Elite Health Plan	Dept: Corporate
POLICIES AND PROCEDURES	Effective Date: January 1, 2025 Policy No: PC202 Revised:
Subject: Reporting Potential Issues or Areas of Non-Compliance, Fraud , Waste and or Abuse	Page 1 of 6

Reviewed and Accepted By:
(Committee or Department Head) _____ Board of Directors _____

Authorized Signature: _____ **Date:** 1-26-2025 _____

I. Purpose:

- To outline required reporting by employees potential fraud, waste or abuse and/or code of conduct violations and the process by which an individual may file a report regarding a potential fraudulent activity or any other violation of Elite Health Plan's Compliance Program (CP) and corresponding Standards of Conduct anonymously and without fear of retaliation, and

- To outline sanctions/penalties imposed on violators

II. Policy:

Employees, governing body, FDRs, contractors and providers are required to report if he/she believes he/she has been part of, or witnessed a fraudulent activity or suspected violation of the Company's Compliance Program or Standards of Conduct or suspected or known violation involving a state or federal program. Any person or entity who becomes aware of conduct that constitutes fraud or that violates the CCP should file a report as quickly as possible or prudent, but within 45 days of witnessing or determining that a violation may have occurred. Individuals who must report alleged incidences of fraud include employees, business associates and provider entities, FDRs, enrollees, governing body, or governmental agencies. Fraud may reported anonymously and without fear of retaliation.

Strict adherence to the Corporate Compliance Program is vital. Violators will be subject to discipline as outlined in this policy, the Standards of Conduct, and the CCP.

III. Procedure:

Individuals are expected to report any suspected violations of the Corporate Compliance Program, Standards of Conduct, or other irregularities to their supervisor, a Compliance Officer, and/or Human Resources promptly, and within 45 days of the alleged incident. If the individual wishes to remain completely

anonymous, he/she may submit a report through the Corporate Compliance Fraud Alert contractor by:

- **Anonymous Reporting App**: Keyword: elitehealthplan
  - Detailed app instructions download here

- Toll-Free Telephone:
  - **English-speaking USA and Canada: 855-894-4982**
  - Spanish-speaking USA and Canada: **800-216-1288**
  - Spanish-speaking Mexico: **800-681-5340**
  - French-speaking Canada: **855-725-0002**
  - Contact us if you need a toll-free # for North American callers speaking languages other than English, Spanish or French

- **E-mail**: reports@syntrio.com (must include company name with report)

- **Fax**: 215-689-3885 (must include company name with report)

Your **suggestion box** can be accessed from your web reporting page, or directly at: https://report.syntrio.com/elitehealthplan/sb.asp.

- Mailing a report to "Fraud Alert Compliance Dept" at 1131 W. 6th Street, Suite 225, Ontario, CA. 91762 and/or calling 800-958-1129

- Submitting a report via email: hotline@elitehealthplanhealth.com or via Plan website: www.elitehealplaninc.compliance or via anonymous hotline @ https://report.syntrio.com/elitehealthplan. All attempts will be made to keep you identity anonymous for those items that are reported in good faith without retaliation.

Information about the Fraud Alert reporting is posted in all Elite Health Plan common and lunchroom areas and on Plan website, and each employee receives a copy of the Anti-Fraud Plan and a desk card with Fraud Alert reference and who to report and how to report. Additionally, all contracting entities receive a copy of the Plan's Compliance program, detailing how to file a report when witnessing a potential fraudulent activity. Significant regulations impacting the plans delegated entities require the Compliance Officer to attend Joint Operations Meetings to provide information. When an individual reports fraud and does not want to remain anonymous, informational updates will be provided as part of the investigation process to be completed in 60 days. Report to MEDIC as required (30 days). FWA incidences are reported to Senior Management, as applicable, the Compliance and Board Compliance Committee, and Quarterly to the Board of Directors. All fraud investigation will be shared with CMS Regional Account Manager. Any pertinent FWA that poses risk to the Plan's reputation, delivery of quality healthcare, legal or MEDIC referral is reported to the Board of Directors prior to the quarterly report.

The Plan's Fraud Hotline and Fraud area on company website is available 24 hours a day, 7 days a week, and 365 days a year. Reporting of fraud to the hotline and website are immediately forwarded to the Compliance Officer to begin investigation. Mailing of fraud information is sent directly to the Compliance Department for investigation. All fraud can reported anonymously and without the fear of retaliation!

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All reports must contain sufficient information for the Elite Health Plan Supervisor, Compliance Officer, Human Resources, and/or Fraud Alert Contractor to investigate the concerns raised. Reporting information may include, but is not limited to:

- A description of the alleged activity of noncompliance and when it occurred;
- The names of the entity/entities involved in the alleged activity
- Relevant supporting documentation

The Compliance Officer will work with Human Resources, and/or relevant department head in cases where an employee has had an allegation filed against him/her. The employee will be given the opportunity, as appropriate, to state his/her position before any disciplinary action is imposed.

A Compliance Officer shall begin an investigation within 3 days of notification, and involve legal, the fraud investigation team, the MEDIC (within 30 days) or law enforcement and take corrective action where appropriate within 60 days from the date the potential misconduct is identified. If a detailed investigation is warranted. The Compliance Officer's investigation shall include interviews and review of relevant documents including pertinent practices and policies as well as consideration of the circumstances under which the act of noncompliance occurred. A Compliance Officer will issue reports to appropriate designated personnel and, if appropriate, to the Board of Directors, Finance Committee of the Board, and/or the appropriate government agency, such as the MEDIC (within 30 days) or law enforcement. All investigations unless an extension is required will be completed within 60 days.

While the Compliance Officer will strive to keep all concerns/complaints confidential to the extent possible, he/she may seek advice and guidance from Legal Counsel or a Plan's contracted Special Investigation Unit (SIU). or Regulatory Consultant or legal to Conduct and conclude any possible

investigation. Ultimately, the Compliance Officer must report all concerns/complaints and the resolution of these concerns/complaints in accordance with the policies set forth in the Corporate Policy & Procedure PC201 "Duties of Compliance Officer".

The Compliance Officer will report alleged fraudulent activities related to Medicare Part D Program to the Medicare Drug Integrity Contractor (MEDIC) within 30 days after a determination that a violation occurred. Should the MEDIC and/or any CMS or law enforcement official require additional information to conduct an investigation, Elite Health Plan will fully cooperate in any way. Examples of Part D fraud may be found in Chapter 9 Prescription Drug Benefit Manual 21 Part D Program to Control Fraud Waste and Abuse" Fraud and abuse activities may be perpetrated by a Part D sponsor, or contracted pharmacy, and a Medicare beneficiary. When in doubt as to whether a fraudulent act has been committed, contact the Plan's Compliance Officer.

If the Compliance Officer determines that an employee, business associate or provider entity, agent, independent contractor, or enrollee has clearly violated the law, the Corporate Compliance Program, or the Standards of Conduct, that individual shall be subject to the appropriate disciplinary action that is timely and consistent.

The disciplinary action includes counseling and retraining but may vary based on the offense to include, but is not limited to the following:

- Verbal warning with training if required
- Written warning with training if required
- Impaired raises or promotions
- Probation
- Suspension
- Demotion
- Dismissal and/or
- Termination of contract

- Reporting to Law Enforcement shall occur where criminal activity has been confirmed

The sanction will depend on the seriousness of the offense, repeat offenses, maliciousness of the act, innocence of the violation, and cooperation with any investigation. A record of the event and the discipline imposed shall be maintained by the relevant department within Elite Health Plan with a copy to be filed in a master file maintained by a Compliance Officer. The Compliance Officer and Senior Management will be responsible for determining the procedures or actions taken to prevent similar occurrences of misconduct in the future. The Compliance Officer, along with any other relevant parties, will tailor a corrective action plan to address the misconduct identified and will provide structure with timeframes so as not to allow continued misconduct. The corrective action plan will be initiated through the Compliance Office and will continually be monitored for its effectiveness. In the event that an employee is found to be non-compliant, immediate retraining will also be required based on the level of disciplinary action; for example termination would not require retraining.

Disciplinary action will be taken against a violator's department head to the extent that circumstances reflect adequate supervision or a lack of due diligence. Disciplinary action will be taken against any department head who retaliates, directly or indirectly, against an employee who reports a violation of law, or the Compliance Program, or the Standards of Conduct. In addition, department heads may be sanctioned for failing to detect non-compliance with applicable policies and legal requirements, where reasonable diligence on their part would have led to the discovery of any problems or violations and would have given Elite Health Plan the opportunity to correct them earlier.

IV. References: -Prescription Drug Benefit Manual Chapter 9 Compliance Program Guidelines; Chapter 21 Medicare Managed Care Manual. - Compliance Program-Policy and Procedure PC201 Duties of Compliance Officer