STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION

REQUEST FOR PROPOSALS
FOR
Third Party Administrator Services for a Tiered Copay Benefit Plan Design

RFP # 31786-00177
RELEASE #5

RFP CONTENTS

6.6. *Pro Forma* Contract

APPENDICES:

7.1. Advanced Control Specialty Formulary Oct 2023
7.2. TN Zip Code Counts v2
7.3. Formulary Disruption Template
7.4. SOT Summary by Plan and Plan Group
7.5. Behavioral Network Access Analysis Instructions
7.6. Medical Network Access Analysis Instructions
7.7 Pharmacy Network Access Analysis Instructions
7.8 Tennessee Behavioral Sample Report
7.9 Tennessee Medical Sample Report
7.10 Tennessee Pharmacy Sample Report
7.11 HIPAA BAA Assessment
7.12 Behavioral Provider and Facility Disruption v2
7.13 Medical Provider Disruption Analysis v2
7.14 Pharmacy Network Disruption Analysis v2
7.15 Example Subrogation Reports
7.16 Implementation and Account team Surveys
7.17 Medical Claims and Utilization History 2023
7.18 MHSA Utilization 2023
7.19 Current_Formulary_Exclusions
7.20 DSS Standard Claims Layout
7.21 Other RX UM Edits
7.22 Percentage of prescriptions filled by state
7.23 Pharmacy Claims Data History
7.24 DSS_File_Format_RX
7.25 Proposed Pharmacy Networks
7.26 Rx Claims (1 of 4) - 3Q2022
7.27 Rx Claims (2 of 4) - 4Q2022
7.28 Rx Claims (3 of 4) - 1Q2023
7.29 Rx Claims (4 of 4) - 2Q2023
7.30 RX UM drug list
7.31 RxClaims Summary Information
7.32 Simplified wellness activity layout
7.33 State of TN NDC level Specialty drug list as of 10-31-23
7.34 Subrogation Contractor Requirements

7.35	**Supplier Direct Deposit Authorization**
7.36	**ASP Reconciliation Template**
7.37	**Benefits Administration 834 Guidance Manual**
7.38	**Current State of TN formulary Oct 2023**
7.39	**TPA Bank Draft Report Template**

1. INTRODUCTION

The State of Tennessee, State, Local Education, and Local Government Insurance Committees, hereinafter referred to as "the State," issues this Request for Proposals (RFP) to define minimum contract requirements; solicit responses; detail response requirements; and, outline the State's process for evaluating responses and selecting a contractor to provide the needed goods or services.

Through this RFP, the State seeks to procure necessary goods or services at the most favorable, competitive prices and to give ALL qualified respondents, including those that are owned by minorities, women, service-disabled veterans, persons with disabilities and small business enterprises, an opportunity to do business with the state as contractors, subcontractors or suppliers.

1.1. Statement of Procurement Purpose

The State intends to secure one self-funded contract with a Third Party Administrator (TPA) for a broad Preferred Provider Organization (PPO) network for medical, behavioral health, and pharmacy benefits (pharmacy may be carved out at the State's request) servicing all ninety-five (95) Tennessee counties statewide as well as nationally for Members residing or traveling outside of the state. The TPA shall provide access to an existing (current) high-quality cost effective broad commercial network that meets the state's access requirements. The State intends to procure a contract with a TPA who has a current tiered copay only benefit design, which is applied to all providers in a broad national network, that is currently in place with other large self-funded employers. This contract and benefit design shall include all medical and behavioral healthcare services as well as pharmacy services (unless the State requests to carve out pharmacy). The tiered copay only benefit design sets member copay ranges, beyond a preferred and non-preferred status, for ALL national provider and specialist office visits, healthcare services including surgeries and procedures, admissions, behavioral healthcare services, and pharmacy benefit services based upon the quality and cost of the providers, facilities, pharmaceuticals, healthcare services and outcomes. Cost and quality data must be displayed online in a transparent, customer friendly way that is easily accessible by members. Members pay a copay for all services covered by this contract up to a maximum out of pocket amount. Copays and the maximum out of pocket amounts will be finalized by the State after the award of the contract during implementation.

The State will select the best evaluated proposal resulting in a single contract. The TPA shall provide network administration, utilization management, claims adjudication, call center services, and benefits communication materials for Members approved to receive this benefit. While all three Insurance Committees may choose to offer this product to their plan Members, it is possible that the benefit will be offered to select groups initially. Additional groups may be added during the contract term at the Insurance Committees direction. The Contractor shall perform all services described in the Scope of Services of the pro forma contract (RFP Attachment 6.6).

1.1.1 Background and Context

The State is the largest purchaser of employer-based health care services in Tennessee. The State operates three financially independent self-funded public sector plans which provide health benefits to approximately 295,000 employees, retirees and dependents of the State, the University of Tennessee (UT) system, the Tennessee Board of Regents (TBR) system, Local Education Agencies (LEAs), and Local Government agencies (LGA). Approximately half (146,000) of the Members are employees and retirees while dependents make up the other half. See the most recent Annual Report for a description of program and plan information. The report is available at www.tn.gov/partnersforhealth/publications/reports.html.

The State has existing contracts with multiple vendors to deliver health benefits to all Members across the state and to those residing or traveling out of the state. BlueCross BlueShield of Tennessee and CIGNA Healthcare administer the State's current self-funded PPOs and Consumer Driven High Deductible Plans with Health Savings Accounts (CDHP/HSAs) benefits. A separate carve out contract with Optum delivers the employee assistance program (EAP) and mental health and substance use benefits while CVS Caremark delivers pharmacy benefit management services through another carved out contract. The employee population health program is administered by Sharecare and delivers disease management, lifestyle

management, and weight management. Supplemental Medical Insurance for Retirees with Medicare is offered to eligible retirees and is administered by UMR/POMCO. The State's current benefit designs may be reviewed at http://partnersforhealthtn.gov/ and are out of scope of this contract.

State Group Insurance Plan

The State Group Insurance Plan is governed by the State Insurance Committee and is a financially separate, self-funded program. The State plan provides medical coverage to approximately 143,000 state and higher education employees, pre-65 retirees, COBRA participants and their dependents. The State, as the employer, contributes monthly to premiums in an amount equal to approximately 80% of the premium cost of one or more of the basic health plans. Approximately $612 million in medical Claims and $397 million in pharmacy and $26 million in behavioral health Claims were paid under these Plan options during Plan year 2022.

In addition to the core medical benefits listed above, voluntary benefits offered to State Plan Members and retirees include:

- Prepaid dental plan - Cigna
- Preferred dental organization plan – Delta Dental
- Vision plan – EyeMed
- Life Insurance – Securian Financial
- Disability Insurance – MetLife
- Health Savings and Flexible Savings Accounts – Optum Banking

Local Education Group Insurance Plan

The Local Education Group Insurance Plan is governed by the Local Education Insurance Committee and is a financially separate, self-funded program for employees and retirees of 127 Local Education Agencies (LEA) who elect to secure health insurance coverage through this Plan. The Local Education Plan offers similar health benefits as the State Plan which are administered by the State's contracted TPAs.

The Local Education Plan enrollment has approximately 62,000 employees/retirees with a total of over 125,000 covered lives. Most of the employees are teachers; the balance is comprised of administrators, cafeteria workers, maintenance and other support personnel. The State, through a budget funding formula, pays the LEA 45% of the aggregate average premium for each instructional staff and 30% of the aggregate average premium for each non-instructional staff. Approximately $431 million in medical Claims and $282 million in pharmacy and $14 million in mental health Claims were paid under these Plan options during Plan year 2022.

In addition to health insurance coverage, LEAs may participate in the same dental and vision products as State Plan Members.

Local Government Group Insurance Plan

The Local Government Group Insurance Plan is governed by the Local Government Insurance Committee and is also a financially separate, self-funded program available to employees of 392 local governments or quasi-governmental entities in Tennessee who elect to secure health insurance coverage through this Plan. The health benefits and their administrators are identical to those under the Local Education Plan.

The Local Government Plan enrollment is approximately 17,000 employees with a total of over 27,000 covered lives. Approximately $125 million in medical Claims and $70 million in pharmacy and $3 million in mental health claims were paid under these Plan options during Plan year 2022. The State does not provide any funding to participating Local Government Agencies.

In addition to health insurance coverage, Local Government Agencies may participate in the same dental and vision products as State Plan Members.

Other Recent, Relevant Initiatives and Developments

The Plans strive to provide comprehensive, affordable, dependable and sustainable health benefits for our 295,000 Members with the aim of keeping expenditures at or below annual projected medical trend. Like all employers, we continue to search for, and implement, plan design concepts that deliver best value, reduce costs and improve quality for our Members.

Population Health:
Because of our heavy chronic disease burden, population health has been at the core of our Plan design since 2011. Reducing health risk and improving clinical outcomes is the focus for the population health initiative and continues to be the driving force in determining future population health incentives. Population health program availability differs between the State, Local Education, and Local Government Plans.

1.1.2. The maximum liability for the resulting contract will be determined through the best evaluated cost proposal and estimated cost associated with this service. The maximum liability will exceed one dollar ($1.00).

1.2. **Scope of Service, Contract Period, & Required Terms and Conditions**

The RFP Attachment 6.6., *Pro Forma* Contract details the State's requirements:

- Scope of Services and Deliverables (Section A);
- Contract Period (Section B);
- Payment Terms (Section C);
- Standard Terms and Conditions (Section D); and,
- Special Terms and Conditions (Section E).

The *pro forma* contract substantially represents the contract document that the successful Respondent must sign.

1.3. **Nondiscrimination**

No person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of a Contract pursuant to this RFP 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, Tennessee state constitutional, or statutory law. The Contractor pursuant to this RFP shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

1.4. **RFP Communications**

1.4.1. The State has assigned the following RFP identification number that must be referenced in all communications regarding this RFP:

RFP # 31786-00177

1.4.2. **Unauthorized contact about this RFP with employees or officials of the State of Tennessee except as detailed below may result in disqualification from consideration under this procurement process.**

1.4.2.1. Prospective Respondents must direct communications concerning this RFP to the following person designated as the Solicitation Coordinator:

Heather Pease
Procurement and Contracts Director
Tennessee Department of Finance & Administration, Division of Benefits Administration
312 Rosa L. Parks Avenue, Suite 1900
Nashville, Tennessee 37243
heather.pease@tn.gov

Telephone: 615.253.1652
Fax: 615.253.8556

1.4.2.2. Notwithstanding the foregoing, Prospective Respondents may alternatively contact:

a. staff of the Governor's Office of Diversity Business Enterprise for assistance available to minority-owned, woman-owned, service-disabled veteran-owned, businesses owned by persons with disabilities, and small businesses as well as general, public information relating to this RFP (visit https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/governor-s-office-of-diversity-business-enterprise--godbe--/godbe-general-contacts.html for contact information); and

b. the following individual designated by the State to coordinate compliance with the nondiscrimination requirements of the State of Tennessee, Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, and associated federal regulations:

Lucian Geise, General Counsel
Tennessee Department of Finance & Administration
312 Rosa L. Parks Avenue, Suite 2000 Nashville, Tennessee 37243
Phone Number: 615-532-9617
Fax:615-532-8532
FA.CivilRights@tn.gov

1.4.3. Only the State's official, written responses and communications with Respondents are binding with regard to this RFP. Oral communications between a State official and one or more Respondents are unofficial and non-binding.

1.4.4. Potential Respondents must ensure that the State receives all written questions and comments, including questions and requests for clarification, no later than the Written Questions & Comments Deadline detailed in the RFP Section 2, Schedule of Events.

1.4.5. Respondents must assume the risk of the method of dispatching any communication or response to the State. The State assumes no responsibility for delays or delivery failures resulting from the Respondent's method of dispatch. Actual or digital "postmarking" of a communication or response to the State by a specified deadline is not a substitute for the State's actual receipt of a communication or response. It is encouraged for Respondents to submit bids digitally.

1.4.6. The State will convey all official responses and communications related to this RFP to the prospective Respondents from whom the State has received a Notice of Intent to Respond (refer to RFP Section 1.8).

1.4.7. The State reserves the right to determine, at its sole discretion, the method of conveying official, written responses and communications related to this RFP. Such written communications may be transmitted by mail, hand-delivery, facsimile, electronic mail, Internet posting, or any other means deemed reasonable by the State. For internet posting, please refer to the following website: https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/supplier-information/request-for-proposals--rfp--opportunities1.html.

1.4.8. The State reserves the right to determine, at its sole discretion, the appropriateness and adequacy of responses to written comments, questions, and requests related to this RFP. The State's official, written responses will constitute an amendment of this RFP.

1.4.9. Any data or factual information provided by the State (in this RFP, an RFP amendment or any other communication relating to this RFP) is for informational purposes only. The State will make reasonable efforts to ensure the accuracy of such data or information, however it is the

Respondent's obligation to independently verify any data or information provided by the State. The State expressly disclaims the accuracy or adequacy of any information or data that it provides to prospective Respondents.

1.5. **Assistance to Respondents With a Handicap or Disability**

Prospective Respondents with a handicap or disability may receive accommodation relating to the communication of this RFP and participating in the RFP process. Prospective Respondents may contact the Solicitation Coordinator to request such reasonable accommodation no later than the Disability Accommodation Request Deadline detailed in the RFP Section 2, Schedule of Events.

1.6. **Respondent Required Review & Waiver of Objections**

1.6.1. Each prospective Respondent must carefully review this RFP, including but not limited to, attachments, the RFP Attachment 6.6., *Pro Forma* Contract, and any amendments, for questions, comments, defects, objections, or any other matter requiring clarification or correction (collectively called "questions and comments").

1.6.2. Any prospective Respondent having questions and comments concerning this RFP must provide them in writing to the State no later than the Written Questions & Comments Deadline detailed in the RFP Section 2, Schedule of Events.

1.6.3. Protests based on any objection to the RFP shall be considered waived and invalid if the objection has not been brought to the attention of the State, in writing, by the Written Questions & Comments Deadline.

1.7. **Pre-Response Conference**

A Pre-response Conference will be held at the time and date detailed in the RFP Section 2, Schedule of Events. Pre-response Conference attendance is not mandatory, and prospective Respondents may be limited to a maximum number of attendees depending upon overall attendance and space limitations.

The conference will be held at:

WebEx Information:

Join from the meeting link
https://tn.webex.com/tn/j.php?MTID=m85c149c67c41f29fbbfd470ade140532

Join by meeting number

Meeting number (access code): 2304 237 5584

Meeting password: cnRc8dM9wm9

The purpose of the conference is to discuss the RFP scope of goods or services. The State will entertain questions, however prospective Respondents must understand that the State's oral response to any question at the Pre-response Conference shall be unofficial and non-binding. Prospective Respondents must submit all questions, comments, or other concerns regarding the RFP in writing prior to the Written Questions & Comments Deadline date detailed in the RFP Section 2, Schedule of Events. The State will send the official response to these questions and comments to prospective Respondents from whom the State has received a Notice of Intent to respond as indicated in RFP Section 1.8 and on the date detailed in the RFP Section 2, Schedule of Events.

1.8. **Notice of Intent to Respond**

Before the Notice of Intent to Respond Deadline detailed in the RFP Section 2, Schedule of Events, prospective Respondents should submit to the Solicitation Coordinator a Notice of Intent to Respond (in the form of a simple e-mail or other written communication). Such notice should include the following information:

- the business or individual's name (as appropriate);
- a contact person's name and title; and
- the contact person's mailing address, telephone number, facsimile number, and e-mail address.

A Notice of Intent to Respond creates no obligation and is not a prerequisite for submitting a response, however, it is necessary to ensure receipt of any RFP amendments or other notices and communications relating to this RFP.

1.9. **Response Deadline**

A Respondent must ensure that the State receives a response no later than the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events. The State will not accept late responses, and a Respondent's failure to submit a response before the deadline will result in disqualification of the response. It is the responsibility of the Respondent to ascertain any additional security requirements with respect to packaging and delivery to the State of Tennessee. Respondents should be mindful of any potential delays due to security screening procedures, weather, or other filing delays whether foreseeable or unforeseeable.

2. RFP SCHEDULE OF EVENTS

2.1. The following RFP Schedule of Events represents the State's best estimate for this RFP.

EVENT	TIME (central time zone)	DATE
1. RFP Issued		February 7, 2024
2. Disability Accommodation Request Deadline	2:00 p.m.	February 12, 2024
3. Pre-response Conference	10:00 a.m.	February 13, 2024
4. Notice of Intent to Respond Deadline	2:00 p.m.	February 14, 2024
5. Written "Questions & Comments" Deadline	2:00 p.m.	February 20, 2024
6. State Response to Written "Questions & Comments"		March 12, 2024
7. Written "Questions & Comments" Round 2 Deadline	2:00 p.m.	March 19, 2024
8. State Response to Written "Questions & Comments" Round 2 ***NOTE: Vendors may submit no more than five (5) questions to the State in the 2nd round of Written Questions and Comments.**		April 2, 2024
9. Response Deadline	2:00 p.m.	April 9, 2024
10. State Opening of Cost Proposals		April 11, 2024
11. Cost Proposal Analysis		April 11, 2024 – May 9, 2024
12. State Completion of Technical Response Evaluations		May 3, 2024
13. State Notice of Intent to Award Released and RFP Files Opened for Public Inspection	1:00 p.m.	May 23, 2024
14. End of Open File Period		May 30, 2024
15. State sends contract to Contractor for signature		June 3, 2024
16. Contractor Signature Deadline	2:00 p.m.	June 7, 2024

2.2. **The State reserves the right, at its sole discretion, to adjust the RFP Schedule of Events as it deems necessary.** Any adjustment of the Schedule of Events shall constitute an RFP amendment, and the State will communicate such to prospective Respondents from whom the State has received a Notice of Intent to Respond (refer to section 1.8).

3. RESPONSE REQUIREMENTS

3.1. Response Form

A response to this RFP must consist of two parts, a Technical Response and a Cost Proposal.

3.1.1. **Technical Response**. RFP Attachment 6.2., Technical Response & Evaluation Guide provides the specific requirements for submitting a response. This guide includes mandatory requirement items, general qualifications and experience items, and technical qualifications, experience, and approach items all of which must be addressed with a written response and, in some instances, additional documentation.

NOTICE: A technical response must not include any pricing or cost information. If any pricing or cost information amounts of any type (even pricing relating to other projects) is included in any part of the technical response, the state may deem the response to be non-responsive and reject it.

3.1.1.1. A Respondent should duplicate and use the RFP Attachment 6.2., Technical Response & Evaluation Guide to organize, reference, and draft the Technical Response by duplicating the attachment, adding appropriate page numbers as required, and using the guide as a table of contents covering the Technical Response.

3.1.1.2. A response should be economically prepared, with emphasis on completeness and clarity. A response, as well as any reference material presented, must be written in English and must be written on standard 8 ½" x 11" pages (although oversize exhibits are permissible) and use a 12 point font for text. All response pages must be numbered.

3.1.1.3. All information and documentation included in a Technical Response should correspond to or address a specific requirement detailed in the RFP Attachment 6.2., Technical Response & Evaluation Guide. All information must be incorporated into a response to a specific requirement and clearly referenced. Any information not meeting these criteria will be deemed extraneous and will not contribute to evaluations.

3.1.1.4. The State may determine a response to be non-responsive and reject it if:

a. the Respondent fails to organize and properly reference the Technical Response as required by this RFP and the RFP Attachment 6.2., Technical Response & Evaluation Guide; or

b. the Technical Response document does not appropriately respond to, address, or meet all of the requirements and response items detailed in the RFP Attachment 6.2., Technical Response & Evaluation Guide.

3.1.2. **Cost Proposal**. A Cost Proposal must be recorded on an exact duplicate of the RFP Attachment 6.3., Cost Proposal & Scoring Guide.

NOTICE: If a Respondent fails to submit a cost proposal exactly as required, the State may deem the response to be non-responsive and reject it.

3.1.2.1. A Respondent must only record the proposed cost exactly as required by the RFP Attachment 6.3., Cost Proposal & Scoring Guide and must NOT record any other rates, amounts, or information.

3.1.2.2. The proposed cost shall incorporate ALL costs for services under the contract for the total contract period, including any renewals or extensions.

3.1.2.3. A Respondent must sign and date the Cost Proposal.

3.1.2.4. A Respondent must submit the Cost Proposal to the State on a separate e-mail, digital online submission, or USB flash drive from the Technical Response (as detailed in RFP Sections 3.2.3., et. seq).

3.2. **Response Delivery**

3.2.1. A Respondent must ensure that both the Technical Response and Cost Proposal files meet all form and content requirements, including all required signatures, as detailed within this RFP.

3.2.2. A Respondent must submit their response as specified in one of the two formats below.

3.2.2.1. Digital Media Submission

3.2.2.1.1. Technical Response

The Technical Response document should be in the form of one (1) digital document in "PDF" format properly recorded on its own otherwise blank USB flash drive or uploaded to our digital submission platform and should be clearly identified as the:

"RFP #3186-00177 TECHNICAL RESPONSE ORIGINAL"

and one (1) digital copy of the Technical Response each in the form of one (1) digital document with **separate individual corresponding appendices or exhibits** in "PDF" format properly recorded on its own otherwise blank USB flash drive clearly labeled:

"RFP #3186-00177 TECHNICAL RESPONSE COPY"

The customer references should be delivered by each reference in accordance with RFP Attachment 6.4. Reference Questionnaire.

3.2.2.1.2. Cost Proposal:

The Cost Proposal should be in the form of one (1) digital document in "XLS" format properly recorded on a separate, otherwise blank USB flash drive clearly labeled:

"RFP #3186-00177 COST PROPOSAL"

An electronic or facsimile signature, as applicable, on the Cost Proposal is acceptable.

3.2.2.2. E-mail Submission

3.2.2.2.1. Technical Response

The Technical Response document should be in the form of one (1) digital document in "PDF" format or other easily accessible digital format attached to an e-mail to the Solicitation Coordinator. Both the subject and file name should be clearly identified as follows:

"RFP #3186-00177 TECHNICAL RESPONSE"

The customer references should be delivered by each reference in accordance with RFP Attachment 6.4. Reference Questionnaire.

3.2.2.2.2. Cost Proposal:

The Cost Proposal should be in the form of one (1) digital document in "XLS" format or other easily accessible digital format attached to an e-mail to the Solicitation Coordinator. Both the subject and file name should be clearly identified as follows:

"RFP #3186-00177 COST PROPOSAL"

An electronic or facsimile signature, as applicable, on the Cost Proposal is acceptable.

3.2.3. For e-mail submissions, the Technical Response and Cost Proposal documents must be dispatched to the Solicitation Coordinator in **separate** e-mail messages. For digital media submissions, a Respondent must separate, seal, package, and label the documents and copies for delivery as follows:

3.2.3.1. The Technical Response and copies must be placed in a sealed package that is clearly labeled:

"DO NOT OPEN… RFP #3186-00177 TECHNICAL RESPONSE FROM [RESPONDENT LEGAL ENTITY NAME]"

3.2.3.2. The Cost Proposal must be placed in a separate, sealed package that is clearly labeled:

"DO NOT OPEN… RFP #3186-00177 COST PROPOSAL FROM [RESPONDENT LEGAL ENTITY NAME]"

3.2.3.3. The separately, sealed Technical Response and Cost Proposal components may be enclosed in a larger package for mailing or delivery, provided that the outermost package is clearly labeled:

"RFP #3186-00177 SEALED TECHNICAL RESPONSE & SEALED COST PROPOSAL FROM [RESPONDENT LEGAL ENTITY NAME]"

3.2.3.4. Any Respondent wishing to submit a Response in a format other than digital may do so by contacting the Solicitation Coordinator.

3.2.4. A Respondent must ensure that the State receives a response no later than the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events at the following address:

Heather Pease, Director of Procurements & Contracts
Department of Finance and Administration, Division of Benefits Administration
312 Rosa L. Parks Avenue, Suite 1900
heather.pease@tn.gov
Telephone: 615.253-1652
Fax: 615.253.8556

3.3. Response & Respondent Prohibitions

3.3.1. A response must not include alternate contract terms and conditions. If a response contains such terms and conditions, the State, at its sole discretion, may determine the response to be a non-responsive counteroffer and reject it.

3.3.2. A response must not restrict the rights of the State or otherwise qualify either the offer to deliver goods or provide services as required by this RFP or the Cost Proposal. If a response restricts the rights of the State or otherwise qualifies either the offer to deliver goods or provide services as required by this RFP or the Cost Proposal, the State, at its sole discretion, may determine the response to be a non-responsive counteroffer and reject it.

3.3.3. A response must not propose alternative goods or services (*i.e.*, offer services different from those requested and required by this RFP) unless expressly requested in this RFP. The State may consider a response of alternative goods or services to be non-responsive and reject it.

3.3.4. A Cost Proposal must be prepared and arrived at independently and must not involve any collusion between Respondents. The State will reject any Cost Proposal that involves collusion, consultation, communication, or agreement between Respondents. Regardless of the time of detection, the State will consider any such actions to be grounds for response rejection or contract termination.

3.3.5. A Respondent must not provide, for consideration in this RFP process or subsequent contract negotiations, any information that the Respondent knew or should have known was materially incorrect. If the State determines that a Respondent has provided such incorrect information, the State will deem the Response non-responsive and reject it.

3.3.6. A Respondent must not submit more than one Technical Response and one Cost Proposal in response to this RFP, except as expressly requested by the State in this RFP. If a Respondent submits more than one Technical Response or more than one Cost Proposal, the State will deem all of the responses non-responsive and reject them.

3.3.7. A Respondent must not submit a response as a prime contractor while also permitting one or more other Respondents to offer the Respondent as a subcontractor in their own responses. Such may result in the disqualification of all Respondents knowingly involved. This restriction does not, however, prohibit different Respondents from offering the same subcontractor as a part of their responses (provided that the subcontractor does not also submit a response as a prime contractor).

3.3.8. The State shall not consider a response from an individual who is, or within the past six (6) months has been, a State employee. For purposes of this RFP:

3.3.8.1. An individual shall be deemed a State employee until such time as all compensation for salary, termination pay, and annual leave has been paid;

3.3.8.2. A contract with or a response from a company, corporation, or any other contracting entity in which a controlling interest is held by any State employee shall be considered to be a contract with or proposal from the employee; and

3.3.8.3. A contract with or a response from a company, corporation, or any other contracting entity that employs an individual who is, or within the past six (6) months has been, a State employee shall not be considered a contract with or a proposal from the employee and shall not constitute a prohibited conflict of interest.

3.3.9. This RFP is also subject to Tenn. Code Ann. § 12-4-101—105.

3.4. Response Errors & Revisions

A Respondent is responsible for any and all response errors or omissions. A Respondent will not be

allowed to alter or revise response documents after the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events unless such is formally requested, in writing, by the State.

3.5. **Response Withdrawal**

A Respondent may withdraw a submitted response at any time before the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events by submitting a written request signed by an authorized Respondent representative. After withdrawing a response, a Respondent may submit another response at any time before the Response Deadline. After the Response Deadline, a Respondent may only withdraw all or a portion of a response where the enforcement of the response would impose an unconscionable hardship on the Respondent.

3.6. **Additional Services**

If a response offers goods or services in addition to those required by and described in this RFP, the State, at its sole discretion, may add such services to the contract awarded as a result of this RFP. Notwithstanding the foregoing, a Respondent must not propose any additional cost amounts or rates for additional goods or services. Regardless of any additional services offered in a response, the Respondent's Cost Proposal must only record the proposed cost as required in this RFP and must not record any other rates, amounts, or information.

NOTICE: If a Respondent fails to submit a Cost Proposal exactly as required, the State may deem the response non-responsive and reject it.

3.7. **Response Preparation Costs**

The State will not pay any costs associated with the preparation, submittal, or presentation of any response.

4. GENERAL CONTRACTING INFORMATION & REQUIREMENTS

4.1. RFP Amendment

The State at its sole discretion may amend this RFP, in writing, at any time prior to contract award. However, prior to any such amendment, the State will consider whether it would negatively impact the ability of potential Respondents to meet the response deadline and revise the RFP Schedule of Events if deemed appropriate. If an RFP amendment is issued, the State will convey it to potential Respondents who submitted a Notice of Intent to Respond (refer to RFP Section 1.8). A response must address the final RFP (including its attachments) as amended.

4.2. RFP Cancellation

The State reserves the right, at its sole discretion, to cancel the RFP or to cancel and reissue this RFP in accordance with applicable laws and regulations.

4.3. State Right of Rejection

4.3.1. Subject to applicable laws and regulations, the State reserves the right to reject, at its sole discretion, any and all responses.

4.3.2. The State may deem as non-responsive and reject any response that does not comply with all terms, conditions, and performance requirements of this RFP. Notwithstanding the foregoing, the State reserves the right to waive, at its sole discretion, minor variances from full compliance with this RFP. If the State waives variances in a response, such waiver shall not modify the RFP requirements or excuse the Respondent from full compliance, and the State may hold any resulting Contractor to strict compliance with this RFP.

4.4. Assignment & Subcontracting

4.4.1. The Contractor may not subcontract, transfer, or assign any portion of the Contract awarded as a result of this RFP without prior approval of the State. The State reserves the right to refuse approval, at its sole discretion, of any subcontract, transfer, or assignment.

4.4.2. If a Respondent intends to use subcontractors, the response to this RFP must specifically identify the scope and portions of the work each subcontractor will perform (refer to RFP Attachment 6.2., Section B, General Qualifications & Experience Item B.12).

4.4.3. Subcontractors identified within a response to this RFP will be deemed as approved by the State unless the State expressly disapproves one or more of the proposed subcontractors prior to signing the Contract.

4.4.4. After contract award, a Contractor may only substitute an approved subcontractor at the discretion of the State and with the State's prior, written approval.

4.4.5. Notwithstanding any State approval relating to subcontracts, the Respondent who is awarded a contract pursuant to this RFP will be the prime contractor and will be responsible for all work under the Contract.

4.5. Right to Refuse Personnel or Subcontractors

The State reserves the right to refuse, at its sole discretion and notwithstanding any prior approval, any personnel of the prime contractor or a subcontractor providing goods or services in the performance of a contract resulting from this RFP. The State will document in writing the reason(s) for any rejection of personnel.

4.6. **Insurance**

The State will require the awarded Contractor to provide a Certificate of Insurance issued by an insurance company licensed or authorized to provide insurance in the State of Tennessee. Each Certificate of Insurance shall indicate current insurance coverages meeting minimum requirements as may be specified by this RFP. A failure to provide a current, Certificate of Insurance will be considered a material breach and grounds for contract termination.

4.7. **Professional Licensure and Department of Revenue Registration**

4.7.1. All persons, agencies, firms, or other entities that provide legal or financial opinions, which a Respondent provides for consideration and evaluation by the State as a part of a response to this RFP, shall be properly licensed to render such opinions.

4.7.2. Before the Contract resulting from this RFP is signed, the apparent successful Respondent (and Respondent employees and subcontractors, as applicable) must hold all necessary or appropriate business or professional licenses to provide the goods or services as required by the contract. The State may require any Respondent to submit evidence of proper licensure.

4.7.3. Before the Contract resulting from this RFP is signed, the apparent successful Respondent must be registered with the Tennessee Department of Revenue for the collection of Tennessee sales and use tax. The State shall not award a contract unless the Respondent provides proof of such registration or provides documentation from the Department of Revenue that the Contractor is exempt from this registration requirement. The foregoing is a mandatory requirement of an award of a contract pursuant to this solicitation. To register, please visit the Department of Revenue's Tennessee Taxpayer Access Point (TNTAP) website for Online Registration and the Vendor Contract Questionnaire. These resources are available at the following: https://tntap.tn.gov/eservices/_/#1

4.8. **Disclosure of Response Contents**

4.8.1. All materials submitted to the State in response to this RFP shall become the property of the State of Tennessee. Respondents are cautioned not to provide any materials in response to this RFP that are trade secrets, as defined under Tenn. Code Ann. § 47-25-1702 and any other applicable law. By submitting a response to this RFP, the respondent acknowledges and agrees that the State shall have no liability whatsoever for disclosure of a trade secret under the Uniform Trade Secrets Act, as provided at Tenn. Code Ann. § 47-25-1701-1709, or under any other applicable law. Selection or rejection of a response does not affect this right. By submitting a response, a Respondent acknowledges and accepts that the full response contents and associated documents will become open to public inspection in accordance with the laws of the State of Tennessee.

4.8.2. The State will hold all response information, including both technical and cost information, in confidence during the evaluation process.

4.8.3. Upon completion of response evaluations, indicated by public release of a Notice of Intent to Award, the responses and associated materials will be open for review by the public in accordance with Tenn. Code Ann. § 10-7-504(a)(7).

4.9. **Contract Approval and Contract Payments**

4.9.1. After contract award, the Contractor who is awarded the contract must submit appropriate documentation with the Department of Finance and Administration, Division of Accounts.

4.9.2. This RFP and its contractor selection processes do not obligate the State and do not create rights, interests, or claims of entitlement in either the Respondent with the apparent best-evaluated response or any other Respondent. State obligations pursuant to a contract award shall commence only after the Contract is signed by the State agency head and the Contractor

and after the Contract is approved by all other state officials as required by applicable laws and regulations.

4.9.3. No payment will be obligated or made until the relevant Contract is approved as required by applicable statutes and rules of the State of Tennessee.

4.9.3.1. The State shall not be liable for payment of any type associated with the Contract resulting from this RFP (or any amendment thereof) or responsible for any goods delivered or services rendered by the Contractor, even goods delivered or services rendered in good faith and even if the Contractor is orally directed to proceed with the delivery of goods or the rendering of services, if it occurs before the Contract Effective Date or after the Contract Term.

4.9.3.2. All payments relating to this procurement will be made in accordance with the Payment Terms and Conditions of the Contract resulting from this RFP (refer to RFP Attachment 6.6., *Pro Forma* Contract, Section C).

4.9.3.3. If any provision of the Contract provides direct funding or reimbursement for the competitive purchase of goods or services as a component of contract performance or otherwise provides for the reimbursement of specified, actual costs, the State will employ all reasonable means and will require all such documentation that it deems necessary to ensure that such purchases were competitive and costs were reasonable, necessary, and actual. The Contractor shall provide reasonable assistance and access related to such review. Further, the State shall not remit, as funding or reimbursement pursuant to such provisions, any amounts that it determines do not represent reasonable, necessary, and actual costs.

4.10. Contractor Performance

The Contractor who is awarded a contract will be responsible for the delivery of all acceptable goods or the satisfactory completion of all services set out in this RFP (including attachments) as may be amended. All goods or services are subject to inspection and evaluation by the State. The State will employ all reasonable means to ensure that goods delivered or services rendered are in compliance with the Contract, and the Contractor must cooperate with such efforts.

4.11. Contract Amendment

After Contract award, the State may request the Contractor to deliver additional goods or perform additional services within the general scope of the Contract and this RFP, but beyond the specified Scope, and for which the Contractor may be compensated. In such instances, the State will provide the Contractor a written description of the additional goods or services. The Contractor must respond to the State with a time schedule for delivering the additional goods or accomplishing the additional services based on the compensable units included in the Contractor's response to this RFP. If the State and the Contractor reach an agreement regarding the goods or services and associated compensation, such agreement must be effected by means of a contract amendment. Further, any such amendment requiring additional goods or services must be signed by both the State agency head and the Contractor and must be approved by other state officials as required by applicable statutes, rules, policies and procedures of the State of Tennessee. The Contractor must not provide additional goods or render additional services until the State has issued a written contract amendment with all required approvals.

4.12. Severability

If any provision of this RFP is declared by a court to be illegal or in conflict with any law, said decision will not affect the validity of the remaining RFP terms and provisions, and the rights and obligations of the State and Respondents will be construed and enforced as if the RFP did not contain the particular provision held to be invalid.

4.13. **Next Ranked Respondent**

The State reserves the right to initiate negotiations with the next ranked Respondent should the State cease doing business with any Respondent selected via this RFP process.

5. EVALUATION & CONTRACT AWARD

5.1. Evaluation Categories & Maximum Points

The State will consider qualifications, experience, technical approach, and cost in the evaluation of responses and award points in each of the categories detailed below (up to the maximum evaluation points indicated) to each response deemed by the State to be responsive.

EVALUATION CATEGORY	MAXIMUM POINTS POSSIBLE
General Qualifications & Experience (refer to RFP Attachment 6.2., Section B)	**5**
Technical Qualifications, Experience & Approach (refer to RFP Attachment 6.2., Section C)	**40**
Technical Qualifications, Network Analysis (refer to RFP Attachment 6.2., Section D) Part 1 Network Management Part 2 Network Access Part 3 Disruption Analysis	 **5** **5** **5**
Cost Proposal (refer to RFP Attachment 6.3.) 1. Total Administrative Fees with Pharmacy 2. Total Administrative Fees without Pharmacy 3. Pharmacy Guarantees 4. Medical Cost Savings Guarantee	 **18** **9** **12** **1**

5.2. Evaluation Process

The evaluation process is designed to award the contract resulting from this RFP not necessarily to the Respondent offering the lowest cost, but rather to the Respondent deemed by the State to be responsive and responsible who offers the best combination of attributes based upon the evaluation criteria. ("Responsive Respondent" is defined as a Respondent that has submitted a response that conforms in all material respects to the RFP. "Responsible Respondent" is defined as a Respondent that has the capacity in all respects to perform fully the contract requirements, and the integrity and reliability which will assure good faith performance.)

5.2.1. **Technical Response Evaluation.** The Solicitation Coordinator and the Proposal Evaluation Team (consisting of three (3) or more State employees) will use the RFP Attachment 6.2., Technical Response & Evaluation Guide to manage the Technical Response Evaluation and maintain evaluation records.

5.2.1.1. The State reserves the right, at its sole discretion, to request Respondent clarification of a Technical Response or to conduct clarification discussions with any or all Respondents. Any such clarification or discussion will be limited to specific sections of the response identified by the State. The subject Respondent must put any resulting clarification in writing as may be required and in accordance with any deadline imposed by the State.

5.2.1.2. The Solicitation Coordinator will review each Technical Response to determine compliance with RFP Attachment 6.2., Technical Response & Evaluation Guide, Section A— Mandatory Requirements. If the Solicitation Coordinator determines that a response failed to meet one or more of the mandatory requirements, the Solicitation Coordinator will review the response and determine whether:

a. the response adequately meets RFP requirements for further evaluation;

b. the State will request clarifications or corrections for consideration prior to further evaluation; or,

c. the State will determine the response to be non-responsive to the RFP and reject it.

5.2.1.3. Proposal Evaluation Team members will independently evaluate each Technical Response (that is responsive to the RFP) against the evaluation criteria in this RFP, and will score each in accordance with the RFP Attachment 6.2., Technical Response & Evaluation Guide.

5.2.1.4. For each response evaluated, the Solicitation Coordinator will calculate the average of the Proposal Evaluation Team member scores for RFP Attachment 6.2., Technical Response & Evaluation Guide, and record each average as the response score for the respective Technical Response section.

5.2.1.5. Before Cost Proposals are opened, the Proposal Evaluation Team will review the Technical Response Evaluation record and any other available information pertinent to whether or not each Respondent is responsive and responsible. If the Proposal Evaluation Team identifies any Respondent that does not meet the responsive and responsible thresholds such that the team would not recommend the Respondent for Cost Proposal Evaluation and potential contract award, the team members will fully document the determination.

5.2.2. **Cost Proposal Evaluation.** The Solicitation Coordinator will open for evaluation the Cost Proposal of each Respondent deemed by the State to be responsive and responsible and calculate and record each Cost Proposal score in accordance with the RFP Attachment 6.3., Cost Proposal & Scoring Guide.

This information for each responsible Respondent will be forwarded to an independent consulting firm under contract with the Department of Finance & Administration, Division of Benefits Administration based on the RFP Schedule of Events. Any review or analysis of the cost proposal will be done by an independent consulting firm and Benefits Administration staff not associated with the evaluation team. The Solicitation Coordinator is the only person during the evaluation that will have access to both the Technical Response and the Cost Proposal information. At no time will Cost Proposal information be provided to individual evaluation team members.

The consulting firm will also check for the completion of the cost proposals according to the directions contained in RFP Attachment 6.3. Cost Proposal & Scoring Guide. If any questions surface regarding the completion of the forms, the firm is instructed to contact the Solicitation Coordinator with the concern and the Solicitation Coordinator will take appropriate steps to determine the Proposal's responsiveness. The results from the analysis will be provided to the Solicitation Coordinator. The Solicitation Coordinator will calculate and record each Cost Proposal score in accordance with the RFP Attachment 6.3. Cost Proposal & Scoring Guide.

Please note: Tenn. Code Ann. § 10-7-504(n)(1)(A) provides that the following documents submitted to the state in response to a request for proposal or other procurement method shall remain confidential after completion of the evaluation period:

A. Discount, Rebate, pricing or other financial arrangements at the individual drug level between pharmaceutical manufacturers, pharmaceutical wholesalers/distributors, and pharmacy benefits managers, as defined in Tenn. Code Ann. § 56-7-3102 that a proposer:

i. Submits to the state in response to a request for proposals or other procurement methods for pharmacy-related benefits or services;

ii. Includes in its cost or price proposal, or provides to the state after the notice of intended award of the contract is issued, where the Respondent is the apparent contract awardee; and
iii. Explicitly marks as confidential and proprietary; and

B. Discount, Rebate, pricing or other financial arrangements at the individual provider level between health care providers and health insurance entities, as defined in Tenn. Code Ann.56-7-109, insurers, insurance arrangements and third party administrators that a Respondent:

i. Submits to the state in response to a request for proposals or other procurement method after the notice of intended award of the contract is issued, where the Respondent is the apparent contact awardee, in response to a request by the state for additional information, and
ii. Explicitly marks as confidential and proprietary

As such, the State commits to maintain strict confidentiality and oversight over any proprietary data, to the extent permitted by the statute.

5.2.3. **Total Response Score.** The Solicitation Coordinator will calculate the sum of the Technical Response section scores and the Cost Proposal score and record the resulting number as the total score for the subject Response (refer to RFP Attachment 6.5., Score Summary Matrix).

5.3. **Contract Award Process**

5.3.1 The Solicitation Coordinator will review the Proposal Evaluation Team determinations and scores for consideration along with any other relevant information that might be available and pertinent to contract award.

5.3.2. Benefits Administration's executive director will determine the apparent best-evaluated Response using the scoring provided by the Proposal Evaluation Team. To effect a contract award to a Respondent other than the one receiving the highest evaluation process score, the Solicitation Coordinator must provide written justification and obtain the written approval of the Chief Procurement Officer and the Comptroller of the Treasury.

5.3.3. Benefits Administration will present the apparent best-evaluated Response recommendation to the State, Local Education, and Local Government Insurance Committees, as applicable, for approval to enter into a contract with the best-evaluated Respondent.

5.3.4. The State will issue a Notice of Intent to Award identifying the apparent best-evaluated response and make the RFP files available for public inspection at the time and date specified in the RFP Section 2, Schedule of Events.

NOTICE: The Notice of Intent to Award shall not create rights, interests, or claims of entitlement in either the apparent best-evaluated Respondent or any other Respondent.

5.3.5. The Respondent identified as offering the apparent best-evaluated response must sign a contract drawn by the State pursuant to this RFP. The Contract shall be substantially the same as the RFP Attachment 6.6., *Pro Forma* Contract. The Respondent must sign the contract by the Contractor Signature Deadline detailed in the RFP Section 2, Schedule of Events. If the Respondent fails to provide the signed Contract by this deadline, the State may determine that the Respondent is non-responsive to this RFP and reject the response.

5.3.6. Notwithstanding the foregoing, the State may, at its sole discretion, entertain limited terms and conditions or pricing negotiations prior to Contract signing and, as a result, revise the *pro forma* contract terms and conditions or performance requirements in the State's best interests, PROVIDED THAT such revision of terms and conditions or performance requirements shall NOT

materially affect the basis of response evaluations or negatively impact the competitive nature of the RFP and contractor selection process.

5.3.7. If the State determines that a response is non-responsive and rejects it after opening Cost Proposals, the Solicitation Coordinator will re-calculate scores for each remaining responsive Cost Proposal to determine (or re-determine) the apparent best-evaluated response.

RFP #31786-00177 STATEMENT OF CERTIFICATIONS AND ASSURANCES

The Respondent must sign and complete the Statement of Certifications and Assurances below as required, and it must be included in the Technical Response (as required by RFP Attachment 6.2., Technical Response & Evaluation Guide, Section A, Item A.1.).

The Respondent does, hereby, expressly affirm, declare, confirm, certify, and assure ALL of the following:

1. The Respondent will comply with all of the provisions and requirements of the RFP.
2. The Respondent will provide all services as defined in the Scope of the RFP Attachment 6.6., *Pro Forma* Contract for the total Contract Term.
3. The Respondent, except as otherwise provided in this RFP, accepts and agrees to all terms and conditions set out in the RFP Attachment 6.6., *Pro Forma* Contract.
4. The Respondent acknowledges and agrees that a contract resulting from the RFP shall incorporate, by reference, all proposal responses as a part of the Contract.
5. The Respondent will comply with:
   (a) the laws of the State of Tennessee;
   (b) Title VI of the federal Civil Rights Act of 1964;
   (c) Title IX of the federal Education Amendments Act of 1972;
   (d) the Equal Employment Opportunity Act and the regulations issued there under by the federal government; and,
   (e) the Americans with Disabilities Act of 1990 and the regulations issued there under by the federal government.
6. To the knowledge of the undersigned, the information detailed within the response submitted to this RFP is accurate.
7. The response submitted to this RFP was independently prepared, without collusion, under penalty of perjury.
8. No amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Respondent in connection with this RFP or any resulting contract.
9. Both the Technical Response and the Cost Proposal submitted in response to this RFP shall remain valid for at least 120 days subsequent to the date of the Cost Proposal opening and thereafter in accordance with any contract pursuant to the RFP.
10. The Respondent affirms the following statement, as required by the Iran Divestment Act Tenn. Code Ann. § 12-12-111: "By submission of this bid, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of its knowledge and belief that each bidder is not on the list created pursuant to §12-12-106." For reference purposes, the list is currently available online at: https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/library-/public-information-library.html.

By signing this Statement of Certifications and Assurances, below, the signatory also certifies legal authority to bind the proposing entity to the provisions of this RFP and any contract awarded pursuant to it. If the signatory is not the Respondent (if an individual) or the Respondent's company *President* or *Chief Executive Officer*, this document must attach evidence showing the individual's authority to bind the Respondent.

DO NOT SIGN THIS DOCUMENT IF YOU ARE NOT LEGALLY AUTHORIZED TO BIND THE RESPONDENT

SIGNATURE: _____

PRINTED NAME & TITLE: _____

DATE: _____

RESPONDENT LEGAL ENTITY NAME: _____

TECHNICAL RESPONSE & EVALUATION GUIDE

SECTION A: MANDATORY REQUIREMENTS. The Respondent must address all items detailed below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the response page number for each item in the appropriate space below.

The Solicitation Coordinator will review the response to determine if the Mandatory Requirement Items are addressed as required and mark each with pass or fail. For each item that is not addressed as required, the Solicitation Coordinator must review the response and attach a written determination. In addition to the Mandatory Requirement Items, the Solicitation Coordinator will review each response for compliance with all RFP requirements.

RESPONDENT LEGAL ENTITY NAME:			
Response Page # (Respondent completes)	**Item Ref.**	**Section A— Mandatory Requirement Items**	**Pass/Fail**
		The Response must be delivered to the State no later than the Response Deadline specified in the RFP Section 2, Schedule of Events.	
		The Technical Response and the Cost Proposal documentation must be packaged separately as required (refer to RFP Section 3.2., *et. seq.*).	
		The Technical Response must NOT contain cost or pricing information of any type.	
		The Technical Response must NOT contain any restrictions of the rights of the State or other qualification of the response.	
		A Respondent must NOT submit alternate responses (refer to RFP Section 3.3.).	
		A Respondent must NOT submit multiple responses in different forms (as a prime and a subcontractor) (refer to RFP Section 3.3.).	
	A.1.	Provide the Statement of Certifications and Assurances (RFP Attachment 6.1.) completed and signed by an individual empowered to bind the Respondent to the provisions of this RFP and any resulting contract. The document must be signed without exception or qualification.	
	A.2.	Provide a statement, based upon reasonable inquiry, of whether the Respondent or any individual who shall cause to deliver goods or perform services under the contract has a possible conflict of interest (*e.g.*, employment by the State of Tennessee) and, if so, the nature of that conflict. NOTE: Any questions of conflict of interest shall be solely within the discretion of the State, and the State reserves the right to cancel any award.	
	A.3.	Provide a current bank reference indicating that the Respondent's business relationship with the financial institution is in positive standing. Such reference must be written in the form of a standard business letter, signed, and dated within the past three (3) months.	

RESPONDENT LEGAL ENTITY NAME:			
Response Page # (Respondent completes)	**Item Ref.**	**Section A— Mandatory Requirement Items**	**Pass/Fail**
	A.4.	Provide two current positive credit references from vendors with which the Respondent has done business written in the form of standard business letters, signed, and dated within the past three (3) months.	
	A.5.	Provide at least one of the following financial documents dated within the last three (3) months: (1) an official document or letter from an accredited credit bureau, indicating a satisfactory credit score for the Respondent (NOTE: A credit bureau report number without the full report is insufficient and will not be considered responsive.); (2) income statement, indicating the Respondent's financial operations; or (3) balance sheet, showing the Respondent's flow of funds. Any documentation disclosing the amount of cash flows from operating activities should be for the Respondent's most current operating period and must indicate whether the cash flows are positive or negative. If the cash flows are negative for the most recent operating period, the documentation must include a detailed explanation of the factors contributing to the negative cash flows. NOTICE: All persons, agencies, firms, or other entities that provide opinions regarding the Respondent's financial status must be properly licensed to render such opinions. The State may require the Respondent to submit proof of such licensure detailing the state of licensure and licensure number for each person or entity that renders the opinions.	
	A.6.	Provide a current credit rating from Moody's, Standard & Poor's, Dun & Bradstreet, A.M. Best or Fitch Ratings, verified and dated within the last three (3) months and indicating a positive credit rating for the Respondent. OR, in lieu of the aforementioned credit rating, provide an official document or letter from an accredited credit bureau, dated within the last three (3) months and indicating a satisfactory credit score for the Respondent (NOTE: A credit bureau report number without the full report is insufficient and will not be considered responsive.)	
	A.7	Provide the Respondent's most recent independent audited financial statements. Said independent audited financial statements must: (1) reflect an audit period for a fiscal year ended within the last 36 months; (2) be prepared with all monetary amounts detailed in United States currency; (3) be prepared under United States Generally Accepted Accounting Principles (US GAAP); (4) include the auditor's opinion letter; financial statements; and the notes to the financial statements; and (5) be deemed, in the sole discretion of the State to reflect sufficient financial stability to undertake the subject contract with the State if awarded pursuant to this RFP. **OR**, in lieu of the aforementioned independent audited financial statements, provide a financial institution's letter of commitment for a general Line of Credit in the amount of **WRITTEN AMOUNT ≥ ONE MILLION DOLLARS** ($**NUMBER AMOUNT**), U.S. currency, available to the Respondent. Said	

RESPONDENT LEGAL ENTITY NAME:			
Response Page # (Respondent completes)	**Item Ref.**	**Section A— Mandatory Requirement Items**	**Pass/Fail**
		letter must specify the Respondent's name, be signed and dated within the past three (3) months by an authorized agent of the financial institution, and indicate that the Line of Credit shall be available for at least PERIOD ≥ **6 MONTHS**. NOTES: ▪ Reviewed or Compiled Financial Statements will not be deemed responsive to this requirement and will not be accepted. ▪ All persons, agencies, firms, or other entities that provide opinions regarding the Respondent's financial status must be properly licensed to render such opinions. The State may require the Respondent to submit proof that the person or entity who renders an opinion regarding the Respondent's financial status is licensed, including the license number and state in which the person or entity is licensed.	
	A.8.	Submit a written statement indicating that the claims processing and member services units offered as part of this proposal meet the following minimum qualifications: (a) as of the proposal date, the Respondent has been under contract for at least two (2) years to provide services similar to that offered in this proposal to one or more groups with a combined minimum of no less than ten thousand (10,000) members; (b) the Respondent has adjudicated medical claims for calendar year 2022 in excess of one hundred million dollars ($100,000,000).	
	A.9.	Provide written confirmation that the Respondent has contracted to provide medical claims administration services with a tiered benefit copay design to at least two (2) clients with a combined minimum of no less than ten thousand (10,000) members for at least two years.	
	A.10.	Provide written confirmation that the Respondent has complied with all State insurance department filings. Provide a copy of the current license for Third Party Administrator (TPA) of Life and/or Health Insurance from the Tennessee Department of Commerce and Insurance.	
	A.11.	Provide written confirmation that this proposal is offered with NO minimum participation requirements (*i.e.*, a minimum percentage or number of eligible Members enrolled), and that the Respondent understands that any resulting contract will NOT include such requirements. NOTE: The State shall NOT guarantee that a certain percentage or number of potential Members will enroll with a Contractor.	
	A.12.	Provide written confirmation that the Respondent will obtain National Committee for Quality Assurance (NCQA) Health Plan Accreditation at a level of 3.5 - 5 stars on or before December 31, 2025 (or a later date as specified by the State) and shall maintain it thereafter, as referenced in Contract Section A.22.l.	
	A.13.	Submit a written confirmation that **ALL** examples and illustrations that the Respondent includes in its Technical Proposal constitute an offer to provide the same such service or product in Tennessee for the administrative fees that the Respondent bids in its Cost Proposal **UNLESS** the Respondent prominently explicitly states in bolded, capital letters beside each separate,	

RESPONDENT LEGAL ENTITY NAME:			
Response Page # (Respondent completes)	**Item Ref.**	**Section A— Mandatory Requirement Items**	**Pass/Fail**
		excepted example that "**THIS SPECIFIC EXAMPLE IS FOR ILLUSTRATION PURPOSES ONLY AND WILL NOT BE PROVIDED TO THE STATE UNDER THIS CONTRACT FOR THE ALL-INCLUSIVE ADMINISTRATIVE FEES BID IN THIS RFP.**"	
	A.14.	Provide a written attestation that if awarded the contract the Respondent 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.	
State Use – Solicitation Coordinator Signature, Printed Name & Date:			

TECHNICAL RESPONSE & EVALUATION GUIDE

SECTION B: GENERAL QUALIFICATIONS & EXPERIENCE. The Respondent must address all items detailed below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the response page number for each item in the appropriate space below. Proposal Evaluation Team members will independently evaluate and assign one score for all responses to Section B— General Qualifications & Experience Items.

RESPONDENT LEGAL ENTITY NAME:		
Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
	B.1.	Detail the name, e-mail address, mailing address, telephone number, and facsimile number, if applicable, of the person the State should contact regarding the response.
	B.2.	Describe the Respondent's form of business (*i.e.*, individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and business location (physical location or domicile).
	B.3.	Detail the number of years the Respondent has been in business.
	B.4.	Briefly describe how long the Respondent has been providing the goods or services required by this RFP.
	B.5.	Describe the Respondent's number of employees, client base, and location of offices.
	B.6.	Provide a statement of whether there have been any mergers, acquisitions, or change of control of the Respondent within the last ten (10) years. If so, include an explanation providing relevant details.
	B.7.	Provide a statement of whether the Respondent or, to the Respondent's knowledge, any of the Respondent's employees, agents, independent contractors, or subcontractors, involved in the delivery of goods or performance of services on a contract pursuant to this RFP, have been convicted of, pled guilty to, or pled *nolo contendere* to any felony. If so, include an explanation providing relevant details.
	B.8.	Provide a statement of whether, in the last ten (10) years, the Respondent 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.
	B.9.	Provide a statement of whether there is any material, pending litigation against the Respondent that the Respondent should reasonably believe could adversely affect its ability to meet contract requirements pursuant to this RFP or is likely to have a material adverse effect on the Respondent's financial condition. If such exists, list each separately, explain the relevant details, and attach the opinion of counsel addressing whether and to what extent it would impair the Respondent's performance in a contract pursuant to this RFP. NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Respondent must be properly licensed to render such opinions. The State may require the Respondent to submit proof of license for each person or entity that renders such opinions.
	B.10.	Provide a statement of whether there are any pending or in progress Securities Exchange Commission investigations involving the Respondent. If such exists, list each separately, explain

RFP ATTACHMENT 6.2. — SECTION B (continued)

RESPONDENT LEGAL ENTITY NAME:		
Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
		the relevant details, and attach the opinion of counsel addressing whether and to what extent it will impair the Respondent's performance in a contract pursuant to this RFP. NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Respondent must be properly licensed to render such opinions. The State may require the Respondent to submit proof of license for each person or entity that renders such opinions.
	B.11.	Provide a brief, descriptive statement detailing evidence of the Respondent's ability to deliver the goods or services sought under this RFP (*e.g.*, prior experience, training, certifications, resources, program and quality management systems, *etc.*).
	B.12.	Provide a statement of whether the Respondent intends to use subcontractors to meet the Respondent's requirements of any contract awarded pursuant to this RFP, and if so, detail: (a) the names of the subcontractors along with the contact person, mailing address, telephone number, and e-mail address for each; (b) a description of the scope and portions of the goods each subcontractor involved in the delivery of goods or performance of the services each subcontractor will perform; and (c) a statement specifying that each proposed subcontractor has expressly assented to being proposed as a subcontractor in the Respondent's response to this RFP.
	B.13.	Provide documentation of the Respondent's commitment to diversity as represented by the following: (a) Business Strategy. Provide a description of the Respondent's existing programs and procedures designed to encourage and foster commerce with business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises. Please also include a list of the Respondent's certifications as a diversity business, if applicable. (b) Business Relationships. Provide a listing of the Respondent's current contracts with business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises. Please include the following information: (i) contract description; (ii) contractor name and ownership characteristics (*i.e.*, ethnicity, gender, service-disabled veteran-owned or persons with disabilities); (iii) contractor contact name and telephone number. (c) Estimated Participation. Provide an estimated level of participation by business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities and small business enterprises if a contract is awarded to the Respondent pursuant to this RFP. Please include the following information: (i) a percentage (%) indicating the participation estimate. (Express the estimated participation number as a percentage of the total estimated contract value that will be dedicated to business with subcontractors and supply contractors having such ownership characteristics only and **DO NOT INCLUDE DOLLAR AMOUNTS**); (ii) anticipated goods or services contract descriptions; (iii) names and ownership characteristics (i.e., ethnicity, gender, service-disabled veterans, or disability) of anticipated subcontractors and supply contractors. NOTE: In order to claim status as a Diversity Business Enterprise under this contract, businesses must be certified by the Governor's Office of Diversity Business Enterprise (Go-DBE). Please visit the Go-DBE website at https://tn.diversitysoftware.com/FrontEnd/StartCertification.asp?TN=tn&XID=9810 for more information.

RFP ATTACHMENT 6.2. — SECTION B (continued)

RESPONDENT LEGAL ENTITY NAME:		
Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
		(d) Workforce. Provide the percentage of the Respondent's total current employees by ethnicity and gender. NOTE: Respondents that demonstrate a commitment to diversity will advance State efforts to expand opportunity to do business with the State as contractors and subcontractors. Response evaluations will recognize the positive qualifications and experience of a Respondent that does business with enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises and who offer a diverse workforce.
	B.14.	Provide a statement of whether or not the Respondent has any current contracts with the State of Tennessee or has completed any contracts with the State of Tennessee within the previous five (5) year period. If so, provide the following information for all of the current and completed contracts: (a) the name, title, telephone number and e-mail address of the State contact knowledgeable about the contract; (b) the procuring State agency name; (c) a brief description of the contract's scope of services; (d) the contract period; and (e) the contract number.
	B.15.	Provide a statement and any relevant details addressing whether the Respondent is any of the following: (a) is presently debarred, suspended, proposed for debarment, or voluntarily excluded from covered transactions by any federal or state department or agency; (b) has within the past three (3) years, been convicted of, or had a civil judgment rendered against the contracting party from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (c) is presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed above; and (d) has within a three (3) year period preceding the contract had one or more public transactions (federal, state, or local) terminated for cause or default.
	B.16.	Provide customer references from individuals for projects similar to the goods or services sought under this RFP and which represent: ▪ two (2) accounts Respondent currently services that currently offer a tiered benefit copay design with a combined minimum of no less than ten thousand (10,000) members; and ▪ one (1) completed contract for an account that offered a tiered benefit copay design. References from at least three (3) different individuals are required to satisfy the requirements above. The standard reference questionnaire, which must be used and completed, is provided at RFP Attachment 6.4. References that are not completed as required may be deemed non-responsive and may not be considered. The Respondent will be solely responsible for obtaining fully completed reference questionnaires and ensuring they are e-mailed to the solicitation coordinator. In order to obtain and submit the completed reference questionnaires follow the process below.

RFP ATTACHMENT 6.2. — SECTION B (continued)

RESPONDENT LEGAL ENTITY NAME:		
Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
		E-mail: (a) Add the Respondent's name to the standard reference questionnaire at RFP Attachment 6.4. and make a copy for each reference. (b) E-mail the reference with a copy of the standard reference questionnaire. (c) Instruct the reference to: (i) complete the reference questionnaire; (ii) sign and date the completed reference questionnaire; (iii) E-mail the reference directly to the Solicitation Coordinator by the RFQ Technical Response Deadline with the Subject line of the e-mail as "[Respondent Name] Reference for RFP 31786-00177. NOTES: ▪ The State will not accept late references or references submitted by any means other than the two which are described above, and each reference questionnaire submitted must be completed as required. ▪ The State will not review more than the number of required references indicated above. ▪ While the State will base its reference check on the contents of the reference e-mails, the State reserves the right to confirm and clarify information detailed in the completed reference questionnaires and may consider clarification responses in the evaluation of references. The State is under no obligation to clarify any reference information.
	B.17.	Provide a statement of whether, within the past five (5) years, either the Respondent or the Respondent's parent organization, affiliates, and subsidiaries (if any) has had a contract to provide medical claims administration services terminated prior to the contract end date or not re-contracted as a result of service/performance issues. If so, include an explanation of all relevant details including any corrective action taken by the Respondent to address the issues.
SCORE *(for all Section B—Qualifications & Experience Items above)*: *(maximum possible score = 5)*		
State Use – Evaluator Identification:		

TECHNICAL RESPONSE & EVALUATION GUIDE

SECTION C: TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH. The Respondent must address all items (below) and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the response page number for each item in the appropriate space below.

A Proposal Evaluation Team, made up of three or more State employees, will independently evaluate and score the response to each item. Each evaluator will use the following whole number, raw point scale for scoring each item:

0 = little value ***1 = poor*** ***2 = fair*** ***3 = satisfactory*** ***4 = good*** ***5 = excellent***

The Solicitation Coordinator will multiply the Item Score by the associated Evaluation Factor (indicating the relative emphasis of the item in the overall evaluation). The resulting product will be the item's Raw Weighted Score for purposes of calculating the section score as indicated.

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
General (Contract Section A.1)					
	C.1	Provide a brief description of your copay only plan design program that tiers ALL providers, specialists, facilities, pharmacies, and services using cost and quality data including the name, how long has it been offered, number of tiers, how the tiers/copays work by provider, facility, pharmacy, and service including episodic care like surgeries, procedures, and admissions?		5	
	C.2	Is medical, behavioral, Rx, and clinical care data fully integrated in your proposed tiered copay program plan including all providers, facilities, pharmacies, and services?		5	
	C.3	How many members (employees and dependents) are currently enrolled in your tiered copay program and how many additional lives is your organization expecting to add effective January 1st, 2024?		2	
	C.4	What are your book of business savings results achieved by your organization's tiered copay program?		3	
	C.5	What differentiates your tiered copay program from other like programs in the market today?		4	
Implementation (Contract Section A.3) The Contractor is expected to assume all responsibilities described in the Pro Forma Contract (RFP Attachment 6.6). The State expects that all implementation tasks be performed and reviewed for completion during the implementation period. This applies to a new Contractor or the incumbent Contractor.					
	C.6	Provide a detailed project implementation plan (as an exhibit) demonstrating the tasks and timeline required to achieve completion and confirming your ability to assume all responsibilities as described in the Pro Forma contract by Go-Live. Provide details about the major implementation tasks, their owners, any potential implementation risks or issues, and your plan to mitigate such risks or issues.		3	
	C.7	Provide a roster of the proposed implementation team members detailing each member's primary work		2	

		location, implementation role, responsibilities, and estimated number of hours per week during implementation.			
	C.8	Describe how you will ensure the accuracy of the benefits setup, including the Formulary and all Claims accuracy testing processes. Explain the documentation confirming accurate setup that will be provided to State staff prior Go-Live, after any benefit change, and prior to January 1st of each plan year.		5	
	C.9	Provide examples and references of how your solution has been successfully deployed alongside other PPO plan design(s) in a multi-choice plan environment.		4	
Staffing (Contract Section A.5.) The Contractor's account management team is important for the long-term success and working relationship during the contract term. Dedicated resources ensure adequate support of a large complex contract.					
	C.10	Identify the designated account management team you propose to work on this account (pending State approval). Provide an organization chart, including names and titles, of management and key personnel that will be responsible for account management including the estimated number of hours per week. Indicate whether the person who will fill each position is already employed by your firm or whether they will be recruited upon Contract award. If the person(s) are already employed, provide a brief resume to include their title, role, work history, education (if applicable), and length of time with your company. At a minimum, the positions should include: i. Account Executive (Designated) – Responsible for overall account relationship including strategic planning in relation to plan performance, consultative services, recommendations for benefit design and cost containment opportunities, and overseeing contractual services. ii. Account Manager (Designated) – Responsible for providing daily operational support, member support, as well as strategic planning and analysis. iii. Operations Manager – Responsible for all benefits set up and claims operations. iv. Enrollment Analyst – Responsible for all 834 file loads and enrollment corrections/updates. v. Reporting Analyst – Responsible for all reporting including Ad-Hoc requests. vi. Medical/Clinical Program Director – Responsible for all UM, Case Management, and other clinical support. vii. Licensed Chief Pharmacist – responsible for clinical pharmacological advice in the review and development of benefits and UM viii. Member Services Manager – Responsible for all call center and customer service functions.		3	

	C.11	Detail the level of decision-making authority available to the Account Team to resolve issues of importance to the State.		5	
	C.12	Define how the Account Team will be responsive, creative, and innovative in developing solutions and recommendations to reduce healthcare cost, improve quality of healthcare, improve access to healthcare, and increase Member satisfaction.		4	
Provider and Pharmacy Networks (Contract Section A.6)					
	C.13	Explain the data, information, or other supports you utilize to educate providers and assist in their efforts to manage care, improve care quality, and improve clinical outcomes.		4	
Member Services (Contract Section A.7.) The State requires the Contractor to provide Member services and Member navigation services to assist Members with resources and services, including but not limited to, claim and bill resolution, maximizing available benefits, navigating appeals, finding high quality/low cost care, and closing gaps in care.					
	C.14	Briefly summarize the experience and qualifications of the dedicated member services staff.		3	
	C.15	Briefly describe how dedicated member service representatives and advocates will be trained on this account prior to annual enrollment and ongoing account training.		4	
	C.16	Briefly describe your ability to provide members with the navigation services described above and in the Pro Forma Contract.		4	
	C.17	Describe your value-based copay product structure and benefit design and how it guides members to cost efficient in-person and/or virtual care options within a broad network.		4	
	C.18	Provide a description of the member experience starting from pre-enrollment, enrollment, provider search, and receiving care.		3	
	C.19	Describe any other decision support tools or resources available for members participating in your tiered copay program.		3	
	C.20	How does your organization's tiered copay program assist members in seeking high value care options from the highest quality, lowest cost providers? How does your solution include both cost and quality assessments?		4	
	C.21	Share results your organization's program has achieved in the following areas and any other areas you wish to share: -Member satisfaction -Member engagement -Utilization of high-value care -Reduction in unnecessary care -Other		3	
Member Appeals Process (Contract Section A.8.) The State requires the Contractor to provide Members with two internal and one independent review appeals. 100% of expedited appeals for urgent care shall be decided within 72 hours, 95% of non-urgent preservice appeals shall be decided within 30 days and 95% non-urgent post service appeals within 60 days.					

	C.22	Confirm your ability to provide members with two internal appeals and at least one independent review appeal, not including peer to peer and provider appeals.		5	
	C.23	Provide your 2022 appeal processing outcomes for your fully insured book of business. Appeals | CY 2022 Expedited within 72 hours | % Preservice within 30 days | % Post service within 60 days | %		5	
Utilization Management (Contract Section A.9.) The Contractor shall provide the utilization management services required in the Pro Forma Contract including utilization management of high cost services, services utilized to treat complex conditions, lengthy facility-based care, specialty medications, etc.					
	C.24	Identify any third parties used to carry out the following services: utilization management, prior approval, predeterminations, specialty drug management, precertification and/or prior notification of inpatient and outpatient services.		3	
	C.25	Confirm public accessibility of your medical and pharmacy policies on your website for both members and providers?		5	
	C.26	Briefly describe how your medical policies are developed and applied in processing claims?		4	
	C.27	Briefly describe your management, oversight, and your adherence to your published medical necessity coverage policies.		5	
	C.28	List and briefly describe all case management services and the associated conditions available to our Members including but not limited to cancer, cardiac surgeries, maternity, severe injury/trauma, neonate admissions, cognitive or physical disability, dialysis, transplants, autism, an autism spectrum disorder, or a developmental disorder.		4	
	C.29	Confirm your ability to provide members with expert medical opinion services. Do you contract with a third party for these services and if so, who?		3	
	C.30	Confirm that all costs associated with any utilization management, payment optimization, affordability solutions and any other program or mechanism utilized by you or a subcontractor to ensure evidence based services are being provided at the optimal place of service with clinical oversight and compliance with medical policies and guidelines are included in the administrative fees as proposed in the cost proposal and are not charged to the state in any other cost, capitation, or other payment model.		5	
	C.31	Describe how your proposed plan offering reduces both the consumption of unnecessary care as well as reduces the overall cost paid for the services consumed by our members immediately and over time.		4	
Value Based Initiatives (Contract Section A.13) Primary care integration and accountable care organizations have been in the market for a few years. Our Members currently have access to our carrier designed care transformation programs however, they are not currently required nor incentivized to participate.					
	C.32	Briefly summarize your approach to clinical care transformation.		3	

	C.33	Explain how your clinical care transformation approach encourages providers to focus on the entire patient care journey including chronic condition management, episodic condition management, mitigation of social determinants of health, transition of care post hospitalization, reducing and redirecting care to the most appropriate settings, and integrating behavioral health.		5	
	C.34	Briefly describe the integration and measurement of behavioral health care in your clinical care transformation approach. Include any current NCQA (Behavioral Health Integration) or URAC (Measurement Based Care) distinctions, or similar, or plans to obtain such distinctions, or similar, in the next plan year.		4	
	C.35	What is the distribution of your providers that participate in a primary care delivery reform program (e.g., an ACO, PCMH or other delivery model) across the copay tiers?		3	
Call Center (Contract Section A.14.) Describe the following characteristics of the Member services unit/call center. If there are multiple facilities or groups serving the account, please answer each question for each facility and/or group.					
	C.36	Location and hours of operation of the call center, including a back-up call center for operational readiness in the event of a natural disaster, etc.		2	
	C.37	The flexibility of the call center to handle fluctuations in call volume, its scalability, and the proportion of its capacity currently in use.		2	
	C.38	Confirm your ability to record and index all calls for retrieval to review potential member or member services representative issues.		2	
	C.39	Provide the number of dedicated member services representatives that will be assigned to this account.		3	
Claims Processing, Payment, and Reconciliation (Contract Section A.15.)					
	C.40	Confirm your ability to accurately process, pay, and reconcile claims in accordance with the Pro Forma Contract requirements and Plan Documents.		3	
	C.41	Describe the initial and ongoing testing and auditing of the claims system for accuracy, timeliness, and quality.		3	
	C.42	When errors are found, what is the time frame for correction of the claim?		3	
	C.43	Confirm your ability to ensure that the State only pays for the negotiated provider payment terms and no payment differential is retained by the Contractor, including bill negotiation services, recoveries, overpayments, etc. except as expressly stated in C.3.		5	
	C.44	Confirm the usage of a Pharmacy POS system that meets national security standards and includes data protection capabilities and can meet, or exceed, all contractual claims processing/adjudication requirements. (a) Is the POS system flexible and can the Respondent customize the system based upon client needs?		5	
Member Communications/Materials (Contract Section A.16.) Member Handbooks, Welcome Kits, and ID Cards (Contract Section A.17.)					

The State expects the Contractor to provide a fresh perspective with respect to marketing materials and Member engagement in addition to the minimum Member communications materials.					
	C.45	Confirm your ability to provide an annual written marketing and communications plan for ongoing member education.		3	
	C.46	Describe how you approach marketing and communications to benefit coordinators and members during annual enrollment and throughout the plan year on the tiered copay benefit design and the web/mobile application to encourage enrollment, plan design understanding, and active engagement.		5	
	C.47	Briefly describe any new or innovative marketing or communication approaches to member education that easily describe complex health care issues to members with low health literacy and the average health care consumer.		4	
	C.48	Describe how people are incented to engage with and utilize your solution as well as evidence that people actively engage with your solution. Additionally, provide proof points that this engagement results in lower rates of unnecessary care as well as lower rates of consumption at low value providers.		5	
	C.49	Briefly describe your strategy around using social media and other new technologies to communicate benefits to members.		3	
	C.50	Confirm your ability to create and provide all member materials including but not limited to member handbooks, welcome kits, ID Cards, etc. according to contract standards.		3	
Splash Page, Website, and Mobile Application (Contract Section A.18.) The State thinks Member education and navigation are critical with respect to online web-based resources including information regarding quality healthcare, quality providers, and cost transparency.					
	C.51	Confirm your ability to support State members with a custom splash page containing benefits, plan information, forms and materials that is available to prospective enrollees as well as enrolled members without a login/password.		5	
	C.52	Briefly describe the current web-based capabilities available to members. Include a list of services and identify those that are also mobile enabled or available through your mobile application. Include screen shots (no more than 5) that detail the primary website or mobile app capabilities available for members and a copy of your site map(s). For any capabilities that are not in current operation, submit draft materials.		5	
	C.53	Briefly describe your available consumer cost transparency and quality tools. Include the sources of data presented to members, and how frequently data is updated. Provide screen shots (no more than 5) representing the different types of cost and quality data contained in these tools. If you have changes or updates planned to your tools, please briefly describe those anticipated changes and the timing for such changes.		5	
Pharmacy (Contract Section A.19.)					

	C.54	Describe the number of times per year (how often, or which months) that your Preferred Drug List (PDL) is updated and the process and timing for adding products new to the market to the Formulary including the criteria and frequency of review used to make additions to the Specialty Drug list.		3	
	C.55	Formulary Disruption The State currently has an open formulary (see Appendix 7.1) with a few exclusions specifically listed in Appendix 7.19. Regarding the Respondent's Formulary management policies, procedures, and processes describe or provide: (a) A copy of the Formulary and the name of the Formulary you intend the State to use for its current benefit plans if selected as the best evaluated Respondent. For the purposes of the RFP analysis, this MUST be an open formulary with exclusions (only as listed in Appendix 7.19) and utilization management such as Step Therapy, quantity limits and/or PA requirements that aligns with the current plan design in Appendices 7.21 and 7.30. (b) A disruption analysis related to a switch from the current Formulary to the new Formulary. Complete the tables in RFP Appendix 7.3. for this analysis.		4	
	C.56	Explain how Formulary products are selected and what place price has in the placement of drugs on the Formulary including the specialty drug list. Are ICER reports used in determining the formulary? If so, how?		3	
	C.57	Where on your formulary are current biosimilar medications positioned? What steps, if any, are you taking to increase their utilization?		4	
	C.58	Briefly describe your organization's efforts to remove hyperinflated, wasteful, or otherwise low-value medications and products from your formulary. How can your organization assist the state group insurance program to reduce spend on products with less clinical value or for which there are other less costly OTC products or medications available?		4	
	C.59	List any recommended clinical management/utilization (Prior Authorization, Step Therapy, Quantity Limits etc.) programs to assess the appropriateness of therapy prior to dispensing products.		2	
	C.60	Briefly describe any clinical support available to members taking specialty medications through your own specialty pharmacy if you have one. Examples include access to nurses or pharmacists for consultation and education, any efforts commonly used to improve adherence rates for Specialty Drugs, and any case management programs including outreach and any coordination of care activities. When is this clinical support available to plan members (days and hours)?		4	
Quality Assurance Program (A.22) The State thinks quality of care is important for Member safety and to mitigate unnecessary medical costs. We monitor our plan's HEDIS measures, track leapfrog hospital quality results, and review choosing wisely guidelines.					

	C.61	Explain the tools you utilize, or have developed, to differentiate facility and provider quality beyond standard credentialing, how those differentiators are publicized to members, and how they are used to shift members to high quality providers.		5	
Fraud and Abuse (Contract Section A.23.)					
	C.62	Confirm your ability to implement procedures for preventing and detecting fraud and abuse as described in the Pro Forma contract.		3	
	C.63	Briefly describe the claim system processes and edits in place to identify improper provider billing. Specifically address up-coding, unbundling of services, and duplicate bill submissions.		5	
	C.64	Please briefly describe your ability to perform hospital claim reviews for payments greater than $100,000 including but not limited to, appropriate level of care coding and billing for miscellaneous items already included in the DRG.		4	
	C.65	How do you detect claims fraud? Are your adjudicators trained to identify potentially fraudulent claim expenses and claiming patterns?		4	
Reporting and Systems Access (Contract Section A.24.)					
	C.66	Confirm your ability to provide all reports and data in the format, in the level of detail, and on the timelines required in the Pro Forma contract.		5	
	C.67	Briefly describe the process by which State staff can add new members to the eligibility system and how soon, after an addition, claims can be adjudicated for the member.		4	
	C.68	Detail the extent to which authorized State staff will have access to the Respondent's system(s) for the purpose of creating and generating ad-hoc reports.		4	
Data Integration and Technical Requirements (Contract Section A.25.) and Information Systems (Contract Section A.26.)					
	C.69	Confirm that your enrollment file team has read and reviewed the State's 834 Companion Guide and confirm your ability to process the State's full standard 834 enrollment file including the quality control processes that will be used to ensure the timely, accurate and complete update of enrollment files as well as how enrollment errors will be resolved and communicated to the State.		5	
	C.70	Briefly describe any modifications to existing hardware and software that will be required to meet the requirements of the Pro Forma contract and the timeframe to make any needed modifications.		3	
	C.71	Confirm your ability to meet the Pro Forma contract System and Information Security and Access Management Requirements.		3	
Compliance (Contract Section A.30.)					
	C.72	Describe how your organization will ensure compliance with Public Chapter 1070 and Tenn. Code Ann. § 56-7-2359 as it relates to the state group insurance program.		5	

	C.73	Describe your approach to coverage of all Affordable Care Act (ACA) required medical, behavioral, and pharmacy benefits and all USPSTF "A" and "B" rated benefits, preventive services, and vaccinations and ensuring plan compliance with all associated requirements under Section 2713 of the ACA.		5	
	C.74	Describe how your organization will ensure the State's compliance with all requirements (No Surprises Act, Data Collection Reporting, Gag Clauses, etc.) of the 2021 Consolidated Appropriations Act and Transparency in Coverage rules, including required federal reporting.		5	
	C.75	Describe how you will perform an annual non-quantitative treatment limitation review and report final findings to the State, prior to each plan year benefit implementation, to ensure compliance with the Mental Health Parity and Addiction Equity Act.		5	
Privacy & Security of Protected Health Information (Contract Attachment B)					
	C.76	Describe the safeguards to protect the privacy and confidentiality of Members and to prevent unauthorized use or disclosure of Protected Health Information (PHI) that you create, receive, transmit, or maintain. Complete Appendix 7.11 regarding HIPAA Business Associate Assessment and submit it with your technical response as a separate appendix/exhibit file. **DO NOT** modify any of the questions asked in the appendix.		5	

The Solicitation Coordinator will use this sum and the formula below to calculate the section score. All calculations will use and result in numbers rounded to two (2) places to the right of the decimal point.		**Total Raw Weighted Score:** *(sum of Raw Weighted Scores above)*	
Total Raw Weighted Score **Maximum Possible Raw Weighted Score** *(i.e., 5 x the sum of item weights above)*	**X 40** *(maximum possible score)*	**= SCORE:**	
State Use – Evaluator Identification:			
State Use – Solicitation Coordinator Signature, Printed Name & Date:			

RFP ATTACHMENT 6.2.— SECTION D

TECHNICAL RESPONSE & EVALUATION GUIDE

SECTION D PART 1.: NETWORK MANAGEMENT. The Respondent must address all items below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the proposal page number for each item in the appropriate space below.

A Proposal Evaluation Team, made up of three or more State employees, will independently evaluate and score the Respondent's response to items in Section D, Part 1. Each evaluator will use the following whole number, raw point scale for scoring each item:

0 = little value ***1 = poor*** ***2 = fair*** ***3 = satisfactory*** ***4 = good*** ***5 = excellent***

The Solicitation Coordinator will multiply the Item Score by the associated Evaluation Factor (indicating the relative emphasis of the item in the overall evaluation). The resulting product will be the item's raw, weighted score for purposes of calculating the section score as indicated.

RESPONDENT LEGAL ENTITY NAME:					
Proposal Page # (Respondent completes)	**Item Ref.**	**Section D— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
Provider and Pharmacy Networks (Contract Section A.6)					
Medical and Behavioral Provider Networks					
	D.1.1.	Define if all of your networks are managed by your company or if you subcontract any portion of your network from another organization. If you subcontract, please provide information about the subcontracted network.		**3**	
	D.1.2.	Describe your network provider services including provider training, technical assistance, and how quality standards are communicated and enforced. Include your provider education and outreach reporting and efforts to help lower tiered providers improve their performance and tiering status.		**5**	
	D.1.3.	Describe your approach to provider network management to ensure your network maintains high quality high performing providers at a reasonable cost. Include your approach to involuntary termination as necessary.		**5**	
	D.1.4.	Describe your approach to network development (including physician profiling and hospital profiling), maintenance (including the standard period of provider agreement renegotiation and renewal), and provider credentialing.		**3**	
	D.1.5.	Describe your openness to work with the State to fill gaps in your provider networks as identified by members, the State, and through any program or data analysis.		**4**	
	D.1.6.	Describe the quality measures and cost criteria used to identify high performing providers and how those providers are tiered to encourage member utilization.		**5**	
Pharmacy Network					

	D.1.7	Explain the ongoing frequency of pharmacy network efforts including contract renegotiation and renewal with pharmacies.		**4**	
	D.1.8	List any major chain pharmacies that do not participate in your Retail-30, 90-day-at-retail or vaccination networks and specify which network/s (e.g., 30-day. 90 days, or vaccine network) they are not in.		**4**	
	D.1.9	Describe your specialty pharmacy program. Is it managed by your organization as the PBM or by an outside vendor?		**4**	
	D.1.10	Do you have your own specialty pharmacy within your specialty pharmacy network and if so, confirm members are not required to use your pharmacy over the others in the network?		**3**	
	D.1.11	Confirm that the specialty pharmacies in your specialty network do not auto ship and will contact the plan Member before filling to ensure the medication is still needed, and the Member is using the medication (to reduce plan cost and waste).		**3**	
National Provider Network					
	D.1.12	Describe your currently established national network you are proposing to use for this contract, including the provider and facility participation that enrolled members will access if they live out of state or are traveling.		**3**	
	D.1.13	Describe any limitations regarding your national network including, but not limited to, less competitive pricing arrangements, utilization management/prior authorizations, provider quality management, member access, and level of claims data available.		**4**	

The Solicitation Coordinator will use this sum and the formula below to calculate the section score. All calculations will use and result in numbers rounded to two (2) places to the right of the decimal point.	**Total Raw Weighted Score:** *(sum of Raw Weighted Scores above)*	
Total Raw Weighted Score / **Maximum Possible Raw Weighted Score**	**X 5** *(maximum possible score)* **= SCORE:**	
State Use – Evaluator Identification:		
State Use – Solicitation Coordinator Signature, Printed Name & Date:		

TECHNICAL PROPOSAL & EVALUATION GUIDE

SECTION D, PART 2: NETWORK ACCESS. The Respondent must address all items below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the proposal page number for each item in the appropriate space below.

A Proposal Evaluation Team, made up of three or more State employees, will independently evaluate and score the Respondent's response to items in Section D, Part 1. Each evaluator will use the following whole number, raw point scale for scoring each item:

0 = little value ***1 = poor*** ***2 = fair*** ***3 = satisfactory*** ***4 = good*** ***5 = excellent***

The Solicitation Coordinator will, then, multiply the Item Score by the associated Evaluation Factor (indicating the relative emphasis of the item in the overall evaluation). The resulting product will be the item's raw, weighted score for purposes of calculating the Section D, Part 1 score as indicated.

RESPONDENT LEGAL ENTITY NAME:					
Name of currently established Proposed Broad Network to be used for this contract					
Proposal Page # (Respondent completes)	**Item Ref.**	**Section D— Technical Qualifications, Experience & Approach Items**	**Item Raw Score**	**Evaluation Factor**	**Raw Weighted Score**
Network Accessibility (Contract Attachment B)					
Medical Provider Network Access Analysis. For the currently established proposed **medical provider** network to be used for this contract, coordinate with Quest and submit your **Network Access Analysis Report** for your participating Acute Care Hospitals, Primary Care Physicians, Pediatricians, Obstetricians/Gynecologists, Cardiologists and Endocrinologists **IN TENNESSEE ONLY**, as required in **Appendix 7.6,** as illustrated in **Appendix 7.9**. and using the State's total Tennessee participant population data provided in **Appendix 7.2, TN ZIP Code Counts.** **Note: Evaluators will use the Network Access Analysis Report to score the following categories based upon the proposed medical provider network as it compares to the Comparative Medical Provider Network Access Analysis in Appendix 7.9.**					
	D.2.1	**Acute Care Hospitals**		**5**	
	D.2.2	**Primary Care Physicians**		**4**	
	D.2.3	**Pediatricians**		**4**	
	D.2.4	**Obstetricians/Gynecologists**		**4**	
	D.2.5	**Cardiologists**		**3**	
	D.2.6	**Endocrinologists**		**2**	
Behavioral Provider Network Access Analysis. For the currently established proposed **behavioral provider** network to be used for this contract, coordinate with Quest and submit your **Network Access Analysis Report** for your participating Acute Care Facilities, Psychiatrists and Advanced Practice Psychiatric Nurses, Psychologists, Child/Adolescent Providers, All other Masters Level Providers, Medication Assisted Treatment Providers, Intermediate Care Facilities, and Intensive Outpatient Facilities **IN TENNESSEE ONLY**, as required in **Appendix 7.5**, as illustrated in					

Appendix 7.8. and using the State's total Tennessee participant population data provided in **Appendix 7.2, TN ZIP Code Counts.** **Note: Evaluators will use the Network Access Analysis Report to score the following categories based upon the proposed behavioral provider network as it compares to the Comparative Behavioral Provider Network Access Analysis in Appendix 7.8.**					
	D.2.7	**Psychiatrists and Advanced Practice Psychiatric Nurses**		**5**	
	D.2.8	**Psychologists**		**4**	
	D.2.9	**Child/Adolescent Providers**		**4**	
	D.2.10	**All other Masters Level Providers**		**3**	
	D.2.11	**Medication Assisted Treatment Providers**		**3**	
	D.2.12	**Inpatient Acute Care Facilities**		**5**	
	D.2.13	**Intermediate Care Facilities** (Residential and Partial)		**3**	
	D.2.14	**Intensive Outpatient Facilities**		**3**	
Retail-30 Pharmacy Network Access Analysis. For the currently established proposed **retail-30 pharmacy** network to be used for this contract, coordinate with Quest and submit your **Retail-30 Pharmacy Network Access Analysis Report** for your participating retail pharmacies **IN TENNESSEE ONLY**, as required in **Appendix 7.7**, as illustrated in **Appendix 7.10**. and using the State's total Tennessee participant population data provided in **Appendix 7.2, TN ZIP Code Counts.**					
Note: Evaluators will use the Network Access Analysis Report to score the following categories based upon the proposed retail-30 pharmacy network as it compares to the Comparative Retail Pharmacy Network Access Analysis in Appendix 7.10.					
	D.2.15	**Urban Retail Pharmacies**		**5**	
	D.2.16	**Suburban Retail Pharmacies**		**5**	
	D.2.17	**Rural Retail Pharmacies**		**4**	
The Solicitation Coordinator will use this sum and the formula below to calculate the section score. All calculations will use and result in numbers rounded to two (2) places to the right of the decimal point.			**Total Raw Weighted Score:** (sum of Raw Weighted Scores above)		
Total Raw Weighted Score / **Maximum Possible Raw Weighted Score**		**X 5** (maximum possible score)	**= SCORE**		
State Use – Evaluator Identification:					
State Use – Solicitation Coordinator Signature, Printed Name & Date:					

TECHNICAL PROPOSAL & EVALUATION GUIDE

SECTION D, PART 3: NETWORK DISRUPTION. The Respondent must address all items below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the proposal page number for each item in the appropriate space below.

Complete and address the Technical Proposal & Evaluation Guide – Section D.3 for the medical, behavioral, and pharmacy provider networks you are proposing to use for this contract.

A Proposal Evaluation Team, made up of three or more State employees, will independently evaluate and score the Respondent's response to items in Section D, Part 3. Each evaluator will use the following whole number, raw point scale for scoring each item:

0 = little value 1 = poor 2 = fair 3 = satisfactory 4 = good 5 = excellent

The Solicitation Coordinator will calculate the raw scores as explained in the raw score calculation notes following the table below, and, then, multiply each raw score by the associated Evaluation Factor (indicating the relative emphasis of the item). The resulting product will be the item's raw, weighted score for purposes of calculating the Section D, Part 3 score as indicated.

RESPONDENT LEGAL ENTITY NAME:					
Proposal Page # (Respondent completes)	**Item Ref.**	**Section D— Technical Qualifications, Experience & Approach Items**	**Item Raw Score**	**Evaluation Factor**	**Raw Weighted Score**
	D.3.1	**Medical Provider Disruption Analysis.** Using the provider listing in Appendix 7.13 and following the instructions on tab 1 (Utilized Providers), indicate the tier or out of network status of the providers listed, related to the proposed network as of the proposal date. Summarize the information in Table 2. **Note: The State will provide the Respondent's information along with Incumbent information in Appendix 7.13 to the Evaluation team.**		**4**	
	D.3.2	**Behavioral Provider Disruption Analysis.** Using the behavioral provider listing in Appendix 7.12 and following the instructions on tab 1 (Utilized Facilities) and tab 2 (Utilized Providers), indicate the tier or out of network status of the providers listed, related to the proposed network as of the proposal date. Summarize the information in Table 2 of each tab. **Note: The State will provide the Respondent's information along with Incumbent information in Appendix 7.12 to the Evaluation team.**		**5**	
	D.3.3	**Retail-30 Pharmacy Disruption Analysis.** Using the pharmacy listing in Appendix 7.14 and following the instructions on tab 1 (Utilized Pharmacies), indicate the tier or out of network status of the pharmacies listed, related to the proposed retail-30 network as of the proposal date. Summarize the information in Table 4.		**4**	

		Note: The State will provide the Respondent's information along with Incumbent information in Appendix 7.14 to the Evaluation team.			
The Solicitation Coordinator will use this sum and the formula below to calculate the section score. All calculations will use and result in numbers rounded to two (2) places to the right of the decimal point.				**Total Raw Weighted Score:** *(sum of Raw Weighted Scores above)*	
Total Raw Weighted Score / **Maximum Possible Raw Weighted Score**			**X 5** *(maximum possible score)*	**= SCORE:**	
State Use – Evaluator Identification:					
State Use – Solicitation Coordinator Signature, Printed Name & Date:					

RFP ATTACHMENT 6.3.

COST PROPOSAL & SCORING GUIDE

The Respondent shall complete and submit its Cost Proposal in accordance with the instructions given in RFP Section 3.2.2.2.2 The Respondent shall use an XLS spreadsheet to prepare the Cost Proposal. This spreadsheet is found at the following website address, under the section labeled RFP # 31786-00174:

https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/supplier-information/request-for-proposals--rfp--opportunities1.html

Further instructions specific to the content of the Cost Proposal are found in the above referenced spreadsheet.

The spreadsheet will calculate the Total Evaluation Cost Amount. This Amount will be used in the formula in the cost proposal to derive the Proposer's Cost Proposal score.

REFERENCE QUESTIONNAIRE

The standard reference questionnaire provided on the following pages of this attachment should be completed by all individuals offering a reference for the Respondent.

The Respondent will be solely responsible for obtaining completed reference questionnaires as detailed below. Provide references from individuals for projects similar to the goods or services sought under this RFP and which represent:

- two (2) contracts Respondent currently services that currently offer a tiered benefit copay design with a combined minimum of no less than ten thousand (10,000) members; and
- one (1) completed contract for an account that offered a tiered benefit copy design.

References from at least three (3) different individuals are required to satisfy the requirements above. The individual contact reference provided for each contract or project shall not be a current State employee of the procuring State agency. Procuring State agencies that accept references from another State agency shall document, in writing, a plan to ensure that no contact is made between the procuring State agency and a referring State agency. The standard reference questionnaire, should be used and completed, and is provided on the next page of this RFP Attachment 6.4.

In order to obtain and submit the completed reference questionnaires following the process below.

Email:

(a) Add the Respondent's name to the standard reference questionnaire at RFP Attachment 6.4. and make a copy for each reference.

(b) E-mail a reference questionnaire to each reference.

(c) Instruct the reference to:

  (i) complete the reference questionnaire;

  (ii) sign and date the completed reference questionnaire;

  (iii) E-mail the reference directly to the Solicitation Coordinator by the RFP Technical Response Deadline with the Subject line of the e-mail as "[Respondent's Name] Reference for RFP **# 31786-00177**".

NOTES:

- The State will not accept late references or references submitted by any means other than the two which are described above, and each reference questionnaire submitted must be completed as required.
- The State will not review more than the number of required references indicated above.
- While the State will base its reference check on the contents of the reference e-mails included in the Technical Response package, the State reserves the right to confirm and clarify information detailed in the completed reference questionnaires, and may consider clarification responses in the evaluation of references.
- The State is under no obligation to clarify any reference information.

RFP #31786-00177 REFERENCE QUESTIONNAIRE

REFERENCE SUBJECT: RESPONDENT NAME (completed by Respondent before reference is requested)

The "reference subject" specified above, intends to submit a response to the State of Tennessee in response to the Request for Proposals (RFP) indicated. As a part of such response, the reference subject must include a number of completed reference questionnaires (using this form).

Each individual responding to this reference questionnaire is asked to follow these instructions:

- complete this questionnaire (either using the form provided or an exact duplicate of this document);
- sign and date the completed questionnaire and follow the process outlined below;

E-Mail:

- e-mail the completed questionnaire to:
  Solicitation Coordinator Name and E-Mail Address

---

(1) What is the name of the individual, company, organization, or entity responding to this reference questionnaire?

(2) Please provide the following information about the individual completing this reference questionnaire on behalf of the above-named individual, company, organization, or entity.

NAME:	
TITLE:	
TELEPHONE #	
E-MAIL ADDRESS:	

(3) How many lives are covered under your medical benefits in total?

(4) Did you or do you currently offer a tiered copay plan design option from the reference subject?

(5) If so, how long have/did you offered a tiered copay design option and how many lives are/were covered under the tiered copay design?

(6) What goods or services does/did the reference subject provide to your company or organization?

(7) Are the goods or services that the reference subject provided to your company or organization completed or ongoing? Were the goods or services provided in compliance with the terms of the contract, on time, and within budget? Please explain.

(8) Is the reference subject is currently providing goods or services to your company or organization under the same or a subsequent contract? Are these goods or services being provided in compliance with the terms of the contract, on time, and within budget? Please explain.

(9) How satisfied are you with the reference subject's ability to perform based on your expectations and according to the contractual arrangements?

REFERENCE SIGNATURE:
(by the individual completing this request for reference information)

DATE:

SCORE SUMMARY MATRIX

	RESPONDENT NAME		*RESPONDENT NAME*		*RESPONDENT NAME*	
GENERAL QUALIFICATIONS & EXPERIENCE (maximum: 5)						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE:		**AVERAGE:**		**AVERAGE:**	
TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH (maximum: 40)						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE:		**AVERAGE:**		**AVERAGE:**	
Technical Qualifications, Network Analysis Part 1 Network Management (maximum: 5)						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE:		**AVERAGE:**		**AVERAGE:**	
Technical Qualifications, Network Analysis Part 2 Network Access (maximum: 5)						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE:		**AVERAGE:**		**AVERAGE:**	
Technical Qualifications, Network Analysis Part 3 Disruption Analysis (maximum: 5)						

EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE:		**AVERAGE:**		**AVERAGE:**	
COST PROPOSAL **(maximum: 40)**	**SCORE:**		**SCORE:**		**SCORE:**	
TOTAL RESPONSE EVALUATION SCORE: **(maximum: 100)**						
Solicitation Coordinator Signature, Printed Name & Date:						

RFP ATTACHMENT 6.6.

RFP # 31786-00177 *PRO FORMA* CONTRACT

The *Pro Forma* Contract detailed in following pages of this exhibit contains some "blanks" (signified by descriptions in capital letters) that will be completed with appropriate information in the final contract resulting from the RFP.

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
Department of Finance & Administration, Division of Benefits Administration, State Insurance Committee, Local Education Insurance Committee, Local Government Insurance Committee
AND
CONTRACTOR NAME

This Contract, by and between the State of Tennessee, Department of Finance & Administration, Division of Benefits Administration, State Insurance Committee, Local Education Insurance Committee, Local Government Insurance Committee ("State") and Contractor Legal Entity Name ("Contractor"), is for the provision of Scope of Goods or Services Caption, as further defined in the "SCOPE". State and Contractor may be referred to individually as a "Party" or collectively as the "Parties" to this Contract.

The Contractor is a/an Individual, For-Profit Corporation, Non-Profit Corporation, Special Purpose Corporation Or Association, Partnership, Joint Venture, Or Limited Liability Company.
Contractor Place of Incorporation or Organization: Location
Contractor Edison Registration ID # Number

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 shall serve all Members, both statewide and nationally, through their Broad Networks.

c. The Contractor shall administer a Preferred Provider Organization self-funded medical benefit design option using a tiered Copayment design with no Deductible, to be agreed upon by the State In Writing. The plan design shall assign different Copayments based upon the tier status of every provider, specialist, facility, pharmacy, and service based upon quality and cost data analytics. Tiering shall extend beyond a two-tier preferred and non-preferred status and include tiered Copayments for all provider specialties, facilities, pharmacies, and services. Episodic care such as surgeries, procedures, and admissions shall also be tiered based upon the cost and quality of the provider and facility in the episode and shall be bundled so that the Member Copayment includes all services rendered by all providers and facilities. The Contractor shall offer an online platform clearly presenting the Member's Copayment options for every provider, facility, and service, which shall be based on underlying cost and quality data. The Contractor shall administer this benefit design option inclusive of behavioral health benefits with the same Copayment and tiering of providers, facilities, and services. At the State's request pharmacy services shall also be administered, with the same tiered Copayment design by both formulary and pharmacy. However, the State reserves the right to carve out pharmacy benefits at any time. If carved out, the respective pharmacy, not including medical specialty, contract requirements will not apply.

d. The Contractor shall provide administrative services for Members of the State's Plan Groups, who elect to enroll in the Copay plan option offered by the State.

e. The Plan's participating employers may adjust the premium that they charge Members to enroll with the Contractor to account for changes in the Contractor's provider payment terms and other factors as the State deems appropriate. Similarly participating employers, including the State, may elect to adjust their contribution based on these and other factors. Decisions on these issues are final and not subject to appeal.

A.2. **Definitions.** For purposes of this Contract, definitions shall be as follows and as set forth in the Contract.

a. **Account Executive**: Designated full-time employee of the Contractor who has primary oversight and management of the Contract and all services, deliverables, and requirements within.

b. **Account Manager**: Designated full-time employee of the Contractor who supports the Contract primarily handling Member services and issues including claims, benefits, and provider concerns.

c. **Administrative Fees:** The fee for all administrative, clinical, Utilization Management, cost containment solution services paid by the State to the Contractor. It is the only compensation due the Contractor under the contract. The Contractor's monthly compensation is a function of the contractor's Administrative Fee multiplied by the number of participating employees per month ("PEPM"). The Administrative Fee shall constitute all payments due to the Contractor and shall include, but not be limited to, all costs incurred by the Contractor to comply with all state and federal laws including, but not limited to, appeals by pharmacies to the Tennessee Department of Commerce & Insurance associated with PBM claim reimbursement related to Tennessee Public Chapter 1070 and independent dispute resolution fees related to the Consolidated Appropriations Act, 2021.

d. **Affiliate:** An entity: (1) which is directly or indirectly, through one or more intermediaries, controlling such party; (2) which is under the same direct or indirect ownership or control as such party; or (3) which is directly or indirectly, through one or more intermediaries, owned or controlled by such party. For purposes of this definition and the Agreement, "control" (including the terms controlling, controlled by or under common control with) means (a) the possession, direct or indirect, (b) the power to direct or cause the direction of the management or policies of an entity, or (c) the ability to direct an entity's affairs or to control the composition of its board of directors or equivalent body, whether through (i) 50% of more of voting securities, (ii) partnership or Membership interests, (iii) by contract or (iii) any other means. Further, a Group Purchasing Organization shall also be considered an Affiliate to the extent the GPO meets the above definition.

e. **Agency Benefits Coordinator ("ABC")**: An Agency Benefits Coordinator serves as the liaison between the Plan and Members. There is at least one ABC in every employer agency/entity.

f. **At-Risk Performance Payment:** Contractor's payment based on KPI performance listed on the SLA Scorecard set forth in Contract Attachment D. The payment is calculated based on the SLA Scorecard quarterly score and percentage of the Administrative Fees at risk.

g. **Authorized Generic:** a drug that is marketed, sold or distributed in the United States as a Generic Drug version of a Brand Drug where the authority for such marketing, sale and or distribution is based upon a Manufacturer's New Drug Application (NDA) or Biologic License Application (BLA) for the associated Brand Drug. Also, the Authorized Generic is marketed, sold or distributed under a different labeler code, product code, trade name, trademark, or packaging (other than repacking the listed drug for use in institutions) than the Brand Drug. Authorized Generics will be identified using MediSpan Multisource Code of "M" (co-branded product) with a Brand Drug Code of "B" (Branded Generic Name).

h. **Average Sales Price ("ASP"):** Equals the volume-weighted, per-unit average of Manufacturer sales prices for each product that falls within a single 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.

i. **Average Speed of Answer ("ASA"):** The average waiting time between (a) the moment at which a caller to the Contractor's call center first hears an introductory greeting and enters the queue and (b) the time at which a Member services representative at the call center answers the call. For this definition, the term "answer" shall mean begin an uninterrupted dialogue with the caller. If a Member services representative asks the caller to hold during the first sixty (60) seconds of the dialogue, the Contractor shall not consider the call to be answered for purposes of this definition until the Member services representative returns to the caller and begins an uninterrupted dialogue.

j. **Average Wholesale Price ("AWP"):** is a reference price for prescription drug products. Pharmacy reimbursement can be calculated based on AWP minus a percentage. The AWP is the Average Wholesale Price per unit for a product's NDC-11 on the date the Claim is adjudicated as set forth from the most current pricing information from Medi-Span.

k. **Balance Bill or Billing:** Seeking payment from a Member for any charged amount(s) over and above the MAC or contract rates.

l. **Benefits Administration ("BA"):** The division of the Tennessee Department of Finance & Administration that administers the Plans.

m. **Biosimilar Drug:** a biological product that is highly similar to a US-licensed reference biological product notwithstanding minor differences in clinically inactive components, and for which there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product as defined in the Biologics Price Competition and Innovation Act of 2009 at 42 U.S.C. §262(i)(2) and approved under Section 351(k) of the Public Health Services Act and as identified in the Purple Book.

n. **Brand Drug:** an FDA approved drug, or a drug that is Designated by FDA a DESI (Drug Efficacy Study Implementation) drug, or product, which is manufactured and distributed by an innovator drug company, or its licensee, set forth in Medi-Span's National Drug Data File (MS) as a Brand Drug identified by all of the products meeting at least one of the following criteria:
   (1) Brand Name code of "T" and Multisource Code "M"
   (2) Brand Name code of "B" or "T" and Multisource Code of "N"
   (3) Brand Name code of "B" or "T" and Multisource Code "O" and a DAW code of 0, 1, 2, 7, 8, or 9

   For the avoidance of doubt, Brand Drugs shall also include brand name vaccines, supplies, medical devices, kits, diabetic supplies, OTC products, and test strips.

o. **Broad Network:** The Contractor's most inclusive provider network containing the largest number of contracted providers and hospital facilities.

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

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

r. **CFR:** Code of Federal Regulations.

s. **Clean Claim:** A claim received by the Contractor for adjudication, and which requires no further information, adjustment, or alteration by the provider 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.

t. **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.

u. **Compound Prescription:** a mixture of two (2) or more ingredients when at least one of the ingredients in the preparation is an FDA approved federal legend drug, and the mixture of which is not otherwise generally available in an equivalent commercial form or strength in response to a physician's prescription to create a medication tailored to the specialized medically required need for an individual patient. A Compound Drug is identified by the compound indicator on the Claim feed. It excludes the addition of any flavoring to any prescription or medication requiring reconstitution (e.g., powdered oral antibiotics, topical acne preparations, etc.).

v. **Copayment:** That portion of the MAC (flat dollar amount) for each medical, behavioral health or pharmaceutical service provided to a Member that is the responsibility of the Member.

w. **Covered Drug or Covered Product:** a drug, device or supplies that is covered under the Formulary adopted by the State and requires a prescription for dispensing and/or coverage as a plan benefit.

x. **Days' Supply:** the number of days the Brand Drug, Generic Drug or Specialty Drug is to be taken as prescribed and submitted to Contractor by the dispensing Pharmacy.

y. **Dedicated:** Wholly assigned to the State and this contract without supporting additional clients or other non-State contracts.

z. **Deductible:** The amount that must be paid by each Member prior to payment of covered benefits by the Contractor.

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

bb. **DESI drug:** A drug that has been Designated as experimental or ineffective by the Food and Drug Administration (FDA).

cc. **Designated:** Assigned to support this contract but may support additional clients or contracts.

dd. **Decision Support System ("DSS"):** A database and query tool containing health care information and claims data which allows for analytics and executive decision making.

ee. **Discount(s):** The percentage difference between the applicable AWP for a covered service and (i) the MAC, where applicable, or (ii) the Contractor's negotiated reimbursement amount with a participating Pharmacy for prescription drugs, OTCs and other services provided by such Pharmacy to Members. The Discount excludes the Dispensing Fee, Copayment and sales tax, if any. For Discount purposes and other related contract calculations, Single-Source Generics should be considered as Multi-source generics and must not be considered Brands for the purpose of pricing or guarantee reconciliation.

ff. **Dispensing Fee:** the fee paid to the dispensing Pharmacy for the professional service of filling a Claim and is equal to the Total Claim Cost less the Ingredient Cost and less the applicable sales tax. U&C Claims will always have a zero-dollar Dispensing Fee.

gg. **Drug Utilization Review ("DUR")** - A POS Claim edit to facilitate Drug Utilization Review (DUR) objectives.

hh. **EAP:** Employee Assistance Program

ii. **Edison:** The State's enterprise resource planning system, which supports human resources, payroll, insurance, contracting, procurement and other agency functions.

jj. **eValue8:** A quality assessment of TPAs 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.

kk. **Flexible Spending Arrangement ("FSA"):** A health Flexible Spending Arrangement allows employees to be reimbursed for medical expenses. FSAs are usually funded through voluntary salary reduction agreements with employers. No employment or federal income taxes are deducted from employee contributions. The employer may also contribute.

ll. **Formulary or Formularies** – the list of FDA-approved prescription drugs and supplies developed by a Pharmacy and Therapeutics Committee ("P&T Committee"). The Formulary consists of (i) a ranking of Covered Products into preferred and non-preferred tiers, (ii) a listing of Non-Covered Products, and (iii) associated utilization review programs pursuant to standard clinical criteria, which may include, but not be limited to, Prior Authorizations, Step Therapy and/or quantity limits for one or more Covered Products.

mm. **Generic Drug:** an FDA approved drug, or a drug that is Designated by FDA a DESI (Drug Efficacy Study Implementation) drug, or product, that is therapeutically equivalent to other pharmaceutically equivalent products, as set forth in Medi-Span's National Drug Data File (MS) as a Generic Drug identified by all products meeting at least one of the following criteria:

(1) Brand Name code of "G" for all Multisource Codes (M, N, O, and Y)
(2) Multisource Code of "Y"
(3) Multisource Code of "M" with a Brand Drug Code of "B" (Authorized Generic)
(4) "O" with a DAW code of 3, 4, or 6
(5) Multisource Codes (M, N, O, and Y) with a DAW code of 5 (House Generic).

For the avoidance of doubt, Generic Drugs shall also include generic vaccines, supplies, medical devices, kits, diabetic supplies, OTCs, and test strips.

nn. **Go-Live or Go-Live Date:** January 1, 2025

oo. **Group Purchasing Organization ("GPO"):** an entity that aggregates the purchasing power of a group of businesses to obtain Discounts or Rebates from Pharmaceutical Manufacturers. These services may include contracting with Manufacturers for Manufacturer Payments or any similar service conducted on behalf of the Contractor. Any entity who provides the same or similar services as the Contractor on behalf of the Contractor under this Agreement shall also be considered a GPO. For purposes of this Agreement, Rebate aggregators or any similar/competing entity shall also be a GPO. For purposes of this Agreement, Rebate aggregators or any similar/competing entity shall also be a GPO.

pp. **Guaranteed Minimum Manufacturer Payment or Rebate Guarantee:** the minimum Rebate per Rx by dispensing channel. The performance will be calculated for the annual period using the following formula for each dispensing Channel independently, then summed: 'The calculation of the Annual Rebate Guarantee Amount will be [Rebate Guarantee] multiplied by [total Rx count minus the exclusions as identified by the State in Contract Section A.19.y.].

qq. **Healthcare Common Procedure Coding System ("HCPCS"):** The Healthcare Common Procedure Coding System is a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology.

rr. **Head of Contract:** Eligible employee, retiree, surviving dependent, or individual qualified under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) who is enrolled in one of the medical benefit options of the Plans and considered to be the primary policyholder.

ss. **Health Savings Account ("HSA"):** A tax-exempt trust or custodial account set up with a qualified trustee for individuals covered under a qualifying high Deductible health plan to save or pay for certain medical expenses not covered by the health plan.

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

uu. **HITECH:** Health Information Technology for Economic and Clinical Health Act Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5 (Feb. 17, 2009) and implementing regulations.

vv. **House Generics:** a Brand Drug submitted with a Dispense As Written (DAW) 5 code in place of the generic equivalent and where the Pharmacy is reimbursed at a Generic Drug rate, including MAC, as applicable. For reconciliation of the Generic Drug Discount guarantees, the AWP of House Generic drugs shall be the per unit AWP of the generic equivalent and not the AWP of the Brand Drug. House Generics will be identified using Medi-Span Multisource Code M, N, O, or Y and a Dispense as Written (DAW) code of 5.

ww. **Identical, Related or Similar ("IRS"):** Drugs that are identical, related or similar to drugs identified as LTE (Less Than Effective) by the FDA.

xx. **Inflation Protection Payments:** payments received by your firm (if any; and whether separately made or in the form of increased Rebates) or PBM Affiliates from a Pharmaceutical Manufacturer for the purpose of adjusting for year over year price inflation of the Manufacturer's price to your firm for prescriptions on which Rebates are paid; in accordance with and pursuant to applicable pharmaceutical Manufacturer agreements.

yy. **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.

zz. **Ingredient Cost:** Will be defined for the Contract according to the criteria below:

(1) For retail, Ingredient Cost means the lowest of:

a. U&C Price
b. MAC, where applicable; or
c. Mutually agreed upon baseline pricing measure value (i.e., AWP, NADAC, WAC, or other) less all applicable Discounts or other applicable

reimbursement amounts negotiated with the participating Retail Pharmacy which adheres to Discount Guarantees, as applicable, and as set forth in this Contract.

(2) For brands dispensed via the Contractor's Mail order and Specialty Pharmacies, Ingredient Cost means the Discounted price using the guaranteed Discount percentage set forth in the price schedule(s) of this Contract, based on the baseline pricing measure value (i.e., AWP, NADAC, WAC, or other) as mutually agreed upon by the parties.

(3) For generics dispensed via the Contractor's Mail Order and Specialty Pharmacies, Ingredient Cost means the lower of the MAC, where applicable, or the Discounted price using the default Discount percentage set forth in the Price Schedule(s), based on the baseline pricing measure value (i.e., AWP, NADAC, WAC, or other) as mutually agreed upon by the parties.
Ingredient Cost does not include the Dispensing Fee, the Copayment, Coinsurance, Deductibles or sales tax, if any.

aaa. **Inpatient Care:** Inpatient health services, including hospital services, skilled facility care, residential treatment services, partial hospitalization services and intensive outpatient therapy.

bbb. **In Writing:** Written communication between the Parties, which may be in the form of an official memo, or documents sent via post mail, fax, or email communications.

ccc. **Key Performance Indicators ("KPI"):** Performance indicators which are the metrics used to measure and evaluate Contractor's performance against the desired outcomes. These indicators are used to determine Contractor's At-Risk Performance Payment as set forth in Contract Section C and Contract Attachment D.

ddd. **Leapfrog Surveys:** Surveys conducted by the nonprofit Leapfrog Group that assess the safety and quality of healthcare facilities.

eee. **Less Than Effective ("LTE")**: Drugs considered by the FDA to have a lack of substantial evidence of effectiveness for all labeled indications and for which there is no compelling justification for their medical need.

fff. **Limited Distribution Specialty Drug:** those Specialty Drugs only available through select Pharmacy Providers as determined by the drug Manufacturer.

ggg. **Local Education Agency ("LEA"):** A local education agency pursuant to Tenn. Code Ann. § 49-3-302.

hhh. **Local Government Agency ("LGA"):** A local government agency pursuant to Tenn. Code Ann. § 8-27-207.

iii. **Low Volume Pharmacy:** A network Pharmacy who has provided certification to the Contractor, Contractor's Affiliate, or their Subcontractor(s), that their annual prescription volume is at a level that, if the Pharmacy were a TennCare-participating ambulatory Pharmacy, would qualify the Pharmacy for the enhanced amount of professional Dispensing Fee for a Low Volume Pharmacy under the operative version of the Division of TennCare Pharmacy Provider Manual, or a successor manual.

jjj. **Mail Order Pharmacy or Mail Order**: an automated Pharmacy that processes prescriptions at one or more central locations and delivers them through the mail or other third-party delivery service to the locations of customers and does not have a physical customer-facing storefront. If such an automated Pharmacy dispenses Specialty Drugs and non- Specialty Drugs, such Mail Order Pharmacy shall constitute a Mail Order Pharmacy solely with respect to the dispensing of non-Specialty Drugs and shall

constitute a Specialty Pharmacy with respect to the dispensing of Specialty Drugs. These Pharmacies are identified by a National Council for Prescription Drug Program's (NCPDP's) dispenser type code of '05'.

kkk. **Manufacturer Administrative Fees ("MAF"):** fees for services rendered to Pharmaceutical Manufacturers in relation to administrative duties in connection with aggregation, allocating, collecting, and invoicing for Rebates. Manufacturer Administrative Fees are considered inclusive of "rebate Administrative Fee(s)," "formulary Administrative Fees," "GPO fees" or any other fee paid to Contractor, Contractor's Affiliate, or their Subcontractor(s), or a GPO in relation to administrative duties in connection with the collection of Manufacturer Payments, excluding fees retained by the GPO for Contractor's participation in the GPO.

lll. **Manufacturer or Pharmaceutical Manufacturer:** a pharmaceutical, biotech, medical equipment or device manufacturer and any other entity that directly or indirectly performs sales, distribution and/or marketing functions (including wholesalers and distributors) with respect to any such manufacturer's products.

mmm. **Manufacturer Payments:** any and all compensation, financial benefits and remuneration Contractor, Contractor Affiliates, Subcontractor, or a GPO, receives from a Pharmaceutical Manufacturer, that is in any way attributable to the State's Claims and/or utilization, including but not limited to, Discounts; credits; Rebates, regardless of how categorized; market share incentives, chargebacks, commissions, Inflation Protection adjustments or payments, access fees, MAF, and administrative and management fees. Manufacturer Payments also include any fees received for sales of utilization data to a Pharmaceutical Manufacturer. For avoidance of doubt, Manufacturer Payments excludes Other Pharmaceutical Manufacturer Revenue that is not in any way attributable to the State's Claims and/or utilization.

nnn. **Material Change**: one or more of the following circumstances:

(1) A change in the Pricing Source's method of calculation, including if the Pricing Source ceases to be published or otherwise becomes unavailable or if the Contractor becomes required to change the Pricing Source to an alternate option, if such change has or upon becoming effective will have a material adverse impact on the benefits, costs or economics for Contractor or the State that arise from or relate to this Contract.

(2) Unexpected industry changes, limited to: Unexpected Generic Drug introductions, unexpected OTC introductions, unexpected FDA recalls or market withdrawals, and unexpected launches of Biosimilars.

(3) A change in law as pertains to payment of Rebates by Pharmaceutical Manufacturers.

(4) A change in any federal or state laws or regulations that causes any aspect of the services to become unnecessary or necessary at a lower level of effort on the part of the Contractor and the State determines to eliminate or reduce the Contractor's obligations under this Contract with respect to such services to address such change in law, if the elimination or a reduction in scope of such aspect of the services would result in a material reduction in the Contractor's cost of performance under this Contract.

(5) Client-initiated change to benefit design or formulary (including Utilization Management) that impacts Rebates negatively by more than five hundred thousand dollars ($500,000) per year. Such a change initiated by the State is limited to changes to the Pharmacy benefit program, plan design, or formulary alignment. In the event a modification to financial guarantees is necessary, the parties will mutually agree on an appropriate adjustment which shall be

economically neutral to the impact of the change, such agreement not to be unreasonably withheld.

(6) Change in the scope of services to be performed by the Contractor, but not limited to: Retail networks, Mail Order service, formulary management or Rebate administration, customer care services, or Specialty Pharmacy services.

For the avoidance of doubt, changes in Pricing Source inflation rates, as applicable, differences between underwriting projections and actual performance (other than covered in above items), drug mix shifts due to any dynamics other than those listed above, and Pharmaceutical Manufacturer merger and acquisition activity shall not constitute a Material Change.

In the event that Manufacturer Rebates are substantially replaced in the marketplace by an alternate strategy, prior to the Effective Date of this Contract or during the Contract term, the Contractor will work with the State in a collaborative manner to establish appropriate alternate contract provisions to reflect such alternate strategy.

ooo. **Maximum Allowable Charge ("MAC"):** The maximum reimbursement rate the health plan will allow as payment for the cost of services such as procedures, professional fees, technical fees, or prescribed medicines.

ppp. **Medication Therapy Management ("MTM"):** a pharmacist provided service that includes: (1) complete review of all medications, including herbals and over-the-counter products; (2.) personal medication record (e.g., drugs, instructions, prescribers, allergies, problems); (3.) medication action plan for the patient; (4.) intervention and/or referral to other healthcare providers; and (5.) documentation.

qqq. **Member:** Employees and their dependents, retirees and their dependents and/or survivors, and individuals qualified under The Federal Consolidated Omnibus Budget Reconciliation Act ("COBRA") and their dependents who are enrolled in the health plan options sponsored by the State, Local Education, and Local Government Insurance Committees.

rrr. **Multi-source ("MS")**: Brands and Generic Drugs available from more than one source.

sss. **NADAC:** The National Average Drug Acquisition Cost. NADAC represents a national pricing benchmark, published by CMS, that is reflective of actual invoice costs that pharmacies pay to acquire prescription and over-the-counter drugs. It is based upon invoice cost data collected from retail community pharmacies and reflects actual drug purchases.

ttt. **National Drug Code ("NDC" or "NDC-11")**: A universal product identifier. The National Drug Code (NDC) Number is a unique, eleven-digit, three-segment number that identifies the labeler/vendor, product, and trade package size.

uuu. **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.

vvv. **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.

www. **Network Provider:** An entity or individual (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, behavioral health provider,

laboratory, durable medical equipment supplier, pharmacy etc.) that has an agreement with the Contractor to provide covered medical, behavioral, pharmaceutical, or other health care services to plan Members and submits claims for reimbursement according to specific terms and rates within a specific network.

xxx. **Other Pharmaceutical Manufacturer Revenue:** any revenue that PBM or PBM Affiliates receive from Pharmaceutical Manufacturers. This may include but is not limited to: Off Invoice Wholesaler Remuneration, Pharmacy Purchase Discounts (i.e., Mail Order Volume Discounts), Transmission Fees, and Specialty Service Fees.

yyy. **Out-of-Network:** The services received and the benefit level available, when delivered by providers that do not have a contractual agreement with the Contractor to provide covered medical, behavioral, or pharmaceutical services according to specific terms and rates within a specific network.

zzz. **Out-of-Pocket Maximum:** The sum of any Member cost sharing required or incurred for any covered benefit up to a limit as defined by the Plan.

aaaa. **Out-of-Network Provider:** An entity or individual (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, behavioral health provider, laboratory, durable medical equipment supplier, pharmacy etc.) that does not have an agreement with the Contractor to provide covered medical, behavioral, pharmaceutical, or other health care services to Members and submits claims for reimbursement.

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

cccc. **Pass Through Transparent Pricing:** A pricing structure comprised of fixed guaranteed Discounts at the Contractor's Mail Order Pharmacy and Specialty Pharmacy and a full pass through (100%) of the Contractor's contracted rates with Participating Pharmacies and Pharmaceutical Manufacturers. In this arrangement, the Contractor retains the difference between Mail Order and Specialty Pharmacy acquisition costs and the amounts guaranteed to the State. The Contractor passes through (1) its contracted rates with Participating Pharmacies and (2) all Manufacturer Payments it receives from Pharmaceutical Manufacturers in excess of the State's guaranteed Manufacturer Payments. The amount billed to the State at Retail Pharmacies will be equal to the amount paid by Contractor to the Retail Pharmacies. The Contractor's only profits are the Administrative Fee and Other Pharmaceutical Manufacturer Revenue not directly attributable to the State's Claims and/or utilization. The Contractor is also allowed to retain the difference between Mail Order and Specialty Pharmacy acquisition costs and the amounts guaranteed to the State, as described in this Contract. All financial negotiated Retail Pharmacy contracts and Rebate contracts are fully disclosed to and auditable by the State or its authorized agent. The State is protected in this model by requiring guaranteed Discounts, fees, and Manufacturer Payments from the Contractor and any Contractor Affiliates. Discounts and Manufacturer Payments achieved on the State's behalf that exceed the financial guarantees are payable to the State. Dispensing Fees that are paid lower than the guaranteed are also passed through to the State. Hence, the financial guarantees are the minimum Discounts and Manufacturer Payments the State will achieve and the maximum Dispensing Fees and Administrative Fees the State will pay.

dddd. **Patient Centered Medical Home ("PCMH"):** A model of care, typically primary care but can include specialty care, that puts patients at the forefront of care. PCMHs build better relationships between patients and their clinical care teams.

eeee. **Pharmacy or Participating Pharmacy:** a Retail Pharmacy, Mail Order Pharmacy, Specialty Pharmacy, non-traditional Pharmacy (such as I/T/U, LTC, HIF, Military, TER or VA) or other Pharmacy that participates in the PBM's network of Participating Pharmacies pursuant to an agreement between the Participating Pharmacy and PBM for such Pharmacy's dispensing of Covered Drugs to Members.

ffff. **Pharmacy Benefits Manager ("PBM"):** the combination of (i) a business or other entity that, pursuant to a contract with the State, either directly or through an intermediary, manages the prescription drug benefit provided by the State including, but not limited to, the processing and payment of Claims for prescription drugs, the performance of Drug Utilization Review, the processing of drug Prior Authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs; and (ii) all entities that have a majority ownership interest in, or majority control over, the business or other entity that is in contract with the State referenced in (i).

gggg. **Pended Claim:** A claim that is suspended or held in the claims adjudication system until the missing or inconsistent information that is required to complete claims processing can be updated on the claim.

hhhh. **PEPM:** Per Employee per month. For purposes of this definition, "employee" shall include any enrollee in the Plans and who is also a Head of Contract

iiii. **Plan Group:** One of three or more groups: the State Plan (comprised of the Central State as one employer as well as the University of Tennessee as another employer and the Tennessee Board of Regents which is comprised of many different campuses and employer groups), the Local Education Plan (many different school systems), or the Local Government Plan (many different city or county governments or quasi-governmental entities).

jjjj. **Plan Documents:** The legal publications that define eligibility, enrollment, benefits and administrative rules of the Plans.

kkkk. **Point Solution:** A service or program offered within the benefits program that fills a gap in the healthcare system. Such solutions may be delivered via an alternative delivery model such as interactive video conferencing or an interactive mobile application. Such solutions are often focused on a specific condition or developed to solve specific challenges.

llll. **Population Health and Wellness Contractor(s) ("PH/W"):** State's Contractor responsible for the majority of population health and wellness programs (web portal, chronic condition management, lifestyle counseling, weight management, biometric screenings, challenges, incentive tracking, reporting, etc.).

mmmm. **Preferred Provider Organization ("PPO"):** A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers, while also offering access to Out-of-Network Providers at an additional cost.

nnnn. **Prior Authorization ("PA"):** A program requirement where certain health care services, treatments, drugs, or procedures must gain approval before services are rendered and payment can be authorized.

oooo. **Protected Health Information ("PHI"):** As defined in the HIPAA Privacy Rule, 45 CFR § 160.103.

pppp. **Public Key Infrastructure ("PKI"):** The framework and services that provide for the generation, production, distribution, control, accounting, and destruction of public key certificates. Components include the personnel, policies, processes, server platforms, software, and workstations used for the purpose of administering certificates and public-private key pairs, including the ability to issue, maintain, recover, and revoke public key certificates.

qqqq. **Public Sector Plans ("Plans"):** Refers to all benefit options sponsored by the State, Local Government, and Local Education Insurance Committees (e.g. health plan options, life insurance, other voluntary benefits). The Plan is available to eligible employees and dependents of participating State (Central State and Higher Education), Local Government, and Local Education agencies.

rrrr. **Rebate(s):** All revenue received by the Contractor and any Contractor Affiliates (including Rebate aggregators or any similar contracted entities) from outside sources related to the Plan's utilization or enrollment in programs also known as Total Manufacturer Value. Also, the amounts paid to the Contractor, Contractor Affiliates, or a GPO, (i) pursuant to the terms of an agreement with a Pharmaceutical Manufacturer pursuant to the terms of a Rebate contract, negotiated directly or indirectly with a pharmaceutical company by Contractor, Contractor Affiliates, or a GPO, (ii) in consideration for the inclusion of such Manufacturer's drug(s) on the Formulary, and (iii) which are directly or indirectly related and attributable to, and calculated based upon, the specific and identifiable utilization of certain prescriptions by Members. This includes but is not limited to: access fees, market share fees, Rebates, Specialty Drug Rebates, onsite Pharmacy Claims, low day supply Claims, Generic Drug Claims, Biosimilar Drugs, Formulary access fees, service fees, Manufacturer Administrative Fees and marketing grants from Pharmaceutical Manufacturers, wholesalers and data warehouse contractors, Discounts, credits, Inflation Protection, charge backs, commissions, and any fees received for sales of utilization data to a pharmaceutical Manufacturer. Rebates do not include purchase Discounts (e.g., prompt pay Discounts) from mail and specialty products, the value of drug Manufacturer coupons, or the value from any other patient assistance programs.

ssss. **Retail Pharmacy:** Any type of Pharmacy other than a Mail Order Pharmacy or Specialty Pharmacy, and includes any independent pharmacies, supermarket pharmacies, chain pharmacies or mass merchandiser pharmacies having a state license to dispense medications to the general public.

tttt. **Retail-30:** A network Retail Pharmacy that offers up to a 30-day supply of medications.

uuuu. **Retail-90 or 90-Day-at-Retail:** A network Retail Pharmacy that offers a 90-day ('mail at retail') supply of medications.

vvvv. **Retrospective DUR ("Retro-DUR"):** A post payment Claims analysis to facilitate Drug Utilization Review (DUR) objectives.

wwww. **RFP:** Request for Proposals.

xxxx. **Section 508:** To ensure accessibility among persons with a disability, the Contractor's multimedia/video tools, website, social media content, and any other applicable Member content shall substantially comply with Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d) and implementing regulations at 36 CFR 1194 Parts A-D.

yyyy. **Service Level Agreement ("SLA") Scorecard:** Performance management scorecard that contains Contractor's KPIs and desired outcomes in Contract Attachment D. The At-

Risk Performance Payments will be based on the Contractor's ability to meet the listed KPIs.

zzzz. **Single-Source Generic(s) or SSG(s):** Generic Drugs that are manufactured by one Generic Drug manufacturing company.

aaaaa. **Span of Control:** Information Technology and telecommunications capabilities that the Contractor itself operates or for which it is otherwise legally responsible according to the terms and conditions of this Contract. The Span of Control also includes Systems and telecommunications capabilities outsourced by the Contractor.

bbbbb. **Specialty Drugs:** Certain pharmaceuticals, biotech or biological drugs, that are used in the management of complex or genetic disease that meet at least one of the first two criteria (1 and 2) and all the last three criteria (3-5) in order to be placed on your Specialty Drug list:

(1) Produced through DNA technology or biological processes
(2) Targets a complex disease caused by a combination of genetic, environmental and lifestyle factors
(3) Unique handling, distribution, and/or administration requirements such that the drug cannot be safely dispensed from a Mail Order Pharmacy
(4) Requires a customized medication management program that includes medication use review, patient training, coordination of care and adherence management for successful use such that more frequent monitoring and training is required
(5) Are not a device, supply, medical food, or durable medical equipment.

Lastly, only newly FDA-approved and launched drugs, and drugs not on the market as of January 1, 2025, may be considered for addition to the Specialty Pharmacy drug price list after this date, unless the Specialty Pharmacy gains access to a previously unavailable Limited Distribution Specialty Drug.

ccccc. **Specialty Service Fees:** fees collected by a PBM or PBM Affiliates from pharmaceutical companies for certain costs or services associated with stocking, handling and dispensing certain Specialty Drugs, such as distribution data reporting, inventory tracking and management, FDA Risk Evaluation and Mitigation Strategy (REMS) support and enhanced adverse even reporting and coordination.

ddddd. **Splash Page:** Dedicated and customized webpage for this Contract containing program information, specific to the Plan, which does not require a Member to log in.

eeeee. **State, Local Government, and Local Education Insurance Committees:** Policy making bodies for the State, Local Government, and Local Education Plans established under Tenn. Code Ann. §8-27-101, 8-27-207, and 8-27-301 respectively.

fffff. **State Holidays:** Days on which official holidays and commemorations as defined in Tenn. Code Ann. §15-1-101 *et seq*. are observed.

ggggg. **Step Therapy:** The practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug and stepping up through a sequence of alternative drug therapies as preceding treatment option fails. Step Therapy programs apply coverage rules at the point of service when a Claim is adjudicated. If a Claim is submitted for a second-line drug and the Step Therapy rule was not met, the Claim is rejected, and a message is transmitted to the Pharmacy indicating that the patient should be treated with the first-line drug before coverage of the second-line drug can be authorized.

hhhhh. **Third Party Administrator ("TPA"):** The State's contracted medical contractor(s) responsible for processing medical claims and providing other administrative support for the contract.

iiiii. **Transmission Fees:** fees paid by Participating Pharmacies that directly or indirectly arise from Claims or Covered Drugs dispensed to Members. These fees shall not constitute Pharmacy Rebates if (a) such fees do not in aggregate exceed $0.15/Claim (b) such fees constitute a fair and reasonable compensation for services actually performed by PBM for a Participating Pharmacy and (c) the receipt and retention of such fees by PBM are in compliance with all applicable laws.

jjjjj. **URAC:** an independent, nonprofit organization that promotes health care quality through its accreditation and certification programs. Originally, URAC was incorporated under the name Utilization Review Accreditation Commission. However, that name was shortened to the acronym URAC in 1996 when URAC began accrediting other types of organizations such as health plans and Preferred Provider Organizations.

kkkkk. **Utilization Management ("UM"):** includes any cost containment programs, performed by the Contractor and/or its subcontractor(s), utilizing medical policies and/or other clinical criteria and treatment guidelines that combine evidenced based care, optimal treatment, optimal provider, and optimal site of care.

lllll. **Zero Balance Due or ZBD:** any Claim where the Member pays the total amount of the Claim, including any applicable sales tax, and the plan pays zero. ZBD Claims are calculated at the original Discounted Ingredient Cost prior to the application of the Member copay and are not artificially inflated to a 100% Discount or zero-dollar amount.

A.3. 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 January 1, 2025 (Go-Live).

b. The Contractor shall implement the Information Systems and other processes required to process all 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 Plan Documents (which are located on the State's website) and all applicable 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 Go-Live. All other implementation team Members that the Contractor referenced in its proposal to the State shall be approved by the State and shall be available as needed during the implementation but should be Designated to this project at least two (2) months prior to Go-Live and at least thirty (30) days after Go-Live. The Contractor's implementation team shall include a full-time Account Executive 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 contractors 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 offices in Nashville, TN, or virtually as necessary, within the first thirty (30) days after the Contract effective date. State staff shall provide access and orientation to the 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 effective date (refer also to Contract Attachment B, Liquidated Damages). 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 claims administrative services no later than Go-Live, 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) identification and timing of deliverables and milestones;
(3) names and titles of key implementation staff;
(4) identification and timing of the state's responsibilities;
(5) data requirements (indicate type and format of data required);
(6) identification and timing for the testing, acceptance and certification of receipt of the State's enrollment information;
(7) identification and timing for testing and certification of claims processing and payment and the reconciliation process;
(8) Member communications;
(9) schedule of in-person meetings and conference calls;
(10) Drug Formulary development
(11) transition requirements with the incumbent claims administrator(s); and
(12) staff assigned to attend and present (if required) at annual enrollment/ educational sessions.

f. At the State's request, the Contractor shall provide for a comprehensive operational readiness review by the State, and/or its authorized representative, within sixty (60) days prior to Go-Live (refer also to Contract Attachment B, Liquidated Damages). 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.*, Member services, call center cultural readiness, training, and website development). The review may also include reviews of documentation that includes but is not limited to:

(1) policy and procedures manual;
(2) call center training and 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. The State and/or its authorized representative shall also conduct an additional, pre-implementation review of the Contractor's progress towards fulfilling the Information Systems and claims processing and payment requirements of this Contract. Such review by the State, and/or its authorized representative, may include onsite or remote reviews, including but not limited to staff interviews, system demonstrations, systems testing, and document review.

h. During onsite visits as part of a readiness review or a pre-implementation review, the Contractor shall provide onsite workspace and access to a 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 with the State concerning project development, project implementation and Contractor performance at least weekly during implementation and the first month following Go-Live, 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 Executive, Account Manager, and other 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 State shall complete an Implementation Performance Assessment survey of the Contractor's performance to determine the State's satisfaction with the implementation process and Contractor. Results shall be shared with the Contractor including the identification of any deficiencies. The Contractor shall respond within fifteen (15) days of receiving the results with a corrective action plan as necessary to remedy any identified deficiencies. In response to the corrective action plan, the Contractor shall comply with all recommendations and requirements agreed upon by the State within the timeframes agreed upon by the State.

k. "Lessons Learned" Debriefing. The Contractor shall conduct a self-assessment regarding implementation of this Contract, prepare a report summarizing its findings, including success, challenges, and lessons learned, and provide an in-person or remote debriefing presentation to the State. The report and presentation shall be provided to the State no later than ninety (90) days post Go-Live.

A.4. Administrative Services

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

(1) industry best practices;
(2) the overall cost impact to the Plans;
(3) any potential cost impact to the Contractor's fee;
(4) impact upon Utilization Management performance standards;
(5) impact upon the Contractor's performance;
(6) necessary changes in the Contractor's reporting requirements; and/or
(7) system changes.

b. The Contractor shall collaborate and assist with 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 Plans. The Contractor shall collaborate with the State on any recommended actions in order to comply with such laws, rules or policies.

d. The Contractor shall refer calls from 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. The Contractor shall cooperate with the State in analyzing the impact of proposed legislation on the operation of the Contract. Unless otherwise directed by the State, the Contractor shall respond In Writing with a summary of Plan impact, section by section impact, and cost breakdown analysis to all inquiries from the State regarding responses to proposed legislation within forty-eight (48) hours of the State's request. The Contractor shall defer to the State's interpretation of the applicability of proposed legislation to the State Plans. The Contractor's analysis shall include legislation that is not directly applicable to the State Plans but which may indirectly affect the Contract by increasing the cost of Contractor's operations.

g. The Contractor shall meet with authorized representatives of the State, at the request of either party, periodically 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.

h. As requested by the State, but no less than semi-annually, the Contractor shall meet with the State to provide information concerning its efforts to develop cost containment mechanisms, value based initiative outcomes, administrative improvements, 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 Plans. The Contractor shall also provide information to the State regarding the administration of the benefit, cost and utilization trends, Utilization Management, internal procedures for billing and reconciliation of transactions, the provision of medical treatment, fraud and abuse activities, and other administrative matters. These meetings will typically occur at the State of Tennessee offices in Nashville, TN, however, at its discretion, the State may request for the meeting to take place by teleconference.

i. 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.

j. The Contractor shall refer all media and legislative inquiries to BA, which will have the sole and exclusive responsibility to respond to all such inquiries. 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 State on all correspondence.

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

l. 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 Member information, utilization, and pricing information, in marketing or expanding non-State business relationships or for any pecuniary gain.

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

n. 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, including but not limited to, file and data sharing between contractors. (Refer to Attachment D, SLA Scorecard.) The situation shall be researched and resolved in a timeframe mutually agreed upon with the State.

o. The Contractor shall provide the service of transitioning all existing services awarded under this contract to the next awarded contract holder at no additional cost to the State. A written transition plan shall be provided to the State within nine (9) months prior to the end of the current Contract.

A.5. 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 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 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, pharmacists, and physicians whose primary duties are to conduct medical necessity reviews of claims, including review of complex or questionable claims.

e. The Contractor's Utilization Management (UM) reviewers, or subcontractor reviewers, shall be familiar with the terms of the Plan Documents. The UM reviewers shall consist of qualified nurse, pharmacist, 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.

g. The Contractor shall Designate a full time Account Executive, Account Manager, and licensed chief pharmacist as Members of the account team. The Account Executive 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. The Account Manager shall have the responsibility and authority to respond promptly to Member, claims, and provider issues or inquiries as identified by the State. The chief pharmacist shall have the responsibility for providing the State with clinical pharmacological advice in the review and development of a specific Formulary for the Plan, Pharmacy benefit design and utilization review activities to include PA, Step Therapy, and other approaches to managing the prescription drug benefits for the Plan. At a minimum, the Account Executive shall meet in person with the State semi-annually and more often if required by the State. At its discretion, the State may allow the Contractor to participate in such meetings by teleconference. The Account Executive shall also be available via phone and email after hours, including weekends.

h. The State shall perform an account satisfaction survey of the Contractor's performance annually during the contract period to determine the State's satisfaction with the ongoing account team and Contractor. Results shall be shared with the Contractor including the identification of any deficiencies. The Contractor shall respond within fifteen (15) days of receiving the results with a corrective action plan as necessary to remedy any identified deficiencies.

i. The Contractor agrees that the State may approve or disapprove the staff assigned to this Contract prior to the proposed assignment including approving the implementation and account teams. 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 be approved In Writing during implementation and 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 notify the State within two (2) weeks of identifying said vacancy and provide a replacement, subject to final approval by the State, 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.6. Provider and Pharmacy Networks

a. The Contractor shall maintain a Broad, high performance (or tiered) network of medical and behavioral health providers, facilities, and pharmacies, as measured by their adherence to a standard set of evidence-based clinical protocols, cost efficiency (e.g., cost per episode) and quality measures that serves Members covered by this Contract in all ninety-five (95) Tennessee counties, as well as Members residing or traveling outside of the state.

b. The Contractor shall provide a network that provides high quality, cost effective medical services and includes major hospital facilities/systems and major medical provider groups. At the State's request, the Contractor shall add any requested provider to the network, assuming they meet all of the Contractor's quality and credentialing requirements and are agreeable to market competitive reimbursement rates. Unless

otherwise directed by the State, the network 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, laboratories, durable medical equipment suppliers, and all other medical facilities, services and providers necessary to provide covered benefits.

c. The Contractor shall provide and maintain a national provider network for this Contract that provides high quality, cost effective behavioral health services and includes a full spectrum and adequate number of behavioral health Network Providers that meet the required geographic and service access to Members primarily located throughout the State of Tennessee. The Contractor's behavioral health provider network shall include appropriately licensed and credentialed behavioral health practitioners, including, but not limited to, psychiatrists, including addiction psychiatrists, Advanced Practice Psychiatric Nurses -board certified, licensed psychologists, licensed clinical social workers (LCSWs), licensed marital and family therapists (LMFTs), licensed professional counselors (LPCs), licensed and/or board certified applied behavioral analysts, substance abuse professionals (SAPs), and drug and alcohol counselors representative of the culture, race, sex and age of the population to be served. The Contractor's network shall also include a sufficient selection of licensed and credentialed programs and facilities (acute, residential, intensive outpatient, detoxification facilities and other necessary programs and services) in the network to provide access to Behavioral Health Services. The Contractor's network shall include providers with expertise related to domestic violence, eating disorders/body image disorders, applied behavioral analysis, and gambling addiction, as well as substance abuse providers that provide detoxification for adolescents. A combined ninety percent (90%) of all the Contractor's psychiatrist and Advanced Practice Psychiatric Nurses shall be board certified and reported during the quarterly administrative review meetings.

d. The Contractor shall establish and maintain its broadest available national Pharmacy/statewide any willing provider Retail-30, Retail-90, Specialty, vaccine administering, and Mail Order networks. These networks shall be adequate to provide covered Pharmacy services and Pharmacy location sites available and accessible to comply with this contract and in support of all Tennessee state laws. The Contractor shall offer:
   (1) a statewide any willing Provider/national network of pharmacies for the thirty (30) day network wherein Members may fill a prescription for their applicable thirty (30) day cost share.
   (2) a Mail Order Pharmacy for ninety (90) day prescription fills.
   (3) a statewide any willing Provider/national Retail-90 Pharmacy network of pharmacies wherein Members can fill their ninety (90) day prescriptions for the same cost share as Mail Order and the plan would pay the same reimbursement rates for the medication as the Mail Order reimbursement rates.
      i. To comply with Tenn. Code Ann. § 56-7-2359, the Contractor shall allow any willing network retail pharmacies that agree with the Contractor's terms and conditions for Mail Order Pharmacy to participate in a Retail-90 network.
   (4) a statewide any willing Provider/national network of Specialty pharmacies from which Members must choose a Pharmacy to fill any Specialty Medication; and
   (5) a statewide any willing Provider/national network of pharmacies that include the ability to have a broad array of vaccines administered at the State-determined cost sharing.
   (6) a report of Member utilization of all network pharmacies broken down by Pharmacy channel upon request by the State.

e. Mail Order Network:

(1) The Mail Order Pharmacy shall possess sufficient staff and facilities capable of meeting the following requirements:

i. Turnaround time specific to Clean Claims not requiring intervention (non-protocol or clean cleans) - 96% shipped within two (2) Business Days (not an average). This guarantee is measured in Business Days from the date the prescription drug Claim is received by the vendor (either via paper, phone, fax or Internet) to the date it is shipped

ii. Turnaround time specific to Claims that require additional intervention - 96% of prescriptions requiring administrative/clinical intervention will be shipped within four (4) Business Days (not an average). This guarantee is measured in Business Days from the date the prescription drug Claim is received by the vendor (either via paper, phone, fax or Internet) to the date it is shipped

iii. Mail Order dispensing accuracy – 99.95% accuracy. Dispensing Accuracy Rate means (i) the number of all Mail Order prescriptions dispensed in a contract quarter less the number of those prescriptions dispensed in such contract quarter which are reported and verified as having been dispensed with the incorrect drug, strength, dosage form, patient name, directions, packing non-conformance, or address causing medication to be delivered incorrectly divided by (ii) the number of all Mail Order prescriptions dispensed in such contract quarter.

iv. The Mail Order Pharmacy shall possess a current license to dispense controlled drugs (Schedule 2, 3, 4 and 5 substances).

(2) The Contractor's Mail Order Pharmacy will not be required to dispense prescriptions for greater than a ninety (90) day supply of Covered Drugs, per prescription or refill, subject to the professional judgment of the dispensing pharmacist, limitations imposed on controlled substances (see Tennessee Code Annotated 63-1-164), and Manufacturer's recommendations. Exceptions to the ninety (90) day limit include medications that may be packaged by the drug Manufacturer in quantities of just over ninety (90) days and that do not lend themselves to being split by the pharmacist (e.g., insulins); in those instances, the Mail Order Pharmacy may fill using the packaging as is and charge ninety (90) day cost sharing to the Member. Prescriptions may be refilled providing the prescription states that refills remain. All prescriptions filled must comply with Tennessee laws and regulations.

(3) The Contractor shall guarantee that MAC pricing will apply at mail for Generic Drugs, as applicable. Contractor shall guarantee that a Generic Drug will never cost more at mail than at a Retail Pharmacy.

(4) The Contractor shall guarantee that the mutually agreed upon baseline measure value (i.e., AWP, NADAC, WAC, or other) applied to Mail Order Claims must be based on the actual NDC or NDC-11 of the package size dispensed.

(5) The PBM Mail Order Pharmacy shall inform the Member, the prescriber, and the State if it substitutes products that will result in Member or plan cost that is greater than the cost that would have been incurred had the prescription been dispensed as written. The Contractor shall only engage in such substitutions when there are widespread marketplace drug availability issues with the more cost-effective product, if there is a Member safety issue or if there is a drug interaction or efficacy issue – and only with prescriber approval, if applicable.

(6) The Mail Order Pharmacy shall communicate to the Member, by phone, e-mail or text, any delays, beyond three (3) Business Days, in delivery of prescriptions. Members shall be notified of such delays within twenty-four (24) hours of the discovery of the delay.

(7) The Mail Order Pharmacy shall provide Members refunds for monies owed back to them instead of maintaining credits at the mail facility.

(8) The State will not pay any outstanding balances owed by Members to the Contractor or its network Pharmacy Providers.

(9) The Contractor shall obtain open refill files from the State's current Mail Order contractor. At the term of this contract the Contractor shall ensure their Mail Order contractor provides open refill files to the State's new PBM contractor.

(10) The Contractor shall maintain a secure website supporting the Mail Order function, which allows Members to access their Pharmacy Claims and request and pay for refills online. Said website shall be operational no later than thirty (30) days prior Go-Live.

f. Specialty Network:

(1) The Specialty Pharmacy network shall be the preferred Pharmacy Provider of certain drugs. The Specialty Pharmacy network shall guarantee more favorable reimbursement rates than the Retail, Mail Order, and 90-day At Retail networks on the Designated products, in the aggregate, and possess unique clinical monitoring, Member assistance, and distribution capabilities.

(2) The Contractor, or other third-party Specialty Pharmacy that has contracted with the Contractor, may provide Specialty Drugs. The Contractor shall add new Specialty products and the pricing for these products to the list of Specialty Drugs.

(3) Unless otherwise directed by the State, all drugs placed on the Contractor's Specialty Drug list shall meet the definition of Specialty Drugs in Contract Section A.2. The Contractor cannot reclassify an existing Specialty Drug as non-specialty or non-specialty drug as Specialty without mutual agreement with justification.

(4) Unless otherwise directed by the State, the Contractor shall limit Specialty Drugs to no more than a thirty (30) day supply, which it shall provide exclusively via Specialty network pharmacies. The Contractor must solicit pharmacies inside the State of Tennessee to join their Specialty Pharmacy network, to comply with Tenn. Code Ann § 56-7-2359, even if the Contractor operates its own Specialty Pharmacy. Neither the Contractor nor the Contractor's staff shall attempt to steer Members to utilize any particular Pharmacy within the Specialty Pharmacy Network, so long as Members do utilize a Pharmacy in said network for their Specialty medications.

(5) Contractor understands that the sole Administrative Fee (PEPM) paid to the Contractor monthly constitutes all services payable under this Contract, including Specialty Drug management (Step Therapy, first fill counseling, recalls, Member adherence education, PA, and similar industry standard PBM activities that relate to Specialty Drug management including but not limited to nursing services or charges.)

(6) The Contractor shall guarantee that the mutually agreed upon baseline measure value (i.e., AWP, NADAC, WAC, or other) applied to Specialty Claims will be based on the actual NDC or NDC-11 of the package size dispensed.

(7) In addition to the Contractor's own requirements for Pharmacy participation in the Specialty Pharmacy Network, the State imposes the following requirements:

i. State Specialty Network Participation Criteria

a) Storage, Shipping & Handling: Pharmacy must have the ability to properly store, handle and ship (if offered) medications per the product labeling.

b) Registration and Licensure: Pharmacy must be registered/licensed and in good standing with the Board of Pharmacy in the state in which it is located and in Tennessee, if located out of state.

c) Member Counseling & Clinical Monitoring: Pharmacy must have a licensed pharmacist on staff to assist with, and counsel, Members on issues common to Specialty Medications. Such issues include identification and management of potential side effects, appropriate use of the medication and the importance of medication adherence.

d) Member Notification of Recalls: In the event of any product recalls, the Pharmacy will identify and notify affected Members.

(8) The Contractor shall notify affected Members by letter within thirty (30) calendar days after any Specialty Pharmacy drops out or leaves the Specialty Pharmacy network. Upon notification that any Specialty Pharmacy is leaving the Specialty Pharmacy Network, the Contractor shall determine if any Members have utilized said Pharmacy within the previous ninety (90) calendar days and mail these Members a notification letter that the Pharmacy is leaving the network on a specific date and also include with the letter a printed list of remaining contracted Specialty Network Pharmacies. The State has the right to review any such letter and make appropriate edits prior to approval and mailing. In addition, the Contractor must notify the State In Writing within ten (10) Business Days any time a Specialty Pharmacy leaves the Specialty Pharmacy network. Refer also to Contract Attachment B, Liquidated Damages.

g. The Contractor shall not require the State to mandate the use of Mail Order pharmacies or require Members to utilize one single Pharmacy or a single chain of pharmacies.

h. Should the number of Retail Pharmacies in your network be reduced by more than 3% of all pharmacies in the network (add, drop certain chains, etc.) and/or one of the top 5 Pharmacy chains by store count before the effective date and or any point during the contract term, you will provide the State with an improved pricing offer for the proposed reduced Retail network at least ninety (90) calendar days prior to the effective date of such change. If the revised pricing that results from a change in the Pharmacy network is not acceptable to the State, the State reserves the right to renegotiate pricing.

i. The Contractor's networks proposed in the RFP and throughout the service period shall meet, at a minimum, the geographic access standards specified in Contract Attachment B, Liquidated Damages.

j. The Contractor shall provide the State with geographic access reports on a quarterly basis showing service and geographic access standards compliance (refer also to Contract Attachment B, Liquidated Damages and Attachment C, Reporting Requirements). The State shall inform the Contractor of acceptable geographic access report companies and shall provide the approved data analysis, report format, and an updated Tennessee ZIP code list annually for the report delivery periods that year. 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. If requested, the Contractor shall develop and implement a corrective action plan to correct deficiencies. The State reserves the right to review the corrective action plan and require changes, where appropriate.

k. The Contractor shall maintain a sufficiently extensive and accessible medical 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

l. The Contractor shall maintain a sufficiently extensive and accessible behavioral health provider network such that Members are able to schedule and receive appointments from a geographically-accessible provider within the following appointment standards Monday through Friday, 7:00 A.M. to 7:00 P.M. Central Time:

(1) Emergency/crisis service: four (4) hours
(2) Urgent visit: twenty-four (24) hours
(3) Routine/Initial visit: seventy two (72) hours

m. The Contractor shall maintain a current record of compliance with appointment access standards, including monitoring activities, findings, and corrective actions and shall provide a report upon request by the State.

n. The Contractor shall maintain a current record of network physicians not accepting Members as new patients and shall provide a report upon request by the State.

o. The Contractor shall maintain a record of all voluntary and involuntary network changes including any additions, deletions, terminations and reason for change, in the Contractor's provider network(s) and shall provide a report of said changes upon request by the State.

p. The Contractor shall notify the State In Writing of any termination of a hospital, physician group of ten (10) or more, or a physician group providing care that would be eligible for continuity of care exceptions, 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 any hospital or physician within a minimum of the last six (6) months. The notice shall include the provider's name and the effective date of the termination and shall offer assistance with finding a new provider, including the option to call the Contractor's toll-free number or access the provider directory on the Contractor's website, as well as with transitioning to a new provider. 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. In instances of hospital closures, the Contractor shall mail written notice to impacted Members within thirty (30) calendar days of the closure and include a list of the closest network hospital(s). Refer also to Contract Attachment B, Liquidated Damages.

q. If one of the top five network Pharmacy chains leaves the Contractor's network or notifies Contractor of plans to leave its network, the Contractor shall immediately notify the State as well as draft Member notification letters for mailing to affected Members at the Contractor's cost. Letters must be mailed at least thirty (30) calendar days before the effective date the Pharmacy intends to leave the network and should list the three (3) pharmacies closet to the Member that remain in the applicable network. The State must approve notification letters before they are mailed. Refer also to Contract Attachment B, Liquidated Damages.

r. The Contractor shall not take action to disenroll network primary care providers, behavioral health 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 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 ensure that no specific payment be made directly or indirectly to a provider, provider group, facility, or organization as an inducement to reduce or limit medically necessary services furnished to an individual.

u. The Contractor shall contract only with providers who are duly licensed to provide such 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.

v. 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.

w. The Contractor shall provide Network Providers with reports and other information regarding their tiered status and any quality and other performance metrics used by the Contractor to set the tier of the Network Provider so the Network Provider can work to improve their tiering status. The Contractor shall be available to meet with the Network Provider as needed to walk through and discuss the reports and other performance information.

x. The Contractor shall offer all medical and behavioral health Network Providers additional training in advanced suicide risk management and prevention at no cost to the provider or the State.

y. The Contractor shall maintain a provider Denied Claim appeals policy and process and shall provide the State with a copy of said process thirty (30) days prior to Go-Live. The Contractor shall provide the State with a list of medical and behavioral health provider Denied Claim appeals every quarter (refer also to Contract Attachment C, Reporting Requirements). The State shall select a random sample of Denied Claim appeals from the report for further review and explanation. The Contractor shall complete a question log based upon the Contractor's documented process regarding the selected Denied Claim appeals. The completed log shall be maintained by the State on record as verification of contractor compliance with internal policy.

z. 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.

aa. The Contractor shall require all Network Providers to file claims associated with their services directly with the Contractor on behalf of Members.

bb. 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.

cc. The Contractor shall identify medical and behavioral health Network Providers who fail to meet pre-determined, minimum standards relating to referrals to Out-Of-Network Providers and shall provide a report to the State upon request In Writing.

dd. 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, physician groups of twenty (20) or more, or broad classification of providers.

ee. The Contractor shall amend its provider agreements with primary care providers (at time of their renewal) to require network primary care providers to screen Members for depression when staff-assisted depression care supports are in place. The provider agreements shall include reimbursement fee schedules for collaborative care CPT codes. Once such amendments are in place, the Contractor shall also include depression screening in an annual wellness visit/physical as an element in any primary care chart reviews that it conducts. The goal is to ensure 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.

ff. If a Member is undergoing active treatment with an Out-of-Network Provider for a serious medical or behavioral health condition at Go-Live or upon newly enrolling in the Plans, the Contractor shall arrange for a transition of care agreement with the Out-of-Network Provider. Members or their authorized representative have the greater of thirty (30) days from Go-Live or benefit effective date to request a transition of care exception. The Member's financial liability shall be limited to any cost-sharing (e.g., in-network Copayment amounts) that would have applied if the treating provider was a Network Provider. The Out-of-Network Provider shall be reimbursed at the MAC or other negotiated amount throughout the approved transition of care period with an agreement to accept said rate as payment in full.

gg. If a Member is undergoing active treatment for a serious medical or behavioral health condition when a provider leaves the network, the Contractor shall arrange for a continuity of care agreement with the terminating provider. Members or their authorized representative have the greater of thirty (30) days from the date of provider termination or thirty days from notification of the termination (either by written notice, EOB, or other means) to request a continuity of care exception. The Member's financial liability shall be limited to any cost-sharing (*e.g.*, in-network Copayment amounts) that would have applied prior to the provider leaving the network and the terminating provider shall be reimbursed at their terminated contracted rate throughout the approved continuity of care period with an agreement to accept said rate as payment in full.

hh. If the Contractor is unable to deliver covered benefits and medically necessary care through Network Providers, the Contractor shall arrange for such services to be rendered by Out-Of-Network Providers. Unique care exceptions due to network adequacy should be requested and reviewed prior to a Member receiving services. A unique care exception may be approved by the State In Writing, retroactively in a critical care situation if the carrier would have otherwise approved the care. 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 Copayment amounts), except expenses determined not to be medically necessary and expenses that exceed the Maximum Allowable Charge, unless otherwise directed by the State.

ii. The Contractor shall report to the State on a monthly basis all transition of care, continuity of care, and unique care exception requests, whether they were granted or denied, and any reason for approval or denial (refer also to Contract Attachment C, Reporting Requirements).

A.7. Member Services

a. All Member services representatives handling inquiries related to the Plans shall be familiar with the terms and provisions of the Plan Documents, including without limitation,

eligibility, benefits, excluded services and procedures, applicable cost-sharing, including Copayments, 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 Plans. A Contractor may be allowed, by the State In Writing, 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 Member services representative staff to respond to Member 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 Contract section A.18. Member services representatives shall connect or warm transfer Members to other State contractors for benefit services as needed based upon the Member's inquiry or issue. The Contractor shall not answer technical questions regarding the State's eligibility and enrollment policy and shall refer these questions to the State.

d. The Contractor's Member service representatives shall have access to an application, which allows them to review alternative drug therapies (Formulary status, Generic Drug alternatives available, etc.) for Members who may request this information.

e. The Contractor's Member service representatives shall assist Members with locating geographically accessible Network Providers, network Pharmacies, and network facilities and educating Members on the tiered costs associated with their options.

f. The Contractor shall provide appointment scheduling assistance with medical Network Providers on behalf of Members who are unable to secure an appointment with a geographically-accessible Network Provider within the timeframes specified in Contract Section A.6.e. or upon request by the Member for Contractor's assistance.

g. The Contractor shall offer appointment scheduling assistance for any Member seeking assistance in identifying and securing an appointment with a geographically-accessible behavioral health Network Provider within the timeframes specified in Contract A.6.k. and A.6.l. without requiring the Member to first attempt calling and scheduling an appointment on their own without success. Should the Member decline appointment scheduling assistance the Contractor shall provide the Member with a list of Network Providers who meet the Member's requested provider demographics and condition specialty area.

h. The Contractor shall have healthcare navigators and advocacy staff to support Members with resources and services, including but not limited to:

(1) finding and scheduling appointments with high quality, low cost providers;
(2) educating Members on how to understand their EOBs and provider bills;
(3) working with Members and providers on claims and billing resolution;
(4) maximizing benefits;
(5) closing gaps in care;
(6) navigating denials and appeals;
(7) recommending use of virtual or condition specific Point Solutions;
(8) recommending Contractor sponsored expert medical opinion services and/or case management; and
(9) connecting or warm transferring to other State contractors for benefit services.

i. Member services representatives and healthcare navigators shall be fully trained on the contractor's website to guide Members through website navigation to review claims, find Network Providers and Pharmacies, identify provider quality ratings, estimate future medical and Pharmacy costs, and access additional contractor resources.

j. The Member services representatives and healthcare navigators shall be trained to direct Members to high performance, high quality Network Providers, Pharmacies, and/or facilities particularly when there are associated Member benefit incentives.

k. 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.

l. 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 Go-Live. Adherence to the standards shall be measured, monitored and reviewed by the Contractor according to Contractor policies and procedures.

m. The Contractor shall evaluate Member services representative calls per Contractor policies and procedures in order to assess the call handling quality and shall report the findings to the State as requested.

n. 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 from Members or the State within one (1) Business Day.

o. The Contractor's Dedicated Account Manager shall 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.

p. The Contractor shall maintain a procedure for resolving complaints informally by phone, including reconsiderations and initiating peer to peer reviews. Where a complaint cannot be resolved to the Member's satisfaction, the Contractor shall advise the Member of their right to file an appeal and shall provide instructions and assistance as needed by the Member for doing so.

q. Unless otherwise approved by the State In Writing, 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 contractor that is certified by NCQA to perform CAHPS surveys, and the contractor shall perform the CAHPS adult commercial survey. The Contractor shall report the results of the survey to the State by July 20 of each calendar year (refer also to Contract Attachment D, Service Level Agreement and Attachment C, Reporting Requirements). The level of overall customer satisfaction shall be equal to or greater than ninety percent (90%) in the first year of the Contract, and shall be equal to or greater than ninety-five

percent (95%) in all subsequent year(s) within the contract term. Based upon the results of the survey, the Contractor shall also develop an action plan to correct problems or deficiencies identified through this activity and deliver said action plan with the CAHPS survey results. The State reserves the right to review the action plan and require changes, where appropriate.

A.8. Member Appeals Process

a. The Contractor shall maintain an appeals process in compliance with Section 2719 of PPACA (42 U.S.C. 300gg-19), 45 CFR 147.136, and the Plan Document, 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 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). Certain issues are not appealable including, but not limited to, Member cost sharing amounts, Formulary decisions, Plan exclusions and Pharmacy network coverage. If any part of section A.8. 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 two internal reviews as well as an external independent review which allows claimants to review their file, to present evidence and testimony as part of the appeals process. The internal review(s) 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. Failure to do so may result in At-Risk Performance Payments as specified in Contract Attachment D, SLA Scorecard:

(1) One hundred percent (100%) of all expedited appeals for urgent care (not involving a third party review) shall be decided no later than 72 hours after receipt of the request for an expedited review for urgent care.
(2) Ninety-five percent (95%) of denied non-urgent pre-service (care not yet received) appeals shall be decided within thirty (30) days after receipt of the request.
(3) Ninety-five percent (95%) of denied non-urgent post-service (care already received) appeals shall be decided within sixty (60) days after receipt of the request.

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

h. 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.

i. 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.

j. 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.

k. At least one (1) month prior to Go-Live, 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 to comply and align with regulatory and Plan 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 or their authorized representative one hundred and eighty (180) calendar days to initiate an internal appeal following notice of an adverse determination. The Contractor shall provide notice to the Member of all unfavorable internal appeal determinations and advise them of their right to initiate an external appeal within four (4) months of receiving said notice.

A.9. 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, condition, and treatment needs. In carrying out this function, the Contractor shall provide a system for reviewing the appropriateness and medical necessity of inpatient facility care, skilled nursing facility stays, inpatient rehabilitative care, oncology (chemotherapy and radiation therapy), pharmaceuticals including Specialty Drugs (medical or Pharmacy), outpatient facility based care, diagnostic testing, and other levels of care included in the Contractor's suite of UM programs, or as specified by the State, and for prior authorizing these and other covered benefits.

b. The State shall have the option to approve and apply any UM programs and criteria developed by the Contractor, including UM programs performed by a subcontractor or

other entity at the time of contract effective date or at any point during the contract claims processing period, and the costs shall be included in the existing Administrative Fees listed in Contract Section C.3. The Contractor will, upon request, provide a complete list of all currently available UM programs to the State and the Contractor will maintain an inventory of the UM programs the State has both selected and not selected. When there is a change (addition, deletion, or other Program change) to the list of the Contractor's available clinical programs, the Contractor will present the opportunity or change to the State within ten (10) Business Days of availability and will provide the State with an updated UM program list and the State's selection inventory at the same time. The State may also "opt-out" of any UM program and will make all final determinations regarding participation in any UM programs.

c. The Contractor will proactively provide the complete UM program list and the State's selection inventory to the State at least once every six (6) months and within two (2) Business Days of receipt of written request from the State. Refer also to Contract Attachment C, Reporting Requirements.

d. The Contractor shall maintain an online publicly accessible library of medical necessity coverage policies and ensure that submitted claims are processed in accordance with published policies. Should these clinical guidelines be revised, the Contractor shall notify the State sixty (60) days prior to the implementation of any major guideline revisions. In addition, the Contractor shall provide an impact analysis of any major guideline revisions that may have a significant impact on utilization or cost trends. The State shall have the option to approve and apply any UM programs and criteria developed by the Contractor that replace the oversight or adherence of a published medical necessity coverage policy and the costs shall be included in the existing Administrative Fees listed in Contract Section C.3.

e. 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 PA and decision making and who are familiar with the Plan Documents.

f. The Contractor shall provide both short and long term UM services based on evidence-based formal written clinical guidelines utilized by experienced mental health and substance abuse clinicians for the entire term of the contract. Mental health Utilization Management shall further consist of the following, when appropriate as determined on a case by case basis:

(1) Discussions between the Contractor's clinical staff and appropriate combination(s) of: the patient, the patient's family and/or their health care proxy, and the attending provider(s);
(2) Development of alternative treatment plans when benefit coverage is no longer available;
(3) Development of alternative treatment plans for complex or unusual cases where standard treatment guidelines may not meet the needs of the patient i.e. cases involving trauma, multiple diagnosis, transitional age from pediatric to adult, and gender specific programs, and other circumstances that may need additional consideration;
(4) Consultation and review of all records by board certified specialty matched psychiatric advisors, in cases where peer-to-peer review leads to disagreements regarding medical necessity or appropriateness of care;
(5) Provisions for periodic onsite visits by utilization and case management clinical staff to high volume and non-compliant providers, in order to continually improve the efficiency and effectiveness of these services.

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

h. 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.

i. The Contractor shall collaborate with the State and its contractors to develop a discharge planning and notification protocol and process by which the Contactor's Utilization Management staff work with the facility, patient's physicians, PH/W contractor (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. Consistent with this protocol, the Contractor shall ensure that Network Providers complete a written discharge plan (including, for example, the dates of admission and discharge, follow-up care required, secured appointment date and time with an outpatient Network Provider, and current medications) prior to the discharge of any Member who is being discharged from, at a minimum, Inpatient Care.

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

k. The Contractor shall provide clinical, Utilization Management programs specific for Specialty Drugs/self-administered injectable medications. A clinician shall be available, through the Specialty Pharmacy network, to patients taking Specialty Medications twenty-four (24) hours a day, seven (7) days a week.

l. The Contractor shall require PA of the following services. Subject to State approval In Writing, the Contractor may require PA of other services or remove a service from this list with supporting evidence.

(1) 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;
(2) Home health services (including home infusion);
(3) Private duty nursing;
(4) Inpatient rehabilitation services (including pulmonary and cardiac);
(5) Non-emergent ambulance transport;
(6) Miscellaneous HCPCS codes when administered in a medical setting (including but not limited to all provider administered J-codes, Q-codes, and C-codes);
(7) Chemotherapy;
(8) Radiation therapy;
(9) Outpatient surgical procedures with documented medical policy criteria, including those performed at ambulatory surgery centers (does not apply to screening colonoscopy or provider office procedures);
(10) Genetic Testing;
(11) Specialty Drugs dispensed through the medical or Pharmacy benefit;
(12) Applied Behavioral Analysis;
(13) Transcranial Magnetic Stimulation;
(14) and Other services specified by the State, In Writing, or in the Plan Document.

m. The Contractor's point of sale claims adjudication system shall determine whether a prescribed drug requires PA and if so, ensure that the Member received the necessary approval prior to authorizing the transaction and permitting reimbursement. All PA services shall be provided at no additional cost to the State.

n. By Go-Live the Contractor shall offer to prescribing physicians an online PA portal whereby the physician can go online to initiate a PA request via secure medium. If approved, the Contractor will render a PA number and length of time the authorization is approved. If denied contractor will notify prescriber. Providing this information strictly via telephone or customer service record ("CSR") does not exempt the Contractor from this requirement. The Contractor shall distribute all PA call center toll-free telephone numbers, facsimile numbers, web addresses and e-mail addresses, as well as the appropriate mailing address for PA requests, at all prescriber and Pharmacy Provider training sessions and education programs.

o. The Contractor shall disclose and share, In Writing, all Covered Drug PA criteria and procedures and decision trees applicable to the State during plan implementation and within two (2) Business Days of written request from the State at any time during the Term of the Contract at no additional charge.

p. The State, or its qualified auditor selected in the sole opinion of the State, shall have the ability at any time to do clinical auditing of Specialty Claims approved by the Contractor for filling and payment. The State, or its qualified auditor, will be auditing to verify that the Contractor is following the specific criteria of each PA program, such that documentation such as medical records or chart notes are provided and align with PA decisions, as required in each PA program, respectively. Evidence based PA criteria are needed and must be adhered to when approving Specialty Drug Claims for filling and payment.

q. Unless otherwise directed by the State, the Contractor shall complete ninety-seven percent (97%) of all medical and behavioral health PAs within the following standards for timeliness of PA and UM decision making. Failure to do so may result in At-Risk Performance Payments as specified in Contract Attachment D, SLA Scorecard:

(1) For non-urgent pre-certification or PA decisions, the Contractor shall make the decision within seven (7) calendar days of receipt of the request;

(2) For urgent PA 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.

r. The Contractor shall ensure that PA staff evaluates ninety-nine percent (99%) of pharmaceutical PA requests, notifies the prescribing physician and issues a determination within twenty-four (24) hours, In Writing. The Contractor shall implement an agreed upon set of edits and PA criteria on Go-Live. Additional pharmaceutical PA edits may be implemented at the State's direction at any point without additional cost to the State. Failure to do so may result in At-Risk Performance Payments as specified in Contract Attachment D, SLA Scorecard.

s. The Contractor shall provide a therapeutic substitution and Generic Drug dispensing program with provisions for written, phone, virtual, and/or face-to-face contact with prescribing physicians and Members to advise them of the potential savings resulting from substituting a costlier drug with a lower cost medically appropriate alternative drug. The Contractor shall report results of the Program to the State on an annual basis, and more frequently as requested by the State. Refer also to Contract Attachment C, Reporting Requirements. The Contractor shall receive prior approval In Writing from the State prior to implementing Member-targeted activities.

t. The Contractor shall maintain a Generic Drug dispensing rate ("GDR") of 85.0% or higher, including all vaccines.

u. The Contractor shall submit quarterly medical and behavioral PA and Utilization Management reports with information regarding each decision outcome and associated timeline filed with the Contractor. The Contractor shall also submit a quarterly Pharmacy PA report that includes PA statistics by drug (at the NDC-11 level) including, but not limited to, the number of PAs submitted, the number approved and denied, the number of denied PAs that were appealed, the cost of alternative filled medications, the number of Members who abandoned therapy after denial without an alternative fill (i.e., walkways), and the net savings of each program (provided in both dollars and as a PMPM). Refer also to Contract Attachment C, Reporting Requirements.

v. If the Contractor is missing any information necessary to make a pre-certification, PA, 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.

w. 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.

x. 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 Plan Documents and any state or federal laws shall take precedence over any protocol used by the Contractor.

y. 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.

z. The Contractor shall submit to the State, at least two (2) months prior to Go-Live, a copy of all documents describing its UM programs, evaluation methodology, and audit plan and within two (2) Business Days of written request from the State at any time during the Term of the Contract at no additional charge. The Contractor shall notify the State, In Writing, within thirty (30) days of any significant changes to its UM program.

aa. The Contractor shall provide a written report to the State upon request, regarding the demonstrated effectiveness of its UM program. Any significant changes or findings of its Utilization Management program are to be provided at the semi-annual review meetings.

bb. At the State's request, the Contractor shall provide expert medical opinion services for Members diagnosed with a complex medical condition or surgical interventions such as but not limited to cancer, musculoskeletal, transplant, autoimmune, renal disease, women's health, cardiac/vascular, gastrointestinal. Expert medical opinion services may be provided by the Contractor or a subcontractor and shall be reimbursed pursuant to Contract Section C.3. Services shall include an assigned Member care coordinator, medical record collection and consolidation, expert medical review by a provider within seven (7) days, provider consultation with the Member and/or Member's authorized representative, provider consultation with the Member's initial/primary provider (if applicable), written expert medical opinion in a Member approved format (mail, secure email, electronic file, etc.), referrals to in-network specialists, and follow-up medical care coordination. Expert medical opinion services shall be available to the Member through the Contractor's call center, website, or mobile application. The Contractor shall administer Member utilization incentive options such as, but not limited to, an enhanced benefit design at the state's request. The Contractor shall also recommend the expert medical opinion service option to any Member calling the Contractor call center requesting benefit information or a PA for a qualifying condition or surgical intervention.

cc. If implemented, the Contractor shall submit a quarterly expert medical opinion report with information on each case including but not limited to the case type, any diagnosis or treatment changes, referrals to in-network specialists, and any estimated cost savings (refer also to Contract Attachment C, Reporting Requirements).

dd. Step Therapy:

(1) The Contractor shall administer and maintain a Step Therapy program that promotes the use of the most cost-effective drug therapy for a specific indication, regardless of drug class.

(2) At the State's request, the Contractor shall implement a Step Therapy program targeting specific drugs and/or drug classes at any time during the contract and the Program shall be implemented by the Contractor at no cost to the State.

(3) As each Formulary is re-evaluated and/or expanded, the Contractor shall develop proposed Step Therapy criteria for non-preferred drugs and certain preferred drugs and present those criteria to the State for review and input. The Contractor shall base these recommendations on therapeutic best practices and drive utilization to the most cost-effective agents or classes.

(4) The Contractor shall describe the drugs and the criteria included in the Step Therapy program on all Formulary documents. The Contractor shall code these criteria into the POS system such that the system shall have an edit on all drugs in the target classes that Pharmacy Providers submit for dispensing. Before the new drug may gain approval through a PA, the Contractor shall review the Claims history of prior use of a more cost-effective drug and approve the PA only if such evidence is present.

ee. The Contractor agrees that the State, at the State's sole discretion, may utilize third party services for PA and UM for Specialty Drugs and/or non-Specialty Drugs without objection, charge, or penalty if the State chooses to exercise this right. The Contractor will also, at no charge and as directed by the State, provide support needed by such third party or parties to perform its services including, but not limited to, exchanging needed claims, accumulator, and eligibility data; redirecting prescriber, Member, drug Manufacturer, and/or Pharmacy inquiries related to such services to the applicable entity; and providing needed access to PBM Claims and/or PA override systems allowing such third party or parties to enter P A and other claims reject overrides and quantity limits, run test claims, confirm Member eligibility in real-time, look up claims history in real-time, and look up state-specific drug coverage status in real-time.

ff. At the State's request, the Contractor shall support the State's efforts to develop a MTM program. Such assistance shall include providing requested Member Pharmacy data, communicating with and educating participating network pharmacies, and assisting in the identification of Members who should receive MTM services.

gg. At the State's request, the Contractor shall implement an opioid management program that is no less strict than the current CDC-recommendations https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf (with PA requests that may allow a higher MME per day, as approved by the State, if appropriately documented by a Provider). Any program targeting opioids or opioid management must comport with Tennessee law at all times during the Term.

hh. Prior to implementing any program or service for which the Contractor receives external funding, the Contractor shall disclose the details of such program and such sources of external funding to the State. The State shall have the authority to opt-out of any such program that the State determines is not in the best interest of its Members.

ii. At the State's request, the Contractor shall implement a program for poly-chronic patients taking multiple medications and will contact these Members to assist them with their medication use and enroll them in programs or engage them in other methods that may encourage use of different medications or strengths of existing medications in order to lower Member and plan cost and improve Member medication utilization.

A.10. Prospective/Concurrent DUR

a. The Contractor shall furnish a fully automated prospective/concurrent DUR system that meets all applicable state and federal requirements. The DUR function shall meet minimum federal DUR regulations as well as the additional specifications in this section and Contract Section A.11. as well as being flexible enough to accommodate any future changes required by the State. The Contractor shall recommend to the State, annually at review meetings, new DUR edits that improve quality and reduce Pharmacy Program costs.

b. Prior to authorizing Claims and permitting reimbursement, the Contractor's system shall provide DUR services that apply State-approved edits to all Claims. The edits shall provide clinically appropriate information described in Contract Section A.15.c. to the dispensing pharmacist.

c. The Contractor's POS system shall apply the results of DUR processing in the Claim adjudication process. Claims that reject as a result of DUR processing shall include situation specific messaging and error codes that enable the Pharmacy Provider to take appropriate actions. The Contractor may use an existing DUR package which meets all applicable state and federal requirements. The Contractor's system shall include the following minimum DUR features at installation:

(1) Potential Drug Problems Identification - The Contractor's system shall perform automated DUR functions. The system shall automatically identify and report issues to the Pharmacy Provider including, but not limited to:

i. Problems that involve potential drug overutilization
ii. Problems that involve therapeutic duplication of drugs when the submitted Claim is associated with other drugs or historical Claims identified for a given Member
iii. Problems that involve drug use contraindicated by age, gender and presumed diagnosis codes on historical Claims for a given Member
iv. Problems that involve drug use contraindicated by other drugs on current or historical Claims for a given Member (drug-to-drug interactions)
v. The level of severity of drug-to-drug interactions
vi. Potentially incorrect drug dosages or a change to the quantity per prescription to ensure the most cost-effective strength is dispensed
vii. Potentially incorrect drug treatments
viii. Insufficient or excessive drug usage
ix. Potential drug abuse and/or misuse based on a given Member's prior use of the same or related drugs; and
x. Early refill conditions and provide, at the drug code level, the ability to deny these Claims. The Contractor shall customize refill-too-soon edits.

(2) POS Pharmacy Provider Cancel or Override Response to DUR Messages – Prior to the final submission of POS Pharmacy Claims, the Contractor's system shall automatically generate DUR messages in a manner that shall enable a Pharmacy Provider to cancel submission of the Claim or to submit it if it is a message that can be overridden by the Pharmacy. Providers are individually responsible for acting or not acting upon information generated and transmitted through the DUR Services, and for performing services in each jurisdiction consistent with the scope of their licenses. The DUR services are necessarily limited by the amount, type and accuracy of Member information made available to the Contractor.

(3) Flexible Parameters for Generation of DUR Messages - The Contractor's system shall have the ability to transmit new or revised DUR messages and to define the DUR criteria that activate these messages.

(4) DUR Member Profile Records - The Contractor's system shall provide and maintain Member profiles for DUR processing of submitted Claims. The Contractor shall base Member profiles on presumed diagnoses from Pharmacy Claims and other data available.

(5) Disease/Drug Therapy Issues Screening - The DUR system shall have the capability to screen for drug therapy concerns by specific drugs relative to high-risk diseases including, but not limited to, cardiovascular disease; diabetes; psychiatric disease; and respiratory disease.

(6) Patient Counseling Support - The Contractor's system shall present DUR results to Pharmacy providers in a format that supports the ability to advise and counsel Members appropriately.

A.11. Retrospective DUR (Retro-DUR)

a. The Contractor shall provide a Retro-DUR program supported by licensed clinical pharmacists. The Contractor shall develop, maintain and update a set of evidence-based clinical criteria, which the Contractor shall use to detect potential problems such as polypharmacy and related over-utilization, underutilization, drug-to-drug interactions, therapeutic duplications, incorrect drug dosage and duration of treatment, possible fraud

and abuse issues, and other instances of inappropriate drug therapy as may also be related to a Member's age or disease state. The Contractor's Retro-DUR system shall:

(1) Provide Provider practice analyses that includes identification of Key Performance Indicators such as Generic Drug dispensing rate, controlled substance prescribing rates, Formulary compliance, etc.
(2) Trend Providers' prescribing habits and identify those who practice outside of their peers' norm
(3) Identify patients who may be abusing resources through polypharmacy utilization patterns or visiting multiple Providers
(4) Identify patients with excessive use of controlled substances or other highly abused medications
(5) Produce reports that detail patient and prescriber trends and that identify potential quality of care problems and/or potential fraud and abuse; and
(6) Have in place an intervention process and a system for tracking prescriber response to the interventions.

b. The Contractor shall utilize evidence-based clinical criteria to conduct quarterly prescriber and Member profile reviews. The Contractor shall set the number of Member and prescriber profile reviews, with approval In Writing by the State, to be conducted quarterly. The Contractor will notify the State In Writing of the focus of, and methodology to be used in, the profile reviews at least thirty (30) calendar days prior to the initial review start date.

c. The Contractor shall complete quarterly prescriber and Member profile reviews and distribute results/interventions, as recommended by the clinical pharmacist, to prescribers within ninety (90) calendar days of the end of the quarter. The Contractor shall implement interventions designed to address problems identified during profile reviews. These interventions may include mailings, phone calls, virtual interactions, or face-to-face visits. Other interactions may occur after receiving approval from the State. Communications shall consist of an intervention letter to the prescriber and/or Pharmacy Provider detailing the reason for the letter, the purpose of the intervention and providing educational information. Member profile(s) illustrating the potential problem and suggesting corrective action may also be included. The State will approve any summaries, correspondence or other documents produced as a result of the review process prior to their distribution.

d. The Contractor shall maintain a system capable of tracking all interventions and determining cost savings related to the specific interventions.

e. DUR and Retro-DUR Reporting

(1) The Contractor shall have a qualified DUR clinical pharmacist, Designated to the Plan, prepare presentations and attend meetings with the State to present DUR and RetroDUR data, findings, utilization, and recommendations for improvement. Such presentations shall occur up to four (4) times annually, as requested by the State. When requested, the Contractor shall present, at a minimum, the following reports/information for each of the State sponsored plans, which shall convey rolling twelve (12) month trends:

i. Utilizing-Members data
ii. Utilization by age demographics
iii. Utilization by top twenty (20) therapeutic classes determined both by number of Claims and by payment amount
iv. Top twenty (20) drugs as ranked by Claim count and by total payment
v. DUR data including totals of DUR messages sent and savings associated with the top twenty (20) drugs associated with each DUR edit
vi. Retro-DUR reviews, summary of the interventions and estimated cost savings information as associated with both Member and Provider profile review and interventions
vii. Distribution of Clinical Alerts as prepared monthly by the Contractor's Clinical Management staff; and
viii. Any additional reports included in the Contractor's standard DUR reporting package.

(2) The Contractor shall, upon request of the State, report quarterly the outcomes of the Retro-DUR initiatives. The Contractor's system shall track the impact of DUR initiatives by comparing specified data elements pre- and post-intervention. At the State's request, the data elements tracked will vary according to the focus of study and/or type of intervention employed and may include, but shall not be limited to:
i. Drug change within a sixty (60) or ninety (90) day period of the intervention, or within another time period as otherwise directed by the State
ii. Total number of drugs pre- and post-intervention
iii. Change in dose/dosing frequency of medication within a sixty (60) or ninety (90) day period of intervention or within another time period as otherwise directed by the State
iv. Daily dose of drug in question pre and post intervention
v. Assessment of various interactions (as relevant to the activity) pre- and postintervention which may include drug-to-drug interactions (e.g., number of drugs identified and severity index), pregnancy interactions, disease state interactions, therapeutic duplications, allergy interactions, and age-related medication problems
vi. Compliance with national guidelines (e.g., percentage of patients with CHF on beta-blocker, diuretic, etc.) depending on the disease state targeted by the Retro-DUR initiative
vii. Generic Drug medication utilization
viii. Emergency supply frequency
ix. Formulary compliance; and
x. Patient adherence as defined by medication possession ratio.

A.12. Specialized Case Management

a. The Contractor shall provide specialized behavioral health case management services through its staff who are experienced Master's or PhD level clinicians with a minimum of five (5) years of experience in mental health and/or substance abuse treatment, including two (2) years with mental health and/or substance abuse case management. The Contractor shall provide appropriate clinical supervision of case managers, including medical review of all alternative treatment plans for specific patients.

b. The Contractor shall provide medically necessary medical case management services. This shall include identifying and outreaching to Members with high-risk conditions such as but not limited to terminal illness, cancer, major cardiac surgery, severe injury, major trauma, high-risk maternity, neonate admissions, cognitive or physical disability, dialysis, and transplants. Registered nurse case managers shall work with the Member, health

care providers, primary caregivers and appropriate contractors to coordinate the most appropriate, cost-effective care and care settings. This shall include transition to Designated contractors 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 contractors.

c. Case managers shall provide the following services:

(1) Patient advocacy, including but not limited to assistance gathering clinical history to ensure appropriate level of care approvals and placement (through provider outreach calls) with a provider and/or facility with the best quality and fit for the Member's clinical needs;
(2) Clinical coordination of care and services for high risk Members requiring or admitted to facility-based care;
(3) Telephonic and electronic visits, to ensure the quality, effectiveness, and appropriateness of treatment and discharge planning;
(4) Consultations with the patient (if clinically appropriate), family and attending provider;
(5) Development of alternative treatment plans, where benefit coverage allows flexibility in determining the most clinically appropriate, cost-effective alternative treatment for the Member;
(6) Participation, as necessary, in the appeals process; and
(7) Coordination of care with other appropriate State contractors.

d. 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 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 contractors for assistance.

e. Unless otherwise directed by the State, the Contractor shall identify Members for specialized case management through referral (including self-referral), Prior Authorization, review of medical, behavioral, and Pharmacy claims data, and review of other data maintained by the Contractor.

f. The Contractor shall develop criteria to identify Members appropriate for specialized case management, which may include Members who have a serious or persistent mental or medical illness, who have had an inpatient admission for a health condition within the past two (2) years, frequent emergency room utilization, and/or meet additional criteria, which may include, but is not limited to, the following:

(1) The Member is an adolescent;
(2) The Member has co-occurring (physical health and mental health or substance use) disorders;
(3) The Member is at risk of or had an inpatient readmission within ninety (90) days of discharge;
(4) The Member had a mental health or substance use admission during the previous twelve (12) months;
(5) The Member has inpatient discharge without subsequent lower levels of care follow up;
(6) The Member is at risk for future suicide or injury;
(7) The Member has Medication safety-adherence concerns such as lack of adherence to dispensed quantity of medication, contraindicated medications or multiple concurrent medications within the same drug class dispensed;
(8) The Member is expected to generate $50,000 or more in claims; or
(9) The Member is over sixty (60) years of age.

g. The Contractor's specialized case managers shall outreach to the identified Member via case management invitation letter, prior approved by the State, and a direct to Member follow up phone call.

h. The Contractor shall provide expanded case management specifically for families with a Member diagnosed with autism, an autism spectrum disorder, or a developmental disorder. The case manager shall work with the family as a whole to ensure engagement with all available services for the diagnosed Member as well as additional family Members. The case manager shall also assist the family with any community resources that may be of assistance to support the diagnosed Member and the family.

i. The Contractor shall provide case management services to plan participants who fill Specialty Medications through the Contractor's own Specialty Pharmacy. This shall include identifying and outreaching to Members with conditions such as cancer, rheumatoid arthritis, Hepatitis C, Multiple Sclerosis, and Hemophilia (conditions listed here are examples only and not an all-inclusive list). Registered pharmacists shall work with the Member, health care Providers, primary caregivers and the state's contracted medical vendors to coordinate the most appropriate, cost-effective site of care and place-of-fill for Specialty Medications.

j. The Contractor shall submit a description of its case management program to the State no later than two (2) months prior to Go-Live. The State reserves the right to review the description and request changes. The Contractor shall notify the State, In Writing, thirty (30) days prior to any significant changes to the program. The State reserves the right to review the proposed change(s) and request revisions.

k. The Contractor shall update the State, at the semi-annual review meetings, regarding the utilization of case management services, including but not limited to the number of Members receiving case management along with any significant changes or findings.

A.13. Value Based Initiatives

a. The Contractor shall offer a PCMH or similar program, as approved by the State In Writing, with specific objectives of improving clinical outcomes, patient experience, overall cost control, and net savings across the continuum of services. The State recommends that the Contractor's program include NCQA PCMH recognition or similar. The Contractor shall disclose to the State the quality measures and necessary parameters for practices to receive enhanced payments. Prior to any enhanced payments the Contractor shall verify that practices have achieved the defined quality measures and additional necessary parameters and shall report to the State performance outcomes and total payments earned.

b. PCMH or similar program initiatives shall include Collaborative Physical and Behavioral Health Care for all attributed patients. Collaborative care shall at a minimum include a behavioral health screening using an age appropriate nationally recognized tool, discussion with the provider if the screening is positive, and referral to a licensed behavioral health professional or coordinator for follow up. Behavioral health quality metrics shall be included in overall PCMH or similar program measurements and reported to the State in the overall PCMH performance reporting. The Contractor's program shall include NCQA PCMH Distinction in Behavioral Health Integration, URAC Measurement Based Care Distinction, or similar defined measurement parameters, as approved by the State In Writing.

c. The Contractor shall receive prior approval In Writing from the State for any Member attribution model and associated program payments in a PCMH, Accountable Care Organization, or any other similar model.

d. The Contractor shall include in its provider network, transplant facilities that are Medicare-approved facilities. 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. The Contractor shall establish transplant Centers of Excellence and the State may offer cost-sharing benefits or incentives for Members who receive transplants at a Contractor Designated Center of Excellence.

e. The Contractor shall build by December 31, 2025 and maintain a network of Centers of Excellence for treatment or surgical interventions including but not limited to: bariatric surgery (COE use required), orthopedic surgery, oncology/cancer surgery, and, gene therapy. 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/or 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.

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

g. The Contractor shall report descriptive information and data about its value based 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, discretionary billing;
(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;
(4) The projected financial impact to the plan as a result of the program; and
(5) If approved, semi-annual reporting (refer also to Contract Attachment C, Reporting Requirements) on the number of Members served, program specific measurement based outcomes, utilization, and financial impact including any savings as a result of the program.

h. As directed by the State, the Contractor shall enter into direct contracts, on the State's behalf, for select Point Solutions that fill gaps in the State's current healthcare benefit offerings or help to solve specific challenges. The Contractor shall collaborate with the State during the direct contracting process in the development of fee schedules, standard protocols and measures, claims processing and payment, or other value based payment, semi-annual reporting (if applicable, see also Contract Section A.13.g.5.) and implement any associated Member cost-sharing benefits or incentives (e.g., waiver of cost sharing, etc.). These Point Solutions shall not negatively impact the Contractor's risk of performance or trend guarantees and shall be excluded from guarantee calculations as necessary. Alternatively, should the Contractor enter into direct contracts for Point Solutions for their greater book of business, the Contractor shall offer, at the State's

request, said Point Solutions to the State for implementation, at no additional administrative cost to the State above and beyond program costs.

i. The Contractor shall offer to Members at least one national Telemedicine/Telehealth service benefit option that meets or exceeds T.C.A. and State of Tennessee Medical Board requirements and regulations and allows Members easy access to twenty-four seven (24/7) non-urgent acute care. The Contractor shall submit a quarterly telehealth utilization report that includes the number of enrollments/activations, number of encounters, top diagnosis, and top prescriptions (refer also to Contract Attachment C, Reporting Requirements).

j. The Contractor shall offer to Members at least one web based diabetes prevention program option based upon the Center for Disease Control's Diabetes Prevention Program including, but not limited to, Member and provider outreach and education. The Contractor shall be able to vary provider program payments based on Member participation and outcomes and must be billed as a claim. The Contractor shall submit a quarterly Diabetes Prevention Program outcomes report that includes the cumulative enrollees, enrollees by program stage, total weight loss, average weight loss by program stage, enrollees by weight loss range (below 0%, 0-3%, 3.01-5%, 5.01-7%, 7.01-10% and 10.01%+) and starting BMI (<25,25-29, 30-34, 35-39 and 40+) (refer also to Contract Attachment C, Reporting Requirements).

k. The State requests a mid-contract industry and innovation review and planning meeting. Said meeting shall occur at either the State offices or at the Contractor's offices and shall include Contractor executives and key leadership individuals with direct knowledge and influence of the Contractor's corporate vision and direction. Meeting date, agenda, and attendees shall be mutually developed, at a minimum, by the State program director and Contractor Account Executive.

l. At the State's request, the Contactor shall implement value based payments on medications where provider payments are differentiated based on quality, efficacy, and/or patient outcomes (or any combination of these). The Contractor shall not implement such value based payments to pharmacies or Manufacturers without prior approval In Writing from the State. Upon implementation of any value based payments, the Contractor shall report descriptive information and data about its value based payments in sufficient detail to enable the State to adequately monitor the Contractor's payments. Refer also to Attachment C, Reporting Requirements. The information that may be requested may include the following:
   (1) The drug name(s), NDC, and full GPI
   (2) Drug Manufacturer name
   (3) The total number of prescriptions filled
   (4) The total number of Members filling a prescription for each drug
   (5) The projected financial impact and savings to the plan as a result of the Program.

A.14. Call Center

a. The Contractor shall operate a call center that uses a toll-free telephone number Dedicated to the Plans as the entry point for Members contacting the Contractor. At the request of the Contractor, in lieu of a Dedicated toll-free telephone number, the State may approve a dedicated call tree including all prompts and branches, In Writing.

b. The Contractor's call center shall be open and staffed with trained personnel on the first day of annual enrollment.

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 located in the continental United States 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 shall have 24/7 Pharmacy call center support for Members experiencing issues with obtaining their pharmaceuticals.

g. The Contractor's call center shall be equipped to support and communicate with persons with a hearing or speech impairment via Telecommunications Relay Services (TRS).

h. 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.

i. The Contractor shall provide the State's 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 (refer also to Contract Attachment D, SLA Scorecard):

   (1) Daily 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 Member 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 90-20, meaning 90% 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 monthly basis beginning with the start of annual enrollment period (refer also to Attachment C, Reporting Requirements).

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 outbound 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 or other contractors.

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 review previously recorded calls from a remote location.

v. The call management system shall enable the logging of all calls, including but not limited to:
   (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. The Contractor shall provide Members and Pharmacy Providers with an option on the toll free telephone number to immediately consult with a licensed pharmacist between the hours of 7am – 7pm Central Standard Time Monday through Friday. Outside of the hours of 7am – 7pm Central Standard Time Monday through Friday, Members and Pharmacy Providers will have an option to receive a call back from a pharmacist within one (1) hour. This help desk shall be available twenty-four (24) hours a day, seven days a week to respond to questions and problems from Pharmacy Providers and Members. The Contractor shall supply all the required information systems, telecommunications, and personnel to perform these operations.

y. The Contractor shall notify the State of any call center disruptions lasting more than an hour. Call center disruptions include, but are not limited to, unexpected technical issues, scheduled maintenance, or known unknown risks (e.g., weather-related).

A.15. Claims Processing, Payment and Reconciliation

a. The Contractor shall process all claims for covered benefits provided to Members in strict accordance with the Plan Documents, applicable Contractor medical coverage 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 the Plans' covered benefits or apply their standard book of business changes to benefits set up, procedures, or claims processing guidelines during the term of this Contract without the prior notification to and approval In Writing from the State. The Contractor shall retain records of all State approvals for benefit set up that do not align with the Contractor's standard book of business. The Contractor may be assessed liquidated damages as set forth in Attachment B, Liquidated Damages for any claims that are not processed according to State approved covered benefits.

b. The Contractor shall provide an integrated, electronic retail, Mail Order and Specialty POS Claims processing system which uses the specified, current NCPDP format, for prescription drug claims that can meet the needs of the State and the Plan. The POS system shall automate the entire Pharmacy Claims processing system and shall price and adjudicate Claims online, in real time, and in accordance with the Plan Documents. The Contractor's POS system shall allow it to interface with the existing Pharmacy switch networks that connect Pharmacy Providers with the Contractor's system. The Contractor shall provide system design, modification, development, implementation and operation for the Plan POS system.

c. The Pharmacy POS Claims system shall fully integrate the PA, quantity limits, and Step Therapy programs and have edits to verify the current Formulary and Claim completeness as Claims are submitted.

d. POS system messages shall in no way steer or encourage Members or Providers to utilize a particular Pharmacy.

e. The Pharmacy POS system shall generate a Claim pay status of pay or deny. The system shall allow a Pharmacy to initiate a reversal (void) of a submitted Claim. The telecommunications system supporting the POS function shall be available for Claims submissions by pharmacies twenty-four (24) hours-a-day, seven (7) days-a-week (except for regularly scheduled and separately approved downtimes). The Contractor shall not charge participating Pharmacy providers any POS fees for services, including but not limited to Transmission Fees, rendered under this contract. Network Pharmacy Providers are responsible for purchasing POS hardware, software and all telecommunications

linkages. The Contractor shall require all participating network Pharmacy Providers to have the POS function. POS system used by contracted pharmacies to process Pharmacy Claims shall be accessible and operational 99.90% of the time excluding scheduled maintenance.

f. The Contractor shall operate a claims management system that tracks accumulations toward Out-of-Pocket Maximums, tracks Copayment amounts and appropriately links claim history, enrollment information, Member services, provider network, and Utilization Management information. This shall include the electronic exchange of all claims data to the HSA/FSA contractor as well as Member maximum out-of-pocket accumulator data with the HSA/FSA and any other State contractors as requested by the State.

g. 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 Plan(s) annually prior to the start of the benefit plan year or 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. Refer also to Contract Attachment B, Liquidated Damages.

h. 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.

i. The Contractor shall ensure that participating pharmacies submit Member Claims through POS telecommunications devices. However, the Contractor shall also process Paper Claims within thirty (30) days of receipt when submitted by Members or by a prescriber on behalf of a Member.

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

k. The Contractor shall require Network Providers submitting a claim with a miscellaneous pharmaceutical HCPCS code to include the name of the drug and the National Drug Code (NDC) and the number of units on the associated professional claim form (HCFA 1500) or facility claim form (UB92).

l. The Contractor shall submit to the State, at least one (1) month prior Go-Live, a summary of its methodology for conducting internal claims audits, including audits to determine claims payment, processing, and financial accuracy and claims payment turnaround. The State reserves the right to review the methodology and request 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 request changes, where appropriate.

m. 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.

n. The Contractor's Pharmacy POS adjudication system must have the ability to reject Claims when the Member's Plan coverage is secondary to another plan and notify Members and the Retail Pharmacy why the Claim rejected. The Contractor must process secondary coverage Claims for possible reimbursement as appropriate

o. 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.

p. The Contractor shall process medical and behavioral health claims, either filed directly by Members and/or provider(s), in an accurate and timely manner and in accordance with the following 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. The Contractor shall report Clean Claim automatic adjudication on a quarterly basis (refer also to Contract Attachment C, Reporting Requirements and Attachment D, SLA Scorecard).

(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, measured by the time elapsed from the date a claim is received to the date the claim is paid with only the received date and not the processed date included in the calculation. The Contractor shall report payment turnaround on a quarterly basis in a report format specified by the State (refer also to Contract Attachment C, Reporting Requirements and Attachment D, SLA Scorecard).

(3) Financial accuracy shall be ninety-nine percent (99%) or higher. Financial accuracy shall be calculated on a statistically valid, random sample with a minimum 95% confidence level and 5% margin of error and reported by taking the total benefit dollars paid in the population, minus the sum of the weighted absolute value of overpayments and underpayments, divided by the total dollars paid in the population. The Contractor shall report financial accuracy on a quarterly basis in a report format specified by the State (refer also to Contract Attachment C, Reporting Requirements and Attachment D, SLA Scorecard).

(4) Claims processing accuracy shall be ninety-six percent (96%) or higher on claims processed by the Contractor. Processing accuracy shall be measured by dividing the weighted number of claims processed without any type of error by the total number of claims in the population. To measure claims processing accuracy, the Contractor shall select a statistically valid, random sample of processed claims with a minimum a 95% confidence level and 5% margin of error for testing. The Contractor shall report claims processing accuracy on a quarterly basis in a report format specified by the State (refer also to Contract Attachment C, Reporting Requirements and Attachment D, SLA Scorecard).

(5) Claims payment accuracy shall be ninety-seven point five percent (97.5%) or higher on claims paid by the Contractor. Payment accuracy shall be measured by the weighted number of correct benefit claim payments (claim payments with no errors) by the total number of claim payments in the population. To measure claims payment accuracy, the Contractor shall select a statistically valid, random sample of Paid Claims with a minimum a 95% confidence level and 5% margin of error for testing. The Contractor shall report claims payment accuracy on a quarterly basis in a report format specified by the State (refer also to Contract Attachment C, Reporting Requirements and Attachment D, SLA Scorecard).

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

processing on a quarterly basis (refer also to Contract Attachment C, Reporting Requirements and Attachment D, SLA Scorecard).

(7) 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.

q. The Contractor shall process Pharmacy claims, either filed directly by Members and/or provider(s), in an accurate and timely manner and in accordance with the following claim processing standards.

(1) The Contractor shall process ninety-nine point five percent (99.5%) of Pharmacy POS Claims on a daily basis within five (5) seconds excluding scheduled maintenance downtime. For POS System Processing the calculation shall be the number of Claims processed within five (5) seconds during each twenty-four (24) hour period shall be the numerator and the number of Claims processed during each twenty-four (24) hour period shall be the denominator. To measure compliance with this standard, the Contractor shall measure for each Claim the time from when the Claim is received by the Contractor's processor to the time the results are transmitted from the Contractor's processor. The Contractor's measure shall reflect the time required for all procedures required to complete Claim adjudication (refer also to Contract Attachment C, Reporting Requirements and Attachment D, SLA Scorecard).

(2) On a quarterly basis, the Contractor shall accurately process greater than or equal to 99.9% of Claims at Retail, greater than or equal to 99.9% of Claims at Mail Order, and greater than or equal to 99.9% of Claims at Specialty, either filed directly by Members and/or their prescriber(s). Claims Processing Accuracy shall be measured by dividing the weighted number of Claims processed without any type of error by the total number of Claims in the population (refer also to Contract Attachment C, Reporting Requirements and Attachment D, SLA Scorecard). The Contractor shall also include, within the report detail, how the Contractor calculated performance (i.e., "show your work").

(3) Claims payment accuracy shall be ninety-nine point nine percent (99.9%) or higher for retail, Mail Order, and specialty. Based on vendor's internal quality review. Calculated as all Claims audited and found to be without adjudication error of any kind (i.e., any Claim processing inaccuracy that results in an incorrect charge to the State or its plan Members), divided by all Claims audited (refer also to Contract Attachment C, Reporting Requirements and Attachment D, SLA Scorecard).

r. The Contractor shall ensure that every Paid Claim is attributed to one of the State's funding accounts. Any later adjustments of Claims requested or initiated by either the State or by the Contractor shall be debited or credited to one of the State's funds and not to the funds that are paid to the Contractor in the way of Administrative Fees. Any adjustments or later Claims processed that results in the State being owed money or the State owing money for a Claim processed should be debited or credited against one of the State's funds and NOT against any Administrative Fee payments.

s. Contractor's payment process shall comply with any state prompt pay laws. In the absence of any prompt pay laws in Tennessee for PBMs, BA has chosen to use the following language regarding prompt payment of pharmacies: the lesser of thirty (30) calendar days or the contracted turnaround time with the Pharmacy.

t. The Contractor's claims management system shall retain claim history on-line for at least three (3) years and it must be made available either online or upon request. This does

not limit the Contractor's obligations to retain all records in accordance with Contract Section D.11, Records.

u. The Contractor shall test the accuracy of automated features of the claims management system at least annually as part of its internal audit program policies and procedures.

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

w. The Contractor shall use a clinical edit software program that automatically evaluates all network 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.

x. At the POS, the Contractor shall identify and deny Claims that contain invalid Provider numbers. Pharmacy Providers shall submit Claims and be identified by their individual and specific NPI. Prescribers shall be identified on all Pharmacy Claims by their specific NPI or DEA Numbers, or any other identifying number as required by the State, federal law, or HIPAA.

y. The Contractor shall identify and deny Pharmacy Claims (unless specifically instructed differently by the State) that contain NDC or NDC-11 numbers that contain non-covered drug codes, LTE drug codes based on the Drug Efficacy Study Implementation ("DESI"), drug codes which are IRS to DESI Drugs classified as LTE and any terminated or obsolete drug codes. Such Claims shall reject with situation specific messaging and error codes.

z. 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. The Contractor shall provide a copy of their standards for updating Network Provider rate information in their claims management system at least 30 days prior to Go-Live. Network Provider rate information shall be updated in the claims management system according to the Contractor's documented standards.

aa. The Contractor shall, at the State's request and with prior approval, perform drug price comparisons with one or more prescription Discount programs at the point of sale thereby allowing Members to pay lower prices, when available, on certain medications while having the amount paid by the Member seamlessly applied to their deductible and/or Out-of-Pocket Maximum.

bb. The Contractor's Member services representatives shall have access to claims management and other systems as necessary to respond to inquiries from Members.

cc. Explanation of Benefits (EOB)

(1) The Contractor shall generate and mail an EOB to the Member each time the Contractor processes a medical or behavioral health claim from a provider where the Member cost share is greater than zero, unless specifically requested by a 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, 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, 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 electronic EOB statements if requested by the Member.

(2) The Contractor shall also generate and mail an EOB to the Member each time the Contractor processes a medical or behavioral health claim submitted by the Member where their cost share is greater than zero, unless specifically requested by a 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 electronic EOB statements if requested by the Member.

(3) The Contractor's system must provide Members a POS explanation of Pharmacy benefits for Claims processed through its Retail, Mail Order, and Specialty Pharmacies, and concurrently provide online Claims records for prescriptions dispensed through all channels, which lists the individual Member's pharmaceutical out-of-pocket expenses, the Plan's costs, and concurrently provides online any cost savings opportunities for the Member.

dd. If a Member receives a covered benefit from a Network Provider, the Network Provider's contract rate shall be used to determine the allowed amount. The Member shall not be responsible for payment in excess of their Copayment amount. If the Contractor determines that a service to be provided to a Member is ineligible for payment (e.g., the service exceeded the applicable service limitation, was not medically necessary, was experimental or investigational, or the service was subject to PA and was not approved by the Contractor), but the Network Provider proceeds with rendering the service: (a) The Contractor shall develop an advanced beneficiary notice (ABN) template and shall provide copies of the template to Network Providers; and (b) Network Providers shall require the Member to sign and date such ABNs acknowledging that the Contractor will not cover the cost of services not authorized by the Contractor, prior to rendering non covered services, should the Member choose to receive said services. The Member shall not be responsible for payment to the provider unless the Network Provider can provide a copy of an ABN for the specific services rendered and the date of service, signed by the Member prior to the service being rendered. Providers shall not require Members to sign ABNs for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services provided at an in-network hospital or ambulatory surgical center.

ee. The Contractor shall only pay claims that are for covered benefits provided to eligible Members and provided in accordance with the Contractor's medical policies, PA, UM agreements between the Contractor and Providers, other applicable requirements, and with the Plan Documents.

ff. Intentionally left blank.

gg. The Contractor shall not knowingly 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. If it is later determined that a payment has been made for a preventable event or condition, the Contractor will reverse the payment or recoup the payment from the provider.

hh. The Contractor shall pay claims for services from medical and behavioral health 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.

ii. The Contractor, GPO, and any Contractor Affiliates shall pass through the full value of any and all payment terms or contracted rates that the Contractor has negotiated with providers, pharmacies, supply and device Manufacturers, and pharmaceutical Manufacturers (including, but not limited to, Discounts, Dispensing Fees, and any other contracted terms) and Pharmaceutical Manufacturers (Rebates, MAF, Manufacturer Payments) directly to the State. The Contractor shall not receive any differential, or spread, between the contracted 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. The Contractor shall provide a quarterly report to demonstrate the level of Pass-Through Transparent Pricing. The Contractor understands and agrees to the statement in contract section C.3.t and acknowledges that this will be audited on an annual basis by the State's benefits and actuarial consultants, in order to comply with Tenn. Code Ann. § 4-3-1021. Refer to Contract Attachment C, Reporting Requirements.

jj. The Contractor shall remit to the State no less frequently than quarterly a check for 100% of all Rebates and Manufacturer Payments accrued which were obtained on behalf of the State, by the Contractor (including Rebate aggregators or any similar contracted entities), due to the use of medical services, devices, and pharmaceuticals (including Specialty Drugs) by Members of the Plans. The State reserves the right to audit the Rebate payments in accordance with A.24.a to ensure 100% of all Rebates accrued were paid to the State correctly.

kk. The Contractor, or any third party that negotiates and collects Manufacturer Payments allocable to the State, shall provide with each quarterly payment remitted to the State, a report showing the amount of the payment broken down by Plan Group fund (i.e. State Actives, State Retirees, etc.) and further broken down by service or product name, the calendar quarter that the various Manufacturer Payment amounts are attributable and the appropriate codes to identify the service or product (e.g. NDC-11, NDC plus the appropriate HCPCS Level II code, J-codes, etc.). The Contractor shall also provide an annual reconciliation report demonstrating true-up to one hundred percent (100%) no later than one hundred fifty (150) days after the end of each calendar year. Refer also to Contract Attachment C, Reporting Requirements.

ll. The Contractor shall ensure that any payments funded by the State are accurate and in compliance with the terms of this Contract; agreements between the Contractor and providers; and state and federal laws and regulations.

mm. The State shall determine all policies and benefits related to the Plans and shall have the sole responsibility for and authority to clarify and/or revise the benefits available under the 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 from the State 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.

nn. The Contractor understands that the Plans cannot and do not cover all medical, pharmaceutical, and behavioral health 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 State 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 State 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.

oo. The Contractor shall identify and pursue claims that may be subject to coordination of benefits (COB) in accordance with the regulations promulgated by the Plan Document and Tennessee Department of Commerce and Insurance, Chapter 0780-1-53 Tenn. Comp. R. & Regs. The Contractor shall provide a report of said activities to the State upon request. The Contractor shall provide a weekly report of necessary updates to Member eligibility records regarding coordination of benefits and other payer coverage (refer also to Contract Attachment C, Reporting Requirements).

pp. The Contractor shall notify the State, in a weekly report, the receipt of any notices from Medicare that Medicare may have made primary payments for services when it should have been the secondary payer for the timeframe from Go-Live through the claims runout period (a Medicare Secondary Payer demand letter). Refer also to Contract Section A.15.eee. and Contract Attachment C, Reporting Requirements. 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.

qq. The Contractor shall implement a process to carry out recoveries, including but not limited to subrogation, and report recovery activities to the State. The Contractor shall submit to the State a monthly recoveries report of all recoveries including but not limited to subrogation in a format prior approved by the State (refer also to Contract Attachment C, Reporting Requirements).

rr. The Contractor shall implement a process to identify all Claims paid on behalf of a Member affected by a retroactive termination during the period of retroactivity. The Contractor shall notify the State within thirty (30) calendar days of a retroactive Member termination and assist the State in the recovery of impacted Claims.

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

tt. 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 Go-Live, detailed information on the Contractor's process for determining experimental/investigational procedures and services. The Contractor shall notify the State, In Writing, within thirty (30) days of any significant changes to its process.

uu. 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.

vv. Reconciliation

(1) The Contractor shall submit claims and bank draft reports to the State in sufficient detail for the State to record and reconcile claims. The format of the claims reports shall include at a minimum: each bank draft amount; date of bank draft; number, date range, and amount of associated claims adjudicated per draft; account number; fund code; any non-claim based payments which shall be separate and identified; etc. The report format shall be prior approved by the State and the frequency of report delivery shall match the frequency of the

Contractor's bank drafts (refer also to Contract Attachment C, Reporting Requirements).

(2) The Contractor shall submit to the State a monthly reconciliation report which shall include the total paid amount for all claims by agency (State/Higher Ed, LEA, LGA), Active or Retiree, and plan 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 financial reporting system for use in the State's reconciliation process. The financial reporting system shall provide State users with the ability to access claim level detail.

ww. The Contractor shall pursue claims up to the maximum recoupment periods permitted under Tenn. Code Ann. § 56-7-110 and 56-7-3103.

xx. 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.

yy. 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.

zz. 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.

aaa. The Contractor shall provide a list of medical and behavioral health Denied Claims every quarter for the previous quarter (refer also to Contract Attachment C, Reporting Requirements). The State shall conduct a review of a random sample of twenty-five (25) medical Denied Claims and twenty-five (25) behavioral health Denied Claims per quarter and shall send said claims to the Contractor for review and comment. The Contractor shall review the reason for the denial and confirm that the claim was appropriately denied within thirty (30) days of receipt. Any claims found to be inappropriately denied shall be reprocessed for payment by the Contractor. per quarter and shall send said claims to the Contractor for review and comment. The Contractor shall review the reason for the denial and confirm that the claim was appropriately denied within thirty (30) days of receipt. Any claims found to be inappropriately denied shall be reprocessed for payment by the Contractor. per quarter and shall send said claims to the Contractor for review and comment. The Contractor shall review the reason for the denial and confirm that the claim was appropriately denied within thirty (30) days of receipt. Any claims found to be inappropriately denied shall be reprocessed for payment by the Contractor. per quarter and shall send said claims to the Contractor for review and comment. The Contractor shall review the reason for the denial and confirm that the claim was appropriately denied within thirty (30) days of receipt. Any claims found to be inappropriately denied shall be reprocessed for payment by the Contractor.

bbb. The State shall conduct a monthly review of medical and behavioral health Pended Claims. The Contractor shall provide a current list of Pended Claims every month

including the current status of prior and newly Pended Claims and the top reasons claims are pended (refer also to Contract Attachment C, Reporting Requirements).

ccc. The Contractor shall provide a quarterly incurred but not reported (IBNR) report of monthly claims and enrollment data by the following splits for the forty-eight (48) months leading up to and including the most recent month to the State actuarial contractor. Claims should be summarized by both the month of service and payment (standard lag/triangle data summary) for the following:

(1) Active/Retired (claims and enrollment),
(2) Medical/Pharmacy (claims only), and
(3) State/Local Education/Local Government (claims and enrollment).

ddd. 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.

eee. Upon conclusion of the service delivery period (1/1/2025-12/31/2027) 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 pharmacy and medical services rendered and supplies purchased during the service delivery period of this Contract as well as provider reimbursement or recoupment attributable to claims incurred during the service delivery period of this Contract with no additional administrative cost to the State. The Contractor shall also be responsible for the payment of Rebates on all Claims incurred prior to termination or cancellation. The medical claims runout period shall extend through the final day of the eighteenth (18th) month following 12/31/27 and the pharmacy claims runout shall extend through the final day of the sixth (6th) month following 12/31/27. In addition, in the event of termination of this Contract prior to 12/31/27, the Contractor shall continue to provide and pay claims for services to any Member who is receiving Inpatient Care on the effective date of termination. Said coverage shall discontinue when the Member is discharged from Inpatient Care.

fff. The Contractor shall process all the State's Claims on the same platform and shall not transition the State from the Claims adjudication platform that they are implemented onto during the Term without prior notification In Writing to the State.

A.16. Member Communications/Materials

a. The Contractor, in collaboration with the State, shall develop a detailed written Member engagement plan for Member education at least two (2) months prior to the annual enrollment prior to Go-Live. This plan shall include the overall goals, methods, tools, technology, and timelines for Member engagement during implementation and annual enrollment including but not limited to benefit fair materials, ABC materials, enrollment emails, Splash Page (see Contract Section A.18), and Member welcome kits and ID cards (see Contract Section A.17). In addition, the Contractor shall update this plan on an annual basis or as needed by the State to reflect any changes in marketing strategy and updated methods, tools or technology and/or address emerging needs to engage with Members. The Contractor's marketing plan will reflect a thoughtful, proactive approach to drive engagement and utilization of applicable services and programs. The Contractor is encouraged to relay what resources they have that will support marketing and communications. All plan updates shall be approved In Writing by the State

(1) The Contractor shall collaborate with other contractors to generally promote benefits, population health and wellness program initiatives, annual exams,

preventive screenings, EAP, and other health, wellness and benefit programs, if applicable.

(2) The Contractor will provide a quarterly analytics report of marketing and communications efforts and results that should include email, website and/or other communications statistics. The Contractor shall use the State's template or the Contractor's template with prior approval In Writing by the State. Analytics should include metrics on both activities conducted and results achieved to drive engagement and utilization of applicable ParTNers for Health services and programs for heads of contracts, and enrolled spouses and dependents if applicable and data is available (refer also to Contract Attachment C, Reporting Requirements).

(3) The Contractor agrees that all materials distributed and prepared or produced by the Contractor shall be accurate in all material respects.

b. The Contractor shall, in consultation with the State, develop and disseminate Member information and communication materials. All materials must have approval In Writing by the State prior to distribution (refer also to Attachment D, Service Level Agreement). The Contractor shall ensure that all Member materials and other communications meet any state or federal regulatory compliance (e.g., Civil Rights Compliance), if applicable. The Contractor shall develop all materials in conformance with the style, formatting and other related standards developed by the State and its marketing staff. All marketing and communications materials, including contact information for any Members, shall become property of the State.

(1) Materials could include, but are not limited to, Member handbooks, provider directories, identification (ID) cards, welcome packets, letters, emails, brochures, flyers, webinars, website copy, website images, mobile app and app content specific to the Plan, social media content, PowerPoints, training materials, marketing materials specific to Plan or agency and videos.

(2) Marketing/segmenting: Contractor may offer or suggest marketing and communications based on segmentation of population (e.g., demographics, geography, etc.). The Contractor may provide data to address paths and barriers to engagement.

(3) The Contractor shall, upon request by the State, personalize materials and digital communications. Exceptions may be granted by the State, In Writing, when the materials or digital communications are for a Contractor's greater book of business and the State is opting into a communications campaign not otherwise required by this Contract.

(4) The Contractor shall provide, upon request by the State, marketing and communications samples of how they introduce Plan options to Members and continually drive engagement and utilization of preferred services.

(5) The Contractor shall use graphics to communicate key messages to populations with limited literacy, limited health plan literacy or limited English proficiency. The Contractor shall also prominently display the call center's telephone number in large, bolded typeface and hours of operation on all materials.

(6) The Contractor shall provide text and graphics, if applicable, for the State's communication to Members.

(7) As part of its submission to the State, the Contractor in consultation with the State, shall specify how the materials will be distributed i.e., email, regular mail, other.

c. 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 annual enrollment material included in the annual enrollment plan that may be helpful to potential Members. Items may include, but not be limited to, informational fliers, program specific information, toll-free call center number, website address, website logon information, a confidentiality

statement, procedures for accessing services, and other pertinent updates, changes and/or materials.

d. The Contractor shall assist the State in the education and dissemination of information regarding the program. This assistance may include but not be limited to:

(1) Written information;
(2) Audio/video and webinar presentations;
(3) Member and Agency Outreach: With notification In Writing to the State, attendance at meetings, workshops, benefits fairs, marketing events and conferences (approximately 60-70 annually but possibly more in the first year of the contract).
   i. Educating State staff, ABCs, Members and other persons prior to and during annual enrollment at benefits education events to explain and demonstrate how the copay plan benefits and mobile app work to encourage enrollment.
   ii. Educating State staff, ABCs, Members and other persons on Contractor's administrative and benefits procedures. Specifically, when a new agency joins the Plan, Contractor may be asked to attend onsite enrollment and benefits educational events.
   iii. Educating Members and ABCs could include targeted agency outreach and partnering with other state departments on outreach efforts across the state on benefit implementation, engagement and education.
   iv. Any on-site visits to agencies, marketing or other state department co-marketing efforts shall require prior notification In Writing to the State. The State also reserves the right to request Contractor's attendance at specific events.

e. Unless otherwise specified, the Contractor shall be responsible for all costs related to the design, development, printing, distribution, mailing (if applicable) and revision of all materials that are required to be produced under the terms of this contract.

f. The Contractor shall use First Class Mail for all mailings, unless otherwise directed or unless otherwise approved by the State In Writing. With prior approval, the State may approve marketing, bulk or alternative rates.

g. Contractor shall comply with the Federal Register Nondiscrimination in Health Programs and Activities (81 FR 31375, 45 CFR 92).

h. The Contractor shall provide the State with draft versions of all communications materials and letters at least fourteen (14) Business Days prior to planned printing, assembly, and/or distribution (including web posting). The Contractor shall not distribute any materials until the State issues approval In Writing to the Contractor for the respective materials (refer also to Attachment D, Service Level Agreement).

i. The State has and retains the ability to edit and customize all Plan communication pieces distributed by the Contractor, including the right to require that the State branding "ParTNers for Health" logo be included on any Plan specific Member letters correspondence, or other materials. The Contractor shall ensure communications are specific to the Plan design and not simply a rebranding/repackaging of standard book-of-business materials or communications unless it is to remain in compliance with other regulatory requirements.

j. The Contractor shall work in conjunction with the State's staff to ensure continuity of branding across all program materials, flyers (including digital), mailings, emails, website, apps, social media and any other communications information, tools, methods, and resources. 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 approval In Writing by the State. All marketing and communications materials, including contact information for any Members, shall become property of 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 for perpetuity) for any and all marketing and communication materials.

l. The Contractor shall distribute materials that are culturally sensitive and professional in content, appearance and design with prior approval In Writing by the State.

m. The Contractor shall provide electronic templates of all finalized materials in a format that the State can easily alter, edit, revise and update.

n. Unless otherwise prior approved In Writing by the State, the Contractor shall design all marketing and communication materials at a sixth (6.0) grade reading level or lower using the Flesch-Kincaid Index, or a comparable product. 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 certification of the reading level of each piece of material.

o. At the State's request and upon sufficient notice, the Contractor shall notify Members, In Writing, of any benefit, Plan or program changes no less than thirty (30) Business Days prior to the implementation of the change.

p. Unless otherwise directed by the State, the Contractor shall print and distribute any mass mailings developed by the State within fourteen (14) Business Days of receiving the language/copy from the State.

q. The Contractor shall ensure that up-to-date versions of all printed Member marketing and communication materials can be downloaded from the Splash Page. The Contractor shall provide an electronic copy of all marketing and communication materials, including provider directories, at the State's request to the State for posting on the State's website.

r. The Contractor shall update web-based versions of all materials as Plan changes are made and correct errors. The Contractor shall update web-based versions at the request of the State, within five (5) Business Days. New Plan year information must be added no later than one (1) month prior to annual enrollment.

s. Unless approved in advance and In Writing by the State, the Contractor shall not distribute any promotional materials or gifts to employees or Members, even if such gifts are of a de minimis value (e.g., magnets, pens, etc.).

t. Postage and production costs incurred by the Contractor, which are the direct result of communications requested by the State for benefit Plan changes outside of annual enrollment, shall be treated as pass-through costs and shall include substantiating documentation, including a line-item description of the postage and production costs incurred by the Contractor. The State shall pay the postage, printing and production costs of such mailings pursuant to Contract Section C.3. However, if a mistake is the result of the Contractor's error and is not corrected prior to printing or distribution, the Contractor shall pay the postage, printing and production costs for these communications. The Contractor shall produce and distribute corrected versions of individual materials at the State's discretion within ten (10) Business Days.

A.17. Member Handbooks, Welcome Kits, and ID Cards

a. The Contractor, following review and approval In Writing by the State, shall write, update, print and distribute, upon the State's request, Member handbooks and shall maintain an up-to-date version of the Member handbook on the State's Splash Page and website (see Contract Section A.18).

b. The Contractor shall mail a Member handbook, with a cover letter if requested by the State, no later than ten (10) Business Days from receipt of a Member's request for a copy. The Contractor shall, at a Member's request, mail a copy of the current provider directory to the Member within ten (10) Business Days of receiving the Member's request to have a copy.

c. The Member handbook shall include information on each of the Contractor's Plan options available to Members and new employees for the effective plan year. Handbooks shall be reviewed an updated each year no later than two (2) months prior to the start of the next plan year. Handbooks shall include, but are not limited to, detailed benefits and excluded services and procedures; detailed 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 population health; and provide other information helpful to Members.

d. Unless otherwise directed by the State, the Contractor shall mail ninety-five percent (95%) of annual welcome kits to Members no later than fourteen (14) Business Days prior to Go-Live and thereafter, fourteen (14) Business Days prior to the start of each benefit year. The welcome kit shall include but is not limited to: a welcome letter, an ID card (if applicable and can be mailed separately), a postcard to request a printed copy of the Member handbook and/or provider directory, a URL to the customized Splash Page maintained by the Contractor, the Contractor's toll-free Member services number, informational program fliers, and general website login information. (Refer also to Attachment B, Liquidated Damages)

e. As a new Member(s) join the program, or if a Member transitions from one Plan option to another during the plan year, the Contractor shall mail ninety-eight (98%) of welcome kits and ID cards (can be mailed separately) no later than five (5) Business Days from the date of complete and accurate enrollment information passed to the Contractor on the enrollment file. (Refer also to Attachment D, SLA Scorecard.)

f. Upon the State's request, the Contractor shall provide Member handbooks to specified parties, e.g., ABCs, within fourteen (14) days Business Days of the State's request to provide copies. The number of Member handbooks, provider directories, flyers and other relevant information to be printed shall be in sufficient quantities for distribution by the Contractor to the State's Members, plus a quantity of handbooks and brochures as requested by the State for distribution to potential new Members, unless otherwise directed In Writing by the State.

g. The Contractor shall provide enrolled Members with ID cards and shall establish a process that allows Members to request replacement or duplicate cards by phone, online, mobile app (if applicable) and/or other possible future methods or technology upon request. ID cards shall be mailed to Members no later than five (5) Business Days from receipt of the Member's request for a replacement card. Members shall also have access to a digital ID card.

h. The cost of creating and mailing ID cards are the responsibility of the Contractor.

i. Ninety-five percent (95%) of initial Member ID cards must be mailed to all Members no later than fourteen (14) Business Days prior to Go-Live as long as all implementation milestones have been met. (Refer also to Attachment B, Liquidated Damages)

j. The ID card shall include the State's "ParTNers for Health" color logo, on the top front of the card, as directed by the State and the Contractor's logo may also appear on the front.

(1) The words "Administered by CONTRACTOR NAME: may appear beneath this in a smaller font size.
(2) The front of the card shall also include the following information: Member name, Member number, Member Plan Group name and/or number; benefit option (e.g., Premier PPO), network name (if applicable), RxBIN, RxPCN, RxGRP, Issuer code, and cost sharing amounts, as requested an required by law.
(3) The back of the card shall include the following information: disclaimers regarding PA, card effective date (may appear on the front of the card), the Contractor's Member and provider services phone numbers and hours of operation, the address for Claims submission, and the phone number for other State contractors including the EAP and PH/W. The State has final approval of the ID card appearance and language/copy.
(4) ID cards shall contain a unique Member number for each Member, which shall be the employee's unique Edison ID, the full eight (8) digit number (with leading zeroes), provided on the monthly enrollment file. Such identifier shall NOT be the Member's federal Social Security Number. Contractor may add additional identifiers if prior approved by the State In Writing.

k. As directed by the State, the Contractor shall re-issue ID cards to reflect approved Plan design changes, included but not limited to, changes in cost sharing, within the timeframe specified by the State

A.18. Splash Page, Contractor Website, and Mobile Application

a. The Contractor shall maintain a Splash Page Dedicated to and customized to the State, containing program information specific to the Plan Membership, which does not require a Member to log in. 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 Splash Page must be prior approved In Writing by the State. The Contractor shall obtain prior approval In Writing from the State for any links from the site to an external website/portal or webpage.

b. The Splash Page shall at a minimum contain the following information or a link to the information:
(1) Contractor Member services phone number and hours;
(2) Plan benefits including, but not limited to;
i. Current listing of the most recent Formulary or preferred drug list (with a prominent effective date shown on page 1 of the PDL)
(3) Member handbook(s);
(4) Provider directory as a PDF;
(5) Up-to-date searchable internet-based Provider directory (specific to the Plan if applicable);
(6) Member tools and information;
(7) Information on how to understand an EOB, including a sample;
(8) Pharmacy search function that will allow Members to search for a Pharmacy type of their choice (including but not limited to Retail-30 Pharmacy, Retail-90 Pharmacy, Specialty Pharmacy, and Vaccine Pharmacy);
(9) A list of individual pharmacies (including at a minimum: name, NCPDP number, NPI, address, city, state, zip code, and telephone number);
i. A list of all pharmacies in the national Retail-30 network;

ii. A list of all pharmacies participating in the special 90-Day-At-Retail network;
iii. A list of all Specialty Pharmacies (especially those in Tennessee);
iv. A list of all pharmacies participating in the vaccine network;

(10) A separate list of drugs that are considered Specialty Drugs that the Member may only obtain in thirty (30) day supply increments;
(11) A list of all drugs that have Quantity Limits, PA requirements, and Step Therapy requirements. Those with quantity limits or morphine milligram equivalents per day limits should be listed by drug name and the day limit for each. Those with Step Therapy limits should list the drug that must be utilized prior;
(12) Provide links to other State contractors' websites; and
(13) Other information as requested by the State.

c. The Contractor shall link the Splash Page to the State website, other State contractor websites, microsites, content or other web or mobile device enabled video/multimedia tools apps, methods or technology as determined by the State that are useful or applicable for Members (State-approved tools from other approved contractors).

d. The Splash Page shall have the capability to host streamed content (both audio and video) from other contractors including video/multimedia tools as determined by the State if useful and applicable to Members.

e. Contractor shall have a link to the Contractor's website with a Member log-in portal on the Splash Page so Members can view Member-specific documents, including but not limited to claims information, Plan documents and other material pertaining to benefits. The Contractor's Splash Page and website shall be maintained and available twenty-four (24) hours a day, three hundred sixty-five (365) days a year except for maintenance windows.

f. The Contractor's website for this program shall be enabled for mobile devices, mobile app or by other methods that may apply. The website shall at a minimum contain:

(1) Member specific benefits;
(2) Transparent Copayment information based upon cost and quality tiering by provider, facility, procedure, test, prescription, Pharmacy, and other medical and behavioral health services as applicable;
(3) Member claims history and information on how to understand an EOB with a sample;
(4) Have an intuitive user interface, including a frequently asked questions (FAQs) section and other resources;
(5) Online secure messaging or chat capabilities to answer questions from Members;
(6) Access to temporary Member ID cards;
(7) Any applicable Member forms (e.g., claim forms, appeal forms, etc.);
(8) Provide links to other State contractors' websites;
(9) Include up-to-date information on a Member's out-of-pocket costs;
(10) Include up-to-date information on a Member's HSA and FSA balance (if applicable and requested by the State);
(11) Contain Contractor medical and pharmaceutical coverage policies;
(12) Contain condition specific information to educate Members about their diagnosis or upcoming treatments and procedures;
(13) Contain information to educate Members about unneeded tests and procedures (e.g., information from Choosing Wisely).
(14) Mail Order refill/order tracking;
(15) Pharmacy locator;
(16) Formulary support; and
(17) Drug pricing tool

g. The Contractor's website shall also contain consumer cost transparency and quality tools which allow Members to research the price and quality of health care services. At a minimum the tools must:

(1) Allow Members to search and compare information easily, using a variety of parameters including but not limited to provider, facility, location, service, quality measures, procedure, price and condition;
(2) Alternative medications in the same class and with the same efficacy that would be less expensive to the Member plus other savings opportunities and the cost associated with those, such as switching to a 90-day supply or utilizing a cash pay program;
(3) Present price information based on how a current claim would process based on the Member's benefits, and shall not be limited to 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) with cost categories (provider, facility, ancillary, etc.) so Members understand the total cost for that episode and their share of cost;
(5) Alert Members about opportunities for savings;
    i. 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, etc.);
(6) Include at a minimum, the following information in a quarterly transparency tool report (see Contract Attachment C, Reporting Requirements):
Track the number of Members accessing the transparency tool;
    i. Track the number of Members who are return users of the tool;
    ii. Track the most frequent cost and quality searches made by Members; and
    iii. Identify those Members who searched for a service within ninety (90) Calendar days of purchasing such service.

h. The Contractor's website shall also include provider, prescriber, and pharmacist information that includes but it not limited to:
(1) Provider administration manual;
(2) Provider coverage policies and guidelines;
(3) Prescriber interactive formulary with links to PA criteria and instructions, PA forms, and PA web-based applications; and
(4) Pharmacist interactive inquiry system to verify status of pending payments and other function(s) as deemed necessary by the State as well as Pharmacist resources and education materials.

i. The Splash Page and Contractor website shall be fully operational except for Member data/PHI at least thirty (30) days prior to the first day of annual enrollment, including annual benefit updates pertinent to the upcoming plan year. Refer also to Contract Attachment B, Liquidated Damages.

j. The Contractor shall submit the text and screenshots of the Splash Page, grant the State access to the customized development Splash Page, and provide log-in credentials for the Contractor's website for this program to the State for review and approval at least two (2) months prior to annual enrollment.

k. Unless otherwise approved by the State, the Contractor shall update content and/or documents posted to the Splash Page or website within five (5) Business Days of the State's prior approval of changes to said content and/or documents.

l. The Contractor shall ensure that all up-to-date versions of all printed materials can be downloaded from the Splash Page or accessible via a mobile device, or other method, if applicable.

m. Contractor shall obtain prior approval In Writing from the State for any links from the site to a non-governmental website or webpage.

n. The Contractor shall host the website on a non-governmental server, which shall be located within the United States. The contractor shall have adequate server capacity and infrastructure to support the likely volume of traffic from Members without disruption or delay.

o. The Contractor shall obtain and cover the cost of the domain name for the Contractor's Splash Page. The Splash Page URL must be prior approved by the State In Writing.

p. To ensure accessibility among persons with a disability, the Contractor's Splash Page and the Contractor's website shall comply with Section 508. If the Contractor posts any video content it shall include closed captioning option and/or include text scripting to comply with Section 508 for these products.

q. In order to ensure accuracy, the internet-based, searchable provider and Pharmacy directory shall include provider name, specialty, Pharmacy name, address and phone number and shall be updated within 10 (ten) Business Days of a provider's network effective or termination date and whether the provider is accepting Members as new patients. The Contractor shall provide the internet-based provider directory on its Contractor website and a link on the Splash Page at least thirty (30) days prior to the first date of annual enrollment.

r. The Contractor shall include a mobile application for use by Members with the same functionality as available on the Contractor's website and Member portal. The Contractor must agree to and adhere to all security measures as it relates to Member data. The Contractor must provide a one hundred percent (100%) secure web-based application that requires only a web-browser and an Internet connection.

s. At the State's request, the Contractor's mobile application(s) shall be linked with other web applications to allow for seamless data linkage (this may include, but is not limited to, single sign-on) of Member information including the ability for Members to, as applicable, access claims and EOB information, view and order ID cards, upload information (through a mobile device), or link to other technology or information that is helpful to the Member. The Contractor must work with any and all State contractors on data updates and shall send and/or receive files as needed.

t. The Contractor agrees that the State shall have the authority to request revisions to the Contractor's online terms and conditions or online service agreement at any time and that the State shall be provided with a copy of any terms and conditions that a Member must consent to in order to be provided with online account access prior to Go-Live. If the Contractor revises the online terms and conditions or online service agreement, the Contractor agrees to provide the State with a copy of the proposed changes at least sixty (60) Business Days prior to the new effective date and will allow the State to make revisions.

A.19. Pharmacy

a. The Contractor shall offer integrated Pharmacy benefits to all plan Members enrolled in this plan offering, using the Contractor's recommended drug list (also known as a

formulary). The formulary shall be regularly updated on a schedule to be determined and agreed to In Writing by the state.

b. The Contractor shall design, develop, and implement a Formulary, or Formularies, to comply with coverage defined in the Plan Documents. The Formulary/Formularies shall include FDA-approved drugs that have been evaluated for inclusion by the Contractor's Pharmacy and therapeutics committee. The Contractor shall be the exclusive Formulary administrator of all Formularies for the prescription drug benefits under this contract. The initial Formulary, or Formularies, that will impact Members on Go-Live shall be in place and ready for state review no later than 60 days prior to Go-Live and shall comply with the Plan Documents throughout the life of the contract.

c. By Go-Live the Contractor shall assume responsibility for administering and maintaining the Formulary/Formularies, including the PA criteria and clinical programs. The Contractor shall also assume responsibility for administering and maintaining additional Formularies during the term of this contract at the State's request.

d. If requested by the State, the Contractor shall allow the addition of a new and/or different Formulary and shall be able to manage different Formularies. The Contractor will work with the State to add or adjust contractual discount guarantees as needed, based on the adoption of new and/or different Formularies. The Contractor shall also allow Formulary customizations at the State's request at no additional cost to the State, including the ability to remove or add any products, including over the counter ("OTC") products. The Contractor shall implement customized formularies within an acceptable timeframe proposed by the Contractor and approved by the State In Writing.

e. The Contractor shall monitor Formulary compliance and, if requested by the State, report compliance information to the State quarterly. If requested by the State, Contractor shall provide suggestions for improving Formulary compliance.

f. The Contractor shall implement changes to the Formulary, Step Therapy, PA, and other clinical edit requirements within forty-five (45) Business Days of the State's approval or request. Additional time, beyond forty-five (45) Business Days, may be granted with the State's prior approval In Writing. Changes shall include modifications to the POS system and all supporting systems and documents. The Contractor shall notify Pharmacy Providers and affected Members In Writing at least forty-five (45) days prior to the implementation, unless the State requests a shorter notification time. The State must provide prior approval In Writing for all Pharmacy Provider and Member notifications

g. The Contractor shall not implement or administer any program that results in the therapeutic switching of Members from lower net cost products to higher net cost products. The only exceptions are for Member safety or efficacy issues or, upon notification to the State and with prescriber approval, in response to widespread marketplace drug availability issues with the more cost-effective product.

h. Final decisions for inclusion or exclusion from the Formulary shall be at the sole discretion of the State. No Utilization Management tools (such as Step Therapy, PA, and quantity limits) will apply unless the state grants approval to such Utilization Management tools during contract implementation or during the term of the contract.

i. Formulary Design and Development:

(1) Based on the recommendations by the Contractor's P&T Committee, the Contractor shall design the Formulary to (i) maximize the prescribing and dispensing of safe and clinically effective drugs within each therapeutic class that are the most clinically effective as well as the most cost-effective for the State; (ii)

ensure that the more costly drugs, which do not have any significant clinical or therapeutic advantage over others in their class, are used only when medically necessary; have a higher Formulary tier; (in certain instances, these drugs may be excluded from the Formulary); and (iii) ensure that ninety-five percent (95%) or more of Mail Order prescriptions and ninety percent (90%) or more of retail prescriptions for Multi-source drugs shall be dispensed with a Generic Drug product (refer also to Attachment D, SLA Scorecard).

(2) The Contractor's P&T Formulary review process shall be an evidence-based review of clinical guidelines and medical literature to identify which agents and classes of drugs shall be included on the Formulary. Within the classes of drugs determined to be included on the Formulary, the Contractor shall determine which drugs within each class are safe, clinically effective, cost rational and provide equivalent clinical outcomes. The Committee's recommendations for inclusion on the Formulary shall be based on a thorough review of clinical effectiveness, safety, and health outcomes, followed by an analysis of the relative costs of the drugs in each class under consideration. The Contractor shall, at the State's request, provide the State documentation describing the Formulary review process, and the logic and methodology utilized by the Contractor's P&T Committee.

(3) The Contractor shall identify therapeutic alternatives and opportunities for savings and report these opportunities quarterly to the State. The Contractor shall also present recommendations at the annual review meeting concerning therapeutic categories that should be avoided with regard to inclusion on the Formulary, if applicable.

(4) The Contractor may modify drugs included on the Formulary as a result of factors including, but not limited to, medical appropriateness, manufacturer Rebate arrangements, and patent expirations. The Contractor shall notify the State of modifications to the Formulary, which will include a statement as to the reason for the modification. If one of the top twenty (20) drugs (by prescription volume) utilized by eligible Members is being modified, the Contractor shall provide a more detailed analysis justifying the proposed modification including financial analysis.

(5) Upon review and approval by the State, the Contractor shall implement Formulary management programs, which may include cost containment initiatives, such as therapeutic interchange programs; communications with eligible Members, participating pharmacies and/or physicians (including communications regarding Generic Drug substitution programs); and financial incentives to participating pharmacies for their participation.

(6) The Contractor shall design, develop, implement, administer and maintain a listing of quantity limits for certain preferred and non-preferred drugs. The Contractor shall base this list on therapeutic best practices (current clinical guidelines) or opportunities to reduce the cost of the most appropriate dosage form. The Contractor shall include drugs and quantities on the quantity limits listing in the Formulary documents and shall code these limits and Pharmacy messaging into the POS system.

(7) The Contractor shall ensure the Formulary is readily available on the Internet for both prescribers and Members and that prescribers and Members can easily identify utilization restrictions, or Formulary alternatives for non-Formulary or high-cost products.

(8) The Contractor shall coordinate its Formulary development process and criteria with the Contractor's clinical program requirements (PA, Step Therapy, etc.) to ensure consistent processes and minimize Member or prescriber impact.

(9) The Contractor shall ensure that the Pharmacy Program and POS system include provisions for the dispensing of an emergency supply (early refill, Member lost prescription, vacation supply, dose increase, etc.), as described and determined by the Plan Document.

(10) The Contractor shall work with the state to implement utilization edits on medications deemed by the State or Contractor to be wasteful or of low value. Affected Members should be lettered by the Contractor at least 60 days prior to the change, and as new drugs are added to the wasteful, low-value program and current utilizers are identified.

(11) The Contractor shall have a program in place to reduce the utilization of drugs with hyperinflated costs that provide no meaningful clinical value. The State's intent is to reduce the utilization of such drugs and redirect Members to other medications of less cost that provide better clinical value. Affected Members should be lettered by the Contractor at least 60 days prior to the change, and as new drugs are added to the Program and current utilizers are identified.

j. The Contractor shall not require participation in any Formulary management programs or alter pricing and Rebate Guarantees based on the state's decision not to participate in any Formulary management program. The State will make all final determinations regarding participation in Formulary management programs.

k. The Contractor shall allow Members impacted by a State-approved Formulary management program change a period of no less than sixty (60) days, unless otherwise agreed to by the State, to comply with the change and shall allow Member exemptions/Continuity of Therapy Utilization at the State's request.

l. The Contractor shall send Member and prescriber notification letters at least 45 days in advance of formulary updates to advise Members and their prescribers of any change that negatively impacts the Member once the formulary changes. The Member and prescriber letters shall indicate the formulary change date, the Member's currently used medication(s) and the soon-to-be formulary alternatives. The State shall not be billed for these letters, and they shall be included in the monthly Administrative Fee paid to the Contractor.

m. Upon request by the State, the Contractor will work with State to reduce the use of coupons or drug cards utilized at retail pharmacies to keep these from artificially contributing to a Member's maximum out of pocket costs or Deductibles.

n. 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 Drugs as directed by the State. The Contractor shall evaluate and transition appropriate outpatient specialty pharmaceuticals to the most clinically appropriate cost effective site of care such as physician offices or home health from hospital settings which tend to have higher costs, and where appropriate to the Pharmacy benefit which may have lower costs than medical.

o. The Contractor shall pay for allowable, medically-necessary office visits for Members who bring Pharmacy-supplied Specialty Drugs to a provider for administration.

p. The Contractor shall ensure that its Network Providers comply with the applicable Drug Utilization Review and PA requirements for office-administered, office-supplied Specialty

Drugs. The Contractor shall further ensure that its Network 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 training, references and educational materials to ensure provider compliance.

q. The Contractor is responsible for the provision or payment of outpatient Pharmacy services. The Contractor is responsible for coordinating with 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.17.c.).
(2) Inclusion of Pharmacy benefits information in the Contractor's annual enrollment materials for distribution to Members, as requested and approved by the State. Such materials shall include network lists, website information, toll-free Member services number, policies and procedures, confidentiality statement, hyperlinks to the State and other contractors (as directed by the State), and other updates and/or changes that may be helpful to Members. At the state's request and direction, the Contractor shall also include in its annual Welcome Packet to Members, at the conclusion of the state's open enrollment period, any letter or other Pharmacy benefits related materials.
(3) The Contractor shall aggregate all Pharmacy claims with medical and behavioral claims data so that Members' total out of pocket costs and maximum out of pocket costs are tracked in real time across all benefits and available to Members at anytime upon logging into the Contractor's website.
(4) Intervening with individual Network Providers or Pharmacies, as identified by the Contractor and as directed by 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 PA processes and procedures. The goal of these interventions will be to improve prescribing practices by the identified Network Provider or Pharmacy. Interventions shall be individualized, as requested by the State.

r. The State seeks to transition as much appropriate outpatient Specialty Drug dispensing as possible to the Pharmacy benefit or for those Specialty Drugs that are physician-administered to the most clinically appropriate cost effective site of care such as, physician's offices or home health from hospital inpatient and outpatient settings which tend to have higher costs. The state recognizes that some dispensing of Specialty Drugs will continue through the medical benefit but seeks to reimburse medical providers for the provision of Specialty Drugs via the medical benefit on an ASP+ model. Refer to Contract Section C.3.g.

s. 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 pharmaceutical HCPCS 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 include but is not limited to; National Drug Code (NDC), HCPCS code, drug name, strength, number of units, place of service, paid amount, paid date, ASP, and ASP% and 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.

t. Other than those addressed in this Contract, the Contractor shall not collect any additional fees, premiums, or revenue from the State of Tennessee.

u. Baseline Pricing Measure:

(1) The Contractor shall guarantee the mutually agreed upon baseline pricing measure (i.e., AWP, NADAC, WAC, or other) used to price Claims will be the one associated with the actual NDC or NDC-11 for the product on the date dispensed and the actual package size from which the product was dispensed at a participating Pharmacy, Mail Order Service Pharmacy, and Specialty Pharmacy. The Contractor shall communicate any exceptions to this rule (e.g., Compound Prescriptions, etc.) to the State In Writing and such exceptions are subject to approval by the State.

(2) If using various sources to price Claims, the Contractor shall use the version of the baseline pricing measure (per the terms of this Section) that provides the lowest price available.

(3) If the Contractor supports an AWP-based pricing strategy:
   i. For Claims processed at Participating Pharmacies that do not qualify as a Low Volume Pharmacy: The Contractor shall use the post-settlement AWP for this Contract's pricing terms.
   ii. For Claims processed at Participating Pharmacies that do qualify as a Low Volume Pharmacy: The Contractor shall use NADAC for this Contract's pricing terms. a) In the event that Covered Drugs lack a reported NADAC value as of the date the Claims for such Covered Drugs are adjudicated, such Claims will adjudicate with an Ingredient Cost consistent with the network applicable to Participating Pharmacies not qualifying as a Low Volume Pharmacy.

(4) If the Contractor does not support an AWP-based pricing strategy:
   i. The Contractor shall use NADAC as the basis for this Contract's pricing terms for all Claims.
   ii. In the event that Covered Drugs lack a reported NADAC value as of the date the Claims for such Covered Drugs are adjudicated, such Claims will default to the PBM's standard adjudication logic.

(5) The Contractor shall guarantee that in the event there are changes in the marketplace to the baseline measure used for the Ingredient Costs of drugs (i.e., post-settlement AWP, NADAC, WAC, or other) the Contractor shall adjust accordingly to provide an equivalent price. The Contractor shall provide notice to the State and the conversion shall be agreed upon In Writing before any changes are made.

In the event of substantial changes in the marketplace that are outside of the Contractor's control which impact the pricing components of this agreement, the Contractor may request approval from the State to make adjustments to their pricing and guarantees. Such adjustments must be prior approved In Writing by the State and must result in cost neutrality or cost savings to the State, as compared to the terms that were in place prior to the adjustments going into effect. The Contractor must provide the State and/or its consulting actuary NDC-11 level information to analyze the request and its impact prior to its implementation and to ensure that the result is cost neutral or provides cost savings to the State. The State may deny any such requests and all decisions of the State are final.

For avoidance of doubt, known launches of biosimilars and Authorized Generic Drugs for brand-name reference products that occur before and throughout the term of the Contract, known market events in the respiratory category, insulin price reductions and related insulin market changes are expected to occur before

or during the term of the Contract, including but not limited to price reductions and maximum price caps (AMP cap). The Contractor agrees these known market events will not constitute “Unexpected industry changes, limited to: unexpected Generic Drug introductions, unexpected OTC introductions, unexpected FDA recalls or market withdrawals or unexpected launches of Biosimilars,” i.e., will not constitute a Material Change. If the State either directs or approves a change in Biosimilar strategy, respiratory strategy, or insulin strategy during the Contract term, the Contractor agrees that any adjustments made to Rebate Guarantees shall be either economically neutral or favorable to the State. A change in Biosimilar strategy will not result in adjustment to Rebate Guarantees in any other distribution channel besides Specialty. A change in insulin strategy will not result in an adjustment to Rebate Guarantees in any other distribution channels besides Retail-30 and Retail-90, and Mail. Furthermore, the Contractor shall provide the State with NDC-11 level information to ensure economically neutral or favorable adjustments are made to the Rebate Guarantee.

Except as explicitly set forth in the definition of Material Change, pricing and financial guarantees will only change with the explicit written approval of the State. Should there be an event of Material Change, the Contractor shall provide the request to the State along with the reason for the change, a State-specific analysis of the financial impact and any Member impact. The State will have forty-five (45) calendar days to review and determine if the change is reasonably acceptable. If the State, in good faith, determines that the change is not reasonably acceptable, except as required by law, it will not occur during the term of the Agreement. For the avoidance of doubt, changes in AWP inflation rates, differences between underwriting projections and actual performance (other than covered in above items), drug mix shifts due to any dynamics other than those listed above, and pharmaceutical Manufacturer merger and acquisition activity shall not constitute a Material Change.

(6) The Contractor shall apply a MAC List at Mail Order pharmacies and at Retail-90 network pharmacies for Generic Drug medications. The list will have prices equivalent to or lower than the MAC List prices applied to retail Claims and effective MAC Discounts are required to be more aggressive than effective non-MAC AWP Discounts. The Contractor shall use the same MAC List for network Pharmacies (Retail-30, Retail-90, Specialty and Mail Order) and shall, upon the State’s request, provide the most current MAC List to the State on a quarterly basis and as requested by the State in a spreadsheet format. The Contractor will employ your most aggressive (i.e., highest discount) MAC list prices which must include a minimum of 95% of all Generic Drugs. In addition, the MAC List pricing schedule at Mail Order and Retail-90 (including Specialty Drugs) will include the same or more favorable pricing (lower per unit prices) than at Retail-30 for every MAC drug. The Contractor’s MAC pricing schedule at Mail Order and Retail-90 will include a comparable list of low-cost Generic Drugs included in retail Generic Drug fixed price programs at competitive pricing. In all cases when a Member moves from the retail channel to the mail channel, the Member will NOT be charged more unless there has been a Manufacturer price increase or the Retail Pharmacy’s Usual & Customary charge was the Member’s previous charge. Products will be added to the MAC list no later than twenty-one (21) days after the products become available.

(7) The Contractor shall utilize a brand/Generic Drug indicator based on data elements available from only one nationally recognized source such as Medi-Span, etc. unless a change in the indicator will lower the price for the State or the State agrees that the change is acceptable.

(8) The Contractor shall apply 'lowest-of-pricing' logic at retail, Mail Order, 90-Day-At-Retail, and Specialty Pharmacies, which means that the plan and plan Members will pay the lesser of (i) Copayment, (ii) Ingredient Cost as defined in this section or MAC, plus Dispensing Fee or (iii) U & C. In no event will the Member or plan cost share be greater than the contracted cost. The State will not be billed for any Zero Balance Due Claims.

(9) The Contractor shall not charge a minimum Copayment for any Mail Order, Retail-30, 90-Day-At-Retail, or Specialty Pharmacy Claims.

v. Prescriptions dispensed from Mail Order must be priced according to the baseline pricing measure, per the terms of Section A.19.u, and receive Mail Order Rebate Guarantees, regardless of the day-supply dispensed.

w. The Contractor shall adhere to the discount guarantees, Dispensing Fee guarantees, and any associated requirements for each listed in contract Section C.3.

x. All brand specialty Claims, regardless of where filled, shall be included in the same specialty Manufacturer Payment Guarantees and specialty network discount guarantees listed in Contract Section C.3.b.

y. Pharmacy Manufacturer Payments:

(1) The Contractor, or any other entity that negotiates and collects Manufacturer Payments allocable to the State shall pass the full value (100%) of all Rebates properly allocated to the State via check and shall report such payments as required in section A.15.jj and A.15.kk. The Contractor shall not enter into any agreement with a Pharmaceutical Manufacturer for Rebates with the impact to reduce or otherwise circumvent monies received from Pharmaceutical Manufacturers as being considered Rebates. Further, the Contractor will not require the State to enroll in programs, other than standard formulary participation without any exclusions (beyond those exclusions identified in the State's Plan Documents or as otherwise as agreed to In Writing by the State) to receive Manufacturer Payments.

(2) The State shall have the ability at any time to exclude or block from coverage one or more drugs for any reason. If such changes result in a material impact to the Contractor's ability to meet the applicable Rebate Guarantee, Contractor shall notify the State within thirty (30) calendar days of the State's requested change. Any changes the State then decides to pursue may result in a Contract amendment.

(3) Contractor shall pay the State no less than the minimum Rebate Guarantees. The Contractor shall also pay to the State any additional Rebate yield, above the guarantees, thereby resulting in 100% of Manufacturer Payments being passed to the State.

(4) Contractor shall only exclude the following Claims from the calculation of Manufacturer Payment Guarantee; however, if Contractor does in fact receive Manufacturer Payments on any of these products or Claims, they will be passed back to Participating Groups in their entirety: Subrogation Claims; COVID Vaccine and Vaccine Administration Fee Claims, authorized and approved COVID treatment Claims and other COVID testing-related Claims; 340B Claims; COB Claims; Vaccine Claims; Paper Claims; and Compounds.

(5) For Specialty Drugs, Rebates and Manufacturer Payments shall be based on 30 day supply adjusted Claim count. Manufacturer Payment guarantees shall take into consideration anticipated movement of Brand Drugs to Generic Drugs throughout the term of the Contract.

(6) If the State chooses to implement POS Rebates for any or all plan options, the Contractor will administer Rebates at the POS at the NDC-11 level within sixty (60) calendar days' notice by the State.

(7) The value of Pharmaceutical Manufacturer coupons or the value of any and all other patient assistance programs cannot be considered Manufacturer revenue or Manufacturer Payments and shall neither count toward the calculation nor reconciliation of Manufacturer Payments and Manufacturer Payment Guarantees.

(8) Contractor shall invoice Pharmaceutical Manufacturers for all Manufacturer Payments attributable to State Member utilization that the State is qualified to earn pursuant to the State's benefit design and the Contractor's contracts with Pharmaceutical Manufacturers, collect the associated Manufacturer Payment funds, and remit them to the State. If a bona fide dispute exists as to the eligibility of a Claim to earn a Manufacturer Payment, the Contractor is authorized to negotiate a commercially reasonable settlement with a Manufacturer to resolve the dispute, provided that the Contractor negotiates such settlement in good faith, with recognition of the State's interest in maximizing Manufacturer Payment collection.

z. The Contractor shall maintain the thirty (30) day and ninety (90) day supply limits for Members as appropriate; however, in certain circumstances where Members are vacationing or traveling for longer periods of time the State – at its sole discretion – may grant a courtesy override depending on the individual circumstances. The Contractor in any such instance shall contact the State to inquire if an extended supply or courtesy vacation override may be approved. In these instances, the Contractor shall make special provision for the Member to pay the applicable cost sharing for the extended vacation override (e.g., multiple Copayments or Coinsurance). Further, the Contractor shall keep detailed records related to such in its POS and financial systems in the event of an audit.

aa. Each fall, no later than November 1, the Contractor shall provide to the State test results documents of the following Plan Year's benefits set-up in the Contractor's Claims adjudication platform broken down by Generics, preferred brands, non-preferred brands, Specialty Drugs and by 30 (thirty) and 90 (ninety) day supplies. As well as the maximum out of pocket amount. This is to ensure proper benefit design set up. Additionally, if any benefits are changed by the state midyear, Contractor staff shall – prior to the benefits going into production in the Contractor's system – provide screenshots and meet with State staff to walk through the benefit change to ensure Contractor's correct setup and understanding of the change(s).

bb. The Contractor shall provide most favored nation ("MFN") terms for Pharmacy wherein it shall not provide any similar account more favorable pricing terms than that provided to the State. If there are changes to any of the MFN measurement components or methodology and those changes are reasonably designed to achieve greater comparability under this provision, the State will approve In Writing before those changes are implemented. The Contractor must agree to an annual market check, if requested by the State, to compare the aggregate value of financial terms of the Contract (including but not limited to discount guarantees, Rebates, Administrative Fees, Dispensing Fees). There shall not be a minimum threshold of savings as a result of the market check in order for the Contractor to offer better pricing to the State. If the market check indicates that at least one comparator group has more favorable pricing terms than the State in

aggregate, the parties shall negotiate to reach mutual agreement on revised pricing terms and other applicable pricing provisions. The Contractor shall implement mutually agreed upon improved pricing for the State by, at a minimum, the identified difference in value no later than January 1 of the next Plan Year. If the market check indicates no pricing adjustments are needed, the contract pricing will continue until a new market check warrants a change. The market check will focus on comparable arrangements in the marketplace, including but not limited to aggregate value of the Discounts, minimum Rebates, Dispensing Fees, and Administration Fee pricing terms, for the purpose of recommending adjustments necessary to restore and maintain competitive advantage. The State's benefits consultant and actuarial consulting firm will determine similar employer groups for size and benefit structure to serve as comparison(s). The State's contracted benefits and actuarial consulting firm shall complete the market check with the full cooperation of the Contractor. There shall not be a minimum threshold of savings as a result of the market check in order for the Contractor to offer better pricing to the State.

A.20. Employee Assistance Program

a. The Contractor is not responsible for providing benefits or paying claims for employee assistance program services, however, the Contractor shall play a role in ensuring Members are informed of and transferred to the EAP contractor as needed.

b. The Contractor is responsible for working directly with the State's EAP contractor as needed for Member care coordination and education. Coordination by the Contractor shall include the following:

(1) Inclusion of employee assistance program information in its Member handbook (see Contract Section A.17.c.), including the toll-free telephone number to contact the EAP contractor.
(2) Inclusion of the EAP contractor's telephone number on the back of the Member identification card (see Contract Section A.17.j.).
(3) Other activities necessary for the appropriate coordination of benefits.

A.21. Population Health Management and Wellness Services

a. The State contracts with a contractor to provide certain population health services, including wellness, weight management, and chronic condition management. The Contractor is not responsible for the provision of these population health services. However, the Contractor is responsible for coordinating with the PH/W contractor as necessary to ensure that Members receive appropriate population health services. Coordination by the Contractor shall include the following:

(1) Inclusion of population health and wellness information in its Member handbook (see Contract Section A.17.c.), including the toll-free telephone number to contact the PH/W contractor.
(2) Inclusion of the PH/W contractor's telephone number on the back of the Member identification card (see Contract Section A.17.j.).
(3) Inclusion of population health benefits information in the Contractor's annual enrollment materials and welcome packets for distribution to Members as requested and approved by the State. 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 PH/W contractor in a manner and format and at a frequency specified by the State.

b. As directed by the State, the Contractor shall implement cost-sharing incentives (*e.g.*, waiver of or provision of lower Copayment amounts) for Members engaged in chronic condition management and other programs as reported to the Contractor by the State or the PH/W contractor.

c. As directed by the State, the Contractor shall report to the PH/W contractor those Members who complete state specified wellness activities to earn incentives and/or requirements delivered by the Contractor such as, but not limited to, case management, preventive screenings, or other programs/activities. Refer also to Attachment C, Reporting Requirements.

A.22. 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 Go-Live, a summary of its quality assurance program. The Contractor shall notify the State, In Writing, within thirty (30) days of any significant changes to its quality assurance program.

c. The Contractor shall establish a quality assurance committee comprised of qualified medical experts, including adequate representation of medical specialties, which shall meet according to Contractor program policies and procedures. 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 encourage its network hospitals and ambulatory surgery centers to complete the Leapfrog Surveys annually and shall provide a report of facility participation upon request.

f. Unless otherwise directed by the State, the Contractor shall complete the eValue8 process in 2025 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 Alliance of Healthcare Purchaser Coalitions and/or other entity as directed by the State, participating in the validation process, and participating in onsite visits with the State to discuss the results and identify areas for improvement. The Contractor shall also participate in specific eValue8 modules as requested by the State. Such modules may occur on a different timetable than the core process conducted every other year. The Contractor shall also participate in site visits 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 Plan Documents and any guideline, protocol, or

pathway in State law shall take precedence over any guideline, protocol, or pathway used by the Contractor. The Contractor's website (see Contract Section A.18.) shall contain all such guidelines, protocols, or pathways that are applicable to the 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. The Contractor shall submit to the State at least one month prior to Go-Live, a summary of its standards, protocols, and thresholds for tracking incidents and issues with Network Providers and shall provide a report of the Network Provider tracking results upon request. The Contractor shall notify the State, In Writing, within thirty (30) days of any significant changes to its Network Provider tracking standards and protocols.

i. 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.

j. Unless otherwise directed by the State, qualified Members of the Contractor's clinical staff shall participate in conference calls, at a frequency to be mutually determined, with the State's contractors (EAP, PH/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 contractors, and develop recommendations for resolving the issue/concern. The EAP contractor, PH/W contractor and/or the State may also identify Members.

k. As requested 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 EAP contractor, the PH/W contractor and/or other State contractors to improve coordination of their services to Members.

l. The Contractor shall obtain Health Plan Accreditation at a level of 3.5-5.0 stars by NCQA. If the Contractor is NCQA accredited as of Go-Live, the Contractor shall maintain such accreditation throughout the term of this Contract and submit a copy of report card performance of accreditation annually by October 20th (refer also to Contract Attachment C, Reporting Requirements). If the Contractor is not NCQA accredited, or is not currently accredited at the required level, for its products as of Go-Live, the Contractor shall obtain such accreditation by October 20, 2026 (or a later date as specified by the State) and shall maintain it thereafter. Failure to obtain and maintain accreditation may result in liquidated damages as specified in Contract Attachment B, Performance Guarantees.

m. The Contractor shall possess and maintain full Pharmacy Benefit Management accreditation status with URAC during the entire term of this contract. Failure to obtain and maintain accreditation may result in liquidated damages as specified in Contract Attachment B, Performance Guarantees. The Contractor shall submit accreditation certification to the State annually (refer also to Contract Attachment C, Reporting Requirements).

n. The Contractor shall annually submit to the State a report, in a format approved by the State; with a three year trend of HEDIS results for Plan Members by Plan Group and combined, compared to its self-funded and fully-insured combined book of business

products offered in the State, state benchmark, and national benchmark (refer also to Contract Attachment C, Reporting Requirements).

A.23. 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. The State shall perform a quarterly review for potential duplicate claims payments to ensure the Contractor's claim edits are identifying duplicate claims and correcting any overpayments. Any duplicate claims identified as questionable by the State shall be submitted to the Contractor for further research. The Contractor shall respond within thirty (30) days of notification with additional claim detail to confirm or deny duplicate claims. Any confirmed duplicate claims shall be reprocessed to reimburse the State.

d. The Contractor shall perform a hospital/facility and professional claims review audit including elements not submitted on the claim such as medical record, itemized bill and Manufacturer invoices for each claim with a total allowed amount equal to or greater than one hundred thousand dollars ($100,000) including but not limited to appropriate level of care coding and billing for miscellaneous items already included in the daily reimbursement grouper. The Contractor shall report the results of all hospital/facility and professional claims review audits at the semi-annual administration program review meetings.

e. The Contractor shall contact pharmacies with aberrant Claims or trends to gain an acceptable explanation for the finding or to submit a corrected Claim. The Contractor shall develop a trend or log of aberrancies that shall be shared with the State, upon the State's request. Upon the occurrence, the Contractor shall summarize findings from the reports and share with the State to address Program revisions and remit payment to the State for any Claims recovered from pharmacies that were paid in error. Each payment shall be made by check and the contractor shall provide substantiating documentation in Excel format at the fund level (State Actives, State Retirees, Local Education Actives, Local Education Retirees, Local Government Actives, and Local Government Retirees).

f. The State may request that the Contractor initiate a field audit when desk audits consistently identify aberrations that cannot be explained by other means or upon requests from legal authorities or regulatory agencies. The objective of the field audit shall include financial recovery, and elimination of the aberrant practice. The Contractor shall have the qualified staff available to conduct field audits or have an agreement with a contractor acceptable to the State within ninety (90) days of the date the Contractor assumes full responsibility for the program.

g. In the event the Contractor discovers evidence that an unusual transaction has occurred that merits further investigation, the Contractor shall simultaneously inform BA 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 BA 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.

h. The Contractor shall submit to the State, at least two (2) months prior to Go-Live, a copy of the documents describing its fraud and abuse program. The State reserves the right to review the documents and request 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 request changes, where appropriate.

i. The Contractor shall report to the State at the semi-annual administration program review meetings, 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 Plans associated with the Contractor's detection of such fraudulent or wasteful activities.

j. The Contractor shall audit at least five percent (5%) of network Pharmacies in Tennessee annually. The same audits performed on the Contractor's Retail Pharmacy network will be conducted on the Mail Order and Specialty pharmacies.

A.24. Reporting & Systems Access

a. The Contractor shall submit all 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, Reporting Requirements. As appropriate, reporting shall continue during the claims runout period. Refer also to Contract Attachment D, SLA Scorecard.

b. The Contractor shall provide the State access to its internal client financial reporting system, including program and fiscal information regarding Members served, payable amounts, services rendered, claim level data etc. and the ability for said personnel to develop and retrieve reports. The Contractor shall provide training in and documentation on the use of this mechanism no later than two weeks prior to Go-Live or within one month of the system becoming operational. The Contractor shall provide access to this reporting functionality to a minimum of three (3) State employees no later than two weeks prior to the Go-Live date or within one month of the system becoming operational. Additional or replacement users may be added at any time at the State's request. Until system access is established, no later than one year post Go-Live, the Contractor shall provide ad-hoc reports as requested by the State.

c. The Contractor shall provide requested State employees with access to the Contractor's enrollment system no later than two weeks prior to Go-Live, unless otherwise approved by the State In Writing. 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 enrollment 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 than one (1) month prior to Go-Live. Such training may be delivered remotely or in-person. Until system access is established, no later than one year post Go-Live, the Contractor shall provide ad-hoc reports as requested by the State.

e. At the State's request, the Contractor shall provide reporting specific to the activity and outcomes associated with all the UM tools and programs provided by the Contractor. The Contractor shall deliver such reports to the State within five (5) Business Days of the State's request.

f. The Contractor, as requested by the State, shall generate a file of Members on a monthly basis with a first fill during the previous month for any antidepressant or anti-anxiety medication. Contractor shall share via secure server or email this list of Members and Edison I.D. numbers with the State's EAP/BHO contractor so that said contractor may communicate with the identified Members on the State's behalf by notifying them of the EAP/BHO program and its associated Benefits.

g. The Contractor shall provide the State access to an ad-hoc reporting analyst to assist in the development of reports that cannot be generated using the Contractor's standard reporting package or cannot be generated in a usable format by the State. 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, not including legislative bill analysis, within two Business Days. All ad-hoc reports shall be provided at no additional cost to the State (see also Contract Attachment C, Reporting Requirements).

h. The Contractor is an insurance company and holder as defined by Tenn. Code Ann. § 66-29-102 for purposes of unclaimed property arising from the performance of this Contract. The Contractor shall comply with all applicable escheat state laws and regulations including but limited to Tenn. Code Ann. § 66-29-107. The Contractor shall be responsible for compiling reports which meet National Association of Unclaimed Property Administrators (NAUPA) specifications and filing any required reports with the State through the ReportItTN.gov online portal. The Contractor shall provide copies of all escheat reports and supporting documentation to the State upon request.

i. Contractor shall ensure that its reporting system available to state staff allows for pulling Claims data by, at a minimum, various dates, groups, plan types, Member ID (Edison ID) and can be broken down by product name, Pharmacy name, address, city and state, the NDC of the product, and GPIs 2 through 14 (code and description) that applies to the product, as well as provide the Pharmacy-submitted drug cost, net plan paid amount, and any Member Cost Share. Until system access is established, no later than one year post Go-Live, the Contractor shall provide ad-hoc reports as requested by the State.

j. 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 D, Service Level Agreement).
(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.25. Data Integration and Technical Requirements

a. The Contractor shall establish and maintain an electronic data interface with the State's Edison System for the purpose of retrieving and processing Member enrollment information. The Contractor shall be responsible for providing and installing the hardware and software necessary for the interface. When the Contractor requires the exchange of PHI with the State, the State requires the use of second level authentication. Second level authentication is accomplished using the State's standard software product, which supports Public Key Infrastructure. The Contractor shall design a solution and submit to the State In Writing how their design meets the requirements of this Contract using industry standard software that can transmit files in a secure fashion. The initial implementation phase of this solution and the final production solution will differ in the method of authentication. The requirement for this solution is that all files that are transmitted will be encrypted, and the method of transmission will also be encrypted. Decryption of the files that are downloaded from this solution will not be decrypted until they are securely stored within the Contractor's environment. Additionally, federal standards require encryption of all electronic protected health data at rest as well as during transmission. The State uses public key encryption with Advanced Encryption Standard to encrypt PHI. If the State plans to adopt a different or additional encryption standard or tool in the future, the State will notify the Contractor and the Contractor shall comply. The Contractor shall establish and maintain the security of all confidential state data according to all applicable state and federal standards within thirty (30) days of the State's use of the new or additional encryption standard or tool. Refer also to Attachment B, Liquidated Damages.

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 Go-Live, the Contractor shall complete testing of the transmission, receipt, and loading of the test enrollment file from the State.

d. At least one (1) month prior to Go-Live, the Contractor shall load, test, verify and make the State's enrollment information available online for use (refer also to Contract Attachment B, Liquidated Damages). The Contractor shall certify, In Writing, to the State that the Contractor understands and can fully accept and utilize the enrollment files as provided by the State, in the format provided by the State, with no modifications.

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

(1) Enrollment Update: To ensure that the State's enrollment records remain accurate and complete, the Contractor shall retrieve, unless otherwise directed by the State, via secure medium, enrollment files from the State, in the State's Edison 834, which may be revised. Files may be provided and retrieved on either a daily or weekly basis depending upon the Contractor's recommendation during implementation and the State's approval, In Writing. 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. Change files will not be sent.

(2) 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 daily or weekly file, as agreed upon during implementation, with the exception of initial or annual open enrollment eligibility files which will be loaded within 5 business days of receipt, assuming the open enrollment data is made available 35 Calendar days prior to Go Live.

(3) The Contractor shall submit to the State a daily or weekly enrollment file error report, in a format agreed upon by the State, within one (1) Business Day of receipt of the daily or weekly file, as agreed upon during implementation, which shall contain a) only errors that require correction and b) an indication of the correction required to resolve the error (also refer to Contract Attachment C, Report Requirements).

(4) The Contractor and/or its subcontractors shall resolve all additional enrollment discrepancies, not identified during processing, as identified by the State or Contractor within one (1) business day of identification (also refer to Attachment D, SLA Scorecard).

(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.

f. State Enrollment System Data Verification: Upon request by the State, not to exceed two (2) 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 verification against the State's Edison database. The purpose of this data verification will be to determine the extent to which the Contractor is maintaining its database of State Members. The State will communicate results of this verification to the Contractor, including any Contractor requirements, and associated timeframes, for resolving the discrepancies identified.

g. 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 quarterly, 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 in a retirement benefit program including Head of Contract and dependents, and identify if they have both parts A and B and the effective dates, which shall be shared with the State. Refer also to Contract Attachment C, Reporting Requirements.

h. Local Government CMS Data Match: The Contractor shall also provide a monthly report of all Local Government retirees, incuding Head of Contract and dependents, who will become eligible for Medicare in the subsequent month (refer also to Contract Attachment C, Reporting Requirements).

i. CMS Data Match and Local Government CMS Data Match reports shall include, at a minimum, the following data elements:

(1) Retiree budget code
(2) Retiree benefit program
(3) Retiree SSN
(4) Edison ID number
(5) Retiree First and Last Name
(6) Retiree Date of birth
(7) Retiree street address, City, State, ZIP
(8) Effective date of coverage under state retirement health plan
(9) Dependent SSN if they are Medicare eligible
(10) Dependent First and Last Name if there are Medicare eligible
(11) Dependent date of birth
(12) Medicare part A effective date (date for the Member being reported; either retiree or dependent)
(13) Medicare part A term date

(14) Medicare part B effective date (date for the Member being reported; either retiree or dependent)
(15) Medicare part B term date

j. The Contractor shall establish and maintain systems and processes to receive all appropriate and relevant data from entities and contractors providing services to Members, including contractors under contract with the State (*e.g.*, EAP contractor, PH/W contractor, the HSA/FSA contractor) 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.

k. The Contractor shall provide transmittal of claims data via secure medium at a frequency and format determined by the State to any additional third parties including the State's PH/W contractor, EAP contractor, HSA/FSA contractor or others as identified by the State at no additional cost to the State.

l. Decision Support System

(1) The Contractor shall transmit medical, behavioral, and Pharmacy claims data to the State's current health care DSS contractor and, if directed by the State, to the Department of Finance and Administration, Office for Information Resources in the format detailed in RFP 31786-00177 Appendix 7.20 "DSS Standard Claims Layout" and Appendix 7.24 "DSS_File_Format_RX" 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) calendar 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. Refer also to Contract Attachment B, Liquidated Damages.
(2) The Contractor shall ensure that all medical and behavioral claims processed for payment have financial fields, valid NPIs, individual social security numbers, the complete most recent International Classification of Diseases codes and Current Procedural Terminology-4/HCPCS codes (and when applicable, updated versions of each). The file submitted to the State's current health care DSS contractor 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. The Pharmacy claims data shall include GPI, GCN, Pharmacy Provider ID, NDC or NDC 11, individual social security numbers, and all payment sources and amounts for all prescription drug claims. The Contractor shall add data as required by the State's DSS contractor and/or the State for the purpose of processing claims data. The State has final approval for all file layouts.
(3) All Claims data shared with the DSS contractor shall include all payment sources and amounts such that the total Claim nets out to zero after the Member Cost Share and plan cost share. This shall include any third-party payments, and any adjustments to the Contractor's file to include all relevant fields shall be at the Contractor's expense.
(4) Claims data provided to the DSS contractor shall meet the quality standards detailed in Contract Attachment D, SLA Scorecard as determined by the State's DSS contractor. The Contractor shall not withhold any processed claims data from the file submission.

(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 contractor 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 provide the data without any restrictions on its use and shall not change the file layout or content without prior approval In Writing.

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

m. 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 Go-Live 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, PAs, overrides (Mail Order, specialty, and retail), preferred drug list, refills, and reference data. If requested, the data will be used to transfer prescriptions to the Contractor's Mail Order and Specialty Pharmacy. Open refills shall be loaded 12 calendar days prior to Go-Live.

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

o. 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.

p. 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 Contractor shall also share at least one (1) year of historical data with the State's new vendor(s) at the Term of this contract. 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.

q. If a Member changes their benefit option or TPA outside of the Annual Enrollment Period, then the Contractor shall transfer to the new TPA or benefit option the in-network and Out-of-network paid amounts, and 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 TPA 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 PA or Utilization Management information to the new TPA as appropriate. The Contractor shall also transfer said data to the State's other Contractors, with whom accumulator data is shared, within fourteen (14) calendar days. 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.26. 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 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 HIPAA and the 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. All contract related information retained by the Contractor including but not limited to, communications and files related to plan Members, shall be made available to the State upon request. 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 beyond the extent necessary to perform the duties outlined within this contract without the prior written consent of the State, which consent will not unreasonably be withheld.

g. System Availability

(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.18., 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. 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 contractors are available and operational according to the specifications and schedule associated with each exchange.

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, 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) The Contractor shall conduct a security risk assessment at least annually and communicate the results to the State in compliance with Contract Attachment E. The first report shall be provided one (1) month prior to Go-Live and annually thereafter (refer also to Contract Attachment C, Reporting Requirements). 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)).

(11) To maintain the privacy of PHI, the Contractor shall enable Transport Layer Security (TLS) on the mail server used for daily communications (i.e. email) between the State and the Contractor. TLS shall be enabled no later than Go-Live and shall remain in effect throughout the term of the contract.

A.27. Audit Authority

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 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, and subcontractors.

b. The State has sole authority to determine who to choose for any kind of audit related to the services contained in the contract. This includes, but does not limit the selection to, state employees, state employees from the Comptroller's audit staff, and BA's consulting or auditing firm.

c. If the State contracts with a private entity (non-state employees) to conduct an audit of the Contractor, the State will require the auditing entity to negotiate a reasonable confidentiality agreement with the Contractor. The Contractor shall not attempt to limit the State's audit rights in any way or timeframe; the State in its sole authority and with execution of any confidentiality document shall be allowed to audit the Contractor on any contracted service, claims processing, customer service, or any other provision of this contract by whomever the State in its sole authority deems appropriate.

d. In no instance shall the Contractor advise the State that one set of auditors is appropriate while another set is not. In addition, the State may audit or re-audit any time period in accordance with the timeframe for audits listed in Contract Section D.11. Previous audits of a set of claims, providers, time periods, or any other sort of audit does not negate the State's right to re-audit the same information again later. There shall be no audit blackout periods at any point during a year and any charges or fees in any form for any audits that the State chooses to exercise.

e. The Contractor shall provide access, at any time during the term of this contract and for five (5) years after final contract payment (longer if required by law), to the State and/or its 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 representative's location, the State's location, or at the Contractor's corporate site.

f. The Contractor shall, at its own cost, provide the State and/or its representative with prompt and complete access to any data, data extracts, documents, access to systems,

and other information necessary to ensure Contractor compliance with all requirements of this Contract.

g. 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 provide written responses to all 'findings' received during the audit process to assist in clarification and suggested resolutions. The Contractor shall also provide a formal audit response within thirty (30) days of the audit conclusion, or at a later date if mutually determined with the State to be more reasonable based on the number and type of findings.

h. The Contractor shall fund the following audits which shall be conducted by a qualified organization or representative chosen by the State and the scope of the audit shall be defined by the State:
   (1) A pre-and/or post implementation audit to review, at a minimum, whether the Contractor's adjudication system is configured according to the State's benefit design at contract Go-Live and in subsequent years if benefit changes are made;
   (2) An operational audit focusing on, at a minimum, staffing, customer service capabilities, TPA audit programs, and claims administration; and
   (3) Any follow-up audits if significant deficiencies, as determined by the State, are noted.

i. 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.

j. If the outcome of the audit results in an amount due to the State, the Contractor shall pay the amount due within (30) thirty days of final audit report notification from the State. Any amount due the State which is not paid within (30) thirty days of the final audit report will be deducted from the total amount due from the fees due to the Contractor pursuant to C.3 until the full amount due is paid. 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.

k. Any Claims extract that may be provided to the State Comptroller's audit staff for their audit purposes must include, among other standard fields, the adjudication date (e.g. date the Pharmacy was paid by the PBM) for each individual Claim.

l. Pharmacy Rebate audits can include, but are not limited to, review and examination of Manufacturer Rebate contracts, Rebate payments, special Discounts, fee reductions, incentive programs or the like with Pharmacy Manufacturers, and Program financial records as necessary to perform an accurate and complete audit of Rebates received by the State. To the extent that the Contractor contracts with a separate Group Purchasing Organization (GPO) in connection with Rebates or Manufacturer Payments for the State, the State may (a) directly confirm the existence of contract(s) between the Contractor and such third-party GPO (I.e., view the contract introduction, recitals, and signature block) and (b) audit all aspects of such contract with the establishment of applicable third-party confidentiality agreement(s), which may include non-disclosure agreements (NDAs), if any, as reasonably required by the GPO. Upon request by the State, or its Designated authorized independent auditor, and upon completion of confidentiality agreement(s) or non-disclosure agreements (NDAs) as required by the Contractor or as required by the Contractor's third party Rebate contracts, the Contractor shall provide full disclosure of Rebates and Manufacturer Payments received by the Contractor, its Affiliates, subsidiaries, or subcontractors on behalf of the State. This disclosure shall include line-item detail by NDC or NDC-11 and line-item detail by pharmaceutical Manufacturer

showing Actual Cost remitted and other related Claim and financial information as needed to satisfy the scope of the audit. One hundred percent (100%) of all drugs dispensed and paid for from Go-Live, January 1, 2025, until the termination of Benefits shall be included in any kind of Pharmacy audit, regardless of tier level (Generic Drug, preferred brand, or non-preferred brand or absence of a tier assignment), and without regard to enrollment plan type, number of Members enrolled in said Plan, Copayment assigned by the State (or lack thereof), Spread or differential between drug tier Copayments, or any kind of utilization.

m. The Contractor and any PBM Affiliates and GPOs shall disclose to the State's authorized representative any and all Manufacturer Payments including but not limited to Manufacturer Administrative Fees or other reimbursements received in connection with any Rebates, Discounts, fee reductions, incentive programs, or the like received by Contractor as a result of the drug Manufacturer Payments, which include volume of pharmaceutical use by, or on behalf of, the State. In addition, the Contractor shall, upon request by the State, disclose any and all fees or other reimbursements received in connection with any grants, educational programs or other incentive programs received by the Contractor on behalf of the State.

n. The Division of State Audit may request full Claims extract for their audit purposes at any time. Contractor shall work with State Audit to supply them a full Claims extract including (but not limited to) such variables as date filled, Pharmacy name, address, and phone number, drug name and NDC or NDC-11, quantity dispensed, gross cost, plan cost, Member cost, prescriber name and NPI, adjudicated (paid date; the date that the actual Pharmacy was paid) – all for each Claim processed under this contract and provided in any Claims extract to the Division of State Audit.

o. The State, or its contracted Benefits consultant and actuarial consulting firm, will audit the Manufacturer Payments that are accrued and paid to the State. These Payments shall be one hundred percent (100%) auditable to the NDC or NDC-11 level.

p. The Contractor shall comply with Tenn. Code Ann § 4-3-1021. This requires BA to compile a report each July 1 using data from various audit reports completed during the year and publish the results in a report every July 1st to the Tennessee Speakers of the House and Senate, the Comptroller of the Treasury, and Members of the Tennessee General Assembly. BA requires the participation and timely assistance of the Contractor to work with the actuaries and Benefits analysts both in and outside the State to ensure that each report is completed timely. Compliance with this state law requires that the Contractor be audited by the State's contracted Benefits consultants each year through a series of four audits: a financial/Claims audit, a Rebate audit (drug Manufacturers selected by the State), a passthrough pricing analysis, and a Pharmacy pricing comparison report. Reconciliation of the PBM's payments to pharmacies with the State's reimbursement to the PBM is required to comply with Tenn. Code Ann § 4-3-1021(c) (5).

    (1) The State, or its contracted Benefits consultants, will have access to any data necessary to ensure the Contractor is complying which includes, but is not limited to, one hundred percent (100%) of Claims data, which includes at least all NCPDP fields from the most current version and release, Retail Pharmacy contracts, Pharmaceutical Manufacturer contracts, GPO, Mail Order and Specialty Pharmacy contracts to the extent they exist with other contractor(s), Utilization Management reviews, clinical program outcomes, appeals, and any additional information needed to complete the audits.

A.28. Compliance

a. The Contractor shall perform an annual non-quantitative treatment limitation review, prior to each plan year benefit implementation and report final outcomes to the State In Writing, to ensure compliance with the Mental Health Parity and Addiction Equity Act and any other federal and state laws. Refer also to Attachment C, Reporting Requirements.

b. The Contractor shall ensure compliance with Tennessee Public Acts Chapters 405, 569, and 1070 as passed during the 112th General Assembly. The Contractor will be responsible for all related costs for complying with these laws including, but not limited to, appeals by pharmacies to the Tennessee Department of Commerce & Insurance associated with PBM claim reimbursement related to Tennessee Public Chapter 1070.

c. Benefits Administration and the Contractor shall document and agree to prior to Go-Live, In Writing, the tasks, processes, functions and responsibilities of the Contractor related to the requirements of Public Law 116-260 (the Consolidated Appropriations Act of 2021) and 85 Federal Register 72158 (Transparency in Coverage). The Contractor shall comply with all aspects of the No Surprises Act including the Independent Dispute Resolution process at no additional cost to the State.

d. The Contractor shall assist the State in complying with all requirements of the Consolidated Appropriations Act of 2021, and Transparency in Coverage rules including Prescription Drug Data Collection (RxDC) reporting requirements at no additional cost to the State. The Contractor must provide, at no additional cost to the State, copies of all data that the Contractor provides to CMS each year to meet their portion of the RxDC reporting requirements (e.g., files D3-D8 and the prescription drug portion of the narrative response).

e. The Contractor shall provide the State with a Gag Clause Prohibition Compliance Attestation annually by the federal deadline with the Centers for Medicare and Medicaid Services (CMS) to comply with the Consolidated Appropriations Act of 2021. Refer also to Attachment C, Reporting Requirements.

f. The Contractor will be responsible for ensuring that all benefits and programs offered by the State and administered by the Contractor meet all current and future requirements of the PPACA and shall advise the State on all such benefits and programs, including benefit design, Formulary design and management, cost sharing structure, and appeals of all levels. The Administrative Fees in Contract Section C.3 shall include all possible work to ensure that the State and the Contractor are compliant with the PPACA.

g. Any fines for non-compliance related to services provided by the Contractor under this Contract will be the Contractor's sole responsibility.

A.29. Warranty

a. Contractor represents and warrants that the term of the warranty ("Warranty Period") shall be the greater of the Term of this Contract or any other warranty generally offered by Contractor, its suppliers, or Manufacturers to customers of its goods or services. The goods or services provided under this Contract shall conform to the terms and conditions of this Contract throughout the Warranty Period. 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 the State is authorized to possess and use all equipment, materials, software, and deliverables provided under this Contract.

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, and 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. Any exercise of the State's rights under this Section shall not prejudice the State's rights to seek any other remedies available under this Contract or applicable law.

A.30. Inspection and Acceptance

a. 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.

A.31. The Contractor shall limit resources to US-based (onshore) resources only (includes personnel).

B. TERM OF CONTRACT:

This Contract shall be effective on July 1, 2024 ("Effective Date") and extend for a period of seventy-two (72) months after the Effective Date ("Term"). This provides for 6 months of implementation, forty-eight (48) months of service delivery to Members, and 18 months of runout. 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 Written Dollar Amount ($Number) ("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 for Administrative Fees based upon the following payment methodology:

PLACEHOLDER FOR COST PROPOSAL TABLE(S)

c. The Contractor shall offer an annual medical savings guarantee for annual savings less than 15% as a result of the Copayment benefit plan for plan years 2025-2027. As calculated by the State's consulting actuary, using allowed amounts for incurred in-network claims from the base period (Jan 2024 – Dec 2024) to the guarantee period (Jan 2025 – Dec 2025). For future savings measurements, the base period and guarantee period roll forward each year thereafter. The determination of the payout will be adjusted for:

(1) Claimants and their associated claims in excess of $100,000 (including claims under $100K);
(2) Demographic changes from the Base Period to the Guarantee Period;
(3) Geographic factors that change from the Base Period to the Guarantee Period; and
(4) Other factors as determined by the State.

The Contractor guarantees to reimburse the State or have withheld the Administrative Fees detailed in the table below within thirty (30) days of notification.

PLACEHOLDER FOR COST PROPOSAL TABLE(S)

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 at least weekly by ACH debit from the Contractor to a Designated State 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.15.oo.

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 that the Contractor 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.e 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, approved and accepted 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. When such recoveries are made by subrogation subcontractor(s), the Contractor may retain the lesser of an additional 20% of the gross recoveries or the actual amount paid to the 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:

Plan Year 2025	Plan Year 2026	Plan Year 2027
ASP + 28%	ASP + 26%	ASP + 26%

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

h. The Contractor shall guarantee that:

(1) The Dispensing Fee per Paid Claim is based on Paid Claims only, not Claims that are reversed or rejected.
(2) Usual & customary priced Claims will not be assessed a Dispensing Fee.
(3) The average Dispensing Fee per Paid Claim shall not exceed the guaranteed maximum average per Paid Claim.
(4) Retail Claims priced using the usual & customary price (or submitted price, etc.) will not be included in the guaranteed maximum average Dispensing Fee per Paid Claim.
(5) The financial guarantees are not contingent upon the State maintaining a minimum number of enrolled Members.
(6) The financial terms are for this Contract are State specific and are not book of business averages or discounts.
(7) The guaranteed Discount off AWP shall only exclude the following types of claims: Compounds, bulk chemicals, powders, COB claims, Subrogation claims,

Prescriptions filled at VA Hospitals, Claims processed at 340B pricing, and Out of Network Paper claims.

i. The State is not required to make any Plan design changes or implement any programs in order to receive or maintain Discount, Dispensing Fee, Rebate, or Manufacturer Payment Guarantees, including but not limited to Pharmacy discount card programs.

j. The Contractor's specialty network Discount guarantees for Brand Specialty Drugs will include new drugs added to the list of Specialty Drugs each year and Limited Distribution Specialty Drugs that the Contractor's Specialty Pharmacy has access to. For purposes of annual financial reconciliation, specialty network Discount reconciliation will be on Brand Drugs only. Generic Specialty Drugs will be calculated as Retail-30 generics.

k. The Contractor will calculate the achieved Discounts with the following formula: [1 minus (total Discounted Ingredient Cost, excluding Dispensing Fees and penalties due to DAW Claims and prior to application of Copayments, of applicable prescription drug Claims for the measurement period) divided by total AWP for the measurement guarantee period]. Both the Discounted Ingredient Cost and the AWP will be calculated as of the date of adjudication. Discounted Ingredient Cost will always be the lowest of the post settlement, reconciled AWP Discount, MAC or U&C adjudication methodology.

l. The Contractor shall individually measure the brand Discount guarantees, generic Discount guarantees, and Dispensing Fee guarantees for the Retail-30 network, Mail Order Pharmacy program, specialty network, and Retail-90 Pharmacy network. Specialty reconciliation will be on Brand only. All Brand drugs that are on the Contractor's specialty drug list, will be included in the Specialty Network Discount Guarantees. Brand drugs not on the Contractor's specialty drug list will be included in the non-specialty Discounts, and the channel of distribution dictates the Discount Guarantees for any Brand drug not included on the Contractor's specialty drug list. Generic specialty will be calculated with Retail-30 generics. Over performance in one contract area will not offset under performance in other contract areas.

m. The Contractor shall measure guaranteed Discounts and Dispensing Fees within ninety (90) days following the end of each quarter and reconcile with the State annually during the first quarter of the following calendar year. Refer also to Attachment C, Reporting Requirements.

n. The Contractor shall reimburse the State the difference between actual Discounts and fees and the contracted overall effective Discounts (i.e., Discount guarantees and Dispensing Fee guarantees) by cash or check only. Credits to the Plan are not acceptable unless otherwise approved by the State In Writing. The Contractor will pay one hundred percent (100%) of any guarantee shortfalls to the State within forty-five (45) days of the close of each annual reconciliation period with the State retaining one hundred percent (100%) of any savings above the guarantees. Should the Contractor miss the annual retail Generic Drug Discount guarantee by at least two (2) percentage points, the State will receive one hundred percent (100%) of the shortfall plus an additional payment of ten (10) percent of the shortfall amount (under-performance payment). The Contractor will not be able to offset or recoup any under-performance payment in any reconciliation.

o. The Contractor agrees that any and all amounts owed to the State including Rebates, Manufacturer Payments, guarantee shortfalls, and recoveries identified during Claims audits will be paid by the appropriate due date. Any amounts unpaid after the stated due date will bear interest at nine percent (9%) per year accruing after the due date until payment is received for all payments due to the State.

p. The Contractor shall measure the guaranteed minimum Manufacturer Payments each quarter, with an annual true-up. The Contractor shall pay the State no less than the guaranteed minimum Manufacturer Payments plus any additional Rebate and Manufacturer Payment yield, above the guarantee, thereby resulting in 100% of Manufacturer Payments being passed to the State. Payment shall occur via check sixty (60) calendar days after the end of each calendar quarter. True-up to one hundred percent (100%) will occur one hundred fifty (150) calendar days after the end of each calendar year. Specialty reconciliation will be on Brand Drugs only. All Brand drugs that are on the Contractor's specialty drug list will be included in the Specialty Guaranteed Minimum Manufacturer Payment Per Paid Claim. Brand drugs not on the Contractor's specialty drug list will be included in the non-specialty Guaranteed Minimum Manufacturer Payment Per Paid Claim, and the channel of distribution dictates the Guaranteed Minimum Manufacturer Payment Per Paid Claim for any Brand drug not included on the Contractor's specialty drug list. Generic specialty will be calculated as Retail-30 Generic. Refer also to Attachment C, Reporting Requirements.

q. The Contractor shall pay out to the State all Manufacturer Payments earned by the State regardless of termination of this contract with final reconciliation and payment made to the State 180 calendar days post termination.

r. Any Rebates and Manufacturer Payments received from Manufacturers after the reconciliation will be applied to the next reconciliation and will be clearly noted in the next reconciliation.

s. For Discount purposes and other related contract calculations, Single-Source Generics should be considered as Multi-Source generics and must not be included in the Brand Drugs bucket for the purpose of pricing or guarantee reconciliation.

t. The Contractor shall reconcile claims, as required in this Contract Section to a minimum Discount Guarantee by channel using the Medi-span post-settlement Average Wholesale Price (AWP) methodology. The Contractor understands and agrees that this contract is deemed a '100% fully pass-through, transparent contract'. The minimum Discount Guarantees will be subject to all Payment Terms and Conditions in the Pro Forma Contract. The Contractor shall use the Medi-Span post-settlement Average Wholesale Price (AWP) methodology to provide Guarantees. The Contractor understands and agrees that the same costs charged to the Plan and Members, combined, are the same costs paid to network pharmacies.

u. Transmission fees paid by Participating Pharmacies that directly or indirectly arise from Claims or Covered Drugs dispensed to Members shall not constitute Pharmacy Rebates if (a) such fees do not in aggregate exceed $0.15/Claim (b) such fees constitute a fair and reasonable compensation for services actually performed by PBM for a Participating Pharmacy and (c) the receipt and retention of such fees by PBM are in compliance with all applicable laws.

v. Value Based Payments. The State shall reimburse the Contractor for approved costs resulting from any State approved value based initiatives.

w. Amounts due the State. The Contractor will remit amounts due the State that cannot be properly offset against recent claims no less than quarterly (e.g. funds received during run out period for subrogation cases or fraud repayments). Amounts owed the State of more than $25,000 are payable within 30 days.

x. The Contractor shall reimburse, when necessary and appropriate, monies to plan Members when an overpayment has occurred by the Member.

C.4 At-Risk Performance Payments and SLA Scorecard. The Parties shall conduct a scorecard assessment (Contract Attachment D), beginning after Go-Live, on a quarterly basis (every three months) during the Term. Based on the SLA Scorecard, Contractor shall send the State an At-Risk Performance Payment (if applicable) quarterly (every three months) during the Term in accordance with Contract Attachment D. This payment is due within forty-five (45) calendar days of the quarterly SLA scorecard assessment.

C.5. Travel Compensation. The Contractor shall not be compensated or reimbursed for travel time, travel expenses, meals, or lodging.

C.6 Purchase Order in lieu of Invoice. The State will generate a monthly purchase order and initiate payment of the purchase order for the administration fees, based upon the State's record of enrolled Members as of the first day of the month, utilizing the rates listed in C.3. above.

C.7. Reconciliation of Payment. 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.

C.8. Payment of Purchase Order. A payment by the State shall not prejudice the State's right to object to or question any payment, purchase order, 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 reflected on the purchase order.

C.9. Payment Reductions. The Contractor's payment shall be subject to reduction for amounts included in any purchase order 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.10. 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:

Heather Pease, Procurement and Contracting Director
Tennessee Department of Finance & Administration
Division of Benefits Administration
312 Rosa L. Parks Avenue, Suite 1900
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: Department of Finance & Administration, Division of 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.10.

C.11. 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.12. 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.13. 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 that are or shall become due and payable to the State of Tennessee by the Contractor.

C.14. 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 the "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, payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee, may be made by ACH; and

c. The Contractor shall complete, sign, and return to the State the State-provided W-9 form. The taxpayer identification number on the W-9 form must be the same as the Contractor's Federal Employer Identification Number or Social Security Number referenced in the Contractor's Edison registration information.

C.15. Compensation Disclosure. All sources of indirect or transactional payment or compensation to the Contractor and any and all PBM Affiliates including GPOs, as a result of or in connection with the State's business, must be disclosed to the State In Writing. The Contractor, and any and all PBM Affiliates, including GPOs, shall submit an annual disclosure detail statement of all such sources of revenue, within sixty (60) days prior to the end of the year for the subsequent calendar year.

The annual disclosure detail statement shall be updated and submitted to the State within sixty (60) calendar days of any changes throughout the year.

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:

Heather Pease Director of Procurements & Contracts
Finance and Administration, Division of Benefits Administration
William R. Snodgrass TN Tower, 19th Floor
312 Rosa L. Parks Ave.
Nashville, TN 37243
heather.pease@tn.gov
Telephone # 615-253-1652
FAX # 615-253-8556

The Contractor:

Contractor Contact Name & Title
Contractor Name
Address
Email Address
Telephone # Number
FAX # Number

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 in a timely or proper manner, or if the Contractor materially violates any terms of this Contract ("Breach Condition"),the State shall have the right to immediately 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 Condition and the State may seek other remedies allowed at law or in equity for breach of this Contract.

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 under 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 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 by submitting to the State a completed Attestation (accessible through the Edison Supplier Portal) and included at Attachment A, 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 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 from 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, 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. The Contractor's liability for all claims arising under this Contract shall be limited to an amount equal to one (1) times the total Paid Claims, as defined in Contract Section A.2., that have processed throughout the one year of contract performance immediately preceding the breach. If the breach occurs in the first year of the contract, the calculation will be based on processed Claims from the beginning of contract performance until the date of the breach, prorated to equal one year; PROVIDED THAT in no event shall this Section limit the liability of the Contractor for: (i) intellectual property or any Contractor indemnity obligations for infringement for third-party intellectual property rights; (ii) any claims covered by any specific provision in the Contract providing for liquidated damages; or (iii) any claims for intentional torts, criminal acts, fraudulent conduct, or acts or omissions that result in personal injuries or death. For clarity, except as otherwise expressly set forth in this Section, Contractor's indemnification obligations and other remedies available under this Contract are subject to the limitations on liability set forth in this Section.

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' fees, court costs, expert witness fees, and other litigation expenses 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 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 and any other relevant laws and regulations regarding privacy (collectively the "Privacy Rules"). The obligations set forth in this Section shall survive the termination of this Contract.

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

b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by the

Privacy Rules, in the course of performance of the Contract so that both parties will be in compliance with the Privacy Rules.

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

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

e. The Contractor shall not sell Member information or use Member information unless it is aggregated blinded data, which is not identifiable on a Member basis. The State must approve, In Writing, the use of and sale of any of our Member or Plan data, even if being used in an aggregated, blinded data format.

f. The Contractor shall not use Plan Member identified or non-aggregated information for advertising, marketing, promotion or any activity intended to influence sales or market share of any product or service except when permitted by the State, such as advertisements of the Program for enrollment purposes.

g. 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, including the cost of credit protection. 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.

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, disqualified, or presently fall under any of the prohibitions of sections a-d.

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 for the affected obligations 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 State and federal laws and regulations applicable to Contractor in the Contractor's 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, without regard to its conflict or choice of law rules. 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 - 408.

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, 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), which includes:
    i. Contract Attachment A
    ii. Contract Attachment B
    iii. Contract Attachment C
    iv. Contract Attachment D: and
    v. Contract Attachment E
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.

D.31. Iran Divestment Act. The requirements of Tenn. Code Ann. § 12-12-101, *et seq*., addressing contracting with persons as defined at Tenn. Code Ann. §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.

D.32. Insurance. Contractor shall maintain insurance coverage as specified in this Section. The State reserves the right to amend or require additional insurance coverage, coverage amounts, and endorsements required under this Contract. Contractor's failure to maintain or submit evidence of insurance coverage, as required, is a material breach of this Contract. If Contractor loses insurance coverage, fails to renew coverage, or for any reason becomes uninsured during the Term, Contractor shall immediately notify the State. All insurance companies providing coverage must be: (a) acceptable to the State; (b) authorized by the Tennessee Department of Commerce and Insurance ("TDCI"); and (c) rated A- / VII or better by A.M. Best. All coverage must be on a primary basis and noncontributory with any other insurance or self-insurance carried by the State. Contractor agrees to name the State as an additional insured on any insurance policy with the exception of workers' compensation (employer liability) and professional liability (errors and omissions) insurance. All policies must contain an endorsement for a waiver of subrogation in favor of the State. Any deductible or self insured retention ("SIR") over fifty thousand dollars ($50,000) must be approved by the State. The Deductible or SIR and any premiums are the

Contractor's sole responsibility. The Contractor agrees that the insurance requirements specified in this Section do not reduce any liability the Contractor has assumed under this Contract including any indemnification or hold harmless requirements.

To achieve the required coverage amounts, a combination of an otherwise deficient specific policy and an umbrella policy with an aggregate meeting or exceeding the required coverage amounts is acceptable. For example: If the required policy limit under this Contract is for two million dollars ($2,000,000) in coverage, acceptable coverage would include a specific policy covering one million dollars ($1,000,000) combined with an umbrella policy for an additional one million dollars ($1,000,000). If the deficient underlying policy is for a coverage area without aggregate limits (generally Automobile Liability and Employers' Liability Accident), Contractor shall provide a copy of the umbrella insurance policy documents to ensure that no aggregate limit applies to the umbrella policy for that coverage area. In the event that an umbrella policy is being provided to achieve any required coverage amounts, the umbrella policy shall be accompanied by an endorsement at least as broad as the Insurance Services Office, Inc. (also known as "ISO") "Noncontributory—Other Insurance Condition" endorsement or shall be written on a policy form that addresses both the primary and noncontributory basis of the umbrella policy if the State is otherwise named as an additional insured.

Contractor shall provide the State a certificate of insurance ("COI") evidencing the coverages and amounts specified in this Section. The COI must be on a form approved by the TDCI (standard ACORD form preferred). The COI must list each insurer's National Association of Insurance Commissioners (NAIC) number and be signed by an authorized representative of the insurer. The COI must list the State of Tennessee – CPO Risk Manager, 312 Rosa L. Parks Ave., 3rd floor Central Procurement Office, Nashville, TN 37243 as the certificate holder. Contractor shall provide the COI ten (10) business days prior to the Effective Date and again thirty (30) calendar days before renewal or replacement of coverage. Contractor shall provide the State evidence that all subcontractors maintain the required insurance or that subcontractors are included under the Contractor's policy. At any time, the State may require Contractor to provide a valid COI. The Parties agree that failure to provide evidence of insurance coverage as required is a material breach of this Contract. If Contractor self-insures, then a COI will not be required to prove coverage. Instead Contractor shall provide a certificate of self-insurance or a letter, on Contractor's letterhead, detailing its coverage, policy amounts, and proof of funds to reasonably cover such expenses. The State reserves the right to require complete copies of all required insurance policies, including endorsements required by these specifications, at any time.

The State agrees that it shall give written notice to the Contractor as soon as practicable after the State becomes aware of any claim asserted or made against the State, but in no event later than thirty (30) calendar days after the State becomes aware of such claim. 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 or its insurer, 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.

The insurance obligations under this Contract shall be: (1)—all the insurance coverage and policy limits carried by the Contractor; or (2)—the minimum insurance coverage requirements and policy limits shown in this Contract; whichever is greater. Any insurance proceeds in excess of or broader than the minimum required coverage and minimum required policy limits, which are applicable to a given loss, shall be available to the State. No representation is made that the minimum insurance requirements of the Contract are sufficient to cover the obligations of the Contractor arising under this Contract. The Contractor shall obtain and maintain, at a minimum, the following insurance coverages and policy limits.

a. Commercial General Liability ("CGL") Insurance

1) The Contractor shall maintain CGL, which shall be written on an ISO Form CG 00 01 occurrence form (or a substitute form providing equivalent coverage) and shall cover liability arising from property damage, premises and operations products and completed operations, bodily injury, personal and advertising injury, and liability assumed under an insured contract (including the tort liability of another assumed in a business contract).
The Contractor shall maintain single limits not less than one million dollars ($1,000,000) per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this policy or location of occurrence or the general aggregate limit shall be twice the required occurrence limit.

b. Workers' Compensation and Employer Liability Insurance

1) For Contractors statutorily required to carry workers' compensation and employer liability insurance, the Contractor shall maintain:

i. Workers' compensation in an amount not less than one million dollars ($1,000,000) including employer liability of one million dollars ($1,000,000) per accident for bodily injury by accident, one million dollars ($1,000,000) policy limit by disease, and one million dollars ($1,000,000) per employee for bodily injury by disease.

2) If the Contractor certifies that it is exempt from the requirements of Tenn. Code Ann. §§ 50-6-101 – 103, then the Contractor shall furnish written proof of such exemption for one or more of the following reasons:

i. The Contractor employs fewer than five (5) employees;

ii. The Contractor is a sole proprietor;

iii. The Contractor is in the construction business or trades with no employees;

iv. The Contractor is in the coal mining industry with no employees;

v. The Contractor is a state or local government; or

vi. The Contractor self-insures its workers' compensation and is in compliance with the TDCI rules and Tenn. Code Ann. § 50-6-405.

c. Automobile Liability Insurance

1) The Contractor shall maintain automobile liability insurance which shall cover liability arising out of any automobile (including owned, leased, hired, and non-owned automobiles).

2) The Contractor shall maintain bodily injury/property damage with a limit not less than one million dollars ($1,000,000) per occurrence or combined single limit.

d. Technology Professional Liability (Errors & Omissions)/Cyber Liability Insurance

1) The Contractor shall maintain technology professional liability (errors & omissions)/cyber liability insurance appropriate to the Contractor's

profession in an amount not less than ten million dollars ($10,000,000) per occurrence or claim and ten million dollars ($10,000,000) annual aggregate, covering all acts, claims, errors, omissions, negligence, infringement of intellectual property (including copyright, patent and trade secret); network security and privacy risks, including but not limited to unauthorized access, failure of security, information theft, damage to destruction of or alteration of electronic information, breach of privacy perils, wrongful disclosure and release of private information, collection, or other negligence in the handling of confidential information, and including coverage for related regulatory fines, defenses, and penalties.

2) Such coverage shall include data breach response expenses, in an amount not less than ten million dollars ($10,000,000) and payable whether incurred by the State or Contractor, including but not limited to consumer notification, whether or not required by law, computer forensic investigations, public relations and crisis management firm fees, credit file or identity monitoring or remediation services and expenses in the performance of services for the State or on behalf of the State hereunder.

e. Crime Insurance

1) The Contractor shall maintain crime insurance, which shall be written on a "loss sustained form" or "loss discovered form" providing coverage for third party fidelity, including cyber theft and extortion. The policy must allow for reporting of circumstances or incidents that may give rise to future claims, include an extended reporting period of no less than two (2) years with respect to events which occurred but were not reported during the term of the policy, and not contain a condition requiring an arrest or conviction.

2) Any crime insurance policy shall have a limit not less than one million dollars ($1,000,000) per claim and one million dollars ($1,000,000) in the aggregate. Any crime insurance policy shall contain a Social Engineering Fraud Endorsement with a limit of not less than two hundred and fifty thousand dollars ($250,000). This insurance may be written on a claims-made basis, but in the event that coverage is cancelled or non-renewed, the Contractor shall purchase an extended reporting or "tail coverage" of at least two (2) years after the Term.

D.33. Major Procurement Contract Sales and Use Tax. Pursuant to Tenn. Code Ann. § 4-39-102 and to the extent applicable, the Contractor and the Contractor's subcontractors shall remit sales and use taxes on the sales of goods or services that are made by the Contractor or the Contractor's subcontractors and that are subject to tax.

D.34. 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.

D.35. Boycott of Israel. The Contractor certifies that it is not currently engaged in, and covenants that it will not, for the duration of the Contract, engage in a Boycott of Israel, as that term is defined in Tenn. Code Ann. § 12-4-119.

D.36. Prohibited Contract Terms. The prohibited contract terms and conditions enumerated in Tenn. Code Ann. § 12-3-515, shall be a material provision of this Contract. The Contractor acknowledges, understands, and agrees that the inclusion of a term or condition prohibited by Tenn. Code Ann. § 12-3-515, shall be null and void and the Contract shall be enforceable as if the Contract did not contain such term or condition.

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, the special terms and conditions shall be subordinate to the Contract's other terms and conditions.

E.2. 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 Response to RFP #31786-00177 (Attachment 6.2) 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 monthly report of participation in the performance of this Contract by small business enterprises and businesses owned by minorities, women, service-disabled veterans, and persons with disabilities. Such reports shall be provided to the State of Tennessee Governor's Office of Diversity Business Enterprise in the TN Diversity Software available online at: https://tn.diversitysoftware.com/FrontEnd/StartCertification.asp?TN=tn&XID=9810.

E.3. Additional lines, items, or options. At its sole discretion, the State may make written requests to the Contractor to add lines, items, or options that are needed and within the Scope but were not included in the original Contract. Such lines, items, or options will be added to the Contract through a Memorandum of Understanding ("MOU"), not an amendment.

a. After the Contractor receives a written request to add lines, items, or options, the Contractor shall have ten (10) Business Days to respond with a written proposal. The Contractor's written proposal shall include:
   (1) The effect, if any, of adding the lines, items, or options on the other goods or services required under the Contract
   (2) Any pricing related to the new lines, items, or options
   (3) The expected effective date for the availability of the new lines, items, or options; and
   (4) Any additional information requested by the State.

b. The State may negotiate the terms of the Contractor's proposal by requesting revisions to the proposal.

c. To indicate acceptance of a proposal, the State will sign it. The signed proposal shall constitute a MOU between the Parties, and the lines, items, or options shall be incorporated into the Contract as if set forth verbatim.

d. Only after a MOU has been executed shall the Contractor perform or deliver the new lines, items, or options.

E.4. Prohibited Advertising or Marketing. The Contractor shall not suggest or imply in advertising or marketing materials that Contractor's goods or services are endorsed by the State. The restrictions on Contractor advertising or marketing materials under this Section shall survive the termination of this Contract.

E.5. Liquidated Damages. If the Contractor fails to perform in accordance with any term or provision of this contract, only provides partial performance of any term or provision of the Contract, violates any warranty, or any act prohibited or restricted by the Contract occurs, ("Liquidated Damages Event"), the State may assess damages on Contractor ("Liquidated Damages"). 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 Contractor's failure to fulfill its obligations regarding the Liquidated Damages Event as these amounts are likely to be uncertain and not easily proven. Contractor has carefully reviewed the Liquidated Damages contained in Attachment B and agrees that these amounts represent a reasonable relationship between the amount and what might reasonably be expected in the event of a Liquidated Damages Event and are a reasonable estimate of the damages that would occur from a Liquidated Damages Event. The Parties agree 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 Damages are in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or any other sections of this Contract.

The State is not obligated to assess Liquidated Damages 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.

E.6. Personally Identifiable Information. While performing its obligations under this Contract, Contractor may have access to Personally Identifiable Information held by the State ("PII"). For the purposes of this Contract, "PII" includes "Nonpublic Personal Information" as that term is defined in Title V of the Gramm-Leach-Bliley Act of 1999 or any successor federal statute, and the rules and regulations thereunder, all as may be amended or supplemented from time to time ("GLBA") and personally identifiable information and other data protected under any other applicable laws, rule or regulation of any jurisdiction relating to disclosure or use of personal information ("Privacy Laws"). Contractor agrees it shall not do or omit to do anything which would cause the State to be in breach of any Privacy Laws. Contractor shall, and shall cause its employees, agents and representatives to: (i) keep PII confidential and may use and disclose PII only as necessary to carry out those specific aspects of the purpose for which the PII was disclosed to Contractor and in accordance with this Contract, GLBA and Privacy Laws; and (ii) implement and maintain appropriate technical and organizational measures regarding information security to: (A) ensure the security and confidentiality of PII; (B) protect against any threats or hazards to the security or integrity of PII; and (C) prevent unauthorized access to or use of PII. Contractor shall immediately notify State: (1) of any disclosure or use of any PII by Contractor or any of its employees, agents and representatives in breach of this Contract; and (2) of any disclosure of any PII to Contractor or its employees, agents and representatives where the purpose of such disclosure is not known to Contractor or its employees, agents and representatives. The State reserves the right to review Contractor's policies and procedures used to maintain the security and confidentiality of PII and Contractor shall, and cause its employees, agents and representatives to, comply with all reasonable requests or directions from the State to enable the State to verify or ensure that Contractor is in full compliance with its obligations under this Contract in relation to PII. In accordance with the timeframe for audits listed in Contract Section D.11 and in consultation with the State, 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. The obligations set forth in this Section shall survive the termination of this Contract.

E.7. Contractor Hosted Services Confidential Data, Audit, and Other Requirements

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

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

2. The Contractor shall encrypt Confidential State Data at rest and in transit using the current version of Federal Information Processing Standard ("FIPS") 140-2, AES-256, or 140-3 (current applicable version) validated encryption technologies. Upon request, the Contractor shall provide the State with a copy or set of the Confidential State Data that can be decrypted.

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

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

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

4. The Contractor must annually perform Penetration Tests and Vulnerability Assessments against its Processing Environment. "Processing Environment" shall mean the combination of software and hardware on which the Application runs. "Application" shall mean the computer code that supports and accomplishes the State's requirements as set forth in this Contract. "Penetration Tests" shall be in the form of attacks on the Contractor's computer system, with the purpose of discovering security weaknesses which have the potential to gain access to the Processing Environment's features and data. The "Vulnerability Assessment" shall be designed and executed to define, identify, and classify the security holes (vulnerabilities) in the Processing Environment. Contractor shall provide a letter of attestation that the penetration testing and vulnerability assessments per NIST 800-115 have been performed annually and any material weaknesses have been remediated.

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

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

7. Contractor must enter into a Business Associate Agreement (BAA) with the State.

b. Minimum Requirements

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

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

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

c. Comptroller Audit Requirements

Upon reasonable notice and at any reasonable time, the Contractor and Subcontractor(s) agree to allow the State, the Comptroller of the Treasury, or their duly appointed representatives to perform information technology control audits of the Contractor and all

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

The information technology control audit may include a review of general controls and application controls. General controls are the policies and procedures that apply to all or a large segment of the Contractor's or Subcontractor's Information Systems and applications and include controls over security management, access controls, configuration management, segregation of duties, and contingency planning. Application controls are directly related to the application and help ensure that transactions are complete, accurate, valid, confidential, and available. The audit shall include the Contractor's and Subcontractor's compliance with the State's Enterprise Information Security Policies and all applicable requirements, laws, regulations or policies.

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

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

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

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

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

        i. Recovery Point Objective ("RPO"). The RPO is defined as the maximum targeted period in which data might be lost from an IT service due to a major incident: one (1) hour

        ii. Recovery Time Objective ("RTO"). The RTO is defined as the targeted duration of time and a service level within which a business process must be restored after a disaster (or disruption) in order to avoid unacceptable consequences associated with a break in business continuity: seventy-two (72 hours)

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

e. The Contractor and any Subcontractor used by the Contractor to host State data, including data center vendors, shall be subject to an annual engagement by a CPA firm in accordance with the standards of the American Institute of Certified Public Accountants ("AICPA") for a System and Organization Controls for service organizations ("SOC") 2 Type II audit. The State shall approve the SOC audit control objectives. The Contractor shall provide the State with the Contractor's and Subcontractor's annual audit report within 30 days from when the CPA firm provides the audit report to the Contractor or Subcontractor. The Contractor shall submit corrective action plans to the State for any issues included in the audit report within 30 days after the CPA firm provides the audit report to the Contractor and Subcontractor.

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

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

E.8. Extraneous Terms and Conditions. Contractor shall fill all orders submitted by the State under this Contract. No purchase order, invoice, or other documents associated with any sales, orders, or supply of any good or service under this Contract shall contain any terms or conditions other than as set forth in the Contract. Any such extraneous terms and conditions shall be void, invalid and unenforceable against the State. Any refusal by Contractor to supply any goods or services under this Contract conditioned upon the State submitting to any extraneous terms and conditions shall be a material breach of the Contract and constitute an act of bad faith by Contractor.

E.9. Survival. The terms, provisions, representations, and warranties contained in this Contract which by their sense and context are intended to survive the performance and termination of this Contract, shall so survive the completion of performance and termination of this Contract.

IN WITNESS WHEREOF,

CONTRACTOR LEGAL ENTITY NAME:

CONTRACTOR SIGNATURE **DATE**

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

STATE AGENCY NAME:

NAME & TITLE **DATE**

ATTACHMENT A

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	
EDISON VENDOR IDENTIFICATION NUMBER:	

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. Attach evidence documenting the individual's authority to contractually bind the Contractor, unless the signatory is the Contractor's chief executive or president.

PRINTED NAME AND TITLE OF SIGNATORY

DATE OF ATTESTATION

PERFORMANCE GUARANTEES AND LIQUIDATED DAMAGES

To effectively manage contractual performance, the State has established liquidated damages to evaluate the Contractor's obligations with respect to the Contract. 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.

The Parties agree that the Liquidated Damages represent solely the anticipated 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.

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.

PERFORMANCE GUARANTEES	
1. Implementation	
Guarantee	The Contractor shall complete all tasks, deliverables, and milestones included in the project implementation plan, as required in Contract Section A.3.e. necessary to install the program by Go-Live.
Assessment	One thousand dollars ($1,000) for each Business Day for each late deliverable and/or milestone leading up to and by Go-Live.
Justification	This is a critical portion of the implementation of a new contract and needed before starting implementation to ensure all aspects of implementation are enacted accurately and timely. This assessment calculates the potential impact of missed or inaccurate implementation milestones.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live.
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.3.f., prior to Go-Live.
Assessment	Ten thousand dollars ($10,000) per finding if the issue is not resolved prior to Go-Live.
Justification	Operational readiness review requires the Contractor and the State to investigate and navigate any potential issues, deadlines, and milestones leading up to Go-Live and operations.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live.
3. Edison System Interface	
Guarantee	Contractor's interface with the Edison System shall be fully operational by the date specified in Contract Section A.25.a.
Assessment	Ten thousand dollars ($10,000) per Business Day beyond the deadline that the interface is not fully operational.
Justification	This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live.
4. Call Center Operational	
Guarantee	The Contractor's call center shall be fully operational no later than the date specified in Contract Section A.3.a.
Assessment	Ten thousand dollars ($10,000) for every Business Day beyond the deadline that the call center or other system is not operational.
Justification	This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live.

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 or before Go-Live.
Assessment	Twenty-five thousand dollars ($25,000) for each Business Day beyond Go-Live that medical claims administrative services are not fully operational.
Justification	Program go-live is an imperative performance guarantee listed in the Contract. If there is a delay in this, the State is unable to provide medical benefits coverage to our Members. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months Go-Live.
6. Plan Design	
Guarantee	The Contractor shall correctly adjudicate claims in accordance with the plan design and State approved covered benefits, see Contract section A.15.a. and A.15.g.
Assessment	One hundred dollars ($100) per occurrence (defined as an individual claim) plus the actual costs incurred of the incorrectly processed claim. This includes any administrative costs incurred by the Contractor or State to correctly reprocess claims or reimburse members and the plan for any overpayment.
Justification	Plan design information must be accurate as to not cause confusion or financial hardship to Members. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Reported after each occurrence. Measured, reconciled and assessed quarterly.
7. Website and Splash Page	
Guarantee	The Contractor's website and splash page for the Public Sector Plans shall be available on the internet and fully operational, with the exception of member data/Protected Health Information at least thirty (30) days prior to the first day of annual enrollment (generally October 1)as specified in Contract Section A.18.i.
Assessment	One thousand dollars ($1,000) per Business Day, per site until operational or updated.
Justification	This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live and annually thereafter.
8. Initial and Annual Welcome Packet and ID Card Distribution	
Guarantee	Ninety-five percent (95%) of welcome packets and ID cards shall be produced and mailed no later than fourteen (14) days prior to Go-Live and annually as required in Contract Section A.17.d and A.17.i.
Assessment	Ten thousand dollars ($10,000) if the guarantee is not met.
Justification	This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed no later than three months after Go-Live.

9. Plan Changes		
Guarantee	Unless otherwise directed by the State, the Contractor shall correctly implement any plan design changes annually no later than January 1st of the benefit plan year or within sixty (60) days of written notification from the State for mid-year changes as required in Contract Section A.15.g.	
Assessment	Twenty-five thousand dollars ($25,000) per incorrect plan design setup such as, but not limited to, incorrect member cost share, incorrect covered services or excluded services.	
Justification	Plan changes must be timely and accurately implemented as to not cause confusion or financial hardship to Members. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.	
Measurement	Reported after each occurrence. Measured, reconciled and assessed quarterly.	
10. 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.6.f.8., A.6.p. and A.6.q.	
Assessment	Ten thousand dollars ($10,000) per occurrence (defined as each provider termination) if the guarantee is not met.	
Justification	Members must be notified timely of any provider terminations as to not cause confusion or financial hardship to Members. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.	
Measurement	Reported after each occurrence. Measured, reconciled and assessed quarterly.	
11. Medical Provider/Facility Network Accessibility		
Guarantee	As measured by the Geographic Access Provider & Facility Network Accessibility Analysis, the Contractor's medical provider and facility network shall assure that 95% of all State, Local Education, and Local Government Plan enrolled members residing in Tennessee shall have the Access Standard indicated, as required in Contract Section A.6.i. and A.6.j. Should there be a deficiency in the network due to the unavailability of licensed providers in a specific area, the Contractor shall provide sufficient documentation and a corrective action plan with their access analysis report to request reconsideration of the access standard for that provider type for the reporting period in question.	
Definition	**Provider Group – Urban**	**Access Standard**
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 5 miles
	Obstetricians/Gynecologists	2 physicians within 5 miles
	Pediatricians	2 physicians within 5 miles
	Cardiologists	1 physician within 5 miles
	Endocrinologists	1 physician within 10 miles
	Acute Care Hospitals	1 facility within 10 miles
	Provider Group – Suburban	**Access Standard**

	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 10 miles
	Obstetricians/Gynecologists	2 physicians within 10 miles
	Pediatricians	2 physicians within 10 miles
	Cardiologists	1 physician within 10 miles
	Endocrinologists	1 physician within 15 miles
	Acute Care Hospitals	1 facility within 10 miles
	Provider Group – Rural	**Access Standard**
	PCPs (Internal Medicine, General or Family Practitioners)	2 physicians within 15 miles
	Obstetricians/Gynecologists	2 physicians within 25 miles
	Pediatricians	2 physicians within 25 miles
	Cardiologists	1 physician within 20 miles
	Endocrinologists	1 physician within 50 miles
	Acute Care Hospitals	1 facility within 20 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 Geographic Access report of provider access for urban, suburban, and rural areas. Unless otherwise directed by the State, the Contractor shall use the default definitions for urban, suburban, and rural areas. Unless otherwise directed by the State, the Contractor shall use the approved data analysis, report format, and Tennessee zip code list provided by the State prior to each reporting period.	
Justification	The Contract requires minimum access standards and without those, Members do not have access to providers within the access standards and therefore the potential to go without medical services and increased financial hardship. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.	
Measurement	Compliance report is the quarterly Geographic Access Analysis submitted by the Contractor. Measured, reported, reconciled, and assessed quarterly.	
12. Behavioral Provider/Facility Network Accessibility		
Guarantee	As measured by the Geographic Access Provider & Facility Network Accessibility Analysis, the Contractor's behavioral provider and facility network shall assure that 95% of all State, Local Education, and Local Government Plan enrolled members residing in Tennessee shall have the Access Standard indicated, as required in Contract Section A.6.i. and A.6.j. Should there be a deficiency in the network due to the unavailability of licensed providers in a specific area, the Contractor shall provide sufficient documentation and a corrective action plan with their access analysis report to request reconsideration of the access standard for that provider type for the reporting period in question.	
Definition	**Provider Group - Urban**	**Access Standard**
	Psychiatrists and Advanced Practice Psychiatric Nurses	2 providers within 10 miles
	Psychologists	2 providers within 10 miles
	Child/Adolescent Providers	2 providers within 10 miles

	All other Master's Level Providers	2 providers within 10 miles
	Medication Assisted Treatment Providers	1 provider within 10 miles
	Inpatient Acute Care Facilities	1 facility within 20 miles
	Intermediate Care Facilities (Residential and Partial)	1 facility within 20 miles
	Intensive Outpatient Facilities	1 facility within 20 miles
	Provider Group – Suburban	**Access Standard**
	Psychiatrists and Advanced Practice Psychiatric Nurses	2 providers within 15 miles
	Psychologists	2 providers within 15 miles
	Child/Adolescent Providers	2 providers within 15 miles
	All other Master's Level Providers	2 providers within 15 miles
	Medication Assisted Treatment Providers	1 provider within 15 miles
	Inpatient Acute Care Facilities	1 facility within 30 miles
	Intermediate Care Facilities (Residential and Partial)	1 facility within 30 miles
	Intensive Outpatient Facilities	1 facility within 30 miles
	Provider Group – Rural	**Access Standard**
	Psychiatrists and Advanced Practice Psychiatric Nurses	2 providers within 30 miles
	Psychologists	2 providers within 30 miles
	Child/Adolescent Providers	2 providers within 30 miles
	All other Master's Level Providers	2 providers within 30 miles
	Medication Assisted Treatment Providers	1 provider within 30 miles
	Inpatient Acute Care Facilities	1 facility within 40 miles
	Intermediate Care Facilities (Residential and Partial)	1 facility within 40 miles
	Intensive Outpatient Facilities	1 facility within 40 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 Geographic access report of provider access for urban, suburban, and rural areas. Unless otherwise directed by the State, the Contractor shall use the default definitions for urban, suburban, and rural areas. Unless otherwise directed by the State,	

	the Contractor shall use the approved data analysis, report format, and Tennessee zip code list provided by the State prior to each reporting period.	
Justification	The Contract requires minimum access standards and without those, Members do not have access to providers within the access standards and therefore the potential to go without behavioral services and increased financial hardship. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.	
Measurement	Compliance report is the quarterly Geographic Access Analysis submitted by the Contractor. Measured, reported, reconciled and assessed quarterly.	
13. Pharmacy Network Accessibility		
Guarantee	As measured by the Geographic Access Provider & Facility Network Accessibility Analysis, the Contractor's Retail Pharmacy network shall assure that 90% of all State, Local Education, and Local Government Plan enrolled members residing in Tennessee shall have the Access Standard indicated, as required in Contract Section A.6.i. and A.6.j.	
Definition	Urban	1 pharmacy within 1.5 miles
	Suburban	1 pharmacy within 3 miles
	Rural	1 pharmacy within 10 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 Geographic access report of provider access for urban, suburban, and rural areas. Unless otherwise directed by the State, the Contractor shall use the default definitions for urban, suburban, and rural areas. Unless otherwise directed by the State, the Contractor shall use the approved data analysis, report format, and Tennessee zip code list provided by the State prior to each reporting period.	
Justification	The Contract requires minimum access standards and without those, Members do not have access to providers within the access standards and therefore the potential to go without pharmacy services and increased financial hardship. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.	
Measurement	Compliance report is the quarterly Geographic Access Analysis submitted by the Contractor. Measured, reported, reconciled and assessed quarterly.	
14. Enrollment Set-Up		
Guarantee	As required in Contract Section A.25.d., enrollment information shall be loaded, tested, verified and available online for use no later than thirty (30) days prior to Go-Live.	
Assessment	Ten thousand ($10,000) for each Business Day beyond the date specified in Contract Section A.25.d.	
Justification	Enrollment file set-up is a critical step in providing Members medical benefits. Without the accurate and timely set-up of this file, there is a potential harm to Members financially and in receiving medical services. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.	
Measurement	Measured, reported, reconciled and assessed no later than three (3) months after Go-Live.	

15. 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.25.l.1).
Assessment	Five thousand dollars ($5,000) per Business Day up to the twentieth (20th) Business Day.
Justification	Timely submission of claims data ensures that the State and Members have accurate and timely information. The State relies on the claims data information for reporting and planning purposes. Members rely on this data for Plan information such as deducible and out of pocket maximum amounts. This assessment and amount take into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Measured, reported, reconciled and assessed quarterly.
16. NCQA Accreditation	
Guarantee	The Contractor shall submit a copy of their NCQA Health Plan Report Card Accreditation at a level of 3.5 or more stars as specified in Contract Section A.22.l.
Assessment	Twenty thousand dollars ($20,000) per guarantee that is not met.
Justification	This accreditation sets out minimum standards and measurement that a Contractor must meet to receive NCQA accreditation. This assessment and amount take into account the State's increased oversite and management of the Contractor without this accreditation.
Measurement	Measured, reported, reconciled and assessed annually.
17. URAC Accreditation	
Guarantee	The Contractor shall possess and maintain full Pharmacy Benefit Management accreditation status with URAC during the entire term of this contract as specified in Contract Section A.22.m.
Assessment	Twenty thousand dollars ($20,000) per year that guarantee that is not met.
Justification	This accreditation sets out minimum standards and measurement that a Contractor must meet to receive URAC accreditation. This assessment and amount takes into account the State's increased oversite and management of the Contractor without this accreditation.
Measurement	Measured, reported, reconciled and assessed annually.
18. Privacy and Security of Protected Health Information Impacting 1 to 499 Members	
Guarantee	In accordance with Contract Section D.20 and Contract Attachment E, 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). Pursuant to 45 CFR 164.402, breach is defined as the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI.
Assessment	Four Thousand Eight Hundred dollars ($4,800) per violation until resolved. The guarantee and assessment estimate the impact on the State including the unpredictability of the timing of a breach; specifics of the breach's scope; length of time

	of investigation completion; number of Member calls to the BA service center; and level of legislative inquiries. ***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.***
Justification	This assessment is based on the previous experience BA has had in responding to similar incidents impacting less than five hundred (500) Members which includes the following predicted costs to BA: 1. HIPAA Compliance Officer time including investigating the breach, monitoring the HIPAA privacy hotline and email address estimated at seventy-five (75) hours; 2. Director of Financial Management and Program Integrity time and work estimated at seven and half (7.5) hours; 3. Program Director associated with this contract time and work estimated at fifteen (15) hours; 4. Executive Director's time and work estimated at one (1) hour; 5. Department attorney time including legal review estimated at one (1) hour; and 6. Service Center staff time and work answering Member questions/concerns estimated at fifteen (15) hours
Measurement	Reported after each occurrence. Measured, reconciled and assessed quarterly.
19. Privacy and Security of Protected Health Information Impacting 500 or more Members	
Guarantee	In accordance with Contract Section D.20 and Contract Attachment E, 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). Pursuant to 45 CFR 164.402, breach is defined as the acquisition, access, use, or disclosure of protected health information in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI.
Assessment	Nineteen Thousand dollars ($19,000) per incident basis violation until resolved This assessment is based on the previous experience BA has had in responding to similar incidents impacting five hundred (500) or more Members which includes the following predicted costs to BA: 1. HIPAA Compliance Officer time including investigating the breach, monitoring the HIPAA privacy hotline and email address estimated at one hundred thirty (130) hours; 2. Director of Financial Management and Program Integrity time and work estimated at thirty (30) hours
Justification	The guarantee and assessment estimate the impact on the State including the unpredictability of the timing of a breach; specifics of the breach's scope; length of time of investigation completion; number of Member calls to the BA service center; and level of legislative inquiries. A breach impacting five hundred (500) or more Members has additional required steps and procedures including notification to the Office of Civil Rights ("OCR") with the U.S. Department of Health & Human Services ("HSS"); documentation to OCR for a required

	investigation; the drafting and mailing of Member notification letters; and a federally-required media release to media outlets across the State.
Measurement	Reported after each occurrence. Measured, reconciled and assessed quarterly.

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. The reports shall be used by the State to assess the medical TPA performance and utilization, as well as reconcile any liquidated damages and Service Level Agreements. 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.

Note: Any report due on a holiday or weekend will then be due on the following Business Day.

Reports shall include:

1. **Geographic Access Report**, submitted quarterly in compliance with contract section A.6.j.
2. **NCQA Credentials Verification Organization Certification,** annually in compliance with contract section A.6.n.
3. **Provider Denied Claim Appeals Report,** submitted quarterly in compliance with contract section A.6.y.
4. **Continuity of Care and Unique Care Exception Report**, submitted monthly in compliance with contract section A.6.ii.
5. **CAHPS Survey**, survey results submitted annually by July 20th with the associated corrective action plan in compliance with contract section A.7.q.
6. **Appeals Report**, submitted quarterly in compliance with contract section A.8.g.
7. **UM Program List and Selection Inventory**, submitted semi-annually in compliance with contract section A.9.c.
8. **Therapeutic Substitution and Generic Drug Dispensing Results Report**, submitted annually in compliance with contract section A.9.s.
9. **Prior Authorization and Utilization Management Report**, submitted quarterly in compliance with contract section A.9.u.
10. **Expert Medical Opinion Report,** submitted monthly in compliance with contract section A.9.cc.
11. **Value Based Initiatives and Payments Report,** In compliance with contract section A.13.g.(5) and A.13.l.
12. **Telehealth Utilization Report,** submitted quarterly in compliance with contract section A.13.i.
13. **Diabetes Prevention Program Outcomes Report,** submitted quarterly in compliance with contract section A.13.j.

14. **Call Center Statistics**, submitted in compliance with contract section A.14.k.
15. **Claims SLA and KPI Metrics Report,** submitted quarterly in compliance with contract section A.12.p.(1-6).
16. **Pharmacy Claims Metrics Report,** submitted quarterly in compliance with contract section A.12.q.(1-3).
17. **Pass-Through Pricing Report,** submitted quarterly in compliance with contract section A.12.ii.
18. **Rebates and Manufacturer Payments Report**, submitted quarterly, no later than sixty (60) days following the end of each quarter, in compliance with contract section A.15.kk an C.3.p.
19. **Rebate Reconciliation Report**, annually, no later than one hundred fifty (150) days after the end of the calendar year, in compliance with A.15.kk and C.3.p.
20. **Coordination of Benefits Report**, submitted weekly in compliance with contract section A.15.oo.
21. **Medicare Secondary Payer Report,** submitted weekly in compliance with contract section A.15.pp.
22. **Recoveries Reports**, submitted monthly in compliance with contract section A.15.qq.
23. **Bank Draft Report,** submitted at the same frequency as Contractor's bank drafts in compliance with contract section A.15.vv.(1).
24. **Reconciliation Report**, submitted monthly in a format prior approved by the State in compliance with contract section A.15.vv.(2).
25. **Denied Claims Report,** submitted quarterly in compliance with contract section A.15.aaa.
26. **Pended Claims Report,** submitted monthly in compliance with contract section A.15.bbb.
27. **Member Engagement Plan**, submitted two months prior to the annual enrollment before Go-Live and annually thereafter in compliance with contract section A.16.a.
28. **Marketing and Communications Report,** submitted quarterly in compliance with contract section A.16.a.(2).
29. **Transparency Tool Report,** submitted quarterly in compliance with contract section A.16.g.(6).
30. **ASP Specialty Drug Reconciliation Report**, submitted annually in compliance with contract sections A.19.s. and C.3.g. of this contract and will be validated by the State's actuarial consultant.
31. **Wellness Activity Completion**, submitted at the request of the State in compliance with contract section A.21.c.
32. **NCQA Health Plan Accreditation Certification,** in compliance with contract section A.22.l.
33. **HEDIS Report**, submitted annually by August 15th in compliance with contract section A.22.n.
34. **Ad-Hoc Reports**, in compliance with contract section A.24.g.
35. **Daily or Weekly Enrollment File Error Report**, submitted within one (1) Business Day of receipt of the daily or weekly enrollment file in compliance with contract section A.25.e(3).
36. **CMS Data Match Report**, submitted quarterly in compliance with contract section A.25.g this contract.
37. **Local Government CMS Data Match Report**, submitted monthly in compliance with contract section A.25.h.
38. **Security Risk Assessment Results Report**, submitted one (1) month prior to Go-Live and, thereafter, annually in compliance with contract section A.26.i(10).

39. **NQTL Review Outcomes Report**, submitted annually in compliance with contract section A.28.a.

40. **Gag Clause Compliance Attestation**, submitted annually in compliance with contract section A.28.e.

41. **Discount and Dispensing Fee Reconciliation Report,** submitted quarterly and annually, within 90 days of the end of each quarter/year, in compliance with contract section C.3.m.

42. **Disaster Recovery Test Results Summary**, annually in compliance with contract section E.7.d.(2).

43. **Security Report:** SOC 2 Type 2 Report, ISO27001 or FedRAMP submitted annually after Go-Live in compliance with contract section E.7.e.

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

Contract Attachment D

Service Level Agreement Scorecard

Below is the SLA Scorecard and associated KPIs used to measure the Contractor's performance against the desired outcomes. KPIs shall be evaluated, scored, and reconciled quarterly via the SLA Scorecard with relevant documentation. Contractor must submit the SLA Scorecard each calendar quarter documenting the Contractor's outcome for each of the KPI for the previous quarter, in which services were delivered, as well as any At-Risk Performance Payment due (if applicable).

It is agreed by the State and the Contractor that any At-Risk Performance Payment 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 fees at risk. If payment is not made by the due date, the At-Risk Performance Payment amount may be withheld from future payments by the State without further notice.

Use the following for the quarterly calculations – the Contractor will fill in the Quarterly Score column for each individual KPI. If the individual KPI does not apply for the reported quarter, place 'n/a' in the Quarterly Score column. The total possible score will be adjusted accordingly. The State will calculate the Total Quarterly Score using the following formula: Quarterly Score divided by total possible quarterly score multiplied by 100%. The At Risk Performance Payment will be determined by this percentage (see table below).

KPI		Description	Performance Requirement	Vendor Performance	Score if Met	Quarterly Score
1.	Expedited Appeals	One hundred percent (100%) of expedited appeals for urgent care, not involving a third-party review, shall be decided within seventy-two (72) hours, as required in Contract Section A.8.f.1.	100%	100% 98.0-99.9% 96.0-97.9% Less than 96%	10 8 6 0	
2.	Non-Urgent Pre-Service Appeals	Ninety-five percent (95%) of non-urgent pre-service appeals shall be decided within thirty (30) days, as required in Contract Section A.8.f.2.	95%	95% or greater 93.0-94.9% 91.0-92.9% Less than 91%	8 6 4 0	
3.	Non-Urgent Post-Service Appeals	Ninety-five percent (95%) of non-urgent post-service appeals within sixty (60) days, as required in Contract Section A.8.f.3.	95%	95% or greater 93.0-94.9% 91.0-92.9% Less than 91%	8 6 4 0	
4.	Medical PA and UM Evaluation	The Contractor shall complete ninety-seven percent (97%) of all prior authorizations and utilization management decisions within the timeframes specified in Section A.9.q.	97%	97% or greater 95.0-96.9% 93.0-94.9% Less than 93%	10 8 6 0	

5.	Pharmacy PA Evaluation	The Contractor's PA staff shall evaluate ninety-nine percent (99%) of PA requests within twenty-four (24) hours as required in contract section A.9.r.	99%	99% or greater 97.0%-98.9% 95.0%-96.9% Less than 95%	8 6 4 0	
6.	Average Speed of Answer	The Contractor shall maintain an average daily ASA of thirty (30) seconds and callers may not be placed on hold after the call is answered, as required in Contract Section A.14.j.1.	30 second average	30 Sec Avg or less 30.1 – 35.9 Sec Avg 36 - 40.9 Sec Avg 41 Sec Avg or greater	8 6 4 0	
7.	First Call Resolution	The Contractor shall maintain a first call resolution rate of 85%, as required in Contract Section A.14.j.2.	85%	85% or greater 83.0-84.9% 81.0-82.9% Less than 81%	8 6 4 0	
8.	Claims Auto-Adjudication	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, as required in Contract Section A.15.p.1.	80%	80% or greater 75.0-79.9% 70.0-74.9% Less than 70%	8 6 4 0	
9.	Claims Payment Turnaround – 14 Days	The Contractor shall reimburse network providers within fourteen (14) calendar days for ninety-two percent (92%) of clean claims as required in Contract Section A.15.p.2.	92%	92% or greater 90.0-91.9% 87.0-89.9% Less than 87%	8 6 4 0	
10.	Claims Payment Turnaround – 30 Days	The Contractor shall reimburse network providers within thirty (30) calendar days for ninety-eight percent (98%) of all claims as required in Contract Section A.15.p.2.	98%	98% or greater 95.0-97.9% 91.0-94.9% Less than 91%	10 8 6 0	
11.	Financial Accuracy	Financial accuracy shall be ninety-nine percent (99%) or higher as required in Contract Section A.15.p.3.	99%	99% or greater 96.0-98.9% 91.0-95.9% Less than 91%	10 8 6 0	

12.	Claims Processing Accuracy	Claims processing accuracy shall be ninety-six percent (96%) or higher as required in Contract Section A.15.p.4.	96%	96% or greater 93.0-95.9% 91.0-92.9% Less than 91%	10 8 6 0	
13.	Claims Payment Accuracy	Claims payment accuracy shall be ninety-seven point five percent (97.5%) or higher as required in Contract Section A.15.p.5.	97.5%	97.5% or greater 95.0-97.49% 91.0-94.9% Less than 91%	10 8 6 0	
14.	Claim Adjustment Completion	The Contractor shall complete ninety-five percent (95%) of all claim adjustments within seven (7) calendar days, as required in Contract Section A.15.p.6.	95%	95% or greater 93.0-94.9% 91.0-92.9% Less than 91%	8 6 4 0	
15.	POS Claims Processing	The Contractor shall process ninety-nine percent (99%) of pharmacy POS claims on a daily basis within five (5) seconds, as required in Contract Section A.15.q.1.	99%	99% or greater 97.0-98.9% 95.0-96.9% Less than 95%	6 4 2 0	
16.	Rx Claims Processing Accuracy	Rx claims processing shall be ninety-nine point nine percent 99.9% or higher for retail, mail order, and specialty, as required in Contract Section A.15.q.2.	99.9%	99.9% or greater 97.0-99.89% 95.0-96.9% Less than 95%	6 4 2 0	
17.	Rx Claims Payment Accuracy	Claims payment accuracy shall be ninety-nine point nine percent (99.9%) or higher for retail, mail order, and specialty, as required in Contract Section A.15.q.3.	99.9%	99.9% or greater 97.0-99.89% 95.0-96.9% Less than 95%	6 4 2 0	
18.	Distribution of Ongoing Member ID Cards/Welcome Packets	Ninety-five percent (98%) of new member welcome kits and ID cards shall be produced and mailed within five (5) days of receipt of complete and accurate eligibility information, as required in Contract Section A.17.e.	98%	98% or greater 953.0-97.9% 91.0-94.9% Less than 91%	10 8 6 0	
19.	Generic Drug Substitution - Mail Order	As required in Contract Section A.19.i.(1), ninety-five percent (95%) or more of Mail Order prescriptions for Multi-source drugs shall be dispensed with a Generic Drug product.	95%	95% or greater 93.0-94.9% 91.0-92.9% Less than 91%	10 8 6 0	

20.	Generic Drug Substitution - Retail	As required in Contract Section A.19.i.(1), ninety percent (90%) or more of retail prescriptions for Multi-source drugs shall be dispensed with a Generic Drug product.	95%	95% or greater 93.0-94.9% 91.0-92.9% Less than 91%	10 8 6 0	
21.	Eligibility Discrepancies	Resolve all eligibility discrepancies (any difference of values between the State's database and the Contractor's database), not identified during processing, as identified by the State or Contractor within one (1) business day of notification by the State or identification by the Contractor, as required in Contract Section A.25.e.4.	100%	100% 98.0-99.9% 96.0-97.9% Less than 96%	10 8 6 0	
Total Sum Available Quarterly Scores						
Total Sum Achieved Quarterly Scores						
Quarterly Calculated Performance Percentage (Total Sum Achieved Quarterly Scores/ Total Sum of Available Quarterly Scores for all applicable KPIs) *100						

Quarterly Calculated Performance Percentage	At Risk Performance Payment
>=96%	0% of previous quarter Administrative Fees
91 – 95.9%	.25% of previous quarter Administrative Fees
86 – 90.9%	.50% of previous quarter Administrative Fees
81 – 85.9%	.75% of previous quarter Administrative Fees
76 – 80.9%	1% of previous quarter Administrative Fees
71 – 75.9%	1.5% of previous quarter Administrative Fees
66 – 70.9%	2% of previous quarter Administrative Fees
61 – 65.9%	3% of previous quarter Administrative Fees
<61%	4% of previous quarter Administrative Fees

KPI		Description	Performance Requirement	At Risk Performance Payment
22.	**Unauthorized Usage of Information**	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 as required in Contract Section A.4.l.	If the Contractor uses data without prior approval	$50,000 per incident.

23.	**Reporting**	The Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract as required in Contract Section A.24.a, A.24.j.7., and Contract Attachment C, Reporting Requirements.	If the Contractor fails to deliver any report on time.	$1,000 per late or undelivered report.
24.	**Medical and Behavioral Health Claims Data Quality**	As assessed by the State's DSS contractor, the Contractor's data submission to the DSS contractor shall meet the following measures as required in Contract Section A.25.l.(4). Measures and Benchmarks: • 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	If the Contractor fails to meet any requirement.	$5,000 if any requirement is missed
25.	**Pharmacy Claims Data Quality**	As assessed by the State's DSS contractor, the Contractor's data submission to the DSS contractor shall meet the following measures as required in Contract Section A.25.l.(4). Measures and Benchmarks: i. Date of birth: Data missing for ≤ 3% of Claims ii. Pharmacy Provider ID missing: Data missing for ≤ 1.5% of Claims; and iii. NDC or NDC 11 missing: Data missing for ≤ 1.5% of Claims	If the Contractor fails to meet any requirement.	$5,000 if any requirement is missed
26.	**Member Satisfaction Survey**	The level of overall customer satisfaction, as measured annually by the CAHPS Member Satisfaction survey(s) required by Contract Section A.7.q., shall be equal to or greater than eighty-five percent (90%) in the first year of the Contract, and shall be equal to or greater than ninety percent (95%) in all subsequent year(s) within the contract term.	If the Contractor fails to meet the requirement.	$20,000 if requirement is missed.

27.	**Authorization of Member Communications**	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 as required in Contract Section A.16.b and A.16.h.	If the Contractor distributes materials without prior State approval, In Writing.	$25,000 for each instance.
28.	**Timely Notification**	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 including but not limited to file and data sharing between contractors, as required in Contract Section A.4.n.	If the Contractor fails to notify the State within three (3) Business Days	$10,000 per incident.

Contract Attachment E

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 _____ (hereinafter "Business Associate"). Covered Entity and Business Associate may be referred to herein individually as "Party" or collectively as "Parties."

BACKGROUND

Parties acknowledge 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:**
Third Party Administrator Services for a Tiered Copay Benefit Plan Design	**April 1, 2024**

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 protect the Covered Entity's PHI reasonably and appropriately 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, 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, in accordance with 164.502(e)(1)(ii), ensure that any subcontractors that create, receive, maintain, or transmit Protected Health Information on behalf of business associate agree to the same restrictions and conditions that apply to the 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 (up to five (5) days) report, to Business Associate, immediately 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 breach.

2.7 As required by the Breach Notification Rule, Business Associate 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 an Actual Breach of Unsecured PHI immediately upon becoming aware of the Breach.

2.7.2 Business Associate shall cooperate with Covered Entity in timely manner 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.

2.8 If Business Associate receives 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 thirty (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 thirty (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 an accounting of disclosures of PHI in accordance with 45 CFR § 164.528, provided that Business Associate shall have at least thirty (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, and the PHI is in the sole possession of the Business Associate, Business Associate will provide the requested copies to the individual and notify the Covered Entity of such action. 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.

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, in accordance with 164.502(e)(1)(ii), ensure that any subcontractors that create, receive, maintain, or transmit Protected Health Information on behalf of business associate agree to the same restrictions and conditions that apply to the business associate with respect to such information.

3.4 Business Associate shall require its employees, agents, and subcontractors to report to Business Associate within five (5) Business Days, any Security Incident (as that term is defined in 45 CFR § 164.304) of which it becomes aware. 45 CFR 164.314(a)(2)(C) requires that business associate shall report to the covered entity any security incident of which is becomes aware, including breaches of unsecured protected health information as required by 164.410. Business Associate shall promptly (up to 48 hours) report 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 username, 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
Attn: Chanda Rainey
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
Director of Procurements and Contracts

312 Rosa L. Parks Avenue
1900 W.R.S. Tennessee Towers
Nashville, TN 37243-1102
Phone: (615) 532-4598
Facsimile: (615) 253-8556

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

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).

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 Agreement 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 Memorandum 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: Chanda Rainey
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
E-Mail: benefits.privacy@tn.gov

With a copy to:
ATTN: Heather Pease
Director of Procurements & Contracts
At the address listed above
Phone: (615) 253-1652
Facsimile: (615) 253-8556
E-Mail: heather.pease@tn.gov

BUSINESS ASSOCIATE:

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

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,

CONTRACTOR NAME	**Date:**
James E. Bryson, Commissioner of Finance & Administration	**Date:**