2012 Medicare Compliance Plan

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Medicare Compliance Officer

Compliance Plan Governance

The Medicare Compliance Plan is updated annually and is approved by the Boards of Directors for the Health Net subsidiaries that hold contracts with the Centers for Medicare & Medicaid Services ("CMS"): Health Net of Arizona, Inc.; Health Net of California, Inc.; Health Net Community Solutions, Inc; Health Net Health Plan of Oregon, Inc; and Health Net Life Insurance Company. The Medicare Compliance Plan is then reviewed by the Board of Directors for the parent company, Health Net, Inc. (hereafter, "Company").

The Medicare Compliance Plan is a component of Health Net's overall compliance program and reinforces the Company's commitment to ethical standards of conduct. The overall compliance program at Health Net includes the Code of Business Conduct and Ethics, which is endorsed by Health Net's Chief Executive Officer and Chief Operating Officer, and approved by the Health Net, Inc. and subsidiary Boards of Directors. The Medicare Compliance Plan builds on the foundation established by the Company's Corporate Compliance Program, including measures related to mandatory compliance training, HIPAA Privacy Program training, Fraud, Waste and Abuse detection, prevention and correction, including a hotline for anonymous reporting, and specialized training for functional areas supported by department Policies and Procedures.

One of the key elements in the Medicare Compliance Plan is the creation of a Medicare Compliance Committee, which is charged with supporting the Medicare Compliance Officer in review and oversight of the Medicare Compliance Program. The Committee is responsible to senior management, the Chief Executive Officer and the Health Net, Inc. and subsidiary Boards of Directors for reviewing the effectiveness of the compliance program through self-audits and monitoring of metrics and key indicators and to ensure prompt and effective corrective actions are taken where deficiencies are noted. The Medicare Compliance Officer and the Committee are responsible for escalating compliance deficiencies and ongoing issues of non-compliance to senior management, the Chief Executive Officer and the Health Net, Inc. and subsidiary Boards of Directors.

Health Net makes this Medicare Compliance Plan available to all Health Net associates and Board of Directors ("Directors"), as well as contractors, subcontractors, vendors, agents, and first-tier, downstream and related entities ("FDRs"). The Medicare Compliance Officer reserves the right to amend and update components of the Medicare Compliance Program, including the material in this Medicare Compliance Plan, at any time to make changes based on regulatory guidance, enhancements to the program to improve effectiveness or for any other reason.

The information contained in this Medicare Compliance Plan, including names and titles of Health Net associates, is correct as of the date of publication and may change without prior notice.

All Health Net associates who support Medicare programs must read and understand the content of the Medicare Compliance Plan.

Please contact the Medicare Compliance Department if you have questions regarding information contained in this Medicare Compliance Plan.

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THE HEALTH NET COMPLIANCE PROGRAM

Organizational integrity is at the core of Health Net's values and begins with each individual associate. At Health Net, each associate is required to observe the spirit and letter of all applicable laws and regulations, as well as demonstrate the highest standards of proper conduct and personal integrity. Associates are expected to conduct themselves in an ethical and lawful manner, both inside and outside of the workplace, by refraining from any non-compliant, illegal, dishonest or unethical activities. Proper conduct is an individual responsibility. The Health Net Code of Business Conduct and Ethics expresses these commitments as key values of our Company.

Health Net considers its Compliance Program to be an essential tool for promoting regulatory compliance and ethical conduct; preventing, detecting and resolving non-compliant and illegal conduct, including fraud, waste or abuse of government programs, whether committed by Health Net associates or by those outside the Company.

Health Net's Compliance Program includes, but is not limited to, the following elements:

- Written Policies and Procedures and Standards of Conduct
- A Compliance Officer and Compliance Committee
- Training and Education
- Effective Lines of Communication
- Auditing and Monitoring
- Enforcement of Standards through well-publicized disciplinary guidelines
- Detecting and responding to offenses and developing Corrective Action Plans

An effective Compliance Program has a compliance plan, which is a written document that describes the specific manner in which the Compliance Program elements are met for our Medicare Advantage ("MA") and Part D Prescription Drug ("Part D") lines of business. The compliance plan also clearly states the Company's expectations for associate conduct and provides associates with guidance in abiding by the elements of the Compliance Program.

This Medicare Compliance Plan was developed under the direction of the Health Net Medicare Compliance Officer, is approved by the Boards of Directors of the Health Net subsidiaries that hold contracts with CMS, and is reviewed by the Health Net, Inc. Board of Directors.

This Medicare Compliance Plan applies to all Health Net associates, Directors, subcontractors, and agents whose jobs touch upon the Medicare program, even indirectly. For other Health Net associates not involved in the Medicare program, this Medicare Compliance Plan is part of the overall Health Net Compliance Program and sets forth Health Net's commitment to compliance and provides general guidelines on compliance programs within the Company.

The Medicare Compliance Plan and associated policies and procedures are reviewed and revised at least annually or more frequently if there are changes in regulatory requirements or business needs. The Medicare Compliance Plan includes ongoing risk assessment so the program evolves in response to issues that arise, with resources for oversight deployed based on the Company's business circumstances. The Medicare Compliance Plan includes processes for assessing the effectiveness of the Compliance Program, through the use of effective, two-way communications and reporting metrics.

The Medicare Compliance Officer is responsible for oversight of the Medicare Compliance Plan, providing Compliance Program guidance, and reporting incidents of suspected or identified non-compliance to senior Management and the Health Net, Inc. and/or subsidiary Boards of Directors.

Health Net leaders of each functional area are responsible for maintaining overall compliance with the changing requirements of CMS.

Health Net senior leaders and the Health Net, Inc. and subsidiary Boards of Directors are accountable for the effectiveness of the Compliance Program.

WRITTEN POLICIES, PROCEDURES AND STANDARDS OF CONDUCT

Health Net's overall expectations for associate conduct begins with the Company's commitment to comply with all Federal and State regulations, standards, and sub-regulatory guidance. Compliance training occurs as part of the new hire process and is conducted annually thereafter, as determined by Health Net. In addition, Health Net has policies and procedures that establish expectations that Health Net associates—as well as FDRs—are expected to follow. The Company maintains an extensive library of policies and written guidelines so all associates know and understand their individual responsibility for compliant and ethical business practices.

The Company's core standards are described below.

Health Net Code of Business Conduct and Ethics (Code of Conduct)

The Code of Business Conduct and Ethics articulates the Company's commitment to conduct business in a lawful and ethical manner in compliance with Federal and state requirements. The Code of Conduct is endorsed by the Chief Executive Officer and Chief Operating Officer of the Company and approved by the Health Net, Inc. and subsidiary Boards of Directors. The Code of Conduct is designed to guide Health Net Associates and business partners in upholding our high standards of fair and ethical practices.

All Health Net Associates must read the Code of Conduct and sign an acknowledgement that they agree to abide by the Code of Conduct. An electronic copy of the Code of Conduct is provided to all newly-hired Associates and is available to review on the Health Net's intranet and Internet sites by all Associates, as well as FDRs.

Each Health Net manager, director and officer of the company is responsible for reinforcing the Code of Conduct in their respective departments. In support of the Code of Conduct, the Company has developed written policies, which provide Associates with practical guidance in meeting Health Net's standards of acceptable behavior. Associate policies are stored in the National Policy Library, an electronic repository of policies available to all Associates.

Health Net requires that all FDRs supporting the MA and Part D program adopt and abide by the Health Net Code of Conduct or implement their own Code of Conduct that incorporates standards of conduct and compliance requirements similar to Health Net's Code of Conduct.

On an annual basis, Health Net reviews the Code of Conduct for possible revisions that may result from a change in Company policy or changes in applicable laws or regulations.

HIPAA Privacy Program (Privacy Program)

The HIPAA Privacy Program sets the standards for Associates in safeguarding confidential and protected health information. The Company is committed to complying with applicable laws, regulations and policies related to privacy of health information. All associates are required to complete training on Health Net's Privacy Program policies and are required to perform their work duties with a conscious regard for the privacy rights of Health Net's

members.

Under the direction of the Health Net Privacy Officer, the Privacy Program focuses on educating Associates on their ongoing responsibility to protect member privacy and secure member information. The Privacy Officer manages and updates our privacy policies and procedures, which are available to all Health Net Associates via the electronic National Policy Library.

All FDRs must abide by the Health Net Privacy Program policies or demonstrate that they have a dedicated Privacy Officer who is responsible for ensuring that all individuals within the respective delegated entity or vendor are trained on HIPAA regulations and the process for reporting privacy breaches. The FDR's Privacy Officer is also responsible for managing any issues related to privacy breaches and reporting to Health Net should a privacy breach occur, which impacts Health Net members or business.

Fraud, Waste and Abuse ("FWA") Plan

Health Net maintains an FWA Plan that demonstrates the Company's commitment to prevent, detect and correct incidents that could lead to fraud, waste or abuse. Health Net's FWA Plan includes initial background checks to review associates' backgrounds for OFAC exclusions. Additional screenings for criminal convictions, OIG exclusions and other background records are examined prior to employing an associate in a position of trust. Upon hire, individuals must agree to comply with the Health Net Code of Conduct and complete all mandatory FWA training courses.

Health Net uses a number of system edits and programmatic reviews of data designed to detect potential fraud. Health Net maintains an FWA hotline for anonymous reporting and a Special Investigations Unit (SIU) that investigates all reports of potential fraud, waste or abuse. The SIU works with designated state and Federal agencies, the Medicare Drug Integrity Contractor ("MEDIC"), and law enforcement to pursue individuals or organizations who may be involved in activities that fall under the FWA umbrella and will pursue prosecution of health care fraud and abuse.

Fraudulent activity may involve an Associate, Director, member or FDR who is involved in inappropriate schemes or behavior, or a health care provider who is involved in false documentation, inappropriate prescriptions, falsification of conditions in order to help an individual receive an otherwise uncovered service under Medicare or Federal programs or a combination of scenarios.

All Health Net Associates, Directors and FDRs play an important role in the Health Net fraud prevention program and are required to report suspected fraud, waste or abuse.

Please refer to Attachment A to the Medicare Compliance Plan for details on the Fraud, Waste and Abuse Plan.

National Policy Library

Health Net's Policies and Procedures represent its response to day-to-day risks to help reduce the prospect of fraudulent, wasteful and abusive activity by identifying and responding to risk areas. Because risk areas evolve and change over time, Health Net's

Policies and Procedures are reviewed and revised annually or more often when Health Net process or CMS requirements necessitate a change.

Health Net maintains a National Policy Library in a central electronic repository so all Health Net Associates may easily find and access Health Net Policies and Procedures.

The National Policy Library has a dedicated Administrator who assists Associates in developing, writing, approving, storing, and retrieving Health Net policies. Policy authors from across the enterprise utilize a specific set of tools to create and revise policies, and work with the Administrator to:

- Reduce risk of conflict with other policies
- Ensure consistency in formatting and design
- Ensure appropriate authority
- Enjoy on-line accessibility

Health Net's policies demonstrate to Associates, business partners, and the community at large our strong commitment to honest and responsible business conduct. Health Net's published policies establish procedures and provide direction to Associates to promote compliance with laws and regulations, and to reduce the prospect of fraudulent, wasteful, or abusive activities in our daily work.

Health Net requires that all FDRs adopt Health Net's policies and procedures or maintain similar policies and procedures that comply with current regulations or sub-regulatory guidance from CMS.

Medicare Compliance Policies and Procedures

Health Net has developed Medicare Compliance Policies and Procedures to ensure process controls are in place to meet specific requirements of the Medicare program. The following policies and procedures support the Health Net Medicare Compliance Plan and work in conjunction with department policies developed by and used on a day-to-day basis by Health Net business areas:

- Associate Policy: Preventing and Detecting Fraud, Waste and Abuse of Federal Health Care Programs (Policy MP27-72938)
- Associate Policy: Reporting and Investigating Violations / Non-Retaliation (Policy MP86-145819)
- Medicare Compliance: Compliance Officer and Compliance Committee (Policy PS729-65015)
- Medicare Compliance: Medicare Compliance Plan (Policy HR328-1543)
- Medicare Compliance: Written Policies and Procedures and Standards of Conduct

(Policy PS729-65015)

- Medicare Compliance: Effective Lines of Communication (Policy HR329-81145)
- Medicare Compliance: Enforcement of Standards (Policy HR329-83126)
- Medicare Compliance: Escalation of Compliance Issues (Policy SN37-112439)
- Medicare Compliance: Monitoring and Auditing (Policy HR810-84520)
- Medicare Compliance: Enforcement of Standards (Policy HR329-83126)
- Medicare Compliance: Prompt Responses to Detected Offenses (Policy EJ44-83932)
- Medicare Compliance: Training and Education (Policy HR329-83615)

The policies and procedures listed above provide specific guidance for Associates' use in day-to-day Medicare operations.

Delegated Entities, Vendors, Agents and First Tier, Downstream & Related Entities (FDRs)

FDRs responsible for administration of Health Net's Medicare programs may either adopt Health Net's policies, procedures and Code of Business conduct and Ethics or implement their own policies, procedures and/or standards of conduct. FDR policies, procedures and standard of conduct are subject to review and approval by Health Net.

MEDICARE COMPLIANCE OFFICER & COMPLIANCE COMMITTEE

Health Net's Chief Compliance Officer has designated a Medicare Compliance Officer to direct the Medicare Compliance Program for Health Net.

The Medicare Compliance Officer oversees the Medicare Compliance Department and works directly with the Chief Medicare Officer, the Chief Compliance Officer and the Medicare Compliance Committee to coordinate Medicare compliance activities.

The Medicare Compliance Officer works with senior management of each Health Net business unit to monitor the units' operational compliance.

Medicare Compliance Officer

Gay Ann Williams, Vice President, Government Affairs, is the Medicare Compliance Officer for Health Net, Inc. She reports to Patricia Clarey, Senior Vice President, Chief Regulatory & External Relations Officer, who serves as Health Net's Chief Compliance Officer.

The Medicare Compliance Officer is charged with overall responsibility for the effectiveness of the Medicare Compliance Program. The Medicare Compliance Officer routinely reports Medicare compliance activities to the Medicare Compliance Committee and the Chief Compliance Officer. The Medicare Compliance Officer routinely reports compliance activities to the Audit Committee of the Board of Directors. At any time, the Medicare Compliance Officer may, at her discretion, escalate compliance issues directly to the Company's executive management team, the Chief Executive Officer, the Chief Operating Officer or the Health Net, Inc. or subsidiary Boards of Directors, who are accountable for ensuring the Company's compliance goals are met. .

The Medicare Compliance Officer plays a key role in assessing the effectiveness of the Medicare Compliance Program and the organization's performance in meeting CMS standards.

The Medicare Compliance Officer ensures processes are in place to monitor and oversee activities performed by the various business units and FDRs. With the support of Health Net senior management and the Medicare Compliance Committee, the Medicare Compliance Officer ensures consistent disciplinary guidelines are enforced for incidents of non-compliance with company standards.

The Medicare Compliance Officer, in conjunction with the Medicare Compliance Department, coordinates compliance activities with other Health Net compliance Associates, such as:

- The Health Net Ethics Officer for matters related to the Health Net Code of Business Conduct and Ethics
- The Health Net Privacy Officer for matters related to HIPAA and the Privacy Program
- The Health Net Special Investigations Unit, for matters related to investigations of Medicare fraud, waste, or abuse

- Organization Effectiveness for matters related to Associate disciplinary actions

Medicare Compliance Department

The Health Net Medicare Compliance Department supports the Medicare Compliance Officer.

The Medicare Compliance Department provides support to the Medicare Compliance Officer in promoting ethical conduct, instilling a company-wide commitment to Medicare compliance, and exercising diligence in ensuring the overall Medicare Compliance Program requirements are met. The Medicare Compliance Department is responsible for:

- Representing Health Net before all applicable state and federal regulatory agencies on Medicare-related issues and serving as liaison for communications between the Company and the Centers for Medicare and Medicaid Services.

- Establishing the overall framework for the Medicare Compliance Program to promote compliance with applicable Medicare Advantage and Part D regulatory and legal requirements.

- Ensuring consistent and timely reporting of relevant Medicare compliance issues to the Medicare Compliance Officer. The Medicare Compliance Officer, in turn, reports compliance matters to the Medicare Compliance Committee and has authority to escalate issues to senior management and the Board of Directors.

- Assisting, advising and overseeing the individual business units and health plans in the design, administration, and implementation of their individual Medicare compliance work plans and policies.

- Establishing key performance measures, metrics, and reporting protocols as part of the organization's audit and monitoring of key risk areas.

- Monitoring and reporting key compliance and performance metrics for the purpose of resolving identified patterns and trends, working with business units on internal corrective actions, and assessing the effectiveness of the Medicare Compliance Program.

- Assessment of new risk areas based on information gathered from a variety of sources, including new CMS guidance, internal assessments, member complaints, CMS inquiries or other avenues; and recommending new or revised metrics, policies and procedures, enhanced training courses, or other activities that may be tracked and measured to demonstrate compliance.

- Reporting incidents of potential or identified non-compliance, and working with the applicable business units to implement appropriate and timely corrective actions that will result in measurable compliance.

- Developing relevant and effective Medicare compliance training programs that support the Medicare Compliance Program and build compliance awareness for Associates, Directors and FDRs.

- Performing independent review and ongoing monitoring of identified risk areas, as well as monitoring of compliance or performance deficiencies; and ensuring effective corrective actions are implemented in a timely manner.

- Partnering with Internal Audit to have high-priority risk areas included in the Internal Audit annual work plan and to provide background and consultative guidance to Internal Audit on any audit topic involving Health Net's MA or Part D contracts.

The Medicare Compliance Officer meets with the Medicare Compliance Department on a regular basis regarding the implementation of the Medicare Compliance Program.

Medicare Compliance Committee

Health Net's Medicare Compliance Committee (the "Committee") is charged with assisting the Health Net, Inc. and subsidiary Boards of Directors and senior management in overseeing the Company's compliance program. The Committee is responsible for assisting the Medicare Compliance Officer in achieving and maintaining compliance throughout the organization.

The Committee focuses on Medicare compliance issues with performance outcomes routinely reported to the Committee. The Committee is chaired by the Medicare Compliance Officer with executive sponsorship of the Chief Compliance Officer and the Chief Government Programs Officer. The Committee is comprised of leadership Associates from key business and operational areas across the enterprise. The Committee meets regularly at a frequency established by the Medicare Compliance Officer, but no less than once per quarter.

A key focus of the Committee is the ongoing review of Medicare Compliance Program activities. The Committee monitors key performance reports and metrics, ensures mandatory compliance training is completed, and oversees updates to policies and procedures as the result of regulatory guidance changes. The Committee monitors Medicare Compliance Program performance through proactive measures, analysis of business and clinical operations, and daily adherence to Health Net policies and procedures. The Committee monitors corrective actions to ensure they are promptly implemented and that monitoring processes are in place for sustained compliance.

The Committee ensures that Associates, Directors, members and FDRs have an effective process for reporting compliance questions and potential fraud, waste or abuse without fear of retaliation.

Governing Body

The Health Net, Inc. Board of Directors is ultimately accountable for compliance within Health Net and is obligated to oversee Health Net's Medicare Compliance Program. The Board of Directors delegates Medicare Compliance Program oversight to the Audit Committee, but the Board of Directors as a whole remains accountable for ensuring the effectiveness of the Medicare Compliance Program.

The Board of Directors for each of the Health Net subsidiaries that hold contracts with CMS are also obligated to oversee the Medicare Compliance program for the MA and Part D contracts under their purview. When compliance issues are presented to Health Net, Inc., or subsidiary Boards of Directors or the Audit Committee, further inquires are made and appropriate action is taken to address and satisfactorily resolve those issues.

The Medicare Compliance Officer has unfettered access to the Health Net, Inc. and subsidiary Boards of Directors and the Audit Committee.

As required by Federal regulations, the Health Net, Inc. and subsidiary Boards of Directors are knowledgeable on the content and operations of the Medicare Compliance Program. The Health Net, Inc. and subsidiary Boards of Directors and the Audit Committee receive compliance training and education as to the structure and operation of the Medicare Compliance and FWA Program to enable them to be engaged, to ask questions and to exercise independent judgment over the compliance issues with which it is presented. The Health Net, Inc. and subsidiary Boards of Directors and the Audit Committee are knowledgeable about compliance risks and strategies, understand the measurements of outcome, and are able to gauge effectiveness of the Medicare Compliance Program.

Senior Management

The CEO and other senior management are engaged in the Medicare Compliance Program. The CEO and senior management ensure the Medicare Compliance Officer is integrated into the organization and has the resources necessary to operate a robust and effective Medicare Compliance Program. The CEO receives regular reporting from the Medicare Compliance Officer and/or Corporate Compliance Officer of risk areas facing the organization, the strategies being implemented to address them and the results of those strategies. The CEO receives regular reporting of all compliance enforcement, from Notices of Noncompliance to formal enforcement action.

TRAINING AND EDUCATION

Training and education are an important element in Health Net's overall Compliance Program. At Health Net, compliance training is not optional and refresher training for all Associates occurs on an annual basis.

Health Net requires that Associates at all levels of the Company complete mandatory compliance training courses. The compliance training courses listed below are assigned to newly-hired associates with a due date for completion and must be repeated annually, unless otherwise noted.

Code of Business Conduct and Ethics

This course was established to ensure compliance with Health Net's standards of conduct and ethical behavior for all Associates and members of the Board of Directors.

Health Net General Compliance Program

This course reviews the laws and regulations that govern the healthcare industry and guide the Company's relations with members, regulators, shareholders, and the communities in which it does business. This course is required to be completed once within 90 days of employment.

HIPAA: An Introduction

This course provides an overview of the HIPAA laws relating to privacy and security of protected health information (PHI) and personally identifiable information (PII). The course reviews Health Net's policies and procedures regarding the handling of PHI and PII.

Medicare General Compliance

This course provides a high level overview of Health Net's Medicare Compliance Program.

The Painful Price of Health Care Fraud

This course provides an understanding of health care fraud and its effects on all parties.

Pharmaceutical Fraud, Waste and Abuse (FWA)

This course explains the differences between fraud, waste, and abuse, outlines basic steps for identifying potentially fraudulent schemes, and provides instruction on how to report suspected incidents of fraud, waste and abuse for investigation.

Fraud, Waste and Abuse Compliance Training for FDRs

All FDRs and FDR employees who assist in the administration or delivery of Health Net's MA and Part D programs, whether full-time, part-time, temporary, volunteer or otherwise, are required to take general compliance training within 90 days of contracting and annually thereafter, regardless of whether they are deemed to have met the FWA training and education requirement

- Contracted providers have the option of taking Health Net's Fraud, Waste and Abuse Compliance training on-line via Health Net's provider website or by requesting a

hardcopy version of the training.

- California contracted providers have the option to complete the Medicare Fraud, Waste and Abuse (FWA) Compliance Training course offered by the Industry Collaboration Effort ("ICE") .

Health Net requires that FDRs maintain thorough and accurate records of all completed training and present such records to Health Net upon request.

Specialized Compliance Training

Specialized compliance training is provided to Health Net associates and temporary employees who work with the Medicare programs on issues posing compliance risks based on the associate's job

Specialized compliance training is provided upon initial hire or appointment to the job function, when requirements change, when the associate was found to be non-compliant with program requirements, and when the associate's business unit was previously found to be non-compliant with program requirements or implicated in misconduct.

Specialized compliance training may be developed by the Medicare Compliance department, by the Business Solutions Training department, by the Special Investigations Unit (SIU), or by the applicable business unit(s). Formal specialized compliance training may be conducted through interactive sessions led by expert facilitators, web-based tools, the LMS, live or videotaped presentations, written materials, or any combination of these techniques, or any other methods Health Net deems appropriate and effective.

FDRs are required to develop and administer specialized compliance training to their employees who work with the MA and Part D programs.

Tracking Mandatory Compliance Training

At Health Net, every level of management is responsible for ensuring their associates complete all required compliance training by the required due date.

Mandatory training courses are delivered electronically via Health Net's Learning Management System, which tracks training completion rates by Associate and alerts managers to any overdue training requirements.

Associates and managers receive regular reminders of their training obligations, as well as personalized email reminders of outstanding compliance training requirements. Completion of mandatory compliance training courses is tied to each Associate's annual performance goals. Failure to complete required compliance training subjects Associates and their managers to performance actions, up to and including termination of employment.

EFFECTIVE LINES OF COMMUNICATION

Health Net works diligently to foster a culture of compliance throughout the organization. This is achieved by regularly communicating the importance of performing our jobs in compliance with regulatory requirements, and reinforcing the Company's expectation of ethical and lawful behavior.

The Company has systems in place to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance from Associates, Directors, members and FDRs.

To encourage two-way communication, the Medicare Compliance Department has partnered with Health Net's Communications Department to develop a compliance communications plan. The areas below are key areas of the Medicare Compliance Department communications strategy:

Medicare Compliance Intranet Website

The Medicare Compliance Department maintains an intranet website dedicated to educating Associates in key compliance areas related to Medicare Advantage and Part D lines of business. On the Medicare Compliance site, Associates can find, among other things:

- The Medicare Compliance Plan
- A link to Medicare Compliance Frequently Asked Questions
- An email link for submitting questions to the Medicare Compliance Department
- Instructions for reporting potential incidents of non-compliance, fraud, waste or abuse
- Training materials relating to key Medicare compliance requirements
- Links to Medicare Advantage and Part D compliance-related websites

Health Net Corporate Compliance Website

The Health Net Corporate Compliance Department maintains an intranet website dedicated to educating Associates in key compliance areas, such as HIPAA Privacy, the Code of Business Conduct and Ethics, and mandatory training requirements.

The site includes:

- An electronic version of the Health Net Code of Business Conduct and Ethics
- Instructions for reporting suspected violations of the Code
- HIPAA Privacy and breach reporting policies
- Information related to the laws and regulations that govern our business

- Interactive activities to promote compliance awareness and reinforce compliance training

- A link to the National Policy Library, where Associates may view policies and find guidance

Communicating Compliance Concerns

Health Net strives to foster an environment where Associates seek and receive prompt guidance on compliance issues. Whenever an Associate questions the compliant or ethical nature of a particular action, the Associate is encouraged to seek guidance from any number of sources, including:

- Company policies

- A supervisor or manager

- The Health Net Chief Compliance Officer

- The Medicare Compliance Officer

- The Health Net Integrity Line

- The Health Net Fraud, Waste and AbuseHotline

- The Legal Department

Any Health Net Associate aware of any violation of the *Code of Business Conduct and Ethics* has a duty to report the violation either to his/her supervisor, the Chief Compliance Officer, the Legal Department or to the Health Net Integrity Line.

The Company does not tolerate retaliation against Health Net Associates who make good-faith reports of potential or suspected violations. Health Net's stance on non-retaliation is described in a number of policies, procedures, guidelines, and in required training materials so all Associates are aware of the requirements.

Health Net Integrity Line

The Health Net Integrity Line is a confidential, toll-free resource available to Associates and FDRs twenty-four hours a day, seven days a week to report violations of—or raise questions or concerns relating to—the Health Net Code of Business Conduct and Ethics.

Health Net Integrity Line

1-888-866-1366

Calls to the Health Net Integrity Line can be made anonymously. Calls are never traced or recorded. The Health Net Integrity Line is operated by a third-party vendor to ensure

confidentiality.

All calls to the Health Net Integrity Line are investigated by the Company's Chief Compliance Officer or her designee. Results of investigations are reported back to the caller. The Medicare Compliance Officer reviews all calls received by the Health Net Integrity Line, as well as the results of all Medicare-related investigations.

The Company tracks calls to the Health Net Integrity Line to ensure proper investigation and resolution of reported matters; and to identify patterns and opportunities for additional training or corrective action.

The Corporate Compliance Department regularly promotes awareness of The Health Net Integrity Line through a variety of materials, published at intervals throughout the year, including:

- Articles on Health Net Connect, the company's intranet website
- Posters displayed in common work areas
- Brochure mailings with wallet-size reminder cards
- Electronic newsletters

Health Net Fraud, Waste and Abuse Hotline

The Health Net Fraud Hotline is a confidential, toll-free resource available to Associates, Directors, members and FDRs twenty-four hours a day, seven days a week to report violations of, or raise questions or concerns relating to, fraud, waste and abuse.

Associates, Directors, members and FDRs may call:

Health Net Fraud, Waste and Abuse Hotline

1-800-977-3565

Calls to the Health Net Fraud Hotline can be made anonymously. Calls are never traced or recorded.

The Company tracks calls to the Health Net Fraud, Waste and Abuse Hotline to ensure proper investigation and resolution of reported matters; and to identify patterns and opportunities for additional training or corrective action. All calls to the Health Net Fraud Hotline are investigated by the Health Net Special Investigations Unit (SIU). The Medicare Compliance Officer reviews all calls received by the Health Net Fraud, Waste and Abuse Hotline, as well as the results of Medicare-related investigations that are determined to include potential FWA.

Health Net educates Associates about the Health Net Fraud Hotline through:

- The Painful Price of Healthcare Fraud and Pharmaceutical Fraud, Waste and Abuse (FWA), mandatory compliance training courses taken annually

- The Medicare General Compliance training

- The Medicare Compliance intranet website

- Posters displayed in common work areas

- Health Net Policies and Procedures

Members and FDRs are educated regarding the Health Net Fraud Hotline through:

- The Healthnet.com internet website

- The Fraud, Waste and Abuse Compliance training for FDRs

- Provider Newsletters and Updates

Corporate Compliance & Ethics Week

The Company participates in Corporate Compliance & Ethics Week. Throughout the week the Company delivers focused, all-associate communications designed to build compliance, privacy, information security, and ethics awareness. The schedule of activities includes live presentations, creative education methods, and other activities designed to increase awareness of the Company's compliance expectations and reward associates for their ongoing compliance efforts.

ENFORCEMENT OF STANDARDS

As part of the Company's compliance program, Health Net has published the Code of Business Conduct and Ethics, which establishes standards of conduct that all associates must follow. Every associate is responsible for abiding by the Code of Conduct and for reporting any situation where an associate believes illegal or unethical conduct may have occurred. FDRs must also comply with standards Health Net has established or demonstrate that they have implemented similar standards of conduct.

Health Net takes its commitment to the Code of Conduct very seriously, and takes appropriate and immediate investigative and disciplinary action if anyone violates the Code of Conduct, Health Net policies or the law.

Health Net's strong commitment to ethical values and compliant conduct includes:

Involvement of Chief Executive Officer and other Senior Management

The President and Chief Executive Officer (CEO) of Health Net, Inc., and the Executive Vice President and Chief Operating Officer (COO) of Health Net, Inc., are involved in establishing Health Net's standards of conduct. Their commitment to compliance and ethical business practices is conveyed through their jointly-signed "Welcome Letter," which is included as the first page in the Code of Business Conduct and Ethics.

Enforcing Standards of Conduct

Health Net's policies provide specific instructions for handling reports of potential violations of company policies, administrative rules, regulations, or law. Any Health Net Associate who suspects a potential violation of policy or law is required to report the matter to:

- Their department supervisor or manager
- The Chief Compliance Officer
- The Medicare Compliance Officer
- The Health Net Integrity Line
- The Health Net Fraud Hotline
- Filing a completed "Report Fraud, Waste and Abuse" form to the Medicare Compliance department either through the mail or email.

Health Net does not tolerate retaliation against associates who report potential violations in good faith. A description of Health Net's policy on non-retaliation is found in our Code of Business Conduct and Ethics, and is reinforced in a number of policies, procedures, guidelines, and training materials.

Performance Improvement

Serious/severe performance or conduct problems may result in immediate written notice or termination of employment.

For associate conduct problems that do not rise to the level of serious/severe, Health Net utilizes a progressive coaching and performance improvement process, which offers a fair, equitable and consistent method of guiding associates toward acceptable job performance and conduct.

Publicizing Disciplinary Guidelines

All Health Net associates are informed that violations of the Code of Business Conduct and Ethics, Health Net policies, regulations or laws may result in appropriate disciplinary action, up to and including termination of employment.

Health Net publicizes compliance-related disciplinary actions through articles posted on Health Net Connect, the Company's intranet site, training videos and in-person associate presentations.

MONITORING AND AUDITS

Monitoring and auditing are critical elements in Health Net's Medicare Compliance Program. Compliance-related elements are used to develop our metrics for evaluating performance against regulatory standards. Monitoring and auditing allows Health Net to identify areas that require corrective action in order for the Company to achieve compliance with specific regulatory requirements. This process of self-identification and corrective action, along with monitoring that such actions are effective, is a key element of our program.

Auditing and monitoring activities are determined through an annual risk assessment that reviews program risk areas, establishes metrics for self-reporting and self-audits from the operational areas, requires corrective actions for areas found to be non-compliant, and requires corrective actions be taken to address identified risks. Compliance risks are separately reviewed through a variety of oversight activities, including:

- Medicare Compliance Department risk reviews
- Internal Audit
- Business Unit Self-Audits and Monitoring
- Third Party Data Validation Audits
- Monitoring and Auditing of First Tier, Downstream and Related Entities (FDRs)
- Special Investigations Unit Monitoring, Audits and Investigations
- Auditing by regulators or other external parties
- Business Unit Self-Audits and Monitoring
- Health Net Pharmaceutical Services (HNPS) oversight monitoring and audits

The various components that make up Health Net's monitoring and audit activities are:

Medicare Compliance Department Risk Reviews

The Medicare Compliance Department reviews business unit operations as part of its overall program to identify and mitigate compliance risks. The Medicare Compliance Department performs an annual risk assessment using data and information from a variety of sources, which may include:

- Regulatory risks based on CMS guidance
- Risks as identified in the OIG work plan
- Audit findings from CMS
- Notices of Non-Compliance from CMS
- Complaints filed with CMS (CTMs)
- Complaints related to sales and marketing issues
- Secret Shopper issues and findings identified by CMS

- Audit findings from business unit self-audits
- Identified high risk areas
- Corrective Action Plan monitoring
- Member "touch points" such as Appeals & Grievances, Claims, Member Services, Enrollment/Disenrollment, and Premium Billing

The result of the risk assessment drives the development of the Medicare Compliance Department's annual work plan for oversight monitoring and risk reviews. Medicare Compliance may modify its annual work plan based on issues that arise within the organization, focusing on high risk areas to confirm effective corrective actions were taken based on detected areas of non-compliance or compliance risk. Medicare Compliance audits are based on regulatory guidance and, depending on the department being audited, may rely on CMS guidance outlined in the:

- The Medicare Managed Care Manual
- The Medicare Prescription Drug Benefit Manual
- The CMS Monitoring Guide
- Other applicable CMS guidance

At the conclusion of a risk review, Medicare Compliance prepares a report of findings and observations, which are shared with the applicable business unit(s). The business unit(s) develops a corrective action plan to address the findings/observations and ensure compliance is achieved and maintained. The findings/observations and corrective action plan are reported to the Medicare Compliance Officer, the Committee, and the Chief Compliance Officer. In turn, the Chief Compliance Officer may report the audit findings and corrective action plan to the applicable subsidiary Boards of Directors and/or the Audit Committee of the Health Net, Inc. Board of Directors.

Internal Audit

The Internal Audit Department performs audits as part of its overall program to identify and mitigate organizational risks. Internal Audit initiates an annual risk assessment process that includes associate surveys and interviews. The Internal Audit Plan is presented to and approved by the Audit Committee of the Board of Directors.

Business Unit Self-Audits and Monitoring

Key Health Net business units and operational departments conduct monthly self-auditing to measure their departments' performance against CMS requirements. These audits may be self-audits by the department staff or conducted by Health Net's Business Solutions department. The Business Solutions department performs quality assurance audits against CMS standards for specific operational areas, including Enrollment/Disenrollment, Claims, and Appeals & Grievances. The results of Business Solutions audits are reported along with

other Compliance metrics to the Medicare Compliance Officer and the Committee.

Third Party Validation Review Audits

Health Net contracts with independent third parties to audit the Company's processes and operations against CMS standards and requirements. The results of the third party audits are reported to senior management, the Medicare Compliance Officer, the Chief Compliance Officer, the Chief Operating Officer, and Chief Executive Officer, and the Committee.

Monitoring and Auditing of First Tier, Downstream, and Related Entities (FDRs)

Health Net contracts with various parties to administer and/or deliver Medicare Advantage and Part D benefits on Health Net's behalf. These first-tier parties and their downstream contractors must abide by specific Health Net contractual and regulatory requirements. Various Health Net departments are responsible for overseeing the ongoing compliance of FDRs including, but not limited to:

- Credentialing
- Delegation Oversight
- Health Net Pharmaceutical Services (HNPS)
- Provider Network Management
- Membership Accounting
- Medicare Operations
- Medicare Sales
- Strategic Partners

Health Net employs multiple methods to monitor and audit FDRs, including on-site audits, desk reviews and monitoring of self-audit reports. Oversight activities and results are reported regularly to the Medicare Compliance Officer and the Committee. Departments responsible for overseeing FDRs must ensure appropriate corrective actions are implemented on a timely basis.

Special Investigations Unit Monitoring, Audits and Investigations (Fraud, Waste and Abuse Issues)

Health Net's Special Investigations Unit ("SIU") is responsible for investigating issues of possible Medicare fraud, waste and/or abuse. The SIU also develops and implements training and awareness programs to promote Health Net's commitment to combating fraud, waste and abuse among associates, business partners and FDRs.

Health Net Fraud, Waste and Abuse Hotline

1-800-977-3565

The SIU is the focal point for FWA investigations for the Company and works with the Medicare Drug Integrity Contractor ("MEDIC"), law enforcement or other agencies, as required.

The SIU employs analytical data mining to identify referral patterns, possible payment errors, utilization trends and other indicators of potential fraud, waste, and abuse. The SIU performs proactive and reactive data analysis of medical and prescription drug claims to detect outliers that may indicate potential fraud, waste, and abuse. This process enhances Health Net's investigations, highlights high risk areas, and improves the Company's ability to combat fraud, waste, and abuse.

The SIU reports consolidated metrics for Health Net and program integrity units, including the pharmacy claims processor, to the Medicare Compliance Committee and the Audit Committee of the Board of Directors on a quarterly basis.

Auditing by Federal Agencies or External Parties

Health Net views regulatory audits and reviews as an opportunity confirm its ongoing compliance efforts are effective and successful. In cases where an audit outcome indicates the Company has not met a regulatory requirement, Health Net uses the audit findings to perform root cause analysis and develop corrective action plans to address identified areas of non-compliance. Health Net may also contract with external companies to perform compliance related reviews and assist with programmatic changes to help drive the organization's compliance.

Health Net cooperates with federal agencies or eternal parties when audits are conducted and provides auditors access to information and records related to Health Net's business processes and those of Health Net's FDRs.

The Medicare Compliance Department services as the point of contact for all regulatory audits related to the Medicare Advantage and Part D program and coordinates auditor requests with all internal departments. Staff from other Health Net compliance departments are charged with coordinating state audits or reviews, and the Medicare Compliance team may assist in those audits to the extent they apply to specific issue related to the Medicare products.

CORRECTIVE ACTION PROCEDURES

Health Net takes corrective actions whenever there is a confirmed incident of non-compliance. Health Net may identify the incident of non-compliance through a variety of sources, such as self-reporting channels, CMS audits, internal audits, hotline calls, external audits or member complaints. Whenever Health Net identifies an incident of misconduct, non-compliance or fraud, waste or abuse, the Company takes prompt action to investigate the matter, determine root cause and outline effective corrective action.

The Medicare Compliance Officer (in conjunction with the Privacy Officer, SIU and other key staff) is responsible for reviewing cases of misconduct or non-compliance related to the Medicare program and, when applicable, for disclosing such incidents to CMS. Because of the complex nature of some of the cases that may be involved, particularly fraud investigations, the Medicare Compliance Officer may delegate all or a portion of this responsibility to the appropriate internal expert, for example to the SIU for the detailed reporting to the MEDIC or law enforcement.

Any time an incident of non-compliance is discovered or a department's process or system results in non-compliance with CMS requirements, the business area is required to submit a corrective action plan to the Medicare Compliance Department. Corrective action plans represent a commitment from the business unit to correct the identified issue in a timely manner. Corrective actions may include revising processes, updating policies or procedures, retraining staff, reviewing systems edits and other root causes. Corrective action plans must achieve sustained compliance with the overall CMS requirements for that specific operational department

The status of open corrective action plans is reported to the Medicare Compliance Officer and the Committee. The Medicare Compliance Department monitors corrective action plan implementation and requires that the business department regularly report the completion of all interim action steps. Once a corrective action plan is complete, the Medicare Compliance Department validates the corrective action plan by monitoring individual action items over a period of time to demonstrate sustained compliance was achieve and the corrective action plan was effective.

The Committee is charged with reviewing ongoing activity to ensure that corrective action plans being undertaken are timely and effective and to report ongoing non-compliance risks to senior management.

Health Net requires that FDRs submit a corrective action plan when deficiencies are identified through oversight compliance audits, ongoing monitoring or self-reporting. Health Net takes appropriate action against any contracted organization that does not comply with a corrective action plan or does not meet its regulatory obligations, up to and including termination of their agreement. FDR's delegated to perform specific administrative or plan functions are bound contractually through written agreements with Health Net that stipulate compliance with CMS requirements and provisions for removal of delegation or termination for failure to cure performance deficiencies.

Health Net's Sales Allegation Committee is responsible for reviewing all sales allegations or complaints of marketing misrepresentation against a sales producer. The Regional Sales Allegation

Committee investigates each allegation and determines whether the sales producer is “at fault.” Complaints against a sales producer may be received through a variety of sources, including, beneficiary complaints filed with CMS, the CMS regional office, Member Call Center, the Membership Department, the Medicare Compliance Department, the Health Net Integrity Line, the Health Net Fraud, Waste and Abuse Hotline or through the Appeals and Grievance Department. An “at fault” finding requires Health Net implement prompt corrective action with the sales producer, such as re-training, re-testing, or ride-alongs, or it may involve specific sanctions such as suspension of sales production, or termination of employment or the producer agreement.

ATTACHMENT A

HEALTH NET FRAUD, WASTE AND ABUSE ("FWA") PREVENTION AND DETECTION PLAN

Overview

Health Net does not tolerate fraud, waste or abuse ("FWA") of Medicare program resources and has implemented this FWA Plan to help prevent, detect and correct areas where FWA activity may occur. All Health Net associates, Directors and FDRs are prohibited from committing or participating in fraudulent, wasteful or abusive activities.

The Health Net FWA Plan outlines various methods Health Net employs to detect and prevent fraud, waste or abuse. Health Net's FWA Plan includes prevention through awareness, screening, training, and disciplinary standards that are built upon the foundation of the Health Net Code of Business Conduct and Ethics ("Code of Conduct").

The FWA Plan includes written policies and procedures on detecting and preventing FWA, as well as policies related to FWA investigations and reporting.

Health Net maintains a Fraud Hotline for anonymous reporting of suspected FWA, as well as a Special Investigations Unit (SIU) that follows up on all reported potential offenses. The SIU works with designated state and Federal regulatory agencies, the Medicare Drug Integrity Contractor ("MEDIC") and law enforcement in pursuit of individuals who may be involved in activities that fall under the FWA umbrella.

Fraudulent activity may be perpetrated by a member or subscriber involved in inappropriate schemes or behavior, or a health care provider involved in false documentation, inappropriate prescriptions, falsification of conditions in order to help an individual receive an otherwise uncovered service under Medicare or Federal programs or a combination of scenarios. Fraud raises the cost of care for all individuals in the health care system.

All Health Net associates, Directors, and FDRs play an important role in preventing Medicare fraud, waste, and abuse, and are required to immediately report any suspected instances of FWA.

Elements of Fraud Prevention

The Health Net FWA Plan is a subset of the overall Compliance Program at Health Net, which includes Corporate Compliance, HIPAA Privacy and Security, and the Medicare Compliance Program. Elements of the prevention activities are integrated into the overall compliance program to address each of the seven (7) elements of an effective compliance program:

1. Written Policies and Procedures and Standards of Conduct
2. Compliance Officer and Compliance Committee

3. Training and Education
4. Effective Lines of Communication
5. Enforcement of Standards through well publicized disciplinary guidelines
6. Monitoring and Auditing
7. Prompt Responses to Detected Offenses and Corrective Action Procedures

Health Net employs the following processes to detect potential fraudulent activity:

- Monitoring and auditing performed by the Medicare Compliance Department, SIU, business units and departments responsible for overseeing the ongoing compliance of FDRs.

- Raising associate awareness of potential fraudulent activities through required all-associate training, posters, Compliance Week activities, policies and procedures and the Medicare Compliance Department intranet site

- Publicizing communication channels such as the 24-hour Health Net Fraud Hotline and the Health Net Integrity Line

- Regular communications to associates, which reinforce their role in identifying fraudulent activities in their course of performing their daily work

Definition of Fraud, Waste and Abuse

Fraud: Fraud means an intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and that the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or to some other person.

Waste: Waste is the inappropriate utilization and/or inefficient use of resources.

Abuse: Abuse occurs when an individual or entity unintentionally provides information to Medicare which results in higher payments than the individual or entity is entitled to receive.

Examples of Fraud, Waste and Abuse

Health Net investigates and pursues prosecution of health care related fraud and abuse. In addition to potential fraud identified internally by employees and externally by members and FDRs, fraudulent or abusive practices may be identified by review of data to look for patterns of over- or under-utilization, including things identified through systems edits such as:

- Pharmacy claim systems edits to look at age and gender
- Edits and controls to look at Medicare Secondary Payer and COB
- Controls on early pharmacy refills outside of long-term care settings
- Edits to prevent payment for statutorily excluded drugs
- Limits on the number of times a prescription can be refilled
- Brand name versus generic drugs
- Number of prior authorizations
- Real time contraindication (e.g. drug interactions)
- Therapeutic edits

- Excessive claims for controlled substances
- Insufficient or excessive dosage edits
- Step therapy edits
- Identifying drugs provided outside of the Part D benefit by Patient Assistance Programs

We separately review for potential marketing or sales agent fraud, and receive referrals from Health Net operational areas, such as the Member Call Center, Appeals and Grievances, Claims, Pharmacy Services and Enrollment/Disenrollment

Examples of fraud include:
- Billing for services not furnished
- Billing for services at a higher rate than is actually justified
- Soliciting, offering or receiving a kickback, bribe or rebate
- Deliberately misrepresenting services, resulting in unnecessary cost, improper payments or overpayment
- Violation of the physician self-referral ("Stark") prohibition

Examples of abuse include:
- Charges in excess for services or supplies
- Providing medically unnecessary services
- Providing services that do not meet professionally recognized standards
- Billing Medicare based on a higher fee schedule than is used for patients not on Medicare

Examples of waste include:
- Over-utilization of services
- Misuse of resources

FWA Training Programs

Health Net requires all new associates who support the Medicare program complete the following mandatory training courses on fraud, waste and abuse prevention and detection:

- The Painful Price of Health Care Fraud – Provides an overview of health care fraud and its effects on all parties; and
- Pharmaceutical Fraud, Waste and Abuse (FWA) – Explains the differences between fraud, waste, and abuse, and outlines basic steps for identifying potential fraudulent schemes, and instructions on how to report suspected incidents of fraud, waste or abuse for investigation.

All associates who support the Medicare program must repeat these courses on an annual basis.

Similar training is required of all FDRs. Health Net makes its FWA training program available to all FDRs via Health Net's website.

Medicare Fraud, Waste and Abuse Risk Assessment

The Medicare Compliance Department performs an annual risk assessment, which includes an assessment of the various ways fraud and misconduct can occur (or has occurred) by and

against Health Net. Fraud risk assessment also considers Health Net's ability to override, deter or remediate potential schemes that may have circumvented existing control activities. The results of the risk assessment are reported to the Committee, along with appropriate recommendations for additional education, FDR oversight, system edits or enhanced audit protocols.

Identification and Reporting

Health Net requires all associates and FDRs report suspected fraud immediately. Reports may be made through the Fraud Hotline, the Health Net Integrity Line, to the SIU or Medicare Compliance Officer, or to an associate's supervisor or manager. Health Net also identifies potential fraud through member and provider calls, complaints filed with CMS, appeals and grievances, claims processing, enrollment activities or through various systems edits and reviews.

Health Net performs prospective and retrospective screenings of associates, Directors, agents, providers and FDRs against the GSA and OIG exclusion lists.

Health Net departments with responsibility for overseeing delegated entities and vendors perform regular oversight audits and reviews which include areas such as claims, where patterns and trends are reviewed for potential FWA implications. All suspected incidents of fraud are referred to Health Net's Special Investigations Unit.

Special Investigations Unit ("SIU")

Health Net is committed to reducing health insurance costs through the detection, investigation, prevention and civil/criminal prosecution of fraud, waste and abuse. This commitment has been continuously reinforced at Health Net through the development of policies and procedures and the allocation of resources for Health Net's anti-fraud efforts.

The Special Investigations Unit ("SIU") works with various Health Net business units and FDR fraud teams to investigate suspected incidents of fraud and work with law enforcement and the MEDIC to pursue prosecution.

The SIU maintains case related information in a dedicated database, which allows the SIU to track, profile and accurately obtain qualitative and complete data concerning fraud investigations.

The Medicare Compliance department works with the SIU to identify and resolve reports of potential fraudulent activity. The SIU may independently receive reports of FWA through other areas, such as:

- The Customer Call Center
- The Appeals and Grievance Department
- Health Net Pharmaceutical Services
- Delegated provider groups
- Health Net's Claims Department
- Health Net's Membership Department
- Health Net's Corporate Compliance Department or Medicare Compliance Department

- The Fraud Hotline
- The Health Net Integrity Line
- Law enforcement
- The MEDIC

The SIU is staffed by Health Net associates with both clinical and non-clinical expertise that allows them to perform a variety of investigations and to review different data sets. Such reviews may include claims data, pharmacy data, member fraud, and provider fraud.

If the SIU determines that potential fraud or misconduct related to the Part D program has occurred within the Company or at the FDR level, the SIU will referred the case to the MEDIC as soon as possible, but no later than 60 days after the determination that a violation may have occurred. Health Net's overall FWA program is enhanced by partnering with the MEDIC. The MEDIC can help identify and address patterns across multiple sponsors and coordinate with the OIG, law enforcement or Department of Justice related to any scams or schemes.

In the event an investigation confirms FWA occurred, the SIU and the Medicare Compliance Department work with applicable business areas or FDRs to determine appropriate corrective action, which may include employment or contract termination.

The SIU has developed policies and procedures to ensure process controls are in place to meet specific requirements of the Medicare Program. The following policies and procedures support the Health Net Fraud, Waste and Abuse Prevention and Detection Plan and work in conjunction with department policies and desktop instructions that are developed and used on a daily basis by Health Net business areas:

- SIU Initial Intake and Assessment of Referrals (Policy PW323-10182)
- FWA Case Investigations (Policy PW323-10375)
- SIU FWA Training (Policy PW323-95230)
- SIU Governing Regulations/Laws (Policy PW323-93652)
- SIU – FWA Financials (Policy PW323-134448)
- SIU Oversight & Monitoring (Policy PW323-123443)