MEDICAL MUTUAL OF OHIO

Corporate Compliance Program

Last Updated: August 7, 2017

Contents

Background:

This document contains the Medial Mutual Corporate Compliance Program, which includes regulatory compliance, Medicare Part C and Part D compliance, and Affordable Care Act (ACA) compliance. In addition, the Fraud, Waste and Abuse (FWA) plan has been incorporated into the Corporate Compliance Plan.

Medical Mutual of Ohio's compliance program is designed to meet and build upon the requirements for an effective compliance program set forth in the United States Sentencing Commission's Federal Sentencing Guidelines for Organizations. The Federal Sentencing Guidelines impose penalties on organizations whose employees or agents have committed federal crimes. Penalties imposed by federal judges can include restitution, remedial action, community service, and fines and are based on a point system that is designed to measure the severity of the offense.

The Federal Sentencing Guidelines strongly encourage organizations to develop effective programs to prevent and detect violations of the law. They also prescribe what should be included in an effective compliance program. Where organizations demonstrate an effort to implement the elements of an effective compliance program, federal judges will lower the penalties imposed on the organization.

For a compliance program to be considered effective, it should include the following:

1. Standards and procedures to prevent and detect criminal conduct.
2. Responsibility at all levels of the program, together with adequate program resources for its managers.
3. Due diligence in hiring and assigning personnel to positions with substantial authority.
4. Communicating standards and procedures, including a specific requirement for training at all levels.
5. Monitoring, auditing, and non-retaliatory internal guidance and reporting systems, including periodic evaluation of program effectiveness.
6. Promotion and enforcement of compliance and ethical conduct.
7. Taking reasonable steps to respond appropriately and prevent further misconduct upon detecting a violation.

While the adoption of a compliance program based on the Federal Sentencing Guidelines serves primarily to mitigate the federal criminal penalties in the event an organization is convicted of a crime, the compliance requirements outlined in the Sentencing Guidelines are applicable to an organization's entire compliance program and can assist in decreasing the severity of the civil fines imposed on an organization by regulatory agencies. Increasingly, state insurance departments are conducting risk-based financial examinations of insurers, which often include a review of the insurer's

compliance program. Fines and penalties resulting from market conduct examinations can be mitigated if the insurer has in place an effective compliance program and can demonstrate that compliance violations were inconsistent with the insurer's established policies and procedures

The Company makes this Compliance Program, which includes the specific product compliance components, available to the Board of Directors and all Medical Mutual employees, contractors, subcontractors, vendors, agents, and first tier, downstream, and related entities ("FDRs") who provide services for its members.

The Compliance Officer reserves the right to amend and update components of the Corporate Compliance program, including the material in this Compliance Plan, at any time based on regulatory guidance, enhancements to the program to improve effectiveness, or for any other reason.

Under the direction of the Compliance Officer, the Company's leaders of each operational area are responsible for maintaining compliance with this Compliance Plan, and with the changing requirements of the Centers for Medicare and Medicaid Services (CMS)

The information contained in this Compliance Plan may change at any time without prior notice. If material amendments or updates are made, these changes will be reflected in all future training and communications.

I. Commitment to Legal Compliance

The Company shall comply with all applicable federal and state laws and regulations governing the health insurance industry, including those addressing Medicare Part C and Part D, the Affordable Care Act (ACA), the Mental Health Parity and Addiction Equity Act (MHPAEA), as well as all federal requirements designed to prevent FWA, including any applicable provisions of federal criminal law, the False Claims Act, the anti-kickback statute, and HIPAA rules. The Company maintains written guidelines that are available to all employees so that they may know and understand their individual responsibilities for compliant and ethical business practices. No employee or vendor will be punished or subject to reprisal by the Company for reporting a violation or suspected violation of the law. If required. Medical Mutual will submit for review applicable changes to this Plan to appropriate governmental agencies.

See also Company Policy No. 2002.002 (*Code of Conduct*).

See also Company Policy No. 2003.004 (*Compliance with Laws*).

See also Company Policy No. 2010.002 (*Non-Retaliation*).

See also Company Policy No. 2003.011 (*Corporate HIPAA Privacy Training*).

The Company's operational areas have developed compliance policies and procedures to ensure process controls are in place to meet specific requirements of Medicare Parts C and D, the ACA and MHPAEA. These policies and procedures support this Compliance Program and work in conjunction with departmental policies developed and used on a day-to-day basis by the Company's business areas.

The regulatory compliance program further ensures appropriate review and implementation of new and existing laws. Medical Mutual has created a regulatory review process led by the Legal Department. The Legal Department gathers information on new and revised regulations and distributes them to the appropriate business areas. Each business area is then responsible for reviewing the regulations, assessing the impact of them, and determining whether they require the development of new policies and procedures or amendments to existing ones. The Legal Department is available to assist in assessing the impact of new regulations and drafting any required policies and procedures. This may include periodic meetings to discuss the impact of new state and federal requirements and determine the actions needed to ensure compliance.

The Company's leaders of each operational area are responsible for maintaining these policies and procedures.

II. Compliance Officer & Compliance Committee

A. Chief Compliance Officer

The Chief Compliance Officer is responsible for oversight of the Compliance Program, providing Compliance Program guidance, and reporting incidents of suspected and/or identified non-compliance to senior management, the Chief Executive Officer (CEO), and/or the Board of Directors' Audit Committee, as applicable.

The Compliance Committee is responsible for reviewing the effectiveness of the Compliance Program through self-audits and monitoring of metrics and key indicators in order to ensure prompt and effective corrective actions are taken where deficiencies are noted. The Compliance Officer will work with the Compliance Committee to escalate compliance deficiencies and ongoing issues of non-compliance to senior management, the CEO, and/or the Board of Directors' Audit Committee, as may be warranted.

The Chief Compliance Officer has direct access to the Audit Committee of the Board of Directors and to the Company's CEO. The Chief Compliance Officer will provide periodic compliance updates to the Board of Directors' Audit Committee, including issues identified, investigated, and resolved by the compliance program. The Chief Compliance Officer will be responsible for providing to the Board of Directors' Audit Committee information necessary for the Board to be knowledgeable about the content and operation of the compliance program and to allow them to exercise reasonable oversight with respect to the implementation and effectiveness of the compliance program.

The Chief Compliance Officer is also responsible for designating a Medicare Compliance Officer for Medicare Part C and Part D products who will be responsible for oversight of the Company's Medicare Part C and Part D Compliance program. The Medicare Compliance Officer is also responsible for investigating any allegations of misconduct related to the FFM and Medicare Part C and Part D products and taking corrective action.

B. Compliance Committee

To improve communication and oversight on compliance issues, the Company has established a Compliance Committee. In addition to providing a forum for discussing compliance issues, the Committee is responsible for handling Company-wide compliance issues. The Committee serves as the focal point for compliance activities.

A separate Medicare Compliance Committee has been established for Medicare Parts C- and D-related compliance issues. The Committee serves as the focal point for compliance activities. One of the Committee's roles is to advise the Chief Compliance Officer and assist in the implementation of the Compliance Program.

Each Committee generally will meet quarterly. Both are composed of representatives from different operational areas of the Company, including Legal, Actuarial, Finance, Sales and Marketing, Care Management, Operations, Fraud, and Information Technology (IT).

In consultation with the Chief Compliance Officer, the Compliance Committee will develop strategies to promote compliance with federal and state requirements; review and approval of compliance risk assessments; review, approve, and assist in updating compliance policies and procedures; review internal and external audit work plans, audit results, and corrective action plans; share information on Medicare Parts C and D compliance issues that are reported; and review and approval of FWA training. The Chief Compliance Officer will provide periodic reports to the CEO and the Board of Directors' Audit Committee on the Compliance Committee's activities.

III. Product Licensing and Certification

In order to ensure compliance with the Affordable Care Act (ACA) regulations, including the Qualified Health Plan (QHP) certification and benefit standards, the Company shall ensure that each QHP offered by the Company is licensed and in good standing to offer health insurance coverage in the state of Ohio. If the Company later expands into other states, the Company shall ensure it is licensed and in good standing in those states as well. The Company shall also comply with the certification standards as set forth in 45 CFR Part 156 Subpart C.

In addition to compliance with ACA regulations, the Company regularly monitors its compliance with state licensing statutes and certification requirements. The Company does this by monitoring all legislation that is passed in all states in which it conducts business, as well as monitoring all Department of Insurance bulletins in every state in

which it conducts business. Whenever the requirements change, the Company takes the necessary actions in order to remain compliant.

IV. Training and Education

Compliance training programs are essential to ensuring that appropriate information regarding the Company's compliance program and specific risk areas are communicated to Company personnel. Upon hire and on an annual basis thereafter, all employees are required to complete Code of Conduct, HIPAA Data Security and Privacy, and Medicare and FWA training.

At the direction of the Medicare Compliance Officer, the Company will conduct training for the following: employees responsible for Medicare Part C and Part D compliance, including the chief executive and senior administrators or managers; Board of Directors; and FDRs.

All FDRs that provide services to Medicare Parts C and/or Part D enrollees are required to complete compliance FWA training. First tier, downstream, and related entities have the option of taking the Company's compliance FWA training, complete CMS's online training, or conduct their own training. FDRs who have met the FWA certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the training and educational requirements for FWA.

While the Company's FDRs, contractors, and agents are responsible for training of their own employees on Medicare Part D compliance, the Medicare Compliance Officer will ensure that oversight and monitoring of training and education by FDRs, contractors, and agents are performed. FDRs must maintain documentation for a period of ten years, including attendance logs, training materials, and testing results, of all employees, contractors, and volunteers who completed the trainings, whether through Medical Mutual, CMS, or their respective companies.

New employees with Medicare Parts C and D responsibilities will be trained no later than ninety days after date of hire by the Company's Human Resources Department. Existing employees with Medicare Parts C and D responsibilities will be trained at least annually. The Medicare Compliance Officer shall ensure that the Human Resources Department maintains records on the training provided and attendance at training sessions for at least ten years. Unexcused absences from mandatory training sessions will be grounds for possible disciplinary action.

Training and education sessions are designed to address pertinent laws related to Medicare Parts C and D FWA. These sessions may include topics such as:

- A description of the compliance program;
- An overview of how to ask compliance questions and how to identify and report suspected or detected non-compliance;

- A review of policies related to contracting with the government;
- An overview of HIPAA privacy requirements and the importance of safeguarding personal information;
- Laws and regulations related to Medicare Parts C and D FWA;
- Obligations of FDRs to have appropriate policies and procedures to address FWA;
- Protections for sponsor's and FDR employees who report FWA; and
- Types of FWA that can occur in Medicare Parts C and D.

Also at the direction of the Compliance Officer, the Company will conduct annual training for all employees involved with the FFM. As applicable, department-specific training will include FFM requirements related to specific job functions, as supported by departmental policies and procedures. At the direction of the Compliance Officer, the Company will conduct training for employees responsible for FFM compliance.

Training and education sessions are designed to address pertinent laws related to FFM issuers on the FFM and may include topics such as:

- A description of the compliance program;
- An overview of how to ask compliance questions and how to identify and report suspected or detected non-compliance;
- A review of policies related to contracting with the government;
- An overview of HIPAA privacy requirements and the importance of safeguarding personal information;
- Protections for employees and downstream entities who report non-compliance; and
- Types of non-compliance that can occur in the FFM.

Methods of training may include in-person group training, videoconference training, and use of online training modules.

Each member of the Company's management is responsible for ensuring that his or her employees complete all required compliance training. The Chief Compliance Officer is responsible for regularly reminding the Company's management of their training obligations. Failure to complete required compliance training may result in disciplinary action, up to and including termination of employment.

V. Effective Lines of Communication

In accordance with its Code of Conduct, the Company seeks to maintain open communications on matters of common concern with all employees to the fullest extent possible. The Company is committed to the policy that all employees and FDRs have an obligation to report problems and concerns involving actual or suspected compliance violations.

Reporting violations:

COMPLIANCE HOTLINE:	1-800-762-8130
COMPLIANCE CONNECTION:	MMO.INTERCEDESERVICES.COM
COMPLIANCE OFFICER:	MAIL ZONE 01-10B-1900

The Compliance Hotline and Compliance Connection are available to all Company employees with questions or concerns regarding compliance. They also serve as a means to report violations or suspected violations. The Compliance Hotline is a 24-hour hotline. All reports received are kept confidential to the extent practicable. The hotline permits anonymous reporting and an individual with a question or concern is not required to identify him- or herself. It is necessary, however, that enough information be provided to enable the Compliance Officer to initiate an investigation. Reports may also be made in person to the Company's Chief Compliance Officer. All reports can be made without fear of retaliation. No employee will be punished or subject to reprisal by the Company because he or she, in good faith, participates in the compliance program, including reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.

The Compliance Hotline and Compliance Connection are also available to all FDRs, vendors, contractors, agents, providers, and business partners as a means to gain additional information or to report violations, or suspected violations, with respect to the vendor relationship between the Company and the vendor.

Violations or suspected violations may also be made in person to the Chief Compliance Officer. All such inquiries received are kept confidential to the extent practicable. In person conversations are not recorded. All inquiries can be made without fear of retaliation.

Establishing effective relationships with regulators is a critical component of Medical Mutual's regulatory Compliance Plan and essential to its success. The Legal Department is the initial point of contact for communications with state insurance departments and other regulatory agencies, but Medical Mutual employees in compliance areas are encouraged to establish effective one-on-one relationships with their regulatory counterparts. For example, employees who prepare contracts and certificates are encouraged to develop relationships with the state insurance department contract analysts; actuaries are encouraged to become familiar with their counterparts in state insurance departments; and individuals with financial reporting responsibilities are encouraged to develop relationships with the individuals in state insurance departments who handle financial analysis and exams.

VI. Disciplinary Standards

The Company enforces its compliance standards through well-publicized disciplinary guidelines, such as its Code of Conduct, which encourages good-faith participation in the compliance program by all affected individuals. The Company's Code of Conduct

stipulates, among other things, that to maintain the Company's high standards, employees must:

1. be familiar with the Company's policies and procedures;

2. report suspected Code of Conduct violations promptly;

3. cooperate with all investigations;

4. reserve the Company's reputation and represent the Company in an ethical manner; and

5. never make false, misleading or purposefully inaccurate statements to coworkers, customers, business partners, regulators or law enforcement officials.

All employees are required to review the Code of Conduct at least annually and must participate in required Company compliance training. Being unaware of corporate policies and procedures or using poor judgment are not appropriate reasons for violations. If employees violate the Code, they could receive discipline up to and including discharge.

VII. Routine Monitoring and Identification of Compliance Risks

Effective monitoring is essential to the success of the Company's Compliance Program. Effective monitoring is necessary to identify emerging compliance problems and to determine if existing compliance policies and procedures are effectively communicated and implemented. Because the Company's regulatory compliance obligations and requirements continuously change, it is important to routinely monitor compliance activities and verify that the Company's policies and procedures are updated in accordance with applicable rules, regulations, and laws in order to avoid potential compliance problems.

A. Auditing and Monitoring by the Company

Effective auditing and monitoring are essential components of Medical Mutual's Compliance Plan. To ensure effective compliance monitoring, each business area is expected to report compliance issues and violations to the Legal Department. This allows the Legal Department to assist in mitigating issues and violations that could result in regulatory fines, private lawsuits, or damage the company's reputation.

The Company undertakes periodic audits of critical compliance areas to determine whether policies and procedures are being effectively communicated and implemented. Compliance audits are conducted at the direction of the Company's Chief Compliance Officer, who may engage an independent third party with expertise in the particular compliance area being audited. Each audit is designed for two purposes: first, to detect any weaknesses in existing compliance policies and procedures; second, to identify

ways in which any identified weaknesses can be strengthened through updated policies, processes, and procedures, improved use of technology, or other changes to the Company's compliance system.

Staff dedicated to the audit function will be responsible for monitoring and auditing the Company's operational areas to ensure compliance with all federal and state regulations, Medicare Parts C and D, and the ACA. Areas subject to audit may include marketing; agents and brokers; enrollment and disenrollment; credentialing, grievances and appeals; benefit and formulary administration; claims processing; HIPAA compliance; and FDR oversight and monitoring.

The Company will monitor FDRs' activities and performance to ensure that they fulfill their contractual requirements for both the FFM and Medicare Part C and Part D, and that they meet established performance standards. The Company shall ensure that a delegation agreement has been properly executed prior to employing the services of an FDR. As contractually permitted, the Company will monitor its FDRs' activities and performance to ensure that they fulfill their contractual requirements, meet established performance standards, and are in compliance with federal and state requirements.

The Company can use multiple methods to monitor and audit FDRs, including risk assessments, on-site audits, desk reviews, and monitoring of self-audit reports. The Company conducts risk assessments to identify the highest risk FDRs in order to choose which FDRs to audit. The Company may conduct these audits using its employees, or it may contract with independent third parties to conduct these audits. The Company's staff dedicated to FDR monitoring and auditing will employ audits to validate compliance, develop corrective action plans in response to detected offenses, and report oversight activities to the Compliance Committee.

B. Auditing by Federal Agencies and External Parties

The Company cooperates with federal agencies and external parties when audits of the Company's compliance program are conducted. As required by law, the Company will disclose to the governing agency, such as CMS, HHS, or the Ohio Department of Insurance, any information it may require to audit the Company's compliance program, including but not limited to, payment-related oversight and FWA. The Company will allow CMS or a National Benefit Integrity Medicare Drug Integrity Contractor ("NBI MEDIC") to inspect, evaluate, and audit its records and provide CMS with access to the Company's records and facilities, as well as to enable CMS to evaluate Medicare Part C and Part D compliance. The Company will also allow the governing agency to inspect, evaluate, and audit its records and provide access to the Company's records and facilities. The Company acknowledges that a governing agency has a right to do the following:

1. inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the Company's government contracts, such as the Company's Medicare Part C and Part D Contracts and FFM/QHP Contracts;

2. inspect or otherwise evaluate the Company's facilities when there is reasonable evidence of some need for the inspection;

3. audit and inspect any books, contracts, and records of the Company that pertain to the contract between the Company and the federal or state regulatory entity governing the insurance products offered by the Company;

4. examine the ability of the organization and its FDRs to bear the risk of potential financial losses;

5. audit services performed or determinations of amounts payable under the contract; or

6. reconcile benefit liabilities.

The Company also acknowledges that HHS has a right to do the following:

1. periodically audit financial records related to the Company's participation in the FFM, and evaluate the ability of the Company to bear the risk of potential financial losses;

2. conduct compliance reviews or otherwise monitor the Company's compliance with all FFM standards applicable to the Company offering QHP(s) in the FFM; and

3. audit the Company at any time to ensure compliance with minimum essential coverage that is recognized as "other coverage," per 45 C.F.R. § 156.604(a).

As an Issuer offering QHPs in the FFM, the Company acknowledges that, upon request and for a period of ten years, it must make available to HHS, the Office of the Inspector General (OIG), the Comptroller General, or their designees all records related to the Company's participation in the FFM, pursuant to 45 C.F.R. § 156.705. Similarly for Medicare Parts C and D products, the Company acknowledges that CMS or its designee may audit Medicare records for a period of ten years from the termination date of the Medicare contract, pursuant to 42 C.F.R. §§ 422.504 and 423.505. These record retention requirements also apply to the Company's delegated entities and FDRs for both Medicare Parts C and D and QHP products, pursuant to 45 C.F.R. § 156.340 and 42 C.F.R. §§ 422.504 and 423.505. The Company's delegated entities and FDRs agree that this right to inspect, evaluate, and audit any pertinent information extends for any particular contract period for ten years from the final date of the contract or from the date of completion of any audit, whichever is later.

The Compliance Officer is responsible for responding to requests by the governing agency, such as HHS, CMS, or its designee to inspect records or facilities. The Compliance Officer will coordinate internal efforts to make available the Company's premises, physical facilities and equipment, records relating to its Medicare Parts C and

D or QHP enrollees, and any additional relevant information that the governing agency may require.

The Company's Pharmacy Benefit Manager (PBM), in particular, agrees by contract to comply with all applicable federal and state laws and regulations, provide data for CMS audit requirements, and support audits CMS may perform on the Company's Medicare Part D transactions or processes.

VIII. Responding to Detected Offenses and Implementing Corrective Actions

A detected compliance violation that is left uncorrected can endanger the mission, reputation, and legal status of the Company. In accordance with its Code of Conduct and this Corporate Compliance Program, the Company conducts timely and thorough investigations of all fraudulent or abusive activities, resolves such activities, and reports such activities to the appropriate regulatory agency as required. The Company is committed to being proactive in detecting and correcting compliance violations. Whenever the Company discovers a compliance violation—either through a customer complaint, an employee or vendor report, or as part of an internal audit—the Company addresses the violation and implements any policies and procedures necessary to prevent the violation from reoccurring. As part of its Compliance Program, the Company maintains records of its most recent audits and documents the steps taken to remedy compliance violations.

As a Medicare Parts C and D and QHP plan sponsor, the Company conducts a timely and reasonable inquiry upon discovery of evidence of misconduct related to payment or delivery of items or services under its contracts. The Company also conducts appropriate corrective actions in response to potential violations related to payments or delivery of items or services under those contracts. The Company will similarly ensure that corrective actions are undertaken by FDRs when needed.

The Company's Chief Compliance Officer and Financial Investigations Unit are responsible for investigating any allegations of misconduct related to any products and taking appropriate corrective actions.

The Medicare Compliance Officer or Financial Investigations Unit will maintain documentation for each report of potential FWA received through any of the reporting methods (hotline, mail, or in-person) that summarizes the initial report of noncompliance, the investigation, the results of the investigation, and any corrective and/or disciplinary action(s) taken as a result of the investigation. The Company will voluntarily self-report potential fraud or misconduct related to Medicare or the ACA to the appropriate governing agency, as appropriate.

Corrective actions may include appropriate disciplinary action against employees and/or FDRs, up to and including termination. A corrective action plan template is attached as Exhibit A.

IX. Fraud, Waste, and Abuse (FWA) Plan

The Company's comprehensive FWA plan is designed to prevent, detect, and correct noncompliance with federal and state requirements. The Company accomplishes these measures by:

1. coordinating and cooperating with MEDICs, CMS, and law enforcement, for auditing purposes;
2. responding through the Chief Compliance Officer, or through the Medicare Compliance Office for Medicare Part C and Part D, to reports of potential and actual instances of FWA, including coordinating internal investigations and developing appropriate corrective and disciplinary actions;
3. maintaining documentation by the Chief Compliance Officer for each report of potential FWA received through any of the reporting methods (*i.e.*, hotline, mail, in-person) which summarizes the initial report of noncompliance, the investigation, the results of the investigation, and all corrective and/or disciplinary action(s) taken as a result of the investigation;
4. conducting compliance training that addresses pertinent laws related to FWA, including any applicable training related to specific job functions, as supported by departmental policies and procedures;
5. conducting HIPAA training and education;
6. maintaining procedures for internal monitoring and auditing to test and confirm compliance with the Medicare Parts C and D and ACA benefit regulations, contractual agreements, and applicable federal and state laws, as well as internal policies and procedures to protect against potential FWA; and
7. receiving and reviewing of data reports from the Company's Pharmacy Benefit Manager (PBM), including reports on utilization and claims data.

The Company's Plan also incorporates the following additional elements:

1. Self-reporting: consistent with its Code of Conduct, the Company recognizes the importance of voluntarily self-reporting potential fraud or misconduct related to either Medicare Parts C and D or the ACA to the appropriate government authority.

2. Excluded individuals/entities: the Company recognizes its obligations not to pay for any services that are prescribed or provided by a provider excluded by either the HHS Office of Inspector General (OIG) or General Services Administration (GSA). Accordingly, the Company reviews the OIG List of Excluded Individuals/Entities (LEIE) database and the GSA Excluded Parties List System (EPLS) when new employees are hired to confirm that these lists do not identify any newly hired employees. The Company also reviews the OIG and GSA exclusion lists on a monthly basis to identify any existing

employees, managers, board members, and officers that assist in the administration or delivery of benefits for members of any federally funded programs. In addition, the Company's PBM and FDRs have agreed by contract not to employ or subcontract with any excluded individual, and they agree to review the OIG exclusion file to verify that persons in their employ are in good standing. If any illegal remuneration is identified through auditing, reporting to the Compliance Officer, or otherwise, the Company will take appropriate action.

3. Contracts: the Company's contract with its first tier PBM requires that any services or other activity performed by the PBM in accordance with the contract will comply with the Company's contractual obligations to the governing agency of each program. Any downstream subcontractors must comply with the terms and conditions of the PBM's contract with the Company. If the governing agency or the Company determines that the PBM has not performed satisfactorily under the agreement, either the governing agency or the Company may revoke any of the activities or reporting responsibilities delegated to the PBM by contract.

4. Disclosure: the Company acknowledges its obligation to disclose information to the governing agency regarding any formal actions, reviews, findings, or other similar actions by states, other regulatory bodies, or any other certifying or accrediting organization. Furthermore, the Company agrees to provide notice based on best knowledge, information, and belief to the governing agency of any integrity items related to payments from governmental entities, both federal and state, for healthcare or prescription drug services. This includes any investigations, legal actions, or matters subject to arbitration brought involving the Company and its subcontractors (excluding contracted network providers), including any key management or executive staff, or any major shareholders (five percent or more), by a government agency (state or federal) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. In providing the notice, the Company agrees to keep the government informed of when the integrity item is initiated and when it is closed. The Company will also provide notice based on best knowledge in the event that the Company or any of its subcontractors is criminally convicted, has a civil judgment entered against it for fraudulent activities, or is sanctioned under any federal program involving the provision of healthcare or prescription drug services.

I. Exhibit A: MEDICAL MUTUAL® Corrective Action Plan

Today's Date:		Product Type	FEHP		QHP		Commercial	

Finding				
Issue Date(s):	**Method of Detection:**	**Contact Info or N/A:**	**Issue Description:**	**Issue related to FDR function (Y/N):**

Impact Analysis
Root Cause(s): Be sure to identify true root cause (Ask yourself why the compliance incident occurred multiple times).

Specific Regulation pertaining to issue:	Legal or Financial impact or N/A:	Business areas impacted:	Systemic Issue (Y/N):	Prior Incident (Y/N):	Prior Incident Date(s), Description and/or CAP# or N/A:

Corrective Action Plan (CAP)

CAP must include action(s) taken to remediate systematic issues, outreach to remediate affected members and actions taken to prevent reoccurrence when applicable.

Corrective Action Type: (e.g. P&P update, Training, Mbr Notice, Monitoring)	Corrective Action Taken:	Responsible Person:	Responsible Department:	Date Remediation Initiated:	Date Remediation Completed:

Signature of Submitter:		Date:	
VP signature:		Date:	

For Internal Compliance Use Only				
CAP#	**Date CAP issue Self-reported to ODI, CMS or N/A:**	**Who was the issue reported to at ODI, CMS or N/A:**	**Compliance CAP Review Date:**	**Compliance CAP Review Comments:**

Compliance Reviewer Signature:		Date:	