The following Privacy Notice is provided to all HealthPlus members:

The HealthPlus Privacy Notice describes how personal and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Information We Have

We receive enrollment information about you, which includes your date of birth, sex, identification number and other personal information, including social security numbers. We also receive bills, physician reports and other information about your medical care. For some health insurance programs, HealthPlus may have credit card and/or bank account information which is supplied by you for payment of premiums.

Our Privacy Policy

We care about your privacy and we guard your information carefully. We are required by law to maintain the privacy of your information in oral, written, and electronic formats and to provide you with this notice of our legal duties and our privacy practices. We will not sell any information about you. Only people who have both the need and the legal right may see your information. Unless you give us a written authorization, we will only disclose your information for purposes of treatment, payment, business operations or when we are required by law to do so.

Treatment

We may disclose medical information about you for the purpose of coordinating your health care. For example, we may notify your personal doctor about treatment you receive in an emergency room.

Payment

We may use and disclose medical information about you so that the medical services you receive can be properly billed and paid for. For example, we may ask a hospital emergency department for details about your treatment before we pay the bill for your care.

Business Operations

We may need to use and disclose medical information about you in connection with our business operations. For example, we may use
medical information about you to review the quality of services you receive and to investigate fraud and abuse.

Health-Related Benefits and Services

We, or our agents, may contact you about other health-related benefits and services that may be of interest to you.

As Required By Law

We will release information about you when we are required by law to do so. Examples of such releases would be for law enforcement or national security purposes, subpoenas or other court orders, public health services, communicable disease reporting, disaster relief, review of our activities by government agencies, to avert a serious threat to health or safety or in other kinds of emergencies.

Employer Plans
We will share only enrollment information or summary health information (or other information if required by law) with an employer or plan sponsor. However, we may share your personal and medical information with the employer or plan sponsor if you are a participant or dependent in a self-funded employer health plan and the employer has provided us with written assurances that the information will be kept confidential and will not be used for an improper purpose.

Authorizations
If you give us a written authorization to do so, we may use and disclose your personal information. If you give us a written authorization, you have the right to change your mind and revoke that authorization.

Copies of this Notice
You have the right to receive an additional copy of this notice at any time. Even if you have agreed to review this notice electronically, you are still entitled to a paper copy of this notice. Please call or write to us to request a copy.

Change to this Notice
We reserve the right to revise this Privacy Notice. A revised notice will be effective for medical information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. Any changes to our notice will be published in our enrollee newsletter.

Other Laws and Regulations
HealthPlus must comply with all federal and state laws and regulations. Michigan law and other federal law may provide additional protection for your personal health information (e.g., HIV/AIDS, behavioral health, and minors).

Your Right to Inspect and Copy
Upon written request, you have the right to inspect the information we have about you and to get copies of that information.

Your Right to Amend
If you feel that the information about you, which we have, is incorrect or incomplete, you can make a written request to us to amend that information. We can deny your request for certain limited reasons, but we must give a written reason for our denial.

Your Right to a List of Disclosures
Upon written request, you have the right to receive a list of our disclosures of your information, except when you have authorized those disclosures or if the disclosures are made for treatment, payment or health care operations. We are not required to give you a list of disclosures made before April 14, 2003.

Your Right to Request Restrictions on Our Use or Disclosure of Information
If you do so in writing, you have the right to request restrictions on the information we may use or disclose about you. We are not required to agree to such requests.

Your Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Your request must be in writing. For example, you can ask that we contact you only at home or only at a certain address or only by mail.

How to Use Your Rights Under This Notice
If you want to use your rights under this notice, you may call us or write to us. If your request to us must be in writing; we will help you prepare your written request, if you wish.

Complaints and Communications to Us
If you want to exercise your right under this Notice, or if you wish to communicate with us about privacy issues, or if you wish to file a complaint, you can write to:

Compliance and Privacy/Security Official
2050 S. Linden Road
Flint, Michigan, 48532

Or call the Compliance Hotline at 1-800-345-9956. You will not be penalized for filing a complaint.

Complaints to the Federal Government
If you believe that your privacy rights have been violated, you have the right to file a complaint with the federal government.

You may write to:

Office of the Secretary
Department of Health and Human Services
200 Independence Avenue, S.W. Washington D.C. 20201

You will not be penalized for filing a complaint with the federal government.

When we refer to HealthPlus, we, or our, we mean HealthPlus of Michigan, Inc. and its affiliated entities, HealthPlus Partners, Inc., HealthPlus Options, Inc., and HealthPlus Insurance Company.

The purpose of the HealthPlus Compliance Program is to prevent, detect, and correct illegal, improper, and unethical conduct, and to protect HealthPlus and the public from misconduct. Our compliance program acts as an oversight mechanism to assure that all applicable laws, regulations, and internal policies and procedures are appropriately being followed. Establishing a compliance program confirms our commitment to honest and responsible conduct by providing guidance and education to employees, members, providers, employer groups, contractors, and first-tier, downstream, and related entities, identifying and preventing criminal and unethical conduct, and improving the quality, efficiency, and consistency of services. Issues are thoroughly and quickly reviewed and appropriate action is taken in a timely manner. HealthPlus encourages employees, members, providers, practitioners, and first-tier, downstream, and related entities to report any potential compliance issue. You can report issues anonymously, and HealthPlus cannot retaliate against you for reporting violations to us or to the government.

Fraud** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR 455.2).

This includes, but is not limited to the Federal False Claims Act, 31 U.S.C 3729-3731 and the Michigan Health Care False Claims Act 323 of 1984 (see Attachment A).

Fraud (Medicare Part D) means intentional deception or misrepresentation of the truth by an individual or individuals, resulting in some unauthorized benefit to the individual(s) or some other person

- Health care fraud is defined in Title 18, US Code §1347
- The violator may be:
- A health care practitioner or supplier
- An employee of any provider
- A billing service
- A beneficiary and/or caregiver

Fraud (County Health Plan – Plan A Definition) means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CR 455.2).

Waste (Medicare Part D) means overutilization of services, or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather the misuse of resources.

Abuse* means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Abuse (MIChild Definition) provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the MIChild program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the MIChild program.

Abuse (Medicare Part D) means gross negligence or reckless disregard for the truth in a manner that could result in an unauthorized benefit and unnecessary costs either directly or indirectly

Abuse (County Health Plan – Plan A Definition) means provider practices that are inconsistent with sound fiscal business, or medical practices, and result in an unnecessary cost to the Adult Benefits Waiver program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Adult Benefits Waiver program.

*This definition pertains to all product lines, with the exception of Medicare Part D, MIChild and County Health Plan-Plan A.

**This definition pertains to all product lines (including MIChild), with the exception of Medicare Part D and County Health Plan – Plan A.

Reporting

HealthPlus maintains a strict non-retaliation procedure to protect employees, members, and providers who report compliance problems and concerns. Those who report issues may do so without fear of retaliation or retribution. Fraud, waste, and abuse (FWA) can be reported anonymously and you will not be penalized for filing a complaint with HealthPlus or the federal or state government. To report a potential compliance issue for all product lines:

Compliance Hotline: 1-800-345-9956 #4 (you do not have to leave your name)

Call or Write: Theresa M. Schurman, Esq.
Corporate Compliance & Privacy/Security Official
HealthPlus of Michigan
2050 S. Linden Road, Flint, MI 48532
810-720-8199 tschurma@healthplus.org.

Medicaid/MIChild FWA can also be reported directly to:
Michigan Department of Community Health
Medicaid Integrity Program
400 S. Pine Street, 6th Floor, Lansing, MI 48909
1-866-428-0005
http://www.michigan.gov/mdch/0,1607,7-132-2946_24460---,00.html
Or the Office of Inspector General (OIG) of Health & Human Services 1-800-222-8558

Examples of FWA by a member include the following:

- Changing a prescription
- Identify theft
- Changing medical records
- Doctor shopping
- Changing referral forms
- Prescription stockpiling
- Resale of medications on the black market
- Prescription diversion /inappropriate use

- Misrepresentation of eligibility status
- Letting someone else use their HealthPlus insurance card to get medical services
- Using transportation services to do something other than going to the doctor.

Examples of FWA by a provider/prescriber include the following:

- medical record) submitted through a prior authorization or other formulary oversight m Lying about credentials such as a college degree
- Billing for services that were not done
- Billing a balance that is not allowed
- Double billing, upcoding, and unbundling
- Collusion among providers – providers agreeing on minimum fees they will charge and accept
- Underutilization-not ordering medically necessary covered services
- Script mills
- Falsifying information (not consistent with mechanism in order to justify coverage
- Remuneration for prescription drug-switching

Examples of FWA by a pharmacy include:

- Inappropriate billing practices
- Drug diversion
- Billing for:
- multiple payers for same Rx
- non-covered items as covered
- brand when generic is dispensed prescriptions not picked up
- Dispensing expired/adulterated prescription drugs
- Prescription drug-shorting
- Inappropriate use of DAW codes
- TrOOP manipulation
- Failure to offer negotiated prices
- Bait and switch pricing
- Billing for non-existent prescriptions
- Illegal remuneration schemes

Examples of FWA by an employee of HealthPlus include the following:

- Lying about a provider's credentials or provider network
- Forging a signature on a contract
- Intentionally submitting false claims
- Rigging bids – collusion between state employees and HMO employees
- Excessive salaries and fees to close associates of HMOs
- Plan intentionally denies benefits
- Inappropriate incentive plans
- Inappropriate cost-shifting to carved out services
- Embezzlement or theft
- Self-dealing – awarding a contract based solely on friendship or family relationships
- Bust-outs – Plan does not pay providers

Deficit Reduction Act

Policies and Procedures

The 2005 Deficit Reduction Act (DRA) established a new Medicaid Integrity Program that is very similar to the Medicare Integrity Program. The 2005 DRA funded this new Fraud and Abuse detection program with an increased level of funding up to $75 billion by 2009. This level of funding indicated the rising intensity of Medicaid scrutiny. When an organization comes under the scrutiny of the Medicaid Integrity Program, one of the items that will be reviewed is whether the organization did an adequate job of communicating the details of the False Claims Act (FCA) and the whistleblower protections throughout the organization and to agents and contractors. The attached document outlines the False Claims Act and HealthPlus' role in assuring its compliance.

If you have any questions regarding the DRA or FCA, please contact HealthPlus' Compliance & Privacy/Security Official, Theresa M. Schurman, Esq., at (810) 720-8199 or at tschurma@healthplus.org. The HealthPlus Internet website www.healthplus.org may be accessed to review HealthPlus' Corporate Compliance Program, details of the False Claims Act, and HealthPlus' procedure for identifying and reporting Fraud, Waste, & Abuse.

False Claims Act

Policies and Procedures

As a recipient of federal health care program funds, including Medicare and Medicaid, HealthPlus is required by law to include in its policies and provide to all employees, members, agents, and contractors, detailed information regarding the federal False Claims Act and applicable state civil and criminal laws intended to prevent and detect fraud, waste, and abuse in federal health care programs.

What is the False Claims Act?
The False Claims Act is a federal law that makes it a crime for any person or organization to knowingly make a false record or file a false claim to any federal health care program, which includes any plan or program that provides health benefits (whether directly, through insurance, or otherwise) which is funded directly, in whole or in part, by the United States Government or any State health care program. "Knowingly" includes having actual knowledge that a claim is false or acting with "reckless disregard" as to whether a claim is false. Examples of potential false claims include knowingly billing Medicare for services that were not provided, submitting inaccurate or misleading claims for actual services provided, or making false statements to obtain payment for services.

The False Claims Act contains provisions that allow individuals with original information concerning fraud involving government health care programs to file a lawsuit on behalf of the government and, if the lawsuit is successful, to receive a portion of recoveries received by the government.

State Laws
In most states, it is a crime to obtain something (e.g., such as a Medicaid payment or benefit) based on false information. In addition to the federal law, Michigan has adopted similar laws allowing individuals to file a lawsuit in state court for false claims that were filed with the state for payment, such as the Medicaid program.

Penalties for Violating the False Claims Act
There are significant penalties for violating the federal False Claims Act. Financial penalties to an organization that submits a false claim can total as much as three times the amount of the claim plus fines of $5,500-$11,000 per claim. In addition to fines and penalties, the courts can impose criminal penalties against individuals and organizations for willful violations of the False Claims Act. The false claims laws adopted in Michigan also carry significant fines and penalties of $5,000-$10,000 per claim.

Protections Under the False Claims Act
The federal False Claims Act protects anyone who files a lawsuit under the Act from being fired, demoted, threatened, or harassed by his or her employer as a result of filing a False Claims Act lawsuit. Similar protections are also provided to individuals under the False Claims Act laws adopted in Michigan.

Our Commitment to Integrity
HealthPlus is committed to fully complying with all laws and regulations that apply to our health care organizations. We have established a Corporate Compliance Program as evidence of our commitment to operating with the highest degree of integrity.

The Corporate Compliance Program includes the Standards of Conduct, policies and procedures, training and education, auditing and monitoring, and mechanisms for individuals to raise issues and concerns without fear of retaliation. Information regarding HealthPlus Compliance Program may be accessed through the HealthPlus website at www.healthplus.com.

Whether you are an employee, member, vendor, provider, or another business partner of HealthPlus, you are reminded to:

- Act with honesty and integrity in all of your business activities
- Follow all laws and regulations that apply to your work activities, including requirements of Medicare, Medicaid, and other federal health care programs
- Contact one of the following resources available within HealthPlus if you have knowledge of or concern regarding a potential false claim:

o HealthPlus Compliance & Privacy/Security Official:
  - Theresa M. Schurman, Esq.
    Compliance & Privacy/Security Official
    2050 S. Linden Road
    Flint, Michigan 48532
    (810) 720-8199
    tschurma@healthplus.com

o HealthPlus Hotline:
  1-800-345-9956 (*message may be left anonymously)*

HealthPlus policies strictly prohibit retaliation in any form against an individual reporting an issue or concern in good faith. Retaliation is subject to discipline up to and including dismissal from employment or termination of the business relationship with HealthPlus.

Please contact the Compliance Official through the information listed above if you have any questions.

Additional Fraud and Abuse Regulations

- Health Care Fraud, 18 U.S.C. 1347
- False Statements Relating to Health Care Matters, 18 U.S.C. 1035
- Medicare-Medicaid Anti-Fraud and Abuse Amendments 42 U.S.C. 1320a-7b(a)
- Theft or Embezzlement in Connection with Health Care, 18 U.S.C. 669
- Obstruction of Criminal Investigation of Health Care Offenses, 18 U.S.C. 1518
- Federal Anti-Kickback Statue, 42 U.S.C. 1320a-7b(b)
- Civil Monetary Penalties, 42 U.S.C. 1320a-7a
- OIG Exclusion Authority, 42 U.S.C. 1320a-7
- Sarbanes-Oxley Act, 2002