Priority Health

1231 East Beltline Ave. NE
Grand Rapids, MI 49525

616.942.0954
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priorityhealth.com

January 4, 2024

To Whom It May Concern,

We engaged an independent third-party accounting firm to provide a type II Service Organization Controls report 1 (SOC 1) in accordance with the Statements on Standards for Attestation Engagements No. 18 over our claims administration process. The SOC 1 report, officially named "Report on Priority Health Managed Benefits (PHMB), Inc.'s Description of Its Medical and Pharmacy Claims Processing System and on the Sutiability of the Design and Operating Effectiveness of Controls" (Report), was issued on December 20, 2023 and covered the period November 1, 2022 – October 31, 2023. The audit firm issued an unqualified opinion. Based on internally performed follow-up procedures and to the best of our knowledge, there were no significant changes in either design or operation of the control objectives and related controls that would adversely affect the conclusions reached in the Report through the date of this letter.

This communication is not intended to provide a certification of Priority Health's internal control environment or imply that formal evaluation of the stated objectives was performed subsequent to the period end. Additionally, user organizations should consider the user controls outlined in the Report when evaluating the impact of PHMB controls to their organization.

This letter is intended solely for the information and use of PHMB customers, the independent auditors of PHMB customers, and those who have read and agreed to the "Agreement required from Prospective User Entities" associated with the Report. It is not intended to be used by anyone other than these specified parties. Please direct any questions to internalaudit@spectrumhealth.org, and I or another member of my team will respond accordingly.

Sincerely,

Robert A Kinsman Jr

Robert Kinsman Jr.
VP, Internal Audit

System and Organization Controls (SOC) 1 Type 2

Report on Management of Priority Health Managed Benefit Inc.'s Description of Its Medical and Pharmacy Claims Processing System and on the Suitability of the Design and Operating Effectiveness of Controls

Throughout the Period
November 1, 2022 to October 31, 2023

BDO

Priority Health

Contents

I. Independent Service Auditor's Report on a SOC 1 Examination

BDO

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330 N Wabash Avenue, Suite 3200
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Independent Service Auditor's Report on a SOC 1 Examination

To the Management of
Priority Health Managed Benefit Inc.
Grand Rapids, Michigan

Scope

We have examined management of Priority Health Managed Benefit Inc.'s (Priority Health or service organization) accompanying description of its medical and pharmacy claims processing system (the system) titled *Management of Priority Health Managed Benefit Inc.'s Description of Its Medical and Pharmacy Claims Processing System* for processing user entities' transactions throughout the period November 1, 2022 to October 31, 2023 (description) and the suitability of the design and operating effectiveness of controls included in the description to achieve the related control objectives stated in the description, based on the criteria identified in *Management of Priority Health Managed Benefit Inc. Assertion* (assertion). The controls and control objectives included in the description are those that management of Priority Health believes are likely to be relevant to user entities' internal control over financial reporting. The description does not include aspects of the system that are not likely to be relevant to user entities' internal control over financial reporting.

The information included in Section V, *Other Information Provided by Priority Health Managed Benefit Inc. That Is Not Covered by the Independent Service Auditor's Report on a SOC 1 Examination*, is presented by management of Priority Health to provide additional information and is not part of Priority Health's description of its system made available to user entities during the period November 1, 2022 to October 31, 2023. Information included in Section V has not been subjected to the procedures applied in the examination of the description of the system and of the suitability of the design and operating effectiveness of controls to achieve the related control objectives stated in the description of the system, and accordingly, we express no opinion on it.

Priority Health uses subservice organizations to perform certain activities. A list of these subservice organizations and the activities performed is provided in Section III. The description includes only the control objectives and related controls of Priority Health and excludes the control objectives and related controls of the subservice organizations. The description also indicates that certain control objectives specified by Priority Health can be achieved only if complementary subservice organization controls assumed in the design of Priority Health's controls are suitably designed and operating effectively, along with the related controls at Priority Health. Our examination did not extend to controls of the subservice organizations, and we have not evaluated the suitability of the design or operating effectiveness of such complementary subservice organization controls.

The description indicates that certain control objectives specified in the description can be achieved only if complementary user entity controls assumed in the design of Priority Health's controls are suitably designed and operating effectively, along with related controls at the service organization. Our examination did not extend to such complementary user entity controls, and we have not evaluated the suitability of the design or operating effectiveness of such complementary user entity controls.

Service Organization's Responsibilities

In Section II, Priority Health has provided an assertion about the fairness of the presentation of the description and the suitability of the design and operating effectiveness of controls to achieve the related control objectives stated in the description. Priority Health is responsible for preparing the description and its assertion, including the completeness, accuracy, and method of presentation of the description and the assertion; providing the services covered by the description; specifying the control objectives and stating them in the description; identifying the risks that threaten the achievement of the control objectives; selecting the criteria stated in the assertion; and designing, implementing, and documenting controls that are suitably designed and operating effectively to achieve the related control objectives stated in the description.

Service Auditor's Responsibilities

Our responsibility is to express an opinion on the fairness of the presentation of the description and on the suitability of the design and operating effectiveness of controls to achieve the related control objectives stated in the description, based on our examination.

Our examination was conducted in accordance with attestation standards established by the AICPA. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether, in all material respects, based on the criteria in management's assertion, the description is fairly presented and the controls were suitably designed and operating effectively to achieve the related control objectives stated in the description throughout the period November 1, 2022 to October 31, 2023. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

An examination of a description of a service organization's system and the suitability of the design and operating effectiveness of controls involves:

- Performing procedures to obtain evidence about the fairness of the presentation of the description and the suitability of the design and operating effectiveness of controls to achieve the related control objectives stated in the description, based on the criteria in management's assertion.
- Assessing the risks that the description is not fairly presented and that the controls were not suitably designed or operating effectively to achieve the related control objectives stated in the description.
- Testing the operating effectiveness of those controls that management considers necessary to provide reasonable assurance that the related control objectives stated in the description were achieved.
- Evaluating the overall presentation of the description, suitability of the control objectives stated therein, and suitability of the criteria specified by the service organization in its assertion.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements relating to the engagement.

Inherent Limitations

The description is prepared to meet the common needs of a broad range of user entities and their auditors who audit and report on **user entities' financial statements and may not, therefore, include every aspect of the system that each individual user entity may consider important in its own particular environment. Because of their nature, controls at a service organization may not prevent, or detect and correct, all misstatements in processing or reporting transactions. Also, the projection to the future of any evaluation of the fairness of the presentation of the description, or conclusions about the suitability of the design or operating effectiveness of controls to achieve the related control objectives, is subject to the risk that controls at a service organization may become ineffective.**

Description of Tests of Controls

The specific controls we tested and the nature, timing, and results of those tests are listed in Section IV.

Opinion

In our opinion, in all material respects, based on the criteria described in Priority Health Managed Benefit Inc.'s assertion:

a. The description fairly presents Priority Health's medical and pharmacy claims processing system that was designed and implemented throughout the period November 1, 2022 to October 31, 2023.

b. The controls related to the control objectives stated in the description were suitably designed to provide reasonable assurance that the control objectives would be achieved if the controls operated effectively throughout the period November 1, 2022 to October 31, 2023 and if the subservice organizations and user entities applied the complementary controls assumed in the design of Priority Health's controls throughout the period November 1, 2022 to October 31, 2023.

c. The controls operated effectively to provide reasonable assurance that the control objectives stated in the description were achieved throughout the period November 1, 2022 to October 31, 2023 if complementary subservice organization controls and complementary user entity controls assumed in the design of Priority Health's controls operated effectively throughout the period November 1, 2022 to October 31, 2023.

Restricted Use

This report, including the description of tests of controls and results thereof in Section IV, is intended solely for the information and use of Priority Health, user entities of Priority Health's system during some or all of the period November 1, 2022 to October 31, 2023, and their auditors who audit and report on such user entities' financial statements or internal control over financial reporting and have a sufficient understanding to consider it, along with other information, including information about controls implemented by user entities themselves, when assessing the risks of material misstatement of user entities' financial statements.

This report is not intended to be, and should not be, used by anyone other than these specified parties.

BDO USA, P.C.

December 21, 2023

II. Management of Priority Health Managed Benefit Inc. Assertion

Priority Health

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Management of Priority Health Assertion

We have prepared the accompanying description of Management of Priority Health Managed Benefit Inc.'s (Priority Health or service organization) medical and pharmacy claims processing system (the system) titled *Management of Priority Health Managed Benefit Inc.'s Description of Its Medical and Pharmacy Claims Processing System* for processing user entities' transactions throughout the period November 1, 2022 to October 31, 2023 (description) for user entities of the system during some or all of the period November 1, 2022 to October 31, 2023 and their auditors who audit and report on such user entities' financial statements or internal control over financial reporting and have a sufficient understanding to consider it, along with other information, including information about controls implemented by the subservice organizations and user entities of the system themselves, when assessing the risks of material misstatement of user entities' financial statements.

Priority Health uses subservice organizations to perform certain activities. A list of these subservice organizations and the activities performed is provided in Section III. The description includes only the control objectives and related controls of Priority Health and excludes the control objectives and related controls of the subservice organizations. The description also indicates that certain control objectives specified by Priority Health can be achieved only if complementary subservice organization controls assumed in the design of Priority Health's controls are suitably designed and operating effectively, along with the related controls at Priority Health. The description does not extend to controls of the subservice organizations.

The description indicates that certain control objectives specified in the description can be achieved only if complementary user entity controls assumed in the design of Priority Health's controls are suitably designed and operating effectively, along with related controls at the service organization. The description does not extend to controls of the user entities.

We confirm, to the best of our knowledge and belief, that:

a. The description fairly presents the medical and pharmacy claims processing system made available to user entities of the system during some or all of the period November 1, 2022 to October 31, 2023 for processing their transactions as it relates to controls that are likely to be relevant to user entities' internal control over financial reporting. The criteria we used in making this assertion were that the description:

    i. Presents how the system made available to user entities of the system was designed and implemented to process relevant user entity transactions, including, if applicable:

        (1) The types of services provided, including, as appropriate, the classes of transactions processed.

        (2) The procedures, within both automated and manual systems, by which those services are provided, including, as appropriate, procedures by which transactions are initiated, authorized, recorded, processed, corrected as necessary, and transferred to the reports, and other information prepared for user entities of the system.

(3) The information used in the performance of the procedures, including, if applicable, related accounting records, whether electronic or manual, and supporting information involved in initiating, authorizing, recording, processing, and reporting transactions; this includes the correction of incorrect information and how information is transferred to the reports and other information prepared for user entities.

(4) How the system captures and addresses significant events and conditions other than transactions.

(5) The process used to prepare reports and other information for user entities.

(6) Services performed by a subservice organization, if any, including whether the inclusive method or the carve-out method has been used in relation to them.

(7) The specified control objectives and controls designed to achieve those objectives, including, as applicable, complementary subservice organization controls and complementary user entity controls assumed in the design of the service organization's controls.

(8) Other aspects of our control environment, risk assessment process, information and communications (including the related business processes), control activities, and monitoring activities that are relevant to the services provided.

ii. Includes relevant details of changes to the service organization's system during the period covered by the description.

iii. Does not omit or distort information relevant to the service organization's system, while acknowledging that the description is prepared to meet the common needs of a broad range of user entities of the system and their user auditors and may not, therefore, include every aspect of the system that each individual user entity of the system and its auditor may consider important in its own particular environment.

b. The controls related to the control objectives stated in the description were suitably designed and operating effectively throughout the period November 1, 2022 to October 31, 2023 to achieve those control objectives if the subservice organizations and user entities applied the complementary controls assumed in the design of Priority Health's controls throughout the period November 1, 2022 to October 31, 2023. The criteria we used in making this assertion were that:

i. The risks that threaten the achievement of the control objectives stated in the description have been identified by management of the service organization.

ii. The controls identified in the description would, if operating effectively, provide reasonable assurance that those risks would not prevent the control objectives stated in the description from being achieved.

iii. The controls were consistently applied as designed, including whether manual controls were applied by individuals who have the appropriate competence and authority.

Priority Health Managed Benefit Inc.

December 21, 2023

III. Management of Priority Health Managed Benefit Inc.'s Description of Its Medical and Pharmacy Claims Processing System

Management of Priority Health Managed Benefit Inc.'s Description of Its Medical and Pharmacy Claims Processing System

Overview

This is a System and Organization Controls (SOC) 1 Type 2 report on Priority Health Managed Benefit Inc.'s (Priority Health, service organization, or Company) medical and pharmacy claims processing system (the system) for processing user entities' transactions throughout the period November 1, 2022 to October 31, 2023, which may be relevant to the internal control over financial reporting of user entities. The description has been prepared in accordance with the guidance issued by the AICPA, specifically, AT-C Section 320, *Reporting on an Examination of Controls at a Service Organization Relevant to User Entities' Internal Control Over Financial Reporting*.

Founded more than 30 years ago, Priority Health is the second-largest health plan in Michigan, servicing more than one million members. Priority Health is a majority-owned subsidiary of Priority Health Managed Benefits, a wholly-owned subsidiary of Corewell Health.

Services Provided

Priority Health provides contracted management and administrative services to Priority Health and its subsidiaries. Priority Health Managed Benefits is a third-party administrator, supporting a variety of self-funded benefit products, including medical, health reimbursement accounts, flexible spending accounts, and dental. Priority Health offers an extensive portfolio of health benefit options for employer groups and individuals, including fully funded commercial and administrative services only (ASO) and individual and government Medicare and Medicaid plans. Priority Health contracts with various health care providers to offer coverage for medical, hospital, pharmacy, and other health care services throughout Michigan.

The scope of this report is limited to Priority Health Managed Benefits' third-party administrator services provided to self-funded employer groups and does not include any other services provided by Priority Health Managed Benefits or any services provided by Priority Health.

Scope

This description addresses only Priority Health's medical and pharmacy claims processing system provided to user entities and excludes other services provided by Priority Health. The description is intended to provide information for user entities of the system and their independent auditors who audit and report on such user entities' financial statements, to be used in obtaining an understanding of the system and the controls over that system that are likely to be relevant to user entities' internal control over financial reporting. The description of the system includes certain business process controls and IT general controls that support the delivery of Priority Health's system. The description does not encompass all aspects of the services provided or procedures followed that are unrelated to internal control over financial reporting activities performed at Priority Health.

The following applications are in scope for this report:

Application	Description	Operations Affected	Source Code Developed	Operating System	Database and Database Server	Authentication Path
Clinical Editing Software (CES)	Clinical editing software over medical claims	Claims	Vendor (Optum)	Windows	Oracle with Linux server	Separate application IDs and passwords
ECMPro	Interfaces with Facets to provide claims pricing.	Claims	Vendor (Optum)	Windows	Oracle with Linux server	Active Directory (AD)
Electronic data interchange (EDI)	Processes claims and enrollments received via EDI	Claims, enrollment	In-house	Windows	Oracle with Linux server	AD
Facets	Administer and process medical claims	Claims, enrollment, group medical authorization, customer service, billing	Vendor (Cognizant)	Windows	Oracle with Linux server	AD
Guiding Care	Application used for patient authorization, disease management, and utilization management	Claims	Vendor (HealthEdge Software, Inc.)	Software as a service (SaaS)	SaaS	AD
Rate Manager	Interfaces with Facets to provide claims pricing	Claims	Vendor (Optum)	Windows	SQL with Windows server	AD

The applications listed above are supported by the following tools:

- ***Application Express (APEX)*** **– Vendor provided tool, that allows PH to create applications within, used to process claims and enrollment data received via EDI.**
- ***BusinessObjects*** **– Vendor-developed (SAP SE) reporting tool that pulls information from the database environment to support operations (e.g., monitoring claims aging).**
- ***OnBase*** **– Vendor-developed (Hyland Software) workflow tool used to support quality audits and medical authorization processes.**
- ***RPX*** **– Internally developed tool that pulls information from the database environment to provide standardized reporting.**

Priority Health uses subservice organizations to perform certain services. A list of these subservice organizations and the services performed is provided in the following table. The description does not disclose the actual controls at the subservice organizations.

Subservice Organization	Services Performed
HealthEdge Software, Inc.	Provides a cloud-based application, Guiding Care, used for patient authorization, disease management, and utilization management.
Cigna Corporation	Prices claims for members who utilize national access to a commercial provider network. Claims are then sent back to Priority Health through EDI.
Express Scripts Holding Company (ESI)	Provides pharmacy claims administration services, including hosting and maintaining the application used to process pharmacy benefits manager (PBM) claims.
Private Healthcare Systems, Inc. (PHCS/MultiPlan)	Provides medical claims repricing services. Repriced claims are then sent back to Priority Health through EDI.

Internal Control Framework

This section provides information about the five interrelated components of internal control at Priority Health: control environment, risk assessment process, monitoring activities, information and communications, and control activities.

Priority Health's internal control components include controls that may have a pervasive effect on the organization, specific processes, account balances, disclosures, classes of transactions, or applications. Some of the components of internal control have more of an effect at the entity level, while other components are primarily related to specific processes or applications.

Control Environment

Management Philosophy

The control environment of Priority Health is influenced through the communication of several core organizational values that are intended to build team member awareness of overall goals, strategies, and principles. The core values include (1) compassion, (2) collaboration, (3) clarity, (4)

curiosity, and (5) courage. Highlighting these values to team members allows the organization to pursue its mission to improve health, instill humanity, and inspire hope. Strategies and objectives adopted by executive management are based on the organization's mission and outlined annually in the organization's initiatives, which are communicated to team members.

Commitment to Integrity and Ethical Values

Priority Health has a formal Code of Excellence that obligates team members, providers, agents, consultants, students, vendors, suppliers, and volunteers to maintain the highest ethical and legal standards in the conduct of the organization's business. The Code of Excellence is accessible via the Company's intranet and is accessible to third parties upon request. Personnel are required to read and accept the Code of Excellence upon hire and to formally reaffirm it annually during continued training.

Prior to beginning work at Priority Health, all personnel undergo background screening against regulatory screening databases.

Corporate Governance

Priority Health has its own Board of Directors, which meets quarterly. The following committees of the Board of Directors are used to provide more specific oversight:

- *Finance and Audit Committee (FAC)* — This committee provides oversight for the annual financial audit, internal audit activity, and financial performance and management functions.
- *Quality Integration Committee (QIC)* — This committee provides oversight and final approval of the Compliance Program, which includes reviewing integration and continuous improvement in (1) the clinical quality of care and services delivered to Priority Health members, (2) the efficiency of clinical programs, and (3) compliance with laws, regulations, good business practices, and professional ethics.

In addition to the above committees, Digital Services leadership provides periodic updates to the Board of Directors and shares content about the threat landscape and the Information Security Program's effectiveness and progress.

The authority and responsibilities of the Board of Directors and its designated committees are formally documented via bylaws or charters and are reviewed periodically. The FAC is composed of select individuals who are independent of management to provide oversight of internal controls. The FAC meets semiannually to execute oversight of the Company's system of internal controls.

Organizational Structure and Responsibilities

Priority Health has implemented an organizational structure that details reporting lines and authorities that is available to the organization and updated as needed. Executive management and area/activity owners evaluate organizational structures regularly to align positions with the operational activities performed. Written job descriptions outlining roles and responsibilities are maintained.

Commitment to Attract, Develop, and Retain

Hiring practices of Priority Health reflect the organization's commitment to hire and retain talented, qualified, and ethical team members. Formal hiring policies are designed to confirm that individuals are hired based solely on their qualifications and ability to perform a given role.

Priority Health encourages continuous learning for team members. Learning is achieved through on-site courses and training, off-site seminars and conferences, online training, and on-the-job training. Upon hire, and at least annually, team members are required to complete regulatory training that includes HIPAA security and privacy awareness. Failure to complete training is monitored by the Compliance Department and communicated to leadership.

In addition, the organization provides information and communication to team members related to strategic goals and objectives, specific organizational policies and procedures, and government regulations. Department management is responsible for identifying individual training needs and budgeting appropriately. Security members attend technical trainings on at least an annual basis to maintain or expand competencies.

Leaders are required to evaluate the performance of their team members at least once a year by collaborating with other leaders to obtain a full perspective on how well each individual performs essential job functions, achieves goals and expectations, and demonstrates behaviors aligned with Priority Health's values. A coaching and correction process is used as needed to facilitate team-member performance-improvement opportunities.

Accountability

Priority Health has established standards and guidelines in the Code of Excellence, including ethical behavior guidelines, reporting guidelines, and a sanctions policy for personnel who violate the Code of Excellence. An anonymous third party-administered compliance hotline for internal users exists for reporting incidents, concerns, and complaints, which are monitored by the Compliance Department for resolution.

Risk Assessment Process

Priority Health has created a framework for an ongoing, sustainable enterprise risk management (ERM) process aligned to the National Association of Insurance Commissioners' (NAIC) Own Risk and Solvency Assessment (ORSA) requirements. ERM is an internal process undertaken to assess the adequacy of Priority Health's risk management and current and prospective solvency positions under normal and severe stress scenarios.

Within this framework, Priority Health examines its complete portfolio of risks, considers how those risks interrelate, and develops an appropriate risk mitigation approach and action plan to address high-risk areas in a manner that is consistent with the organization's long-term strategy and overall risk appetite. The following lower-level risk assessments act as inputs to the overarching ERM process:

- *Compliance Risk Assessment* – Compliance risks are assessed as part of the Compliance Program. The compliance risk assessment is facilitated by the Compliance Department and communicated to both the Compliance Committee and the QIC.

- *Operations Risk Assessment* — Operational risks are assessed as part of an annual risk assessment process for operational departments and for projects, events, and factors spanning multiple departments. Results and top risks and action plans are communicated to executive leadership for approval.
- *Finance Risk Assessment* — Financial risks are assessed as part of the recurring Model Audit Rule (MAR) audit and ERM process. Results of the MAR audit are communicated to executive leadership, and the results of the ERM process are communicated to executive leadership and the Board of Directors.
- *Information Security Risk Assessment* — An annual information security risk assessment is performed to identify and evaluate significant risks to achieving organization objectives. Security risk assessments are communicated to the Priority Health ERM committee and Digital Security Leadership. The assessment is facilitated by the Information Security Risk Team, under the direction of the Chief Information Security Officer (CISO) and is designed to determine the current state of information security and provide recommendations for mitigation when vulnerabilities impacting risks are identified. The following activities support the Information Security Risk Assessment:
    - At least weekly, the Cyber Resilience and Response team summarizes threat-intelligence updates outlining potential threats and distributes to Digital Services management.
    - At least quarterly, the Privacy and Security teams meet to discuss changes in the industry and regulations to assess the impact on the current environment.

Monitoring Activities

Internal Audit

Priority Health has an Internal Audit Department led by the Vice President of Internal Audit that is independent of management responsible for executing the controls. The Internal Audit Department develops an internal audit plan using a risk-based approach, which is approved by the FAC. The audit plan is revised annually to allow for changes in the risk environment, as noted through various organizational risk assessments, new or modified regulatory requirements, changes in the environment, and coverage by other evaluation activities. The internal audit plan is focused on areas of high risk to the organization that are not covered through other recurring evaluations. Internal audit conducts activities in accordance with the approved audit plan. Internal audit personnel perform audit procedures using department guidelines, document the procedures and results in working papers, and prepare an audit report and the findings from those procedures.

Internal Audit reports audit results to management and the FAC periodically. Internal Audit reviews management's status updates on open audit findings, focusing on those not completed by the original defined deadline, and it follows up with responsible management to determine the cause of the delay. Routine updates to the FAC include the status of management's remediation of open audit findings.

Monitoring of Subservice Organizations

Agreements are established with third parties and subcontractors that include clearly defined terms, conditions, and responsibilities, as well as Priority Health's security commitments. Standard

templates approved by Legal are used when contracting with third parties and subcontractors. Significant deviations from templates are reviewed with Legal prior to signing.

A vendor security risk management program has been instituted over relevant critical vendors in order to assess risks that might be relevant to the internal system components. Prior to onboarding new vendors or services, Information Security Risk Management reviews the information collected from the questionnaires and assigns a risk level associated with the third-party services or software. Identified risks are assigned to vendor-relationship owners.

Information and Communications

Internal Communication

Priority Health uses multiple communication channels to help ensure timely team member awareness of organizational information, events, and performance. These channels can be categorized according to the audience to whom information is disseminated and include team members, management, and executive leadership.

The Company's intranet is used to provide communications regarding issues affecting the organization and access to organizational policies for all team members. Descriptions of key applications and supporting tools are posted on the Company's intranet and are available to its internal users. This description delineates the boundaries of the system and key aspects of processing. Information Security policies are established, documented, maintained, and reviewed periodically.

The Company's strategies are outlined in its strategic initiatives and communicated to personnel during staff meetings at least semiannually. At least annually, Digital Services personnel hold a meeting to address departmental initiatives impacting organizational goals and objectives.

Departmental and direct-report meetings facilitated by managers allow information specific to business departments or individuals to be shared. Major changes to roles and responsibilities of key personnel are also communicated to affected personnel through email communications.

External Communication

External communications with members, providers, employers, and agents are important and vary based on each group's needs and the type of information being disseminated. One form of communication consistent across parties is the Company's website, priorityhealth.com. The Privacy Policy and Terms of Use descriptions are available on the Priority Health website and include information on policies and procedures used to protect protected health information (PHI). The Company's website also serves as a means to communicate the existence of the compliance hotline to external users. An anonymous third-party-administered compliance hotline for external users allows submitting grievances and appeals, reporting fraud and abuse, and submitting general inquiries and complaints about site security and accessibility. These are monitored by the Compliance Department for resolution.

Email communications are used primarily when communicating with external parties about updates to tools and applications. Marketing communicates changes and end-user impact to provider- and employer-group portal users.

Agreements are established with vendors that include clearly defined terms, conditions, responsibilities, and security commitments.

Control Objectives and Related Control Activities

The service organization has developed a variety of policies and procedures, including related control activities, to help ensure that the service organization's objectives are carried out and that risks are mitigated. These control activities help ensure that services are administered in accordance with the service organization's policies and procedures.

Control activities are performed at multiple levels throughout the organization and at various stages during the relevant business process. Controls may be preventive or detective in nature and may encompass a range of manual and automated controls, including authorizations, reconciliation, and IT controls. Duties and responsibilities are allocated among personnel to ensure that a proper segregation of duties is maintained.

Priority Health has specified the control objectives and identified the controls that are designed to achieve the related control objectives below. Numerical cross-references are used to reference controls in Section III to the related control and testing in Section IV.

Claims administration is the process by which a member's insurance benefits are applied to a claim to determine appropriate payment. In order for a claim (medical or pharmacy) to adjudicate properly, the following must be set up within the system: a provider network with a pre-established pricing agreement, benefit plans, group demographics, and a member. Upon claim submission, certain services require further investigation by a Claims Examiner and/or review for medical necessity before the claim can adjudicate. The following represents the key processes and data sets required for a claim to adjudicate in accordance with the member's benefits, including the supporting information-systems controls environment.

Control Objective 1 – Application Change Management

Controls provide reasonable assurance that changes to application programs and related data management systems relevant to user entities' internal control over financial reporting are authorized, tested, documented, approved, and implemented.

Formal system-development and change-management policies are maintained over the authorization, testing, documentation, and approval of changes to existing databases and applications prior to implementation. These policies include the necessary change management processes to deliver and manage the integration of processes, procedures, and technologies, and to produce the desired deliverables. The change control process implemented at Priority Health is used to manage all changes, including the following types of changes relevant to the scope of this report:

- Vendor-application and tool upgrades and patches
- Custom code changes to applications and tools developed in-house
- OnBase workflow changes
- Database upgrades, patches, and configuration changes

The Vendor Application Administration (VAA) team monitors the release of BusinessObjects, CES, ECM Pro, Facets, OnBase, and Rate Manager patches by the vendor; Infrastructure Services monitors the release of database security patches. Custom code changes to applications and tools developed in-house and OnBase workflow changes are identified through normal business processes, system issues, or strategic plans by business users. While APEX and RPX changes are subject to the same change management controls, the impact is limited to reports that support the claims administration process. Guiding Care is hosted, and application and supporting infrastructure changes are managed by the vendor, HealthEdge Software, Inc.

Once a change is identified, developer or Digital Services-related personnel initiates a change request within the Service Management platform. The change request is used to manage the workflow of the change, including approval gathering and notifications of potential outages.

Database and application changes are tested in accordance with change management policies and procedures (1.1). A testing strategy is developed for significant application and database changes, which may include unit, system, integration, and user acceptance testing, as appropriate for the type of change. During system implementations or upgrades involving data conversion or migration, appropriate testing is performed to verify the accuracy of data prior to go-live. For custom-developed or modified code, the developer performs unit testing in the development environment.

Database and application changes are reviewed by the technical approver in accordance with change management policies and procedures (1.2). This approval is recorded within the change request to authorize the change. The technical approver authorizing the change must be a member of that group that owns the configuration item being affected by the change.

Once the appropriate technical approver has authorized the change, it is forwarded to the relevant Change Advisory Board (CAB) for approval. Database and application changes are approved for implementation in accordance with change management policies and procedures (1.3). Lower-risk changes (as identified by the requester per the risk survey) are reviewed daily by the CAB. Higher-risk changes are reviewed weekly by the Enterprise CAB, which includes the change managers along with representatives from the Service Desk, Production Application Support Team (PAST), and Major Incident Management. After the review of the change, the Enterprise CAB will approve the change for implementation and it is scheduled to proceed as documented.

The implementation process is managed and documented through the use of the ticketing system, along with the necessary documentation regarding the testing and rollout process. Changes are migrated into production either manually or systematically via CoPilot (in-house developed migration tool). The ability to promote changes into production is limited to authorized individuals based on business need (1.4).

- Vendor application patches and OnBase workflow changes are migrated manually by the VAA team.
- Database updates, patches, and configuration changes are manually migrated by Infrastructure Services.
- Custom code changes to applications and tools developed in-house are migrated through the use of CoPilot, which logs the activity and provides a mechanism for reversing a change if necessary.

Separate environments are used for development, testing, and production (1.5). Custom code changes to applications and tools developed in-house are coded using the version control software Subversion (SVN) as well as Bitbucket or Stash (tools purchased from Atlassian). Bitbucket/Stash tracks the user, date, and time and the changes made each time an object is checked into or out of the software.

Certain authorized individuals have access to both the development and production environments based on business need. To help ensure that all custom code changes are authorized, tested, documented, and approved, Priority Health has implemented a compensating control: For applications without a separation of duties between development and migration, custom code changes are reviewed each month by the PAST to ensure the appropriate change process was followed (1.6).

The process for emergency changes is similar to the process described for normal changes, with the exception that, due to the criticality of the change, the documentation and approvals can be completed prior to or after the change is implemented.

Control Objective 2 – Logical and Physical Access to Applications and Data

Controls provide reasonable assurance that logical and physical access to programs, data, and computer resources relevant to user entities' internal control over financial reporting is restricted to authorized and appropriate users.

To prevent individuals from gaining unauthorized logical and physical access to programs and data, Digital Services policies and procedures are documented and maintained. The Primary Information Security Policy and Information Security Program Policy provide direction for security-related issues and are available to team members via the Company's intranet.

User Access Administration Procedures

Requests for new user accounts and changes to existing user accounts for internal applications are initiated through a provisioning tool. Management and/or the appropriate application or data owner approve the addition of new users and changes to existing user access rights within in-scope applications (2.1). Once the request is approved, the associated tasks are automatically generated and managed through the provisioning tool.

Requests to remove team member access as the result of terminations or transfers are initiated by the terminating or transferring manager or Human Resources (HR) through the creation of a provisioning tool request. The associated tasks are generated in the provisioning tool and assigned to the administrators for logical security as a result of the request. A user's AD account and in-scope, AD-authenticated application account(s) are disabled, locked, or revoked upon notification of the user's termination, as outlined in the Separation from Employment and the Non-Employed Team Members policies (2.2). A user's access is disabled, locked, or revoked from in-scope applications that do not authenticate through AD in a timely manner upon notification of the user's termination, as outlined in the Separation from Employment and the Non-Employed Team Members policies (2.3). Management reviews terminated accounts on a monthly basis to determine that, in instances of untimely removal from the network, access remained unused (2.4).

User Authentication

Prior to authenticating to specific applications, users must be authenticated through AD in order to access the Priority Health production applications and systems:

- CES and APEX users are set up with local accounts.
- Facets authenticates through AD and Oracle. Users must be in the appropriate AD group to see the Facets icon on their desktop. Facets users must also have a corresponding Oracle account in the Facets database to log in. The Facets-application account username must match the Oracle username.
- OnBase, Guiding Care, Rate Manager, BusinessObjects, EDI, and RPX are authenticated through AD using single sign-on (SSO).
- Logical access is not applicable to how Priority Health uses ECM Pro, as no end users are defined within the application.

Users are required to enter a valid username and password to access technology resources. Passwords are managed through AD to systematically enforce password complexity, length, expiration, reuse, and account-lockout settings that are aligned with Priority Health's password-policy requirements (2.5). For privileged shared and service accounts, a Privileged Access Management (PAM) tool is used to manage the rotation of these accounts (expiration) and supplement AD settings with computer-generated passwords that are randomly generated (complexity and reuse) at a length that exceeds the AD setting for those group policies (2.6).

User Access Reviews

Administrative access to in-scope applications and their supporting infrastructure is reviewed quarterly to validate access is limited to authorized individuals based on business need (2.7).

The Digital Services (DS) team reviews security rights annually to validate that users' Oracle access privileges are appropriate (2.8). Oracle role ownership is confirmed at the start of the review. Role owners review and validate that both the access rights and the individuals assigned to each role are appropriate.

Annually, a review is performed to validate that users' assigned Facets security group access is commensurate with job responsibilities, and that security groups assigned to the applications within Facets align with the use of the application (2.9). Changes identified during these user access reviews are made following the user access administration process.

Pharmacy Benefit Manager Application Access

Priority Health's employee access to the application of the PBM, ESI, is requested through the Pharmacy Operations team member (Pharmacy). Upon receipt, Pharmacy sends the request for access to the PBM for administration. Semiannually, Pharmacy reviews a list of users with access to the PBM's application and communicates any necessary modifications to the PBM for correction (2.10).

Physical Access

Priority Health operates its information systems out of two data center locations in the greater Grand Rapids area. Access to Digital Services' critical environments is granted only when there is

an identified business need. This includes a limited number of individuals within Digital Services; Facilities, Services, and Planning (FSP); Real Estate; and Security Operations. Data center access is controlled by ID card-based systems, or by granting physical access remotely by authorized personnel in the Network Operations Center (NOC) (2.11). Visitors to the data center are escorted by authorized personnel and registered upon entering and leaving. Personnel who need to access the data center must complete a change request form detailing the reason access is required. Approval is provided by the NOC.

Access to Priority Health facilities is controlled by ID card-based systems (2.12).

Card-key access to the data centers is reviewed quarterly to validate that individuals with access are appropriate (2.13). Findings of inappropriate access are investigated, and changes are made following the user access administration process.

Control Objective 3 — Computer Operations

Controls provide reasonable assurance that processing relevant to user entities' internal control over financial reporting is scheduled and that deviations are identified and resolved.

Job Scheduling

Priority Health uses the Master Job Scheduler (MJS), an in-house-developed job scheduling tool, for regularly scheduled core operational jobs, including claims adjudication, enrollment file processing, and Facets interfaces. Job processes are systematically logged at end-of-job completion, and errors are investigated and resolved as appropriate (3.1). Tickets are created and initially assigned to Customer Support for resolution. Customer Support follows a predefined process and instructions to restart failed jobs and, in the event that a job cannot be restarted, assigns the ticket to appropriate support personnel for resolution based on documented procedures.

Access to the MJS is administered according to job function, specifically those whose job responsibilities include schedule administration. Access to the automated and non-routine job scheduling tools is reviewed quarterly, and individuals with inappropriate access are removed (3.2).

Backups

The scheduling and running of backup jobs vary by system in accordance with predefined policies and procedures. Backup software is configured to automatically perform database backups in accordance with the backup schedule, and if scheduled backups fail, the appropriate team receives automatic notifications. Processing errors are investigated and resolved as appropriate (3.3).

Access to create, modify, or delete schedules within the backup software is limited to authorized personnel with job responsibilities that require such access (3.4).

Data Integrity Validations

As records are updated within Facets, they are written to a Transaction Log within the source database. A series of jobs are scheduled to automatically replicate the information in the Transaction Log to the Priority Health database. A series of jobs are also scheduled to automatically replicate data between tables in the Priority Health database. Nightly data integrity checks for automated jobs are performed on key tables within the Priority Health database to verify the

completeness and accuracy of data housed in the data store database back to the source. Any integrity issues are investigated and resolved as appropriate (3.5). Quarterly, database comparisons are performed to verify the completeness and accuracy of data within the Priority Health database back to the Facets application source, and errors are investigated and resolved as appropriate (3.6). Digital Services investigates and resolves errors identified during the nightly and quarterly integrity checks.

Control Objective 4 — Provider Setup and Maintenance

Controls provide reasonable assurance that changes to provider and pricing data affecting medical claims processing are made in a complete, accurate, and timely manner.

Key demographic information (e.g., address information, tax identification number, name change) is set up in Facets by Provider Credentialing, and data management and pricing information is set up in Facets by Provider Reimbursement (PR). During the period November 1, 2022 through February 28, 2023, 10% of new participating provider setups were quality reviewed by someone independent of the setup, and identified errors are resolved. Effective March 1, 2023, five new or modified participating providers setups per analyst per week were quality reviewed by someone independent of the setup, and identified errors are resolved (4.1). During the period November 1, 2022 through May 31, 2023, 10% of new participating reimbursement setups were quality reviewed by someone independent of the setup, and identified errors are resolved. Effective June 1, 2023, ten new or modified participating reimbursement setups per analyst per week were quality reviewed by someone independent of the setup, and identified errors are resolved (4.2). Two percent of the new nonparticipating provider and modified provider configuration records are reviewed on a monthly basis in detail through quality reviews by someone independent of the change, and identified errors are resolved (4.3). If information in Facets does not agree with source documentation, the necessary corrections are made. Pricing configuration setups (new and modified fee agreements) entered into Facets are audited to the original contract and request form, and identified errors are resolved (4.4).

The amount a provider is paid for billed procedures and services depends on the fee agreement to which they are attached. A fee agreement comprises fee schedules, which are a group of procedure codes, and related services with payment amounts defined as a percentage of billed charges, flat rates, or maximum allowable amounts. The Provider Reimbursement Fee Agreement team (PRFA) prepares fee schedule and fee agreement documentation for input into Facets based on existing policies and procedures and information provided by Provider Contracting. Fee schedules can either be uploaded into Facets in a batch or sent to the Provider Reimbursement Analyst (PRA) for manual entry. PRFA sends batch fee-schedule changes to Digital Services for upload. Then, new and modified fee schedules uploaded by Digital Services are independently reviewed in detail through quality reviews, and identified errors are resolved (4.5).

Monthly, Provider Network Analytics (PNA) performs quality reviews over a defined sample of claims to determine whether they are paying according to the terms specified within the provider contract, and identified errors are resolved (4.6). The quality audit also has the opportunity to identify whether changes to the provider or pricing record were made by an unauthorized individual.

Control Objective 5 – Group and Benefit Administration

Controls provide reasonable assurance that changes made to group and benefit data affecting medical claims processing are complete and accurate.

Group and benefit setup begins with the sale or renewal of a benefit plan. Once a sale or renewal is made, Sales and/or Legal provides Group Administration with standard group and product documentation as outlined in policies and procedures, and the documentation is subsequently uploaded or scanned into OnBase and then indexed by Sales and/or Group Administration. Data is then provided to Group Administration via the workflow tool in OnBase, a feature that routes documentation (e.g., enrollment, group) to appropriate departments for processing and tracks completion. Group Administration enters group information into Facets, and Product Configuration enters benefit information.

Group Administration enters group demographic and billing-related information received from Sales to facilitate administration of the plan. New and modified self-funded groups in Facets are then reviewed on a daily basis by someone independent of the change, and identified errors are corrected (5.1).

Group plan selection involves identifying the services covered (e.g., medical, pharmacy) and coverage amounts (e.g., copayments, deductibles) that will be offered by the employer. Product Configuration is then responsible for building those benefits so that Group Administration can attach them to the group. New and modified benefit setups are reviewed by someone independent of the change, and identified errors are corrected (5.2).

Group Administration has defined which individuals outside the Group Administration and Product Configuration departments are authorized to update group and benefit information within Facets. A defined percentage of product and group updates made by individuals outside the Group Administration and Product Configuration departments are reviewed by a Quality Auditor on a monthly basis to verify that the changes made by non-Group Administration staff members were authorized transactions based on the role in accordance with the established procedure. Identified unauthorized changes are investigated, and appropriate actions are taken (5.3). If transactions performed by unauthorized users are discovered during the quality audit, it is researched and appropriate action is taken based on findings. Results are reported to department management.

Both reviews consist of pulling the source documentation obtained from Sales to determine whether the group and benefit records in Facets are complete and accurate.

Control Objective 6 – Member Enrollment

Controls provide reasonable assurance that changes made to member data affecting medical claims processing are complete and accurate.

Enrollment information is received either manually (e.g., mail, fax, email, customer service inquiry) or electronically via EDI and Priority Health's Secure File Transfer Protocol (SFTP) server.

Enrollment forms received manually are scanned into OnBase and indexed by Enrollment. Once this process is complete, the forms are added to the Enrollment workflow and manually keyed into Facets by an Enrollment Specialist and ultimately subjected to the quality audits described below. Procedures and job aids exist to outline the appropriate setup of enrollment records in the system.

Enrollment files received through the SFTP server are scanned for malicious content and moved to the EDI processor. Enrollment transactions received through EDI are subject to edits and validations for proper format, content, and completeness throughout EDI processing (6.1). Enrollment information received through the EDI processor and passing certain edit/validation checks is automatically loaded into Facets. File processing is initiated once the enrollment information has been loaded into Facets.

EDI enrollment transactions resulting in errors or warnings during the EDI edits process are either suspended and automatically listed on an EDI service receipt sent to the Enrollment team for correction, or rejected back to the submitter within two business days if the entire file fails the edits (6.2). Upon receiving the EDI service receipt, the Enrollment Specialist responsible for the group generates an EDI Edits Report out of RPX, reviews the errors and warnings identified, and resolves errors and warnings based on policy and procedure documentation.

A defined percentage of new or modified enrollment transactions are reviewed on a daily basis by someone independent of the person making the change, and identified errors are corrected (6.3). Volumes and frequency of reviews are indicated within established policies and procedures.

Enrollment management has defined which individuals outside the Enrollment department are authorized to update enrollment information within Facets. A defined percentage of enrollment updates made by individuals outside the Enrollment department are reviewed by a Quality Auditor on a monthly basis to verify that the individuals who updated the enrollment information within Facets was authorized to do so and that the change made was appropriate (6.4). If transactions performed by unauthorized users are discovered during the quality audit, it is researched and appropriate action is taken based on findings. Results are reported to department management.

Control Objective 7 – Claims Administration

Controls provide reasonable assurance that medical claim payments and related adjustments are authorized, accurate, and processed in a timely manner.

Medical Claims Processing

Claims are loaded into Facets either electronically through the EDI process or manually by a Claims Examiner. Standard paper claims, which account for a very small percentage of total claims, are gathered by the Document Control Center (DCC) and Claims Services and are physically sent on a daily basis to a third-party vendor for optical character recognition (OCR) scanning. The vendor scans standard paper claims and, upon successfully completing OCR, transmits claims information back to Priority Health for loading into Facets via EDI. Non-standard forms are scanned directly into OnBase by the DCC team and manually entered into Facets by Claims Services.

Incoming claim files loaded into Facets via the EDI process follow a process similar to that for enrollment files as documented above and are subject to the following controls:

- Claim transactions are subject to edits and validations for proper format, content, and completeness throughout EDI processing (7.1). Possible edits that may need to take place include claim lines missing the units, end dates that are not present or are invalid, and diagnosis codes that are missing.

- Logic within EDI is configured to identify claims eligible for repricing and to send those claims to the appropriate repricing vendor (7.2).

Upon completion of the edit and validation process, a summary of EDI claims received from providers, including details regarding the claims EDI edits, is sent to the submitter(s).

New medical claims are subject to the following automated processes, which may result in a claim pending for additional review:

- Claims are evaluated for the possibility of duplication within Facets. A claim submission where a previous claim has been submitted for the member with the same exact date of service, charge amount, procedural code, revenue code, and provider ID is considered an exact duplicate and automatically denied by Facets. A claim submission where a previous claim has been submitted for the member with a combination of same date of service, charge amount, procedural code, and/or revenue code is considered a potential duplicate and pended for further review by a Claims Examiner (7.3).
- During the adjudication process, Facets is configured to verify and process claims sequentially against predefined checkpoint rules to validate eligibility, provider, diagnostic, and procedure codes, and coordination of benefits (COB), to pend claims for third-party liability (TPL) cases, and to determine the appropriate contract fee schedules, deductibles, and copayments (7.4).
- Facets is also configured to flag a claim for authorization or medical-necessity review during the adjudication process. The Medical Management department reviews a set number of tasks, such as medical authorization, medical necessity, and pended claims, per clinical reviewer per month, to determine whether they were reviewed and resolved appropriately, and identified errors are corrected (7.5).
- Logic within CES is configured to identify claims for potential up-coding and fee unbundling, and Facets uses code-review software to identify claims with potential up-coding and fee unbundling (7.6). The Code Review department reviews potential up-coded and fee-unbundled claims flagged by Facets for clinical edit accuracy (7.7).

The ability to process claims is limited to authorized personnel and is based on dollar-limit thresholds. Access to process claims and the assigned dollar-limit thresholds are part of the standard user administration.

Procedures and tools exist to help identify and investigate potential subrogation and TPL cases based on predefined diagnosis codes. Once a potential case is identified, the claim is pended and reviewed by the Third-Party Liability Services (TPLS) team. The TPLS team determines whether the claim should be paid or denied, and it updates Facets accordingly. Once subrogation cases are closed, funds are returned to the self-funded group in accordance with the negotiated settlement and are documented in the subrogation case file (7.8).

Claims Services personnel use the Inventory Management Policy to define expectations for timely claims inventory management. Management uses system-generated claim aging and turnaround time reports to monitor claims processing for compliance with the policy (7.9). Management also uses a dashboard to monitor claims inventory.

Once a claim is paid, additional information may become available that would have altered the amount a claim would have paid. Claims requiring adjustment as a result of provider, pricing, group, or benefit changes are tracked in the Configuration Log. Claims are appropriately investigated and adjusted as a result of items added to the Configuration Log (7.10). When the original claim is adjusted in Facets based on the additional information, it is reprocessed and subjected to the same processing controls as a new claim. An adjustment typically results in either an overpayment or underpayment of the original claim. When an underpayment occurs, the difference is paid to the provider through the normal claims adjudication process. When an overpayment occurs, claims procedures are designed to auto-recover up to a defined threshold amount from the provider's next payment or send overpayment request letters to the provider (7.11).

Claims requiring adjustment as a result of claim costs exceeding the member's deductible or out-of-pocket limit are identified through a daily automated report. Each claim is investigated, and the appropriate adjustments are made in Facets (7.12).

Claims Services provides new-examiner and ongoing training programs to educate Claims Services personnel on proper procedures and system usage through audit types below:

- *Trainee* – Training programs are designed specifically by level for Claims Services personnel and are required to be taken in progression. Training is targeted at new hires and Claims Services personnel who require a refresher course. After training has occurred, the Claims Examiner is subject to a 100% audit of claims processed. Once the examiner reaches the desired performance results, the percentage of claims audited is gradually lowered through manager approval until the percentage reaches the standard audit threshold.
- *Focused* – When an examiner who has knowledge of processing has been trained on a new task or retained on a specific subject or pend code, a focused audit may be performed. The percentage is determined by management, and time frames may vary based on experience.
- *Subject* – A subject audit is performed based on management request. Target areas include but are not limited to a person, job title, provider group, provider type, type of bill, type of service, dollar amount, employer group, type of business category, etc. Management determines the percentage and frequency.
- *Standard Claims Quality Audit* – Upon completion of training courses and the corresponding training audits, Claims Examiners are subject to the standard random claims quality audit.
    - 1% of claims processed with human intervention are audited by someone independent of the claim processor, and any audit findings are resolved (7.13).

Deductible and Stop-Loss Notification

Group agreements define the specific and aggregate stop-loss amounts along with the group's chosen reinsurance carrier. Twice a month, OnBase automatically identifies cases where a self-funded group's total paid claims have reached 50% of the deductible amount or exceeded the stop-loss amount at either a specific (individual) or aggregate (group) level. Notification is sent to the reinsurance carrier when a case reaches 50% of a specific deductible amount. The Claims department submits cases with claims exceeding the stop-loss amount to the appropriate reinsurance carrier (7.14).

Separation of Duties

Digital Services coordinates reviews of security rights within Facets. Quarterly, the security rights for key business functions are reviewed to validate that proper separation of duties is maintained (7.15).

Control Objective 8 – Pharmacy Administration

Controls provide reasonable assurance that product, group, member, and authorization data used in the processing and reporting of pharmacy claims is complete and accurate.

The PBM, ESI, pays claims based on formulary, group, benefit, and enrollment data provided by Priority Health. Changes to the Priority Health prescription drug formulary originate from Pharmacy and Therapeutics Committee (PTC) decisions and policies. The Pharmacy team completes documentation based on PTC decisions and policies and sends the completed request to the PBM Account Management team. To determine whether the change request is accurate prior to being sent to ESI for setup within its system, formulary changes are independently reviewed, and any errors identified are corrected before being submitted (8.1). The review includes comparing the completed change form with the original change request or PTC policy.

A daily scheduled job automatically extracts member information added or changed within Facets within the last day and sends it to the PBM. The PBM then sends reports detailing the total of updated, changed, and rejected member records. Daily, Pharmacy reviews commercial group and member error reports received from the PBM. Any errors are investigated and corrected by the appropriate department (8.2).

A job automatically pulls group information from Facets, and a designee from Group Administration submits the report via email to the PBM for loading into its system. Benefit information submitted to the PBM is monitored within the Global Log by Pharmacy so that requests are processed by the PBM promptly. The PBM notifies Pharmacy once a benefit build is complete. New and modified pharmacy benefits sent to the PBM are audited by someone independent of the change, and identified errors are corrected (8.3). The review evaluates the accuracy of the benefit information communicated to ESI against the source documentation used by Product Configuration to complete the benefit build or change request.

Certain services outlined in the formulary also require a review for medical necessity and appropriateness before claims can be submitted and paid. Approvals and denials completed by a pharmacist or pharmacy coordinator are reviewed by a Pharmacy Quality Assurance Coordinator independent of the individual who created the order before they are finalized (8.4).

At the end of each financial cycle defined by the PBM, Priority Health is provided a data file containing claim detail and an invoice (Summary Reports), which gives the total dollar amount of pharmacy claims paid by line of business. Weekly, a Medical Cost Analyst reconciles the pharmacy claims data to the invoice received from the PBM, and differences are resolved as appropriate (8.5).

Control Objective 9 – Information Provided to User Entities

Controls provide reasonable assurance that information provided to user entities that is relevant to the user entities' internal control over financial reporting are complete and accurate.

The service organization provides the following key reports as information to user entities that is relevant to the user entities' internal control over financial reporting:

- Self-funded funding invoice
    - The self-funded funding invoice is a weekly report summarizing the funds that will be needed to pay for claims. The report is generated out of RPX. Changes made to this report are authorized, tested, reviewed, and approved in accordance with the change management process (9.1).
- Self-funded monthly reporting package
    - The self-funded monthly reporting package consists of a group of reports that are sent to user entities that cover enrollment, administrative fees, stoploss, medical and pharmacy claims. Employer Insights and DS perform validation procedures each month to ensure the reporting package is complete and accurate (9.2).

Complementary Subservice Organization Controls

In some instances, a service organization's controls cannot provide reasonable assurance that its control objectives were achieved without the subservice organizations performing certain activities in a defined manner. Such activities are referred to as complementary subservice organization controls (CSOCs). The following CSOCs are those controls that Priority Health's management assumed, in the design of the system, would be implemented by a subservice organization and are necessary, in combination with controls at Priority Health, to provide reasonable assurance that the service organization's control objectives are achieved.

Number	CSOC	Applicable Control Objective
Cigna Corporation and Private Healthcare Systems, Inc.		
1.	Controls provide reasonable assurance that changes to applications, databases, and operating systems are authorized, tested, and approved prior to implementation.	CO1
2.	Controls provide reasonable assurance that logical access to applications, databases, and operating systems is restricted to authorized individuals.	CO2
3.	Controls provide reasonable assurance that system processing is scheduled and authorized and that processing issues are identified and resolved in a timely manner.	CO3
4.	Controls provide reasonable assurance that new clients and client updates with financial impact are set up accurately and with authorized approval prior to implementation in production.	CO4

Number	CSOC	Applicable Control Objective
5.	Controls provide reasonable assurance that new providers and provider demographic changes are set up accurately and with authorized approval prior to implementation in production.	CO4
6.	Controls provide reasonable assurance that rate-sheet, fee-schedule, and repricing data is accurately set up, tested, and approved prior to being placed into production.	CO4
7.	Controls provide reasonable assurance that claims are repriced in a timely manner, accurately, and against the right provider.	CO4
Express Scripts Holding Company and HealthEdge Software, Inc.		
8.	Controls provide reasonable assurance that changes to existing applications are authorized, tested, approved, implemented, and documented, in accordance with management's policies.	CO1
9.	Controls provide reasonable assurance that physical access to computer equipment is limited to properly authorized individuals.	CO2
10.	Controls provide reasonable assurance that logical access to system resources (e.g., programs, data, and parameters) is restricted to properly authorized individuals.	CO2
Express Scripts Holding Company		
11.	Controls provide reasonable assurance that processing is scheduled appropriately and that deviations are identified and resolved.	CO3
12.	Controls provide reasonable assurance that member enrollment information is created and maintained based on proper authorization and is recorded in the system completely and accurately.	CO4
13.	Controls provide reasonable assurance that claims billing transactions are valid and are processed completely, accurately, and only once.	CO7
14.	Controls provide reasonable assurance that benefit plan specifications, additions, or changes are documented, approved, and entered for processing completely and accurately.	CO8
15.	Controls provide reasonable assurance that changes or additions to the Integrated Drug Master File and Formulary Rules Station are authorized and entered for processing completely and accurately.	CO8
16.	Controls provide reasonable assurance that pharmacy information is created and maintained based on proper authorization and is recorded in the system completely and accurately.	CO8
17.	Controls provide reasonable assurance that pharmacy claims transactions are valid and are processed completely, accurately, and only once.	CO8

Complementary User Entity Controls

In some instances, a service organization's controls cannot provide reasonable assurance that its control objectives were achieved without user entities performing certain activities in a defined manner. Such activities are referred to as complementary user entity controls (CUECs). The following CUECs are those controls that Priority Health's management assumed, in the design of the system, would be implemented by user entities and are necessary, in combination with controls at Priority Health, to provide reasonable assurance that the service organization's control objectives are achieved.

Number	CUEC	Applicable Control Objective
1.	User entities are responsible for reconciling submission of group transactions and enrollment transactions communicated to Priority Health with receipts of group transactions and enrollment transactions processed by Priority Health.	CO5, CO6
2.	User entities are responsible for ensuring that group data and enrollment data input directly by personnel of the user organization is controlled, authorized, confirmed, and validated to help ensure the accuracy of claims processing and master file information.	CO5, CO6
3.	User entities are responsible for reviewing and reconciling the claims output reports for completeness and accuracy.	CO5, CO7, CO8
4.	User entities are responsible for reviewing funding requests and reconciling the information to the organization's bank information.	CO7

IV. Priority Health Managed Benefit Inc.'s Description of Its Control Objectives and Related Controls, and Independent Service Auditor's Tests of Controls and Results of Tests

Priority Health Managed Benefit Inc.'s Description of Its Control Objectives and Related Controls, and Independent Service Auditor's Tests of Controls and Results of Tests

This report, when combined with an understanding of the controls at user entities, is intended to assist auditors in planning the audit of user entities' financial statements or user entities' internal control over financial reporting and in assessing control risk for assertions in user entities' financial statements that may be affected by controls at Priority Health. The examination was performed in accordance with attestation standards established by the AICPA, specifically, AT-C Section 320, *Reporting on an Examination of Controls at a Service Organization Relevant to User Entities' Internal Control Over Financial Reporting*.

Our examination was limited to the control objectives and related controls specified by Priority Health in Section IV of this report and did not encompass all aspects of the services provided or controls of Priority Health or extend to controls performed by user entities. Unique processes or control situations not included in the description are outside the scope of this examination.

It is the responsibility of each user entity and its independent auditor to evaluate this information in conjunction with the evaluation of internal control over financial reporting at the user entity in order to assess the total internal control. If internal control is not effective at user entities, Priority Health's controls may not compensate for such weaknesses.

The scope of the examination included tests of the operating effectiveness of controls over Priority Health's medical and pharmacy claims processing system, including controls related to changes to the system applications, but did not include tests related to the functioning of or calculations performed by the software used in the delivery of the system or of reports generated by the software.

Priority Health's internal control represents the collective effect of various factors on establishing or enhancing the effectiveness of the controls specified by Priority Health. In planning the nature, timing, and extent of our testing of the controls to achieve the control objectives specified by Priority Health, we considered aspects of Priority Health's control environment, risk assessment process, monitoring activities, and information and communications.

Tests of Controls

Our testing of controls was restricted to the controls specified by Priority Health and was not extended to controls performed by user entities or other controls that were not documented as tested under each control objective listed in this section of the report.

The description of tests of controls and results of those tests are presented in this section of the report and are the responsibility of BDO USA, P.C., the service auditor. The description of the control objectives, the related controls, and the complementary subservice organization and user entity controls to achieve the objectives have been specified by, and are the responsibility of Priority Health.

The basis for all tests of operating effectiveness includes inquiry of the individual(s) responsible for the control. As part of our testing of each control, we inquired of the individual(s) to determine the fairness of the description of the control and to evaluate the design and implementation of the

control. As part of our inquiries, we also gained an understanding of the knowledge and experience of the personnel managing the control(s) and corroborated evidence obtained as part of other testing procedures. While inquiries were performed for every control, our inquiries were not listed individually for every control activity tested and shown in Section IV.

Additional testing of the control activities may have been performed using the following methods:

Method	Description
Inquiry	Inquired of appropriate personnel and corroborated responses with management.
Observation	Observed the application, performance, or existence of the specific control(s), as represented by management.
Inspection	Inspected documents and records indicating performance of the control.
Reperformance	Reperformed the control or processing application to ensure the accuracy of its operation.

When using information produced by the service organization, we evaluated whether the information was sufficiently reliable for our purposes by obtaining evidence about the accuracy and completeness of such information and evaluating whether the information was sufficiently precise and detailed for our purposes.

Control Objective 1 – Application Change Management

Controls provide reasonable assurance that changes to application programs and related data management systems relevant to user entities' internal control over financial reporting are authorized, tested, documented, approved, and implemented.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
1.1	Database and application changes are tested in accordance with change management policies and procedures.	Inspected supporting documentation for a selection of custom code changes to applications and tools developed in-house and supporting database changes to determine that changes were tested in accordance with change management policies and procedures.	No exceptions noted.
1.2	Database and application changes are reviewed by the technical approver in accordance with change management policies and procedures.	Inspected supporting documentation for a selection of custom code changes to applications and tools developed in-house and supporting database changes to determine that changes were reviewed by the technical approver in accordance with change management policies and procedures.	No exceptions noted.
1.3	Database and application changes are approved for implementation in accordance with change management policies and procedures.	Inspected supporting documentation for a selection of custom code changes to applications and tools developed in-house and supporting database changes to determine that changes were approved for implementation in accordance with change management policies and procedures.	No exceptions noted.

Control Objective 1 – Application Change Management

Controls provide reasonable assurance that changes to application programs and related data management systems relevant to user entities' internal control over financial reporting are authorized, tested, documented, approved, and implemented.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
1.4	The ability to promote changes into production is limited to authorized individuals based on business need.	Inspected system-generated access listings of users with access to implement non-SaaS application and tool changes to determine that the ability to promote changes into production was limited to authorized individuals based on business need.	No exceptions noted.
1.5	Separate environments are used for development, testing, and production.	Inspected the application environments to determine that separate environments were used for development, testing, and production.	No exceptions noted.
1.6	All custom code changes to applications developed in-house are reviewed each month by the PAST to ensure the appropriate change process was followed.	Inspected supporting documentation for a selection of months to determine that all custom code changes to applications developed in-house were reviewed each month by the PAST to ensure the appropriate change process was followed.	No exceptions noted.

Control Objective 2 – Logical and Physical Access to Applications and Data

Controls provide reasonable assurance that logical and physical access to programs, data, and computer resources relevant to user entities' internal control over financial reporting is restricted to authorized and appropriate users.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
2.1	Management and/or the appropriate application or data owner approve the addition of new users and changes to existing user access rights within in-scope applications.	Inspected supporting documentation for a selection of new users and changes to existing user access rights within in-scope applications, to determine that management and the application or data owner's approvals were obtained and that access was administered as requested.	No exceptions noted.
2.2	A user's AD account and in-scope, AD-authenticated application account(s) are disabled, locked, or revoked upon notification of the user's termination, as outlined in the Separation from Employment and the Non-Employed Team Members policies.	Inspected access termination requests and system-generated access listings for a selection of terminated employees and contractors to determine that Active Directory account access was disabled, locked, or revoked a timely manner upon the user's termination date.	**Exception noted.** For two out of 45 terminated employees/ contractors selected for testing, AD access was not disabled timely (within 30 days) following the employee/ contractors' termination date.
2.3	A user's access is disabled, locked, or revoked from in-scope applications that do not authenticate through AD in a timely manner upon notification of the user's termination, as outlined in the Separation from Employment and the Non-Employed Team Members policies.	Inspected access termination requests and system-generated access listings for a selection of terminated employees and contractors to determine that application access was revoked in a timely manner upon the user's termination date.	No exceptions noted.

Control Objective 2 – Logical and Physical Access to Applications and Data

Controls provide reasonable assurance that logical and physical access to programs, data, and computer resources relevant to user entities' internal control over financial reporting is restricted to authorized and appropriate users.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
2.4	Management reviews terminated accounts on a monthly basis to determine that, in instances of untimely removal from the network, access remained unused.	Inspected Information Security Compliance's terminated accounts review for a selection of months to determine that the review was completed for terminated accounts where AD access was not removed within 30 days of the user's termination date and included a determination that the accounts were not used after the user's termination date.	No exceptions noted.
2.5	Users are required to enter a valid username and password to access technology resources. Passwords are managed through AD to systematically enforce password complexity, length, expiration, reuse, and account lockout settings that are aligned with Priority Health's password policy requirements.	Inspected system configurations for the in-scope applications, AD and supporting infrastructure to determine that users were required to enter a valid username and password to access DS resources.	No exceptions noted.
		Inspected AD group policies to determine that password complexity, minimum length, expiration, reuse, and account lockout were systematically enforced and aligned with Priority Health's password policy requirements.	No exceptions noted.

Control Objective 2 – Logical and Physical Access to Applications and Data

Controls provide reasonable assurance that logical and physical access to programs, data, and computer resources relevant to user entities' internal control over financial reporting is restricted to authorized and appropriate users.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
2.6	For privileged generic and service accounts, a PAM tool is used to manage the rotation of these accounts (expiration) and supplement AD settings with computer generated passwords that are randomly generated (complexity and reuse) at a length that exceeds the AD setting for those group policies.	Inspected a listing of privileged generic and service accounts from AD and compared it to a listing of accounts managed in the PAM tool to determine that in-scope generic and service accounts from AD were enrolled in and being managed with the PAM tool.	No exceptions noted.
		Inspected the password settings for the privileged generic and service accounts being managed in the PAM tool to determine that passwords were scheduled to rotate on a defined basis and passwords were set to be computer generated using random characters at a length that exceeded the AD setting for those group policies.	No exceptions noted.
2.7	Administrative access to in-scope applications and their supporting infrastructure is reviewed quarterly to validate access is limited to authorized individuals based on business need.	Inspected the administrative access review for a selection of quarters to determine that administrator access to in-scope applications and their supporting infrastructure was reviewed by the IS team to validate access was limited to authorized individuals based on business need.	No exceptions noted.
2.8	The DS team reviews security rights annually to validate that users' Oracle access privileges are appropriate.	Inspected supporting documentation for the annual Oracle user access review to determine that the DS team completed the annual review of Oracle user access privileges.	No exceptions noted.

Control Objective 2 – Logical and Physical Access to Applications and Data

Controls provide reasonable assurance that logical and physical access to programs, data, and computer resources relevant to user entities' internal control over financial reporting is restricted to authorized and appropriate users.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
2.9	Annually, a review is performed to validate that users' assigned Facets security group access is commensurate with job responsibilities, and that security groups assigned to the applications within Facets align with the use of the application.	Inspected supporting documentation for the annual application owner review to determine that the review was completed to validate that the rights associated within their application assigned to each security group were appropriate.	No exceptions noted.
		Inspected supporting documentation for the annual security group owners review to determine that the review was completed to validate the users assigned to each security group and associated access privileges were appropriate.	No exceptions noted.
2.10	Semiannually, Pharmacy reviews a list of users with access to the PBM's application and communicates any necessary modifications to the PBM for correction.	Inspected supporting documentation for a selected semiannual review to determine that the list of users with access to the PBM application was reviewed by Pharmacy Operations and any requested modifications were performed as requested.	No exceptions noted.
2.11	Data center access is controlled by ID card-based systems, or by granting physical access remotely by authorized personnel in the NOC.	Observed the data center doors to determine that access was controlled by ID card-based systems.	No exceptions noted.
2.12	Access to Priority Health facilities is controlled by ID card-based systems.	Inspected listing of users with ID cards to determine that access to Priority Health facilities was controlled by ID card-based systems.	No exceptions noted.

Control Objective 2 – Logical and Physical Access to Applications and Data

Controls provide reasonable assurance that logical and physical access to programs, data, and computer resources relevant to user entities' internal control over financial reporting is restricted to authorized and appropriate users.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
		Observed facility doors to determine that the facilities used a card-key system to control access.	No exceptions noted.
2.13	Card-key access to the data centers is reviewed quarterly to validate that individuals with access are appropriate.	Inspected the physical access review for a selection of quarters to determine that the review was completed to validate that individuals with physical access were appropriate.	No exceptions noted.

Control Objective 3 — Computer Operations

Controls provide reasonable assurance that processing relevant to user entities' internal control over financial reporting is scheduled and that deviations are identified and resolved.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
3.1	Job processes are systematically logged at end-of-job completion, and errors are investigated and resolved as appropriate.	Inspected supporting documentation for a selection of logged job schedule errors to determine that errors were investigated and resolved.	No exceptions noted.
3.2	Access to the automated and non-routine job scheduling tools is reviewed quarterly, and individuals with inappropriate access are removed.	Inspected supporting documentation for a selection of quarters to determine that access to the MJS automated job scheduling tool was reviewed.	No exceptions noted.
		A component of the control that requires access removal requests to be made as necessary did not operate during the examination period. Corroboratively inquired with the Security Analyst Lead, Information Services and the Manager, Servers and Storage to determine there were no individuals identified from the quarterly job scheduling tool review that required access removal.	Since the circumstances that warrant the operation of this control did not occur during the examination period, this part of the control could not be tested.
3.3	Backup software is configured to automatically perform database backups in accordance with the backup schedule, and if scheduled backups fail, the appropriate team receives automatic notifications. Processing errors are investigated and resolved as appropriate.	Inspected the backup software configuration to determine that backups were scheduled daily.	No exceptions noted.
		Inspected the backup software configuration to determine that an alert was automatically sent when a backup processes.	No exceptions noted.
		Inspected the backup log for a selection of days to determine that the backup was successfully run or processing errors were investigated and resolved as appropriate.	No exceptions noted.

Control Objective 3 – Computer Operations

Controls provide reasonable assurance that processing relevant to user entities' internal control over financial reporting is scheduled and that deviations are identified and resolved.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
3.4	Access to create, modify, or delete schedules within the backup software is limited to authorized personnel with job responsibilities that require such access.	Inspected system-generated access listings of users with access to create, modify, or delete schedules within the current backup software to determine that access was limited to authorized personnel with job responsibilities that require such access.	No exceptions noted.
3.5	Nightly data integrity checks for automated jobs are performed on key tables within the Priority Health database to verify the completeness and accuracy of data housed in the data store database back to the source. Any integrity issues are investigated and resolved as appropriate.	Inspected supporting documentation for a selection of job and date combinations to determine that the nightly data integrity checks for data pulled from Facets to key tables were performed and any integrity issues were investigated and resolved.	No exceptions noted.
3.6	Quarterly, database comparisons are performed to verify the completeness and accuracy of data within the Priority Health database back to the Facets application source, and errors are investigated and resolved as appropriate.	Inquired of management and inspected the script used to complete the database scans to determine that the scans were complete and accurate.	No exceptions noted.
		Inspected the database scan results for a selection of quarters to determine that the quarterly database scan of Priority Health database data to the Facets application source was performed to verify the completeness and accuracy of the data and any identified errors were investigated and resolved.	No exceptions noted.

Control Objective 4 – Provider Setup and Maintenance

Controls provide reasonable assurance that changes to provider and pricing data affecting medical claims processing are made in a complete, accurate, and timely manner.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
4.1	During the period November 1, 2022 through February 28, 2023, 10% of new participating provider setups were quality reviewed by someone independent of the setup, and identified errors are resolved. Effective March 1, 2023, five new or modified participating providers setups per analyst per week were quality reviewed by someone independent of the setup, and identified errors are resolved.	Inspected documentation for a selection of weeks between November 1, 2022 and February 28, 2023 to determine that 10% of new participating provider and pricing setups were quality reviewed by someone independent of the setup.	No exceptions noted.
		Inspected documentation for a selection of analysts and weeks between March 1, 2023 and October 31, 2023 to determine that five new participating provider and pricing setups per analyst were reviewed by someone independent of the setup.	No exceptions noted.
		Inspected documentation for a selection of errors to determine that errors in new participating provider and pricing setups were identified and resolved.	No exceptions noted.
4.2	During the period November 1, 2022 through May 31, 2023, 10% of new participating reimbursement setups were quality reviewed by someone independent of the setup, and identified errors are resolved. Effective June 1, 2023, ten new or modified participating reimbursement setups per analyst per week were quality reviewed by someone independent of the setup, and identified errors are resolved.	Inspected documentation for a selection of weeks between November 1, 2022 and May 31, 2023 to determine that 10% of new participating reimbursement setups were quality reviewed by someone independent of the setup.	No exceptions noted.
		Inspected documentation for a selection of analysts and weeks between June 1, 2023 and October 31, 2023 to determine that ten new or modified participating reimbursement setups per analyst were reviewed by someone independent of the setup.	No exceptions noted.

Control Objective 4 – Provider Setup and Maintenance

Controls provide reasonable assurance that changes to provider and pricing data affecting medical claims processing are made in a complete, accurate, and timely manner.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
		Inspected documentation for a selection of errors to determine that errors in new or modified participating reimbursement setups were identified and resolved.	No exceptions noted.
4.3	Two percent of the new nonparticipating provider and modified provider configuration records are reviewed on a monthly basis in detail through quality reviews by someone independent of the change, and identified errors are resolved.	Inspected documentation for a selection of months to determine that two percent of new nonparticipating provider and modified provider configuration records were reviewed by someone independent of the change, and identified errors were resolved.	No exceptions noted.
4.4	Pricing configuration setups (new and modified fee agreements) entered into Facets are audited to the original contract and request form, and identified errors are resolved.	Inspected documentation for a selection of new and modified fee agreements to determine that the fee agreements were reviewed for accuracy by an independent person and identified errors were corrected and reaudited.	No exceptions noted.
4.5	New and modified fee schedules uploaded by Information Services are independently reviewed in detail through quality reviews and identified errors are resolved.	Inspected documentation for a selection of new and modified fee schedule uploads to determine that they were reviewed and identified errors were resolved.	No exceptions noted.
4.6	Monthly, Provider Network Analytics (PNA) performs quality reviews over a defined sample of claims to determine that if they are paying according to the terms specified within the provider contract and identified errors are resolved.	Inspected supporting documentation for a selection of months to determine that a quality review was performed and identified errors are resolved.	No exceptions noted.

Control Objective 5 – Group and Benefit Administration

Controls provide reasonable assurance that changes made to group and benefit data affecting medical claims processing are complete and accurate.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
5.1	New and modified self-funded groups in Facets are reviewed on a daily basis by someone independent of the change, and identified errors are corrected.	Inspected supporting documentation for a selection of days to determine that new and modified groups were audited by an individual independent of the person making the change.	No exceptions noted.
		Inspected supporting documentation for a selection of errors that occurred during the examination period to determine that identified errors were corrected.	No exceptions noted.
5.2	New and modified benefit setups are reviewed by someone independent of the change, and identified errors are corrected.	Inspected supporting documentation for a selection of days to determine that new and modified benefit setups were reviewed by an individual independent of the person making the change.	No exceptions noted.
		Inspected supporting documentation for a selection of errors that occurred during the examination period to determine that identified errors were corrected.	No exceptions noted.

Control Objective 5 – Group and Benefit Administration

Controls provide reasonable assurance that changes made to group and benefit data affecting medical claims processing are complete and accurate.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
5.3	A defined percentage of product and group updates made by individuals outside of the Group Administration and Product Configuration departments are reviewed by a Quality Auditor on a monthly basis to verify that the changes made by non-Group Administration staff were authorized transactions based on the role in accordance with the established procedure. Identified unauthorized changes are investigated, and appropriate actions are taken.	Inspected supporting documentation for a selection of months to determine that the defined percentage of product and group updates made by individuals outside of the Group Administration and Product Configuration departments were reviewed to verify that the changes made by non-Group Administration staff were authorized transactions based on the role in accordance with the established procedure.	No exceptions noted.
		A component of the control that requires unauthorized changes to be investigated and appropriate actions to be taken did not operate during the examination period. Corroboratively inquired with the Director of Quality Analytics and Manager of Operations Quality to determine there were no unauthorized changes that required investigation and resolution.	Since the circumstances that warrant the operation of this control did not occur during the examination period, this part of the control could not be tested.

Control Objective 6 – Member Enrollment

Controls provide reasonable assurance that changes made to member data affecting medical claims processing are complete and accurate.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
6.1	Enrollment transactions received through EDI are subject to edits and validations for proper format, content, and completeness throughout EDI processing.	Inspected a list of enrollment edit checks and validations completed during the EDI process to determine that edits and validations were in place related to proper format, content, and completeness.	No exceptions noted.
		Inspected supporting documentation for a selection of edits and validations to determine that the system appropriately denied or processed the transaction.	No exceptions noted.
6.2	EDI enrollment transactions resulting in errors or warnings during the EDI edits process are either suspended and automatically listed on an EDI service receipt sent to the Enrollment team for correction, or rejected back to the submitter within two business days if the entire file fails the edits.	Inspected the automated email for a test of one EDI enrollment batch resulting in automatically suspended EDI enrollment transactions to determine that errors and warnings were included on the EDI service receipt sent to the Enrollment team.	No exceptions noted.
		Inspected tickets and email communication for a selection of rejected EDI enrollment files to determine that the file was returned to the submitter within two business days.	No exceptions noted.
6.3	A defined percentage of new or modified enrollment transactions are reviewed on a daily basis by someone independent of the person making the change, and identified errors are corrected.	Inspected a listing of Enrollment Services staff within OnBase to determine that the defined percentage of enrollment transactions processed by Enrollment Services staff was configured to be selected automatically for daily audits.	No exceptions noted.

Control Objective 6 – Member Enrollment

Controls provide reasonable assurance that changes made to member data affecting medical claims processing are complete and accurate.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
		Inspected enrollment documentation for a selection of audited transactions to determine the enrollment transaction was reviewed by someone independent of the person making the change and identified errors are corrected.	No exceptions noted.
6.4	A defined percentage of enrollment updates made by individuals outside the Enrollment department are reviewed by a Quality Auditor on a monthly basis to verify the individuals who updated the enrollment information within Facets was authorized to do so and the change made was appropriate.	Inspected the listing of non-Enrollment Services staff within OnBase to determine that the appropriate percentage of enrollment transactions processed by non-Enrollment Services staff was configured to be selected automatically for monthly audits.	No exceptions noted.
		Inspected listing of processed versus listing of audited enrollment transactions for a selection of individuals outside of the Enrollment department within a sample of months to determine that the appropriate percentage of enrollment updates made by individuals outside the Enrollment department was reviewed by Quality Auditor in accordance with the non-Enrollment Staff Verification Audit Procedure.	No exceptions noted.

Control Objective 6 – Member Enrollment

Controls provide reasonable assurance that changes made to member data affecting medical claims processing are complete and accurate.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
		Inspected non-Enrollment Staff Verification Audit Procedure and supporting documentation for a selection of updates made by individuals outside of the Enrollment department to determine that an audit was performed to verify the update was made appropriately and that the individual who made the update was authorized to do so.	No exceptions noted.

Control Objective 7 – Claims Administration

Controls provide reasonable assurance that medical claim payments and related adjustments are authorized, accurate, and processed in a timely manner.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
7.1	Claim transactions are subject to edits and validations for proper format, content, and completeness throughout EDI processing.	Inspected a list of claim edit checks completed during the EDI process to determine that edits and validations related to proper format, content, and completeness were in place.	No exceptions noted.
		Inspected supporting documentation for a selection of claim transactions that did not pass the edit and validation check to determine that the system appropriately failed the claims transactions.	No exceptions noted.
		Inspected supporting documentation for a selection of claim transactions that passed the edit and validation check to determine that the system appropriately passed the claims transactions.	No exceptions noted.
7.2	Logic within EDI is configured to identify claims eligible for repricing and to send those claims to the appropriate repricing vendor.	Inspected supporting documentation for a selection of claims matching each repricing scenario to determine that the EDI Processor application appropriately identified claims eligible for repricing and sent them to the appropriate repricing vendor.	No exceptions noted.

Control Objective 7 – Claims Administration

Controls provide reasonable assurance that medical claim payments and related adjustments are authorized, accurate, and processed in a timely manner.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
7.3	A claim submission where a previous claim has been submitted for the member with the same exact date of service, charge amount, procedural code, revenue code, and provider ID is considered an exact duplicate and automatically denied by Facets. A claim submission where a previous claim has been submitted for the member with a combination of same date of service, charge amount, procedural code, and/or revenue code is considered a potential duplicate and pended for further review by a Claims Examiner.	Inspected the exact duplicate claim rules and a duplicate claim transaction where a previous claim had been submitted for the member with the same exact date of service, charge amount, procedural code, revenue code, and provider ID to determine that the Facets system automatically denied the claim.	No exceptions noted.
		Inspected the potential duplicate claim rules and one potential duplicate claim transaction where a previous claim had been submitted for the member with a combination of same date of service, charge amount, procedural code, and/or revenue code to determine that the Facets system automatically pended the claim for further review.	No exceptions noted.
7.4	During the adjudication process, Facets is configured to verify and process claims sequentially against predefined checkpoint rules to validate eligibility, provider, diagnostic, and procedure codes, and COB, to pend claims for third-party liability cases, and to determine that the appropriate contract fee schedules, deductibles, and copayments.	Inspected system settings from Facets and examples of claims for each edit check to determine that the Facets system pended or denied the claim according to the type of edit being executed.	No exceptions noted.

Control Objective 7 – Claims Administration

Controls provide reasonable assurance that medical claim payments and related adjustments are authorized, accurate, and processed in a timely manner.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
7.5	The Medical Management department reviews a set number of tasks, such as medical authorization, medical necessity, and pended claims, per clinical reviewer per month, to determine whether they were reviewed and resolved appropriately, and identified errors are corrected.	Inspected review documentation for a selection of months and clinical reviewers to determine the Medical Management department reviewed a set number of tasks and corrected identified errors.	No exceptions noted.
7.6	Logic within CES is configured to identify claims for potential up-coding and fee unbundling, and Facets uses code-review software to identify claims with potential up-coding and fee unbundling.	Inspected CES rule sets to determine that appropriate edits were in place to identify claims for potential up-coding and fee unbundling.	No exceptions noted.
		Inspected Facets rule sets to determine that edits were in place to identify claims for potential up-coding and fee unbundling.	No exceptions noted.
7.7	The Code Review department reviews potential up-coded and fee-unbundled claims flagged by Facets for clinical edit accuracy.	Inspected supporting documentation for a selection of potential up-coded and fee-unbundled claims flagged by Facets to determine that the Code Review department reviewed the claim for clinical edit accuracy.	No exceptions noted.
7.8	Once subrogation cases are closed, funds are returned to the self-funded group in accordance with the negotiated settlement and documented in the subrogation case file.	Inspected supporting documentation for a selection of closed subrogation cases to determine that funds were returned in accordance with the negotiated settlement and documented in the subrogation case file.	No exceptions noted.

Control Objective 7 – Claims Administration

Controls provide reasonable assurance that medical claim payments and related adjustments are authorized, accurate, and processed in a timely manner.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
7.9	Claims Services personnel use the Inventory Management Policy to define expectations for timely claims inventory management. Management uses system-generated claim aging and turnaround time reports to monitor claims processing for compliance with the policy.	Inspected policy and procedure documentation to determine that guidelines were in place to direct Claims personnel in the timeliness of processing for clean claims.	No exceptions noted.
		Inspected the logic and claims aging reports to determine that clean claims were monitored for compliance with the department policy.	No exceptions noted.
		Inspected turnaround time reports for a selection of months to determine that claims were processed in accordance with the time frames defined within the Inventory Management Policy.	No exceptions noted.
7.10	Claims are appropriately investigated and adjusted as a result of items added to the Configuration Log.	Inspected supporting documentation for a selection of items added to the Configuration Log to determine that investigation and adjustments to claims were made and were approved by appropriate individuals.	No exceptions noted.
7.11	When an overpayment occurs, claims procedures are designed to auto-recover up to a defined threshold amount from the provider's next payment or send overpayment request letters to the provider.	Inspected supporting documentation for a selection of overpayments identified in Facets to determine that recoveries were made or overpayment request letters were sent to the provider.	No exceptions noted.

Control Objective 7 – Claims Administration

Controls provide reasonable assurance that medical claim payments and related adjustments are authorized, accurate, and processed in a timely manner.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
7.12	Claims requiring adjustment as a result of claim costs exceeding the member's deductible or out-of-pocket limit are identified through a daily automated report. Each claim is investigated, and the appropriate adjustments are made in Facets.	Inspected supporting documentation for a selection of days and member overages to determine that the out-of-pocket limits were monitored, and adjustments were made in Facets.	No exceptions noted.
7.13	1% of claims processed with human intervention are audited by someone independent of the claim processor, and any audit findings are resolved.	Inspected system settings to determine that 1% of claims processed with human intervention was configured to be audited.	No exceptions noted.
		Inspected supporting documentation for a selection of days and claims processors to determine that claims were audited by someone independent of the claim processor and any audit findings were resolved.	No exceptions noted.
7.14	Notification is sent to the reinsurance carrier when a case reaches 50% of a specific deductible amount. The Claims department submits cases with claims exceeding the stop-loss amount to the appropriate reinsurance carrier.	Inspected supporting documentation for a selection of cases that reached 50% of the deductible or the claims exceeded the stop-loss amount for self-funded groups to determine that a notification was evaluated to be sent by a Stop-Loss Coordinator to the appropriate reinsurance carrier for each case with "warning" or "over" message.	No exceptions noted.

Control Objective 7 – Claims Administration

Controls provide reasonable assurance that medical claim payments and related adjustments are authorized, accurate, and processed in a timely manner.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
7.15	Quarterly, the security rights for key business functions within Facets are reviewed to validate that proper separation of duties is maintained.	Inspected the segregation of duties review for a selection of quarters to determine that security rights for key business functions was reviewed to validate that separation of duties was maintained.	No exceptions noted.
		Inspected supporting documentation for segregation of duties conflicts identified during the separation of duties review to determine that the conflicts were researched and resolved or accepted by the business.	No exceptions noted.

Control Objective 8 – Pharmacy Administration

Controls provide reasonable assurance that product, group, member, and authorization data used in the processing and reporting of pharmacy claims is complete and accurate.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
8.1	To determine whether the change request is accurate prior to being sent to ESI for setup within its system, formulary changes are independently reviewed, and any errors identified are corrected before being submitted.	Inspected supporting documentation for a selection of formulary change requests to determine that Pharmacy Operations performed an independent review for accuracy and issues identified were corrected.	No exceptions noted.
8.2	Daily, Pharmacy reviews commercial group and member error reports received from the PBM. Any errors are investigated and corrected by the appropriate department.	Inspected supporting documentation for a selection of errors to determine that the errors were investigated and resolved by the appropriate department.	No exceptions noted.
8.3	New and modified pharmacy benefits sent to the PBM are audited by someone independent of the change, and identified errors are corrected.	Inspected supporting documentation for a selection of new and modified pharmacy benefits sent to the PBM to determine that new and modified benefit setups were reviewed by an individual independent of the person making the change.	No exceptions noted.
		Inspected supporting documentation for a selection of errors that occurred during the examination period to determine that identified errors were corrected.	No exceptions noted.

Control Objective 8 – Pharmacy Administration

Controls provide reasonable assurance that product, group, member, and authorization data used in the processing and reporting of pharmacy claims is complete and accurate.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
8.4	Approvals and denials completed by a pharmacist or pharmacy coordinator are reviewed by a Pharmacy Quality Assurance Coordinator independent of the individual who created the order before they are finalized.	Inspected supporting documentation for a selection of pharmacy approvals and denials to determine that the approval or denial was completed by a pharmacist or coordinator and reviewed by a Pharmacy Quality Assurance Coordinator independent of the individual who created the order prior to being finalized.	No exceptions noted.
8.5	Weekly, a Medical Cost Analyst reconciles the pharmacy claims data to the invoice received from the PBM, and differences are resolved as appropriate.	Inspected the reconciliation between pharmacy claims data and the invoice received for a selection of weeks to determine that differences were resolved as appropriate.	No exceptions noted.

Control Objective 9 – Information Provided to User Entities

Controls provide reasonable assurance that information provided to user entities that is relevant to the user entities' internal control over financial reporting are complete and accurate.

Control Number	Controls Specified by Priority Health Managed Benefit Inc.	Tests of Controls Performed by BDO USA, P.C.	Results of Tests
9.1	The Self-Funded Funding Invoice report is generated out of RPX. Changes made to this report are authorized, tested, reviewed, and approved in accordance with the change management process.	Inspected supporting documentation for a selection of custom code changes to applications and tools developed in-house and supporting database changes to determine that changes were tested, reviewed, and approved in accordance with change management policies and procedures.	No exceptions noted.
9.2	Employer Insights and DS perform validation procedures each month to ensure the reporting package is complete and accurate.	Inspected validation documentation for a selection of reports and months to determine Employer Insights and DS performed validation procedures to ensure the reporting package was complete and accurate.	No exceptions noted.

V. Other Information Provided by Priority Health Managed Benefit Inc. That Is Not Covered by the Independent Service Auditor's Report on a SOC 1 Examination

Other Information Provided by Priority Health Managed Benefit Inc. That Is Not Covered by the Independent Service Auditor's Report on a SOC 1 Examination

Management Responses to Exceptions Noted

Control Number	Controls Specified by Priority Health	Results of Tests	Management Response
2.2	A user's AD account and in-scope AD-authenticated application account(s) are disabled, locked, or revoked upon notification of the user's termination, as outlined in the Separation from Employment and the Non-Employed Team Members policies.	**Exception noted.** For two out of 45 terminated employees/ contractors selected for testing, AD access was not disabled timely (within 30 days) following the employee/ contractors' termination date.	For one of the two terminated users, there was a delay in the request to remove access from the user's leader to Digital Services (DS). Once DS received notification, AD access was disabled the same day. And through control 2.4, no user activity between termination and disabled date was identified. For the other user was impacted by the process of integrating two legacy identity management platforms. As the user was disabled within one platform but still active in the other, AD access was not disabled. In the weeks that followed, the platforms were integrated and comparison of users and statuses was performed. The user's termination was confirmed as part of this process, resulting in AD access being disabled. To prevent further failures, management plans to enhance education around termination requests, and perform analysis of untimely access request trends to drive understanding, accountability and further improvements with a cross functional group of leaders. The Identity management platform integration should also prevent future disparate user statuses and improve accuracy of AD access removals.