Banner Health Insurance Division Companies

Compliance Program and Fraud, Waste and Abuse Plan

January 1, 2022 through December 31, 2022

Letter from Leadership

Dear Employees and Business Partners,

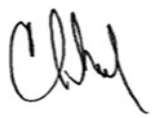
The Banner Insurance Division (BID) which includes Banner Health Network (BHN), Banner Plan Administration (BPA), Banner Network Colorado (BNC), Banner Network Southern Arizona (BNSA), Banner Medicare Advantage Prime, Banner Medicare Advantage Plus, and Banner Medicare Advantage RX (BMA), and Banner-University Family Care/ACC (B-UFC/ACC) and Banner-University Family Care/ALTCS (B-UFC/ALTCS) and Banner Medicare Advantage Dual (BMA-D), are committed to ethical and legal conduct, including meeting the obligations of any governmental health care programs involving the delivery of health care services. BHN, BNC, BNSA, BMA, BMA-D and BPA participate in multiple government programs including: Medicare Advantage; Part D (Prescription Drug Plans, or PDPs), the Center for Medicare & Medicaid Innovation (CMMI) Accountable Care Organizations (ACOs); the Centers for Medicare & Medicaid Services (CMS) while B-UFC/ACC and B-UFC/ALTCS are Medicaid participants.

A key component of our commitment to meeting our obligations under these governmental programs and contractual relationships includes adopting standards that uphold these ethical business principles, which underly this Compliance Program. The Compliance Program is described in several documents including the Code of Conduct, policies and procedures, and the Fraud, Waste, and Abuse Plan. All Banner Health (BH) employees and Governing Bodies must adhere to these Banner principles and First Tier, Downstream, and Related Entities (FDRs), subcontractors and agents (Business Partners) must make a commitment to adhere to the Banner Code of Conduct or adopt one that is comparable. BID does not condone unethical, non-compliant, or criminal conduct by Employees or Business Partners.

Reducing duplication of effort and conflict is important, as the rules governing the healthcare industry are unusually complex. Activities that may be perfectly legal in other industries may be crimes in government programs, and Employees and Business Partners could face penalties for violations of the law. In conjunction with BH, CMS, Arizona Health Care Cost Containment System (AHCCCS), and all government programs, this Compliance Program is integrated into our services to address the Medicare and Medicaid program requirements, as well as overall company ethical activities. By integrating the Compliance Program across these separate BH entities, we link together the various program rules and align any potential differences between the programs to help Banner Employees and Business Partners deal with the complexities of government programs.

Your knowledge of, and dedication to, these standards allow us to serve our customers in a professional, caring, and compliant manner while maintaining the standards of legal and ethical conduct that we have adopted. On behalf of BHN, BPA, BNC, BNSA, BMA, BMA-D and B-UFC, thank you.

Sincerely,



Chuck Lehn
President

Compliance Program
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The Banner Health Insurance Division Companies (BID)

The following companies (hereinafter "BID" except in those instances where a component of this Compliance Program applies to one or some but not all of BID) are all affiliates of Banner Health (BH) and are part of the Banner Health Insurance Division:

- Banner Health Network (BHN)
- Banner Plan Administration (BPA)
- Banner Network Colorado (BNC)
- Banner Network Southern Arizona (BNSA)
- Banner Medicare Advantage Dual (BMA-D)
- Banner University Family Care – AHCCCS Complete Care (B-UFC/ACC)
- Banner – University Family Care – ALTCS (B- UFC/ALTCS) .
- Banner Medicare Advantage Prime,
- Banner Medicare Advantage Plus,
- Banner Medicare Advantage Rx

BH is regarded and recognized as a top health system in the country for the clinical quality consistently provided to patients. BH is deeply committed to its mission: Making health care easier, so life can be better.

In addition, BID, the insurance arm of BH, through contracts with governmental entities as well as through formal contracts with employer groups and multiple managed care organizations, both manages the direct care for members of these organization as well as provides administrative services. Current such arrangements are described below:

Banner Health Network (BHN)

BHN is an ACO that joins Arizona's largest health care provider, Banner Health, and an extensive network of primary care and specialty physicians to provide the most comprehensive health care solutions for Maricopa County and beyond. Nationally known as an innovative leader in value-based models, BHN medical providers can now be fully aligned in collaborative efforts to keep members and beneficiaries in optimal health and reduce costs for employers and individuals.

Banner Network Southern Arizona (BNSA)

BNSA functions as an ACO and was designed to provide a highly- coordinated patient care experience for beneficiaries of government and private sector insurance plans in southern Arizona.

Banner Network Colorado (BNC)

Banner Network Colorado (BNC) functions as an ACO and was designed to provide a highly-coordinated patient care experience for beneficiaries of government and private sector insurance plans in Larimer and Weld counties of Northern Colorado's Front Range.

Banner Plan Administration (BPA)

BPA is a third-party administrator (TPA) licensed in the State of Arizona, providing TPA services for Arizona MAOs and Commercial health plans through contractual arrangements entered into on behalf of BPA by its affiliate, BHN.

Banner--University Family Care – ALTCS (B--UFC-ALTCS)

Banner -- University Family Care, Inc. (B-UFC) is the legal entity that contracts with the Arizona Health Care Cost Containment System (AHCCCS) to arrange for health services through a Medicaid HMO Model. B—UFC/ALTCS is the name B-UFC uses for its AHCCCS Arizona Long Term Care Services (ALTCS) plan.

Banner--University Family Care – AHCCCS Complete Care (B--UFC-ACC)

The Banner--University Family Care, Inc. is the legal entity that contracts with AHCCCS to provide integrated services through a Medicaid HMO Model. Banner--University Family Care – ACC (B—UFC/ACC) is the name B-UFC uses for its AHCCCS Complete Care plan.

Banner Medicare Advantage Dual (BMA-D)

.Banner Medicare Advantage-Dual is the legal entity that contracts with CMS to provide Medicare Advantage/Part D (MAPD) products to dually- eligible Medicaid-Medicare beneficiaries.

Banner Medicare Advantage Plans (BMA)

Banner Medicare Advantage Prime is the name of Banner Health's HMO Medicare Advantage/Part D (MAPD) product.

Banner Medicare Advantage Plus is the name of Banner Health's PPO Medicare Advantage/Part D (MAPD) product.

Banner Medicare Advantage RX (BMA)

Banner Medicare Advantage RX is the name of Banner Health's Prescription Drug Plan (standalone PDP).

The Compliance Program Overview

The primary goal of this Compliance Program is to provide the guidance and oversight that ensures BID's compliance with state and federal law, rules, regulations, and requirements which in turn facilitates improved quality and efficiency of the delivery of healthcare. This includes identifying and correcting inappropriate or illegal conduct to reduce fraud, waste, and abuse (FWA).

The Compliance Program is updated annually, approved, and adopted by BID's Boards of Directors/Managers ("Boards") and BID's Compliance Committees and is applicable to all Insurance Division lines of business. To ensure adoption of the Compliance Program, BID require that all of BID's employees (including managers and directors) and the Boards (these individuals are collectively referred to as "Employees" throughout this document) to adopt and operate in accordance with this Compliance Program. In addition, subcontractors, vendors, participating providers, suppliers, first-tier, downstream and related entities (FDRs), and agents (hereinafter "Business Partners") are required to adopt this Compliance Program or a comparable compliance program. To assure this, all Employees must read, understand, and agree to comply with this Compliance Program and Business Partners must attest to or provide evidence of having a comparable Compliance Program or using BID's program.

While this Program is reviewed annually, any new governmental rule-making or interpretive guidance may require an update. As required, significant changes to the Compliance Program are provided to the appropriate governmental entity for review. Once approved by BID's Boards and Compliance Committees, BID's Compliance Departments will provide Employees and Business Partners who have adopted this Program with any updates. We know this Compliance Program can be complex, so please do not hesitate to contact the Compliance Departments or Compliance Officers listed below if you have any questions regarding information contained in this Compliance Program:

B-UFC/ACC and B-UFC/ALTCS:
Theresa (Terri) Dorazio, Medicaid Compliance Officer
520-874-2847 (Tucson Office) / 520-548-7862 (Cell) / 520-874-7072 (Fax) /
Theresa.dorazio@bannerhealth.com
Office: 2701 E. Elvira, Tucson AZ 85756

BMA-D and BMA:
Adam Barker, Medicare Compliance Officer
(602) 747-8452 (Office) / 602-705-2363 (Cell) / 602-747-3387 (Fax) /
BMAComplianceOfficer@BannerHealth.com
Office: 2901 N Central Avenue, Phoenix, AZ 85012 (North Tower, 3rd floor)

BHN/BPA/BNC/BNSA:
Interim: Kristina Corlette, ACO and First-Tier Compliance Officer
602-747-2431 (Office) / 602-747-3387 (Fax) /
Kristina.Corlette@bannerhealth.com
Office: 2901 N Central Avenue, Phoenix, AZ 85012 (North Tower, 3rd floor)

Laws, Regulations, and Other Requirements

The key laws, regulations, and other requirements which govern this Compliance Program include:

- Statutes and Regulations for Self-funded Employee Health Plans (ERISA)
- Commercial/Employer Group Plans
- CMS' Innovation (CMMI) Programs, including but not limited to Accountable Care Organization (ACO) statutes and regulations such as the Medicare Shared Savings Program (MSSP).
- Statutes, regulations and CMS sub-regulatory guidance for Medicare Part C and D and contractual obligations
- Statutes and Regulations related to the Arizona Medicaid Managed Care program - Arizona Health Care Cost Containment System (AHCCCS) and contractual obligations.
- Statutory Fraud waivers associated with any above programs.

BHN/BNC/BNSA:

BHN, BNSA and BNC apply principles related to those for CMS/CMMI Programs, these can be found in 42 C.F.R. 425 Final Rule and any guidance issued by CMS.

BMA and BMA-D:
BMA and BMA-D apply the Medicare Part C and D guidelines to operate an effective Compliance Program, as applicable. These requirements can be found in the C.F.R., Chapter

42, parts 422 and 423 at: 42 C.F.R. § § 422.503(b)(4)(vi) and 423.504(b)(4)(vi). CMS publishes compliance program guidelines in publication 100-18, Medicare Prescription Drug Benefit Manual, Chapter 9 and in publication 100-16, Medicare Managed Care Manual, Chapter 21.

B-UFC:
B-UFC/ACC and B-UFC/ALTCS apply the principles outlined in the AHCCCS guidelines to operate an effective Compliance Program that meets regulatory requirements. These requirements can be found at 42 C.F.R. 438.608, 455.17, 455.101, 455.104, 455.105 and 455.1(a)(1) as well as in Arizona Revised Statutes (A.R.S.), Section 13-2310. In addition, the Arizona Administrative Code Title 9 Health Services: Chapter 22 AHCCCS – Administration, Chapter 21 AHCCCS – Behavioral Health Services for persons with Serious Mental Illness, Chapter 28 AHCCCS – Arizona Long Term Care System and Chapter 34 AHCCCS – Grievance System provide regulatory guidance. AHCCCS includes requirements in paragraph 58 of its contract with B-UFC/ACC and paragraph 64 of its contract with B--UFC/ALTCS as well as sub-regulatory guidance in the AHCCCS Contractor Operations Manual (ACOM), Chapter 100, Policy 103.

BPA/:
BPA applies all of the above guidelines as relevant to the specific delegated activities that they are performing on behalf of other departments of BID.

Banner Health's Corporate Integrity Agreement:

On April 10, 2018, BH entered into a Settlement. and as part of the settlement, BH also entered into a Corporate Integrity Agreement (CIA) with the U.S. Department of Health and Human Services Office of Inspector General (OIG). The CIA commits all of BH to engage in certain compliance and reporting efforts until 2023. The Insurance Division Companies are subject to compliance with the CIA, which can be found on the OIG website (https://oig.hhs.gov/compliance/corporate-integrity-agreements/cia-documents.asp).

Governance of the Compliance Program

Board Compliance Oversight

BID's Boards delegated to oversee the various lines of business are ultimately responsible for the Compliance Program, including ensuring adherence to all compliance policies and procedures. The Board's oversight includes the following: 1) review and approve the Compliance Program; 2) review and recommend Compliance Program monitoring and auditing activities; and 3) assist with development strategies to promote compliance with the Compliance Program.

Compliance Committees
Key to the Compliance Program are BID's Compliance Committees ("Committees") for the AHCCCS, Medicare, and other government programs lines of business. These Committees are responsible for supporting the Compliance Officers and for reviewing, approving and ensuring implementation of the Compliance Program. They evaluate Compliance Program effectiveness through review of risk assessments, auditing, monitoring of metrics as well as key indicators; and ensuring prompt and effective corrective actions are taken where deficiencies are noted. The Compliance Committees are responsible to BID's senior-most executive leaders and Boards and are responsible for escalating compliance deficiencies and ongoing issues of non-compliance to senior management or leaders, and the applicable Boards.

Senior Management
The Executive Teams recognize the importance of the Compliance Program in BID's success, and all are active members of the Compliance Committees.

Compliance Officers
The Compliance Officers have express authority to meet with BID's applicable Boards and have direct access to BHN's President, B-UFC 's Chief Executive Officer (CEO), BMA-D's CEO, BMA's CEO, BPA's Vice President, BNSA's Director, BNC's Director and BID's senior management. In addition, B—UFC's Compliance Officer has a dotted line report to the Senior Director for Compliance – Insurance Division and the BH Chief Compliance Officer. The Compliance Officers are responsible for escalating compliance deficiencies and ongoing issues of non-compliance to senior management or leaders, and the applicable Boards. Finally, the Compliance Officers reserve the right to amend and update components of this Compliance Program at any time and to make changes based on regulatory guidance or to enhance the program to improve effectiveness.

The Compliance Program Components

BID is required to adopt and implement an effective Compliance Program which must include measures to prevent, detect, and correct Federal and State Government program non-compliance, as well as FWA. This Compliance Program includes the following components:

Component 1: Written Policies, Procedures and Standards of Conduct
Component 2: Compliance Officer, Compliance Committee, and High-Level Oversight
Component 3: Effective Training and Education
Component 4: Effective Lines of Communication
Component 5: Well-Publicized Disciplinary Standards
Component 6: Effective System for Routine Monitoring and Identification of Compliance Risks
Component 7: Procedures and System for Prompt Response to Compliance Issues
Component 8: Fraud, Waste, and Abuse Plan

In order for this Compliance Program to be effective it must be fully implemented, including a written document which outlines all aspects of the Compliance Program, and explains how each component above will be carried out and tailored to BID's unique organization, operations, and circumstances. BID dedicates adequate resources to support an effective Compliance Program.

While BID may delegate certain administrative or health care services to FDRs, they do not delegate the Compliance Program or high-level compliance functions (e.g., Compliance Officer, Compliance Committee, compliance reporting to senior management, etc.) to FDRs. BID may use FDRs for lower-level compliance activities such as monitoring, auditing, and training. However, BID maintains the ultimate responsibility for fulfilling terms and conditions of its government program contracts, and for meeting government program requirements.

Component 1: Written Policies, Procedures and Code of Conduct

Written Policies and Procedures

BID expects Employees to behave in a manner that demonstrates a strong commitment to comply with all federal and state regulations, standards, and sub-regulatory guidance. BH and BID's policies and procedures are the infrastructure which supports the Code of Conduct

standards described below and demonstrate to Employees the commitment to operating in an appropriate and compliant manner. They also providing direction to reach compliance with federal and state laws, regulations, rules, and requirements, and to reduce potential FWA.

BH maintains a central electronic repository of policies and procedures so that Employees can know and understand their individual responsibility for compliant and ethical business. BID's policies and procedures are reviewed and revised at least annually or more frequently if there are changes in regulatory requirements or business needs.

BID utilizes BH corporate policies and procedures to address over-arching protocols, processes, or activities, such as in the areas of Ethics & Compliance, Privacy, Human Resources, and Information Technology. In addition, BID has policies and procedures which are created within departments or department units to address specific contractual obligations. These policies are managed by dedicated Employees who follow the BH processes in the development, writing, approval, storage, and reevaluation.

Finally, BID's Business Partners, including FDRs and their employees, are provided with access to key policies and procedures in provider manuals on BID's websites and upon request.

Code of Conduct (attached hereto as AddendumA)

As a subsidiary of BH, BID has adopted BH's Code of Conduct. BH's Code of Conduct states the over-arching principles and standards by which BID operates and defines the underlying framework for the compliance policies and procedures.

This Code of Conduct provides the standards by which Employees will conduct themselves, in order to protect and promote organization-wide integrity, ensure adherence to BID's values, and enhance the organization's ability to achieve its mission. BID's Employees from the top to the bottom of the organization have the responsibility to perform their duties in compliance with laws, regulations, and are expected to report issues of suspected non-compliance or potential FWA and all reported issues will be promptly reviewed and addressed.

Business Partners are also expected to either adopt the BH Code of Conduct or a comparable one and to report issues of non-compliance and potential FWA through the appropriate methods. All reported issues will be promptly reviewed and addressed.

The Banner Health Code of Conduct is made available to FDRs on the applicable Compliance website.

Fraud and Abuse Regulations and Laws

Entities that accept reimbursement for services provided to Medicare and Medicaid patients/beneficiaries or members such as BID, are subject to several laws and regulations designed to prevent fraud. Listed below are several applicable laws and regulations including:

- Title XVIII of the Social Security Act;
- Medicare Regulations Governing Parts C and D found at 42 C.F.R. § § 422 and 423 respectively;
- Patient Protection and Affordable Care Act (Pub. L. No 111-148, 124 Stat. 119);
- Health Insurance Portability and Accountability Act (HIPAA) (public Law 104-191);
- False Claims Acts (31 U.S.C. § § 3729-3733);
- Federal Criminal False Claims Statutes (18 U.S.C. § 287.1001);
- Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)) and any associated waivers;

- The Beneficiary Inducement Statute (42 U.S.C. § 1320a-7a(a)(5)) and any associated waivers;
- Civil Monetary Penalties of the Social Security Act (42 U.S.C. § 1395w-27(g)) and any associated waivers;
- Physician Self-Referral (Stark) Statute (42 U.S.C. § 1395nn) and any associated waivers;
- HIPAA Privacy and Security Provisions, as modified by HITECH Act and the Omnibus Rule;
- Prohibitions against employing or contracting with persons or entities that have been excluded or precluded from doing business with the Federal Government (42 U.S.C. § 1395w-27(g)(1))(G);
- Fraud Enforcement and Recovery Act of 2009;
- All sub-regulatory guidance produced by CMS and HHS such as manuals, training materials, HPMS memos, and guides;
- □ Waivers promulgated for Value-based or CMMI projects;
- CMS Preclusion List (CMS 4185-F [RIN 0938-AT59); and
- Federal criminal law.

These laws were created to ensure that the federal funds intended to finance Medicare and Medicaid are used only for that purpose. Some of the most important of these laws are discussed below:

Federal and State False Claim Acts

The Federal False Claim Act (FCA) makes it a crime for any person or organization to knowingly create a false record or file a false claim with the government for payment. A false claim is an attempt to obtain payment by presenting false or misleading information related to the claim. "Knowing" means not only actual knowledge of the falsity of the information but also deliberate ignorance or reckless disregard for the truth or falsity of the information. No specific intent to defraud the government is required.

Examples of possible false claims in the healthcare context include, but are not limited to the following:

- Billing for services or supplies that were not provided;
- Misrepresenting services actually provided such as assigning a code for a more complicated procedure than actually performed (upcoding);
- Dividing a procedure or service typically billed as one procedure into multiple parts (unbundling);
- Duplicate billing for services rendered;
- Falsely certifying that services were medically necessary;
- Falsely certifying that an individual meets the Medicare requirements for home health or any other service;
- Providing services that were not ordered by a physician or another provider; and
- Billing for services that were provided at a sub-standard quality.

Penalties are severe for violating the FCA. Individuals and entities are subject to significant civil penalties per false claim (adjusted annually for inflation), plus three times the value of the false claim. Violation of the FCA may also lead to exclusion from participation in Federal healthcare programs. Health care providers who are convicted of violating the FCA can be subject to civil monetary penalties.

A person called a relator (or whistleblower) who knows that a false claim was filed for payment can file a lawsuit in Federal court on behalf of the government and, in some cases, receive a percentage of the money recovered. The FCA protects a relator from being fired, demoted,

threatened, or harassed by their employer for filing a FCA lawsuit. In addition, states may also have their own “false claims acts.”

Anti-Kickback Statute
The Anti-Kickback Statute (AKS) is a criminal statute that prohibits knowingly and willfully offering, paying, soliciting, or receiving anything of value, in cash or in kind, to induce referrals for items or services for which payment may be made under a Federal healthcare program including Medicare and Medicaid. This law applies to relationships among various providers – not just physicians and hospitals.

Safe harbors to the prohibitions set forth in the AKS do exist, and they are managed in consultation with the BH Legal Department or the Ethics & Compliance Department. If a job involves these issues, BH employees must consult the Legal Department or the Ethics & Compliance Department.

Prohibition of Physician Self-Referrals (commonly called the Stark law)
Generally, a physician (which is broadly defined to include chiropractors, podiatrists, family members and more) who receives payment directly or indirectly from, or has an investment interest in, a healthcare business such as a BH hospital or clinic may not refer patients to that business for services for which Medicare will pay unless the arrangement qualifies for exception from the prohibition of physician self-referrals. Several exceptions/waivers exist, and any potential relationship must be reviewed and approved in advance by BH’s Legal Department.

Government Relations and Political Activities/Contributions

BH must comply with all Federal, State, and local laws governing participation in government relations and political activities. See above identified policy.

Additional Code of Conduct Requirements for BID

In addition to the BH Code of Conduct standards listed above, BID is committed to complying with additional Code of Conduct standards, including:

Gifts to Public Officials
Federal law makes it a crime to give, offer, or promise anything of value to any public official for or because of any official act performed or to be performed by such official. It is also a federal crime to make any payments to public employees, made on account of or as compensation for public duties.

Payments to Agents and Consultants
Agreements with Business Partners (including agents or FDRs) must be in writing. Such agreements must clearly and accurately set forth the services to be performed, the basis for earning the commission or fee involved, and the applicable rate or fee. Any such payment must be reasonable in amount, not excessive in terms of industry practices, not exceed any applicable statutory or regulatory maximums, and be commensurate with the value of the services rendered.

Other Improper Payments (applicable to Medicare Advantage Prescription Drug (MAPD) Plans and Prescription Drug Plans (PDPs)) The use of MAPD plan funds or assets for any unlawful or unethical purpose is prohibited by an Employee, agent, or FDR on behalf of the MAPD plans. The making of any payment to a third party for any purpose other than that disclosed on the payment documentation is also prohibited.

Federal Procurement Integrity Act

BID's Medicare lines of business are subject to the Federal Procurement Integrity Act when bidding on federal contracts. This law prohibits certain business conduct for companies seeking to obtain work from the Federal Government. During the bidding process, Employees may not:

- offer or discuss employment or business opportunities at BID with agency procurement officials;
- offer or give gratuities or anything of value to any agency procurement official; or
- seek or obtain any confidential information about the selection criteria before the contract is awarded.

In addition, other federal provisions prohibit federal officials from accepting anything of value, (subject to reasonable exceptions) such as modest items of food and refreshments. Because of these restrictions, no Employees shall either offer or make a gift to a federal employee.

Cooperate with All Investigations

BH expects truthful and honest responses from Employees when participating in internal investigations, external agency reviews, audits, investigations, or legal demands. BH cooperates with any audit, inspection, investigation, or evaluation any records, books, contracts, documents, other evidence, or facilities. During a government investigation, all policies enabling the destruction of documents shall be suspended until the Entity/Facility Compliance Officer has reinstated the policies. If a subpoena or other legal document (such as a Civil Investigative Demand) from any government agency is received, the manager shall contact the Entity/Facility Compliance Officer.

It is against policy and a violation of the law to prevent, obstruct, mislead, delay, or attempt to prevent, obstruct, mislead, or delay the communication of information or records to a government investigator[1]. Employees who knowingly and willingly falsify, conceal, or cover up, by a trick, scheme, or device, a material fact or make any false statements or fraudulent representations to a federal agency may be subject to fines, imprisonment or both[2].

BID is prepared to demonstrate its compliance program upon request by AHCCCS, CMS, DHHS, OIG, the Comptroller General, the State or Federal Government, other government programs, or designees. BID will allow reasonable access to Employees and records and requires Business Partners to comply to these governmental requests as well.

The CMS/CMMI Program ACO contracts with CMS require that their providers/suppliers participate and fully cooperate in any audits conducted by CMS, DHHS, OIG, or the Comptroller General and CMS reserves the right to recalculate the amount of shared savings or shared losses when applicable.

BH Employees approached by someone stating they are a government agent, should attempt to confirm the representative's authority and must immediately notify their managers. The manager will immediately notify the Entity/Facility Compliance Officer who will determine the legitimacy and scope and establish the proper procedures for cooperating with the investigation.

[1] 18 U.S.C. § 1518
[2] 18 U.S.C. § 1518

Individuals may agree, or refuse to talk, with a government investigator and recognize that they have the right to seek legal counsel before responding to any questions. In all cases, it is imperative to tell the truth.

Retention of Records

BH has established a policy and procedure for the appropriate use, maintenance, retention, and destruction of BH records that conforms to the most stringent requirements from the federal and state obligations.

Specifically, for AHCCCS, BID must maintain records as follows:

BID shall maintain records relating to covered services and expenditures including reports to AHCCCS and documentation used in the preparation of reports to AHCCCS. BID shall comply with all specifications for record keeping established by AHCCCS. All records shall be maintained to the extent and in such detail as required by AHCCCS rules and policies. Records shall include, but not be limited to, financial statements, records relating to the quality of care, medical records, prescription files, and other records specified by AHCCCS.

BID shall preserve and make available all records for a period of five years from the date of the final payment under the AHCCCS contract unless a longer period is required by law or by Banner policy. In the event of a contract termination or expiration of a contract with AHCCCS, B-UFC/ACC and B-UFC/ALTCS will retain, preserve, and make available records within the timeframes required by state, federal law and shall make available, at all reasonable times during the term of the AHCCCS contract, any of its records for inspection, audit, or reproduction by any authorized representative of AHCCCS, State or Federal Government. BID shall be responsible for any costs associated with the reproduction of the requested information.

BID shall comply with the federal record keeping requirements shall comply with the record retention periods specified in HIPAA laws and regulations including, but not limited to, 45 C.F.R. 164.530(i)(2) and in 42 C.F.R. 438.3(u) and retain such records for a period of no less than 10 years.

For retention of patient medical records, B-UFC shall ensure compliance with A.R.S. 12-2297 which provides, in part, that a health care provider shall retain patient medical records according to the following:

1. If the patient is an adult, the provider shall retain the patient medical records for at least six years after the last date the adult patient received medical or health care services from that provider.
2. If the patient is under 18 years of age, the provider shall retain the patient medical records either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received medical or health care services from that provider, whichever date occurs later.

The language is contained in provider contracts for B-UFC and in the provider manual.

Business Partners Written Policies and Procedures

BID requires that delegated Business Partners maintain policies and procedures that meet or exceed BID' policies and procedures and are compliant with AHCCCS, CMS, and government program rules, regulations, or requirements. BID will audit delegated Business Partner's policies

and procedures to ensure compliance as outlined in Component 6: Effective System for Routine Monitoring and Identification of Compliance Risks.

Component 2: Compliance Officer, Compliance Committee, and High-Level Oversight

The Compliance Officers serve in an independent role as the primary focal points for BID's compliance activities. The Compliance Officers have primary responsibility for overseeing and monitoring the Compliance Program implementation as well as monitoring that all policies and procedures are accurate and integrated into BID's operations. Coordination and communication of compliance activities are key functions of the Compliance Officer.

The Compliance Officers are full-time employees, and the Compliance Officer for B-UFC must reside in the State of Arizona. The Compliance Officers are not legal counsel to the CMS/CMMI Program ACO or a CMS/CMMI Program ACO provider/supplier, and they have the ability to report directly to BHN's President, BMA's CEO, BNSA's Director, BNC's Director, BPA's Vice President (VP) Administrative Services Organization (ASO) Administrator, BMA-D's and B-UFC 's CEO. In addition, they have express authority to provide unfiltered, in-person reports to BID's Boards at the Compliance Officer's discretion.

The Compliance Officers and Compliance Committees must periodically report directly to the Boards on the activities and status of the Compliance Program, including issues identified, researched, and resolved by the Compliance Program. However, the Compliance Officers need not await approval of the Board to implement needed compliance actions and activities.

Compliance Officer Responsibilities

BID has written criteria for selecting the Compliance Officers. The Compliance Officers have job descriptions that clearly outline the responsibilities and authority of the positions, which includes:

- Being a Banner employee.
- Involvement with the day-to-day operations of the compliance program and business operations
- Defining the Compliance Program structure, educational requirements, reporting and complaint mechanisms, response and correction procedures, and compliance expectations for all Employees and Business Partners.
- Overseeing and monitoring the implementation of the Compliance Program.
- Ensuring Employees and Business Partners have access to the Compliance Program.
- Answering Employees and Business Partner questions concerning compliance issues.
- Ensuring that the most current government directions are periodically reviewed and reflected in the Compliance Program and/or Code of Conduct or BID policies.
- Ensuring the annual Compliance Program is reviewed and approved by the Compliance Committee and Boards.
- Ensuring distribution of annual Compliance Program to all relevant Employees and made available to the Business Partners.
- Holding periodic meetings with BID's management teams.
- Providing regular compliance reports to relevant Senior Leaders, Boards, and Compliance Committees.
- Ensuring procedures are in place to screen monthly for ineligible or precluded providers, Employees and Business Partners.

- Coordinate any personnel issues with BID Human Resources, Security, Legal or other departments as appropriate.
- Developing, presenting or ensuring compliance training is provided to Employees and made available to Business Partners.
- Creating policies, reporting procedures, programs, and communication materials that are well-defined and published which encourage all Employees and Business Partners to report program non-compliance and suspected FWA and other improprieties without fear of retaliation.
- Reviewing and acting on compliance issues and directing internal investigations and any subsequent corrective measures with all relevant parties, including but not limited to FWA issues.
- Maintaining the compliance reporting mechanism and accurate documentation and closely coordinating with Internal Assurance and Employees.
- Recommending policy, procedure, and process changes.
- Conducting and/or directing oversight of FDRs.
- Conducting and/or directing audits of any area or function.
- Overseeing the creation and monitoring of the implementation of corrective action plans (CAPs).
- Interviewing employees and other relevant individuals regarding compliance issues.
- Reviewing company contracts and other documents pertinent to the Medicare and Medicaid programs or other government programs.
- Independently seeking advice from legal counsel.
- Reporting potential FWA to CMS, AHCCCS, its designee, other government programs, applicable MAO, or law enforcement.

Compliance Committees

The Compliance Officers chair the various Compliance Committees, and each Committee must include the associated entity's senior-most leadership in addition to management and personnel from key functional areas including auditors and others from various departments within the organization who understand the vulnerabilities within their respective areas of expertise.

The Compliance Committees will advise the Compliance Officers and assist in implementing the Compliance Program. Compliance Committee members should include individuals with a variety of backgrounds and reflect the size and scope of relevant entity. Members should have decision-making authority in their respective areas of expertise.

The Compliance Committees will assist the Compliance Officers in monitoring, reviewing, and assessing the effectiveness of the Compliance Program and timeliness of reporting and has the following responsibilities with respect to compliance activities:

- Ensuring effective processes to detect, correct, and prevent noncompliance.
- Ensuring a system for Employees and Business Partners to ask compliance questions, raise concerns, and report potential cases of FWA and non-compliance in a timely manner confidentially or anonymously (if desired), without fear of retaliation.
- Ensuring appropriate, up-to-date compliance policies and procedures addressing Compliance Program components.
- Periodically reviewing the training plans and completion data.

- Ensuring relevant standards of conduct and policies.
- Ensuring the development of internal systems and controls designed to ensure compliance as a part of daily operations.
- Assisting in developing strategies to promote compliance and detecting any potential violations.
- Approving a system to solicit, evaluate, and respond to complaints and problems.
- Reviewing and addressing reports of monitoring and auditing.
- Reviewing, assisting, and monitoring for effective corrective and preventive action plans.
- Assisting in development of innovative ways to implement appropriate corrective and preventive action.
- Ensuring compliance with applicable regulations regarding self-reporting of identified compliance issues.
- Approving the Compliance Program and FWA Plan, compliance risk assessment and the compliance monitoring and auditing work plans.
- Supporting the Compliance Officers' needs for sufficient Employees and resources.
- Ensuring a method for members to report potential FWA.
- Providing regular and ad hoc reports on the status of compliance with recommendations to BID's Boards.

High-Level Oversight

BID's Boards must be knowledgeable about the content and operation of the Compliance Program and conduct reasonable oversight with respect to the implementation and effectiveness of BID's Compliance Program. When compliance issues are presented to the Board, it makes further inquiry and takes appropriate action to ensure the issues are resolved.

BID's Boards receive training and education as to the structure and operation of the Compliance Program. The Boards are knowledgeable about compliance risks and strategies, understand the measurements of outcome, and are able to gauge effectiveness of the Compliance Program.

Board oversight includes:

- Approving the Standards of Conduct, Compliance Program and FWA Plan and Audit Work Plan.
- Understanding BID's Compliance Program structure.
- Remaining informed about Compliance Program outcomes, including results of internal and external audits.
- Remaining informed about governmental, contractor, or MAO compliance enforcement activity such as Notices of Non-Compliance, Warning Letters and/or more formal sanctions.
- Receiving regularly scheduled, periodic updates from the Compliance Officer and Compliance Committee.
- Reviewing the results of performance and effectiveness assessments of the Compliance Program.

The Boards review measurable evidence that the Compliance Program is detecting and correcting government program non-compliance on a timely basis. BID takes steps to ensure that CMS or government programs can validate, through review of Board meeting minutes or other documentation, the active engagement of the Boards in the oversight of the Compliance Program.

BHN's President, the CEOs of BMA, BMA-D, and B-UFC, BNSA's Director, BNC's Director, and the BPA VP ASO Administrator, as well as senior management are highly engaged in the Compliance Program and receive periodic report regarding risks, strategies to address them and the results

thereof. The Executive Teams recognize the importance of the Compliance Program in BID's success and are also advised of all governmental and contractor compliance enforcement activity. In addition, the senior-most leaders and Executive Teams ensure that the Compliance Officers are integrated into the organization and are given the credibility, authority, and resources to operate a robust and effective Compliance Program.

Component 3: Effective Training and Education

Training and education of Employees, which includes all employees, managers, and directors, and, when relevant, Business Partners, discussed below is an important component of BID's Compliance Program. Employees will receive standard training regarding the organization and its adherence to federal and state statutes and requirements and ongoing communication information to Employees regarding compliance issues.

Compliance training and education is required of all new Employee hires and temporary employees within 60 days of initial hiring and annually thereafter unless extended by official governmental action. All employees receive education on the federal laws, administrative remedies for false claims and statements, any state laws relating to civil or criminal penalties for false claims and statements, and the whistleblower protections under such laws. Employees providing services under AHCCCS or BMA-D contracts may have additional training sessions and are required to attest that they have received, read, understood, and will apply materials describing various laws, regulations, and policies.

BID's managers are responsible for ensuring that Employees have completed all required compliance training. Required training courses are delivered via classroom sessions or electronically via BH's web-based MyHR Learning (Learning) for Employees.

Completion of mandatory training is tied to each employee's annual performance goals. Failure to complete required training will result in performance actions, possibly including termination of employment.

Formal Specialized Training Programs

Employees will receive specialized training based on their roles, responsibilities, and job functions within BID. These include the following:

- Written copies of relevant laws, regulations, guidance, policies/procedures, and guidelines regarding activities conducted by that Employee or that Employee's department as well as access to AHCCCS or CMS resources.
- Specialized trainings that are applicable to daily work performance and responsibilities may be based on a new or changing regulation or business requirement, or an area that has been identified as a potential risk or for which a CAP has been issued.

BID's Employees are required to complete all assigned training modules and/or read the assigned materials and must sign (attest) that they have received, read, and understand the training.

Training sessions, including attendance sheets and test scores, will be maintained for a period of 10 years.

FDR Compliance and FWA Training

All FDRs must, at a minimum, complete compliance requirements mandated by governmental requirements and are required to attest, upon request.

For BMA-D and BMA:
These lines of business have General Compliance and FWA training on their websites or the FDR must complete a comparable training. For FDRs that provide services for Medicare Members, they must attest upon request that all employees engaged in the administration of Medicare Part C and D benefits have satisfied the CMS compliance requirements as outlined in the FDR Oversight programs. BMA-D also has additional training related to the CMS Model of Care.

For BNSA/BHN/BPA: Please see the Medicare Advantage Annual Compliance Oversight Policy and Procedure.

For B-UFC:
B-UFC has General Compliance and FWA training on its websites. FDRs will have an option to take this training or a comparable training. FDRs will be required to complete an attestation and submit it to B-UFC indicating that the employees have satisfied the training requirement. For FDRs under the Medicaid lines of business, the following are required training elements:

a. Detailed information about the federal False Claims Act;
b. The administrative remedies for false claims and statements;
c. Any state laws relating to civil or criminal liability or penalties for false claims and statements; and
d. The whistleblower protections under such laws.

Documentation of FDR internal training can be provided in a variety of ways and the applicable BH Department tracks completion of training by FDRs as per policy.

BID maintains ongoing communication and distributes information to Business Partners regarding compliance issues, in order to reflect the most recent and accurate information available regarding applicable federal and state laws and regulations.

Component 4: Effective Lines of Communication

Creating a culture of compliance throughout the organization is an important strategic goal for BID. One element is establishing and implementing effective lines of communication, and ensuring confidentiality between the Compliance Officers, members of the Compliance Committees, Employees, and Business Partners (especially FDRs). BID regularly communicates the importance of complying with regulatory requirements and reinforcing BID's expectations of ethical and lawful behavior. Information communicated includes the Compliance Officers' names, office locations and contact information (see below), laws, regulations, guidance, the Code of Conduct, and policies/procedures for Employees and when applicable, Business Partners.

Employees and Business Partners are free to communicate their concerns to the Compliance Officers via phone call, email, in-person report, mail, or fax (see below) or to any member of the Compliance Committees. The methods available for reporting compliance or FWA concerns and

the non-retaliation policy is publicized via policies/procedures, posters, the Compliance Program, Compliance Week, training programs, and specific BID intranet and websites for all lines of business. BID established systems to receive, record, and respond to compliance questions or reports of potential or actual noncompliance from Employees or Business Partners or Plan members/beneficiaries.

To further ensure effective lines of communication between BID and FDRs, members of the Compliance Department participate in recurring Joint Operations Committee (JOC) meetings between BID and delegated FDRs. In addition, BID provides the FDRs with access to their websites and a compliance attestation is sent annually. Both are resources for the FDRs that communicate BID's expectations including reporting non-compliance issues.

Any reports from Employees, Business Partners, and enrollees received through any channel of communication of a potential or observed violation will be documented and investigated promptly by the Compliance Departments to determine authenticity and significance. This information is then reviewed by the Compliance Officers and reported to the Compliance Committees and the applicable BID Boards and documented in Compliance Committee and Board minutes.

Communication Options

An open line of communication is critical to the success of the Compliance Program and multiple lines of communication are accessible to all Employees or Business Partners. Business Partners per their contracts, are expected and encouraged to report any actual or suspected violation of the laws or regulations relating to Medicare, AHCCCS, government program, or any other state or federal law.

Concerns can be reported to an Employee's supervisor or to the Compliance Officers via phone call, email, in-person report, mail, or fax (see below for contact information) or via the ComplyLine at **1-888-747-7989** / **https://bannerhealthcomplyline.ethicspoint.com**. Concerns can also be reported to BHN's President, The CEO of BMA, BMA-D or B-UFC CEO, BNC or BNSA's Director, or BPA's VP ASO Administrator.

Any Employee who is aware of a violation of the law or regulation and does not report it, or who is not aware of a violation of a law or regulation that should have been detected, is subject to disciplinary action, up to and including termination of employment or relationship with BH. Business Partners who do not report a violation of the law or regulation may be subject to sanctions or termination of their contract.

ComplyLine for Reporting Potential Misconduct

All calls to the ComplyLine are confidential and reviewed by BH Corporate Compliance or the relevant Compliance Officers or designee. BH tracks calls to the ComplyLine to ensure proper research and resolution and to identify patterns and opportunities for additional training or corrective action.

- All Banner Health Employees or Business Partners who want to report potential misconduct can use the contracted toll-free ComplyLine number at **1-888-747-7989** or online at **https://bannerhealthcomplyline.ethicspoint.com** to confidentially and anonymously report potential or observed violations of BH or BID's compliance policies, suspected CMS/CMMI Program ACO problems, or federal or state requirements. BID will make every reasonable effort to maintain the anonymity of any Employees or Business Partner who reports suspected or observed misconduct, but are informed there may be some circumstances

under which it is necessary to disclose the reporter's identity. Reports and questions can also be directed to BID' management teams, senior leaders or the Compliance Officers.

- In addition, enrollees, Employees, or other individuals who want to report potential or observed misconduct or potential FWA can contact the Customer CareCenter.
- Providers who want to report potential observed misconduct or potential FWA should contact the Provider Experience Center at 1-800-827-2464 or via email at ProviderExperienceCenter@bannerhealth.com, the toll-free ComplyLine number at **1-888-747-7989** or online at **https://bannerhealthcomplyline.ethicspoint.com**, the relevant Compliance Officers, or the applicable Senior Leader. They can remain anonymous if they wish but are informed their identity may need to be revealed during the investigation.

Compliance Resources

Please see above page 4 for direct compliance contact information.

If you are unsure about whom to contact with a compliance-related question or issue for these activities, or if you receive a response you do not consider adequate, you may contact the Compliance Department in confidence using one of the following methods:

	**U.S. Mail:** Banner Medicaid and Medicare Health Plans Compliance Dept. 2701 E. Elvira Road Tucson, AZ 85756 Banner Health Ethics and Compliance Department 2901 N. Central Ave., Ste 160 Phoenix, AZ 85012	**Interoffice Mail:** Compliance Dept. Elvira Road, Tucson Ethics and Compliance Dept. Phoenix Plaza, North Tower, 3rd Floor
	**Email:** BHPCompliance@bannerhealth.com BHNCompliance@bannerhealth.com	**Secure Fax:** (520) 874-7072 (602) 747-3387

Component 5: Well-Publicized Disciplinary Standards

As noted earlier, BID has published the BH Code of Conduct, which articulates: 1) expectations for reporting compliance issues and how Employees and Business Partners will be assisted in issue resolution; 2) the requirement that Employees and Business Partners identify noncompliance and unethical behavior; and 3) stipulates BH and BID's policy on non-retaliation for reporting suspected noncompliance. Employees and Business Partners are required to comply with the BH Code of Conduct or a comparable one, and to report any situation where Employees or Business Partners believes illegal, unethical, or noncompliant conduct may have occurred.

FDRs must comply with the Code of Conduct or demonstrate that the FDR has implemented a similar Code of Conduct. BID take the Code of Conduct seriously and will immediately

investigate and take disciplinary action if anyone violates the Code of Conduct, BH or BID' policy or the law.

Enforcing the Code of Conduct

BH and BID policies provide specific instructions for handling reports of potential violations of policies, rules, regulations, or law. Any Employees or Business Partner who identifies a potential violation of policy or law, non-compliance, or unethical behavior is required to report the matter to their supervisor, manager, director, Compliance Officer as per above. or the senior-most executive leader.

BID does not tolerate retaliation. No Employees or Business Partner may discriminate or retaliate against another Employees, Business Partner, or member/beneficiary who has, in good faith, complied with the requirements of the Compliance Program by reporting his or her concerns to a supervisor, manager director, the Compliance Officer as per above.

Publicizing Disciplinary Guidelines

BID provides guidance and education about disciplinary action against any Employees and Business Partners who fail to comply with BID's Code of Conduct, policies and procedures, federal and state health care program requirements, and laws, as well as those who have engaged in wrongdoing. BID will enforce disciplinary policies consistently.

Business Partners are made aware of these obligations through contractual language and FDR Oversight plan activities.

Employment of and Contracting with Ineligible Persons

BID will not delegate substantial authority to make decisions to entities that it knows, or should have known, have a propensity to engage in inappropriate or improper conduct. BID's organizational policies prohibit hiring or entering into contracts with individuals or entities who have been recently convicted of a criminal offense related to health care, or who are listed as debarred, suspended, and excluded, or are ineligible for participation in federal health care programs, or lawfully prohibited from participating in any public procurement activity, or from participating in non-procurement activities.

Exclusion Screening:
BH and BID conduct exclusion screening prior to hire or contracting and monthly thereafter of all Employees and Business Partners to verify if they appear in databases directed by AHCCCS, CMS, or government programs. BID requires that any FDR also conduct this sanction screening as outlined above.

Preclusion Screening:
The Preclusion List from CMS is a list of providers and prescribers who are precluded from receiving payment for Medicare items and services or Part D drugs furnished or prescribed to Medicare members. BH reviews the Preclusion List monthly for listed providers and prescribers and takes appropriate actions.

FDRs must have policies and procedures that prohibits employment, payment or contracting with practitioners (or entities that employ or contract with such practitioners) that are precluded from

receiving Medicare funds. Applicable FDRs are required to review the Preclusion List monthly post receipt of from a Medicare Advantage Plan and take action as appropriate.

BMA-D and BMA shall provide the List to their applicable contracted FDRs.

Enforcing Disciplinary Standards

BID enforces disciplinary standards in a timely, consistent, and effective manner when non-compliance or unethical behavior is determined, and the Compliance Program includes several key policies that impact those Human Resources operations and activities.

To assure compliance, the BH Human Resources Department periodically reviews records of discipline to ensure that disciplinary actions are appropriate to the seriousness of the violation, fairly and consistently administered, and imposed within a reasonable timeframe.

Component 6: Effective System for Routine Monitoring and Identification of Compliance Risks

An ongoing evaluation process is critical to having a successful Compliance Program. The Compliance Program incorporates ongoing internal monitoring and auditing activities, regular reporting of audit outcomes to the Compliance Officers, BID' executives, the applicable Compliance Committees and Boards, and implementing corrective actions as necessary to improve contract compliance and operational excellence. This process of BID's self-identification and corrective action along with monitoring the effectiveness of the corrective action is a key component of the Compliance Program.

Annual compliance risk assessments are conducted to identify areas of risk within BID. From this activity, the audit programs, monitoring, and other Compliance Program activities are developed. General auditing and monitoring of BID operations is done utilizing BID's established metrics drawn from applicable regulatory standards. The audit and monitoring activities then identify areas that require corrective action.

Auditing and monitoring activity also include oversight of administrative activities that BID has delegated to an FDR to ensure FDR's compliance with all federal and state laws and regulations.

General Auditing and Monitoring Process

BID's general auditing and monitoring procedures include, but are not limited to, the following components:

Risk Assessment
While a risk assessment is required for the Medicare line of business, BID conducts an annual risk assessment for all lines of business. In addition, the Compliance Departments continuously review the risk assessment to ensure that BID can respond to new issues that arise. The Compliance Officers, members of the applicable Compliance Committees, Board members and additional Employees may participate in the risk assessment process. Once the process is completed, the identified items are ranked to determine areas within the organization at greatest risk. BID will document their annual risk assessment activities, findings and any corrective or preventive actions adopted. The annual risk assessment will utilize data and information from a variety of sources including, but not limited to:

- Government program guidance;
- Compliance actions from CMS or AHCCCS;
- Complaints;
- Management survey and/or applicable leader and Employees interviews;
- Secret shopper issues and findings identified by CMS/AHCCCS;
- Audit findings;
- CAP monitoring; and
- New operational systems or practices.

The results of the risk assessments drive the development of the annual audit work plans for oversight audits. These may be modified based on issues that arise within BID during the execution of the annual audit work plans. The audit work plans include:

- Audits to be performed;
- Audit schedules, including start and end dates;
- Audit description;
- Audit rationale;
- Person(s) responsible;
- Description of deficiencies and if required Corrective Action;
- External audits contractually required by federal and state agencies; and/or
- Tracking Compliance Monitoring Activities.

Insurance Division Audit

The Compliance Department has implemented an audit function, which includes adequate and dedicated audit Employees responsible to perform quality audits as part of overall program to identify and reduce risk and ensure compliance. Employees dedicated to the audit function are knowledgeable about operational requirements for the areas under review and are independent and do not engage in self-policing. BID's audit processes of all functional areas may include scheduled, unannounced, or spot check audits.

The auditor provides a summary report of audit results to applicable BID departments including any findings of noncompliance. If non-compliance is identified, a corrective action is issued to the Department which is required to submit a Corrective Action Plan (CAP). The Department's CAP must identify the root cause, explain how correction will be implemented, how the solution will be verified as effective, and how the Department will monitor its performance to ensure the deficiency is unlikely to reoccur. As applicable, the Compliance Departments also validate all completed CAPs and collect monitoring activities to ensure the intended result was achieved. Overall reporting of audit activities and results are provided to the applicable BID Operational Area Leaders, Compliance Committee and Board.

BH Internal Assurance

In addition, BH has an Internal Assurance department that performs audit activities and the Compliance Audit team, and the Internal Assurance Audit team collaborate regularly.

Insurance Division Department Monitoring

Departments are required to conduct monitoring to measure performance against CMS, AHCCCS, government program, and/or DOL/ADOI requirements. Monitoring results are reported along with other compliance metrics to BID's Leadership. Medicare Internal Monitoring and CAPs are reported to the applicable Compliance Committees and Boards.

Other Compliance Activities

Based on the risk assessment, other compliance activities such as training and other activities are identified and are made part of the annual Compliance plan to supplement the audit and monitoring activities. This information is reported during applicable Compliance Committees and in aggregate form to the relevant Board.

External Auditors

BID also contracts with external auditors to audit processes and operations including any required third-party annual audit of a Compliance Program. The results of these contracted or other relevant external audits are reported to senior management, the Compliance Officers, the applicable Compliance Committees, and Boards.

Monitoring and Auditing of FDRs

BID entities are responsible for oversight of FDRs based on contractual requirements. Operational oversight is managed through an Oversight Committee to review the regular and ongoing oversight of relationships with delegated FDRs. Committee members are from appropriate departments and department units with specific Departments assigned as owners to oversee specific delegated FDRs based on subject matter expertise. BID's relationship with delegated FDRs is memorialized in a written agreement that includes expectations of performance as well as penalties for failures to meet those expectations up to and including termination of the contract. FDR monitoring and audits are reported during applicable Compliance Committees and to relevant Boards.

Fraud, Waste and Abuse (FWA) Research

The Compliance Department is responsible for coordinating research of potential FWA. In addition, training and awareness programs are developed and implemented to promote BID's commitment to ethical conduct for all Employees and Business Partners. Team members may refer to the Medicare Drug Integrity Contractor (MEDIC), law enforcement, Arizona Inspector General or other agencies, case/care management or may take other actions as applicable.

As a First-Tier Entity, BPA compliance may report to the applicable MA Plan Special Investigations Unit (SIU)/Compliance Contact or the MEDIC.

For all lines of business, identification of potential FWA may result in formal contract actions up to and including contract termination. Results of FWA research efforts are reported to the applicable Compliance Officers, Compliance Committees and Boards.

Auditing of BID by State or Federal Agencies or External Parties

BID considers regulatory audits and reviews as an opportunity to confirm effectiveness of its compliance efforts. BID cooperates with state and federal agencies or external vendors when audits are conducted and provide auditors access to information and records related to BID and delegated FDR operations.

Should the outcome of an audit indicate that it has not met a regulatory requirement, BID will use the audit findings to perform root cause analyses and develop CAPs to address identified areas of noncompliance. BID may also contract with external vendors to perform audits and assist with operational/program changes to enhance BID's compliance.

Tracking and Documenting Compliance and Compliance Program Effectiveness

BID tracks and documents compliance efforts, to show the extent to which operational areas and FDRs are meeting compliance goals. Issues of non-compliance identified and shared with BID's senior management, the applicable Compliance Committee and relevant Board.

AHCCCS Deliverables Related to Required Audits

B-UFC submits required contractual deliverables to the OIG according to the information in ACOM 103 and the Attachment 3: Contractor Chart of Deliverables for both the BUFC-ACC and the BUFC-ALTCS contracts with AHCCCS.

The Corporate Compliance Audit Report and External Audit Plan/Schedule are submitted semi-annually. Any External Auditing Schedule changes are submitted within 7 days of the change.

Component 7: Procedures and System for Prompt Response to Compliance Issues

BID has established and implemented procedures and a system for promptly responding to compliance issues as they are raised; investigating potential compliance problems as identified during self-evaluations and audits; correcting such problems to reduce the potential for recurrence; and to ensure ongoing compliance with all government program regulations.

BID may detect noncompliance through multiple avenues including self-reporting, AHCCCS or Medicare audits, other government program audits, internal audits, ComplyLine calls, external audits, or member/beneficiary complaints.

When an incident is identified, BID will take prompt action to (1) research the matter through timely and reasonable inquiries and determine if non-compliance exists. If non-compliance is identified, the root cause is determined, and an effective corrective action is implemented. BH and BID maintain policies and procedures to outline how to promptly respond to any detected offenses and develop CAPs related to relevant contracts. BID has procedures to voluntarily self-report potential fraud or misconduct related to governmental programs.

Timely and Reasonable Inquiry

BID will make a timely well-documented, and reasonable inquiry into any situation where evidence suggests there has been misconduct related to BID's contractual requirements. This includes any misconduct by Employees or Business Partners.

For B-UFC, per state Medicaid requirements (AHCCCS), the Compliance Officer or designee shall immediately report, within ten calendar days, any incidents of alleged fraud, waste, or abuse to the AHCCCS-OIG through the online reporting form and include any information which may assist the AHCCCS-OIG in its investigation. Once the case is referred, B-UFC will not take any actions to recoup or otherwise offset any suspected overpayments.

Corrective Action

Any time an incident of noncompliance is discovered, or a department's processes or systems results in noncompliance, the department is required to submit a CAP to the applicable Compliance Department. CAPs represent a commitment from the department to correct the underlying problem of an identified issue in a timely manner and to prevent future

noncompliance. The status of open CAPs is reported to the applicable Compliance Officer, Compliance Committees, and applicable Boards.

Corrective Action Plans may also be required of FDRs.

Self-Reporting

Should BID discover an incident of significant federal healthcare non-compliance, potential fraud, or misconduct, BID will report the incident to the applicable delegating health plan, or government agency or its designees as required by law or contract. In addition, CMMI program is required to report any probable violations of law to an appropriate law enforcement agency.

Component 8: Fraud, Waste and Abuse Plan

Health care fraud is a crime that has a significant effect on the private and public health care payment system. Program abuse results in unnecessary costs to government programs. Due to the profound impact FWA has on health care financing, government programs require BID to actively pursue the prevention, detection, research, reporting, and correction of FWA.

BID does not tolerate FWA of any government program resources and has implemented this FWA Plan to help prevent, detect, investigate, report, and correct areas where FWA activity may occur. BID's FWA Plan is a component of the Compliance Program and the focus on reducing FWA is woven throughout this document. BID takes a layered approach which includes considering multiple aspects of FWA: prevention, detection, research, reporting, and correction.

Examples of *fraud* include, but are not limited to:

- Billing for services that were not rendered;
- Misrepresenting as medically necessary non-covered or screening services by reporting them as covered procedure or revenue codes;
- Signing blank records or certification forms, or falsifying information on records or certification forms for the sole purpose of obtaining payment;
- Upcoding or consistently using procedure/revenue codes that describe more extensive services than those actually performed;
- Using an incorrect or invalid provider number in order to be paid or to be paid at a higher rate of reimbursement;
- Selling or sharing Medicare/AHCCCS health insurance identification numbers so that false claims can be filed; and
- Falsifying information on applications, medical records, billing statements, cost reports or on any documents filed with the government.

Examples of *waste and abuse* include, but are not limited to:

- Billing for services or items in excess of those needed by themember;
- Unbundling services that are to be bundled or double billing in order to receive increased payment;
- Adding inappropriate or incorrect information to cost reports;
- Collecting in excess of the deductible or co-insurance amounts; and
- Requiring a deposit or other payment from members as a condition for admission, continued care or other provision of service.

Examples of member fraud include, but are not limited to:

- Misrepresenting or concealing facts that would cause the Health Plans to provide coverage to persons who are otherwise not eligible.

FWA Prevention

FWA prevention is an important first step in the FWA plan and occurs via multiple avenues including policies and procedures, awareness/training, screening, and risk assessment.

Policies & Procedures

BID's Compliance Officers and Compliance Departments reference state and federal policy and have developed FWA policies and procedures that are clear, concise, well-defined, and updated regularly. BID Employees and Business Partners may reference these policies and procedures to better understand the overall FWA process.

Awareness

Companies' Employees:
BID ensure all Employees are made aware of the importance of preventing, detecting, investigating, reporting, and correcting FWA through training, which is documented and maintained for a minimum of 10 years.

Business Partners (FDR):
Business Partners are required by federal law to have programs to prevent, detect, investigate, report, and correct FWA. BID ensures all Business Partners are made aware of the importance of these activities through the contract process and with follow-up through the FDR Oversight Plan. FDRs are responsible for training their employees upon hire and annually thereafter and to maintain records of such training. In addition, specialized FWA training for FDR Employees based on their individual job functions, may be developed by BID or the FDR.

All contracted providers have access to FWA materials via the provider manual, provider portal, and from their Provider Relations Representatives for all lines of business.

B-UFC Members receive FWA materials in the Member Handbook. Information to report FWA is found on the intranet for employees and on applicable websites for members and providers.

Screening

A key element of the FWA Plan is ensuring Employees and Business Partners are fit for employment/contracting in the health care industry.

For Employees:
All Banner Health employees have pre-employment background checks to review for felony convictions and Employees, volunteers, consultants, and governing body members are all screened against the databases directed by AHCCCS, CMS, or government programs prior to hire or start of activities. This review is then continued on a monthly basis for all of those individuals and entities.

For Business Partners: BID's organizational policies prohibit hiring or entering into contracts with individuals or entities who are ineligible for participation in federal health care programs, or lawfully prohibited from participating in any public procurement activity or from participating in

non-procurement activities. BH, including BID, reviews the relevant lists prior to contracting. BH and BID then screen all Business Partner entities monthly.

Fiscal Agents as defined in 42 C.F.R. 455.101 that have control interest, and their managing employees are screened monthly. Fiscal Agents are required to provide timely notification to BID of any changes in ownership or managing employees.

Likewise, BID require its FDRs to screen all employees and Downstream Entities monthly as required by AHCCCS, CMS, and government programs. FDRs are required to attest to monthly screenings as requested and documentation of regular screening must be provided to upon request.

Any confirmed positive exclusion for a provider/vendor requires action according to federal healthcare program requirements. B-UFC's Compliance Department also notifies the AHCCCS OIG in the event there is a confirmed positive exclusion for a different state Medicaid plan other than Arizona and would then follow AHCCCS OIG guidance.

FWA Detection

BID has a multiple and layered operational process in an effort to detect potential FWA. BID's detection methods include the following elements: the annual risk assessment (discussed above), monitoring and auditing; publicizing communication channels to Employees; Business Partners, Providers, and members/beneficiaries; and regularly communicating to Employees and Business Partners.

Monitoring

BID is required to perform effective monitoring in order to prevent and detect FWA. All Employees and Business Partners are encouraged to monitor their work and interactions for any suspected FWA.

Specific system applications and departments conduct routine monitoring on an ongoing basis to proactively identify potential FWA.

The Compliance Department

B-UFC/ACC; B-UFC/ALTCS, BMA Prime, BMA Plus, BMA RX, and BMA-Dual :The Compliance Department employs FWA Specialists to conduct audits and reviews. The FWA Specialists along with the Compliance Officers and other applicable Compliance Employees conduct surveillance, interviews, and other methods of review relating to potential FWA. The FWA Specialists coordinate all FWA monitoring and facilitate additional FWA steps.

For BPA, Claims Auditors conduct monthly quality audits to review processed claims for financial and processing accuracy. They look for unusual claims' payment patterns. Compliance Employees also monitor sanction screening and exclusion databases to ensure employees and vendors are eligible to participate in federal and state programs.

BPA:

The Compliance Department for BPA is not delegated directly as of January 1, 2020 for FWA activities under its contracts with Managed Care entities. It provides support in investigations and follow-up when directed.

Operational Activities

Claims Committees/Departments

The BID Claims Department applies pre-payment system edits, live payment edits and coordination of benefits. In addition, BID's Pharmacy Benefit Manager (PBM) employs point-of-sale edit software and coordination of benefits. The Claims Department also monitors for trends and provider patterns and reports any suspicious activities to the Compliance Department and conducts quality audits of its individual Claims Processors.

BID conducts data analysis and data mining, to compare claim information against other data to identify unusual patterns, suggesting potential errors and/or potential fraud and abuse. Data analysis is factored into prescribing and dispensing practices of providers who serve a particular population. Use of data analysis includes monitoring pharmacy, dental and medical billing to detect unusual patterns.

BPA has a Claims Committee which is composed of BPA management and other Employees from cross-functional areas throughout BPA, including the Compliance Department. Applicable results are also reported to the BHN and BPA Compliance Committee and the BHN and BPA Board.

Banner Health (BH) Information Technology

BID addresses the issue of fraud and abuse through several BH software solutions that aid in the prevention and detection of FWA, including claims processing, editing, and review, as well as pricing, customer relations, prior authorization, and provider portal software systems.

Finance Department

The BID Finance Department ensures compliance and contract adherence through consistent, thorough financial analysis and review. As part of that, it contracts with vendors to conduct retrospective third-party liability monitoring and review of claims data for payment reprocessing.

Clinical Network/Provider Relations

In the course of servicing providers, BID Care Transformation Representatives make announced and unannounced provider office visits and nay be joined by other BID representatives. If a provider is confirmed by the OIG, the Attorney General's Office, or MEDIC to be engaged in fraudulent activity, immediate action is taken to terminate the provider as per contract.

Medical Management

The Medical Management Department includes a Medical Management Systems Unit which is staffed in part to retrospectively review specific claims including durable medical equipment, professional fees and facility claims. For retrospective review, medical records are examined to determine medical necessity and appropriate medical care. This type of review covers any services or treatment including medications that have already been administered or provided. The reviews conducted are based on CMS or other government program guidelines and business decisions that pertain to correct coding and associated reimbursements. Should fraud or abuse be suspected, a referral is made to the FWA Specialist or other appropriate entity.

FDRs

All BID FDRs have access to the applicable BID Websites which identifies how to report referrals to the BID Compliance Department or to AHCCCS or Medicare directly.

FWA Committee
Banner Medicaid and Medicare Health Plans have created an FWA Committee which is responsible for overseeing the coordination of FWA activities; developing FWA interventions; monitoring FWA activities including tracking & trending reports; and reporting results to the Compliance Committees and Boards.

Customer Care Center / Call Center
The Customer Care Center monitors incoming member calls for any FWA activities and reports suspected FWA activity voluntarily disclosed by members, providers, or other callers to the Compliance Department. Furthermore, the BID Customer Care Department conducts outbound service verification calls on an ongoing basis and annually with a random sample.

BH Pharmacy Department
On behalf of BID, the BH Pharmacy Department works to provide safe and appropriate medications, but it sometimes identifies members who misuse medications, the most common of which are prescribed opioids. When substantiated, the member is reported to AHCCCS OIG and/or MEDIC and referred to the Case/Care Management Department.

Claims Recovery Unit
The Claims Recovery Unit (CRU) performs systemic post payment review of claims payments to ensure that payments for health care services are accurate based on CMS guidelines, provider contracts and nationally accepted, widely acknowledged coding standards. The CRU will audit overutilization of billed services or other practices that result in unnecessary reimbursements, waste, or costs to CMS or AHCCCS. This CRU program is aligned to the Compliance Program and the FWA Plan. The CRU meets regularly with internal FWA to discuss any potential FWA issues based on retro reviews.

Subcontractors
BID collaborates with providers and subcontractors to identify fraud and abuse.

BID's Pharmacy Benefits Manager (PBM), provides fraud and abuse data-mining decision-support tools and services. The PBM evaluates claims data, MEDIC reported targets, areas of high incidence of fraud and other potential areas of abuse and also conducts desk or onsite audits on its network pharmacies.

The PBM reports suspicious activities to BID and supplies quarterly and annual reports that identify any prevented overpayments.

BID 's dental network subcontractor, monitors its contracted providers via qualitative and quantitative utilization data, analyze 100% of paid claim history and conduct medical record reviews on the network. Should aberrant patterns be identified, they may implement a provider education program, report the provider to BID or directly to AHCCCS OIG. Their representatives are required to make unannounced dental office visits to confirm the location is a legitimate business.

FWA Research

BID will review in a timely and reasonable manner any potential misconduct, including but not limited to, activities associated with treatment, payment, operations, delivery of services, or prescription drug items as outlined in their various contracts. This includes any misconduct by Employees or Business Partners. Should FWA be suspected, the Compliance Department is responsible for coordinating the review.

BID utilizes FWA software to analyze claims data and reports any potential FWA. BID Data mining permits BID to identify patterns that appear aberrant when compared to other like claims and to further review to validate the vendor's findings.

Due to the complex nature of some of Medicare cases that may be involved, particularly fraud audits and reviews, the applicable CO may also refer the matter to the MEDIC within two weeks of the date the potential misconduct is identified or reported so that investigations into suspected or observed fraudulent or abusive activity may be expedited.

For cases of suspected FWA involving the state Medicaid program (AHCCCS), B-UFC shall report the incident to the AHCCCS-OIG as required.

If B-UFC identifies an incident that warrants self-disclosure, it will be reported immediately within ten (10) calendar days to the AHCCCS-OIG using the Provider Self-Disclosure form.

For BPA cases involving the delegating health plans, the relevant Employee will report/refer any potential fraud to the delegated health plan's Compliance or SIU areas.

FWA Correction

Upon completing an audit or review of a specific issue, the following activities may occur:

BID FDRs:
- Education
- Prospective Review
- Recovery
- Administrative Remedy
- Government Agency Referral
- Change in Policy
- Contract Restriction or Termination
- Case Closure

For BID Members:
- Member Education
- Care Management Referrals
- Increased Monitoring
- Network Restriction
- Government Agency Referral
- Case Closure

For BHN/BPA/BNC/BNSA, audits and reviews may result in:
- Provider Education
- Member Education
- Case Management Referrals
- Increased Monitoring
- Contract Restriction or Termination

- Government Agency Referral
- Referral to MA Plans
- Case Closure

FWA Reporting and Tracking

BID requires any Employees or Business Partner who suspects inappropriate FWA behavior to report the suspicion to the Compliance Department. FWA reporting can be done by telephone, email, internet message submission, and mail. Employees and Business Partners may also use the ComplyLine at **1-888-747-7989** / **https://bannerhealthcomplyline.ethicspoint.com** for anonymous and confidential reporting of any suspected FWA. The Compliance Departments also formally report any suspected FWA to the designated state and federal agencies, including the AHCCCS-OIG, the MEDIC, delegating health plans, and law enforcement.

Instances of suspected FWA shall be reported to AHCCCS OIG directly at:

Provider Fraud
To report suspected fraud by medical provider, please call the number below:
- In Arizona: 602-417-4045
- Toll Free Outside of Arizona Only: 888-ITS-NOT-OK or 888-487-6686
- Or by accessing the AHCCCS website directly at: https://www.azahcccs.gov/Fraud/ReportFraud/

Member Fraud
To report suspected fraud by an AHCCCS member, please call the number below:
- In Arizona: 602-417-4193
- Toll Free Outside of Arizona Only: 888-ITS-NOT-OK or 888-487-6686
- Or by accessing the AHCCCS website directly at: https://www.azahcccs.gov/Fraud/ReportFraud/

Questions
If you have questions about AHCCCS fraud, abuse of the program, or abuse of a member, please contact the AHCCCS OIG.
- Email: AHCCCSFraud@azahcccs.gov

Instances of suspected FWA can be reported to Medicare:

Providers are required to report all suspected fraud, waste, and abuse to the Health Plan or to Medicare directly.

Mail: US Department of Health and Human Services
Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, DC 20026

Phone: 1-800-HHS-TIPS (1-300-447-8477)
Fax: 1-800-223-8164
TTY: 1-800-377-4950
Website:
https://forms.oig.hhs.gov/hotlineoperations

Any reports received—through any channel of communication—of a potential or observed violation of compliance policies, federal and state requirements, regulations, or statutes will be documented. This information will be included in reports to the Compliance Committees.

As noted above, BH and BID have written policies of non-retaliation toward any person who reports a potential or observed violation. Employees and Business Partners will be made aware of these policies and encouraged to report incidents of potential or observed FWA or other compliance concerns. All involved will be made aware of the fact that the identity of any anonymous reporter may have to be revealed.

Reporting B-UFC FWA to AHCCCS

If B-UFC determines that potential fraud or misconduct related to the AHCCCS program has occurred, B-UFC will report to the AHCCCS-OIG as required and in accordance with AHCCCS ACOM policy 103, Fraud, Waste and Abuse and B-UFC policy and procedure.

Reporting FWA to Medicare

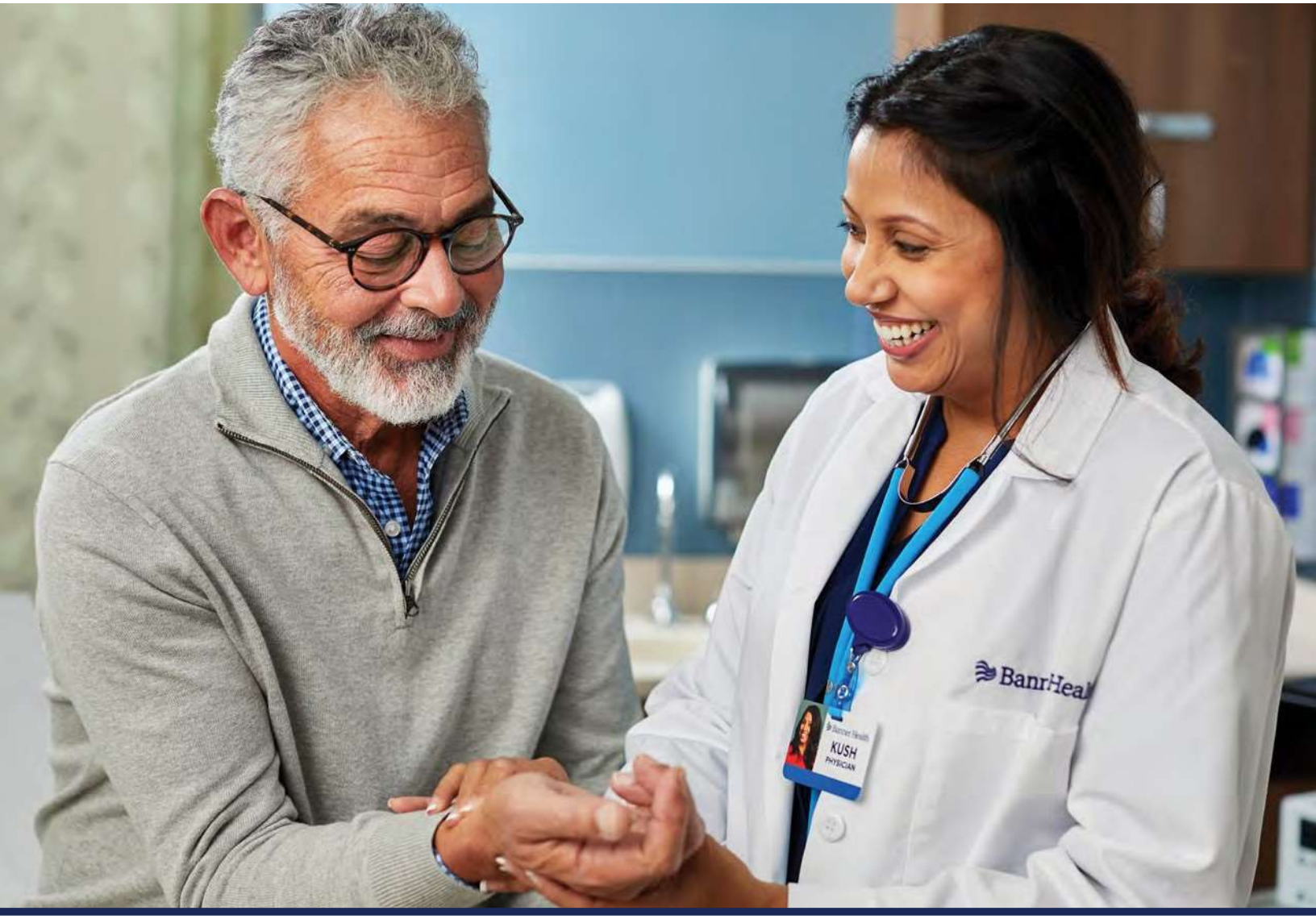
If BID determine that potential fraud or misconduct related to the Medicare Advantage Prescription Drug Plan Part D program or CMMI Program has occurred, BID will report the potential fraud or misconduct to either (a) directly to the MEDIC, or (b) to the applicable third-party payer as per policy or specific contractual obligation.

BID may also consider reporting potentially fraudulent conduct to law enforcement or government authorities such as the OIG or the DOJ.

FWA Tracking

BID will maintain files for a period of 10 years on both in-network and out-of-network providers who have been the subject of complaints, reviews, violations, and prosecutions. BID also maintain files that contain documented warnings (e.g., fraud alerts) and educational contacts, the results of previous reviews, and copies of complaints resulting from audits and reviews. BID will comply with requests by law enforcement, CMS, AHCCCS, or CMS designee regarding monitoring of providers within BNSA/BHN's/BNC's/B-UFC/BMA-D/BPA 's network that CMS or AHCCCS has identified as potentially abusive or fraudulent.

Banner Health



Code of Conduct

Banner Health Mission, Values, and Purpose

Our Nonprofit Mission

Making health care easier, so life can be better.

Our Values

- Customer obsessed
- Relentless improvement
- Courageously innovate
- Disciplined focus
- Foster accountability
- Continuously earn trust

Our Purpose

Banner can and will create a new model that answers America's health care challenges today and in the future.

Inspired to change the health care landscape in our communities – big and small – our talented and passionate teams care deeply about individuals who are responsible for the needs of their extended families.

Taking access and delivery from complex to easy, from costly to affordable and from unpredictable to reliable, we give every individual we serve confidence in their health care experience and its outcome.

Letter from Peter Fine

Dear Team Members:

A key component of Banner's success is maintaining the highest ethical standards in everything we do. Throughout our history, we have been committed to demonstrating the reliability, honesty and integrity of a leading health care organization and a participant in Federal health care programs.

This Code of Conduct provides guidance to help ensure our work at Banner is always conducted in an ethical manner. It contains resources that allow us to make sound, ethical decisions in the workplace that are consistent with Banner's values. It is also a symbol of our commitment to "doing the right thing." Please read the Code of Conduct. If you have any questions or are unsure how to apply it, please contact your supervisor, department manager or director, Compliance Officer, the Ethics & Compliance Department, or the ComplyLine (by calling **1-888-747- 7989** or online at **https://bannerhealthcomplyline.ethicspoint.com**). There will be no retaliation for asking questions, raising concerns or reporting improper conduct in good faith.

Each one of us has an essential role to play in preserving Banner's ethical culture. We make choices every day about how to conduct ourselves at work, and we must ensure that every decision is made with integrity. Working together, we can continue to build upon Banner's position as a leader in patient care and corporate responsibility.

Best regards,

Peter S. Fine, FACHE
Chief Executive Officer

Letter from David Ledbetter

Dear Team Members:

Banner has a longstanding Compliance Program. The Program was initially implemented in the 1990s and has continually expanded as Banner has acquired new facilities and areas of business. Banner's Compliance Program incorporates the seven elements that originated in the Federal Sentencing Guidelines:

- Compliance Personnel and Structure
- Compliance Documents
- Compliance Training and Education
- Reporting and Investigating
- Monitoring and Auditing
- Response and Prevention
- Enforcement and Discipline

One of the key Compliance Documents is the Code of Conduct. This Code of Conduct describes Banner's Compliance Program in greater detail. It also provides guidance on how to conduct our work and make decisions within appropriate ethical and legal standards. Finally, it serves as a resource for understanding some of the complex laws and regulations governing the health care industry. Please carefully review this Code of Conduct and seek assistance if you have any questions.

The success of Banner's Compliance Program depends upon the active participation of every Team Member. Thank you for your continuing commitment to Banner.

Sincerely yours,

David Ledbetter
Vice President, Chief Ethics & Compliance Officer

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Purpose of our Code of Conduct

At Banner Health (Banner), we strive to always act with integrity and work within the law. Banner's Code of Conduct provides guidance to board members, employees, medical staff, volunteers, students, contractors, agents and others (collectively referred to as "Team Members" in this document) to assist us in carrying out our daily activities within appropriate ethical and legal standards. Although referred to as "Team Members" throughout this Code of Conduct, those that are not employed by Banner may have different obligations depending on their relationship with Banner. Legal obligations apply to our relationships with our patients, beneficiaries, third-party payers, independent contractors, vendors, consultants and one another. These obligations require that we conduct business not only in compliance with laws and regulations, but also in an ethical manner.

This Code of Conduct is a summary of Banner's Compliance Program as well as Banner's policies regarding ethical conduct and workplace behavior. The purpose of our Code of Conduct is to provide general guidance on subjects of interest within the organization. It does not eliminate or supersede other policies. Rather, this Code of Conduct should be used in conjunction with these policies.

The standards set forth in this Code of Conduct apply to all Team Members and Banner entities.

Team Member Responsibilities

Fulfillment of Banner's commitment to the Code of Conduct is dependent upon the commitment of our Team Members. It is expected that all Team Members will:

- Comply with Banner's Compliance Program, this Code of Conduct, Banner's policies and Banner's Corporate Integrity Agreement
- Take responsibility for their own actions
- Know and comply with applicable laws and regulations, including Federal health care program requirements
- Seek guidance when in doubt about their job responsibilities
- Refrain from involvement in illegal, unethical or other improper acts
- Promptly report any potential or suspected violation of this Code of Conduct, Banner's policies or applicable laws or regulations
- When requested, assist Banner personnel and authorized outside personnel in investigating alleged violations

Banner provides Team Members with policies, training and/or other aids to help fulfill their responsibilities under the Code of Conduct.

Leadership Responsibilities

While all Team Members are obligated to follow the Code of Conduct, Banner expects leaders to set the example, to be in every respect, role models. We expect everyone in the organization with supervisory responsibility to exercise that responsibility in a manner that is kind, sensitive, thoughtful and respectful.

Each supervisor should create an environment where everyone is encouraged to raise concerns and propose ideas. Supervisors should also ensure that their teams have sufficient information to comply with laws, regulations, this Code of Conduct, Banner policies, Banner's Corporate Integrity Agreement, as well as the resources to resolve ethical dilemmas.

Banner's Corporate Integrity Agreement

In April 2018, Banner agreed to pay the United States over $18 million to settle allegations that 12 of its hospitals in Arizona and Colorado admitted patients for medical treatment who should have been treated on an outpatient basis. The settlement resolved a 2013 lawsuit filed in the United States District Court for the District of Arizona under the qui tam or whistleblower provisions of the False Claims Act. As part of the settlement, Banner entered into a Corporate Integrity Agreement (CIA) with the U.S. Department of Health and Human Services Office of Inspector General (OIG).

Under the CIA, Banner must maintain – and in some cases expand – its Compliance Program to meet the CIA requirements. Fortunately, Banner already had an established Compliance Program that met many of the requirements in the CIA. However, certain changes – including new compliance personnel, policies, procedures and processes – were implemented.

Non-compliance with CIA requirements can result in serious consequences, including monetary penalties and exclusion from participation in Federal health care programs. Therefore, it is very important that Banner and all Team Members comply with CIA requirements. The CIA – as well as an executive summary – are available on the Ethics & Compliance Department's intranet website.

Banner's Compliance Program

Program Structure

Banner created the Compliance Program several years ago to reinforce Banner's commitment to conducting its business with integrity. Through its Compliance Program, Banner maintains a culture that promotes the prevention, detection and resolution of conduct that does not conform to laws, regulations, Banner policies and/or this Code of Conduct. Banner's Compliance Program is described below.

Compliance Personnel and Structure

The Chief Compliance Officer (David Ledbetter) manages the Ethics & Compliance Department and oversees Banner's Compliance Program. The Chief Compliance Officer reports directly to Banner's Chief Executive Officer and the Audit Committee of the Board of Directors. The Ethics & Compliance Department provides day-to-day implementation, oversight and enforcement of Banner's Compliance Program. Among other duties, the Ethics & Compliance Department:

- Develops compliance policies
- Creates and implements compliance training programs
- Researches and investigates compliance issues (including ComplyLine cases)
- Provides advice on coding, billing, regulatory, and other compliance matters
- Assists with monitoring activities
- Conducts compliance audits and internal investigations
- Oversees Banner's response to government audits and investigations

The Ethics & Compliance Department also has designated Compliance Officers who are responsible for overseeing the Compliance Program in each of their respective areas. These areas include hospitals, provider groups, ancillary service areas, research and Banner's Insurance Division. These Compliance Officers are responsible for operating the Compliance Program at their specific entities.

Compliance committees provide operational leaders with opportunities to advise and assist compliance personnel with the implementation and oversight of Banner's Compliance Program.

Compliance Documents

With respect to our Compliance Program, Banner sets standards primarily through this Code of Conduct and compliance policies. The Code of Conduct is a guide to the overall conduct of operations, whereas compliance policies provide guidance on specific topics and business activities.

Compliance policies are available on the intranet website.

Compliance Training and Education

Compliance training and education is mandatory at Banner. Team Members receive training on Banner's CIA requirements, Banner's Compliance Program and applicable Federal health care program requirements when they first begin working at Banner, when significant changes occur and annually thereafter. In addition, specialized training in areas of compliance risk (e.g., quality, coding, billing, cost reporting, health plan specific requirements and referral source arrangements) may be required of certain individuals based upon their role in the organization. Team Members who fail to complete compliance training may be subject to corrective action or sanctions.

Most compliance training and education is provided and monitored through MyHR | Workday.

Reporting and Investigating

All Team Members are required to immediately report "Potential Compliance Issues," which are defined as any suspected or actual violations of this Code of Conduct, Banner policies, and laws and regulations relating to Federal health care programs. Potential Compliance Issues include, but are not limited to, fraud, waste and abuse.

To obtain guidance on or report a Potential Compliance Issue, Team Members may choose from several avenues, including their supervisor, department manager or director, Compliance Officer, the Ethics & Compliance Department, or the ComplyLine.

The ComplyLine is Banner's confidential hotline; it is hosted by a company independent of Banner. The ComplyLine can be contacted at any time by calling **1-888-747-7989** or online at **https://bannerhealthcomplyline.ethicspoint.com**. Team Members do not have to disclose their names and, if requested, anonymity will be maintained to the extent possible and in accordance with applicable laws.

Banner prohibits retaliation against any Team Member who seeks help or who reports a Potential Compliance Issue in good faith. Anyone who retaliates or encourages others to do so will be subject to corrective action, up to and including termination of employment or contractual relationship with Banner. Team Members who deliberately make false accusations to harm or retaliate against other Team Members are subject to discipline.

Monitoring and Auditing

An effective compliance program requires the use of audits and other evaluation techniques to monitor compliance and assist in the resolution of identified issues. At Banner, monitoring activities are primarily performed by operational personnel with the assistance of the Ethics & Compliance Department. Operational personnel can identify the risk areas within their operations, develop appropriate controls and policies and monitor whether those controls and policies are implemented and followed.

In contrast to monitoring activities, auditing is performed by the Ethics & Compliance Department or by external auditors acting under the Department's direction. Audit activities are planned and prioritized using a risk assessment and considering a variety of factors, including prior audit results; recent investigations, litigation and settlements; compliance complaints; and government activities. The resulting audit plan is brought to the relevant Board or Board Committee for approval. In addition to these planned audits, special audits may be conducted in response to identified issues, inquiries or requests.

Response and Prevention

Banner is committed to investigating all reported issues promptly and confidentially to the extent possible. The Ethics & Compliance Department investigates reported Potential Compliance Issues. If a reported issue is related to a business area such as patient privacy, human resources or risk management, it is referred to the appropriate department for investigation. Team Members are required to participate fully and honestly in all Potential Compliance Issue investigations. Failure to do so may result in corrective action, up to and including termination.

The Ethics & Compliance Department coordinates any findings from investigations of Potential Compliance Issues and recommends corrective actions. These may include revising policies and procedures, providing education, making prompt restitution of any overpayments, notifying the appropriate governmental agency, instituting the necessary corrective action and assisting and monitoring the implementation of systemic changes to prevent similar violations from reoccurring in the future.

Enforcement and Discipline

Team Members who knowingly violate Banner's Code of Conduct, compliance policies, laws and regulations related to Federal health care programs or any other aspect of Banner's Compliance Program may be subject to appropriate corrective action, up to and including termination of employment or contractual relationship with Banner.

In addition, if Banner becomes aware that an individual or entity is excluded or ineligible to participate in Federal health care programs, Banner will, at a minimum, remove the individual or entity from responsibility for, or involvement with, Banner's business operations related to any Federal health care program(s) from which the individual or entity has been excluded, debarred, suspended or otherwise declared ineligible.

Interactions with the Government

Investigations and Audits

Government investigations and oversight activities are common in health care and procedures for cooperating with these investigations may be complex. While many oversight activities may be scheduled, if any person approaches Team Members and identifies himself or herself as a government investigator or auditor, they should immediately contact their supervisor and the Ethics & Compliance Department.

The supervisor will notify Administration. The Ethics & Compliance Department will assist in verifying the investigator's credentials, determining the legitimacy of the investigation, following proper procedures for cooperating with the investigation and notifying the Legal Department if necessary.

In some cases, government investigators or persons presenting themselves as government investigators may contact Team Members outside of the workplace or during non-work hours. While Team Members have the right to speak to such a person, they should not feel pressured to do so. Team Members may first want to contact a Compliance Officer, the Ethics & Compliance Department, or the Legal Department. Team Members have the right to refuse to talk to the person as well as the right to have an attorney or a Banner representative present if they decide to speak with the government investigator.

Many government audits or oversight activities begin with a written notification by email, letter or fax or a phone call rather than an in-person visit by a representative. If a Banner entity receives a letter from a State or Federal agency requesting information for an audit, Team Members should date-stamp the letter with the date received and immediately contact a supervisor and the Ethics & Compliance Department. Similarly, if a Banner entity receives a subpoena or other written request for information (such as a Civil Investigative Demand), Team Members should immediately contact a supervisor and the Ethics & Compliance Department before responding.

Team Members must never:

- Destroy or alter any information in anticipation of a request for a document or record by a government agency or court
- Lie or make false or misleading statements to any government investigator
- Attempt to persuade anyone to provide false or misleading information to a government investigator or auditor
- Refuse to cooperate with a government investigation or audit

Accreditation and Surveys

Banner deals with all accreditation bodies in a direct, open and honest manner. No action is taken in relationships with an accreditation body to mislead the accreditor or its survey teams either directly or indirectly.

In any case where Banner determines to seek any form of accreditation, all standards of the accreditation body are important and must be followed. If Team Members are aware of any noncompliance with accreditation standards or misstatements to the accreditation body, they must report them immediately to Banner's Regulatory Program.

Patient Relationships

Quality of Care

Banner strives to provide high quality, cost-effective health care to all patients. We are committed to the delivery of safe, effective, efficient and compassionate patient care. We treat all patients with warmth, respect, dignity and provide care that is both necessary and appropriate. We never distinguish among patients based on race, ethnicity, religion, gender, gender identity or expression, sexual orientation, national origin, age, disability, veteran status or other characteristic protected by law.

Healthcare is a service industry, and teamwork and collaboration are essential to providing excellent service and solving problems — no matter how big or small.

We work together to achieve the common goal of serving our patients.

Patient Rights

Banner also strives to ensure that patients and/or their representatives have the information necessary to exercise their rights. Team Members receive training regarding patient rights in order to clearly understand their role in supporting those rights. Some of those rights are discussed below.

Banner acknowledges and promotes the patient's right to make free and informed decisions regarding their medical treatment. We seek to involve patients in all aspects of their care, including giving consent for treatment and making healthcare decisions. As applicable, each patient or patient representative is provided with a clear explanation of care including, but not limited to, diagnosis, treatment plan, right to accept or refuse care and an explanation of the risks, benefits and alternatives associated with available treatment options. Patients also have the right to request transfers to other facilities; in such cases, the patient is given an explanation of the benefits, risks, and alternatives of the transfer.

Patients have the right to execute advance directives and to have Team Members comply with those directives. Team Members are expected to take reasonable steps to determine the patient's wishes concerning the designation of a representative to exercise the patient's rights.

Patients have the right to file a grievance. Banner maintains processes for prompt resolution of patient grievances, which include informing patients whom to contact regarding grievances and providing written notice to patients following the investigation of the grievances.

Patient Confidentiality

We collect information about the patient's medical condition, history, medication and family illnesses in order to provide quality care. We realize the sensitive nature of this information and are committed to maintaining its confidentiality. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Banner policies, we do not use, disclose or discuss patient-specific information (including patient-financial information) with others unless it is necessary to serve the patient or is permitted or required by law.

Additional information about HIPAA is provided in the Applicable Legal Requirements Section.

Business Transactions with Patients

We understand that close relationships form between patients and their healthcare providers. However, Team Members must avoid conducting business transactions with patients that may result in actual or potential conflicts of interests. For similar reasons, Team Members should not use their own money to buy gifts or items for patients. We do not want our patients to think they will receive better or worse care if they have personal relationships or outside business arrangements with their healthcare providers. We strive to have open, objective relationships with our patients.

Health Plan Member Relationships

Banner also tries to ensure that Health Plan Members (HP Members) and/or their representatives have the information necessary to exercise their rights. Team Members receive training about HP Member rights in order to clearly understand their role in supporting those rights. Some of those rights are discussed below.

Member Rights

Banner acknowledges that HP Members have the right to have full information from both providers – including explaining medical conditions and treatment options – and from their Health Plan, provided in a way that the HP Member can understand. In addition, when able to make their own healthcare decisions HP Members have the right to fully participate in those decisions or to give someone the legal authority to make those decisions. HP Members have the right to execute advance directives and to have Team Members comply with those directives. Team Members are expected to take reasonable steps to determine the HP Member's wishes concerning the designation of a representative to exercise the Member's rights.

HP Members, or their representatives, also have the right to file grievances to ask a Health Plan to reconsider coverage decisions, the right to raise concerns about discrimination or concerns about being treated unfairly or without respect. Team Members are expected to take reasonable steps to respond to such issues as required by law and Banner policy.

Member Confidentiality

Just as with patients treated by Banner facilities and providers, Banner Health Plans collect information about HP Members and their medical condition, history, medication and family illnesses in order to provide appropriate coverage. Banner recognizes the sensitive nature of this information and is committed to maintaining its confidentiality. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Banner policies, Banner and its Team Members do not use, disclose or discuss HP Member-specific information (including HP Member financial information) with others unless it is necessary to serve the HP Member or is permitted or required by law.

Additional information about HIPAA is provided in the Applicable Legal Requirements Section.

Physician and Other Provider Relationships

Interactions with Physicians and Other Providers

Facilities owned and operated by Banner reflect a collaboration between those who perform non-clinical functions and those who perform clinical functions. As with any collaboration, each party has important roles and responsibilities. Banner is committed to providing a supportive and respectful work environment for all Team Members, including our physicians and other providers who practice in our entities.

All business arrangements with physicians and other providers must be structured to ensure compliance with legal requirements and, where appropriate, set forth expectations regarding compliance with laws, regulations, Banner's CIA, this Code of Conduct, and applicable Banner policies.

Two overarching principles govern our facility interactions with physicians and other providers:

- **We do not pay for referrals.** We accept patient referrals and admissions based on patients' medical needs and our ability to render the needed services. We do not directly or indirectly give or offer anything of value in exchange for patient referrals as that would be a violation of the law.
- **We do not accept payment for referrals or authorizations to accept patients.** No Team Member or any person acting on Banner's behalf is permitted to directly or indirectly solicit or receive anything of value in exchange for a patient referral or authorization to accept a patient. The acceptance of any such remuneration would be a violation of the law.

Violation of these principles may have serious consequences for Banner and the individuals involved, including civil and criminal penalties and possible exclusion from Federal health care programs.

Qualified to Provide Care

Only physicians and other providers who have the necessary training and are properly credentialed will be permitted to provide patient care services at Banner.

Business Courtesies and Tokens of Appreciation

Any entertainment, gift or token of appreciation offered to physicians or other providers who are in a position to refer patients to Banner must comply with all applicable laws and regulations. Team Members must consult Banner policies and/or the Ethics & Compliance Department prior to offering any business courtesy or token of appreciation to a potentialreferral source.

Any items of value provided to physicians or other providers who are associated with Banner's Accountable Care Organizations (ACO) must meet the requirements of those federal programs.

Business and Financial Information

Accuracy, Retention and Disposal of Documents and Records

Team Members are responsible for the integrity and accuracy of Banner's documents and records. Team Members must not only comply with regulatory and legal requirements but must also ensure that documents and records are available to support our business practices. No one may falsify information on any document or record.

Medical records must provide reliable documentation of the services we render. It is important that all Team Members provide accurate information in the medical record and do not destroy or alter any information considered part of the official medical record. Team Members must make every effort to ensure that medical record entries are clear and complete and reflect exactly the care that was provided to a patient.

Records related to Managed Care activities must provide reliable documentation of the activities Banner is contracted to provide. Destruction and alteration can only be accomplished as per written policy and in accordance with relevant regulatory and sub-regulatory requirements.

Banner documents and records are retained in accordance with the law and our record retention policy. Our policy applies to paper documents such as letters and memos; computer-based information such as email or computer files; and any other medium that contains information about the organization or its business activities.

Coding, Billing and Claim Payment Services

Banner strives to ensure that our bills and claims payment activities meet Federal health care program requirements, and we prohibit any employee or agent of Banner from knowingly presenting or causing to be presented claims for payment or approval which are false, fictitious, or fraudulent.

Banner submits accurate claims and pays claims that are supported by documentation in the medical record. Services must be accurately and completely coded to ensure proper billing or payment and medical record documentation must support all services. Banner has policies relating to the timely completion of medical record documentation by providers to support billing. All Banner providers should be aware of policies on completing and authenticating medical records.

Banner has implemented policies, procedures and systems to facilitate accurate billing to government payers, commercial insurance payers, and patients. In addition, Banner also has policies and procedures related to making accurate payments to providers who submit claims to Banner's Insurance Division. These policies, procedures, and systems conform to pertinent Federal and State laws and regulations. Specialized training is mandatory for Team Members who have responsibility for entering charges or paying claims.

If Team Members suspect that improper coding and/or billing is occurring or improper claims have been submitted or paid, they should discuss the issue with their supervisor, department manager or director, Compliance Officer, the Ethics & Compliance Department or contact the ComplyLine.

Banner Proprietary Information

While working at Banner, Team Members may acquire knowledge and information relating to trade secrets, commercially sensitive information and financial information about Banner. In addition, Team Members may create or develop systems, procedures, software and/or processes. These are all confidential, the property of Banner, and may not be disclosed for a purpose unrelated to Banner business without prior written authorization from senior management or a written agreement. Examples of proprietary information include:

- Business programs or projections
- Wage and salary data
- Customer or patient lists
- Merger or acquisition agreements
- Litigation materials or information prepared in anticipation of litigation
- Physician and hospital agreements
- Unusual or sensitive management developments

Proprietary information should only be accessed by or given to other Team Members who have a legitimate need to know the information within the scope of their job duties.

Cybersecurity

Because so much of our clinical and business information is generated and contained within our computer systems, it is essential that Team Members adhere to our cybersecurity policies and standards. Team Members are only allowed to use the account assigned to them and cannot share or disclose it with anyone else. They must safeguard their passwords and any other forms of authentication. Team Members must never use tools or techniques to break or exploit Banner cybersecurity measures or those used by other companies or individuals.

Portable computer devices such as laptops are targets for theft. They should be stored in secure locations when not in use. Access to these devices should be password protected. Banner information should be stored on network servers where data is backed up regularly.

Team Members must protect patient and Banner proprietary information when it is emailed outside Banner; stored or posted on an internal app; sent through the Internet; stored on approved portable devices such as laptops, tablets and mobile phones; or transferred to approved removable devices. Team Members must be extremely careful in the use of social media and the Internet to never inappropriately disclose patient or Banner proprietary information. Team Members having access to email and the Internet should follow all policies relating to their proper usage.

Team Members should immediately report any potential security breaches to the Cybersecurity Department.

Electronic Media

All Banner communication systems – including, but not limited to, computers, email, Intranet, Internet, apps and telephones – are the property of the organization and are to be used primarily for business purposes and in accordance with Banner policies and standards. Limited reasonable personal use of Banner communication systems is permitted; however, users should assume those communications are not private. Users of Banner communication systems should presume no expectation of privacy in anything they create, store, send or receive on these systems, and Banner reserves the right to monitor and/or access usage and content consistent with Banner policies.

Team Members may not use Banner devices or Banner communication systems to view, post, store, transmit, download, or distribute any threatening materials; knowingly, recklessly or maliciously false materials; obscene materials; or anything constituting or encouraging a criminal offense, giving rise to civil liability or otherwise violating any laws. These systems also cannot be used to send chain letters, personal broadcast messages or copyrighted documents that are not authorized for reproduction.

Team Members who abuse our communications systems or use them excessively for non-business purposes may be subject to disciplinary action.

Financial Records and Reporting

Banner has established and maintains a high standard of accuracy and completeness in the documentation and reporting of all financial records. These records serve as a basis for managing our business and are important in meeting our obligations to Team Members, patients, physicians, suppliers, donors and others. They are also necessary for compliance with tax and financial reporting requirements.

All financial information must reflect actual transactions and conform to generally accepted accounting principles (GAAP). Banner maintains a system of internal controls to provide reasonable assurances that all transactions are executed in accordance with management's authorization and are recorded in a proper manner so as to maintain accountability of the organization's assets. Financial reports fairly and consistently reflect Banner's performance and accurately disclose the results of operations.

Medicare Fee-for-Service Cost Reports

Banner complies with Federal and State laws, regulations and guidelines relating to cost reports. These laws, regulations and guidelines define what costs are allowable and outline the appropriate methodologies to claim reimbursement for the cost of services provided to program beneficiaries. All issues related to the preparation, submission and settlement of cost reports must be performed by or coordinated with the Reimbursement Services Department.

Applicable Legal Requirements

False Claims Act

The Federal False Claims Act (FCA) makes it a crime for any person or organization to knowingly create a false record or file a false claim with the government for payment. A false claim is an attempt to obtain payment by presenting false or misleading information related to the claim. "Knowing" means not only actual knowledge of the falsity of the information but also deliberate ignorance or reckless disregard for the truth or falsity of the information. No specific intent to defraud the government is required.

Under certain circumstances, an inaccurate Medicare or Medicaid claim could become a false claim. Examples of possible false claims in the healthcare context include, but are not limited to, the following:

- Billing for services or supplies that were not provided
- Misrepresenting services actually provided such as assigning a code for a more complicated procedure than actually performed (upcoding)
- Dividing a procedure or service typically billed as one procedure into multiple parts (unbundling)
- Duplicate billing for services rendered
- Falsely certifying that services were medically necessary
- Falsely certifying that an individual meets the Medicare requirements for home health or any other service
- Providing services that were not ordered by a physician or another provider
- Billing for services that were provided at a sub-standard quality

Penalties are severe for violating the FCA. Individuals and entities are subject to significant civil penalties per false claim (adjusted annually for inflation), plus three times the value of the false claim. Violation of the FCA may also lead to exclusion from participation in Federal health care programs.

A person called a relator (or whistleblower) who knows that a false claim was filed for payment can file a lawsuit in Federal court on behalf of the government and, in some cases, receive a percentage of the money recovered as a reward for bringing original information about a violation to the government's attention. The FCA protects a relator from being fired, demoted, threatened or harassed by their employer for filing the FCA lawsuit. If an employee is harmed by his/her employer, the employee may file a retaliation lawsuit against that employer in Federal court and is entitled to reinstatement, two times the amount of back pay and compensation for any special damages as a result of the discrimination (such as litigation costs and reasonable attorneys' fees).

Deficit Reduction Act

The Deficit Reduction Act of 2005 (DRA) contains specific provisions aimed at reducing Medicaid fraud and abuse and applies to all healthcare providers receiving at least $5 million in annual Medicaid payments. The DRA also encourages States to enact legislation that is comparable to the FCA to have consistent enforcement throughout the country. Under the DRA, States may keep an additional 10% of any recoveries obtained if they have a State law that:

- Establishes liability for the same types of false claims prohibited under the FCA;
- Contains incentives that are at least equal to the Federal whistleblower incentives;
- Provides for qui tam lawsuits to be filed under seal; and
- Provides for civil penalties at least as high as the Federal penalties.

Regardless of whether they qualify for an incentive, all States in which Banner operates have laws similar to the FCA as well as laws that prohibit fraudulent or deceptive behavior. Arizona, for example, has laws that forbid activities such as (a) theft, (b) forgery, (c) fraudulent schemes, artifices, and practices, and (d) concealing the same. Ariz. Rev. Stat. §§ 13-1802, 13-2002, 13-2310, 13-2311. Arizona also specifically requires providers to report fraud and abuse. Ariz. Rev. Stat. §§ 36-2918, 36-2918.01.

Physician Self-Referral Law

The Physician Self-Referral (Stark) Law prohibits a physician from referring Medicare patients for designated health services (DHS) to an entity with which the physician (or immediate family member) has a financial relationship, unless a specific exception applies. The law also prohibits the entity that is providing the DHS from submitting claims to Medicare for services resulting from a prohibited referral from the physician.

Key terms:

- "DHS" include inpatient or outpatient hospital services, most clinical laboratory services, most radiology imaging services, durable medical equipment, home health, physical therapy, occupational therapy, speech language therapy, parenteral and enteral nutrients, prosthetics and orthotics, and outpatient drug prescriptions.
- "Referral" is broadly defined to include requests, orders, certifications, and re-certifications by physicians that include DHS.
- "Financial relationship" includes both ownership and compensation arrangements and includes almost any type of remuneration in cash or in kind, direct or indirect.

To comply with the Stark Law, Team Members should work with the Legal Department and/or Ethics & Compliance Department to ensure that physicians arrangements fall within an exception. Some common exceptions are:

- Office and equipment leases
- Personal services arrangements (contracts)
- Recruitment arrangements
- Medical staff incidental benefits
- Nonmonetary items and services up to an annual limit
- Donation of electronic health record items and services

Each exception has several requirements — all requirements of an exception must be met or the arrangement does not comply with the Stark Law. Good or bad intent does not matter. If there is a financial relationship with a referring physician, the relationship must satisfy an exception — even if the arrangement has nothing to do with Medicare patients.

Examples of Stark Law violations are a non-employed physician providing services without a contract or occupying hospital space without a lease agreement.

Penalties for violating the Stark Law may include an obligation to refund money, civil monetary penalties (adjusted annually for inflation) for each violation as well as any circumvention scheme, a civil assessment up to three times the amount claimed, exclusion from participation in Federal health care programs and liability under the FCA.

In general, these Stark requirements apply across Banner but under certain circumstances, some activities are permitted by the federal government when they involve Accountable Care Organizations (ACO) and the contracts related to ACO activities. Questions about Stark and ACO activities should be directed to the Legal Department.

Anti-Kickback Statute

The Anti-Kickback Statute (AKS) is a criminal statute that prohibits knowingly and willfully offering, paying, soliciting or receiving anything of value, in cash or in kind, to induce referrals for items or services for which payment may be made under a Federal health care program. This law applies to relationships among various providers — not just physicians and hospitals. Team Members should never tie compensation or other remuneration to referrals or potential referrals by providers to Banner, and they should never solicit or receive any compensation or benefit that is tied to the referral of business to a provider.

Certain business arrangements may be acceptable under the AKS if they satisfy safe harbors. Examples of those safe harbors include, but are not limited to:

- Investments in ambulatory surgery centers
- Personal services and management contracts
- Certain leases
- Certain managed care arrangements
- Discounts (e.g., for purchases from vendors and group purchasing organizations)
- Arrangements with bona fide employees

All the elements of the safe harbor must be satisfied in order to qualify; however, unlike the Stark Law, if an arrangement falls outside the safe harbor, it is not necessarily noncompliant but must be evaluated on a case-by-case basis.

An example of an AKS violation includes a facility paying a physician or a nursing home for referring patients to the facility.

Violations of the AKS may result in criminal and/or civil penalties. Criminal penalties may include fines up to $25,000 per violation and up to a 5-year prison term per violation. Civil penalties may include civil monetary penalties (adjusted annually for inflation) for each violation, a civil assessment up to three times the amount of the kickback, exclusion from participation in Federal health care programs and liability under the FCA.

In general, these AKS requirements apply across Banner but under certain circumstances, some activities are permitted by the federal government when they involve Accountable Care Organizations (ACO) and the contracts related to ACO activities. Questions about AKS and ACO activities should be directed to the Legal Department.

Health Insurance Portability and Accountability Act

Team Members must preserve the privacy and security of protected health information (PHI) in accordance with all applicable laws, including, but not limited to, HIPAA. Banner has developed and implemented specific HIPAA policies which address:

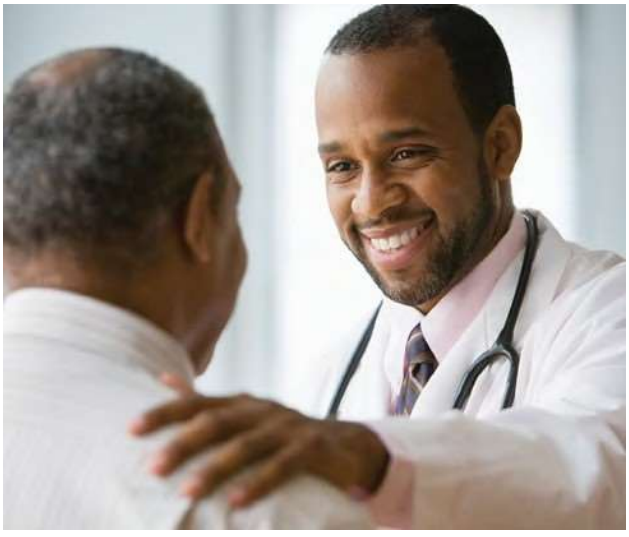
- **Right to Privacy:** Banner patients have certain rights regarding the privacy and confidentiality of their PHI. Banner will limit the use and access to PHI as permitted or required by law and Banner policies. Team Members and other persons subject to Banner policies may only access PHI as necessary to perform their job functions.
- **Patient Rights:** Banner patients have certain rights related to their PHI, and all Team Members will comply with Banner policies regarding those rights.
- **Provision of Notice:** As required by law, a Notice of Privacy Practices describing how Banner uses and discloses PHI is made available to Banner patients.
- **Privacy Officer:** Banner has a Chief Privacy Officer who is responsible for the development and implementation of HIPAA policies.
- **Education:** Banner is committed to providing education on HIPAA to Team Members.

Unlawful access, use, or disclosure of PHI may be reportable to the patient, government agencies and, in some cases, to the media. Violations of HIPAA may result in civil and/or criminal penalties, including a range of civil monetary penalties, fines and up to 10 years in jail.

Team Members should contact the HIPAA Privacy Office to report a privacy or security incident or if they have any questions about the permissible use or disclosure of PHI.

Emergency Medical Treatment and Labor Act

Banner complies with the Emergency Medical Treatment and Labor Act (EMTALA), which requires Medicare-participating hospitals to screen patients for an emergency medical condition and, if one exists, to provide stabilizing treatment, regardless of the patients' ability to pay. EMTALA applies not only to patients in the emergency department and obstetrical department but also to individuals anywhere on the hospital's campus who have a medical condition that a prudent layperson would believe is an emergency medical condition. In an emergency situation or if the patient is in labor, Banner will not delay the medical screening examination and necessary stabilizing treatment in order to seek financial and demographic information.



Banner also does not transfer patients with emergency medical conditions based only on their ability or inability to pay or any other discriminatory factor. Patients with emergency medical conditions are only transferred to another facility at the patient's request or if a physician certifies that the benefits of transfer outweigh the risks. Physician certification is appropriate where the patient's medical needs cannot be met at the Banner facility (e.g., we do not have the capacity or capability), and appropriate care is available at another facility that has accepted the patient.

Penalties for violating EMTALA include civil monetary penalties (adjusted annually for inflation) and exclusion from participation in Federal health care programs. Responsible physicians — which includes treating physicians as well as on-call physicians who failed to appear within a reasonable time at the hospital to provide services — also face civil monetary penalties and exclusion under EMTALA.

Antitrust Laws

Banner complies with antitrust laws in our dealings with competitors and customers. Antitrust laws and other laws governing competition are designed to promote and protect free, lawful and fair competition in the marketplace. These laws apply to conduct at all levels of an organization. In general terms, antitrust and other laws governing competition require Banner to compete on an individual basis rather than join with other companies or competitors in agreements to restrict competition.

Generally, antitrust laws prohibit:

- Abuse of market power to engage in unfair price discrimination and other forms of unfair methods of competition;
- Agreements or actions with competitors that restrain trade in some way or are inconsistent with concepts of free, open, and fair competition;
- Abuse or exchange of intellectual property or confidential or proprietary business information with competitors; and
- Transactions that may lessen competition or tend to create a monopoly, a dominant position in the market, or market power.

Failure to comply with the antitrust laws could lead to criminal and civil penalties for Banner and Team Members personally, significant business disruptions and harm to Banner's reputation. Team Members should discuss any concerns regarding a particular action or arrangement and the applicability of the antitrust laws with the Legal Department.

Under certain circumstances, some activities may be permitted by the federal government when they involve Accountable Care Organizations (ACO) and the contracts related to ACO activities. Questions about antitrust and ACO activities should be directed to the Legal Department.

Intellectual Property Laws

Intellectual property includes patents, trademarks, service marks, trade secrets and copyrights. Intellectual property is protected by Federal and State laws. Inventions or techniques created by Team Members while working at Banner are the property of Banner, unless there is a written agreement between Banner and Team Members stating differently.

If Team Members use Banner's intellectual property in their work, they should be very careful to not inappropriately disclose this information to others. The use of this information for their own purposes is prohibited.

During the course of employment, Team Members may have access to intellectual property owned by other businesses. This intellectual property should not be disclosed without complying with all confidentiality obligations set forth in Banner policies and/or any applicable agreements.

Violations of intellectual property laws may result in civil and/or criminal damages for the Team Member as well as Banner.

Political Activities and Contributions

Banner must comply with all Federal, State, and local laws governing participation in government relations and political activities. As a general policy, Banner does not use corporate resources for political purposes such as promoting or benefiting any candidate for office or to reward government officials, nor shall Team Members engage in activities that jeopardize our tax-exempt status.

All Banner contacts and transactions with government representatives must be conducted honestly and ethically. Any attempt to influence the decision-making process of a government representative by an improper offer of any benefit is absolutely prohibited. Any request or demand by a government representative for an improper benefit should be immediately reported to Government Relations and the Ethics & Compliance Department.

Team Members may personally participate in and contribute to political organizations or campaigns as long as it is on their own time, financed exclusively with their own funds and resources, and done outside of any Banner facility.

Public Policy Positions

Banner's public policy positions are consistent with our role as a not-for-profit organization and reflect our mission, values and purpose.

Banner engages in public policy debate only when it has special expertise that can inform the public policy process. When the organization is directly impacted by public policy decisions, Banner may provide relevant, factual information about the impact of such decisions. Banner only takes positions that it believes can be shown to be in the larger public interest, and it encourages trade associations with which it is associated to do the same.

At times, Banner may ask employees to make personal contact with government representatives or write letters on specific issues. In addition, some Team Members may interface on a regular basis with government representatives as part of their position descriptions. If Team Members are making these communications on behalf of the organization, they must be familiar with any regulatory constraints and always observe them.

Tax Exempt Status

As a tax-exempt entity under section 501(c)(3) of the Internal Revenue Code, Banner has a legal and ethical obligation to comply with applicable tax laws, engage in activities which further its exempt charitable purpose and ensure that its resources are used to benefit the communities it serves rather than any private or individual interests. Consequently, Banner and its employees must avoid compensation and service arrangements in excess of fair market value, utilize Banner's facilities and assets for exempt purposes, accurately report payments to appropriate taxing authorities and file all tax returns according to applicable law.

Employees, physicians, and all who do business with Banner must comply with the various Internal Revenue Service rules and regulations that apply to transactions between tax-exempt entities and other private parties. These rules deal with issues commonly referred to as "inurement" and "private benefit." Violation of these rules could result in the loss of tax-exempt status for Banner or the imposition of sanctions, including those penalties imposed under the Federal Intermediate Sanctions Law. Because these transactions involve complicated tax issues, they should be reviewed and approved in writing in advance by the Legal Department.

Workplace Conduct and Employment Practices

Guiding Principles

Team Members must represent Banner accurately and honestly, deal fairly with everyone and refrain from any activity intended to defraud anyone of money, property or services. Team Members must always treat each other with dignity, respect, and courtesy and demonstrate behavior that fosters trust in all their activities.

Equal Employment Opportunity

Banner believes in providing equal employment opportunity to qualified individuals and prohibits discrimination in any work-related decision on the basis of race, color, national origin, religion, age, disability, sex, sexual orientation, veteran status, genetic information or any other protected status.

Our interactions with one another should always be fair, objective, and professional. Each of us is responsible for supporting fair employment values by complying with labor and employment laws. Banner will make reasonable accommodations for individuals with physical or mental disabilities, in accordance with applicable laws.

Harassment and Workplace Violence

Banner does not tolerate harassment or abuse of any kind. Degrading or humiliating jokes, slurs, intimidation or other harassing conduct is not acceptable in our workplace. Any form of sexual harassment is strictly prohibited.

We should all feel safe at Banner. Team Members should speak up if a coworker's conduct ever makes them feel uncomfortable. Supervisors who learn of any such alleged incident or concern should immediately report it to the Human Resources Department. Human Resources will promptly and thoroughly investigate any complaints and take appropriate action. Anyone found to be engaging in unlawful harassment will be subject to corrective action, up to and including termination of employment or contractual relationship with Banner.

Legal Holds

Employees must reply to and comply with Legal Hold notices issued by Banner. Legal Hold notices direct an employee to preserve documents and information that may be relevant to legal claims by or against Banner. Legal Hold notices are sent out to ensure that Banner meets its legal obligation to preserve evidence, and an employee's failure to respond to or comply with, a Legal Hold notice is grounds for corrective action, up to and including termination of employment.

Conflicts of Interest

Avoid conflicts of interests and the appearance of conflicts of interest.

A conflict of interest occurs if an outside interest or activity may influence or appear to influence the ability of Team Members to exercise objectivity or meet their job responsibilities. Participation in activities that conflict with the employment responsibilities of Team Members is not acceptable. A reasonable guideline to follow would be that a potential conflict of interest exists when an objective observer might wonder whether a Team Member is motivated solely by his/her responsibilities to Banner or by other interests.

Banner's Conflict of Interest policy provides additional guidance in this area. The policy requires that board members, officers, administrators, employed physicians, and other Team Members designated by their supervisors or the Vice President of Internal Audit to submit a Conflict of Interest Disclosure Survey annually. All other Team Members are required to disclose a potential or actual conflict of interest to their administrators, supervisors or to the Internal Audit Department prior to making a decision or taking any action that is or may be affected by that conflict. Supervisors or administrators may consult with the Internal Audit Department for assistance in resolving conflicts. Failure to disclose and withdraw from conflicts of interest can result in corrective action, up to and including termination.

Guidelines for some common conflict of interest situations:

- Corporate opportunities discovered through work at Banner belong first to Banner. Team Members owe a duty to Banner to advance its legitimate business interests. Team Members are prohibited from using Banner's confidential or proprietary information for personal gain.
- Outside employment must not interfere with the duties of Team Members at Banner. Team Members must disclose and discuss with their supervisors all outside jobs, relationships, or transactions that may create a conflict of interest.
- Team Members may not use Banner resources or facilities to support their own outside business activities or those of another organization.
- Relationships may affect our judgment, but a close relationship with another person does not automatically mean that there is a conflict of interest. Team Members should discuss the potential conflict of interest with a supervisor or the Internal Audit Department.

Coworker Interactions

In the normal day-to-day operations of an organization like Banner, there are issues that arise relating to how people in the organization deal with one another. It is impossible to foresee all of these, and many do not require explicit treatment in a document like this. A few routinely arise.

One involves gift giving among Team Members. While we wish to avoid any strict rules, no one should ever feel compelled to give a gift to anyone, and any gifts offered or received should be appropriate to the circumstances. For example, a lavish gift to anyone in a supervisory role would clearly violate Banner policy.

Another situation that may arise frequently involves charitable fund-raising or volunteering efforts undertaken by individuals, in which no one should ever be compelled to participate. Similarly, when Banner decides to support charitable organizations such as the United Way, Team Members should never feel compelled to contribute to the charitable organization, nor should there be any workplace consequences of such non-participation.

Solicitation

Banner has established rules for any solicitation and distribution activities that are conducted by vendors as well as by Team Members. Any solicitation or distribution must be conducted in accordance with the Solicitation and Distribution policy. Questions about this policy should be directed to the Legal Department.

Relationships with Vendors

Vendors and others with whom we do business are vital to our success. We confirm that they are not excluded from Federal health care programs before working with them. Once they are working with Banner, we expect them to adhere to this Code of Conduct, or an equivalent Code of Conduct, and to always treat us with the same respect, fairness, and professionalism that we demonstrate to them.

Banner manages its vendor relationships in a fair and reasonable manner, free from conflicts of interest and consistent with all applicable laws, regulatory requirements, contractual obligations, and good business practices. We promote competitive procurement to the maximum extent practicable. Our selection of vendors will be made on the basis of objective criteria related to cost, quality, and outcomes. We employ the highest ethical standards in source selection, negotiation, determination of contract awards and the administration of all procurement activities.

If we entrust vendors with confidential information, we expect them to uphold our trust and protect our information. In turn, we comply with contractual obligations not to disclose a vendor's confidential information unless permitted under the contract or otherwise authorized by the vendor.

Gifts, Business Meals and Entertainment

All gifts, business meals and entertainment provided and received must be reasonable and small enough that they do not influence our decisions. We never offer or accept anything of value in exchange for referrals or other business. We communicate to vendors, providers, patients and others that our values restrict what we can give and receive because we want our services and business relationships to stand on their own. We recognize that certain items are appropriate and do not present a risk of influencing our decisions. Team Members must make sure that even permitted items do not damage our reputation or our integrity under the circumstances.

What is a gift? A gift is any item of value — including everything ranging from marketing items like t-shirts to flowers and gift baskets — if the recipient is not expected to pay for the item.

What is a business meal? A business meal is any meal where the predominant purpose of the meal is to discuss Banner business.

What constitutes entertainment? Entertainment is attendance at any event such as a sporting event, concert, or play where the recipient is not expected to pay for the entrance fee or ticket.

What if I receive something that is not permitted? If an item is not permitted, it should be returned to the giver or, if this is impossible, must be surrendered to one of Banner's charitable foundations for its unrestricted use. Perishable items may be donated to a charity or shared in the work area. If Team Members are unsure whether an item is permitted, they should contact their supervisor, department manager or director, Compliance Officer, or the Ethics & Compliance Department.

Permitted gifts, meals and entertainment.

The items below are permitted but must be reasonable and appropriate under the circumstances and all requirements of Banner policy must be met.

Occasional gifts:

- Except as permitted by law, regulations or sub-regulatory guidance, purchased by Banner for a patient /Member with a retail value that does not exceed $15 per item and $75 in total per year and is not cash or its equivalent. **Examples:** A hospital may provide a $10 t-shirt to the parents of a newborn. A clinic may give a $15 bag to a diabetic patient for his insulin supplies.
- Received from a vendor with a retail value that does not exceed $50 per item per Team Member and $200 in total per year and is not cash or cash equivalent. **Examples:** An accounting firm may purchase a $50 watch for a retiring Banner employee. A vendor may provide a $100 fruit basket to the radiology department if the basket is shared among department members.
- Except as permitted under ACO activities, purchased by Banner for a physician in limited circumstances as long as the value of the item is within the non-monetary compensation limit and the item is not cash or cash equivalent. Contact the Compliance Officer and, in the case of hospitals, medical staff services before proceeding. **Example:** A hospital may buy gift baskets valued at $80 for each member of the medical staff to celebrate Doctor's Day. The hospital must log the gift basket as non-monetary compensation for each physician in the database.
- Received from a physician as long as the amount does not exceed $50 per item per employee and $200 in total per year, and the item is not cash or cash equivalent. **Example:** A physician may provide each nurse on the unit a $50 holiday turkey. Note: A gift received from a physician cannot affect or even appear to affect any decisions made in a work capacity with respect to that physician.

Occasional business meals:

- Received from a vendor as long as the business meal does not exceed $50 per person. Example: A computer hardware vendor may take a Team Member to a $30 lunch to discuss the performance of the hardware.
- Purchased by Banner for a physician, or received from a physician, in limited circumstances. Contact the Compliance Officer before proceeding. **Example:** A chief nursing officer may take the physician who serves as medical director of the ICU to lunch to discuss infection control rates. The physician's medical director agreement must state that the physician will attend meals from time to time to discuss the physician's duties or the lunch would need to be logged as non-monetary compensation in the database.

Occasional business entertainment:

- Received from a vendor as long as the cost does not exceed $500 per year or a max of 4 events per year from the same vendor, and the vendor attends the event with the employee to discuss business. **Example:** A vendor may take a quality manager to a museum event with a ticket price of $450.
- Purchased by Banner for a physician, or received from a physician, in limited circumstances. Contact the Compliance Officer before proceeding. **Example:** The hospital may host an annual physician appreciation dinner for its medical staff.

Prohibited gifts, meals and entertainment.

Some examples of items that are not permitted include:

- Gifts received from or purchased for government officials
- Free health care items or services of any value unless specifically permitted by Banner policy or as authorized by statute, regulation or sub-regulatory guidance
- Cash, money orders, stock, negotiable instruments or other cash equivalents provided to or received from patients, vendors, customers, physicians or government officials
- Items solicited by the recipient in violation of the law
- Gifts provided to or received from anyone during a pending Banner purchasing decision

Controlled Substances

Team Members may routinely have access to prescription drugs, including controlled substances. Drugs are governed and monitored by Federal and State regulatory agencies and can only be administered pursuant to a provider order. All drugs and related supplies must be handled properly and only by authorized individuals in order to minimize risks to patients, visitors and Team Members. If Team Members become aware of inadequate security or the diversion of drugs from the organization, the incident must be reported immediately. Banner strictly enforces reporting of any known or suspected violations of drug diversion within the organization.

License and Certification Renewals

Banner does not allow any employee, independent contractor or privileged provider to work without valid, current credentials. Team Members must have evidence of current and valid licensure, certification, registration or other credential as required by their position description. Team Members must also comply at all times with Federal and State requirements applicable to their respective disciplines.

Personal Use of Banner Resources

All Team Members are expected to be good stewards of our charitable assets. They are expected to maintain and properly care for our organization's assets for the benefit of the communities we serve. Organization assets — including time, materials, supplies, equipment and information — are to be maintained for business-related purposes. As a general rule, personal use of any Banner asset without prior supervisory approval is prohibited.

Banner property should not be removed from its facilities unless it is necessary to do so to perform the jobs of Team Members. Team Members must return the property to its proper location as soon as it is no longer needed off-site for business purposes.

Marketing Practices

Marketing and Public Relations Guidelines

Banner may use marketing and public relations to educate the public, provide information to the community, increase awareness of our services, to market its Managed Care plans and to recruit physicians and employees. We present only truthful, fully informative, and non-deceptive information regarding available services, products and the level of licensure and certification. We do not make guarantees and promises in Banner written materials and advertisements and we avoid the use of hyperbole in promoting our services and programs.

While continuing to follow all regulatory requirements for marketing and sales activities, some exceptions may apply for Banner's Managed Care products.

While it is permissible to compare and contrast our services and prices, it is against Banner policy to intentionally disparage other persons or businesses based on information that is untrue, or not known to be true or to intentionally interfere with another business's contractual relationships through wrongful means.

Branding standards

All Banner entities must conform to Banner's branding standards to maintain a consistent and recognizable image.

Third party use of Banner names and logos

To ensure proper use of our names and logos in advertising, news releases, case studies or other promotions, Team Members will refer any requests from third parties to the Marketing and Public Relations Department. Unless authorized to do so, Team Members should not promise, in writing or in conversation, that Banner or its employees will endorse a third-party product or service.

Gathering information about competitors

Banner may obtain information about other organizations, including our competitors, through legal and ethical means such as public documents, public presentations, journals, magazine articles and other published and spoken information. However, Banner will not obtain proprietary or confidential information about a competitor through illegal means.

External Communications

Team Members must never speak with the media about Banner (including its patients, providers, employees, and services), unless they have been explicitly authorized to do so by Banner's Public Relations Department. Public Relations serves as the first point of contact with the news media regarding all inquiries related to the organization and its services. Public Relations will follow established processes when engaging with the news media, including the identification of appropriate subject matter experts and spokespersons as well as observing related privacy practices required by Federal law.

Social Media Sites

Team Members should follow the Employee Handbook and the Social Media policy with regard to their social media sites. Team Members should never share information that reveals a patient's identity or health condition or Banner proprietary information on any social media sites.

Health, Safety and Environmental Compliance

Banner policies have been developed to protect Team Members from potential workplace hazards. Team Members must become familiar with and understand how these policies apply to their specific job responsibilities and seek advice from their supervisor or Safety Officer whenever they have a question or concern.

Team Members are responsible for maintaining a safe environment by participating in training and drills, promptly reporting identified hazards, utilizing safe work practices, and adhering to all safety policies and procedures. It is important that Team Members immediately advise their supervisor or Safety Officer of any serious workplace injury or any situation presenting a danger or injury so timely corrective action may be taken to resolve the issue.

Banner complies with all environmental laws and operates every facility, provider group, ancillary service area and insurance division with the necessary permits, approvals and controls. We diligently employ the proper procedures to provide a good environment of care and to prevent pollution.

Clinical Research

Clinical research regarding the safety and efficacy of drugs, biologics, devices, diagnostic products and treatment regimens takes place at many Banner entities. There are different types of clinical research, including, but not limited to, clinical trials, prevention studies, retrospective chart reviews and screening studies. All research involving human subjects or their PHI must comply with Federal, State, and local research standards to protect the rights, welfare, and well-being of research subjects. Banner must also ensure all claims for reimbursement to government and private payors accurately represent the services provided and comply with pertinent Federal and State laws. Questions regarding the ethical conduct of research or the legal and regulatory requirements applicable to a particular research project should be directed to the Human Research Protection Program (HRPP) Director.

InstitutionalReview Boards

Per Federal regulations (45 C.F.R. § 46 and 21 C.F.R. § 56), all clinical research involving human subjects must have Institutional Review Board (IRB) approval prior to implementation. An IRB is a committee of physicians, scientists, community advocates and others who ensure that research is ethical and that the rights, welfare, and safety of human subjects isprotected.

Banner has its own IRB that is registered with the Office for Human Research Protections (OHRP) in compliance with Federal regulations (45 C.F.R. § 46, subpart E and 21 C.F.R. § 56.106). In addition, Banner relies on another qualified IRB to provide oversight for clinical research involving multiple sites or centers.

Ethical Foundation

Banner is committed to protecting the rights, safety and welfare of all human subjects recruited to participate in research activities. Human subject research protection is a shared responsibility of Banner's HRPP, the IRB, investigators, research staff, participants, and sponsors. In the conduct of all human research, regardless of funding source or sponsorships, Banner upholds the ethical principles of the Belmont Report. Those ethical principles are:

- Respect for Persons: Recognition of the personal dignity and autonomy of individuals and special protection of those persons with diminished autonomy. This principle is applied through the informed consent process.
- Beneficence: Obligation to protect persons from harm by maximizing anticipated benefits and minimizing possible risk of harm. This principle is applied through the assessment of risks and benefits.

- Justice: Fairness in the distribution of research benefits and burdens. This principle is applied through the selection of subjects.

Clinical trials should be conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki and that are consistent with good clinical practice and the applicable regulatory requirements.

Research Misconduct

Banner is committed to high ethical standards in research and will not tolerate any type of research misconduct. Research misconduct means fabrication, falsification, or plagiarism in proposing, performing or reviewing research or in reporting research results. It does not include honest error or differences of opinion.

Informed Consent

The informed consent process is intended to ensure that a potential research subject understands the purpose of the research as well as the potential risks, benefits and alternatives to participation. As part of that process, the researcher (or his/her delegate) explains the details of the research to the potential subject and answers all the subject's questions. The potential subject must be given adequate time to consider whether he/she will participate. Throughout the process, the researcher must ensure the subject's continued willingness to participate in clinical research and provide updated information to the subject when appropriate.

The informed consent document must contain all elements required by the regulations. The document must be reviewed and approved by an IRB. The informed consent document must be in a language understandable to the research subjects. For example, if the subjects do not speak or read English, they must be given an IRB-approved informed consent document written in their primary language.

Participation in clinical research is voluntary. Refusal to participate in clinical research does not compromise an individual's access to any other health care services at Banner.

Privacy and Confidentiality

Research regulations require the inclusion of adequate provisions to protect the privacy of human subjects and the confidentiality of information shared during clinical research participation. As part of their review of clinical research, the IRB must determine that the privacy and confidentiality of subjects are adequately and appropriately protected.

In addition, HIPAA covers the PHI of all subjects participating in clinical research. An authorization or waiver must be in place in order for researchers to access PHI for research purposes.

Financial Considerations

Banner policies regarding research-related items and services provided to patients enrolled in clinical research require that we accurately bill in accordance with all relevant laws, regulations, guidelines regulatory and contractual requirements.

Banner has established standards for the disclosure, review and management of conflicts of interest in research. A conflict of interest exists when financial or other personal considerations may compromise or appear to compromise a researcher's professional judgment in conducting, overseeing, reporting, or publishing research or, most importantly, in protecting human subjects. Clinical research data and results must not be influenced by outside interests. Researchers are responsible for complying with all Banner policies regarding conflicts of interest.

Conclusion

Compliance at Banner is everyone's responsibility, and this Code of Conduct is just one of the resources available to Team Members. If Team Members have any questions or are unsure how to apply this Code of Conduct, they should contact their supervisor, department manager or director, Compliance Officer, the Ethics & Compliance Department or the ComplyLine.

Acknowledgment

As part of their compliance training, Team Members are required to acknowledge that they have agreed to the following statements in order to receive credit for the course.

I certify that I have reviewed Banner's Code of Conduct and understand that it represents mandatory policies of the organization. I agree to abide by the Code of Conduct.

Addendum B: Definitions

Abuse – Includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare or Medicaid programs or other government programs; improper payment; payment for services that fail to meet professionally recognized standards of care; or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Accountable Care Organization (ACO) – Groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to populations of patients.

Agents – Independent agents/brokers used to sell Medicare Advantage Part C and D plans.

AHCCCS (Arizona Health Care Cost Containment System) – Arizona's Medicaid program.

Audit – A formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as a base measure.

Beneficiary/Member – A member of a Medicare, Medicaid, or other government program.

Board of Directors/Managers – A body of elected or appointed individuals who oversee BID activities.

Business Partners – The collective grouping of all FDRs, subcontractors, and agents.

CMS/CMMI Programs – For purposes of this document, includes both CMS and CMMI programs for which BH contracts directly with CMS or CMMI. For example, the Medicare Shared Savings Program (MSSP).

CMS (Centers for Medicare & Medicaid Services) – An agency within the U.S. Department of Health and Human Services (DHHS) responsible for administration of several key federal health care programs including Medicare; Medicaid; and other health-related programs.

Commercial Health Plan – Health plans that offer any type of health benefit not obtained from a federal healthcare program. The insurance may be employer-sponsored or privately purchased.

ComplyLine – A hotline operated by a third-party vendor to ensure confidentiality and anonymous reporting.

U.S. Department of Health and Human Services (DHHS, or HHS) – The federal agency whose mission is to enhance and protect the health and well-being of all Americans by providing for effective health and human services and fostering advances in medicine, public health, and social services. HHS is the parent organization to many federal agencies including the CDC, CMS, OCR, and OIG.

Employee Retirement Income Security Act (ERISA) – Federal law that sets standards of protection for individuals in most voluntarily established private sector retirement plans.

Federal Health Care Program – Any plan or program that provides health benefits (whether directly, through insurance, or otherwise) which is funded in whole or in part by the United States Government (other than the Federal Employees Health Benefit Program) or any state health care program (as defined in 42 U.S.C. § 1320a-7(h)). Federal Health Care Programs include, but are not limited to, Medicare, Medicaid, Indian Health Service, TRICARE/CHAMPUS/Department of Defense health care programs, and Veterans Administration.

First Tier, Downstream, and Related Entities (FDRs) – A First Tier Entity is a party that enters into a written arrangement with a Health Plan to provide administrative or health care services. A Downstream Entity is a party that enters into a written arrangement with a First Tier Entity. These written arrangements continue down to the level of provider of both health and administrative services. A Related Entity is an entity that is related to Health Plan by common ownership or control and: 1) performs some Health Plan management functions under contract or delegation; 2) furnishes services to members under an oral or written agreement; or 3)leases real property or sells materials to a Health Plan at a cost of more than $2,500 during a contract period.

Fiscal Agent – Business Partners, FDRs, Subcontractors and Agents that process or pay health service claims .

Fraud – Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

General Services Administration's (GSA) Excluded Parties List System (EPLS) on the System for Award Management (SAM) – An electronic, web-based system that identifies parties suspended, debarred, proposed for debarment or otherwise excluded from receiving federal contracts, certain sub-contracts and certain types of federal financial and non-financial assistance and benefits.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Federal legislation and its implementing regulations and guidance that provides data privacy and security provisions for safeguarding medical information.

Managed Care Organization (MCO) – A Company that agrees to provide most Medicare, Medicaid, and/or Marketplace benefits to members in exchange for a monthly payment from the Federal or State Government and/or individual private payer.

Medicare Advantage Organizations (MAO) – Health plans that are approved by Medicare and provided by private insurance companies. Medicare sets the rules for MAOs and regulates the private insurance companies who operate the MAO.

Medicare Shared Savings Program (MSSP) – Established by Section 3022 of the Affordable Care Act (ACA), the MSSP is a type of ACO offering which agrees to be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service (FFS) beneficiary population. The MSSP has different tracks that allow ACOs to select an arrangement that makes the most sense for their organization.

Misconduct – Any action or behavior that does not conform to the organization's stated or intended standards, guidelines or procedures, or is a violation of any federal/state law or regulation.

Monitoring Activities – Regular reviews performed as part of BID's normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

Medicare Drug Integrity Contractor (PPI MEDIC) – An organization that CMS has contracted with to perform specific program integrity functions for Parts C and D under the Medicare Integrity Program. The PPI MEDIC's primary role is to identify potential fraud, waste, and abuse in Medicare Parts C and D.

Non-Compliance – Failure or refusal to act in accordance with the organization's Compliance Program, or other standards or procedures, or with federal or state laws or regulations.

Office of Civil Rights (OCR) – The HHS OCR enforces federal civil rights laws, conscience, and religious freedom laws, HIPAA Privacy, Security, and Breach Notification Rules, and the Patient Safety Act and Rule.

Office of the Inspector General for HHS (OIG) – The OIG's mission is to protect the integrity of the HHS programs as well as the health and welfare of program beneficiaries via audits, investigations, and evaluations aimed at assisting the health care industry in its efforts to comply with the Nation's fraud and abuse laws, and to educate the public about fraudulent schemes so they can protect themselves and report suspicious activities.

Employees – Refers to all of the BH or BID employees, including the Boards of Directors/Managers.

Subcontractor – See First Tier, Downstream, and Related Entities.

Third Party Administrator – In the State of Arizona, a health administrator, also known as a third-party administrator (TPA) collects money or processes claims for residents of Arizona in connection with health insurance coverage. (*See* Arizona Revised Statutes (A.R.S.) § 20-485).

Waste – Over-utilization of services or other practices that, directly or indirectly, result in unnecessary costs to Federal and State Government programs. Waste is generally not considered to be criminally negligent, but rather, the misuse of resources.