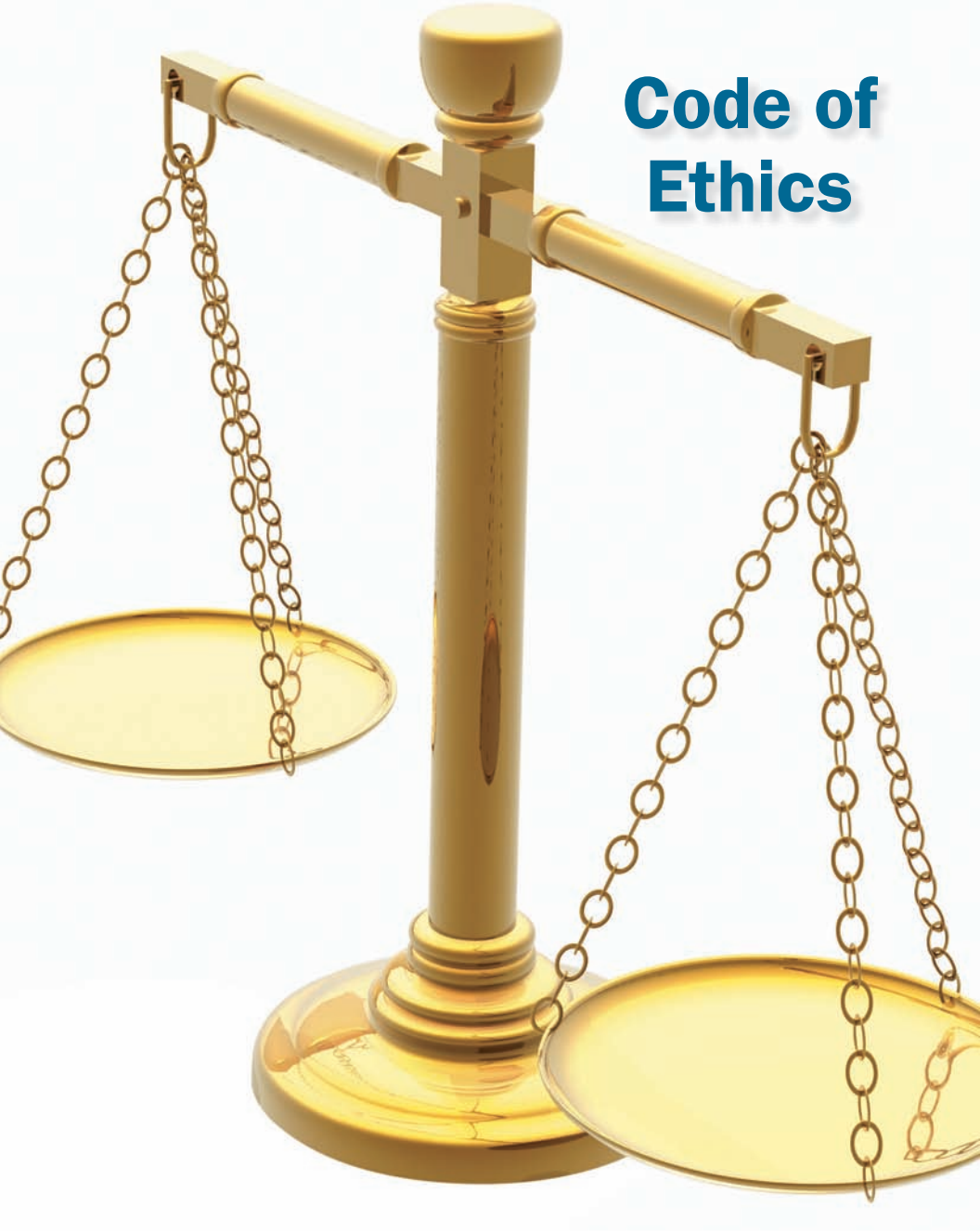
Code of Ethics



Southeast Georgia Health System

Code of Ethics

SOUTHEAST GEORGIA
HEALTH SYSTEM

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PART I – INTRODUCTION TO SOUTHEAST GEORGIA HEALTH SYSTEM & ITS COMPLIANCE PROGRAM

Members of The Glynn-Brunswick Memorial Hospital Authority ("Hospital Authority"), doing business as Southeast Georgia Health System and its affiliates (collectively, the "Health System") believe that dedication to the highest ethical standards is essential to our Mission, Vision and Values. This dedication is a solemn commitment to our patients, to our community, to those government agencies that regulate us, and to ourselves.

Mission:

Southeast Georgia Health System will provide safe, quality, accessible, and cost-effective care to meet the health needs of the people and communities it serves.

Vision:

Southeast Georgia Health System will be the region's healthcare provider and employer of choice.

Values:

In creating a culture which supports our mission and vision, the values which are sought and rewarded throughout Southeast Georgia Health System will be:

- Customer focus
- Caring
- Teamwork
- Continuous improvement
- Open communication
- Dedication and integrity

Purpose of Our Code of Ethics

Our **Code of Ethics (the "Code")** provides guidance and assistance in carrying out our daily activities within appropriate ethical and legal standards. These obligations apply to our relationships with patients, physicians, third-party payers, independent contractors, vendors, consultants and each other.

The Code is a critical component of our Compliance Program. **The Code does not, nor is it intended to, cover every situation you may encounter.** It provides broad guidelines which are supported in greater detail by Southeast Georgia Health System policies and procedures.

Who This Code Applies To

This Code applies to the following individuals and entities:

- Members of The Glynn-Brunswick Memorial Hospital Authority, and others who serve on advisory and other boards for the Health System and its affiliates.
- Team members, including volunteers, employed physicians and allied health professionals, members of the Medical Staff on both campuses, medical, nursing and other health care students, contract employees, agency staff, et al.
- Employees of contractors and Business Associates performing services for the Health System under formal written agreements and Business Associate Agreements.
- Vendor representatives who sell products and services to the Health System.
- On the Brunswick Campus: Its hospital, behavioral health unit, outpatient rehabilitation & wound care center, sleep management center, orthopaedic care center of excellence, and bariatric center of excellence.
- On the Camden Campus: The King's Bay Community Hospital, Inc. doing business as the Southeast Georgia Health System-Camden Campus, and its sleep management center.
- Senior Care Centers ("SCC"): SCC–Brunswick and SCC–St. Marys.
- Southeast Georgia Health System Foundation, Inc.

- Cooperative Healthcare Services, Inc., collectively referred to as "Cooperative": Its employed physicians/groups; its outpatient care centers in endocrinology & diabetes, and infectious diseases; its Glynco, Glynn and St. Simons Immediate Care Centers; its Brantley, McIntosh, and Glynn Family Medicine Centers; and its Community Care Center.

Role of Leadership

While we are obligated to follow our Code, we expect our leaders to set an example and to be, in every respect, role models. Leaders must ensure that those on their team have sufficient information to comply with all laws, regulations and policies, as well as the resources to resolve ethical dilemmas. Leaders should create a culture that encourages everyone in the organization to raise concerns as they occur. We must never sacrifice ethical behavior in the pursuit of business objectives. All of our leaders are prepared to support you in meeting the standards set forth in this Code of Ethics.

The Compliance Program

To promote the highest standards of ethics and compliance with all laws and regulations, members of the Hospital Authority appointed a Corporate Compliance Officer who is responsible for establishing and maintaining an effective Compliance Program. They also created a board-level Compliance Committee that meets at least quarterly to facilitate resolution of compliance issues throughout the Health System. As a result of these efforts, our commitment to compliance affects all levels of the organization.

PART II – PATIENTS & OUR MEDICAL STAFF

We treat all patients with dignity and respect. We provide care that is both medically necessary and appropriate. We make no distinction in the admission, transfer or discharge of patients or in the care we provide based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression. Clinical care is based on identified patient need, not on patient financial status.

A. Medical Staff Financial Arrangements & Referrals

While we employ a number of physicians and allied health professionals, the majority of our Medical Staff on the Brunswick and Camden Campuses are independent contractors who have applied for Medical Staff membership and/or privileges and, if granted, have agreed to follow the respective Medical Staff By-laws, Rules and Regulations, and Departmental policies for each campus.

Physicians (including hospital-based provider groups) and other health professionals may have financial arrangements with us, including, but not limited to, compensation for administrative or management services, income guarantees, certain types of loans and certain subsidized administrative services. Any business arrangement with a physician must be structured to ensure compliance with state and federal laws. This includes federal anti-kickback and Stark physician self-referral laws, which prohibit referrals of patients by a physician to an entity in which he/she has a financial relationship. Such arrangements must be in writing, reviewed by the Southeast Georgia Health System President & Chief Executive Officer, and approved by members of the Hospital Authority.

In order to legally meet all standards regarding referrals, admissions and discharges to our Health System, we adhere to the following:

- We do not pay for referrals. We accept patient referrals and admissions based solely on the patient's clinical needs and our capabilities to deliver the required services.
- We do not accept payment for the referrals we make. No team member is permitted to solicit or receive anything of value, directly or indirectly, in exchange for making a patient referral to an organization.
- Patients are free to select their health care providers and suppliers.
- When making patient referrals to another health care provider, we do not take into account the volume or value of referrals that the provider has made or may make to us.

B. Patient Rights

Upon registration, patients receive a written statement of their patient rights. We ensure that patients are involved in all aspects of their care; we properly register all patients and obtain their general consent for routine tests, treatments and procedures; we obtain informed consent from patients who may receive invasive procedures; and we provide a process for resolution of any complaints. Each patient is provided with a clear explanation of his/her care including, but not limited to, a diagnosis, a treatment plan, the right to refuse or accept care, information on advance directives, a *Notice of Privacy Practices,* and an explanation of the risks and benefits associated with available treatment options.

C. Patient Referrals & Discharge Planning

Federal Medicare regulations and certain state regulations govern the discharge planning process. We all must recognize that the discharge of a patient to a residence or some other post-acute care setting is a critically important clinical decision that must be made in the best interest of the patient. We follow all federal and state regulations and provide Medicare beneficiaries with an explanation of their Medicare discharge appeal rights.

Patients are free to select their health care providers and suppliers subject to the requirements of their health insurance plans. The choice of a hospital, a diagnostic facility, or a supplier should be made by the patient.

D. Patient Transfers

Congress passed the Consolidated Omnibus Budget Reconciliation Act of 1986, which included the federal Emergency Medical Treatment & Active Labor Act ("EMTALA"). This act mandates that emergency medical treatment must be provided to all patients regardless of their ability to pay. We ensure that prompt and effective delivery of emergency care will not be delayed in order to determine a patient's insurance or financial status. Under EMTALA, every patient who seeks care at one of our Emergency Care Centers will receive an appropriate **Medical Screening Examination.** Furthermore, a patient with an **Emergency Medical Condition** or who is

in active labor will be cared for until their condition has been stabilized. Patients will be transferred to another facility only if the patient's medical needs cannot be met at the Health System and a higher level of care is available at another hospital that has beds available and has agreed to accept the transfer.

EMTALA carries reporting obligations in cases where a patient has been transferred improperly either to or from the Emergency Care Center. Any team member who believes that a patient has been transferred improperly must report the incident using our electronic incident reporting system, Quantros.

PART III – PATIENT CONFIDENTIALITY & HIPAA

A. Patient Confidentiality

Team members have access to confidential information about patients and their care. Any violation of a patient's confidentiality is taken very seriously. No physician, allied health professional, member of a physician's office staff, team member, contractor, or student, et al. has a right to any patient information other than the **minimum necessary** to perform their job. Team members should never discuss work-related issues involving patients and their care outside the facility with their family and friends.

Discussing a patient's medical condition or providing any information about patients to anyone other than those who have a "need to know" the information, **may result in corrective action, up to and including immediate termination.**

Team members are not authorized to access their own medical records or records of their family or friends. Every individual must sign a **Release of Information Form** in the **Medical Records Department,** which authorizes us to provide them with copies of the documents requested. Medical records are confidential and may not be released except with the consent of the patient, or in other limited circumstances. Additional protections apply to mental health, drug and alcohol abuse treatment, HIV infection, and certain other records. Medical records should not be physically removed from the

facility unless you have prior written authorization. They should not be altered or destroyed, except in accordance with our record retention policies located in our Management of Information manual. Any unauthorized release of, or access to, medical records should be immediately reported using our electronic incident tracking system, Quantros.

B. Compliance with the HIPAA Privacy Rule

Congress passed the Health Insurance Portability & Accountability Act of 1996. Its Privacy Regulations, which became effective April 14, 2003, govern the manner in which we use Protected Health Information (PHI). In 2003, the Hospital Authority appointed a **Privacy Officer** who is responsible for implementing and maintaining Privacy Rule policies and procedures.

However, each of us has a legal obligation to protect PHI, which is any information in any form (oral, electronic or paper records) that identifies an individual and provides his/her past, present or future health status or condition (i.e., diagnosis, treatment, etc.). Any potential disclosures should be reported immediately to the Privacy Officer in the Compliance Office.

C. Affiliated Covered Entity ("ACE") Status

(For HIPAA Covered Entities under common ownership & control)

The Health System is an integrated healthcare delivery network that owns several hospitals, long-term care facilities, etc., each of which is a legally separate covered entity under common ownership and control. The Hospital Authority formally adopted ACE status in a resolution it approved on December 20, 2002. It allows multiple, legally separate covered entities under common ownership or control to disseminate one Notice of Privacy Practices; comply with one set of policies and procedures; appoint one Privacy Officer and one Information Security Officer; use one Business Associate Agreement; administer common training programs, et al.

D. Organized Health Care Arrangement ("OHCA") Status

(For HIPAA Covered Entities that are <u>not</u> under common ownership or control)

The Health System has multiple, clinically integrated health care settings

where multiple Covered Entities who are not under common ownership or control need to share PHI in order to provide healthcare to a common set of patients. This includes, but is not limited to, its hospitals and independent physicians on the Medical Staff of the Brunswick and Camden campuses who are Covered Entities in their own right. The Hospital Authority formally adopted OHCA status in a Resolution it approved on February 26, 2003. It allows use of a joint *Notice of Privacy Practices;* joint policies and procedures; appointment of one Privacy Officer and one Information Security Officer; to share PHI for treatment, payment and health care operations. In addition to providing health care to a common set of patients, members of each Medical Staff and other medical professionals under the OHCA status, jointly perform peer review, quality improvement, medical education, and other services for the Health System.

However, when you are a patient being treated in your own physician's office, he/she is responsible for issuing a separate ***Notice of Privacy Practices.*** Additionally, while OHCA status allows multiple Covered Entities (i.e., the hospital and its physicians) to share some administrative responsibilities, each Covered Entity retains individual liability for its acts and omissions under the HIPAA Privacy regulations and for all other purposes.

E. Compliance with the HIPAA Information Security Rule

Effective April 21, 2005, we are required to have administrative, physical and technical safeguards in place to protect the confidentiality, integrity and availability of **electronic** PHI. In 2003, the Hospital Authority appointed an **Information Security Officer,** who is responsible for establishing and maintaining an Information Security program designed to protect our information resources.

PART IV – COMPLIANCE WITH LAWS & REGULATIONS

We must be knowledgeable about and ensure compliance with all laws and regulations. Each of us has a **duty to report** suspected violations to his/her immediate supervisor, a member of the Compliance Office or, in their absence, the Administrator-On-Call. Additionally, we have a confidential

telephone reporting system called the **Compliance Line,** where individuals may anonymously report potential problems without fear of retribution. With all these resources available, claims of ignorance, good intentions or bad advice are not acceptable excuses for noncompliance.

A. Retention of Records

Medical and business documents are retained in accordance with the law and our record retention policy in the Management of Information manual. This includes paper such as letters and memoranda, and computer-based information such as e-mail or computer files. You must not remove or destroy records prior to the date specified in the records retention policy. In addition, no one may alter or falsify information on any record or document.

B. Confidentiality and Electronic Record Security

Confidential information, such as patient lists, clinical records, pricing and cost data, that is used in the performance of your job must not be shared with others outside the Health System without prior written approval. We prohibit unauthorized access to our computer systems, either directly, or by network or telephone, including sharing your password with others. We prohibit the destruction or corruption of electronically stored or processed data without following proper protocol.

C. Cost Reports

We receive reimbursement under government programs which require the submission of certain reports regarding our operating costs. We comply with federal and state laws which define what costs are allowable and outline the appropriate methodologies to claim reimbursement for the cost of services provided to Medicare and Medicaid patients. Given the complexity, all issues related to the completion and settlement of cost reports should be forwarded to the Health System's Finance Department.

D. Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 included Section 6032 entitled *"Employee Education About False Claims Recovery."* Any entity within a

state that receives at least $5 million annually in Medicaid payments is required by law to inform its team members and any of its contractors or agents about false claims recovery.

We provide our team members with the following detailed information on:

- our existing compliance culture and program,
- the Federal False Claims Act and any administrative remedies in The Program Fraud Civil Remedies Act 31 U.S.C. §§ 3801-12.
- state False Claims Act or state laws pertaining to civil or criminal penalties for false claims and statements,
- whistleblower protections provided under such laws, and
- the role of such laws in detecting and preventing fraud, abuse or waste, and what to do if a team member suspects a potential violation of our policies.

E. Federal False Claims Act, Title 31, United States Code § 3729 - 3733

The Federal False Claims Act ("FCA") was first enacted in 1863 during the Civil War to fight fraud identified among defense contractors. It has undergone changes and now applies to any federally-funded contract or program, except tax fraud. The FCA was expanded to include the Medicare and Medicaid programs in 1986. Since its enactment, the Federal Government has recovered billions of dollars through litigation and settlement of allegations that corporations and individuals violated the Statute and thereby improperly obtained Federal health care program funds.

FCA establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the United States Government for payment. FCA prohibits a person from knowingly making a false claim when the person:

- has actual knowledge that information on a claim is false,
- acts in deliberate ignorance of the truth, or
- acts in reckless disregard of the truth or in the submission of false information on a claim to the U.S. Government or its contractors.

F. Penalties

Health care providers and suppliers (persons and organizations) who violate the Federal FCA may be subject to civil monetary penalties ranging from not less than $5,000 to more than $10,000 for each false claim submitted. In addition to this civil monetary penalty, providers and suppliers can be required to pay three (3) times the amount of damages sustained by the U.S. Government for each false claim. If a provider or supplier is convicted of a FCA violation, the Office of the Inspector General of the U.S. Department of Health & Human Services may seek to exclude the provider or supplier from participation in federal health care programs.

G. Whistleblower *(Qui Tam)* Provisions

Any person may bring an action under the FCA and is called a *qui tam* relator or whistleblower. Any case must be brought within six (6) years of the filing of the false claim. A whistleblower must have a copy of his/her complaint and all relevant evidence served on the U.S. Department of Justice. The case remains sealed for at least 60 days or longer and is not served on the defendant so that the Government can investigate the complaint. After its investigation, the Government may pursue the matter in its own name or decline to proceed. If the Government declines, then the whistleblower has a right to bring a lawsuit in Federal Civil Court.

H. Awards to Whistleblowers

If the Government proceeds with the case, the whistleblower may receive between 15% and 25% of any monies recovered, depending on his/her contribution to the success of the case. If the Government declines to pursue the case and the whistleblower's lawsuit is successful, he/she will be entitled to between 25% and 30% of the amount recovered. The whistleblower may also be entitled to reasonable expenses including attorney's fees and costs for bringing the lawsuit. FCA also provides that whistleblowers who pursue a clearly frivolous lawsuit can be held liable to a defendant for attorney's fees and costs.

I. Non-Retaliation Protections

In addition to a financial reward, the FCA entitles whistleblowers to additional relief, including employment reinstatement, double back pay, and any other compensation arising from retaliatory conduct against a whistleblower for filing an action under the False Claims Act or committing other lawful acts, such as investigating a false claim or providing testimony for, or assistance in, a False Claims Act action.

J. State False Claims Act

The Deficit Reduction Act of 2005 encouraged states to enact their own False Claims Act statutes by increasing the share of funds a state may receive out of the proceeds of any state action or settlement of a false claim. Georgia opted to take advantage of those incentives to enact its own False Claims Act, the State False Medicaid Claims Act at O.C.G.A. 49-4-168.

K. Charges, Billing & Claims Submission

We promote full compliance with all laws governing the submission of claims to federal, state and other third party insurers. Many of our team members have responsibility for entering charges and procedure codes for services rendered. Each of these individuals is required to exercise diligence, care and integrity in reviewing departmental charges timely for accuracy. They must also ensure that all Medicare Bulletins have been carefully reviewed for the latest information on medical necessity and reimbursement changes impacting on the services they provide. The right to bill the Medicare and Medicaid programs, granted through the award of a Provider Number, carries a responsibility that must not be abused.

We are committed to maintaining the accuracy of every claim we process and submit to a third party payer. Our team members are prohibited from knowingly presenting or causing to be presented improper or duplicate charges for health care services, supplies or equipment that are then submitted as claims for payment. It is illegal to make any false statement to the government, including statements on Medicare or Medicaid claim forms. Examples of false claims include, but are not limited to:

- Claiming reimbursement for services that have not been provided.
- Selecting a procedure code that is more complex than the actual procedure performed (i.e., "upcoding").
- Selecting several codes to bill each service separately when those services should be billed under one procedure code designated for the entire group of services (i.e., "unbundling").
- Including inappropriate, unallowable, or inaccurate costs on cost reports.
- Forging a health care professional's signature on orders for services, medication, or changes in patient status.
- Falsely indicating that a particular health care professional performed a procedure. (Example: Using another professional's computer access code to record patient information when that professional never saw the patient.)
- Billing for a length of stay beyond what is medically necessary.
- Billing for services that are not medically necessary.
- Billing duplicate charges.
- Billing excessive charges.
- Failing to report overpayments or credit balances.
- Unlawfully giving health care providers, such as physicians, inducements in exchange for referrals for service.

L. Controlled Substances Laws & Regulations

The Health System, through its pharmacy, is registered to compound and dispense narcotics and other controlled substances. Improper use of these substances is illegal and extremely dangerous. No health care professional may prescribe or dispense controlled substances except in conformity with state and federal laws and within the terms of the **health care professional's license.**

Team members must carefully follow record keeping procedures established by their departments and the pharmacy. Unauthorized manufacture, distribution, use, or possession of controlled substances is strictly prohibited and will be prosecuted to the full extent of the law. Any team member who

suspects any unauthorized handling of controlled substances is to provide the information immediately to the Compliance Office.

M. Compliance with Environmental Laws

We must comply with our policies and procedures that promote the protection of workplace health and safety. You are required to understand how these policies apply to your specific job and to seek advice from your immediate supervisor whenever you have a question or concern. We use a medical waste tracking system, biohazard labels, and biohazard containers for the disposal of infectious or physically dangerous medical or biological waste. We comply with environmental laws, including but not limited to, the Clean Air Act, the Resources Conservation and Recovery Act, and other laws regulated by the U.S. Department of Labor's Occupational Safety & Health Administration ("OSHA"). It is important that you notify your supervisor of any workplace injury, or any situation presenting a danger of injury, so that timely action may be taken.

N. Tax-Exempt Organizations

The Health System holds federal tax-exempt status as a not-for-profit organization operating on behalf of the community for charitable purposes. We provide community benefits such as health promotion and wellness programs. We accept tax-deductible charitable contributions. Any income derived from activities unrelated to the charitable purposes shall be reported and appropriate taxes will be paid.

O. Tax-Exempt Bonds

Our tax-exempt bonds are publicly-traded securities and are subject to certain provisions of the federal securities laws. These laws govern the dissemination or use of information relating to the business activities of the Health System and its affiliates. We are committed to complying with all federal securities laws and regulations as they relate to our health care revenue bond transactions and disclosures.

PART V – EMPLOYMENT PRACTICES

A. Conflicts of Interest & Management Disclosure Process

We avoid all potential conflicts of interest in order to ensure that we act with total objectivity in carrying out our duties for the Health System. Our Conflicts of Interest policy prevents designated Health System leaders, and their spouses, children and/or siblings, from placing their interests before those of the Health System. The policy defines those situations which raise potential conflicts of interest, provides guidelines for resolution, and mandates that members of the Hospital Authority, advisory or other boards, and all members of Management disclose annually any existing financial, personal and/or contractual relationships that may be potential conflicts of interest.

We should not have other outside employment or business interests that place us in the position of (1) appearing to represent the Health System, (2) providing goods or services substantially similar to those provided by the Health System, or (3) lessening our efficiency, productivity, or dedication to the Health System in performing our everyday duties. If you have a question regarding these policies, contact the Compliance Office.

B. Discrimination, Harassment & Workplace Violence

We are committed to a policy of nondiscrimination and equal opportunity for all team members without regard to race, color, sex, religion, age, national origin, ancestry, disability, or sexual orientation. Our policy of nondiscrimination extends to the care of our patients. Team members have the right to work in an environment free of harassment and workplace violence. Harassment includes potential incidents of workplace violence, including robbery and other crimes, stalking, sexual harassment, violence directed at the employer, terrorism and hate crimes. Any form of unlawful harassment is strictly prohibited. If a team member believes that he/she has been discriminated against or harassed on the basis of race, sex or another protected category, he/she should contact the Human Resources Department so that an investigation may be initiated in accordance with our policies and procedures. As part of our commitment to a safe workplace,

firearms, other weapons, explosive devices, or other dangerous materials are prohibited on our premises.

C. Use of Southeast Georgia Health System Resources

Employee Time: Employee work time is a "thing of value" belonging to the Southeast Georgia Health System. Employees may not use work time for personal business.

Telephones and Electronic Mail: Telephones and e-mail are to be used for Health System related purposes only. Incidental use for local personal calls or messages that do not interfere with your work is not a misuse of our resources. Personal long distance telephone calls may not be charged to the Health System. Sharing personal e-mail with other team members via the Health System's e-mail system is prohibited.

Equipment and Supplies: Computers, copy machines, office supplies, and other equipment are to be used for Health System purposes only.

Internet: Access to the Internet on our computers is for work-related purposes only. Improper or illegal use of the Internet by our team members may subject them to disciplinary action, up to and including termination, and should be reported immediately to the Information Security Officer in the Information Systems Department.

Personal Electronic Equipment: Use of personal electronic equipment such as cell phones with cameras, personal laptops, et al., should not be used to record patient care or health care operations.

Social Networks: Use of social networks such as *Facebook, Twitter,* et al., to send and/or receive derogatory remarks about Health System activities or patients is not allowed and such activity should be reported immediately in the Health System's electronic incident reporting system, Quantros, or by contacting the Information Security Officer. Human Resource's Corrective Action policy, Level IV – Termination, states that a team member should

not engage in a *"willful or negligent act or conduct that is detrimental to patient care or Health System operations..."*.

D. Drug and Alcohol-Free Workplace

We are committed to a workplace in which team members are free from impairment brought about by drugs or alcohol. Reporting to work under the influence of any illegal drug or alcohol; having an illegal drug in your system; or using, possessing, or selling illegal drugs while on work time or property may result in immediate termination. We use drug testing as a means of enforcing this policy.

PART VI – MARKETING & MARKET COMPETITION

We may use marketing and/or advertising practices in an effort to educate the public, report to the community, increase awareness of services provided by us directly or through contractual arrangement, increase support for the Health System, or recruit employees. All advertising and marketing strategies will be truthful, fair and accurate and will not seek to solicit patients for services beyond the capacity or licensure of the Southeast Georgia Health System and its affiliates. All marketing initiatives are reviewed periodically to ensure that our health care services are represented accurately and in a responsible manner. We are committed to complying with all anti-trust laws, which prohibit agreements to fix prices, divide markets, boycott competitors, and/or unreasonably restrain competition. These prohibited arrangements can include certain attempts to bundle services together, certain exclusionary activities, and agreements that have the effect of harming a competitor or unlawfully raising prices.

A. Discounts & Payments Under Anti-Kickback Laws

Federal and state laws prohibit us from knowingly and willfully offering, paying, asking or receiving any money or other benefit, directly or indirectly, in return for obtaining favorable treatment in the award of a contract or the referral of patients.

B. Gifts, Entertainment & Travel

Gifts, Meals, Favors: Team members may not offer, accept, or solicit gifts or other incentives or kickbacks from current or potential external contacts who seek business with the Health System. Such contacts include, but are not limited to, sales representatives, pharmaceutical company representatives, durable medical equipment & supplies vendors, and companies seeking to provide consulting, accounting, billing, financial and other services to the Health System. The Health System strives to preserve and protect its reputation, and to avoid even the appearance of impropriety when accepting gifts, meals or favors.

- Team members may never accept cash or cash equivalents, such as gift certificates, theater or other tickets, etc.
- Team members may not accept substantial/extravagant gifts, entertainment, meals or favors.
  - Substantial value: When acceptance of items or services could be construed by others, including other competitors and community members, as intending to unduly influence the team member in the performance of his/her duties.
  - Nominal value: Token promotional items or consumable/perishable gifts and food *(e.g., pens, mugs, key chains, note pads, pizza, donuts, candy, fruit, flowers, etc.)* given to a department are allowed. This means that the items and food are reasonable and not given in order to improperly influence business decisions. Team members are to use common sense and good judgment in accepting gifts, meals, entertainment and consider all the facts. There may be circumstances when accepting a gift of nominal value could still detract from the Health System's reputation or show favoritism to one vendor over another.
  - Educational Component: Vendors who seek to provide an educational inservice with a department may provide food of nominal value.

Travel, Entertainment, Conferences: Team members may not accept free travel or entertainment, including transportation to and from airports, etc., from those seeking business with the Health System, unless written

approval is obtained from the appropriate Administrative Council member, i.e., a member of the senior management team reporting to the President & Chief Executive Officer of the Health System.

- Team members may attend local or out-of-town, vendor-sponsored events such as workshops, seminars or conferences that have an educational purpose when the Health System pays for travel and any overnight stays. Meals at such conferences may be accepted, assuming discussions ensue of an educational nature.
- Team members may arrange and pay for travel for themselves and others (i.e., members of the medical staff, etc.) who may be part of a work group seeking to evaluate bids to purchase a particular item or service. However, the vendors may not pay for any travel expenses. The team may also accept food during presentations, assuming it is reasonable in value and would not unduly influence the team's decision-making process.
- Team members are not to accept free entertainment (i.e., free golf, boating, theater or sporting events, etc.) unless participation is sponsored by the Health System, or written approval is obtained from the appropriate Administrative Council member.

If you are not sure whether acceptance of a gift, travel, etc., might be construed as a conflict of interest, you should contact the appropriate Administrative Council member or the Compliance Office for further assistance.

C. Discussion with Competitors

There should be no written or oral discussions with competitors regarding prices, pricing formulas, bids, bid formulas, discounts, credit arrangements, compensation practices, and any other confidential information. The rates we charge for patient care and related items and services are determined solely by us after we take into account all relevant factors, including costs, market conditions, and widely used reimbursement schedules such as the Medicare Fee Schedule. Joint ventures and affiliations that may require pricing discussions must be individually reviewed for compliance with antitrust regulations.

D. Trade Associations & Outside Activities

Team members are involved in a number of trade and professional associations, which promote quality patient care by allowing us to learn new skills, develop policies and discuss public policy issues. We may participate in and receive the results of general surveys, but must not share business information with trade associations. If you are asked to provide a trade association with information about our business practices, you should consult with the appropriate Administrative Council member or the Compliance Office prior to disclosing any information.

We do not require prior approval to participate in outside educational, professional, political, philanthropic, social or recreational activities. **However team members should be clear in all their activities and words that they do not represent Southeast Georgia Health System in these outside activities.**

E. Physician Services – Credentialing, Peer Review

Credentialing and peer review activities carry antitrust implications. While it is appropriate for physicians to review the work of their peers, special care is taken to ensure that credentialing, peer review and physician discipline are conducted only through appropriate Medical Staff Committees. These Committees comply with federal and state laws governing peer review and other related matters.

F. Unfair or Deceptive Trade Practices

In addition to the antitrust laws, we are committed to complying with the Federal Trade Commission Act, which prohibits the use of *"unfair or deceptive acts and practices."* This also includes the distribution of advertising and marketing materials that are false or misleading.

PART VII – PURCHASING

Purchasing decisions will be based on the supplier's ability to meet our needs and not on personal relationships and friendships. We promote competitive bidding to the maximum extent possible. When no competitive bid proposal

is requested, the vendor chosen meets the highest ethical standards, i.e., any conflicts of interest, including physician ownership, are fully disclosed; there is no unwarranted favoritism; and selection criteria is documented. Our selection of contractors, suppliers and vendors will be made on the basis of objective criteria. We employ the highest ethical standards in the administration of all purchasing activities.

A. Independent Contractors and Vendors

All contractors and vendors who provide items or services to us must comply with all applicable laws and our policies. Management is required to monitor the activities of contractors in their areas. Any irregularities, questions, or concerns on those matters should be directed to the Compliance Office.

B. Excluded Parties *(Excluded from Participation in Federal Health Care Programs)*

We comply with federal law which prohibits employing or contracting with persons who are excluded from participation in a federal health care program. Accordingly, prior to employing or contracting with any individual or company, we will take appropriate steps to confirm that they have not been excluded. If we learn that a prospective employee, physician or contractor is excluded, they will not be hired or allowed to render services to us, directly or indirectly.

PART VIII – EXTERNAL & INTERNAL INVESTIGATIONS

A. Response to External Government Investigations & Accreditation Surveys

We will be forthright in dealing with any government investigation or inquiry, or any accreditation agency survey. Requests for information will be answered timely with complete, factual and accurate information. We will cooperate and be courteous to all representatives who have provided appropriate credentials, and provide them with the information to which they are entitled during any review or unannounced survey. The Compliance Office should be notified immediately when any investigator, state surveyor or accreditation agency representative requests information or presents at one of our facilities.

B. Internal Reviews & Investigations

We are committed to investigate all reported concerns promptly and confidentially. If you are involved in any investigation, it is expected that you will cooperate timely and to the best of your ability. Failure to cooperate fully and timely with an ongoing investigation may lead to suspension and/or potential termination. The Compliance Office, along with appropriate senior management from the department(s) under review, will recommend a course of action, procedural changes, and/or further education and training that may be needed.

When an internal investigation substantiates a reported violation, it is our policy to:

- initiate corrective action, including, as appropriate, making prompt restitution of any overpayment amounts,
- notify the appropriate government agency,
- institute whatever disciplinary action is necessary in accordance with our Corrective Action policies and procedures in the Human Resources Department, and,
- implement systemic changes and further training to prevent a similar violation from occurring in the future.

PART IX – REPORTING VIOLATIONS

A. Personal Obligation to Report

We are committed to complying with all laws and regulations and to correcting wrongdoing wherever it may occur. Each of us has a responsibility for reporting any activity that appears to violate applicable laws, regulations, or this Code of Ethics. There will be no retribution or discipline for anyone who, in good faith, reports a suspected violation. We will make every effort to maintain, within the limits of the law, the confidentiality of any individual who reports misconduct.

B. Reporting Potential Violations

If you become aware of dangerous, illegal or unprofessional activity that could pose a risk to patients or damage the public's trust in the standard of care they receive or the way we conduct business, it is important that such concerns are reported to an appropriate person at an early stage to enable us to take necessary corrective action as quickly as possible. You are encouraged to report any situation that you feel is a potential violation of any regulation or ethical standard.

To obtain further guidance or to report a suspected violation, you may choose to contact:

- your immediate supervisor, manager or director,
- a nursing supervisor, if applicable,
- a member of senior management,
- the Compliance Office,
- the Administrator-On-Call, or,
- the Compliance Line at **888-313-1534.**

The Compliance Line is answered by a company we contract with to answer these calls 24-hours a day, seven days-a-week. You will be given a reference number and a time to call back to receive a response to your inquiry. You may remain completely anonymous. Your conversation is never recorded and the telephone number that you are calling from is not identified.

PART X – DISCIPLINARY ACTIONS RELATING TO COMPLIANCE VIOLATIONS

Any violation of applicable laws, regulations or our policies will subject the individual to disciplinary action, which may include verbal or written warning, disciplinary probation, reduction in salary, demotion, termination from employment, or revocation of medical staff membership and/or privileges. In addition, certain violations require reports to external organizations for legal purposes. We are mandated by law to report certain violations which may interfere with patient care. We will comply with all federal, state and local reporting requirements. For example, team members must maintain current licensure, if applicable, or they may not work in their respective professions.

Implemented: October 1998; Latest Revision: March 2011.

EXHIBIT A – Acknowledgement & Confidentiality Statement

I, _____, as a team member of the Southeast Georgia Health System and its affiliates, acknowledge that I have received a copy of the ***Code of Ethics,*** the ***Notice of Privacy Practices,*** and certain policies that comply with the Privacy and Security Regulations under the Health Insurance Portability & Accountability Act ("HIPAA").

I understand that it is my responsibility to read them carefully and to seek further guidance from my immediate supervisor, manager or director, the Corporate Compliance Officer/Privacy Officer if I have any questions.

I further acknowledge that:

1. I understand that all patient information, including billing and financial data, is confidential.
2. I agree to keep patient information confidential.
3. I agree to comply with all our policies and procedures, including those implementing the HIPAA Privacy and Information Security Rules.
4. I understand that if I violate patient confidentiality by using or disclosing patient information improperly, I may be subject to disciplinary action, up to and including termination of my employment.
5. I understand and agree that our policies and procedures will apply to any patient information I have access to even after I terminate my employment or other relationship with the Southeast Georgia Health System.
6. If employed, I understand that my continued employment depends on my full compliance with all policies and procedures, the Joint Commission standards, and compliance with all federal, state, and local regulations governing Medicare, Medicaid or other federally-funded health care programs.

Signature: _____ Date: _____

Name: _____
(PRINT Full Name)

Team Member Number: _____
(if applicable)

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