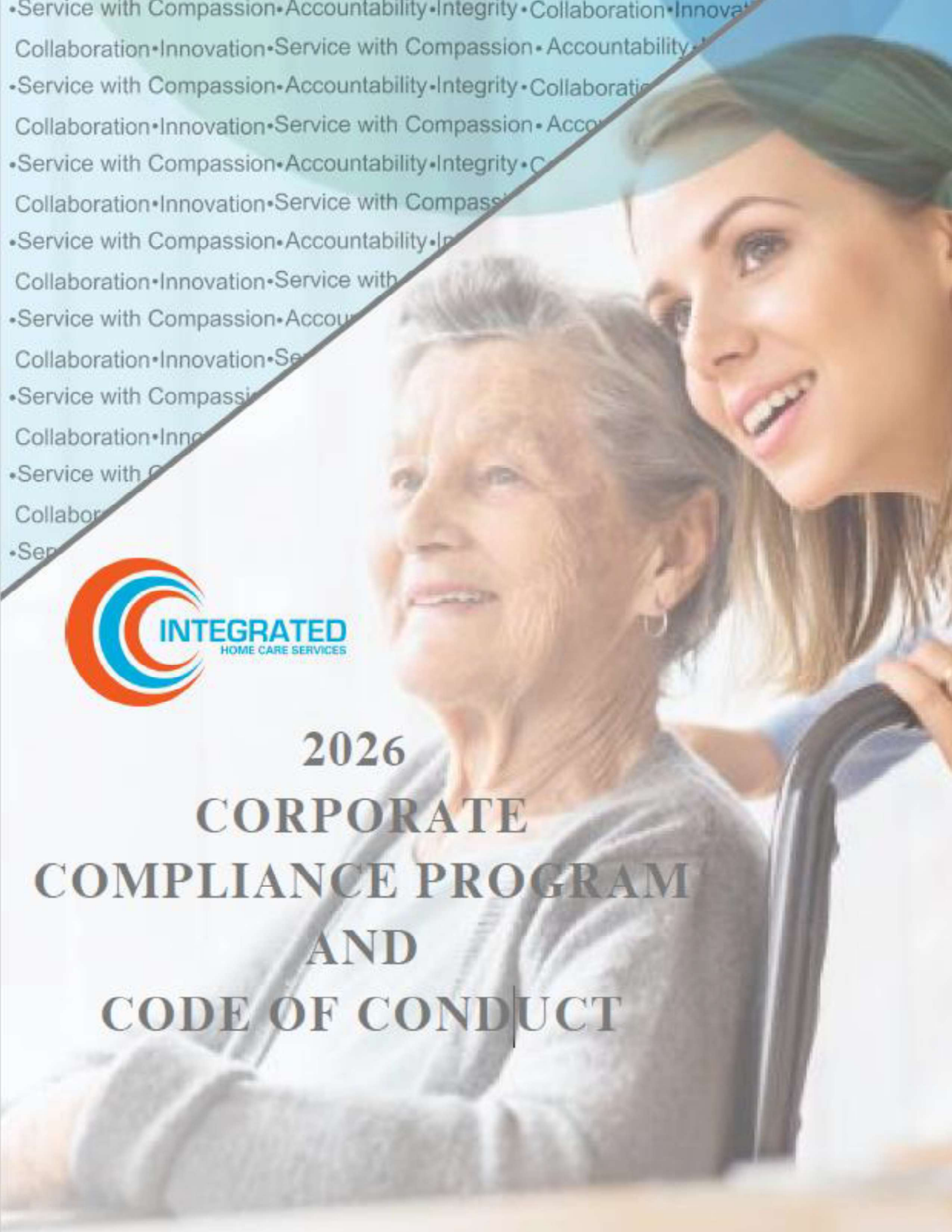

2026 CORPORATE COMPLIANCE PROGRAM AND CODE OF CONDUCT

Message from our Chief Executive Officer, Mr. Christopher J. Bradbury:

Dear Colleague:

Integrated Home Care Services, Inc. (IHCS) was founded with a deep commitment to the community to provide superior products and services to its health plan partners and their members. Facilitating access to high quality home care services is a key goal of this organization.

Our Compliance Program and Code of Conduct is the foundation of our corporate program. It serves to articulate our standards as we approach our work with integrity, ethical conduct and professionalism. Our process strives to gain a better understanding of the issues that are most important to our internal and external stakeholders and obtain sustainable results in a responsible manner. We conduct our business with integrity and accountability and embrace a philosophy of full transparency in all our governance, operational and business dealings, which is the cornerstone of our corporate culture.

The IHCS Compliance Plan/Code of Conduct is designed to help guide you in making ethical decisions to preserve this strong culture of compliance. The information provided applies to all of us – employees, Board of Directors, temporary staff, volunteers, providers, suppliers and vendors.

You are a valuable member of our team and our most important asset. Thank you for helping us build a strong compliance posture as we continue to develop our health care organization of which I am proud to be the steward.

Christopher J. Bradbury, CEO

Table of Contents

Introduction:

A Message from our Chief Compliance Officer

At Integrated Home Care Services (IHCS), our commitment to integrity, accountability, and ethical conduct is the foundation of everything we do. Our Compliance Program and Code of Conduct reflects that commitment guiding our actions, shaping our culture, and ensuring we meet the legal and regulatory standards that govern our work.

This program is more than a set of policies—it's a shared responsibility. Every team member, from frontline staff to executive leadership, plays a vital role in upholding our values and protecting the trust placed in us by patients, partners, and regulators. We are committed to creating an environment where questions are welcomed, concerns are addressed, and compliance is part of our everyday decision-making.

No Compliance Plan or Code of Conduct can be successful if it is not fully embedded in the Company's culture and every employee feels part of it. The Compliance Program of Integrated Home Care Services includes each one of you, regardless of your function in the Company. It is intended to be a living document that will be reviewed periodically and amended as needed to reflect the changes in law and development of our business.

As Chief Compliance Officer, I am proud to support a program that empowers our teams, strengthens our operations, and reinforces our reputation for excellence.

Thank you for your continued commitment to doing what's right.

Sincerely,

Gladiris Galiano, Esq. CHC.,

Enterprise Chief Compliance Officer and Vice President

Purpose of the Integrated Home Care Services (IHCS) Code of Conduct and Corporate Compliance Program

At IHCS, we recognize that working in the healthcare industry is a privilege that comes with a great deal of responsibility. We focus on providing and arranging for our health plan partners and their patients the highest standard of care aimed at achieving quality outcomes inclusive of a safe, supportive environment, and the best possible care experience.

We conduct our work in a highly regulated environment. As we provide healthcare services, we must also meet federal, state and local laws. It is important for all of us to remember that Integrated Home Care Services exists to uphold our legal and ethical responsibilities.

This Code of Conduct and Corporate Compliance Program introduces our team members to the various areas of the laws, rules and ethical standards requiring our focus and understanding.

Specifically, the purpose of our Code of Conduct is to outline the expected behaviors and ethical standards that guide individual actions, especially when facing ethical dilemmas. It promotes integrity, respect, and honest interactions both within and outside our organization. By setting clear boundaries, it helps prevent misconduct and discourages actions that could harm our company or its reputation. The Code also reinforces our organizational values by reflecting our mission, vision, and core principles, aligning employee behavior with strategic goals. Finally, it serves as a practical reference tool for employees when they are uncertain about the appropriate course of action.

On the other hand, our Corporate Compliance Program is a structured framework of policies, procedures, and practices designed to ensure that our organization operates with integrity and in full compliance with applicable laws, regulations, and industry standards. It plays a critical role in preventing and detecting misconduct by establishing proactive mechanisms to identify and address noncompliance, unethical or illegal behavior. The program also fosters a culture of accountability and ethical decision-making across all levels of the organization. By supporting internal controls and risk management efforts, it helps safeguard our company from potential fines, legal liabilities, and reputational harm. Ultimately, the Corporate Compliance Program reinforces our commitment to ethical excellence and responsible business conduct.

We ask that you read our Compliance Program and Code of Conduct and become familiar with its contents. Please use this document as your first resource when you have a question or concern. Of course, no code of conduct can cover every possible situation. When your question cannot be fully addressed by this guidance, please contact our Integrated Home Care Services Compliance Department who can provide direction.

Who is Covered by this Code of Conduct and Corporate Compliance Program

The standards presented in this Compliance Program and Code of Conduct apply to all of us including employees, board of directors, temporary staff, volunteers, providers, suppliers, contractors and vendors.

Individuals who supervise our business partners, contractors and consultants are responsible for communicating these standards and for evaluating those aspects of the Compliance Program and Code of Conduct that apply to the services they provide.

What are our Responsibilities

Each one of us is responsible for acting with integrity, honesty, courage, respect for others, accountability and obedience to the law. This is especially necessary when we encounter difficult situations. Meeting our legal responsibilities helps us to meet the needs of our patients first. Each of us must:

1 Know and obey the law.

2 Know and follow the Code of Conduct and Corporate Compliance Program and applicable policies and procedures.

3 Comply with required Compliance training courses, policies and procedures and standards of conduct attestations in a timely manner at the time of hire and yearly thereafter.

4 Keep up to date on current standards and expectations.

5 Promptly report concerns or possible violations and fully cooperate with investigations.

What if you violate the code of conduct

You may be subject to disciplinary action, which will be determined by the seriousness and frequency of the violation. Disciplinary actions may range from education, verbal warnings, formal written warnings, and suspensions up to and including termination.

What are our Mission Vision and Values

Our **mission** is to go beyond to be the trusted ally that helps patients, providers, and plans to achieve their goals in the home.

Our **vision** is to unlock the full potential of care in the home

Our **values** are to ensure the highest quality of care in the home and to do be able to achieve that we commit to the following:

- **Service with Compassion**- we put our patients first in everything we do and go above and beyond just like we do with family
- **Accountability –** We make bold promises and deliver on our commitments
- **Integrity**- We promote honesty, integrity and openness in all we do
- **Collaboration**- We believe in the power of working together
- **Innovation –** We believe room for improvement always exists

Code of Conduct

Integrated Home Care Services' expectations are based on our Mission and Values, which point us to the responsibilities we have, and how to go about fulfilling them as we conduct business and clinical services in an ethical manner. Doing so is good for business, and it also prevents fraud, waste and abuse, and facilitates detection of and reporting of improprieties, which leads to mitigation, therefore; we expect all of us to refrain from all conduct that may violate any rules, laws or policies, and any activity which could impact eligibility for participation in public healthcare programs. To uphold these expectations and ensure our actions consistently reflect our mission and values, it is essential that we remain vigilant in identifying and managing potential conflicts of interest.

Responsibilities for Leaders: We all contribute to the success of IHCS by abiding with the Compliance Program and Code of Conduct. Our leaders play a key role in modeling our values and guiding teams to meet ethical, legal, and regulatory standards. They help foster an environment where team members feel comfortable asking questions and raising concerns.

In their roles, leaders are expected to:

- Create a workplace culture that encourages open communication and strong working relationships.
- Serve as a resource by helping team members understand how compliance policies apply to everyday work.

- Respond promptly and effectively to concerns involving the Compliance team when appropriate.
- Maintain a safe and respectful work environment where no one feels pressured to act against legal or ethical standards.
- Support team members in using resources responsibly and efficiently.

Making the Right Decisions: In our highly regulated industry, the path is not always clear. At times, you may be uncertain of how to act or respond. You are not alone, and we encourage all team members to seek help and guidance as needed. If you have a question or concern, contact our knowledgeable Compliance team or other experts within our organization.
How will you know when to ask for help? If your answer to any of the following questions is "no," or if you are unsure, please stop and seek assistance.

Is my behavior or action consistent with our Compliance Program and Code of Conduct, policies and procedures?

Is it the right thing to do considering our purpose, vision and values?

Does my decision promote integrity in my workplace?

Can I say that I would be proud of my choice if our patients, my family members or the public learn about my action or failure to act?

Avoiding Conflict of Interests: Upholding the IHCS values means we do the right thing with openness and pride. We are committed to acting with integrity and identifying, disclosing and managing, or eliminating conflicts of interest. A conflict of interest may arise when an Integrated Home Care Services team member or partner takes actions for personal gain or has outside interests making it difficult to perform his or her work objectively and effectively. Conflicts of interest also arise when individuals receive special benefits because of their position in the organization. **Conflicts of interest must be disclosed during the hiring process and promptly reported if they arise at any point thereafter to the Chief Compliance Officer and Vice president of Human Resources.** On a yearly basis you are required to attest that you comply with compliance and training requirements including our policies and procedures and standard of conduct.

Avoiding Gifts or Payments: The Company or a representative may not provide a *referral source* with anything of value in order to induce the referral source to refer patients or business to the Company. The Federal Anti-Kickback Statute provides as follows: "Whoever knowingly and willfully offers or pays any remuneration to a potential referral source to induce such person to refer an individual for services performed by the Company that are covered by a Federal Medicare Program or State Health Program shall be guilty of a felony." It is the policy of the Company not to enter into any payment arrangement or make any payments or give anything of value to physicians or their family members. (Federal Anti-Kickback Statute).

If the Company or its employees offer gifts to ***health care providers*****,** such gifts must be truly nominal, clearly unrelated to referrals and unlikely to influence future referrals. Accordingly,

unsolicited, non-monetary gifts (not cash or Cash equivalent) must be nominal items with a retail value of not more than $50.00 per occasion per health care provider, not to exceed $300 annually. (Stark Law)

The Company will never provide gifts to patients that are cash or cash equivalents. If Company employees offer gifts to ***patients*****,** such gifts must be truly nominal, clearly unrelated to referrals and unlikely to influence future referrals. In the rare event, the company provides any gift to patients, must be nominal (they have a retail value of less than $15 individually or $75 Annually per patient). (Civil Monetary Penalties Law)

Please remember:

a. We should use good judgment and discretion to avoid even the appearance of impropriety or obligation in giving or receiving gifts and entertainment.

b. We must ensure any gift given or received, or entertainment hosted or attended does not violate the law, customary business practices, or our COC.

c. We should not accept any single gift valued at over $50 per occasion (or an equivalent amount in local currency) and we will follow above limits for Patients and Health Care providers.

d. We must ensure the total value of any combination of gifts to or from a single entity never exceeds $300 per person in a calendar year (or an equivalent in local currency).

e. If some of us are going to be a speaker at a conference, we may accept a conference fee waiver when all speakers in the same category receive the same courtesy, but we may not accept Travel and Lodging from the vendor.

In the case of doubt, employees must consult with the Compliance Department to err on the side of caution and ensure full adherence to applicable policies, procedures, and legal requirements. [1]

Excluded Individuals or Entities from Federal and/or State Health Care Programs: IHCS will not employ or contract with individuals or entities excluded from participation in federal and/or state health care programs. IHCS adheres to federal guidelines from the Office of Inspector General (OIG) regarding exclusion screening by performing monthly checks of employees, contractors, and vendors against the OIG/GSA Exclusion Lists. Termination is required if an individual or entity appears on the list. (42 U.S.C. § 1320a–7 – Exclusion from participation in federal health care programs, 42 CFR § 422.752(a)(8), 42 CFR § 423.752(a)(6), 42 CFR § 1001.1901).

[1] Please also be aware that the U.S. Foreign Corrupt Practices Act (FCPA) has anti bribery provisions that prohibits giving "anything of value" to foreign officials with corrupt intent to influence decisions and the U.S. Federal Ethics Rules sets different benchmarks for Public Officials/Federal Employees ($20 per occasion /$50 annually (5 CFR § 2635.204).

IHCS also adheres to Florida's Agency for Health Care Administration (AHCA) requirements for background screening. This includes:

1. Section 435.05(2), Florida Statutes that requires employees to attest they meet screening requirements and notify employers immediately if arrested for disqualifying offenses.

2. Section 408.809(2), Florida Statutes: Requires proof of compliance with Level 2 screening standards and

3. AHCA Form #3100-0008: Used to document attestation and eligibility status for employment in healthcare settings.

IHCS also works in conjunction with Health Plans verifying Medicare Preclusion Lists and verifying state exclusions, as appropriate.

Preventing Fraud Waste and Abuse: In addition to complying with the above-mentioned laws, the prevention of fraud, waste and abuse is the responsibility of every IHCS team member and business partner. Fighting the inappropriate loss of Medicare and Medicaid healthcare dollars through fraud, waste, abuse, and other improper payments is a priority for Integrated Home Care Services.

Home health agencies and durable medical equipment (DME) providers offer services and supplies vulnerable to fraud. Integrated Home Care Services plays a significant role in the fight against fraud, waste, and abuse in Medicare and Medicaid home health, home infusion, and DME. While the specific requirements for home health, home infusion and DME can vary from state to state, all States require furnished services to be medically necessary. Integrated Home Care Services and its team members and business partners have a responsibility to know the rules for home health, home infusion, and DME services as required by Medicare and State Medicaid programs.

Examples of home health fraud include attesting falsely to the medical necessity of home health services, accepting compensation for ordering specific services irrespective of medical necessity, or physicians signing plans of care for beneficiaries not under their care. Examples of DME fraud, waste, and abuse include physicians selling medically unnecessary prescriptions and DME companies recruiting patients and then billing Medicaid for more expensive equipment than what is delivered.

The Patient Protection and Affordable Care Act, more commonly known as the Affordable Care Act, enacted in 2010, provides tools to prevent, detect and take strong enforcement action against fraud in Medicare, Medicaid and private insurance.

The Affordable Care Act (ACA) seeks to improve anti-fraud and abuse measures by focusing on prevention rather than the traditional "pay-and-chase" model of catching criminals after they have committed fraud.

Accordingly, the enrollment process into Medicare or Medicaid became more rigorous by requiring background checks, site visits, fingerprinting, and criminal history reviews for high-risk providers before they can bill Medicare or Medicaid. Providers and suppliers are required to implement compliance programs as a condition of enrollment in Medicare, Medicaid, or CHIP. In addition to an increase in sentencing and in civil and monetary penalties. The law enables the Secretary of the Department of Health and Human Services to deny enrollment to prevent or combat fraud, waste and abuse. As well, the Secretary can withhold Medicare or Medicaid payment if an allegation of fraud is under investigation or pending investigation. In addition to data sharing among CMS data systems including Medicare, Medicaid, VA, DoD, SSA, and IHS, improving fraud detection, the government integrated data analytics to identify claims in real time identifying suspicious billing patterns before payment. Finally, Recovery Audit Contractors (RACs) have been expanded to include Medicare Advantage (Part C) and Part D, enhancing efforts to identify and recover improper payments. Providers are now required to return overpayments within 60 days of identification. Additionally, CMS has increased the deactivation and revocation of Medicare billing privileges to further prevent fraudulent billing activities.

To help reduce opportunities for DME fraud, the ACA:

- Requires a physician, nurse practitioner, clinical nurse specialist, or physician assistant to have a face- to-face encounter (including via telehealth) with an individual before issuing a certification for DME.
- Requires that DME supplies must be ordered by an enrolled Medicare eligible professional or physician.
- Requires more thorough screening of those types of providers and suppliers that have been identified in the past as posing a higher risk of fraud.
- Allows HHS to prohibit new DME providers from joining the program in certain geographic areas or where necessary to prevent or combat fraud, waste or abuse.

To help reduce opportunities for fraud in home health, the ACA:

- Requires physicians who order home health services to be enrolled in Medicare.
- Requires a face-to-face encounter no more than 90 days prior to or within 30 days after the state of home health care.

In the state of Florida, the DME and Home Health Services are considered high-risk areas for fraud, waste and abuse. On July 29, 2021, the Florida Agency for Health Care Administration (AHCA) announced that the longstanding moratorium on home health agencies seeking Medicaid enrollment was to end. With the implementation of the Electronic Visit Verification (EVV) mandate in effect as a fraud prevention measure, AHCA lifted the moratorium statewide and begin

accepting applications on September 1, 2021. AHCA implemented enhanced screening processes and stringent provider qualification requirements for those requiring enrollment in Medicaid.

Examples of Fraud, Waste and Abuse:

In the **Home Health** Setting:

- Upcoding the types of services provided to receive higher payment.
- Submitting bills for patients who are not homebound.
- Visits by home health staff, that are not medically necessary.
- Home health visits that a doctor ordered, but that a patient did not receive.
- Bills for services and equipment a patient never received.
- Fake signatures on medical forms or equipment orders.

In the **DMEPOS** setting:

- A physician receives kickbacks from a DME company for providing false Certificates of Medical Necessity (CMN) for purchased power wheelchairs.
- A DME company recruits patients and then bills Medicaid for more expensive equipment than delivered.
- A Physician sells fraudulent prescriptions, authorization forms, and patient information to a DME company.
- At the prompting of a DME provider, a physician signs a stack of blank CMNs and prior authorization forms that the DME provider then completed with false information and billed for reimbursement.
- A Physician signs an authorization form for the DME provider without verifying medical necessity for the items or medical supplies requested.

How IHCS prevents Fraud Waste and Abuse:

Confirming eligibility: Verifying the eligibility status of patients at the time of service.
Including identifiers: Verifying all required identifiers are present in orders and applicable medical information for determination. If required by the State when ordering services or supplies, the ordering
provider's signature and National Provider Identifier (NPI) should be included on the CMN or other prior authorization form.
Verifying Medical orders are appropriate: Ensuring orders received for determination complies with the medical needs of the beneficiary as set by the State/Medicare.
Maintaining organized records: We keep patient records organized and up to date in our system and confirm that the patient's condition warrants the service requested in the CMN or prior authorization request.

Educating Staff: Integrated Home Care Services educates staff on the issues and schemes that constitute fraud, waste, and abuse, in accordance with federal and state requirements.
Ensuring practice within scope: Always documenting the medical necessity of the service(s) ordered. Being aware that if a medically unnecessary service is billed or if the documentation does not justify medical necessity, it may be considered a "false claim."
Protecting ourselves and our company: Stay vigilant and avoid engaging with professionals who make inappropriate requests. These may include asking for a "quick signature" on a document for a patient who was never seen, requesting additional patient services based on convenience rather than medical necessity, seeking beneficiary medical identifiers without a legitimate need, or offering remuneration in exchange for beneficiary referrals.

U.S. Foreign Corrupt Practices Act, Anti-Corruption and Anti-Bribery compliance:

As a U.S. company, IHCS is subject to the US Foreign Corrupt Practices Act (FCPA), which makes it a criminal offense for IHCS and/or its officers, directors, employees and any third party doing business with or for IHCS to offer, pay, or give any payment or other item of having value to any foreign official, political party, official or candidate of a political party, or public international organization, for the purpose of influencing any act or decision broadly designed to obtain, retain or direct business to a health plan.

IHCS' is committed to the prevention, detection and elimination of all forms of corrupt business practices. Any form of bribery or corruption, whether in commercial dealings with private parties, *or in dealings with officials of any state, local, federal or foreign government, is strictly prohibited. Therefore:*

- IHCS is committed to the prevention, detection, and elimination of all forms of corrupt business practices.
- IHCS officers, directors, employees, and any third parties doing business with or for a health plan are explicitly prohibited to offer, pay, or give any payment or other item of having value to any foreign official, political party, official or candidate of a political party, or public international organization, for the purpose of influencing any act or decision broadly designed to obtain, retain or direct business to IHCS.
- IHCS Business Owners and Vendors are required to demonstrate compliance through transparent and comprehensive relationship disclosures as part of the conflict of interest and related policies and procedures.

Confidentiality of Patient Information and Protected Health Information:

The information we create, use, and disclose while caring for our patients is sensitive and personal. We are committed to keeping all patient information protected and secure.

To support this commitment, we receive training to understand the requirements Integrated Home Care Services must meet to comply with HIPAA and other privacy and security regulations.

We only discuss patients and their care with authorized individuals, in appropriate settings, and in low voices to maintain confidentiality.

We verify the identity of anyone requesting a copy of a patient's record and require a completed authorization form before releasing information.

We access only the minimum necessary patient information needed to perform our job duties.

We ensure individuals have timely access to their healthcare information.

We also provide patients with our Notice of Privacy Practices to inform them of their rights and how their information is used and protected.

We hold business partners to the same standards when they conduct business on our behalf.

Security Procedures:

IHCS and its Suppliers are required to use security procedures that are reasonably sufficient to ensure that all transmissions of Documents are authorized and to protect its business records and data from improper access.

License Certifications and Excluded Persons:

The Integrated Home Care Services' purpose and values guide the requirements we set for our team members. We are committed to ensuring that only individuals who are eligible to participate in federal healthcare programs work at Integrated Home Care Services. We ensure that care providers have valid licensure, certification, registration or other credentials.

Team members bear responsibility for maintaining the status of their credentials and providing evidence to Integrated Home Care Services. Individuals who do not have valid, current licenses are not allowed to work.

We each take responsibility to ensure that our license or certificate is current.

We report to our supervisor and to our Chief Compliance Officer immediately if we discover a lapse in licensure or credentials. Upon discovery, the team member with improper credentials stops working immediately.

We institute protocols to verify that all individuals working at Integrated Home Care Services are eligible to participate in federal programs.

We have a monthly process to screen all team members, network providers, and business partners with access to member information to ensure that Integrated Home Care Services does not employ

or contract with persons or entities excluded from Medicare, Medicaid or any federal health care program.

We require all team members and business partners to disclose immediately if they are excluded from Medicare, Medicaid or any federal health care program.

Health and Safety/Substance Abuse/Equal Employment:

IHCS values a safe and healthy work environment. Creating an atmosphere of honesty and mutual respect enhances our relationships with business partners.

We are committed to providing the resources, protocols and practices to create a safe and healthy work environment, free of alcohol and drugs. Integrated Home Care Services provides safeguards — including policies, training and equipment — to give team members the opportunity to take action and responsibility for their own health and safety.

We require reporting of any serious workplace injury or illness.

We encourage team members to seek advice from their supervisor or safety officer if they have questions or concerns and to follow their local safety plan when emergencies arise.

We require team members to know and understand safety policies and procedures.

We ask team members to consult with a supervisor to the extent that they are concerned with how their use of prescription or over-the-counter drugs may interfere with their performance at work, or if they observe an individual who appears to be impaired in the performance of his or her job.

We take immediate action if an individual reports to work under the influence of drugs or alcohol; this may include drug testing of individuals, and we prohibit the use of any drug which is illegal under state or federal law.

We are committed to providing equal opportunity in employment to all associates and applicants. No one may be discriminated against in employment because of race, color, religion, sex, gender (including gender identity), age, national origin, marital status, sexual orientation, veteran status, disability, genetic information, or any other status or condition protected by applicable federal, state, or local laws, except where a bona fide occupational qualification applies.

Supplier Diversity, Quality of Care and Patient Safety:

We support supplier diversity as a core value. Our partnership with a diverse supplier base is important, because a supply chain that is as diverse as our members helps us meet our members' diverse needs. IHCS procures products and services when feasible from small, minority-, women-, veteran, veteran disabled, service disabled, lesbian, gay, bisexual, transgender and queer (LGBTQ), disability-owned business enterprises.

At Integrated Home Care Services, Inc., we understand that our patients are unique individuals. We provide care in a safe, effective and efficient manner. To encourage this effort, our clinical quality improvement team builds and designs systems and processes incorporating best practices in caring for patients.

- We follow up with patients and other caregivers to create a safe environment and improve communication.
- We encourage anyone on any team to stop a process if he or she thinks it is incorrect.
- We maintain standards for licenses and credentials for caregivers who work in all locations.
- We report unanticipated outcomes to a supervisor and prepare for appropriate follow-up and communication with the patient and family.
- We recognize that communication and language barriers can negatively impact on the quality of care and lead to poor clinical outcomes.

IHCS has established operational capabilities to support patients with limited English proficiency, as well as those who are deaf, hard of hearing, blind, or visually impaired, by providing appropriate communication assistance.

We understand that our TPA program must ensure that the health care we arrange for is safe, effective, patient-centered, timely, efficient and equitable.

Patient Rights:

We are committed to informing our patients of their rights and to protecting their rights. We deliver high-quality care when we respect and support patients and their loved ones and give them information to make decisions regarding the care they are offered.

We provide each patient with a written statement of patient rights and a notice of privacy practices.

We provide kind and respectful care no matter a patient's personal values and beliefs, age, sex, race, color, religion, disability, national origin, ability to pay, or any other category protected by state or federal law.

We seek to resolve patient complaints promptly and to provide contact information so patients can report grievances.

We seek to follow a program by which all patients have the right to be free of any coercion as to selection of a provider, health plan or medical procedure.

Summary of Internal Resources and Important Regulations for your Reference:

Internal Resources:

The Integrated Home Care Services Employee Handbook is your guide to:

- Company policies and practices for health and safety in the workplace
- General employment practices and employee programs
- Employees conduct guidelines, details on disciplinary action for violations and the whistleblower policy
- Operating policies supporting ethical behavior
- Policies on proper use of company resources

The corporate and business unit specific Compliance Programs support you with protocol for:

- Written standards or policies and procedures, and standards of conduct
- Governance by a Chief Compliance Officer, Privacy Officer, and Committee
- Compliance training and education
- Effective lines of communication
- Application of standards through publicized guidelines
- Monitoring and/or auditing
- Responding promptly to reported or detected offenses and developing corrective action

Business specific tools may be provided to you in training and made available to you based on your job functions, which address items such as:

- Confidentially, data privacy and security
- Administrative and clinical quality assurance
- Integrity and accuracy in documentation and in billing and claims related transactions
- Avoidance of conflicts of interest and violations of laws
- Cooperation with investigations and audits
- The various needs for, and methods of reporting of violations

Important Regulations:

Federal Laws:

Civil False Claims Act –

Citation: 31 U.S.C. § 3729

Summary: Imposes liability on individuals or entities that knowingly submit false claims to the government. Penalties include treble damages and civil fines.

Health Care Fraud Statute –

Citation: 18 U.S.C. § 1347

Summary: Criminalizes schemes to defraud health care benefit programs. Violators may face up to 10 years in prison, or more if bodily harm or death occurs. Example: Physician submits claims to a Medicare Advantage Plan for office visits and services that were not provided.

Anti- Kickback Statute –

Citation: 42 U.S.C. § 1320a–7b

Summary: Prohibits offering or receiving anything of value to induce referrals for services reimbursed by federal health care programs. Intent must be proven.

Stark Statute (Physician Self-Referral Law) –

Citation: 42 U.S.C. § 1395nn

Summary: Prohibits physicians from referring patients for certain services to entities with which they or their family have a financial relationship, unless exceptions apply.

The Stark Statute prohibits a physician from making referrals for certain designated health services to an entity when the physician (or a member of his or her family) has an ownership/investment interest or a compensation arrangement.

Civil Monetary Penalties Laws –

Citation: 42 U.S.C. § 1320a–7a (Section 1128A(a)(5) of the Social Security Act)

Summary: Authorizes the OIG to impose fines for false claims, improper billing, and other violations. Penalties vary by offense and may include exclusion

The Office of Inspector General (OIG) may impose civil penalties for several reasons, including arranging for services or items from an excluded individual or entity, providing services or items while excluded, failing to grant OIG timely access to records, knowing of and failing to report and return an overpayment, making false claims, paying to influence referrals.

HIPAA (Health Insurance Portability and Accountability Act)

Citation: 45 CFR Parts 160, 162, 164

Summary: Establishes national standards to protect individuals' medical records and personal health information. Applies to covered entities and business associates.

Fair Labor Standards Act (FLSA)

Citation: 29 U.S.C. Chapter 8

Summary: Sets federal standards for minimum wage, overtime pay, child labor, and recordkeeping for employees in the private sector and government.

Exclusion from Federal Health Care Programs-

Citation: 42 U.S.C. § 1320a–7 , 42 C.F.R. § 422.752(a)(8), 42 C.F.R. § 423.752(a)(6), 42 C.F.R. § 1001.1901

Summary: Mandates exclusion of individuals/entities convicted of certain offenses (e.g., fraud, abuse) from participating in Medicare, Medicaid, and other federal programs.

No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded.

Specially Designated Nationals and Blocked Persons List (SDN) is also checked.

HCS adheres to federal guidelines from the Office of Inspector General (OIG) regarding exclusion screening: Monthly checks of employees, contractors, and vendors against the OIG Exclusion List. Termination is required if an individual appears on the list.

Florida State Laws:

Florida AHCA Background Screening

Citation: Section 435.05(2) & 408.809(2), Florida Statutes

Summary: Requires Level 2 background screening and attestation of eligibility for employment. Employees must notify employers immediately if arrested for disqualifying offenses

IHCS endeavors to hire personnel that are suitable for the healthcare industry in terms of background and experience while remaining in compliance with Fair Labor Standards Act and the AHCA Attestation of Compliance with Background Screening Requirements. This is applicable to determinations made during pre-hire screening and periodically thereafter for continued employment status determination.

Individuals convicted of, or who have pending charges for, offenses listed on the AHCA Form # 3100- 0008 will not be considered for employment. Also, should any employee, regular, contracted or temporary, appear on an OIG Exclusion List monthly check, he/she will be terminated in accordance with the Office of Inspector General guidelines. IHCS agrees to fair labor practices that include freedom from harassment and basic human rights. This includes transporting, harboring, recruiting, transferring, or receiving vulnerable individuals by means of threat, force, coercion, abduction, or fraud for the purpose of exploitation.

Reporting, Confidentiality and Non retaliation:

IHCS does not tolerate violations of law, policy, or ethical standards, including illegal acts, improper conduct, or unethical behavior. Such actions can negatively impact on our business and may result in sanctions, civil or criminal penalties, or the loss of licensure, accreditation, or contracts.

It is essential that any suspected, alleged, or known violations are reported promptly. Team members who become aware of the activity by anyone acting on behalf of Integrated Home Care Services are expected to report it to their manager or supervisor, who is responsible for escalating the concern for investigation.

If reporting to a supervisor is not appropriate or comfortable, concerns may also be reported directly to any officer, board member, or designated compliance contact.

Stakeholders, including consumers, suppliers, network providers, and business associates, may report concerns confidentially and anonymously to Integrated Home Care Services, Inc. All reports made in good faith are protected from retaliation.

IHCS team members have several ways to seek guidance or report violations and concerns. For human resources-related issues—such as payroll questions, interpersonal conflicts, or disagreements with supervisors—we encourage resolution at the local level whenever possible. Team members may also reach out directly to the VP of Human Resources or their designee.

For compliance-related concerns, team members are encouraged to first speak with their supervisor or another manager. If that is not comfortable or appropriate, concerns may be reported directly to the Chief Compliance Officer or another member of local compliance team.

You may also report concerns through the Compliance Hotline at 954-381-7954. Timely reporting allows us to properly review and investigate any issues.

IHCS investigates all suspected violations and takes disciplinary action when necessary. We make every effort to maintain confidentiality when a reporter wishes to remain anonymous. **Retaliation against anyone who reports a concern in good faith is strictly prohibited.**

Remember that in addition to reporting any violations or concerns you may have, you can always contact your compliance department for guidance at:

- Compliance Hotline: 954-381-7954
- Compliance Fax Line: 954-624-8738
- Compliance E-Mail: compliance@ihcscorp.com
- Chief Compliance Officer, Gladiris Galiano at: ggaliano@ihcscorp.com
- For anonymous reports you can write at: 3700 Commerce Parkway, Miramar FL 33025 Attention: Compliance Department

Note: This information is available in your Identification card.

At IHCS, we all play a role in maintaining a culture of integrity and accountability. Whether you're an employee, contractor, or downstream provider, it's important to speak up if you notice a potential violation of our Code of Conduct, a compliance concern, or suspected Fraud, Waste, and Abuse (FWA).

Reporting concerns helps us address issues early and protect our patients, our colleagues, and our organization. You can do so anonymously or confidently, knowing that **IHCS does not tolerate retaliation.**

A final note about IHCS Code of Conduct:

The IHCS Code of Conduct, as complemented by the Employee Handbook, and the Provider Manual establish the foundation from which all Policies and Procedures of the company are derived. The Code of Conduct sets out basic principles which Integrated Home Care Services and its subsidiaries, directors, officers, and employees must follow. The Code of Conduct is an over-arching document that delineates the fundamental standards from which all organizational policies and procedures and organizational and business decisions may be drawn from, or evaluated against, and is written in clear, concise, easily understood language.

In some instances, the Code deals fully with the subject matter covered. In many cases, however, the subject discussed has so much complexity that additional guidance is necessary for those directly involved with the particular area to have sufficient direction. To provide additional guidance, a comprehensive set of compliance policies and procedures which expand upon or supplement many of the principles articulated in the Code of Conduct have been developed and are available through the Compliance Department.

Remember that you can always contact your compliance department for guidance or to report any concerns you may have with the information provided above. You can do so anonymously or confidently, knowing that **IHCS does not tolerate retaliation.** *Working together, we help ensure our standards are upheld and our environment remains one of trust and transparency.*

Corporate Compliance Program

At Integrated Home Care Services (IHCS) our commitment to ethical conduct, regulatory compliance, and operational integrity is central to how we serve our patients, partners, and communities. The Compliance Plan you are about to read is based on the seven (7) elements for an effective compliance program included in Chapter 8 of the Federal Sentencing Guidelines Manual and applicable Medicare Compliance requirements:

1. Written Policies and Procedures
2. Compliance Officer and Compliance Committee
3. Training and Education
4. Effective Lines of Communication
5. Enforcements of Disciplinary Standards
6. Monitoring and Auditing
7. Timely and Reasonable Inquiry of Detected Offenses and Corrective Action Plans

Each of these elements is described in detail in the following sections.

Together, they reflect our shared responsibility to uphold the standards that define IHCS and ensure we continue to operate with integrity and excellence.

Written Policies and Procedures

Our Company has written Policies and Procedures and Standards of Conduct that articulate our commitment to comply with all applicable Federal and State standards, Third Party Administrator Regulations, Medicare requirements for Durable Medical Equipment, including the accreditation standards under the Accreditation Commission for Health Care (ACHC), the Conditions of Participation for the Home Care Agencies and the Board of Certification/Accreditation for our orthotics and prosthetics line of business, among others.

Our Policies, Procedures and Standards of Conduct describe our expectations that all our employees -including temporary employees, volunteers, and Board of Directors - conduct themselves in an ethical manner; those issues of noncompliance and potential FWA are reported through appropriate mechanisms; and those reported issues will be addressed and corrected. We review them once a year, at a minimum, to incorporate any changes in applicable laws, regulations, and other operational requirements. The rules of ethics and disciplinary guidelines are included in the Code of Conduct and the Employee Manual, respectively. All employees and delegated entities, as appropriate, receive a copy, are educated on such documents, and are required to comply with them.

As a condition of employment, we require our employees to certify that they have received, read, and will comply with all written Compliance Policies and Standards of Conduct. Compliance Policies and Standards of Conduct are included in the New Hire package and are distributed to employees and delegated entities within the first 30 days of hire/contracting, when updated as applicable and yearly thereafter. In addition, employees receive training in the Compliance Policies and Standards of Conduct upon hire, when they are amended (as applicable) and yearly.

Compliance Officer and Compliance Committee

Our company has a Chief Compliance Officer that is a full-time employee solely dedicated to overseeing the Compliance Program and operations throughout the organization and has the authority to report directly to the Company's Chief Executive Officer and all other members from the Board of Directors. The Company's Chief Compliance Officer is in charge of developing, monitoring and implementing the Enterprise Compliance Program, Policies and Procedures. In this process, our Chief Compliance Officer and the Compliance Team, work directly with the Executive Management team, the Senior Management team and Operational Subject Matter Experts, as appropriate to ensure the Compliance Program is effectively implemented and executed according to applicable laws and regulations[2]. The Company's Chief Compliance Officer leads the Compliance and Quality Committee[3] and coordinates regular Compliance Committee meetings with Senior Management and operational Subject Matter Experts to keep them informed about the progress of the Company's Compliance Program, recent regulatory changes, projects, incidents, and non-compliant cases, from receipt until resolution.

The Chief Compliance Officer chairs the Compliance and Quality Committee, an interdisciplinary group composed of Executive Staff, Senior Leadership, and key Subject Matter Experts. The Committee supports the design, implementation, oversight, and operation of the Corporate Compliance Plan.

Additional attendees may be invited on an ad hoc basis depending on the topics under discussion.

The Committee meets quarterly and is responsible for:

- Approving structural and organizational elements of the Compliance Program.

- Reviewing and updating compliance policies and procedures.

- Ensuring effective compliance training and education programs.

- Monitoring the effectiveness of the Compliance Program.

- Assisting the CCO with risk assessments and the development of monitoring and auditing work plans.

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[2] Please note that although the Medicare requirements for having a Compliance Committee in place are directed towards Medicare Plan Sponsors, we replicate a similar model to ensure delegated activities are fully compliant with CMS' regulations. Plans Sponsors should also note that compliance functions cannot be delegated.
*Ad hoc members.

[3] Our Compliance and Quality Committee—also referred to as the Compliance, Quality, and Safety Committee or the PI/QI Committee—adapts its name depending on the auditor (e.g., DMEPOS, HHA, Medicare Advantage, Medicaid) to ensure alignment with their expectations and terminology. While the name may vary, the scope of the committee consistently encompasses all requirements set forth by the relevant regulatory entities.

- Reviewing reports of non-compliance and ensuring appropriate corrective actions are implemented and monitored.

- Supporting the CCO in preparing reports for Senior Leadership and the Board of Directors.

- Ensuring the organization maintains a system for employees, patients, and First Tier, Downstream, and Related Entities (FDRs) to confidentially or anonymously report compliance concerns or potential fraud, waste, and abuse (FWA) without fear of retaliation.

- Assisting the CCO with licensing, audit requests, regulatory reporting, and implementation of regulatory requirements relevant to their areas.

Meeting agendas, minutes, and attendance records are maintained by the Compliance Department. The Committee also convenes as needed to address operational compliance issues and to support the preparation of the Internal Risk Assessment.

The Compliance Committee is responsible for coordinating with their respective areas to ensure all operational projects follow applicable law, regulations and that policies and procedures are completed successfully. The Compliance Committee meets on a regular basis to discuss any important compliance issues from an operational perspective and implement any necessary measures to comply with applicable laws and regulations. The Committee also meets for the preparation of the Company's Internal Risk Assessment, as further provided below. The Chief Compliance Officer or designee is responsible for sending meeting invites and maintaining minutes of meetings held.

Operational Subject Matter experts along the organization are in charge of regularly monitoring their operations and notifying any existing or potential gaps in terms of operational compliance with regulations, as well as any instances of non-compliance or FWA cases to the Chief Compliance Officer/Department as soon as they become aware of the issues. The Compliance Officer may refer, as necessary, any of these issues to the Compliance Committee, Chief Executive Officer or to our Board of Directors, as appropriate.

In addition, the Company's Compliance Department tracks applicable laws and regulations and performs action plans to communicate, ensure understanding and operational implementation of regulatory changes or new provisions. Upon applicability the Compliance Department provides a summary of legal and regulatory requirements, due dates and responsible parties to our clients.

The Company's Compliance Department encourages self-reporting of non-compliance situations to the Compliance Department via policies, posters, and verbal reassurance. Communication is generally received via incident reports, but also via the Compliance Hotline and our Customer Services Department, among others. The Compliance Department ensures all incidents, inquiries, and noncompliance situations reported are well- documented. The Chief Compliance Officer will self-report to clients, accreditation agencies and regulators, as appropriate.

The Chief Compliance Officer has direct access to the CEO and Board Members and reports regularly to the Board of Directors on the progress of the compliance program.

The Company's Chief Compliance Officer collaborates with our clients' Compliance Officers via Compliance-to-Compliance meetings or quarterly/biannually Client Meetings, as appropriate. The Compliance-to-Compliance meetings or the Quarterly/Biannually Client meetings are available for those clients who desire to keep constant communication with our Compliance team. These meetings are another vehicle to help ensure compliance program success and effective lines of communications between our clients and our company. Some clients prefer to centralize communication through our Account Management Department. In such cases, the IHCS Compliance Department continues to support teams using the client's preferred method of communication.

The Chief Compliance Officer follows applicable state and federal laws and regulations including, but not limited to, the Federal Food and Drug Administrations, The Occupational and Safety Act, the Accreditation Commission for Health Care requirements, Accreditation Commission for Healthcare, Medicare Conditions of Participations, Board of Accreditation Certification, Local Coverage Determinations and National Coverage Determination Guidelines, the Chapter 9 and 21 of the Prescription Drug Benefit Manual and the Code of Federal Regulations, specifically 42 CFR 423.504, and 42 CFR 422.503 as the basic guidance for the Compliance Program. The Chief Compliance Officer's role and/or functions may be redefined over time by new laws and regulations. The Company will promptly implement such changes as applicable.

Effective Training and Education

Our Company has implemented an effective Training and Education Program where training is provided to all Company employees, including temporary employees, volunteers and Board of Directors, senior leadership, and delegated entities, as appropriate. Training and Education occurs annually, and it is part of the orientation to new employees, provided within 30 days of hiring/contracting.

There are two types of trainings included in the training Program: The General Compliance and FWA Training and the Specialized Compliance Trainings.

The General Compliance Training (Compliance and Fraud Waste and Abuse Training) and HIPAA training are provided within 30 days of initial hiring (or contracting in the case of delegated entities) and annually thereafter as a condition of employment or contract. Among the topics included in the General Compliance training are pertinent laws related to fraud waste and abuse, the reporting requirements, and available methods for reporting noncompliance and potential FWA and privacy and confidentiality, like the Anti-Kickback Statute, False Claims Act and HIPAA. Topics and examples are tailored by job functions. It also covers the Compliance Program, Standards of Conduct, Compliance Policies and reinforces the message that our Company is committed to business ethics and complies with all statutory, regulatory and Medicare program requirements. The training also addresses our process to make compliance inquiries and report potential cases of non-compliance in a confidential manner or anonymously, if desired, emphasizing our non-retaliation policy for compliance related questions or reports of potential non-compliance situations, as provided in our Code of Conduct.

Employees and Delegated entities are reminded that non-compliant /fraudulent behavior may result in mandatory re-training and disciplinary actions, up to and including possible termination of employment or contract termination when such behavior is serious or repeated or when knowledge of a possible violation is not reported. Attendance and participation in formal training programs is a condition of continued employment/contract. Therefore, refusal to complete training and education can result in termination of employment or non-renewal of contract, in the case of delegated entities.

In terms of Specialized Compliance Training, depending on the need our Company can use internet-based tools or specific external training companies to provide training on special areas of Durable Medical Equipment/Medical Gases (FDA), pharmacy, clinical and Home Care Trainings among others. These training courses are tailored to the specific competencies the employee needs to perform regarding their assigned functions.

Specialized training is necessary upon initial hire/contracting in case of delegated entities, appointment to the job function, when requirements change, when an employee or delegated entity works in an area previously found to be non-compliant with regulatory requirements or implicated in past misconduct, and at least annually thereafter, as a condition of employment. The Company

may also use specialized trainings ("hands-on"/one on one) created in house or training created by other trustworthy private entities or government agencies like CMS or the OIG. Examples of specialized training are Food and Drug Administration, Medical Gases, Medicare Organizational Determinations and Grievances.

Because some of our companies are enrolled as Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) providers in the Medicare Program and accredited by the Accreditation Commission for Health Care (ACHC), they are deemed by Medicare regulations to have met the Fraud, Waste, and Abuse (FWA) training and education requirements.

However, several of our DMEPOS entities hold exclusive delegation contracts to provide services to Medicare Advantage members. As such, and due to our role as a Third-Party Administrator (TPA), we are required to comply with Medicare's mandatory compliance training requirements. Accordingly, we provide comprehensive Medicare Compliance and FWA training across all applicable entities to ensure consistent adherence to regulatory expectations.

The Company's Compliance Department reviews all training materials, including specialized training developed by internal departments, to ensure alignment with regulatory requirements and applicable laws. If any training is found to be insufficient, the Compliance Department will request revisions to ensure the content meets compliance standards.

Reference: Chapter 9 and 21 Section 50.3 and related sections addressing Effective Training and Education and the Code of Federal Regulations at 42 CFR § 423.504 (b) (4)(vi)(C) and 42 C.F.R. §§ 422.503(b)(4)(vi)(C).

Effective Lines of Communication

The Company's Compliance Department encourages direct lines of communication. The Chief Compliance Officer and staff receive, record, and respond to actual and potential situations of non-compliance from employees, contractors, delegated entities, providers, clients' beneficiaries, and directors while maintaining confidentiality, allowing anonymity if desired through a telephone hotline and e-mail, and ensuring non-retaliation against those who report an act in good faith. The toll-free Compliance Hotline and Hotmail are available 24 hours a day.

The Compliance Team fosters an open communication policy by making its contact information available to those who would like to use it to report, in a confidential or anonymous manner, actual or possible situations of non-compliance or ask questions regarding any other compliance matter.

Our Company's Hotline information is published in common places inside the organization and is included at the back of every employee *ID card* and in the compliance materials and presentations. Delegated entities, as appropriate, receive the information and attest about the proper display and

dissemination among their employees. The Company also publishes this information on its common areas.

Integrated Home Care Services Compliance Hotline number is 954-381-7954

Employees and delegated entities can also report Compliance /FWA issues anonymously via correspondence to:

Compliance Department
3700 Commerce Parkway,
Miramar FL 33025

For confidential reports, employees and delegated entities may also report Compliance or Fraud Waste and Abuse concerns to the following contacts:

Chief Compliance Officer - Gladiris Galiano, Esq., CHC (ggaliano@ihcscorp.com)

Telephone: (844)- 215 - 4264 ext. 7820

Compliance Analyst – Gina Nerey (gnerey@ihcscorp.com)

Telephone: (844)- 215 - 4264 ext.

Informants can also send an email to compliance@ihcscorp.com

Informants are reminded that the information they provide will be treated as confidential. Retaliation is prohibited when reporting an act in good faith.

Our Compliance Department has procedures in place to provide timely responses to the hotline reports, assuring confidentiality and progress updates. Follow-up investigations are initiated no later than two (2) weeks after receiving the complaint. Cases will be referred to appropriate state agencies, MEDICS or other entities, as necessary. Clients are informed, as applicable. All investigations are kept in the Company's records and are available to Medicare, our Accreditation agencies, or other appropriate Federal and/or State agencies upon proper request.

Reference: 42 C.F.R. §422.503(b)(4)(vi)(D) and 42 CFR § 423.504(b)(4)(vi)(D)- Medicare Managed Care Manual Chapter 21 section 50.4 *et seq.*

Enforcements of Disciplinary Standards

The Company believes that timely, consistent, and effective enforcement of standards is an essential element to prevent, detect and reduce fraud, waste, and abuse and other instances of non-compliance. Our Disciplinary Standards are included in our Policies and Procedures and are part of the General Compliance training that is provided when the employee starts in the organization and yearly thereafter. Our Employees and Delegated Entities, as appropriate, are informed that

violations of standards will result in appropriate disciplinary actions, up to and including termination of employment/contract. Our employees, and delegated entities, as applicable, are trained and educated on the Company's compliance expectations and on our Code of Conduct. Employees and Delegated Entities (as applicable) are provided with Compliance Standards and are required to attest that they received such materials. Our CEO and Board of Directors sign, support and approve all Standards of Conduct each time they are revised and annually thereafter.

Reference: 42 CFR §422.503(b)(4)(vi)(E), 42 CFR §423.504(b)(4)(vi)(E)- Prescription Drug Benefit Manual Chapter 9 sections 50.5 to 50.5.3

Monitoring and Auditing

Development of the Company's Risk Assessment:

To establish an effective system for auditing and monitoring, the company performs an internal Risk Assessment. The internal Risk Assessment is performed by the Compliance and Quality Committee in conjunction with all operational Subject Matter Experts during the fourth quarter of every year and more often, if necessary. The analysis considers all business operational areas of the Company. Each operational area is assessed for the types and levels of compliance risks that the area may present to the Medicare Program, Medicaid Program, Accreditation Commission for Health Care Requirements, The Federal Drugs Administration, the Department of Transportation, Contractual Key Performance Indicators, the Occupational Safety and Health Administration, the Medicare Conditions of Participation and to the Company. Among the factors considered are:

- Size of the Department.
- Complexity of work.
- Amount of training that has taken place.
- Past compliance issues; and
- Budget.

Areas of particular concern include Organizational Determinations, Grievances, Medical Gases Requirements (CGMP, CFR, NFPA, OSHA, FDA) compliance with Contractual Key Performance Indicators such as Call Center Metrics, Turnaround times, compliance with Regulatory Requirements such as Privacy, Security, Training and OIG/GSA Checks.

Specifically, our Company evaluates each area under the following methodology:

Risk Assessment Methodology

Companies are required to have an effective compliance program. The United Stated Federal Sentencing Guidelines provides the parameters for an effective compliance program, including the requirement to periodically assess risk (USSG § 8B2.1 (c)). As a delegated entity to Medicare Advantage Plans, we are contractually required to comply with the Medicare Compliance Guidelines, which also requires the performance of a risk assessment to guide internal monitoring and auditing.

To ensure we comply, and we help our clients comply with these requirements, we have established the following methodology to assess compliance risks. The following questions will be evaluated to determine the level of risk applicable. A "yes" response means risk. The questions to be answered are the following:

1. Is the activity a new regulatory requirement (State or Federal law or regulation)?
2. Is the activity/risk new for the department?
3. Is the party responsible new to the organization?
4. Is the party responsible inexperienced with the new responsibility?
5. Has there been high staff turnover or agency reorganization affecting this department? If it is an issue of staffing, consider the following factors:
   - ✓ Is the department/area workload volume being accurately forecasted?
   - ✓ Is the turnover rate higher than what the department head planned?
   - ✓ How close is the department/area to hiring the resources they need?
   - ✓ Is the productivity of new hires different than the department head projections?
6. Does the department/area lack effective documented procedures (P&Ps) and/or controls?
7. Has it been more than one year since the department received a single audit?
8. Were there findings or violations in the past or are there any outstanding findings

   (Non-compliance Notices/ ACHC Audit Reports/ Warning Letters/ FDA or Medicare Audit Reports/ Internal Audit Reports)?"
9. Is the activity one of the areas that is most likely to be audited?
10. Is the activity directly related to patient access to benefits?
11. Is the activity causing patient/client harm?
12. Is the activity causing financial risk? (fines, monetary penalties, or affecting company or client's solvency, Financial Statements or Medicare Trust fund Ex. Billing issues)"
13. Is the activity causing a fraud risk?
14. Is the activity causing a waste risk?

15. Is the activity causing an abuse risk?

16. Is the activity affecting the Company's reputation?

A yes response to questions 8 to 16 represents a high likelihood of receiving an external audit and/or high impact on the organization if the activity is determined to be out of compliance.
Each response will be quantified to determine the initial risk score level as follows:

High Risk: An operational activity that has 9 or more questions with a yes answer or has a "yes" to at least one of the questions 8 to 16.

Medium Risk: An operational activity / issue that has between 4 and 8 questions with a "yes" answer and did not answer "yes" to questions 8 to16.

Low Risk: An operational activity that has 3 or less questions with a "yes" answer; and did not answer "yes" to questions 8 to 16.

Once the initial risk score level is obtained, the committee reexamine the likelihood of the activity and if there are mitigation activities currently in place reducing the likelihood or the impact. Risk Scores will be adjusted based on the likelihood and mitigation factors.

After determining the initial risk score, the committee reviews the activity's likelihood and any existing mitigation measures and will assign an adjusting factor as follows:

- Likelihood: Rare (1) to Almost Certain (5)
- Impact: Minor (1) to Severe (5)

Compliance risk areas are assessed using the abovementioned methodology. Our Compliance Committee evaluates the results and requests from the Compliance Officer to incorporate them as applicable into its Monitoring and Auditing Plan. Audit and monitoring activity is organized based on risk issues, priority level and resources availability. Factors such as size of the department, availability of resources, the complexity of work, the amount of training that has taken place, past compliance issues and budget are considered.

Risk areas that are identified through Medicare or FDA audits and oversight, as well as through our own monitoring, audits and investigations are considered priority risks. The Compliance Department also revises resources such as CMS's managed Care Manuals, FDA Manuals and CMS' Program Audit Process and Protocols.

Reference: United Stated Federal Sentencing Guidelines (USSG § 8B2.1 (c). 42 C.F.R. §§ 422.503(b)(4)(vi)(F), 42 CFR § 423.504(b)(4)(vi)(F) and Managed Care Manual Chapter 21: Compliance Program Guidelines §50.6.2 – Development of a System to Identify Compliance Risks

Timely and Reasonable Inquiry of Detected Offenses and Corrective Action Plans

We understand the importance of conducting a timely and reasonable inquiry where evidence suggests there has been misconduct or non-compliance situations. In such cases, the Company starts an investigation as quickly as possible, but no later than two (2) weeks from the date, the potential misconduct has been identified. Misconduct can occur at our Company or its delegated entities, however, regardless of where the misconduct is identified, the investigations are initiated according to the standard set forth above.

The company conducts Corrective Actions/Preventive Action Plans, (CA/PA) in response to potential violations as appropriate. Corrective actions are designated to correct the core problem that results in program violations and to prevent future misconduct. Noncompliance situations related to delegated functions are communicated to the client so that it can be worked in collaboration with them ensuring compliance with regulations and contractual obligations. If the corrective action plan is with one of the company's delegated entities, the Company enforces it via a written agreement that includes the timeframes to perform the requested action, and the ramifications should the contractor fail to implement the corrective actions requested.

The Corrective Action Plan key elements are:

- Facts (including dates and any specific information needed to understand and be able solve the issue)
- Regulation governing the situation
- Identification of the root cause of the noncompliance situation including the number of beneficiaries impacted if applicable
- Action Plan to correct the deficiency with due dates, responsible parties (this may also reference any penalties or disciplinary actions imposed as part of the corrective actions to prevent the issue from reoccurring)

All audit reports/Corrective Action Plan are tailored to address the particular deficiency identified, including timeframes for specific corrections, are discussed with appropriate operational parties and deficiencies are validated with additional regular monitoring / auditing until sustained compliance is achieved. They also include the ramifications should the internal operational area fail to implement the corrective actions requested.

The Chief Compliance Officer's designee tracks the implementation of Corrective Action Plans until their resolution to ensure their effectiveness.

All company records, audits and compliance documents and records are retained for a minimum of ten (10) years.

Reference: 42 CFR § 422.503 (b)(4)(vi)(G), 42 CFR § 423.504(b)(4)(vi)(G); Medicare Managed Care Manual - Compliance Program Guidelines § 50.7 et seq.

Board of Directors Approval

This Compliance Plan has been reviewed and approved by the Company's Board of Directors.

By my signature below, I certify that I have reviewed, approved, and am committed to supporting the enforcement and oversight of our Company's Compliance Plan.

Name: Christopher J. Bradbury

Signature: 

Date: 11.24.2025

History of Changes:

January 6, 2025 - Annual approval

August 25, 2025 - Full review conducted, transitioned to new enterprise format

November 21, 2025 – Annual review conducted. Updated *"Avoiding Gifts and Payments"* section.