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AGREEMENT
BETWEEN
HEALTH AND HUMAN SERVICES COMMISSION
AND
MEDICARE ADVANTAGE PLAN
HHSC Contract No. HHS000820400001

Article I. Background....2
Article II. Definitions....2
Article III. MA Health Plan's Obligations....3
Section 3.01 Plan Offer to Dual Eligible Individuals Residing in CMS-approved Service Areas....3
Section 3.02 Enrollment....4
Section 3.03 Healthcare Services....4
Section 3.04 Copies of MA Agreement....5
Section 3.05 Cost Sharing Protections for Dual Eligible Members....5
Section 3.06 Compliance with Laws....5
Article IV. State Obligations....5
Section 4.01 Payment....5
Section 4.02 Eligibility Verification....6
Article V. Compensation....6
Section 5.01 Payment....6
Section 5.02 Rights of Set-off....6
Article VI. Term....7
Section 6.01 Term....7
Article VII. Remedies....7
Section 7.01 Understanding and expectations....7
Section 7.02 Tailored remedies....7
Section 7.03 Termination....9
Article VIII. Dispute Resolution....10
Section 8.01 General Agreement of the Parties....10
Section 8.02 Duty to Negotiate in Good Faith....10
Section 8.03 Claims for Breach of Agreement....10
Article IX. Miscellaneous Provisions....11
Section 9.01 Non-Debarment....11
Section 9.02 Severability....11
Section 9.03 Successors and Assigns....11
Section 9.04 Assignment....12
Section 9.05 Modification, Amendment, or Waiver....12
Section 9.06 Notices....12
Section 9.07 Record Retention and Audit....12
Section 9.08 SAO Audit....13
Section 9.09 Access to records, books, and documents....13
Section 9.10 Governing Law & Venue....13
Section 9.11 Publicity....14
Section 9.12 Anti-trust....14
Section 9.13 CMS Approval....14
Section 9.14 Requests for public information....14
Section 9.15 Privacy, Security, and Breach Notification....15

ATTACHMENT A: PROPOSED MA PRODUCT SERVICE AREAS
ATTACHMENT B: TEXAS MEDICAID SUMMARY OF BENEFITS

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THIS AGREEMENT (Agreement**)** is made and entered into by the Texas Health and Human Services Commission (HHSC), an administrative agency within the executive department of the State of Texas, having its principal office at 4900 North Lamar Boulevard, Austin, Texas, 78751, and HealthSpring Life & Health Insurance Company, Inc. (MA Health Plan), a corporation that offers or administers a Medicare Advantage Plan organized under the laws of the State of Texas and having a principal place of business at 2800 North Loop West, Suite 500, Houston, TX 77092. HHSC and MA Health Plan may be referred to herein as a "Party" or, collectively, as the "Parties."

Article I. BACKGROUND

The MA Health Plan has entered into a Medicare Advantage Plan Agreement (MA Agreement) with the Centers for Medicare and Medicaid Services (CMS). Pursuant to the Texas State Plan, HHSC is financially responsible for the Cost Sharing Obligations attributable to Dual Eligible Members enrolled in the MA Agreement. HHSC will pay the MA Health Plan a per Dual Eligible Member monthly capitated payment in exchange for the MA Health Plan's payment of Cost Sharing Obligations to healthcare service providers. The MA Health Plan shall track and pay all eligible providers the Cost-Sharing Obligations incurred on behalf of Dual Eligible Members with applicable Medicaid eligibility categories covered under this Agreement. This Agreement sets out the responsibilities of the Parties for Dual Eligible Members enrolled in the MA Health Plan Medicare Advantage Plan.

Article II. DEFINITIONS

Coinsurance is a percentage of costs normally paid by a MA Health Plan member for medical services provided under an MA Product. Coinsurance amounts must comply with the terms of the MA Agreement.

Co-payments are fixed dollar amounts that an MA member normally must pay for a medical service provided under a Medicare Advantage Product. Co-payment amounts must comply with the terms of the MA Agreement.

Cost Sharing Obligations mean those financial payment obligations incurred by HHSC in satisfaction of the Deductibles, Coinsurance, and Co-payments for the Medicare Part A and Part B programs with respect to Dual Eligible Members. Effective January 1, 2020, Cost Sharing Obligations include co-insurance provided during a Dual Eligible Member's Medicare-covered stay in a skilled nursing facility when the Dual Eligible Member is enrolled in a MA Health Plan that is contracted with HHSC and receives Medicaid services under the State's fee-for-service model. For purposes of this Agreement, Cost Sharing Obligations do not include: (1) Medicare premiums that HHSC is required to pay under the Texas State Plan on behalf of Dual Eligible Members, (2) wrap-around services that are covered by Medicaid, and (3) Coinsurance for Part A services provided during a Dual Eligible Member's Medicare-covered stay in a nursing facility when the member is also enrolled in STAR+PLUS for their Medicaid services. Payment of coinsurance to the skilled nursing facility for a Part A skilled stay is covered by the STAR+PLUS MCO.

Deductible means fixed dollar amounts that an MA Health Plan member normally must pay out-of-pocket before the costs of services are covered by an MA Health Plan. Deductibles must comply with the terms of the MA Agreement.

Dual Eligible means a Medicare managed care recipient who is also eligible for Medicaid, and for whom HHSC has a responsibility for payment of Cost Sharing Obligations under the Texas State Plan. For purposes of this Agreement, Dual Eligible individuals are limited to the following categories of recipients: QMB Only, QMB Plus, and SLMB Plus.

Dual Eligible Member means a Dual Eligible who is eligible to participate in, and voluntarily enrolled in, the MA Health Plans MA Product.

DocuSign Envelope ID: 691EE5F6-4042-48FA-9EA4-31B7EA33E057

MA Agreement means the Medicare Advantage Plan Agreement between the MA Health Plan and CMS to provide an MA Product.

MA Product means the Medicare Part C and other health plan services provided to MA Health Plan members pursuant to an MA Agreement.

Network Provider means a provider who has a contract with the MA Health Plan, or its subcontractor, for the delivery of healthcare services to the MA Health Plan's members.

Qualified Medicare Beneficiary (QMB) means an individual who is entitled to Medicare Part A, meets federal income criteria, and whose resources do not exceed twice the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid payment of Medicare premiums, Deductibles, Coinsurance, and Co-payments (except for Medicare Part D) (collectively, these benefits are called "QMB Medicaid Benefits"). Categories of QMBs are:

- **QMB Only** – means a QMB who does not qualify for any additional QMB Medicaid Benefits.
- **QMB Plus** – means a QMB who also meets the financial criteria for full Medicaid coverage. QMB Plus individuals are entitled to QMB Medical Benefits, plus all benefits available under the Texas State Plan for fully eligible Medicaid recipients.

Specified Low-income Medicare Beneficiary (SLMB) means in individual who is entitled to Medicare Part A and meets federal income and resource criteria. A SLMB is eligible for payment of Medicaid payment of Medicare Part B premiums. Categories of SLMBs are:

- **SLMB Only** – means a SLMB does not qualify for any additional Medicaid benefits.
- **SLMB Plus** – means a SLMB who also meets the financial criteria for full Medicaid Coverage. SLMB Plus individuals are entitled to payment of Medicare Part B premiums, plus all benefits available under the Texas State Plan for fully eligible Medicaid recipients.

Article III. MA HEALTH PLAN'S OBLIGATIONS

Section 3.01 Plan Offer to Dual Eligible Individuals Residing in CMS-approved Service Areas.

(a) The MA Health Plan must offer the MA Product to Dual Eligible individuals who: (1) reside in a Texas service area where the MA Health Plan has been authorized, per CMS, to offer the MA Health Plan, and (2) are otherwise eligible to receive the MA Product. A service area is the geographic area in which a member or potential members reside and for whom the MA Health Plan is approved by CMS to provide services by CMS.

(b) The MA Health Plan has applied to the CMS to provide the MA Product in the Texas service areas described in **Attachment A, Proposed MA Product Service Areas,** which is attached to and incorporated into this Agreement. No later than 15 business days after CMS approves or denies the MA Health Plan's application to provide the MA Product in a Texas service area, the MA Health Plan must provide the HHSC point-of-contact identified in Section 9.06 with written notice of such CMS action. **MA Health Plan represents and agrees that the information included in Attachment A, Proposed MA Product Service Areas, is accurate and complete as of the date of MA Health Plan's execution of this Agreement.** Additionally, the MA Health Plan must notify the HHSC point-of-contact of all amendments to the MA Agreement's Texas service areas including but not limited to the addition, deletion, or modification to a Texas service area, CMS contract code, plan identification, or plan name. The MA Health Plan must notify the HHSC point-of-contact no later than 15 business days after the effective date of such an amendment to the MA Agreement.

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(c) No later than 15 business days after receiving the MA Health Plan notice of CMS' approval of or amendment to one or more Texas service areas, HHSC will notify the MA Health Plan of the effective date of coverage of the Texas service area(s) under this Agreement. All modifications requiring changes to HHSC's system(s) will be effective prospectively. The MA Health Plan must begin covering Cost Sharing Obligations for Dual Eligible Members in the Texas service areas that are added to the scope of this Agreement on the effective date identified in HHSC's notice, and HHSC will pay for these Dual Eligible Members in accordance with Article V.

(d) HHSC authorizes the MA Health Plan to add the MA Product to Texas service areas that are not identified in **Attachment A**, **Proposed MA Product Service Areas,** provided it receives prior CMS approval and complies with the notice requirements specified in this Agreement.

Section 3.02 Enrollment.

(a) Unless a Dual Eligible is otherwise not eligible to enroll in the MA Product under federal Medicare Advantage plan rules, the MA Health Plan must accept all Dual Eligible individuals who select the MA Health Plan's MA Product without regard to physical or mental condition, health status or need for or receipt of healthcare services, claims experience, medical history, genetic information, disability, marital status, age, sex, national origin, race, color, or religion, and must not use any policy or practice that has the effect of such discrimination.

(b) MA Health Plan must provide enrollment files of Dual Eligible Members covering monthly reporting periods. The files must comply with State formatting requirements. After the conclusion of a monthly reporting period, the MA Health Plan must submit the enrollment file no earlier than the first business day and no later than 20 calendar days following the expiration of a 3-month lag period. HHSC will then verify eligibility of the Dual Eligible Members with HHSC's eligibility system and CMS enrollment information and return the validated enrollment information to the MA Health Plan by the fifth business day of the month following receipt of the enrollment file. By way of example, the MA Health Plan must submit the January 2021 enrollment file no earlier than May 1, 2021 (the first business day of the month) and no later than May 20, 2021. HHSC will return validated enrollment information to the MA Health Plan no later than June 7, 2021 (the fifth business day of the month).

If the enrollment file does not include a Dual Eligible Member by the 20th calendar day deadline, the MA Health Plan: (1) will lose the opportunity to receive the per member per month (PMPM) capitation payment for such Dual Eligible Member for the reporting period, and (2) will be responsible for all Cost Sharing Obligations for such Dual Eligible Member for the reporting period.

Section 3.03 Healthcare Services.

The MA Health Plan must provide the MA Product to all Dual Eligible Members who are qualified to receive such services under the terms of the MA Agreement.

The MA Health Plan must pay all eligible Network Providers and out-of-network providers the Cost Sharing Obligations incurred on behalf of Dual Eligible Members. Nothing in this Agreement precludes the MA Health Plan from entering into agreements with Network Providers or out-of-network providers that vary the amount or method of payment for the Cost Sharing Obligations or from utilizing the MA Health Plan's coordination of benefits procedures.

DocuSign Envelope ID: 691EE5F6-4042-48FA-9EA4-31B7EA33E057

Section 3.04 Copies of MA Agreement.

Upon execution of this Agreement, the MA Health Plan must provide the HHSC point-of-contact, identified in Section 9.06, with a copy of the MA Agreement and all attachments. The MA Health Plan must provide the actuarial value for Medicare Cost Sharing Obligations for the projection period consistent with the CMS bid submission. The MA Health Plan agrees to provide HHSC a summary of its benefit designs for Dual Eligible Members as well as financial data in a set and format enabling HHSC to determine the cost of services and utilization experience in order to calculate the PMPM rates. In addition, the MA Health Plan must also provide all amendments to the MA Agreement or the Bid Pricing Tool to the HHSC point-of-contact within 15 business days of receiving a request for this information.

Section 3.05 Cost Sharing Protections for Dual Eligible Members.

(a) The MA Health Plan must notify its Network Providers (via a provider manual, provider bulletin, or other contractual document) that Network Providers:

(1) must not hold a Dual Eligible Member liable for the Cost Sharing Obligations; and

(2) must accept as payment in full the MA Health Plan's payment of the Cost Sharing Obligations and must not seek additional payment from HHSC or a Dual Eligible Member for healthcare services covered under the MA Product offered by the MA Health Plan and provided to the Dual Eligible Member.

The MA Health Plan must provide the HHSC point-of-contact identified in Section 9.06 with a copy of such written notice.

(b) The MA Health Plan and its Network Providers must not impose cost-sharing requirements on a Dual Eligible Member that would exceed the amount permitted under the Texas State Plan for Medical Assistance, per section 1852(a)(7) of the Act and 42 C.F.R. §422.504(g)(1)(iii).]

Section 3.06 Compliance with Laws.

(a) The MA Health Plan must comply with all applicable laws, rules, and regulations governing this Agreement. This includes all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended or modified.

(b) Additionally, the MA Health Plan must comply with HIPAA notification requirements, including those set forth in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. § 17932 as amended or modified. If, in HHSC’s determination, the MA Health Plan has not provided notice in the manner or format prescribed by the HITECH Act, then HHSC may require the MA Health Plan to provide this notice.

(c) The MA Health Plan must notify HHSC immediately of breaches or reasonably suspected breaches of unsecured protected health information, as defined by the HITECH Act, limited to only Dual Eligible Members.

Article IV. STATE OBLIGATIONS

Section 4.01 Payment.

HHSC will pay the MA Health Plan in accordance with Article V of this Agreement.

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Section 4.02 Eligibility Verification.

(a) HHSC will verify Medicaid eligibility by the fifth business day of the month following the receipt of the MA Health Plan's monthly enrollment file, in accordance with Section 3.02(b).

(b) To verify Medicaid eligibility of an individual member, HHSC agrees to provide the MA Health Plan with real-time access to HHSC's claims administrator's Medicaid eligibility verification system.

Article V. COMPENSATION

Section 5.01 Payment.

(a) HHSC will pay the MA Health Plan a PMPM capitation payment of **$10.00** as payment for the Cost Sharing Obligations for each Dual Eligible Member who is enrolled in the MA Product in a CMS-authorized Texas service area and confirmed by HHSC as eligible to participate, regardless of whether the Dual Eligible Member receives healthcare services during the period covered by the payment. HHSC will pay each PMPM capitation payment to MA Health Plan within 30 calendar days after HHSC returns the validated enrollment file to the MA Health Plan in accordance with Section 3.02(b).

(b) If the MA Health Plan includes a Dual Eligible Member on the monthly enrollment file by the deadline set forth in Section 3.02 and HHSC fails to pay the PMPM capitation payment for such Dual Eligible Member based on State error, HHSC will pay the MA Health Plan any undisputed PMPM capitation payment owed the later of: (1) 30 calendar days after receiving written notice of the error from the MA Health Plan, or (2) 30 calendar days after the resolution of the dispute.

(c) The PMPM capitation payment will be payment in full for the Cost Sharing Obligations attributable to a Dual Eligible Member as well as all costs associated with the administration of this Agreement. Neither the MA Health Plan nor its Network Providers will seek additional payment from HHSC, Dual Eligible Members, or healthcare providers for such Cost Sharing Obligations.

Section 5.02 Rights of Set-off.

With respect to any amount that HHSC in good faith determines should be reimbursed to it or is otherwise payable to it by the MA Health Plan pursuant to this Agreement, HHSC may deduct the entire amount owed against the charges otherwise payable or expenses owed to it under this Agreement until such time as the entire amount determined to be owed has been paid. HHSC will provide the MA Health Plan with written notice of and supporting information concerning such offsets, and will be relieved of its obligation to make any payments to the MA Health Plan until such time as all such amounts have been paid to HHSC.

Section 5.03 Modification of Payment.

The PMPM capitation rate is subject to modification in accordance with Section 9.07 if HHSC reasonably determines that: (1) changes in state or federal laws, rules, regulations, or policies materially affect the rate; (2) an amendment, modification, or change to the MA Agreement materially affects the rate; or (3) other information justifies a modification to the rate. HHSC will provide the MA Health Plan notice of a modification to the rate sixty (60) days prior to the effective date of the change, unless HHSC determines that circumstances warrant a shorter notice period. If the MA Health Plan does not accept the rate change, the parties may terminate this Agreement in accordance with Section 7.03.

DocuSign Envelope ID: 691EE5F6-4042-48FA-9EA4-31B7EA33E057

Article VI. TERM

Section 6.01 Term.

This Agreement is effective January 1, 2021 and ends the earlier of: (1) December 31, 2021, or (2) when terminated by a party in accordance with Section 7.03.

Article VII. REMEDIES

Section 7.01 Understanding and expectations.

The remedies described in this Article are directed to MA Health Plan's timely and responsive performance of this Agreement, and the creation of a flexible and responsive relationship between the parties. The MA Health Plan will be subject to performance evaluation by HHSC. Performance reviews may be conducted at the discretion of HHSC at any reasonable time and may relate to any responsibility or requirement of the MA Health Plan under this Agreement. Any responsibilities or requirements not fulfilled by the MA Health Plan may be subject to the remedies set forth in this Agreement.

Section 7.02 Tailored remedies.

(a) Understanding of the Parties.

The MA Health Plan agrees and understands that HHSC may pursue tailored contractual remedies for material noncompliance with this Agreement, to the extent that noncompliance is not due to adherence with the requirements of the MA Agreement. At any time and at its discretion, HHSC may impose or pursue one or more remedies for each item of material noncompliance and will determine remedies on a case-by-case basis. HHSC's pursuit or non-pursuit of a tailored remedy does not constitute a waiver of any other remedy that HHSC may have at law or equity.

(b) Corrective action plan.

(1) At its option, HHSC may require the MA Health Plan to submit a written plan (Corrective Action Plan) to correct or resolve a deficiency or breach of this Agreement, as determined by HHSC.

(2) The Corrective Action Plan must provide:

(A) A detailed explanation of the reasons for the cited deficiency;

(B) The MA Health Plan's assessment or diagnosis of the cause; and

(C) A specific proposal to cure or resolve the deficiency; and

(D) The MA Health Plan's timeline for cure or resolution of the deficiency.

(3) The Corrective Action Plan must be submitted by the deadline set forth in HHSC's written request for a Corrective Action Plan, unless an extension is granted by HHSC. The Corrective Action Plan is subject to approval by HHSC.

(4) HHSC will notify the MA Health Plan in writing of HHSC's final disposition of HHSC's concerns. If HHSC accepts MA Health Plan's proposed Corrective Action Plan, HHSC may:

(A) Condition such approval on completion of tasks in the order of priority that HHSC may reasonably prescribe;

(B) Disapprove portions of the MA Health Plan's proposed Corrective Action Plan; or

(C) Require additional or different corrective actions relating to the breach.

Notwithstanding the submission and acceptance of a Corrective Action Plan, the MA Health Plan remains responsible for achieving all contractual requirements.

(5) HHSC's acceptance of a Corrective Action Plan under this Section will not:

(A) Excuse the MA Health Plan's prior substandard performance;

(B) Relieve the MA Health Plan of its duty to comply with performance standards; or

(C) Prohibit HHSC from assessing additional tailored remedies or pursuing other appropriate remedies for continued substandard performance.

(c) Administrative remedies.

(1) At its discretion, HHSC may impose one or more of the following remedies for each item of material noncompliance and will determine the scope and severity of the remedy on a case-by-case basis:

(A) Assess liquidated damages up to $500 per month or portion of the month the MA Health Plan fails to provide a complete copy of the MA Agreement and all amendments, modifications, or changes as required by Section 3.05;

(B) Conduct accelerated monitoring of the MA Health Plan. Accelerated monitoring includes more frequent or more extensive monitoring by HHSC or its agent;

(C) Require additional, more detailed data or reports to be submitted by the MA Health Plan;

(D) Withhold or recoup payment to the MA Health Plan; or

(E) Terminate the Agreement in accordance with Section 7.03.

(2) For purposes of this Agreement, an item of material noncompliance means a specific action of the MA Health Plan that:

(A) Violates a material provision of this Agreement;

(B) Represents a failure of MA Health Plan to be reasonably responsive to a request by HHSC for information, assistance, or support relating to this Agreement within the timeframe specified by HHSC.

(3) HHSC will provide notice to the MA Health Plan of its assessment of an administrative remedy, with the exception of accelerated monitoring, which may be unannounced.

(d) Damages.

(1) HHSC will be entitled to actual or liquidated damages resulting from the MA Health Plan's failure to comply with any of the terms of this Agreement. In some cases, the actual damage to HHSC as a result of the MA Health Plan's failure to meet any aspect of the responsibilities of this Agreement is difficult or impossible to determine with precise accuracy. Therefore, liquidated damages will be assessed in writing against and paid by the MA Health Plan in accordance with Section 7.02(c)(1)(A)–(B). Liquidated damages may be assessed if HHSC determines such failure is the fault of the MA Health Plan (including the MA Health Plan's subcontractors or agents) and is not materially caused or contributed to by HHSC or its agents. If at any time, HHSC determines the MA Health Plan has not met any aspect of the responsibilities of this Agreement due to mitigating circumstances, HHSC reserves the right to waive all or part of the liquidated damages.

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All such waivers must be in writing, contain the reasons for the waiver, and must be signed by the appropriate executive of HHSC.

(2) The liquidated damages prescribed in Section 7.02(c)(1)(A)–(B) are not intended to be in the nature of a penalty; but are intended to be reasonable estimates of HHSC's projected financial loss and damage resulting from the MA Health Plan's nonperformance, including financial loss as a result of project delays. Accordingly, in the event the MA Health Plan fails to perform in accordance with this Agreement, HHSC may assess liquidated damages only as provided in this Article.

(3) If the MA Health Plan fails to perform any of the responsibilities described in this Agreement, HHSC may assess liquidated damages for each occurrence of a liquidated damages event, to the extent consistent with HHSC's tailored approach to remedies and Texas law.

(4) HHSC may elect to collect liquidated damages:

(A) Through direct assessment and demand for payment delivered to the MA Health Plan; or

(B) By deduction of amounts assessed as liquidated damages as set-off against payments then due to the MA Health Plan or that become due at any time after assessment of the liquidated damages. HHSC will make deductions until the full amount payable by the MA Health Plan is received by HHSC.

(e) Equitable Remedies.

(1) The MA Health Plan acknowledges that, if the MA Health Plan breaches its material obligation under this Agreement, HHSC may be irreparably harmed. In such a circumstance, HHSC may proceed directly to court to pursue equitable remedies.

(2) If a court of competent jurisdiction finds that the MA Health Plan breached any such obligations, the MA Health Plan agrees that without any additional findings of irreparable injury or other conditions to injunctive relief, it will not oppose the entry of an appropriate order compelling performance by the MA Health Plan and restraining it from any further breaches.

Section 7.03 Termination.

(a) This Agreement may be terminated by mutual written agreement of the parties.

(b) HHSC may terminate the Agreement in whole or in part and at any time when, in its sole discretion, it determines that termination is in the best interests of HHSC. The termination will be effective on the date specified in HHSC's notice of termination. HHSC will provide the MA Health Plan written notice of this termination at least 30 calendar days prior to the effective date of termination, unless HHSC determines that circumstances warrant a shorter notice period.

(c) In addition to the reasons set forth above or as otherwise provided by the U.S. Bankruptcy Code, or any successor law, HHSC may terminate this Agreement upon the following conditions:

(1) HHSC may terminate this Agreement at any time if a court of competent jurisdiction finds MA Health Plan failed to adhere to any laws, ordinances, rules, regulations, or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of MA Health Plan's duties under this Agreement.

(2) HHSC may terminate this Agreement at any time following the determination by a competent judicial or quasi-judicial authority and MA Health Plan's exhaustion of all legal

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remedies that MA Health Plan, its employees, agents, subcontractors, or representatives have either offered or given anything of value to an officer or employee of HHSC or the State of Texas in violation of state law. For purposes of this Section, a "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes , but is not limited to, cash, food, lodging, entertainment, and charitable contributions. The term does not include contributions to holders of public office or candidates for public office that are paid and reported in accordance with state or federal law.

(3) HHSC may terminate the Agreement if funds for the continued fulfillment of this Agreement by HHSC are at any time not forthcoming or are insufficient, through failure of any entity to appropriate funds or otherwise. HHSC will provide the MA Health Plan written notice of such termination at least 120 calendar days prior to termination, unless circumstances warrant a shorter notice period.

(4) The Parties have the mutual right to terminate the Agreement at any time and in whole or in part if one or the other determines, at each party's sole discretion, that the other party has materially breached the Agreement.

(d) The MA Health Plan may terminate this Agreement by providing HHSC written notice at least 30 calendar days prior to termination. The termination will be effective on the date specified in the MA Health Plan's notice of termination.

(e) In the event of termination pursuant to this Section (7.03), HHSC will pay the PMPM capitation payment for Cost Sharing Obligations incurred through the effective date of termination, provided the MA Health Plan has complied with the submission requirements set forth in Section 3.02(b). All pertinent provisions of the Agreement will form the basis of settlement. This provision will survive the termination of the Agreement.

Article VIII. Dispute Resolution

Section 8.01 General Agreement of the Parties.

The parties mutually agree that the interests of fairness, efficiency, and good business practices are best served when the parties employ all reasonable and informal means to resolve any dispute under this Agreement. The parties express their mutual commitment to using all reasonable and informal means of resolving disputes prior to invoking a remedy provided elsewhere in this Section.

Section 8.02 Duty to Negotiate in Good Faith.

Any dispute that in the judgment of any party to this Agreement may materially or substantially affect the performance of this Agreement will be reduced to writing and delivered to the other party within ten business days. The parties must then negotiate in good faith and use every reasonable effort to resolve such dispute and the parties shall not resort to any formal proceedings unless they have reasonably determined that a negotiated resolution is not possible. The resolution of any dispute disposed of by agreement between the parties shall be reduced to writing and delivered to all parties within ten business days.

Section 8.03 Claims for Breach of Agreement.

(a) *General Requirement.* As required by Tex. Gov't Code Chapter 2260, the MA Health Plan's claim for breach of this Agreement must be resolved in accordance with the dispute resolution process established by HHSC in accordance with Tex. Gov't Code Chapter 2260.

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(b) *Negotiation of Claims*. The parties expressly agree that if the MA Health Plan's claim for breach of this Agreement cannot be resolved by the Parties in the ordinary course of business or through the use of all reasonable and informal means will be submitted to the negotiation process provided in Tex. Gov't Code Chapter 2260, Subchapter B.

(1) To initiate the process, the MA Health Plan must submit written notice to HHSC that specifically states that the MA Health Plan invokes the provisions of Tex. Gov't Code Chapter 2260, Subchapter B. The notice must comply with the requirements of Tex. Gov't Code Chapter 2260, Subchapter B and Tex. Admin. Code-Chapter 392, Subchapter B.

(2) The parties agree that the MA Health Plan's compliance with Tex. Gov't Code Chapter 2260, Subchapter B, will be a condition precedent to the filing of a contested case proceeding under Tex. Gov't Code Chapter 2260, Subchapter C.

(c) *Contested Case Proceedings*. The contested case process provided in Tex. Gov't Code Chapter 2260, Subchapter C, will be the MA Health Plan's sole and exclusive process for seeking a remedy for any and all alleged breaches of contract by HHSC if the parties are unable to resolve their disputes under Section 8.03(b). The parties expressly agree that compliance with the contested case process provided in Tex. Gov't Code Chapter 2260, Subchapter C, will be a condition precedent to seeking consent to sue HHSC from the Texas Legislature under Chapter 107, Texas Civil Practices and Remedies Code. Neither the execution of this Agreement by HHSC nor any other conduct of any representative of HHSC relating to this Agreement will be considered a waiver of HHSC's sovereign immunity to suit.

(d) *HHSC Rules.* The submission, processing, and resolution of MA Health Plan's claim is governed by 1 Tex. Admin. Code Chapter 392, Subchapter B, in addition to the provisions of Tex. Gov't Code Chapter 2260.

(e) *MA Health Plan's Duty to Perform.* Neither the occurrence of an event constituting an alleged breach of contract nor the pending status of any claim for breach of contract is grounds for the suspension of performance, in whole or in part, by the MA Health Plan of any duty or obligation with respect to the performance of this Agreement. Any changes to the Agreement as a result of a dispute resolution will be implemented in accordance with Section 9.05.

Article IX. MISCELLANEOUS PROVISIONS

Section 9.01 Non-Debarment.

The MA Health Plan represents that neither it nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any state or federal healthcare program.

Section 9.02 Severability.

If any provision of the Agreement is for any reason held to be unenforceable, the rest of it remains fully enforceable.

Section 9.03 Successors and Assigns.

This Agreement binds all parties and their respective heirs, personal representatives, and, to the extent permitted by Section 9.04, successors and assigns.

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Section 9.04 Assignment.

(a) The MA Health Plan must not assign all or any portion of its rights under or interests in this Agreement or delegate any of its duties without prior written consent of HHSC. Any written request for assignment or delegation must be accompanied by written acceptance of the assignment or delegation by the assignee or delegation by the delegate. Except where otherwise agreed in writing by HHSC, assignment or delegation will not release the MA Health Plan from its obligations under this Agreement.

(b) The MA Health Plan understands and agrees HHSC may in one or more transactions assign, pledge, or transfer this Agreement. This assignment will only be made to another state agency or a non-state agency that is contracted to perform agency support.

Section 9.05 Modification, Amendment, or Waiver.

This Agreement may only be modified, amended, or waived by mutual written agreement. No course of dealing between the parties will modify, amend, or waive any provision of this Agreement or any rights or obligations of any party under this Agreement.

Section 9.06 Notices.

All notices, consents, requests, instructions, approvals, or other communications provided for in this Agreement will be in writing and delivered by personal delivery, overnight courier, mail, e-mail or electronic facsimile addressed to the receiving party at the address listed in this Section. All communications will be effective when received.

HHSC: Managed Care Compliance & Operations

Shannon Peterson

4900 N Lamar Blvd, Mail Code H-340

Austin, Texas 78751

Fax 512-730-7452

Email CMD_ManagedCareOrganizations@hhs.texas.gov

MA Health Plan: HealthSpring Life & Health Insurance Company, Inc.

Name: Dudley Gerow

Address: 2800 North Loop West

Suite 500

Houston, TX 77092

Fax: 512-590-6077

A party may change the contact information in this Section by giving written notice to the other party.

Section 9.07 Record Retention and Audit.

(a) The MA Health Plan agrees to maintain, and require its subcontractors to maintain, supporting information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state requirements. These documents, including all original claims forms, will be maintained and retained by the MA Health Plan or its subcontractors for a period of ten (10) years after the expiration of the contract period or until the resolution of all litigation, claim, financial management review, or audit pertaining to this Agreement, whichever is longer. The MA Health Plan agrees to timely repay any undisputed audit exceptions taken by HHSC in any audit of the Agreement.

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(b) If HHSC determines that it has overpaid the MA Health Plan, HHSC will provide the MA Health Plan with written notice of the overpayment, including the amount of overpayment and supporting information. The MA Health Plan must promptly pay HHSC the amount of any undisputed overpayment the MA Health Plan owes HHSC, plus interest. Interest on this amount will be calculated from the date of receipt by the MA Health Plan of the undisputed overpaid amount until the date of payment to HHSC, and will be calculated at the Department of Treasury's Median Rate (resulting from the Treasury's auction of 13-week bills) for the week in which liability is assessed. In the event an audit reveals an overpayment caused in whole or in part by the MA Health Plan's, its subcontractors' or agents' error, MA Health Plan must reimburse HHSC for all costs of the audit.

(c) For purposes of this Section 9.07 only, the term "subcontractor" does not include Network Providers.

Section 9.08 SAO Audit.

The MA Health Plan understands that acceptance of funds under this Agreement acts as acceptance of the authority of the State Auditor's Office (SAO), or any successor agency, to conduct an investigation in connection with those funds. The MA Health Plan further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested. The MA Health Plan must ensure that this clause concerning the authority to audit funds received indirectly by subcontractors through MA Health Plan and the requirement to cooperate is included in any subcontract it awards.

Section 9.09 Access to records, books, and documents.

(a) Upon reasonable notice, MA Health Plan must provide, and require its subcontractors to provide, the officials and entities identified in this Section with prompt, reasonable, and adequate access to any records, books, documents, and papers that are directly pertinent to the performance of this Agreement.

(b) MA Health Plan and its subcontractors must provide the access described in this Section upon HHSC's request. This request may be for, but is not limited to, the following purposes: examination; audit; investigation; contract administration; or the making of copies, excerpts, or transcripts.

(c) The access required must be provided to the following officials or entities or their designees: the United States Department of Health and Human Services; the Comptroller General of the United States; HHSC; the HHSC Office of Investigations and Enforcement; the Office of the State Auditor of Texas; Texas or federal law enforcement agencies; a special or general investigating committee of the Texas Legislature; and any other entity identified by HHSC.

(d) MA Health Plan agrees to provide the access described wherever MA Health Plan maintains these books, records, and supporting documentation. MA Health Plan further agrees to provide such access in reasonable comfort and to provide any furnishings, equipment, or other conveniences deemed reasonably necessary to fulfill the purposes described in this Section. MA Health Plan must require its subcontractors to provide comparable access and accommodations.

(e) Upon request, MA Health Plan must provide copies of the information described in this Section free of charge to HHSC and the entities described in subsection (c).

Section 9.10 Governing Law & Venue.

This Agreement is governed by the laws of the State of Texas and interpreted in accordance with Texas law, except to the extent preempted by federal law. Provided the MA Health Plan first complies with

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the procedures set forth in Article VIII, "Dispute Resolution," proper venue for a claim arising from this Agreement will be in a court of competent jurisdiction in Travis County, Texas. Additionally, any equitable remedy pursued by HHSC as referenced in Section 7.02(e) will be filed in a court of competent jurisdiction in Travis County, Texas.

Section 9.11 Publicity.

Except as otherwise required by this Agreement or by law, the MA Health Plan must not use the name of HHSC, the State of Texas, or any other state agency, or refer to HHSC or any state agency directly or indirectly in any media release, public announcement, or public disclosure relating to the Agreement or its subject matter, including in any promotional or marketing materials, customer lists, or business presentations (other than proposals or reports submitted to HHSC, an administrative agency of the State of Texas, or a governmental agency or unit of another state or the federal government).

Section 9.12 Anti-trust.

The MA Health Plan hereby certifies to HHSC that neither the MA Health Plan, nor the person represented by the MA Health Plan, nor any person acting for the represented person, has been found by a judgment of a court of law to have violated the anti-trust laws codified by Chapter 15, Texas Business and Commerce Code, or the federal anti-trust laws.

Section 9.13 CMS Approval.

This Agreement is subject to, and conditioned upon, CMS' approval of a Texas State Plan Amendment governing the use of a capitated fee arrangement with MA Health Plan's to satisfy HHSC's Cost Sharing Obligations.

Section 9.14 Requests for public information.

(a) HHSC agrees to promptly notify the MA Health Plan of a request for disclosure of information filed in accordance with the Texas Public Information Act, Tex. Gov't Code Chapter 552, that consists of information identified by the MA Health Plan as "confidential information," including information to which the MA Health Plan believes it has a proprietary or commercial interest. HHSC will deliver a copy of the request for public information to the MA Health Plan.

(b) With respect to any information that is the subject of a request for disclosure, the MA Health Plan is required to demonstrate to the Texas Office of Attorney General the specific reasons why the requested information or data is confidential or otherwise excepted from required public disclosure under law. The MA Health Plan must provide the HHSC point-of-contact identified in Section 9.06 with copies of all communications made under this section.

(c) The MA Health Plan must make information defined as public information not otherwise excepted from disclosure under the Texas Public Information Act, Tex. Gov't Code Chapter 552 available to HHSC in a format agreeable to HHSC, accessible by the public, and at no additional charge to HHSC.

(d) To the extent authorized under the Texas Public Information Act, HHSC agrees to safeguard from disclosure information received from the MA Health Plan that the MA Health Plan identifies as confidential information. The MA Health Plan must clearly mark such information as confidential information or provide written notice to the HHSC point-of-contact identified in Section 9.06 that it considers the information confidential and must explain why the information is confidential under the recognized exceptions of the Texas Public Information Act.

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Section 9.15 Privacy, Security, and Breach Notification

(a). "HHS Confidential Information" means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to the MA Health Plan or that the MA Health Plan may create, receive, maintain, use, disclose or have access to on behalf of HHS that consists of or includes any or all of the following:

(1) Dual Eligible Information;

(2) Protected Health Information, as defined by HIPAA, in any form including without limitation, Electronic Protected Health Information or Unsecured Protected Health Information;

(3) Sensitive Personal Information defined by Texas Business and Commerce Code Ch. 521;

(4) Federal Tax Information;

(5) Personally Identifiable Information;

(6) Social Security Administration Data, including, without limitation, Medicaid information;

(7) All privileged work product of HHS;

(8) All information designated as confidential under the constitution and laws of the State of Texas and of the United States, including the Texas Health & Safety Code and the Texas Public Information Act, Texas Government Code, Chapter 552.

(b). Any HHS Confidential Information received by the MA Health Plan in performing services under this Agreement may be disclosed only in accordance with applicable law and this Agreement. By signing this agreement, the MA Heath Plan certifies that the MA Health Plan is, and intends to remain for the term of this agreement, in compliance with all applicable state and federal laws and regulations with respect to privacy, security, and breach notification, including without limitation, the following:

(1) The relevant portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 42 U.S.C. Chapter 7, Subchapter XI, Part C;

(2) 42 CFR Part 2 and 45 CFR Parts 160 and 164;

(3) The relevant portions of The Social Security Act, 42 U.S.C. Chapter 7;

(4) The Privacy Act of 1974, as amended by the Computer Matching and Privacy Protection Act of 1988, 5 U.S.C. § 552a;

(5) Internal Revenue Code, Title 26 of the United States Code including IRS Publication 1075;

(6) OMB Memorandum 07-18;

(7) Texas Business and Commerce Code Chapter 521;

(8) Texas Health and Safety Code Chapters 81, 181 and 611;

(9) Texas Human Resources Code § 12.003;

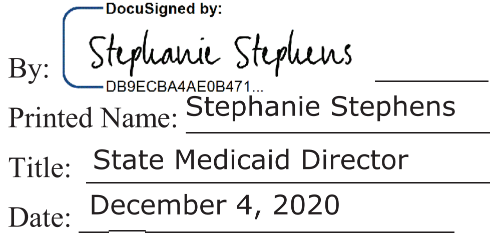
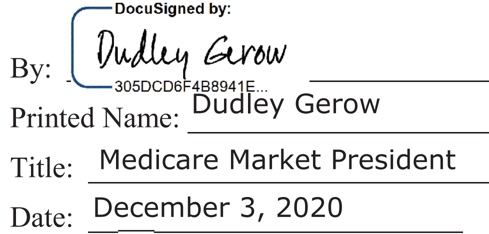
(10) Title 3 of the Texas Occupations Code, as applicable;

(11) Constitutional and common law privacy; and

(12) Any other applicable law controlling the release of information created or obtained in the course of providing the services described in the Agreement.

The MA Health Plan further agrees to comply with all amendments, regulations, and guidance relating to those laws, to the extent applicable.

This Agreement is executed by the parties in their stated capacities below.

HEALTH AND HUMAN SERVICES COMMISSION	MEDICARE ADVANTAGE HEALTH PLAN
By:  DocuSigned by: Stephanie Stephens DB9ECBA4AE0B471...	By:  DocuSigned by: Dudley Gerow 305DCD6F4B8941E...
Printed Name: Stephanie Stephens	Printed Name: Dudley Gerow
Title: State Medicaid Director	Title: Medicare Market President
Date: December 4, 2020	Date: December 3, 2020

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ATTACHMENT A— PROPOSED MA PRODUCT SERVICE AREAS

CMS Contract Code	Contract Name	Plan ID	Plan Name	Proposed Service Areas (List All Counties to be Served by Name)	Partial Counties to be Served (List By Name and ZIP Code)
H4513	Cigna Fundamental Medicare (HMO)	H4513-009	Cigna Fundamental Medicare (HMO)	Angelina, Brazoria, Cameron, Chambers, Fort Bend, Galveston (Full), Hardin, Harris, Hidalgo, Jasper, Jefferson, Liberty, Montgomery, Nacogdoches, Newton, Orange, Polk, San Jacinto, Tyler, Walker, Waller, Webb, Willacy	n/a
H4513	Cigna Fundamental Medicare (HMO)	H4513-062	Cigna Fundamental Medicare (HMO)	Atascosa, Bandera, Bexar, El Paso, Guadalupe, Kendall, Wilson	n/a
H4513	Cigna Preferred Medicare (HMO)	H4513-061	Cigna Preferred Medicare (HMO)	Angelina, Atascosa, Bandera, Bexar, Brazoria, Chambers, Fort Bend, Galveston (Full), Guadalupe, Hardin, Harris, Jasper, Jefferson, Kendall, Liberty, Montgomery, Nacogdoches, Newton, Orange, Polk, San Jacinto, Tyler, Walker, Waller, Wilson, Cameron, Hidalgo,Webb, Willacy, El Paso	n/a
H4513	Cigna Preferred Medicare (HMO)	H4513-026	Cigna Preferred Medicare (HMO)	Henderson, Rusk, Smith, Upshur, Van Zandt	n/a
H4513	Cigna Preferred Medicare (HMO)	H4513-028	Cigna Preferred Medicare (HMO)	Bexar, Collin, Dallas, Denton, Hood, Johnson, Parker, Tarrant, Wise	n/a

DocuSign Envelope ID: 691EE5F6-4042-48FA-9EA4-31B7EA33E057

H7787	Cigna Preferred Medicare (PPO)	H7787-001	Cigna Preferred Medicare (PPO)	Collin, Dallas, Denton, Johnson, Tarrant	n/a
H7787	Cigna Fundamental Medicare (PPO)	H7787-002	Cigna Fundamental Medicare (PPO)	Collin, Dallas, Denton, Johnson, Tarrant	n/a
H7849	Cigna True Choice Medicare (PPO)	H7849-038	Cigna True Choice Medicare (PPO)	Fort Bend, Galveston, Harris, Liberty, Montgomery, Walker	n/a
H7849	Cigna True Choice Medicare (PPO)	H7849-039	Cigna True Choice Medicare (PPO)	Cameron, Hidalgo, Willacy	n/a
H7849	Cigna True Choice Medicare (PPO)	H7849-040	Cigna True Choice Medicare (PPO)	Dallas, Denton, Parker, Johnson, Rusk, Smith, Tarrant, Upshur, Van Zandt, Wise	n/a
H7849	Cigna True Choice Medicare (PPO)	H7849-041	Cigna True Choice Medicare (PPO)	El Paso	n/a
H4513	Cigna-HealthSpring Preferred Rx CY (HMO)	H4513-804	Cigna-HealthSpring Preferred Rx CY (HMO)	Statewide	n/a

ATTACHMENT B – TEXAS MEDICAID SUMMARY OF BENEFITS

Texas Medicaid covers the following benefits if the Member meets all applicable requirements.

Benefit Category	Texas Medicaid
Ambulance Services (medically necessary ambulance services)	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Assistive Communication Devices (also known as Augmentative Communication Device (ACD) System)	For Members who meet the criteria, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Bone Mass Measurement (for people who are at risk)	Bone density screening is a benefit of Texas Medicaid. For Members who meet the criteria, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Cardiac Rehabilitation	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted $0 co-pay for Medicaid-covered services
Chiropractic Services	Chiropractic manipulative treatment (CMT) performed by a chiropractor licensed by the Texas State Board of Chiropractic Examiners is a benefit of Texas Medicaid. Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Colorectal Screening Exams (for people aged 50 and older)	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Dental Services (for people who are 20 years of age or younger; or 21 years of age or older in an ICF-IID)	For Members who meet the criteria, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Diabetic Supplies (includes coverage for test strips, lancets, and screening tests)	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services

Benefit Category	Texas Medicaid
Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Doctor and Hospital Choice	Members should follow Medicare guidelines related to hospital and doctor choice.
Doctor Office Visits	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Durable Medical Equipment (includes wheelchairs, oxygen)	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Emergency Care (Any emergency room visit if the member reasonably believes he or she needs emergency care.)	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
End-Stage Renal Disease	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Health/Wellness Education (nutritional counseling for children, smoking cessation for pregnant women, and adult annual exam)	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Hearing Services	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, private duty nursing services, and personal care services)	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services

Benefit Category	Texas Medicaid
Hospice	Medicaid pays for this service for certain Waiver Members if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services *Note: When adult clients elect hospice services, they waive their rights to all other Medicaid services related to their terminal illness. They do not waive their rights to Medicaid services unrelated to their terminal illness.*
Immunizations	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Inpatient Hospital Care	Inpatient hospital stays are a covered benefit. Medicaid pays coinsurance, co-payments, and deductibles for Medicare covered services. Members should follow Medicare guidelines related to hospital choice. $0 co-pay for Medicaid-covered services
Inpatient Mental Health Care	Inpatient psychiatric hospital stays are a covered benefit for Members under the age 21, and Members 65 years of age and older. Inpatient acute care hospital stays for psychiatric treatment are a covered benefit for Members 21 through 64 years of age, in accordance with 42 CFR §438.6(e), although Medicaid MCOs may choose to cover stays at psychiatric facilities in lieu of acute care hospitals. Medicaid pays coinsurance, co-payments, and deductibles for Medicare covered services. Members should follow Medicare guidelines related to hospital choice. $0 co-pay for Medicaid-covered services
Mammograms (Annual Screening)	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Monthly Premium	Medicaid assistance with premium payment may vary based on your level of Medicaid eligibility.
Orthotic and Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	For Members birth through age 20 (CCP), Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. Medicaid pays for breast prostheses for Members of all ages if not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services

Outpatient Mental Health Care	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Benefit Category	**Texas Medicaid**
Outpatient Rehabilitation Services	For Members birth through age 20, Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Outpatient Services/Surgery	Medicaid pays for certain surgical services if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Outpatient Substance Use Disorder (assessment, ambulatory treatment/detox, and MAT)	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Pap Smears and Pelvic Exams (for women)	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Podiatry Services	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Prescription Drugs	Medicaid pays for this service if it is not covered by Medicare. Medicaid will not cover any Medicare Part D drug.
Prostate Cancer Screening Exams	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Skilled Nursing Facility (SNF) (in a Medicare-certified Skilled Nursing Facility)	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Telemedicine Services	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Transportation (routine)	The Medicaid Medical Transportation Program (MTP) provides non-emergency transportation, if it is not covered by Medicare. $0 co-pay for Medicaid-covered services

Benefit Category	Texas Medicaid
Urgently Needed Care (this is NOT emergency care, and in most cases, is out of the service area)	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services
Vision Services	Medicaid pays for this service if it is not covered by Medicare or when the Medicare benefit is exhausted. $0 co-pay for Medicaid-covered services Services by an optician are limited to fitting and dispensing of medically necessary eyeglasses and contact lenses.

HOME AND COMMUNITY BASED WAIVER SERVICES	
Those who meet QMB requirements and also meet the financial criteria for full Medicaid coverage, may be eligible to receive all Medicaid services not covered by Medicare, including Medicaid waiver services. Waiver services are limited to individuals who meet additional Medicaid waiver eligibility criteria.	
Community Living Assistance and Support Services (CLASS) Waiver	Information on waiver services and eligibility for this waiver can be found on the following Texas Health and Human Services webpage. https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/community-living-assistance-support-services-class. For additional information, contact the Texas Health and Human Services Commission (HHSC).
Deaf Blind with Multiple Disabilities Waiver (DBMD)	Information on waiver services and eligibility for this waiver can be found on the following Texas Health and Human Services webpage. https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/deaf-blind-multiple-disabilities-dbmd. For additional information, contact the Texas Health and Human Services Commission (HHSC).
Home and Community Services (HCS) Waiver	Information on waiver services and eligibility for this waiver can be found on the following Texas Health and Human Services webpage. https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/home-community-based-services-hcs. For additional information, contact the Texas Health and Human Services Commission (HHSC).
Medically Dependent Children Program (MDCP)	Information on waiver services and eligibility for this waiver can be found on the following Texas Health and Human Services webpage. https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/medically-dependent-children-program-mdcp. For additional information, contact the Texas Health and Human Services Commission (HHSC).

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STAR+PLUS Program (operating under the Texas Healthcare Transformation and Quality Improvement Program Waiver)	Information on waiver services and eligibility for this waiver can be found on the following Texas Health and Human Services webpage/ https://hhs.texas.gov/services/health/medicaid-chip/programs/starplus. For additional information, contact the Texas Health and Human Services Commission (HHSC).
Texas Home Living Waiver (TxHmL)	Information on waiver services and eligibility for this waiver can be found on the following Texas Health and Human Services webpage. https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/texas-home-living-txhml. For additional information, contact the Texas Health and Human Services Commission (HHSC).