REVENUE CONTRACT

(state revenue contract with an individual, business, non-profit, or government entity of another state or country and from which the state receives monetary compensation)

Begin Date	End Date	Agency Tracking #	Edison ID
January 1, 2024	December 31, 2024	31865-00501	78841

Procuring Party Legal Entity Name	Procuring Party Registration ID
Cariten Health Plan, Inc.	0000093686

Service Caption

Special Needs Plan (SNP) for Medicare/Medicaid Dual Eligible Enrollees

Ownership/Control

☐ Minority Business Enterprise (MBE):

☐ African American ☐ Asian American ☐ Hispanic American ☐ Native American

☐ Woman Business Enterprise (WBE)

☐ Service-Disabled Veteran Enterprise (SDVBE)

☐ Disabled Owned Businesses (DSBE)

☐ Small Business Enterprise (SBE): $10,000,000.00 averaged over a three (3) year period or employs no more than ninety-nine (99) employees.

☐ Government ☐ Non-Minority/Disadvantaged ☒ Other:

Selection Method & Process Summary (mark the correct response to confirm the associated summary)

☐ Competitive Award	Describe the competitive award process used. Include Solicitation Number, if applicable:
☒ Other	The procuring party selection was directed by law, court order, settlement agreement, or resulted from the state making the same agreement with all interested parties or all parties in a predetermined "class." The requisite Special Contract request was approved for contracting with the respective party.

CPO USE - RV

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
DIVISION OF TENNCARE
AND
CARITEN HEALTH PLAN, INC.

This Contract, by and between the State of Tennessee, Department of Finance and Administration, Division of TennCare, hereinafter referred to as the 'State" or "TennCare" and Cariten Health Plan, Inc., hereinafter referred to as the "Procuring Party" or "Contractor," is for the operation of a Medicare Advantage ("MA") Plan, as further defined in the "SCOPE OF SERVICES."

The Procuring Party is a For Profit Corporation.
Procuring Party Place of Incorporation or Organization: Tennessee
Contractor Edison Registration ID # 0000093686

WHEREAS, the Division of TennCare administers the Medicaid program in the State of Tennessee under Title XIX of the Social Security Act under the terms of the Tennessee State Medical Assistance Plan and the TennCare III Section 1115 research and demonstration waiver; and

WHEREAS, the Contractor seeks to enter into a contract ("MA Agreement") with the Centers for Medicare and Medicaid Services ("CMS") to provide an MA Plan that is a Dual Eligible Special Needs Plan ("D-SNP");

WHEREAS, under the Medicare Improvement for Patients and Providers Act of 2008 ("MIPPA") and resulting regulations, CMS requires the MA Plan to enter into an agreement with the State in order to be eligible to operate as a D-SNP;

WHEREAS, the Division of TennCare has a long-established a policy of not contracting with any new "unaligned" D-SNPs—MA plans that are not contracted with TennCare to also administer the Medicaid benefit to individuals eligible for both programs—in order to advance integrated care;

WHEREAS, the Division of TennCare, as part of the 2021 procurement for new Medicaid Managed Care Organizations and aligned D-SNPs, provided advance notification that upon completion of the competitive procurement, it would no longer contract with unaligned D-SNPs; and

WHEREAS, the Division of TennCare, has subsequently agreed, absent performance issues, to delay full implementation of this policy only until the next Medicaid MCO procurement and herein reiterates notification of this policy years in advance of its effective date;

NOW THEREFORE, in order to assure the efficient implementation and operation of the above described program, TennCare and the Contractor agree to the following terms.

A. SCOPE OF SERVICES:

A.1. DEFINITIONS:

a. Anchor Date – The date of receipt of notification by the Contractor of upcoming (i.e., planned) or current inpatient admissions and current or recently completed observation days or emergency department visits. The anchor date is not included in the calculation of days within which the Contractor is required to take action.

b. Appeal – Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 C.F.R. Part 422. These procedures include reconsideration by the Medicare health plan and if necessary, an independent

review entity, hearings before Administrative Law Judges, review by the Medicare Appeals Council, and judicial review.

c. Business Day – Monday through Friday, except for State of Tennessee holidays.

d. Care Coordinator – The individual who has primary responsibility for performance of care coordination activities for a CHOICES member as specified in the Contractor Risk Agreement and meets the qualifications specified in the Contractor Risk Agreement.

e. Confidential Information - Any non-public, confidential or proprietary information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, which is supplied by TennCare to the Contractor under this Contract. Any information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, relating to individuals enrolled in the TennCare program ("TennCare members"), or relating to individuals who may be potentially enrolled in the TennCare program, which is provided to or obtained through the Contractor's performance under this Contract, shall also be treated as "Confidential Information" to the extent that confidential status is afforded such information under state and federal laws or regulations. All confidential information shall not be subject to disclosure under the Tennessee Public Records Act.

f. Contractor Risk Agreement (CRA) – The Contract between TennCare Managed Care Organizations and TennCare regarding requirements for operation and administration of the managed care TennCare program, including CHOICES and ECF CHOICES.

g. Cost Sharing Obligations - Medicare deductibles, premiums, co-payments and coinsurance that TennCare is obligated to pay for certain Medicare beneficiaries (QMBs, SLMB-Plus's, and Other Medicare/Medicaid Dual Eligibles). For SLMB-Plus's and Other Medicare/Medicaid Dual Eligibles, TennCare is not required to pay Medicare co-insurance on those Medicare services that are not covered by TennCare unless the enrollee is a child under twenty-one (21) or an SSI beneficiary. No Plan can impose cost sharing obligations on its members which would be greater than those that would be imposed on the member if they were not a member of the Plan.

h. Dual Eligible - As used in this Contract, a Medicare enrollee who is also eligible for certain benefits from TennCare, which may include TennCare benefits that Medicare does not cover and/or payment of Medicare Cost Sharing Obligations under the State Plan. For purposes of this Contract, Dual Eligibles are limited to the following categories of recipients: QMB Only, QMB Plus, SLMB Plus, and Other Full Benefit Dual Eligible ("FBDE").

i. Dual Eligible Member - An enrollee who is Dual-Eligible and is enrolled in a D-SNP Plan.

j. Eligibility "Deeming" Period – For purposes of this contract, a 90-day period of continued enrollment in the D-SNP following a loss of Medicaid eligibility for individuals who lose Medicaid eligibility but are expected to regain Medicaid coverage within the 90-day period. The Contractor's Eligibility Deeming Period shall not exceed 90 days.

k. Employment and Community First (ECF) CHOICES – A managed long-term services and supports program that offers home and community-based services to eligible individuals with intellectual and developmental disabilities enrolled in the program in order to promote competitive employment and integrated community living as the first and preferred option.

l. Encounter - A Medicare Part C covered service or group of covered services, as defined by the MA-SNP Agreement, delivered by a health care service provider to a Dual Eligible Member during a visit between the Dual Eligible Member and health care service provider.

m. Encounter Data - In the context of the MA Agreement, data elements from an Encounter service event for a fee-for-service claim or capitated services proxy claim.

n. Full Benefit Dual Eligible (FBDE) - An individual who is eligible both for Medicare Part A and/or Part B benefits and for TennCare benefits [services], including those who are categorically eligible, those who qualify as medically needy under the State Plan or pursuant to the TennCare III demonstration

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o. Grievance - Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

p. Individually Identifiable Health Information – information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

q. MA Agreement - The Medicare Advantage Agreement between the Contractor and CMS to provide Medicare Part C and other health plan services to the Contractor's members.

r. Marketing - Shall have the meaning established under 45 CFR § 164.501 and includes the act or process of promoting, selling, leasing or licensing any TennCare information or data for profit without the express written permission of TennCare.

s. Observation – Observation services include short-term ongoing treatment and assessment for the purpose of determining whether a member can be discharged from the hospital or will require further treatment as an inpatient.

t. Personally Identifiable Information (PII) – any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, Social Security Number, date and place of birth, mother's maiden name, biometric records, including any other personal information which can be linked to an individual.

u. Protected Health Information/Personally Identifiable Information (PHI/PII) – (45 C.F.R. § 160.103; OMB Circular M-06-19 located at https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/memoranda/2006/m06-19.pdf)
– Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.

v. Qualified Medicare Beneficiary (QMB) – An individual who is entitled to Medicare Part A, who has income that does not exceed one hundred percent (100%) of the Federal

Poverty Level (FPL), and whose resources do not exceed twice the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid Payment of Medicare Premiums, Deductibles, Coinsurance, and Co-payments (except for Medicare Part D). Collectively, these benefits [services] are called "QMB Medicaid Benefits [Services]." Categories of QMBs covered by this Contract are as follows:

- QMB Only – QMBs who are not otherwise eligible for full Medicaid, but for whom TennCare provides Medicare cost sharing assistance.
- QMB Plus – QMBs who also meet the criteria for full Medicaid coverage and are entitled to all benefits [services] under the State Plan for fully eligible Medicaid recipients, as well as Medicare cost sharing assistance.

w. Specified Low-Income Medicare Beneficiary (SLMB) PLUS - An individual entitled to Medicare Part A who has income that exceeds 100% FPL but less than 120% FPL, and whose resources do not exceed twice the SSI limit, and who also meets the criteria for full Medicaid coverage. Such individuals are entitled to payment of the Medicare Part B premium, as well as full State Medicaid benefits.

x. Special Needs Plan (SNP) or Plan - A type of Medicare Advantage plan that also incorporates services designed for a certain class of members. In the case of this Contract, the special class of members are persons who are Dual eligible. These plans must be contracted with TennCare and approved by CMS. A SNP plan may also provide Medicare Part D drug coverage.

y. SSA-supplied Data – Information, such as an individual's Social Security Number, supplied by the Social Security Administration to the State to determine entitlement or eligibility for federally-funded programs (Computer Matching and Privacy Protection Agreement, "CMPPA" between SSA and F&A; Individual Entity Agreement, "IEA" between SSA and the State).

z. State Plan - The program administered by TennCare pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

aa. Subcontract - An agreement between the MA Health Plan and a third party under which the third party agrees to accept payment for providing health care services for the MA Health Plan's members.

bb. Subcontractor - A third party with which the MA Health Plan has a subcontract.

cc. Support Coordinator – The individual who has primary responsibility for performance of support coordination activities for an ECF CHOICES member as specified in the Contractor Risk Agreement and meets the qualifications specified in the Contractor Risk Agreement.

dd. TennCare - The medical assistance program administered by Tennessee's Division of TennCare pursuant to Title XIX of the Social Security Act, the Tennessee State Plan, and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

ee. TennCare CHOICES in Long-Term Care (CHOICES) – A program in which long-term care services for elders and/or persons with physical disabilities are integrated into TennCare's managed care delivery system.

ff. TennCare Custom SNIP 7 Encounter Edits Listing - A list of TennCare proprietary, custom developed Strategic National Implementation Process (SNIP) edits that specifically address claims and encounter data requirements imposed by TennCare.

gg. TennCare Edifecs Ramp Manager - A web-based resource that allows claims and encounter data submitters to conduct self-service testing of their files in order to receive feedback regarding their file's compliancy status.

hh. TennCare Member or Member - A TennCare member who enrolls in a TennCare MCO under the provisions of the Contractor Risk Agreement. Synonymous with enrollee.

ii. TennCare MCO or MCO - A Managed Care Organization (MCO) under contract with the State to provide TennCare benefits.

A.2. CONTRACTOR'S RESPONSIBILITIES:

a. **Continued Operation of the Contractor's D-SNP through the Next Medicaid MCO Procurement**

This Contract provides for continued operation of H4461-022--an unaligned D-SNP contracted with TennCare as reflected by a signed and fully executed TennCare contract in effect as of January 1, 2024, with a Summary of Benefits explicitly identifying such D-SNP plan. This Contract also includes continued operation of H4461-038 per agreement. H4461-022 and H4461-038 are subject to eligibility and enrollment requirements and restrictions as described in this Contract. Only D-SNPs meeting these criteria and operating in compliance with the terms of this Contract shall be eligible to continue to operate as an unaligned D-SNP in Tennessee. The Contract may be extended only through the next Medicaid MCO Procurement, date TBD. The Contractor affirms by signature of this Contract the Contractor's understanding of this policy.

b. **Service Area.**

The Plan shall specify its service area as Statewide, a specific Grand Region or regions of the State, or other specific geographic criteria (i.e., specific counties or metropolitan areas). The service area for this contract shall be the counties specified in Attachment F.

c. **Benefits.**

1. TennCare uses a modified MCO system to provide TennCare benefits to TennCare enrollees. Each TennCare member is enrolled in an MCO. There are carve-outs for retail pharmacy services and dental services as applicable. It is the understanding of the Parties that any benefits provided by the Plan, even if they are also covered benefits under TennCare, are provided pursuant to the understanding between the Plan and the enrollee. TennCare shall not be responsible for payment for these benefits, nor shall TennCare be responsible for ensuring the availability or quality of these benefits. TennCare will pay the appropriate cost sharing for these services as mandated by Federal law and TennCare rules.

2. The Contractor shall not be responsible for the provision or reimbursement of any Medicaid benefits, unless such benefits are also covered by the Contractor, in which case, the Contractor shall be responsible for the provision and reimbursement of such covered services in accordance with its summary of benefits, and for coordination of Medicaid benefits beyond the scope of its covered benefits as described in A.2.c.7. TennCare's list of covered benefits is set forth in Attachment D.

3. For any dual eligible member receiving LTSS but not enrolled in CHOICES or ECF CHOICES or other MLTSS program, the Contractor's D-SNP remains responsible for coordinating the full range of Medicaid, including LTSS, and Medicare benefits, and shall collaborate with the Independent Support Coordinator or Department of Intellectual and Developmental Disabilities (DIDD) Case Manager, or ICF/IID Interdisciplinary Team to facilitate such coordination.

4. The Contractor shall provide the Summary of Benefits to its members as detailed in Attachment A.

5. The Contractor shall provide a copy of the Summary of Benefits as approved by CMS at the beginning of each Plan year. The Contractor should consult TennCare Rule 1200-13-13-04 and the TennCare website under Members: Benefits-Covered Services for a comprehensive list of covered TennCare benefits and the fit between Medicare and TennCare coverage. Further, to the extent necessary, the State will provide the Plan with information regarding Medicaid benefits in order for the Plan to meet CMS requirements for the Statement of Benefits.

6. The Contractor shall refer a Dual Eligible Member who is a QMB Plus or other FBDE to the member's TennCare MCO for the provision of TennCare benefits that are not covered by the Plan.

7. The Contractor shall be responsible for providing care coordination for all Medicare and Medicaid services for all FBDE members, pursuant to this Contract and to policies and protocols developed by TennCare. The Contractor shall coordinate TennCare benefits not covered by the Contractor with the FBDE member's TennCare MCO. The Contractor shall be responsible for the following:

    i. Providing notification within two (2) business days from the notification date to a FBDE member's TennCare MCO of all FBDE members' inpatient admissions, including planned and unplanned admissions to the hospital or a Skilled Nursing Facility (SNF), as well as observation days and emergency department visits. The Contractor shall report each inpatient admission, observation day, and emergency department visit separately. The Contractor's implementation of emergency department visit notifications will occur at a later date to be determined by TennCare.

    ii. Coordinating with FBDE member's TennCare MCO regarding discharge planning from any inpatient setting when Medicaid LTSS (NF or HCBS) or Medicaid home health or private duty nursing services, may be needed upon discharge in order to ensure that care is provided in the most appropriate, cost effective and integrated setting. The Contractor shall engage in care coordination with FBDE member and the member's TennCare MCO following observation days and emergency department visits to address member needs and coordinate Medicaid benefits, as appropriate. Discharge planning shall meet minimum requirements as specified by TennCare in policy or protocol.

    iii. Coordinating with FBDE member's TennCare MCO Care Coordinator or Support Coordinator, as applicable, to share information gained from such methods as notifications from hospitals, case managers, claims reporting, etc. to ensure timely discharge planning and coordination.

    iv. Coordinating with a FBDE member's TennCare MCO regarding CHOICES or ECF CHOICES LTSS that may be needed by the member; however, the Contractor shall remain responsible for ensuring access to all Medicare benefits covered by the Contractor, including SNF and home health, and shall not supplant such medically necessary covered services with services available only through TennCare.

    v. Coordinating with a FBDE member's TennCare MCO Care Coordinator or Support Coordinator, as applicable, and ensuring timely access to medically necessary covered Medicare benefits needed by FBDE member enrolled in the CHOICES or ECF CHOICES program.

vi. Participating upon request in needs assessments and/or the development of an integrated person-centered plan of care or person-centered support plan, as applicable, for a TennCare CHOICES or ECF CHOICES member, encompassing Medicare benefits provided by the Contractor as well as Medicaid benefits provided by the TennCare MCO.

vii. Coordinating with FBDE member's TennCare MCO and ensuring timely access to medically necessary covered Medicare benefits needed by FBDE member.

viii. Accepting and processing in a timely manner referrals for case management and/or disease management from a FBDE member's MCO, including a CHOICES or ECF CHOICES member's TennCare MCO Care Coordinator or Support Coordinator, as applicable. For purposes of this section, accepting and processing referrals shall be considered timely if received within three (3) business days from the date the referral is received.

ix. Coordinating with each TennCare MCO for nursing facility diversion program to:

    a. Facilitate appropriate communication among the Contractor's providers (including hospitals and physicians) and the member's TennCare MCO;

    b. Provide training for the Contractor's key staff and providers regarding NF diversion and HCBS alternatives;

    c. Identify members who may be candidates for diversion (both CHOICES and ECF CHOICES members and non-CHOICES and non-ECF CHOICES members who may need NF services and qualify for CHOICES or ECF CHOICES upon hospital discharge or exhausting a Medicare SNF benefit); and

    d. Carry out follow-up activities to help sustain community living.

x. Referring to a FBDE member's TennCare MCO any FBDE member receiving SNF services that may be a candidate for transition to the community and coordinating with the FBDE member's TennCare MCO to facilitate timely transition, as appropriate, including coordination of services covered by the Contractor and services covered only by the TennCare MCO.

xi. Including as part of the Contractor's SNP Model of Care, training for staff and providers regarding the following:

    a. The Contractor's responsibility for coordination of Medicare and Medicaid benefits for FBDE members;

    b. The Contractor's policies and processes for coordination of Medicare and Medicaid benefits for FBDE members;

    c. The target populations for TennCare managed long-term services and supports programs, including the CHOICES and ECF CHOICES program; and

    d. Benefits covered under the TennCare program, including the CHOICES and ECF CHOICES program.

xii. For Contractor's dually eligible members receiving Opioid Treatment Program (OTP) Services, the Contractor shall be responsible for the continuity of the member's care and access to opioid treatment providers and shall develop and

maintain policies and procedures to address this responsibility. The Contractor shall:

(1) Ensure continuity of care for dually eligible plan members who are currently receiving OTP service through Medicaid providers;

(2) Use CMS and Substance Abuse and Mental Health Services Administration (SAMHSA) resources to identify Medicare-enrolled OTP providers, in order to establish networks and ensure beneficiary access to certified OTP providers; and

(3) Ensure providers do not hold dually eligible enrollees liable for Medicare Part B deductibles as well as any copayment or coinsurance a Medicare Advantage Organization may assess for OTP services, when the Medicaid program is responsible for paying such amounts.

8. In the event a specific benefit is covered by both the Plan and TennCare, TennCare shall be the payor of last resort.

9. The Contractor agrees that all instances in the Contractor's marketing materials that include reference to "more", "extra", or "additional" Medicare benefits, or use similar language to indicate the receipt of benefits above and beyond traditional Medicare benefits, must explicitly state that such increased benefits are applicable to Medicare only and do not indicate increased Medicaid benefits to avoid potential member confusion. Additionally, each marketing item must include the following disclaimer:

   Notice: TennCare is not responsible for payment for these benefits, except for appropriate cost sharing amounts. TennCare is not responsible for guaranteeing the availability or quality of these benefits.

10. The Contractor shall develop policies and procedures for coordination of Medicare and Medicaid benefits for FBDEs and shall submit such policies and procedures to TennCare for review and written approval prior to implementation. The Contractor's operations shall be subject to on-site review, observation, and audit by TennCare to confirm the Contractor's compliance with approved policies and procedures regarding coordination of Medicare and Medicaid benefits and the terms of this Contract.

11. The Contractor shall make available to TennCare upon request all information regarding the Contractor's performance for the D-SNP plan, including, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, Medicare Advantage Star Quality ratings, including poor performing icons, notices of non-compliance, audit findings and corrective action plans. Audit findings that result in Immediate Corrective Action Required shall be submitted to TennCare within ten (10) calendar days of responding to CMS. The Contractor shall conduct additional quality improvement activities as determined by and at the request of TennCare based on poor performance or opportunities for improved quality and cost efficiency.

12. The Contractor shall participate in meetings as requested by TennCare to discuss the program and its operations, and to address performance issues and concerns. The Contractor shall be required to have appropriate staff attend certain on-site meetings held at TennCare offices or at other sites as requested and designated by TennCare. TennCare shall notify the Contractor in writing of any specific performance deficiencies and request corrective action. The Contractor shall respond in writing with a corrective action plan within thirty (30) calendar days of receipt of such notification and implement and monitor the plan upon approval by TennCare. Additionally, both Parties agree to cooperate in carrying out the activities described in any applicable Corrective Action Plan mandated by CMS.

13. The Contractor shall operate a call center with dedicated representatives who are trained on Medicare and TennCare benefits provided and/or coordinated under this Contract and who are capable of handling questions and concerns regarding the benefits provided across both contracts. For any instance in which additional expertise is needed to assist the member, e.g., for questions specifically concerning the Contractor's behavioral health or long-term services and supports, the Contractor's staff shall be responsible for conducting warm transfers to appropriate contacts who can address these issues for the caller.

14. The Contractor shall provide its Health Risk Assessment and Medicare plan of care template and policies to TennCare for review and comment, and shall participate in person-centered practices training provided or arranged by TennCare.

d. **Data.**

1. The Contractor shall submit to TennCare, in a mutually agreed upon electronic format, the following data:

(a) Encounter data for any and all claims, including Part D claims to the extent the Contractor has access to such information and including claims with no patient liability. Encounter data submissions shall be in accordance with the following:

(1) The Contractor shall collect encounter data as required by TennCare and CMS and participate in any other required surveys or studies.

(2) The Contractor's systems are required to conform to HIPAA-standard transaction code sets as specified in the HIPAA Implementation and TennCare Companion guides.

(3) The Contractor shall submit encounter data that meets established TennCare data quality standards. These standards are defined by TennCare to ensure receipt of complete and accurate data for program administration and will be closely monitored and strictly enforced. TennCare will revise and amend these standards as necessary to ensure continuous quality improvement. The Contractor shall make changes or corrections to any systems, processes, or data transmission formats as needed to comply with TennCare data quality standards as originally defined or subsequently amended. The Contractor shall comply with industry-accepted clean claim standards for all claims and encounter data, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of a claim. In the event that the Contractor denies provider claims for reimbursement due to lack of sufficient or accurate data required for proper adjudication, the Contractor shall submit all available claim data to TennCare without alteration or omission. Where the Contractor has entered into capitated reimbursement arrangements with providers, the Contractor must require submission of all utilization or claims and encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims; the Contractor shall require this submission from providers as a condition of the capitation payment and shall make every effort to enforce this contract provision to ensure timely receipt of complete and accurate data. The Contractor shall be required to submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by TennCare, in order to support comprehensive financial reporting and utilization analysis. The Contractor must submit all encounter data according to standards and formats as defined by TennCare, complying with HIPAA standard code sets and maintaining integrity with all reference data sources, including provider and member data. All encounter data submissions

will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing. Any batch submission which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates shall be rejected and returned to the Contractor for correction within two (2) business days.

(4) TennCare shall reject an entire file or an individual encounter failing certain edits, as deemed appropriate and necessary by TennCare to ensure accurate processing or encounter data quality, and shall return these transactions to the Contractor for research and resolution. TennCare shall require expeditious action on the part of the Contractor to resolve errors or problems associated with said claims or the adjudication thereof, including any necessary changes or corrections to any systems, processes or data transmission formats. The Contractor shall, unless otherwise directed by TennCare, address entire file rejects within two (2) business days of rejection and individual encounter rejects within forty-five (45) calendar days of rejection. Such errors will be considered acceptably addressed when the Contractor has either confirmed and corrected the reported issue or disputed the reported issue with supporting information or documentation that substantiates the dispute. TennCare may require resubmission of the transaction with reference to the original in order to document resolution. Failure to address the preceding file rejects within two (2) business days as stated above may result in the assessment of liquidated damages in accordance with the liquidated damages section of this Contract.

(5) Within two (2) business days of the end of each of the Contractor's payment cycles, the Contractor shall generate claims and encounter data files for that payment cycle from its claims management system(s) and/or other sources. If the Contractor has more than one (1) payment cycle within the same calendar week, the encounter data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week.

(6) Any claims and encounter data from a subcontractor shall be included in the file from the Contractor. The Contractor shall not submit separate claims and encounter files from subcontractors.

(7) The files shall contain settled claims and claim adjustments, including, but not limited to, adjustments necessitated by payment errors processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the Contractor has a capitation arrangement.

(8) The level of detail associated with encounters from providers with whom the Contractor has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the Contractor received and settled a fee-for-service claim.

(9) The Contractor shall adhere to federal payment rules and regulations in the definition and treatment of certain data elements, e.g., units of service, that are HIPAA-standard fields in the encounter data submissions.

(10) The Contractor shall provide claims and encounter data files electronically to TennCare in adherence to the procedure and format indicated in the HIPAA Implementation and TennCare Companion guides.

(11) The Contractor shall institute processes to ensure the validity and completeness of the data it submits to TennCare. At its discretion, TennCare shall conduct general data validity, integrity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be

audited include, but are not limited to: member ID, date of service, provider ID (including NPI number and Medicare I.D. Number), category and subcategory (if applicable) of service, diagnosis codes, procedure codes and modifiers, revenue codes, adherence to benefit limits, date of claim processing and, date of claim payment. Control totals shall also be reviewed and verified.

(12) Claims and encounter records shall be submitted such that payment for discrete services that may have been submitted in a single claim can be ascertained in accordance with the Contractor's applicable reimbursement methodology for that service.

(13) The Contractor shall be able to receive, maintain and utilize data extracts from TennCare and its contractors, e.g., pharmacy data from TennCare or its pharmacy benefit manager (PBM).

(14) The Contractor shall not implement imitations of TennCare's Custom SNIP 7 Encounter Edits Listing or likewise use the TennCare Edifecs Ramp Manager tool for the purpose of preventing submission of post adjudicated encounter production data to TennCare. It is permissible for the Contractor to implement imitations of TennCare Custom SNIP 7 Encounter Edits Listing prior to claim adjudication.

2. This information shall be submitted on a schedule agreed to by both parties and will be provided at no cost to TennCare. TennCare shall use this information to fulfill its crossover claims payment function, to coordinate care for its Dual Eligible Members and for purposes of monitoring fraud and abuse as required by federal and state law. Information submitted under this provision will be considered non-public information. Failure to adhere to this agreed upon schedule may result in the assessment of liquidated damages in accordance with the liquidated damages section of this Contract. The Contractor shall have a representative dial into the weekly IT conference call. The Contractor shall have a minimum of one (1) representative attend the monthly IT on-site meeting in person.

3. The Contractor shall receive, process, update, and submit all applicable outbound and/or inbound enrollment and ancillary/supplemental files sent by TennCare in a TennCare prescribed HIPAA-compliant format and a frequency that shall be established and required by TennCare. In addition, the Contractor shall meet the following requirements:

(a) The Contractor shall update its enrollment databases, including, but not limited to, MCO assignment within twenty-four (24) hours of receipt of said files.

(b) The Contractor shall transmit to TennCare, in the formats and methods specified in the HIPAA Implementation and TennCare Companion guides, or as otherwise specified by TennCare, member address changes, telephone number changes, and primary care provider (PCP).

(c) The Contractor shall be capable of uniquely identifying a distinct TennCare member across multiple populations and systems within its span of control.

(d) The Contractor shall be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by TennCare, and resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

(e) The Contractor shall be responsible for establishing connectivity to TennCare's/the state's wide area data communications network, and the relevant

information systems attached to this network, in accordance to all applicable TennCare and/or state policies, standards and guidelines.

(f) The Contractor's systems shall be able to transmit, receive and process data in HIPAA-compliant or TennCare-specific formats and methods, including, but not limited to, Secure File Transfer Protocol (SFTP) over a secure connection such as a VPN, that are in use at the start of systems readiness review activities. These formats are detailed in the HIPAA Implementation and TennCare Companion guides.

(g) In the event of a declared major failure or disaster, the Contractor's core eligibility/enrollment/encounter or other systems that interact with TennCare shall be back online within seventy-two (72) hours of the event.

(h) Regardless of the architecture of its systems, the Contractor shall develop and be continually ready to invoke a BC-DR (Business Continuity/Disaster Recovery) plan that is reviewed and prior approved in writing by TennCare.

(i) The Contractor shall cooperate in a "readiness review" conducted by TennCare to review the Contractor's IT readiness for electronic data interchange. This review may include, but is not limited to, on-site review of the Contractor's systems, a system demonstration (including systems connectivity testing), and other readiness review components as determined by TennCare.

(j) The Contractor shall also work with TennCare pertaining to any testing initiative as required by this Contract, including providing sufficient systems access to allow testing by TennCare of the Contractor's systems during readiness review and testing with TennCare prior to the use of a new vendor if the vendor will be submitting claims to the plan related to this Contract that will then go to TennCare for processing.

(k) In the event that reports are required, the Contractor shall comply with all the reporting requirements established by TennCare. TennCare shall provide the Contractor with the appropriate reporting formats, instructions, submission timetables, and technical assistance as required. TennCare may, at its discretion, change the content, format or frequency of reports.

(l) TennCare may, at its discretion, require the Contractor to submit additional reports both ad hoc and recurring. If TennCare requests any revisions to the reports already submitted, the Contractor shall make the changes and re-submit the reports, according to the time period and format required by TennCare.

(m) For any medical records or other health and enrollment information it maintains with respect to enrollees, an MA organization must establish procedures to do the following:

1. Abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. The MA organization must safeguard the privacy of any information that identifies a particular enrollee and have procedures that specify:

    a. For what purposes the information will be used within the organization; and
    b. To whom and for what purposes it will disclose the information outside the organization.

2. Ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.

3. Maintain the records and information in an accurate and timely manner.
4. Ensure timely access by enrollees to the records and information that pertain to them.

(n) Ensure that medical information is released only in accordance with applicable Federal or State law, or under court orders or subpoenas.

(o) Maintain the records and information in an accurate and timely manner.

(p) Ensure timely access by enrollees to the records and information that pertain to them.

(q) The Contractor shall be required to notify TennCare within two (2) business days of any changes made to the Contractor's CMS Contract Numbers. Notification of such changes shall be made in writing to TennCare.

e. **Eligibility.**

1. The unaligned D-SNP may offer continued enrollment for members in the eligibility groups specified below who are enrolled January 1, 2024, subject to requirements and restrictions defined herein.

2. The contractor shall not enroll any new individuals who have Medicaid, including QMB-Plus, SLMB-Plus, and Full Benefit Dual Eligibles; nor shall the contractor enroll individuals in any group not specified in this Contract. New enrollment shall be open only to partial dual categories specified below.

3. The Contractor affirms by signature of this Agreement the Contractor's understanding and commits to abide by these terms.

4. The Contractor's operations shall be subject to on-site review, observation, and audit by TennCare to confirm the Contractor's compliance with enrollment. The Contractor shall be subject to corrective actions, up to and including financial sanctions and termination of agreement for failure to comply with the terms and conditions of new plan enrollment.
5. The H4461-022 D-SNP is closed to any new enrollment and the Contractor shall conduct no marketing related to this plan.

6. The H4461-038 D-SNP shall be permitted to enroll only individuals who attain dual eligibility status as a QMB-Only. The Contractor shall not enroll any individuals who have Medicaid, including QMB-Plus, SLMB-Plus, and Full Benefit Dual Eligibles in the H4461-038 plan; nor shall the Contractor enroll individuals in any group not specified in this Agreement.

7. The only members or categories of eligibility for participation in the H4461-022 Plan are Full Benefit Dual eligible who were enrolled as FBDEs in H4461-022 or H4461-038 as of August 1, 2022.
8. As of January 1, 2024, the only members or categories of eligibility for participation in the H4461-038 plan are QMB-Only.

9. A QMB-Only enrolled in H4461-038 who attains full Medicaid eligibility shall no longer qualify for enrollment in either H4461-022 or H4461-038 and shall be disenrolled.
10. The Contractor affirms by signature of this Agreement the Contractor's understanding and commits to abide by these terms.

11. In accordance with 42 CFR §422.52(d) a D-SNP shall use the eligibility deeming period of ninety (90) days to maintain continuous coverage when a member temporarily loses Medicaid eligibility. A member who loses FBDE eligibility but attains partial dual

eligibility may be enrolled in H4461-038. However, a member who attains FBDE eligibility may NOT be enrolled in either plan.

12. Medicaid Eligibility data shall be made available to the Contractor by TennCare (see A. 3) only for purposes of serving individuals who have either:

    (a) Affirmed in writing, for example, by completion of a SNP enrollment application by letter, email or facsimile of the intention to join the Plan and whose TennCare eligibility category needs to be verified before the individual may be enrolled in the Plan; or

    (b) Members already enrolled in the Plan whose TennCare eligibility needs to be confirmed for: 1) renewal of a contract term, 2) verification of continuing membership on a periodic basis, or 3) before the provision of a benefit.

13. Medicaid Eligibility data shall not be supplied for the purposes of allowing the Plan to market its services to persons who are not members or who have not agreed to become members.

14. Contractor shall provide its eligibility information on members of its Plan to TennCare or TennCare's designee at no charge to TennCare.

f. **Provider Network Information.**

1. The Contractor shall submit a quarterly Provider Enrollment File report that includes information on all providers of the Plan's covered health benefits. This includes but is not limited to, PCPs, physician specialists, hospitals, and home health agencies. The report shall include contract providers as well as all non-contract providers with whom the Contractor has a relationship. This list need not include retail pharmacies. The Contractor shall submit this report by the 15th of the following months: February, May, August and November. Each quarterly Provider Enrollment File shall include information on all providers of health benefits and shall provide a complete replacement for any previous Provider Enrollment Files submission. Any changes in the provider's contract status from the previous submission shall be indicated in the file generated in the quarter the change became effective and shall be submitted in the next quarterly file. The provider network information shall be updated regularly as specified by TennCare. The Contractor shall contact TennCare's Office of Provider Networks for the proper format for the submission.

2. The Contractor shall not enter into contracts. agreements. arrangements-whether formal or informal-with any providers, or alternatively, issue any guidance documents, memorandums. written instructions. or verbal commands which contain clauses, provisions, expectations, payment methodologies, or any other language that has the intent or effect of: 1) limiting those providers' participation in any other integrated or coordinated program of care for FBDEs, including but not limited to, a TennCare Waiver demonstration program, any other D-SNP program, or any program connected to or administered by a TennCare MCO; or 2) limiting a FBDE beneficiary's choice of Medicare providers. If the Contractor violates the provisions of this section A.2.f, such action shall be grounds for immediate termination of this contract pursuant to section D.4 Termination for Cause.

g. **Confidentiality, Use and Disclosure of Confidential Information**.

The Contractor shall agree to the attached Trading Partner Agreement, Attachment B, and Business Associate Agreement, Attachment C, governing the use and handling of the data it receives from TennCare under this Contract.

h. The Contractor shall, upon prior review and approval by the Centers for Medicare and Medicaid Services (CMS), submit to TennCare for review and prior written approval, all marketing materials, items, layouts, plans, etc. that will be distributed directly or indirectly to FBDE members or potential FBDE members for the purposes of soliciting and/or maintaining enrollment in the Contractor's plan. The Contractor shall include in its submission, documentation of CMS approval of such materials, items, layouts, plans, etc. The Contractor shall be strictly prohibited from using any eligibility or enrollment information that has been provided by TennCare for purposes of coordinating benefits for members for any marketing activities or to solicit additional members for enrollment in its D-SNP.

i. The Contractor shall transmit crossover claims to the member assigned MCO on and after claim dates of service January 1, 2024.

j. **Deliverables**.

1. In addition to the encounter and provider file reports required under this Contract, the Contractor shall submit to TennCare the following deliverables in a format prescribed by TennCare:

(a) A Quarterly Dual Eligible Coordination Report - The report consists of notification of hospital admissions and coordination of care.

(b) A Quarterly D-SNP Appeals Report – The report details the number of medical and pharmacy appeals received each quarter.

(c) A Quarterly D-SNP Grievance Report – This report provides information related to grievances received by the D-SNP.

(d) A Quarterly D-SNP Enrollment Report using the template provided by TennCare which shall include the following:

i. Member first and last name
ii. Member social security number
iii. CMS contract number
iv. Plan number
v. Enrollment date
vi. Eligibility Category
vii. Identify individuals in Eligibility Deeming Period
viii. Date of last effective date if deeming

(e) Ad hoc reports as requested by TennCare.

2. The above deliverables are subject to audit upon request by TennCare either through ongoing, periodic audits in a manner prescribed by TennCare or ad hoc.

3. The Contractor is required to submit copies of provider agreement templates, unique provider agreements, provider manuals/handbooks, and amendments thereto, intended for use in the Contractor's D-SNP lines of business, to the Tennessee Department of Commerce and Insurance (TDCI) TennCare Oversight Division for review and acceptance, which may occur after an agreement has been signed by all parties, but should be within a reasonable timeframe to provide for review by TDCI to ensure that these documents align with requirements set forth by TennCare in this Contract.

k. **Coordination with TennCare Managed Care Organizations**.

The Contractor shall, upon request, coordinate with TennCare MCO(s) in the development of needs assessments and/or development of an integrated Person-Centered Support Plan (PCSP) for a TennCare CHOICES member, or PCSP for an ECF CHOICES member, encompassing Medicare and Medicaid benefits provided by the TennCare MCO. Per the requirements of the CRA, TennCare MCOs are responsible for submitting any such needs assessments and/or PCSPs to the Contractor within two (2) business days of developing or substantively updating such documents. The Contractor, upon receipt of such documentation, shall be responsible for reviewing the member's PCSP, and updating it in collaboration with the applicable TennCare MCO based on changes to the member's condition or needs of which the Contractor is aware.

I. **Provider Agreement Requirements**

1. Nondiscrimination Requirements. Provider agreements shall include the following nondiscrimination provisions:

   a. *General Requirements.* Language that no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its agreement with the Contractor or in the employment practices of the provider. The provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees, TennCare applicants, and enrollees.

   b. *Policies, Procedures, and Training.* The provider shall be interacting with individuals from diverse cultural backgrounds including, individuals with LEP, individuals with low literacy, individuals with disabilities, including individuals with vision, cognitive, hearing, and speech disabilities, therefore, the provider shall have policies and procedures for delivering services in a nondiscriminatory and cultural competent manner, providing free language and communication assistance services to individuals, providing individuals with reasonable accommodations, and discrimination complaint procedures. The provider's staff members carrying out the terms of the provider agreement shall receive annual training on the provider entity's: policies on how to deliver services in a nondiscriminatory and culturally competent manner, complaint procedures, process to obtain free language assistance services for LEP individuals, process for providing free effective communication services (auxiliary aids or services) to individuals with disabilities, and process for providing reasonable accommodations for individuals with disabilities. The provider entity's new hires carrying out the terms of the provider agreement shall receive this training within thirty (30) days of joining the entity's workforce.

   c. *Discrimination Complaints.* The provider shall provide any discrimination complaint received relating to TennCare's services and activities within in two (2) days of receipt to TennCare's Office of Civil Rights Compliance ("OCRC") at HCFA.Fairtment@tn.gov. The provider agrees to cooperate with OCRC and other federal and state authorities during discrimination complaint investigations and to assist individuals in obtaining information on how they can report a complaint or get assistance for a disability related need that involves TennCare's services or activities by contacting OCRC. To satisfy this obligation the provider may direct the individual to OCRC's webpage at: https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html or to call TennCare Connect at 855-259-0701 if they need assistance with filing a complaint.

   d. *Electronic and Information Technology Accessibility Requirements.* To the extent that the provider is using electronic and information technology to fulfill its

obligations under this Contract, the provider agrees to comply with the electronic and information technology accessibility requirements under the federal civil rights laws including Section 504 and Section 508 of the Rehabilitation Act of 1973 ("Section 508"), the Americans with Disabilities Act, and 45 C.F.R. pt. 92 (or any subsequent standard adopted by an oversight administrative body, including the Federal Accessibility Board). To comply with the accessibility requirements for Web content and non-Web electronic documents and software, the provider shall use the most current W3C's Web Content Accessibility Guidelines ("WCAG") level AA or higher with a goal to transition to WCAG 3 level silver (For the W3C's guidelines see: https://www.w3.org/WAI/standards-guidelines/ and Section 508 standards: https://www.access-board.gov/ict/).

e. *Ethical and Religious Directives*. For Provider Agreement that include Ethical and Religious Directives provisions, include the following requirements:

I. The Provider shall provide a list of the services it does not deliver due to the Ethical and Religious Directives to the CONTRACTOR. The CONTRACTOR shall furnish this list to TENNCARE, notating those services that are TennCare covered services. This list shall be used by the CONTRACTOR and TENNCARE to provide information to TennCare members about where and how the members can obtain the services that are not being delivered by the Provider due to Ethical and Religious Directives.

II. Should an issue arise at the time of service, the Provider shall inform TennCare members that the member's MCO has additional information on providers and procedures that are covered by TENNCARE. The Provider is not required to make specific recommendations or referrals.

f. *Cultural Competency*. The Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with Limited English Proficiency, disabilities and diverse cultural and ethnic backgrounds regardless of a member's sex. This includes the Contractor having the capabilities to ensure physical access, reasonable accommodations, and accessible equipment for the furnishing of services to members with physical or mental disabilities.

A.3. TENNCARE RESPONSIBILITIES:

a. TennCare's Cost Sharing Obligations. Federal law imposes certain cost sharing responsibilities on TennCare for its Dual Eligible members. These cost sharing obligations include costs for premiums, deductibles and co-insurance or co-payment amounts. Any of the Contractor's subcontractors or providers who attempt to file claims for co-payments or co-insurance allowed by law shall be required to become registered TennCare providers, according to the procedures developed by TennCare. These procedures may be found on the TennCare website. The Plan will notify its network providers that they shall not bill enrollees for benefits provided, unless direct billing is permitted under State and Federal law.

Additionally, the Contractor shall adhere to the following requirements regarding balance billing for enrollees under this Contract:

1. The Contractor shall educate its network providers about balance billing protections for QMB Only, including that such protections apply regardless of whether TennCare is liable to pay full Medicare cost sharing amounts. The Contractor shall instruct providers to either accept Contractor payment or bill the State for applicable cost sharing and accept the State's payment as payment in full;

b. Eligibility Data. TennCare shall make all reasonable efforts to supply Medicaid eligibility information upon the receipt of the request from the Contractor using a "realtime" access method chosen from the options described below. The Contractor shall pay for access and use of this data, according to the option chosen in Section C, Payment Terms and Conditions:

TNAnytime Online: Access to TennCare's Eligibility Information may be achieved through a user interface and socket program, and the sole charge is an annual user access fee for a premium services subscription. This method only processes a request for one (1) individual at a time.

TNAnytime Batch: Access to TennCare's Eligibility Information may be achieved through a batch interface and Secure Socket Layer or similar encryption method. The user is charged a setup fee (for transaction testing), a per transaction fee, and an annual user access fee for a premium services subscription. This method can process requests for many individuals at once. The State shall provide the response within twenty four (24) hours of the request.

The choice of method shall be binding for the term of this Contract from signing by both parties, unless TennCare agrees to allow a mid-term change. Such agreement shall not be unreasonably withheld. In the event of such a change, the Contractor shall agree to abide by all timelines, testing procedures and any other requirements mandated by TennCare to make the changeover.

Once data interface as specified in Section A.2.d.3. is tested and approved by TennCare for implementation, the Contractor shall no longer rely on TNAnytime for access to eligibility data. The data shall be submitted by TennCare and loaded by the Contractor.

c. Provider Data. TennCare will make reasonable commercial efforts to make available its list of TennCare providers to the Contractor upon Contractor's request prior to plan start-up. TennCare will also update the Provider listing on a regular basis.

d. TennCare shall review and approve or deny the Contractor's marketing materials within fifteen (15) calendar days of receipt.

e. Training. TennCare shall provide training and technical assistance to plans upon request concerning person-centered practices, including training and technical assistance specific to the requirements of Section A.2.c.14 of this Contract.

A.4. Payments Due Upon Termination. In addition to the terms as set out in Sections C, D.3 and D.4, upon termination by either party, should there be outstanding payments due to the State as allowed under this Contract, the Contractor shall satisfy any and all payments within 30 (thirty) days after the date of the termination of the Contract. If the State is not satisfied that the Contractor has fulfilled its obligations under this Contract, the State shall follow any and all recourse available to it under state or federal law for actual monetary damages or liquidated damages.

The date of termination under D.3 and D.4 may be subject to CMS requirements on Contractor's requirements to notify its beneficiaries in advance of termination. CMS requires the SNP to give sixty (60) days' advance notice to its enrollees if the SNP contract is going to be terminated.

A.5. Control Memorandum Process.

a. The Control Memorandum ("CM") process shall be utilized by the State to clarify Contract requirements, issue instruction to the Contractor, document action required of the Contractor, or request information from the Contractor. In addition, the CM process shall be used by the State to impose assessments of damages, either actual or liquidated. This process will be used to address issues or matters that do not require a contract amendment. Each CM must be in writing and indicate the date on which it was issued. CMs may provide relevant history, background, and other pertinent information regarding the issue(s) being addressed in the CM. Each CM will establish a deadline or timeframe for the Contractor's reply or other action. All CMs submitted to the Contractor must be signed and approved by the State's Project Director (or his/her designee). When the CM pertains to damages, either actual or liquidated, the State may issue consecutive CMs, as may be necessary or appropriate.

b. A CM may include one (1) or more of the five (5) components of the CM process described below:

1. On Request Report – a request directing the Contractor to provide information by the time and date set out in the CM.
2. Control Directive (CD) – instructions that require the Contractor to complete, within a designated timeframe, one (1) or more deliverables or to perform any other request from the State that is within the scope of the Contract. The CD may include a Corrective Action Plan. A CD may also provide clarification of certain Contract terms. Once a CM/CD has been issued, it shall be considered to be incorporated into this Contract.
3. Notice of Potential Damages (Actual or Liquidated) (NPD) – notification to the Contractor that the State has determined that a potential Contract performance or compliance failure exists and that the State is contemplating assessing damages. The NPD shall identify the Contract provision(s) on which the State determination rests.
4. Notice of Calculation of Potential Damages (Actual or Liquidated) (NCPD) – notification to the Contractor that provides a calculation of the amount of potential damages that the State is contemplating assessing against the Contractor. NPDs and NPCDs may be issued consecutively or simultaneously.
5. Notice of Intent to Assess Damages (Actual or Liquidated) (NIAD) – notification to the Contractor that the State is assessing damages and specifying whether the damages, due to a performance or compliance failure, are actual damages or Liquidated Damages and setting out the performance or compliance failure underlying each intended damage assessment. The NIAD shall identify the NPD and NCPD upon which it is based. The NIAD shall specify the total amount and type of damages, whether actual or liquidated, that the State intends to assess. The State may not issue a NIAD without first issuing a NPD and a NPCD. The State may not obtain both Liquidated Damages and Actual Damages for the same occurrence of a Contract performance or compliance failure.

c. Damages for failure to comply with CM. The Contractor shall fully comply with all CMs. Failure to do so may result in the State pursuing recovery of damages, as defined in Section E.13, including Liquidated Damages as listed in Contract Attachment E, a corrective action plan, and/or termination of the Contract.

d. Appeal of Damages by Contractor. Contractor may appeal either the basis for NPD or calculation of NCPD potential damages, either actual or liquidated. To do so, the Contractor shall submit to the State's Project Director (or his/her designee) a written response to the NPD and/or NCPD within ten (10) business days of receipt of a CM which includes a NPD or a NCPD. The State's Project Director (or his/her designee) shall review the appeal and provide notice of his/her determination to the Contractor through a CM. If the Contractor disagrees with the State's Project Director's (or his/her designee)

initial appeal determination or the State's Project Director (or his/her designee) is unable to resolve the appeal, the Contractor may submit a written request to the State's Project Director (or his/her designee) that the matter be escalated to senior management of the Agency. Contractor shall submit such a request for escalation within ten (10) business days of its receipt of the initial appeal determination from the State's Project Director (or his/her designee) or of notification by the State's Project Director that he/she is unable to resolve the appeal. The State's senior management shall provide written notice of its final determination to the Contractor within (10) days of the receipt of the appeal from the Contractor. Upon appeal or escalation, the State shall not increase the amount of the potential damages.

A.6. Network Connection: Access to information provided by the State will come through a secure connection method determined by the State.

B. TERM OF CONTRACT:

B.1. This Contract shall be effective on January 1, 2024 ("Effective Date"), and ending on December 31, 2024 ("Term"). The State shall have no obligation for goods or services provided by the Procuring Party prior to the Effective Date.

B.2. Renewal Options**.** This Contract may be renewed upon satisfactory completion of the Term. The State reserves the right to execute up to four (4) renewal options under the same terms and conditions for a period not to exceed twelve (12) months each by the State, at the State's sole option. In no event, however, shall the maximum Term, including all renewals or extensions, exceed a total of sixty (60) months.

C. PAYMENT TERMS AND CONDITIONS:

The Contractor shall pay the amounts specified below according to the option selected for setup fees and per transaction fees. Payment shall be made by the Contractor within thirty (30) days of receipt of an invoice from TennCare for access to eligibility data. The invoices shall be issued monthly unless the Contractor has specified a service with an annual fee. A decision as to payment methodology (i.e., check, electronic deposit, etc.) shall be made between the parties at the commencement of the Contract term. The Contractor is responsible for all invoices covering access during the term of this Contract even if they are submitted after the Contract has been terminated.

____**TennCare Online System (TCOS):** A Access to TennCare's Eligibility Information may be achieved through a user interface and socket program, and the sole charge is an annual seventy-five dollar ($75.00) user access fee for a premium services subscription.

__X__**Secure File Transfer Protocol (SFTP) Batch**: access to TennCare's Eligibility Information may be achieved through a Virtual Private Network (VPN) connection to TennCare's SFTP server. The user is charged a Two Thousand Five Hundred Dollar ($2,500.00) setup fee (for transaction testing, VPN setup and directory, security, and scripting costs) and Two Cents ($.02) per transaction. Due to the cost to the state to conduct the testing, VPN setup and directory, security, and scripting, the set-up fee is due upon receipt of executed contract. Without sufficient timely payment, no testing will begin. (**Note: Set-Up Fee is waived for any vendor already connected to server.**)

D. STANDARD TERMS AND CONDITIONS:

D.1. Required Approvals. The State is not bound by this Contract until it is signed by the contract parties and approved by appropriate officials in accordance with applicable Tennessee laws and regulations (depending upon the specifics of this contract, said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

D.2. Modification and Amendment. This Contract may be modified only by a written amendment signed by all parties hereto and approved by both the officials who approved the base contract and, depending upon the specifics of the contract as amended, any additional officials required by Tennessee laws and regulations (said officials may include, but are not limited to, the Commissioner of Finance and Administration, the Commissioner of Human Resources, and the Comptroller of the Treasury).

D.3. Termination for Convenience. The Contract may be terminated by either party by giving written notice to the other, at least thirty (30) days before the effective date of termination. Said termination shall not be deemed a breach of contract by the State. Should the State exercise this provision, the State shall have no liability to the Procuring Party. Should either the State or the Procuring Party exercise this provision, the Procuring Party shall be required to compensate the State for satisfactory, authorized services completed as of the termination date and shall have no liability to the State except for those units of service which can be effectively used by the Procuring Party. The final decision, as to what these units of service are, shall be determined by the State. In the event of disagreement, the Procuring Party may file a claim with the Tennessee Claims Commission in order to seek redress.

Upon such termination, the Procuring Party shall have no right to any actual general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

D.4. Termination for Cause. If either party fails to properly perform or fulfill its obligations under this Contract in a timely or proper manner or violates any terms of this Contract, the other party shall have the right to immediately terminate the Contract. The Procuring Party shall compensate the State for completed services.

D.5. Subcontracting. Neither the Procuring Party nor the State shall assign this Contract or enter into a subcontract for any of the services performed under this Contract without obtaining the prior written approval of the other. If such subcontracts are approved, they shall contain, at a minimum, sections of this Contract below pertaining to "Conflicts of Interest," "Nondiscrimination," and "Records " (as identified by the section headings).

D.6. Conflicts of Interest. The Procuring Party warrants that no amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Procuring Party in connection with any work contemplated or performed relative to this Contract other than as required by section A. of this Contract.

D.7. Nondiscrimination. The Contractor hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor on the grounds of handicap or disability, age, race, creed, color, religion, sex, national origin, or any other classification protected by federal or state law. The Contractor shall, upon request, show proof of nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination. In addition, the Contractor shall comply with the provisions of Contract Section E.12. Section D.7 shall not be deemed to limit or abridge any requirement set forth in Section E.12.

D.8. Records. The Procuring Party shall maintain documentation for its transactions with the State under this Contract. The books, records, and documents of the Procuring Party, insofar as they relate to work performed or money paid under this Contract, shall be maintained for a period of ten (10) full years from the final date of this Contract and shall be subject to audit, at any reasonable time and upon reasonable notice, by the state agency, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.9. Strict Performance. The Procuring Party shall maintain documentation for its transactions with the State under this Contract. The books, records, and documents of the Procuring Party, insofar as they relate to work performed or money paid under this Contract, shall be maintained for a period of ten (10) full years from the final date of this Contract and shall be subject to audit, at any reasonable time and upon reasonable notice, by the state agency, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.10. Independent Contractor. The parties hereto, in the performance of this Contract, shall not act as employees, partners, joint venturers, or associates of one another. It is expressly acknowledged by the parties hereto that such parties are independent contracting entities and that nothing in this Contract shall be construed to create an employer/employee relationship or to allow either to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purpose whatsoever.

Claims against the State of Tennessee, or its employees, or injury damages expenses or attorney's fees are heard and determined by the Tennessee Claims Commission or the Tennessee Board of Claims in the manner prescribed by law (Tennessee Code Annotated, Sections 9-8-101 et seq., 9-8-301 et seq., and 9-8-401 et seq.). Damages recoverable against the State of Tennessee shall be expressly limited to claims paid by the Board of Claims or the Claims Commission pursuant to Tennessee Code Annotated, Section 9-8-301 et seq.

D.11. State Liability. The State shall have no liability except as specifically provided in this Contract.

D.12. Force Majeure. The obligations of the parties to this Contract are subject to prevention by causes beyond the parties' control that could not be avoided by the exercise of due care including, but not limited to, natural disasters, riots, wars, epidemics, or any other similar cause.

D.13. State and Federal Compliance. The Procuring Party and the State shall comply with all applicable State and Federal laws and regulations in the performance of this Contract.

D.14. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Procuring Party agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Contract. The Procuring Party acknowledges and agrees that any rights or claims against the State of Tennessee or its employees hereunder, and any remedies arising therefrom, shall be subject to and limited to those rights and remedies, if any, available under Tennessee Code Annotated, Sections 9-8-101 through 9-8-

407.

D.15. Completeness. This Contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.

D.16. Severability. If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this Contract are declared severable.

D.17. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

D.18. HIPAA Compliance. The State and Procuring Party shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Health Information Technology for Economic and Clinical Health (HITECH) Act and any other relevant laws and regulations regarding privacy (collectively the "Privacy Rules").

a. Procuring Party warrants to the State that it is familiar with the requirements of the Privacy Rules and will comply with all applicable requirements in the course of this Contract.

b. Procuring Party warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by the Privacy Rules, in the course of performance of the Contract so that both parties will be in compliance with the Privacy Rules.

c. The State and the Procuring Party will sign documents, including but not limited to business associate agreements, as required by the Privacy Rules and that are reasonably necessary to keep the State and Procuring Party in compliance with the Privacy Rules. This provision shall not apply if information received or delivered by the parties under this Contract is NOT "protected health information" as defined by the Privacy Rules, or if the Privacy Rules permit the parties to receive or deliver such information without entering into a business associate agreement or signing another such document.

d. The Procuring Party will indemnify the State and hold it harmless for any violation by the Procuring Party or its subcontractors of the Privacy Rules. This includes the costs of responding to a breach of protected health information, the costs of responding to a government enforcement action related to the breach, and any fines, penalties, or damages paid by the State because of the violation.

D.19. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Procuring Party by the State or acquired by the Procuring Party on behalf of the State shall be regarded as confidential information in accordance with the provisions of applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the Procuring Party to safeguard the confidentiality

of such material or information in conformance with applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards.

The Procuring Party's obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the Procuring Party of this Contract; previously possessed by the Procuring Party without written obligations to the State to protect it; acquired by the Procuring Party without written restrictions against disclosure from a third party which, to the Procuring Party's knowledge, is free to disclose the information; independently developed by the Procuring Party without the use of the State's information; or, disclosed by the State to others without restrictions against disclosure. Nothing in this paragraph shall permit Procuring Party to disclose any information that is confidential under federal or state law or regulations, regardless of whether it has been disclosed or made available to the Procuring Party due to intentional or negligent actions or inactions of agents of the State or third parties.

It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Contract.

E. SPECIAL TERMS AND CONDITIONS:

E.1. Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Contract, these special terms and conditions shall control.

E.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract shall be in writing and shall be made by certified, first class mail, return receipt requested and postage prepaid, by overnight courier service with an asset tracking system, or by EMAIL or facsimile transmission with recipient confirmation. Any such communications, regardless of method of transmission, shall be addressed to the respective party at the appropriate mailing address, facsimile number, or EMAIL address as set forth below or to that of such other party or address, as may be hereafter specified by written notice.

The State:

Deputy Commissioner
Department of Finance and Administration
Division of TennCare
310 Great Circle Road
Nashville TN 37243
Telephone # (615) 507-6444
FAX # (615) 253-5607

The Procuring Party:

George Renaudin, President, Medicare & Medicaid
320 Seven Springs Way
Brentwood, TN 37027
grenaudin@humana.com
Telephone # 800-580-1000

All instructions, notices, consents, demands, or other communications shall be considered effectively given upon receipt or recipient confirmation as may be required.

E.3 Tennessee Department of Revenue Registration. The Procuring Party shall be registered with the Department of Revenue for the collection of Tennessee sales and use tax. This registration requirement is a material requirement of this Contract.

E.4. Debarment and Suspension. The Procuring Party certifies, to the best of its knowledge and belief, that it, its current and future principals, its current and future subcontractors and their principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or agency;

b. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

c. are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in section b. of this certification; and

d. have not within a three (3) year period preceding this Contract had one or more public transactions (federal, state, or local) terminated for cause or default.

The Procuring Party shall provide immediate written notice to the State if at any time it learns that there was an earlier failure to disclose information or that due to changed circumstances, its principals or the principals of its subcontractors are excluded, disqualified, or presently fall under any of the prohibitions of sections a-d.

E.5. Personally Identifiable Information. While performing its obligations under this Contract, Contractor may have access to Personally Identifiable Information held by the State ("PII"). For the purposes of this Contract, "PII" includes "Nonpublic Personal Information" as that term is defined in Title V of the Gramm-Leach-Bliley Act of 1999 or any successor federal statute, and the rules and regulations thereunder, all as may be amended or supplemented from time to time ("GLBA") and personally identifiable information and other data protected under any other applicable laws, rule or regulation of any jurisdiction relating to disclosure or use of personal information ("Privacy Laws"). Contractor agrees it shall not do or omit to do anything which would cause the State to be in breach of any Privacy Laws. Contractor shall, and shall cause its employees, agents and representatives to: (i) keep PII confidential and may use and disclose PII only as necessary to carry out those specific aspects of the purpose for which the PII was disclosed to Contractor and in accordance with this Contract, GLBA and Privacy Laws; and (ii) implement and maintain appropriate technical and organizational measures regarding information security to: (A) ensure the security and confidentiality of PII; (B) protect against any threats or hazards to the security or integrity of PII; and (C) prevent unauthorized access to or use of PII. Contractor shall immediately notify State: (1) of any disclosure or use of any PII by Contractor or any of its employees, agents and representatives in breach of this Contract; and (2) of any disclosure of any PII to Contractor or its employees, agents and representatives where the purpose of such disclosure is not known to Contractor or its employees, agents and representatives. The State reserves the right to review Contractor's policies and procedures used to maintain the security and confidentiality of PII and Contractor shall, and cause its employees, agents and representatives to, comply with all reasonable requests or directions from the State to enable the State to verify or ensure that Contractor is in full compliance with its obligations under this Contract in relation to PII. Upon termination or expiration of the Contract or at the State's direction at any time in its sole discretion, whichever is earlier, Contractor shall immediately return to the State any and all PII which it has received under this Contract and shall destroy all records of such PII.

The Contractor shall report to the State any instances of unauthorized access to or potential disclosure of PII in the custody or control of Contractor ("Unauthorized Disclosure") that come to the Contractor's attention. Any such report shall be made by the Contractor within forty-eight (48) hours after the Unauthorized Disclosure has come to the attention of the Contractor. Contractor shall take all necessary measures to halt any further Unauthorized Disclosures. The Contractor, at the sole discretion of the State, shall provide no cost credit monitoring services for individuals whose PII was affected by the Unauthorized Disclosure. The Contractor shall bear the cost of notification to all individuals affected by the Unauthorized Disclosure, including individual letters and public notice. The remedies set forth in this Section are not exclusive and are in addition to any claims or remedies available to this State under this Contract or otherwise available at law. The obligations set forth in this Section shall survive the termination of this Contract.

E.6. Business Associate. As the Contractor will provide services to TennCare pursuant to which the Contractor will have access to, receive from, create, or receive on behalf of TennCare Protected Health Information, or Contractor will have access to, create, receive, maintain or transmit on behalf of TennCare Electronic Protected Health Information (as those terms are defined under HIPAA and HITECH), Contractor hereby acknowledges its designation as a business associate under HIPAA and agrees to comply with all applicable HIPAA regulations and the terms in the associated Business Associate Agreement.

E.7. Notification of Breach and Notification of Suspected Breach. The Contractor shall notify TennCare's Privacy Office immediately upon becoming aware of and in no case later than forty-eight (48) hours after discovery of any incident, either confirmed or suspected, that represents or may represent unauthorized access, use or disclosure of encrypted or unencrypted computerized data that materially compromises the security, confidentiality, or integrity of enrollee PHI maintained or held by the Contractor, including any unauthorized acquisition of enrollee PHI by an employee or otherwise authorized user of the Contractor 's system. This includes, but is not limited to, loss or suspected loss of remote computing or telework devices such as laptops, Personal Digital Assistants (PDAs), Blackberrys or other Smartphones, Universal Serial Bus (USB) drives, thumb drives, flash drives, Compact Discs (CDs), and/or hard disks.

E.8. Social Security Administration (SSA) Required Provisions for Data Security.

a. Definitions.

1. SSA-supplied data" or "data" as used in this section means an individual's personally identifiable information (e.g., name, social security number, income), supplied by the Social Security Administration to TennCare to determine entitlement or eligibility for federally funded programs pursuant to a Computer Matching and Privacy Protection Act Agreement and Information Exchange Agreement between SSA and the State of Tennessee.

b. The Contractor shall comply with limitations on use, treatment, and safeguarding of data under the Privacy Act of 1974 (5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget guidelines, the Federal Information Security Management Act of 2002 (44 U.S.C. §3541, *et seq.*), and related National Institute of Standards and Technology guidelines, which provide the requirements that the SSA stipulates that the Contractor must follow with regard to use, treatment, and safeguarding data in the event data is exchanged with a federal information system. In addition, the Contractor shall have in place administrative, physical, and technical safeguards for data. The Contractor shall also comply with Section 1106(a) of the Act (42 U.S.C. 1306) and the regulations promulgated pursuant to that section (20 C.F.R. Part 401).

c. The Contractor shall specify in its agreements with any agent or subcontractor that will have access to data that such agent or subcontractor agrees to be bound by the same restrictions,

terms and conditions that apply to the Contractor pursuant to this Section;

d. The Contractor shall not duplicate in a separate file or disseminate, without prior written permission from TennCare, the data governed by the Contract for any purpose other than that set forth in this Contract for the administration of the TennCare program. Should the Contractor propose a redisclosure of said data, the Contractor must specify in writing to TennCare the data the Contractor proposes to redisclose, to whom, and the reasons that justify the redisclosure. TennCare will not give permission for such redisclosure unless the redisclosure is required by law or essential to the administration of the TennCare program.

e. The Contractor agrees to abide by all relevant federal laws, restrictions on access, use, and disclosure, and security requirements in this Contract.

f. The Contractor shall maintain a current list of the employees of such contractor with access to SSA data and provide such lists to TennCare upon request and at any time there are changes.

g. The Contractor shall restrict access to the data obtained from TennCare to only those authorized employees who need such data to perform their official duties in connection with purposes identified in this Contract. The Contractor shall not further duplicate, disseminate, or disclose such data without obtaining TennCare's prior written approval.

h. The Contractor shall ensure that its employees:

1. Properly safeguard SSA-supplied data furnished by TennCare under this Contract from loss, theft, or inadvertent disclosure;
2. Receive regular, relevant, and sufficient SSA data-related training, including use, access, and disclosure safeguards and information regarding penalties for misuse of information;
3. Understand and acknowledge that they are responsible for safeguarding this information at all times, regardless of whether or not the Contractor employee is at his or her regular duty station;
4. Ensure that laptops and other electronic devices/ media containing SSA-supplied data are encrypted and/or password-protected;
5. Send emails containing SSA-supplied data only if the information is encrypted or if the transmittal is secure; and,
6. Limit disclosure of the information and details relating to a SSA-supplied data loss only to those with a need to know.

i. Contractor employees who access, use, or disclose TennCare or TennCare SSA-supplied data in a manner or purpose not authorized by this Contract may be subject to civil and criminal sanctions pursuant to applicable federal statutes.

j. Loss or Suspected Loss of Data - If an employee of the Contractor becomes aware of suspected or actual loss of SSA-supplied data, the Contractor must notify TennCare immediately upon becoming aware to report the actual or suspected loss. The Contractor must provide TennCare with timely updates as any additional information about the loss of SSA-supplied data becomes available. If the Contractor experiences a loss or breach of said data, TennCare will determine whether or not notice to individuals whose data has been lost or breached shall be provided and the Contractor shall bear any costs associated with the notice or any mitigation.

k. TennCare may immediately and unilaterally suspend the data flow under this Contract, or terminate this Contract, if TennCare, in its sole discretion, determines that the Contractor has: (1) made an unauthorized use or disclosure of TennCare SSA-supplied data; or (2) otherwise violated or failed to follow the terms and conditions of this Contract.

E.9. Employees Excluded from Medicare, Medicaid, or CHIP. The Contractor does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly employ, in the performance of

this Contract, employees who have been excluded from participation in the Medicare, Medicaid, and/or CHIP programs pursuant to the Social Security Act, Section 1128 (Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs).

E.10. Offer of Gratuities. By signing this Contract, the Contractor signifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the federal General Accounting Office, federal Department of Health and Human Services, the Center for Medicare and Medicaid Services, or any other state or federal agency has or will benefit financially or materially from this Contract. This Contract may be immediately terminated by TennCare if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, its agent, or employees.

E.11. Discovery and Litigation. TennCare is frequently involved in litigation as either a party or a non-party with relevant information. If any such litigation should arise, the Contractor shall cooperate fully and timely with any State attorneys or paralegals, which shall include the following responsibilities:

a. **Litigation Support**. The Contractor shall make its personnel available to testify in Tennessee, whether in person before a tribunal or by deposition. The Contractor agrees to waive any objections to any subpoena issued by a Tennessee tribunal, in any case relating to this Contract.

b. **Discovery and Litigation Hold Requirements**. The Contractor shall cooperate with all TennCare requests to aid in data and document retention and collection, as required for litigation. The Contractor shall promptly provide the State with all information within the Contractor's control if required to do so by a discovery demand or court order. The State will exert its best effort to narrow the scope of any discovery request.

The obligation to meet the requirements listed above shall survive the termination of the Contract and shall extend to any subcontractor hired by the Contractor to provide goods or perform services on its behalf as required herein.

E.12. Nondiscrimination Compliance Requirements.

No person on the grounds of disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state civil rights laws shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor. The Contractor agrees to cooperate with the Division of TennCare's Office of Civil Rights ("OCRC") in carrying out its federal and state nondiscrimination compliance obligations, which include and are not limited to: the Title VI of the Civil Rights Act of 1964, Section 504 and 508 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and 42 U.S.C. § 18116 (codified at 45 C.F.R. pt. 92) and Section D.7 of this Contract. The Contractor shall provide OCRC with the name and contact information for a staff member who will work with OCRC to fulfill the nondiscrimination compliance activities related to the terms of this Contract.

a. *Policies and Procedures and Training.* The Contractor shall be interacting with individuals from diverse cultural backgrounds including, individuals with Limited English Proficiency ("LEP"), individuals with low literacy, individuals with disabilities, including individuals with vision, cognitive, hearing, and speech disabilities, therefore, the Contractor shall have policies and procedures for providing services in a nondiscriminatory and cultural competent manner, providing free language and communication assistance services to individuals, providing individuals with reasonable accommodations, and discrimination complaint procedures. The Contractor's staff members carrying out the terms of this Contract shall receive annual training on the entity's: policies on how to provide services in a nondiscriminatory and culturally competent manner, complaint procedures, process to obtain free language assistance

services for LEP individuals, process for providing free effective communication services (auxiliary aids or services) to individuals with disabilities, and process for providing reasonable accommodations for individuals with disabilities. The Contractor's new hires carrying out the terms of this Contract shall receive this training within thirty (30) days of joining the Contractor's workforce.

b. *Ethical and Religious Directives.* Should the Contractor not provide certain services covered under this Contract due to their sincerely held ethical/moral beliefs and/or religious directives the Contractor shall comply with the following requirements:

i. The Contractor shall provide a list of the services it does not deliver due to the Ethical/Moral and Religious Directives to TennCare. This list shall be used by TennCare to provide information to TennCare members about where and how the members can obtain the services that are not being delivered by the Contractor due to their sincerely held ethical/moral beliefs and/or religious directives.
ii. Should an issue arise at the time of a service interaction, the Contractor shall inform TennCare members that the member's managed care organization can assist them with that issue. The Contractor is not required to make specific treatment recommendations or referrals.

c. *Electronic and Information Technology Accessibility Requirements.* To the extent that the Contractor is using electronic and information communication technology to fulfill its obligations under this Contract, the Contractor agrees to comply with the electronic and information technology accessibility requirements under the federal civil rights laws including Section 504 and Section 508 of the Rehabilitation Act of 1973 ("Section 508"), the Americans with Disabilities Act, and 45 C.F.R. pt. 92 (or any subsequent standard adopted by an oversight administrative body, including the Federal Accessibility Board). To comply with the accessibility requirements for Web content and non-Web electronic documents and software, the Contractor shall use the most current W3C's Web Content Accessibility Guidelines ("WCAG") level AA or higher with a goal to transition to WCAG 3 level silver (For the W3C's guidelines see: https://www.w3.org/WAI/standards-guidelines/ and Section 508 standards: https://www.access-board.gov/ict/). Additionally, the Contractor agrees to comply with Title VI of the Civil Rights Act of 1964, by adding a system function that allows users to translate the content into a language other than English. This requirement may be satisfied by the provision of a link to a machine translate tool or translating the page into non-English languages as directed by TennCare.

The Contractor shall comply with the civil rights requirements set forth in 42 C.F.R. § 433.112 regarding the design, development, installation or enhancement of mechanized processing and information retrieval systems. In addition, the Contractor shall participate in the State's effort to comply with the nondiscrimination requirements for acquiring automatic data and processing equipment and services set forth in 45 C.F.R. § 95.633.

d. *Cultural Competency*. The Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with Limited English Proficiency, disabilities and diverse cultural and ethnic backgrounds regardless of a member's sex. This includes the Contractor having the capabilities to ensure physical access, reasonable accommodations, and accessible equipment for the furnishing of services to members with physical or mental disabilities.

In accordance with the requirements set forth in 42 U.S.C. § 300kk, to the extent practicable, the Contractor shall develop and maintain the ability to collect and report data on race, ethnicity, sex, primary language, and disability status for applicants and members and from applicants' and members' parents or legal guardians if applicants or members are minors or legally incapacitated individuals. In collecting this data, the

Contractor shall use the Office of Management and Budget (OMB) data collection standards for race, ethnicity, sex, primary language, and disability measures.

Pursuant to 42 C.F.R. § 438.340, the Contractor shall collaborate with TennCare and other entities designated by TennCare to develop and implement projects to promote equity and to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, disability, and other statuses protected under federal and state civil rights laws.

e. *Discrimination Complaints and Assistance.* The Contractor shall provide any discrimination complaint received relating to this Contract's services and activities within in two (2) days of receipt to OCRC at HCFA.Fairtment@tn.gov. The Contractor agrees to cooperate with OCRC and other federal and state authorities during discrimination complaint investigations and to assist individuals in obtaining information on how they can report a complaint or get assistance for a disability related need that involves TennCare's services or activities by contacting OCRC. To satisfy this obligation the Contractor may direct the individual to OCRC's webpage at: https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html or to call TennCare Connect at 855-259-0701 if they need assistance with filing a complaint.

f. *Readiness Review***.** Prior to the contract start date, the Contractor's designated staff member shall participate in a nondiscrimination/civil rights readiness review phase. This process is to assist the Contractor with implementing the Contract's nondiscrimination requirements.

g. *Nondiscrimination Compliance Reports.* The Contractor shall submit the following nondiscrimination compliance deliverables to OCRC using TennCare's Office of Compliance Management Oversight Processing System ("TOPS") as follows:

i. Annual Compliance Questionnaire. On an annual basis, using TOPS, OCRC shall provide the Contractor with a Nondiscrimination Compliance Questionnaire. The Contractor shall answer the applicable questions and submit the completed questionnaire to OCRC within sixty (60) days of receipt of the questionnaire with any requested documentation, which shall include, the Contractor's: Assurance of Nondiscrimination, nondiscrimination policies, data capturing the amount of language and communication assistance services provided to individuals, and a civil rights and cultural compliance training report.

ii. Quarterly Compliance Reports. The Contractor shall submit a quarterly Non-discrimination Compliance Report which shall include the following:

a. A civil rights and cultural compliance training report;
b. The NCC shall provide a listing of all discrimination claims that are reported to the Contractor that are claimed to be related to the provision of and/or access to the services provided under the scope of this Contract.
c. The language and communication assistance report shall capture a summary listing of language and communication assistance services that were requested by members and/or participants (i.e. Arabic; large print; Sign Language) and the methods used to provide those services.

h. *Nondiscrimination Notice and Taglines.* Should the Contractor create materials (flyers, emails, text messages), the Contractor shall ensure that communications critical to obtaining services and vital documents that are targeted to participants, enrollees, applicants, and members of the public shall be printed with the notice of nondiscrimination and taglines required by TennCare. Written materials specific to TennCare program members shall be approved by TennCare prior to the materials being sent to these individuals and at a minimum vital documents shall be translated and available in Spanish and Arabic.

i. *Enrollee/Member Enrollment, Disenrollment, Re-enrollment.*

i. The Contractor shall accept enrollees in the order in which applications are approved and enrollees are assigned to the Contractor (whether by selection or assignment). The Contractor shall not use any policy or practice that has the effect of discriminating against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability.

ii. The Contractor shall accept an enrollee in the health condition the enrollee is in at the time of enrollment and shall not discriminate against individuals on the basis of health status, the need for health care services, or on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability.

j. *Provider Participation, Reimbursement, or Indemnification.*

i. The Contractor shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. The Contractor's ability to credential providers as well as maintain a separate network and not include any willing provider is not considered. The Contractor's written policies and procedures for the selection and retention of providers shall not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment.

ii. The Contractor shall not discriminate against providers and entities in accordance with the federal prohibition against discrimination as provided for under the collective "federal health care provider conscience protection statutes," referenced individually as the Church Amendments, 42 U.S.C. § 300a–7, section 245 of the Public Health Service Act, 42 U.S.C. § 238n, and the Weldon Amendment, Consolidated Appropriations Act, 2010, Public Law 111–117, Div. D, Sec. 508(d), 123 Stat. 3034, 3279–80. In addition, as a participant in a program receiving federal funds, Providers shall not be subjected to discrimination because of their race, color, national origin, disability, age, sex, conscience and religious freedom, or other statuses protected by federal and/or state law.

E.13. Liquidated Damages. In the event of a Contract performance or compliance failure by the Contractor, the State may, but is not obligated to address such Contract performance or compliance failure and/or assess damages ("Liquidated Damages") in accordance with Attachment E of the Contract. The State shall notify the Contractor of any amounts to be assessed as Liquidated Damages via the Control Memorandum process specified in Contract Section A.5. The Parties agree that due to the complicated nature of the Contractor's obligations under this Contract it would be difficult to specifically designate a monetary amount for a Contractor performance or compliance failure, as these amounts are likely to be uncertain and not easily proven. Contractor has carefully reviewed the Liquidated Damages contained in Contract Attachment E and agrees that these amounts represent a reasonable relationship between the amount and what might reasonably be expected in the event of a Contract performance or compliance failure, are a reasonable estimate of the damages that would occur from a Contract performance or compliance failure and are not punitive. The Parties agree that although the Liquidated Damages represent the reasonable estimate of the damages and injuries sustained by the State due to the Contract performance or compliance failure, they do not include any injury or damage sustained by a third party. The Contractor agrees that the Liquidated Damages are in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or any other sections of this Contract.

The State is not obligated to assess Liquidated Damages as a result of a Contract performance or compliance failure before availing itself of any other remedy. In the event of multiple Contract performance or compliance failures, the Parties recognize

that the cumulative effect of these Contract performance failures may exceed the compensation provided by Liquidated Damages. The State may choose to avail itself of any other remedy available under this Contract or at law or equity. The Parties further recognize that the State may not obtain both Liquidated Damages and Actual Damages for the same occurrence of a Contract performance or compliance failure.

Without regard to whether the State has imposed Liquidated Damages or pursued any other remedy due to any action or inaction by the Contractor, the State may impose a corrective action plan or similar measure through a Control Memorandum. Such measure is neither punitive nor related to any damages the State might suffer.

E.14. Contractor Hosted Services Confidential Data, Audit, and Other Requirements

a. "Confidential State Data" is defined as data deemed confidential by State or Federal statute or regulation. The Contractor shall protect Confidential State Data as follows:

(1) The Contractor shall ensure that all Confidential State Data is housed in the continental United States, inclusive of backup data.

(2) The Contractor shall encrypt Confidential State Data at rest and in transit using the current version of Federal Information Processing Standard ("FIPS") 140-2 or 140-3 (current applicable version) validated encryption technologies. The State shall control all access to encryption keys. The Contractor shall provide installation and maintenance support at no cost to the State.

(3) The Contractor and the Contractor's processing environment containing Confidential State Data shall either (1) be in accordance with at least one of the following security standards: (i) International Standards Organization ("ISO") 27001; (ii) Federal Risk and Authorization Management Program ("FedRAMP"); or (2) be subject to an annual engagement by a CPA firm in accordance with the standards of the American Institute of Certified Public Accountants ("AICPA") for a System and Organization Controls for service organizations ("SOC") Type II audit. The State shall approve the SOC audit control objectives. The Contractor shall provide proof of current ISO certification or FedRAMP authorization for the Contractor and Subcontractor(s), or provide the State with the Contractor's and Subcontractor's annual SOC Type II audit report within 30 days from when the CPA firm provides the audit report to the Contractor or Subcontractor. The Contractor shall submit corrective action plans to the State for any issues included in the audit report within 30 days after the CPA firm provides the audit report to the Contractor or Subcontractor.

If the scope of the most recent SOC audit report does not include all of the current State fiscal year, upon request from the State, the Contractor must provide to the State a letter from the Contractor or Subcontractor stating whether the Contractor or Subcontractor made any material changes to their control environment since the prior audit and, if so, whether the changes, in the opinion of the Contractor or Subcontractor, would negatively affect the auditor's opinion in the most recent audit report.

No additional funding shall be allocated for these certifications, authorizations, or audits as these are included in the Maximum Liability of this Contract.

(4) The Contractor must annually perform Penetration Tests and Vulnerability Assessments against its Processing Environment. "Processing Environment" shall mean the combination of software and hardware on which the Application runs. "Application" shall mean the computer code that supports and accomplishes the State's requirements as set forth in this Contract. "Penetration

Tests" shall be in the form of attacks on the Contractor's computer system, with the purpose of discovering security weaknesses which have the potential to gain access to the Processing Environment's features and data. The "Vulnerability Assessment" shall be designed and executed to define, identify, and classify the security holes (vulnerabilities) in the Processing Environment. The Contractor shall allow the State, at its option, to perform Penetration Tests and Vulnerability Assessments on the Processing Environment.

(5) Upon State request, the Contractor shall provide a copy of all Confidential State Data it holds. The Contractor shall provide such data on media and in a format determined by the State

(6) Upon termination of this Contract and in consultation with the State, the Contractor shall destroy all Confidential State Data it holds (including any copies such as backups) in accordance with the current version of National Institute of Standards and Technology ("NIST") Special Publication 800-88. The Contractor shall provide a written confirmation of destruction to the State within ten (10) business days after destruction.

b. Minimum Requirements

(1) The Contractor and all data centers used by the Contractor to host State data, including those of all Subcontractors, must comply with the State's Enterprise Information Security Policies as amended periodically. The State's Enterprise Information Security Policies document is found at the following URL: https://www.tn.gov/finance/strategic-technology-solutions/strategic-technology-solutions/sts-security-policies.html.

(2) The Contractor agrees to maintain the Application so that it will run on a current, manufacturer-supported Operating System. "Operating System" shall mean the software that supports a computer's basic functions, such as scheduling tasks, executing applications, and controlling peripherals.

(3) If the Application requires middleware or database software, Contractor shall maintain middleware and database software versions that are at all times fully compatible with current versions of the Operating System and Application to ensure that security vulnerabilities are not introduced.

c. Comptroller Audit Requirements

Upon reasonable notice and at any reasonable time, the Contractor and Subcontractor(s) agree to allow the State, the Comptroller of the Treasury, or their duly appointed representatives to perform information technology control audits of the Contractor and all Subcontractors used by the Contractor. Contractor will maintain and cause its Subcontractors to maintain a complete audit trail of all transactions and activities in connection with this Contract. Contractor will provide to the State, the Comptroller of the Treasury, or their duly appointed representatives access to Contractor and Subcontractor(s) personnel for the purpose of performing the information technology control audit.

The information technology control audit may include a review of general controls and application controls. General controls are the policies and procedures that apply to all or a large segment of the Contractor's or Subcontractor's information systems and applications and include controls over security management, access controls, configuration management, segregation of duties, and contingency planning. Application controls are directly related to the application and help ensure that transactions are complete, accurate, valid,

confidential, and available. The audit shall include the Contractor's and Subcontractor's compliance with the State's Enterprise Information Security Policies and all applicable requirements, laws, regulations or policies.

The audit may include interviews with technical and management personnel, physical inspection of controls, and review of paper or electronic documentation.

For any audit issues identified, the Contractor and Subcontractor(s) shall provide a corrective action plan to the State within 30 days from the Contractor or Subcontractor receiving the audit report.

Each party shall bear its own expenses incurred while conducting the information technology controls audit.

d. Business Continuity Requirements. The Contractor shall maintain set(s) of documents, instructions, and procedures which enable the Contractor to respond to accidents, disasters, emergencies, or threats without any stoppage or hindrance in its key operations ("Business Continuity Requirements"). Business Continuity Requirements shall include:

(1) "Disaster Recovery Capabilities" refer to the actions the Contractor takes to meet the Recovery Point and Recovery Time Objectives defined below. Disaster Recovery Capabilities shall meet the following objectives:

i. Recovery Point Objective ("RPO"). The RPO is defined as the maximum targeted period in which data might be lost from an IT service due to a major incident: 24 Hours

ii. Recovery Time Objective ("RTO"). The RTO is defined as the targeted duration of time and a service level within which a business process must be restored after a disaster (or disruption) in order to avoid unacceptable consequences associated with a break in business continuity: 24 Hours

(2) The Contractor and the Subcontractor(s) shall perform at least one Disaster Recovery Test every three hundred sixty-five (365) days. A "Disaster Recovery Test" shall mean the process of verifying the success of the restoration procedures that are executed after a critical IT failure or disruption occurs. The Disaster Recovery Test shall use actual State Data Sets that mirror production data, and success shall be defined as the Contractor verifying that the Contractor can meet the State's RPO and RTO requirements. A "Data Set" is defined as a collection of related sets of information that is composed of separate elements but can be manipulated as a unit by a computer. The Contractor shall provide written confirmation to the State after each Disaster Recovery Test that its Disaster Recovery Capabilities meet the RPO and RTO requirements.

IN WITNESS WHEREOF,

CARITEN HEALTH PLAN, INC.:

6/23/2023

PROCURING PARTY SIGNATURE **DATE**

George Renaudin, President, Medicare and Medicaid

PRINTED NAME AND TITLE OF PROCURING PARTY SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF TENNCARE:

6/30/2023

JIM BRYSON, COMMISSIONER **DATE**

ATTACHMENT A

SUMMARY OF BENEFITS

2023

Summary of Benefits

Humana Gold Plus SNP-DE H4461-022 (HMO D-SNP)

Greater Tennessee

Our service area includes the following county/counties in Tennessee: Anderson, Bedford, Benton, Bledsoe, Blount, Bradley, Campbell, Cannon, Carroll, Carter, Cheatham, Chester, Claiborne, Clay, Cocke, Coffee, Crockett, Cumberland, Davidson, Decatur, DeKalb, Dickson, Dyer, Fayette, Fentress, Franklin, Gibson, Giles, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hardeman, Hardin, Hawkins, Haywood, Henderson, Henry, Hickman, Houston, Humphreys, Jackson, Jefferson, Johnson, Knox, Lake, Lauderdale, Lawrence, Lewis, Lincoln, Loudon, Macon, Madison, Marion, Marshall, Maury, McMinn, McNairy, Meigs, Monroe, Montgomery, Moore, Morgan, Obion, Overton, Perry, Pickett, Polk, Putnam, Rhea, Roane, Robertson, Rutherford, Scott, Sequatchie, Sevier, Shelby, Smith, Stewart, Sullivan, Sumner, Tipton, Trousdale, Unicoi, Union, Van Buren, Warren, Washington, Wayne, Weakley, White, Williamson, Wilson.

Humana.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-833-2364 (TTY: 711)**.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **Humana.com/medicare** or call **1-800-833-2364 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. This plan may enroll FBDE, QMB+, SLMB+.

2023

Summary of Benefits

Humana Gold Plus SNP-DE H4461-022 (HMO D-SNP)

Greater Tennessee

Our service area includes the following county/counties in Tennessee: Anderson, Bedford, Benton, Bledsoe, Blount, Bradley, Campbell, Cannon, Carroll, Carter, Cheatham, Chester, Claiborne, Clay, Cocke, Coffee, Crockett, Cumberland, Davidson, Decatur, DeKalb, Dickson, Dyer, Fayette, Fentress, Franklin, Gibson, Giles, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hardeman, Hardin, Hawkins, Haywood, Henderson, Henry, Hickman, Houston, Humphreys, Jackson, Jefferson, Johnson, Knox, Lake, Lauderdale, Lawrence, Lewis, Lincoln, Loudon, Macon, Madison, Marion, Marshall, Maury, McMinn, McNairy, Meigs, Monroe, Montgomery, Moore, Morgan, Obion, Overton, Perry, Pickett, Polk, Putnam, Rhea, Roane, Robertson, Rutherford, Scott, Sequatchie, Sevier, Shelby, Smith, Stewart, Sullivan, Sumner, Tipton, Trousdale, Unicoi, Union, Van Buren, Warren, Washington, Wayne, Weakley, White, Williamson, Wilson.

Humana.

Let's talk about Humana Gold Plus SNP-DE H4461-022 (HMO D-SNP)

Find out more about the Humana Gold Plus SNP-DE H4461-022 (HMO D-SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus SNP-DE H4461-022 (HMO D-SNP) is a Coordinated Care plan HMO with a Medicare contract and a contract with the TennCare (Medicaid) program. Enrollment in this Humana plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, ask us for the "Evidence of Coverage".

As a member you must select an in-network doctor to act as your Primary Care Provider (PCP). Humana Gold Plus SNP-DE H4461-022 (HMO D-SNP) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services. You have access to Care Managers. Care Managers are nurses or care coordinators who support your health and well-being by providing additional services including: acute and chronic-care management, telephonic and in-person health support, assistance in coordinating Medicare and Medicaid benefits, educational resources and workshops, and support for families and caregivers.

To be eligible

To enroll in Humana Gold Plus SNP-DE H4461-022 (HMO D-SNP), a Dual Eligible Special Needs Plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B, live in our service area and also receive certain levels of assistance from the TennCare (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are dual eligible.

Humana Gold Plus SNP-DE H4461-022 (HMO D-SNP) may enroll FBDE, QMB+, SLMB+.

Qualified Medicare Beneficiary Plus (QMB+): Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

Specified Low-Income Medicare Beneficiary Plus (SLMB+): Helps pay Part B premiums and provides full Medicaid benefits for Medicaid services provided by Medicaid providers.

Full Benefit Dual Eligible (FBDE): Financial assistance may be available to pay Medicare Part A Premiums, and/or Medicare Part B Premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) and provides full Medicaid benefits.

Plan name:

Humana Gold Plus SNP-DE H4461-022 (HMO D-SNP)

More about Humana Gold Plus SNP-DE H4461-022 (HMO D-SNP)

As a member of this plan, you will not be responsible for cost sharing for plan benefits. The Medicaid Comparison Chart shows specific benefits that Medicaid may cover for some dual eligible members. You will work with your Humana care coordinator to understand and access these benefits from the TennCare (Medicaid) after any Humana Gold Plus SNP-DE H4461-022 (HMO D-SNP) benefits are used. The Covered Medical and Hospital Benefits chart shows the benefits you will receive from Humana.

Be sure to show the TennCare (Medicaid) ID card in addition to your Humana membership card to make your provider aware that you also have Medicaid coverage. You may be required to pay a small Medicaid specific co-payment. Your services are paid first by Humana and then by Medicaid.

How to reach us:

If you have questions about your benefits or your level of eligibility for assistance from Medicaid, you should contact Humana's Customer Care department or the TennCare (Medicaid) for further details.

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (TTY: 711)**.

October 1 - March 31:
Call 7 days a week from 8 a.m. - 8 p.m.

April 1 - September 30:
Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website: **Humana.com/medicare**.

Medicaid benefits last validated on 07/01/2022 and are subject to change.

For the most current Tennessee Medicaid coverage information, please visit the TennCare (Medicaid) website at **https://www.tn.gov/tenncare/** or call the Medicaid Hotline at 1-800-342-3145 (TTY: 711).

A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!

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Monthly Premium, Deductible and Limits

Monthly plan premium	**$0** You must keep paying your Medicare Part B premium. Your Part A and/or Part B premium may be paid on your behalf by the TennCare (Medicaid) Program.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$0** if you qualify for "Extra Help"
Maximum out-of-pocket responsibility	This plan does not have a maximum out-of-pocket responsibility.

Covered Medical and Hospital Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN
ACUTE INPATIENT HOSPITAL CARE	
	$0 copay
OUTPATIENT HOSPITAL COVERAGE	
Outpatient surgery at outpatient hospital	**$0** copay
Outpatient surgery at ambulatory surgical center	**$0** copay
DOCTOR OFFICE VISITS	
Primary care provider (PCP)	**$0** copay
Specialists	**$0** copay
PREVENTIVE CARE	
	Our plan covers many preventive services at no cost when you see an in-network provider including: • Abdominal aortic aneurysm Screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
	• Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including flu shots, hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Annual Wellness Visit • Lung cancer screening • Routine physical exam • Medicare diabetes prevention program Any additional preventive services approved by Medicare during the contract year will be covered.
EMERGENCY CARE	
Emergency room If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$0** copay
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$0** copay
DIAGNOSTIC SERVICES, LABS AND IMAGING	
Diagnostic mammography	**$0** copay
Diagnostic radiology	**$0** copay
Lab services	**$0** copay
Diagnostic tests and procedures	**$0** copay
Outpatient X-rays	**$0** copay
Radiation therapy	**$0** copay
HEARING SERVICES	
Medicare-covered hearing	**$0** copay
Routine hearing	**HER945** • **$0** copay for routine hearing exams up to 1 every year.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Humana.

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
	• **$0** copay for each Advanced level hearing aid up to 1 per ear every 3 years. Hearing aid purchase includes: • Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models **You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (for TTY, dial 711).**
DENTAL SERVICES	
Medicare-covered dental	**$0** copay
Routine dental Dental services are subject to our standard claims review procedures which could include dental history to approve coverage. Dental benefits under this plan may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**. Network dentists have agreed to provide services at contracted fees (the in-network fee schedules, of INFS). If a member visits a participating network dentist, the member will not receive a bill for changes more than the negotiated fee schedule on covered services (annual maximum still applies). Use the HumanaDental Medicare network for the Mandatory Supplemental Dental. The provider locator can be found at **Humana.com** > Find a Doctor >	**DEN458** • Plan covers up to **$4,000** allowance every year for non-Medicare covered preventive and comprehensive dental services. • You are responsible for any amount above the dental coverage limit. • Any amount unused at the end of the year will expire. • Your benefit can be used for most dental treatments such as: • Preventive dental services, such as exams, routine cleanings, etc. • Basic dental services, such as fillings, extractions, etc. • Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges, etc. • Note: The allowance cannot be used on cosmetic services and implants.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
from the Search Type drop down select Dental > under Coverage type select All Dental Networks > enter zip code > from the network drop down select HumanaDental Medicare.	
VISION SERVICES	
Medicare-covered vision services	**$0** copay
Medicare-covered diabetic eye exam	**$0** copay
Medicare-covered glaucoma screening	**$0** copay
Medicare-covered eyewear (post-cataract)	**$0** copay
Routine vision The provider locator for routine vision can be found at **Humana.com** > Find a Doctor > select Vision care icon > Vision coverage through Medicare Advantage plans.	**VIS701** • **$0** copay for routine exam up to 1 per year. • **$400** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year.
MENTAL HEALTH SERVICES	
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$0** copay
Outpatient group and individual therapy visits	**$0** copay
SKILLED NURSING FACILITY (SNF)	
Your plan covers up to 100 days in a SNF	**$0** copay
PHYSICAL THERAPY	
	$0 copay

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Humana.

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
AMBULANCE	
Ambulance	**$0** copay
TRANSPORTATION	
	$0 copay for plan approved location up to 100 one-way trip(s) per year. This benefit is not to exceed 50 miles per trip. The member *must* contact transportation vendor to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider.
MEDICARE PART B DRUGS	
Chemotherapy drugs	**$0** copay
Other Part B drugs	**$0** copay

Prescription Drug Benefits

PRESCRIPTION DRUGS	
Medicare Part D Drugs	See chart below for plan coverage information for prescription drugs

$0 Rx Copay Benefit If you qualify for "Extra Help", you will pay **$0** for all Medicare Part D covered prescription drugs on your formulary, for all tiers, and through all stages.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Pharmacy options		
Mail Order	**Mail Order cost-sharing** **$0**	CenterWell Pharmacy™, Walmart Mail, PillPack Other pharmacies are available in our network. To find pharmacy mail order options go to **Humana.com/pharmacyfinder**
Retail	**Retail cost-sharing**	All network retail pharmacies
For generic drugs (including brand drugs treated as generic), either:	**30-day supply** **$0**	**90-day supply*** **$0**
For all other drugs, either:	**$0**	**$0**

Other pharmacies are available in our network.
*Some drugs are limited to a 30-day supply

To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 Monday — Friday, 7 a.m. — 7 p.m. TTY users should call 1-800-325-0778. For more information on pharmacy-specific cost-sharing, please call us or refer to Chapter 6 of the Evidence of Coverage for more details.

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,400**, you pay nothing for all drugs.

Additional Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN
Medicare-covered foot care (podiatry)	**$0** copay
Medicare-covered chiropractic services	**$0** copay
MEDICAL EQUIPMENT/SUPPLIES	
Durable medical equipment (like wheelchairs or oxygen)	**$0** copay
Medical Supplies	**$0** copay
Prosthetics (artificial limbs or braces)	**$0** copay

Humana.

	WHAT YOU PAY ON THIS HUMANA PLAN
Diabetic monitoring supplies	**$0** copay
REHABILITATION SERVICES	
Occupational and speech therapy	**$0** copay
Cardiac rehabilitation	**$0** copay
Pulmonary rehabilitation	**$0** copay
TELEHEALTH SERVICES (in addition to Original Medicare)	
Primary care provider (PCP)	**$0** copay
Specialist	**$0** copay
Urgent care services	**$0** copay
Substance abuse or behavioral health services	**$0** copay

Medicaid Benefit Comparison

The benefits described in the Covered Medical and Hospital Benefits sections above are covered by Humana Gold Plus SNP-DE H4461-022 (HMO D-SNP). Below is a comparison of benefits that some Medicaid eligible individuals could receive directly from the TennCare (Medicaid). For each benefit listed below, you can see what the TennCare (Medicaid) covers and what our plan covers. All Medicaid benefits are subject to Medicaid eligibility guidelines and requirements, and are available only to full dual eligible individuals. If you have questions about your Medicaid eligibility and what benefits you are entitled to, review your member handbook or contact the TennCare (Medicaid) at 1-800-342-3145.

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Acute inpatient hospital care	Covered	Covered
Ambulance	Covered	Covered
Ambulatory surgical center	Covered	Covered
Dentures	Not Covered	Covered
Diagnostic services/labs/imaging	Covered	Covered
Doctor office visits (Primary care provider (PCP)/specialists	Covered	Covered
Emergency care	Covered	Covered
Eyeglasses	Covered	Covered
Hearing aids	Not Covered	Covered

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Home and community based waiver service programs	Covered	Not Covered
Inpatient hospital, nursing facility and intermediate care facility services in institutions for mental diseases (MD), age 65 and older	Covered	Covered with limitations
Inpatient psychiatric services, under age 21	Covered	Covered with limitations
Intermediate care facility for intellectual disabilities (ICF-IDD)	Covered	Not Covered
Intermediate care facility services for individuals with intellectual disabilities	Covered	Covered with limitations
Mental health services (outpatient group therapy and individual therapy visit)	Covered	Covered
Nursing facility services, other than in an institution for mental diseases	Covered	Covered with limitations
Outpatient hospital coverage	Covered	Covered
Personal emergency response system (PERS)	Not Covered	Covered
Physical therapy	Covered	Covered
Prescription drugs – Medicare Part B drugs	Covered	Covered
Prescription drugs – outpatient prescription drugs; Medicare covered & non-Medicare covered	Covered	Covered
Preventive care (e.g., flu vaccine, diabetic screenings)	Covered	Covered
Routine non-emergency medical transportation	Covered	Covered
Skilled nursing facility	Covered	Covered
Urgently needed services	Covered	Covered

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.
This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of coverage and services. Visit **Humana.com/medicare** to view a copy of the EOC or call **1-800-833-2364**.

Humana Healthy Options Allowance

$175 automatically loaded on a prepaid card every month to use toward the purchase of food, over-the-counter (OTC) products, and home supplies from a national network of retailers. The card may also be used to pay for non-medical transportation, general supports for living (such as rent assistance, internet, and utilities), social needs, aging support and assistive devices, pest control, and pet care and supplies. Unused amount expires at the end of the month. Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

Humana Spending Account Card

The allowance listed below will be loaded onto this prepaid card. Each allowance is separate from any other allowance listed. Allowances shown are accessed by using this card. Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

*Healthy Options Allowance

HMO Travel Benefit

Members can receive in-network benefits when services are received from a participating HMO National Network provider during their travels to other states and Puerto Rico.

Special Supplemental Benefits for the Chronically Ill (SSBCI) Humana Flexible Care Assistance

Humana Flexible Care Assistance is available to members with chronic health conditions, who are participating in care management services, and meet program criteria. Eligible members may receive medical expense assistance and other additional benefits, either primarily health related or non-primarily health related, to address the member's unique individual needs. Benefits are limited up to **$500** per year and must be coordinated and authorized by a care manager. There is no cost to participate.

Chiropractic services

Routine chiropractic:
$0 copay per visit for up to 12 visits.

Smoking cessation program

To further assist in your effort to quit smoking or tobacco product use, we cover one additional counseling quit attempt within a 12-month period as a service with no cost to you. This is in addition to the two counseling attempts provided by Medicare and includes up to four face-to-face visits. This service can be used for either preventive measures or for diagnosis with a tobacco related disease.

Routine foot care

$0 copay per visit for up to 6 visits

Humana Well Dine® Meal Program
Humana's home delivered meal program for members following an inpatient stay in the hospital or nursing facility.

Over-the-Counter (OTC) mail order
$175 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.

Personal Emergency Response System
The personal emergency response system provides help in emergency situations. The medical alert service comes with an installed in-home communication device and a wearable button. You have the choice between a push button unit (with or without AutoAlert fall detection) or a wrist unit (without AutoAlert).

Post Discharge Personal Home Care
$0 copayment for a minimum of 4 hours per day, up to a maximum of 28 hours per year for certain in-home support services following a discharge from a skilled nursing facility or from an inpatient hospitalization. Services must be initiated within 30 days of discharge event and utilized within 60 days of discharge for each qualifying event up to the maximum annual allowance.

Authorization may be required. Contact the plan for details.

Rewards and Incentives
Go365 by Humana® a Rewards and Incentive program for completing certain preventive health screenings and health and wellness activities.

Wigs (related to chemotherapy treatment)
Up to an unlimited maximum benefit per year.

SilverSneakers® fitness program
Basic fitness center membership including fitness classes.

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Find out **more**

You can see our plan's **provider and pharmacy directory** at our website at **humana.com/finder/search** or call us at the number listed at the beginning of this booklet and we will send you one.

You can see our plan's **drug guide** at our website at **humana.com/medicaredruglist** or call us at the number listed at the beginning of this booklet and we will send you one.

To find out more about the coverage and costs of Original Medicare, look in the current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Humana has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2023 based on a review of Humana's Model of Care.

NOTICE: TennCare is not responsible for payment for these benefits, except for appropriate cost-sharing amounts. TennCare is not responsible for guaranteeing the availability or quality of these benefits. Any reference to more, extra, or additional Medicare benefits, is applicable to Medicare only and does not indicate increased Medicaid benefits.

Your provider may choose to submit to the TennCare (Medicaid) for consideration of additional secondary payment for an amount applied to deductibles, coinsurance, or copayments. If you are Cost Share Protected, providers are required by federal regulation to accept Humana Gold Plus SNP-DE H4461-022 (HMO D-SNP) primary payment and the TennCare (Medicaid) secondary payment as payment in full for covered Medicare Part A and Part B services – even when the Medicaid payment is zero or a provider chooses to not submit to Medicaid.

If you are cost-share protected by the TennCare (Medicaid), Humana Gold Plus SNP-DE H4461-022 (HMO D-SNP) providers aren't allowed to collect or bill you for services and items covered under Medicare Part A and Part B, including deductibles, coinsurance, and copayments – even when Medicaid payment is zero or a provider chooses to not submit to Medicaid. If a provider asks you to pay, that's against the law. You may however be responsible for a small Medicaid copayment.

If you are cost-share protected and you are billed or asked to pay the provider for deductibles, coinsurance, or copayments on covered Medicare Part A and Part B services tell your provider you are cost-share protected and can't be charged. If you have already made payment you have the right to a refund. If your provider will not stop billing, you can call us at 1-800-457-4708 or you can call Medicare at 1-800-Medicare (1-800-633-4227), (TTY 1-877-486-2048). Humana or Medicare can ask your provider to stop billing you and refund any payment you have made.

Telehealth services shown are in addition to the Original Medicare covered telehealth. Your cost may be different for Original Medicare telehealth.

Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your evidence of coverage for additional details on what your plan may cover or other rules that may apply.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable federal civil rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html.**
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

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Humana Gold Plus SNP-DE H4461-022
(HMO D-SNP)
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Greater Tennessee

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2023

Summary of Benefits

Humana Gold Plus SNP-DE H4461-038 (HMO D-SNP)

Greater Tennessee

Our service area includes the following county/counties in Tennessee: Anderson, Bedford, Benton, Bledsoe, Blount, Bradley, Campbell, Cannon, Carroll, Carter, Cheatham, Chester, Claiborne, Clay, Cocke, Coffee, Crockett, Cumberland, Davidson, Decatur, DeKalb, Dickson, Dyer, Fayette, Fentress, Franklin, Gibson, Giles, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hardeman, Hardin, Hawkins, Haywood, Henderson, Henry, Hickman, Houston, Humphreys, Jackson, Jefferson, Johnson, Knox, Lake, Lauderdale, Lawrence, Lewis, Lincoln, Loudon, Macon, Madison, Marion, Marshall, Maury, McMinn, McNairy, Meigs, Monroe, Montgomery, Moore, Morgan, Obion, Overton, Perry, Pickett, Polk, Putnam, Rhea, Roane, Robertson, Rutherford, Scott, Sequatchie, Sevier, Shelby, Smith, Stewart, Sullivan, Sumner, Tipton, Trousdale, Unicoi, Union, Van Buren, Warren, Washington, Wayne, Weakley, White, Williamson, Wilson.

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Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-833-2364 (TTY: 711)**.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **Humana.com/medicare** or call **1-800-833-2364 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. This plan may enroll QMB.

2023

Summary of Benefits

Humana Gold Plus SNP-DE H4461-038 (HMO D-SNP)

Greater Tennessee

Our service area includes the following county/counties in Tennessee: Anderson, Bedford, Benton, Bledsoe, Blount, Bradley, Campbell, Cannon, Carroll, Carter, Cheatham, Chester, Claiborne, Clay, Cocke, Coffee, Crockett, Cumberland, Davidson, Decatur, DeKalb, Dickson, Dyer, Fayette, Fentress, Franklin, Gibson, Giles, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hardeman, Hardin, Hawkins, Haywood, Henderson, Henry, Hickman, Houston, Humphreys, Jackson, Jefferson, Johnson, Knox, Lake, Lauderdale, Lawrence, Lewis, Lincoln, Loudon, Macon, Madison, Marion, Marshall, Maury, McMinn, McNairy, Meigs, Monroe, Montgomery, Moore, Morgan, Obion, Overton, Perry, Pickett, Polk, Putnam, Rhea, Roane, Robertson, Rutherford, Scott, Sequatchie, Sevier, Shelby, Smith, Stewart, Sullivan, Sumner, Tipton, Trousdale, Unicoi, Union, Van Buren, Warren, Washington, Wayne, Weakley, White, Williamson, Wilson.

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Let's talk about Humana Gold Plus SNP-DE H4461-038 (HMO D-SNP)

Find out more about the Humana Gold Plus SNP-DE H4461-038 (HMO D-SNP) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus SNP-DE H4461-038 (HMO D-SNP) is a Coordinated Care plan HMO with a Medicare contract and a contract with the TennCare (Medicaid) program. Enrollment in this Humana plan depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, ask us for the "Evidence of Coverage".

As a member you must select an in-network doctor to act as your Primary Care Provider (PCP). Humana Gold Plus SNP-DE H4461-038 (HMO D-SNP) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services. You have access to Care Managers. Care Managers are nurses or care coordinators who support your health and well-being by providing additional services including: acute and chronic-care management, telephonic and in-person health support, assistance in coordinating Medicare and Medicaid benefits, educational resources and workshops, and support for families and caregivers.

To be eligible

To enroll in Humana Gold Plus SNP-DE H4461-038 (HMO D-SNP), a Dual Eligible Special Needs Plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B, live in our service area and also receive certain levels of assistance from the TennCare (Medicaid). If you receive both Medicare and Medicaid benefits, this means you are dual eligible.

Humana Gold Plus SNP-DE H4461-038 (HMO D-SNP) may enroll QMB.

Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).

Plan name:

Humana Gold Plus SNP-DE H4461-038 (HMO D-SNP)

More about Humana Gold Plus SNP-DE H4461-038 (HMO D-SNP)

As a member of this plan, you will not be responsible for cost sharing for plan benefits. The Medicaid Comparison Chart shows specific benefits that Medicaid may cover for some dual eligible members. You will work with your Humana care coordinator to understand and access these benefits from the TennCare (Medicaid) after any Humana Gold Plus SNP-DE H4461-038 (HMO D-SNP) benefits are used. The Covered Medical and Hospital Benefits chart shows the benefits you will receive from Humana.

Be sure to show the TennCare (Medicaid) ID card in addition to your Humana membership card to make your provider aware that you also have Medicaid coverage. You may be required to pay a small Medicaid specific co-payment. Your services are paid first by Humana and then by Medicaid.

How to reach us:

If you have questions about your benefits or your level of eligibility for assistance from Medicaid, you should contact Humana's Customer Care department or the TennCare (Medicaid) for further details.

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (TTY: 711)**.

October 1 - March 31:
Call 7 days a week from 8 a.m. - 8 p.m.

April 1 - September 30:
Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website: **Humana.com/medicare**.

Medicaid benefits last validated on 07/01/2022 and are subject to change.

For the most current Tennessee Medicaid coverage information, please visit the TennCare (Medicaid) website at **https://www.tn.gov/tenncare/** or call the Medicaid Hotline at 1-800-342-3145 (TTY: 711).

A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!

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Monthly Premium, Deductible and Limits

Monthly plan premium	**$0** You must keep paying your Medicare Part B premium. Your Part A and/or Part B premium may be paid on your behalf by the TennCare (Medicaid) Program.
Medical deductible	This plan does not have a deductible.
Pharmacy (Part D) deductible	**$0** if you qualify for "Extra Help"
Maximum out-of-pocket responsibility	This plan does not have a maximum out-of-pocket responsibility.

Covered Medical and Hospital Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN
ACUTE INPATIENT HOSPITAL CARE	
	$0 copay
OUTPATIENT HOSPITAL COVERAGE	
Outpatient surgery at outpatient hospital	**$0** copay
Outpatient surgery at ambulatory surgical center	**$0** copay
DOCTOR OFFICE VISITS	
Primary care provider (PCP)	**$0** copay
Specialists	**$0** copay
PREVENTIVE CARE	
	Our plan covers many preventive services at no cost when you see an in-network provider including: • Abdominal aortic aneurysm Screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
	• Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including flu shots, hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Annual Wellness Visit • Lung cancer screening • Routine physical exam • Medicare diabetes prevention program Any additional preventive services approved by Medicare during the contract year will be covered.
EMERGENCY CARE	
Emergency room If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care.	**$0** copay
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$0** copay
DIAGNOSTIC SERVICES, LABS AND IMAGING	
Diagnostic mammography	**$0** copay
Diagnostic radiology	**$0** copay
Lab services	**$0** copay
Diagnostic tests and procedures	**$0** copay
Outpatient X-rays	**$0** copay
Radiation therapy	**$0** copay
HEARING SERVICES	
Medicare-covered hearing	**$0** copay
Routine hearing	**HER945** • **$0** copay for routine hearing exams up to 1 every year.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
	• **$0** copay for each Advanced level hearing aid up to 1 per ear every 3 years. Hearing aid purchase includes: • Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models **You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (for TTY, dial 711).**
DENTAL SERVICES	
Medicare-covered dental	**$0** copay
Routine dental Dental services are subject to our standard claims review procedures which could include dental history to approve coverage. Dental benefits under this plan may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**. Network dentists have agreed to provide services at contracted fees (the in-network fee schedules, of INFS). If a member visits a participating network dentist, the member will not receive a bill for changes more than the negotiated fee schedule on covered services (annual maximum still applies). Use the HumanaDental Medicare network for the Mandatory Supplemental Dental. The provider locator can be found at **Humana.com** > Find a Doctor >	**DEN441** • Plan covers up to **$3,000** allowance every year for non-Medicare covered preventive and comprehensive dental services. • You are responsible for any amount above the dental coverage limit. • Any amount unused at the end of the year will expire. • Your benefit can be used for most dental treatments such as: • Preventive dental services, such as exams, routine cleanings, etc. • Basic dental services, such as fillings, extractions, etc. • Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges etc. • Note: The allowance cannot be used on cosmetic services and implants.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
from the Search Type drop down select Dental > under Coverage type select All Dental Networks > enter zip code > from the network drop down select HumanaDental Medicare.	
VISION SERVICES	
Medicare-covered vision services	**$0** copay
Medicare-covered diabetic eye exam	**$0** copay
Medicare-covered glaucoma screening	**$0** copay
Medicare-covered eyewear (post-cataract)	**$0** copay
Routine vision The provider locator for routine vision can be found at **Humana.com** > Find a Doctor > select Vision care icon > Vision coverage through Medicare Advantage plans.	**VIS701** • **$0** copay for routine exam up to 1 per year. • **$400** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames. • Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year. • Maximum benefit coverage amount is limited to one time use per year.
MENTAL HEALTH SERVICES	
Inpatient Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital	**$0** copay
Outpatient group and individual therapy visits	**$0** copay
SKILLED NURSING FACILITY (SNF)	
Your plan covers up to 100 days in a SNF	**$0** copay
PHYSICAL THERAPY	
	$0 copay

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

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Covered Medical and Hospital Benefits (cont.)

	WHAT YOU PAY ON THIS HUMANA PLAN
AMBULANCE	
Ambulance (ground)	**$0** copay
Ambulance (air)	**$0** copay
TRANSPORTATION	
	$0 copay for plan approved location up to 100 one-way trip(s) per year. This benefit is not to exceed 50 miles per trip. The member *must* contact transportation vendor to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider.
MEDICARE PART B DRUGS	
Chemotherapy drugs	**$0** copay
Other Part B drugs	**$0** copay

Prescription Drug Benefits

PRESCRIPTION DRUGS	
Medicare Part D Drugs	See chart below for plan coverage information for prescription drugs

$0 Rx Copay Benefit If you qualify for "Extra Help", you will pay **$0** for all Medicare Part D covered prescription drugs on your formulary, for all tiers, and through all stages.

You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.

Pharmacy options		
Mail Order	**Mail Order cost-sharing** **$0**	CenterWell Pharmacy™, Walmart Mail, PillPack Other pharmacies are available in our network. To find pharmacy mail order options go to **Humana.com/pharmacyfinder**
Retail	**Retail cost-sharing**	All network retail pharmacies
For generic drugs (including brand drugs treated as generic), either:	**30-day supply** **$0**	**90-day supply*** **$0**
For all other drugs, either:	**$0**	**$0**

Other pharmacies are available in our network.
*Some drugs are limited to a 30-day supply

To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 Monday — Friday, 7 a.m. — 7 p.m. TTY users should call 1-800-325-0778. For more information on pharmacy-specific cost-sharing, please call us or refer to Chapter 6 of the Evidence of Coverage for more details.

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,400**, you pay nothing for all drugs.

Additional Benefits

	WHAT YOU PAY ON THIS HUMANA PLAN
Medicare-covered foot care (podiatry)	**$0** copay
Medicare-covered chiropractic services	**$0** copay
MEDICAL EQUIPMENT/SUPPLIES	
Durable medical equipment (like wheelchairs or oxygen)	**$0** copay
Medical Supplies	**$0** copay
Prosthetics (artificial limbs or braces)	**$0** copay

	WHAT YOU PAY ON THIS HUMANA PLAN
Diabetic monitoring supplies	**$0** copay
REHABILITATION SERVICES	
Occupational and speech therapy	**$0** copay
Cardiac rehabilitation	**$0** copay
Pulmonary rehabilitation	**$0** copay
TELEHEALTH SERVICES (in addition to Original Medicare)	
Primary care provider (PCP)	**$0** copay
Specialist	**$0** copay
Urgent care services	**$0** copay
Substance abuse or behavioral health services	**$0** copay

Medicaid Benefit Comparison

The benefits described in the Covered Medical and Hospital Benefits sections above are covered by Humana Gold Plus SNP-DE H4461-038 (HMO D-SNP). Below is a comparison of benefits that some Medicaid eligible individuals could receive directly from the TennCare (Medicaid). For each benefit listed below, you can see what the TennCare (Medicaid) covers and what our plan covers. All Medicaid benefits are subject to Medicaid eligibility guidelines and requirements, and are available only to full dual eligible individuals. If you have questions about your Medicaid eligibility and what benefits you are entitled to, review your member handbook or contact the TennCare (Medicaid) at 1-800-342-3145.

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Acute inpatient hospital care	Not Covered	Covered
Ambulance	Not Covered	Covered
Ambulatory surgical center	Not Covered	Covered
Dentures	Not Covered	Covered
Diagnostic services/labs/imaging	Not Covered	Covered
Doctor office visits (Primary care provider (PCP)/specialists	Not Covered	Covered
Emergency care	Not Covered	Covered
Eyeglasses	Not Covered	Covered
Hearing aids	Not Covered	Covered

BENEFIT	MEDICAID BENEFIT	OUR PLAN BENEFIT
Inpatient hospital, nursing facility and intermediate care facility services in institutions for mental diseases (MD), age 65 and older	Not Covered	Covered with limitations
Inpatient psychiatric services, under age 21	Not Covered	Covered with limitations
Intermediate care facility services for individuals with intellectual disabilities	Not Covered	Covered with limitations
Mental health services (outpatient group therapy and individual therapy visit)	Not Covered	Covered
Nursing facility services, other than in an institution for mental diseases	Not Covered	Covered with limitations
Outpatient hospital coverage	Not Covered	Covered
Personal emergency response system (PERS)	Not Covered	Covered
Physical therapy	Not Covered	Covered
Prescription drugs – Medicare Part B drugs	Not Covered	Covered
Prescription drugs – outpatient prescription drugs; Medicare covered & non-Medicare covered	Not Covered	Covered
Preventive care (e.g., flu vaccine, diabetic screenings)	Not Covered	Covered
Routine non-emergency medical transportation	Not Covered	Covered
Skilled nursing facility	Not Covered	Covered
Urgently needed services	Not Covered	Covered

More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.
This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of coverage and services. Visit **Humana.com/medicare** to view a copy of the EOC or call **1-800-833-2364**.

Humana Healthy Options Allowance

$175 automatically loaded on a prepaid card every month to use toward the purchase of food, over-the-counter (OTC) products, and home supplies from a national network of retailers. The card may also be used to pay for non-medical transportation, general supports for living (such as rent assistance, internet, and utilities), social needs, aging support and assistive devices, pest control, and pet care and supplies. Unused amount expires at the end of the month. Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

Humana Spending Account Card

The allowance listed below will be loaded onto this prepaid card. Each allowance is separate from any other allowance listed. Allowances shown are accessed by using this card. Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

*Healthy Options Allowance

HMO Travel Benefit

Members can receive in-network benefits when services are received from a participating HMO National Network provider during their travels to other states and Puerto Rico.

Special Supplemental Benefits for the Chronically Ill (SSBCI) Humana Flexible Care Assistance

Humana Flexible Care Assistance is available to members with chronic health conditions, who are participating in care management services, and meet program criteria. Eligible members may receive medical expense assistance and other additional benefits, either primarily health related or non-primarily health related, to address the member's unique individual needs. Benefits are limited up to **$500** per year and must be coordinated and authorized by a care manager. There is no cost to participate.

Chiropractic services

Routine chiropractic:
$0 copay per visit for up to 12 visits.

Smoking cessation program

To further assist in your effort to quit smoking or tobacco product use, we cover one additional counseling quit attempt within a 12-month period as a service with no cost to you. This is in addition to the two counseling attempts provided by Medicare and includes up to four face-to-face visits. This service can be used for either preventive measures or for diagnosis with a tobacco related disease.

Routine foot care

$0 copay per visit for up to 6 visits

Humana Well Dine® Meal Program
Humana's home delivered meal program for members following an inpatient stay in the hospital or nursing facility.

Personal Emergency Response System
The personal emergency response system provides help in emergency situations. The medical alert service comes with an installed in-home communication device and a wearable button. You have the choice between a push button unit (with or without AutoAlert fall detection) or a wrist unit (without AutoAlert).

Post Discharge Personal Home Care
$0 copayment for a minimum of 4 hours per day, up to a maximum of 28 hours per year for certain in-home support services following a discharge from a skilled nursing facility or from an inpatient hospitalization. Services must be initiated within 30 days of discharge event and utilized within 60 days of discharge for each qualifying event up to the maximum annual allowance.

Authorization may be required. Contact the plan for details.

Rewards and Incentives
Go365 by Humana® a Rewards and Incentive program for completing certain preventive health screenings and health and wellness activities.

Wigs (related to chemotherapy treatment)
Up to an unlimited maximum benefit per year.

SilverSneakers® fitness program
Basic fitness center membership including fitness classes.

Find out **more**

You can see our plan's **provider and pharmacy directory** at our website at **humana.com/finder/search** or call us at the number listed at the beginning of this booklet and we will send you one.

You can see our plan's **drug guide** at our website at **humana.com/medicaredruglist** or call us at the number listed at the beginning of this booklet and we will send you one.

To find out more about the coverage and costs of Original Medicare, look in the current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Humana has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2023 based on a review of Humana's Model of Care.

NOTICE: TennCare is not responsible for payment for these benefits, except for appropriate cost-sharing amounts. TennCare is not responsible for guaranteeing the availability or quality of these benefits. Any reference to more, extra, or additional Medicare benefits, is applicable to Medicare only and does not indicate increased Medicaid benefits.

Your provider may choose to submit to the TennCare (Medicaid) for consideration of additional secondary payment for an amount applied to deductibles, coinsurance, or copayments. If you are Cost Share Protected, providers are required by federal regulation to accept Humana Gold Plus SNP-DE H4461-038 (HMO D-SNP) primary payment and the TennCare (Medicaid) secondary payment as payment in full for covered Medicare Part A and Part B services – even when the Medicaid payment is zero or a provider chooses to not submit to Medicaid.

If you are cost-share protected by the TennCare (Medicaid), Humana Gold Plus SNP-DE H4461-038 (HMO D-SNP) providers aren't allowed to collect or bill you for services and items covered under Medicare Part A and Part B, including deductibles, coinsurance, and copayments – even when Medicaid payment is zero or a provider chooses to not submit to Medicaid. If a provider asks you to pay, that's against the law. You may however be responsible for a small Medicaid copayment.

If you are cost-share protected and you are billed or asked to pay the provider for deductibles, coinsurance, or copayments on covered Medicare Part A and Part B services tell your provider you are cost-share protected and can't be charged. If you have already made payment you have the right to a refund. If your provider will not stop billing, you can call us at 1-800-457-4708 or you can call Medicare at 1-800-Medicare (1-800-633-4227), (TTY 1-877-486-2048). Humana or Medicare can ask your provider to stop billing you and refund any payment you have made.

Telehealth services shown are in addition to the Original Medicare covered telehealth. Your cost may be different for Original Medicare telehealth.

Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your evidence of coverage for additional details on what your plan may cover or other rules that may apply.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Important

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  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html.**
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

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State of Tennessee
Department of Finance and Administration
Division of TennCare

Trading Partner Agreement

THIS TRADING PARTNER AGREEMENT ("Agreement") is between The State of Tennessee, Department of Finance and Administration, Division of TennCare ("TennCare" or "the State"), 310 Great Circle Road, Nashville, TN 37243, and Cariten Health Plan Inc. ("Trading Partner") located at 2160 Lakeside Centre Way, Suite 200, Knoxville, TN 37922,, including all office locations and other business locations at which Trading Partner data may be used or maintained. Trading Partners may be referred to herein individually as "Party" or collectively as "Parties."

1. PURPOSE AND BACKGROUND

1.1 The Division of TennCare includes TennCare, the state Medicaid agency, Cover Tennessee, the Health Insurance Exchange Planning Initiative, the Division of State Health Planning, and the Office of eHealth Initiatives.

1.2 This Agreement is ancillary to any State Contract ("SC"), Contractor Risk Agreement ("CRA") and Business Associate Agreement ("BAA") entered into between Trading Partner and a Division of TennCare, where applicable. The provisions of the SC, CRA and BAA are hereby incorporated by reference and shall be taken and considered as part of this Agreement the same as if fully setout herein.

1.3 TennCare, in its capacity as the Medicaid Agency ("TennCare") for the State of Tennessee, by law, must operate the TennCare Medicaid Management Information System ("TCMIS"). The TCMIS contains information regarding claims adjudication, eligibility verification, prior authorization and other information related to the TennCare Program and other TennCare programs.

1.4 The State owns the data in the TCMIS and operates the system in which the claims and eligibility data flow. Trading Partners provide the pipeline network for the transmission of electronic data; thus, are required to transport TCMIS data to and from the State and providers of TennCare services.

1.5 This Agreement delineates the responsibilities of the State and the Trading Partner in transporting TCMIS data in operation of the TennCare programs.

2. SCOPE

2. 1 System Access. The State agrees to provide Trading Partner with electronic access to the TCMIS and network for the purpose of exchanging transactions via Trading Partners' computer systems and network or its authorized designee's computer systems and network.

2.1.1 To the extent Trading Partner executes a contract with TennCare service providers, or their authorized designee (clearinghouse, Value-Added Network (VAN), billing service, etc.), Trading Partner shall represent that it has on hand all necessary authorizations for submitting and receiving TCMIS data. Said contract must stipulate that providers use software tested and approved by Trading Partner as being in the proper format and compatible with the TCMIS.

2.1.1.1 Trading Partner agrees that the TCMIS data transmitted or received by it shall be released only in support of the terms of an executed contract between Trading Partner and the authorized party requesting information to the extent authorized party's request is for the purposes of reporting eligibility for State benefits specific to individuals and dates of service and a treatment relationship exists to support and justify the authorized party's request in keeping with this Agreement.

2.1.2 Prior to the submission of any transactions to the TCMIS production systems, Trading Partner agrees to submit test transactions to the State for the purpose of determining that the transactions comply with all requirements and specifications required by the State.

2.1.3 Successful transaction testing must be achieved by Trading Partner for each provider number that the Trading Partner represents before any production transaction submissions are processed for that provider. No electronic transaction received by the State for providers without successful transaction testing shall be processed.

2.1.4 The parties agree that the State shall make the sole determination that test data is acceptable and that transaction testing is successful. This capability to submit test transactions shall be maintained by Trading Partner throughout the term of this Agreement.

2.2 Transaction Types. Trading Partner agrees to submit to the TCMIS and any other TennCare systems only those individual transaction types for which specific approval from the State has been requested and received via the Electronic Data Interchange Request Form available under Electronic Data Interchange ("EDI") on the TennCare website. Prior to the submission of any transaction types to the TCMIS production system or to any other TennCare systems, or as a result of changes to an existing transaction type or system, Trading Partner agrees to submit test transactions to the State for both the additional and any previously approved transaction types.

2.3 Data Submission. Trading Partner shall prepare and submit or receive TCMIS and other TennCare related data using network connectivity, protocols, and media approved by the State. The addition and deletion by the State of approved submission network connectivity, protocols, and media may occur from time to time. To the extent the deletion of a network connectivity, protocol, or media is contemplated from the approved list, the State shall supply the Trading Partner with ninety (90) days' notice of the date of impending deletion.

2.4 Transmission Speed. For electronic transmission, such as File Transfer Protocol (FTP), that does not involve the physical exchange of storage media, the Trading Partner agrees to provide a minimum design transmission speed of 56 kilobits per second (KBS) with an effective transmission speed of at least eighty percent (80%) of the design transmission speed on a dedicated, secure channel or Virtual Private Network (VPN) from the Trading Partner data center to the State's facility. Trading Partner is free to choose type of channel and ultimate speed above 56 KBS as long as the selected transmission method is approved by TennCare. Trading Partner must coordinate any equipment selection or changes with the State to ensure compatibility with the State's facilities. Trading Partner is responsible for all costs including installation costs, equipment, and line charges.

2.5 Data Encryption. Trading Partner must encrypt all data transmitted on channels not otherwise secured and maintain full compatibility with the State's facilities. The State reserves the right to determine when encrypted transmissions are necessary and what encryption technologies and implementations are considered sufficiently secure.

2.6 Compression/Decompression. Trading Partner must be capable of compressing and transmitting and receiving and decompressing transaction data files that are compressed and decompressed using the algorithms commercially known as "zip" or "gzip."

2.7 Remote Access Request. Trading Partner shall execute a Remote Access Request with the State, found on the TennCare website.

3. DEFINITIONS

3.1 "Confidential Information" shall mean any non-public, confidential or proprietary information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, which is supplied by the State to the Trading Partner under this Agreement. Any information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, relating to individuals enrolled in any TennCare program ("enrollees"), or relating to individuals who may be potentially enrolled in a TennCare program, which is provided to or obtained through the Trading Partner's performance under this Agreement, shall also be treated as "Confidential Information" to the extent that confidential status is afforded such information under state and federal laws or regulations. All confidential information shall not be subject to disclosure under the Tennessee Public Records Act, Tenn. Code. Ann. § 10-7-501 *et seq*.

3.2 "Covered entity" shall mean (1) A health plan (2) A health care clearinghouse (3) or a health care provider who transmits any health information in electronic form in connection with a transaction covered by 45 CFR Parts 160 & 164.

3.3 "*En Masse* Inquiry" shall mean data matching of less than fifty percent (50%).

3.4 "Health care clearinghouse" shall mean a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that does either of the following

functions: (1) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction. (2) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

3.5 "Health care provider" shall mean a provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

3.6 "Health plan" shall mean an individual or group plan that provides, or pays the cost of, medical care information or when requesting protected health information (PHI) from another covered entity, a covered entity must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. A covered entity must limit any request for PHI to that which is reasonably necessary to accomplish the purpose for which the request is made, when requesting such information from other covered entities.

3.7 "Individually identifiable health information" means any information, including demographic information collected from an individual, that (a) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (b) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and identifies the individual; or, with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

3.8 "Payment" shall mean (1) The activities undertaken by: (i) A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or (ii) A health care provider or health plan to obtain or provide reimbursement for the provision of health care; and (2) The activities in paragraph (1) of this definition relate to the individual to whom health care is provided.

3.9 "Proprietary Information" shall mean TennCare processes, procedures, software, methods and any property of, or relating to, TennCare data.

3.10 "Protected Health Information" (PHI) shall mean individually identifiable health information that is transmitted by electronic media, maintained in electronic media; or transmitted or maintained in any other form or medium.

3.11 "Standard Eligibility Transaction" shall mean the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 270/271 eligibility inquiry from a sender that is a health plan or health care provider and the designated response from the State.

3.12 "Treatment" shall mean the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care

providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

3.13 "Treatment Relationship" shall have the following meanings:

3.13.1 "Direct Treatment Relationship" shall mean a treatment relationship between an individual and a health care provider that is not an indirect treatment relationship.

3.13.2 "Indirect Treatment Relationship" shall mean a relationship between an individual and a health care provider in which (1) The health care provider delivers health care to the individual based on the orders of another health care provider; and (2) The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual.

4. COMPLIANCE

4.1 Trading Partner agrees to comply with all State and federal laws, regulations, and policies as they exist or as amended that are or may be applicable to this Agreement, including, but not limited to, ancillary agreements such as the SC, CRA and BAA (Section 1).

4.1.1 Proprietary and Confidential Information [See 3.1 & 3.9]. All proprietary information, including but not limited to, provider reimbursement information provided to TennCare, shall be deemed confidential and not subject to disclosure under the Tennessee Public Records Act.

4.1.2 Duty to Protect. Confidential Information (i) shall be held by the Trading Partner in strictest confidence at all times; (ii) shall not be disclosed or divulged by the Trading Partner to any person or entity, except those employees and agents of the Trading Partner who require access to such information, and only after those employees and agents have been instructed that the information is subject to the confidentiality obligations set forth herein; and (iii) shall not be used by the Trading Partner for any purpose not set forth herein or otherwise authorized in writing by the TennCare program. The Parties shall diligently exercise the highest degree of care to preserve the security and integrity of, and prevent unauthorized access to, the Confidential Information. By executing this Agreement, Trading Partner and TennCare assure that each respective organization has established written policies and procedures relating to confidentiality, including the confidentiality of protected health information and eligibility information. The Trading Partner and TennCare further assure, by executing this Agreement, that its respective organization has implemented administrative, technical and physical safeguards and mechanisms that protect against the unauthorized or inadvertent disclosure of confidential information to any person or entity outside its organization.

4.1.3 Any information obtained by TennCare Trading Partners, intermediaries or carriers in the course of carrying TennCare agreements shall not be disclosed and remain confidential; furthermore, such requests which have been made pursuant to the Tennessee Public Records Act shall be denied under authority of an appropriate exemption.

4.2 Explicit Data Sharing. TennCare contemplates data sharing within the ambit of HIPAA to include, but not be limited to; specific testing environments for the purpose of establishing a treatment relationship or to respond to Medicare Advantage plan finder file eligibility inquiries for the purpose of identifying dual-eligibles enrolled in the Medicare Advantage plan.

Such transactions shall be implemented under the health care operations exception set forth in HIPAA and for payment purposes, respectively.

4.2.1 Data Storage. Trading Partner, if a Health Care Clearinghouse, shall not store eligibility information received on behalf of a request by a subscriber provider except to the extent confirmation of delivery is necessary. In no event shall Trading Partner store eligibility information beyond a reasonable threshold period defined by the State as a maximum of thirty (30) days unless otherwise required by law, nor shall Trading Partner retain TennCare related data for independent third-party documentation without prior approval and written authorization from the State program.

4.2.2 To the extent Trading Partner is classified as a Health Care Clearinghouse, Trading Partner shall not inquire *en masse* for eligibility data for an entire subscriber provider roster where the inquiry is not in the context of immediate treatment, payment or health care operations.

To the extent Trading Partner is classified as a Health Care Clearinghouse, Trading Partner may forward requests on behalf of and on the explicit request of health care provider subscribers who in turn can request the eligibility data only to support a direct patient treatment relationship and verification of eligibility to support treatment, payment or health care operations for a patient who represents that he/she is covered by Medicaid or the applicable TennCare program or whom the health care provider reasonably believes to be covered by Medicaid or the applicable TennCare program.

4.2.3 Prohibition of Data Mining. Unless otherwise agreed to by the parties and in support of functions contained in the agreements listed in Section 1.2, Trading Partner is prohibited from any and all automated extraction of predictive information from data for the purpose of finding patterns of behavior and trends or anomalies that may otherwise escape detection, the advanced statistical analysis and modeling of the data to find useful patterns and relationships, and the use of computational techniques involving statistics, machine learning and pattern recognition to analyze the data.

4.3. Treatment Relationship. To the extent data sharing or electronic data interchange (EDI) is utilized between the Parties for the purposes of provision, coordination or management of a treatment relationship, such use or disclosure shall be governed by strict compliance with return and destruction of protected health information (PHI) referenced in Section 9.3 of this Agreement.

4.3.2 Medicare Advantage Plan. The State may use or disclose PHI for its payment purposes, as well as for the payment purposes of another covered entity that receives the information. The State will accept and respond to Medicare Advantage plans' "finder files" to enable Medicare

Advantage plans to claim the appropriate payment rate for their dual eligible enrollees pursuant to the limiting provisions within this Agreement.

4.3.2.1 Access/Usage Fee. TennCare reserves the right to amend this Agreement to institute fees predicated upon Trading Partner's access to and usage of enrollee data absent a bidirectional relationship for such data.

4.3.3 Suspension of Access. TennCare reserves the right to suspend Trading Partner's access in the event of Trading Partner's inappropriate use of access as determined by TennCare, including, but not limited to, in the event fifty percent (50%) of Trading Partner requests received are not matched. TennCare may evaluate such patterns for indications of inappropriate use, including inquiry outside of the context of immediate treatment, payment or healthcare operations, or where the Trading Partner has no reasonable cause to believe that information requested was for individuals eligible for the applicable TennCare program.

5. CLAIMS, CHARGES AND PAYMENT

5.1 Consideration. The Trading Partner certifies that all services for which reimbursement will be claimed shall be provided in accordance with all federal and State laws pertaining to TennCare Programs.

5.1.1 The Trading Partner certifies that all charges submitted for services and items provided shall not exceed Trading Partner's and/or Provider's usual and customary charges for the same services and items provided to persons not entitled to receive benefits under TennCare Programs.

5.1.2 The Trading Partner understands that any payments made in satisfaction of claims submitted through Electronic Media shall be delivered from federal and State funds and that any false claims, statements or documents, or concealments of a material fact may be subject to prosecution under federal and state law.

5.2 Access. The Trading Partner and/or Provider shall allow TennCare access to claims data and assures that claims data shall be submitted by authorized personnel so as to preclude erroneous payments received by the Trading Partner and/or Provider regardless of the reason for such erroneous payments.

6. GUIDELINES FOR TENNCARE STANDARD ELECTRONIC TRANSACTIONS

6.1 HIPAA Transactions. The State has adopted the HIPAA transaction standards and has created companion documentation to assist in conducting electronic transactions with the State. The ASC X12 and National Council for Prescription Drug Programs ("NCPDP") standards required by HIPAA regulation are formulated to minimize the need for users to reprogram their data processing systems for multiple formats by allowing data interchange through the use of common interchange structures.

6.2 Acknowledgement Capacity. The State shall acknowledge standard transactions from an authorized Trading Partner. No other transactions are acknowledged including proprietary formats and those from an unauthorized submitter.

6.3 HIPAA Companion Guide. All TennCare specific information can be found in the TennCare HIPAA Companion Guide, which is a de facto part of this Trading Partner Agreement. The TennCare HIPAA Companion Guide is a multi-part document that can be accessed from the TennCare SFTP server or provided by e-mail via written request.

6.3.1 270/271 Healthcare Eligibility Benefit Inquiry/Response. Transaction Standard for Eligibility for a Health Plan - This transaction is used by fee-for-service ("FFS") providers to receive eligibility information about a subscriber. The State may also use this transaction set to verify eligibility for a third party health plan or Medicare Advantage plan. Data sharing or EDI utilized between the Parties shall be for the purposes of provision, coordination or management of a current treatment relationship or for an enrollee for whom an open balance exists which has been timely filed and is within the State's look-back time parameters.

6.3.2 276/277 Health Care Claim Status. Transaction Standard for Health Care Claim Status and Response – This transaction is used by the FFS provider to get the status of a claim.

6.3.3 278 Referral Certification and Authorization. Transaction Standard for Referral Certification and Authorization – This transaction is used by FFS providers to request prior authorization for clients receiving services from a FFS provider.

6.3.4 820 Payment Order/Remittance Advice. Transaction Standard for Health Plan Premium Payments – This transaction shall be sent to the Managed Care Contractors ("MCCs") and shall contain the capitated payment summary for the month.

6.3.5 834 Benefit Enrollment and Maintenance. Transaction Standard for Enrollment and Disenrollment in a Health Plan – This transaction is sent to the MCCs and shall contain enrollment information for the MCC. A 271U response transaction that primarily contains service limits information is always distributed with an 834.

6.3.6 835 Remittance Advice. Transaction Standard for health Care Payment and Remittance Advice - This transaction is used by FFS providers to receive an electronic remittance advice.

6.3.7 837 Professional. Transaction Standard for Health Care Claims or Equivalent Encounter Information: Professional – This transaction is used to submit professional claims from FFS providers and encounter data information from the MCCs.

6.3.8 837 Dental. Transaction Standard for Health Care Claims or Equivalent Encounter Information: Dental - This transaction is used to submit dental encounter data from the Dental MCC.

6.3.9 837 Institutional. Transaction Standard for Health Care Claims or Equivalent Encounter Information: Institutional - This transaction is used to submit institutional claims from FFS providers and encounter data information from the MCCs.

6.3.10 NCPDP 1.2 or PAS 45. Transaction Standard for Health Care Claims or Equivalent Encounter Information: Pharmacy -This transaction is used to submit retail pharmacy crossover claims from the Durable Medical Equipment Regional Carrier ("DMERC") and encounter data information from the Pharmacy MCC and DSNPs.

6.4 HL7 and Other Standard Transactions. TennCare has adopted HL7 to support its Health Information Exchange (HIE) activities and may adopt other standard transactions as needed to support its business activities. Companion Guides or usage documentation may be provided to define TennCare specific information using an appropriate format for the given transaction standard.

7. ELECTRONIC DATA INTERCHANGE (EDI) DOCUMENTS

7.1 EDI Request Form. The EDI Request Form may be found on the TennCare website. It outlines all transactions used between applicable TennCare programs and the Trading Partner including HIPAA transactions and proprietary formats. For most proprietary formats, the transaction name is sufficient identification information; however, a file format and/or additional clarification data for any proprietary format may be appended to the EDI Request Form, if necessary. All completed EDI Request Forms and related questions should be directed to the TennCare EDI Unit via mail or email at the address below.

7.1.1 Updates to the EDI Request Form may be made at any time by mutual agreement of both parties. Each update of the EDI Request Form supersedes all prior versions; therefore, each EDI Request Form must contain all transactions between both parties.

7.2 HIPAA Acknowledgment. All X12 transactions received by the State shall receive a 999 acknowledgement regardless of their HIPAA status.

7.2.1 Each Trading Partner has the option to send back to the State 999 acknowledgement transactions on all formats, except the State outbound 834 and 271U transactions, which require acknowledgements. The Trading Partner must indicate their acknowledgement intent for every transaction on the EDI Request Form.

7.2.2 Any transaction, per the Trading Partner Agreement, requiring an acknowledgement back to the State where an acknowledgement is not received, shall result in a transmission re-send before the next update cycle is processed.

7.3 Transaction Tables. The "Transaction Frequency" column shall contain the anticipated normal frequency of this transaction. Anticipated values are "D" for daily, "W" for weekly, "S" for semi-monthly, "M" for monthly, "Q" for quarterly, "A" for annually, "R" for on-request, "O" for other. Multiple indicators may be used for a transaction that has multiple processing cycles.

7.3.1 The "Transaction Source" column shall contain the origination source for the transaction. For transactions that come from the State, this column is already filled in with "TennCare". For

transactions from the Trading Partner, "TP" may be used. For transactions created by a third party for the Trading Partner, enter the third party's name.

7.3.2 The "Trading partner access person" column shall contain the name(s) of all individuals listed on the Security Forms below who shall access the given transaction.

7.3.3 The blank transaction rows on the request form are for proprietary file formats. Each production file sent between the State and the Trading Partner shall be represented on this form. Trading Partners that have multiple sources for a given transaction should include the file format once for each source.

7.4 Unique Identifier. The State shall assign a unique identification number or "Submitter ID" to every Trading Partner. For most Trading Partners, the Submitter ID shall be based upon tax ID – Employer Identification Number (EIN) or Social Security Number (SSN) – since the tax ID is already a required identifier on many HIPAA transactions. The assigned Submitter ID shall be used on all HIPAA transactions. The Submitter ID shall be used as the Receiver ID for transactions that originate from the State.

7.4.1 The Trading Partner may provide a GS02 sender code on the EDI Request form. This code shall be used as the GS03 receiver code for transactions originating from the State. A default value of the Trading Partner's Submitter ID shall be used if a value is not specified.

8. SECURITY

8.1 Security Forms. Trading Partner shall complete an acknowledgement of the State Acceptable Use Policy for every individual that shall access the State System. The State's security standards and the Center for Medicare and Medicaid Services (CMS) privacy and security regulations require the assignment of individual IDs.

8.1.1 For all forms requiring signatures, two (2) signed copies of completed forms must be mailed or a copy emailed to the TennCare EDI Unit at the address below. All forms must be completed as accurately as possible.

8.1.2 Upon processing of security forms, the State will countersign and return a copy of the forms for Trading Partner's files, along with Trading Partner's pertinent sign-on information.

8.1.3 Additional Security Forms may be submitted by the Trading Partner at any time after the execution of this Agreement to request access for additional individuals. Standard State processing shall apply to the additional requests.

8.2 Terminated Employees - Security. It is the responsibility of the Trading Partner to notify the State when a listed individual leaves the employment of the Trading Partner or has a legal name change. Failure to do so may result in the contract termination.

8.3. Access Request. Trading Partner shall submit a completed TennCare Access Request form for each type of access desired for the transmission or reception of transaction data, and for each Trading Partner workforce individual controlling such transmissions or receptions.

8.3.1 The Trading Partner shall submit for the State's approval a list of from one (1) to three (3) Trading Partner workforce individuals authorized to submit Access Requests on behalf of the Trading Partner.

8.3.2 It is the responsibility of the Trading Partner to notify the State when a Trading Partner workforce individual authorized to submit Access Request forms leaves the employment of the Trading Partner or has a legal name change.

8.4 Remote Access Request. The Trading Partner shall complete and provide to the State a Remote Access Request. It is the responsibility of the Trading Partner to notify the State, by providing an updated Remote Access Request, any material changes to their systems and networks that would have impact on their connectivity with the State's networks.

9. TERM AND TERMINATION

9.1 Term. This Agreement shall be effective as of the date on which it has been signed by both parties and the term of this Agreement shall be for one year from the effective date, at which time it will automatically renew for successive periods of one (1) year unless otherwise terminated in accordance with this Agreement.

9.1.1 This Agreement may be terminated by either party by giving at least thirty (30) days advanced written notice to the other party. Any provisions required by State or federal statue shall survive the expiration, cancellation, or termination of this Agreement.

9.2 Termination for Cause. This Agreement authorizes and Trading Partner acknowledges and agrees TennCare shall have the right to immediately terminate this Agreement and suspend operations, including, but not limited to, all processing operations, or any part thereof, or payments to providers, if Trading Partner fails to comply with, or violates a material provision of this Agreement.

9.2.1 Upon TennCare's knowledge of a material breach by Trading Partner, TennCare shall either: (i) Provide notice of breach and an opportunity for Trading Partner to reasonably and promptly cure the breach or end the violation, and terminate this Agreement if Trading Partner does not cure the breach or end the violation within the reasonable time specified by TennCare; or (ii) Immediately terminate this Agreement if Trading Partner has breached a material term of this Agreement and cure is not possible; or (iii) If termination, cure, or end of violation is not feasible, TennCare shall report the violation to the Secretary.

9.3 Effect of Termination. Upon termination of this Agreement for any reason, Trading Partner shall, at its own expense, either return and/or destroy all confidential information (including PHI) received, from the applicable TennCare program or created or received by Trading Partner on behalf of the applicable TennCare program. This provision applies to all confidential information

regardless of form, including but not limited to electronic or paper format. This provision shall also apply to PHI and other confidential information in the possession of sub-contractors or agents of Trading Partner.

9.3.1 The Trading Partner shall consult with the State as necessary to assure an appropriate means of return and/or destruction and shall notify the State in writing when such destruction is complete. If information is to be returned, the Parties shall document when all information has been received by the State.

9.3.2 The State shall not prohibit the retention of a single separate, archived file of the confidential TennCare information by the Trading Partner if the method of such archiving reasonably protects the continued privacy and security of such information and the Trading Partner obtains written approval at such time from the State. Otherwise, neither Trading Partner nor its subcontractors and agents shall retain copies of the State's confidential information, including enrollee PHI, except as provided herein.

9.3.3 The Parties agree to anticipate the return and/or the destruction of the State's confidential information, and understand that removal of the confidential information from Trading Partner's information system(s) and premises will be expected in almost all circumstances. The Trading Partner shall notify the State whether it intends to return and/or destroy the confidential information with such additional detail as requested. In the event Trading Partner determines that returning or destroying confidential information received by or created for the State at the end or other termination of this Agreement is not feasible, Trading Partner shall provide notification to the State of the conditions that make return or destruction unfeasible.

9.3.4 The Parties contemplate the State's confidential information shall not be merged or aggregated with data from sources unrelated to this Agreement, or Trading Partner's other business data, including for purposes of data backup and disaster recovery, until the parties identify the means of return or destruction of State data or State confidential information at the conclusion of this Agreement, or otherwise make an express alternate agreement consistent with the provisions of this Section.

9.3.5 Upon written mutual agreement of the Parties that return or destruction of all State confidential information is unfeasible and upon express agreement as to the means of continued protection of the data, Trading Partner shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI or other confidential information to those purposes that make the return or destruction unfeasible, for so long as Trading Partner maintains such PHI or other confidential information.

10. GENERAL PROVISIONS

10.1 Regulatory Reference.A reference in this Agreement to a State or federal law or regulation means the State or federal law or regulation as in effect or as amended.

10.2 Amendment. The Parties agree to take such action to amend this Agreement from time to time as is necessary to comply with related State and federal regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended.

10.3 Assignment. Trading Partner shall not sell, transfer, assign or dispose of this Agreement, whole or in part, or any right, title or interest therein, to any other party without the express written consent of TennCare. Such consent, if granted, shall not relieve Trading Partner of its obligations under the Agreement.

10.4 Billing Service(s). In the event a billing service is used, the Trading Partner hereby certifies that the billing service is authorized to submit claims on the Trading Partner's behalf using Electronic Media. The Trading Partner agrees that if the billing agreement with the billing service is terminated, the Trading Partner shall immediately report the termination in writing to TennCare. The Trading Partner must complete a new security agreement and testing cycle when making a change from one billing service to another.

10.5 Entire Agreement. This Agreement, together with all addenda attached hereto and incorporated by reference herein, and construed in conjunction with a SC, CRA and/or BAA, contains the entire agreement of the parties and supersedes any previous understanding, commitment or agreement, oral or written, concerning the subject matter hereof, all of which are hereby incorporated. Any change to this Agreement shall be effective only when set forth in writing and executed by the parties.

10.6 Prohibition of Offshore Disclosure. Nothing in this Agreement shall permit the Trading Partner to view, share, and use or disclose TennCare confidential information in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States without prior approval and express written authorization from TennCare.

10.7 Survival. The respective rights and obligations of Trading Partner under Section 9.3 of this Agreement shall survive the termination of this Agreement.

10.8 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Trading Partner and TennCare to comply with State and federal laws or regulations.

10.9 Headings. Paragraph Headings are used in this Agreement are for the convenience of the Parties and shall have no legal meaning in the interpretation of the Agreement.

10.10 Notices and Communications. All instructions, notices, consents, demands, or other communications required or contemplated by this Agreement shall be in writing and shall be delivered by hand, by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below, or to such other party, facsimile number, or address as may be hereafter specified by written notice. (For purposes of this section, effective notice to "Respective Party" is not dependent on whether the person named below remains employed by such Party.) The Parties agree to use their best efforts to immediately notify the other Party of changes in address,

telephone number, and fax numbers and to promptly supplement this Agreement as necessary with corrected information.

BUREAU OF TENNCARE:

TennCare EDI Unit
State of Tennessee
Dept. of Finance and Administration
Division of TennCare
310 Great Circle Road, Nashville, TN 37243
Email: EDI.TennCare@tn.gov

TRADING PARTNER:

Cariten Health Plan Inc.
2160 Lakeside Centre Way, Suite 200
Knoxville, TN 37922
Email:

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the date of hand delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the facsimile machine at the receiving location and receipt is verbally confirmed by the sender.

10.11 Strict Compliance. No failure by any Party to insist upon strict compliance with any term or provision of this Agreement, to exercise any option, to enforce any right, or to seek any remedy upon any default of any other Party shall affect, or constitute a waiver of, any Party's right to insist upon such strict compliance, exercise that option, enforce that right, or seek that remedy with respect to that default or any prior, contemporaneous, or subsequent default. No custom or practice of the Parties at variance with any provision of this Agreement shall affect, or constitute a waiver of, any Party's right to demand strict compliance with all provisions of this Agreement.

10.12 Severability. With respect to any provision of this Agreement finally determined by a -- court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect.

10.13 State Liability. The State shall have no liability except as specifically provided in this Agreement.

10.14 Intellectual Property. Neither party shall acquire any rights in the other party's Proprietary and/or Confidential Information under this Agreement except the limited rights necessary to perform or carry out the intended purposes set forth in this Agreement. This Agreement grants no license by either party to the other, either directly or by implication, estoppel or otherwise. All right, title and interest emanating from ownership of the Proprietary and/or Confidential Information shall remain vested in the State.

10.15 Injunctive Relief. The parties acknowledge that any remedy at law for the breach threatened breach of the provisions of this Agreement may be inadequate to fully and properly protect TennCare and, therefore, the parties agree that TennCare may be entitled to injunctive relief in

addition to other available remedies; provided, however, that nothing contained herein shall be construed as prohibiting the State from pursuing any other remedies available in law or in equity for such breach or threatened breach.

10.16 Force Majeure. The obligations of the parties to this Agreement are subject to prevention by causes beyond the parties' control that could not be avoided by the exercise of due care including, but not limited to, acts of God, riots, wars, strikes, epidemics or any other similar cause.

10.17 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee except to the extent that Tennessee law has been pre-empted by federal legislation and without giving effect to principles of conflicts of law. Jurisdiction shall be Davidson County, Nashville, Tennessee, for purposes of any litigation resulting from disagreements of the parties for purpose of this Agreement.

IN WITNESS WHEREOF, the Parties execute this Agreement to be valid and enforceable from the last date set out below:

By: _____
Stephen Smith, Director

Date: 6/30/2023

State of Tennessee
Dept. of Finance and Administration
Division of TennCare
310 Great Circle Road, Nashville, TN 37243

By: _____
George Renaudin, President, Medicare and Medicaid

Date: 6/23/2023

Cariten Health Plan Inc.
2160 Lakeside Centre Way, Suite 200
Knoxville, TN 37922

HIPAA Business Associate Agreement

THIS HIPAA BUSINESS ASSOCIATE AGREEMENT ("Agreement") is between The State of Tennessee, Division of TennCare ("TennCare" or "Covered Entity"), located at 310 Great Circle Road, Nashville, TN 37243 and Cariten Health Plan ("Business Associate"), located at, 500 W. Main St., Louisville, KY 40202, including all office locations and other business locations at which Business Associate data may be used or maintained. Covered Entity and Business Associate may be referred to herein individually as "Party" or collectively as "Parties."

BACKGROUND

The Parties acknowledge that they are subject to the Privacy and Security Rules (45 C.F.R. Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, and as amended by the final rule modifying the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act (HITECH). If Business Associate provides services to Covered Entity pursuant to one or more contractual relationships, said Agreements are detailed below and hereinafter referred to as "Service Agreements."

LIST OF AGREEMENTS AFFECTED BY THIS HIPAA BUSINESS ASSOCIATE AGREEMENT:

DSNP Contract between State of Tennessee, Department of Finance and Administration, Divisionof TennCare and Cariten Health Plan

In the course of performing services under a Service Agreement, Business Associate may come into contact with, use, or disclose Protected Health Information ("PHI"). Said Service Agreements are hereby incorporated by reference and shall be taken and considered as a part of this document the same as if fully set out herein.

In accordance with the federal privacy and security rules and regulations set forth at 45 C.F.R. Part 160 and Part 164, Subparts A, C, D and E, which require Covered Entity to have a written memorandum with each of its Business Associates, the Parties wish to establish satisfactory assurances that Business Associate will appropriately safeguard PHI that Business Associate may receive (if any) from or on behalf of Covered Entity, and, therefore, execute this Agreement.

1. DEFINITIONS

All capitalized terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms defined in 45 C.F.R. Parts 160 through 164 or other applicable law or regulation. A

reference in this Agreement to a section in the Privacy or Security Rule means the section as in effect or as amended.

1.1 "Commercial Use" means obtaining PHI with the intent to sell, transfer or use it for commercial, or personal gain, or malicious harm; sale to third party for consumption, resale, or processing for resale; application or conversion of data to make a profit or obtain a benefit contrary to the spirit of this Agreement, including but not limited to presentation of data or examples of data in a conference or meeting setting where the ultimate goal is to obtain or gain new business.

1.2 "Confidential Information" shall mean any non-public, confidential or proprietary information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, which is supplied by TennCare to the Business Associate under this Agreement. Any information, whether written, graphic, oral, electronic, visual or fixed in any tangible medium or expression, relating to individuals enrolled in the TennCare program ("TennCare enrollees"), or relating to individuals who may be potentially enrolled in the TennCare program, which is provided to or obtained through the Business Associate's performance under this Agreement, shall also be treated as "Confidential Information" to the extent that confidential status is afforded such information under state and federal laws or regulations. All confidential information shall not be subject to disclosure under the Tennessee Public Records Act.

1.3 "Electronic Signature" means an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

1.4 "Marketing" shall have the meaning under 45 C.F.R. § 164.501 and the act or process of promoting, selling, leasing or licensing any TennCare information or data for profit without the express written permission of TennCare.

2. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Privacy Rule)

2.1 Compliance with the Privacy Rule. Business Associate shall fully comply with the requirements under the Privacy Rule applicable to "business associates," as that term is defined in the Privacy Rule and not use or further disclose PHI other than as permitted or required by this Agreement, the Service Agreements, or as required by law. In case of any conflict between this Agreement and the Service Agreements, this Agreement shall govern.

2.2 HITECH Act Compliance. The Health Information Technology for Economic and Clinical Health Act (HITECH) was adopted as part of the American Recovery and Reinvestment Act of 2009. HITECH and its implementing regulations impose new requirements on Business Associates with respect to privacy, security, and Breach notification. Business Associate hereby acknowledges and agrees that to the extent it is functioning as a Business Associate of Covered Entity, Business Associate shall comply with any applicable provisions of HITECH. Business Associate and the Covered Entity further agree that the provisions of HIPAA and HITECH that apply to business associates and that are required to be incorporated by reference in a business associate agreement have been incorporated into this Agreement between Business Associate and Covered Entity. Should any provision not be set forth specifically, it is as if set forth in this Agreement in its entirety and is effective as of the Applicable Effective Date, and as amended.

2.3 Business Management. Business Associate may use and disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of Business Associate. Business Associate may provide data aggregation services relating to the Health Care Operations of TennCare, or as required by law. Business Associate is expressly prohibited from

using or disclosing PHI other than as permitted by this Agreement, any associated Service Agreements, or as otherwise permitted or required by law, and is prohibited from uses or disclosures of PHI that would not be permitted if done by the Covered Entity.

2.4 Privacy Safeguards and Policies. Business Associate shall use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by the Service Agreement(s), this Agreement or as required by law. This includes the implementation of Administrative, Physical, and Technical Safeguards to reasonably and appropriately protect the Covered Entity's PHI against any reasonably anticipated threats or hazards, utilizing the technology commercially available to the Business Associate (See also Section 3.2). The Business Associate shall maintain appropriate documentation of its compliance with the Privacy Rule, including, but not limited to, its policies, and procedures, records of training and sanctions of members of its Workforce.

2.5 Business Associate Contracts. Business Associate shall require any agent, including a Subcontractor, to whom it provides PHI received from, maintained, created or received by Business Associate on behalf of Covered Entity, or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI or other confidential TennCare information, to agree, by written agreement with Business Associate, to substantially similar, but not less stringent restrictions and conditions that apply through this Agreement to Business Associate with respect to such information except for the provision at section 4.6, which shall only apply to the Business Associate notwithstanding the requirements in this section 2.5.

2.6 Mitigation of Harmful Effect of Violations. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

2.7 Reporting of Violations in Use and Disclosure of PHI. Business Associate shall require its employees, agents, and Subcontractors to promptly report to Business Associate immediately upon becoming aware of any use or disclosure of PHI in violation of this Agreement and to report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement. The Business Associate shall report such violation to Covered Entity immediately upon becoming aware of, and in no case later than 48 hours after discovery.

2.8 Breach of Unsecured Protected Health Information. As required by the Breach Notification Rule, Business Associate shall, and shall require its Subcontractor(s) to, maintain systems to monitor and detect a Breach of Unsecured PHI, whether in paper or electronic form.

2.8.1 Business Associate shall provide to Covered Entity notice of a Breach of Unsecured PHI immediately upon becoming aware of the Breach, and in no case later than 48 hours after discovery.

2.8.2 Business Associate shall cooperate with Covered Entity in timely providing the appropriate and necessary information to Covered Entity.

2.8.3 Covered Entity shall make the final determination whether the Breach requires notification to affected individuals and whether the notification shall be made by Covered Entity or Business Associate.

2.9 Access of Individual to PHI and other Requests to Business Associate. If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate agrees to provide access to PHI in a Designated Record Set to Covered Entity in order to meet its requirements under 45 C.F.R. § 164.524. If Business Associate receives a request from an Individual for a copy of the Individual's PHI, and the PHI is in the sole possession of the Business Associate, Business Associate will provide the requested copies to the Individual in a timely manner. If Business Associate receives a request for PHI not in its possession and in the possession of the Covered Entity, or receives a request to exercise other Individual rights as set forth in the Privacy Rule, Business Associate shall promptly forward the request to Covered Entity. Business Associate shall then assist Covered Entity as necessary in responding to the request in a timely manner. If a Business Associate provides copies of PHI to the Individual, it may charge a reasonable fee for the copies as the regulations shall permit.

2.10 Requests to Covered Entity for Access to PHI. The Covered Entity shall forward to the Business Associate in a timely manner any Individual's request for access to or a copy (in any form they choose, provided the PHI is readily producible in that format) of their PHI that shall require Business Associate's participation, after which the Business Associate shall provide access to or deliver such information as follows:

(a) The Parties understand that if either Party receives a request for access to or copies of PHI from an Individual which the Party may complete with only its own onsite information, the time for such response shall be thirty (30) days, with notification to the Covered Entity upon completion.

(b) If the Covered Entity receives a request and requires information from the Business Associate in addition to the Covered Entity's onsite information to fulfill the request, the Business Associate shall have fifteen (15) days from date of Covered Entity's notice to provide access or deliver such information to the Covered Entity so that the Covered Entity may timely respond to the Individual within the thirty (30) day requirement of 45 C.F.R. § 164.524.

(c) If the Party designated above as responding to the Individual's request is unable to complete the response to the request in the time provided, that Party shall provide the Individual, or Individual's designee, with a written statement of the reasons for the delay and the date by which the Party will complete its action on the request. The Party may extend the response time once for no more than thirty (30) additional days.

(d) Business Associate is permitted to send an Individual or Individual's designee unencrypted emails including Electronic PHI if the Individual requests it, provided the Business Associate has advised the Individual of the risk and the Individual still prefers to receive the message by unencrypted email.

2.11 Individuals' Request to Amend PHI. If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate agrees to make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 C.F.R. § 164.526, regarding an Individual's request to amend PHI. The Business Associate shall make the amendment promptly in the time and manner designated by Covered Entity, but shall have thirty (30) days' notice from Covered Entity to complete the amendment to the Individual's PHI and to notify the Covered Entity upon completion.

2.12 Recording of Designated Disclosures of PHI. Business Associate shall document any and all disclosures of PHI by Business Associate or its agents, including information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

2.13 Accounting for Disclosures of PHI. The Business Associate agrees to provide to Covered Entity or to an Individual, or Individual's designee, in time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. The Covered Entity shall forward the Individual's request requiring the participation of the Business Associate to the Business Associate in a timely manner, after which the Business Associate shall provide such information as follows:

(a) If Covered Entity directs Business Associate to provide an accounting of disclosures of the Individual's PHI directly to the Individual, the Business Associate shall have sixty (60) days from the date of the Individual's request to provide access to or deliver such information to the Individual or Individual's designee. The Covered Entity shall provide notice to the Business Associate in time to allow the Business Associate a minimum of thirty (30) days to timely complete the Individual's request.

(b) If the Covered Entity elects to provide the accounting to the Individual, the Business Associate shall have thirty (30) days from date of Covered Entity's notice of request to provide information for the Accounting to the Covered Entity so that the Covered Entity may timely respond to the Individual within the sixty (60) day period.

(c) If either of the Parties is unable to complete the response to the request in the times provided above, that Party shall notify the Individual with a written statement of the reasons for the delay and the date by which the Party will complete its action on the request. The Parties may extend the response time once for no more than thirty (30) additional days.

(d) The accounting of disclosures shall include at least the following information:

(1) date of the disclosure;
(2) name of the third party to whom the PHI was disclosed,
(3) if known, the address of the third party;
(4) brief description of the disclosed information; and
(5) brief explanation of the purpose and basis for such disclosure.

(e) The Parties shall provide one (1) accounting in any twelve (12) months to the Individual without charge. The Parties may charge a reasonable, cost-based fee, for each subsequent request for an accounting by the same Individual if he/she is provided notice and the opportunity to modify his/her request. Such charges shall not exceed any applicable State statutes or rules.

2.14 Minimum Necessary. Business Associate shall use reasonable efforts to limit any use, disclosure, or request for use or disclosure of PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request in accordance with the requirements of the Privacy Rule.

2.14.1 Business Associate represents to Covered Entity that all its uses and disclosures of, or requests for, PHI shall be the minimum necessary in accordance with the Privacy Rule requirements.

2.14.2 Covered Entity may, pursuant to the Privacy Rule, reasonably rely on any requested disclosure as the minimum necessary for the stated purpose when the information is requested by Business Associate.

2.14.3 Business Associate shall adequately and properly maintain all PHI received from, or created or received on behalf of, Covered Entity.

2.15 Privacy Compliance Review upon Request. Business Associate agrees to make its internal practices, books and records, including policies, procedures, and PHI, relating to the use and disclosure of PHI received from, created by or received by Business Associate on behalf of Covered Entity available to the Covered Entity or to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the requester, for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule.

2.16 Cooperation in Privacy Compliance. Business Associate agrees to fully cooperate in good faith and to assist Covered Entity in complying with the requirements of the Privacy Rule.

3. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Security Rule)

3.1 Compliance with Security Rule. Business Associate shall fully comply with the requirements under the Security Rule applicable to "Business Associates," as that term is defined in the Security Rule. In case of any conflict between this Agreement and Service Agreements, this Agreement shall govern.

3.2 Security Safeguards and Policies. Business Associate shall implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity as required by the Security Rule. This includes specifically, but is not limited to, the utilization of technology commercially available at the time to the Business Associate to protect the Covered Entity's PHI against any reasonably anticipated threats or hazards. The Business Associate understands that it has an affirmative duty to perform a regular review or assessment of security risks, conduct active risk management and supply best efforts to assure that only authorized persons and devices access its computing systems and information storage, and that only authorized transactions are allowed. The Business Associate will maintain appropriate documentation of its compliance with the Security Rule.

3.3 Security Provisions in Business Associate Contracts. Business Associate shall ensure that any agent to whom it provides Electronic PHI received from, maintained, or created for Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI supplied by Covered Entity, shall execute a bilateral contract (or the appropriate equivalent if the agent is a government entity) with Business Associate, incorporating substantially similar, but not less stringent restrictions and conditions in this Agreement with Business Associate regarding PHI except for the provision in Section 4.6.

3.4 Reporting of Security Incidents. The Business Associate shall track all Security Incidents as defined and as required by HIPAA and shall periodically report such Security Incidents in summary fashion as may be requested by the Covered Entity. The Covered Entity shall not consider as Security Incidents, for the purpose of reporting, external activities (port enumeration, etc.) typically associated with the "footprinting" of a computing environment as long as such activities have only identified but not compromised the logical network perimeter, including but not limited to externally facing firewalls and web servers. The Business Associate shall reasonably use its own vulnerability assessment of damage potential and monitoring to define levels of Security Incidents and responses for Business Associate's operations. However, the Business Associate shall expediently notify the Covered Entity's Privacy Officer of any related Security Incident, immediately upon becoming aware of any unauthorized acquisition including but not limited to use, disclosure, modification, or destruction of PHI by an employee or otherwise authorized user of its system of which it becomes aware.

3.4.1 Business Associate identifies the following key contact persons for all matters relating to this Agreement:

Greg Pullen
500 W. Main St. HUM 19
Louisville, KY 40202
gpullen@humana.com
(502) 580-6230

Business Associate shall notify Covered Entity of any change in these key contacts during the term of this Agreement in writing within ten (10) business days.

3.5 Contact for Security Incident Notice. Notification for the purposes of Sections 2.8and 3.4 shall be in writing made by email/fax, certified mail or overnight parcel immediately upon becoming aware of the event, with supplemental notification by facsimile and/or telephone as soon as practicable, to:

TennCare Privacy Officer
310 Great Circle Rd.
Nashville Tennessee 37243
Phone: (615) 507-6697
Facsimile: (615) 734-5289 Email:
Privacy.Tenncare@tn.gov

3.6 Security Compliance Review upon Request. Business Associate shall make its internal practices, books, and records, including policies and procedures relating to the security of Electronic PHI received from, created by or received by Business Associate on behalf of Covered Entity, available to the Covered Entity or to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the requester, for purposes of determining Covered Entity's, Business Associate's compliance with the Security Rule.

3.7 Cooperation in Security Compliance. Business Associate shall fully cooperate in good faith to assist Covered Entity in complying with the requirements of the Security Rule.

3.8 Refraining from intimidation or retaliation. A Covered Entity or Business Associate may not threaten, intimidate, coerce, harass, discriminate against, or take any other retaliatory action against any Individual or other person for-- (a) Filing of a complaint under 45 C.F.R. § 160.306; (b) testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing; or (c) opposing any act or practice made unlawful, provided the Individual or person has a good faith belief that the practice opposed is unlawful, and the manner of opposition is reasonable and does not involve a disclosure of PHI in violation of HIPAA.

4. USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Use and Disclosure of PHI for Operations on Behalf of Covered Entity. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform Treatment, Payment or Health Care Operations for, or on behalf of, Covered Entity as specified in Service Agreements, provided that such use or disclosure would not violate the Privacy and Security Rule, if done by

Covered Entity.

4.2 Other Uses of PHI. Except as otherwise limited in this Agreement, Business Associate may use PHI within its Workforce as required for Business Associate's proper management and administration, not to include Marketing or Commercial Use, or to carry out the legal responsibilities of the Business Associate.

4.3 Third Party Disclosure Confidentiality. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that disclosures are required by law, or, if permitted by law, this Agreement, and the Service Agreement, provided that, if Business Associate discloses any PHI to a third party for such a purpose, Business Associate shall enter into a written agreement with such third party requiring the third party to: (a) maintain the confidentiality, integrity, and availability of PHI and not to use or further disclose such information except as required by law or for the purpose for which it was disclosed, and (b) notify Business Associate of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the PHI is Breached immediately upon becoming aware.

4.4 Other Uses Strictly Limited. Nothing in this Agreement shall permit the Business Associate to share PHI with Business Associate's affiliates or contractors except for the purposes of the Service Agreement(s) between the Covered Entity and Business Associate(s) identified in the "LIST OF AGREEMENTS AFFECTED BY THIS HIPAA BUSINESS ASSOCIATE AGREEMENT" on page one (1) of this Agreement.

4.5 Covered Entity Authorization for Additional Uses. Any use of PHI or other confidential TennCare information by Business Associate, its Subcontractors, its affiliate or Contractor, other than those purposes of this Agreement, shall require express written authorization by the Covered Entity, and a Business Associate agreement or amendment as necessary. Activities which are prohibited include, but not are not limited to, Marketing or the sharing for Commercial Use or any purpose construed by Covered Entity as Marketing or Commercial use of TennCare enrollee personal or financial information with affiliates, even if such sharing would be permitted by federal or state laws.

4.6 Prohibition of Offshore Disclosure. Nothing in this Agreement shall permit the Business Associate to share, use or disclose PHI in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States without express written authorization from the Covered Entity.

4.7 Prohibition of Other Uses and Disclosures. Business Associate shall not use or disclose PHI that is Genetic Information for underwriting purposes. Moreover, the sale, marketing or the sharing for commercial use or any purpose construed by Covered Entity as the sale, marketing or commercial use of TennCare enrollee personal or financial information with affiliates, even if such sharing would be permitted by federal or state laws, is prohibited.

4.8 Data Use Agreement - Use and Disclosure of Limited Data Set. Business Associate may use and disclose a Limited Data Set that Business Associate creates for Research, public health activity, or Health Care Operations, provided that Business Associate complies with the obligations below. Business Associate may not make such use and disclosure of the Limited Data Set after any cancellation, termination, expiration, or other conclusion of this Agreement.

4.9 Limitation on Permitted Uses and Disclosures. Business Associate will limit the uses and disclosures it makes of the Limited Data Set to the following: Research, public health activity, or Health Care Operations, to the extent such activities are related to covered functions, including business planning and development such as conducting cost-management and planning-related analysis related to managing and operating Business Associates functions, formulary development and administration, development and improvement of methods of payment or coverage policies, customer service, including the provision of data analysis for policy holders, plan sponsors, or other customers, to the extent such activities are related to covered functions, provided that PHI is not disclosed and disclosure is not prohibited pursuant to any other provisions in this Agreement related to Marketing or Commercial use.

4.10 Business Associate shall enter into written agreements that are substantially similar to this Business Associate Agreements with any Subcontractor or agent which Business Associate provides access to Protected Health Information.

4.11 Business Associates shall implement and maintain information security policies that comply with the HIPAA Security Rule.

5. OBLIGATIONS OF COVERED ENTITY

5.1 Notice of Privacy Practices. Covered Entity shall provide Business Associate with the notice of Privacy Practices produced by Covered Entity in accordance with 45 C.F.R. § 164.520, as well as any changes to such notice.

5.2 Notice of Changes in Individual's Access or PHI. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses.

5.3 Notice of Restriction in Individual's Access or PHI. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use of PHI.

5.4 Reciprocity for Requests Received by Business Associate. The Parties agree that this Section (Section 5) is reciprocal to the extent Business Associate is notified or receives an inquiry from any Individual within Covered Entity's covered population.

6. TERM AND TERMINATION

6.1 Term. This Agreement shall be effective as of the date on which it has been signed by both parties and shall terminate when all PHI which has been provided, regardless of form, by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if the Parties agree that it is unfeasible to return or destroy PHI, subsection 6.3.5 below shall apply.

6.2 Termination for Cause. This Agreement authorizes and Business Associate acknowledges and agrees Covered Entity shall have the right to terminate this Agreement and Service Agreement in the event Business Associate fails to comply with, or violates a material provision of this Agreement and any provision of the Privacy and Security Rules.

6.2.1 Upon Covered Entity's knowledge of a Breach by Business Associate, Covered Entity shall either:

(a) Provide notice of breach and an opportunity for Business Associate to reasonably and promptly cure the breach or end the violation, and terminate this BAA if Business Associate does not cure the breach or end the violation within the reasonable time specified by Covered Entity; or

(b) Immediately terminate this BAA if Business Associate has breached a material term of this BAA and cure is not possible.

6.3 Effect of Termination. Upon termination of this Agreement for any reason, except as provided in subsections 6.3.2 and 6.3.5 below, Business Associate shall at its own expense either return and/or destroy all PHI and other confidential information received from Covered Entity or created or received by Business Associate on behalf of Covered Entity. This provision applies to all confidential information regardless of form, including but not limited to electronic or paper format. This provision shall also apply to PHI and other confidential information in the possession of sub-contractors or agents of Business Associate.

6.3.1 The Business Associate shall consult with the Covered Entity as necessary to assure an appropriate means of return and/or destruction and shall notify the Covered Entity in writing when such destruction is complete. If information is to be returned, the Parties shall document when all information has been received by the Covered Entity.

6.3.2 This provision (Section 6.3 and its subsections) shall not prohibit the retention of a single separate, archived file of the PHI and other confidential TennCare information by the Business Associate if the method of such archiving reasonably protects the continued privacy and security of such information and the Business Associate obtains written approval at such time from the Covered Entity. Otherwise, neither the Business Associate nor its Subcontractors and agents shall retain copies of TennCare confidential information, including enrollee PHI, except as provided herein in subsection 6.3.5.

6.3.3 The Parties agree to anticipate the return and/or the destruction of PHI and other TennCare confidential information, and understand that removal of the confidential information from Business Associate's information system(s) and premises will be expected in almost all circumstances. The Business Associate shall notify the Covered Entity whether it intends to return and/or destroy the confidential with such additional detail as requested. In the event Business Associate determines that returning or destroying the PHI and other confidential information received by or created for the Covered Entity at the end or other termination of the Service Agreement is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible.

6.3.4 Except for Business Associate Agreements in effect prior to April 21, 2005 when the Security Rule became effective, for the renewal or amendment of those same Agreements, or for other unavoidable circumstances, the Parties contemplate that PHI and other confidential information of the Covered Entity shall not be merged or aggregated with data from sources unrelated to that Agreement, or Business Associate's other business data, including for purposes of data backup and disaster recovery, until the parties identify the means of return or destruction of the TennCare data or other confidential information of the Covered Entity at the conclusion of the Service Agreement, or otherwise make an express alternate agreement consistent with the provisions of Section 6.3 and its subsections.

6.3.5 Upon written mutual agreement of the Parties that return or destruction of PHI is unfeasible and upon express agreement as to the means of continued protection of the data, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction unfeasible, for so long as Business Associate maintains such PHI.

7. MISCELLANEOUS

7.1 Regulatory Reference. A reference in this Agreement to a section in the Privacy and/or Security Rule means the section as in effect or as amended.

7.2 Amendment. The Parties agree to take such action to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act, Public Law 104-191. Business Associate and Covered Entity shall comply with any amendment to the Privacy and Security Rules, the Health Insurance Portability and Accountability Act, Public Law 104-191, and related regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended, including, but not limited to, changes required by the American Recovery and Reinvestment Act of 2009, Public Law 111-5.

7.3 Survival. The respective rights and obligations of Business Associate under Confidentiality and Section6.3 of this Agreement shall survive the termination or expiration of this Agreement.

7.4 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity and the Business Associate to comply with the Privacy and Security Rules.

7.5 Headings. Paragraph Headings used in this Agreement are for the convenience of the Parties and shall have no legal meaning in the interpretation of the Agreement.

7.6 Notices and Communications. All instructions, notices, consents, demands, or other communications required or contemplated by this Agreement shall be in writing and shall be delivered by electronic mail, hand, by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below, or to such other party, facsimile number, or address as may be hereafter specified by written notice. (For purposes of this section, effective notice to "Respective Party" is not dependent on whether the person named below remains employed by such Party.) The Parties agree to use their best efforts to immediately notify the other Party of changes in address, telephone number, and fax numbers and to promptly supplement this Agreement as necessary with corrected information.

Notifications relative to Sections 2.8 and 3.4 of this Agreement must also be reported to the Privacy Officer pursuant to Section 3.5.

COVERED ENTITY:

Stephen Smith, Director
Division of TennCare
310 Great Circle Rd.
Nashville, TN 37243

BUSINESS ASSOCIATE:

Greg Pullen
500 W. Main St. HUM 19
Louisville, KY 40202
gpullen@humana.com

Fax: (615) 253-5607

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the date of hand delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the facsimile machine at the receiving location and receipt is verbally confirmed by the sender.

7.7 Transmission of PHI or Other Confidential Information. Regardless of the transmittal methods permitted above, Covered Entity and Business Associate agree that all deliverables set forth in this Agreement that are required to be in the form of data transfers shall be transmitted between Covered Entity and Business Associate via the data transfer method specified in advance by Covered Entity. This may include, but shall not be limited to, transfer through Covered Entity's SFTP system. Failure by the Business Associate to transmit such deliverables in the manner specified by Covered Entity may, at the option of the Covered Entity, result in liquidated damages if and as set forth in one (1) or more of the Service Agreements between Covered Entity and Business Associate listed above. All such deliverables shall be considered effectively submitted upon receipt or recipient confirmation as may be required.

7.8 Strict Compliance. No failure by any Party to insist upon strict compliance with any term or provision of this Agreement, to exercise any option, to enforce any right, or to seek any remedy upon any default of any other Party shall affect, or constitute a waiver of, any Party's right to insist upon such strict compliance, exercise that option, enforce that right, or seek that remedy with respect to that default or any prior, contemporaneous, or subsequent default. No custom or practice of the Parties at variance with any provision of this Agreement shall affect, or constitute a waiver of, any Party's right to demand strict compliance with all provisions of this Agreement.

7.9 Severability. With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect.

7.10 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee except to the extent that Tennessee law has been pre-empted by HIPAA and HITECH and without giving effect to principles of conflicts of law. Jurisdiction shall be Davidson County, Nashville, Tennessee, for purposes of any litigation resulting from disagreements of the parties for purpose of this Agreement and the Service Agreement (s).

7.11 Compensation. There shall be no remuneration for performance under this Agreement except as specifically provided by, in, and through, existing administrative requirements of Tennessee State government and Services Agreement(s) referenced herein.

7.12 Validity of Execution. Unless otherwise agreed, the parties may conduct the execution of this Business Associate Agreement transaction by electronic means. The parties may agree that an electronic record of the Agreement containing an Electronic Signature is valid as an executed Agreement.

IN WITNESS WHEREOF, the Parties execute this Agreement to be valid and enforceable from the last date set out below:

DIVISION OF TENNCARE:

By: _____
Stephen Smith, Director

Date: 6/30/2023

Division of TennCare
310 Great Circle Road
Nashville, TN 37243
Fax: (615) 253-5607

BUSINESS ASSOCIATE:

By: _____

George Renaudin, President, Medicare and Medicaid

Date: 6/23/2023

Cariten Health Plan Inc.

500 W. Main St.

Louisville, KY 40202

ATTACHMENT D

TENNCARE COVERED BENEFITS

The benefits available to TennCare enrollees are listed in the TennCare Rules for TennCare Medicaid and TennCare Standard and are available on TennCare 's website. Definitions of specific services and services that are excluded from coverage are also listed in the rules. These rules should be consulted for information on particular limitations and coverage details.
Reference: See TennCare Rules 1200-13-13-.04 and 1200-13-14-.04 (Covered Services) and TennCare Rules 1200-13-13-.10 and 1200-13-14-.10 (Exclusions).

TennCare benefits include, but are not limited to, the following:

- Community health services
- Dental services
- Durable medical equipment
- Emergency air and ground transportation services
- EPSDT services for TennCare Medicaid-eligible children under age 21; preventive, diagnostic, and treatment services for TennCare Standard-eligible children under age 21
- Home health care1
- Hospice care
- Inpatient and outpatient substance abuse benefits
- Inpatient hospital services
- Lab & X-ray services
- Medical supplies
- Mental health case management
- Mental health crisis services
- Non-emergency transportation services
- Occupational therapy
- Organ and tissue transplant services and donor organ/tissue procurement services
- Outpatient hospital services
- Outpatient mental health services
- Pharmacy services
- Physical therapy services
- Physician services
- Private duty nursing services15
- Psychiatric inpatient facility services
- Psychiatric rehabilitation services
- Reconstructive breast surgery
- Renal dialysis clinic services
- Speech therapy services
- Vision services (for children under age 21)

Additional benefits are covered for children under 21 as medically necessary.

1 Home health benefits are limited for adults as follows: Part-time or intermittent nursing services must be no more than 1 visit/day, lasting less than 8 hours, and no more than 27 total hours of nursing care per week. Part-time or intermittent nursing services are not covered if the only skilled nursing function is administration of medication on an as needed basis. Home health aide services must be provided at no more than 2 visits/day, with care provided less than or equal to 8 hours/day. Nursing services and home health aide services combined must total less than or equal to 8 hours/day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 nursing care. See TennCare Medicaid rule 1200-13-13-.01 and TennCare Standard rule 1200-13-14-.01.

ATTACHMENT E

LIQUIDATED DAMAGES

In the event of a Contract performance or compliance failure by Contractor and such Contract performance or compliance failure is not included in the following table with an associated Liquidated Damage amount, the parties hereby agree that the State may choose one of the following courses of action in order to obtain redressability for such Contract performance or compliance failure: (1) the State may assess actual damages resulting from the Contract performance or compliance failure against the Contractor in the event that such actual damages are known or are reasonably ascertainable at the time of discovery of such Contract performance or compliance failure or (2) if such actual damages are unknown or are not reasonably ascertainable at the time of discovery of the Contract performance or compliance failure, the State may (a) require the Contractor to submit a corrective action plan to address any such Contract performance or compliance failure and (b) assess liquidated damages against Contractor for an amount that is reasonable in relation to the Contract performance or compliance failure as measured at the time of discovery of the Contract performance or compliance failure. In the event that the State chooses to assess a Liquidated Damage for a Contract performance or compliance failure according to the immediately preceding sentence, in no event shall such Liquidated Damage be in excess of $1,000 for any single Contract performance or compliance failure.

TennCare may elect to apply the following liquidated damages remedies in the event the Contractor fails to perform its obligations under this Contract in a proper and/or timely manner. Upon determination by TennCare that the Contractor has failed to meet any of the requirements of this Contract in a proper and/or timely manner, TennCare will notify the Contractor in writing of the performance or compliance failure and of the potential liquidated damages to be assessed. Should the performance or compliance failure remain uncorrected for more than thirty (30) calendar days from the date of the original notification of the performance or compliance failure by TennCare, TennCare may impose an additional liquidated damage of Five Hundred Dollars ($500) per day from the date of the original notification to Contractor until said performance or compliance failure is resolved.

All liquidated damages remedies set forth in the following table may, at TennCare's election, be retroactive to the date of the initial occurrence of the failure to comply with the terms of the Contract as set forth in the notice of performance or compliance failure from TennCare and may continue until such time as the TennCare Deputy Commissioner, or the Deputy Commissioner's representative, determines the performance or compliance failure has been cured.

If liquidated damages are assessed, TennCare shall reduce the amount of any payment due to the Contractor in the next invoice by the amount of damages. In the event that damages due exceed the amount TennCare is to pay to Contractor in a given payment, TennCare shall invoice Contractor for the amount exceeding the amount payable to Contractor, and such excess amount shall be paid by Contractor within thirty (30) calendar days of the invoice date. In situations where the Contractor wishes to dispute any liquidated damages assessed by TennCare, the Contractor must submit a written notice of dispute, including the reasons for disputing the liquidated damages, to the TennCare Deputy Commissioner or the Deputy Commissioner's representative within thirty (30) calendar days of receipt of the notice from TennCare containing the total amount of damages assessed against the Contractor. If the Contractor fails to timely dispute a liquidated damages assessment as set forth herein, such failure shall constitute a bar to the Contractor seeking to have the assessment amount overturned in a forum or court of competent jurisdiction.

Liquidated damages will apply to the Contract performance or compliance failures listed below. Contractor acknowledges that the actual damages likely to result from Contract performance or compliance failures are difficult to estimate and may be difficult for the State to prove. The parties intend that the Contractor's payment of assessed liquidated damages will compensate the State for breach of

the Contractor obligations under this Contract. Liquidated damages do not serve as punishment for any breach by the Contractor.

	PROGRAM ISSUES		DAMAGE
1.	Failure by the Contractor to meet the standards for privacy, security, and confidentiality of individual data as evidenced by a breach of the security per Section E. 5. and E.7 and Contractor's failure to timely and reasonably comply with its obligation to appropriately respond to any such breach		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member. For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter
2.	Failure by the Contractor to execute the appropriate agreements to effectuate transfer and exchange of enrollee PHI or TennCare confidential information including, but not limited to, a data use agreement, trading partner agreement, business associate agreement or qualified protective order prior to the use or disclosure of PHI to a third party. (See E.6. and Attachment C, Business Associate Agreement between the parties)		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member. For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter
3.	Failure by the Contractor to seek express written approval from TennCare prior to the use or disclosure of enrollee data or TennCare confidential information in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States. (See E.6 and Attachment C, Business Associate Agreement between the parties)		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member. For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter
4.	Failure by the Contractor to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of suspected breach per Sections (See E.7 and Attachment C, Business Associate Agreement between the parties)		For any occurrence affecting less than five hundred (500) members, the damage that may be assessed shall be one thousand dollars ($1,000.00) per affected member. For any occurrence affecting five hundred (500) members or more, the damage that may be assessed shall be up to one thousand dollars ($1000) per affected member for the first five hundred (500) affected members and then ten dollars ($10.00) per additional affected member thereafter.
5.	Failure by the Contractor to submit acceptable Claims and Encounter Files pursuant to Section A.2.d.		The damage that may be assessed shall be $500 per day for each calendar day acceptable Claims and Encounter

			Files are late.
6.	Failure by the Contractor to correct and resubmit rejected Encounters within 45 days not resubmitted with an 'Accepted' status pursuant to Section A.2.d.		Encounters that are rejected in Edifecs and pursuant to Section A.2.c will appear on the 45 day report and will receive liquidated damages in the amount of $100 per encounter per reporting period from day 45 up until the encounter is an 'Accepted' status.
7.	Failure by the Contractor to comply with Eligibility terms as specified in Section A.2.e.		The damage that may be assessed shall be $10,000 per member newly enrolled into the Contractor's D-SNP that is not eligible to enroll as described in Section A.2.d. In addition to payment of such fine, the Contractor shall immediately disenroll such member(s), providing notification as required by CMS.
8.	Failure by the Contractor to submit an acceptable Provider Enrollment File pursuant to Section A.2.f.		The damage that may be assessed shall be $500 per day for each calendar day an acceptable Provider Enrollment File is late.
9.	Failure by the Contractor to comply with the prohibition against limiting provider participation or a beneficiary's choice of providers as described in Section A2.f.2 of this Contract.		$10,000 for each violation that TENNCARE determines that the CONTRACTOR is not in compliance with the requirements of Section A..2.f.2 of this Contract.
10.	Failure by the Contractor to submit required deliverables pursuant to Sections A.2.j. by the designated deadline		The damage that may be assessed shall be $500 per day for each calendar day an acceptable required reporting data is late.
11.	Failure by the Contractor to respond to CM pursuant to A.5. or failure to submit audit findings that result in Immediate Corrective Action Required within ten (10) calendar days of responding to CMS pursuant to A.2.c.11.		The damage that may be assessed shall be $500 per day for each calendar day an acceptable response to CM or Immediate Corrective Action Required is submitted late.

ATTACHMENT F

SERVICE AREA

The Contractor shall ensure the following counties listed are consistent with the Contractor submission to the Centers of Medicare and Medicaid Services.

Anderson	Franklin	Lewis	Scott
Bedford	Gibson	Lincoln	Sequatchie
Benton	Giles	Loudon	Sevier
Bledsoe	Grainger	Macon	Shelby
Blount	Greene	Madison	Smith
Bradley	Grundy	Marion	Stewart
Campbell	Hamblen	Marshall	Sullivan
Cannon	Hamilton	Maury	Sumner
Carroll	Hancock	McMinn	Tipton
Carter	Hardeman	McNairy	Trousdale
Cheatham	Hardin	Meigs	Unicoi
Chester	Hawkins	Monroe	Union
Claiborne	Haywood	Montgomery	Van Buren
Clay	Henderson	Moore	Warren
Cocke	Henry	Morgan	Washington
Coffee	Hickman	Obion	Wayne
Crockett	Houston	Overton	Weakley
Cumberland	Humphreys	Perry	White
Davidson	Jackson	Pickett	Williamson
DeKalb	Jefferson	Polk	Wilson
Decatur	Johnson	Putnam	
Dickson	Knox	Rhea	
Dyer	Lake	Roane	
Fayette	Lauderdale	Robertson	
Fentress	Lawrence	Rutherford	