AMENDED ANTI-FRAUD PLAN
FOR AVMED, INC.
Amended March 2021

AvMed, Inc. hereby amends the Anti-Fraud Plan of its Special Investigations Unit ("SIU") which was created to identify, investigate, and rectify instances of fraud, waste, and abuse committed by participating and non-participating providers and facilities, all vendors, associates, members, and unaffiliated third parties. AvMed's Special Investigative Unit operationally established as the Audit Services & Investigations ("AS&I") resides in the AvMed Corporate Assurance & Advisory Department, collaborates with and is supported by the Compliance Department, Risk Management Department, and Legal Department. This Plan is also designed as an element of the AvMed Compliance Program. AvMed has a fiduciary responsibility to the broader health care community to detect and investigate instances of false claims, improper billing and coding practices, and other schemes that adversely impact patient safety, the quality of health care services being delivered and that impose a tremendous financial burden on the health care system.

In addition, AvMed's Anti-Fraud Plan is in compliance with Section 626.9891(a)(b), Florida Statutes, Section 626.9891(3), Florida Statutes, and Rule 69D-2.001-005, Florida Administrative Code. Likewise, as a Medicare Advantage Organization under contract with the Centers for Medicare and Medicaid Services, federal law, including but not limited to 42 C.P.R. 423.504(b)(4)(vi) for Part D plan sponsors, requires that AvMed have in place a comprehensive fraud and abuse plan to detect, correct, and prevent fraud, waste and abuse.

MISSION STATEMENT

AvMed will not tolerate health care fraud, waste, or abuse in any of its relationships with either internal or external clientele. Furthermore, AvMed will establish and maintain internal controls designed to prevent schemes with unaffiliated third parties. AvMed will investigate, identify, report, and, when appropriate, refer for prosecution, situations in which suspected fraud, waste, or abuse has occurred.

AvMed has adopted the following mission statement for its fraud and abuse program:

> *The AvMed Anti-Fraud Program seeks to meet the customer's expectation that we will reimburse only for services that are medically necessary and appropriate and that the benefits will be issued only to eligible subscribers and providers. We strive toward this goal by providing a central point for the detection, investigation, and resolution of fraud, waste, and/or abuse.*

ANTI-FRAUD GOALS

AvMed's goals and priorities are key to its anti-fraud program success. Key benefits include:

- **Quality**- Improving the quality of patient care is a priority.
- **Customer Relations** - An effective anti-fraud program demonstrates the company's strong commitment to honest and responsible provider and corporate conduct.
- **Assessment of Risk** - The program will facilitate a more accurate view of risk and exposure relating to fraud and abuse.
- **Public and Legislative Compliance** - The program facilitates compliance with state and federal laws, and demonstrates an aggressive approach to fighting fraud/ abuse.
- **Civic Responsibility** - Combating fraud/ abuse through identifying and preventing criminal and unethical conduct is considered a public duty.
- **Financial Savings** - Through prevention, early detection and recovery, minimizing the loss to AvMed and its clients from false claims.
- **Deterrence** - Future deterrence of fraud, waste, and abuse.
- **Objective Claims Handling** - Standard, unbiased claims review is required by law and is smart business.

ANTI-FRAUD PLAN

The components of the Anti-Fraud Plan are as follows:

I. Prevention, Detection and Investigation of Insurance Fraud
II. Recovery
III. Reporting
IV. Education and Training
V. Primary Contact Persons/Organizational Chart

I. PREVENTION, DETECTION, INVESTIGATION OF INSURANCE FRAUD

A. Internal Fraud

Prevention, Detection and Investigation

AvMed has adopted fraud prevention, detection, and investigation procedures. The following is a summary of AvMed's fraud, waste, and abuse control procedures that serve to prevent internal fraud, waste, and abuse.

Comprehensive Internal Compliance Program

The current AvMed Compliance Program provides, among other things, for the reporting of compliance issues. Associates are required to report improper activity to their supervisors, General Counsel, the VP of Compliance and Chief Audit Executive, the Director of Audit Services, the Director of Compliance, the SIU or anonymously to the Compliance Hotline 1-877-AVM-DUTY (1-877-.286-3889) The Compliance Program expressly prohibits retaliation against those who, in good faith, report concerns or participate in the investigation

of compliance issues. The Compliance Program provides that compliance concerns will be investigated rigorously and resolved promptly. Investigations regarding compliance violations are conducted by General Counsel, Audit Services, Compliance, the SIU, or Human Resources, depending upon the nature of the violation. Compliance and fraud, waste and abuse training is provided to all new associates and to existing associates on an annual basis.

B. External Fraud

Prevention and Detection

AvMed strives to detect and prevent health care and insurance fraud, waste, and abuse by receiving referrals from a variety of sources and through the use of sophisticated fraud detection technology.

AvMed seeks to detect fraud, waste, and abuse through a variety of methods as follows:

a. Insurance Fraud Detection Technology

Data will be routinely and randomly analyzed by the AvMed Medical Department, Network Department, Pharmacy Department, and the SIU, based upon tips from all sources, to include external vendors, specific to provider, facility, member and pharmaceutical fraud, waste and abuse as well as independent research. This data analysis will be critical in the identification of repetitive fraud, waste, and abuse patterns. Output reports will be used for existing cases as well as the bases for new ones.

AvMed will utilize data mining capabilities and other advanced technology to prevent and detect insurance fraud, waste, and abuse.

AvMed's SIU performs ongoing computer-based analysis of provider, facility, member, and pharmaceutical data. Patterns of over-utilization, false claims, or other unusual billing practices are identified, investigated and if applicable follow-up education and/or referral to external law enforcement are performed. Additionally, proprietary system flags or edits within the claims systems automatically segregate claims with certain predetermined characteristics.

b. Fraud/Suspicious Claim Referral Sources

The identification and prevention of fraud, waste, and abuse is a cooperative effort, involving all associates. All associates are required to cooperate in any investigation conducted by AvMed, its regulatory agency, or law enforcement.

The SIU department receives referrals about fraud, waste and abuse and/ or suspicious claims from the following sources:

- Hotline 1-877-AVM-DUTY
- Tips from new enrollees, current and former members, providers, other insurers and the general public received by AvMed;
- Referrals from AvMed associates, peer health insurance organizations, and from other medical providers;
- Media reports;
- Through involvement in the National Health Care Anti-Fraud Association;
- Information obtained in conjunction with studies conducted by AvMed and/ or its external vendors;
- Office of Inspector General's (OIG) database of excluded individuals/ entities;
- Referrals from law enforcement agencies such as the Florida Department of Law Enforcement, the Florida Division of Insurance Fraud, Office of Insurance Regulation, Centers for Medicare and Medicaid Services, MEDICs, the FBI, or other agencies engaged in identifying, investigating, and prosecuting fraudulent activities.

Investigation

a. SIU investigators are provided with and follow established procedures in conducting prompt investigations. The investigations procedures include, but are not limited to, the following topics:

   - Information for investigators regarding general investigation guidelines; conducting interviews; report writing; information disclosure; law enforcement relations;
   - The process to be employed when a suspicious claim is identified;
   - The suspicious claim indicators;
   - The duties and functions of the SIU department.

b. Through the course of its investigations, the SIU may work with any other departments within AvMed to review questionable claims and provide guidance.

c. The quality and credibility of allegations or suspicious situations are assessed.
   Initial exposures and recovery potential are identified to determine if a case should be opened.

d. Cases are prioritized pursuant to commonly accepted business practices and business objectives.

e. An investigative action plan/timeline is developed to guide the investigation. The action plan is periodically reviewed and revised as circumstances change.

f. Relevant claim data for the period in question is obtained and reviewed and evidence is gathered to support data analysis and allegations.

g. An investigative summary or report is prepared which summarizes the investigative findings, displays a comprehensive understanding of the facts and financial implications, recommends a corrective action plan to include reporting as appropriate, and follow- up.

II. RECOVERY

AvMed contracts with numerous commercial client groups, as well as governmental clients including, but not limited to, the Florida Division of State Group Insurance, the U.S. Office of Personnel Management for the Federal Employee Health Benefit Program and the Centers for Medicare and Medicaid Services as a Medicare Advantage organization. AvMed acknowledges its responsibility to be a proper steward and to ensure that only eligible employees or beneficiaries are afforded coverage, only medically necessary and medically appropriate services are covered and that anti-fraud, waste and abuse programs and procedures are in place. Additionally, AvMed acknowledges its responsibility to recoup overpayments to providers, vendors or others under commercial and governmental contracts as a means of reducing unnecessary medical claims costs. To this end, the AvMed Audit Services and Investigations Department utilizes state of the art technology to detect improper billing and coding practices and employs competent investigators, data analysts and other professionals to detect, remedy, and recoup overpayments due to claims unbundling and up-coding. These recovery efforts are integral to the anti-fraud, waste and abuse efforts of AvMed and supplement the other responses to such behaviors and the procedures outlined in the AvMed Compliance Program.

III. REPORTING

Pursuant to Section 626.989(6), Florida Statutes, if the Director, in collaboration with the Compliance Officer and General Counsel, determines that a claim or case meets the minimal threshold under Florida law as defined by Section 626.989(1), Florida Statutes, information regarding suspected fraud, waste and abuse shall be reported to the Florida Department of Financial Services, Division of Insurance Fraud ("Division"), CMS, MEDICs, and/ or other law enforcement agencies. Reports to the Division will be via their website and CMS/MEDICs via the MEDIC Referral Form. All case files being referred will contain documentation that clearly defines and supports the allegation of suspicious activity, will include detection and reported dates and will be in compliance with 42 C.F.R. 423.504(b)(4)(vi)

Pursuant to Section 626.989(1), Florida Statutes, a fraudulent insurance act is committed if a person knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer/ HMO, self-insurer, agent, broker, etc., any written statement as part of, or in support of, an application for the issuance of, or the rating of, insurance, or a claim for payment or other benefit, which the person knows to contain materially false information concerning any material fact. Also, a fraudulent insurance act is committed if the person conceals, for the purpose of misleading another, information concerning any material fact.

AvMed shall cooperate fully with the Florida Division of Insurance Fraud, CMS, MEDICs, and/ or other law enforcement agencies in their prosecution or additional investigation of cases reported on behalf of AvMed.

IV. EDUCATION AND TRAINING

A. Education/Fraud, Waste and Abuse Awareness Training

Pursuant to Section 626.9891(3)(c), Florida Statutes, anti-fraud education and training of claims adjusters or other personnel is mandatory.

AvMed has an ongoing Fraud Awareness Campaign. The purpose of this program is to encourage and assist AvMed's associates, members, vendors, providers and other customers to identify, detect, and report health care and insurance fraud, waste, and abuse.

The corporate training program is broad in scope. The intent is to address health insurance fraud, waste, and abuse and the impact that it can have on AvMed and the program is designed to be a web based training. Its objectives are to provide staff members with specific tools to detect fraud, waste, and abuse, instruct them in the procedures for reporting cases of suspected fraud, waste, and abuse, and create an awareness of the staggering financial and service consequences of fraud, waste, and abuse. AvMed's Audit Services and Investigations, Corporate Learning & Development, and Assurance and Compliance, departments collaborate in executing its Fraud Awareness Campaign.

All personnel are required to complete Compliance & Fraud Awareness Training every year. All new AvMed Staff members are provided Fraud Awareness Training as part of the orientation process. Records of training completion are maintained by the Corporate Learning & Development Department. Failure to timely complete AvMed's Compliance and Fraud Awareness Training will result in disciplinary action.

The focus is on the critical role that each associate plays in the eradication of fraud, waste, and abuse committed against AvMed and its customers. Highlights of the program include:

- Definition of fraud, waste and abuse;
- Tools for fraud, waste and abuse detection ("red flags");
- AvMed's prevention efforts;
- Reporting fraud, waste and abuse;
- Review of actual investigations;
- Current industry trends in the fraud, waste, and abuse arena.
- Investigative Procedures;
- Unique Department Procedures; and
- Case Management System.

B. Investigator
Education/Training

Upon hire, SIU investigators complete a comprehensive fraud detection-training course that provides the new investigator with information about AvMed's Anti-Fraud Plan as well as material regarding techniques used to combat fraud, waste, and abuse.

SIU staff members receive technical fraud, waste, and abuse training through attendance at the National Health Care Anti-Fraud Association's various seminars and workshops. SIU staff members who attend participate in the sessions that relate most directly to their specialty or position.

Additional training sessions include technical/ computer training that occur throughout the year and address various computer applications used in SIU.

V. PRIMARY CONTACT PERSONS/ORGANIZATIONAL CHART

In accordance with Section 626.9891(3)(d), Florida Statutes, the personnel identified in this Anti- Fraud Plan should be extended immunity from civil liability concerning the sharing of information regarding persons suspected of committing fraudulent insurance acts with Anti- Fraud personnel employed by other HMOs and/ or insurers pursuant to Section 626.989(4)(d), Florida Statutes.

- Any inquiries regarding the AvMed Anti-Fraud Plan should be directed to:

  AvMed Compliance Program
  AvMed, Inc.
  PO Box 749
  Gainesville, FL 32627-0749