Shriners Hospitals for Children®

SHRINERS HOSPITALS FOR CHILDREN®

CORPORATE COMPLIANCE PLAN

1.0 INTRODUCTION

Shriners Hospitals for Children ("SHC") is committed to conducting itself according to applicable business ethical standards and federal, state and local laws, rules and regulations. SHC recognizes that both deliberate and unintentional misconduct in providing health care undermines the efficient functioning of SHC's system to the detriment of both our patients and taxpayers. By following our own compliance policies and conducting our business with integrity, we not only help to ensure that we comply with the law, we also better serve our patients, our clients, our co-workers and ourselves.

1.1 SHC's mission is protected when compliance requirements are fully integrated into our daily activities. SHC has developed this Corporate Compliance Plan (the "Plan") to establish a framework to manage compliance-related risks in SHC's business activities, including the activities of its hospitals, ambulatory surgery centers, clinics, research facilities, and related facilities (collectively, the "Hospitals").

1.2 The objectives of the Plan are to ensure that we meet our ethical standards and comply with applicable laws and obligations. Towards achieving that goal, SHC has set the following plan:

- Establishing compliance rules and procedures that are reasonable capable of reducing the risks of misconduct.
- Providing oversight for compliance with laws, regulations and special conditions imposed upon SHC by any licensing, regulatory, or accreditation authorities.
- Assigning high-level personnel to implement the Plan.
- Establishing standards and procedures for effective communication of the Plan to Workforce Members through training programs and dissemination of the information.
- Taking reasonable steps to achieve compliance with SHC policies by using monitoring and auditing systems reasonably designed to prevent and detect misconduct.

- Establishing and publicizing a reporting system which Workforce Members and others may use to report compliance violations without fear of retaliation.

- Taking appropriate responses to compliance violations detected, including modifying the Plan as needed to prevent similar violations in the future.

1.3 The Plan provides a compliance roadmap for SHC and its Hospitals. The Plan facilitates compliance with applicable legal and regulatory obligations by a member of SHC Boards of Directors and Trustees, a member of a Hospital's Board of Governors, employees, volunteers, contractors, subcontractors, consultants, medical staff members, medical and other students, affiliate scientific and research staff, interns, residents, fellows, and allied health providers who provide services to patients at a Hospital (collectively, the "Workforce Members").

1.4 The requirements included in this Plan are minimum requirements. Compliance with these requirements is mandatory at all times. In those jurisdictions where applicable laws or regulations set stricter rules for managing Compliance Risk than those specified in this Plan, the stricter rules apply.

2.0 COMPLIANCE RISK

2.1 The purpose of the Plan is to help SHC manage its Compliance Risk. "Compliance Risk" means any activity which impairs SHC's integrity, which means its ability to conduct business in an honest, fair and accountable way. It is a failure, or perceived failure, to not comply with applicable federal, state and local laws and regulations, SHC's Code of Ethics, SHC's Standards of Business Conduct, the Plan, and other SHC policies and procedures which could damage SHC's reputation, lead to legal or regulatory sanctions, and/or cause a financial loss.

2.2 Effectively managing Compliance Risk protects SHC's mission. Integrating a strong compliance program into daily business activities helps SHC to ensure that compliant conduct forms an integral part of everyday behavior and decision making. This helps protect SHC's mission, its reputation, and minimizes the risk of regulatory action.

2.3 The Plan covers three conduct-related integrity risk areas:

- Personal conduct-related integrity risks that can arise based on Workforce Member activity

- Healthcare conduct-related integrity risks that can arise based on the treatment, services and activities in which SHC engages

- Organizational conduct-related risks that can arise as a result of SHC structure, governance, strategy and business decisions

The types of Compliance Risk which are covered by the Plan are specified in Appendix A to the Plan.

2.4 Certain SHC activities are outside the scope of the Plan, including the following SHC support functions:

- Risk management activities (other than HIPAA-related activities)
- Employment-related activities
- Tax and accounting-related activities
- Business operational activities
- Legal-related activities
- Clinical-related activities
- Investment activities
- Public Relations activities

However, certain of these activities may require Plan-related auditing and monitoring to ensure a Compliance Risk in one of these areas is removed or sufficiently mitigated.

3.0 ORGANIZATIONAL COMMITMENTS TO THE PLAN

3.1 SHC's Boards of Directors and Trustees (the "Joint Boards") and each Hospital's Board of Governors are fully committed to achieving SHC's mission within appropriate legal and ethical standards. The Plan is created to implement Section 503.9(b) of SHC's corporate bylaws (the Code of Ethics) and Section 101.2 of the SHC Hospital Regulations. These documents may be found in Appendix B to the Plan.

3.2 The Joint Boards and each Hospital's Board of Governors acknowledge their collective obligation to create a work environment within SHC that promotes ethical conduct.

3.3 The Joint Boards and each Hospital's Board of Governors acknowledge their continuing obligation to remain informed of the Plan's content to ensure its continued effectiveness.

3.4 The Plan will be modified, if and when needed, to meet or exceed the applicable requirements of an effective compliance program as defined by the Department of Health and Human Services Office of Inspector General and the United States Federal Sentencing Guidelines. The Plan will also be modified, if and when needed, to meet or exceed the applicable requirements of state laws or regulations.

4.0 PLAN OVERSIGHT AND IMPLEMENTATION

4.1 The Joint Boards is the governing body of SHC. The Joint Boards is the owner of the Compliance Risk.

4.1.1 The Joint Boards is ultimately responsible for any business, healthcare, or strategic activities and decisions that entail such risk.

4.1.2 The Joint Boards has primary responsibility for Plan oversight. The Joint Boards has a fiduciary duty to SHC to ensure the Plan's implementation and effectiveness.

4.2 The Joint Boards oversees the Plan through its Corporate Compliance Committee. The Corporate Compliance Committee provides periodic reports to the Joint Boards regarding the Plan. The Joint Boards evaluates and acts on Plan-related matters which are reported to it. The Corporate Compliance Committee meets at least quarterly and receives reports from the Chief Compliance Officer. The reports include information and updates regarding Plan-related activities and any changes in applicable legal and regulatory obligations. The Corporate Compliance Committee evaluates the information and takes appropriate action to ensure the continued effectiveness of the Plan.

4.3 Each Hospital's Board of Governors has a fiduciary obligation to ensure the implementation and effectiveness of the Plan at its respective Hospital. A Board of Governors may oversee the Plan through a compliance committee or its equivalent. That committee provides periodic reports to the Board of Governors regarding the Plan. The Board of Governors evaluates and acts on Plan-related matters which are reported to it and in a manner consistent with the Plan approved by the Joint Boards. Any action taken by the Board of Governors shall be reported to the Chief Compliance Officer.

4.4 Management must create an environment of awareness and accountability in which the importance of meeting compliance obligations is well understood. Management must identify and communicate minimum compliance requirements that each Workforce Member must fulfill in day-to-day business activities and to reward or sanction Workforce Member performance against the requirements.

4.5 Chief Compliance Officer.

4.5.1 The Joint Boards mandates the Chief Compliance Officer (the "CCO") develop, coordinate and maintain the components of the Plan and related standards, guidelines and procedures.

4.5.2 The Joint Boards delegates to the CCO day-to-day responsibility for the operations, planning and oversight of the Plan. The Joint Boards will provide the CCO with adequate resources, appropriate authority and direct access to both the Joint Boards and the Corporate Compliance Committee to execute the CCO's responsibilities under the Plan.

4.5.3 The role of the CCO is to:

- Understand and advocate the compliance requirements;
- Develop and enhance tools to strengthen SHC's ability to detect, communicate, manage and report on Compliance Risks;
- Support SHC's mission by establishing roles and responsibilities to help embed good compliance practices throughout SHC;
- Deepen the culture of compliance by partnering with management and the Hospitals to increase the culture of trust, accountability, transparency and integrity in evaluating, managing and in reporting on Compliance Risk.

4.5.4 The CCO has the following responsibilities:

- Supervise the implementation of the Plan;
- Advise senior management on compliance issues and support them with Compliance Risk issues as they arise;
- Establish and ensure a high-quality compliance network within SHC;
- Establish a compliance framework and ensure that this framework and compliance-related policies are implemented;
- Ensure adequate monitoring and control through effective communication with management;

- Develop, maintain, advise on, endorse and communicate new and changed SHC compliance policies and minimum standards; and

- Ensure timely and appropriate reviews of Compliance Risk issues.

4.5.5 The CCO reports to the Chairman of the Corporate Compliance Committee and administratively to SHC's Executive Vice President.

4.5.6 The CCO regularly communicates and consults with SHC's senior management and the Corporate Compliance Committee regarding Plan-related matters, including incidents of actual or suspected violations of compliance requirements.

4.5.7 The CCO, at his or her discretion, delegates certain Plan-related duties to members of SHC's Corporate Compliance Department. The CCO ensures that any delegated duties are performed appropriately.

4.6 The CCO manages and is supported by SHC's Corporate Compliance Department (the "Department"). The Department performs its duties according to an annual Corporate Compliance work plan. The work plan is approved and monitored by the Corporate Compliance Committee. The work plan includes each of the following elements:

- Coordinating all compliance efforts at SHC.

- Developing and delivering compliance education to Workforce Members.

- Develop communications (emails, newsletters, etc.) that encourage Workforce Members to report actual or suspected violations of compliance requirements.

- Advising Workforce Members on compliance requirements.

- Auditing and Monitoring whether compliance requirements are being followed.

- Communicating any new compliance requirements or guidance on existing standards.

- Handling inquiries and incidents of suspected or actual violations of compliance requirements.

4.7 Authority of the CCO and the Department.

4.7.1 The CCO is vested by the Joint Boards with the requisite authority to implement and perform the obligations specified in this Plan. At the direction of the Corporate Compliance Committee or Joint Boards, as appropriate, he CCO has primary authority to address the Compliance Risk. The CCO will, as appropriate, collaborate with other SHC stakeholders to resolve Compliance Risks with which the Department and that other department share responsibility.

4.7.2 When the CCO perceives a Compliance Risk the CCO or his/her designee must investigate and challenge any actions or concerns without influence from management.

4.7.3 If, in the reasonable view of the CCO, a course of management action would result in an unacceptable Compliance Risk, the CCO may direct management to postpone execution of the course of action until the issue has been resolved by the CCO and management. The CCO may escalate to the Corporate Compliance Committee for further action.

4.7.4 The CCO may, at his or her discretion, escalate significant compliance issues affecting SHC to the Corporate Compliance Committee.

4.7.5 To perform the Plan requirements, the CCO and the Department has, at all times, access in accordance with applicable laws and regulations, as well as policies and procedures of the Joint Boards, to all activities within their area of responsibility. This includes access to all documentation, systems, and Workforce Members.

4.7.6 The CCO is positioned independently from SHC management and operations. To ensure that the CCO perform his/her duties independently from those responsible for or involved in SHC management or operational activities, and free from improper influence or fear of retaliation, the CCO may only be removed from his or her position by a majority vote of the Joint Boards. A corporate director in the Department may be removed from his or her position by the CCO with prior notice given to the Corporate Compliance Committee Chairman.

5.0 POLICIES AND PROCEDURES

5.1 Managing Compliance Risks and complying with applicable laws, regulations and standards is the responsibility of every Workforce Member. The Plan is

intended to establish SHC's expectation that Workforce Members will perform their duties according to compliance requirements. The purpose of SHC's Standards of Business Conduct is to develop and maintain a standard of conduct that is acceptable to SHC, its patients and their families, third parties with which SHC does business, and other Workforce Members. The Standards of Business Conduct reminds a Workforce Members of what is expected of them, and that their conduct affects SHC and its mission. The Standards of Business Conduct may be found in Appendix C to the Plan.

5.2 The Plan complements SHC's Core Values. The Core Values guide Workforce Members as they conduct their daily activities at SHC. The Core Values stress excellence, innovation, commitment, integrity, teamwork, stewardship and respect.

5.3 The Department is responsible for the Standards of Business Conduct and proposes modifications if and when necessary to ensure continued compliance by Workforce Members with a Compliance Standard.

5.4 The Department ensures the distribution of the Standards of Business Conduct to Workforce Members. Each Workforce Member who receives a copy signs a written acknowledgment that they have reviewed the Standards of Business Conduct and will follow its requirements. The acknowledgment form may be found in Appendix D to the Plan.

5.5 The Department establishes procedures to prevent the intentional or inadvertent destruction of Plan-related documents which SHC is required to maintain. Similarly, if the CCO learns that a government agency has either issued a subpoena to SHC or is conducting an investigation regarding any SHC activity, the CCO (or the Vice President, Legal) directs the relevant Workforce Members to retain all documents relating to the subject matter of the government agency's inquiry.

6.0 COMMUNICATIONS

6.1 A critical element of the Plan is the effective communication of compliance requirements. SHC's commitment to an active compliance effort is repeatedly communicated to Workforce Members through a variety of channels to encourage both communication and the reporting of incidents of actual or suspected violations of compliance requirements.

6.2 In addition to formal compliance training, Workforce Members receive frequent reminders of SHC's commitment to compliance, the various ways to report concerns, and SHC's strict policy of non-retaliation for reporting potential compliance issues. The communication may take the following forms:

- Periodic memos from the CCO or other SHC executives
- Department newsletters or compliance-related articles in other newsletters
- Emails
- Posters in common areas

6.3 An essential function of the Department is to proactively identify issues and prevent compliance violations from occurring. Processes are in place to ensure that Workforce Members know about the various communications channels they may use to express compliance-related concerns.

6.3.1 Workforce Members may consult their supervisor, senior management, a member of the Department or the CCO regarding any uncertainty or questions about compliance requirements.

6.3.2 Workforce Members are required to report any actual or suspected violations of compliance requirements (a "Report") to their supervisor, senior management, a member of the Department, or the CCO.

6.3.3 If a Workforce Member is uncomfortable making a Report as specified in Section 6.3.2, a Report may be made instead to the Compliance Hotline. Reports may be made either through a toll-free number or through a web-based portal. The Compliance Hotline is operated by a third-party vendor. A Report may be made anonymously.

6.4 Additional Considerations.

6.4.1 The Joint Boards and each Hospital's Board of Governors is committed to a culture that encourages open communication without a fear of retaliation. SHC's non-retaliation policy is attached to this Plan as Appendix E.

6.4.2 Each member of SHC management has an "open door policy" to allow Workforce Members to seek compliance guidance or make a Report.

6.4.2 Managers will respond appropriately and honestly when they receive a Report. It is the responsibility of that manager to refer such Reports to the Department and to comply with SHC's non-retaliation policy.

6.4.3 Any Workforce Member who receives a Report will maintain the confidentiality of the report to the extent permitted by applicable law, regulation or other

disclosure obligation. Information relating to a Report will be disclosed only on a need-to-know basis.

6.4.4 The CCO, or his or her designee, administers the Compliance Hotline and maintains a tracking log of all Reports received, as well as the results of any investigations conducted and the outcome of the investigation. The CCO, or his or her designee, reports at least quarterly to the Corporate Compliance Committee regarding statistical and trending information.

6.4.5 The CCO ensures that all records relating to Reports are preserved according to applicable law or regulation.

7.0 RESPONDING TO REPORTS

7.1 Violations of compliance requirements threaten SHC's mission and may result in exclusion from Federal healthcare programs, among other penalties. Accordingly, the CCO must respond promptly to Reports.

7.2 The CCO, or his or her designee, reviews all Reports made to the Compliance Hotline or which have been referred to the Department. An assessment is then made to determine the appropriate disposition of the Report.

7.3 The CCO, or his or her designee, conducts or oversees the investigation of the Report. Executive management, and legal counsel, is notified if a serious allegation has been received or later appears valid. An investigation is conducted according to the Department's standard practices.

7.4 The Department maintains records of investigations conducted of Reports. The records of an investigation contain:

- Documentation of the alleged violation
- A description of the investigation process
- Interview memoranda and material documents
- The results of the investigation

7.5 If an investigation substantiates the violation of a compliance requirement, appropriate corrective action will be taken, including each of the following:

- Prompt restitution of any overpayments
- Notification to the appropriate government agency, where appropriate

- Review of current policies and procedures to determine if any modifications are warranted
- Workforce Member education
- Referral to law enforcement authorities, where appropriate
- Possible disciplinary action of involved Workforce Members, up to and including termination of employment or its relationship with SHC, in accordance with Human Resources policy.
- The creation of a corrective action plan to reduce the chance that a compliance violation will occur again.

7.6 Compliance-related investigations shall be conducted according to the standards specified in Appendix F.

8.0 TRAINING AND EDUCATION

8.1 Training and education is an essential component of an effective compliance program. The amount of training provided to Workforce Members will be directly related to how much their duties require them to be involved with compliance requirements.

8.2 The Department is responsible for developing and implementing processes to ensure that education and training programs, and appropriate supplemental materials, regarding compliance requirements are developed and available to Workforce Members.

8.3 Compliance training is provided on a regular basis to ensure that Workforce Members are educated as to the purpose, contents and requirements of the Plan. Training is essential to ensure that each Workforce Member is able to perform his or her duties properly.

8.4 The Department creates and maintains a training and education program on compliance requirements. Participation in the training and education program is mandatory for each Workforce Member. Training and education modules are tailored to specific audiences, as appropriate, to ensure effectiveness.

8.5 Training programs are conducted according to SHC's Compliance Education Policy. The Department ensures that:

- Each Workforce Member receives or has access to the Plan, the Standards of Business Conduct, the Code of Ethics, and other compliance policies that are relevant to his or her duties.

- Each Workforce Member receives appropriate training on the Plan, the Standards of Business Conduct, the Code of Ethics, and other compliance policies that are relevant to that person's duties during his or her initial orientation and periodically thereafter.

- Certain Workforce Members, considering the nature of their specific job duties, receive supplemental training as needed regarding specific compliance requirements.

- Any Workforce Member who provides training is sufficiently qualified to teach the particular subject matter to that audience.

- An effectiveness assessment is conducted annually to determine whether any training content should be modified to ensure that compliance requirements are followed. The assessment considers the presentation format, the frequency of sessions, as well as the need for additional general or specific training.

- Feedback is sought from training participants to identify potential areas for improvement in the training modules.

- Attendance at or completion of required compliance training is documented.

- Appropriate disciplinary or similar action is taken against those Workforce Members who knowingly fail to attend required training.

8.6 Once trained, each Workforce Member takes responsibility to follow compliance requirements. This promotes a compliance culture in SHC.

9.0 RISK ASSESSMENT

9.1 The Plan uses a risk-based approach to managing compliance within SHC. This allows SHC resources to be prioritized and allocated to the most-needed areas.

9.2 The CCO facilitates the completion of annual assessment to identify areas of unacceptable risks of a violation of compliance requirements. The assessment also examines whether the Plan elements have been satisfied. The results of the assessment may require establishing or improving internal compliance controls, policies or procedures, or training.

9.2 SHC's risk priorities are assessed annually. Additional risk areas identified by the Department of Health and Human Services Office of Inspector General may be included in the assessment. This allows SHC both to review what has taken place over previous planning periods and to consider risks deemed significant by regulators.

10.0 AUDITING AND MONITORING

10.1 Ongoing auditing and monitoring is an essential part of any effective compliance program. Auditing and monitoring activities shall be conducted on an ongoing basis under the direction of the CCO.

10.2 The CCO, in consultation with the Corporate Compliance Committee, prepares a compliance audit plan designed to test various SHC internal controls to ensure that the risks of a violation of compliance requirements are minimized. The compliance audit plan is evaluated annually to reflect then-current areas of compliance risk. The types of audits and areas to be audited are determined each year by the Corporate Compliance Committee.

10.3 The CCO, at his or her discretion, oversees the conducting of discrete audits within SHC to test specific SHC internal controls. The CCO may, with the approval of the Chairman of the Corporate Compliance Committee, engage external resources to conduct the audit. These audits may be performed in collaboration with the Legal Department.

10.4 The results of any audits are shared with the Corporate Compliance Committee, a Hospital's Board of Governors, and the Joint Boards, as appropriate. Results are also shared with managers to provide timely and focused feedback on how well they are fulfilling their own obligations under the Plan.

10.5 The monitoring of SHC's compliance program involves an assessment of the Plan. A comprehensive review of the Plan is conducted annually. The results of the review and any proposed modification of the Plan are submitted to the Corporate Compliance Committee for recommendation to the Joint Boards for approval.

11.0 HIPAA PRIVACY AND SECURITY RULES

11.1 SHC is subject to detailed rules that govern the use and disclosure of an individual's health information and standards for an individual's privacy rights to understand and control how their health information is used. SHC has developed privacy procedures to ensure compliance with the Health Insurance Portability and Accountability Act ("HIPAA") and HITECH rule. SHC also trains Workforce Members on their obligations regarding these requirements.

11.2 A Corporate Privacy and Information Security Officer (the "CPISO") is a member of the Department. The CPISO is responsible for managing SHC's compliance with HIPAA, applicable state laws and SHC privacy policies. This includes the implementation, maintenance of and adherence to SHC's policies and procedures relating to the confidentiality of protected health information ("PHI").

11.3 The PISO is similarly responsible for establishing and updating policies and procedures to protect the confidentiality, integrity, and availability of SHC's information systems and electronic PHI, as well as promoting the compliance of SHC's information systems with applicable federal and state laws and regulations.

12.0 AUTHORITY AND ENFORCEMENT

12.1 Workforce Members must perform their duties according to the Plan and compliance requirements. Workforce Members who violate the Plan or compliance requirements, or who fail to make a Report shall be subject to disciplinary action, up to and including termination of employment or relationship with SHC. The specific disciplinary action imposed depends on the nature, severity and frequency of the violation.

12.2 SHC has established a process to ensure that it does not knowingly hire, employ, or contract with any individual or entity whom SHC knows, after reasonable inquiry, is currently listed by a federal agency as excluded, suspended or otherwise ineligible to participate in federal or federally funded programs.

* * *

For additional information regarding this Plan, please contact

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Approved by the Joint Boards: 2016 11 16

APPENDIX A TO THE PLAN

The following types of Compliance Risk are included in the Plan:

- Topics covered in SHC's Code of Ethics
- Topics covered in SHC's Standards of Business Conduct
- Conflicts of interest
- Quality of patient care and services
- Federal, state and local regulatory compliance
- Environmental compliance
- Marketing, fundraising and political activities
- Information security, confidentiality and privacy obligations
- Fiscal responsibility (accuracy of financial records; payer-specific guidelines; and billing, charging, and coding for services)
- Retaliation against Workforce Members who report compliance-related concerns
- Compliance Education Training Policy

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APPENDIX B TO THE PLAN

Section 503.9(b) (Code of Ethics) of corporate bylaws

Section 101.2 of the Hospital Regulations

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APPENDIX C TO THE PLAN

Standards of Business Conduct

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APPENDIX D TO THE PLAN

Acknowledgment

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APPENDIX E TO THE PLAN

Non-Retaliation Policy

[SEE ATTACHED POLICY]

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APPENDIX F TO THE PLAN

Compliance-related investigations shall be conducted according to the following standards:

- Investigations shall be considered to be conducted at the direction of and under the authority of the Joint Boards.

- The objective of the investigations process is to establish the true facts relevant to an allegation in order to facilitate appropriate action.

- Investigations shall be conducted in a manner that supports the objectives of the Plan, the Compliance Hotline, and the best interests of SHC.

- Investigations shall be conducted objectively, competently, professionally, efficiently and completed in a timely manner. Investigation participants shall be treated as colleagues.

- An investigation is warranted if a reasonable basis exists to believe that a violation of a compliance requirement may have occurred. Therefore, a preliminary assessment shall first be made of the Report to determine its appropriate resolution and whether any compliance-related issues exist.

- If the fact-finding of a Report is referred by the Department to another internal department after the preliminary assessment is made, the Department remains responsible to ensure that the Report is appropriately resolved.

- Allegations which do not constitute a violation of a compliance requirement but indicate issues within management discretion or interpersonal issues shall not be investigated by the Department.

- Investigations shall be conducted in a fair and transparent manner. Subjects of an investigation are entitled to a presumption of innocence throughout an investigation. Subjects shall also be given the opportunity to respond to the evidence gathered and put forward their version of the facts.

- Confidentiality is required for effective investigation. Therefore, information relating to an investigation shall be disclosed only on a need-to-know basis, as necessary to complete the investigation or comply with applicable laws or regulations.

- Appropriate investigation-related documentation shall be retained by the Department to show that the Report was addressed, to document the factual findings which were made regarding the Report, and the evidentiary support for those findings.

- Any retaliation, intimidation or disciplinary action is prohibited against any workforce member who makes a Report in good faith or participates in an investigation, even if it is determined that no compliance violation occurred.

- Any Workforce Member who administers the investigation process or conducts an investigation shall be protected from any adverse employment action because of that activity, unless an independent justification exists.

- All Workforce Members shall cooperate with an investigation, make themselves available to an investigator upon request, be fully forthcoming and truthful with investigators, and provide complete and accurate information.

- No Workforce Member shall take any action that would be reasonably likely either to compromise an investigation, interfere with the successful gathering of accurate facts, or to negatively affect the status of anyone who may be involved in an investigation.

- It may be appropriate to inform Workforce Members that SHC or the government is investigating certain matters and that investigators may contact Workforce Members in connection with the investigation. Where appropriate, Workforce Members will be informed of their rights and obligations regarding a request for an interview. Workforce Members will also be advised to notify the CCO if he or she is contacted by a government official regarding any investigation or inquiry.