STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BENEFITS ADMINISTRATION
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Stuart C. McWhorter
COMMISSIONER

Laurie Lee
EXECUTIVE DIRECTOR

M E M O R A N D U M

TO: Krista Lee Carsner, Executive Director
Fiscal Review Committee Members

FROM: Laurie Lee, Benefits Administration

DATE: October 11, 2019

SUBJECT: Amendment Request to the Third Party Administrator Contracts

Benefits Administration (BA) submits for consideration by the Fiscal Review Committee the following amendments to the Cigna Health and Life Insurance Company (Cigna) contracts (Edison #47414, 47341, 47338, and 50294) for third party administrator (TPA) services for the State Public Sector Plans.

Through competitive bid processes, Cigna was awarded three regional contracts and a statewide contract. BA requests a one-year extension to all four contracts with changes in the maximum liability due to the extension. There is no administrative rate increase associated with this request. BA is requesting the one-year extension due to the lack of operational and procurement capacity in BA to manage a fifth major procurement in 2020. Unanticipated changes in BA's overall procurement schedule have resulted in BA procuring four other contracts in the next six months.

BA calculated a two percent enrollment growth year over year for the contract maximum liabilities. Enrollment growth is realized through new employment hires, new local agencies joining the plan, or through member choice of provider network movement between carriers. Likewise, enrollment decreases can also occur through the reverse scenarios. The requested maximum liability increases and decreases take into account the movement of members on and off the plan as well as movement between the carriers.

Edison #47414 – Amendment Two with a maximum liability increase of $5,600,000.

Edison #47341 – Amendment One with a maximum liability decrease of $3,636,000.

Edison #47338 – Amendment One with a maximum liability decrease of $9,771,500.

Edison #50294 – Amendment One with a maximum liability decrease of $33,938,602.

BA also wanted to provide additional information including questions regarding legal action or illegal activity:

1. *Provide information on the circumstances and status of any disciplinary action taken or pending against the vendor during the past 5 years with state agencies/departments, professional organizations, or through any legal action.*

   Cigna's response: Although CHLIC and certain other operating subsidiaries of Cigna may have been subject to regulatory actions, fines, sanctions and/or administrative penalties by certain federal and state governmental regulatory bodies, CHLIC's ability to fulfill its obligations under the State of Tennessee's contracts is not materially impacted.

2. *Provide any information regarding the due diligence that the Department has taken to ensure that the vendor is not or has not been involved in any circumstances related to illegal activity, including but not limited to fraud.*

   During the Request for Proposal (RFP) process we require all potential bidders to provide the following information:

   - Provide a statement of whether the company or, to the company's knowledge, any of the company's employees, agents, independent contractors, or subcontractors, involved in the delivery of goods or performance of services on a contract, have been convicted of, pled guilty to, or pled *nolo contendere* to any felony. If so, include an explanation providing relevant details.
   - Provide a statement of whether, in the last ten (10) years, the Company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, include an explanation providing relevant details.
   - Provide a statement of whether there is any material, pending litigation against the Company that the Company should reasonably believe could adversely affect its ability to meet contract requirements or is likely to have a material adverse effect on the Company's financial condition.
   - Provide a statement whether there is any pending or in progress Securities Exchange Commission investigations involving the Company.

   On a semi-annual basis, BA requires all of our vendors to attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. Cigna has provided this attestation on time and throughout the life of this contract.

   Cigna has also signed the Iran Divestment Certification pursuant to Tenn. Code Ann. 12-12-101 et seq. Through this amendment, the Iran Divestment Act language is being added to the contract.

   BA also conducted an internet search for current information, lawsuits or any information regarding fraud. This search included using a website dedicated to consumer reviews of websites, local businesses and nationwide companies involved in lawsuits. We did not find any previous or pending legal action.

Enclosed in the Fiscal Review packet you will also find a supplemental report on any liquidated damages assessed by BA for the life of the contract (see pages X through X). A total of $82,500 has been assessed due to performance guarantees. This report reflects any liquidated damages assessed for any of the three regional and single statewide contracts.

The original contract is included for review. BA submits the above referenced contract amendments for consideration and approval by the Fiscal Review Committee.

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Seannalyn Brandmeir, Procurement and Contracting Manager	*Contact Phone:	615-532-4598
*Presenter's name(s):	Laurie Lee, Executive Director; Christa Martin, Director of Financial Management and Program Integrity; Dr. Andrea Dowdy, Clinical Director; Seannalyn Brandmeir, Procurement and Contracting Manager		
Edison Contract Number: (*if applicable*)	47414,47341, 47338, 50294	RFS Number: (*if applicable*)	31786-00125 31786-00132
*Original or Proposed Contract Begin Date:	9/1/2015 (47414,47341, 47338) 7/1/2016 (50294)	*Current or Proposed End Date:	6/30/2023
Current Request Amendment Number: (*if applicable*)	47414 - Two 47341 - One 47338 - One 50294 -One		
Proposed Amendment Effective Date: (*if applicable*)	January 1, 2020		
*Department Submitting:	Finance and Administration		
*Division:	Benefits Administration		
*Date Submitted:	October 11, 2019		
*Submitted Within Sixty (60) days:	Yes		
If not, explain:			
*Contract Vendor Name:	Cigna Health and Life Insurance Company		
*Current or Proposed Maximum Liability:	47414 - Current: $36,000,000.00 Proposed: $41,600,000.00 47341 - Current: $39,936,000.00 Proposed: $36,300,000.00 47338 - Current: $47,771,500.00 Proposed: $38,000,000.00 50294 - Current: $41,938,602.00 Proposed: $8,000,000.00		
*Estimated Total Spend for Commodities:			

*Current or Proposed Contract Allocation by Fiscal Year: 47414
(***as Shown on Most Current Fully Executed Contract Summary Sheet)***

FY: 2016	FY: 2017	FY: 2018	FY: 2019	FY 2020	FY 2021	FY 2022
$3,775,000	$7,260,000	$6,925,000	$6,700,000	$6,705,000	$6,820,000	$3,415,000

*Current Total Expenditures by Fiscal Year of Contract: 47414
(***attach backup documentation from Edison)***

FY: 2016	FY: 2017	FY: 2018	FY: 2019	FY: 2020	FY
$3,771,263.15	$7,259,738.14	$6,924,495.56	$6,695,641.94	$1,097,842.65	$

*Current or Proposed Contract Allocation by Fiscal Year: 47341

Supplemental Documentation Required for Fiscal Review Committee

(*as Shown on Most Current Fully Executed Contract Summary Sheet)*						
FY: 2016	FY: 2017	FY: 2018	FY: 2019	FY 2020	FY 2021	FY 2022
$3,145,000	$6,305,000	$6,135,000	$5,855,000	$5,840,000	$5,990,000	$3,030,000

*Current Total Expenditures by Fiscal Year of Contract: 47341 (*attach backup documentation from Edison*)					
FY: 2016	FY: 2017	FY: 2018	FY: 2019	FY: 2020	FY
$3,140,004.88	$6,301,942.62	$6,132,321.34	$5,850,927.94	$950,668.80	$

*Current or Proposed Contract Allocation by Fiscal Year: 47338 (*as Shown on Most Current Fully Executed Contract Summary Sheet)*						
FY: 2016	FY: 2017	FY: 2018	FY: 2019	FY 2020	FY 2021	FY 2022
$3,255,000	$6,550,000	$6,475,000	$6,165,000	$6,145,000	$6,265,000	$3,145,000

*Current Total Expenditures by Fiscal Year of Contract: 47338 (*attach backup documentation from Edison*)					
FY: 2016	FY: 2017	FY: 2018	FY:2019	FY: 2020	FY
$3,250,859.02	$6,546,253.58	$6,471,716.93	$6,162,898.08	$1,002,814.86	$

*Current or Proposed Contract Allocation by Fiscal Year: 50294 (*as Shown on Most Current Fully Executed Contract Summary Sheet)*						
FY: 2017	FY: 2018	FY: 2019	FY: 2020	FY 2021	FY 2022	FY
$360,000	$980,000	$1,380,000	$1,870,000	$2,235,000	$1,175,000	

*Current Total Expenditures by Fiscal Year of Contract: 50294 (*attach backup documentation from Edison*)					
FY: 2017	FY: 2018	FY: 2019	FY:2020	FY:	FY
$357,853.50	$976,592.68	$1,375,443.16	$252,134.40		

IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:	n/a
IF surplus funds have been carried forward, please give the reasons and provide the authority for the carry forward provision:	n/a
IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:	n/a

*Contract Funding Source/Amount:			
State:		Federal:	
Interdepartmental:	47414 - $41,600,000 47341 - $36,300,000 47338 - $38,000,000 50294 - $8,000,000	*Other*:	
If "*other*" please define:			

Supplemental Documentation Required for Fiscal Review Committee

If "*interdepartmental*" please define:	Paid through plan member premiums
Dates of All Previous Amendments or Revisions: (*if applicable*)	Brief Description of Actions in Previous Amendments or Revisions: (*if applicable*)
47414 – Amendment One 11/1/2018	Decrease in maximum liability
Method of Original Award: (*if applicable*)	RFP
*What were the projected costs of the service for the entire term of the contract prior to contract award? How was this cost determined?	Costs were determined by the current enrollment numbers along with an estimated growth percentage in enrollment, and monthly premium amounts.
*List number of other potential vendors who could provide this good or service; efforts to identify other competitive procurement alternatives; and the reason(s) a sole-source contract is in the best interest of the State.	In 2015, we listed 5 potential bidders for the RFP and resulting contract.

Cigna Healthcare

Cigna TPA Middle

Edison Contract #	47341
Vendor Number	5518
Reports Pulled:	8/12/2019

Fiscal Year	Expenditures
FY 2016	3,140,004.88
FY 2017	6,301,942.62
FY 2018	6,132,321.34
FY 2019	5,850,927.94
YTD FY 2020	950,668.80
Total Expenditures	22,375,865.58

Cigna Healthcare

Cigna TPA Middle

Edison Contract #	47341
Vendor Number	5518
Reports Pulled:	8/12/2019

TN_PU_CN021 - Payments Against a Contract

Payments against a Contract 12

Unit	Sum Merchandise Amt	Edison Contract ID	Vendor ID	Vendor Name	Type	PO ID	Voucher ID	Invoice	Date	Fiscal Year
31786	514,964.25	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001308	00005871	Cigna 0116M	1/25/2016	2016
31786	10,813.42	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001309	00005873	Cigna CDHP 0116M	1/25/2016	2016
31786	514,101.83	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001308	00005898	Cigna 0216M	2/9/2016	2016
31786	10,979.27	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001309	00005899	Cigna CDHP 0216M	2/9/2016	2016
31786	513,007.22	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001308	00005944	Cigna 0316M	3/8/2016	2016
31786	11,410.48	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001309	00005948	Cigna CDHP 0316M	3/8/2016	2016
31786	511,415.06	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001308	00006031	Cigna 0416M	4/11/2016	2016
31786	11,609.50	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001309	00006032	Cigna CDHP 0416M	4/11/2016	2016
31786	509,756.56	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001308	00006084	Cigna 0516M	5/10/2016	2016
31786	11,775.35	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001309	00006085	Cigna CDHP 0516M	5/10/2016	2016
31786	507,998.55	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001308	00006155	Cigna 0616M	6/10/2016	2016
31786	12,173.39	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001309	00006156	Cigna CDHP 0616M	6/10/2016	2016
FY 2016	3,140,004.88									

Payments against a Contract 24

Unit	Sum Merchandise Amt	Edison Contract ID	Vendor ID	Vendor Name	Type	PO ID	Voucher ID	Invoice	Date	Fiscal Year
31786	12,505.09	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001366	00006211	Cigna CDHP 0716M	7/15/2016	2017
31786	507,003.45	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001361	00006206	Cigna 0716M	7/19/2016	2017
31786	505,577.14	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001361	00006255	Cigna 0816M	8/8/2016	2017
31786	13,035.81	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001366	00006257	Cigna CDHP 0816M	8/8/2016	2017
31786	505,975.18	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001361	00006314	Cigna 0916M	9/9/2016	2017
31786	13,831.89	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001366	00006317	Cigna CDHP 0916M	9/9/2016	2017
31786	14,030.91	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001366	00006393	CignaCDHP1016M	10/12/2016	2017
31786	504,383.02	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001361	00006394	Clgna1016M	10/12/2016	2017
31786	502,790.86	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001361	00006431	Cigna 1116M	11/8/2016	2017
31786	14,362.61	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001366	00006432	Cigna CDHP 1116M	11/8/2016	2017
31786	503,288.41	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001361	00006480	Cigna 1216M	12/9/2016	2017
31786	15,092.35	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001366	00006483	Cigna CDHP 1216M	12/9/2016	2017
31786	21,533.75	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001417	00006525	Cigna CDHP 0117M	1/13/2017	2017
31786	514,974.95	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001411	00006527	Cigna 0117 M	1/13/2017	2017
31786	512,241.10	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001411	00006585	Cigna 0217M	2/9/2017	2017
31786	21,983.15	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001417	00006590	Cigna CDHP 0217M	2/9/2017	2017
31786	22,544.90	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001417	00006636	Cigna CDHP 0317M	3/8/2017	2017
31786	509,694.50	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001411	00006640	Cigna 0317M	3/8/2017	2017
31786	508,046.70	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001411	00006746	Cigna 0417M	4/12/2017	2017
31786	22,694.70	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001417	00006749	Cigna CDHP 0417M	4/12/2017	2017
31786	506,286.55	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001411	00006816	Cigna 0517M	5/8/2017	2017
31786	22,956.85	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001417	00006817	Cigna CDHP 0517M	5/8/2017	2017
31786	503,927.20	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001411	00006880	Cigna 0617M	6/9/2017	2017
31786	23,181.55	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001417	00006883	Cigna CDHP 0617M	6/9/2017	2017
FY 2017	6,301,942.62									

Payments against a Contract 24

Unit	Sum Merchandise Amt	Edison Contract ID	Vendor ID	Vendor Name	Type	PO ID	Voucher ID	Invoice	Date	Fiscal Year
31786	500,706.50	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001468	00006953	Cigna 0717M	7/13/2017	2018
31786	23,256.45	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001472	00006955	Cigna CDHP 0717M	7/13/2017	2018
31786	23,406.25	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001472	00007010	Cigna CDHP 0817M	8/8/2017	2018
31786	497,710.50	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001468	00007016	Cigna 0817M	8/8/2017	2018
31786	496,100.15	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001468	00007056	Cigna 0917M	9/12/2017	2018
31786	24,155.25	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001472	00007060	Cigna CDHP 0917M	9/12/2017	2018
31786	494,152.75	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001468	00007117	Cigna 1017M	10/11/2017	2018
31786	24,305.05	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001472	00007119	Cigna CDHP 1017M	10/11/2017	2018
31786	492,879.45	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001468	00007160	Cigna 1117M	11/8/2017	2018
31786	24,492.30	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001472	00007161	Cigna CDHP 1117M	11/8/2017	2018
31786	24,567.20	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001472	00007210	Cigna CDHP 1217M	12/11/2017	2018
31786	492,504.95	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001468	00007212	Cigna 1217M	12/11/2017	2018
31786	23,529.90	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001520	00007257	Cigna CDHP 0118M	1/12/2018	2018
31786	481,999.48	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001508	00007258	Cigna 0118M	1/12/2018	2018
31786	23,491.64	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001520	00007302	Cigna CDHP 0218M	2/9/2018	2018
31786	480,775.16	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001508	00007303	Cigna 0218M	2/9/2018	2018
31786	479,512.58	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001508	00007375	Cigna 0318M	3/8/2018	2018
31786	23,835.98	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001520	00007376	Cigna CDHP 0318M	3/8/2018	2018
31786	23,529.90	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001520	00007443	Cigna CDHP 0418M	4/10/2018	2018
31786	478,900.42	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001508	00007444	Cigna 0418M	4/10/2018	2018
31786	476,796.12	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001508	00007486	Cigna 0518M	5/8/2018	2018
31786	23,338.60	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001520	00007487	Cigna CDHP 0518M	5/8/2018	2018
31786	474,768.34	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001508	00007555	Cigna 0618M	6/11/2018	2018
31786	23,606.42	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001520	00007556	Cigna CDHP 0618M	6/11/2018	2018
FY 2018	6,132,321.34									

Payments against a Contract 24

Unit	Sum Merchandise Amt	Edison Contract ID	Vendor ID	Vendor Name	Type	PO ID	Voucher ID	Invoice	Date	Fiscal Year
31786	472,549.26	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001553	00007633	Cigna 0718M	7/13/2018	2019
31786	23,491.64	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001551	00007634	Cigna CDHP 0718M	7/13/2018	2019
31786	470,980.60	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001553	00007694	Cigna 0818M	8/9/2018	2019
31786	23,415.12	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001551	00007695	Cigna CDHP 0818M	8/9/2018	2019
31786	469,679.76	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001553	00007738	Cigna 0918M	9/13/2018	2019
31786	23,491.64	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001551	00007739	Cigna CDHP 0918M	9/13/2018	2019
31786	466,159.84	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001553	00007792	Cigna 1018M	10/10/2018	2019
31786	23,568.16	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001551	00007793	Cigna CDHP 1018M	10/10/2018	2019
31786	466,427.66	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001553	00007854	Cigna 1118M	11/9/2018	2019
31786	23,529.90	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001551	00007855	Cigna CDHP 1118M	11/9/2018	2019
31786	465,815.50	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001553	00007900	Cigna 1218M	12/10/2018	2019
31786	23,529.90	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001551	00007901	Cigna CDHP 1218M	12/10/2018	2019
31786	463,998.30	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001560	00007946	Cigna 0119M	1/9/2019	2019
31786	23,493.09	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001561	00007947	Cigna CDHP 0119M	1/9/2019	2019
31786	461,652.90	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001560	00008019	Cigna 0219M	2/8/2019	2019
31786	23,297.64	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001561	00008020	Cigna CDHP 0219M	2/8/2019	2019
31786	460,949.28	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001560	00008078	Cigna 0319M	3/14/2019	2019
31786	23,454.00	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001561	00008079	Cigna CDHP 0319M	3/14/2019	2019
31786	459,112.05	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001560	00008145	Cigna 0419M	4/8/2019	2019
31786	23,532.18	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001561	00008146	Cigna CDHP 0419M	4/8/2019	2019
31786	457,392.09	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001560	00008219	Cigna 0519M	5/8/2019	2019
31786	23,375.82	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001561	00008220	Cigna CDHP 0519M	5/8/2019	2019
31786	454,655.79	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001560	00008272	Cigna 0619M	6/10/2019	2019
31786	23,375.82	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001561	00008273	Cigna CDHP 0619M	6/10/2019	2019
FY 2019	5,850,927.94									

Payments against a Contract

Unit	Sum Merchandise Amt	Edison Contract ID	Vendor ID	Vendor Name	Type	PO ID	Voucher ID	Invoice	Date	Fiscal Year
31786	452,623.11	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001612	00008349	Cigna 0719M	7/10/2019	2020
31786	23,571.27	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001613	00008350	Cigna CDHP 0719M	7/10/2019	2020
31786	450,864.06	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001612	00008434	Cigna 0819M	8/7/2019	2020
31786	23,610.36	0000000000000000000047341	0000005518	Cigna Healthcare	DFA	0000001613	00008435	Cigna CDHP 0819M	8/7/2019	2020
FY 2020	950,668.80									

Cigna Healthcare

Cigna TPA Middle

Edison Contract #	47341
Vendor Number	5518
Reports Pulled:	8/12/2019

TN_PU_CN026 - Payments not on a contract

Payments Not On Contract	0						
Unit	Sum Merchandise Amt	Edison Contract ID	Vendor ID	Vendor Name	PO_ID	D.VOUCHER_ID	Year

Cigna Healthcare

Cigna TPA Middle
Edison Contract # 47341
Vendor Number 5518
Reports Pulled: 8/12/2019

TN_PU_CN028- POs by Contract ID

POs by Contract_ID	206									
Unit	PO No.	PO Status	Budget Status	PO Line	Supplier	Supplier	Sum PO Amount	Sum Voucher Amount	Contract	Contract Line
31786	0000001308	Compl	Valid	1	0000005518	CIGNA Health and Life Insurance Company	83,323.04	83,323.04	00000000000000000000047341	1
31786	0000001308	Compl	Valid	2	0000005518	CIGNA Health and Life Insurance Company	24,379.95	24,379.95	00000000000000000000047341	1
31786	0000001308	Compl	Valid	3	0000005518	CIGNA Health and Life Insurance Company	1,691.67	1,691.67	00000000000000000000047341	1
31786	0000001308	Compl	Valid	4	0000005518	CIGNA Health and Life Insurance Company	490,982.34	490,982.34	00000000000000000000047341	1
31786	0000001308	Compl	Valid	5	0000005518	CIGNA Health and Life Insurance Company	289,938.97	289,938.97	00000000000000000000047341	1
31786	0000001308	Compl	Valid	6	0000005518	CIGNA Health and Life Insurance Company	91,582.37	91,582.37	00000000000000000000047341	1
31786	0000001308	Compl	Valid	7	0000005518	CIGNA Health and Life Insurance Company	146,346.04	146,346.04	00000000000000000000047341	1
31786	0000001308	Compl	Valid	8	0000005518	CIGNA Health and Life Insurance Company	67,766.31	67,766.31	00000000000000000000047341	1
31786	0000001308	Compl	Valid	9	0000005518	CIGNA Health and Life Insurance Company	3,084.81	3,084.81	00000000000000000000047341	1
31786	0000001308	Compl	Valid	10	0000005518	CIGNA Health and Life Insurance Company	1,032,781.12	1,032,781.12	00000000000000000000047341	1
31786	0000001308	Compl	Valid	11	0000005518	CIGNA Health and Life Insurance Company	473,070.54	473,070.54	00000000000000000000047341	1
31786	0000001308	Compl	Valid	12	0000005518	CIGNA Health and Life Insurance Company	135,665.30	135,665.30	00000000000000000000047341	1
31786	0000001308	Compl	Valid	13	0000005518	CIGNA Health and Life Insurance Company	2,952.13	2,952.13	00000000000000000000047341	1
31786	0000001308	Compl	Valid	14	0000005518	CIGNA Health and Life Insurance Company	398.04	398.04	00000000000000000000047341	1
31786	0000001308	Compl	Valid	15	0000005518	CIGNA Health and Life Insurance Company	168,569.94	168,569.94	00000000000000000000047341	1
31786	0000001308	Compl	Valid	16	0000005518	CIGNA Health and Life Insurance Company	58,710.90	58,710.90	00000000000000000000047341	1
31786	0000001309	Compl	Valid	1	0000005518	CIGNA Health and Life Insurance Company	42,225.41	42,225.41	00000000000000000000047341	1
31786	0000001309	Compl	Valid	2	0000005518	CIGNA Health and Life Insurance Company	9,917.83	9,917.83	00000000000000000000047341	1
31786	0000001309	Compl	Valid	3	0000005518	CIGNA Health and Life Insurance Company	1,000.00	-	00000000000000000000047341	1
31786	0000001309	Compl	Valid	4	0000005518	CIGNA Health and Life Insurance Company	6,003.77	6,003.77	00000000000000000000047341	1
31786	0000001309	Compl	Valid	5	0000005518	CIGNA Health and Life Insurance Company	597.06	597.06	00000000000000000000047341	1
31786	0000001309	Compl	Valid	6	0000005518	CIGNA Health and Life Insurance Company	1,000.00	-	00000000000000000000047341	1
31786	0000001309	Compl	Valid	7	0000005518	CIGNA Health and Life Insurance Company	1,000.00	-	00000000000000000000047341	1
31786	0000001309	Compl	Valid	8	0000005518	CIGNA Health and Life Insurance Company	1,227.29	1,227.29	00000000000000000000047341	1
31786	0000001309	Compl	Valid	9	0000005518	CIGNA Health and Life Insurance Company	5,274.03	5,274.03	00000000000000000000047341	1
31786	0000001309	Compl	Valid	10	0000005518	CIGNA Health and Life Insurance Company	3,516.02	3,516.02	00000000000000000000047341	1
31786	0000001361	Compl	Valid	1	0000005518	CIGNA Health and Life Insurance Company	86,805.89	86,805.89	00000000000000000000047341	1
31786	0000001361	Compl	Valid	2	0000005518	CIGNA Health and Life Insurance Company	25,507.73	25,507.73	00000000000000000000047341	1
31786	0000001361	Compl	Valid	3	0000005518	CIGNA Health and Life Insurance Company	1,758.01	1,758.01	00000000000000000000047341	1
31786	0000001361	Compl	Valid	4	0000005518	CIGNA Health and Life Insurance Company	466,934.09	466,934.09	00000000000000000000047341	1
31786	0000001361	Compl	Valid	5	0000005518	CIGNA Health and Life Insurance Company	280,386.01	280,386.01	00000000000000000000047341	1
31786	0000001361	Compl	Valid	6	0000005518	CIGNA Health and Life Insurance Company	87,203.93	87,203.93	00000000000000000000047341	1
31786	0000001361	Compl	Valid	7	0000005518	CIGNA Health and Life Insurance Company	153,212.23	153,212.23	00000000000000000000047341	1
31786	0000001361	Compl	Valid	8	0000005518	CIGNA Health and Life Insurance Company	66,041.47	66,041.47	00000000000000000000047341	1
31786	0000001361	Compl	Valid	9	0000005518	CIGNA Health and Life Insurance Company	2,918.96	2,918.96	00000000000000000000047341	1
31786	0000001361	Compl	Valid	10	0000005518	CIGNA Health and Life Insurance Company	1,023,062.31	1,023,062.31	00000000000000000000047341	1
31786	0000001361	Compl	Valid	11	0000005518	CIGNA Health and Life Insurance Company	465,308.76	465,308.76	00000000000000000000047341	1
31786	0000001361	Compl	Valid	12	0000005518	CIGNA Health and Life Insurance Company	135,433.11	135,433.11	00000000000000000000047341	1
31786	0000001361	Compl	Valid	13	0000005518	CIGNA Health and Life Insurance Company	4,079.91	4,079.91	00000000000000000000047341	1
31786	0000001361	Compl	Valid	14	0000005518	CIGNA Health and Life Insurance Company	331.70	331.70	00000000000000000000047341	1
31786	0000001361	Compl	Valid	15	0000005518	CIGNA Health and Life Insurance Company	169,598.21	169,598.21	00000000000000000000047341	1
31786	0000001361	Compl	Valid	16	0000005518	CIGNA Health and Life Insurance Company	60,435.74	60,435.74	00000000000000000000047341	1
31786	0000001366	Compl	Valid	1	0000005518	CIGNA Health and Life Insurance Company	53,337.36	53,337.36	00000000000000000000047341	1
31786	0000001366	Compl	Valid	2	0000005518	CIGNA Health and Life Insurance Company	11,012.44	11,012.44	00000000000000000000047341	1
31786	0000001366	Compl	Valid	3	0000005518	CIGNA Health and Life Insurance Company	1,000.00	-	00000000000000000000047341	1
31786	0000001366	Compl	Valid	4	0000005518	CIGNA Health and Life Insurance Company	7,231.06	7,231.06	00000000000000000000047341	1
31786	0000001366	Compl	Valid	5	0000005518	CIGNA Health and Life Insurance Company	663.40	663.40	00000000000000000000047341	1
31786	0000001366	Compl	Valid	6	0000005518	CIGNA Health and Life Insurance Company	1,000.00	-	00000000000000000000047341	1
31786	0000001366	Compl	Valid	7	0000005518	CIGNA Health and Life Insurance Company	1,000.00	-	00000000000000000000047341	1
31786	0000001366	Compl	Valid	8	0000005518	CIGNA Health and Life Insurance Company	1,227.29	1,227.29	00000000000000000000047341	1
31786	0000001366	Compl	Valid	9	0000005518	CIGNA Health and Life Insurance Company	6,202.79	6,202.79	00000000000000000000047341	1
31786	0000001366	Compl	Valid	10	0000005518	CIGNA Health and Life Insurance Company	3,184.32	3,184.32	00000000000000000000047341	1
31786	0000001411	Compl	Valid	1	0000005518	CIGNA Health and Life Insurance Company	90,554.10	90,554.10	00000000000000000000047341	1
31786	0000001411	Compl	Valid	2	0000005518	CIGNA Health and Life Insurance Company	26,327.35	26,327.35	00000000000000000000047341	1
31786	0000001411	Compl	Valid	3	0000005518	CIGNA Health and Life Insurance Company	1,535.45	1,535.45	00000000000000000000047341	1
31786	0000001411	Compl	Valid	4	0000005518	CIGNA Health and Life Insurance Company	437,827.95	437,827.95	00000000000000000000047341	1
31786	0000001411	Compl	Valid	5	0000005518	CIGNA Health and Life Insurance Company	266,793.80	266,793.80	00000000000000000000047341	1
31786	0000001411	Compl	Valid	6	0000005518	CIGNA Health and Life Insurance Company	79,843.40	79,843.40	00000000000000000000047341	1
31786	0000001411	Compl	Valid	7	0000005518	CIGNA Health and Life Insurance Company	154,705.95	154,705.95	00000000000000000000047341	1
31786	0000001411	Compl	Valid	8	0000005518	CIGNA Health and Life Insurance Company	60,182.15	60,182.15	00000000000000000000047341	1
31786	0000001411	Compl	Valid	9	0000005518	CIGNA Health and Life Insurance Company	2,921.10	2,921.10	00000000000000000000047341	1
31786	0000001411	Compl	Valid	10	0000005518	CIGNA Health and Life Insurance Company	999,727.75	999,727.75	00000000000000000000047341	1
31786	0000001411	Compl	Valid	11	0000005518	CIGNA Health and Life Insurance Company	502,990.95	502,990.95	00000000000000000000047341	1
31786	0000001411	Compl	Valid	12	0000005518	CIGNA Health and Life Insurance Company	135,606.45	135,606.45	00000000000000000000047341	1
31786	0000001411	Compl	Valid	13	0000005518	CIGNA Health and Life Insurance Company	8,426.25	8,426.25	00000000000000000000047341	1
31786	0000001411	Compl	Valid	14	0000005518	CIGNA Health and Life Insurance Company	2,471.70	2,471.70	00000000000000000000047341	1
31786	0000001411	Compl	Valid	15	0000005518	CIGNA Health and Life Insurance Company	37.45	37.45	00000000000000000000047341	1
31786	0000001411	Compl	Valid	16	0000005518	CIGNA Health and Life Insurance Company	63,215.60	63,215.60	00000000000000000000047341	1
31786	0000001411	Compl	Valid	17	0000005518	CIGNA Health and Life Insurance Company	54,677.00	54,677.00	00000000000000000000047341	1
31786	0000001411	Compl	Valid	18	0000005518	CIGNA Health and Life Insurance Company	9,549.75	9,549.75	00000000000000000000047341	1
31786	0000001411	Compl	Valid	19	0000005518	CIGNA Health and Life Insurance Company	2,658.95	2,658.95	00000000000000000000047341	1
31786	0000001411	Compl	Valid	20	0000005518	CIGNA Health and Life Insurance Company	224.70	224.70	00000000000000000000047341	1
31786	0000001411	Compl	Valid	21	0000005518	CIGNA Health and Life Insurance Company	93,962.05	93,962.05	00000000000000000000047341	1
31786	0000001411	Compl	Valid	22	0000005518	CIGNA Health and Life Insurance Company	60,931.15	60,931.15	00000000000000000000047341	1
31786	0000001417	Compl	Valid	1	0000005518	CIGNA Health and Life Insurance Company	82,127.85	82,127.85	00000000000000000000047341	1
31786	0000001417	Compl	Valid	2	0000005518	CIGNA Health and Life Insurance Company	16,440.55	16,440.55	00000000000000000000047341	1
31786	0000001417	Compl	Valid	3	0000005518	CIGNA Health and Life Insurance Company	374.50	374.50	00000000000000000000047341	1
31786	0000001417	Compl	Valid	4	0000005518	CIGNA Health and Life Insurance Company	15,579.20	15,579.20	00000000000000000000047341	1
31786	0000001417	Compl	Valid	5	0000005518	CIGNA Health and Life Insurance Company	224.70	224.70	00000000000000000000047341	1
31786	0000001417	Compl	Valid	6	0000005518	CIGNA Health and Life Insurance Company	2,097.20	2,097.20	00000000000000000000047341	1
31786	0000001417	Compl	Valid	7	0000005518	CIGNA Health and Life Insurance Company	1,000.00	-	00000000000000000000047341	1
31786	0000001417	Compl	Valid	8	0000005518	CIGNA Health and Life Insurance Company	1,000.00	-	00000000000000000000047341	1
31786	0000001417	Compl	Valid	9	0000005518	CIGNA Health and Life Insurance Company	11,946.55	11,946.55	00000000000000000000047341	1
31786	0000001417	Compl	Valid	10	0000005518	CIGNA Health and Life Insurance Company	6,104.35	6,104.35	00000000000000000000047341	1

31786	0000001437	Compl	Valid	1	0000005518	CIGNA Health and Life Insurance Company	4,102,000.00	-	00000000000000000000047341	1
31786	0000001468	Compl	Valid	1	0000005518	CIGNA Health and Life Insurance Company	91,490.35	91,490.35	00000000000000000000047341	1
31786	0000001468	Compl	Valid	2	0000005518	CIGNA Health and Life Insurance Company	24,454.85	24,454.85	00000000000000000000047341	1
31786	0000001468	Compl	Valid	3	0000005518	CIGNA Health and Life Insurance Company	1,348.20	1,348.20	00000000000000000000047341	1
31786	0000001468	Compl	Valid	4	0000005518	CIGNA Health and Life Insurance Company	417,118.10	417,118.10	00000000000000000000047341	1
31786	0000001468	Compl	Valid	5	0000005518	CIGNA Health and Life Insurance Company	255,184.30	255,184.30	00000000000000000000047341	1
31786	0000001468	Compl	Valid	6	0000005518	CIGNA Health and Life Insurance Company	73,776.50	73,776.50	00000000000000000000047341	1
31786	0000001468	Compl	Valid	7	0000005518	CIGNA Health and Life Insurance Company	150,474.10	150,474.10	00000000000000000000047341	1
31786	0000001468	Compl	Valid	8	0000005518	CIGNA Health and Life Insurance Company	58,459.45	58,459.45	00000000000000000000047341	1
31786	0000001468	Compl	Valid	9	0000005518	CIGNA Health and Life Insurance Company	3,258.15	3,258.15	00000000000000000000047341	1
31786	0000001468	Compl	Valid	10	0000005518	CIGNA Health and Life Insurance Company	982,875.25	982,875.25	00000000000000000000047341	1
31786	0000001468	Compl	Valid	11	0000005518	CIGNA Health and Life Insurance Company	499,545.55	499,545.55	00000000000000000000047341	1
31786	0000001468	Compl	Valid	12	0000005518	CIGNA Health and Life Insurance Company	133,733.95	133,733.95	00000000000000000000047341	1
31786	0000001468	Compl	Valid	13	0000005518	CIGNA Health and Life Insurance Company	8,576.05	8,576.05	00000000000000000000047341	1
31786	0000001468	Compl	Valid	14	0000005518	CIGNA Health and Life Insurance Company	2,471.70	2,471.70	00000000000000000000047341	1
31786	0000001468	Compl	Valid	15	0000005518	CIGNA Health and Life Insurance Company	224.70	224.70	00000000000000000000047341	1
31786	0000001468	Compl	Valid	16	0000005518	CIGNA Health and Life Insurance Company	58,272.20	58,272.20	00000000000000000000047341	1
31786	0000001468	Compl	Valid	17	0000005518	CIGNA Health and Life Insurance Company	52,991.75	52,991.75	00000000000000000000047341	1
31786	0000001468	Compl	Valid	18	0000005518	CIGNA Health and Life Insurance Company	8,800.75	8,800.75	00000000000000000000047341	1
31786	0000001468	Compl	Valid	19	0000005518	CIGNA Health and Life Insurance Company	2,696.40	2,696.40	00000000000000000000047341	1
31786	0000001468	Compl	Valid	20	0000005518	CIGNA Health and Life Insurance Company	224.70	224.70	00000000000000000000047341	1
31786	0000001468	Compl	Valid	21	0000005518	CIGNA Health and Life Insurance Company	92,351.70	92,351.70	00000000000000000000047341	1
31786	0000001468	Compl	Valid	22	0000005518	CIGNA Health and Life Insurance Company	55,725.60	55,725.60	00000000000000000000047341	1
31786	0000001472	Compl	Valid	1	0000005518	CIGNA Health and Life Insurance Company	88,793.95	88,793.95	00000000000000000000047341	1
31786	0000001472	Compl	Valid	2	0000005518	CIGNA Health and Life Insurance Company	17,077.20	17,077.20	00000000000000000000047341	1
31786	0000001472	Compl	Valid	3	0000005518	CIGNA Health and Life Insurance Company	1,123.50	1,123.50	00000000000000000000047341	1
31786	0000001472	Compl	Valid	4	0000005518	CIGNA Health and Life Insurance Company	16,140.95	16,140.95	00000000000000000000047341	1
31786	0000001472	Compl	Valid	5	0000005518	CIGNA Health and Life Insurance Company	224.70	224.70	00000000000000000000047341	1
31786	0000001472	Compl	Valid	6	0000005518	CIGNA Health and Life Insurance Company	2,321.90	2,321.90	00000000000000000000047341	1
31786	0000001472	Compl	Valid	7	0000005518	CIGNA Health and Life Insurance Company	1,000.00	-	00000000000000000000047341	1
31786	0000001472	Compl	Valid	8	0000005518	CIGNA Health and Life Insurance Company	74.90	74.90	00000000000000000000047341	1
31786	0000001472	Compl	Valid	9	0000005518	CIGNA Health and Life Insurance Company	13,107.50	13,107.50	00000000000000000000047341	1
31786	0000001472	Compl	Valid	10	0000005518	CIGNA Health and Life Insurance Company	5,317.90	5,317.90	00000000000000000000047341	1
31786	0000001490	Compl	Valid	1	0000005518	CIGNA Health and Life Insurance Company	6,917,000.00	-	00000000000000000000047341	1
31786	0000001508	Compl	Valid	1	0000005518	CIGNA Health and Life Insurance Company	91,288.36	91,288.36	00000000000000000000047341	1
31786	0000001508	Compl	Valid	2	0000005518	CIGNA Health and Life Insurance Company	23,721.20	23,721.20	00000000000000000000047341	1
31786	0000001508	Compl	Valid	3	0000005518	CIGNA Health and Life Insurance Company	2,027.78	2,027.78	00000000000000000000047341	1
31786	0000001508	Compl	Valid	4	0000005518	CIGNA Health and Life Insurance Company	524,888.94	524,888.94	00000000000000000000047341	1
31786	0000001508	Compl	Valid	5	0000005518	CIGNA Health and Life Insurance Company	253,013.38	253,013.38	00000000000000000000047341	1
31786	0000001508	Compl	Valid	6	0000005518	CIGNA Health and Life Insurance Company	68,217.58	68,217.58	00000000000000000000047341	1
31786	0000001508	Compl	Valid	7	0000005518	CIGNA Health and Life Insurance Company	154,570.40	154,570.40	00000000000000000000047341	1
31786	0000001508	Compl	Valid	8	0000005518	CIGNA Health and Life Insurance Company	56,050.90	56,050.90	00000000000000000000047341	1
31786	0000001508	Compl	Valid	9	0000005518	CIGNA Health and Life Insurance Company	2,372.12	2,372.12	00000000000000000000047341	1
31786	0000001508	Compl	Valid	10	0000005518	CIGNA Health and Life Insurance Company	886,981.58	886,981.58	00000000000000000000047341	1
31786	0000001508	Compl	Valid	11	0000005518	CIGNA Health and Life Insurance Company	531,201.84	531,201.84	00000000000000000000047341	1
31786	0000001508	Compl	Valid	12	0000005518	CIGNA Health and Life Insurance Company	139,266.40	139,266.40	00000000000000000000047341	1
31786	0000001508	Compl	Valid	13	0000005518	CIGNA Health and Life Insurance Company	2,295.60	2,295.60	00000000000000000000047341	1
31786	0000001508	Compl	Valid	14	0000005518	CIGNA Health and Life Insurance Company	459.12	459.12	00000000000000000000047341	1
31786	0000001508	Compl	Valid	15	0000005518	CIGNA Health and Life Insurance Company	82,450.30	82,450.30	00000000000000000000047341	1
31786	0000001508	Compl	Valid	16	0000005518	CIGNA Health and Life Insurance Company	53,946.60	53,946.60	00000000000000000000047341	1
31786	0000001520	Compl	Valid	1	0000005518	CIGNA Health and Life Insurance Company	994.76	994.76	00000000000000000000047341	1
31786	0000001520	Compl	Valid	2	0000005518	CIGNA Health and Life Insurance Company	120,978.12	120,978.12	00000000000000000000047341	1
31786	0000001520	Compl	Valid	3	0000005518	CIGNA Health and Life Insurance Company	229.56	229.56	00000000000000000000047341	1
31786	0000001520	Compl	Valid	4	0000005518	CIGNA Health and Life Insurance Company	229.56	229.56	00000000000000000000047341	1
31786	0000001520	Compl	Valid	5	0000005518	CIGNA Health and Life Insurance Company	14,156.20	14,156.20	00000000000000000000047341	1
31786	0000001520	Compl	Valid	6	0000005518	CIGNA Health and Life Insurance Company	4,744.24	4,744.24	00000000000000000000047341	1
31786	0000001551	Compl	Valid	1	0000005518	CIGNA Health and Life Insurance Company	1,530.40	1,530.40	00000000000000000000047341	1
31786	0000001551	Compl	Valid	2	0000005518	CIGNA Health and Life Insurance Company	120,442.48	120,442.48	00000000000000000000047341	1
31786	0000001551	Compl	Valid	3	0000005518	CIGNA Health and Life Insurance Company	573.90	573.90	00000000000000000000047341	1
31786	0000001551	Compl	Valid	4	0000005518	CIGNA Health and Life Insurance Company	229.56	229.56	00000000000000000000047341	1
31786	0000001551	Compl	Valid	5	0000005518	CIGNA Health and Life Insurance Company	13,582.30	13,582.30	00000000000000000000047341	1
31786	0000001551	Compl	Valid	6	0000005518	CIGNA Health and Life Insurance Company	4,667.72	4,667.72	00000000000000000000047341	1
31786	0000001553	Compl	Valid	1	0000005518	CIGNA Health and Life Insurance Company	90,217.08	90,217.08	00000000000000000000047341	1
31786	0000001553	Compl	Valid	2	0000005518	CIGNA Health and Life Insurance Company	24,486.40	24,486.40	00000000000000000000047341	1
31786	0000001553	Compl	Valid	3	0000005518	CIGNA Health and Life Insurance Company	2,104.30	2,104.30	00000000000000000000047341	1
31786	0000001553	Compl	Valid	4	0000005518	CIGNA Health and Life Insurance Company	529,939.26	529,939.26	00000000000000000000047341	1
31786	0000001553	Compl	Valid	5	0000005518	CIGNA Health and Life Insurance Company	245,667.46	245,667.46	00000000000000000000047341	1
31786	0000001553	Compl	Valid	6	0000005518	CIGNA Health and Life Insurance Company	63,549.86	63,549.86	00000000000000000000047341	1
31786	0000001553	Compl	Valid	7	0000005518	CIGNA Health and Life Insurance Company	155,067.78	155,067.78	00000000000000000000047341	1
31786	0000001553	Compl	Valid	8	0000005518	CIGNA Health and Life Insurance Company	54,061.38	54,061.38	00000000000000000000047341	1
31786	0000001553	Compl	Valid	9	0000005518	CIGNA Health and Life Insurance Company	2,563.42	2,563.42	00000000000000000000047341	1
31786	0000001553	Compl	Valid	10	0000005518	CIGNA Health and LIfe Insurance Company	857,827.46	857,827.46	00000000000000000000047341	1
31786	0000001553	Compl	Valid	11	0000005518	CIGNA Health and Life Insurance Company	517,160.42	517,160.42	00000000000000000000047341	1
31786	0000001553	Compl	Valid	12	0000005518	CIGNA Health and Life Insurance Company	134,560.42	134,560.42	00000000000000000000047341	1
31786	0000001553	Compl	Valid	13	0000005518	CIGNA Health and Life Insurance Company	2,180.82	2,180.82	00000000000000000000047341	1
31786	0000001553	Compl	Valid	14	0000005518	CIGNA Health and Life Insurance Company	459.12	459.12	00000000000000000000047341	1
31786	0000001553	Compl	Valid	15	0000005518	CIGNA Health and Life Insurance Company	81,761.62	81,761.62	00000000000000000000047341	1
31786	0000001553	Compl	Valid	16	0000005518	CIGNA Health and Life Insurance Company	50,005.82	50,005.82	00000000000000000000047341	1
31786	0000001560	Compl	Valid	1	0000005518	CIGNA Health and Life Insurance Company	88,773.39	88,773.39	00000000000000000000047341	1
31786	0000001560	Compl	Valid	2	0000005518	CIGNA Health and Life Insurance Company	25,017.60	25,017.60	00000000000000000000047341	1
31786	0000001560	Compl	Valid	3	0000005518	CIGNA Health and Life Insurance Company	1,055.43	1,055.43	00000000000000000000047341	1
31786	0000001560	Compl	Valid	4	0000005518	CIGNA Health and Life Insurance Company	524,939.61	524,939.61	00000000000000000000047341	1
31786	0000001560	Compl	Valid	5	0000005518	CIGNA Health and Life Insurance Company	233,836.38	233,836.38	00000000000000000000047341	1
31786	0000001560	Compl	Valid	6	0000005518	CIGNA Health and Life Insurance Company	62,504.91	62,504.91	00000000000000000000047341	1
31786	0000001560	Compl	Valid	7	0000005518	CIGNA Health and Life Insurance Company	151,669.20	151,669.20	00000000000000000000047341	1
31786	0000001560	Compl	Valid	8	0000005518	CIGNA Health and Life Insurance Company	50,347.92	50,347.92	00000000000000000000047341	1
31786	0000001560	Compl	Valid	9	0000005518	CIGNA Health and Life Insurance Company	2,579.94	2,579.94	00000000000000000000047341	1
31786	0000001560	Compl	Valid	10	0000005518	CIGNA Health and Life Insurance Company	834,258.78	834,258.78	00000000000000000000047341	1
31786	0000001560	Compl	Valid	11	0000005518	CIGNA Health and Life Insurance Company	516,769.80	516,769.80	00000000000000000000047341	1
31786	0000001560	Compl	Valid	12	0000005518	CIGNA Health and Life Insurance Company	140,841.27	140,841.27	00000000000000000000047341	1
31786	0000001560	Compl	Valid	13	0000005518	CIGNA Health and Life Insurance Company	1,954.50	1,954.50	00000000000000000000047341	1
31786	0000001560	Compl	Valid	14	0000005518	CIGNA Health and Life Insurance Company	429.99	429.99	00000000000000000000047341	1
31786	0000001560	Compl	Valid	15	0000005518	CIGNA Health and Life Insurance Company	74,935.53	74,935.53	00000000000000000000047341	1
31786	0000001560	Compl	Valid	16	0000005518	CIGNA Health and Life Insurance Company	47,846.16	47,846.16	00000000000000000000047341	1
31786	0000001561	Compl	Valid	1	0000005518	CIGNA Health and Life Insurance Company	1,524.51	1,524.51	00000000000000000000047341	1
31786	0000001561	Compl	Valid	2	0000005518	CIGNA Health and Life Insurance Company	118,755.42	118,755.42	00000000000000000000047341	1

31786	0000001561	Compl	Valid	3	0000005518	CIGNA Health and Life Insurance Company	273.63	273.63	00000000000000000000047341	1
31786	0000001561	Compl	Valid	4	0000005518	CIGNA Health and Life Insurance Company	234.54	234.54	00000000000000000000047341	1
31786	0000001561	Compl	Valid	5	0000005518	CIGNA Health and Life Insurance Company	15,831.45	15,831.45	00000000000000000000047341	1
31786	0000001561	Compl	Valid	6	0000005518	CIGNA Health and Life Insurance Company	3,909.00	3,909.00	00000000000000000000047341	1
31786	0000001612	Dispatched	Valid	1	0000005518	CIGNA Health and Life Insurance Company	195,000.00	29,708.40	00000000000000000000047341	1
31786	0000001612	Dispatched	Valid	2	0000005518	CIGNA Health and Life Insurance Company	60,000.00	8,091.63	00000000000000000000047341	1
31786	0000001612	Dispatched	Valid	3	0000005518	CIGNA Health and Life Insurance Company	4,000.00	234.54	00000000000000000000047341	1
31786	0000001612	Dispatched	Valid	4	0000005518	CIGNA Health and Life Insurance Company	1,080,000.00	174,263.22	00000000000000000000047341	1
31786	0000001612	Dispatched	Valid	5	0000005518	CIGNA Health and Life Insurance Company	500,000.00	77,007.30	00000000000000000000047341	1
31786	0000001612	Dispatched	Valid	6	0000005518	CIGNA Health and Life Insurance Company	145,000.00	20,365.89	00000000000000000000047341	1
31786	0000001612	Dispatched	Valid	7	0000005518	CIGNA Health and Life Insurance Company	325,000.00	49,253.40	00000000000000000000047341	1
31786	0000001612	Dispatched	Valid	8	0000005518	CIGNA Health and Life Insurance Company	120,000.00	15,909.63	00000000000000000000047341	1
31786	0000001612	Dispatched	Valid	9	0000005518	CIGNA Health and Life Insurance Company	8,000.00	781.80	00000000000000000000047341	1
31786	0000001612	Dispatched	Valid	10	0000005518	CIGNA Health and Life Insurance Company	1,800,000.00	271,010.97	00000000000000000000047341	1
31786	0000001612	Dispatched	Valid	11	0000005518	CIGNA Health and Life Insurance Company	1,100,000.00	170,236.95	00000000000000000000047341	1
31786	0000001612	Dispatched	Valid	12	0000005518	CIGNA Health and Life Insurance Company	310,000.00	45,813.48	00000000000000000000047341	1
31786	0000001612	Dispatched	Valid	13	0000005518	CIGNA Health and Life Insurance Company	6,000.00	664.53	00000000000000000000047341	1
31786	0000001612	Dispatched	Valid	14	0000005518	CIGNA Health and Life Insurance Company	2,000.00	78.18	00000000000000000000047341	1
31786	0000001612	Dispatched	Valid	15	0000005518	CIGNA Health and Life Insurance Company	170,000.00	24,431.25	00000000000000000000047341	1
31786	0000001612	Dispatched	Valid	16	0000005518	CIGNA Health and Life Insurance Company	110,000.00	15,636.00	00000000000000000000047341	1
31786	0000001613	Dispatched	Valid	1	0000005518	CIGNA Health and Life Insurance Company	4,000.00	547.26	00000000000000000000047341	1
31786	0000001613	Dispatched	Valid	2	0000005518	CIGNA Health and Life Insurance Company	240,000.00	39,676.35	00000000000000000000047341	1
31786	0000001613	Dispatched	Valid	3	0000005518	CIGNA Health and Life Insurance Company	1,000.00	156.36	00000000000000000000047341	1
31786	0000001613	Dispatched	Valid	4	0000005518	CIGNA Health and Life Insurance Company	1,000.00	78.18	00000000000000000000047341	1
31786	0000001613	Dispatched	Valid	5	0000005518	CIGNA Health and Life Insurance Company	30,000.00	5,277.15	00000000000000000000047341	1
31786	0000001613	Dispatched	Valid	6	0000005518	CIGNA Health and Life Insurance Company	10,000.00	1,446.33	00000000000000000000047341	1

	38,674,196.78	22,375,865.58
PO lines not used	(11,028,000.00)	
Payments	(22,375,865.58)	
	5,270,331.20	

Remaining on PO 1612	5,031,512.83
Remaining on PO 1613	238,818.37
	5,270,331.20

Cigna Healthcare

Cigna TPA Middle		
Edison Contract #	47341	
Vendor Number	5518	
Total Contract Amount	39,936,000.00	
Payments	22,375,865.58	(from Summary Spreadsheet)
Remaining Balance	17,560,134.42	
Remaining Amount Edison	12,289,803.22	
Difference	5,270,331.20	
Reconciliation:		
(PO 1612):		
Total Blanket PO Amount	5,935,000.00	
Expended on Blanket PO	(903,487.17)	
(PO 1613):		
Total Blanket PO Amount	286,000.00	
Expended on Blanket PO	(47,181.63)	
Total Remaining on Blanket PO's	5,270,331.20	
Difference explained if zero	-	

Cigna Healthcare

Cigna TPA Middle

Edison Contract #	47341
Vendor Number	5518

New contract amt	36,300,000
Current contract	39,936,000
Contract decrease	**(3,636,000)**

New contract amt by FY	**Amount**
2016	3,145,000
2017	6,305,000
2018	6,135,000
2019	5,855,000
2020	5,840,000
2021	5,990,000
2022	3,030,000
	36,300,000

Liquidated Damages Assessment Report

LD Number	Year Assessed	Quarter	Amount Assessed	Guarantee	Assessment
22	2016	1Q	$4,500.00	***Claims Data Submission:*** The Contractor shall submit claims data to the State's DSS vendor no later than fifteen (15) days following the end of each calendar month, or more frequently as directed by the State (see Contract Section A.20).	Five hundred dollars ($500) per day for the first and second business days out of compliance; one thousand dollars ($1,000) per business day thereafter.
27	2016	1Q	$400.00	***Reporting:*** The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract.	Five hundred dollars ($500) per day for the first and second business days out of compliance; one thousand dollars ($1,000) per business day thereafter.
27	2016	2Q	$1,100.00	***Reporting:*** The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract.	One hundred dollars ($100) for each report not delivered to the State within the time frame specified in the Contract.
14	2016	2Q	$5,000.00	***Member Notice of Provider Termination:*** The Contractor shall provide written notice to members regarding terminated hospitals and physician groups, as specified in Contract Section A.3.	One hundred dollars ($100) for each report not delivered to the State within the time frame specified in the Contract.
8	2016	IMP	$3,000.00	***Website:*** The Contractor's website for the Public Sector Plans shall be available on the internet and fully operational, with the exception of member data/Protected Health Information on or before the date specified in Contract Section A.24.	Five thousand dollars ($5,000) per occurrence (defined as each provider termination) if the guarantee is not met.
27	2016	3Q	$900.00	***Reporting:*** The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract.	One hundred dollars ($100) for each report not delivered to the State within the time frame specified in the Contract.
16	2016	4Q	$1,000.00	***Prior Authorizations:*** The Contractor shall complete ninety-seven percent (97%) of all prior authorizations within the timeframes specified in Section A.4.g.	One thousand dollars ($1,000) for each quarter in which the guarantee is not met.
27	2016	4Q	$2,400.00	***Reporting:*** The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract.	One hundred dollars ($100) for each report not delivered to the State within the time frame specified in the Contract.
28	2016	IMP	$200.00	***Reporting:*** The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract.	$100.00 for each report not delivered to the State within the time frame specified in the Contract.

27	2017	1Q	$2,300.00	***Reporting:*** The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract.	One hundred dollars ($100) for each report not delivered to the State within the time frame specified in the Contract.
2	2017	1Q	$38,000.00	***Claims Data Submission:*** The Contractor shall submit claims data to the State's DSS vendor no later than fifteen (15) days following the end of each calendar month, or more frequently as directed by the State (see Contract Section A.20)	Five hundred dollars ($500) per day for the first and second business days out of compliance; one thousand dollars ($1,000) per business day thereafter.
22	2017	2Q	$5,500.00	***Claims Data Submission:*** The Contractor shall submit claims data to the State's DSS vendor no later than fifteen (15) days following the end of each calendar month, or more frequently as directed by the State (see Contract Section A.20)	Five hundred dollars ($500) per day for the first and second business days out of compliance; one thousand dollars ($1,000) per business day thereafter.
27	2017	2Q	$1,000.00	***Reporting:*** The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract.	One hundred dollars ($100) for each report not delivered to the State within the time frame specified in the Contract.
27	2017	3Q	$2,000.00	***Reporting:*** The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract.	One hundred dollars ($100) for each report not delivered to the State within the time frame specified in the Contract.
19	2017	4Q	$3,000.00	***Eligibility Posting:*** One hundred percent (100%) of electronically transmitted enrollment updates, including the resolution of any errors identified during processing, shall be processed within four (4) business days of receipt of the weekly file as required in Contract Section A.20	Five hundred dollars ($500) per day for the first (1st) and second (2nd) business days out of compliance; one thousand dollars ($1,000) per business day thereafter.
22	2017	4Q	$500.00	***Claims Data Submission:*** The Contractor shall submit claims data to the State's DSS vendor no later than fifteen (15) days following the end of each calendar month, or more frequently as directed by the State (see Contract Section A.20)	Five hundred dollars ($500) per day for the first and second business days out of compliance; one thousand dollars ($1,000) per business day thereafter.
27	2017	4Q	$1,400.00	***Reporting:*** The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract.	One hundred dollars ($100) for each report not delivered to the State within the time frame specified in the Contract.

Liquidated Damages Assessment Report

27	2018	1Q	$1,400.00	***Reporting:*** The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract.	One hundred dollars ($100) for each report not delivered to the State within the time frame specified in the Contract.
27	2018	2Q	$1,000.00	***Reporting:*** The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract.	One hundred dollars ($100) for each report not delivered to the State within the time frame specified in the Contract.
22	2018	3Q	$500.00	***Claims Data Submission:*** *The Contractor shall submit claims data to the State's DSS vendor no later than fifteen (15) days following the end of each calendar month, or more frequently as directed by the State (see Contract Section A.20)*	Five hundred dollars ($500) per day for the first and second business days out of compliance; one thousand dollars ($1,000) per business day thereafter.
27	2018	3Q	$1,700.00	***Reporting:*** The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract.	One hundred dollars ($100) for each report not delivered to the State within the time frame specified in the Contract.
7	2018	4Q	$4,400.00	***Average Speed of Answer:*** The Contractor's Call Center shall maintain a daily average speed of answer of 30 seconds.	Four hundred dollars ($400) for each day the guarantee is not met (include all hours the call center is open).
27	2018	4Q	$400.00	***Reporting:*** The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract.	One hundred dollars ($100) for each report not delivered to the State within the time frame specified in the Contract.
27	2019	1Q	$600.00	***Reporting:*** The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract.	One hundred dollars ($100) for each report not delivered to the State within the time frame specified in the Contract.
27	2019	2Q	$300.00	***Reporting:*** The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract.	One hundred dollars ($100) for each report not delivered to the State within the time frame specified in the Contract.
			$82,500.00		

Amendment Request

This request form is not required for amendments to grant contracts. Route a completed request, as one file in PDF format, via e-mail attachment sent to: Agsprs.Agsprs@tn.gov

APPROVED	
CHIEF PROCUREMENT OFFICER	DATE

Agency request tracking #	**31786-00125**
1. Procuring Agency	**Benefits Administration**
2. Contractor	**Cigna Health and Life Insurance Company**
3. Edison contract ID #	**47341**
4. Proposed amendment #	**One**
5. Contract's Original Effective Date	**9/1/2015**
6. Current end date	**8/31/2022**
7. Proposed end date	**6/30/2023**
8. Current Maximum Liability or Estimated Liability	**$39,936,000.00**
9. Proposed Maximum Liability or Estimated Liability	**$36,300,000.00**
10. Strategic Technology Solutions Pre-Approval Endorsement Request *– information technology service (N/A to THDA)*	☒ **Not Applicable** ☐ **Attached**
11. eHealth Pre-Approval Endorsement Request *– health-related professional, pharmaceutical, laboratory, or imaging*	☒ **Not Applicable** ☐ **Attached**
12. Human Resources Pre-Approval Endorsement Request *– state employee training service*	☒ **Not Applicable** ☐ **Attached**
13. Explain why the proposed amendment is needed **Decrease in the maximum liability**	
14. If the amendment involves a change in Scope, describe efforts to identify reasonable, competitive, procurement alternatives to amending the contract. **n/a**	

Agency request tracking #	**31786-00125**
Signature of Agency head or authorized designee, title of signatory, and date (the authorized designee may sign his or her own name if indicated on the Signature Certification and Authorization document)	

CONTRACT AMENDMENT COVER SHEET

Agency Tracking #	Edison ID	Contract #	Amendment #
31786-00125		47341	1

Contractor Legal Entity Name	Edison Vendor ID
Cigna Health and Life Insurance Company	5518

Amendment Purpose & Effect(s)

One year extension of the contract

Amendment Changes Contract End Date: ☒ YES ☐ NO **End Date:** **6/30/2023**

TOTAL Contract Amount INCREASE or DECREASE per this Amendment (zero if N/A)**:** **-$3,636,000**

Funding —

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2016			$3,145,000		$3,145,000
2017			$6,305,000		$6,305,000
2018			$6,135,000		$6,135,000
2019			$5,855,000		$5,855,000
2020			$5,840,000		$5,840,000
2021			$5,990,000		$5,990,000
2022			$3,030,000		$3,030,000
TOTAL:					**$36,300,000.00**

American Recovery and Reinvestment Act (ARRA) Funding: ☐ YES ☒ NO

Budget Officer Confirmation: There is a balance in the appropriation from which obligations hereunder are required to be paid that is not already encumbered to pay other obligations.

CPO USE

Speed Chart (optional)

Account Code (optional)

AMENDMENT ONE
OF CONTRACT #47341

This Amendment is made and entered by and between the State of Tennessee, State Insurance Committee, Local Education Insurance Committee, and Local Government Insurance Committee, hereinafter referred to as the 'State" and Cigna Health and Life Insurance Company hereinafter referred to as the "Contractor". For good and valuable consideration, the sufficiency of which is hereby acknowledged, it is mutually understood and agreed by and between said, undersigned contracting parties that the subject contract is hereby amended as follows:

1. **Contract section A.9.mm is deleted in its entirety and replaced with the following:**

   Upon conclusion of the service delivery period (1/1/16-12/31/21) of this Contract, or in the event of its termination or cancellation for any reason, the Contractor shall be responsible for the processing of all claims incurred for medical services rendered and medical supplies purchased during the period of this Contract as well as provider reimbursement or recoupment attributable to claims incurred during the period of this Contract with no additional administrative cost to the State. The claims run out period shall extend through the final day of the eighteenth (18th) month following 12/31/21. In addition, in the event of termination of this Contract, the Contractor shall continue to provide and pay claims for services to any member who is hospitalized on the effective date of termination. Said coverage shall discontinue when the member is discharged from the hospital.

2. **Contract section B is deleted in its entirety and replaced with the following:**

   This Contract shall be effective on September 1, 2015 ("Effective Date") and extend for a period of ninety-four (94) months after the Effective Date ("Term"). The State shall have no obligation for goods or services provided by the Contractor prior to the Effective Date.

3. **Contract section C.1 is deleted in its entirety and replaced with the following:**

   C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Thirty-Six Million Three Hundred Thousand Dollars ($36,300,000.00) ("Maximum Liability"). This Contract does not grant the Contractor any exclusive rights. The State does not guarantee that it will buy any minimum quantity of goods or services under this Contract. Subject to the terms and conditions of this Contract, the Contractor will only be paid for goods or services provided under this Contract after a purchase order is issued to Contractor by the State or as otherwise specified by this Contract.

4. **Contract section C.1 is deleted in its entirety and replaced with the following:**

   D.31 Iran Divestment Act. The requirements of Tenn. Code Ann. § 12-12-101 et. seq., addressing contracting with persons as defined at T.C.A. §12-12-103(5) that engage in investment activities in Iran, shall be a material provision of this Contract. The Contractor certifies, under penalty of perjury, that to the best of its knowledge and belief that it is not on the list created pursuant to Tenn. Code Ann. § 12-12-106.

5. **Contract section C.3.b. is deleted in its entirety and replaced with the following:**

   The Contractor shall be compensated based upon the following payment methodology:

   (1) Total Enrollment Level-Based Fee.

TOTAL ENROLLMENT * LEVELS (**all** members, not just employees)	FEE PER EMPLOYEE PER MONTH (PEPM) BY CONTRACT PERIOD					
	January 1 – December 31, 2016	January 1 – December 31, 2017	January 1 – December 31, 2018	January 1 – December 31, 2019	January 1 – December 31, 2020	January 1 – December 31, 2021

Below 10,000	$64.88	$67.37	$69.96	$72.65	$75.46	$75.46
10,000 – 29,999	$48.57	$50.36	$52.22	$54.14	$56.14	$56.14
30,000 – 49,000	$45.75	$47.03	$48.36	$49.73	$51.15	$51.15
50,000 – 74,999	$40.57	$41.54	$42.54	$43.57	$44.62	$44.62
75,000 – 99,999	$36.66	$37.45	$38.26	$39.09	$39.95	$39.95
100,000 and above	$33.17	$33.81	$34.46	$35.12	$35.79	$35.79

* "Total enrollment levels" reflects all members (i.e., all employees, retirees, and dependents) covered in all regions by the Contractor. January enrollment will be used to determine the enrollment-based fee level annually, and the fee level set in January of each year shall remain constant for the remainder of the calendar year. The sum of the PEPM and the number of employees (or heads of contract), not total enrollment levels; will generate the Contractor's total payment.

The Contractor shall be compensated based upon the following payment rates for optional Telemedicine/TeleHealth services implemented at the direction of the State:

(1) Total Enrollment Level Based Fee.

TOTAL ENROLLMENT * LEVELS (**all** members, not just employees)	FEE PER EMPLOYEE PER MONTH (PEPM) BY CONTRACT PERIOD					
	January 1 – December 31, 2016	January 1 – December 31, 2017	January 1 – December 31, 2018	January 1 – December 31, 2019	January 1 – December 31, 2020	January 1 – December 31, 2021
Below 10,000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
10,000 – 29,999	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
30,000 – 49,000	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
50,000 – 74,999	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
75,000 – 99,999	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
100,000 and above	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

* "Total enrollment levels" reflects all members (i.e., all employees, retirees, and dependents) covered in all regions by the Contractor. January enrollment will be used to determine the enrollment-based fee level annually, and the fee level set in January of each year shall remain constant for the remainder of the calendar year. The sum of the PEPM and the number of employees (or heads of contract), not total enrollment levels; will generate the Contractor's total payment.

Carriers will invoice the State based on enrollment as approved by the State.

6. Contract section C.3.c. is deleted in its entirety and replaced with the following:

The Contractor shall maintain an annual medical trend rate at or below six percent (6%). During any plan year, if the trend rises above six percent (6%) as calculated using allowed amounts for in-network claims incurred, the Contractor guarantees to reimburse the State or have withheld the percentage of administrative fees detailed in the table below.

	PERCENTAGE OF ADMINISTRATIVE FEES AT RISK				
	1/1/17 – 12/31/17	**1/1/18 – 12/31/18**	**1/1/19 – 12/31/19**	**1/1/2020 – 12/31/2020**	**1/1/2021 – 12/31/2021**
REGIONAL NETWORK TREND GUARANTEE	100%	100%	100%	100%	100%

7. Contract section C.3.g. is deleted in its entirety and replaced with the following:

During the term of this contract the average, aggregate reimbursement for all specialty drugs dispensed in a physician's office, hospital setting (outpatient), or any other setting (including but not limited to oncology clinics) shall not exceed:

CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
ASP + 38%	ASP + 38%	ASP + 36%	ASP +36%	ASP +33%	ASP +33%

ASP = Average Sales Price as defined in A.25.

Compliance with the aggregate ASP+ percentage standard for the previous calendar year will be reconciled annually using the ASP drug pricing files from CMS and reported to the State in the ASP reconciliation report (see Contract Sections A.6.f and Contract Attachment C, Reporting Requirements). The reconciliation shall be validated by the State's consulting actuary and all monies exceeding the above limits will be payable to the State by the Contractor within thirty (30) days of state notification.

Required Approvals. The State is not bound by this Amendment 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).

Amendment Effective Date. The revisions set forth herein shall be effective January 1, 2020. All other terms and conditions of this Contract not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

CIGNA HEALTH AND LIFE INSURANCE COMPANY:

SIGNATURE **DATE**

PRINTED NAME AND TITLE OF SIGNATORY (above)

STATE INSURANCE COMMITTEE,
LOCAL EDUCATION INSURANCE COMMITTEE,
LOCAL GOVERNMENT INSURANCE COMMITTEE:

STUART C. MCWHORTER, CHAIRMAN **DATE**

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
STATE INSURANCE COMMITTEE,
LOCAL EDUCATION INSURANCE COMMITTEE,
LOCAL GOVERNMENT INSURANCE COMMITTEE,
AND
CIGNA HEALTH AND LIFE INSURANCE COMPANY

This Contract, by and between the State of Tennessee, State Insurance Committee, Local Education Insurance Committee, and the Local Government Insurance Committee, ("State") and Cigna Health and Life Insurance Company, ("Contractor"), is for the provision of medical claims administration services for the State's Public Sector Plans for the West Grand Division of Tennessee, as further defined in the "SCOPE OF SERVICES."

The Contractor is For-Profit Corporation.
Contractor Place of Incorporation or Organization: Connecticut
Contractor Edison Registration ID # 5518

A. SCOPE

A.1. General

a. The Contractor shall provide all goods or services and deliverables as required, described, and detailed below and shall meet all service and delivery timelines as specified by this Contract.

b. The Contractor is serving Grand Division Service Area West (refer to Contract Section A.25), and providing the Local Plus network for the West region.

c. The Contractor shall provide administrative services, in accordance with this Contract, for the State's Public Sector Plans eligible individuals, hereinafter referred to as "members", who elect to enroll in one of the options offered by the State.

d. The State may adjust the premium that it charges members to enroll with the Contractor in order to account for changes in the Contractor's provider payment terms and other factors as the State deems appropriate. Such adjustments may vary by third party administrator. Similarly, the State may elect to adjust the State contribution for State and higher education employees based on these and other factors. The State's decisions on these issues are final and not subject to appeal.

e. Pursuant to Section D.16., the Contractor and the State will jointly work to interpret and implement the requirements of the Patient Protection and Affordable Care Act (PPACA) Public Law 111-148 as amended by Public Law 111-152. To the extent that any foregoing requirements of this contract conflict with PPACA then the Contractor shall immediately consult with the State and adjust its process in order to comply with the federal law.

A.2. Implementation

a. The Contractor's call center and other information systems, including but not limited to its claims management system, shall be fully operational on the date specified in Contract Section A.24.

b. The Contractor shall implement the information systems and other processes required to process all medical claims and perform all other services described herein. The Contractor shall work with the State to ensure that the Contractor satisfies applicable

requirements of this Contract, including requirements in the State Plan, Local Education Plan, and Local Government Plan Documents (referred to as the "Plan Documents" and which are located on the State's website at http://tennessee.gov/finance/ins/publications.shtml and State and Federal law.

c. The Contractor shall have a designated full-time implementation manager who is responsible for leading and coordinating all contract implementation activities as well as a designated implementation team. Unless otherwise directed by the State, the implementation manager should be designated full-time to this implementation project through sixty (60) days after the go-live date. All other implementation team members that the Contractor referenced in its proposal to the State and reflected in Attachment F, shall be available as needed during the implementation but should be dedicated to this project at least two (2) months prior to the go-live date specified in Contract Section A.24. and at least thirty (30) days after the go-live date. The Contractor's implementation team shall include a full-time Account Manager designated to this Contract, who will be the main contact with the State for all of the day-to-day matters relating to the implementation and ongoing operations of this Contract. Also, the Contractor shall assign an Information Systems Project Coordinator to coordinate information technology activities among the Contractor and the State's existing vendors and all internal and external participating and affected entities. All of the Contractor's implementation team members shall have participated, as team members, in the implementation of claims administration services for at least one other large employer (*i.e.*, employer with medical plans covering at least 30,000 lives).

d. All key Contractor project staff shall attend a project kick-off meeting at the State of Tennessee offices in Nashville, TN within the first thirty (30) days after the Contract start date. State staff shall provide access and orientation to the Public Sector Plans and system documentation, as requested by the Contractor.

e. The Contractor shall provide a project implementation plan to the State no later than thirty (30) days after the Contract start date. The plan shall be electronically maintained, daily, in a format accessible to the State. The plan shall comprehensively detail all aspects of implementation, which includes all tasks with deliverable dates necessary to satisfactorily implement all medical claims administrative services no later than the go-live date specified in Contract Section A.24. and a description of the members on the implementation team and their roles with respect to each item/task/function. The plan shall include a detailed timeline description of all work to be performed both by the Contractor and the State. This plan shall require written approval by the State. At a minimum, the implementation plan shall provide specific details on the following:

(1) identification and timing of significant responsibilities and tasks;
(2) names and titles of key implementation staff;
(3) identification and timing of the state's responsibilities;
(4) data requirements (indicate type and format of data required);
(5) identification and timing for the testing, acceptance and certification of receipt of the State's enrollment information;
(6) identification and timing for testing and certification of claims processing and payment and the reconciliation process;
(7) member communications;
(8) schedule of in-person meetings and conference calls;
(9) transition requirements with the incumbent claims administrator(s); and
(10) staff assigned to attend and present (if required) at annual transfer/ educational sessions.

f. At the State's request, the Contractor shall provide for a comprehensive operational readiness review (pre implementation audit) by the State, and/or its authorized

representative, within sixty (60) days prior to the go-live date. Such review by the State, and/or its authorized representative, may include, but not be limited to, an onsite review of the Contractor's operational readiness for all services required in this Contract (*e.g.*, claims processing and payment, member services, training, and website development). The review may also include desk reviews of documentation that includes but is not limited to:

(1) policy and procedures manual;
(2) call center scripts;
(3) information systems documentation; and
(4) the ability to provide, and the process governing the preparation of, any and all deliverables required under this Contract.

g. At its discretion, the State may conduct an additional, pre-implementation review of the Contractor's progress towards fulfilling the information systems requirements of this Contract. Such review by the State, and/or its authorized representative, may include both onsite and desk reviews, including but not limited to staff interviews, system demonstrations, systems testing, and document review.

h. During onsite visits as part of readiness review or a pre-implementation review, the Contractor shall provide onsite workspace and access to a telephone, scanner, printer, copy machine, and Internet connection. The Contractor's staff members shall be freely available to the State officials to answer question during this visit.

i. The Contractor shall conduct status meetings concerning project development, project implementation and Contractor performance at least twice a week during implementation and daily for the two weeks prior to and the first month following the go-live date, unless otherwise approved by the State. Thereafter, all ongoing operational meetings shall be conducted on a State-specified schedule, but shall occur no less than weekly unless otherwise directed by the State. Such meetings shall be either by phone or onsite at the offices of the State, as determined by the State, and shall include the Account Manager and appropriate Contractor staff. Any costs incurred by the Contractor as a result of a meeting with the State shall be the responsibility of the Contractor.

j. No later than forty-five (45) days post-go-live, the Contractor shall provide the State with an Implementation Performance Assessment survey for completion by the State. This assessment will be used to document the State's satisfaction with the implementation process and identify any necessary corrective action(s). The Contractor shall comply with all recommendations/requirements made in writing by the State within the timeframes specified by the State.

A.3. Provider Network

a. The Contractor shall maintain a Preferred Provider Organization (PPO) network in the Grand Division(s) covered by this Contract, as well as a broader national PPO network for members residing or traveling outside of the grand division, that provides high quality, cost effective medical services, and provides adequate geographic and service access to members. Unless otherwise directed by the State, all networks shall include other commercial clients and cannot be established only for State members. The Contractor shall contract with medical providers including, but not limited to, primary care physicians, specialist physicians, nurse practitioners/physician assistants, nurse midwives, hospitals (all levels - primary, secondary and tertiary), skilled nursing facilities, urgent care facilities, convenience clinics, state employee onsite clinics, laboratories, durable medical equipment suppliers, and all other medical facilities, services and providers necessary to provide covered benefits.

b. The Contractor's provider network(s) shall meet, at a minimum, the geographic access standards specified in Contract Attachment B.

c. The Contractor shall provide the State with GeoNetworks® reports on a semi-annual basis showing service and geographic access (refer also to Contract Attachment C, Reporting Requirements). At the State's request, the Contractor shall also submit an access report following a network change. The State shall review the reports and inform the Contractor in writing of any deficiencies. The Contractor shall develop and implement an action plan to correct deficiencies. The State reserves the right to review the action plan and require changes, where appropriate.

d. The Contractor shall maintain a sufficiently extensive and accessible provider network such that members are able to receive appointments from a geographically-accessible provider within the following appointment standards:

(1) urgent visit: twenty-four (24) hours
(2) wellness visit: two (2) months
(3) primary care routine visit: fourteen (14) days
(4) specialty care routine visit: thirty (30) days

e. As directed by the State, the Contractor shall develop and implement a high performance or tiered network of providers and/or facilities as measured by their adherence to a standard set of evidence-based clinical protocols, cost efficiency (*e.g.*, cost per episode) and quality measures. The Contractor shall collaborate with and assist the state and its other vendor partners in the development of such standard protocols and measures and implement any associated member incentives.

f. The Contractor may develop a high performance or tiered network of providers and/or facilities without State direction. Before implementing a high performance or tiered network, the Contractor shall submit its plan for developing and implementing such a network to the State, and the plan shall be approved in writing by the State. The Contractor's plan shall include the information specified by the State, including at a minimum the (1) quality and cost efficiency measures that the Contractor will use to determine whether a provider or facility satisfies the criteria to participate in the network; and (2) proposed member cost-sharing incentives (*e.g.*, lower rates of co-insurance, co-payment in lieu of co-insurance, waiver of or provision of lower deductible amounts) or other incentives for members who receive covered benefits from high performance providers or facilities. The State may approve the Contractor's use of such member incentives regardless of whether other third party administrators for medical services have implemented such member incentives.

g. The Contractor shall participate in a Patient Centered Medical Home (PCMH) pilot (single or multi-insurer) with specific objectives of improving clinical outcomes, patient experience, and net savings across the continuum of services. The insurer shall verify that practices have achieved the necessary parameters prior to the provision of any enhanced payments.

h. PCMH initiatives shall include collaborative physical and behavioral health care for all patients identified with a chronic or persistent medical condition. Collaborative care shall include a behavioral health screening and referral to a licensed behavioral health professional. The Contractor shall also include the behavioral health assessment and subsequent referral, if necessary, as an element in any chart reviews that it conducts.

i. The Contractor shall receive prior approval from the State for any member enrollment in a Patient Centered Medical Home, Accountable Care Organization, or any other similar model.

j. The Contractor shall include in its provider network transplant centers that are Medicare-approved transplant programs. The State considers Medicare-approved transplant programs to be Centers of Excellence for each program type (*e.g.*, heart/lung, heart-only, kidney-only) approved by Medicare. The Contractor shall only authorize and pay for organ transplants performed by a transplant program that is approved by Medicare for the applicable transplant (*e.g.*, heart/lung, heart-only, kidney-only). The Contractor may require additional criteria on their network providers over and above the requirements listed above.

k. As directed by the State, the Contractor shall maintain a network of Centers of Excellence for each of the following: bariatric surgery, orthopedic surgery, oncology/cancer surgery, and cardiology/cardiac surgery. The criteria for Centers of Excellence shall be developed by the Contractor and limited to facilities that adhere to the highest standards of patient safety and quality care. As directed by the State, the Contractor shall only authorize and pay for procedures performed at Centers of Excellence and shall provide incentives to members to use Centers of Excellence for the specified services (including but not limited to lower member cost sharing for procedures performed at such facilities). Additionally, the Contractor shall provide health navigators to direct members to these facilities when medically appropriate.

l. The Contractor shall notify the State of any operations or plans to implement value oriented payments where provider payments are differentiated based on quality and/or efficiency. Examples of such payments include, but are not limited to, incentive payments (e.g. pay for performance), enhanced or reduced reimbursement, capitation, and reference pricing. The Contactor shall not implement such value oriented provider payments without prior approval from the State.

m. The Contractor shall report descriptive information and data about its value oriented provider payments in sufficient detail to enable the State to make an approval determination as well as adequately monitor the Contractor's program and billings following approval. The information that may be requested shall include, but not be limited to, the following:

(1) The type(s) of arrangements, such as, withholds, bonus, capitation;
(2) The percent of any withhold or bonus the plan uses;
(3) The patient panel size and, if the plan uses pooling, the pooling method; and
(4) The projected financial impact to the plan as a result of the program.

n. The Contractor shall ensure that no specific payment be made directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

o. Covered benefits received through network providers located in states contiguous to the State of Tennessee shall be consistent with covered benefits provided through network providers located in Tennessee. The Contractor shall include in its provider network providers including, but not limited to, physicians and hospitals, located in states contiguous to the Grand Division(s) covered by this Contract.

The Contractor shall include providers with service locations in the following statistical areas, as defined by the U.S. Office of Management and Budget (OMB):

- Alabama – Florence-Muscle Shoals MSA
- Mississippi and Arkansas – Memphis Metropolitan Statistical Area (MSA); Memphis-Forrest City Combined Statistical Area
- Kentucky – Union City, TN - KY Micropolitan Statistical Area; Murray, KY Micropolitan Statistical Area

p. The Contractor shall submit a quarterly network changes update report to the State by the 20th of the month following the end of the quarter that includes any changes in the Contractor's provider network (refer also to Contract Attachment C, Reporting Requirements).

q. The Contractor shall notify the State in writing of any termination of a hospital or physician group of twenty (20) or more, regardless of whether the termination is initiated by the Contractor or the provider, within one (1) business day of becoming aware of the termination. The Contractor shall also provide written notice to members who received treatment from the hospital or physician group within the last six (6) months. Unless otherwise directed by the State, the Contractor shall mail the notice to members no less than thirty (30) calendar days prior to the effective date of the termination.

r. The Contractor shall not take action to disenroll network primary care providers or hospital providers except for good reason, which may include: inability to negotiate continuance of its provider agreement; provider failure in the credentialing/recredentialing process; non-compliance with provider agreement requirements; provider request for disenrollment; member complaints; suspicion of provider impairment; loss of license or exclusion from participation in Medicare or Medicaid pursuant to Sections 1128 or 1156 of the Social Security Act; or those who are otherwise not in good standing with the Public Sector Plans.

s. The Contractor shall give affected providers written notice if it declines to include individual or groups of providers in its network.

t. The Contractor shall submit a report annually identifying the percentage of network physicians not accepting members as new patients. The report shall identify the percentages by each of the state grand regions served by the Contractor.

u. The Contractor shall submit to the State an annual provider turnover report that includes the Contractor's voluntary and involuntary turnover rate by provider type (refer also to Contract Attachment C, Reporting Requirements).

v. The Contractor shall maintain NCQA's Credentials Verification Organization certification during the term of this contract. If the Contractor is not certified as of the start date of the contract, they must obtain the certification no later than December 31, 2016, or at a later date if approved by the State.

w. The Contractor shall contract only with providers who are duly licensed to provide such medical services and shall require that all providers maintain all licenses and accreditations in existence at the time of selection as a network provider in order to continue their status as a network provider. The Contractor shall perform on a continuous basis appropriate provider credentialing that assures the quality of network providers. The Contractor shall complete processes necessary to reconfirm the licensure, accreditations, credentials, and standing of network providers no less frequently than every three (3) years.

x. The Contractor shall maintain face-to-face, telephonic, and written communication with providers to ensure a high degree of continuity in the provider network and ensure that the providers are familiar with applicable requirements.

y. The Contractor shall notify all network providers of, and enforce compliance with, all provisions relating to utilization management and other procedures as required for participation in the Contractor's provider network.

z. The Contractor shall require all network providers to file claims associated with their services directly with the Contractor on behalf of members.

aa. The Contractor shall identify and sanction network providers who fail to meet pre-determined, minimum standards relating to referrals to out-of-network providers.

bb. The Contractor shall notify the State in writing at least thirty (30) days prior to any material adjustments to any provider payment terms, including but not limited to provider fee schedules, contract rates, other provider payment arrangements, discounts, rebates, refunds, or credits negotiated with the provider, and the manner in which such adjustments are reasonably likely to affect the cost of claims payments by the State. Such notification shall be made for all hospitals or physician groups of twenty (20) or more.

cc. If the Contractor is unable to deliver covered benefits through network providers, the Contractor shall arrange for such services to be rendered by out-of-network providers. When the Contractor arranges for covered benefits to be provided through an out-of-network provider, the member's financial liability shall be limited to any cost-sharing that would have applied had the service been rendered by a network provider (*e.g.*, in-network co-insurance percentage and in-network deductible amount), expenses determined not to be medically necessary and expenses that exceed the maximum allowable charge, unless otherwise directed by the State. The Contractor shall report to the State on a monthly basis all unique care exception requests and whether they were granted or denied (refer also to Contract Attachment C, Reporting Requirements).

dd. In no case shall network providers balance bill for covered benefits. Rather, the member's liability shall be limited to the allowable member cost-sharing.

ee. The Contractor shall have available for implementation at the State's request a Telemedicine/TeleHealth benefit option that meets or exceeds T.C.A. and State of Tennessee Medical Board requirements and regulations.

A.4. Utilization Management

a. Unless otherwise directed by the State, the Contractor shall maintain a utilization management (UM) function designed to help individual members secure the most appropriate level of care consistent with their health status. In carrying out this function, the Contractor shall provide a system for reviewing the appropriateness and medical necessity of inpatient hospital care, skilled nursing facility stays, inpatient rehabilitative care, and other levels of care included in the Contractor's standard UM programs, or as specified by the State, and for prior authorizing these and other covered benefits.

b. The Contractor shall use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of UM, including prior authorization and decision making.

c. The Contractor shall have in place an effective process that identifies and manages members in need of inpatient hospital care. This shall include:

(1) Identification of patients in need of inpatient hospital care for the purpose of reviewing the level of care requested, determining the extent of care required, and identifying appropriate additional or alternative services as needed; this shall include admission review, or the pre-certification/authorization of an inpatient stay.

(2) Concurrent review during the course of a patient's hospital inpatient stay, where qualified medical management staff coordinate care with the hospital staff and

patients' physicians; this shall include review of the continued hospitalization of patients and identification of medical necessity for stays as well as available alternatives.

(3) Discharge planning, providing a process by which the Contractor's UM staff work with the hospital, patient's physicians, the State's Health Management/Wellness (HM/W) vendor as requested by the State, patient's family, and appropriate community resources to coordinate discharge and post-discharge needs of the patient and reduce the likelihood of readmission.

(4) Review of urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine medical necessity for the service.

d. The Contractor shall have in place an effective process that identifies and manages members in need of skilled nursing facility care. This shall include:

(1) Identification of patients in need of skilled nursing care for the purpose of reviewing the level of care requested, determining the extent of care required, and identifying appropriate additional or alternative services as needed; this shall include admission review, or the pre-certification/authorization of a skilled nursing facility stay.

(2) Concurrent review during the course of a patient's skilled nursing facility stay, where qualified medical management staff coordinate care with the skilled nursing facility staff and patients' physicians; this shall include review of the continued skilled nursing facility stay of patients and identification of medical necessity for stays as well as available alternatives.

(3) Discharge planning, providing a process by which the Contactor's utilization management staff work with the skilled nursing facility, patient's physicians, HM/W vendor, as requested by the State, patient's family, and appropriate community resources to coordinate discharge and post-discharge needs of the patient and reduce the likelihood of readmission.

e. The Contractor shall not require pre-admission certification for inpatient hospital admissions for the normal delivery of children.

f. The Contractor shall require prior authorization of (i) outpatient high-technology diagnostic imaging, including but not limited to Magnetic Resonance Imaging (MRI), Computerized Tomography (CT), Positron Emission Tomography (PET) scans, and nuclear cardiac imaging studies; (ii) home health services, (iii) miscellaneous J-codes and (iv) other services specified by the State. Subject to State approval, the Contractor may require prior authorization of other services.

g. Unless otherwise directed by the State, the Contractor shall adhere to the following standards for timeliness of UM decision making:

(1) For non-urgent pre-certification or prior authorization decisions, the Contractor shall make the decision within fifteen (15) calendar days of receipt of the request;

(2) For urgent prior authorization decisions, the Contractor shall make the decision within seventy-two (72) hours of receipt of the request

(3) For urgent pre-certification or concurrent review decisions, the Contractor shall make the decision within twenty-four (24) hours of receipt of the request;

(4) For retroactive decisions, the Contractor shall make the decision within thirty (30) calendar days of receipt of the request.

h. If the Contractor is missing any information necessary to make a pre-certification, prior authorization, or concurrent review decision, the Contractor shall immediately contact the provider to obtain the missing information. If the information is still missing one (1)

business day after contacting the provider, the Contractor shall make at least one follow-up contact to obtain the missing information.

i. The Contractor shall have an electronic UM system that contains complete (*i.e.*, sufficient to accurately portray the events of the review during an independent medical audit of the UM record) documentation of the review process by capturing administrative and clinical data as well as clinical notes by the UM staff.

j. The Contractor shall use protocols that are diagnosis/procedure specific, consistent with efficient medical practices, and that provide nurse reviewers with guidelines regarding the type of care that is indicated during each day of treatment. Physician reviewers shall be actively involved in the review process in accordance with industry standards. Any provision of the Public Sector Plan Documents and any protocol adopted by the Benefits Administration Division shall take precedence over any protocol used by the Contractor.

k. The Contractor shall maintain a comprehensive internal audit program for utilization management services and shall take prompt corrective action to correct any deficiencies or quality of care issues.

l. The Contractor shall submit to the State, at least two (2) months prior to the go-live date, a copy of all documents describing its UM program, evaluation methodology, and audit plan. The State reserves the right to review these documents and require changes, where appropriate. The Contractor shall notify the State, in writing, within thirty (30) days of any significant changes to its UM program. The State reserves the right to review the change and require changes, where appropriate.

m. The Contractor shall provide a written report to the State on a quarterly basis regarding the utilization of services and the demonstrated effectiveness of its UM program (refer also to Contract Attachment C, Reporting Requirements).

n. The Contractor shall provide medically necessary case management services. This shall include identifying and outreaching to members with high-risk conditions such as terminal illness, severe injury, major trauma, cognitive or physical disability, or transplants. Registered nurse case managers shall work with the member, health care providers, primary caregivers and appropriate vendors to coordinate the most appropriate, cost-effective care settings. This shall include transition to designated vendors for continued follow-up and ongoing management, as designated by the State, as well as clinical management and oversight of activities to ensure timely and effective transition to appropriate vendors.

o. The Contractor shall identify, no less than every six (6) months, members using emergency department services inappropriately or excessively. The Contractor shall outreach to those members not currently engaged in health coaching with the State's wellness vendor for the purpose of educating the member on appropriate emergency department use, enrolling the member in case management, if appropriate, or referring the member to other State vendor's for assistance.

A.5. Quality Assurance Program

a. The Contractor shall maintain a comprehensive quality assurance program that prospectively, concurrently and retrospectively ensures the quality of care provided by network providers as well as the quality of services provided by both network providers and the Contractor.

b. The Contractor shall submit to the State, at least one (1) month prior to the go-live date, a summary of its quality assurance program. The State reserves the right to review the

program documents and require changes, where appropriate. The Contractor shall notify the State, in writing, within thirty (30) days of any significant changes to its quality assurance program. The State reserves the right to review the change and require changes, where appropriate.

c. The Contractor shall establish a quality assurance committee comprised of qualified medical experts, including adequate representation of medical specialties, which shall meet at least quarterly. The quality assurance committee shall be responsible for evaluating the quality of care provided by network providers. Any person employed by the Contractor who identifies a potential quality of care issue involving a network provider shall submit it for investigation by the quality assurance committee. The committee shall promptly investigate any potential quality of care issues.

d. The Contractor shall review and assess the practice patterns of network providers to identify providers practicing outside of peer norms, specifically those identified with significant over-utilization and under-utilization of services or unusually low quality of care scores. The Contractor shall share its findings with network providers and take measures to maintain a quality, efficient and effective network of providers.

e. Unless otherwise directed by the State, the Contractor shall ensure that its network hospitals complete the Leapfrog Hospital Survey annually.

f. Unless otherwise directed by the State, the Contractor shall complete the eValue8 (see Contract Section A.25.) process in 2016 and, thereafter, shall complete the process every other year during the term of this contract. This shall include, but not be limited to, completing the request for information survey, submitting the survey to the National Business Coalition on Health and/or other entity as directed by the State, participating in the validation process, and participating in any onsite visits with the State to discuss the results and identify areas for improvement. The Contractor shall also participate in an annual site visit to address the specific next steps and follow up on issues identified during the most recent eValue8 process.

g. The Contractor shall adopt and implement evidence-based clinical practice guidelines, protocols or pathways incorporating national criteria and local physician input as appropriate. Any provision of the Public Sector Plan Documents and any guideline, protocol, or pathway adopted by the Benefits Administration Division shall take precedence over any guideline, protocol, or pathway used by the Contractor. The Contractor's website (see Contract Section A.16.) shall contain all such guidelines, protocols, or pathways that are applicable to the Public Sector Plans.

h. The Contractor shall maintain standards and protocols for tracking all incidents/potential issues with network providers (*e.g.*, member complaints, irregular billing practices, and quality of care issues). In addition to responding to each incident/issue, the Contractor shall initiate a provider review when the number of incidents/issues reaches a threshold defined in advance by the Contractor. The Contractor shall specify the content of this review, which may range from medical chart audits to an outcomes analysis.

i. At the State's request, the Contractor shall incorporate Bridges to Excellence Recognitions into clinician quality evaluations.

j. Whenever the Contractor identifies a potential quality of service or quality of care issue, the Contractor shall conduct appropriate follow-up, including taking corrective action as necessary to remedy a deficiency.

k. Unless otherwise directed by the State, qualified members of the Contractor's clinical staff shall participate in conference calls, up to but not exceeding once a week, with the

State's contracted vendors (PBM, EAP/BHO, HM/W, etc.) to address issues or concerns regarding coordination of care for individual members, particularly members with complex needs. In preparation for each call, the Contractor shall identify members and their issues/concerns, provide applicable documentation, including clinical information, to the appropriate State vendors, and develop recommendations for resolving the issue/concern. The PBM, EAP/BHO vendor, HM/W vendor and/or the State may also identify members.

l. Unless otherwise directed by the State, qualified members of the Contractor's staff shall participate in conference calls with the State and representatives from the other third party administrator for medical services, the PBM, the EAP/BHO vendor, the HM/W vendor, the H&W Center vendor, and/or other State contracted vendors to improve coordination of their services to members.

m. The Contractor shall obtain Health Plan Accreditation at a level of Commendable or Excellent by the National Committee for Quality Assurance (NCQA). If the Contractor is NCQA accredited as of the start date of this Contract, the Contractor shall maintain such accreditation throughout the term of this Contract. If the Contractor is not NCQA accredited, or is not currently accredited at the required level, for its products as of the start date of this Contract, the Contractor shall obtain such accreditation by December 31, 2016 (or a later date as specified by the State) and shall maintain it thereafter.

n. The Contractor shall annually submit to the State a report, in a format approved by the State, with HEDIS results for its products utilized by the State (refer also to Contract Attachment C, Reporting Requirements).

A.6. Pharmacy

a. The State contracts with a pharmacy benefits manager (PBM) for the purpose of providing most outpatient pharmacy services. However, the PBM is not the exclusive provider of all outpatient pharmacy products. Rather, the Contractor shall have responsibility for paying claims for certain office-administered immunizations (*e.g.*, for seasonal flu, pneumococcal, shingles, etc.), injectables, infusion therapy, and other specialty pharmacy products as directed by the State. The Contractor, as directed by the State, shall work with the State to transition certain outpatient specialty pharmaceuticals to the State's contracted pharmacy benefits manager or to physician offices, particularly specialty drugs administered on an outpatient basis in a hospital setting which tend to have higher costs.

b. The Contractor shall pay for allowable, medically-necessary office visits for members who bring pharmacy-supplied specialty pharmacy products to a provider for administration.

c. The Contractor shall ensure that its network providers comply with the applicable drug utilization review and prior authorization requirements for office-administered, office-supplied specialty pharmacy products. The Contractor shall further ensure that its providers do not bill members for any claims that the Contractor rejects because of the provider's failure to comply with such requirements. Additionally, the Contractor shall provide its network providers with sufficient provider training, references and educational materials to ensure provider compliance.

d. Except as provided in Contract Section A.6.a., above, the Contractor is not responsible for the provision or payment of outpatient pharmacy services. However, the Contractor is responsible for coordinating with the PBM and the State as necessary to ensure that members receive appropriate pharmacy services. Coordination by the Contractor shall include the following:

(1) Inclusion of pharmacy benefit information in its member handbook (see Contract Section A.15.f.), including the toll-free telephone number for the PBM.

(2) Inclusion of the PBM's telephone number, on the back of the member identification card (see Contract Section A.15.e.).

(3) Inclusion of pharmacy benefits information in the Contractor's annual enrollment materials for distribution to members. Such materials shall include network lists, website information, toll-free member services number, policies and procedures, confidentiality statement, hyperlinks to the State and other vendors (as directed by the State), and other updates and/or changes that may be helpful to the State's members. At the state's request and direction, the Contractor shall also include in its annual Welcome Packet to plan members, at the conclusion of the state's open enrollment period, any letter or other pharmacy benefits related materials.

(4) Accepting and maintaining prescription drug data from the PBM in a manner and format and at a frequency specified by the State.

(5) Intervening with individual network providers, as identified by the Contractor, the PBM, the HM/W vendor, the EAP/BHO vendor, the H&W Center vendor, or the State, (1) whose prescribing practices appear to be operating outside industry or peer norms as defined by the State's Contractors, (2) are non-compliant as it relates to adherence to the State's formulary and/or generic prescribing patterns, and/or (3) who are failing to follow required prior authorization processes and procedures. The goal of these interventions will be to improve prescribing practices by the identified network provider. Interventions shall be individualized and face-to-face, as requested by the State. As appropriate, the intervention may be a team effort involving representatives from the Contractor, the PBM, the EAP/BHO vendor, the State, the HM/W vendor, the H&W Center vendor, and/or other appropriate State contracted vendors. The Contractor shall take the lead in organizing the meetings, including all meeting logistics.

e. The state seeks to move as much specialty drug dispensing as possible to our carved-out pharmacy benefits manager (PBM) or for those specialty medications that are physician-administered, to a physician's office. The state recognizes that some dispensing of specialty drugs will continue through the medical benefit, but seeks to reimburse providers for the provision of specialty drugs via our third party administrators of these contracts on an Average Sales Price plus (ASP+) model, refer to Contract Section C.3.f.

f. Each year, the Contractor shall provide the State with a financial reconciliation to show that they have met the aggregate ASP+ percentage standard for the previous calendar year. ASP+ is calculated for every drug filled with a J-code where an ASP was published at time of fill. Using ASP as of the date of fill; ASP% = Sum of Allowed Charges / Sum of (ASP times quantity). This report shall be provided each year no later than the last business day in May unless otherwise approved by the State. (refer also to Contract Attachment C, Reporting Requirements).

g. Each quarter the Contractor shall provide the State of Tennessee Benefits Administration with the dollar amount(s) that they and/or their PBM invoiced drug manufacturers for specialty drugs dispensed and paid for plan members that quarter. One hundred percent (100%) of all drug manufacturer rebates shall be reimbursed to the state and shall be provided with a report demonstrating the amount invoiced to the various drug manufacturers and a separate report detailing the quarter(s) the check amount is for and for what groups (i.e. State Plan Actives, State Plan Retirees, Local Education Plan

Actives, Local Education Plan Retirees, Local Government Plan Actives, and Local Government Plan Retirees).

h. The Contractor shall provide the State with a semi-annual report on medical Specialty Pharmacy spend and utilization including but not limited to; National Drug Code (NDC), drug name, strength, place of service, and paid amount (refer also to Attachment C, Reporting Requirements).

A.7. Behavioral Health

a. The Contractor is not responsible for providing benefits or paying claims for mental health and substance abuse (behavioral health) services, however, the Contractor shall play a role in ensuring network providers deliver collaborative physical/behavioral health care to all patients with an identified chronic or persistent medical condition. Chronic or persistent medical conditions are defined as conditions with a duration of 4-12 weeks or longer.

b. The Contractor is responsible for working directly with the State's "carve-out" Employee Assistance Program (EAP)/Behavioral Health Organization (BHO) vendor. Coordination by the Contractor shall include the following:

(1) Inclusion of behavioral health benefit information in its member handbook (see Contract Section A.15.f.), including the toll-free telephone number to contact the EAP/BHO vendor.

(2) Inclusion of the EAP/BHO vendor's telephone number on the back of the member identification card (see Contract Section A.15.e.).

(3) Inclusion of behavioral health benefits information in the Contractor's annual enrollment materials and welcome packets for distribution to members. Such materials shall include network lists, website information, toll-free member services number, policies and procedures, confidentiality statement and other updates and/or changes that may be helpful to the State's members.

(4) Accepting and maintaining data from the EAP/BHO in a manner and format and at a frequency specified by the State. The Contractor shall also share medical claims data claims amounts with the BHO for the purpose of allowing the TPA Contractor and the BHO to routinely track member out of pocket maximums.

(5) Assistance in the co-management of medical/psychiatric disorders to include consultations when necessary between medical staff.

(6) Clinical education of network providers regarding screening and management of depression and anxiety in the primary care setting, including depression and anxiety as a secondary diagnosis.

(7) Providing individualized and face-to-face (when requested by the State) clinical education to network providers identified by the EAP/BHO vendor, the PBM, the HM/W vendor, the H&W Center vendor, the State, or any other State contracted vendor as needing additional education regarding prescribing patterns and clinical interventions/treatment for behavioral health conditions.

(8) Participating, as applicable, in the EAP/BHO vendor's discharge activities for individual members with both medical and behavioral health needs.

(9) Other activities necessary for the appropriate coordination of benefits and claims payment of medical and behavioral health benefits.

c. The Contractor shall amend its provider agreements with primary care providers (at time of their renewal) to require network primary care providers to screen adults for depression when staff-assisted depression care supports are in place. Once such amendments are in place, the Contractor shall also include depression screening in an adult wellness visit/physical as an element in any primary care chart reviews that it conducts. The goal is to assure accurate diagnosis, effective treatment and follow-up. The lowest effective level of staff-assisted depression care support consists of a screening nurse who advises primary care providers of positive screening results and provides a protocol that facilitates referral to behavioral health treatment. The provider must document in the medical chart the screening and any necessary follow up that has been performed using a nationally-recognized, validated, reliable screening instrument.

A.8. Health Management Services

a. The State contracts with a vendor to provide certain health management services, including wellness and disease management. The Contractor is not responsible for the provision of these health management services. However, the Contractor is responsible for coordinating with the Health Management and Wellness (HM/W) vendor as necessary to ensure that members receive appropriate health management services. Coordination by the Contractor shall include the following:

(1) Inclusion of health management information in its member handbook (see Contract Section A.15.f.), including the toll-free telephone number to contact the HM/W vendor and the Nurse Advice Line and how to access decision aids.

(2) Inclusion of the HM/W vendor's telephone number on the back of the member identification card (see Contract Section A.15.e.).

(3) Inclusion of health management benefits information in the Contractor's annual enrollment materials and welcome packets for distribution to members. Such materials shall include website information, toll-free member service number, policies and procedures, confidentiality statement and other updates and/or changes that may be helpful to the State's members.

(4) Accepting and maintaining data from the HM/W vendor in a manner and format and at a frequency specified by the State.

b. The Contractor shall provide to the HM/W vendor either a daily discharge file or a daily admissions file in a manner and format approved by the State. Admissions files shall include the number of days authorized for inpatient hospitals, rehabilitative facilities, or skilled nursing facilities and any authorizations for home health services.

c. As directed by the State, the Contractor shall implement cost-sharing incentives (*e.g.*, lower rates of co-insurance, provision of co-payments in lieu of co-insurance, waiver of or provision of lower deductible amounts) for members engaged in disease management and other programs as reported to the Contractor by the State or the HM/W vendor.

d. As directed by the State, the Contractor shall report to the HM/W vendor and/or the State those members who fail to complete state specified wellness requirements delivered by the Contractor such as, but not limited to, case management.

A.9. Claims Processing, Payment and Reconciliation

a. The Contractor shall process all claims for covered benefits provided to members in strict accordance with the Public Sector plan documents, applicable Contractor policies and

procedures, in compliance with all applicable state and federal laws, rules and regulations and the terms of this contract including, but not limited to, timely filing. The Contractor shall not modify covered benefits during the term of this Contract without the prior written approval of the State.

b. The Contractor shall operate a claims management system that tracks accumulations toward deductibles and out-of-pocket maximums, tracks co-payments and co-insurance amounts and appropriately links claim history, enrollment information, member services, provider network, and utilization management information. This shall include the daily electronic exchange of all claims data to the HSA vendor as well as member-level deductible and maximum out-of-pocket accumulator data with the Pharmacy vendor, EAP/BHO vendor, Health Savings Account (HSA) fiduciary, and any other State contracted vendor as needed.

c. Upon request by the State, the Contractor shall modify its systems and processes to reflect approved plan design changes, including but not limited to changes in covered benefits, scope of covered benefits, and cost-sharing, to the Public Sector Plan(s) within sixty (60) days of notification by the State. Should said change(s) not be effective within sixty (60) days, the Contractor shall have until the effective date of the change to modify its systems and processes.

d. The Contractor shall ensure that claims submitted by network providers are paperless for the members. The Contractor's agreement with providers shall require network providers to submit claims directly to the Contractor.

e. The Contractor's claims management system shall be able to receive and process (*i.e.*, without subsequent data entry) physician and hospital claim submissions electronically.

f. The Contractor shall process claims, either filed directly by members and/or provider(s), in an accurate and timely manner and in accordance with the requirements in Contract Attachment B. The Contractor shall submit to the State, at least one (1) month prior to the go-live date, a summary of its methodology for conducting internal claims audits, including audits to determine claims payment and processing accuracy and claims payment turnaround. The State reserves the right to review the methodology and require changes, where appropriate. The Contractor shall notify the State in writing at least thirty (30) days in advance of any significant changes to its methodology. The State reserves the right to review the change and require changes, where appropriate.

g. The Contractor shall confirm eligibility of each member as claims are submitted, on the basis of the enrollment information provided by the State, which applies to the period during which the charges were incurred.

h. In concert with its claims payment cycle, the Contractor shall provide an electronic remittance advice (RA) to the provider indicating the disposition of every adjudicated claim submitted by providers. The remittance advice shall contain appropriate explanatory remarks related to payment or denial of each claim. If a claim is partially or totally denied due to insufficient information and/or documentation, then the remittance advice shall specify all such information and/or documentation. Providers that do not have the capability of receiving an RA electronically may have one mailed to them.

i. Claim Processing Standards

(1) Unless otherwise specified by the State, the claims management system shall automatically adjudicate no less than eighty percent (80%) of clean claims, i.e., without recourse to manual or other calculation methods external to the system.

(2) The Contractor shall reimburse network providers within fourteen (14) calendar days for ninety-two percent (92%) of clean claims and within thirty (30) calendar days for ninety-eight percent (98%) of all claims.

(3) The Contractor shall complete ninety-five percent (95%) of all claim adjustments within seven (7) calendar days.

(4) An incomplete claim may be resubmitted with the information necessary to complete the claim. This resubmission shall constitute a new claim only for the purpose of establishing a timeframe for claims processing and payment.

j. The Contractor's claims management system shall retain claim history on-line for at least two (2) years. (This does not limit the Contractor's obligations to retain all records in accordance with Contract Section D.11, Records.)

k. The Contractor shall test the accuracy of automated features of the claims management system (*e.g.*, deductible calculation) at least twice a year as part of its internal audit program.

l. At the State's request, the Contractor shall load Public Sector Plan claims data into an all payer claims database.

m. The Contractor shall use a clinical edit software program that automatically evaluates all claims for medical bills involving the use of current ICD and CPT/HCPCS codes. Clinical claim review software shall be updated no less than once every year, and all changes and new codes shall be incorporated by the Contractor within thirty (30) days of the change becoming effective.

n. The Contractor's claims management system shall automatically price network claims using current network provider rate information. The claims management system shall store network provider information to determine provider status and reimbursement for claims from network providers. Network provider rate information shall be updated in the claims management system according to the following standards:

(1) 90% of network providers shall be updated within fifteen (15) days of the execution of the provider agreement.

(2) 100% of network providers shall be updated within thirty (30) days of the execution of the provider agreement.

o. The Contractor's member services representatives shall have access to claims management and other systems as necessary to respond to inquiries from members.

p. Explanation of Benefits (EOB)

(1) The Contractor shall generate and mail an explanation of benefits (EOB) to the member each time the Contractor processes a claim from a provider. The Contractor shall mail the EOB within five (5) business days of processing the claim. The EOB format and text shall be prior approved in writing by the State and shall include, but not be limited to, the date the Contractor received the claim, the date the Contractor adjudicated the claim, the claim number, identification number of the head-of-contract, the patient name, the date of service, type of service furnished, the provider name, the Contractor's contact information, submitted charges, total amount paid by the plan, the amount paid by another insurance carrier, total amount owed by the member by cost-sharing category (deductible, co-payment, co-insurance, etc.), any non-covered amount,

the out-of-pocket amounts paid for the year, how to file an appeal, adjustments or corrections that affect a member's out-of-pocket costs, and any other information legally required. The Contractor may substitute an electronic EOB if requested by the member.

(2) The Contractor shall also generate and mail an EOB to the member each time the Contractor processes a claim submitted by the member. The Contractor shall mail the EOB within five (5) business days of processing the claim. The EOB format and text shall be prior approved in writing by the State and shall include information similar to the EOB for provider-submitted claims but tailored to member-submitted claims. The Contractor may substitute an electronic EOB if requested by the member.

q. If a member receives a covered benefit from a network provider, the provider's contract rate shall be used to determine the member's deductible (if applicable) and any co-insurance amount and the member shall not be responsible for payment in excess of that amount. In addition, if a member receives a medical service that is a covered benefit from a network provider but the claim for the service is denied as ineligible for payment (*e.g.*, the service exceeded the applicable service limitation, not medically necessary, or the service was subject to prior authorization and was not approved by the Contractor) the member shall not be responsible for payment to the provider in excess of the provider's contract rate.

r. The Contractor shall only pay claims that are for covered benefits provided to eligible members and provided in accordance with the Contractor's utilization management and other applicable requirements and with the Plan Documents.

s. The Contractor shall not pay for services that result from a referral prohibited by Section 1877 of the Social Security Act (Limitation on Certain Physician Referrals).

t. The Contractor shall not pay for preventable events and conditions, *e.g.*, hospital-acquired conditions and preventable surgical errors that are identified as non-payable by Medicare. In addition, as directed by the State, the Contractor shall not pay for other preventable events and conditions that are identified as non-payable by other federal or state payers. At the State's request, the Contractor shall provide a report of these denied claims and the avoided charges to the State.

u. The Contractor shall pay claims for services from out-of-network providers submitted by members by directly reimbursing the provider. However, if the member has already paid said claim, then the Contractor shall reimburse the member directly. In either case the Contractor shall send the member an EOB as required by Contract Section A.9.p.

v. The Contractor shall pass directly to the State the payment terms that the Contractor has negotiated with providers. The Contractor shall not receive any differential between the provider contract rate and the payment funded by the State; the Contractor shall ensure that the State and the member receives the full benefit of any provider payment terms, including, but not limited to, provider fee schedules, contract rates, other payment arrangements, discounts, rebates, refunds, or credits negotiated by the Contractor. All special pricing considerations and financial incentives shall accrue to the State and plan members.

w. The Contractor shall remit to the State no less frequently than quarterly a check 100% of for all rebates accrued during the claim period ending a maximum of six (6) months prior to the rebate payment date which were obtained on behalf of the State due to the use of medical services, devices and pharmaceuticals by members of the Public Sector Plans. A report shall accompany each check containing a breakout by group fund (i.e. State

Actives, State Retirees, etc.) and further broken down by service or product name and the appropriate codes to identify the service or product (e.g. NDC, NDC plus the appropriate HCPCS Level II code, J-codes, etc.). Contractor shall include for each breakout the total amount invoiced to the manufacturer, the total amount collected on behalf of the state, and the amount being paid to the state.

x. The Contractor shall ensure that any payments funded by the State are accurate and in compliance with the terms of this Contract, including the Liquidated Damages requirements of this Contract (see Contract Attachment B); agreements between the Contractor and providers; and State and Federal laws and regulations.

y. The State shall determine all policies and benefits related to the Public Sector Plans and shall have the sole responsibility for and authority to clarify and/or revise the benefits available under the Public Sector Plans. Should the Contractor have a question on policy determinations, benefits, or operating guidelines required for proper performance of the Contractor's responsibilities, the Contractor shall request a determination in writing. The State will then respond in writing making a determination within thirty (30) days. The Contractor shall then act in accordance with such policy determinations and/or operating guidelines.

z. The Contractor understands that the Public Sector Plans cannot and do not cover all medical situations. In a case where the benefits are not referenced in the Plan Documents or are not clear, the Contractor shall comply with any applicable policy issued by the Benefits Administration Division to interpret the Plan Documents. If the benefits are not referenced in any policy or are not clear, the Contractor shall utilize its standard policies in adjudicating claims, and the Contractor shall advise the Benefits Administration Division in writing, as to the difference along with the Contractor's recommendation. Such matters as determined by the State to have a significant impact on administration of plan benefits shall be resolved by the State.

aa. The Contractor shall identify and pursue claims that may be subject to coordination of benefits (COB) in accordance with the regulations promulgated by the Tennessee Department of Commerce and Insurance, Chapter 0780-1-53 Tenn. Comp. R. & Regs. The Contractor shall provide a weekly report of said activities to the State (refer also to Contract Attachment C, Reporting Requirements).

bb. The Contractor shall notify the State on a weekly basis of receipt of any notices from Medicare that Medicare may have made primary payments for services when it should have been the secondary payer (a Medicare Secondary Payer demand letter). The Contractor shall resolve issues as to whether Medicare is the primary or secondary payer within thirty-one (31) days of receiving the demand letter.

cc. The Contractor shall implement a process to carry out subrogation recoveries and report subrogation activities to the State in compliance with the State's subrogation policies, which shall be provided to the Contractor prior to the benefits go-live date.

dd. The Contractor shall determine whether eligible expenses are medically necessary.

ee. The Contractor shall have a process in place based on the most appropriate up to date clinical information for determining those procedures and services that are considered experimental/investigational. Unless otherwise directed by the State, the Contractor shall submit to the State, at least one (1) month prior to the go-live date, detailed information on the Contractor's process for determining experimental/investigational procedures and services. The State reserves the right to review the process and require changes, where appropriate. The Contractor shall notify the State, in writing, within thirty (30) days of any

significant changes to its process. The State reserves the right to review the change and require changes, where appropriate.

ff. Unless otherwise directed by the State, the Contractor shall respond to all claims/data requests from the State within seventy-two (72) hours of receiving the request and shall present the information in the format requested by the State.

gg. Reconciliation

(1) The Contractor shall submit claims reports to the State in sufficient detail for the State to record and reconcile claims. The format of the claims reports shall be prior approved by the State and the frequency shall match the frequency of the Contractor's bank drafts.

(2) The Contractor shall submit to the State a monthly recoveries report in a format prior approved by the State (refer also to Contract Attachment C, Reporting Requirements).

(3) The Contractor shall reconcile, within ten (10) business days of receipt, payment information provided by the State. Upon identification of any discrepancies, the Contractor shall immediately advise the State.

(4) The Contractor shall provide authorized State users with access to its internal client reporting system for use in the State's reconciliation process.

hh. The Contractor's provider agreements shall include the maximum recoupment periods permitted under TCA 56-7-110.

ii. For the payment of all claims under this Contract, the Contractor shall issue payments in the form of checks and/or Automated Clearing House (ACH) electronic funds transfer against the Contractor's own bank account. The Contractor shall maintain security and quality controls over the design, printing and mailing of checks, as well as any fraud prevention feature of checks.

jj. The State will only pay for approved and correctly paid claims, not for rejected, reversed, duplicate claims, claims processed but not paid, or claims paid in error.

kk. The Contractor shall reimburse the State for one hundred percent (100%) of claims paid in error. If the Contractor is unable to withhold the amount from the provider's next payment then the Contractor shall reimburse the State within thirty (30) days of identification of the overpayment, or within a time frame agreed to by the State.

ll. The Contractor shall issue all related U.S. Internal Revenue Service (IRS) Form 1099 reports, submit required 1099 information directly to the IRS utilizing the Contractor's tax ID number, and shall maintain responsibility in matters relating to such information provided to payees and to the IRS, including the payment of any penalties or fees related to such 1099 reporting.

mm. Upon conclusion of this Contract, or in the event of its termination or cancellation for any reason, the Contractor shall be responsible for the processing of all claims incurred for medical services rendered and medical supplies purchased during the period of this Contract as well as provider reimbursement or recoupment attributable to claims incurred during the period of this Contract with no additional administrative cost to the State. The claims run out period shall extend through the final day of the thirteenth (13th) month following Contract termination. In addition, in the event of termination of this Contract, the Contractor shall continue to provide and pay claims for services to any member who is

hospitalized on the effective date of termination. Said coverage shall discontinue when the member is discharged from the hospital.

nn. The Contractor shall require network providers submitting a claim with a J3490 or J3590 code to include the name of the drug and the National Drug Code (NDC) on the associated professional claim form (HCFA 1500) or facility claim form (UB92).

A.10. Fraud and Abuse

a. The Contractor shall implement procedures to prevent and detect fraud or abuse by providers or members and shall perform fraud investigations of members and providers, in consultation with the State, for the purpose of recovery of overpayments due to fraud.

b. The Contractor's procedures for preventing and detecting fraud and abuse shall include, at a minimum, claims edits, post-processing review of claims, utilization management, provider profiling and credentialing, and provisions in the Contractor's provider agreement and/or provider manual. The Contractor's claim edits shall include, at minimum, edits to identify upcoding and duplicate claims.

c. As a means to "doctor shopping" and to mitigate risks relating to fraud, waste, and abuse, the Contractor shall maintain the ability, as may be deemed necessary, to "lock in" or otherwise restrict selected members to one or more specific network providers or group of providers for accessing covered services.

d. In the event the Contractor discovers evidence that an unusual transaction has occurred that merits further investigation, the Contractor shall simultaneously inform the Benefits Administration Division and the Division of State Audit, in the Office of the Comptroller of the Treasury. The State will review the information and inform the Contractor whether it wishes the Contractor to:

(1) Discontinue further investigation if there is insufficient justification; or
(2) Continue the investigation and report back to the Benefits Administration Division and the Division of State Audit; or
(3) Continue the investigation with the assistance of the Division of State Audit; or
(4) Discontinue the investigation and turn the Contractor's findings over to the Division of State Audit for its investigation.

e. The Contractor shall submit to the State, at least two (2) months prior to the go-live date, a copy of the documents describing its fraud and abuse program. The State reserves the right to review the documents and require changes, where appropriate. The Contractor shall notify the State, in writing, within thirty (30) days of any significant changes to its programs related to insurance or provider fraud, abuse, and waste. The State reserves the right to review the change and require changes, where appropriate.

f. The Contractor shall provide a written narrative or report to the State on a semi-annual basis, after the 2nd and 4th calendar quarters, regarding the effectiveness of the Contractor's fraud and abuse program, including its fraud and abuse detection activities, findings from those activities, follow-up on findings, proposed improvement activities, and any estimated savings to the Public Sector Plans associated with the Contractor's detection of such fraudulent or wasteful activities.

A.11. State Audits

a. Upon thirty (30) days written notice and the establishment of applicable third party confidentiality agreement(s), if any, reasonably required by the Contractor, the State and/or its authorized representative shall have the right to examine and audit the

Contractor services and pricing to ensure compliance with all applicable requirements. For the purpose of this requirement, the term, "Contractor," shall include its parent organization, affiliates, subsidiaries, subcontractors, and providers.

b. The Contractor shall provide access, at any time during the term of this contract and for three (3) years after final contract payment (longer if required by law), to the State and/or its authorized representative to examine and audit Contractor services, payments, and pricing pursuant to this Contract. The State reserves the right to request that documentation be provided for review at the authorized representative's location, the State's location, or at the Contractor's corporate site.

c. The Contractor shall, at its own cost, provide the State and/or its authorized representative with prompt and complete access to any data, documents, access to systems, and other information necessary to ensure Contractor compliance with all requirements of this Contract.

d. The Contractor shall provide reasonable cooperation with requests for information, which includes but is not limited to the timing of the audit, deliverables, data/information requests and the Contractor's response time to the State's questions during and after the process. The Contractor shall also provide a response to all "findings" received. Such response shall occur within thirty (30) days, or at a later date if mutually determined with the State to be more reasonable based on the number and type of findings.

e. The State shall not be responsible for time or any costs incurred by the Contractor in association with an audit including, but not limited to, the costs associated with providing data, reports, documentation, systems access, or space.

f. If the outcome of the audit results in an amount due to the State, then the State will work with the Contractor to negotiate terms of repayment. In the absence of such agreement, the State will deduct one-sixth of the total amount due from the fees due to the Contractor pursuant to Section C.3 each month for six months. If the Contractor disagrees with a finding resulting in a payment to the State, the State will review the Contractor's comments, but if the State retains the original audit findings the Contractor will be responsible for any payment to the State.

A.12. Member Services

a. All members services representatives handling inquiries related to the Public Sector Plans shall be familiar with the terms and provisions of the Plan Documents, including without limitation, eligibility, benefits, excluded services and procedures, deductibles, applicable cost-sharing, including co-payments and co-insurance, out-of-pocket maximums, instructions for completing a claim form, determining the status of claims, how to handle a complaint, and the member appeals process.

b. During normal business hours, the Contractor's member services representatives shall be dedicated to the Public Sector Plans. A Contractor may be allowed through written approval by the State to use a "designated" call unit (as opposed to a "dedicated" call center) provided that the unit could meet all other call center standards defined in this Contract.

c. The Contractor shall have sufficient staff to respond to inquiries, correspondence, complaints, and problems related to all aspects of the services required in this contract such as network development or changes, claims processing, appeals, provider participation and use of the Contractor's online tools described in section A.16. The Contractor shall not answer technical questions regarding eligibility policy and shall refer these questions to the State.

d. The Contractor shall provide appointment scheduling assistance to members who are unable to secure an appointment with a geographically-accessible provider within the timeframes specified in Contract Section A.3.d. The State defines "appointment scheduling assistance" to include the following: (1) if the member is unable to secure an appointment with a network provider within a reasonable period of time through the member's own good faith efforts and the member requests the Contractor's assistance, then the Contractor has an affirmative obligation to contact the provider directly to facilitate appointment scheduling. Additionally, (2) if a member is unable to locate a network provider who is accepting new patients through their own good faith efforts and the member requests the Contractor's assistance, then the Contractor has an affirmative obligation to assist the member in locating such a provider and securing an appointment.

e. The Contractor shall have and implement procedures for monitoring and ensuring the quality of services provided by its member services representatives. Such procedures may include, but are not limited to, the following activities:

(1) auditing calls/correspondence for each member services representative;
(2) silent monitoring of calls;
(3) recording calls for quality and training purposes;
(4) skill refresher courses; and
(5) call coaching.

f. The Contractor shall set standards for customer satisfaction for member services representatives based upon, but not limited to, an evaluation of the following areas: documentation, greeting, courtesy, responsiveness, explanation and guiding techniques, and accuracy. The standards shall be disclosed to the State no later than thirty (30) days prior to the go-live date. Adherence to the standards shall be measured, monitored and reviewed by the Contractor each month.

g. The Contractor shall evaluate at least ten (10) calls per customer service representative per month in order to assess the call handling quality and shall report the findings to the State as requested.

h. The Contractor shall provide a personalized response, in writing, to ninety-five percent (95%) of written (mail or email) inquiries from members concerning requested information, including the status of claims submitted and covered benefits, within five (5) business days and ninety-nine (99%) within ten (10) business days. The Contractor shall acknowledge receipt of email inquiries within one (1) business day.

i. The Contractor shall designate a client service liaison to respond to member-related issues identified by the State. For matters designated as urgent by the State, the Contractor shall contact the member and resolve the issue and then notify the State of the resolution.

j. The Contractor shall maintain a procedure for resolving complaints informally by phone. Where a complaint cannot be resolved to the member's satisfaction, the Contractor shall advise the member of his/her right to file an appeal and shall provide instructions for doing so.

k. Unless otherwise directed by the State, the Contractor shall conduct an annual member satisfaction survey using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) adult survey. The Contractor shall contract with a vendor that is certified by NCQA to perform CAHPS surveys, and the vendor shall perform the CAHPS adult commercial survey. The Contractor shall report the results of the survey to the State by June 15 of each calendar year (refer also to Contract Attachment C, Reporting

Requirements). Based upon the results of the survey, the Contractor shall develop an action plan to correct problems or deficiencies identified through this activity. The Contractor shall submit the action plan to the State by August 1st. The State reserves the right to review the action plan and require changes, where appropriate.

A.13. Member Appeals Process

a. The Contractor shall maintain an appeals process in compliance with Section 2719 of PPACA (42 U.S.C. 300gg-19) and 45 CFR 147.136, including all minimum consumer protection standards, by which members may appeal adverse benefit determination decisions including, but not limited to, determinations based on: medical necessity; appropriateness; health care setting; level of care; medical effectiveness; determinations that treatments are experimental or investigational; whether treatments are "emergency care" or "urgent care"; coverage of items or services based on medical conditions; frequency, method, treatment, or setting of a recommended preventive services to the extent not specific in HHS's published lists of recommended preventive services; whether the plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act; if applicable, whether participants or beneficiaries are entitled to a reasonable alternative standard for a reward under a wellness program; and a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time). If any part of section A.13. conflicts with the Federal review and appeal requirements of Section 2719 of PPACA (42 U.S.C. 300gg-19) or 45 CFR 147.136, the Contractor shall follow the federal requirements.

b. The Contractor shall maintain formal appeal procedures affording an internal review as well as an external review which allows claimants to review their file, to present evidence and testimony as part of the appeals process. The internal review shall be conducted by a committee designated by the Contractor that is designed to ensure the independence and impartiality of the persons involved in making the decision. The external review shall be conducted by an Independent Review Organization (IRO).

c. The Contractor must assign an IRO that is accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. The Contractor must contract with at least three (3) IROs and rotate assignments among the IROs to prevent bias and ensure independence. The IRO cannot be eligible for any financial incentives based on the likelihood that the IRO will support a denial of benefits.

d. The Contractor shall include notification of the member's right to appeal in any member communication regarding benefit coverage decisions, including but not limited to, letters to members and providers, member handbooks, and Explanation of Benefit (EOB) statements. The notices must be provided in a culturally and linguistically appropriate manner and are subject to prior written approval from the State.

e. At a minimum, the Contractor shall provide a description of available internal appeals and external review processes, including information on how to initiate an appeal, in member handbooks, on the state specific website and any other documents as requested by the State.

f. The Contractor must provide notification of decisions within the following time frames and all decision notices shall advise of any further appeal options:

(1) No later than 72 hours after receipt of the claim for urgent care. The Contractor must defer to the attending provider's determination as to whether the claim involves urgent care.
(2) 30 days for denials of non-urgent care not yet received
(3) 60 days for denials of services already received

g. The Contractor must provide continued coverage pending the outcome of an appeal. Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

h. The Contractor must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance established to assist individuals with the internal claims and appeals and external review processes.

i. Any appeals of denied requests for continued hospitalization shall be promptly processed and shall involve physician-to-physician consultation between the Contractor's staff and attending physician.

j. At least one (1) month prior to the go-live date, the Contractor shall provide the State information describing in detail the Contractor's appeals process and procedures along with copies of sample determination letters for internal and external appeals. The State reserves the right to review the appeals process and procedures and letters and require changes, where appropriate.

k. The Contractor shall submit quarterly appeals reports with information regarding each appeal filed with the Contractor and the IROs (refer also to Contract Attachment C, Reporting Requirements).

l. The Contractor shall ensure that all records and information related to appeals are preserved as required by other provisions of this Contract or state or federal law.

m. The Contractor shall allow a member one hundred and eighty (180) days to initiate an internal appeal following notice of an adverse determination. Where an internal determination is unfavorable, the Contractor shall advise the member of their right to initiate an external appeal within four (4) months of notice of the internal decision.

A.14. Call Center

a. The Contractor shall operate a call center that uses a toll-free telephone number dedicated to the Public Sector Plans as the entry point for members contacting the Contractor.

b. The Contractor's call center shall be open and staffed with trained personnel on the date specified in Contract Section A.24.

c. The Contractor's call center and dedicated member services representatives shall be located in the continental United States.

d. The Contractor may temporarily route calls to a different call center for occasions related to weather, training, or similar situations. The Contractor shall notify the State of any such instances prior to the switch, or as soon as practical.

e. The Contractor's call center shall, at a minimum, accept calls Monday through Friday 7:00-5:00 CST, except on official State Holidays.

f. The Contractor's call center shall be equipped with TDD (Telecommunications Device for the Deaf) technology in order to serve the hearing impaired population.

g. During normal business hours the Contractor's call center shall have at least one member services representative on duty that is bilingual in English and Spanish. The

Contractor shall provide oral interpretation services via a telephone interpretation service free of charge to callers with Limited English Proficiency.

h. During normal business hours, as well as after hours, calls to the Contractor's call center regarding clinical concerns shall be transferred or forwarded to the State's contracted Nurse Advice line.

i. The Contractor shall provide the State's Agency Benefits Coordinators (ABCs) with a special number or access code that they can use to have immediate access to a member services representative. The Contractor can satisfy this "hotline" requirement by expediting calls to this special number to the front of the general queue – or it may provide dedicated staff to serve callers to this number.

j. The Contractor's call center shall meet each of the following performance standards:

(1) Daily Average Speed of Answer (ASA) of thirty (30) seconds. After answering the call the Contractor may only put callers on hold in order to (a) make outbound calls as necessary or (b) to research a caller's issue.

(2) First Call Resolution of 85% as measured by one or more of the following methods: a member post-call phone or web survey; an end of call script where the customer service representative asks if the member's issue has been resolved; a voice menu allowing the member to indicate if this is the first call they've made to resolve their inquiry or problem; or another method prior approved by the state.

(3) Telephone Service Factor of 80-20, meaning 80% of calls are answered within 20 seconds.

(4) Open call/inquiry closure rate of 90% within five (5) business days.

k. The Contractor shall provide call center statistics to the State on a weekly basis during the annual enrollment period (generally October 1 through November 1), the fifteen (15) days prior to the go-live date through the sixty (60) days after the go-live date. Thereafter, call center statistics shall be provided to the State monthly.

l. The Contractor's call center shall have call management systems and communications infrastructure that can manage the potential call volume and achieve the performance standards described in this Contract.

m. The Contractor's call management systems shall be scalable and flexible so they can be adapted as needed, within negotiated timeframes where applicable, in response to program, benefit, or enrollment changes.

n. The Contractor's call management systems shall be equipped with caller identification. In addition, the Contractor's call center shall adopt caller identification for itself that is prior approved in writing by the State.

o. The Contractor's call management systems shall provide greeting messaging when necessary. The Contractor may play canned music and/or messages prior approved by the State for the callers while they are on hold and shall play messages as directed by the State. The Contractor shall not play advertising or informational messages for callers while they are on hold unless prior approved in writing by the State (or the State directs the Contractor to play certain messages). Additionally, the Contractor's systems shall provide a message that notifies callers that calls are being recorded and may be monitored for quality control purposes.

p. The Contractor's call management system shall record and index all calls such that the Contractor can easily retrieve recordings of individual calls based on the phone number of the caller, the caller's name, the date/time of the call, or the member services representative who handled the call. The Contractor shall be able to provide a full recording of each call upon the State's request, using only the member's name or identifier to locate the call(s).

q. The Contractor's call management systems shall facilitate the processing of all calls received and assign incoming calls to available member services representatives in an efficient manner. The system shall transfer calls to other telephone lines as necessary and appropriate, including transfers to external call centers.

r. The Contractor may use an automated interactive voice response (IVR) system for managing inbound calls, provided that the caller always has the ability to leave the IVR system and wait in queue in order to speak directly with a live-voice member services representative during normal business hours rather than continue through additional prompts. The Contractor's decision tree and menu are subject to State review and prior written approval.

s. The Contractor shall inform callers of their likely wait times (based on real-time information, including call volume and member services representative availability) as they enter the queue. The Contractor shall also provide a "dial back" option that allows callers to receive a call back from the next available member services representative.

t. The Contractor shall have the ability to make outbound calls without interrupting the ability of callers to continue to access the call center.

u. The Contractor's system shall be able to record calls for monitoring and the Contractor shall, at the State's request, allow the State, or its authorized representative to monitor recorded calls from a remote location.

v. The call management system shall enable the logging of all calls, including:

(1) the caller's identifying information (*e.g.*, employee ID);
(2) the call date and time;
(3) the reason for the call (using a coding scheme);
(4) the member services representative that handled the call;
(5) the length of call; and
(6) the resolution of the call (including a resolution code) and, if unresolved, the action taken and follow up steps required.

w. Additionally, the call management systems shall maintain a history of correspondence and call transactions for performance management, quality management and audit purposes. This history shall contain the actual information, a date/time stamp that corresponds to when the transaction took place, the origin of the data management transaction (*e.g.*, the State and/or one of its authorized representatives or the member), and the member services representative that processed the transaction. Related correspondence and calls shall be indexed and properly recorded such that they can be treated in reporting and analysis as part of a distinct transaction.

x. At the State's request, the call center representatives shall be trained to direct members to high performance providers and/or facilities particularly when there are associated member incentives.

A.15. Member Communications/Materials

a. The Contractor shall, in consultation with and following written approval by the State, print and distribute member materials, including but not limited to, member handbooks, identification cards, welcome packets, provider directories (as requested), letters, brochures, mass mailings, fliers and administrative forms and manuals pertaining to or sent to members. Unless otherwise directed by the State, all member materials shall be prior approved in writing by the State.

b. The Contractor shall work in conjunction with the State, its Communications team and any applicable contracted vendors to ensure continuity of branding across all plan and member materials, website, and any other communications information. This branding shall include, but is not limited to, use of the ParTNers for Health logo, color scheme and applicable taglines. All uses of these branding elements shall be subject to prior written approval by the State.

c. Unless otherwise specified, the Contractor shall be responsible for all costs related to the design, development, revision, printing, and distribution of all member materials that are required to be produced under the terms of this Contract. The Contractor shall ensure that up-to-date versions of all printed member materials can be downloaded from its website.

d. Prohibition on Promotional Materials: Unless approved in advance and in writing by the State, the Contractor shall not distribute any promotional materials or gifts to employees or plan members, even if such gifts are of a de minimus value (e.g., magnets, pens, etc.).

e. Member Identification Cards

(1) Unless otherwise directed by the State, the Contractor shall provide members with identification (I.D.) cards on an annual basis.

(2) The cost of creating and mailing I.D. cards shall be borne by the Contractor.

(3) Identification cards shall comply with the State's guidelines for I.D. cards, which include, but are not limited to, the following:

i. The "ParTNers for Health" logo shall appear in either the upper left or upper right corner of the front of the card, as directed by the State, and the Contractor's logo may appear in the other corner.

ii. The words "Tennessee State Group Insurance Program" shall appear in the top center of the front of the card; the words "Administered by CONTRACTOR NAME" may appear beneath this in a smaller font size.

iii. The front of the card shall also include the following information: member name, member number (which shall NOT be the member's Social Security Number), group name and/or number, benefit option (*e.g.*, Partnership PPO), network name (if applicable), and cost sharing amounts.

iv. The back of the card shall include the following information: disclaimers regarding prior authorization, card effective date (may appear on front of the card), the Contractor's member services phone number and hours of operation, and the phone number for other State vendors including the PBM, EAP/BHO, and HM/W vendor.

v. The Contractor shall use the Edison employee identification number as the primary unique identifier for members and shall include this number on the member's identification card.

(4) The format for identification cards shall be prior approved in writing by the State.

(5) The Contractor shall mail identification cards to members no later than twenty-one (21) days prior to the go-live date and thereafter, at the State's request, fourteen (14) days prior to the start of each benefit year. During the benefit year the Contractor shall mail I.D. cards to members no later than ten (10) days from receipt of new enrollment or change in enrollment, as indicated in the enrollment information from the State and no later than ten (10) days from receipt of a member's request for a replacement or duplicate card (at no charge to the member).

(6) The Contractor shall have the capability on its website (see Contract Section A.16.) to allow members to print out temporary cards.

(7) The Contractor shall allow each member to have duplicate cards upon the member's request.

(8) As directed by the State, the Contractor shall re-issue identification cards to reflect approved plan design changes, including but not limited to changes in cost-sharing, within the timeframe specified by the State.

f. Member Handbook

(1) The Contractor, following review and approval by the State, shall annually, prior to the new benefit year, update member handbooks and shall maintain on its website an up-to-date version of the member handbook that incorporates changes made between annual printings.

(2) The member handbook shall be specific to each of the three Public Sector Plans and shall detail benefits and excluded services and procedures; detail cost-sharing requirements and out-of-pocket maximums for each benefit option; describe additional features specific to any of the benefit options; describe procedures for accessing services, including use of network and out-of-network providers and utilization management; describe appeal procedures; include information specified by the State regarding pharmacy benefits, behavioral health benefits, and health management/wellness benefits; and provide other information helpful to members.

(3) Upon the State's request, the Contractor shall provide member handbooks to Agency Benefits Coordinators within fifteen (15) days of the State's request to provide copies.

(4) The Contractor shall mail a member handbook no later than ten (10) days from receipt of a member's request for a copy.

g. On an annual basis, at least two (2) months prior to the State's annual enrollment period, the Contractor shall provide to the State, in electronic format, any enrollment information requested by the State that may be helpful to potential members. Items may include, but not be limited to, a toll-free member services number, website address, website logon information, a confidentiality statement, procedures for accessing services, and other pertinent updates, changes and/or materials.

h. Unless otherwise directed by the State, the Contractor shall mail an annual welcome packet to all enrolled members no later than twenty-one (21) days prior to the go-live date and, thereafter, fourteen (14) days prior to the start of each benefit year. During the benefit year the Contractor shall mail a welcome packet within ten (10) days from receipt

of new enrollment or change in enrollment. The welcome packet shall include, at a minimum, a welcome letter, a member handbook, an I.D. card, a provider directory order form, the Contractor's website address, website logon information, and a confidentiality statement.

i. Throughout the term of this Contract the Contractor shall, at a member's request, mail a copy of the current provider directory to the member within ten (10) days of receiving the member's request to have a copy.

j. The Contractor shall use first class rate for all mailings, unless otherwise directed or prior approved in writing by the State.

k. The Contractor shall have the exclusive responsibility to write, edit, and arrange for clearance of materials (such as securing full time use of a stock photograph used in brochures for perpetuity) for any and all member materials in time for the materials to be approved by the State and printed for the annual enrollment period.

l. The Contractor shall ensure that its member materials are culturally sensitive and professional in content, appearance, and design.

m. The Contractor shall, to the extent practicable, use relatively large and legible fonts in its member materials. Additionally, the Contractor shall make maximum use of graphics to communicate key messages. The Contractor shall also prominently display the Contractor's call center telephone number and hours of operation in large, bolded typeface on all member materials.

n. Unless otherwise prior approved in writing by the State, the Contractor shall design all member materials at the sixth (6.0) grade reading level or lower using the Flesch-Kincaid Index or other suitable metric that the State prior approves in writing. The Contractor shall evaluate materials using the entire text of the materials (except return addresses). When submitting draft materials to the State for approval, the Contractor shall provide a reading level analysis and certification of the reading level of each piece of material.

o. The Contractor shall provide electronic templates of all finalized member materials in a format that the State can easily alter, edit, revise, and update. Absent gross negligence or malfeasance by the Contractor, the Contractor has no liability for errors on other deliverables that the State did not find or correct before giving final approval for the individual materials. However, the Contractor shall produce and distribute corrected versions of the individual materials at the State's direction (refer to Contract Section C.3.d.(3). regarding production and distribution costs).

p. The Contractor covenants that all materials distributed to members and prepared or produced by the Contractor shall be accurate in all material respects.

q. At the State's request, the Contractor shall notify members, in writing, of any benefit changes no less than thirty (30) days prior to the implementation of the change (refer to Contract Section C.3.d.(3) regarding production and distribution costs).

r. Unless otherwise directed by the State, the Contractor shall print and distribute any mass mailings developed by the State within seven (7) business days of receiving the text from the State (refer to Contract Section C.3.d.(3). regarding production and distribution costs).

A.16. <u>Website</u>

a. In addition to the Contractor's own website where plan and member specific information shall be incorporated, the Contractor shall maintain a "splash" page dedicated to and customized for this Contract containing general plan information that does not require a member to login. The design of the splash page, inclusive of the site map, page layout, color/font scheme and branding, static content and any documents which can be accessed via or downloaded from the website, must be prior approved in writing by the State. Additionally, the Contractor shall obtain prior, written approval from the State for any links from the site to an external website/portal or webpage.

b. The Contractor shall agree to link to Benefits Administration's websites, other State contracted vendor websites, microsites, content or other web or mobile device enabled video/multimedia tools or apps as determined by the State that are useful or applicable for members (State approved tools from other approved vendors).

c. The splash page and Contractor website shall be fully operational, with the exception of member data/Protected Health Information (PHI) on or before the date specified in Contract Section A.24.

d. The Contractor shall update content and/or documents posted to the splash page and/or website within five (5) business days of the State's approval of changes to said content and/or documents.

e. In association with the State's annual enrollment period, the Contractor shall provide on the splash page and/or website by the first day of the enrollment period (generally October 1) all State approved information pertinent to the upcoming new plan year.

f. The Contractor shall grant the State access to the customized development splash page and website for review and approval no later than the date specified in Contract Section A.24.

g. The Contractor shall host the website on a non-governmental server, which shall be located within the United States.

h. The Contractor shall ensure that the website/portal meets all of the capacity, availability, performance and security requirements outlined in Contract Sections A.19. and A.21.

i. The Contractor shall obtain and cover the cost of the domain name for the website/portal.

j. To ensure accessibility among persons with a disability, the Contractor's website shall comply with Section 508 of the Rehabilitation Act of 1973 (29 USC Section 794d) and implementing regulations at 36 Code of Federal Regulations (CFR) 1194 Parts A-D.

k. The website/portal shall meet accessibility standards, and at a minimum be Section 508 compliant.

l. At a minimum the website shall contain a home page (or landing page) with general information and links to additional information, including but not limited to frequently asked questions (FAQs), the member handbook, temporary identification cards, evidence-based practice guidelines, protocols, or pathways applicable to the Public Sector Plans, provider cost and quality comparative information, appeals forms, claim forms, information about the explanation of benefits (EOB), including a sample form with an explanation of each item, and contract rates to help members understand their EOBs, an up-to-date searchable internet-based directory of providers, and any other information requested by the State.

m. The internet-based provider directory shall include provider name, specialty, address and phone number and be organized by county and shall accurately reflect network providers who have joined or ceased participation in the network in the past ten (10) calendar days and whether or not the provider is accepting members as new patients. The Contractor shall provide the internet-based provider directory on its website on or before the date specified in Contract Section A.24.

n. The Contractor's website shall contain consumer cost transparency and quality tools which allow members to research the price and quality of health care services. Such tools shall be enabled for mobile devices. At a minimum, the tools must:

(1) Have an intuitive user interface and include a Frequently Asked Questions (FAQs) section and other resources such as online chat function to answer questions from members who are accessing the tool(s) for the first time;
(2) Allow members to search and compare easily, using a variety of parameters including provider, location, service, quality measures, price and condition;
(3) Present price information based on how a current claim would process, not historical claims data. Transparency tools should be updated at least quarterly to ensure most accurate pricing is presented;
(4) Display prices for a total episode of care (e.g. pregnancy through delivery) so members understand the total cost for that episode and their share of cost;
(5) Include pharmacy and behavioral health data, if requested by the State;
(6) Provide links to other State vendors' websites;
(7) Include up-to-date information on a member's out-of-pocket costs;
(8) Include up-to-date information on a member's HSA and FSA balance (if applicable);
(9) Alert members about opportunities for savings;
(10) Provide quality information based on outcome measures when available; otherwise it should be based on nationally-endorsed, consensus-based process measures proven to lead to improved clinical outcomes (e.g. CMS quality measures, Leapfrog quality indicators);
(11) Contain information to educate consumers about unneeded tests and procedures (e.g. information from Choosing Wisely); and
(12) Have the reporting capabilities necessary to:
    i. track the number of members accessing the transparency tool;
    ii. track the number of members who are return users of the tool;
    iii. track the most frequent cost and quality searches made by members; and
    iv. identify those members who searched for a service within ninety (90) days of purchasing such service.

Contractor shall include the data from section A.16.n.(12) in the transparency tool report (see Attachment C, Reporting Requirements).

o. The Contractor's website shall contain member accessible secure messaging capabilities.

p. Video/Multi-media content: If the Contractor posts any video content it shall include closed captioning option in English for these products.

q. Streamed Content: The Contractor's website shall have the capability to host streamed content (both audio and video) from other vendors including video/multimedia tools as determined by the State if useful and applicable to members.

A.17. Administrative Services

a. The Contractor, upon request by the State, shall review and comment on proposed revisions to the benefits in the Public Sector Plans. When so requested, the Contractor shall comment in regard to:

(1) industry practices;
(2) the overall cost impact to the Public Sector Plans;
(3) any cost impact to the Contractor's fee;
(4) impact upon utilization management performance standards;
(5) necessary changes in the Contractor's reporting requirements; and/or
(6) system changes.

b. The Contractor shall provide advice and assistance with regard to questions regarding effective dates, benefits, cost-sharing and cessation of coverage as requested by the State, members, and providers.

c. The Contractor shall keep the State apprised (through such methods as policy briefs, white papers, client communications, etc.) of any new or recently discovered federal or state laws, rules or policies that may impact the Public Sector Plans. The Contractor shall advise the State on any actions that should be taken in order to comply with such laws, rules or policies.

d. The Contractor shall refer calls from Agency Benefits Coordinators (ABCs) regarding eligibility or enrollment systems issues to the State.

e. The Contractor shall respond to all inquiries in writing from the State within two (2) business days after receipt of said inquiry. In cases where additional information to answer the State's inquiry is required, the Contractor shall notify the State immediately as to when the response can be furnished to the State. For matters designated as urgent by the State, the Contractor shall provide a response to the State within four (4) hours during normal business hours. During non-business hours the Contractor shall provide a response to urgent matters to the State within twenty-four (24) hours. Staff members, from the applicable business unit, with final decision making authority shall provide responses.

f. Unless otherwise directed by the State, the Contractor shall respond to all inquiries from the State regarding responses to proposed legislation within forty-eight (48) hours of the State's request.

g. The Contractor, at the request of either party, shall meet with representatives of the State periodically, but no less than monthly, to discuss any problems and/or progress on matters outlined by the State. The Contractor shall have in attendance the staff requested by the State, which may include a Program Director and representatives from the Contractor's organizational units required to respond to topics indicated by the State's agenda. The Contractor shall provide information to the State concerning its efforts to develop cost containment mechanisms and improve administrative activities, as well as trends in the provision of benefits. The Contractor shall provide advice, assistance and information to the State regarding applicable existing and proposed Federal and State laws and regulations affecting the Public Sector Plans. The Contractor shall also provide information to the State regarding the administration of the benefit, internal procedures for billing and reconciliation of transactions, the provision of medical treatment, and other administrative matters. These meetings will typically occur by teleconference, however, at its discretion, the State may request for the meeting to take place at the State of Tennessee offices in Nashville, TN.

h. The Contractor's Medical Director and/or other appropriate staff, as specified by the State, shall present a seminar to Benefits Administration Division staff at least once per year on a topic prior approved by the State.

i. The Contractor shall not modify the services or benefits provided to members during the term of this Contract without the prior written consent of the State.

j. The Contractor shall determine medical eligibility of members who are enrolled as incapacitated dependent children and report the results to the State. All incapacitated dependent children must be verified as incapacitated prior to their 26th birthday to determine their future enrollment in the plan. The Contractor shall also verify continued incapacitation of currently enrolled incapacitated dependent children at regular intervals, as appropriate, based on the likelihood of a change in the status of the incapacitation.

k. The Contractor shall assist the State, if requested, in the education and dissemination of information regarding the options in the Public Sector Plan(s). This assistance may include but not be limited to:

(1) Written information;
(2) Audio/video presentations;
(3) Attendance at meetings, workshops, and conferences; and
(4) Training of State staff and other persons on Contractor's administrative and benefits procedures.

Any onsite visits to member agencies shall require the prior approval of the State.

l. As needed and as part of its education and information role the Contractor shall, as requested by the State, attend Agency Benefits Coordinators (ABCs) trainings and benefits fairs for members at the State, Universities, Local Education Agencies (LEAs), Local Governments (and related entities participating in Local Government plan) and shall participate in ABC calls as needed and requested.

m. The Contractor shall refer all media and legislative inquiries to the Benefits Administration Division, which will have the sole and exclusive responsibility to respond to all such queries. However, the Contractor shall respond directly to audit requests from the Comptroller, to audit requests from divisions within the Department of Finance & Administration, and to subpoenas; in all such instances, the Contractor shall copy the Benefits Administration Division on all correspondence.

n. The Contractor's system(s) shall possess mailing address standardization functionality in accordance with U.S. Postal Service conventions.

o. Unless prior approved in writing by the State, and in compliance with State and Federal law, the Contractor shall not use information gained through this Contract, including but not limited to utilization and pricing information, in marketing or expanding non-State business relationships or for any pecuniary gain.

p. At the State's request, the Contractor shall assist with implementation of the Center for Disease Control's Diabetes Prevention Program including, but not limited to, provider outreach and education and program administration.

q. If requested by the State, the Contractor shall attend State-sponsored vendor summits with representatives from the State, and its related health plan vendors. The purpose of the vendor summit is to identify issues, develop solutions, share information, leverage resources, and discuss and develop policies and procedures as necessary to ensure collaboration among vendors and the State.

r. The Contractor shall notify the State, within three (3) business days of identification, about any situation that appears to negatively impact the administration or delivery of the program, plan, or benefits. Failure to do so may result in Liquidated Damages as specified in Attachment B. The situation shall be researched and resolved in a timeframe mutually agreed upon with the State.

A.18. Staffing

a. The Contractor shall provide and maintain qualified staff to provide services required under this Contract. The Contractor shall ensure that all staff, including the Contractor's employees, independent contractors, consultants, and subcontractors, performing services under this requirement have the experience and qualifications to perform the applicable services.

b. For its work under this Contract, the Contractor shall not use any person or organization that is on the U.S. Department of Health and Human Services' Office of Inspector General (OIG) exclusions list unless the Contractor receives prior, written approval from the State.

c. The Contractor shall ensure that all staff receives initial and ongoing training regarding all applicable requirements of this Contract and the Public Sector Plans. The Contractor shall ensure that staff providing services under this Contract are specifically oriented and trained regarding their functions, knowledgeable about the Contractor's operations relating to the Public Sector Plans, and knowledgeable about their functions and how those functions relate to the requirements of this Contract.

d. The Contractor shall have on staff sufficient qualified and licensed nurses and physicians whose primary duties are to conduct medical necessity reviews of claims, including review of complex or questionable medical claims.

e. The Contractor's utilization management (UM) reviewers shall be familiar with the terms of the Plan Documents. The UM reviewers shall consist of qualified nurse reviewers and physician reviewers. The Contractor shall exercise due diligence and care in its selection and retention of staff that perform UM services. The Contractor shall offer providers uninterrupted telephone access to UM reviewers continuously during the Contractor's normal business hours.

f. The Contractor shall have an ongoing designated, full-time Account Team that can provide daily operational support as well as strategic planning and analysis. All members of the Account Team shall have previous experience administering medical benefits for large employers. An available member of the Account Team shall be available for consultation with the State during the hours of 8:00 a.m. to 4:30 p.m. Central Time, Monday through Friday, as required to fulfill the scope of services specified in this Contract. The Account Manager shall also be available via cell phone and email after hours, including weekends.

g. The Contractor shall designate a full time Account Manager as a member of the Account Team. The Account Manager shall have the responsibility and authority to manage the entire range of services specified in this Contract and shall respond promptly to changes or inquiries in benefit plan design, changes or inquiries in claims processing procedures, or general administrative issues identified by the State. At a minimum, the Account Manager shall meet in person with the State once a month and more often if required by the State. At its discretion, the State may allow the Contractor to participate in such meetings by teleconference.

h. The Contractor shall survey the State annually in January to determine the State's satisfaction with the Account Team and report the results of the survey to the State (see Attachment C, Reporting Requirements).

i. The Contractor agrees that the State may approve or disapprove the staff assigned to this Contract prior to the proposed assignment. The State may also direct the Contractor to replace staff members providing core services as it deems necessary and appropriate. The decision of the State on these matters shall not be subject to appeal.

j. Key personnel commitments made in the Contractor's proposal shall not be changed unless prior approved by the State in writing. The Contractor shall notify the State at least fifteen (15) business days in advance, or as soon as the information is available, of proposed changes and shall submit justification (including proposed substitutions) in sufficient detail regarding education and experience equal to previous staff to the State to evaluate the impact upon the Contract. The decision of the State on these matters shall not be subject to appeal.

k. If any key position becomes vacant, the Contractor shall provide a replacement with commensurate experience and required professional credentials within sixty (60) days of the vacancy unless the State grants an exception to this requirement in writing.

A.19. Information Systems

a. The Contractor's Systems shall have the capability of adapting to any future changes necessary as a result of modifications to the design of the Public Sector Plans or this Contract and its requirements, including e.g., data collection, records and reporting based upon unique identifiers to track services and expenditures across population types/demographic groups, regions/parts of the state. The Systems shall be scalable and flexible so they can be adapted as needed, within negotiated timeframes, e.g., in response to changes in Contract requirements or increases in enrollment estimates. The Contractor's System architecture shall facilitate rapid application of the more common changes that can occur in the Contractor's operation, including but not limited to:

(1) Changes in payment methodology;
(2) Provider reimbursement terms;
(3) Changes in service authorization and utilization management criteria;
(4) Changes in program management rules, e.g. eligibility for certain services; and
(5) Standardized contact/event/service codes.

b. The Contractor shall ensure that its electronic data processing (EDP) and electronic data interchange (EDI) environments (both hardware and software), data security, and internal controls meet all applicable Federal and State standards, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. Said standards shall include but not be limited to the requirements specified under HIPAA for each of the following:

(1) Electronic Transactions and Code Sets
(2) Privacy
(3) Security
(4) National Provider Identifier
(5) National Employer Identifier
(6) National Individual Identifier
(7) Claims attachments
(8) National Health Plan Identifier
(9) Enforcement

Unless the State prior approves in writing the Contractor's use of alternate mitigating controls, the Contractor shall use Federal Information Processing Standards (FIPS) 140-2 compliant technologies to encrypt all PHI in motion or rest, including back-up media.

c. All Contractor systems shall maintain linkages and "parent-child" relationships between initial and related subsequent interactions/transactions/events/activities. Additionally, when the Contractor houses indexed images of documents used by members, providers and subcontractors to transact with the Contractor, the Contractor shall ensure that these documents maintain logical relationships to certain key data such as member identification and provider/subcontractor identification numbers. The Contractor shall also ensure that records associated with a common event, transaction or customer service issue have a common index that will facilitate search, retrieval and analysis of related activities, e.g., interactions with a particular member about the same matter/problem/issue.

d. Upon the State's request, the Contractor shall be able to generate a listing of all members and providers that were sent a particular document, the date and time that the document was generated, and the date and time that it was sent to particular members or providers or groups thereof. The Contractor shall also be able to generate a sample of said document.

e. Retention and Accessibility of Information

(1) The Contractor shall provide, one (1) month prior to go-live, and maintain a comprehensive information retention plan that is in compliance with state and federal requirements.

(2) The Contractor shall maintain information on-line for a minimum of three (3) years, based on the last date of update activity, and update detailed and summary history data monthly for up to three (3) years to reflect adjustments.

(3) The Contractor shall provide forty-eight (48) hour turnaround or better on requests for access to information that is between three (3) years and six (6) years old, and seventy-two (72) hour turnaround or better on requests for access to information in machine readable form that is between six (6) and ten (10) years old.

(4) If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

f. Information Ownership. All information, whether data or documents, and reports that contain or make references to said information, involving or arising out of this Contract is owned by the State. The Contractor is expressly prohibited from sharing or publishing State information and reports or releasing such information to external entities, affiliates, parent company, or subsidiaries without the prior written consent of the State.

g. System Availability, Business Continuity and Disaster Recovery (BC-DR)

(1) The Contractor shall ensure that critical member, provider and other web-accessible and/or telephone-based functionality and information, including the website described in Section A.16., are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled System unavailability agreed upon by the State and the Contractor. Unavailability caused by events outside of the Contractor's span of control is outside of the scope of this requirement. Any scheduled maintenance shall occur

between the hours of midnight and 5:00 a.m. Central Time and shall be scheduled in advance with notification on the member website/portal. The Contractor shall make efforts to minimize any down-time between 5:00 a.m. and 10:00 p.m. Central Time.

(2) The Contractor shall ensure that the Systems within its span of control that support its data exchanges with the State and the State's vendors are available and operational according to the specifications and schedule associated with each exchange.

(3) Regardless of the architecture of its systems, the Contractor shall develop and be continually ready to invoke a business continuity and disaster recovery (BC-DR) plan. The BC-DR plan shall encompass all information systems supporting this Contract. At a minimum the Contractor's BC-DR plan shall address the following scenarios:

i. Central and/or satellite data processing, telecommunications, print and mailing facilities and functions therein, hardware and software are destroyed or damaged;
ii. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage;
iii. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that compromise the integrity of data maintained in a live or archival system; and
iv. System interruption or failure resulting from network, operating hardware, software, communications infrastructure or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the system.

(4) The Contractor shall provide the State results of its most recent test of its BC-DR plan one (1) month prior to the go-live date.

(5) The Contractor shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to the State that it can restore system functions. The Contractor shall submit an annual BC-DR Results Report to the State (refer to Contract Attachment C, Reporting Requirements).

(6) In the event that the Contractor fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Contract, the Contractor shall submit to the State a corrective action plan that describes how the failure will be resolved. The Contractor shall deliver the corrective action plan within ten (10) business days of the State's request.

(7) In the event of a declared major failure or disaster, as defined in the Contractor's BC-DR plan, the Contractor's critical functionality as discussed in Section A.19.g.(1) shall be restored within seventy-two (72) hours of the failure's or disaster's occurrence.

(8) The Contractor shall maintain a duplicate set of all records relating to this Program in electronic medium, usable by the State and the Contractor for the purpose of disaster recovery. Such duplicate records are to be stored at a secure fire, flood, and theft- protected facility located away from the storage location of

the originals. The Contractor shall update duplicate records, at a minimum, on a daily basis and shall retain said records for a period of sixty (60) days from the date of creation. At the State's request, at the end of the term of this Contract or upon notice of termination of this Contract prior to the term date, the Contractor shall convey the original and the duplicate records medium and the information they contain to the State on or before the date of termination.

h. Prior to implementing any major modification to or replacement of the Contractor's core information systems functionality and/or associated operating environment, the Contractor shall notify the State in writing of the change or modification within a reasonable amount of time (commensurate with the nature and effect of the change or modification) if the change or modification: (a) would affect the Contractor's ability to perform one or more of its obligations under this Contract; (b) would be visible to State system users, members and providers; (c) might have the effect of putting the Contractor in noncompliance with the provisions or substantive intent of the Plan Documents and/or this Contract; or (d) would materially reduce the benefits payable or services provided to the average member. If so directed by the State, the Contractor shall discuss the proposed change with the State/its designee prior to implementing the change. Subsequent to this discussion, the State may require the Contractor to demonstrate the readiness of the impacted systems prior to the effective date of the actual modification or replacement.

i. System and Information Security and Access Management Requirements

(1) The Contractor's Systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

i. Restrict access to information on a "least privilege" basis, e.g., users permitted inquiry privileges only will not be permitted to modify information;
ii. Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities and the ability to create, change or delete certain data (global access to all functions shall be restricted to specified staff jointly agreed to by the State and the Contractor);
iii. Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences; and.
iv. Ensure that authentication credentials are not passed in clear text or otherwise displayed or presented.

(2) The Contractor shall make System information available to duly authorized representatives of the State and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

(3) The Contractor's Systems shall contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be mutually agreed upon by the Contractor and the State.

(4) Audit trails shall be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

i. Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;
ii. Have the date and identification "stamp" displayed on any on-line inquiry;
iii. Have the ability to trace data from the final place of recording back to its source data file and/or document;
iv. Be supported by listings, transaction reports, update reports, transaction logs, or error logs; and
v. Facilitate batch audits as well as auditing of individual records.

(5) The Contractor's Systems shall have inherent functionality that prevents the alteration of finalized records.

(6) The Contractor shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The Contractor shall provide the State with access to data facilities upon request. The physical security provisions shall be in effect for the life of this Contract.

(7) The Contractor shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

(8) The Contractor shall include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

(9) The Contractor shall put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of the Contractor's span of control.

(10) Unless the State prior-approves in writing the Contractor's use of alternate mitigating controls, the Contractor shall use Federal Information Processing Standard (FIPS) 140-2 compliant technologies to encrypt all PHI in motion or rest, including back-up media.

(11) The Contractor shall commission a security risk assessment at least annually and communicate the results to the State as part of an information security plan. The first report shall be provided one (1) month prior to the start date of operations and annually thereafter. The risk assessment shall also be made available to appropriate state and federal agencies. At a minimum the assessment shall contain the following: identification of loss risk events/ vulnerabilities; analysis of the probability of loss risk and frequency of events; estimation of the impact of said events; identification and discussion of options for mitigating identified risks; cost-benefit analysis of options; recommended options and action plan for their implementation. The assessment shall be conducted in accordance with the following: requirements for administrative, physical, and technical safeguards to protect health data (45 CFR §§164.304 - 318); rules for conducting risk analysis and risk management activities (45 CFR §164.308); requirements for security awareness training (45 CFR §164.308(a)(5)); requirements for entities to have security incident identification, response, mitigation and documentation procedures (45 CFR §164.308(a)(6)).

(12) To maintain the privacy of PHI, the Contractor shall enable Transport Layer Security (TLS) on the mail server used for daily communications between the

State and the Contractor. TLS shall be enabled no later than January 1, 2016 and shall remain in effect throughout the term of the contract.

A.20. Data Integration and Technical Requirements

a. The Contractor shall maintain an electronic data interface with the State's Edison System for the purpose of processing State member enrollment information. The Contractor shall be responsible for providing and installing the hardware and software necessary. When the Contractor requires the exchange of PHI with the State of Tennessee, the State requires the use of second level authentication. This is accomplished using the State's standard software product, which supports Public Key Infrastructure (PKI). The Contractor shall design a solution, in coordination with the State, to connect to the State's Secure File Transfer Protocol (SFTP) server using a combination of the password and the authentication certificate. The initial sign-on and transmission testing will use a password. Certificate testing may also be performed during the test cycle. Subsequent production sign-on will be done using the authentication certificate. The Contractor will then download the file and decrypt the file in its secure environment. The State of Tennessee uses public key encryption with Advanced Encryption Standard (AES) to encrypt PHI. If the State adopts a different or additional encryption standard or tool in the future, the Contractor shall, with adequate notice, cooperate with the State to maintain the security of protected information according to all applicable State and Federal standards.

b. Notwithstanding the requirement to maintain enrollment data, the Contractor shall not perform changes to enrollment data without the State's approval. This prohibition shall include, but not necessarily be limited to: initiation, termination, and/or changes of coverage.

c. At least two (2) months prior to the go-live date, the Contractor shall complete testing of the transmission, receipt, and loading of the eligibility file from the State.

d. At least one (1) month prior to the go-live date, the Contractor shall load, test, verify and make available online for use the State's eligibility/enrollment information. The Contractor shall certify, in writing, to the State that the Contractor understands and can fully accept and utilize the eligibility/enrollment files as provided by the State.

e. The Contractor shall maintain, in its systems, in-force enrollment records of all individuals covered by the Public Sector Plans.

(1) Weekly Enrollment Update: To ensure that the State's enrollment records remain accurate and complete, the Contractor shall, unless otherwise directed by the State, retrieve, via secure medium weekly enrollment files from the State, in the State's Edison 834 (5010 file format, see RFP 317816-00125 Appendix 7.10. for the current file format), which may be revised. Files will include full population records for all members and will be in the format of ANSI ASC X12N, Benefit Enrollment and Maintenance 834 (5010), version 005010X220A1, with several fields customized by the State.

(2) The Contractor shall complete and submit to the State a Weekly File Transmission Statistics Report within five (5) business days of receipt of the Weekly Enrollment Update. The Contractor shall submit this report via email to designated State staff. (See Contract Attachment C.)

(3) The Contractor and/or its subcontractors, shall electronically process one hundred percent (100%) of electronically transmitted enrollment updates, including the resolution of any errors identified during processing, within four (4)

business days of receipt of the weekly file. The State and the Contractor shall work to develop a process for responding to invalid or non-processed records.

(4) The Contractor and/or its subcontractors shall resolve all enrollment discrepancies as identified by the State or Contractor within one (1) business day of identification.

(5) The Contractor and/or its subcontractors, with collaboration from the State, shall resolve associated system errors, as identified through enrollment discrepancy resolution, in a timeframe mutually agreed upon with the State. The Contractor shall document in an eligibility system modification log, the system error details, the proposed solution, and the final solution as agreed upon by the State. The Contractor shall update and submit this log quarterly (refer also to Contract Attachment C, Reporting Requirements). Subsequent errors identical in nature may be subject to Liquidated Damages as specified in Attachment B.

(6) State Enrollment Data Match: Upon request by the State, not to exceed four (4) times annually, the Contractor shall submit to the State, in a secure manner, its full file of State members, by which the State may conduct a data match against the State's Edison database. The purpose of this data match will be to determine the extent to which the Contractor is maintaining its database of State members. The State will communicate results of this match to the Contractor, including any Contractor requirements, and associated timeframes, for resolving the discrepancies identified by the data match.

f. CMS Data Match: The Contractor shall enter into an agreement with the Centers for Medicare and Medicaid Services (CMS) providing for a data match, no less frequent than monthly, of Contractor's full file of members against CMS Medicare files for purpose of determining the primary payer. Furthermore, the data match shall generate a report of all Medicare enrollees identified, if they have both parts A and B and the effective dates, which shall be shared with the State. The Contractor shall also provide a monthly report of all Local Government retirees who will become eligible for Medicare in the subsequent month (refer also to Contract Attachment C, Reporting Requirements).

g. The Contractor shall establish and maintain systems and processes to receive all appropriate and relevant data from entities and vendors providing services to members, including vendors under contract with the State (*e.g.*, the PBM, EAP/BHO vendor, HM/W vendor, the H&W Center vendor) and integrate such data into Contractor's systems and processes as appropriate no later than one (1) month prior to go-live at no additional cost to the State.

h. The Contractor shall provide transmittal of claims data via secure medium at a frequency determined by the State to any additional third parties including the State's HM/W vendor, EAP/BHO vendor, PBM vendor, HSA vendor or others as identified by the State.

i. Decision Support System

(1) The Contractor shall transmit medical claims data to the State's current health care decision support system (DSS) vendor and, if directed by the State, to the Department of Finance and Administration, Office for Information Resources in the format detailed in RFP 31786-00125 Appendix 7.11 "DSS Vendor File format" or in a mutually agreed upon format. The data feed(s) shall be provided at no additional charge to the State. The Contractor shall transmit the claims data, via a mutually agreed upon secure methodology, no later than fifteen (15) days following the end of each calendar month, or more frequently as directed by the State, until all claims incurred during the term of this Contract have been paid.

(2) The Contractor shall ensure that all claims processed for payment have financial fields, valid provider identifications, the complete most recent International Classification of Diseases codes and Current Procedural Terminology-4/Healthcare Common Procedure Coding System codes (and when applicable, updated versions of each). The file submitted to the State's current health care decision support system (DSS) vendor should contain data elements consistent with industry standards, such as those contained on the Uniform Bill-04, Center for Medicare and Medicaid Services 1450 and Center for Medicare and Medicaid Services 1500 forms and their successors. Examples of these forms are provided in Attachment D. The Contractor shall add data as required by the State's DSS vendor and/or the State for the purpose of processing claims data. The State has final approval for all file layouts.

(3) Claims data provided to the DSS vendor shall meet the quality standards detailed in the Liquidated Damages section of this Contract (Contract Attachment B) as determined by the State's DSS vendor.

(4) The Contractor is responsible for the fee charged by the DSS vendor to develop, test and implement conversion programs for the Contractor's claims data. Furthermore, the Contractor shall pay during the term of this contract all applicable fees as assessed by the State's DSS vendor related to any data format changes or additions, which are Contractor-initiated or are due to meeting compliance with new regulations. The Contractor shall also pay all applicable fees related to any DSS vendor efforts to correct Contractor data quality errors that occur during the term of this contract.

(5) To the extent that the Contractor receives electronic lab results for laboratory tests performed by contract providers, the Contractor shall transmit these lab results to the State's DSS vendor in a mutually agreed upon format. The Contractor shall transmit the data, via a mutually agreed upon secure methodology, no later than fifteen (15) days following the end of each calendar month or more frequently as directed by the State.

(6) The Contractor shall recognize that the medical claims data transmitted pursuant to the provision of this Contract is owned by the State of Tennessee.

j. At the request of the State, the Contractor shall accept and load at least one (1) year of historical data from each current claims administrator no later than one (1) month prior to the go-live date and update/refresh the data until go-live. This includes, but is not limited to, claims history (with proprietary pricing and discount information redacted), provider data, member data, and prior authorization data.

k. The Contractor's systems shall conform to future federal and state specific standards for data exchange by the standard's effective date.

l. The Contractor shall partner with the State and member agencies in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort.

m. Within sixty (60) days of notice of termination of this Contract, the Contractor shall transfer to the State all required data and records necessary to administer the plan(s)/program(s), subject to State and Federal confidentiality requirements. The transfer shall be made electronically via secure medium, in a file format to be determined based on the mutual agreement between the State and the Contractor.

n. If a member changes their Grand Division, benefit option, or third party administrator outside of the Annual Enrollment Period (due to a move, HIPAA qualifying event, etc.), then the Contractor shall transfer to the new third party administrator or benefit option the in-network and out-of-network paid amounts, or any other accumulators, that would have otherwise been applied to the member's current year plan account had the member not made a change. The Contractor shall transfer said data to the member's new third party administrator or benefit option within fourteen (14) calendar days and update the transferred data with new paid claims data. Likewise, the Contractor shall transfer any existing prior authorization or utilization management information to the new third party administrator as appropriate. The Contractor shall also take all reasonable measures to facilitate the member's transition, maintain the member's continuity of care and service delivery, and minimize the administrative burden or other disruption to the member.

A.21. Privacy & Confidentiality

a. The following privacy and confidentiality standards apply to all forms of assistance that the Contractor provides.

b. The Contractor shall develop, adopt, and implement standards, which are, at a minimum, compliant with the HIPAA statute and the HIPAA privacy and security rules in 45 CFR Part 164, to safeguard the privacy and confidentiality of all information about members. For example, the Contractor shall ensure that it does not have completed documents or other types of forms sitting in public view, left in unsecure boxes or files, or left unattended in any off-site location (e.g., in an automobile, etc.). The Contractor's procedures shall include but not be limited to safeguarding the identity of members as plan members and preventing the unauthorized disclosure of information. The Contractor shall comply with HIPAA as amended by HITECH Act (part of the American Recovery and Reinvestment Act, Public Law 111-5), and all implementing regulations including new amendments when they become effective.

c. The Contractor shall not use or further disclose PHI other than as permitted or required by HIPAA and the Business Associate Agreement; or as required by law. Use of PHI for treatment, payment, or health care operations may include disclosure only as permitted by HIPAA, including HIPAA's "minimum necessary" standard.

d. The Contractor shall use appropriate safeguards to prevent the unauthorized use or disclosure of the PHI. Contractor shall immediately report to the State any unauthorized use or disclosure of PHI. Contractor shall comply with the HIPAA Breach Notification Rules found in 45 CFR §, Section 164.400 et al, and shall cooperate with the State in responding to any unauthorized use or disclosure of PHI related to this contract.

e. The Contractor shall mitigate, to the extent practicable, any harmful effect that is known to the Contractor of a use or disclosure of PHI by the Contractor in violation of the requirements of the federal privacy rule.

f. The Contractor shall provide access to PHI in a "designated record set" in order to meet the requirements under 45 CFR §164.524.

g. The Contractor shall make any amendment(s) to PHI in a "designated record set" pursuant to 45 CFR §164.526.

h. The Contractor shall document such disclosures of PHI and information related to such disclosures as would be required to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528.

i. The Contractor shall (i) 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, (ii) report to the State any security incident (within the meaning of 45 CFR § 164.304) of which the Contractor becomes aware, and (iii) ensure that any Contractor employee or agent, including any subcontractor, agrees to the same restrictions and conditions that apply to the Contractor with respect to such information.

j. The Contractor shall not sell Public Sector Plan member or prescriber information or use member or prescriber identified information for advertising, marketing, promotion or any activity intended to influence sales or market share of a medical product or service.

k. At the request of the State, the Contractor shall offer credit protection for those times in which a member's PHI is accidentally or inappropriately disclosed.

l. The Contractor shall comply with all privacy and security requirements of the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health (HITECH) Act.

m. The Contractor shall have full financial responsibility for any penalties, fines, or other payments imposed or required as a result of the Contractor's non-compliance with or violation of HIPAA or HITECH requirements, and the Contractor shall indemnify the State with respect to any such penalties, fines, or payments.

n. The Contractor shall assure that all Contractor staff is trained in all HIPAA requirements, as applicable.

A.22. Reporting & Systems Access

a. The Contractor shall submit reports in a mutually agreeable electronic format (*e.g.*, Microsoft Word or Microsoft Excel), of the type, at the frequency, and containing the detail described in Contract Attachment C. As appropriate, reporting shall continue during the claims run-out period.

b. The Contractor shall provide a mutually agreed upon mechanism for the State to access data, including program and fiscal information regarding members served, services rendered, etc. and the ability for said personnel to develop and retrieve reports. This requirement could be met by the provision of access to a decision support system/data warehouse. The Contractor shall provide training in and documentation on the use of this mechanism. The Contractor shall provide access to this reporting functionality to a minimum of five (5) State employees no later than two weeks prior to the go-live date. Additional or replacement users may be added at any time at the State's request.

c. The Contractor shall provide requested State employees with access to the Contractor's eligibility and internal financial reporting systems no later than two weeks prior to the go-live date. Additional or replacement users may be added at any time at the State's request. Access shall include the ability to do real-time updates to the Contractor's eligibility records.

d. The Contractor shall train the requested State staff (and any additional or replacement users) regarding access to the Contractor's system on all Contractor systems and tools no later less than one (1) month prior to the go-live date. Such training may be delivered remotely or in-person.

e. The Contractor shall provide the State access to an ad-hoc reporting liaison to assist in the development of reports that cannot be generated using the Contractor's standard

reporting package. The Contractor shall deliver such reports to the State within five (5) business days of the State's request. If requested by the State, the Contractor shall deliver up to ten (10) reports annually deemed as "urgent" by the State within two business days. All ad-hoc reports shall be provided at no additional cost to the State

f. The Contractor shall annually provide the State the most recent copy of the Contractor's SSAE 16 SOC1 Type 2 report as well as the SSAE 16 SOC1 Type 2 report for any subcontractor processing claims that represent more than twenty percent (20%) of medical expenses for members.

g. The Contractor shall ensure that reports submitted by the Contractor to the State shall meet the following standards:

(1) The Contractor shall verify the accuracy and completeness of data and other information in reports submitted.

(2) The Contractor shall ensure delivery of reports or other required data on or before scheduled due dates.

(3) Reports or other required data shall conform to the State's defined written standards.

(4) All required information shall be fully disclosed in a manner that is responsive and with no material omission.

(5) As applicable, the Contractor shall analyze the reports for any early patterns of change, identified trend, or outlier (catastrophic case) and shall submit a written summary with the report including such analysis and interpretation of findings. At a minimum, such analysis shall include the identification of change(s), the potential reasons for change(s), and the proposed action(s).

(6) The Contractor shall notify the State regarding any significant changes in its ability to collect information relative to required data or reports.

(7) The submission of late, inaccurate or otherwise incomplete reports shall be considered failure to report within the specified timeframe (see Contract Attachment B).

(8) State requirements regarding reports, report content and frequency of submission may change during the term of the Contract. The Contractor shall have at least forty-five (45) days to comply with changes specified in writing by the State.

A.23. Payment Reform

a. The Contractor shall implement retrospective episode based reimbursement strategies in a manner and on a timeline approved by Benefits Administration (BA). This includes, but is not limited to:

(1) Implementing, as defined in A.23.a (6) below, episodes of care at a pace dictated by BA, likely up to 60 total episodes by the end of 2019 with approximately 5-8 new episodes, directed by BA, per six month period with appropriate lead time to allow for provider contracting. The first performance reports shall begin in January 2017 with the first reconciliation process in 2018;

(2) Constructively participating in Payer Coalition meetings where Tennessee insurers discuss the design and implementation of payment reform;

(3) Having clinical representatives attend Technical Advisory Group meetings to advise on the clinical design of episodes;

(4) Participating in any other payment reform design processes and stakeholder processes as required by BA;

(5) Using a retrospective payment process that is aligned, as directed by BA, with the Tennessee Episode Model of retrospective episodes. The Contractor may customize episode definitions as needed and prospective episodes, similar to the episodes implemented through the State's payment reform initiative, may be considered in lieu of retrospective episodes on a case-by-case basis as approved by BA;

(6) Implementing key episode design choices as directed by BA, including:

   i. Defining a principal accountable provider (PAP) to receive preview and performance reports and be eligible for rewards or subject to penalties;

   ii. Adopting the definition of quality measures and their acceptable thresholds;

   iii. Including care from multiple providers in the episode;

   iv. Utilizing risk adjustment to reduce the impact of difference between patient age, morbidity, and other patient factors on the outcomes of the provider; and

   v. Implementing a financial model that includes contractual rewards and penalties to providers based on the cost and quality of the episodes. The Contractor may set cost thresholds at their discretion.

(7) Delivering preview and performance reports to providers detailing the provider's aggregate performance in meeting pre-defined cost and quality targets. The reports shall have a similar appearance and content as those designed by the State and payer coalition on the following timeline;

   i. Quarterly preview reporting to all impacted providers for, at a minimum, Wave 1 and 2 episodes approved by BA beginning during the first quarter of 2016;

   ii. Performance reporting to impacted providers for, at a minimum, Wave 1 and 2 episodes approved by BA, beginning by January 2017; and

   iii. Reporting for future episode waves shall follow the specific episode implementation timelines as directed by BA.

(8) Engaging in provider education and communication so providers understand the episode of care model and provider reports; and

(9) For each episode chosen by BA, the Contractor shall require participation in episode based payments for all in-network providers who are expected to have at least 40 of these episodes of care across all of their commercial members in the upcoming performance period. The Contractor shall apply the episode model to any episode experienced by:

   i. Public Sector Plan members by January 1, 2017;

ii. At least fifty percent (50%) of the Contractor's fully insured members, and at least ten percent (10%) of the Contractor's self-insured ASO members (not including BA) by January 1, 2017; and

iii. At least sixty percent (60%) of the Contractor's fully insured members, and at least fifteen percent (15%) of the Contractor's self-insured ASO members (not including BA) by January 1, 2019.

The Contractor shall provide a report after each of the above performance dates documenting achievement of the fully insured and self-insured ASO percentages.

b. BA may grant exceptions to proposed deadlines upon request from the Contractor as deemed appropriate by BA. BA's decisions on these issues are final and not subject to appeal.

c. The Contractor shall deliver quarterly financial estimates detailing estimated provider pay-outs and recoupments attributable to implemented episodes. The report shall be in a format determined by the State but, at a minimum, payments shall be categorized by plan.

d. The Contractor shall deliver an annual financial report detailing total provider pay-outs and recoupments attributable to implemented episodes for the previous year. The report shall be in a format determined by the State but must include a breakdown by plan as well as enough information to verify that episodes are attributable to eligible Public Sector Plan members.

A.24. Due Dates for Project Deliverables/Milestones

a. Unless otherwise specified in writing by the State, the Contractor shall adhere to the following schedule for the deliverables and milestones for which it is responsible under this Contract:

Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates:
Implementation		
1. Call center and other information systems are fully operational	A.2.a	December 1, 2015
2. Go-live	A.2.c	January 1, 2016
3. Kick-off meeting for all key Contractor staff	A.2.d	Within thirty (30) days after Contract start date
4. Implementation plan	A.2.e	No later than thirty (30) days after Contract start date
5. Operational readiness review	A.2.f	Within sixty (60) days prior to go-live
6. Implementation Performance Assessment Survey	A.2.j	Forty-five (45) days post go-live
Provider Network		
7. GeoNetworks® Report	A.3.c and Attachment C	Semi-annually after the 1st and 3rd calendar quarters starting with a submission for the 2nd and 3rd

Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates:
		calendar quarters after go-live
8. Quarterly Network Changes Update Report	A.3.p and Attachment C	20th of the month following the end of the quarter
9. Annual New Patient Report	A.3.t and Attachment C	Annually
10. Annual Provider Turnover Report	A.3.u and Attachment C	Annually
11. Monthly Unique Care Exception Report	A.3.cc and Attachment C	Monthly after go-live
Utilization Management		
12. Description of UM program, evaluation methodology, and audit program	A.4.l	Two (2) months prior to go-live
13. Quarterly Utilization Management Report	A.4.m and Attachment C	Quarterly after go-live
14. Emergency Department High Utilizers	A.4.o	Every six (6) months following go-live
Quality Assurance Program		
15. Quality Assurance Program Summary	A.5.b	One (1) month prior to go-live
16. eValue8	A.5.f	Annually
17. Clinical Case Calls	A.5.k	Up to, but not exceeding weekly after go-live
18. Coordination of Service Calls	A.5.l	As directed by the State
19. NCQA Accreditation	A.3.v and A.5.m	No later than December 31, 2016 (unless the State approves a later date)
20. HEDIS Report	A.5.n and Attachment C	Annually by August 15 for prior year
Pharmacy		
21. ASP Financial Reconciliation	A.6.f.	Annually by last business day in May
22. Specialty Drug Report	A.6.g.	Quarterly after go-live
Health Management Services		
23. Discharge & Admission Files	A.8.b	Daily after go-live
24. Wellness Completion	A.8.d and Attachment C	As directed by the State
Claims Processing, Payment and Reconciliation		

Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates:
25. Claims Accumulators	A.9.b	Daily after go-live
26. Claims Audit Methodology	A.9.f	One (1) month prior to go-live
27. Claims Management Accuracy Test	A.9.k	Twice a year
28. Clinical Claims Review Software Update	A.9.m	Annually
29. Rebates	A.9.w	Quarterly after go-live
30. Quarterly COB Report	A.9.aa and Attachment C	Quarterly after go-live
31. Medicare Secondary Payer	A.9.bb	Weekly after go-live
32. Subrogation Reports	A.9.cc and Attachment C	As directed by the State
33. Description of process for determining experimental/investigational procedures and services	A.9.ee	One (1) month prior to go-live
34. Reconciliation Reports	A.9.gg(1) and Attachment C	Same frequency as the Contractor's bank draft
35. Monthly Recoveries Report	A.9.gg(2) and Attachment C	Monthly after go-live
36. Payment Reconciliation	A.9.gg(3)	Within ten (10) business days of receipt of payment information
Fraud and Abuse		
37. Description of Fraud and Abuse Program	A.10.d	Two (2) months prior to go-live
38. Fraud and Abuse Report	A.10.e and Attachment C	Semi-annually after the 2nd and 4th calendar quarters
Member Services		
39. Customer Satisfaction Standards	A.12.f	Thirty (30) days prior to go-live
40. CAHPS Survey	A.12.k and Attachment C	Annually by June 15th; Corrective action plan by August 1st
Member Appeals Process		
41. Description of member appeals process and procedures and sample determination letters	A.13.j	One (1) month prior to go-live
42. Appeals Reports	A.13.k and Attachment C	Quarterly after go-live
Call Center		
43. Call Center Open	A.14.b	October 1, 2015

Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates:
44. Call Center Statistics	A.14.k and Attachment C	Weekly during the annual enrollment period, the fifteen (15) days prior to go-live through the sixty (60) days after go-live. Monthly after the first sixty (60) days.
Member Communication/Materials		
45. I.D. cards	A.15.e(5)	Annually: Twenty-one (21) days prior to go-live and fourteen (14) days prior to the start of each subsequent benefit year Within Ten (10) days for new enrollees or replacement cards
46. Annual Enrollment Information	A.15.g	Annually two (2) months before the annual enrollment period
47. Welcome Packets (including member handbook)	A.15.h	Annually: Twenty-one (21) days prior to go-live and fourteen (14) days prior to the start of each subsequent benefit year Within 10 days of receipt of enrollment information
48. Printed Provider Directory	A.15.i	Within ten (10) days of request
49. Reading Level Analysis	A.15.n	With all draft materials
50. Electronic Templates of all Member Materials	A.15.o	With all final materials
Website		
51. Website go-live	A.16.c	September 16, 2015
52. Website Update	A.16.e	Annually by the first day of annual enrollment
53. Access to Website	A.16.f	September 1, 2015
54. Internet Based Provider Directory	A.16.m	September 16, 2015
55. Transparency Tool Report	A.16.n.(12)	Quarterly after go-live
Administrative Services		
56. Meetings with the State	A.17.g	Monthly after go-live
57. Seminars	A.17.h	Annually
58. Benefits Fairs	A.17.l	As requested by the State
Staffing		
59. Account Team Satisfaction Survey and Report	A.18.h	Annually (each January)

Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates:
Information Systems		
60. Information Retention Plan	A.19.e(1)	One (1) month prior to go-live
61. Business Continuity/Disaster Recovery (BC-DR) Results Report	A.19.g(4)(5) and Attachment C	One (1) month prior to go-live and annually thereafter
62. Duplicate Records	A.19.g(8)	On or before contract termination date
63. Information Security Plan	A.19.i(11)	One (1) month prior to go-live and annually thereafter
64. Transport Layer Security	A.19.i(12)	January 1, 2016
Data Integration & Technical Requirements		
65. Completion of Eligibility File Testing	A.20.c	Two (2) months prior to go-live
66. Edison System Interface/Eligibility File Acceptance	A.20.d	One (1) month prior to go-live
67. Weekly Enrollment Update	A.20.e(1)	Weekly after go-live
68. Weekly File Transmission Statistics Report	A.20.e(2)	Within five (5) business days of receipt of Weekly Enrollment Update
69. Enrollment Updates	A.20.e(3)	Within four (4) business days of receipt of the weekly file
70. Enrollment Discrepancies	A.20.e(4)	Within one (1) business day of identification
71. Eligibility System Modification Log	A.20.e(5)	Quarterly after go-live
72. State Enrollment Data Match	A.20.e(6)	Up to four (4) times annually, as requested by the State
73. CMS Data Match and Report	A.20.f and Attachment C	Quarterly after go-live
74. Local Government Medicare Eligible Report	A.20.f and Attachment C	Monthly after go-live
75. Receipt of Third Party Data	A.20.g	One (1) month prior to go-live
76. Claims Data Transmission to Third Parties	A.20.h	As directed by the State
77. Claims Data Transmission to DSS Vendor	A.20.i	Fifteen (15) days following the end of each calendar month after go-live
78. Electronic Lab Results Transmission to DSS Vendor	A.20.l	Fifteen (15) days following the end of each calendar month after go-live
79. Load Historical Data	A.20.m	One (1) month prior to go-live

Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates:
80. Transmission of Data and Records to State	A.20.p	Within sixty (60) days of notice of termination
81. Transfer of Member Accumulators	A.20.q	Within fourteen (14) calendar days
Reporting & Systems Access		
82. Reports specified in Contract Attachment C	A.22.a and Contract Attachment C	As specified in Contract Attachment C
83. Decision Support Reporting System Access	A.22.b	Two (2) weeks prior to go-live
84. Eligibility and Financial Reporting System Access	A.22.c	Two (2) weeks prior to go-live
85. State Staff Systems Training	A.22.d	One (1) month prior to go-live
86. SSAE 16 Report(s)	A.22.f	Annually after go-live

A.25. Definitions

a. Affiliate: A business organization or entity that, directly or indirectly, is owned or controlled by the Contractor, or owns or controls the Contractor, or is under common ownership or control with the Contractor.

b. Agency Benefits Coordinator (ABC): An Agency Benefits Coordinator serves as the liaison between the Public Sector Plans and members.

c. Average Sales Price (ASP): Equals the volume-weighted, per-unit average of manufacturer sales prices for each product that falls within a single Healthcare Common Procedure Coding System (HCPCS) code. ASP is computed using actual sales revenues to a manufacturer, i.e., list price minus all price concessions (volume discounts, prompt pay discounts, cash discounts, free goods, chargebacks, rebates, etc.). Thus, ASP is not a list price like Wholesale Acquisition Cost (WAC). The ASP methodology uses quarterly drug pricing data submitted to CMS by drug manufacturers. Drug pricing files are available from CMS or on their website.

d. Average Speed of Answer: The average waiting time for a caller before he/she is answered by a service representative.

e. Balance Billing: Seeking payment from a member for any charged amount(s) over and above the maximum allowable charge or contract rates.

f. Benefits Administration: The division of the Tennessee Department of Finance & Administration that administers the Public Sector Plans.

g. Bridges to Excellence: Bridges to Excellence programs recognize and reward clinicians who deliver superior patient care. The programs measure the quality of care delivered in provider practices.

h. Business Days: Traditional workdays, including Monday, Tuesday, Wednesday, Thursday, and Friday. State Government Holidays are excluded.

i. Calendar Days: All seven days of the week.

j. Centers of Excellence: Providers who are selected to perform certain specialized procedures because of their expertise, outcomes and favorable financial arrangements.

k. CFR: Code of Federal Regulations.

l. Clean Claim: A claim received by the Contractor for adjudication, and which requires no further information, adjustment, or alteration by the provider in order to be processed and paid by the Contractor. In addition to the provider, this includes information, adjustment, or alteration by the member, the subscriber, third-party payers (i.e. – Medicare), and/or plan sponsor.

m. Co-insurance: That percentage of the charge for a medical service provided to a member that is the responsibility of the member.

n. Collaborative physical/behavioral health care: An approach to integration in which primary care providers, care managers, and behavioral health consultants work together to provide evidence-based collaborative care and monitor patients' progress.

o. Consumer Driven Health Plan with HSA (CDHP/HSA): A consumer-directed health plan (CDHP) typically involves the combination of high-deductible health coverage with a health savings account (HSA) or health reimbursement arrangement (HRA). CDHPs typically have lower premiums and higher deductibles. HSA or HRA funds can be used for eligible healthcare expenses.

p. Co-payment: That portion of the charge (flat dollar amount) for each medical service provided to a member that is the responsibility of the member.

q. Day(s): Calendar day(s) unless otherwise specified in the Contract.

r. Deductible: The amount specified in the Plan Documents that must be paid by each member prior to payment of any covered benefits by the Contractor.

s. Denied Claim: A claim that is not paid for reasons such as eligibility and coverage rules.

t. DSS: A decision support system is a database and query tool.

u. EAP/BHO: Employee Assistance Program/ Behavioral Health Organization

v. eValue8: A quality assessment of third party administrators and other health care administrative service organizations performed by the National Business Coalition on Health and its local designees that measures and evaluates health plan performance.

w. Fully insured members: Members included in the Contractor's book of business for which the Contractor receives a fixed monthly premium and assumes financial responsibility for the enrollees' medical claims and for all incurred administrative costs. For the purposes of this contract, the Contractor's fully insured members shall exclude Medicaid, CHIP and Medicare members.

x. Grand Division: A defined geographical area that includes specified counties in the State of Tennessee. The Contractor shall serve an entire Grand Division. The following counties constitute the Grand Divisions in Tennessee for this Contract:

East Grand Division – Anderson, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Grainger, Greene, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Marion, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Roane, Scott, Sequatchie, Sevier, Sullivan, Unicoi, Union, and Washington Counties

Middle Grand Division – Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Fentress, Franklin, Giles, Grundy, Hickman, Houston, Humphreys, Jackson, Lawrence , Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, and Wilson Counties

West Grand Division – Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Shelby, Tipton, and Weakley Counties

y. H&W Center: ParTNers Health & Wellness Center (i.e. onsite employee clinic).

z. Head of Contract: Eligible employee, retiree, or individual qualified under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) (not including dependents) who is enrolled in one of the medical benefit options of the Public Sector Plans.

aa. HIPAA: Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and implementing regulations.

bb. HITECH: Health Information Technology for Economic and Clinical Health Act.

cc. HM/W: Health Management and Wellness

dd. Information System(s): A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, *i.e.*, structured data (which may include digitized audio and video) and documents as well as non-digitized audio and video; and/or (b) the processing of information and non-digitized audio and video for the purposes of enabling and/or facilitating a business process or related transaction.

ee. Leapfrog Hospital Survey: Annual Hospital Survey that assesses hospital performance based on national performance measures.

ff. Lock-in: An action by a third party administrator to limit the number or subset of providers from which a member can seek covered services so as to prevent "doctor shopping" and mitigate risks of fraud and abuse.

gg. Member: Any person who is enrolled in one the medical benefit options of the Public Sector Plans administered by the Contractor in accordance with the Plan documents.

hh. National Provider Identification Number (NPI): A 10-position, intelligence-free numeric identifier (10-digit number). The numbers do not carry other information about health care providers, such as the state in which they live or their medical specialty.

ii. **NCQA:** National Committee for Quality Assurance is a non-profit organization dedicated to improving health care quality. **NCQA** accredits and certifies a wide range of health care organizations.

jj. Network Provider: A provider that has a provider agreement with the Contractor to provide services according to specific terms and rates.

kk. Paid Claim: A claim that meets all coverage criteria of the Public Sector Plans and is paid by the Contractor and submitted to the State for reimbursement.

ll. Out-of-Network: The services received and the reimbursement level available when provided by providers that do not have a provider agreement with the Contractor to provide services according to specific terms and rates.

mm. Out-of-Pocket Expenses: The sum of any deductibles, co-payments or co-insurance required or incurred for any covered benefit.

nn. Payment Reform: A state-wide initiative to transition Tennessee's healthcare payment system to better reward patient-centered, high-value health care outcomes for all Tennesseans. The Tennessee Health Care Innovation Initiative is led by Division of Health Care Finance and Administration and the Division of Benefits Administration, and is engaged with a broad group of stakeholders, including the largest private insurers in Tennessee and leading Tennessee healthcare providers.

oo. PBM: Pharmacy Benefits Manager

pp. PEPM: Per Employee per month. For purposes of this definition, "employee" shall include any enrollee in the public sector plans and who is also a head of contract as defined in Section A.25.z.

qq. Plan Documents: The State Plan, Local Education Plan, and Local Government Plan Documents which govern coverage of services and eligibility under each plan.

rr. PPO: Preferred Provider Organization

ss. Public Sector Plans: Benefit plans sponsored by the State, Local Government, and Local Education Insurance Committees, including the Standard PPO, the Partnership PPO, the Limited PPO and any other benefit options, such as a CDHP with HSA or HRA, specified by the State.

tt. RFP: Request for Proposals.

uu. Section 508: Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d) and implementing regulations at 36 CFR 1194 Parts A-D requires that all Web site content be equally accessible to people with disabilities. This applies to Web applications, Web pages and all attached files. It applies to intranet as well as public-facing Web pages.

vv. Specialty Pharmacy: Medications and biologicals used in the treatment of complex clinical conditions. These agents require special handling and/or close supervision or clinical management and tend to be very expensive. They would meet at least two of the first four criteria (a thru D) below and the final criteria (E):

A.) Produced through DNA technology or biologic processes
B.) Targets a chronic and complex disease
C.) Route of administration could be inhaled, infused or injected
D.) Unique handling, distribution and/or administration requirements
E.) Requires a customized medication management program that includes medication use review, patient training, and coordination of care and adherence management for successful use such that more frequent monitoring and training is required.

ww. Spouse: Legally married spouse, as of date of marriage as defined in Chapter 3 of Title 36, *Tennessee Code Annotated*.

xx. State: The State of Tennessee.

yy. State, Local Government, and Local Education Insurance Committees: Policy making bodies for the State, Local Government, and Local Education plans established under *Tennessee Code Annotated* 8-27-101, 8-27-207, and 8-27-301 respectively.

zz. State Government Holidays: Days on which official holidays and commemorations as defined in *Tennessee Code Annotated* 15-1-101 *et seq*. are observed.

aaa. Subcontract: An agreement entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the State under the terms of this Contract, when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Contract.

bbb. Subcontractor: Any organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the State under the terms of this Contract.

ccc. Telecommunication Device for the Deaf (TDD): Special telephone devices with keyboard attachments for use by individuals with hearing impairments who are unable to use conventional phones. Also known as TTY.

A.26. Warranty. Contractor represents and warrants that throughout the Term of this Contract ("Warranty Period"), the goods or services provided under this Contract shall conform to the terms and conditions of this Contract. Any nonconformance of the goods or services to the terms and conditions of this Contract shall constitute a "Defect" and shall be considered "Defective." If Contractor receives notice of a Defect during the Warranty Period, then Contractor shall correct the Defect, at no additional charge.

Contractor represents and warrants that all goods or services provided under this Contract shall be provided in a timely and professional manner, by qualified and skilled individuals, in conformity with standards generally accepted in Contractor's industry.

If Contractor fails to provide the goods or services as warranted, then Contractor will re-provide the goods or services at no additional charge. If Contractor is unable or unwilling to re-provide the goods or services as warranted, then the State shall be entitled to recover the fees paid to Contractor for the Defective goods or services.

A.27. Inspection and Acceptance. The State shall have the right to inspect all goods or services provided by Contractor under this Contract. If, upon inspection, the State determines that the goods or services are Defective, the State shall notify Contractor, and Contractor shall re-deliver the goods or provide the services at no additional cost to the State. If after a period of thirty (30) days following delivery of goods or performance of services the State does not provide a notice of any Defects, the goods or services shall be deemed to have been accepted by the State.

B. TERM OF CONTRACT:

This Contract shall be effective on September 1, 2015, and extend for a period of eighty-four (84) months after the Effective Date ("Term"). The State shall have no obligation for goods or services provided by the Contractor prior to the Effective Date.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Forty-seven million, twenty-four thousand, and five hundred dollars ($47,024,500.00) ("Maximum Liability"). This Contract does not grant the Contractor any exclusive rights. The State does not guarantee that it will buy any minimum quantity of goods or services under this Contract. Subject to the terms and conditions of this Contract, the Contractor will only be paid for goods or services provided under this Contract after a purchase order is issued to Contractor by the State or as otherwise specified by this Contract.

C.2. Compensation Firm. The payment methodology in Section C.3. of this Contract shall constitute the entire compensation due the Contractor for all goods or services provided under this Contract regardless of the difficulty, materials or equipment required. The payment methodology includes all applicable taxes, fees, overhead, and all other direct and indirect costs incurred or to be incurred by the Contractor.

C.3. Payment Methodology. The Contractor shall be compensated based on the payment methodology for goods or services authorized by the State in a total amount as set forth in Section C.1

a. The Contractor's compensation shall be contingent upon the satisfactory provision of goods or services as set forth in Section A.

b. The Contractor shall be compensated based upon the following payment methodology:

(1) Total Enrollment Level-Based Fee.

TOTAL ENROLLMENT * LEVELS (**all** members, not just employees)	FEE PER EMPLOYEE PER MONTH (PEPM) BY CONTRACT PERIOD				
	January 1 – December 31, 2016	January 1 – December 31, 2017	January 1 – December 31, 2018	January 1 – December 31, 2019	January 1 – December 31, 2020
Below 10,000	$64.88	$67.37	$69.96	$72.65	$75.46
10,000 – 29,999	$48.57	$50.36	$52.22	$54.14	$56.14
30,000 – 49,000	$45.75	$47.03	$48.36	$49.73	$51.15
50,000 – 74,999	$40.57	$41.54	$42.54	$43.57	$44.62
75,000 – 99,999	$36.66	$37.45	$38.26	$39.09	$39.95
100,000 and above	$33.17	$33.81	$34.46	$35.12	$35.79

* "Total enrollment levels" reflects all members (i.e., all employees, retirees, and dependents) covered in all regions by the Contractor. January enrollment will be used to determine the enrollment-based fee level annually, and the fee level set in January of each year shall remain constant for the remainder of the calendar year. The sum of the PEPM and the number of employees (or heads of contract), not total enrollment levels; will generate the Contractor's total payment.

The Contractor shall be compensated based upon the following payment rates for optional Telemedicine/TeleHealth services implemented at the direction of the State:

(1) Total Enrollment Level Based Fee.

TOTAL ENROLLMENT * LEVELS (**all** members, not just employees)	FEE PER EMPLOYEE PER MONTH (PEPM) BY CONTRACT PERIOD				
	January 1 – December 31, 2016	January 1 – December 31, 2017	January 1 – December 31, 2018	January 1 – December 31, 2019	January 1 – December 31, 2020
Below 10,000	$0.00	$0.00	$0.00	$0.00	$0.00
10,000 – 29,999	$0.00	$0.00	$0.00	$0.00	$0.00
30,000 – 49,000	$0.00	$0.00	$0.00	$0.00	$0.00
50,000 – 74,999	$0.00	$0.00	$0.00	$0.00	$0.00
75,000 – 99,999	$0.00	$0.00	$0.00	$0.00	$0.00
100,000 and above	$0.00	$0.00	$0.00	$0.00	$0.00

* "Total enrollment levels" reflects all members (i.e., all employees, retirees, and dependents) covered in all regions by the Contractor. January enrollment will be used to determine the enrollment-based fee level annually, and the fee level set in January of each year shall remain constant for the remainder of the calendar year. The sum of the PEPM and the number of employees (or heads of contract), not total enrollment levels; will generate the Contractor's total payment.

Carriers will invoice the State based on enrollment as approved by the State.

c. The Contractor shall maintain an annual medical trend rate at or below six percent (6%). During any plan year, if the trend rises above six percent (6%) as calculated using allowed amounts for in-network claims incurred, the Contractor guarantees to reimburse the State or have withheld the percentage of administrative fees detailed in the table below.

	PERCENTAGE OF ADMINISTRATIVE FEES AT RISK			
	1/1/17 – 12/31/17	**1/1/18 – 12/31/18**	**1/1/19 – 12/31/19**	**1/1/2020 – 12/31/2020**
REGIONAL NETWORK TREND GUARANTEE	100%	100%	100%	100%

d. Claims Payments. The State will fund the Contractor for the total issue amount of the claims payments, net of cancellations, voids or other payment credit adjustments. Unless otherwise mutually agreed in writing by the parties, the Contractor shall notify the State of the funding amount required and the State will fund the Contractor at least weekly, provided that the Contractor's payment process includes timely settlement of ACH transactions. As the parties shall mutually agree in writing, the transfer of said funding to the Contractor for claims payments shall be effected weekly by either ACH debit from the Contractor to a designated State bank account; or wire transfer of funds to the Contractor's designated bank account.

(1) The Contractor acknowledges and agrees that since the State intends to fund payments at the time of issuance, the State will not maintain a separate bank

account or an escrow account with the Contractor or to otherwise pre-fund an account.

(2) The State reserves the right to review documentation either before or after the transfer of funding for claims payments and, as the State may deem appropriate, to adjust the funding amount to be transferred or withhold the amount of any overpaid funding from another funding transfer.

(3) The Contractor acknowledges that funding for Claims Payments shall be adjusted in full consideration of the Contract Scope of Service requirement that the Contractor shall identify and pursue claims that may be subject to coordination of benefits (COB); see Contract Section A.9.

e. The State shall reimburse the Contractor for the actual cost of the following in the performance of this Contract, provided that the Contractor provides documentation of actual costs incurred as required by the State.

(1) Postage. In a situation where unanticipated plan modifications would require notification to plan members that is not detailed in the terms and conditions of this Contract, the State may request the Contractor to produce and mail such notification to plan members. In such extreme situations, the State shall reimburse the Contractor only for the actual cost of postage for mailing materials produced at the specific direction of the State and authorized by the State.

(2) Printing / Production. The State shall reimburse the Contractor an amount equal to the actual net cost of document printing / production as required and authorized by the State as described in Contract Section C.3.d above. Additionally, if error(s) in member materials, approved by the State in writing, are detected after the materials have been mailed, the State will reimburse the Contractor for the production and postage cost of mailing the corrected version.

Notwithstanding the foregoing, the State retains the right to authorize the Contractor to deliver a product to be printed, approve and accept the product but not use the Contractor to print the material. In those situations, the State shall have the discretion to use other printing and production services at its disposal.

f. The State authorizes the Contractor to retain monies received through subrogation, on a per patient basis, of no more than 5% of the gross recoveries received. The Contractor may retain an additional 20% of the gross recoveries, when such recoveries are made by subrogation subcontractor(s). The Contractor's subrogation processes shall include the recovery of claims paid as a result of work related illnesses or injuries relative to worker's compensation claims.

g. During the term of this contract the average, aggregate reimbursement for all specialty drugs dispensed in a physician's office, hospital setting (outpatient), or any other setting (including but not limited to oncology clinics) shall not exceed:

CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
ASP + 38%	ASP + 38%	ASP + 36%	ASP + 36%	ASP + 33%

ASP = Average Sales Price as defined in A.25.

Compliance with the aggregate ASP+ percentage standard for the previous calendar year will be reconciled annually using the ASP drug pricing files from CMS and reported to the State in the ASP reconciliation report (see Contract Sections A.6.f and Contract Attachment

C, Reporting Requirements). The reconciliation shall be validated by the State's consulting actuary and all monies exceeding the above limits will be payable to the State by the Contractor within thirty (30) days of state notification.

h. Value Oriented Payments. The State shall reimburse the Contractor the costs resulting from any State approved value oriented initiatives.

C.4. Travel Compensation. The Contractor shall not be compensated or reimbursed for travel time, travel expenses, meals, or lodging.

C.5. Invoice Requirements. The Contractor shall invoice the State only for goods delivered and accepted by the State or services satisfactorily provided at the amounts stipulated in Section C.3., above. Contractor shall submit invoices and necessary supporting documentation, no more frequently than once a month, and no later than thirty (30) days after goods or services have been provided to the following address:

Sylvia Chunn, Procurement & Contracting Manager
Tennessee Department of Finance & Administration
Benefits Administration Division
William R. Snodgrass Tennessee Tower
312 Rosa L. Parks Avenue, 19th Floor
Nashville, Tennessee 37243

a. Each invoice, on Contractor's letterhead, shall clearly and accurately detail all of the following information (calculations must be extended and totaled correctly):

(1) Invoice number (assigned by the Contractor);
(2) Invoice date;
(3) Contract number (assigned by the State);
(4) Customer account name: Finance and Administration & Benefits Administration;
(5) Customer account number (assigned by the Contractor to the above-referenced Customer);
(6) Contractor name;
(7) Contractor Tennessee Edison registration ID number;
(8) Contractor contact for invoice questions (name, phone, or email);
(9) Contractor remittance address;
(10) Description of delivered goods or services provided and invoiced, including identifying information as applicable;
(11) Number of delivered or completed units, increments, hours, or days as applicable, of each good or service invoiced;
(12) Applicable payment methodology (as stipulated in Section C.3.) of each good or service invoiced;
(13) Amount due for each compensable unit of good or service; and
(14) Total amount due for the invoice period.

b. Contractor's invoices shall:

(1) Only include charges for goods delivered or services provided as described in Section A and in accordance with payment terms and conditions set forth in Section C;
(2) Only be submitted for goods delivered or services completed and shall not include any charge for future goods to be delivered or services to be performed;
(3) Not include Contractor's taxes, which includes without limitation Contractor's sales and use tax, excise taxes, franchise taxes, real or personal property taxes, or income taxes; and
(4) Include shipping or delivery charges only as authorized in this Contract.

c. The timeframe for payment (or any discounts) begins only when the State is in receipt of an invoice that meets the minimum requirements of this Section C.5.

C.6. Payment of Invoice. A payment by the State shall not prejudice the State's right to object to or question any payment, invoice, or other matter. A payment by the State shall not be construed as acceptance of goods delivered, any part of the services provided, or as approval of any amount invoiced.

C.7. Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment that is determined by the State, on the basis of audits conducted in accordance with the terms of this Contract, to not constitute proper compensation for goods delivered or services provided.

C.8. Deductions. The State reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under this or any Contract between the Contractor and the State of Tennessee any amounts which are or shall become due and payable to the State of Tennessee by the Contractor.

C.9. Prerequisite Documentation. The Contractor shall not invoice the State under this Contract until the State has received the following, properly completed documentation.

a. The Contractor shall complete, sign, and present to the State an "Authorization Agreement for Automatic Deposit Form" provided by the State. By doing so, the Contractor acknowledges and agrees that, once this form is received by the State, all payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee, shall be made by automated clearing house.

b. The Contractor shall complete, sign, and present to the State a "Substitute W-9 Form" provided by the State. The taxpayer identification number in the Substitute W-9 Form must be the same as the Contractor's Federal Employer Identification Number or Tennessee Edison Registration ID.

D. MANDATORY TERMS AND CONDITIONS:

D.1. Required Approvals. The State is not bound by this Contract until it is duly approved by the Parties and all appropriate State officials in accordance with applicable Tennessee laws and regulations. Depending upon the specifics of this Contract, this may include approvals by the Commissioner of Finance and Administration, the Commissioner of Human Resources, the Comptroller of the Treasury, and the Chief Procurement Officer. Approvals shall be evidenced by a signature or electronic approval.

D.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. All communications, regardless of method of transmission, shall be addressed to the respective Party at the appropriate mailing address, facsimile number, or email address as stated below or any other address provided in writing by a Party.

The State:

Sylvia D. Chunn, Procurement and Contracting Manager
Finance and Administration, Division of Benefits Administration
William R. Snodgrass TN Tower, 19th Floor
312 Rosa L. Parks Ave., N

Nashville, TN 37243
Sylvia.Chunn@tn.gov
Telephone # 615-253-8358
FAX # 615-253-8556

The Contractor:

Timothy Cullen, Account Executive
CIGNA Health and Life Insurance Company
1000 Corporate Centre Drive, Ste 500
Franklin, TN 37067
Timothy.Cullen@Cigna.com
Telephone # 615.595.3382
FAX # 615.595.3287

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

D.3. Modification and Amendment. This Contract may be modified only by a written amendment signed by all parties and approved by all applicable State officials.

D.4. Subject to Funds Availability. The Contract is subject to the appropriation and availability of State or federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate this Contract upon written notice to the Contractor. The State's exercise of its right to terminate this Contract shall not constitute a breach of Contract by the State. Upon receipt of the written notice, the Contractor shall cease all work associated with the Contract. If the State terminates this Contract due to lack of funds availability, the Contractor shall be entitled to compensation for all conforming goods requested and accepted by the State and for all satisfactory and authorized services completed as of the termination date. Should the State exercise its right to terminate this Contract due to unavailability of funds, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages of any description or amount.

D.5. Termination for Convenience. The State may terminate this Contract for convenience without cause and for any reason. The State shall give the Contractor at least thirty (30) days written notice before the termination date. The Contractor shall be entitled to compensation for all conforming goods delivered and accepted by the State or for satisfactory, authorized services completed as of the termination date. In no event shall the State be liable to the Contractor for compensation for any goods neither requested nor accepted by the State or for any services neither requested by the State nor satisfactorily performed by the Contractor. In no event shall the State's exercise of its right to terminate this Contract for convenience relieve the Contractor of any liability to the State for any damages or claims arising under this Contract.

D.6. Termination for Cause. If the Contractor fails to properly perform its obligations under this Contract, or if the Contractor materially violates any terms of this Contract ("Breach Condition"), the State shall provide written notice to Contractor specifying the Breach Condition. If within thirty (30) days of notice, the Contractor has not cured the Breach Condition, the State may terminate the Contract and withhold payments in excess of compensation for completed services or provided goods. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any breach of this Contract by the Contractor and the State may seek other remedies allowed at law or in equity for breach of this Contract.

a. This opportunity to "cure" shall not apply to circumstances in which the Contractor intentionally withholds its services or otherwise refuses to perform. The State will not consider a request to cure contract performance where there have been repeated problems with respect to identical or similar issues, or if a cure period would cause a

delay that would impair the effectiveness of State operations. In circumstances where an opportunity to cure is not available, termination will be effective immediately.

D.7. Assignment and Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the goods or services provided under this Contract without the prior written approval of the State. Notwithstanding any use of the approved subcontractors, the Contractor shall be the prime contractor and responsible for compliance with all terms and conditions of this Contract. The State reserves the right to request additional information or impose additional terms and conditions before approving an assignment of this Contract in whole or in part or the use of subcontractors in fulfilling the Contractor's obligations under this Contract.

D.8. Conflicts of Interest. The Contractor warrants that no part of the Contractor's compensation 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 Contractor in connection with any work contemplated or performed relative to this Contract.

The Contractor acknowledges, understands, and agrees that this Contract shall be null and void if the Contractor is, or within the past six (6) months has been, an employee of the State of Tennessee or if the Contractor is an entity in which a controlling interest is held by an individual who is, or within the past six (6) months has been, an employee of the State of Tennessee.

D.9. 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.

D.10. Prohibition of Illegal Immigrants. The requirements of Tenn. Code Ann. § 12-3-309 addressing the use of illegal immigrants in the performance of any Contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.

a. The Contractor hereby agrees that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document at Contract Attachment A, hereto, semi-annually during the Term. If the Contractor is a party to more than one contract with the State, the Contractor may submit one attestation that applies to all contracts with the State. All Contractor attestations shall be maintained by the Contractor and made available to state officials upon request.

b. Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the Term, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work under this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work under this Contract. Attestations obtained from such subcontractors shall be maintained by the Contractor and made available to state officials upon request.

c. The Contractor shall maintain records for all personnel used in the performance of this Contract. Contractor's records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.

d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Tenn. Code Ann. § 12-3-309 for acts or omissions occurring after its effective date.

e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not : (i) a United States citizen; (ii) a Lawful Permanent Resident; (iii) a person whose physical presence in the United States is authorized; (iv) allowed by the federal Department of Homeland Security and who, under federal immigration laws or regulations, is authorized to be employed in the U.S.; or (v) is otherwise authorized to provide services under the Contract.

D.11. Records. The Contractor shall maintain documentation for all charges under this Contract. The books, records, and documents of the Contractor, for work performed or money received under this Contract, shall be maintained for a period of five (5) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.12. Monitoring. The Contractor's activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

D.13. Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.

D.14. Strict Performance. Failure by any Party to this Contract to require, in any one or more cases, the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the Parties.

D.15. Independent Contractor. The parties shall not act as employees, partners, joint venturers, or associates of one another. The Parties are independent contracting entities. Nothing in this Contract shall be construed to create an employer/employee relationship or to allow either Party 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 are not employees or agents of the other Party.

D.16. Patient Protection and Affordable Care Act. The Contractor agrees that it will be responsible for compliance with the Patient Protection and Affordable Care Act ("PPACA") with respect to itself and its employees, including any obligation to report health insurance coverage, provide health insurance coverage, or pay any financial assessment, tax, or penalty for not providing health insurance. The Contractor shall indemnify the State and hold it harmless for any costs to the State arising from Contractor's failure to fulfill its PPACA responsibilities for itself or its employees.

D.17. Limitation of State's Liability. The State shall have no liability except as specifically provided in this Contract. In no event will the State be liable to the Contractor or any other party for any lost revenues, lost profits, loss of business, decrease in the value of any securities or cash position, time, money, goodwill, or any indirect, special, incidental, punitive, exemplary or consequential damages of any nature, whether based on warranty, contract, statute, regulation, tort (including but not limited to negligence), or any other legal theory that may arise under this Contract or otherwise. The State's total liability under this Contract (including any exhibits, schedules, amendments or other attachments to the Contract) or otherwise shall under no circumstances exceed the Maximum Liability. This limitation of liability is cumulative and not per incident.

D.18. Limitation of Contractor's Liability. In accordance with Tenn. Code Ann. § 12-3-701, the Contractor's liability for all claims arising under this Contract shall be limited to an amount equal to two (2) times the Maximum Liability amount detailed in Section C.1. and as may be amended, PROVIDED THAT in no event shall this Section limit the liability of the Contractor for intentional torts, criminal acts, fraudulent conduct, or omissions that result in personal injuries or death.

D.19. Hold Harmless. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Contractor, its employees, or any person acting for or on its or their behalf relating to this Contract. The Contractor further agrees it shall be liable for the reasonable cost of attorneys for the State to enforce the terms of this Contract.

In the event of any suit or claim, the Parties shall give each other immediate notice and provide all necessary assistance to respond. The failure of the State to give notice shall only relieve the Contractor of its obligations under this Section to the extent that the Contractor can demonstrate actual prejudice arising from the failure to give notice. This Section shall not grant the Contractor, through its attorneys, the right to represent the State in any legal matter, as the right to represent the State is governed by Tenn. Code Ann. § 8-6-106.

D.20. HIPAA and HITECH Compliance. The State and Contractor 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 under the American Recovery and Reinvestment Act of 2009 (ARRA) and their accompanying regulations, as well as any other relevant laws and regulations regarding privacy.

a. Contractor warrants to the State that it is familiar with the requirements of HIPAA and HITECH and their accompanying regulations, and shall comply with all applicable HIPAA and HITECH requirements in the course of this Contract including but not limited to the following:

(1) Compliance with the Privacy Rule, Security Rule, Notification Rule;
(2) The creation of and adherence to sufficient Privacy and Security Safeguards and Policies;
(3) Timely Reporting of Violations in Use and Disclosure of PHI; and
(4) Time Reporting of Security Incidents.

b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and HITECH and its regulations, in the course of performance of the Contract so that both parties will be in compliance with HIPAA and HITECH.

c. The Contractor agrees that its duties under this contract qualify it as a "business associate" of the State as that term is defined under HIPAA. Contractor will sign the State's business associate agreement, which is attached as Attachment E. The State, in its discretion may, accept changes to the business associate agreement if it finds that such changes are appropriate, or may determine that HIPAA does not require a business associate agreement.

d. The Contractor will indemnify the State and hold it harmless for any violation by the Contractor or its subcontractors of HIPAA and HITECH as well as any other relevant laws and regulations regarding privacy. 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. The Contractor may also be liable for damages for failure to comply with this section, including any applicable liquidated damages set forth in Attachment B.

D.21. Tennessee Consolidated Retirement System. Subject to statutory exceptions contained in Tenn. Code Ann. §§ 8-36-801, *et seq.*, the law governing the Tennessee Consolidated Retirement System ("TCRS"), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established under Tenn. Code Ann. §§ 8-35-101, *et seq.*, accepts State employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this Contract is that of "employee/employer" and not that of an independent contractor, the Contractor, if a retired member of TCRS, may be required to repay to TCRS the amount of retirement benefits the Contractor received from TCRS during the Term.

D.22. Tennessee Department of Revenue Registration. The Contractor shall comply with all applicable registration requirements contained in Tenn. Code Ann. §§ 67-6-601 – 608. Compliance with applicable registration requirements is a material requirement of this Contract.

D.23. Debarment and Suspension. The Contractor 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 offense 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 Contractor 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 or disqualified.

D.24. Force Majeure. "Force Majeure Event" means fire, flood, earthquake, elements of nature or acts of God, wars, riots, civil disorders, rebellions or revolutions, acts of terrorism or any other similar cause beyond the reasonable control of the Party except to the extent that the non-performing Party is at fault in failing to prevent or causing the default or delay, and provided that the default or delay cannot reasonably be circumvented by the non-performing Party through the use of alternate sources, workaround plans or other means. A strike, lockout or labor dispute shall not excuse either Party from its obligations under this Contract. Except as set forth in this Section, any failure or delay by a Party in the performance of its obligations under this Contract arising from a Force Majeure Event is not a default under this Contract or grounds for termination. The non-performing Party will be excused from performing those obligations directly affected by the Force Majeure Event, and only for as long as the Force Majeure Event continues, provided that the Party continues to use diligent, good faith efforts to resume performance without delay. The

occurrence of a Force Majeure Event affecting Contractor's representatives, suppliers, subcontractors, customers or business apart from this Contract is not a Force Majeure Event under this Contract. Contractor will promptly notify the State of any delay caused by a Force Majeure Event (to be confirmed in a written notice to the State within one (1) day of the inception of the delay) that a Force Majeure Event has occurred, and will describe in reasonable detail the nature of the Force Majeure Event. If any Force Majeure Event results in a delay in Contractor's performance longer than forty-eight (48) hours, the State may, upon notice to Contractor: (a) cease payment of the fees until Contractor resumes performance of the affected obligations; or (b) immediately terminate this Contract or any purchase order, in whole or in part, without further payment except for fees then due and payable. Contractor will not increase its charges under this Contract or charge the State any fees other than those provided for in this Contract as the result of a Force Majeure Event.

D.25. State and Federal Compliance. The Contractor shall comply with all applicable State and Federal laws and regulations in the performance of this Contract.

D.26. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Tennessee Claims Commission or the state or federal courts in Tennessee shall be the venue for all claims, disputes, or disagreements arising under this Contract. The Contractor acknowledges and agrees that any rights, claims, or remedies against the State of Tennessee or its employees arising under this Contract shall be subject to and limited to those rights and remedies available under Tenn. Code Ann. §§ 9-8-101 - 407.

D.27. Entire Agreement. This Contract is complete and contains the entire understanding between the parties relating to its subject matter, 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.28. 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 of this Contract shall not be affected and shall remain in full force and effect. The terms and conditions of this Contract are severable.

D.29. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

D.30. Incorporation of Additional Documents. Each of the following documents is included as a part of this Contract by reference. In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this Contract, these items shall govern in order of precedence below:

a. any amendment to this Contract, with the latter in time controlling over any earlier amendments;
b. this Contract with any attachments or exhibits (excluding the items listed at subsections c. through f., below);
c. any clarifications of or addenda to the Contractor's proposal seeking this Contract;
d. the State solicitation, as may be amended, requesting responses in competition for this Contract;
e. any technical specifications provided to proposers during the procurement process to award this Contract; and,
f. the Contractor's response seeking 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. Insurance. The Contractor shall carry adequate liability and other appropriate forms of insurance.

a. The Contractor shall maintain, at minimum, the following insurance coverage:

(1) Workers' Compensation/ Employers' Liability (including all states coverage) with a limit not less than the relevant statutory amount or one million dollars ($1,000,000) per occurrence for employers' liability whichever is greater.

(2) Comprehensive Commercial General Liability (including personal injury & property damage, premises/operations, independent contractor, contractual liability and completed operations/products) with a bodily injury/property damage combined single limit not less than one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) aggregate.

(3) Automobile Coverage (including owned, leased, hired, and non-owned vehicles) with a bodily injury/property damage combined single limit not less than one million dollars ($1,000,000) per occurrence.

(4) Errors and Omission Coverage with a limit of not less than one million dollars ($1,000,000) per claim and two million dollars ($2,000,000) aggregate.

b. The Contractor shall provide a valid Certificate of Insurance naming the State as an additional insured and detailing Coverage Description; Insurance Company & Policy Number; Exceptions and Exclusions; Policy Effective Date; Policy Expiration Date; Limit(s) of Liability; and Name and Address of Insured. Contractor shall obtain from Contractor's insurance carrier(s) and will deliver to the State waivers of the subrogation rights under the respective policies. Failure to provide required evidence of insurance coverage shall be a material breach of this Contract.

E.3. 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 Contractor by the State or acquired by the Contractor on behalf of the State that is regarded as confidential under state or federal law shall be regarded as "Confidential Information." Nothing in this Section shall permit Contractor to disclose any Confidential Information, regardless of whether it has been disclosed or made available to the Contractor due to intentional or negligent actions or inactions of agents of the State or third parties. Confidential Information shall not be disclosed except as required or permitted under state or federal law. Contractor shall take all necessary steps to safeguard the confidentiality of such material or information in conformance with applicable state and federal law.

The obligations set forth in this Section shall survive the termination of this Contract.

E.4. Ownership of Software and Work Products.

a. Definitions.

(1) "Contractor-Owned Software," shall mean commercially available software the rights to which are owned by Contractor, including but not limited to commercial "off-the-shelf" software which is not developed using State's money or resources.

(2) "Custom-Developed Application Software," shall mean customized application software developed by Contractor solely for State.

(3) "Rights Transfer Application Software," shall mean any pre-existing application software owned by Contractor or a third party, provided to State and to which Contractor will grant and assign, or will facilitate the granting and assignment of, all rights, including the source code, to State.

(4) "Third-Party Software," shall mean software not owned by the State or the Contractor.

(5) "Work Product," shall mean all deliverables exclusive of hardware, such as software, software source code, documentation, planning, etc., that are created, designed, developed, or documented by the Contractor exclusively for the State during the course of the project using State's money or resources, including Custom-Developed Application Software. If the deliverables under this Contract include Rights Transfer Application Software, the definition of Work Product shall also include such software. Work Product shall not include Contractor-Owned Software or Third-Party Software.

b. Rights and Title to the Software

(1) All right, title and interest in and to the Contractor-Owned Software shall at all times remain with Contractor, subject to any license granted under this Contract.

(2) All right, title and interest in and to the Work Product, and to modifications thereof made by State, including without limitation all copyrights, patents, trade secrets and other intellectual property and other proprietary rights embodied by and arising out of the Work Product, shall belong to State. To the extent such rights do not automatically belong to State, Contractor hereby assigns, transfers, and conveys all right, title and interest in and to the Work Product, including without limitation the copyrights, patents, trade secrets, and other intellectual property rights arising out of or embodied by the Work Product. Contractor and its employees, agents, contractors or representatives shall execute any other documents that State or its counsel deem necessary or desirable to document this transfer or allow State to register its claims and rights to such intellectual property rights or enforce them against third parties.

(3) All right, title and interest in and to the Third-Party Software shall at all times remain with the third party, subject to any license granted under this Contract.

c. The Contractor may use for its own purposes the general knowledge, skills, experience, ideas, concepts, know-how, and techniques obtained and used during the course of performing under this Contract. The Contractor may develop for itself, or for others, materials which are similar to or competitive with those that are produced under this Contract.

E.5. State Furnished Property. The Contractor shall be responsible for the correct use, maintenance, and protection of all articles of nonexpendable, tangible, personal property furnished by the State for the Contractor's temporary use under this Contract. Upon termination of this Contract, all property furnished shall be returned to the State in good order and condition as when received, reasonable use and wear thereof excepted. Should the property be destroyed, lost, or stolen, the Contractor shall be responsible to the State for the residual value of the property at the time of loss.

E.6. Contractor Commitment to Diversity. The Contractor shall comply with and make reasonable business efforts to exceed the commitment to diversity represented by the Contractor's proposal responding to RFP # 317816-00104 (Attachment 6.2 Section B.15) and resulting in this Contract.

The Contractor shall assist the State in monitoring the Contractor's performance of this commitment by providing, as requested, a quarterly report of participation in the performance of this Contract by small business enterprises and businesses owned by minorities, women, and persons with a disability. Such reports shall be provided to the state of Tennessee Governor's Office of Business Diversity Enterprise in form and substance as required by said office.

E.7. Breach. A party shall be deemed to have breached the Contract if any of the following occurs:

— failure to perform in accordance with any term or provision of the Contract;
— partial performance of any term or provision of the Contract;
— any act prohibited or restricted by the Contract, or
— violation of any warranty.

For purposes of this Contract, these items shall hereinafter be referred to as a "Breach."

a. Contractor Breach— The State shall notify Contractor in writing of a Breach.

(1) In event of a Breach by Contractor, the State shall have available the remedy of Actual Damages and any other remedy available at law or equity.

(2) Liquidated Damages— In the event of a Breach, the State may assess Liquidated Damages as detailed in Contract Attachment B. The State shall notify the Contractor of amounts to be assessed as Liquidated Damages. 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 Breach by Contractor as said amounts are likely to be uncertain and not easily proven. Contractor hereby represents and covenants it has carefully reviewed the Liquidated Damages contained in above referenced Contract Attachment B and agree that said amounts represent a reasonable relationship between the amount and what might reasonably be expected in the event of Breach, and are a reasonable estimate of the damages that would occur from a Breach. It is hereby agreed between the parties that the Liquidated Damages represent solely the damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party. The Contractor agrees that the liquidated damage amount is in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or other section of this Contract.

The State may continue to withhold the Liquidated Damages or a portion thereof until the Contractor cures the Breach, the State exercises its option to declare a Partial Default, or the State terminates the Contract. The State is not obligated to assess Liquidated Damages before availing itself of any other remedy. The State may choose to discontinue Liquidated Damages and avail itself of any other remedy available under this Contract or at law or equity; provided, however, Contractor shall receive a credit for said Liquidated Damages previously withheld except in the event of a Partial Default.

The State may conduct "secret shopper" and other monitoring activities during the operation of this Contract. The State may also assess liquidated damages for breaches of contract that it discovers during these and other activities as detailed in Contract Attachment B.

(3) Partial Default— In the event of a Breach, the State may declare a Partial Default. In which case, the State shall provide the Contractor written notice of: (1) the date which Contractor shall terminate providing the service associated with the Breach; and (2) the date the State will begin to provide the service

associated with the Breach. The Notice of Partial Default and termination of services associated with the Breach shall advise the Contractor whether the State will provide an opportunity to cure. Notwithstanding the foregoing, the State may revise the time periods contained in the notice written to the Contractor.

In the event the State declares a Partial Default, the State may withhold, together with any other damages associated with the Breach, from the amounts due the Contractor the greater of: (1) amounts which would be paid the Contractor to provide the defaulted service; or (2) the cost to the State of providing the defaulted service, whether said service is provided by the State or a third party. To determine the amount the Contractor is being paid for any particular service, the Department shall be entitled to receive within five (5) days any requested material from Contractor. The State shall make the final and binding determination of said amount.

The State may assess Liquidated Damages against the Contractor for any failure to perform which ultimately results in a Partial Default with said Liquidated Damages to cease when said Partial Default is effective. Upon Partial Default, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount. Contractor agrees to cooperate fully with the State in the event a Partial Default is taken.

(4) Contract Termination— In the event of a Breach, the State may terminate the Contract immediately or in stages. The Contractor shall be notified of the termination in writing by the State. Said notice shall hereinafter be referred to as Termination Notice. The Termination Notice may specify either that the termination is to be effective immediately, on a date certain in the future, or that the Contractor shall cease operations under this Contract in stages. In the event of a termination, the State may withhold any amounts which may be due Contractor without waiver of any other remedy or damages available to the State at law or at equity. The Contractor shall be liable to the State for any and all damages incurred by the State and any and all expenses incurred by the State which exceed the amount the State would have paid Contractor under this Contract. Contractor agrees to cooperate with the State in the event of a Contract Termination or Partial Takeover.

The Termination Notice must (1) specify in reasonable detail the nature of the Breach; (2) provide Contractor with an opportunity to cure, which shall be no less than 30 days from the date of the Termination Notice; (3) shall specify the effective date of termination in the event Contractor fails to correct the Breach. The Contractor shall present the State with a written request detailing the efforts it will take to resolve the problem. This opportunity to "cure" shall not apply to circumstances in which the Contractor intentionally withholds its services or otherwise refuses to perform. The State will not consider a request to cure contract performance where there have been repeated problems with respect to identical or similar issues, or if a cure period would cause a delay that would impair the effectiveness of State operations.

b. State Breach— In the event of a Breach of Contract by the State, the Contractor shall notify the State in writing within 30 days of any Breach of Contract by the State. Said notice shall contain a description of the Breach. Failure by the Contractor to provide said written notice shall operate as an absolute waiver by the Contractor of the State's Breach. In no event shall any Breach on the part of the State excuse the Contractor from full performance under this Contract. In the event of Breach by the State, the Contractor

may avail itself of any remedy at law in the forum with appropriate jurisdiction; provided, however, failure by the Contractor to give the State written notice and opportunity to cure as described herein operates as a waiver of the State's Breach. Failure by the Contractor to file a claim before the appropriate forum in Tennessee with jurisdiction to hear such claim within one (1) year of the written notice of Breach shall operate as a waiver of said claim in its entirety. It is agreed by the parties this provision establishes a contractual period of limitations for any claim brought by the Contractor.

E.8. Overpayments. The Contractor shall have responsibility for overpayments to its providers resulting from the negligent, reckless, or willful acts or omissions of the Contractor, its officers, agents or employees, regardless of whether or not such overpayments can be recovered by the Contractor. The Contractor shall repay the State the amount of any such overpayment within thirty (30) calendar days of discovery of the overpayment. Overpayments due to provider fraud or fraud of any other type, other than fraud by employees or agents of the Contractor, will not be considered overpayments for purposes of this Section. The Contractor shall assist in identifying fraud and make reasonable efforts, in consultation with the State, to recover overpayments due to fraud.

E.9. Confidential and Proprietary Information. The State agrees to protect, to the fullest extent permitted by state law, the confidentiality of information expressly identified by the Contractor as confidential and proprietary, including information that would allow a person to obtain unauthorized access to confidential information or to electronic information processing systems owned by or licensed to the State.

E.10. 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 and/or procure 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 twenty-four (24) 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.

IN WITNESS WHEREOF,

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

10/20/15

CONTRACTOR SIGNATURE **DATE**

RICHARD NOVACK, PRESIDENT, GENERAL MANAGER

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

STATE OF TENNESSEE,
STATE INSURANCE COMMITTEE,
LOCAL EDUCATION INSURANCE COMMITTEE,
LOCAL GOVERNMENT INSURANCE COMMITTEE:

11/3/15

LARRY B. MARTIN, COMMISSIONER **DATE**

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	47414
CONTRACTOR LEGAL ENTITY NAME:	**Cigna Health and Life Insurance**
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	[redacted]

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

CONTRACTOR SIGNATURE

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. If said individual is not the chief executive or president, this document shall attach evidence showing the individual's authority to contractually bind the Contractor.

Richard Novack, President & General Manager

PRINTED NAME AND TITLE OF SIGNATORY

10/20/2015

DATE OF ATTESTATION

PERFORMANCE GUARANTEES AND LIQUIDATED DAMAGES

To effectively manage contractual performance, the State has established performance guarantees to evaluate the Contractor's obligations with respect to the Contract(s) (where the Contractor has been awarded multiple regional contracts). The Contractor is expected to perform according to a certain level of standards. If these standards are not met, the State is entitled to impose liquidated damage assessments. The list of Performance Guarantees and associated Liquidated Damages are included in this Attachment.

1. **Performance Reporting:** The Contractor shall develop a Performance Report Card as a means to measure compliance on a quarterly basis. The Contractor shall provide the quarterly performance report card in a manner acceptable to the State, on or before the 20th day of the month following the reporting quarter. Supporting documentation used to calculate the performance guarantees shall be provided with the Performance Report Card. The Performance Report Card shall include cumulative data over the life of the contract. Performance reporting shall be consolidated as one report for all regional contracts awarded to the Contractor.

2. **Payment of Liquidated Damages:** It is agreed by the State and the Contractor that any liquidated damages assessed by the State shall be due and payable to the State within forty-five (45) calendar days after Contractor receipt of the Invoice containing an assessment of liquidated damages. If payment is not made by the due date, said liquidated damages may be withheld from future payments by the State without further notice.

3. **Maximum Assessment:** The maximum amount of Liquidated Damages payable over any twelve (12) month period shall not exceed twenty percent (20%) of the annual fixed price billings. In the event that a single occurrence subjects the Contractor to Liquidated Damages in multiple subsections of this provision, the State is entitled to assess a single Liquidated Damage selected at the discretion of the State.

4. **Waiver of Liquidated Damages:** The State, in its sole discretion, may elect not to assess Liquidated Damages against the Contractor in certain instances, including but not limited to the following:

    a. Where the State determines that only inconsequential damage has occurred, unless the deficiency is part of a recurring or frequent pattern of deficiency, with regard to one (1) or more Contract deliverables or requirements

    b. For performance measures that are resolved based on the Contractor's corrective action plan

    c. If the failure is not due to Contractor fault (i.e. caused by factors beyond the reasonable control and without any material error or negligence of the Contractor, its staff or subcontractors)

    d. Where no damage or injury has been sustained by the State or its members

    e. Where the failure does not result in increased Contract management time or expense

    f. Where the failure results from the State's failure to perform

    g. For other reasons at the State's sole discretion

5. **Performance Guarantees:** In the event that the Contractor has failed to meet a performance guarantee that is set out in the Contract, but for which the Liquidated Damage standards are not spelled out in this Attachment, the State may assess liquidated damages at the rate of five hundred dollars ($500.00) per business day until the guarantee has been met.

6. The Contractor shall pay to the State the indicated total dollar assessment upon notification by the State that an amount is due, through the term of this Contract.

7. Performance guarantees shall be measured specific to the Public Sector Plans. If prior approved by the State in writing, they may be measured on the Contractor's book of business.

PERFORMANCE GUARANTEES	
1. Implementation Plan	
Guarantee	The Contractor shall provide a project implementation plan that meets the requirements of Contract Section A.2.e. to the State no later than thirty (30) days after the contract start date.
Assessment	Five hundred dollars ($500) for each day beyond the deadline that the plan is not provided to the State.
Measurement	Measured, reported, reconciled and paid no later than three (3) months after the go-live date.
2. Operational Readiness	
Guarantee	The Contractor shall resolve all findings identified by the State during its operational readiness review, as required in Contract Section A.2., prior to the go-live date.
Assessment	One thousand dollars ($1,000) per finding if the issue is not resolved prior to go-live.
Measurement	Measured, reported reconciled and paid no later than three (3) months after the go-live date.
3. Edison System Interface	
Guarantee	Contractor's interface with the Edison System shall be fully operational by the date specified in Contract Section A.24.
Assessment	Five thousand dollars ($5,000) per day, for every day beyond the deadline that the interface is not fully operational.
Measurement	Measured and reported beginning the day after the date specified in Contract Section A.24 and continuing – as necessary – until the interface is fully operational. (Reconciled and paid upon final recognition of operational status.)
4. Call Center and Other Systems Operational	
Guarantee	The Contractor's call center and other systems shall be fully operational no later than the date specified in Contract Section A.24.
Assessment	Ten thousand dollars ($10,000) for every day beyond the deadline that the call center or other system is not operational.
Measurement	Measured, reported, reconciled and paid no later than three (3) months after the go-live date.
5. Program Go-Live Date	
Guarantee	All medical claims administrative services for the Public Sector Plans shall take effect (*i.e.*, "go-live") and be fully operational on the go-live date specified in Contract Section A.24.
Assessment	Twenty thousand dollars ($20,000) for every day beyond the deadline that medical claims administrative services are not fully operational.
Measurement	Measured, reported, reconciled and paid no later than three (3) months after the go-live date.
6. Plan Design	

Guarantee	The Contractor shall correctly adjudicate claims in accordance with the plan design.
Assessment	One hundred dollars ($100) per occurrence (defined as an individual claim) plus the actual costs incurred of the incorrectly-processed claim.
Measurement	Measured, reported, reconciled and paid after each occurrence.
7. **Average Speed of Answer**	
Guarantee	The Contractor's call center shall maintain a daily average speed of answer of 30 seconds.
Assessment	Four hundred dollars ($400) for each day the guarantee is not met (include all hours the call center is open).
Measurement	The average shall be calculated using the following formula for each hour the call center is open: Total wait time for all callers (in seconds) / Total number of callers Measured, reported, reconciled and paid monthly
8. **Website**	
Guarantee	The Contractor's website for the Public Sector Plans shall be available on the internet and fully operational, with the exception of member data/Protected Health Information on or before the date specified in Contract Section A.24.
Assessment	One thousand dollars ($1,000) per day that the guarantee is not met.
Measurement	Measured, reported, reconciled and paid no later than three (3) months after the go-live date.
9. **Initial Welcome Packet Distribution**	
Guarantee	Ninety-seven percent (97%) of welcome packets, containing ID cards and member handbooks, shall be produced and mailed no later than twenty-one (21) days prior to the go-live date.
Assessment	Ten thousand dollars ($10,000) if the guarantee is not met.
Measurement	Measured, reported, reconciled and paid no later than three months after the go-live date.
10. **Distribution of Ongoing Welcome Packet**	
Guarantee	Ninety-seven percent (97%) of new member welcome packets shall be produced and mailed within ten (10) days of receipt of complete and accurate eligibility information
Assessment	Five thousand dollars ($5,000) per year in which the guarantee is not met.
Measurement	Measured, reported, reconciled and paid annually.
11. **Member Satisfaction Survey**	
Guarantee	The level of overall customer satisfaction, as measured annually by the CAHPS Member Satisfaction survey(s) required by Contract Section A.12., shall be equal to or greater than eighty-five percent (85%) in the first year of the Contract, and shall be equal to or greater than ninety percent (90%) in all subsequent year(s) within the contract term.
Assessment	Ten thousand dollars ($10,000) for each year that the guarantee is not met.

Measurement	Measured, reported, reconciled and paid annually.	
12. **Appeal Decisions**		
Guarantee	Ninety-five percent (95%) of non-urgent pre-service appeals shall be decided within thirty (30) days, ninety-five percent (95%) of post-service appeals within sixty (60) days, and one hundred percent (100%) of expedited appeals, not involving a third party review, shall be decided within seventy-two (72) hours. In the event that the Contractor requires an external medical consultation, the timeframe shall be extended from seventy-two (72) hours to seven (7) calendar days.	
Assessment	Five thousand dollars ($5,000) if any of the above guarantees are not met.	
Measurement	Measured, reported, reconciled and paid annually.	
13. **Plan Changes**		
Guarantee	Unless otherwise directed by the State, the Contractor shall correctly implement any plan design changes within sixty (60) days of written notification from the State.	
Assessment	One thousand dollars ($1,000) per day if the guarantee is not met.	
Measurement	Measured, reported, reconciled and paid after each occurrence.	
14. **Member Notice of Provider Termination**		
Guarantee	The Contractor shall provide written notice to members regarding terminated hospitals and physician groups, as specified in Contract Section A.3.	
Assessment	Five thousand dollars ($5,000) per occurrence (defined as each provider termination) if the guarantee is not met.	
Measurement	Measured, reported, reconciled and paid after each occurrence.	
15. **Regional Provider/Facility Network Accessibility**		
Guarantee	As measured by the GeoNetworks® Provider & Facility Network Accessibility Analysis, the Contractor's regional provider and facility network shall assure that 95% of all State, Local Education, and Local Government Plan members in the region shall have the Access Standard indicated.	
Definition	**Provider Group – Urban & Suburban**	**Access Standard**
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 20 miles
	Obstetricians/Gynecologists	1 physician within 20 miles
	Pediatricians	1 physician within 20 miles
	Cardiologists	1 physician within 30 miles
	Endocrinologists	1 physician within 30 miles
	Acute Care Hospitals	1 facility within 30 miles
	Provider Group – Rural	**Access Standard**
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 20 miles
	Obstetricians/Gynecologists	1 physician within 30 miles
	Pediatricians	1 physician within 30 miles

	Acute Care Hospitals	1 facility within 30 miles
Assessment	Seventy-five thousand dollars ($75,000) if any of the above listed standards is not met, either individually or in combination. For purposes of measuring compliance with the access standards delineated in this liquidated damage, the Contractor shall provide the State with a GeoNetworks report of provider access for urban, suburban, and rural areas. Unless otherwise directed by the State, the Contractor shall use GeoNetworks' default definitions for urban, suburban, and rural areas. At the Contractor's request, the State may also approve other methodologies.	
Measurement	Compliance report is the semi-annual GeoNetworks Analysis submitted by the Contractor. Measured, reported reconciled and paid semi-annually.	
16. **Prior Authorizations**		
Guarantee	The Contractor shall complete ninety-seven percent (97%) of all prior authorizations within the timeframes specified in Section A.4.	
Assessment	One thousand dollars ($1,000) for each quarter in which the guarantee is not met.	
Measurement	Measured, reported, reconciled and paid quarterly.	
17. **Data Review**		
Guarantee	All plan design implementation data, associated with the program setup, and identified in the implementation plan, as required in Contract Section A.2. shall be delivered to the State for review and approval prior to the go-live date.	
Assessment	One thousand dollars ($1,000) if the guarantee is not met.	
Measurement	Measured and reported no later than three (3) months after the go-live date.	
18. **Eligibility Set-Up**		
Guarantee	As required in Contract Section A.20., eligibility information shall be loaded, tested, verified and available online for use no later than thirty (30) days prior to the go-live date specified in Contract Section A.24.	
Assessment	Five hundred ($500) for each day beyond the date specified in Contract Section A.24.	
Measurement	Measured, reported, reconciled and paid no later than three (3) months after the go-live date.	
19. **Eligibility Posting**		
Guarantee	One hundred percent (100%) of electronically transmitted enrollment updates, including the resolution of any errors identified during processing, shall be processed within four (4) business days of receipt of the weekly file as required in Contract Section A.20.	
Assessment	Five hundred dollars ($500) per day for the first (1st) and second (2nd) business days out of compliance; one thousand dollars ($1,000) per business day thereafter.	
Measurement	Measured and reported weekly; reconciled and paid quarterly.	
20. **Eligibility Discrepancies**		
Guarantee	Resolve all eligibility discrepancies (any difference of values between the State's database and the Contractor's database) as identified within one (1) business day of notification by the State or identification by the Contractor, as required in Contract Section A.20.	

Assessment	Per discrepancy, one hundred ($100) per day for the first (1st) and second (2nd) business days out of compliance; five hundred ($500) per business day thereafter.	
Measurement	Measured and reported quarterly; reconciled and paid quarterly.	
21. **Claims Data Quality**		
Guarantee	As measured by the State's DSS vendor, the Contractor's data submission to said vendor shall meet the following Data Quality measures.	
Definition	**Measure**	**Benchmark**
	Gender	Data missing for </= (less than or equal to) 3% of claims
	Date of birth	Data missing for </= 3% of claims
	Outpatient diagnosis coding	Data invalid or missing for </= 5% of outpatient claims
	Outpatient provider type missing	Data missing for </= 1.5% of outpatient claims
	Provider ID missing	Data missing for </= 1.5% of claims
Assessment	Five thousand dollars $5,000 if any of the above listed standards is not met, either individually or in combination. Quarterly Guarantee.	
Measurement	Measured and reported by the State's DSS vendor quarterly; reconciled and paid quarterly.	
22. **Claims Data Submission**		
Guarantee	The Contractor shall submit claims data to the State's DSS vendor no later than fifteen (15) days following the end of each calendar month, or more frequently as directed by the State (see Contract Section A.20).	
Assessment	Five hundred dollars ($500) per day for the first and second business days out of compliance; one thousand dollars ($1,000) per business day thereafter.	
Measurement	Measured, reported, reconciled and paid monthly.	
23. **Financial Accuracy**		
Guarantee	Financial accuracy shall be ninety-nine point 3 percent (99.3%) or higher.	
Assessment	Five thousand dollars ($5,000) when the guarantee is not met.	
Measurement	• Quarterly internal audit performed by the Contractor on a statistically valid sample. • Calculated by taking the total benefit dollars paid in the population, minus the sum of the weighted absolute value of overpayments and underpayments identified from the sample, divided by the total dollars paid in the population. • Measured and reported quarterly; reconciled and paid annually.	
24. **Overall Claims Processing Accuracy**		
Guarantee	Claims processing accuracy shall be ninety-six percent (96%) or higher.	
Assessment	Five thousand dollars ($5,000) when the guarantee is not met.	
Measurement	• Quarterly internal audit performed by the Contractor on a statistically valid sample.	

	• Measured by dividing the weighted number of claims processed without any type of error by the total number of claims in the population. • Measured and reported quarterly; reconciled and paid annually.
25. **Claims Payment Turnaround**	
Guarantee	The Contractor shall reimburse network providers within fourteen (14) calendar days for ninety-two percent (92%) of clean claims and within thirty (30) calendar days for ninety-eight percent (98%) of all claims.
Assessment	Five thousand dollars ($5,000) when the either of the guarantees are not met.
Measurement	• Quarterly internal audit performed by the Contractor on a statistically valid sample. • Measures the time elapsed from the date a claim is received to the date the claim is processed. Only the received date, not the processed date is included in the calculation. • Measured and reported quarterly; reconciled and paid annually.
26. **Claims Payment Accuracy**	
Guarantee	Claims payment accuracy shall be ninety-seven point five percent (97.5%) or higher
Assessment	Five thousand dollars ($5,000) when the guarantee is not met.
Measurement	• Quarterly internal audit performed by the Contractor on a statistically valid sample. • Measures the frequency of payment errors by dividing the weighted number of correct benefit payments by the total number of payments in the population. • Measured and reported quarterly; reconciled and paid annually.
27. **Reporting**	
Guarantee	The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract.
Assessment	One hundred dollars ($100) for each report not delivered to the State within the time frame specified in the Contract.
Measurement	Measured, reported, reconciled and paid after each occurrence.
28. **Audit Recovery**	
Guarantee	As required in Contract Section A.11, any amount due the State which is not paid by the Contractor within (30) days of the Contractor's receipt of the final audit report shall be subject to a compounding interest penalty of one percent (1%) per month.
Assessment	Compounding interest penalty of one percent (1%) per month for each month payment is not received.
Measurement	Measured, reported, reconciled and paid after each occurrence.
29. **NCQA Accreditation**	
Guarantee	The Contractor shall receive NCQA's Credentials Verification Organization certification as specified in Contract Section A.3.v. and obtain NCQA Health Plan Accreditation at a level of Commendable or Excellent as specified in Contract Section A.5.m.
Assessment	Ten thousand dollars ($10,000) per guarantee that is not met.
Measurement	Copy of completed NCQA survey and final report.

	Measured, reported, reconciled and paid after each occurrence.
30. **Authorization of Member Communications**	
Guarantee	The Contactor shall not distribute any materials to members prior to receiving the express, written authorization by the State for the use of such materials.
Assessment	Twenty-five hundred dollars ($2,500) for each instance that the guarantee is not met (i.e., in which the Contractor distributes unauthorized materials to members). The assessment will be per occurrence or bulk mailing rather than per each mailed or distributed piece of information.
Measurement	The State will notify the Contractor of any such occurrence. Any amounts due for the Contractor's noncompliance with this pre-approval provision shall be paid upon request of the State.
31. **Privacy, Security, and Confidentiality Breach**	
Guarantee	In accordance with Contract Section E.7., the Contractor shall not violate the Privacy and Security Rules (45 CFR 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 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act).
Assessment	For breaches affecting fewer than five hundred (500) members: Two thousand five hundred dollars ($2,500) for the first violation, five thousand dollars ($5,000) for the second violation and ten thousand dollars ($10,000) for the third and any additional violations. For breaches affecting five hundred (500) or more members: Twenty-five thousand dollars ($25,000) per violation. The assessment will be imposed on a per incident basis meaning regardless of how many members are impacted and the assessment will be levied on the graduated basis detailed above. ***In the event Contractor is responsible for Federal Penalties related to a Privacy or HIPAA violation, the State may, at their discretion waive any Liquidated Damages due the State in association with the same violation.***
Measurement	Measured, reported, reconciled and paid after each occurrence.
32. **HEDIS Performance**	
Guarantee	Contractor shall maintain fifty percent (50%) or greater performance of the State Group plan(s) HEDIS measurements against the Contractor's Tennessee Book of Business as demonstrated in the annual HEDIS report.
Assessment	Five thousand dollars ($5,000) per year in which the guarantee is not met.
Measurement	Measured, reported, reconciled and paid annually.
33. **Eligibility System Errors**	
Guarantee	Contractor shall document in an eligibility system modification log, all system error details, the proposed solution, and the final solution as agreed upon by the State.
Assessment	One thousand dollars ($1,000) for first subsequent error identical in nature. Two-thousand dollars ($2,000) for all additional errors identical in nature.
Measurement	Measured, reported, reconciled and paid quarterly.

34. **Timely Notification**	
Guarantee	Contractor shall notify the State, within three (3) business days of identification, about any situation that appears to negatively impact the administration or delivery of the program, plan, or benefits.
Assessment	Five Hundred Dollars ($500) per business day beyond the notification requirement.
Measurement	Measured, reported, reconciled and paid quarterly.
36. **Payment Reform**	
Guarantee	Contractor shall apply the episode model to i. at least fifty percent (50%) of the Contractor's fully insured members, and at least ten percent (10%) of the Contractor's self-insured ASO members (not including BA) by January 1, 2017; and ii. At least sixty percent (60%) of the Contractor's fully insured members, and at least fifteen percent (15%) of the Contractor's self-insured ASO members (not including BA) by January 1, 2019.
Assessment	Ten Thousand dollars ($10,000) for each percentage measure; fully insured and self-insured, per awarded regional Contract.
Measurement	Measured, reported, reconciled and paid no later than three (3) months after each deadline.

REPORTING REQUIREMENTS

As required by this Contract, the Contractor shall submit reports to the State. Reports shall be submitted via secure electronic medium, in a format approved or specified by the State, and shall be of the type and at the frequency indicated below. Each report shall be consolidated and cover all regional contracts awarded to the Contractor. The State reserves the right to modify reporting requirements as deemed necessary to monitor the Public Sector Plans. The State will provide the Contractor with at least ninety (90) days' notice prior to implementation of a report modification.

Unless otherwise directed by the State, the Contractor shall submit reports as follows:

1. Weekly reports shall be submitted by Tuesday of the following week;
2. Monthly reports shall be submitted by the 15th of the following month;
3. Quarterly reports shall be submitted by the 20th of the following month;
4. Semi-Annual Reports shall be submitted by the 20th of the following month;
5. Annual reports shall be submitted within sixty (60) days after the end of the calendar year.

Reports shall include:

1. **Quarterly Performance Report Card**, as detailed at Contract Attachment B (each component to be submitted at the frequency indicated in Contract Attachment B), submitted by secure email, which shall include:
   a. Status report narrative
   b. Performance guarantee compliance results
   c. Supporting detail report for each performance measure
2. **GeoNetworks® Report**, submitted semi-annually after the 1st and 3rd quarters in compliance with contract section A.3.c.
3. **Network Changes Update Report**, submitted quarterly in Excel in compliance with contract section A.3.p.
4. **New Patient Report,** submitted annually in compliance with contract section A.3.t.
5. **Provider Turnover Report**, submitted annually in compliance with contract section A.3.u.
6. **Unique Care Exception Report**, submitted monthly in compliance with contract section A.3.cc.
7. **Quarterly Utilization Management Report**, submitted quarterly in compliance with contract section A.4.m.
8. **HEDIS Report**, submitted annually by August 15th in compliance with contract section A.5.n.
9. **Wellness Completion**, submitted at the request of the State in compliance with contract section A.8.d.
10. **Rebate Report**, submitted quarterly in compliance with contract section A.9.w.
11. **Coordination of Benefits Report**, submitted weekly in compliance with contract section A.9.aa.
12. **Subrogation Reports**, submitted as required by the State's subrogation policies in compliance with contract section A.9.cc.
13. **Reconciliation Report**, submitted at the same frequency as the Contractor's bank drafts in a format prior approved by the State in compliance with contract section A.9.gg(1).

14. **Recoveries Report**, submitted monthly in a format prior approved in writing by the State in compliance with contract section A.9.gg(2).
15. **Fraud and Abuse Report**, submitted semi-annually after the 2nd and 4th calendar quarters in compliance with contract section A.10.e.
16. **CAHPS Survey**, survey results submitted annually by June 15th and corrective action plan submitted annually by August 1st in compliance with contract section A.12.k.
17. **Appeals Report**, submitted quarterly in compliance with contract section A.13.k.
18. **Call Center Statistics**, submitted in compliance with contract section A.14.k
19. **Account Team Satisfaction Survey and Report**, submitted annually in compliance with contract section A.18.h.
20. **Transparency Tool Report,** submitted quarterly in compliance with contract section A.16.n.
21. **BC-DR Results Report**, submitted one (1) month prior to go-live and, thereafter, annually in compliance with contract sections A.19.g(4)(5).
22. **Information Security Plan**, submitted one (1) month prior to go-live and, thereafter, annually in compliance with contract sections A.19.i(11).
23. **Weekly File Transmission Statistics Report**, submitted within five (5) business days of receipt of the Weekly Enrollment Update in compliance with contract section A.20.e(2).
24. **Eligibility System Modification Log**, submitted quarterly in compliance with contract section A.20.e(5).
25. **CMS Data Match Report**, submitted quarterly in compliance with contract section A.20.f this contract.
26. **Local Government Medicare Eligible Report**, submitted monthly in compliance with contract section A.20.f. This report shall include, at a minimum, the following data elements:
    a. Retiree budget code
    b. Retiree SSN
    c. Edison ID number
    d. Retiree First and Last Name
    e. Retiree Date of birth
    f. Retiree street address, City, State, Zip
    g. Effective date of coverage under state retirement health plan
    h. Dependent SSN if they are Medicare eligible
    i. Dependent First and Last Name if there are Medicare eligible
    j. Dependent date of birth
    k. Medicare part A effective date (dates for the member being reported; either retiree or dependent)
    l. Medicare part A term date
    m. Medicare part B effective date
    n. Medicare part B term date
27. **Ad-Hoc Reports**, in compliance with contract section A.22.e.
28. **SSAE 16 Report**, submitted annually after the go-live date in compliance with contract section A.22.f.

29. **Payment Reform Performance Reports**, in compliance with contract section A.23.a. (7, 9) c, and d.

30. **ASP Reconciliation Report**, submitted annually in compliance with contract sections A.6.f and C.3.f of this contract and will be validated by the State's actuarial consultant.

31. **Specialty Pharmacy Report**, submitted semi-annually after the 2nd and 4th quarters in compliance with contract section A.6.h of this contract.

32. **Other Reports**, as specified in this Contract.

HIPAA BUSINESS ASSOCIATE AGREEMENT
COMPLIANCE WITH PRIVACY AND SECURITY RULES

THIS BUSINESS ASSOCIATE AGREEMENT (hereinafter "Agreement") is between **The State of Tennessee, Finance and Administration, Division of Benefits Administration** (hereinafter "Covered Entity") and **Cigna Health and Life Insurance Company** (hereinafter "Business Associate"). Covered Entity and Business Associate may be referred to herein individually as "Party" or collectively as "Parties."

BACKGROUND

Parties acknowledges that they are subject to the Privacy and Security Rules (45 CFR 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 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act), in certain aspects of its operations.

Business Associate provides services to Covered Entity pursuant to one or more contractual relationships detailed below and hereinafter referred to as "Service Contracts."

LIST OF AGREEMENTS AFFECTED BY THIS BUSINESS ASSOCIATE AGREEMENT:

Contract Name:	**Execution Date:**
Edison # 47414 TPA for Health Ins. - Middle	January 1, 2016

In the course of executing Service Contracts, Business Associate may come into contact with, use, or disclose Protected Health Information ("PHI"). Said Service Contract(s) 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 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 and, therefore, make this Agreement.

DEFINITIONS

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 CFR §§ 160.103, 164.103, 164.304, 164.402, 164.501, and 164.504.

1.1 "Breach of the Security of the [Business Associate's Information] System" shall have the meaning set out in its definition at T.C.A. § 47-18-2107

1.2 "Business Associate" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.3 "Covered Entity" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.4 "Designated Record Set" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.5 "Electronic Protected Health Information" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.6 "Genetic Information" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.7 "Health Care Operations" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.8 "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

1.9 "Information Holder" shall have the meaning set out in its definition at T.C.A. § 47-18-2107

1.10 "Marketing" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.11 "Personal information" shall have the meaning set out in its definition at T.C.A. § 47-18-2107

1.12 "Privacy Official" shall have the meaning as set out in its definition at 45 C.F.R. § 164.530(a)(1).

1.13 "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, subparts A, and E.

1.14 "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

1.15 "Required by Law" shall have the meaning set forth in 45 CFR § 164.512.

1.16 "Security Incident" shall have the meaning set out in its definition at 45 C.F.R. § 164.304.

1.17 "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Parts 160 and 164, Subparts A and C.

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

2.1 Business Associate is authorized to use PHI for the purposes of carrying out its duties under the Services Contract. In the course of carrying out these duties, including but not limited to carrying out the Covered Entity's duties under HIPAA, 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 Contracts, or as Required By Law. Business Associate is subject to requirements of the Privacy Rule as required by Public Law 111-5, Section 13404 [designated as 42 U.S.C. 17934] In case of any conflict between this Agreement and the Service Contracts, this Agreement shall govern.

2.2 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 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 Associate shall use appropriate administrative, physical, and technical safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement, Services Contract(s), 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. The Business Associate shall maintain appropriate documentation of its compliance with the Privacy Rule, including, but not limited to, its policies, procedures, records of training and sanctions of members of its Workforce.

2.4 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 information, to agree, by written contract with Business Associate, to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

2.5 Business Associate shall 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.

2.6 Business Associate shall require its employees, agents, and subcontractors to promptly report, to Business Associate, within 10 business days, upon becoming aware of any use or disclosure of PHI in violation of this Agreement. Business Associate shall report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement. Business Associate will also provide additional information reasonably requested by the Covered Entity related to the impermissible use or disclosure of PHI.

2.7 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.

2.7.1 Business Associate shall provide to Covered Entity notice of a Potential or Actual Breach of Unsecured PHI without unreasonable delay and in any event no later than five (5) days after becoming aware of the Breach of Unsecured PHI.

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

2.7.3 Covered Entity shall make the final determination whether the Breach requires notification and whether the notification shall be made by Covered Entity or Business Associate. Business Associate shall offer a recommendation thereof to the Covered Entity, but shall not be deemed to act as the agent (as defined under federal common law) of the Covered Entity.

2.8 If Business Associate receives and/or maintains PHI from Covered Entity in a Designated Record Set, Business Associate shall provide access, at the request of Covered Entity, to PHI in a Designated Record Set to Covered Entity, in order to meet the requirements under 45 CFR § 164.524, provided that Business Associate shall have at least 30 business days from Covered Entity notice to provide access to, or deliver such information.

2.9 If Business Associate receives PHI from Covered Entity in a Designated Record Set, then Business Associate shall make any amendments to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to the 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity, provided that Business Associate shall have at least t 30 business days from Covered Entity notice to make an amendment.

2.10 Business Associate shall make its internal practices, books, and records including policies and 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 Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule.

2.11 Business Associate shall document disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosure of PHI in accordance with 45 CFR § 164.528.

2.12 Business Associate shall provide Covered Entity or an Individual, 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 and accounting of disclosures of PHI in accordance with 45 CFR § 164.528, provided that Business Associate shall have at least 30 business days from Covered Entity notice to provide access to, or deliver such information which shall include, at minimum, (a) date of the disclosure; (b) name of the third party to whom the PHI was disclosed and, if known, the address of the third party; (c) brief description of the disclosed information; and (d) brief explanation of the purpose and basis for such disclosure. Business Associate shall provide an accounting of disclosures directly to an individual when required by section 13405(c) of Public Law 111-5 [designated as 42 U.S.C. 17935(c)].

2.13 Business Associate agrees it must 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.

2.13.1 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.

2.13.2 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.

2.13.3 Business Associate acknowledges that if Business Associate is also a covered entity, as defined by the Privacy Rule, Business Associate is required, independent of Business Associate's obligations under this Memorandum, to comply with the Privacy Rule's minimum necessary requirements when making any request for PHI from Covered Entity.

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

2.15 If Business Associate receives a request from an Individual for a copy of the individual's PHI, that Business Associate maintains in a Designated Record Set, Business Associate will provide the requested copies to the individual. If Business Associate receives a request for PHI 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 notify Covered Entity of such request and forward the request to Covered Entity. Business Associate shall then assist Covered Entity in responding to the request.

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

2.17 Business Associate shall comply with, and shall assist Covered Entity in complying with, responding to Individuals' requests for confidential communications or to restrict the uses and disclosures of their PHI under 45 C.F.R. §164.522. This shall include complying with requests to restrict the disclosure of certain PHI with which Covered Entity is required to agree, in accordance with 45 C.F.R. §164.522.

3 OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Security Rule)

3.1 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 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 and Public Law 111-5. 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 to certify its compliance with the Security Rule.

3.3 Business Associate shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI received from 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, to agree, by written contract (or the appropriate equivalent if the agent is a government entity) with Business Associate, to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

3.4 Business Associate shall require its employees, agents, and subcontractors to report to Business Associate within ten (10) business days, any Security Incident (as that term is defined in 45 CFR § 164.304) of which it becomes aware. Business Associate shall report, without reasonable delay but in any event no later than five (5) days, any Security Incident of which it becomes aware to Covered Entity. Provided however, that such reports are not required for attempted, unsuccessful Security Incidents, including trivial and routine incidents such as port scans, attempts to log-in with an invalid password or user name, denial of service attacks that do not result in a server being taken off-line, malware, and pings or other similar types of events.

3.5 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 Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Security Rule.

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

3.7 Notification for the purposes of Sections 2.8 and 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:

State of Tennessee
Benefits Administration
HIPAA Privacy & Security Officer
312 Rosa L. Parks Avenue
1900 W.R.S. Tennessee Towers
Nashville, TN 37243-1102
Phone: (615) 770-6949
Facsimile: (615) 253-8556

With a copy to:

State of Tennessee
Benefits Administration
Contracting and Procurement Manager
312 Rosa L. Parks Avenue
1900 W.R.S. Tennessee Towers
Nashville, TN 37243-1102
Phone: (615) 253-8358
Facsimile: (615) 253-8556

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

Chief Privacy Officer
Cigna Corporation
900 Cottage Grove Road, Routing B6LPA
Hartford, CT 06152

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

4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in Service Contract(s), provided that such use or disclosure would not violate the Privacy and Security Rule, if done by Covered Entity. Business Associate's disclosure of PHI shall be subject to the limited data set and minimum necessary requirements of Section 13405(b) of Public Law 111-5, [designated as 42 U.S.C. 13735(b)]

4.2 Except as otherwise limited in this Agreement, Business Associate may use PHI as required for Business Associate's proper management and administration or to carry out the legal responsibilities of the Business Associate.

4.3 Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or 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 Except as otherwise limited in this Agreement, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 45 CFR § 164.504(e)(2)(i)(B). Business Associate may de-identify PHI. Once information is de-identified, this Agreement shall not apply.

4.5 Business Associate may use PHI to report violations of law to appropriate Federal and State Authorities consistent with 45 CFR 164.502(j)(1).

4.6 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 member's personal or financial information with affiliates, even if such sharing would be permitted by federal or state laws, is prohibited.

4.7 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.

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

5. OBLIGATIONS OF COVERED ENTITY

5.1 Covered Entity shall provide Business Associate with the Notice of Privacy Practices that Covered Entity produces in accordance with 45 CFR § 164.520, as well as any changes to such notice. Covered Entity shall notify Business Associate of any limitations in its notice that affect Business Associate's use or disclosure of PHI.

5.2 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 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 CFR § 164.522, to the extent that such restriction may affect Business Associate's use of PHI.

6. PERMISSIBLE REQUESTS BY COVERED ENTITY

6.1 Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy or Security Rule, if done by Covered Entity.

7. TERM AND TERMINATION

7.1 Term. This Agreement shall be effective as of the date on which it is signed by both parties and shall terminate when all of the PHI provided 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 it is infeasible to return or destroy PHI, Section 7.3. below shall apply.

7.2 Termination for Cause.

7.2.1. This Agreement authorizes and Business Associate acknowledges and agrees Covered Entity shall have the right to immediately terminate this Agreement and Service Contracts in the event Business Associate fails to comply with, or violates a material provision of, requirements of the Privacy and/or Security Rule or this Memorandum.

7.2.2. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

7.2.2.1. Provide a reasonable opportunity for Business Associate to cure the breach or end the violation, or

7.2.2.2. If Business Associate has breached a material term of this Agreement and cure is not possible or if Business Associate does not cure a curable breach or end the violation within a reasonable time as specified by, and at the sole discretion of, Covered Entity, Covered Entity may immediately terminate this Agreement and the Service Agreement.

7.2.2.3. If neither cure nor termination is feasible, Covered Entity shall report the violation to the Secretary of the United States Department of Health in Human Services or the Secretary's designee.

7.3 Effect of Termination.

7.3.1. Except as provided in Section 7.3.2. below, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of, Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

7.3.2. In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible. Upon mutual agreement of the Parties that return or destruction of PHI is unfeasible, 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.

8. MISCELLANEOUS

8.1 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.

8.2 Amendment. The Parties agree to take such action as is necessary 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, including any amendments required by the United States Department of Health and Human Services to implement the Health Information Technology for Economic and Clinical Health 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.

8.3 Survival. The respective rights and obligations of Business Associate under Section 7.3. of this Memorandum shall survive the termination of this Agreement.

8.4 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.

8.5 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.

COVERED ENTITY:
State of Tennessee
Department of Finance and Administration
Benefits Administration
ATTN:
HIPAA Privacy & Security Officer
312 Rosa L. Parks Avenue
1900 W.R.S. Tennessee Towers
Nashville, TN 37243-1102
Phone: (615) 770-6949
Facsimile: (615) 253-8556

BUSINESS ASSOCIATE:
Chief Privacy Officer
Cigna Corporation
900 Cottage Grove Road,
Routing B6LPA
Hartford, CT 06152

With a copy to:
ATTN: Sylvia Chunn
Procurements & Contracting Manager
At the address listed above
Phone: (615) 253-8358
Facsimile: (615) 253-8556
E-Mail: Sylvia.chunn@tn.gov

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 or electronically by the facsimile machine at the receiving location.

8.6 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

8.7 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.

8.8 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.

8.9 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 contracts referenced herein.

8.10 Security Breach A violation of HIPAA or the Privacy or Security Rules constitutes a breach of this Business Associate Agreement and a breach of the Service Contract(s) listed on page one of this agreement, and shall be subject to all available remedies for such breach.

IN WITNESS WHEREOF,

Victoria Sirica, Manager of Contractual Agreement Unit, Cigna **Date:** 10/20/2015

Larry B. Martin, Commissioner of Finance & Administration **Date:** 11/3/15

Implementation and Account Management Team

NAME	ROLE	PHONE	EMAIL
Tim Cullen	Account Director	615-595-3382	Timothy.cullen@Cigna.com
Thelma Ramos	Account Manager	772-794-0895	Thelma.Rams@Cigna.com
Deanna Walker	Implementation Manager	860-902-6848	Deannadale.walker@Cigna.com
Bonnie H. Hampton	Client Engagement Manager – West	901-748-4114	Bonnie.hampton@Cigna.com
Sharon Tansil	Client Strategy Manager	615-595-3386	Sharon.Tansil@Cigna.com
Dr. Renee McLaughlin	Senior Medical Director	423-763-6764	Renee.mclaughlin@Cigna.com
Jeff Baker	Eligibility Analyst	423-954-5811	Jeffrey.baker@Cigna.com
Celeste Sims	Dedicated Administrative Assistant	615-242-6692	Annceleste.sims@Cigna.com
Lisa Roth-Edwards	Informatics Manager	860-787-6047	Lisa.roth-edwards@Cigna.com
Ronnie Miller	Operations Director		
Jamie Moody	Operations Manager	423-499-3193	Jamie.moody@Cigna.com
Rich Novack	President and General Manager, Mid-South Region	404-443-9026	Richard.Novack@Cigna.com

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Sharon L Pope
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Mary Anne J Queen
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