METHODOLOGY

Dean Health Service Company

Document Title	**Compliance Program**
Deliverable ID	615.0009.01
Department(s)	Compliance; Government Programs Oversight
Abstract	Overview of the methodology the Governance, Risk, and Compliance division follows to ensure the continued operation of an effective Compliance Program applicable to the Health Plan.

Overview

This methodology establishes the Health Plan's Compliance Program, which monitors and enforces high professional and ethical standards. It is designed to prevent, detect, and correct instances of non-compliance or fraud, waste, and abuse. The provisions of this Methodology apply to all of the Health Plan's health insurance products as listed in the About This Document section.

Scope

Unless otherwise specified, the scope and applicability of this methodology includes the Health Plan's employees, contractors, board members, agents, and First-Tier, Downstream, and Related Entities (FDRs).

Methodology

Letter from Our President

The Health Plan strives to maintain a position of leadership in the health insurance industry by improving the health status of our members, delivering a superior level of service and care, and excelling in the areas of customer satisfaction, product innovation, administrative efficiency, and corporate nimbleness. In order to achieve these goals, the Health Plan is committed to maintaining a work environment in which employees perform their duties in accordance with the highest ethical standards and applicable federal, state, and local laws and regulations. We can only achieve our goals through our employees' commitment and dedication to these ethical and legal standards.

In order to assist employees as they navigate through the complexities of the highly regulated health insurance industry, the Health Plan has adopted a formal Compliance Program Methodology. The SSM Health Code of Conduct and Ethics, which is based on standards of integrity and ethics, is foundational to the Health Plan's Compliance Program Methodology. The SSM Health Code of Conduct and Ethics, key elements of which are summarized in the Compliance Program Methodology, provides you with guidance on how to perform your business activities and what to do if you ever have a question or believe a legal or ethical violation has occurred. All employees are responsible for ensuring their conduct and business activities are consistent with the standards in the Compliance Program Methodology and SSM Health Code of Conduct and Ethics.

It is important to remember that we each play a role in ensuring the Health Plan continues to achieve its goals and maintain its position as a leader in the health insurance marketplace.

Les McPhearson
President

Implementation

The Health Plan's Compliance Program Methodology is designed with the following objectives:

- Promote compliance with all applicable federal, state, and local laws, regulations, and guidance, including plans and/or processes to comply with specific Federally-Facilitated Marketplace requirements.
- Satisfy terms in contractual arrangements, including those resulting from participation in state and federally-funded health care programs and the Federally-Facilitated Marketplace.
- Detect and deter criminal conduct or other forms of misconduct that might expose the Health Plan to significant civil liability.
- Promote self-auditing and self-monitoring.
- Promote the Non-Retaliation Policy and the understanding that good-faith participation in the Compliance Program does not result in retaliation.

7 Elements of Compliance

In order to have an effective compliance program to facilitate these objectives, with the SSM Health *Code of Conduct and Ethics* as the foundational driving component, the Health Plan established the following 7 Elements of Compliance, which together, form the Compliance Program.

- Standards of Conduct, Policies, and Procedures
- Compliance Officer and Committee(s) Oversight
- Training and Education
- Monitoring and Auditing
- Reporting and Investigating
- Enforcement, Discipline, and Incentives
- Response and Prevention

Standards of Conduct, Policies, and Procedures

The Health Plan is the insurance services subsidiary of SSM Health and as such, adheres to the SSM Health *Code of Conduct and Ethics* and system-wide policies and procedures to the extent applicable to the Health Plan as a health insurer. All employees, including contractors and FDRs (as applicable) are responsible for adhering to the SSM Health *Code of Conduct and Ethics*. This obligation is emphasized in the annual training and attestation completed by employees and contractors.

The Health Plan is committed to conducting business according to the highest ethical and legal standards, including complying with all applicable federal and state laws, regulations, and guidance. The SSM Health *Code of Conduct and Ethics* explains these standards and provides guidelines for employee decision-making and behavior.

In addition to the SSM Health *Code of Conduct and Ethics*, employees must abide by the Health Plan's policies and procedures. Policies and procedures ensure effectiveness, efficiency, and full compliance with federal and state laws, regulations, and guidance. Each department is responsible for creating, implementing, and maintaining their applicable documents.

Violations of the SSM Health *Code of Conduct and Ethics*, policies, or procedures are taken seriously and may result in discipline.

The Compliance Program Methodology, SSM Health *Code of Conduct and Ethics*, policies, and procedures are reviewed based on established review timeframes to ensure accuracy. Documents are revised and updated as changes are identified, and then distributed to applicable audiences.

Compliance Officer and Committee(s) Oversight

The Health Plan maintains compliance structure and reporting hierarchy to support the Compliance Program Methodology.

The following table lists committees that support the Compliance Program Methodology.

Committee	Details and Reporting
Board of Directors	The Board of Directors (Board) is ultimately responsible for ensuring business activities are carried out lawfully. The Board relies upon the Compliance Program to ensure appropriate processes are in place to prevent, detect, and correct noncompliance. Annually the Chief Compliance Officer (CCO) reports to the Board on the effectiveness of the Compliance Program. The Board delegates functional oversight of the Compliance Program to the Board Audit Committee, a sub-committee of the Board.
Governing Body Sub-Committee	The Governing Body Sub-Committee is responsible for functional oversight of the Compliance Program. Quarterly, the Chief Compliance Officer (CCO) reports to this Committee on the outcomes of the Compliance Program, including significant matters and watch areas. Significant matters may be reported to the Governing Body Sub-Committee more frequently than quarterly at the discretion of the CCO. Semi-annually, the Governing Body Sub-Committee reports to the Board. The Governing Body Sub-Committee delegates operational oversight of the Compliance Program to the Compliance Committee.
Compliance Committee	The Compliance Committee provides day-to-day oversight of all aspects of the Compliance Program and assists the Chief Compliance Officer, Medicare Compliance Officer, Medicaid Program Compliance Officer, and Privacy Officer in ensuring the Compliance Program is effective in preventing, detecting, and correcting noncompliance.
Regulatory Change & Communications Committee	The Regulatory Change & Communications Committee ensures changes to statutes, regulations, and other regulatory guidance impacting the Health Plan's products are appropriately distributed, analyzed, and implemented. This Committee also ensures that regulator communications (e.g., Health Plan Management System memos) are appropriately distributed to each impacted business unit in a timely manner.
Auditing & Monitoring Committee	The Auditing & Monitoring Committee assists the Chief Compliance Officer, Medicare Compliance Officer and Medicaid Program Compliance Officer in overseeing the Health Plan's regulatory auditing and monitoring process. This includes assisting in the creation of annual baseline risk assessments and the creation and implementation of auditing and monitoring work plans.

The following table lists roles that support the Compliance Program Methodology.

Role	Details and Reporting
Chief Compliance Officer	The Chief Compliance Officer (CCO), a full-time employee of the Health Plan, serves as the Health Plan's executive with ultimate responsibility for implementation of the Health Plan's Compliance and Privacy Programs. The CCO reports to the Health Plan's President/CEO and provides regular report outs to the Board, Governing Body Sub-Committee, and the Compliance Committee.
Medicare Compliance Officer	The Medicare Compliance Officer (MCO), a full-time employee of the Health Plan, is responsible for the day-to-day operation and oversight of the Compliance Program as it relates to the Medicare product line. The MCO provides quarterly report outs to the Compliance Committee. The MCO reports directly to the Chief Compliance Officer.
Medicaid Compliance Officer	The Medicaid Program Compliance Officer (MPCO), a full-time employee of the Health Plan, is responsible for the day-to-day operation and oversight of the Compliance Program as it relates to the Medicaid product line. The MPCO provides quarterly report outs to the Compliance Committee. The MPCO reports indirectly to the Chief Compliance Officer via the Director of Government Programs Oversight.
Privacy Officer	The Privacy Officer oversees all activities related to the development, implementation, and maintenance of the Health Plan's privacy policies. The Privacy Officer ensures policies reflect current federal and state law, including laws regarding protected health information (PHI) and member privacy, as well as overseeing employee privacy education and all investigations related to privacy policy violations. The Privacy Officer reports indirectly to the CCO and collaborates closely with the Security Officer.
Security Officer	The Security Officer oversees all activities related to the development, implementation, and maintenance of the Health Plan's security policies. The Security Officer ensures policies reflect current federal and state law and oversees employee security education and all investigations related to security policy violations. The Security Officer reports directly to the Vice President of IT (or designee) and indirectly to the CCO (or designee).

Training and Education

To ensure employees, contractors, and Board members are aware of the Compliance Program Methodology requirements, required training must be completed within 90 days of hire/appointment and annually thereafter. Refer to the following table for identified required training modules by role.

Role	Modules
Employees & Contractors	• Compliance • Fraud, Waste, and Abuse • HIPAA Privacy

Role	Modules
Board	• Compliance • Fraud, Waste, and Abuse
FDRs	Government Programs Oversight FDR training module or sufficient alternative as determined by the Government Programs Oversight team.

Trainings are provided through the Learning Management System (LMS) allowing for efficient internal and/or regulatory audits of completed training. Attendance at training programs is monitored and documented.

Training modules, including training-related communications, are reviewed and updated (if applicable) at least annually.

Monitoring and Auditing

Monitoring and auditing procedures evaluate the Health Plan's (including FDRs) compliance with applicable laws, contractual agreements, policies, and procedures.

The CCO, or designee, conducts an annual baseline risk assessment of the major Medicare, Medicaid compliance and Fraud, Waste, and Abuse (FWA) risk areas. The risk assessment results inform creation of an annual auditing and monitoring work plan that outlines activities to be performed in the following contract year. The development and implementation of the auditing and monitoring work plan is supported by the Auditing & Monitoring Committee and overseen by the Compliance Committee.

Any instances of non-compliance identified through auditing and monitoring activities are documented and remediated. All monitoring and auditing activities are carried out in a professional manner.

Reporting and Investigating

Investigations into potential violations of the Compliance Program Methodology, SSM Health *Code of Conduct and Ethics*, policies, or procedures are initiated as soon as reasonably possible, but no later than 2 weeks following the identification of potential non-compliance. All elements of the investigation are documented and retained per the Health Plan's records retention policy. The following are forefront while handling an investigation:

- Honoring requests for confidentiality, as appropriate
- Identifying individuals who may have knowingly or inadvertently committed a violation
- Determining the root cause of the violation
- Facilitating appropriate corrective actions including, but not limited to, repayment of overpayments or disciplinary actions
- Assisting in the implementation of procedures to avoid future violations
- Subject to ethical standards, protect the Health Plan, and preserve its assets

Employees are instructed to report any potential violations, including fraud and misconduct related to payment or delivery of an item or a service; failing to report a violation may result in disciplinary action. Prompt reporting helps address issues quickly and thoroughly. Per the *Non-Retaliation Policy*, employees are protected from retaliation and intimidation with respect to good faith participation in all aspects of the Compliance Program Methodology (i.e., reporting, investigating, conducting self-evaluations or audit, and remedial actions).

Potential violations may be reported to an employee's supervisor, senior-ranking personnel, Human Resources, the Chief Compliance Officer or other Governance, Risk, and Compliance Division team member, or the Compliance Incident Reporting system. Anonymous and confidential reporting is completed via one of the methods listed in the following table.

Method	Details
Mail	[Entity Name] ATTN: Compliance Department 1277 Deming Way Madison, WI 53717
Phone	Compliance Hotline • (608) 827-4333 • Toll Free (877) 317-0255
Compliance Incident Report	Access via the Health Plan intranet homepage or through ServiceNow, and then fill in as appropriate. **Note:** If reporting improper use or disclosure of protected health information (PHI), indicate possible HIPAA violation or breach of PHI on the form. *This method of report is confidential; however, not anonymous.
Employment Discrimination	Access the Employment Discrimination Compliant form via the Health Plan intranet homepage. **Note:** Employees have the option to file this form with Compliance, Human Resources, or a state or federal agency.
Fraud, Waste, and Abuse	Contact the Special Investigations Unit (SIU) via one of the following methods: • 877-249-2176 (x 4903) • SIU mailbox (SIU.DHP@deancare.com) • Fraud Hotline (877) 249-2176

Enforcement, Discipline, and Incentives

The Health Plan imposes consistent and appropriate discipline on every individual whose action, or inaction, violates the Compliance Program Methodology, SSM Health *Code of Conduct and Ethics*, policy, procedure, and/or law. In doing so, just culture principles are applied unless an alternative disciplinary policy governs.

Dependent on the type, severity, and circumstances of the violation, appropriate discipline may include termination of employment, criminal referral, or reporting to law enforcement or government agencies. The Chief Compliance Officer, Medicare Compliance Officer, Medicaid Program Compliance Officer, or Privacy Officer may choose to self-report suspected or actual non-compliance to state and/or federal regulators. Based on the type of violation, the Compliance Department may work with Human Resources to ensure appropriate disciplinary action is taken and corrective action plans are effectively developed and implemented.

Response and Prevention

Responding to Internal Incident Reports

The Health Plan responds to all non-compliant incident reports in a timely manner, and then uses the information obtained as an opportunity to prevent future related incidents by completing appropriate remediation and/or monitoring activities. The Compliance Department assists departments to ensure remediation efforts are fully completed.

Responding to Government Investigations

The Health Plan cooperates with all reasonable requests made in the course of a government investigation of the Health Plan or its employees.

All requests for information must be directed to the Chief Compliance Officer (CCO). Employees are instructed to contact the CCO immediately if they learn of a government investigation or are asked by a government investigator to provide information. The CCO responds for the corporation. It is the Health Plan's duty to be truthful when speaking with a government investigator.

Conducting Business in a Fair and Honest Manner

Conflict of Interest

The Health Plan is committed to avoiding any perceived or actual conflicts of interest; this includes all foreseeable conflicts of interest in external relationships. The Health Plan requires that employees refrain from engaging in any outside business or financial activity that may interfere with their ability to perform their work honestly and ethically. While employed by the Health Plan, employees may not have another job that could be construed as a conflict of interest (e.g., working for another insurance company).

Employees are also prohibited from performing any task which affects their own employment, medical, or claim record and from disbursing company funds to themselves.

Bribes, Kickbacks, and Other Improper Payments

Gifts may also create a conflict of interest; therefore, employees are prohibited from giving a gift if it is intended to, or might appear to, influence a business decision, or accepting or soliciting any offers resulting in personal benefit. This includes gifts, favors, and other incentives to perform work in a way that benefits outside parties. Trivial items like pens and pencils are the only acceptable item from vendors.

The Health Plan permits expenditures for gifts if the gift is reasonable in value and made for a legitimate business purpose; such expenditures must be properly approved and documented.

In general, gift giving is permitted if:

- Modest in value
- Irregular or infrequent
- Unsolicited
- Not cash or cash equivalents
- Exchanged in a setting appropriate for a business discussion
- Intended to reasonably and appropriately maintain or enhance the business relationship
- Not in violation of any applicable law, regulation, policy, or professional business decorum

- Something that would be openly discussed with co-workers and others

Integrity in Communications, Books, and Records

The Health Plan is committed to the highest standards of business ethics and integrity. We do not make false or misleading statements about any of our products or our competitors' products in our communications, books, or records.

We record and report information accurately and honestly, including information about time worked, business expenses incurred, and other business-related activities.

We maintain records that accurately reflect the Health Plan's assets, liabilities, revenues, and expenses. All of the Health Plan's audit and financial records are maintained in accordance with statutory accounting principles (SAP) and/or generally accepted accounting principles (GAAP), as well as with all applicable federal, state, and local laws. Business records are retained per the Health Plan's records retention policy.

Fair Competition

The Health Plan only seeks to further its interests through honest and legal means. We compete solely based on our own merits and the superiority of our products and services. We comply with all laws regulating competition.

The Health Plan is committed to maintaining the confidentiality of competitively sensitive information. Employees must never discuss or exchange competitively sensitive information with a competitor or potential competitor and must be cautious at industry conferences or meetings. Competitively sensitive information includes, but is not limited to, prices of services, marketing activity, and development plans (e.g., price fixing, contracting [or not] with particular entities, allocating the market or customers). Contact the Compliance department for advice if ever unsure if an exchange is appropriate or if in a conversation that seems inappropriate, leave the conversation immediately.

Preventing Fraud, Waste, and Abuse

The Health Plan recognizes the industry rise in the incidence of health care fraud, waste, and abuse (FWA) cases, the escalating cost of health care eservices, and the complexity of the laws and regulations around this topic. We are committed to providing training and resources on FWA to help identify, prevent, report, and investigate possible cases.

The following list provides definitions for abuse, fraud, and waste.

- **Abuse:** Billing for uncovered services or incorrectly coded services.
- **Fraud:** Intentionally deceiving for the purpose of receiving an unauthorized benefit.
- **Waste:** The unnessecary use of resources that is caused by deficient practices.

The False Claims Act (Act) is the federal government's legal basis for implementing activities and requirements intended to prevent, detect, and correct FWA. The Act imposes liability if an entity knowingly seeks payment from a government entity for a false claim or to avoid paying money owed to the government.

Violating the Act requires federal payment between $10,957 and $21,916, adjusted for inflation, for each false claim, plus 3(x) times the amount of damages sustained by the government (refer to the Federal Register's website). Also, the government could choose to exclude the Health Plan from government contracts (including offering Medicare products), grants, and/or other programs. State laws may apply additional sanctions up to and including imprisonment.

The Special Investigations Unit (SIU) of the Health Plan's Legal department is responsible for preventing, detecting, and investigating FWA at the Health Plan. Employees must report any actual or suspected FWA violations to SIU. If employees fail to report FWA, they may be disciplined. If reported in good faith, employees are not retaliated against for doing so. Refer to the following table for methods of contacting SIU.

Method	Details
Email	SIU mailbox (SIU.DHP@deancare.com)
Form	• Fraud Awareness form via the Dean website (deancare.com) • SIU Referral form via the Health Plan intranet homepage (Departments > Department Site Directory > Legal Services Division)
Phone	• Compliance Hotline (608) 827-4333 or (877) 317-0255 • Fraud Hotline (877) 249-2176

Confidentiality, Privacy, and Security

The Health Plan complies with all applicable privacy and security laws; this includes keeping confidential or proprietary information about the Health Plan, members, and employees safe from inappropriate use or disclosure. A breach of a member's privacy or confidentiality is a violation both in their legal rights as well as the member's valued trust in the Health Plan. If information is used or disclosed in an unauthorized way, individuals may be subject to disciplinary action, up to and including termination, fines, and/or penalties.

The following table lists examples of confidential and proprietary information by type:

Information Type	Examples
Member	• Name, address, phone numbers, birth date, driver's license, Social Security number, or member ID number • Financial information (e.g., credit card or banking information) • Medical information (e.g., treatment, health status, medical history information)
Employee	• Salary and earnings data • Employee ID number
Proprietary and Non-Public	• Financial • Technical and business methodologies • Strategic Plans

The Health Plan utilizes the following practices to ensure the safety of information:

- Use or disclose only the minimum necessary information to perform a valid business need
- Avoid discussions where unauthorized individuals may overhear
- Ensure confidential and/or proprietary information is not left unattended in public areas or visible on desks/computers

- Ensure proper disposal
- Utilize encryption when sent or stored electronically outside of the Health Plan

Protected health information (PHI) is subject to particularly strict requirements. Access, use, or disclosure of PHI is acceptable only to the extent necessary to accomplish assigned job duties. Unless the disclosure is necessary for treatment, payment, or health care operations, a member authorization must be obtained prior to disclosure.

If PHI has been improperly used or disclosed, a Compliance Incident Report, available on the Compliance Catalog (via the Health Plan intranet homepage), must be submitted. The Privacy Officer is responsible for reviewing all Compliance Incident Reports addressing potential HIPAA violations and overseeing any related investigations and notifications.

Responsibilities

Position	Role and/or Responsibilities
Compliance and Government Programs Oversight Department Staff	Comply with this methodology, including the execution, strategy, and communication.

Definitions

Term	Definition
Audit	Formal compliance review using a particular set of standards as base measures.
Dean Health Service Company, LLC	Administers all fully funded and self-funded products offered by SSM Health Care Corporation-owned Health Plan entities.
Employee	Anyone employed by or contracted to provide services to Dean Health Service Company or any applicable SSM-owned health plan entity.
First-Tier, Downstream, and Related Entities (FDRs)	• **First Tier Entity:** Vendor contracted by the Health Plan to perform services related to the Health Plan's Medicare or Medicaid beneficiaries. • **Downstream Entity:** Vendor contracted by a vendor of the Health Plan to perform services related to the Health Plan's Medicare or Medicaid beneficiaries. • **Related Entity:** A subsidiary or affiliate of SSM Health performing services related to the Health Plan's Medicare or Medicaid beneficiaries.
Health Plan	Refers to all SSM Health Care Corporation-owned legal entities for which Dean Health Service Company, LLC, provides administrative services. Such entities include Dean Health Insurance, Inc.; Dean Health Plan, Inc.; SSM Health Insurance Company; SSM Health Plan; and Dean Health Service Company, LLC.
Monitor	Task of performing defined reviews as part of normal operations to confirm ongoing compliance and ensure corrective actions are undertaken and effective.

About This Document

Categorization

State

If scope is limited, deselect the states that do not apply:

☒IL ☒MO ☒OK ☒WI

Licensed Entity

If scope is limited, deselect the entities that do not apply:

☒Dean Health Plan, Inc. (includes products branded as Dean Health Plan and Prevea360 Health Plan)
☒Dean Health Insurance, Inc.
☒Dean Health Service Company (entity branded as WellFirst Health)
☒SSM Health Insurance Company (entity branded as WellFirst Health)
☒SSM Health Plan (includes products branded as WellFirst Health — Provided by SSM Health Plan)

Product Category/Product Line

Select the applicable products. If this document is applicable only to a specific sub-set of a product line, specify that elsewhere (e.g., Abstract, Exceptions).

☒Not applicable (Administrative only)

If this is not administrative only, select the applicable product categories/product lines:

☐Commercial – Fully Funded:
- ☐Individual
- ☐Medicare Supplement
- ☐Large Group
- ☐Small Group

☐Commercial – Self-Funded:
- ☐Administrative Services Only (ASO)

☐Commercial – Stop-Loss
☐Government Programs – Medicaid
☐Government Programs – Medicare

Considerations

☐ Accreditation or Quality Standards: ☐HEDIS ☐NCQA ☐Star Rating
☐ Applicable Audits: ☐MAR ☐CPE ☐Financial/MLR ☐Program Audit/Market Conduct

Exceptions

None identified.

Citations and Guidance

- 42 CFR §422.503(b)(vi)
- 42 CFR §423.504(b)(vi)
- 42 CFR §438.608
- Medicare Managed Care Manual Chapter 21

- Contract for BadgerCare Plus and/or Medicaid SSI HMO Services-Article XII, §M(1)-Program Integrity

Supporting Documentation

Document Title	Deliverable Type	Department	Publication Location
Code of Conduct and Ethics **Code of Conduct and Ethics - Spanish**	Policy	SSM Health	Knowledge Café
Compliance Auditing and Monitoring (CC11)	Policy	Internal Audit	PolicyTech
Compliance Education and Training Programs (CC08)	Policy	Compliance	PolicyTech
Oversight Methodology	Methodology	Government Programs Oversight	Knowledge Café
Dean Health Plan Employee Handbook	Policy	Human Resources	PolicyTech
Effective Lines of Communication/Reporting Compliance Violations (CC12)	Policy	Compliance	PolicyTech
HIPAA Policy	Policy	Compliance	Purple Pages
Procedures and System for Prompt Response to Compliance Issues (CC13)	Policy	Compliance	PolicyTech
Review and Distribution of the Compliance Plan (CC04)	Policy	Compliance	PolicyTech

Document Ownership

Ownership Type	Details
Content Origin	Compliance
SME(s)	Director Government Programs Oversight; Laura LeCaptain Medicaid Compliance Officer; Phong Nguyen Director of Compliance and HIPAA Privacy Officer; Megan Simpson
Approver(s)	VP of Governance, Risk, and Compliance and Chief Compliance Officer; Stephanie Cook

Document History

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Initial release.	04/16/2016
Updated content for accuracy and reformatted in the new template.	01/17/2019
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Wisconsin Regional Board approval on 05/14/2019.	05/24/2019
Updated references from Dean or Dean Health Plan to The Health Plan, revised definition of First-Tier, Downstream, and Related Entities (FDRs), added definition of Employee, revised references of Board Audit Committee to Governing Body Sub-Committee, revised references of Dean Compliance Committee to Compliance Committee, revised references of Purple Pages to Dean Health Plan intranet homepage, and added the Code of Conduct and Ethics – Spanish policy. Updated to new template and published on the Knowledge Café. Approved by Stephanie Cook and the Compliance Committee on 01/20/2020.	01/22/2020
Updated to the latest template, added minor clarifications in the Reporting and Investigating section, and published on the Knowledge Café. Approved by Laura LeCaptain and shared with the Compliance Committee on 04/21/2020.	04/21/2020
Shared with the Board Audit Committee on 04/27/2020. (No changes made.)	04/28/2020
Reformatted in latest corporate template with updates from The Health Plan to Dean Health Service Company (DHSC). Updated definition of Employee. Approved by Stephanie Cook on 05/20/2020.	05/20/2020
Updated in the latest template and replaced references to DHSC with the Health Plan. No content changes made.	04/29/2021