Principles of Business Ethics

Compliance and Fraud Prevention Guide

HUMANA.
Guidance when you need it most

HUMANA.
Guidance when you need it most
Military Healthcare Services

Dear Health Care Professionals, Entities and Vendors:

Our industry's attention has increased its focus on compliance and the hidden cost of health care. Humana is committed to maintaining high ethical standards in the conduct of its business and expects the health care professionals, entities and vendors with which it contracts to follow similar standards. The key to upholding those standards is through the daily decisions and actions of each and every health care professional, entity and vendor.

Humana is providing the resources and opportunities you need to get answers to your questions, such as:

- What is an ethical situation?
- How do I report suspected fraud, waste and abuse?
- What do I do when I believe that Humana's *Principles of Business Ethics: Compliance and Fraud Prevention Guide* is not being upheld?

Humana is committed to detecting, preventing and correcting fraud, waste and abuse and being in compliance with all federal and state rules, laws and regulations.

We ask you to read and reflect on the information presented in this guide. If you would like to receive additional copies of this guide, please contact your local Humana market office.

Thank you for your continued participation in Humana health plans. Together, we can work to maintain high ethical standards.

Sincerely,

David A. Jones, Jr.
Chairman of the Board

Michael B. McCallister
President and CEO

Christopher M. Todoroff
Senior Vice President and
General Counsel
Chief Compliance Officer

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You Are the Key to Integrity

Humana's *Principles of Business Ethics: Compliance and Fraud Prevention Guide* affirms Humana's commitment to integrity and doing business with health care professionals, entities and vendors who are equally committed to upholding Humana's values. As part of the health care delivery system, it is important that we conduct ourselves in an ethical, legal and above-board manner. Integral to such conduct is a commitment to compliance and to detecting, preventing and correcting fraud, waste and abuse in the administration of health plan benefits and services. Our understanding of these commitments and our willingness to raise ethical concerns are essential to the well-being of our members and to the success of our business relationship.

Honesty: Act fairly and honestly with those who are affected by our actions and treat them as we would expect them to treat us if the situation were reversed.

Compliance: Comply not only with the letter of all federal and state rules, laws and regulations, but also with the spirit of the law or regulation. Act in such a manner that the full disclosure of all facts related to any activity would reflect favorably upon the company or you.

Business Responsibility and You: Adhere to the highest ethical standards of conduct in all business activities and act in a manner that enhances Humana's standing as a corporate citizen and ethical competitor within the business community. Pursue no business opportunity that requires violation of these principles.

Responsibility for Reporting Violations: You are responsible for reporting suspected ethical violations. Humana promotes relationships based on mutual trust and respect and provides an environment in which health care professionals, entities and vendors may question a company practice without fear of adverse consequences.

Ethical violations include, but are not limited to, the following: violations of laws or policies, dishonest or unethical behavior, conflicts of interest, fraud, questionable accounting and internal controls or any suspicious activity.

Fraud, Waste and Abuse Detection and Correction: You are responsible for recognizing behavior that may be considered fraud, waste or abuse. When such behavior is detected, it should not only be reported, but measures should also be put in place to confirm that such behavior does not occur in the future.

Humana's *Principles of Business Ethics: Compliance and Fraud Prevention Guide* is designed to provide practical guidance and a reference point for developing your own policy and procedures for compliance and fraud prevention.

Getting Answers to Compliance and Business Ethics Questions

Our fundamental objective is to promote appropriate and efficient use of health care services. We provide the following resources to increase understanding of compliance and fraud prevention.

Ethics Help Line (1-877-5THE KEY)

If you have compliance questions or become aware of any compliance or ethical violation, call the confidential Ethics Help Line at **1-877-5THE KEY** (1-877-584-3539). Ethics Help Line staff are available to take your calls 24 hours a day, seven days a week.

You are encouraged to call the Ethics Help Line for clarification regarding a company policy, or a federal, state or local law or regulation. You may also call the Ethics Help Line to report suspected ethical violations or fraud, waste or abuse. Ethics Help Line staff take your calls very seriously. Calls to the Ethics Help Line are received by trained, external staff who are not Humana employees. They document and forward your information to Humana's Ethics Office for review and determination of action. Calls may be made anonymously, and they cannot be traced or otherwise identified. If you choose to remain anonymous, Humana encourages you to provide enough information regarding the potential violation to allow the company to review the situation and respond appropriately. You will be assigned a confidential identification number to follow up on the status of your call.

You may also report a concern, anonymously if you choose, using the Ethics Help Line Web reporting site at https://www.ethicshelpline.com/ or e-mailing Humana at ethics@humana.com. You will be provided with a confidential report number, personal identification number for confidential follow up and a recommended follow-up date.

Special Investigations Unit

Humana's Special Investigations Unit (SIU) is responsible for detection, correction and prevention of health insurance fraud, waste and abuse. In an effort to facilitate proper business practices and preserve reasonable premium rates, the SIU staff investigates and works with appropriate law enforcement, as well as state and federal agencies, when dealing with insurance fraud, waste and abuse by providers, insureds, agents, employer groups, company employees, first-tier entities, downstream entities, related entities and other individuals.

Humana's SIU may be contacted to report suspected fraud, waste or abuse via:

Phone: English: 1-800-614-4126
Fax: 1-920-617-1594
E-mail: siureferrals@humana.com
Mail: Humana
Special Investigation Unit
1100 Employers Blvd.
Green Bay, WI 54344

Reporting and Investigation of Violations

Reporting of Violations

If you become aware of a possible violation of any federal or state rule, law, regulation or policy, or of any violation of Humana's *Principles of Business Ethics: Compliance and Fraud Prevention Guide*, immediately report it by calling the Ethics Help Line at **1-877-5THE KEY** (1-877-584-3539).

Humana members are reminded to report fraudulent activities upon receipt of a Humana Explanation of Benefits (EOB) or SmartSummary[SM] statement by contacting Humana's Special Investigation Unit (SIU).

No Retaliation

Humana strictly prohibits retaliation against any health care professional, entity or vendor who, in good faith, reports an actual or possible violation of any federal or state law or regulation, any policy or ethical standard. Your call to the Ethics Help Line may be made anonymously.

Reporting mechanisms and our internal processes are designed to raise standards across the industry and contribute to the goals of good governance.

Investigation of Violations

Humana promptly investigates any reported potential violations of its *Principles of Business Ethics: Compliance and Fraud Prevention Guide*, federal or state rules, laws, regulations and other policies and procedures. All reported issues are treated as confidentially as possible. You are expected to cooperate fully in any investigation of an alleged violation. If you wish to remain anonymous, please provide enough information to enable Humana to investigate the issue.

Corrective Action for Violations

Health care professionals, entities and vendors should do what is permissible, acceptable and expected. That means using common sense, good judgment and proper behavior. Violation of any federal or state law or regulation, or of Humana's *Principles of Business Ethics: Compliance and Fraud Prevention Guide* and other policies and procedures could compromise Humana's integrity and reputation, and will result in penalties and/or corrective action, up to and including termination of a provider's contract, and based on the violation, it will be reported to the appropriate authorities.

The following are examples of conduct by health care professionals, entities and vendors that may result in a penalty and/or corrective action:

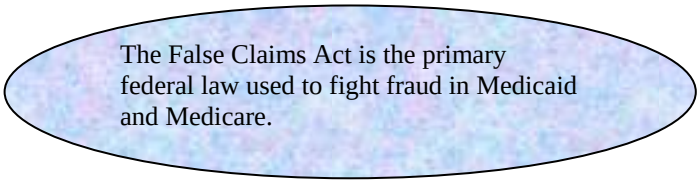
- Failure to detect and report unethical conduct
- Fraudulent, wasteful or abusive billing practices

Compliance with Federal and State Laws

Humana is committed to complying with applicable state and federal rules, laws, regulations, Medicare Parts A, B, C, D, Medicaid requirements and other requirements as they pertain to providing services to its members. Humana requires such compliance not only for the company and its employees, but also for all contracted providers, suppliers and vendors providing services to its members. While there are a multitude of laws and regulations governing the activities of Humana, there are several key laws that govern the actions of health care professionals, entities and vendors.

Federal False Claims Act

This act was enacted to give leverage to the federal government against persons/entities involved in fraudulent activities while dealing with the government and to impose civil penalties. Under the False Claims Act, those who knowingly submit, or cause another person to submit, false claims for payment by the government are liable for three times the government's damages plus civil penalties per false claim. Health care fraud was established as a federal criminal offense, with the basic crime carrying a federal prison term in addition to significant financial penalties (USC, Title 18, Section 1347).



When submitting claims data to the Centers for Medicare & Medicaid Services (CMS) for payment, Humana and Humana's contracted providers or vendors must certify that the claims data are true and accurate to the best of their knowledge and belief. The False Claims Act is enforced against any individual entity that knowingly submits (or causes another individual/entity to submit) a false claim for payment to the federal government. In addition, parties have a continuing obligation to advise the government of any new information indicating the falsity of the original statement. Consequently, if you determine after submitting a claim that the information contained therein is or may be false, you must notify Humana immediately.

The False Claims Act prohibits any person or entity from:

- Knowingly presenting, or causing to be presented, a false or fraudulent claim to an employee of the United States government for payment or approval.
- Knowingly making, using or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government.
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid.
- Knowingly making, using or causing to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money to the government.

A violation of the False Claims Act occurs if the person or entity:

- Has actual knowledge of the fraudulent activity and does not report the occurrence.
- Acts in deliberate ignorance of the truth or falsity of the information.
- Acts in reckless disregard of the truth or falsity of the information; no proof of specific intent to defraud is required.

The False Claims Act has become one of the most widely enforced statutes to fight health care fraud.

The federal government does not consider an innocent mistake as a legitimate defense for submitting a false claim, and the violation could result in a multitude of penalties. Potential cases may be reported to the Office of Inspector General (OIG). The OIG would make the determination whether or not the case warranted additional investigation.

Courts have little discretion when they impose a penalty under the False Claims Act. For example, anyone submitting a false claim for payment or approval may be liable for a civil penalty.

Anti-Kickback Laws

The federal anti-kickback laws that apply to Medicare and Medicaid prohibit health care professionals, entities and vendors from knowingly offering, paying, soliciting or receiving remuneration of any kind to induce the referral of business under a federal program. In addition, most states have laws that prohibit kickbacks and rebates. Remuneration under the federal ant-kickback statute includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

Violators are subject to criminal sanctions, such as imprisonment, as well as high fines, exclusion from Medicare and Medicaid, very costly civil penalties and possible prosecution under many similar state laws.

Waiving copayments in certain instances may be considered an anti-kickback violation.

Giving a physician a gift in exchange for an office visit payment would be considered a kickback.

The anti-kickback law is extremely broad and covers a wider range of activities than just traditional kickbacks. Federal regulations include safe harbors that protect certain technically prohibited activities from prosecution. If you are unsure whether an activity violates the anti-kickback law, you should seek the advice of a legal professional.

Antitrust Laws

State and federal antitrust laws prohibit monopolistic conduct and agreements that restrain trade. Humana is committed to competition and consumer choice in the marketplace. All health care professionals, entities and vendors must adhere to the antitrust laws and must avoid any agreements or understandings with competitors on price, customers, markets or other terms of dealing and avoid trade practices that unfairly or unreasonably restrain competition in dealings with providers or customers.

Examples of illegal practices are price-fixing conspiracies, corporate mergers likely to reduce the competitive vigor of particular markets and predatory acts designed to achieve or maintain monopolistic power.

Fraud, Waste and Abuse

Humana has zero tolerance for any activity that constitutes fraud, waste or abuse. The detection, correction and prevention of fraud, waste and abuse is essential to maintaining a health care system that is affordable for everyone. Both state and federal law enforcement agencies are increasingly focused on investigating health care fraud, waste and abuse. In 2006, CMS issued the Medicare Fraud, Waste and Abuse Guidance that may be found at:

http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBManual_Chapter9_FWA.pdf

The following are definitions of fraud, waste and abuse:

- 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 herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. Some examples of fraud include, but are not limited to:

  - Double billing
  - Billing for more expensive services or procedures than were actually provided or performed
  - Doctor shopping for prescription drugs
  - Eligibility fraud
  - Pharmacies short-filling prescriptions
  - Prescription forging or altering
  - Use of untrained personnel to provide services
  - Distribution of unapproved devices or drugs
  - Fraudulent cost reports
  - Unbundling
  - Submitting a bill to Humana for services never rendered to a Humana Medicare or Medicaid member
  - Falsifying the date of service to correspond with the member's coverage period
  - Submission of false claims
  - Reselling drugs on the black market
  - Illegal usage of free samples
  - Enrolling a group of individuals to form a nonexistent company
  - Performing unnecessary procedures, causing physical risks to patients

An example of double billing is a pharmacist who deliberately charges both the patient and Medicare for the full cost of the same prescription and keeps the extra money.

False claims are the #1 type of Medicaid and Medicare fraud and abuse.

- Waste means to use up health care benefits or spend health care dollars without real need. For example, prescribing a medication for 30 days with a refill when it is not known if the medication will be needed.

- Abuse means provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to the health care system, 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 health care system.

Potential fraud, waste and abuse are risks associated with the business of providing health care insurance and the prescription Part D benefit to:

- Consumers
- Health plans
- Insurance agents and brokers
- Pharmacies
- Pharmacy benefit managers
- Providers (including prescribers, wholesalers and pharmaceutical manufacturers)

An agent who enrolls a group of individuals to form a nonexistent company is committing fraud.

Contracted health care professionals, entities and vendors are responsible for developing their own comprehensive plan for detecting, correcting and preventing fraud, waste and abuse.

The most common kind of fraud involves a false statement, misrepresentation or deliberate omission that is critical to the determination of benefits payable.

Integrity of Company Information

Accuracy of Information

Humana is committed to providing accurate and truthful information in any transaction. Health care professionals, entities and vendors should have internal controls and procedures developed so that reports and records of any type are accurate and reliable. These controls should be designed to maintain the integrity and reliability of reporting to any government or regulatory agencies.

Safeguarding Confidential and Proprietary Information

Personal information is the foundation of the health care industry. In 1996, the Health Insurance Portability and Accountability Act (HIPAA) focused on the balance between the individual's right to privacy of protected health information (PHI) versus the business need to access the information.

As we all play key roles in health care delivery, we have access to significant amounts of detailed information about individuals. Much of this information is required for many reasons, such as diagnosis and treatment of individuals and payment for services received. This information must be safeguarded to prevent inappropriate disclosure and unwarranted invasion of the rights to privacy of our members.

Organizations are required to have policies and procedures regarding the federal and state privacy and security laws and regulations. To meet the basic requirements contained within these laws and regulations, your organization should have the following in place:

- Privacy and security policies that define what types of information are to be safeguarded, such as confidential information, protected health information, financial information or nonpublic personal information.

- Administrative, physical and technical safeguards that assist with the protection of information defined within the privacy and security policies. Organization size and available technology should be considered when determining the appropriate safeguards to implement.

- Development of a privacy, security and ethics training program for new employees with the commitment of your organization to safeguard and respect the privacy of information.

- Written agreements with contractors, including subcontractors and independent contractors, who have access to this information as part of performing a function on your behalf.

- A process for employees to identify and report any violation or potential violation of privacy and/or security.

For additional guidance on examples of implementation and training policies relating to privacy and security laws and regulations, go to the "Privacy Practices" link on Humana.com located at the bottom of the Web page.

Doing Business with the Government

Contracting with the Government

As a government contractor, Humana complies with all applicable federal and state laws, which impose stringent requirements. It is essential that there be strict compliance with all laws and regulations in transacting business with the government. The terms of contracts with the government require explicit compliance.

Health care professionals, entities and vendors who deal with government officials and contracts are responsible for knowing and complying with applicable laws and regulations such as the Procurement Integrity Act.

Procurement Integrity Act

The Procurement Integrity Act (the Act) prohibits Humana, as a federal contractor, from:

- Receiving contractor bid or proposal information that would give Humana an unfair competitive advantage
- Giving anything of value to a procurement official
- Discussing or making an offer of employment to a federal government or military procurement official or certain family members. Some procurement officials have a two-year ban, and some have a lifetime ban on employment discussions with Humana

Violations of the Act committed by contractors or their employees are punishable by fines and imprisonment, loss of government contracts and/or suspension or debarment from participating in federal procurement opportunities.

Humana's policy is to avoid even the appearance of impropriety. We therefore strive to comply with the Act in all respects.

Services performed by health care providers may not be awarded on the basis of bids. Instead, services must be awarded on the basis of demonstrated competence and qualifications.

Conflicts of Interest

Business decisions and actions must be based wholly on the best interests of Humana members and must not be motivated by personal considerations or relationships. A good general rule is to avoid any action or association that would be embarrassing to you or Humana if it were disclosed to the public or be perceived as a potential conflict of interest.

> A physician prescribing a drug who also receives money from the pharmaceutical company, which manufactures the drug, is a conflict of interest.

Individuals Ineligible for Employment

As a health care insurer, Humana is subject to strict government regulation and oversight. The government requires that Humana refrain from hiring or contracting with individuals who have engaged in certain types of activities. Individuals will be ineligible for hire or continued employment or any contractual relationship if they have been or are:

- Convicted of a criminal offense related to health care
- Listed as debarred, excluded or otherwise ineligible for participation in federal health care programs
- Identified and listed on the Executive Order 13224 - Blocking Property and Prohibiting Transactions with Persons Who Commit, Threaten to Commit or Support Terrorism
- Listed on the Department of Health and Human Services Office of Inspector General (OIG) and General Services Administration (GSA) exclusion lists

The exclusion lists are checked upon initial hiring and annually thereafter. Humana reserves the right to obtain certifications from all health care professionals, entities and vendors to verify that their employees are not on such lists.

In addition, Humana is subject to the Violent Crime Control and Law Enforcement Act, which makes it a felony for Humana to hire or contract with an individual who has ever been convicted of any felony involving dishonesty or a breach of trust. These individuals will be ineligible for hire or continued employment at Humana or for any contractual relationship.

Gifts to Health Care Professionals, Entities and Vendors

Many gifts given to health care professionals, entities or vendors by companies serve an important and socially beneficial function. For example, companies have long provided funds for educational seminars and conferences. However, there has been growing concern about certain gifts from industry to health care professionals, entities or vendors. Some gifts that reflect customary practices of the industry may not be consistent with the American Medical Association's (AMA) Principles of Medical Ethics. To avoid the acceptance of inappropriate gifts, health care professionals, entities and vendors should observe the AMA guidelines via their Web site at:

http://www.ama-assn.org/ama/pub/category/4001.html

Humana's Vision

To become
the most
trusted name in
health solutions.

Thank you for your continued support of Humana's *Principles of Business Ethics: Compliance and Fraud Prevention Guide.*

Remember . . . You Are the Key to Integrity!

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