALTH CARE
COMPLIANCE AND ETHICS PROGRAM**

**CHC Policy on Reporting of
Potential Issues or Areas of Noncompliance**

I. DUTY TO REPORT AND COMPLIANCE OFFICER INVESTIGATIONS

- A. Employees are expected to report any suspected violations of the Code of Business Conduct and Ethics, the CHC Compliance and Ethics Program, or other irregularities to their supervisor, manager, a Human Resources Compliance Officer, the General Counsel, Chief Financial Officer or a Compliance Officer. If the employee wishes to remain completely anonymous, that employee may submit his/her report through the CHC Compliance and Ethics Program's Comply Line (1-877-242-5463). This Comply Line number shall be posted in all work locations. All reports must contain sufficient information to investigate the concerns raised. No adverse action or retribution of any kind will be taken by CHC against an employee solely because he or she reports in good faith a suspected violation of the Code of Business Conduct and Ethics, the CHC Compliance and Ethics Program or other irregularity by any person other than the reporting employee. CHC will attempt to treat such reports confidentially and to protect the identity of the employee who has made a report to the maximum extent consistent with fair and rigorous enforcement of the Code of Business Conduct and Ethics and the Compliance and Ethics Program.
- B. Any manager, supervisor, Compliance Officer, or other high-ranking employee who receives a report of a suspected violation or irregularity (e.g., a report made in-person and not placed through the Comply Line) shall complete a Compliance Report Form (*See Attachment A*). The Report Form shall immediately be sent to a Compliance Officer for action. Managers, supervisors and others who receive reports of suspected violations or irregularities shall make themselves available to the Compliance Officer during the investigation.
- C. Upon receipt of the Report Form or a Comply Line Report, a Compliance Officer shall begin promptly an investigation and take corrective action where appropriate.
- D. While the Compliance Officer will strive to keep all concerns/complaints confidential to the extent possible, the Compliance Officer may seek advice and guidance from other Compliance Officers and CHC's legal counsel.

II. DISCIPLINE OF VIOLATORS

- A. The Compliance Officer will work with managers and supervisors to inform any employee of any allegations that may have been filed against him or her arising

**COVENTRY HEALTH CARE
COMPLIANCE AND ETHICS PROGRAM**

**CHC Policy on Reporting of Potential
Issues or Areas of Noncompliance**

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from the Compliance and Ethics Program. The employee will be given the opportunity, as appropriate, to state his or her position before any disciplinary action is imposed.

- B. If the Compliance Officer determines that an employee has clearly violated the law, Code of Business Conduct and Ethics or the CHC Compliance and Ethics Program, that employee shall be subject to appropriate disciplinary action as determined by the Compliance Officer and relevant management.
- C. The disciplinary action imposed may include, but is not limited to:
 - a. verbal warning
 - b. written warning
 - c. probation
 - d. suspension
 - e. demotion
 - f. dismissal

The sanction will depend on the seriousness of the offense. A record of the event and the discipline imposed shall be maintained in the employee's personnel file.

- D. If there has been a violation of state or federal law, consult with CHC legal counsel for possible further reporting obligations.

III. DISCIPLINE OF MANAGERS AND SUPERVISORS

Appropriate action will be taken against a violator's manager(s) or supervisor(s) to the extent that circumstances reflect inadequate supervision or a lack of due diligence. Appropriate action will be taken against any manager or supervisor who retaliates, directly or indirectly, against an employee who reports a violation of law, Code of Ethics or the CHC Compliance and Ethics Program.

ATTACHMENT:

Attachment A: Compliance Report Form

**COVENTRY HEALTH CARE
COMPLIANCE AND ETHICS PROGRAM**

**CHC Policy on Reporting of Potential
Issues or Areas of Noncompliance**

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**ATTACHMENT A
COMPLIANCE REPORT FORM**

- I. **TO BE COMPLETED BY ANY MANAGER, SUPERVISOR, COMPLIANCE OFFICER OR OTHER SENIOR LEVEL EMPLOYEE WHO RECEIVES A REPORT OF SUSPECTED VIOLATION OR NON-COMPLIANCE.**

NAME OF EMPLOYEE PROVIDING INFORMATION: _____

DATE: _____

DESCRIPTION OF ALLEGED VIOLATION:

**Forward this completed form and any associated documentation to the
Chief Compliance Officer at: Compliance@cvtty.com**

All information will be treated as confidential to the fullest extent permitted by law and the identity of the employee making the report will be protected to the maximum extent consistent with fair and rigorous enforcement of the Code of Business Conduct and Ethics and the Compliance and Ethics Program.

**COVENTRY HEALTH CARE
COMPLIANCE AND ETHICS PROGRAM**

**CHC Policy on
Federal and State Government Agency Requests for Information, Audits,
Interviews, Searches and Other Contacts with CHC Regarding CHC or its Affiliates**

I. INTRODUCTION

- A. Federal and state governments have made the investigation and prosecution of health care fraud one of their highest priorities and have adopted and proposed many new initiatives for identifying fraudulent practices. Government investigations of health care companies have become commonplace and it is increasingly likely that governments will conduct audits of CHC. Consistent with that emphasis, it is the aim of CHC to take all reasonable steps to prevent or eliminate any improper activities. CHC's policy has been and will continue to be one of providing full cooperation to these government authorities while at the same time protecting the rights of CHC and all of its employees.
- B. CHC strives to comply with all of the complicated rules and regulations governing the health care industry. Government health care regulations and their enforcement are a very complex area of the law. As government inquiries are important and often complicated, the purpose of this Policy is to provide a uniform method for our employees to respond to any government employee (federal or state) who contacts an employee of CHC either during office hours or at home for information regarding CHC or any other CHC-affiliated entity which or individual who provides health care items or services.

II. DEFINITION OF "FEDERAL AND STATE GOVERNMENT AGENCY"

- A. The employee should be aware that, for purposes of this Policy, a federal or state government agency includes, but is not limited to, the following organizations:

<u>Organization</u>	<u>Function</u>
<i>Center for Health Plans and Providers (CHPPs):</i>	division of CMS responsible for creating and implementing CMS' policies regarding managed care.
<i>Department of Health and Human Services Drug Enforcement Agency (DEA):</i>	federal agency overseeing administration of controlled substances.
<i>Federal Bureau of Investigation (FBI):</i>	investigative arm of federal government programs.

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<i>General Accounting Office (GAO):</i>	investigative arm of Congress responsible for examining all matters relating to the receipt and disbursement of public funds.
<i>Centers for Medicare and Medicaid Services (CMS):</i>	federal agency overseeing administration of the Medicare and Medicaid programs.
<i>Medicare Drug Integrity Contractors (MEDICS)</i>	An organization that CMS has contracted with to perform specific program integrity functions for Part D under the Medicare Integrity Program. The MEDIC is CMS' designee to manage CMS' audit, oversight and anti-fraud and abuse efforts in the Part D benefit.
<i>Medicaid Fraud Control Unit (MFCU):</i>	investigative arm of state Medicaid agency.
<i>Medicaid Programs:</i>	state health insurance programs for the medically indigent.
<i>Medicare Intermediary:</i>	claims processors of the Medicare Part A program (e.g., hospitals, skilled nursing facilities, and home health agencies).
<i>Medicare/DMERCs/ Carrier:</i>	claims processors of the Medicare Part B program (e.g., physicians, ambulances, clinical laboratories, durable medical equipment, and nursing home supplies).
<i>National Supplier Clearinghouse (NSC):</i>	national contractor for Medicare Part B that assigns supplier numbers and conducts audits.
<i>Department of Health and Human Services Office of the Inspector General (OIG):</i>	investigative arm of federal government programs.
<i>State Attorney General's Office:</i>	arm of the state responsible for investigating/prosecuting violations of state laws.
<i>State Departments of Insurance</i>	arm of state that regulates insurance companies (HMO's, indemnity, life, etc.)
<i>State Government:</i>	any other state agency or department.

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COMPLIANCE AND ETHICS PROGRAM**

**CHC Policy on
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- B. If the employee is contacted by an organization that is not on this list, and the employee is unsure whether the organization is a federal or state government agency, then:
 - 1. Contact a Compliance Officer immediately; or
 - 2. If a Compliance Officer is unavailable, contact CHC legal counsel directly.
- C. Be aware that, in initial inquiries regarding a matter to be investigated, the fact that an investigation is underway may not be disclosed to anyone other than a Compliance Officer or CHC legal counsel. For example, if an auditor or other government representative raises questions about matters unrelated to an employee's customary dealings with them, issues related to contracts or business transactions, or suggestions of irregularities in business practices, accounting procedures or the like, an employee should not disregard the information, but should report the inquiry or contact to a Compliance Officer or CHC legal counsel as soon as possible.
- D. **See Exhibit A for Procedures for Federal and State Government Agency Requests for Information, Audits, Interviews, Searches and Other Contacts with CHC.**

III. ADMINISTRATIVE ISSUES

- A. The Deputy Compliance Officer should, once a government contact is initiated, establish a specific file for communications to and from the General Counsel's office. The file and all memos to the CHC legal counsel's office should be captioned with the words "CONFIDENTIAL ATTORNEY-CLIENT PRIVILEGED COMMUNICATION."
- B. The Deputy Compliance Officer **SHOULD NOT** make copies other than a file copy, or in any way further distribute confidential communications with the CHC legal counsel's office or other attorneys. Distribution may destroy the privilege of confidentiality.
- C. IF, AT ANY TIME, THE DEPUTY COMPLIANCE OFFICER IS UNSURE OF WHAT TO DO, CONTACT CHC LEGAL COUNSEL OR THE CHIEF COMPLIANCE OFFICER IMMEDIATELY. THIS POLICY CONTAINS GENERAL GUIDELINES. AT ALL TIMES, FOLLOW INSTRUCTIONS FROM CHC LEGAL COUNSEL OR FROM OTHER COMPLIANCE PERSONNEL.

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**CHC Policy on
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Exhibit A: Procedures for Federal and State Government Agency Requests for Information, Audits, Interviews, Searches and Other Contacts with CHC.

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**CHC Policy on
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EXHIBIT A

**PROCEDURES FOR FEDERAL AND STATE GOVERNMENT AGENCY REQUESTS FOR
INFORMATION, AUDITS, INTERVIEWS, SEARCHES AND OTHER CONTACTS WITH CHC**

I. PROCEDURES

- A. CHC's policy is to cooperate fully during a lawful investigation or inquiry.
- B. When a representative of a federal or state government agency contacts you anywhere, such as at the office **or** at home, for information regarding CHC or any other CHC-affiliated health care entity, or any other entity with which CHC does business, the employee should do the following:
 - 1. If the government representative appears in person, ask to see his or her identification and business card. If these materials are unavailable, ask for the person's name and office, address and telephone number, identification number and call the government representative's office to confirm his or her authority. If more than one government representative appears, there will often be one government representative in charge. You should determine who this government representative is and ask that government representative to provide this information to you.
 - 2. If the government representative wants to speak with you personally, then find out why without getting into details. (**See Section II - Interviews** below after completing all other tasks in this section).
 - 3. If the government representative wants to search a supplier facility or obtain any documents from CHC, ask to see a legal document requesting the search, such as a search warrant and any affidavit supporting the warrant. Make a copy of this legal documentation.
 - 4. Look at the date and time on the legal documentation to make sure that the government representative has a valid document. A government representative may not search a business at a time other than within the time period specified in the legal document. (**See Section III - Searches** below after completing all other tasks in this section).
 - 5. Contact either a Compliance Officer or CHC legal counsel immediately after completing these tasks and relay all information and documentation from business cards/legal documents.
 - 7. Either the CHC legal counsel or a Compliance Officer will give you

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instructions on how to proceed.

8. If you receive a request in the mail from a government representative for documents or a subpoena, give your Deputy Compliance Officer a copy immediately and immediately fax a copy to CHC legal counsel. Do not respond to the request until receiving instructions from CHC legal counsel.
9. Maintain a complete and accurate listing of all visits by government representatives and all documentation supplied to government representatives.

II. INTERVIEWS

- A. It is not unusual for government representatives to try to suggest that you must speak with them when they first contact you or for the government representatives to imply that it is wrong for you to refuse to speak with them during this first contact.
- B. Government representatives may **not** threaten you in any way, require you to speak with them immediately or suggest that they may offer you a "deal" if you provide information to them. If a government representative tries any of these tactics, it is because he/she is trying to intimidate you. You should not let the government representative intimidate you into speaking with him/her before you are ready. No matter what the government representative might tell you, you are allowed to schedule an appointment to speak with them at a different time.
- C. You are entitled to have someone with you during any interview with a government representative. CHC will arrange to have a CHC attorney present at no cost to you or, if you wish, you may consult with an attorney of your own choosing at your expense.
- D. Of course, if you wish, you are free to speak with the government representative. If you choose to be interviewed by a government representative before calling the CHC legal counsel, contact the CHC legal counsel as soon as possible after the interview. Remember that you may also have someone, like a co-worker or family member, present during the interview with the government representative. You are encouraged to take notes during the interview.
- E. During the interview with the government representative, you should follow these simple tips:
 1. Always tell the truth. If you do not recall something or have no knowledge about the topic that the government representative is asking about, say so.

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2. In talking with the government representative, you should be very careful to answer questions completely, accurately and concisely so that there will be no misunderstanding as to what you are saying. It is important to make clear to the government representative whether the information that you are providing is first-hand knowledge, something you have heard, or speculation. It is good practice to avoid speculation, but if you do speculate, it is important to make sure you let the government representative know that you are speculating.
3. Please contact the CHC legal counsel as soon as possible after the interview.

III. SEARCHES

- A. If the government representative wants to obtain documents or search CHC on the spot, you should remember the following:
 1. A "search" occurs any time a government representative enters CHC's premises and begins to look for any documents or ask questions. A search may not be conducted without a legally valid search warrant. However, there are some government agencies that have the authority to assess penalties if representatives of the agency are not granted immediate access upon reasonable request to a health care entity. These agencies include OSHA, state Medicaid fraud control units, the Office of the Inspector General, and the state Medicaid agency. Therefore, CHC employees should strive to be courteous and helpful to government representatives while following the guidelines set forth in this section.
 2. If the warrant is valid, you may not stop the search. However, it is appropriate to request that the government representative allow you to contact the CHC legal counsel to have the CHC legal counsel determine the validity of the warrant. You should follow these steps **after** having the CHC legal counsel determine the validity of the warrant and after the CHC legal counsel instructs you on how to proceed:

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- a. Appoint someone on site to be in charge. That person will be responsible for communicating with the government representative.
- b. Remember, it is a crime to obstruct an agent in the lawful execution of a valid search warrant. Some other examples of unlawful behavior are: altering or destroying documents sought in an investigation; falsely denying knowledge of information; corruptly influencing another person to exercise the privilege against self-incrimination; or intimidating a witness with the intent of influencing testimony or retaliating against a witness for testifying in an official proceeding. However, asking questions and demanding a copy of the warrant are not obstruction. Remain calm, polite and observant. If you notice any other employees engaging in any prohibited conduct, call the CHC legal counsel immediately.
- c. Government representatives may try to obscure the documents that they are seizing from you. Therefore, it is very important that you try to keep a thorough list of *all* documents that the government representative is seizing or copying. You should assign an employee to follow each government representative at a CHC site during their search. This employee should take detailed notes of everything that the government representatives seize and those documents that the government representatives inspect, but do not seize or copy. The employee should also take detailed notes of any conversations that the government representatives may have.
- d. Get a detailed receipt from the government representative of all documents/items for which the government has obtained a copy, including the number of pages copied for reimbursement purposes. If the government representative wishes to take original documents, ask if those documents may first be copied. If the government representative will not allow copies, call CHC legal counsel. If you cannot reach CHC legal counsel, ask if you can first make a list of all documents that the government is taking.

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- e. It is not unusual for government representatives to seize documents or items whose loss will impede the day-to-day operation of CHC, such as member records and computers. If a government representative wants to seize any computers, you should ask the representative if you can copy all files onto a disk. You should also call CHC legal counsel at 800-843-7421 to inform counsel that the government is seizing computers. If the government representative wishes to seize member records, ask if those records may be copied so that member care or member confidentiality will not be compromised. You should also call CHC legal counsel to inform counsel that the government is seizing member records. If you cannot reach CHC legal counsel, take detailed notes.

- B. You are required to answer questions concerning the location of documents.

- C. You are not required to answer other questions, and you can tell the government representative that you prefer to wait until counsel is present. As described above, CHC will supply you with a CHC attorney at no cost to you.

- D. If you are asked to sign an affidavit of any kind, do not comment as to the validity of its contents and explain that you are not authorized to sign any document prior to review by legal counsel.

- E. It is important that all employees: (1) cooperate with the government representative; and (2) provide accurate information to the government representative. Cooperation with government representatives will make it easier for CHC legal counsel to negotiate the return of vital records. Also, providing inaccurate statements to government representatives may result in obstruction of justice charges.

IV. COMMUNICATIONS REGARDING AN INVESTIGATION

Do not discuss the matter with *anyone* without first receiving permission from CHC legal counsel to discuss the matter with that person. Innocent parties may be hurt by rumors regarding the government contact, and CHC will not tolerate the spreading of such rumors by any employee or agent of CHC. If you receive any inquiries from the media or any person or organization where you are unsure of how to respond, you should refer the inquiries to a Deputy Compliance Officer. You should not attempt to provide any explanation other than to state that questions regarding the investigation will be answered by a Deputy Compliance Officer. Make attempts to obtain the identity and telephone number of the inquiring party and to furnish that information to the CHC legal counsel.

COVENTRY HEALTH CARE COMPLIANCE AND ETHICS PROGRAM

CHC Policy on Employee Training

Drafted by: CHC & Epstein Becker & Green Reviewed/Revised by: CHC & EBG Date
Reviewed/Revised/Approved: August 1999

I. INTRODUCTION

CHC recognizes that for this Compliance and Ethics Program to be effective, employees must receive education and training as to the importance of compliance with applicable law and the Compliance and Ethics Program. In this regard, CHC has developed a training program for all of its employees so that all employees are familiar with the Compliance and Ethics Program and understand all of its policies and procedures, including the Code of Business Conduct and Ethics.

II. IMPLEMENTATION

- A. To implement the Compliance and Ethics Program, all existing employees will participate in a one-hour training session after CHC's formal adoption of this Compliance and Ethics Program.
- B. Employees will be asked to sign or electronically acknowledge a Statement of Understanding annually and at the time of hiring that they are aware of and will abide by the Compliance and Ethics Program (**Attachment A**). Employees will also be asked to sign or electronically acknowledge annually and at the time of hiring the Proprietary Information, Confidentiality and Non-Solicitation Agreement (**Attachment B**), the Pharmaceutical Company Relationships Employee Acknowledgement (**Attachment C**), and complete the Business Transactions with a Party In Interest (**Attachment D**).

These Attachments are included in the Code of Business Conduct and Ethics. The Code of Business Conduct and Ethics can be found on the Compliance Center on Coventry Today (<http://cvtynet.cvty.com>).

- C. As part of their initial orientation, all new employees will receive at least one hour of training within the first thirty (30) days of employment that discusses the goals and objectives of the Compliance and Ethics Program and familiarizes new employees generally with the Compliance and Ethics Program. Human Resources is responsible for ensuring the training occurs.

- D. After the initial orientation, all existing employees will receive training at least once a year with respect to the Compliance and Ethics Program and Code of Business Conduct and Ethics. Each employee must attend at least one hour of Corporate Compliance and Ethics Program training in every 12-month period. An employee returning from leave who has missed a regularly scheduled training session, must complete the training session within 30 days of returning to active work status.

III. TRAINING SESSIONS

- A. The Chief Compliance Officer or designee will work with Human Resources to monitor, develop and deliver the training and orientation sessions. Human Resources shall keep a written record of all such training sessions. The Learning Link retains electronic records of all employee training completed via the learning management system. Completion of training is mandatory and will be one criteria for which employees will be evaluated during their reviews. Failure to complete training pursuant to the Compliance and Ethics Program shall result in disciplinary procedures, up to and including discharge or termination from employment.
- B. At the direction of the Chief Compliance Officer, other training sessions may be held as the need arises to address changes in the Compliance and Ethics Program, in federal laws and regulations or any issues of interest. Additional training will be conducted for specific employees who have responsibilities with specific compliance issues, such as employees responsible for government programs. In addition, a Compliance Officer may direct specific employees to attend continuing education classes.

IV. TRAINING CONTENT - COMPLIANCE WITH CHC's CORPORATE COMPLIANCE AND ETHICS PROGRAM

- A. Employees shall be informed during the training session that strict compliance with the Compliance and Ethics Program and the Code of Business Conduct and Ethics is a condition of employment and that compliance with the Compliance and Ethics Program and the Code of Business Conduct and Ethics is one criteria upon which employees will be evaluated.
- B. CHC training sessions may include, but are not limited to, procedures to follow when a federal or state agency requests information from or otherwise contacts CHC.
- C. In conjunction with the annual certification, each employee shall certify electronically or through the Certification Form that he or she received and completed the general one-hour training session. Human Resources shall keep these certifications on file.

EMPLOYEE TRAINING CERTIFICATION FORM

Compliance and Ethics Program Training Date: _____

New Hire Training

Annual Employee Training

Employee Name: _____

Employee Position: _____

Employee Signature Date: _____

Supervisor/Manager Signature: _____

Supervisor/Manager Signature Date: _____

Please return this completed form to a Human Resources representative.

This form is not to be discarded or destroyed without prior consent of CHC legal counsel.

**COVENTRY HEALTH CARE
COMPLIANCE AND ETHICS PROGRAM**

Exhibit 1d

Code of Business Conduct and Ethics

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COVENTRY HEALTH CARE COMPLIANCE AND ETHICS PROGRAM

Code of Business Conduct and Ethics

I. PURPOSE

Coventry Health Care, Inc., together with all of its subsidiaries (“**CHC**”), is dedicated to conducting its business in accordance with the highest standards of ethical conduct. CHC is committed to conducting its business activities with uncompromising integrity and in full compliance with the federal, state and local laws governing its business. This commitment applies to relationships with stockholders, customers (enrollees, federal providers, state and local governments), contractors, vendors, competitors, auditors and all public and government bodies.

To protect CHC’s reputation and to assure uniformity in standards of conduct, CHC has established this Code of Business Conduct and Ethics (“**Code**”) as part of its Compliance and Ethics Program (“**Compliance and Ethics Program**”). Unless a provision of this Code states otherwise, this Code shall apply to all directors, officers and employees of CHC (collectively, “Covered Persons”). For purposes of this Code: (1) the term “employees” shall mean all persons employed directly by CHC, but shall exclude all non-management directors; (2) the term “officers” shall mean all persons in the position of Vice President or any superior position as indicated on CHC’s organizational chart; and (3) the term “directors” shall mean all management and non-management directors on CHC’s Board of Directors.

Under the Compliance and Ethics Program, a Chief Compliance Officer has been appointed to ensure compliance with the Code, to serve as a contact for employees to report any potential violations of laws, regulations or this Code, and to take appropriate action against violators of any such laws, regulations, or this Code. The intent of the Code is to ensure that every Covered Person understands the proper standards of conduct and conforms his or her conduct with all applicable laws, rules and regulations, including the standards issued by the state and federal governmental programs in which CHC participates (e.g., Medicare (Parts C and D), Medicaid and Federal Employee Health Benefits programs).

This Code exists to provide directors, officers, employees, sales representatives, stockholders, suppliers and members of the general public with an official statement of how CHC and its subsidiaries must and will conduct business in the marketplace. Under this Code, all Covered Persons will conduct themselves in the full spirit of honest and lawful behavior. In addition, Covered Persons must not cause another employee or non-employee to act otherwise, whether through inducement, suggestion or coercion. This Code and the policies and procedures of the Compliance and Ethics Program are not meant to cover all situations. Any doubts whatsoever as to the appropriateness of a particular situation, whether or not the situation is described within this Code, should be submitted either to your immediate supervisor or manager, CHC’s Chief Compliance Officer, a Compliance Officer, a Human Resources representative, CHC’s General Counsel or the CHC Comply Line.

All employees of CHC are to read, understand, be familiar with, and immediately after being hired at CHC and at least annually after hire, sign or electronically acknowledge

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and submit to CHC through the CHC Learning Link, their acknowledgment of reading and understanding the attached Statement of Understanding (**Attachment A**), the Proprietary Information, Confidentiality and Non-Solicitation Agreement (**Attachment B**), the Pharmaceutical Company Relationships Employee Acknowledgment (**Attachment C**) and will complete the Business Transactions With A Party In Interest (**Attachment D**). All non-management directors of CHC must also read, understand, be familiar with, and immediately after being elected or appointed to the relevant CHC Board of Directors (the "Board"), and at least annually after such election or appointment, sign the attached Statement of Understanding (**Attachment A**). At the discretion of management, other additional individuals may be asked to read and sign the Statement of Understanding. Only CHC's Chief Compliance Officer or CHC's General Counsel (or the Audit Committee in the case of executive officers and directors of CHC) may make decisions regarding requests for interpretation of or exceptions to this Code.

Any Covered Person violating any provision of this Code will be subject to disciplinary action, up to and including termination of employment. In addition, promotion of and adherence to this Code and to the Compliance and Ethics Program will be one criterion used in evaluating the performance of Covered Persons. To the extent that any additional policies are set forth in any other CHC manual, those policies should be consistent with this Code. In case of any inconsistency, this Code shall govern.

II. CONFLICT OF INTEREST

Covered Persons must avoid situations where their personal interest could conflict or appear to conflict with their responsibilities, obligations or duties to further CHC's interest or present an opportunity for personal gain apart from the normal compensation provided through employment. Conflicts of interest may not always be clear-cut so if you have a question, you should consult with the CHC Compliance Officer or CHC's General Counsel. Any Covered Person who becomes aware of a conflict or potential conflict should bring it to the attention of the Board (in the case of a director), an immediate supervisor or manager, CHC's Chief Compliance Officer, a Compliance Officer, a Human Resources representative, CHC's General Counsel or the CHC Comply Line or consult the procedures described in Section X.G. of this Code. The following guidelines have been developed to help you identify conflicts of interest:

A. Use of Corporate Funds and Assets

Covered Persons may not use assets of the organization for their own personal benefit or gain. All property and business of the organization shall be used in a manner designed to further CHC's interest rather than the personal interest of an individual Covered Person. Covered Persons are prohibited from the unauthorized use or taking of CHC's equipment, supplies, software, data, intellectual property, materials or services. Prior to engaging in any activity on CHC's time which will result in remuneration or the use of CHC's equipment,

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supplies, materials or services for personal or non-work related purposes, Covered Persons shall obtain the approval of their immediate supervisor or manager or other senior management of CHC.

B. Outside Financial Interests

The following is a list of the types of activities by Covered Persons, or household members of such Covered Persons, that might cause conflicts of interest. This list is not exhaustive and any questions regarding activities that may pose a potential conflict of interest should be directed to the Board (in the case of a director), a supervisor or manager, CHC's Chief Compliance Officer, a Compliance Officer, a Human Resources representative, CHC's General Counsel or the CHC Comply Line.

1. Ownership in or employment by any outside concern which does business with CHC. This does not apply to stock or other investments held in a publicly held corporation, provided the value of the stock or other investments does not exceed 5% of the corporation's stock. CHC may, following a review of the relevant facts, permit ownership interests which exceed these amounts if management concludes such ownership interests will not adversely impact CHC's business interest or the judgment of the employee.
2. Conduct of any business not on behalf of CHC, with any vendor, supplier, contractor, or agency, or any of their officers or employees.
3. Representation of CHC by a Covered Person in any transaction in which he or she or a household member has a substantial personal interest.
4. Disclosure or use of confidential, special or inside information of or about CHC, particularly for personal profit or advantage of the Covered Person or a household member or other.
5. Competition with CHC by a Covered Person, directly or indirectly, in the purchase, sale or ownership of property or property rights or interests, or business opportunities.

Covered Persons who may have a conflict of interest must contact the Board (in the case of a director), an immediate supervisor or manager, CHC's Chief Compliance Officer, a Compliance Officer, a Human Resources representative, CHC's General Counsel or the CHC Comply Line for guidance.

C. Outside Activities

Employees should avoid outside employment or activities that may have a negative impact upon their job performance with CHC, and all Covered Persons

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should avoid outside employment or activities that may conflict with their obligations, loyalties or fiduciary responsibilities to CHC.

D. Honoraria

Employees, with the permission of CHC's Chief Compliance Officer or CHC's General Counsel, may participate as faculty and speakers at educational programs and functions on behalf of CHC during office hours. Any honoraria in excess of Five Hundred Dollars (\$500) shall be turned over to CHC unless the employee used time off, paid or unpaid, to attend the program or that portion of the program for which the honoraria is paid.

E. Participation on Boards of Directors/Trustees

1. An employee must obtain approval from CHC's Chief Compliance Officer or CHC's General Counsel prior to serving as a member of the board of directors/trustees of any organization whose interests may conflict with those of CHC. CHC retains the right to prohibit membership on any board of directors/trustees where such membership might conflict with the best interest of CHC.
2. An employee who is asked, or seeks to serve on the board of directors/trustees of any organization whose interest would not have an impact on CHC (for example, civic, charitable, fraternal and so forth) is not required to obtain such prior approval.
3. All compensation received by an employee for board services provided during normal work time may be retained by the employee.
4. An employee, if so required by CHC, must disclose all board of directors/trustees activities in CHC's annual conflict of interest disclosure statement contained in the Business Transactions with a Party of Interest (**Attachment D**).

F. Corporate Opportunities

Covered Persons are prohibited without the consent of the CHC Board of Directors from taking for themselves personally opportunities that are discovered through the use of corporate property, information or position. No Covered Person may use corporate property, information, or position for improper personal gain, and no Covered Person may compete with CHC directly or indirectly without the consent of the Board (or an appropriate committee of the Board). Covered Persons owe a duty to CHC to advance its legitimate interests when the opportunity to do so arises.

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G. Loans

CHC's executive officers and directors may never accept loans or guarantees of obligations from CHC, from other employees, officers or directors of CHC on behalf of or for the benefit of CHC, or from any other person or entity, including suppliers and vendors, having or seeking business with CHC, except as permitted by law. No employee of CHC may accept loans or guarantees of obligations from any person or entity, including suppliers and vendors, having or seeking business with CHC. If you have any doubts as to whether a loan is permissible, contact CHC's Chief Compliance Officer or CHC's General Counsel for guidance.

III. FRAUD AND ABUSE

CHC expects all Covered Persons to comply scrupulously with all federal, state and local laws and government regulations. These laws and regulations prohibit (1) disguised payments in the submission of false, fraudulent or misleading claims to any government entity or third party payor, including claims for services not rendered, claims which characterize the service differently than the service actually rendered, or claims which do not otherwise comply with applicable program or contractual requirements; and (2) making false representations to any person or entity in order to gain or retain participation in a program or to obtain payment for any service. All Covered Persons must report immediately to the Board (in the case of directors), a supervisor or manager, CHC's Chief Compliance Officer, a Compliance Officer, a Human Resources representative, CHC's General Counsel or the CHC Comply Line any actual or perceived violation of this Code, the Compliance and Ethics Program, or any other CHC policy.

1. CHC will not tolerate fraud, waste or abuse in any of its relationships with internal and external parties. CHC will identify, report, monitor, and when appropriate, refer for prosecution situations in which suspected fraud or abuse occurs.
2. CHC is committed to compliance with all laws and regulations that prohibit employment of, payment to, or contracting with individuals or entities excluded or barred from Federal health care programs or sanctioned by the U. S. Department of the Treasury. Federal health care programs include Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan).
3. If any internal or external party, including employees, officers, directors, providers, agents/brokers, vendors, suppliers or contractors have been excluded, sanctioned, barred or convicted of health care fraud, CHC will terminate the employment or contract of such individuals or entities in accordance with CHC's policy.

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4. As part of the annually executed Statement of Understanding (**Attachment A**), each employee will certify annually that he or she has not been convicted of, or charged with, a criminal offense related to health care nor has he or she been listed by a federal agency as debarred, excluded or otherwise ineligible for participation in federally funded health care programs.

IV. DEALING WITH THIRD PARTIES

CHC obtains and keeps its business because of the quality of its products and services. CHC is committed to providing services that meet all contractual obligations and CHC's quality standards. Conducting business, however, with vendors, suppliers, contractors, providers and customers (subscribers or members) can pose ethical or even legal problems, especially in activities where differing local customs and market practices exist. The following guidelines are intended to help all Covered Persons make the "right" decision in potentially difficult situations.

A. Contract Negotiation

CHC has an affirmative duty to disclose current, accurate and complete cost and pricing data where such data is required under appropriate federal or state law or regulation. Employees involved in the pricing of contract proposals or in the negotiation of a contract must ensure the accuracy, completeness and currency of all data generated and given to supervisors and other employees. Furthermore, all representations made by CHC employees to CHC's customers and suppliers, both government and commercial, must be accurate, complete and current. The submission to a federal government customer of a representation, quotation, statement or certification that is false, incomplete or misleading can result in civil and/or criminal liability for CHC, the involved employee and any supervisors who condone such an improper practice. All Covered Persons should endeavor to deal fairly with all of CHC's vendors, suppliers, contractors, providers and customers, to the extent appropriate under applicable law and consistent with CHC policy and their duties of loyalty to CHC. It is inappropriate to take unfair advantage of anyone through manipulation, concealment, abuse of privileged information, misrepresentation of material facts or any other practice that may be considered unfair dealing.

B. Marketing and Advertising Activities

In conducting all marketing and advertising activities, Covered Persons may offer only honest, straightforward, fully informative and nondeceptive information. It is in the best interests of members, CHC and payors alike, for members, physicians and other referral sources to understand fully the services offered by CHC, and the potential financial consequences if CHC's services are ordered. Therefore, Covered Persons shall not distort the truth, make false claims, engage in comparative advertising or attack or disparage another competitor. All direct-to-

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consumer marketing activities that involve giving anything of value to a member require compliance with this Code and the relevant policies.

C. Antitrust and Competition

Antitrust and competition laws apply to all commercial and federal domestic transactions conducted by CHC (and in some cases foreign transactions). These laws are designed to ensure that competition exists and to preserve the free enterprise system. These laws generally prohibit agreements to fix prices or participation in unfair practices that may reduce competition in the marketplace. The antitrust laws applicable to CHC are complex and Covered Persons should consult CHC's Chief Compliance Officer or CHC's General Counsel if any questions arise as to the applicability of these laws to any activities conducted by Covered Persons. At a minimum, antitrust laws prohibit Covered Persons from engaging in the following activities:

1. Discussions or agreements with competitors of CHC regarding price fixing, stabilization or discrimination.
2. Discussions or agreements with suppliers or customers of CHC that unfairly restrict trade or exclude other competitors from the marketplace.
3. Discussions or agreements with competitors of CHC to allocate territories, markets or customers.
4. Discussions or agreements with competitors of CHC to boycott suppliers, customers or providers.
5. Requiring customers of CHC to buy from CHC through the use of coercion, express or implied.

Employees responsible for areas of the business of CHC that may implicate the antitrust and competition laws must be aware of the laws in the jurisdictions in which CHC conducts business and the applicability of those laws. Many countries have antitrust and competition laws that differ from the U.S. laws and employees must be aware of the specific laws in the jurisdictions in which they conduct the business of CHC.

D. Anti-kickback and False Claims Issues

Federal and state laws generally prohibit CHC and Covered Persons from offering or paying anything of value to induce the referral of patients for health care items or services when such items or services are reimbursable by federal health care programs. These laws also prohibit soliciting or accepting anything of value under similar circumstances. In addition, CHC and Covered Persons are subject to various state and federal laws prohibiting the filing of false claims. False claims laws prohibit, among other activities, filing claims for services not

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rendered or not rendered as described in the claim, or otherwise submitting false data to a state or federal health care program and upon which reimbursement may be based in whole or in part. Anti-kickback and false claims laws are complex and Covered Persons should consult CHC's Chief Compliance Officer or CHC's General Counsel when questions arise as to the applicability of these laws to any activities conducted by Covered Persons. Covered Persons should be aware that these laws may apply outside of the Medicare and Medicaid contexts as well.

CHC has adopted various policies designed to ensure compliance with federal and state anti-kickback and false claims laws. For further information, refer to the Coventry Compliance Center on Coventry Today (<http://cvty.net/cvty.com/>).

E. Gifts and Entertainment

1. To avoid both the reality and the appearance of improper relations with vendors, suppliers, contractors, providers or customers (subscribers or members), the following standards apply to receipt of gifts and entertainment by CHC employees. In addition to the standards listed here, CHC employees are required to sign, or acknowledge electronically through the CHC Learning Link, the "Pharmaceutical Company Relationships Employee Acknowledgment" (**Attachment C**).

- a) CHC employees may not accept gifts of money under any circumstances nor may they solicit non-monetary gifts, gratuities or any other personal benefit or favor of any kind from vendors, suppliers, contractors or customers (subscribers or members).

CHC employees and their immediate families may accept unsolicited, non-monetary gifts from a business firm or individual doing or seeking to do business with CHC only if: (1) the gift is no more than the nominal value of \$100 per calendar year; or (2) the gift is advertising or promotional material that has a fair market value of no more than \$100. Gifts of more than \$100 per calendar year may be accepted if protocol, courtesy or other special circumstances exist. However, all such gifts with a fair market value of more than \$100 must first be reported to CHC's Chief Compliance Officer or CHC's General Counsel, who will determine if the CHC employee may accept the gift or must return it.

- b) CHC employees may not encourage or solicit entertainment from any individual or company with whom CHC does business. From time to time, CHC employees may offer and/or accept entertainment, but only if the entertainment is reasonable, occurs infrequently and does not involve lavish expenditures. CHC

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employees who have questions or concerns about entertainment must contact CHC's Chief Compliance Officer or CHC's General Counsel.

2. The purpose of business entertainment and gifts in a commercial setting is to create good will and sound working relationships, not to gain unfair advantage with customers. No gift or entertainment should ever be offered, given, or provided by any CHC employees, family member of a CHC employee or agent to a CHC customer unless it: (1) is not a cash gift, (2) is consistent with customary business practices, (3) is not excessive in value, (4) cannot be construed as a bribe or payoff and (5) does not violate any laws or regulations. Please discuss with a supervisor or manager, CHC's Chief Compliance Officer, a Compliance Officer, a Human Resources representative, CHC's General Counsel or the CHC Comply Line any gifts or proposed gifts that you are not certain are appropriate.

F. Payments to Third Parties

Agreements with agents, sales representatives, vendors, consultants and other contractors should be in writing and should clearly and accurately set forth the services to be performed, the basis for payment and the applicable rate or fee. Payments should be reasonable in amount, not excessive in light of common practice and equal to the value of the products or services. Third parties should be advised that the agreement may be publicly disclosed.

G. No Payments to Government Employees

No CHC employee may offer or make available in any amount, directly or indirectly, any payment of money, gifts, services, entertainment or anything of value to any federal, state or local government official or employee.

H. Billing and Reimbursement

CHC is committed to ensuring that its billing and reimbursement practices comply with all federal and state laws, regulations, guidelines and policies and that all bills are correct and reflect current payment methodologies. CHC is committed further to ensuring that all members and customers receive timely and accurate bills and that all questions regarding billing are answered promptly and accurately.

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V. FINANCIAL REPORTING AND INTERNAL CONTROL

False or misleading entries may not be made in the financial books or employment records of CHC for any reason. No Covered Person may engage in any actions that result in or create false or misleading entries in CHC's books and records.

No payment or receipt on behalf of CHC may be approved or made with the intention or understanding that any part of the payment or receipt is to be used for a purpose other than that described in the documents supporting the transaction. "Slush funds" or similar funds or accounts where no accounting for receipts or expenditures is made on CHC records are strictly prohibited.

A. Personnel Records

Salary, benefit and other personal information relating to employees shall be treated as confidential. Personnel files, payroll information, disciplinary matters and similar information shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. Covered Persons will exercise due care to prevent the release or sharing of information beyond those persons who may need such information to fulfill their job function.

B. Internal Control

CHC has established control standards and procedures to ensure that assets are protected and properly used and that financial records and reports are accurate and reliable. All Covered Persons share the responsibility for maintaining and complying with required internal controls.

C. Financial Reporting

All financial reports, accounting records, research reports, expense accounts, time sheets and other documents must accurately and clearly represent the relevant facts or the true nature of a transaction. Employees who submit timesheets must be careful to do so in a complete, accurate and timely manner. The employee's signature on a timesheet is a representation that the timesheet accurately reflects the number of hours worked on the specified project. Improper or fraudulent accounting, documentation or financial reporting is contrary to the policy of CHC and may be in violation of applicable laws.

D. Expense Accounts

Many CHC employees regularly use CHC business expense accounts, which must be for legitimate business purposes and documented and recorded accurately. The submission of false, inappropriate or inaccurate expenses for reimbursement will result in disciplinary action up to, and including termination of employment, and may result in civil action or criminal charges. If you are not

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sure whether a certain expense is for a legitimate business purpose, ask your supervisor or manager.

E. Protection and Proper Use of Company Assets

Covered Persons are expected to use good judgment in the utilization of CHC, customer and supplier property. The use of CHC assets, facilities or services for any unlawful, improper or unauthorized purpose is strictly prohibited. The use of CHC assets for non-CHC purposes is appropriate only when specifically authorized by CHC policy or procedure or when the user receives express authorization from his or her supervisor or manager. Any personal use of a CHC resource must not result in added cost, disruption of business processes, or any other disadvantage to CHC. Supervisors and managers are responsible for the resources assigned to their respective departments and are empowered to resolve issues concerning their proper use.

The theft or misuse of any property or services by any Covered Persons will result in that person being disciplined, terminated or possibly subjected to civil and criminal penalties. CHC's equipment, systems, facilities, corporate credit cards and supplies must be used only for conducting CHC business or for purposes authorized by management.

VI. COMMUNICATION PRACTICES

A. Confidential Information

Covered Persons may have access to confidential information about CHC, its customers, suppliers and competitors or other information that might be of use to competitors or harmful to CHC or its customers, if disclosed. Until released to the public, this information should not be disclosed to other Covered Persons who do not have a business need to know such information or to non-employees for any reason, except in accordance with established CHC procedures. Confidential information of this kind includes, among other things, information or data on products, business strategies, corporate manuals, processes, systems or procedures. Please refer to the separate CHC policy regarding confidential information entitled "Coventry Health Care, Inc. Statement of Policy Regarding Insider Trading and Confidentiality." Please also see the Proprietary Information, Confidentiality and Non-Solicitation Agreement (**Attachment B**) to this Code.

B. Honest Communication and Fair and Accurate Disclosure

CHC requires candor and honesty from Covered Persons in the performance of their responsibilities and in communication with our attorneys and auditors. No Covered Person shall make false or misleading statements to any member, person or entity doing business with CHC about other members, persons or

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entities doing business or competing with CHC, or about the products or services of CHC or its competitors.

In drafting and filing periodic reports or other documents filed with the Securities and Exchange Commission and in other public communications, Covered Persons should take all steps necessary to ensure full, fair, accurate, timely and complete disclosure. Such steps should include going beyond the minimum requirements to convey a fair and accurate financial picture of CHC to public investors.

Business records and communications often become public, and Covered Persons should always avoid exaggeration, derogatory remarks, guesswork, or inappropriate characterizations of people and companies that can be misunderstood. This applies equally to e-mail, internal memos, and formal reports.

C. Misappropriation of Proprietary Information

Covered Persons shall not misappropriate confidential or proprietary information belonging to another person or entity nor utilize any publication, document, computer program, information or product in violation of a third party's interest in such product. Covered Persons shall not improperly copy for their own use documents or computer programs in violation of applicable copyright laws or licensing agreements. Covered Persons shall not utilize confidential business information obtained from competitors, including customer lists, price lists, contracts or other information in violation of a covenant not to compete, a prior employment agreement or in any other manner likely to provide an unfair or illegal competitive advantage to CHC.

D. Privacy Issues Regarding Written and Electronic Mail

Use of CHC's e-mail systems involves additional considerations and requires special care. Covered persons must bear in mind that e-mail, text messages, instant messages and other electronic communications are not private, and their source is clearly identifiable. These communications may remain part of CHC's business records long after they have supposedly been deleted. Covered Persons must ensure that their personal e-mail does not adversely affect CHC or its public image or that of its customers, partners, associates or suppliers. E-mail may not be used for external broadcast messages or to send or post chain letters, messages of a political or religious nature, or messages that contain obscene, profane, racial or otherwise offensive or discriminatory language or material. Violations of this policy will result in disciplinary action up to, and including termination of employment.

CHC reserves the right, subject to applicable laws, to monitor and review all written and electronic communications that Covered Persons send or receive at work or using CHC's systems, including, but not limited to, electronic mail, text

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messages, instant messages, voicemail, envelopes, packages or messages marked "personal and confidential."

E. Requests for Information

Employees should only respond to inquiries or questions from third parties, either directly or indirectly, if such employee is certain that he or she is authorized to do so. Even if the employee is authorized by CHC regulations to provide such information, if there is a designated spokesperson or coordinated approach to dealing with that information the employee must refer the third party to the appropriate source within CHC. Requests for information from financial and security analysts or investors should always be directed to the Chief Executive Officer or Chief Financial Officer as should requests for information from the media. Requests from an attorney for information or to interview a Covered Person should be directed to CHC's General Counsel.

F. Maintenance of Company Records and Files

All Covered Persons must follow CHC policy regarding the retention, disposal or destruction of any CHC records or files. Laws and regulations require retention of certain CHC records for various periods of time, particularly in the tax, personnel, health and safety, environment, contract, customs and corporate structure areas. Records should always be retained or destroyed according to CHC's record retention policies. The Record Retention and Destruction Policy and state schedules may be accessed through the Coventry Compliance Center on Coventry Today (<http://cvty.net/cvty.com/>). Covered Persons must strictly comply with this policy. In the event of litigation or governmental investigation concerning CHC's records or files, consult CHC's General Counsel.

VII. POLITICAL ACTIVITIES AND CONTRIBUTIONS

CHC encourages each of its Covered Persons to be good citizens and to fully participate in the political process. Covered Persons should, however, be aware that: (1) federal law and the laws of most states prohibit corporate contributions to political candidates, political parties or party officials; and (2) Covered Persons who participate in partisan political activities must ensure that they do not leave the impression that they speak or act for or on behalf of CHC.

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VIII. DISCRIMINATION

CHC believes that the fair and equitable treatment of employees, subscribers, members and other persons is critical to fulfilling its vision and goals.

It is a policy of CHC to enroll subscribers and members without regard to the race, color, religious belief, sex, ethnic background, national origin, alienage, ancestry, citizenship status, age, marital status, pregnancy, sexual orientation, veteran status or physical or mental disability or history of disability of such person, or any other classification prohibited by law.

It is a policy of CHC to recruit, hire, train, promote, assign, transfer, layoff, recall and terminate employees based on their own ability, achievement, experience and conduct without regard to race, color, religious belief, sex, ethnic background, national origin, alienage, ancestry, citizenship status, age, marital status, pregnancy, sexual orientation, veteran status or physical or mental disability or history of disability of such person or any other classification prohibited by law.

No form of harassment or discrimination on the basis of race, color, religious belief, sex, ethnic background, national origin, alienage, ancestry, citizenship status, age, marital status, pregnancy, sexual orientation, veteran status or physical or mental disability or history of disability or any other classification prohibited by law will be permitted. Each allegation of harassment or discrimination will be promptly investigated in accordance with applicable human resource policies and procedures.

IX. IMPLEMENTATION

Strict adherence to this Code is vital. Management is responsible for ensuring that Covered Persons are aware of the provisions of the Code. For clarification or guidance on any point in the Code, consult CHC's Chief Compliance Officer or CHC's General Counsel.

To ensure that proper dissemination and understanding of this Code is achieved, the following implementation will be followed: Employees will sign or electronically acknowledge through the CHC Learning Link the Statement of Understanding, (**Attachment A**), the Proprietary Information, Confidentiality and Non-Solicitation Agreement (**Attachment B**), the Pharmaceutical Company Relationships Employee Acknowledgment (**Attachment C**) and will complete the Business Transactions With A Party In Interest (**Attachment D**) at the time of hire and on an annual basis thereafter. Human Resources shall be responsible for making sure each employee signs or electronically acknowledges and completes the required Attachments A, B, C and D. Signing or acknowledgment and completion of the required Attachments A, B, C and D shall be done in conjunction with the training requirements set forth in CHC's Policy on Employee Training. New employees shall, within the first 30 days of employment,

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complete their compliance training and sign or electronically acknowledge and complete the required Attachments A, B, C and D. Refer to the CHC Policy on Employee Training on the Coventry Compliance Center on Coventry Today (<http://cvtynet.cvty.com/>).

A. Covered Persons

Covered Persons are required to report (in good faith) any actual or suspected dishonest or illegal activities or other violations of this Code. Failure to report dishonest or illegal activities or reporting false information is a very serious violation of this Code and could be cause for immediate termination of employment. The reporting of a suspected Code violation may be made verbally or in writing, but preferably, in writing containing a description of the factual basis for the suspected dishonest or illegal activities (e.g., documents, events, meetings) and, preferably, should be signed. See Section X. below for the procedure to follow for reporting suspected violations of this Code. It is a serious Code violation for any CHC employee to initiate or encourage reprisal action against an employee or other person who in good faith reports known or suspected Code violations.

B. Board of Directors

1. The Audit Committee of the Board of Directors is generally responsible for assuring that the business of CHC is conducted in accordance with the Code. The Audit Committee will assure that the Code is properly administered. If willful violations are discovered, the Audit Committee shall assure that the legal rights of individuals are protected, that CHC's legal obligations are fulfilled and that proper disciplinary and legal actions are taken. The Audit Committee will further see that corrective measures and safeguards are instituted to prevent recurrence of violations.
2. Only the Audit Committee has the authority to waive any provision of this Code with respect to an executive officer or director of CHC. If a waiver of this Code is granted for a director or executive officer, such waiver must be promptly and accurately disclosed as required by law or applicable stock exchange rule.

C. Training

On an annual basis, each employee must complete at least one hour of training dealing with compliance with laws, the Compliance and Ethics Program and/or this Code. This attendance will be documented. See CHC's Policy on Employee Training. In addition, employees directly involved in a government program shall receive additional compliance training in accordance with other government program training policies.

The CHC Chief Compliance Officer shall establish such other training or dissemination of information to Covered Persons, as may be necessary or

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appropriate, to comply with all applicable laws and with this Code, including the continuation of existing compliance programs such as Medicare/Medicaid compliance and compliance with securities laws.

The CHC Compliance Officer shall make periodic reports to CHC's Chief Executive Officer and Board of Directors concerning compliance with the above training requirements.

D. CHC Officers, Supervisors and Managers

All officers, supervisors and managers are required to report (in good faith) any actual or suspected dishonest or illegal activities or other violations of this Code. The procedures for reporting actual or suspected violations are set forth in Section X. below. All officers, supervisors and managers are also responsible for ensuring that each of their employees has completed the annual compliance training, understands the training and has signed and completed, either in writing or electronically through the CHC Learning Link, the required Attachments A, B, C and D. New employees shall, within the first 30 days of employment, complete the compliance and ethics training and sign, or electronically acknowledge through the CHC Learning Link, the Statement of Understanding (**Attachment A**), the Proprietary Information, Confidentiality and Non-Solicitation Agreement (**Attachment B**), the Pharmaceutical Company Relationships Employee Acknowledgment (**Attachment C**) and complete the Business Transactions With A Party In Interest (**Attachment D**).

Officers, supervisors and managers may be sanctioned for failing to instruct adequately their subordinates or for failing to detect non-compliance with applicable policies and legal requirements, where reasonable diligence on the part of the officer, supervisor or manager would have led to the discovery of any problems or violations and would have given CHC the opportunity to correct them earlier.

**X. PROCEDURES FOR REPORTING SUSPECTED VIOLATIONS
(WHISTLEBLOWER POLICY)**

CHC has adopted this policy to promote the reporting or disclosure of Violations and potential Violations. CHC does not encourage frivolous complaints, but it does want any Covered Person or vendor, supplier or agent of CHC (each an "Affected Person") who knows of a Violation or potential Violation to contact a representative of CHC through one of the methods contained in Section X.G. A "Violation" includes the following:

1. violations of law, including any rule of the Securities and Exchange Commission, federal laws related to fraud against CHC's stockholders, and the laws and regulations of any jurisdiction in which CHC operates;

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2. violations of Company policies (including this Code of Business Conduct and Ethics) and statutory or other requirements for good corporate governance;
3. improper accounting entries, violations of internal accounting controls or improper auditing matters;
4. any other matter, which in the good faith belief of any Affected Person, could cause harm to the business or public position of CHC; or
5. any attempt to conceal a Violation or evidence of a potential Violation.

A. General Policy

Any Affected Person who, in Good Faith, reports a Violation is referred to as a “Whistleblower” and is protected from any retaliation by CHC. “Good Faith” means that the Affected Person has a reasonably held belief that the disclosure is true and has not been made either for personal gain or for any ulterior motive.

CHC notes that the Sarbanes-Oxley Act of 2002 (“SOX”) and the False Claims Act provide certain legal protection to whistleblowers. Under Section 806 of SOX, CHC and its officers, employees, contractors, subcontractors and agents cannot discharge, demote, suspend, threaten, harass, or in any other manner discriminate (collectively, “Retaliate”) against employees who provide information in investigations – including internal investigations – into certain types of violations of the securities laws and regulations, or who file proceedings relating to similar violations. Additionally, under Section 1107 of SOX, any person who

knowingly, with the intent to retaliate, takes any action harmful to any person, including interference with the lawful employment or livelihood of any person, for providing a law enforcement officer any truthful information relating to the commission or possible commission of any Federal offense, shall be fined under this title or imprisoned not more than 10 years, or both.

Under Section 3730(h) of the False Claims Act, any employee who is discharged, demoted, harassed or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the False Claims Act is entitled to relief to make that employee whole.

B. Purpose of the Whistleblower Policy

CHC has adopted this whistleblower policy in order to:

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1. cause Violations to be disclosed before they can disrupt the business or operations of CHC, or lead to serious loss,
2. promote a climate of accountability with respect to Company resources, including its employees, and
3. ensure that no Affected Person should feel at a disadvantage in raising legitimate concerns.

This policy provides a means whereby Affected Persons can safely raise, internally and at a high level, serious concerns and disclose information that the Affected Person believes in good faith could constitute a Violation.

For a more detailed description of state and Federal laws which prohibit the filing of false claims and that protect Whistleblowers under such laws, refer to the Coventry Compliance Center on Coventry Today (<http://cvtynet.cvty.com/>).

C. Affected Persons Protected

This procedure offers protection to Affected Persons, who disclose matters that are, or could give rise to, Violations, provided the disclosure is made:

1. In good faith,
2. In the reasonable belief of the individual making the disclosure that the conduct or matter disclosed could give rise to a Violation, and
3. Pursuant to the procedures contained in Section X.G. below.
4. No complaint that satisfies these conditions will result in dismissal or disciplinary action or any other form of discrimination for the complainant. Any acts of Retaliation against a Whistleblower shall be treated by CHC as a serious disciplinary matter and could result in dismissal.

D. Confidentiality of Disclosure

CHC will treat all such disclosures as confidential and privileged to the fullest extent permitted by law. CHC will exercise particular care to keep confidential the identity of any Affected Person, making an allegation under this procedure until a formal investigation is launched. Thereafter, the identity of the Affected Person making the allegation may be kept confidential, if requested, unless such confidentiality is incompatible with a fair investigation or unless there is an overriding reason for disclosure. In this instance, the Affected Person making the disclosure will be so informed. Where disciplinary proceedings are invoked against any individual following a complaint under this procedure, CHC will normally require the name of the Affected Person to be disclosed to the person subject to such proceedings.

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CHC encourages individuals to put their name to any disclosure they make, but any Affected Person may also make anonymous disclosure as provided in Section X.G.1(f) below. In responding to an anonymous complaint, CHC will pay due regard to fairness to any individual named in the complaint, the seriousness of the issue raised, the credibility of the complaint and will undertake to conduct an effective investigation and discovery of evidence.

Investigations will be conducted as quickly as possible, taking into account the nature and complexity of the disclosure.

E. Unsubstantiated Allegations

If an Affected Person makes an allegation in good faith, which is not confirmed by subsequent investigation, no action will be taken against that individual. In making a disclosure, all individuals should exercise due care to ensure the accuracy of the information.

If after investigation a matter raised under this procedure is found to be without substance and to have been made for malicious or frivolous reasons, the Affected Person could become the subject of disciplinary action.

Where an allegation is not substantiated (a) the conclusions of the investigation will be made known both to the Affected Person who made the allegation and to the person against whom the allegation was made and (b) all papers relating to the allegation and investigation will be removed from the record.

F. Follow-Up

CHC's General Counsel will deliver a report of all substantiated disclosures of material Violations and any subsequent actions taken to the Board of Directors.

The conclusion of the investigation will be communicated to the person or persons against whom the complaint or allegation is made and to the Affected Person who made the complaint or allegation.

G. Procedures

1. Any disclosure made by an Affected Person under this policy must be reported to one of the following as appropriate:

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- a) to a supervisor or manager,
- b) to the Chief Compliance Officer or a Compliance Officer of CHC,
- c) to a Human Resources representative,
- d) to CHC's General Counsel,
- e) to the Chief Financial Officer if the allegation relates to financial, accounting or auditing matters, or
- f) if an employee wishes to remain completely anonymous, by calling CHC's anonymous reporting hotline, "The Comply Line" at 1-877-242-5463, which is staffed twenty-four hours a day and seven days a week.

Affected Persons are expected to report any suspected Violations.

The Comply Line number shall be posted in all work locations. All reports must contain sufficient information to investigate the concerns raised. CHC will attempt to treat such reports confidentially and to protect the identity of the individual who has made a report to the maximum extent possible and as may be permitted under applicable law.

2. All reports will be investigated. Upon receipt of credible reports of suspected violations or irregularities, CHC's Chief Compliance Officer, a Compliance Officer or CHC's General Counsel shall see that appropriate corrective action takes place immediately. CHC will weigh relevant facts and circumstances, including, but not limited to, the extent to which the behavior was contrary to the express language or general intent of the Code, the seriousness of the behavior, the person's history with CHC and other factors which CHC deems relevant. No adverse action or retribution of any kind will be taken by CHC against an Affected Person solely because he or she reports in good faith a suspected Violation. Proof of Violations may result in discipline ranging from warnings and reprimands to termination of employment or, where appropriate, the filing of a civil or criminal complaint. Disciplinary decisions will be made by operating management, subject to review by CHC's Chief Compliance Officer, the Chief Human Resources Officer or CHC's General Counsel. Individuals will be informed of the charges against them and will be given the opportunity, as appropriate, to state their position before any disciplinary action is imposed.

If CHC's General Counsel determines that a material or significant violation of this Code or law has occurred, CHC's General Counsel will report such violation to the Board or the appropriate committee of the Board together with any reports or analysis that CHC's General Counsel

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or any member of the Board determines is necessary or appropriate for the Board to review.

An Affected Person must wait at least two weeks for a response after reporting the Violation or potential Violation, unless the Affected Person believes in good faith that conditions warrant a quicker reply, in which case the Affected Person shall detail those conditions as part of his or her initial report.

3. An Affected Person, who is not satisfied with the response after following the procedure set out in Section X.G.1. or who has not received a response within the time period contained in Section X.G.2., may invoke this Section X.G.3. The Affected Person must continue to discuss any issues with the persons identified. However, the disclosure shall thereafter also be directed, in writing, and confidentially, to the Chair of the Board of Directors. The Chair of the Board of Directors shall then make a preliminary investigation of such concerns and report in writing to CHC's General Counsel, with a request that CHC's General Counsel investigate further and report to the Board in a period of time specified by the Chair of the Board of Directors. CHC's General Counsel may appoint another person to undertake the preliminary investigation, provided that the findings and conclusions of the person so appointed shall be reported to, and endorsed by, CHC's General Counsel before the report is made to the Board.
4. If on preliminary examination the complaint or allegation is judged to be wholly without substance or merit, it shall be dismissed and the Affected Person informed of the decision and the reasons for such dismissal. If it is judged that a prima facie case may exist, the matter shall be dealt with in accordance with CHC's normal disciplinary procedures or as otherwise may be deemed appropriate according to the nature of the case. The outcome of the investigation will be reported to the Affected Person.

Subject to Section X.G.4., if any allegation of a Violation relates to a director or executive officer of CHC, the Chair of the Board of Directors may retain independent counsel to investigate the matter and to make a report to the Board.

THIS CODE SETS FORTH GENERAL GUIDELINES ONLY AND MAY NOT INCLUDE ALL CIRCUMSTANCES THAT WOULD FALL WITHIN THE INTENT OF THE CODE AND BE CONSIDERED A VIOLATION THAT SHOULD BE REPORTED. AFFECTED PERSONS SHOULD REPORT ALL SUSPECTED DISHONEST OR ILLEGAL ACTIVITIES WHETHER OR NOT THEY ARE SPECIFICALLY ADDRESSED IN THE CODE.

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H. Website Publication

This Code shall be posted on CHC's intranet and internet websites.

I. Annual Review

This procedure will be reviewed annually by the Board after consultation with CHC's Chief Compliance Officer, taking into account the effectiveness of the policy in promoting proper disclosure, but with a view to minimizing the opportunities to cause improper investigations.

XI. LIMITATION ON EFFECT OF CODE OF BUSINESS CONDUCT AND ETHICS

Nothing contained in this Code is to be construed or interpreted to create a contract of employment, either express or implied, nor is anything contained in this Code intended to alter a person's status of "employment-at-will" with CHC to any other status.

XII. RESERVATION OF RIGHTS

CHC reserves the right to amend the Code of Business Conduct and Ethics, in whole or in part, at any time and solely at its discretion.

ATTACHMENTS:

- Attachment A: Statement of Understanding of and Compliance with CHC's Code of Business Conduct and Ethics
- Attachment B: Proprietary Information, Confidentiality and Non-Solicitation Agreement
- Attachment C: Pharmaceutical Company Relationships Employee Acknowledgment
- Attachment D: Business Transactions With a Party in Interest

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**ATTACHMENT A
STATEMENT OF UNDERSTANDING OF AND COMPLIANCE WITH
CHC'S CODE OF BUSINESS CONDUCT AND ETHICS**

I certify that I have read and understand CHC's Code of Business Conduct and Ethics and relevant other sections of the Compliance and Ethics Program and agree to abide by it during the entire term of my employment at CHC. I acknowledge that:

- (1) I understand how the Code applies to me and agree to fully comply with each of its provisions;
- (2) I further understand that CHC expects each person to whom this Code applies to abide by its terms and conditions and to conduct the business and affairs of CHC in a manner consistent with its general statement of principles;
- (3) I have a duty to report and will report any alleged or suspected violation of any laws, regulations, the Code of Business Conduct and Ethics or the Compliance and Ethics Program to a supervisor or manager, CHC's Chief Compliance Officer, a Compliance Officer, a Human Resources representative, CHC's General Counsel or the CHC Comply Line;
- (4) Neither I nor a family member has been convicted of, or charged with, a criminal offense related to health care nor have I or a family member been listed by a federal agency as debarred, excluded or otherwise ineligible for participation in federally funded health care programs;
- (5) I have received compliance training either within this past year (for existing employees) or, if a new hire, within the first thirty (30) days of employment or, if an independent non-employee member of the Board of Directors, within 60 days of my election as a Director;
- (6) I know of no situation in which my personal interest or the personal interest of a household member could conflict with or appear to conflict with CHC's interests. I am not aware of any additional circumstances, other than those disclosed below, that could represent a potential violation of any law, regulation, the Code of Business Conduct and Ethics or the Compliance and Ethics Program;
- (7) I understand that any violation of any laws, regulations, the Code of Business Conduct and Ethics, the Compliance and Ethics Program, or any other corporate compliance policy or procedure is grounds for disciplinary action, up to and including discharge from employment.

I attest that I have read, understand and agree to abide by this CHC Statement of Understanding.

Name _____ Date _____

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**ATTACHMENT B
PROPRIETARY INFORMATION, CONFIDENTIALITY
AND NON-SOLICITATION AGREEMENT**

You may have access to or be made aware of confidential or proprietary information. This could include, as examples, information about members, employer groups, providers, company financials, internal strategic plans, employee records including salary information, or similarly sensitive data.

You are expected to use such information to perform your duties and to keep it totally confidential. You are not to discuss or share confidential information with anyone inside or outside Coventry Health Care, Inc., its subsidiaries and affiliated entities (collectively, "CHC"), who does not have a direct need-to-know involvement. Violation of confidentiality is grounds for immediate termination of employment. You will also not discuss or share any confidential information after your employment with CHC ends, except as required by law.

Computer data security is as much a concern as safeguarding other confidential materials and information. The computer resources of CHC are vital to our operations. They contain confidential data about members, employer groups, providers, CHC, directors, officers and employees. It is our policy to protect this information, use it only for the purposes intended, and make it available only to those who need it. In this effort, we will be guided by the following principles:

- (1) The computer resources of CHC are to be used only for authorized, legitimate purposes.
- (2) Our computer data is to be used only for the business needs of CHC and its subsidiaries.
- (3) A password will be required to access our computer records. A password is private information and is to be used only by the person to whom it is issued.
- (4) Each of us must recognize the need to protect CHC's computer data. Immediately report suspected abuses or violations of security to a supervisor or manager, CHC's Chief Compliance Officer, a Compliance Officer, a Human Resources representative, CHC's General Counsel or the CHC Comply Line.

During employment with CHC and for the one-year period following termination of employment, you agree not to hire away any then-current employee of CHC, or to persuade any such employee to leave employment with CHC.

I have read and understand the above Proprietary Information, Confidentiality and Non-Solicitation Agreement, and I agree to abide by this Agreement. I also understand that each CHC employee must sign this Agreement or acknowledge their agreement with it by electronic submission through the CHC Learning Link.

Name _____ Date _____

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**ATTACHMENT C
PHARMACEUTICAL COMPANY RELATIONSHIPS
EMPLOYEE ACKNOWLEDGMENT**

It is the policy of Coventry Health Care, Inc., its subsidiaries and other affiliated entities (collectively, "CHC") that all employees maintain certain standards of ethics and conduct as described herein with respect to the possible acceptance of any gifts from any pharmaceutical manufacturers, vendors, suppliers or contractors (each a "Pharmaceutical Company"), regardless of whether CHC currently does business with the Pharmaceutical Company ("Employee Gift Policy"). This Employee Gift Policy also is applicable to the immediate family members (spouse and children) of the CHC Employee.

Any CHC Employee violating this Employee Gift Policy will be subject to disciplinary action that may include termination of employment. CHC also may elect to pursue any and all legal remedies available against any violator of this Employee Gift Policy.

Money Gifts. CHC Employees may not accept gifts of money from a Pharmaceutical Company under any circumstance.

Non-Money Gifts. CHC Employees may not solicit from a Pharmaceutical Company non-monetary gifts, gratuities or any other personal benefits. CHC Employees may accept unsolicited, non-monetary gifts from a Pharmaceutical Company only if: (1) the gift is no more than the nominal value of \$100 per calendar year and is reported to the CHC's Chief Compliance Officer; or (2) the gift is advertising or promotional material that has a fair market value no greater than \$100. Gifts of more than \$100 in value per calendar year may only be accepted if protocol, courtesy or other special circumstances exist; provided however, that CHC employees must first report and receive prior approval of all such gifts from CHC's Chief Compliance Officer, or CHC's General Counsel before accepting gifts of more than \$100 in value per calendar year.

Entertainment. CHC Employees may not encourage or solicit entertainment from a Pharmaceutical Company. From time to time, CHC Employees may accept from a Pharmaceutical Company entertainment; provided however, that such entertainment is reasonable, occurs infrequently and does not involve lavish expenditures. CHC Employees who have questions or concerns regarding the appropriateness of accepting entertainment must contact a supervisor or manager, CHC's Chief Compliance Officer, a Compliance Officer, a Human Resources representative, CHC's General Counsel or the CHC Comply Line.

Trips. CHC Employees may not accept from a Pharmaceutical Company an offer of a free or discounted trip, including plane fare, lodging, associated meals, entertainment, honorariums or meeting registration. If a CHC Employee would otherwise attend the proposed meeting because of its educational value, the CHC Employee should request funding from the CHC health plan budget after receiving approval to do so from his/her supervisor or manager. For a limited number of legally appropriate circumstances, there may be an exception to this general prohibition. Under such circumstances, the CHC Employee must first report and receive prior approval from two officers—CHC's Chief Compliance Officer and at least one of the following

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officers: the Chief Human Resources Officer; the Chief Operating Officer; the Chief Medical Officer; or CHC's General Counsel, or their designee.

Monetary Sponsorship of CHC Educational Meetings. CHC Employees may accept a Pharmaceutical Company's offer to underwrite expenses for a CHC in-house joint educational or training meeting designed by CHC and the Pharmaceutical Company to improve the quality of healthcare delivered to CHC enrollees; provided that the financial support to be received from the Pharmaceutical Company is limited to meeting room rental and CHC's publication of educational or training materials. Other financial support, including hotel accommodations, entertainment or travel expense, is prohibited. Each CHC Employee must first report and receive prior approval for all such sponsorships from CHC's General Counsel.

I have read, understand and agree to abide by the terms of this Employee Gift Policy during my tenure at CHC. Further, I understand that each CHC employee must sign this Employee Gift Policy or acknowledge their agreement with this Employee Gift Policy by electronic submission through the CHC Learning Link.

Name _____ Date _____

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**ATTACHMENT D
BUSINESS TRANSACTIONS
WITH A PARTY IN INTEREST**

Any business transaction(s) between Coventry Health Care, Inc. and/or any of its subsidiaries and

- (1) an individual who is an officer, director or employee of Coventry Health Care, Inc. or any of its subsidiaries, or
- (2) the spouse, child or parent of an individual who is an officer, director or employee of Coventry Health Care, Inc. or any of its subsidiaries,

that has a total value exceeding \$25,000 in any calendar year must be reported to CHC's Chief Compliance Officer immediately.

In the space provided below, please describe any current or potential business transactions that fall within the above definition:

I understand that each employee of Coventry Health Care, Inc. or any of its subsidiaries must complete this Business Transactions With A Party Of Interest and submit it to CHC's Chief Compliance Officer or submit it electronically through the CHC Learning Link.

Name _____ Date _____

Health Care & Pharmacy Anti-Fraud, Waste and Abuse Guide



PURPOSE

This guide has been designed to supplement to your health care and pharmacy anti-fraud training and to be used as a desk reference for detecting, preventing and reporting fraud to the Special Investigation Unit.

POLICY

Coventry Health Care, Inc. (“Coventry”) and its subsidiaries will not tolerate insurance/health care fraud, waste or abuse. Coventry, on its own behalf and on behalf of its subsidiaries, will identify and monitor situations in which suspected fraud, waste or abuse occurs. Coventry may investigate suspected fraud, waste and abuse itself or may subcontract such detection to a third party vendor. Suspected fraud, waste or abuse may be detected through review of claims and utilization management information, CSO internal audits, provider employee complaints (i.e., whistleblowers), or interaction with members, other insurers, and governmental agencies. As a result of these fraud, waste and abuse detection activities and in accordance with applicable law, certain conduct may rise to a level that necessitates taking corrective action or reporting to appropriate regulatory or law enforcement agencies, or both.

TRAINING RESPONSIBILITY

The Health Plan’s Compliance Officer will assure that employees at the Plan receive initial training, within 6 months of hire, and yearly thereafter. Required personnel will continue to receive updated insurance fraud training periodically and will receive updated materials at least every 2 years. Participation in the training program is considered a condition of employment and is required for specified agents and contractors.

WHO SHOULD HAVE THIS GUIDE

- Claims Personnel and Processors
- Contractors and Agents
- Compliance and Regulatory Personnel
- Customer Service Personnel
- Medical Management Personnel
- Pharmacy Personnel
- Other Personnel As Assigned

Health Care & Pharmacy Anti-Fraud, Waste and Abuse Guide

RECOGNIZING FRAUD, WASTED AND ABUSE

WHAT IS FRAUD?

Health Care and Pharmacy fraud may be defined as an intentional deception, concealment, or misrepresentation that could result in some unauthorized benefit to an individual, entity or some other party. The most common kind of fraud involves a false statement, misrepresentation or deliberate omission that is critical to the determination of benefits paid. Fraudulent activities are generally criminal in nature, although the degree of the criminal acts may vary from state to state. For fraud to exist, there are certain elements that need to be present:

- A false representation made in some identifiable quality.
- The actor had knowledge of the false representation.
- The actor intended to use the false representation to defraud.
- The intended victim made a justifiable reliance on the false representation.
- There was a resulting quantifiable damage.

WHAT IS WASTE?

Waste is the use of health care and pharmacy products and services in an ineffective and inefficient manner. This is a result of poor management, carelessness and apathy. Identification of waste requires corrective action to improve processes and/or individual behavior. Waste should not be overlooked and addressed immediately. Waste may also be an indicator of fraudulent and abusive behavior. As such, perceived waste needs to be scrutinized and referred to the SIU.

WHAT IS ABUSE?

Abuse involves practices or behaviors that do not meet the legal definition of fraud. One of the elements of abuse is that it is usually done on a consistent basis. Patterns start to emerge and they often go unchecked unless detected and corrected. Abuse can cause improper reimbursement or inappropriate patient care. Abusive practices include:

- Practices inconsistent with accepted medical standards.
- Services provided without appropriate medical/clinical indications.
- Treatment or services inconsistent with the diagnosis.
- Withholding necessary services.
- Inappropriate coding (upcoding or unbundling).
- Claim padding (adding a diagnosis to justify the services).
- Repetitive or excessive tests, visits, supplies, drugs and treatments.

WHO COMMITS FRAUD?

The factors which drive the individual into choosing fraud as a means to an end are as varied as there are people. However, there are methods and profiles that are more

Health Care & Pharmacy Anti-Fraud, Waste and Abuse Guide

prevalent than others and individuals who are close to the distribution system are easier to identify and observe such as providers and members. There are also institutional providers like a hospitals, nursing homes, home health agencies clinical laboratories, medical equipment dealers, pharmacies or other suppliers who warrant observation. Other groups in this realm include employees of any provider, billing services, beneficiaries or any person in a position to file a claim for benefits.

WHERE TO LOOK FOR PHARMACY FRAUD, WASTE AND ABUSE

GENERAL FRAUD SCHEMES

Bear in mind that there are multiple ways in which fraud, waste and abuse can manifest itself. However, there are some common methods and profiles with which you should be familiar:

- Alternation of Documentation
- Fraudulent Billing Practices
- Unnecessary Treatment
- Benefit Loopholes (co-pays, deductibles and coverage gaps)
- Kickbacks
- Phantom or “Rented” patients
- Misrepresentation of Products, Services, Diagnoses, Treatments, etc.
- Diversion, Gray Market, Street Drugs and Addicts
- Eligibility Schemes

SUMMARY OF FRAUD INDICATORS

Depending upon your role within the health care and pharmacy services industry, indicators of fraud will be dissimilar across the many vocational segments of the delivery system. The following indicators are usually identified when working on claims or when listening to members and providers while engaged in conversation.

- Misspelled medical terminology or terminology presented in layman’s terms
- Service dates, especially non-emergent treatment, on Saturday, Sunday or Holidays
- Alteration of office notes or scripts (dates, prescriptions, refills, white-out, cut and pasted text, different color ink.)
- Photocopies of scripts
- Multiple claims for the same treatment, service or prescription fill were paid
- Prescriptions filled or refilled for a time period longer than that allowed by the Plan or applicable regulations
- Refills billed exceeds the number authorized by the prescriber
- Frequent telephone inquiries on claim status
- Assertive providers who demand same day claim payment and/or special handling

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- Threats of legal action, filing complaints with State or contacting the president of the company
- A provider who voluntarily supplies more information than requested
- A large number of members from one group going to the same facility or same providers
- Large bills are marked PAID
- The insured's address on the claim is the same as that of the provider of service
- Different names or address of dependents and covered person
- Unusual number of claims on dependent children
- History of claims on spouse with a different name
- Use of aliases or multiple spellings of names
- Discrepancy in other information
- Handwritten bills
- Charges do not total correctly on bills
- Member has multiple providers prescribing drugs known to have high street value or known to be abused for recreational use
- No assignment of benefits, especially on large claims or billings
- Claims are for large amounts, such as several thousand dollars
- Absence of documentation or medical records
- Excessive periods of hospitalizations
- Extensive treatment for minor injuries or illnesses
- No medical follow-up after serious illness or injury

SPECIAL INVESTIGATIVE UNIT OVERVIEW

Coventry operates a full-time Special Investigative Unit (SIU) which is responsible for receiving and investigating cases of potential fraud, waste and abuse. Questionable claims as well as suspicious provider and member behavior must be referred to the SIU for handling. The SIU accepts referrals from many entities associated with the products and services Coventry delivers. Potential sources of referrals include:

- Members
- Customer Service Personnel
- Claims Administrators
- The Medicare Part D Vendor, MEDICS
- Pharmacy Vendor, Caremark
- Providers
- Contractors
- Agents & Producers
- National Health Care Anti-Fraud Association
- Law Enforcement Agencies
- Computer Models, Data Analysis and Historical References

SIU INVESTIGATION PROCESS

Health Care & Pharmacy Anti-Fraud, Waste and Abuse Guide

The Investigative Process is very structured and detailed. The SIU itself employs several disciplines including clinical, technical and investigative. Each individual case is handled according to its facts and circumstances. As such, the process has been designed to accommodate the needs of the case and the resources available to the SIU.

For purposes of understanding, a brief overview of the investigative process is as follows:

- A referral is received and logged into the SIU database
- An assessment is made to determine if the referral warrants additional attention from the SIU
- An investigation is initiated to determine if Fraud, Waste or Abuse has occurred and/or continues to occur
- Complete investigation and compile report which includes recommendations
- Submit report to appropriate decision making entity and work with them to resolve issue
- The decision making entity may take corrective action in a variety of forms
- The SIU would report the issue to a governmental agency if required by law or deemed appropriate

REPORTING FRAUD

It is important to remember that you are required to react to fraud indicators when they appear. You should now be aware of the sources of fraud, waste and abuse. You should be aware of what to look and listen for from day to day. And you also know that you have a place to report your suspicions. Now you must take action.

ACTIONS

Upon identification of an indicator you must first record or document all incoming information from the source. Documentation is critical to the early detection and prevention of fraud. Slow down and take the time to gather your thoughts and to thoroughly record the facts.

Once you have the information you are ready to make a referral. Generally speaking, there are three ways to report your concerns to the Special Investigation Unit.

- Claim System Reporting:

For those in the Customer Service and Claims operations, you may be processing information in a system that allows you to enter codes when certain events happen with a claim. You may have the option of entering codes that trigger automatic referrals to the SIU. These codes may be applied when you receive an inbound complaint or grievance. There may be other codes as well which direct the claim through the appropriate process. Do not overlook the importance of properly coding and documenting your system when confronted with an indicator as the anti-fraud detection system is linked to your actions.

Health Care & Pharmacy Anti-Fraud, Waste and Abuse Guide

- Direct Reporting to the SIU

A telephone hotline has been established for reporting Fraud, Waste, and Abuse. The Hotline will direct the user to the proper mailbox for which the message should be left. **The Hotline may be accessed by dialing 1 (866) 806-7020.** The user will then follow a directions provided on the hotline that will allow a message to be left in the correct mail box.

A dedicated e-mail box has also been established for reporting fraud, waste and abuse to the SIU. **The address is CoventrySIU@cvty.com.**

- SIU Referral Form

This form is located on the “Essentials” intranet web site under the Special Investigations Section. Instructions for utilizing the form are included. Once the form is filled out, it can be sent to the SIU electronically or as a hard copy. Of note, use of this method allows the referring party to remain anonymous.

Keep in mind that these methods may not always fit the situation. If that is the case you must make the effort to report your concerns to Coventry through your chain of command. If you are not able to do this, and the referral is from an informant, make sure they are referred to the SIU.

REPORTING COVENTRY EMPLOYEES

If your concerns involve a Coventry Employee, call The Coventry Health Care Comply Line phone number: **1-877-242-5463 (1-877-CHC-LINE)**.

CONCLUSION

The Special Investigation Unit thanks you for taking the time to review this document. We are here to support you so please do not hesitate to contact us if you have any questions.

Suspected Fraud, Waste & Abuse Referral Form Coventry Special Investigation Unit



1. Coventry Health Care Corporation, Inc. (Coventry) will not tolerate health care Fraud, Waste or Abuse (FWA) in any of its relationships with either internal or external stakeholders. The Coventry SIU has been established and empowered to put into place and to operate those mechanisms designed to protect the company from these risks. The SIU will continuously endeavor to detect, investigate, prevent and report suspected FWA perpetrated against Coventry. It is the goal of the SIU, through a comprehensive anti-FWA program, to ensure the safety of our members, maintain a state of regulatory compliance and prevent financial losses from FWA.
2. Referrals of suspected FWA may be made to the SIU by submitting this form via interoffice mail or by US Mail. Informants, anonymous or otherwise, are protected under Federal "Whistleblower" laws from retaliation and retribution and except for when required by law, the SIU will protect your anonymity. Please send completed form to the SIU through one of the following channels:

Interoffice Mail: SIU-Cranberry Township	US Mail: Coventry SIU 120 E. Kensinger Drive Cranberry Twp, PA 16066	E-mail: CoventrySIU@cvtv.com	SIU Fax: 724.778.6827
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3. Potential FWA scenarios can be complicated and often hard to summarize. This referral form is not intended to complicate a referral but to simplify it. Rely on your anti-FWA training and common sense when writing your description. The basic information you want to include can be summarized by answering the following questions: Who is the suspect? What are they doing? Where is this taking place? When did this take place? Why do you think it is FWA? How long has this been going on? Be as detailed as possible in your answers and be sure to include provider and member identification numbers, especially if you wish to remain anonymous. If you have any questions, please send us an e-mail or call our hotline at 866.806.7020. Also, you may search our essentials page for additional information that may help: http://essentials/SIU/siu_coventry_menu.htm
4. Please provide the below information. (be advised an SIU investigator may contact you to discuss the referral unless you wish to remain anonymous):

Referral Information			
Date:	Impacted Health Plan(s):		
Your Name:		Your Title:	
Dept:	Phone:	Email:	

5. Please describe in detail what you suspect to be Fraud, Waste or Abuse being perpetrated against Coventry including and Member's name and ID#, Provider's Name and TIN, Claim numbers and Dates of Service. (use additional sheets if necessary and include any attachments):

Allegation



Procedure: Identifying, Reporting, and Addressing Abusive/Fraudulent Behavior by Providers

SUBJECT:

Abusive/Fraudulent Behavior by Providers

PURPOSE:

The purpose of this policy is to provide consistent company-wide guidelines for identifying, reporting, and addressing suspected fraudulent and/or abusive practices by providers.

POLICY:

Coventry Health Care, Inc. (“Coventry”) will not tolerate health care fraud or abuse. Health care fraud and abuse results in higher health care costs that ultimately are passed on to the customer in the form of higher premiums and fees.

Coventry will identify and monitor situations in which suspected fraud or abuse occurs. Coventry may investigate suspected fraud itself or may subcontract fraud detection to a third party vendor. Suspected fraud may be detected through CSO internal audits, provider employee complaints (i.e., whistleblowers), or interaction with members, other insurers, and governmental agencies. As a result of these fraud detection activities and in accordance with applicable law, certain conduct may rise to a level that necessitates taking corrective action with the provider or reporting to appropriate regulatory or law enforcement agencies, or both.

DEFINITIONS :

A. Fraud

There is no one universal definition of what constitutes fraud. In order to determine whether an activity constitutes fraud, one must refer to individual state law. State law often requires all of the following elements to prove fraud:

- **False representation**
Can occur when a claim includes charges for services that were not rendered, the patient was not seen, and/or the record contains knowingly

false information including intentional upcoding. Insufficient documentation is not in and of itself a false representation. However, a lack of documentation of medical necessity for a particular claim may be an indicator that abuse exists and a pattern of such conduct may suggest the need for further investigation.

- **Knowledge of the false representation**
The submitting party was aware of the falsity.
- **Intent to defraud**
The submitting party submitted false information intentionally, with the intent to get paid.
- **Justifiable reliance by the intended victim**
Payment is made based upon reliance that the claims and supporting documents are valid.
- **Resulting damage**
Monetary or other inappropriate loss results from the misrepresented submission, e.g., claims are paid that otherwise would not have been paid.

Following is a list of several examples of fraud:

- Documented allegations from credible sources that items or services were not furnished or received as billed;
- Duplicate billing to the health plan;
- Billing both the health plan and the patient;
- Amount of bill does not correspond to the services rendered;
- Billing irregularities are so aberrant from the norm that they cause you to question the correctness of the payments you have made, or are currently making;
- Data analysis shows the provider's utilization to be well above that of peers and there does not appear to be any legitimate rationale for the billing aberrations; and
- Statements by members and/or their families attesting to the provider's fraudulent behavior.

B. Abuse

Abuse involves practices that do not meet the legal definition of fraud, or behaviors that do not meet the criteria for fraud; however, the practices involve a pattern of practice that results in improper reimbursement or inappropriate patient care.

Abuse describes incidents or practices of providers that are inconsistent with accepted sound medical practice. Abuse may, directly or indirectly, result in unnecessary costs, improper payment or payment for services that fail to meet professionally recognized standards of care or that are not medically necessary. Abuse involves payment for items or services where there is no legal entitlement to that payment and the provider has not knowingly and intentionally

misrepresented facts to obtain payment. A provider who knowingly engages in this type of behavior may be engaged in fraudulent behavior. A pattern of such conduct may indicate intent to defraud. Patterns of abuse will be investigated to determine if fraud exists.

PROCEDURE:

A. Identification of Fraud/Abuse

1. Coventry either directly or through a third party vendor will investigate suspected fraud/abuse. A third party vendor may investigate suspected fraudulent providers as a result of referral or may identify potential fraudulent activity through comparison of lists of Coventry providers against the vendor's database of suspected fraudulent providers.
2. Coventry will engage in the following activities when it investigates fraud/abuse. These steps may be performed by a third party if Coventry delegates the investigation to a third party vendor.
 - a. Initial Assessment. Assess whether fraudulent/abusive behavior exists.
 - b. Corroboration. Obtain corroboration of suspected fraud/abuse from any of the following sources:
 - provider employees (official and unofficial whistleblower);
 - members; or
 - other sources, such as prepayment and postpayment review of medical records.
 - c. Identification of Pattern. Determine whether activity is isolated or part of a pattern. Pattern may be evidenced by a significant number of claims reviewed indicating fraudulent/abusive behavior. An isolated instance is likely not an indicator of fraudulent/abusive activity.
 - d. Investigation Review. Once the investigation is completed, Coventry and legal counsel will review the results.
3. When a third party is utilized to investigate suspected fraud/abuse, the third party will (a) review claims forwarded by Coventry and return those claims that do not meet screening criteria to the Coventry CSO liaison for release and payment; (b) develop and conduct investigation (review documentation, possible member and/or provider interview) for remaining appropriate claims; (c) report to Coventry its recommendations, including sending all related documentation to medical director for final decision to approve or deny claims when the recommendation is due to lack of medical necessity; and identify

providers deemed to have established a pattern of fraudulent or abusive practices to the medical director at the plan.

B. Corrective Action

Once suspicious activities are validated, through the internal or external investigation, the Health Plan will formulate an action plan. The team members will include: Medical Director, Provider Relations representative, legal counsel and compliance officer of the Health Plan. In developing an action plan, the following guidelines for action should be utilized. The corrective action options that may be exercised and the sequence taken will depend on the level of the conduct.

1. Corrective Action Options:
 - a. Oral and/or written communication to the suspected provider to allow for any credible explanation for the aberrant behavior/practice identified and to allow provider the opportunity to alter identified behavior/practice, or to reach agreement on an alternative solution to the identified behavior/practice.
 - b. Written request to the provider to cease and desist any continuation of identified fraudulent/abusive practices and to follow corrective action plan. This option may serve as a notice of material breach of the provider agreement with the opportunity to cure if such provision in the contract is available. (Plan will document corrective action plan);
 - c. Continued prepayment pending of claims for review by third party to assure compliance with appropriate treatment practices (100% review of all claims submitted by the provider may be appropriate);
 - d. Referral to Coventry recovery department for retrospective review to determine potential for recovery for prior reimbursement of identified inappropriate services; and
 - e. Contract termination in accordance with the contract and the provider termination policy.
2. Submission of Documentation to File. If the provider is a participating provider, verified documentation of provider fraud or abuse should be submitted to the provider's credentialing file. The information should be processed in the same manner as any other information about the provider. Consideration should be made as to whether the conduct is sufficient grounds for termination of the provider's participation agreement.

C. Reporting

1. State Reporting. Coventry and legal counsel will review state law to determine whether reporting to state agencies is mandatory or voluntary. In either instance, the standard for reporting should be reviewed to determine if the conduct satisfies the state reporting requirement. The decision to report needs to be approved by either the Health Plan CEO, the Medical Director, and/or VP for Provider Relations. Counsel should be consulted before a report is made.
 - a. Mandatory state reporting: If reporting is mandatory, Coventry should determine if the conduct meets the legal standard set forth by state law. Coventry should report the fraudulent behavior to the appropriate state agencies.
 - b. Voluntary state reporting: If reporting is voluntary, Coventry should determine whether immunity is provided for good faith reporting. The fraudulent conduct should be reported in states with voluntary reporting if:
 - immunity is provided under state law;
 - standard for immunity in the state is met; and
 - the conduct is such that it would be reported in another state with mandatory reporting.
2. Federal Reporting. The Health Insurance Portability and Accountability Act (“HIPAA”) created the National Healthcare Integrity and Protection Data Bank (HIPDB) for the reporting of certain adverse actions taken against a provider. Health plans are required to report civil judgments against providers related to the delivery of healthcare items or services and formal or official actions taken against a provider by a health plan based on acts or omissions that affect or could affect the payment, provision or delivery of a health care item or service, provided due process is provided to the provider. Coventry shall comply with any reporting obligations to the HIPDB.

Issue Date: March 2002
Reviewed Date:



Retail Pharmacy Audit Program

As of July 19, 2010

Medco maintains an aggressive Pharmacy Audit program that is results oriented, broad sweeping and highly efficient in improving pharmacy performance and compliance. Medco's continual focus on providing value and quality is evident in the significant benefits the Pharmacy Audit Program provides to the plan sponsor:

- **Financial Savings** from Audit Recoveries
- **Modifications in Pharmacy Behavior** resulting in Sentry Effects potentially many times actual recoveries, and increased quality and service levels in our retail pharmacy network
- **A Broad Audit Presence** at both local and national levels to ensure compliance with program guidelines
- **Field Audit Investigators** provide additional provider relations representatives in the pharmacies to provide direction and guidance to pharmacists

The Pharmacy Audit Program has several key objectives:

- **Help to protect the financial integrity** of the provider network by identifying those claims that may have resulted in overpayments to the pharmacies and recovering overcharges where appropriate.
- **Deter fraudulent claim submissions** among participating pharmacies through the prospect of an audit.
- **Educate participating pharmacies** to ensure compliance with program guidelines, through guidance in correct procedures in the administration of our prescription drug program.
- **Sanction pharmacies** that display flagrant or repetitive disregard for program guidelines.

The true goal of an effective pharmacy audit program is to prevent fraudulent claims submissions from occurring. Medco believes that a well-planned and coordinated audit program results in improved provider compliance for our plan sponsors.

Audit Program Overview

Medco's Pharmacy Audit program utilizes claims analysis to identify aberrant dispensing trends, conduct field and desk audits, and generate financial savings for our plan sponsors. By utilizing claims analysis, we continually improve our ability to effectively target our resources, conduct more audits, and analyze more claims.

Audit Selection

All pharmacies participating in Medco's retail networks are evaluated by our claims analysis programs. On a quarterly basis, all claims processed during the previous three months are analyzed as part of Medco's

Audit programs. This constant evaluation process provides the latest available profile for each of our provider pharmacies, allowing for timely and accurate analysis of dispensing patterns.

Pharmacies participating in Medco's prescription drug programs are selected for audit based on several criteria, including:

- **Deviant Pharmacies Identified by Medco's Fraud Claims Analysis**
 - Ø A number of audit criteria are utilized by Medco to identify aberrant dispensing trends including, but not limited to, the following:
 - Claim Cost
 - Utilization of overrides
 - Generic dispensing
 - Product mix
- **Networking** – Medco takes advantages of opportunities to work with law enforcement and regulatory agencies regarding potential inappropriate activities by participating pharmacies.
- **Information from Plan Sponsors and Members** can also lead to quality audits.

The majority of our audits are identified by our claims analysis which utilizes various criteria to identify the audit candidates with the greatest potential for recoveries.

Audit Types

Medco performs both Desk and Field Audits of retail pharmacies. Desk Audits, including a daily targeted review of point of sale claims for accuracy, complement on-site field audits, where claims are evaluated against the pharmacy's prescription records. Combined, Desk and Field Audits provide plan sponsors with a consistent, timely, and accurate approach to managing their pharmacy benefit plan by allowing for both proactive concurrent and retrospective claim review.

Types of Audits

- **Desk Audits**

The Pharmacy Audit Department reviews the previous day's POS claims for accuracy. Claims data is downloaded to a proprietary database system, and run through a series of internally designed filters. The filters are designed to eliminate claims patterns previously reviewed and found to be accurate, and create a subset of claims for additional targeted review.

Targets for additional review include prescription medications that are frequently submitted by participating pharmacies with inaccurate information (i.e., metric quantity). Targets are updated regularly based on both auditing experience and the introduction of new medications in to the marketplace. By keeping the targeting process dynamic rather than static, Medco is able to quickly address new error patterns and proactively resolve any issues identified.

When a misclaimed prescription is identified, the Retail Pharmacy Audit Department works, as necessary, with the pharmacy to reverse the initial incorrect claim and to resubmit the claim with the correct information.

Since the reversal and reentry occurs within cycle, the pharmacy is reimbursed appropriately and the plan sponsor is invoiced correctly. As a result it is not necessary to process credits for these records

- **Field Audits**

Medco's Field Auditors, who review participating pharmacies' prescription records, perform on-site audits. The field auditor compares claims reimbursed to the pharmacy against the pharmacy's paper prescriptions and associated prescription records and notes any discrepancies.

During the on-site audit the Field Auditor will:

- Check the pharmacy's license.
- Utilize both pharmacy knowledge and audit experience to identify potential unusual patterns of claim submissions and claims of interest. For example, unusual combination of medications dispensed to the same patient, a high rate of telephone prescriptions in relation to original prescriptions, low generic substitution rates, etc.
- Verify that a paper prescription exists for all prescription claims reviewed and that the drug names, strengths and quantities billed are in accordance with the physician's prescription order.
- As required, verify that members actually received medications billed through patient and physician confirmation letters.

At the conclusion of the on-site field audit, Medco's Field Auditor will review the discrepancies noted with the pharmacist in charge or the pharmacy owner. The auditor also prepares a detailed itemization of any discrepancies identified during the audit.

Following the field visit, a Pharmacy Audit Analyst will, as necessary, target specific members and physicians to receive confirmation letters. The patient contact is a computer-generated letter mailed to patients of the pharmacy, which is being audited. The letter lists all of the medications, which were reimbursed to the audited pharmacy under the specific patient's member number. The patient is asked to review the accuracy of the drug names, strengths, quantities and dates dispensed. The patient is also requested to complete a form describing the physical characteristics of generically substitutable medications so that Medco can verify that the pharmacy is billing for the medication that was actually dispensed.

In addition, where appropriate, letters are sent to the physicians who are identified as prescribing specific prescriptions. This letter requests the physician to verify the validity of the prescriptions in order to ensure that unauthorized changes were not made. The types of claims identified for physician confirmation letters include: expensive telephone prescriptions, unusual combinations of medications - medications not generally prescribed together, and prescriptions which appear to be altered.

Not only are these letters an important source of audit recovery, but they serve as a strong audit control that will help maintain the integrity of the prescription drug program by ensuring that prescriptions reimbursed are authorized by physicians and received by Medco members.

After the patient and physician contact results are reviewed and evaluated, the Discrepancy Evaluation Report, a detailed report listing each discrepancy identified during the audit, is prepared and forwarded to the pharmacy. Included with the report is the recovery amount represented by the discrepancies found.

The audited pharmacy is given the opportunity to review the Audit Department's findings and, if they elect to, provide support documentation for certain discrepancies. Upon review of the documentation, a recalculation of the amount identified for recovery could be made.

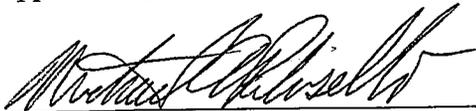
Processing of Audit Recoveries

Retrospective audit recoveries are processed on a cycle basis as claim level audit credits which appear on the plan sponsor's Claims Billing Invoice. Since the pre-invoice savings are corrected within cycle it is not necessary to process audit credits for these transactions.

COVENTRY HEALTH CARE
Special Investigation Unit

POLICY AND PROCEDURE
Document Name: **Fraud Plan**
Revision Policy

Approved by:



Manager – Special Investigation Unit

Effective Date: 1/1/2010
Last Date Revised: 9/10/2010

I. Purpose

To ensure that the Coventry Fraud, Waste & Abuse plans are reviewed on an annual basis by Corporate leadership.

II Policy

Coventry Health Care will annually evaluate the effectiveness of the Anti-Fraud, Waste and Abuse Plan. The review will include, but is not limited to, an examination of applicable laws that may impact the content of the plan, an assessment to ensure updates are made to accommodate changes in the legal and business marketplace, a review of the anti-fraud training protocols and if there was a change in the person or persons responsible for the anti-fraud program. If so, Coventry Health Care will modify this Plan accordingly.

III. Procedure

Beginning in July of 2011 the SIU Manager will initiate the review of the FWA Plans. It will be the responsibility of the SIU Manager to schedule and keep a record of the annual review. The SIU Manager will solicit Corporate leaders to review the relevant documents including but not limited to the Corporate Legal Counsel, the Chief Compliance Officer, the Chief Medicaid Officer and the Chief Medicare Compliance Officer. All revisions will be compiled by the SIU Manager and incorporated into a new draft. The final review will be the responsibility of Corporate Legal Counsel who will ultimately finalize the changes. In any year where changes are made, the document will be then sent to the relevant Coventry Health Plans for adaptation and implementation.