CONTRACT FOR

MEDICAL SERVICES AND COVERAGE

BETWEEN FLORIDA HEALTHY KIDS CORPORATION

AND

SOUTH FLORIDA COMMUNITY CARE NETWORK, LLC D/B/A COMMUNITY CARE PLAN

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Contract to Provide Medical Services and Coverage

This Contract is entered into between the Florida Healthy Kids Corporation ("FHKC"), a Florida not-for-profit corporation, pursuant to Chapter 617 and Section 624.91, Florida Statutes, and South Florida Community Care Network, LLC d/b/a Community Care Plan ("Insurer") (each a "Party" and collectively, the "Parties") to provide medical services and coverage, and supersedes all prior contracts, negotiations, representations or agreements either written or oral between the Parties relating to this Contract.

Section 1 Definitions and Acronyms

1-1 Definitions

The capitalized terms used in this Contract shall have the meanings ascribed in this section unless otherwise expressly stated.

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care, or Enrollee practices that result in unnecessary cost to the Program.

Act: The Social Security Act.

Adverse Benefit Determination: the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by FHKC; the failure of Insurer to act within the timeframes required by law for standard resolution of Grievances and Appeals; and the denial of an Enrollee's request to dispute a financial liability, including cost sharing, Copayments, premiums and other Enrollee financial liabilities.

After-hours Services: outpatient medical services that are not Emergency Services and are provided at a time other than Monday through Friday, 8:00 a.m. to 5:00 p.m.

Agency for Health Care Administration: the lead state agency for Title XXI of the Act for purposes of receipt of federal funds, reporting and for ensuring compliance with federal and state regulations and rules.

Appeal: a review by Insurer of an Adverse Benefit Determination.

Applicant: a parent or guardian of a child or a child whose disability of nonage had been removed under Chapter 743, Florida Statutes, who applies for determination of eligibility for health benefits coverage under Sections 409.810-820, Florida Statutes.

Centers for Medicare and Medicaid Services: the federal agency responsible for administering the Children's Health Insurance Program.

Children's Medical Services Managed Care Plan (CMS Plan): the statewide managed care system for children with special health care needs component of Florida's CHIP.

Contract Year: January 1st through December 31st.

Confidential Information: any portion of any documents, data, or records that is considered to be confidential, trade secret, proprietary, or otherwise not subject to disclosure pursuant to Chapter 119, Florida Statutes, the Florida Constitution or other authority.

Copayment or **Copay:** a specified dollar amount that is an Enrollee's financial responsibility to a Provider for Covered Services at the time of receipt of services.

Corrective Action Plan: a step-by-step plan of action, including estimated dates of completion, developed and implemented to appropriately address errors or deficiencies in Insurer's policies, processes, or other work under this Contract.

Coverage Month: the calendar month in which benefits and services may be provided to Enrollees.

Covered Services: Benefits and services covered under this Program applicable to this Contract as described in Attachment A.

Effective Date: January 1, 2020; the date on which Insurer commences performance of medical services and coverage to Enrollees.

Emergency Medical Condition: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

b. Serious impairment to bodily functions.

c. Serious dysfunction of any bodily organ or part.

Emergency Services: covered inpatient and outpatient services that are as follows:

a. Furnished by a provider that is qualified to furnish these services under Title 42.

b. Needed to evaluate or stabilize an Emergency Medical Condition.

Enrollee: an individual enrolled in Insurer's Florida Healthy Kids plan.

Execution Date: the date on which the last Party to this Contract

signed.

Florida KidCare: the health benefits program administered through Section 409.813, Florida Statutes.

Fraud: an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes Fraud under applicable federal or state law.

Full-pay Plan: the non-Title XXI Florida Healthy Kids health insurance coverage available to children ages five (5) through the end of age eighteen (18) who are ineligible for subsidized Florida Healthy Kids coverage but are otherwise eligible for health benefits established by FHKC.

Grievance: an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee's rights regardless of whether remedial action is requested. Grievances also include an Enrollee's right to dispute an extension of time proposed by Insurer to make an authorization decision.

HIPAA: As may from time-to-time may be amended, the (i) Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, including its Omnibus Rule; (ii) applicable provisions of the Health Information Technology for Economic and Clinical Health Act as incorporated in the American Recovery and Reinvestment Act of 2009; and (iii) their accompanying regulations, including the Privacy Rule (as defined herein) and the Security Rule (as defined herein). "Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR, part 160 and part 164, subparts A and E, providing for Federal privacy protections for an individual's protected health information ("PHI") held by entities subject to HIPAA requirements (each, a "Covered Entity") and describing patient rights with respect to their PHI. "Security Rule" means HIPAA Security Standards (45 C.F.R. Parts 160, 162, and 164).

Invitation to Negotiate: ITN 2018-300-01 Medical Services and Coverage, and all addenda, issued by FHKC to competitively procure this Contract.

Marketing: communication from Insurer or Insurer's employees, network Providers, agents or Subcontractors that can reasonably be interpreted as intended to influence an individual who is not enrolled with Insurer to enroll in Insurer's particular Florida Healthy Kids product or to not enroll in or disenroll from another insurer's Florida Healthy Kids product.

Medically Necessary or **Medical Necessity:** the use of any medical treatment, service, equipment or supply necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity and which is:

a. Consistent with the symptom, diagnosis and treatment of the Enrollee's condition;

b. Provided in accordance with generally accepted standards of medical practice;

c. Not primarily intended for the convenience of the Enrollee, the Enrollee's family or the health care Provider;

d. The most appropriate level of supply or service for the diagnosis and treatment of the Enrollee's condition; and

e. Approved by the appropriate medical body or health care specialty involved as effective, appropriate and essential for the care and treatment of the Enrollee's condition.

The fact that a Provider has prescribed, recommended, or approved a medical treatment, service, equipment, or supply does not in itself make such medical treatment, service, equipment, or supply Medically Necessary.

Medical Services: those services, medical equipment and supplies to be provided by Insurer in accordance with the standards set by FHKC and further described in Attachment A.

Notice: formal notification from one Party to another as required in section 31 of this Contract.

Out-of-pocket Maximum: an Enrollee’s maximum financial responsibility for Covered Services, including premiums paid, during a Title XXI Enrollee’s 12-month continuous eligibility period or, not including premiums paid, during a plan year for a Full-pay Enrollee.

Ownership Interest: the possession of equity in the capital, the stock or the profits of a disclosing entity, as defined in 42 CFR 455.101.

Ownership or Control Interest: a person (individual or corporation) that:

a. Has an Ownership Interest totaling five percent (5%) or more in a disclosing entity;

b. Has an indirect Ownership Interest equal to five percent (5%) or more in a disclosing entity;

c. Has a combination of direct Ownership Interest and indirect Ownership Interest equal to five percent (5%) or more in a disclosing entity;

d. Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity if that interest equals at least five percent (5%) of the value of the property or assets of the disclosing entity;

e. Is an officer or director of a disclosing entity that is organized as a corporation; or

f. Is a partner in a disclosing entity that is organized as a partnership.

Personally Identifiable Information: information that can be used to distinguish or trace an individual’s identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual.

Primary Care Provider: A network Provider who furnishes primary care services to an Enrollee and who is board-certified in pediatrics or family medicine or has an exemption from the board-certification standard from FHKC.

Post-stabilization Care Services: Covered Services related to an Emergency Medical Condition that are provided after an Enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the Enrollee's condition pursuant to 42 CFR 422.113.

Program: the Florida Healthy Kids Title XXI authorized Children's Health Insurance Program ("CHIP") and the Full-pay Plan administered by FHKC as created by and governed under Section 624.91, Florida Statutes, and related state and federal laws.

Protected Health Information: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium except for individually identifiable health information:

a. In education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g;

b. In records described at 20 U.S.C. 1232g(a)(4(B)(iv);

c. In employment records held by a covered entity (under HIPAA) in its role as employer; and

d. Regarding a person who has been deceased for more than fifty (50) years.

Providers: an appropriately licensed individual or entity providing health care services.

Renewal: additional Contract period(s) after the initial Contract term.

Region: any of the eleven (11) geographical areas designated by FHKC and encompassing specified Florida counties pursuant to Section 409.966, Florida Statutes.

Service Area: the designated Region(s) for which Insurer is authorized by the Contract to provide Covered Services to those Enrollees whose home address is located in such Region(s).

Subcontractor: any individual or entity with whom Insurer has a written agreement that relates directly or indirectly to the performance of Insurer's obligations under this Contract. The term Subcontractor includes subsidiaries and affiliates. A network Provider is not a Subcontractor by virtue of the network provider agreement with Insurer.

Subcontract: a contract or other written agreement between Insurer and a Subcontractor or proposed Subcontractor.

Waste: overuse of services or other practices that, directly or indirectly, result in unnecessary costs to the Program, generally caused by the misuse of resources rather than criminally negligent actions.

1-2 Acronyms

Acronyms commonly used in this Contract shall have the meanings ascribed in this section unless otherwise expressly stated.

AHCA: Agency for Health Care Administration

BAA: Business Associate Agreement

CAHPS®: Consumer Assessment of Healthcare Providers and Systems

CAP: Corrective Action Plan

CMS: Centers for Medicare and Medicaid Services

CHIP: Children's Health Insurance Program

CHIPRA: Children's Health Insurance Program Re-Authorization Act of 2009

COOP: Continuity of Operations Plan

EQR: External Quality Review

EQRO: External Quality Review Organization

HHS: U.S. Department of Health and Human Services

IRO: Independent Review Organization

ITN: Invitation to Negotiate

MLR: Medical Loss Ratio

PCP: Primary Care Provider

PHI: Protected Health Information

PII: Personally Identifying Information

PMPM: Per member (i.e., Enrollee) per month

Title XXI: Children's Health Insurance Program

Section 2 Entire Agreement

This Contract contains all terms and conditions agreed upon by the Parties relating to the subject matter of this Contract and supersedes all other agreements, negotiations,

understanding, or representations, verbal or written, between the Parties relative to the subject matter hereof.

2-1-1 Attachments

All attachments to this Contract are hereby incorporated into the Contract by reference.

2-1-2 Modification of Terms

This Contract may be amended by mutual written consent of the Parties at any time.

The terms of this Contract shall be automatically modified without a written agreement to the extent necessary to comply with federal or state laws or regulations.

The terms of this Contract shall be automatically modified without a written agreement to the extent necessary to comply with the requirements of FHKC's contract with the Agency for Health Care Administration (AHCA) upon FHKC's Notice to Insurer.

2-2 Hierarchy of Documents

In the event of conflict among the Contract documents, the order of precedence is as follows:

a. This contract document

b. The attachments to this Contract

c. ITN 2018 300-01 including all addenda, in reverse order of posting by date on the Florida Healthy Kids website

d. Insurer's best and final offer to ITN 2018 300-01

e. Insurer's response to ITN 2018 300-01

In the event the terms of this Contract conflict with federal or state laws or regulations, the federal or state laws or regulations prevail.

2-3 Rules of Interpretation

This Contract is and shall be deemed jointly drafted and written by all Parties to it and shall not be construed or interpreted against the Party originating or preparing it.

Unless otherwise indicated or required by context, the following rules of interpretation apply:

a. All references to a section or attachment are to a section or attachment of this Contract;

b. The term "section" includes subsections, as indicated by the text;

c. The table of contents and section headings are for reference purposes only and do not limit or affect the meaning or interpretation of the text;

d. All singular terms include the plural and all plural terms include the singular;

e. Masculine, feminine and neutral gender terms include all genders;

f. The word “include” and its derivations are deemed to be followed by the phrase “but not limited to”;

g. Reference to a governmental entity or person includes the authorized successors and assigns of the governmental entity or person; and

h. Reference to a federal or state law or regulation includes the federal or state law or regulation as amended or replaced.

Section 3 Contract Term; Service Area; Compensation

3-1 Term

3-1-1 Initial Term

The initial term of this Contract is five (5) years beginning on January 1, 2020 and ending after 11:59 P.M. on December 31, 2024 unless extended, terminated or renewed.

3-1-2 Renewal Term

FHKC may elect to renew this Contract beyond the initial term for up to four (4), one (1) -year Renewal terms. FHKC may exercise the Renewal options of this Contract either in whole or in part.

3-2 Service Area

Insurer’s Service Area comprises the following Regions:

Regions nine (9), ten (10), and eleven (11)

3-3 Compensation

Insurer agrees to perform all obligations under this Contract for the compensation and financial arrangements set forth in this Contract. No additional compensation shall be allowed unless specifically agreed upon in writing by the Parties.

3-3-1 Payments to Insurer

FHKC shall make payments under this Contract monthly in accordance with the enrollment information maintained by FHKC’s system of record. Premiums are paid per Enrollee per month (PMPM) for the Enrollee’s Region of residency. Insurer shall not invoice or bill FHKC.

FHKC will provide Insurer the total authorized premiums for the enrollment month and any retroactive enrollment changes no later than the twentieth (20th) day of the enrollment month. Retroactive disenrollments will be netted out from the active and retroactive enrollments.

FHKC reserves the right to delay premium payment without change in enrollment or any of Insurer's obligations under this Contract when such payment delay is the result of any act described in Section 14 Force Majeure, changes to Florida's CHIP State Plan or other temporary shortfalls resulting from mitigating actions for an emergency or urgent situation. In the event of such delay, FHKC shall act in good faith in resolving and making the delayed premium payments to Insurer.

Insurer shall only retain premium payments for Enrollees for the applicable Coverage Month. Premium payments made for individuals determined to be ineligible for coverage or who are otherwise disenrolled from Insurer's plan for the Coverage Month shall be returned to FHKC.

3-3-1-1Advanced Funds

Insurer agrees to use advanced funds only for the purposes identified under this Contract, if any.

3-3-1-2Overpayments to Insurer

Insurer shall return any overpayments due to unearned or disallowed funds that were paid under this Contract to FHKC within forty-five (45) Calendar Days of identification by either Party.

3-3-1-3Appropriations

FHKC's ability and obligation to make payment for services performed under this Contract is contingent upon annual appropriation from the Florida Legislature and federal CHIP funding.

3-3-2 Premiums

Effective January 1, 2020, the premium paid to Insurer shall be as follows:

Region	Title XXI Enrollee Premium	Full-pay Enrollee Premium	ACA Fee Rate Component
9	$133.41	$205.00	0.00%
10	$125.60	$205.00	0.00%
11	$147.35	$205.00	0.00%

3-3-3 Premium Rate Modifications

3-3-3-1 Health Insurance Providers Fee

In the event Insurer is subject to the health insurance providers fee set forth in section 9010 of the Patient Protection and Affordance Care Act (the "ACA fee") and a suspension or moratorium is enacted for the fee thirty (30) Calendar Days or more before the beginning of a rate period, the premium rate charged for that rate period shall be the premium less the "ACA fee rate component" identified in section 3-3-2. In the event a suspension or moratorium is

enacted for the ACA fee less than thirty (30) Calendar Days before the beginning of a rate period, the premium rate charged for that rate period shall be the premium less the ACA fee rate component; however, FHKC may pay Insurer the premium including the ACA fee rate component during the rate period for an amount of time sufficient to allow FHKC to update its systems with the new rates. Insurer shall refund FHKC the ACA fee rate component for the period of time the ACA fee component was paid by FHKC and the moratorium or suspension was in effect. Insurer shall provide the refund in a manner and timeframe specified by FHKC.

3-3-3-2 Annual Premium Rate Adjustment Requests

Insurer shall provide an annual premium rate adjustment request for the upcoming Contract Year to FHKC by July 1 of each year unless there are no additional Renewal years available under the Contract or this provision is otherwise waived by FHKC. In the annual premium rate adjustment request, Insurer may request to reduce premium rates, make no change to premium rates, increase premium rates or any combination thereof for the Regions in Insurer's Service Area.

Failure to comply with the requirements of section 3-3-3 may result in the denial of a premium rate adjustment request without recourse at FHKC's sole discretion.

A. Service Area

The premium rate adjustment request shall be inclusive of Insurer's Service Area. Insurer shall provide a premium rate adjustment for each Region in Insurer's Service Area in the premium rate adjustment request. The health insurance provider's fee provided for in section 9010 of the Act shall be incorporated into any rate adjustment request according to its applicability to the specific months in the rating period.

B. Timeframe

The premium rate adjustment request applies to an entire Contract year and to all of Insurer's Enrollees in a Region. Premium rates shall not:

a. Include planned mid-plan year premium rate changes;

b. Require different premium rates based on when an Enrollee enrolls with Insurer;

c. Require different premium rates based on an Enrollee's age;

d. Require different premium rates based on an Enrollee's sex; or

e. Be discriminatory in any way.

C. Offshoring

Insurer shall not consider any claims paid to a network Provider, out-of-network Provider, Subcontractor, or financial institution located outside the United States in the development of actuarially sound rates.

D. Actuarial Soundness

Insurer shall provide an actuarial memorandum supporting the premium rate adjustment request. The actuarial memorandum shall include the information and level of detail required by FHKC.

The proposed premium rates shall:

a. Be consistent with actuarially sound principles as required by 42 CFR 457.1203;

b. Not be excessive nor inadequate in accordance with the applicable requirements of Chapter 409, Florida Statutes; and

c. Be designed to reasonably achieve a medical loss ratio (MLR) standard for the Contract year that is at least equal to the greater of eighty-five percent (85%) or the target MLR implicit in Insurer's best and final offer in response to the ITN and provide for reasonable administrative costs in accordance with 42 CFR 457.1203, Section 624.91, Florida Statutes, and section 9-5 of this Contract.

E. Rights and Responsibilities

FHKC may choose to provide Insurer with available trend information that FHKC may utilize when reviewing the premium rate adjustment request.

FHKC may initiate and enter into premium rate adjustment negotiations following Insurer's rate adjustment request submission. FHKC maintains the right to deny a rate adjustment request, require Insurer decrease rates or require Insurer hold rates flat based on the data provided by Insurer, FHKC's analysis, and other relevant factors as determined by FHKC.

Insurer shall respond to FHKC's requests for additional or clarifying information during the premium rate adjustment review process.

F. Premium Rate Adjustment Approval

Any changes to the premium rates must be approved by FHKC's Board of Directors. Premium rate adjustments are also subject to the maximum average rate adjustment recommended by the Social Services Estimating Conference and approval by the Florida Legislature and Governor.

3-3-3-3 Benefit Schedule Change Premium Rate Adjustments

Changes in federal and state law may require changes to the benefit schedule during the Contract term.

FHKC shall notify Insurer of the required change in writing. Insurer may submit a premium rate adjustment request to accommodate the change within thirty (30) Calendar Days of receipt of notice. The premium rate adjustment request must comply with section 3-3-3-2(A)-(F).

If the benefit schedule change results in a reduction in coverage or increases Enrollee cost sharing, FHKC may require that Insurer reduce its premium rate by an amount actuarially equivalent to the benefit reduction.

3-3-3-4 Other Premium Rate Adjustments

Changes in federal law, state law, FHKC policy, or to this Contract may have a substantial cost impact during the Contract Year. FHKC shall notify Insurer of the required change in writing. Insurer may submit a premium rate adjustment request to accommodate the change within thirty (30) Calendar Days of receipt of the notice or as otherwise required by FHKC. The premium rate adjustment request must comply with section 3-3-3-2(A)-(F).

Section 4 Insurer Organization Administration

4-1 Independent Contractor

Insurer performs work under this Contract as an independent contractor and not as an agent, representative or employee of FHKC. Neither Party has the authority to make any representation, warranty or binding commitment on behalf of the other Party, except as expressly provided in this Contract or as otherwise agreed to in writing by the Parties.

4-2 Assignment

Insurer shall not assign this Contract or any of Insurer's obligations under the Contract without prior written consent of FHKC. Any purported assignment without consent is void. Approval of such assignment by FHKC shall not be deemed to provide for the incurrence of any obligation of FHKC in addition to the amount agreed upon in this Contract.

In the event of an assignment, Insurer shall comply with all transition provisions set forth in Section 12-6.

At least one hundred twenty (120) Calendar Days prior to the earlier of (i) the anticipated effective date of an assignment or (ii) the anticipated effective date of a merger or acquisition for which assignment of this Contract is required under Section 4-5, Insurer shall provide FHKC with the transition plan required in Section 12-6.

Failure to comply with this section renders this Contract subject to termination under Section 34-4. The resulting damages of any such failure will not be readily ascertainable, entitling FHKC to liquidated damages in an amount of $250,000 per Region. These liquidated damages are intended only to cover FHKC's internal staffing and administrative costs as well as the diminished value of services provided under the Contract and will not preclude FHKC from recovering other damages it may suffer as a result of such violation.

4-3 Warranty of Security; No Offshoring

Insurer shall be located and conduct all obligations under this Contract within the United States. Additionally, Insurer shall not send, store or allow access to Florida Healthy Kids data outside the United States.

Insurer agrees that a violation of this section will result in immediate and irreparable harm to FHKC and entitles FHKC to a credit in the amount of fifty thousand dollars ($50,000). This credit is intended only to cover FHKC's internal staffing and administrative costs as well as the diminished value of services provided under the Contract and will not preclude FHKC from recovering other damages it may suffer as a result of such violation. For purposes of determining damages due hereunder, a group of violations relating to a common set of operative facts (e.g., same location, same time period, same offshore entity) will be treated as a single event. These liquidated damages are exclusive of any other right to damages, are not intended to be a penalty, and are solely intended to compensate for unknown and unascertainable damages.

A violation of this provision will also entitle FHKC to recover any damages arising from a breach of this section and may result in the termination of this Contract.

Insurer shall provide an annual certification attesting compliance with the warranty of security.

4-4 Ownership and Control

4-4-1 Prohibited Affiliations

Insurer may not have a relationship with the following:

a. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

b. An individual who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described above.

For this provision, relationship is defined as any of the following:

a. A director, officer, or partner of Insurer;

b. A person with beneficial ownership of five percent (5%) of more of Insurer's equity;

c. A network Provider or person with an employment, consulting or other arrangement with Insurer for the provision of items and services that are significant and material to Insurer's obligations under its contract with FHKC or the State; or

d. A Subcontractor.

Insurer understands that failure to comply with this provision is subject to 42 CFR 457.1285, which incorporates 42 CFR 438.610(d).

Insurer shall submit an annual disclosure of any prohibited affiliations to FHKC.

Insurer shall conduct, for any of its employed or subcontracted personnel or entities provided health care, administrative or management services under this Contract, appropriate screening for debarment, ineligibility or exclusion from participation in Medicare, Medicaid, CHIP and any other government health care program. Insurer shall submit a certification to FHKC regarding debarment, suspension, ineligibility and exclusion, as provided by FHKC, at the time of Contract Execution. Such certification attests that neither Insurer nor any of its owners, directors, officers, employees, Subcontractors or Providers is presently debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in the Contract by any federal agency. Insurer shall also require each of its Subcontractors to sign a copy of the certification.

4-4-2 Public Entity Crimes

In accordance with Section 287.017, Florida Statutes, a person or affiliate who has been placed on the convicted vendor list following a conviction for public entity crime may not be awarded or perform work as a contractor, supplier, Subcontractor, or consultant for thirty-six (36) months from the date of being placed on the convicted vendor list.

Section 287.017, Florida Statutes, applies to this Contract by virtue of FHKC's contractual relationship with AHCA.

4-4-3 Ownership or Control Disclosures

Insurer shall provide written disclosures of the following Ownership or Control Interest information to FHKC upon Contract execution, upon any Renewal or extension of the Contract and within thirty-five (35) Calendar Days of any change in ownership of Insurer.

Insurer shall submit the following information for any person (individual or corporation) with an Ownership or Control Interest in Insurer:

a. Name;

b. Address;

   i. For corporations with Ownership or Control Interest, this includes the primary business address, every business location address and all P.O. Box addresses.

c. Date of birth and Social Security Number (in the case of an individual);

d. Tax identification number, for corporations with an Ownership or Control Interest in Insurer or in any Subcontractor in which Insurer has a five percent (5%) or more interest;

e. Whether the person with Ownership or Control Interest in Insurer is related to (as a spouse, parent, child or sibling) another person with Ownership or Control Interest in Insurer;

f. Whether the person with Ownership or Control Interest in any Subcontractor in which Insurer has a five percent (5%) or more interest is related to (as a spouse, parent, child or sibling) another person with Ownership or Control Interest in Insurer;

g. The name of any other disclosing entity, as defined in 42 CFR 455.101, in which an owner of Insurer has Ownership or Control Interest; and

h. The following information for Insurer's managing employees, as defined in 42 CFR 455.101:

   i. Name;

   ii. Address;

   iii. Date of birth; and

   iv. Social Security Number.

Failure to adhere to this requirement may result in Insurer's ineligibility for federal financial participation in payments made to Insurer and may result in termination of this Contract or other consequences in accordance with the Contract and 42 CFR 457.1285 incorporating 42 CFR 438.610.

4-4-3-1 Determination of Ownership or Control Interest Percentages

Direct Ownership or Control Interest is determined by multiplying the percentage of interest that a person (individual or corporation) owns by the percentage of Insurer's assets used to secure the obligation. By way of example, if a person owns ten percent (10%) of a note secured by sixty percent (60%) of Insurer's assets, the person's direct interest in Insurer is six percent (6%) and must be reported.

Indirect Ownership or Control Interest is determined by multiplying the percentage of ownership in each entity. By way of example, if a person owns ten percent (10%) of the stock in a corporation which owns eighty percent (80%) of Insurer's stock, the person's indirect interest in Insurer is eight percent (8%) and must be reported.

4-5 Change of Controlling Interest

No change in Insurer's ownership structure or controlling interest releases Insurer from its obligations under this Contract. For purposes of this Section, a change in ownership or controlling interest includes an asset or stock purchase.

Insurer shall give FHKC at least one hundred eighty (180) Calendar Days' Notice prior to the effective date of any change in controlling ownership. Insurer shall give FHKC Notice of regulatory agency approval, if applicable, prior to any transfer or change in control.

FHKC has the right to elect to continue or terminate this Contract, at its sole discretion, in the event of a change in Insurer's ownership, structure or controlling interest. In such event, FHKC shall provide at least thirty (30) Calendar Days' Notice to Insurer of the decision to terminate the Contract.

FHKC intends to provide Enrollees with a choice of at least two managed care entities in each ~~area of the state~~ Region. In the event of a proposed merger or acquisition between Insurer and another managed care entity that would result in the common ownership of all FHKC-contracted managed care entities in an area of the state, Insurer or the other FHKC-contracted managed care entity(ies) may be required, at FHKC's sole discretion, to assign one of the FHKC contracts in accordance with Section 4-2. In such case, the entities will have the option to determine which entity shall assign its contract, subject to approval by FHKC. If applicable, Insurer must comply with section 628.4615, F.S., and receive OIR approval before a merger or acquisition can occur. Failure to comply with this paragraph renders this Contract subject to termination under Section 34-4. The resulting damages of any such failure will not be readily ascertainable, entitling FHKC to liquidated damages in an amount of $250,000 per Region. These liquidated damages are intended only to cover FHKC's internal staffing and administrative costs as well as the diminished value of services provided under the Contract and will not preclude FHKC from recovering other damages it may suffer as a result of such violation.

4-6 Conflicts of Interest

Insurer agrees that its obligations under this Contract are not in conflict with any other interest to which Insurer is obligated or from which Insurer benefits. Insurer affirms that it meets or exceeds the federal safeguards of 41 U.S.C. 423.

Insurer shall submit the conflict of interest disclosure form provided by FHKC identifying any potential conflicts of interest:

a. Within five (5) Business Days after Insurer's receipt of the executed Contract;

b. Annually by January 15th; and

c. Within ten (10) Business Days after becoming aware of any potential conflicts of interest.

FHKC shall be the sole determiner of whether a conflict of interest exists and the action needed to resolve the conflict.

4-7 Lobbying Disclosure

Insurer shall disclose information regarding the lobbying activities of Insurer, its Subcontractors or its authorized agents in compliance with applicable state and federal requirements. Insurer shall certify that no state or federal funds have been or will be used in lobbying activities. Insurer shall provide the lobbying certification at Contract execution and annually by January 15th.

4-8 Gift Prohibitions

Insurer shall not offer any gifts, including any meal, service or item of value, even if such value is *de minimis*, to FHKC board members, FHKC ad hoc board members or FHKC employees.

4-9 Non-Solicitation

Insurer acknowledges that FHKC recruits and trains personnel to perform work directly and indirectly related to this Contract and that this is a costly and time-consuming effort. Insurer agrees that during the term of this Contract and the twelve (12) months following the termination or expiration of this Contract, Insurer shall not recruit or directly or indirectly employ any individual who is employed by FHKC during the term of this Contract, unless FHKC waives such instance in writing.

4-10 Insurance

During the term of this Contract and entirely at Insurer's expense, Insurer shall continuously maintain insurance coverage that may be reasonably associated with the Contract. Providing and maintaining the required insurance coverage is a material obligation and failure to comply with these requirements shall constitute a material breach. Insurer shall not perform any work in connection with this Contract until such insurance has been secured by Insurer and approved by FHKC. Such coverage must include the following:

a. Commercial general liability insurance. Insurer must continuously maintain commercial general liability insurance (inclusive of any amounts provided by an umbrella or excess policy) with limits of liability necessary to provide reasonable financial protections to Insurer and FHKC under the Contract. Such insurance shall include a hold harmless

agreement in favor of FHKC and must include FHKC as an additional insured for the entire length of the Contract.

b. Professional liability/errors and omissions insurance. Insurer must continuously maintain professional liability or errors and omissions insurance with limits of liability necessary to provide reasonable financial protections to Insurer and FHKC under the Contract. Such insurance shall include an agreement that Insurer shall provide thirty (30) Calendar Days' prior Notice of any cancellation of coverage to FHKC.

c. Cyber liability insurance. Insurer must continuously maintain cyber liability insurance with limits of liability necessary to provide reasonable financial protections to Insurer and FHKC under the Contract. If Insurer self-insures for cyber liability insurance, Insurer shall provide FHKC with the total amount self-insured and the total amount of any excess coverage in place. If Insurer's self-insured amount is lower than the minimum required aggregate, Insurer must provide proof of insurance coverage for an amount that at least meets the minimum required amount in combination with the self-insurance.

d. Worker's compensation insurance. Insurer shall comply with all worker's compensation laws and regulations. Insurer may be self-insured to the extent permitted by law and such self-insurance shall comply with the Florida Worker's Compensation law. In the event hazardous work is being performed by Insurer's employees under this Contract and any class of employees performing the hazardous work is not protected under worker's compensation statutes, Insurer shall provide adequate insurance satisfactory to FHKC for the protection of its employees not otherwise covered. Insurer shall ensure all Subcontractors comply with this provision.

Insurer shall provide a certificate of insurance as proof of coverage for each type of insurance required within ten (10) Business Days of Contract execution. Insurer shall provide proof of continuing coverage to FHKC by December 31st each year or by the date of expiration of the certificate of insurance, whichever is earlier.

4-11 Employment; E-Verify

Insurer shall comply with section 274A (e) of the Immigration and Nationalization Act. FHKC shall consider the employment by any contractor of unauthorized aliens a violation of this act. If Insurer knowingly employs unauthorized aliens, such violation shall be cause for unilateral cancellation of this Contract. Insurer shall include this provision in all Subcontractor Written Agreements with private organizations for work related to this Contract.

Insurer shall use the U.S. Department of Homeland Security's E-Verify Employment Eligibility System to verify the employment status of all new employees employed by Insurer during the term of this Contract.

Insurer shall require all Subcontractors to utilize the E-Verify system to verify the employment status of all new employees contracted by the Subcontractor during the term of the Contract and include such requirement in all Subcontracts.

Compliance with this section is a condition of funds provided through this Contract.

4-12 Background Screening

Insurer shall perform, or ensure performance of, a criminal background screening comparable to a level 2 background screening as described in Section 435.04, Florida Statutes, for all individuals employed, directly or indirectly, by Insurer or Subcontractor(s) in the performance of Insurer's obligations under this Contract who have access to Personal Health Information (PHI), Personally Identifiable Information (PII) or financial information related to this Contract. Such background screening shall be required to be completed prior to each individual's access to data and every five (5) years thereafter. Insurer shall maintain documentation of all background screening records pursuant to section 10 Record Retention.

Unless an exemption is granted, Insurer shall not allow any individual to perform work under this Contract who has unacceptable background screening results as described in:

a. Described in Section 435.04(2) and (3), Florida Statutes;

b. Relating to the criminal use of PII as described in Chapter 817, Florida Statutes;

c. Offenses described in Sections 812.0195, 815.04, 815.08, Florida Statutes; or

d. That were subject to criminal penalties for the misuse of PHI under 42 U.S.C. 1320d-5.

Insurer shall develop and submit policies and procedures related to the background screening requirement, including a procedure to grant an exemption from disqualification for disqualifying offenses revealed by background screening, as described in Section 435.07, Florida Statutes, to FHKC for approval by the date required in the approved implementation plan.

Insurer shall be liable for financial consequences in the amount of one thousand dollars ($1,000) per employee per month for each month in which Insurer has failed to timely complete the background screening. Financial consequences also apply to Subcontractors in the same manner. Insurer shall provide an annual attestation of compliance with this provision.

4-13 Fidelity Bond

Insurer shall maintain a blanket fidelity bond on all personnel in its employment during the life of the Contract. The bond shall be issued in the amount of at least $250,000 per occurrence. The surety company issuing the bond must comply with the provisions of Chapter 624, Florida Statutes. The bond shall protect FHKC from any losses sustained through any fraudulent or dishonest act or acts committed by any employees of Insurer and Subcontractors. Proof of

coverage shall be submitted to FHKC within fifteen (15) Business Days of Contract execution and thereafter by or before the expiration date on the provided fidelity bond.

4-14 Performance Bond

Insurer shall maintain a performance bond in the amount of $250,000 per Region for the life of the Contract. FHKC shall be named the beneficiary of Insurer's bond. The bond shall provide that the insurer or bonding company(s) pay losses suffered by FHKC directly to FHKC. A copy of the bond shall be provided to FHKC within fifteen (15) Business Days of Contract execution and annually thereafter by December 31 or the date of expiration for the copy of the bond provided to FHKC.

Should Insurer terminate the Contract prior to the end of the Contract period, an assessment against the bond shall be made by FHKC to cover the costs of issuing a new solicitation and selecting a new Insurer. Insurer agrees that FHKC's damages in the event of termination shall be considered to be for the full amount of the bond. FHKC need not prove the damage amount in exercising its right of recourse against the bond.

Section 5 Subcontractors

Insurer may delegate performance of work required under this Contract to Subcontractors with prior written approval from FHKC; however, Insurer maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract. Insurer is responsible for all acts or omissions of Subcontractors Insurer utilizes during the term of the Contract. FHKC has no liability of any kind for any Subcontractor demands, losses, damage, negligence or direct or indirect expenses.

In the event FHKC determines a Subcontract is not in compliance with the requirements of this Contract, Insurer must correct the deficiency to receive FHKC approval. FHKC has the right to withhold approval of any Subcontracts or amendments to approved Subcontractor contracts.

Insurer shall submit any proposed new or amended Subcontracts to FHKC for review at least ninety (90) Calendar Days before the proposed effective date of the delegation or amendment. FHKC may, at its sole discretion, waive the submission timeframe upon Insurer request and evidence of good cause.

All requests for Subcontractor approval shall include a copy of the Subcontract. If a request solely involves an amendment, Insurer may submit the proposed amendment without a copy of the approved Subcontract in effect with prior approval from FHKC.

Insurer shall provide Subcontractor disclosures pursuant to 42 CFR 457.1285, which incorporates 42 CFR 438.608(c).

Insurer shall provide the following information about Insurer's Grievance and Appeal process to applicable Subcontractors upon entrance into the Subcontract in accordance with 42 CFR 457.1260, which incorporates 42 CFR 438.414:

a. The right to file Grievances and Appeals;

b. The requirements and timeframes for filing a Grievance or Appeal;

c. The availability of assistance in the filing process; and

d. The right to request an independent review after Insurer has made an adverse Appeal determination.

Insurer's failure to comply with the provisions of this section shall constitute a material breach of this Contract.

5-1 Subcontracts

All Subcontracts must ultimately be executed by both Insurer and the Subcontractor before work directly or indirectly related to this Contract begins. Insurer shall provide any executed Subcontracts to FHKC within seven (7) Business Days after request of such documents.

The Subcontract shall:

a. Specify the delegated activities or obligations, including related reporting responsibilities;

b. Require performance of the delegated activities and reporting responsibilities specified in compliance with Insurer's obligations under this Contract;

c. Provide for the revocation of the delegation of activities or obligations or specify other remedies in instances where either Party determine that the Subcontractor has not performed satisfactorily;

d. Require compliance with all applicable laws, regulations and subregulatory guidance and contract provisions, including audit and record retention requirements; and

e. Require Subcontractor to maintain complete and accurate records.

If the Subcontractor delegation involves coverage of services and claims payment, the Subcontract shall require the Subcontractor to implement and maintain arrangements or procedures designed to detect and prevent Fraud, Waste and Abuse.

If the Subcontractor delegation is for management of Covered Services, including pharmacy benefits management, durable medical equipment or behavioral health services, Insurer shall also include the following in the Subcontractor approval request:

a. Documentation supporting network adequacy and capacity to serve, as applicable for the specific delegations;

b. Copy of applicable licensure, as appropriate;

c. Specification of the Regions covered by the Subcontractor;

d. Description of Insurer's plan to monitor compliance;

e. Confirmation of the Subcontractor's ability to accurately process and pass claims and encounter data to Insurer in a manner that can be stored and utilized by Insurer, including seamless passthrough to FHKC, AHCA and their designees. The confirmation shall include a summary description of Insurer's testing activities with the proposed Subcontractor; and

f. For Subcontractors delegated any functions related to behavioral health Covered Services, Insurer shall provide an analysis of the Subcontractor's compliance with 42 CFR 457.496 and a plan to assure continued compliance with parity of nonquantitative treatment limitations should Subcontractor or Insurer make any changes to utilization management controls or other aspects impacting nonquantitative treatment limitations. The mental health and substance abuse disorder parity analysis and plan are subject to FHKC's acceptance.

5-2 Subcontractor Monitoring

Insurer shall conduct routine monitoring of all Subcontractors. Insurer shall also conduct risk assessments of all Subcontractors and their delegated activities related to this Contract. The outcome of the risk assessment shall directly inform Insurer's Subcontractor monitoring plan. Insurer shall conduct non-routine monitoring, as needed. Insurer shall provide a Subcontractor monitoring schedule for all Subcontractors by the date established in the approved implementation plan and then annually by December 1st.

Insurer shall provide a quarterly summary of Subcontractor monitoring, including any findings and corrective action taken during the quarter. FHKC, at FHKC's sole discretion, may require more frequent reporting should Insurer's performance, the Subcontractor's performance, other risk or perceived value of increased reporting frequency compel such change.

Insurer shall have a contingency plan for each Subcontractor to safeguard performance of the delegated obligations should the Subcontractor cease to perform or adequately perform its obligations under the Subcontract.

In the event FHKC determines a Subcontractor is not in compliance with the requirements of this Contract, Insurer shall promptly correct the Subcontractor's non-compliance.

Insurer shall inform FHKC of any Subcontractor termination, in whole or in part, within the following timeframes:

a. For Subcontractors delegated management of a Covered Benefit: ninety (90) Calendar Days prior to termination;

b. For Subcontractors terminated for cause: one (1) Business Day of the earlier of the date Insurer notifies Subcontractor of intention to terminate or the date of termination; and

c. For all others: thirty (30) Calendar Days prior to termination.

5-3 Subcontractor Solvency

In the event Insurer learns that a Subcontractor has become insolvent or is at unacceptable risk for insolvency, Insurer shall promptly cease delegation of any obligations directly or indirectly related to this Contract to Subcontractor.

Insurer shall notify FHKC within one (1) Business Day of the insolvency or the filing of a petition for bankruptcy by or against a principal Subcontractor.

FHKC, at its sole discretion, may choose to continue or terminate this Contract in the event any of Insurer's Subcontractors file a petition for bankruptcy or for approval of a plan of reorganization or arrangement under the Bankruptcy Act.

Section 6 Systems; Security

Insurer shall maintain policies, procedures and practices related to system security and integrity that are in line with national industry standards and best practices. Insurer shall regularly, no less frequently than annually, review and update its policies, procedures and practices for the following areas:

a. Telework and remote access;

b. External data loss risk management;

c. Internal data loss risk management; and

d. Information and data security.

Insurer shall provide ninety (90) Calendar Days' prior notice of any planned, significant system changes, including changes or upgrades to claims processing, customer service, enrollment or operating systems or any other systems that may materially impact services provided under this Contract.

Insurer shall notify FHKC within three (3) Business Days of identification of any issues impacting Insurer's claims processing related to this Contract.

Insurer's mail gateways shall be capable of, and Insurer shall send, encrypted emails to FHKC when PHI or PII is involved. Insurer shall also ensure its mail gateways are capable of receiving

FHKC's encrypted emails. Insurer's use of an email gateway using a Transport Layer Security connection satisfies this requirement.

Insurer shall obtain a National Institute of Standards and Technology (NIST) compliant information security risk assessment conducted by an independent third party at least every three (3) years with the first assessment obtained within the first Contract Year unless such an assessment was completed within two (2) years prior to the Contract Effective Date. An independent assessment following the NIST SP800-30 guidance, or its successor, satisfies this requirement.

6-1 Security Incidents

Insurer shall report all security incidents to FHKC in accordance with Attachment B. Insurer shall be liable for financial consequences in the amount of five hundred dollars ($500) per Calendar Day for failure to provide all necessary information to FHKC in the format and timeframe required. Financial consequences apply to each Calendar Day beyond the due date until provided to FHKC in the required format, inclusive of the day provided to FHKC.

6-2 Health Information System

Insurer shall maintain a health information system that collects, analyzes, integrates and reports data, including utilization, claims, and Grievances and Appeals.

At a minimum, Insurer's health information system must:

a. Comply with Section 6504(a) of the Affordable Care Act;
b. Collect data on Enrollee and Provider characteristics;
c. Collect data on all services provided to Enrollees through an encounter data system, including data sufficient to identify the Provider who delivers any item or service to Enrollees;
d. Ensure that data received from Providers is accurate and complete by:
    i. Verifying the accuracy and timeliness of reported data, including data reported by Providers with a capitated payment arrangement;
    ii. Screening the data for completeness, logic and consistency; and
    iii. Collecting data from Providers in standardized formats to the extent feasible and appropriate.
e. Make all collected data available to FHKC, AHCA and CMS, upon request.

6-3 Continuity of Operations Plan

Insurer shall have a continuity of operations plan (COOP), or disaster recovery and business continuation plan, along with corresponding policies and procedures, that:

a. Include alternate locations for the provision of key services to Enrollees and Providers such as:

    i. Member services

    ii. Claims processing

    iii. Appeals and Grievances

b. Maintains information systems backups in a manner that mitigates disruption of service (including system access) and ensures against loss of data and data integrity due to hardware or software failures, operational errors, destruction (physical and otherwise), and malicious attacks, including:

    i. Alternate locations for data storage or other means of off-site data backup.

    ii. Safeguards and regular testing against malicious external activities.

    iii. Appropriate partitioning and system monitoring to mitigate the risk of malicious and inadvertent harmful actions by internal parties.

c. Include regular, periodic testing of such plans and procedures, including identification and timely correction of any failures, errors or opportunities for improvement. At a minimum, Insurer shall conduct at least one mock-disaster exercise per Contract Year.

d. Appropriately consider access and use of protected information.

e. Insurer reviews and updates COOP and/or disaster recovery and business continuation plan on a regular basis, and no less than annually.

Insurer shall cooperate with FHKC’s COOP including providing a designated emergency contact to provide and receive status updates.

6-4 Telework and Telecommuting

Insurer shall maintain policies and procedures for telework (i.e., user access from a facility where data does not reside) and telecommuting (i.e., user access from home or travel (e.g., hotel) environment). For purposes of this section, “telework” includes “telecommuting”. Telework policies and procedures, and other related documents, shall meet the standards required for compliance with all laws and regulations, including HIPAA and the Gramm-Leach-Bliley Act.

In addition, Insurer's telework policies and procedures shall at least meet the recommendations and best practices identified in the National Institute of Standards and Technology (NIST), U.S. Department of Commerce Special Publication 800-46, Revision 2 or its replacement, including the recommendations and best practices contained in relevant cross-referenced NIST publications. Insurer shall conduct and consider risk assessments when developing, implementing or changing its telework security policy, particularly for those aspects of the telework security policy for which various approaches may provide acceptable safeguards or for which unauthorized access to PHI or PII is likely to occur without appropriate safeguards.

Insurer shall require multifactor authentication or more stringent practices for any level of remote access.

Insurer shall provide FHKC with enough information to assure FHKC that appropriate policies, procedures and practices are in place, upon request. Such release of information is not required to be at the level of detail that may present a notable security risk.

6-5 Single Sign-On

Insurer shall implement single sign-on between FHKC's Enrollee portal and Insurer's Enrollee portal at the direction of FHKC, subject to the Parties' abilities to satisfy the security requirements of the other Party. Insurer shall cooperate with FHKC during all stages of implementing single sign-on, including any exploratory or information gathering stages. FHKC shall determine any project timeframes, including the final effective date; however, Insurer shall assist FHKC in determining reasonable timeframes by providing any information requested by FHKC.

Section 7 Confidentiality; Public Records

7-1 Confidentiality

Insurer shall treat all information obtained through its performance under this Contract as confidential to the extent such information is protected under Florida and federal law. Insurer shall not use any information except as necessary for the proper discharge of its obligations under this Contract.

Insurer shall not use or disclose any PHI, PII or other identified information obtained through its performance under this Contract, except as allowed under this Contract and Florida and federal laws, including HIPAA and Sections 624.91 and 409.821, Florida Statutes, and Chapter 119, Florida Statutes. Such information shall not be disclosed without the written consent of FHKC, the Applicant, or the Enrollee, except as otherwise required under Florida or federal law.

This provision does not prohibit the disclosure of information in summary, statistical or other de-identified forms.

The Parties agree to maintain the integrity of the other Party's confidential, trade secret or proprietary information to the extent provided under the law and this Contract. Neither Party will disclose or allow others to disclose the other Party's confidential, trade secret or proprietary information except as provided by law or this Contract.

7-2 Redacted Copies of Confidential Information

Records produced or used in relation to the performance of this Contract may be subject to Chapter 119, Florida Statutes. If Insurer considers anything to be Confidential Information, Insurer must simultaneously provide FHKC with a separate, redacted copy of the information it claims as exempt and briefly describe in writing the grounds for claiming exemption. This redacted copy shall contain the Contract name and number and shall be clearly titled "Redacted Copy". The redacted record should redact only those portions of material that Insurer claims are confidential, proprietary, trade secret or otherwise not subject to disclosure. FHKC may require Insurer to provide the redacted copy electronically. The following methods of redacting are not sufficient for designating information as confidential, proprietary, trade secret or otherwise not subject to disclosure:

a. Statements to the effect that the record "may" contain confidential, trade secret, proprietary, or exempt information;

b. Designations outside the body of the record such as in an electronic document title or in the body of an email providing the record; or

c. Placement or formatting that interferes with FHKC's ability to access the information such as using an opaque watermark.

If Insurer fails to submit a redacted copy of information it claims is confidential, proprietary, trade secret or otherwise not subject to disclosure, FHKC is authorized to produce the entire documents, data, or records in response to a public records request or other lawful request for those records.

Records in which the sole confidential information is PHI or PII are excluded from this redaction requirement.

7-3 Request for Confidential Information

In the event of a public records or other disclosure request pursuant to Chapter 119, Florida Statutes, the Florida Constitution or other authority, to which documents marked as "Redacted Copy" are responsive, FHKC will provide Insurer-redacted copies to the requestor. If a requestor asserts a right to the Confidential Information, FHKC will notify Insurer such an assertion has been made. It is Insurer's responsibility to assert that the Confidential Information is not subject to disclosure under Chapter 119, Florida Statutes, or other applicable law. If FHKC becomes subject to a demand for discovery or disclosure under legal process regarding the Confidential Information, FHKC shall give Insurer prompt Notice of the demand prior to

releasing the information (unless otherwise prohibited by applicable law). Insurer shall be responsible for defending its determination that the redacted portions of its records are confidential, proprietary, trade secret, or otherwise not subject to disclosure.

7-4 Indemnification

Insurer shall protect, defend and indemnify FHKC for any and all claims arising from or relating to Insurer's determination that the redacted portions of records are confidential, proprietary, trade secret, or otherwise not subject to disclosure.

7-5 Insurer as Agent

Insurer agrees to advise FHKC prior to the release of any information in response to a request for public records and, upon FHKC's request, provide FHKC with a copy of the requested records at no cost. All records stored electronically must be provided to FHKC in a format that is compatible with the FHKC's information technology systems.

Section 409.821, Florida Statutes, provides certain public records exemptions to Florida KidCare documents. If, under this Contract, Insurer is providing services and is acting on behalf of a public agency, as provided by Section 119.0701, Florida Statutes, Insurer shall:

a. Keep and maintain public records required by the public agency to perform the service.

b. Upon request from the public agency's custodian of public records, provide the public agency with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in this chapter or as otherwise provided by law.

c. Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the Contract term and following completion of the Contract if Insurer does not transfer the records to the public agency.

d. Upon completion of the Contract, transfer, at no cost, to the public agency all public records in possession of the Insurer or keep and maintain public records required by the public agency to perform the service. If Insurer transfers all public records to the public agency upon completion of the Contract, the Insurer shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If Insurer keeps and maintains public records upon completion of the Contract, Insurer shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the public agency, upon request from the public agency's custodian of public records, in a format that is compatible with the information technology systems of the public agency.

e. **IF INSURER HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO INSURER'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS CONTRACT, CONTACT THE EMAIL ADDRESS AND MAILING ADDRESS PROVIDED FOR THE CONTRACT MANAGER.**

Section 8 Intellectual Property

Intellectual property rights existing prior to the Effective Date of this Contract will remain with the respective Party. In the event of a dispute, Insurer is responsible for producing evidence substantiating prior ownership of the intellectual property. Intellectual property developed by Insurer specifically for FHKC under this Contract shall be the property of FHKC.

FHKC shall have unlimited rights to use, disclose and duplicate all information and data developed, derived or provided by Insurer under this Contract regardless of whether such information and data is copyrightable, patentable or trademarkable.

Insurer's use of intellectual property in connection with this Contract that results in any royalties or costs are understood to be included in Insurer's compensation under this Contract and shall not be charged to FHKC, without exception.

Insurer shall indemnify and hold FHKC harmless from any loss, liability or expense resulting from any intellectual property provided by Insurer. Insurer shall not be held liable when such a claim results solely from FHKC's alteration of the intellectual property or solely from the combination, operation or use of the intellectual property with material that was not provided by Insurer.

This provision shall survive termination and expiration of the Contract.

Section 9 Financial Requirements

9-1 General Financial Requirements

At a minimum, Insurer shall meet the solvency requirements necessary to maintain a certificate of authority in the State of Florida, as determined by the applicable laws and regulations and the Office of Insurance Regulation.

In no event shall FHKC or Enrollees be held liable for Insurer's debt. Insurer shall make sufficient provision against the risk of insolvency to ensure Enrollees will not be liable for Insurer's debt in the event Insurer becomes insolvent.

Insurer shall provide Insurer's audited financial statements to FHKC for Insurer's preceding fiscal year by July 1st each year.

Failure to comply with the solvency requirements of this provision constitutes a material breach.

9-2 Bankruptcy

Insurer shall provide FHKC Notice of intent to petition for bankruptcy or reorganization or arrangement at the time of the filing and immediately provide a copy of such filing to FHKC. In the event FHKC chooses to terminate the Contract in accordance with Section 34-3 Termination for Insolvency or Bankruptcy, FHKC shall provide Insurer thirty (30) Calendar Days' Notice.

9-3 Enrollee Protections from Collection

Neither Insurer nor any representative of Insurer shall collect or attempt to collect from an Enrollee any money for services covered by the Program or any monies owed to Insurer by FHKC.

In no event shall an Enrollee be held liable for monies owed to a Provider by Insurer for Covered Services. If a Provider is paid less than billed charges, neither the Provider nor Insurer may hold the Enrollee liable for the remainder of the charges. Enrollees shall remain responsible for any applicable Copayment. Insurer shall include such a prohibition in all Provider contracts for Insurer's Florida Healthy Kids network.

Insurer shall indemnify, defend and hold Enrollees harmless from all financial loss caused by Insurer's failure to comply with this Contract or state or federal laws or regulations.

9-4 Third Party Liability

9-4-1 Subrogation Rights

In the event Insurer provides an Enrollee Covered Services for which a third party is liable, Insurer shall seek reimbursement from the third party or Enrollee, if he or she received third-party payment for medical expenses provided to him or her, for the actual cost of benefits provided.

Insurer is not entitled to reimbursement in excess of the Enrollee's monetary recovery for medical expenses provided from the third party.

9-4-2 Coordination of Benefits

In accordance with Section 624.91(5)(c), Florida Statutes, Florida Healthy Kids insurers are the payers of last resort.

Insurer shall coordinate benefits with any other third-party payer that may be liable for an Enrollee's medical care. Insurer shall adhere to the third party liability requirements at 1902(a)(25) of the Act, including cost avoidance and "pay and chase" requirements.

Insurer shall notify FHKC of any Enrollees Insurer identifies as covered under other health insurance by the fifteenth day of each month. At a minimum, Insurer shall include the Enrollee's name, Florida Healthy Kids member ID, identification of the other carrier, and the effective and termination dates of the other coverage, if available. Insurer shall identify any Enrollees as having other coverage through Florida Medicaid separately.

Insurer shall coordinate benefits with any insurer under contract with FHKC to provide comprehensive dental care benefits to Enrollees, including the provision of prescription coverage for prescriptions prescribed by the Enrollee's dental Provider.

9-5 Medical Loss Ratio

The minimum medical loss ratio (MLR) for each rating period is eighty-five percent (85%).

Likewise, the maximum non-benefit premium component for each rating period shall not exceed fifteen percent (15%). Insurer shall identify what components and subcomponents have been included in its non-benefit expenses, as required by FHKC.

The MLR shall be calculated in accordance with 42 CFR 457.1203, which incorporates 42 CFR 438.8.

FHKC may issue additional written guidance on the definition of medical expense or non-benefit expense to Insurer. Federal and state regulations impacting the calculation of MLRs or non-benefit expense requirements may also be applicable. To the extent permissible by law, FHKC may choose to adopt such regulations early or adopt such regulations that would not otherwise be applicable. Should such guidelines be applied, FHKC shall notify Insurer in writing.

In the event Insurer achieves an MLR less than eighty-five percent (85%) for the rating period, Insurer shall return one hundred percent (100%) of the difference between the actual MLR and the minimum MLR to FHKC. Insurer's MLR rebate shall include both Insurer's Title XXI Enrollees and Insurer's Full-pay Enrollees in the Service Area; however, Insurer shall report the portion of the rebate attributable to the Title XXI Enrollees and the Full-pay Enrollees based on the respective proportion of Enrollee member months for the rating period.

9-5-1 MLR Reporting Requirements

Insurer shall provide a quarterly MLR report to FHKC in the format established by FHKC. The format established by FHKC shall include claims runout periods. The quarterly MLR report is an ongoing report. As such, Insurer shall update the report each quarter to include any additional claims information received since the prior report.

The quarterly MLR report is due as follows:

Reporting Quarter	Due Date
January 1 – March 30	May 31
April 1 – June 30	August 31
July 1 – September 30	November 30
October 1 – December 31	February 28

Insurer shall provide an updated annual MLR report with Insurer's premium rate adjustment request. Insurer shall also identify all non-benefit and medical expense payments to affiliate and subsidiary companies, including an explanation of the relationship.

9-5-2 Experience Adjustment Report

In addition to the quarterly and annual MLR report, Insurer shall provide an experience adjustment report for each Contract Year. The experience adjustment report due date is December 31st the following year.

The MLR rebate, if any, shall be calculated and provided based on the data included in this report. If any MLR rebate is owed to FHKC, Insurer shall remit such payment to FHKC no later than February 1st.

The experience adjustment report shall be in a format established by FHKC and include sufficient documentation, as determined by FHKC, to support Insurer's MLR calculation and to allow FHKC to evaluate the component and subcomponent expenses included. FHKC shall determine the adequacy of the information supplied and whether the MLR calculation is accurate.

Section 10 Record Retention

Insurer shall retain all records associated with this Contract for at least ten (10) years following the term of this Contract, from the final date of the Contract period, or from the date of completion of any audit, whichever is later. Such records include Enrollee Grievance and Appeal records described in 42 CFR 438.416, base data described in 42 CFR 438.5(c), medical loss ratio reports and data, and information and documentation specified in 42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608 and 42 CFR 438.610, as referenced in 42 CFR 438.3(u) incorporated by 42 CFR 457.1201(q).

Insurer shall maintain records and documentation in accordance with generally acceptable accounting principles sufficient to substantiate all administrative and Medical Services expenditures under this Contract.

Insurer shall securely store such records as appropriate for the contents of the record. Insurer is responsible for all storage costs associated with record maintenance under this Contract. Destruction of records is Insurer's responsibility.

Failure to comply with this provision may constitute a material breach and may render this Contract subject to unilateral cancellation by FHKC as determined by FHKC in its sole discretion.

Section 11 Audit Rights

Insurer and Insurer's Subcontractors shall have all books, records, contracts, computers and other electronic systems that pertain to any aspect of services and activities performed, or determination of amounts payable, under this Contract available at any time for inspection, review, audit, investigations or copying to FHKC, any vendor contracted with FHKC or any state or federal regulatory agency as authorized by law or FHKC. Additionally, FHKC, AHCA, AHCA's Office of Inspector General, HHS, CMS, HHS's Office of Inspector General, the Comptroller General of the United States and their designees may, at any time, inspect the premises, physical facilities and equipment where work related to this Contract is conducted.

It is FHKC's intention to provide Insurer with reasonable notice of any audit or inspection of Insurer by FHKC and to conduct any such audits or inspections at reasonable times. This statement of intention shall not limit FHKC's rights as provided under this Contract and does not extend to any other entity in possession of audit rights under this Contract.

Insurer agrees to cooperate in any evaluative efforts conducted by FHKC, FHKC's contractors, or authorized state or federal agencies during the Contract term and for a period of at least ten (10) years following the term of this Contract. These efforts may include a post-Contract audit. In the event records must be sent to FHKC, Insurer is responsible for production, delivery and associated costs.

Insurer shall require any Subcontracts associated with this Contract to include this provision.

Failure to comply with this provision may constitute a material breach and may render this Contract subject to unilateral cancellation by FHKC as determined by FHKC in its sole discretion.

11-1 Audit Reports

At a minimum, FHKC shall conduct periodic audits of the accuracy, truthfulness and completeness of encounter data and financial data submitted by, or on behalf of, Insurer. The results of such audits will be made available on FHKC's public website in accordance with 42 CFR 457.1285 which incorporates 42 CFR 438.602(g).

Insurer shall ensure an annual SOC 2 Type II audit is performed on its application hosting center. Insurer shall provide a copy of the most recent audit report to FHKC by the date established in the approved implementation plan and annually thereafter by the date required by FHKC.

Section 12 Contract Management; Monitoring

Insurer shall comply with all provisions of this Contract and its amendments, if any, and shall act in good faith in the performance of the Contract's provisions. FHKC, in its sole discretion, may assess Insurer financial consequences up to five hundred dollars ($500) per incident of noncompliance. Such financial consequences shall not be assessed if other applicable financial consequences are assessed for the incident.

Insurer shall utilize written policies and procedures to implement all provisions of this Contract.

Insurer shall provide education and training to its staff, as appropriate and applicable to the staff members' duties, including education and training regarding advance directive policies and procedures. Insurer shall allow FHKC to participate in its formal training modules or sessions upon request.

12-1 Implementation; Readiness Assessment

Insurer shall ensure all resources needed for a timely and complete implementation are available.

Insurer shall provide a final implementation plan for approval to FHKC within five (5) Business Days of Contract execution. Insurer may submit the implementation plan in Microsoft Excel or Microsoft Project.

At a minimum, the implementation plan shall include:

a. Each task necessary to fully implement this Contract;

b. The start and end dates for each task;

c. Any task dependencies;

d. Identification of key milestones; and

e. The responsible Party for each task.

If the submitted implementation plan is not subsequently approved by FHKC, Insurer shall have three (3) Business Days from notification of disapproval to submit a revised implementation plan for approval.

Insurer shall be liable for financial consequences equal to one thousand dollars ($1,000) per Calendar Day the implementation plan is late . Financial consequences apply to each Calendar Day beyond the due date until provided to FHKC, inclusive of the date provided to FHKC. Financial consequences apply to the initial due date and to subsequent due dates should the implementation plan require revisions prior to FHKC approval and are limited to a total of fifteen thousand dollars ($15,000).

Insurer shall submit an updated implementation plan on a weekly basis until implementation is complete. The required frequency of the updated implementation plan submission may be changed with approval or direction from FHKC. Changes to task due dates require written approval from FHKC. Financial consequences related to the weekly submissions of updated implementation plans shall be as described in section 27.

Prior to the Effective Date, FHKC may conduct a readiness assessment to ensure Insurer's readiness and ability to perform its obligations under this Contract. The readiness assessment may include, but is not limited to:

a. Desk and onsite reviews of policies and procedures and related documents;

b. Process demonstrations;

c. System demonstrations; and

d. Interviews with Insurer staff.

Insurer shall participate and cooperate in any readiness assessment, including making documents and appropriate staff available.

Insurer shall pass any readiness assessment to FHKC's satisfaction by the dates established during the readiness assessment. Insurer shall be liable for financial consequences equal to three thousand dollars ($3,000) per Calendar Day, limited to a total of sixty thousand dollars ($60,000), for failure to pass. Financial consequences apply to each Calendar Day beyond the date Insurer failed to meet readiness assessment goals until Insurer is able to meet all readiness assessment goals and provide all services required under the Contract.

12-2 Account Management Team

Insurer shall assign an account management team to act as primary contacts for FHKC. The account management team shall include:

a. An executive sponsor;

   i. The executive sponsor must have decision-making authority for Insurer.

   ii. The executive sponsor shall not be the same individual as the contract manager.

b. A contract manager;

   i. The contract manager is subject to the terms of Section 12-3 Contract Managers.

c. A member services manager;

    i. Insurer shall provide FHKC with a designated contact for escalated Enrollee issues. If Insurer chooses to designate an individual other than the member service manager as the designated contact, such individual shall be considered part of the account management team.

d. A clinical specialist, clinical manager or medical director;

    i. In addition to having medical expertise, the clinical specialist must be generally knowledgeable about pharmaceutical-related information. Alternatively, Insurer may provide a pharmacy specialist contact in addition to the clinical specialist contact.

e. A compliance manager;

f. A finance senior manager, director or officer; and

g. Other individuals identified as necessary by the Parties.

Insurer shall provide the name, email address, office telephone number and business mailing address for each person on the account management team to FHKC at the time of Contract execution.

Insurer shall provide written notice to FHKC of any changes to the account management team designations or contact information no later than one (1) Business Day for the executive sponsor and contract manager and five (5) Business Days for any other individual.

Each member of the account management team shall:

a. Be knowledgeable about Insurer's operations relating, directly or indirectly, to Insurer's obligations under this Contract, insofar as such operations relate to his or her job duties.

b. Be knowledgeable about and able to coordinate with other Insurer contacts for work that falls outside of his or her responsibilities or scope of expertise;

c. Dedicate the time and resources necessary to manage FHKC's account, including reasonable availability for and responsiveness to telephonic and email communication and onsite meetings.

At a minimum, Insurer's contract manager, member services manager, and designated contact for escalated Enrollee issues, shall provide a secondary contact and the secondary contact's information, including name, email address and phone number, when the aforementioned primary contact is out of the office or unavailable for extended periods.

This section is intended to provide FHKC with primary contacts for key Contract functions and shall not limit either Party from working with, directly or indirectly, additional individuals.

12-3 Contract Managers

Each Party shall designate a contract manager who will oversee the Party's performance of its obligations during the term of this Contract.

Each Party shall provide the name, email address, direct office telephone number and business mailing address to the other Party and maintain such information with the Contract. The Parties shall provide this information at the time of Contract execution.

Each Party shall provide written notice to the other Party of any changes to the contract manager designation or the contract manager's contact information no later than one (1) Business Day of the change. The Parties shall maintain the revised contract manager information with the Contract.

12-4 Monitoring

FHKC shall monitor, directly and indirectly, Insurer for compliance with this Contract and applicable federal and state laws and regulations. FHKC may also monitor, directly or indirectly, the performance of the Insurer in relation to the Program.

In addition to the data, documentation and information specified in this Contract, Insurer must submit any other data, documentation or information relating to the performance of Insurer's obligations under this Contract required by FHKC or the secretary of HHS.

Insurer shall regularly monitor its own performance under this Contract and the performance of any of its Subcontractors and Providers. Insurer's monitoring shall include:

a. Compliance with Insurer's obligations under this Contract; and

b. Insurer's performance, distinct from compliance, under this Contract related to:

    i. Financial management;

    ii. Management of care, including health outcomes, quality of care, case and disease management programs, and utilization review;

    iii. Satisfaction, including Enrollees and Providers;

    iv. Administrative processes, including claims processing and call center performance; and

    v. Quality improvement, including cultural competency, performance improvement projects, performance measures, and training provided to employees and, if applicable, Providers.

Insurer shall provide a quarterly report that includes cost and utilization information for key metrics identified by FHKC, including potentially preventable events. Insurer and FHKC shall conduct quarterly meetings, via conference calls unless otherwise required by FHKC, to discuss the key metrics and performance guarantees. Insurer shall make staff with the appropriate knowledge and expertise available during these meetings and shall be prepared to discuss the report in detail as well as discuss any other relevant topics such as barriers to care, emerging trends and anticipated legislative actions.

12-5 Corrective Action Plans

FHKC may require Insurer to propose and implement a Corrective Action Plan (CAP) to address and correct the cause of deficiencies in Insurer's performance under this Contract, including failure to meet the performance guarantees in Attachment C and findings from the EQRO compliance validation.

Insurer shall submit a CAP to FHKC for approval within seven (7) Business Days of such request from FHKC, unless FHKC requests another timeframe. The timeframe to provide the corrective action plan is inclusive of the date of request.

If the CAP is not subsequently approved by FHKC, Insurer shall submit a revised CAP within three (3) Business Days from the notification of FHKC's disapproval.

At a minimum, CAPs shall include a description of the problem being corrected, a description of the solution, and an implementation plan detailing the implementation of the solution with anticipated completion dates.

Insurer shall be liable for financial consequences of five hundred dollars ($500) per Calendar Day, limited to fifteen thousand dollars ($15,000) per incident for CAP-submission timeliness failures. Financial consequences apply to each Calendar Day beyond the due date until provided to FHKC, inclusive of the day provided to FHKC. Financial consequences apply to the initial due date and to subsequent due dates should the CAP require revisions prior to FHKC approval.

Insurer shall submit CAP updates on a routine basis. The schedule for such updates shall be established individually for each CAP. Unless otherwise required by FHKC, Insurer shall recommend an update schedule for the CAP to FHKC for approval. Insurer shall be liable for financial consequences of one thousand dollars ($1,000) per Calendar Day, limited to thirty thousand dollars ($30,000) per incident, for failure to complete implementation of the approved CAP by the date established in the CAP schedule. Financial consequences apply to each Calendar Day beyond the due date until the CAP is implemented, inclusive of the day implementation is complete.

12-6 Contract Termination Transition Plan

Upon the termination of this Contract for any reason, including expiration, Insurer shall ensure a smooth transition to any other insurer or contract.

Insurer shall provide a transition plan to FHKC for approval within ninety (90) Calendar Days of the termination date of this Contract. In the event the Contract terminates prior to the expiration date and Insurer is not given more than ninety (90) Calendar Days' Notice, Insurer shall provide a transition plan by the date specified by FHKC or within five (5) Business Days of termination notice receipt if no date is specified.

If the transition plan is not subsequently approved by FHKC, Insurer shall submit a revised transition plan within five (5) Business Days from the notification of FHKC's disapproval.

Insurer's failure to provide a timely transition plan acceptable to FHKC or failure to timely implement such transition plan, in whole or in part, shall be considered an event of default and failure to perform.

In such event Insurer shall be responsible for financial consequences in the amount of $1,000.00 (one thousand dollars) per day, as determined by FHKC. FHKC may also withhold payment to Insurer for nonperformance or unsatisfactory performance of the terms of this Contract.

In the event any transition requires additional work from Insurer after the termination date of the Contract, Insurer shall provide staff, services and other resources for consultation and the complete transition of this Contract, as requested by FHKC.

In the event any post-contract transition period is required, FHKC shall pay Insurer for services provided during this timeframe as agreed upon by the Parties in writing. Neither Party shall unreasonably withhold agreement to any post-Contract transition period payment arrangements. Payment shall only be made to the extent any such post-Contract transition period is at the active choice of FHKC and not caused by any fault or delay by Insurer, as determined by FHKC.

12-7 Performance Guarantees

Insurer's performance under this Contract is subject to the performance guarantees, including reporting requirements, and associated financial consequences established in Attachment C.

12-8 Financial Consequences

Insurer agrees the services provided under this Contract are critical to the success of FHKC's provision of quality services to Enrollees and the administration of the Program. Likewise, Insurer's performance of its obligations under this Contract in a timely and reliable manner and to a high-quality standard is significant to FHKC and FHKC's mission.

Insurer may be subject to financial consequences as described in this Contract for failure to perform its obligations as required. Financial consequences are not liquidated damages and shall be assessed at FHKC's sole discretion. FHKC shall inform Insurer in writing of any financial consequences incurred.

Insurer may dispute or request a waiver of any financial consequences assessed by submitting such request in writing to FHKC's contract manager within five (5) Business Days of receipt of the financial consequences assessment. Requests shall clearly identify the financial consequences being assessed, provide a narrative describing Insurer's reasoning for the dispute or waiver request and include any supporting documentation. FHKC shall review and make a recommendation to the appropriate committee, if required, and respond to the request in writing. FHKC's decision shall be the final determination.

Insurer shall pay any financial consequences within forty-five (45) Calendar Days of notice of assessment. FHKC reserves the right to offset any financial consequences owed by Insurer from any payments owed to Insurer in the event Insurer fails to make timely payment.

Section 13 Intermediate Sanctions

FHKC may impose intermediate sanctions in accordance with 42 CFR 457.1270. In the event FHKC makes any of the following determinations based on findings from onsite surveys, complaints by Enrollees and others, financial status or any other source, sanctions may be imposed as listed. FHKC may impose any or all of the potential sanctions listed for a determination.

a. Insurer fails substantially to provide Medically Necessary services that Insurer is required to provide, under law or under this Contract, to a covered Enrollee.

    i. Potential Sanctions:

        1. Civil money penalties limited to $25,000 for each determination.

        2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.

        3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.

        4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

    ii. FHKC may recommend that CMS impose denial of payment to the state for new enrollees of Insurer. Such denial of payment from CMS automatically results in a denial of payment for those same enrollees from FHKC.

b. Insurer imposes on Enrollees premiums or charges in excess of the premiums or charges permitted under the Program.

i. Potential Sanctions

1. Civil money penalties limited to the greater of $25,000 or double the amount of the excess charges.
2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

c. Insurer acts to discriminate among Enrollees on the basis of their health status or need for health care services, including termination of the enrollment or refusal to reenroll an Enrollee, except as permitted under this Contract, or any practice that would reasonably be expected to discourage enrollment by potential enrollees whose medical condition or history indicates probably need for substantial future Medical Services.

i. Potential Sanctions:

1. Civil money penalties limited to $15,000 for each Enrollee FHKC determines was not enrolled because of a discriminatory practice subject to an overall limit of $100,000 for each determination.
2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

d. Insurer misrepresents or falsifies information that it furnishes to FHKC, the State or CMS.

i. Potential Sanctions:

1. Civil money penalties limited to $100,000 for each determination.
2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.

3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

e. Insurer misrepresents or falsifies information that it furnishes to an Enrollee, potential Enrollee or Provider.

   i. Potential Sanctions:

      1. Civil money penalties limited to $25,000 for each determination.
      2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
      3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
      4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

f. Insurer fails to comply with the requirements for physician incentive plans as required by law.

   i. Potential Sanctions:

      1. Civil money penalties limited to $25,000 for each determination.
      2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
      3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
      4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

g. Insurer has distributed directly, or indirectly through any agent or independent contractor, Marketing materials that have not been approved by FHKC or that contain false or misleading information.

   i. Potential Sanctions:

      1. Civil money penalties limited to $25,000 for each determination.

2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

h. Insurer has violated any of the other requirements of sections 1903(m) or 1932 of the Act, or any implementing regulations.

i. Potential Sanctions:

1. Granting and notifying Enrollees the right to terminate enrollment with Insurer without cause.
2. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
3. Suspension of payment for Enrollees enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

Section 14 Force Majeure

Neither Party shall be responsible for delays or failure to perform its obligations under this Contract resulting from acts beyond the control of the Party. Such acts include blackouts, riots, acts of war, terrorism, epidemics, fire, communication line failure, power failure or shortage, fuel shortages, hurricanes or other natural disasters.

Insurer remains responsible for delays or failures caused or contributed to by the fault or negligence of Insurer or its employees, agents or Subcontractors even when such delay occurred during or because of an act beyond the control of Insurer, to the extent the delay was under the control of Insurer, its employees, agents or Subcontractors.

In the event Insurer has reason to believe a delay or failure could occur and that such delay or failure is excusable under this provision, Insurer shall promptly notify FHKC in writing. FHKC shall be the sole determiner of whether such failure is excusable under this provision.

Section 15 Waiver

A Party's delay or failure to exercise or enforce any of its rights under this Contract shall not constitute or be deemed a waiver of the Party's right thereafter to enforce those rights. Any

single or partial exercise or enforcement of a right shall not preclude any other or further exercise or enforcement of such right or the exercise or enforcement of any other right.

FHKC maintains the right to waive, in whole or in part, any of Insurer's obligations under this Contract unless such waiver would result in unapproved noncompliance with any state or federal law or regulation or FHKC's contract with AHCA.

Section 16 Indemnification

Insurer shall indemnify, defend and hold FHKC and its officers, directors, employees and agents harmless from any and all claims, suits, judgments, liabilities, losses, damages, or costs of any kind, including court costs and attorney fees, arising out of or resulting from the acts or omissions of Insurer and its officers, directors, employees agents, partners, Subcontractors or network Providers, whether acting alone or in collusion with others, in connection with the performance of this Contract, to the extent permitted by law.

The Parties agree to provide timely written Notice of any loss or claim and the opportunity to mitigate, defend and settle such loss or claim as a condition of indemnification by Insurer.

Section 17 Marketing

Insurer shall not engage in Marketing Insurer's Florida Healthy Kids plan without prior written approval from FHKC.

Insurer shall ensure Marketing materials meet the requirements of 42 CFR 457.1207 which incorporates 42 CFR 438.10.

Retention efforts directed at Insurer's Enrollees are subject to all the requirements of this section. Retention efforts do not include activities conducted in the normal course of business, to maintain or improve health outcomes, to maintain or improve quality of care, or to measure Enrollee satisfaction.

17-1 Florida KidCare Marketing

Insurer consents to the use of its name in any Marketing and advertising or media presentations describing Florida KidCare which are developed and disseminated by FHKC. Section 624.91(7)(a), Florida Statutes, applies to this Contract.

Insurer shall not utilize the Marketing materials, logos, trade names, service marks or other materials belonging to FHKC without FHKC's written consent. Written authorization must be received for each individual use or activity prior to use.

Insurer shall not utilize any Marketing materials, logos, trade names, service marks or other materials identifying Florida KidCare without obtaining prior written authorization from the state agency holding the rights to such names or marks.

17-2 Prohibited Statements

Insurer shall not make any written or oral statements suggesting that Florida Healthy Kids enrollees or potential enrollees must enroll with Insurer to obtain or retain Florida KidCare benefits.

Insurer shall not make any written or oral statements suggesting that Insurer is endorsed by FHKC, AHCA, CMS, or any other similar entity, including city or county governments.

Insurer shall not use superlatives (e.g., “the best,” “highest ranked,” rated number 1”) in Marketing materials unless such use is substantiated with supporting data provided to FHKC as a part of the Marketing activities review process.

Insurer shall not use superlatives in its logos or product tag lines (e.g., “XYZ Plan means the first in quality care,” “XYZ Plan means the best in managed care”). This requirement does not prevent Insurer from using other statements in its logos or product tag lines (e.g., “Your health is our major concern,” “Quality care is our pledge to you”).

Insurer shall not compare itself to another insurer or health plan unless:

a. An independent study makes the comparison;
b. Insurer has received written agreement from all other insurers or health plans being compared; and
c. Insurer provides a complete copy of the independent study and written agreements.

17-3 Professional Integrity

At a minimum, Insurer shall maintain industry standards of professional integrity in conducting Marketing activities.

Insurer shall not distribute inaccurate, false or misleading Marketing materials.

Insurer shall not use Marketing materials with negative statements about any other Florida Healthy Kids insurer.

Insurer may not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

Insurer shall not require network Providers or facilities to distribute Marketing materials nor shall Insurer require or allow network Providers or facilities to distribute Marketing materials for Insurer at the exclusion of any other Florida Healthy Kids insurer with which the Provider or facility participates. Insurer shall not compensate any network Provider or facility for distributing Marketing materials.

17-4 Cold-call Marketing

Insurer shall not directly or indirectly engage in cold-call Marketing activities, including door-to-door contact, telephonic contact, email or text message. This provision does not prohibit Insurer from communicating with Enrollees via these mediums in the course of business activities that are not cold-call Marketing activities.

If Insurer receives permission to contact the Enrollee from the Enrollee, Insurer shall not interpret such permission as open-ended permission to contact the Enrollee:

a. After the initial inquiry has been resolved;

b. About topics outside the scope of the original inquiry; or

c. In a manner outside the scope of the original permission.

17-5 Geographic Distribution

Insurer shall not advertise outside its Service Area unless such advertising is unavoidable. For situations in which this is unavoidable, Insurer shall clearly disclose its Service Area.

Insurer shall distribute any approved Marketing materials to its entire Service Area. In the event Insurer's responsibility to provide culturally competent services and communications necessitates variations in Marketing materials among Regions in Insurer's Service Area, Insurer may make those changes necessary for a particular Marketing material to fulfill its cultural competency obligations without being considered noncompliant with this requirement.

17-6 Endorsements and Testimonials

Insurer may use product endorsements and testimonials, subject to the following limitations:

a. The speaker must identify Insurer by name;

b. If an individual is paid to portray a real or fictitious situation, the Marketing material must clearly state, "Paid endorsement";

c. Insurer shall not use quotes from Providers;

d. Insurer shall not use negative testimonials about other Florida Healthy Kids insurers;

e. Insurer shall not compensate potential enrollees for endorsement or promotion; and

f. Enrollees may endorse Insurer only if the Enrollee is currently enrolled with Insurer and voluntarily chooses to provide the endorsement.

Republication of a user's social media or other electronic media content or comment promoting is considered an endorsement or testimonial and is subject to the terms of this provision.

17-7 Events

Marketing events are subject to the approval of FHKC. Unless otherwise required by FHKC, prior approval from FHKC is waived for the following types of events:

a. Public events sponsored by a city or county government or the state government;
    i. This includes events held primarily for participants of a city, county or state-run program, such as sports clubs, art programs and school-sponsored events.
b. Events held by non-profit youth organizations;
    i. Such organizations shall be approved for this waiver on an individual basis and may be approved at the national level.
    ii. Insurer shall submit a written request for approval for each youth organization Insurer would like to include in this waiver. Approval of a waiver for another Florida Healthy Kids insurer does not provide automatic waiver of the same organization for Insurer.
c. Events held by Providers in Insurer's network so long as Insurer ensures the Provider has extended the same invitation to all other Florida Healthy Kids insurers for which the Provider is a network Provider;
d. Other organizations approved by FHKC.
    i. Such organizations shall be approved for this waiver on an individual basis.
    ii. Insurer shall submit a written request for approval for each organization Insurer would like to include in this waiver. Approval of a waiver for another Florida Healthy Kids insurer does not provide automatic waiver of the same organization for Insurer.
    iii. Insurer shall submit the name, location and a description of the organization and their activities, whether such organization is non-profit or for-profit, a description of the events Insurer expects to attend, whether the events are open to the public or limited in any way, and any other information FHKC deems necessary.

Insurer shall only distribute FHKC-approved Marketing materials at events.

Insurer shall provide a quarterly report listing all events attended and events Insurer intended to attend, but which were cancelled or Insurer otherwise did not attend. At a minimum, such reports shall include:

a. Event name;
b. Date of event;

c. Location of event;

d. Host organization;

e. Anticipated participant attendance;

f. Actual participant attendance, if available; and

g. Indication that Insurer did not attend, as applicable, and the reason for non-attendance.

Insurer shall provide an annual report assessing Insurer's Marketing events. The annual Marketing events assessment shall include:

a. A summary breakdown of the types of events attended by:

   i. Organization type;

   ii. Region;

   iii. Overall event purpose; and

   iv. Seasonal trends, if any.

b. An assessment of the Marketing events contribution to enrollment growth or maintenance;

c. A high-level summary of lessons learned; and

d. Any other information required by FHKC.

17-8 Nominal Gifts

Insurer may distribute nominal gifts so long as such gifts are:

a. Provided regardless of enrollment;

b. Valued at no more than fifteen dollars ($15) per item;

c. Valued at no more than seventy-five dollars ($75) in the aggregate per Enrollee on an annual basis; and

d. Not in the form of cash, gift cards, gift certificates, or other monetary rebates.

Nominal gifts require approval from FHKC prior to distribution.

17-9 Marketing Review Process

17-9-1 Marketing Materials

Insurer shall submit Marketing materials to FHKC for approval no less than thirty (30) Calendar Days prior to Insurer's intended utilization date, unless otherwise approved by FHKC. The total Marketing material review time from initial submission to final determination is dependent on

multiple factors, including the condition of the original submission, the time Insurer takes to make any requested changes and the size and complexity of the materials. This provision in no way guarantees a final determination within the thirty (30) Calendar Days.

For Marketing materials with multiple versions, Insurer shall submit a copy of each version with the request.

Insurer shall be responsive to FHKC's comments, questions, requests for more information and other such requests. Failure to be responsive to such requests or failure to provide sufficient information or appropriate changes may result in denial of Insurer's Marketing materials.

Insurer shall provide Marketing materials in the intended final format, including quality of images used and removal of watermarks from stock photos. Insurer may submit Marketing materials that include such marks as stock photo watermarks during the review period but must provide a copy of the final Marketing material with all such marks removed. Such Marketing materials are not considered approved until the submission of the unmarked form to FHKC regardless of any approval of the draft, marked material.

Insurer shall provide Marketing materials electronically and in a format in which FHKC may use standard software functionality to create redlines or insert comments. FHKC may require Insurer to submit any Marketing materials in a different format than the original submission if needed to effectively and efficiently review and provide feedback on the material.

17-9-2 Marketing Events

Insurer shall submit all events subject to prior approval to FHKC for review at least seven (7) Calendar Days prior to the event. If Insurer is invited to attend the event fewer than seven (7) Calendar Days in advance, Insurer shall submit the event to FHKC for approval as soon as reasonably possible.

Insurer shall submit all events to FHKC's public outreach calendar at least seven (7) Calendar Days prior to the event. If Insurer is invited to attend the event fewer than seven (7) Calendar Days in advance, Insurer shall submit the event to FHKC's public outreach calendar the same day the event invitation is accepted if the event does not require prior approval, or the same date the event is approved by FHKC if prior approval is required. Insurer shall inform FHKC if such an event is cancelled or Insurer is unable to attend as expected.

Section 18 Eligibility and Enrollment

18-1 Eligibility

FHKC is the sole authority for determining eligibility for Florida Healthy Kids. Insurer shall cooperate with any changes to eligibility and enrollment-related processes implemented by FHKC.

Insurer shall accept Enrollees FHKC identifies to Insurer for coverage, without restriction. Insurer shall not refuse to provide coverage to any Enrollee on the basis of past or present health status or need for healthcare services.

Insurer shall not refuse to provide coverage to, or use any policy or practice that has the effect of discriminating against, any Enrollee on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability or whether or not an Enrollee has executed an advance directive.

Insurer shall inform FHKC of information Insurer receives about changes in an Enrollee's circumstances that may affect the Enrollee's eligibility, including changes in Enrollee's residence and the death of the Enrollee within five (5) Business Days of receipt of such information.

18-1-1 Requests for Eligibility Review

If Insurer has reasonable cause to believe that an Enrollee is not eligible for the Program, (for example, Insurer believes an Enrollee should be placed in a different state or federal program for which eligibility would render that Enrollee ineligible for the Program), Insurer shall provide a written eligibility review request to FHKC.

Insurer's written eligibility review request shall include:

a. The reason for the eligibility review request;

b. How the relevant considerations were discovered;

c. Confirmation that no other considerations influenced Insurer's decision to request the review, including (specifically, but without limitation):

    i. An adverse change in the Enrollee's health status;

    ii. Utilization of services;

    iii. The Enrollee's diminished mental capacity; or

    iv. Uncooperative or disruptive behavior resulting from the Enrollee's special needs.

FHKC shall review the eligibility request and provide its findings to Insurer, to the extent permitted by law.

In the event Insurer disputes FHKC's determination of a written eligibility request and the request is based upon the Enrollee's eligibility for another state or federal program that would make the Enrollee ineligible for Florida Healthy Kids coverage, FHKC will seek an eligibility determination from the entity administering the federal or state insurance program for which Insurer alleges the Enrollee is eligible. The Parties shall be bound by the entity's response to the eligibility review request. The rights and remedies provided under this section are exclusive to such eligibility disputes.

18-2 Enrollment

FHKC is the sole authority for assigning enrollees to Florida Healthy Kids plans.

An Enrollee's coverage is effective at 12:00 a.m. on the first day of the Enrollee's first Coverage Month, as determined by FHKC.

18-2-1 Enrollment Files

FHKC shall provide Insurer all enrollment information necessary for Insurer to provide the services under this Contract. The enrollment information shall identify Enrollees who have been identified as American Indian or Alaskan Native, the Enrollees who are Title XXI eligible, the Enrollees who are enrolled in the Full-pay Plan and Enrollees who have met the out-of-pocket maximum of five percent (5%) of family income.

FHKC shall provide enrollment information as follows:

a. FHKC shall provide Insurer a preliminary enrollment file at least seven (7) Business Days prior to the start of the Coverage Month.

b. FHKC shall provide Insurer a supplemental enrollment file on the fifth day of the Coverage Month. Coverage for Enrollees identified on the supplemental enrollment file is effective retroactive to the first day of the Coverage Month.

c. FHKC may provide manual enrollment updates for reinstatements or terminations at any time. Coverage for Enrollees identified on manual enrollment updates is effective on the first of the identified Coverage Month.

d. FHKC shall notify Insurer in advance of any planned deviations from the enrollment file timeframes listed herein. Insurer shall accept these planned deviations as well as any unplanned deviations regardless of whether FHKC provided prior notification.

Insurer shall maintain an information system capable of electronically receiving and updating enrollment data as provided by FHKC. Insurer shall accept enrollment data in the format required by FHKC. Insurer shall accurately and timely process enrollment changes in accordance with this section and Attachment C.

The current enrollment file format is in Attachment E. The format is subject to change and shall not require a Contract amendment.

18-2-1-1 Enrollment File Discrepancy Reports

Insurer shall assess the preliminary and supplemental enrollment files each month and provide a discrepancy report to FHKC. Insurer shall report discrepancies on the enrollment file discrepancy report, such as duplicate records, address errors, records rejected by Insurer's system and other errors that call the data into question. Discrepancy reports shall be provided to FHKC within five (5) Business Days of receipt of the supplemental enrollment file.

Insurer shall timely make any corrections to the data required after FHKC's review of the discrepancy reports.

18-2-1-2 Enrollment Reconciliation

FHKC shall provide a monthly capitation file that includes all enrollment changes related to Insurer that have occurred in the month and the amount FHKC paid or offset for each Enrollee listed.

Insurer shall accept the monthly capitation file in the format FHKC requires. The current monthly capitation file format is in Attachment F. The format is subject to change and shall not require a Contract amendment.

Insurer shall use the monthly capitation file as the source for reconciling enrollment and premium payments. Insurer shall reconcile enrollment and premiums received and provide the results of such reconciliation to FHKC quarterly.

18-2-2 Enrollee Assignment Process

During the first Contract Year, FHKC shall auto-assign potential enrollees to available plans on a one-to-one (1:1) basis, upon application approval. Beginning with the second Contract Year, FHKC may choose to:

a. Continue assigning potential enrollees to available plans on a one-to-one (1:1) basis; or

b. Modify the auto-assignment process to an assignment ratio other than one-to-one (1:1) to the benefit of higher performing Florida Healthy Kids insurers. FHKC may consider performance measure results, provision of obligations in compliance with this Contract, quality assessment and performance improvement execution or any other aspect or aspects, in whole or in part, of Insurer's obligations under this Contract, subject to FHKC's sole discretion.

At initial enrollment, enrollees are provided a Free-look Period in which the enrollee has ninety (90) Calendar Days to enroll with another available plan without cause. Enrollees are provided a Free-look Period annually. Enrollees may only request a change in plans outside of a Free-look Period as provided in this section.

FHKC is responsible for notifying enrollees of their right to request a plan enrollment change outside of the Free-look Period, if such choice is available in their Region, as follows:

a. For cause:

   i. The Enrollee has moved out of Insurer's Service Area under this Contract;

   ii. The Enrollee has an active relationship with a health care Provider who is not in Insurer's network but is in the network of another available health plan;

iii. Insurer no longer participates in the Region in which the Enrollee resides;

iv. The Enrollee's health plan is under a quality improvement plan or corrective action plan relating to quality of care intermediate sanctions with FHKC; or

v. Other reasons, including poor quality of care, lack of access to services or lack of access to Providers experienced in providing care needed by Enrollee.

b. Without cause, determined on a case-by-case basis by FHKC.

18-2-3 Enrollment Procedures

18-2-3-1 Primary Care Provider Assignment

Insurer shall offer each Enrollee a choice of Primary Care Providers (PCPs) who meet the credentialing, access and appointment standards of this Contract. In addition to offering Enrollees a choice of PCPs, Insurer shall ensure each Enrollee is assigned to a PCP who acts as an appropriate ongoing source of care and is primarily responsible for coordinating the services accessed by the Enrollee.

Insurer may auto-assign Enrollees to PCPs, but Enrollees must be permitted to select another PCP. Should Insurer choose to auto-assign Enrollees to PCPs, Insurer may consider provider quality metrics and outcomes and shall consider the following when making such assignments:

a. The Enrollee's last PCP assignment, if known;

b. Time and distance from the Enrollee's home address;

c. Sibling assignments; and

d. The Enrollee's age and any age limitations with the PCP.

18-2-3-2 Enrollment Package

Insurer shall provide an enrollment package to new Enrollees within five (5) Business Days' receipt of the enrollment information. The enrollment package shall include or make reference to, the following items in accordance with the terms of Section 21-3, Enrollee Materials:

a. Member identification card;

b. PCP assignment and contact information or PCP selection instructions;

c. Member handbook;

d. Provider directory; and

e. Plan formulary.

18-2-3-3 Health Risk Assessment

Insurer shall have mechanisms in place to assess Enrollees and provide those determined to have special health care needs with direct access to a specialist in a manner that is appropriate for the Enrollee's condition and identified needs. Direct access may include a standing referral or an approved number of visits.

Insurer shall make a best effort to conduct an initial health risk assessment (HRA) within ninety (90) Calendar Days from the coverage effective date for all new Enrollees. Insurer shall make subsequent attempts to contact the Enrollee for an initial HRA if the first attempt is unsuccessful.

Insurer shall conduct an HRA incentive plan, as approved by FHKC, to increase the percentage of new Enrollees who complete an HRA within the first ninety (90) days of enrollment. The HRA incentive plan shall include an annual goal reflecting year-over-year improvement. Insurer shall report on the HRA completion rate quarterly. Based on reported results, FHKC may require Insurer to use a specific incentive methodology.

To prevent duplication of work, Insurer shall accept such information as assessed by another insurer in the Program from FHKC. Likewise, Insurer shall provide such information to FHKC or another Florida Healthy Kids insurer, upon FHKC's request.

FHKC may choose to implement a standardized Florida Healthy Kids HRA. Upon FHKC request, Insurer shall participate in a workgroup to develop the standardized Florida Healthy Kids HRA. Insurer shall utilize and provide ongoing support for the standardized Florida Healthy Kids HRA.

For purposes of this provision, "special health care needs" means health care needs sufficient to meet the clinical eligibility criteria for the CMS Plan.

18-3 Disenrollment

An Enrollee's coverage shall terminate on the last day of the Coverage Month in which the Enrollee:

a. Ceases to be eligible to participate;

b. Establishes residence outside of the Service Area; or

c. Is determined to have acted Fraudulently.

Insurer may not request disenrollment of an Enrollee for any reason.

Termination of coverage and the effective date of such termination shall be determined solely by FHKC.

Section 19 Enrollee Rights

Insurer shall comply with all applicable state and federal laws pertaining to Enrollee rights and shall ensure that Insurer's network Providers observe and protect those rights.

Insurer shall maintain written policies regarding Enrollee rights. Insurer shall provide a copy of such policies to FHKC during implementation of the Contract and by the date established in the approved implementation plan. Insurer shall also provide a copy of its Enrollee rights policies for review prior to the effective date of any change to such policies.

Insurer shall provide education and training on Enrollee rights to its staff.

An Enrollee's exercise of his or her rights shall not adversely affect the way Insurer, or Insurer's network Providers, treat the Enrollee. At a minimum, Insurer must adhere to the Enrollee rights listed in this provision.

In accordance with 42 CFR 457.1220 which incorporates 42 CFR 438.100, Enrollees have the right to:

a. Receive information in accordance with 42 CFR 438.10;
b. Be treated with respect and consideration for his or her dignity and privacy;
c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;
d. Participate in decisions regarding his or her health care, including the right to refuse treatment;
e. Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion;
f. Request and receive a copy of his or her medical records and request that such medical records be amended or corrected; and
g. Receive health care services in accordance with 42 CFR 438.206- 438.210.

Section 20 Cultural Competency

Insurer shall provide services, including oral and written communication to Enrollees, in a culturally competent manner appropriate for the population, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

Insurer shall maintain a comprehensive written cultural competency plan describing how Insurer, its Providers, employees and systems will effectively provide services to Enrollees of all

cultures, races, ethnic backgrounds, and religions in a manner that recognizes, affirms, and respects the worth of the Enrollee and protects and preserves the dignity of each.

Insurer shall submit its initial cultural competency plan for approval by FHKC by the date established in the approved implementation plan and annually thereafter by November 1st.

Section 21 Enrollee Services

Insurer shall maintain an enrollee service unit to provide enrollee-related customer service. The enrollee service unit shall have the ability to answer Enrollee inquiries by telephone, electronic communication and written communication. The enrollee service unit shall be accessible by a toll-free telephone number during the hours of 7:30 a.m. to 7:30 p.m. Eastern Time, Monday through Friday, except on state-recognized holidays.

Insurer shall utilize automatic call distribution equipment and enrollee services representatives staffing sufficient to handle the expected volume of calls. Insurer shall also provide a telecommunication device for the deaf (TTY/TDD) and access to interpreter services. Insurer shall ensure enrollee services representatives are satisfactorily trained and capable of resolving Enrollee and potential Enrollee inquiries in all areas related to Florida Healthy Kids. Insurer's enrollee services representatives shall be familiar with the basic eligibility requirements for the Florida Healthy Kids Program, but shall refer or transfer individuals with detailed questions or concerns to the Florida KidCare call center. Insurer shall monitor the enrollee services line to ensure Insurer meets certain performance standards and for quality assurance, including recording calls, conducting routine audits and other monitoring activities. Insurer shall meet the performance guarantees related to enrollee services included in Attachment C.

Insurer shall provide a nurse line staffed by licensed nurses and available to Enrollees twenty-four (24) hours per day, seven (7) days a week. The nurse line shall provide health education and assist Enrollees in determining which place of care (e.g., urgent care center, emergency department, PCP office) is clinically appropriate for the symptoms described. Insurer shall also provide a behavioral health crisis line staffed by licensed professionals and available to Enrollees twenty-four (24) hours per day, seven (7) days a week. The behavioral health crisis line may be provided as part of the nurse line or separately. If the behavioral health crisis line is part of the nurse line, all licensed nurses must be trained appropriately.

Insurer shall provide a publicly available website with access to Florida Healthy Kids information. The publicly available website shall include:

a. The Enrollee handbook,

b. A printable provider directory,

c. A searchable electronic provider directory,

d. Insurer's preferred drug list (PDL),

e. A link to FHKC's Florida Healthy Kids website, and
f. Any other information that may be needed by Enrollees or potential Enrollees.

Insurer's publicly available website is subject to FHKC approval.

Insurer shall also provide a website with secure access for Enrollees. The non-public website access shall include:

a. The ability for Enrollees to print a temporary ID card,
b. The ability for Enrollees to request a new ID card,
c. Enrollee educational materials (unless Insurer chooses to make such materials available on the publicly-available website), and
d. Cost sharing accumulator information
    i. Insurer shall track the Enrollees' cost share contributions to assist families in tracking their progress towards the out-of-pocket maximum.

Insurer's non-public website is subject to FHKC's approval.

21-1 Escalated Enrollee Issues

FHKC sometimes receives Enrollee complaints or concerns directly from Enrollees or forwarded from state agencies, legislative offices and others. FHKC may forward such issues to Insurer for research and resolution. An escalated Enrollee issue may be designated by FHKC as an urgent escalated Enrollee issue based upon factors such as the Enrollee's health status. All other escalated Enrollee issues are considered routine escalated Enrollee issues.

Insurer shall acknowledge receipt of the escalated Enrollee issue within two (2) hours for urgent escalated Enrollee issues and by close of business for routine escalated Enrollee issues unless a different timeframe is specified by FHKC.

Insurer shall provide regular status updates to FHKC on any activities and progress underway, including when further action and progress are temporarily halted. In the event progress is temporarily halted, Insurer shall allow no more than two (2) Business Days or three (3) Calendar Days between updates, whichever is earlier. Insurer shall not wait to be prompted for status updates by FHKC to provide such updates.

To the extent reasonable and unless otherwise required by FHKC, Insurer shall resolve routine escalated Enrollee issues within five (5) Business Days and urgent escalated Enrollee issues within two (2) Business Days, unless the Enrollee's health requires faster resolution. In the event the expected resolution timeframe is not reasonable to resolve the escalated Enrollee issue, Insurer shall inform FHKC in writing and provide an expected timeframe for resolution and the basis for the extended timeframe, subject to FHKC approval.

Escalated Enrollee issues are not intended to take the place of or circumvent any aspect of the Grievance or Appeal process. The Parties shall act in good faith in the performance of this provision.

21-2 Translation Services; Alternative Formats

Insurer shall provide oral translation services to any Enrollee who speaks any non-English language. Insurer shall notify Enrollees of the availability of oral interpretation services and inform Enrollees how to access such services.

Insurer shall make all written materials available in English, Spanish and all other prevalent non-English languages. Prevalent non-English languages means any language in Insurer's Service Area spoken by approximately five percent (5%) or more of Insurer's Florida Healthy Kids population.

Insurer shall provide translation services to Enrollees at no cost.

21-3 Enrollee Materials

Insurer is responsible for all preparation, cost and distribution of Enrollee materials.

Insurer shall provide all materials to Enrollees and potential Enrollees in a manner and format that may be easily understood and is readily accessible in accordance with 42 CFR 457.1207 which incorporates 42 CFR 438.10. Insurer agrees to follow best practices related to accessibility of materials insofar as such best practices are reasonable and practicable.

Insurer shall use a font size no smaller than 12-point in all written materials.

Insurer shall make all written materials available in alternative formats and in a manner that takes into consideration the Enrollees' special needs, including those who are visually impaired or have limited reading proficiency. Such alternative formats shall include auxiliary aids and services, oral interpretation in any language and written interpretation in the language(s) prevalent in the Service Area. Insurer shall notify all Enrollees that information is available in alternative formats upon request at no cost. Insurer shall also inform Enrollees how to access such services.

Written materials shall include a notice of nondiscrimination and taglines explaining the availability of written or oral translation in the prevalent non-English languages in the Service Area, as required by Section 1557 of the Affordable Care Act, as well as in large print, which means printed in a font size no smaller than 18-point. Insurer shall use the top fifteen (15) prevalent non-English languages determined by HHS unless otherwise approved by FHKC to use another source Insurer believes is more accurate.

Insurer shall inform FHKC of the intended method(s) Insurer will use to distribute Enrollee materials. FHKC may require Insurer use or refrain from using certain method(s).

Insurer shall make good faith efforts to contact or provide materials through alternate, allowable, methods to Enrollees when mail or other communication is returned undeliverable.

21-3-1 Specified Enrollee Materials

At a minimum, Insurer must provide the Enrollee materials specified in this section. As directed by FHKC, Insurer shall coordinate with FHKC and its contractors to promote consistency in messaging to Enrollees.

A. Enrollee Identification (ID) Card.

Insurer shall mail each Enrollee a hardcopy of his or her Enrollee ID card without requiring that the Enrollee first request such hardcopy. The Enrollee ID card shall include Insurer's name, the Enrollee's name, ID number, effective date of coverage and Insurer's contact information. The Enrollee ID card shall identify the Enrollee as a Florida Healthy Kids member and shall not contain any potentially misleading information, such as references to non-Florida Healthy Kids Programs.

B. Enrollee Handbook.

Insurer shall provide an Enrollee handbook based on the model Enrollee handbook provided by FHKC. Insurer shall customize such material to the extent permitted or required by FHKC. The handbook shall include the following elements:

a. A description of benefits and any associated cost sharing sufficient to ensure that Enrollees understand the benefits covered by this Contract, including the scope, amount, duration and limitations associated with a benefit.

b. A description of how to access services, including any requirements for prior authorization of any services, referrals for specialty care or any other restrictions on choice among network Providers.

c. Disclosure of any services Insurer does not cover because of moral or religious objections and instructions about how to obtain information from FHKC about how to access any such services.

d. The extent to which, and how, Enrollees may obtain benefits, including family planning services and supplies from out-of-network Providers and an explanation that Insurer cannot require an Enrollee to obtain a referral before choosing a family planning Provider.

e. A description of Emergency Medical Conditions and services, including post-stabilization services, including what constitutes an emergency, the fact that prior authorization is not required, and that Enrollee has a right to use any hospital or setting for emergency care.

f. The process for selecting and changing the Enrollee's PCP;

g. A description of the Grievance and Appeal process, including the right to file and the availability of assistance in the filing process;

h. A description of the Enrollee's rights and responsibilities;

i. An explanation about how to exercise an advance directive;

j. How to access auxiliary aids and services, including accessing information in alternative formats or languages;

k. The toll-free telephone number for Enrollee Services and any other unit providing services directly to Enrollees;

l. How to report suspected Fraud or Abuse; and

m. Any other information required by FHKC.

C. Provider directory.

Insurer shall make a Provider directory available on Insurer's website in a machine-readable file and format, as specified by the Secretary of HHS, as well as in paper form upon request. Insurer shall also make a searchable electronic Provider Directory available on Insurer's website.

Information included in a hardcopy Provider directory or a printable electronic Provider directory must be updated at least monthly. Searchable electronic Provider directories must be updated no later than thirty (30) Calendar Days after Insurer receives updated Provider information.

At a minimum, the Provider directory must contain the following information for each PCP, specialist (including behavioral health Providers), hospital and pharmacy:

a. Provider name;

b. Provider group affiliation, if any;

c. Specialty, as appropriate;

d. Street Address(es);

e. Telephone number(s);

f. Website URL, if any;

g. Office hours;

h. Age limitations, if any;

i. Non-English languages, including American Sign Language, spoken by the Provider or a skilled medical interpreter at the Provider's office;

j. Whether Provider has completed cultural competency training;

k. Whether Provider's office or facility has accommodations for people with physical disabilities, including offices, exam rooms and equipment; and

l. Whether the Provider is accepting new patients.

D. Preferred Drug List (PDL).

Insurer shall make information about which generic and brand name medications are covered in Insurer's formulary available in print and electronic formats. Insurer's PDL must be available on Insurer's website in a machine-readable file and format, in accordance with state and federal regulations.

Insurer's PDL and all changes to the PDL are subject to approval by FHKC. Insurer shall submit proposed revisions to the PDL to FHKC for approval at least thirty (30) Calendar Days prior to the earlier of the effective date of the changes or the intended Enrollee notification date described below.

Insurer shall notify Enrollees who have filled a prescription in the last twelve (12) months for a medication that is being removed from the PDL or for which additional utilization management requirements will apply sixty (60) Calendar Days prior to the effective date of the change. Insurer shall not notify Enrollees of any changes or potential changes before receiving FHKC approval.

E. Enrollee Handbook notice of Change.

Insurer shall provide Enrollees with a notice of change for any significant changes, as determined by FHKC, made to the Enrollee handbook. Any such notices must be provided to Enrollees at least thirty (30) Calendar Days prior to the effective date of such change.

F. Notice of Network Provider Termination.

Insurer shall notify Enrollees who received services from a terminating provider within the past six (6) months of such termination at least sixty (60) Calendar Days before the effective date of the termination. When such notice is not possible, Insurer shall make a good faith effort to provide written notice to Enrollees who received primary or regular care from a terminating network Provider within fifteen (15) Calendar Days of receipt or issuance of the Provider termination notice.

G. Advance Directives.

Insurer shall provide adult Enrollees with written information on advance directive policies, including a description of applicable Florida law, within five (5) Business Days of the Enrollee's

eighteenth birthday or enrollment in the event an Enrollee enrolls in coverage at age eighteen (18). Such information must be updated to reflect changes in State law within ninety (90) Calendar Days of the effective date of such change.

H. Certificates of Creditable Coverage.

Insurer is responsible for issuing certificates of creditable coverage to Enrollees upon the Enrollee’s request.

21-3-2 Enrollee Material Review Process

All Enrollee materials must be approved by FHKC prior to distribution.

Insurer shall submit Enrollee materials to FHKC for approval no less than thirty (30) Calendar Days prior to Insurer’s intended publication or utilization date, unless otherwise approved or required by FHKC. The total Enrollee material review time from initial submission to final determination is dependent on multiple factors, including the condition of the original submission, the time Insurer takes to make any requested changes and the length and complexity of the materials. This provision in no way guarantees a final determination within the thirty (30) Calendar Days.

For Enrollee materials with multiple versions, Insurer shall submit a copy of each version with the request.

Insurer shall be responsive to FHKC’s comments, questions, requests for more information and other such requests. Failure to be responsive to such requests or failure to provide sufficient information or appropriate changes may result in denial of Insurer’s Enrollee materials.

Insurer shall provide Enrollee materials in the intended final format, including quality of images used and removal of watermarks from stock photos. Insurer may submit Enrollee materials that include marks such as stock photo watermarks during the review period, but must subsequently provide a copy of the final Enrollee material with all such marks removed. Such Enrollee materials are not considered approved until the submission of the unmarked form to FHKC, regardless of any approval of the draft, marked material.

Insurer shall provide Enrollee materials electronically and in a format in which FHKC may use standard software functionality to create redlines or insert comments. FHKC may require Insurer to submit any Enrollee materials in a different format than the original submission if needed to effectively and efficiently review and provide feedback on the material.

Section 22 Benefits

Insurer shall provide the Covered Services described in Attachment A. In the event Insurer requires clarification about any coverage or cost-sharing requirement, Insurer shall consult with

FHKC. Insurer shall have mechanisms in place to help Enrollees and potential Enrollees understand the requirements and benefits of the Plan.

In the event an Enrollee meets the out-of-pocket maximum, Insurer shall be responsible for informing its Providers and ensuring that such Enrollees incur no further out-of-pocket costs for Covered Services. FHKC shall provide Enrollees who have met the out-of-pocket maximum a letter stating that the Enrollee shall not incur any cost-sharing responsibilities for the remainder of the Contract Year.

Insurer shall not avoid costs for services covered under this Contract, including immunization requirements, by referring Enrollees to publicly supported health care resources and requiring the Enrollee to utilize those resources.

Insurer shall ensure that services provided are sufficient in amount, duration and scope to reasonably achieve the purpose for which the services are furnished. Insurer shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness or Enrollee condition. This provision does not prohibit Insurer from placing appropriate limits on services or implementing utilization management controls.

22-1 Utilization Management

Insurer shall establish utilization management controls to ensure Enrollees receive appropriate care. Insurer's utilization management controls shall allow for consideration of factors specific to individual Enrollees such as age and medical history.

Insurer shall not compensate individuals or entities conducting utilization management activities in a way that provides incentives for the individual or entity to deny, limit or discontinue Medically Necessary services to an Enrollee.

Utilization management activities, including prior authorization reviews, shall be conducted by individuals with clinically appropriate backgrounds in a manner that results in interrater reliability sufficient to indicate the appropriateness and validity of the process, including the training given to the reviewers.

22-2 Behavioral Health; Substance Use Disorder Benefits

Insurer shall adopt Section 394.491 and Chapter 397, Florida Statutes, as guiding principles in the delivery of services and supports to Enrollees with behavioral health care needs, including substance use disorder services.

Insurer shall maintain policies and procedures that support:

a. Early identification of behavioral health care needs through the use of valid assessments;

b. The use of services that enhance the Enrollee's likelihood of positive outcomes, improved ability to function at home, school and in the community, and to live drug-free;

c. Enrollees' ability to receive services in the least restrictive and most normal environment that is clinically appropriate;

d. The use of care or case management and coordination of services; and

e. A smooth transition to adult behavioral health care, for older Enrollees.

Insurer shall also make educational materials about recognizing child and adolescent behavioral health care needs and how to obtain access to treatment and support services available to Enrollees.

22-3 Parity

Insurer shall comply with the requirements of 42 CFR 457.496. Insurer shall conduct parity assessments using the Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs published by CMS on January 17, 2017, as amended or replaced, unless such toolkit becomes outdated and not revised or replaced. Insurer shall provide an initial parity assessment during implementation of the Contract by the date established in the approved implementation plan.

Prior to making significant changes to the administration of benefits, including implementing or changing any utilization management policies, whether quantitative or non-quantitative in nature, Insurer shall conduct a parity assessment on the change in question and provide such assessment to FHKC. This requirement does not require Insurer to conduct a full parity assessment.

Insurer shall also conduct parity assessments upon FHKC's request. Insurer shall provide supporting documentation to FHKC, including documentation required by CMS for inclusion in the parity-related provisions of the state plan amendment.

If Insurer utilizes a Subcontractor for behavioral health services, Insurer may allow the Subcontractor to assist in conducting the parity assessment, but Insurer must validate any such work.

All parity assessments must be satisfactory to FHKC. Insurer shall revise any unacceptable parity assessments to FHKC's satisfaction.

In the event Insurer is not at parity in any aspect, Insurer shall implement appropriate, timely changes to become compliant. FHKC shall reserve the right to approve or disapprove Insurer's approach to become compliant.

22-4 Lifetime Limit

Once an Enrollee has accumulated $1 million in claims paid under the Program, the Enrollee's eligibility for the Program ends effective after the last day of the Enrollee's continuous eligibility period, or the functional equivalent for Full-pay Enrollees, unless extended in accordance with any applicable notification, eligibility dispute, or Appeal requirements, as determined by FHKC. Insurer shall not limit, reduce payment, or deny claims solely because an Enrollee has accumulated $1 million or more in paid claims.

Insurer shall submit a monthly report listing all Enrollees with claims costs exceeding seven hundred thousand dollars ($700,000). Insurer shall include sufficient information to identify the Enrollee, the amount of Enrollee's accumulated claims, whether the Enrollee is eligible for case management, and if so, the Enrollee's case management enrollment status, whether the Enrollee has active coverage with Insurer, the termination date of Enrollee's coverage with Insurer and any notes about the record relevant to FHKC. Insurer shall continue to report inactive Enrollees until such Enrollees have been inactive for twelve (12) months. Insurer shall not include any claims incurred prior to January 1, 2020.

FHKC may choose to implement a different methodology for monitoring Enrollees nearing the lifetime limit. Insurer agrees to cooperate with any such changes.

In the event Insurer becomes aware of an Enrollee who experiences a potentially catastrophic event likely to cause the Enrollee to meet and/or exceed the lifetime limit for which Insurer has not yet received significant claims, Insurer shall report the event to FHKC within five (5) Business Days of Insurer's receipt of sufficient information to make such determination. Insurer's awareness of the potentially catastrophic event shall not be based solely upon the claims' staff awareness and shall include any department or business unit within Insurer's organization, including clinical staff and enrollee service representatives. Insurer's report to FHKC shall include, at a minimum, the Enrollee's name, ID number and a summary narrative sufficient to allow FHKC to determine potential next steps needed.

22-5 Telehealth

FHKC considers telehealth to be a modality of care and not a separate form of health care practice. As such, all requirements applicable to Providers delivering in-person services apply to Providers delivering telehealth services, including standards of care and medical record requirements. Insurer shall not apply any policies or procedures to telehealth services that are significantly more restrictive or stringent than those applied to in-person services unless such differences are required to maintain the intent and functionality of a policy or procedure that applies to in-person services.

Insurer shall cover benefits for services provided by telehealth to the extent the same services are provided in-person, when possible and appropriate. Insurer shall cover store-and-forward and remote patient monitoring services telehealth modalities, as appropriate.

Telephone conversations (without two-way, real-time audio and visual components), chart review, email, and facsimile transmissions are not considered telehealth.

22-6 Benefit Determinations; Practice Guidelines

Insurer shall consult with the requesting Provider when making benefit determinations, as appropriate.

Insurer shall follow written policies and procedures and practice guidelines, for making benefit determinations, including processing requests for initial and continuing authorization for services.

Insurer shall adopt practice guidelines:

a. That are based on valid, reliable clinical evidence of Providers in the relevant field;

b. Consider the needs of Enrollees; and

c. In consultation with contracting health care professionals.

Insurer shall review and periodically update its practice guidelines, as appropriate.

Decisions related to utilization management, Enrollee education, coverage of services and other relevant areas shall be consistent with Insurer's adopted practice guidelines. Insurer shall provide any practice guidelines used for the Plan to Enrollees, potential Enrollees and network Providers, upon request.

22-6-1 Adverse Benefit Determinations

Insurer shall provide timely and adequate written notice of an Adverse Benefit Determination. The benefit determination and any notice of Adverse Benefit Determination must be provided within the following timeframes in accordance with 42 CFR 457.1260 and to the extent it incorporates 42 CFR part 438 subpart F:

a. For termination, suspension or reduction of previously approved services, the notice must be provided at least ten (10) Calendar Days before the date of action except when:

    i. Insurer has information confirming the death of the Enrollee;

    ii. Insurer receives a clear signed written statement from the Enrollee stating that the Enrollee no longer wishes to receive services, or the Enrollee gives information that requires termination or reduction of services and the Enrollee indicates understanding that termination or reduction of services must be the outcome of providing such information;

    iii. The Enrollee has been admitted to an institution which causes ineligibility under the plan for further services;

iv. The Enrollee's whereabouts are unknown and the United States Postal Service returns Insurer's mail to the Enrollee with no forwarding address;

v. Insurer establishes that the Enrollee is enrolled in Florida Healthy Kids with another insurer;

vi. A change in the level of medical care is prescribed by the Enrollee's physician;

vii. The notice involves an Adverse Benefit Determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act;

viii. In accordance with 42 CFR 431.213(h); and

ix. Insurer has facts, verified through secondary sources when possible, indicating that action should be taken because of probable Fraud by the Enrollee. In such instances the notice must be provided at least five (5) Calendar Days before the date of action.

b. For denial of payment, the notice must be provided at the time of any action affecting the claim;

c. For standard service authorization decisions that deny or limit services, within fourteen (14) Calendar Days following receipt of request for service, except that Insurer may extend the timeframe up to an additional fourteen (14) Calendar Days if the Enrollee or Provider requests extension or Insurer is able to justify to FHKC a need for additional information and that the extension is in the Enrollee's interests so long as:

    i. Insurer gives the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance; and

    ii. Insurer issues and carries out the determination as expeditiously as the Enrollee's health condition requires, but no later than the date the extension expires.

d. For service authorization decisions not reached within the timeframes required by 42 CFR 438.210(d), which constitutes a denial and thus is an Adverse Benefit Determination, Insurer must provide the notice on the date the timeframe expires;

e. For expedited service authorization decisions, Insurer must provide notice as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours after receipt of the request, except that Insurer may extend the timeframe up to an additional fourteen (14) Calendar Days if the Enrollee or Provider requests extension or Insurer is able to justify to FHKC a need for additional information and that the extension is in the Enrollee's interests; or

f. Insurer shall provide notice of a decision in response to a request for authorization of outpatient drugs by telephone or other telecommunication device within twenty-four (24) hours of the request, in accordance with section 1927(d)(5)(A).

A notice of Adverse Benefit Determination must include:

a. The Adverse Benefit Determination Insurer has made;

b. The reason for the Adverse Benefit Determination;

c. The Enrollee's right to be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Adverse Benefit Determination, including Medical Necessity criteria and processes, strategies or evidentiary standards used in setting coverage limits;

d. The Enrollee's right to request an Appeal, including information on exhausting the Appeal process and the right to request an independent review;

e. The procedures for exercising these rights; and

f. The circumstances under which an Appeal can be expedited and how the Enrollee can request an expedited Appeal.

22-7 Value-add Benefits

Insurer may offer value-add benefits at no cost to FHKC or the Enrollees. Insurer shall offer any value-add benefits proposed during the ITN and listed in Attachment A.

Insurer shall submit any proposed value-add benefits, including a description of the eligible population and any limitations, to FHKC for approval.

Insurer must request and receive FHKC approval to discontinue any value-add benefits. Value-add benefits shall be offered for at least one (1) complete Contract Year and shall not be discontinued during a Contract Year. Any value-add benefits proposed during the ITN and included in this Contract are considered material to the competitive ITN process. As such, Insurer shall not discontinue these value-add benefits without replacing the value-add benefit with an equivalent value-add benefit, subject to FHKC approval. An equivalent value-add benefit must be relevant to the Florida Healthy Kids population and must be expected to fulfill similar needs for Enrollees regarding the number of Enrollees potentially impacted and the level of care. Requests for changes to value-add benefits shall be submitted to FHKC for consideration annually on July 1. Insurer shall provide Enrollees with notice of any value-add benefit changes at least ninety (90) Calendar Days in advance of such changes.

If a value-added service is provided in lieu of a covered service or setting required in this Contract:

a. Such service is subject to FHKC's determination that the alternative service or setting is medically appropriate and cost effective;
b. Enrollees are not required to use the alternative service or setting;
c. The alternative services or setting are authorized and identified in this Contract; and
d. The utilization and actual cost of the alternative services or setting are taken into account when developing the premium rates in accordance with 42 CFR 457.1201(e) which incorporates 42 CFR 438.3(e)(2)(iv).

Insurer shall include all value-add benefits in Insurer's Enrollee handbook.

22-8 Additional Service Commitments

Insurer shall provide any additional service commitments specified in Attachment A. Insurer shall also make available to Enrollees any materials or services generally available to Insurer's other clients, such as educational material, access to relevant websites, or assistance finding and accessing community support services.

The provision of an additional service commitment does not guarantee access or availability of the specified additional service commitment to any Enrollee; access and availability may be dependent upon a variety of variables including location and eligibility requirements.

Insurer shall inform FHKC in writing of any substantial changes to any additional service commitments at least sixty (60) Calendar Days in advance unless otherwise specified.

22-9 Social Determinants of Health

Insurer shall have a mechanism to address social services needs of Enrollees through available community-based social service resources. Insurer shall not require Enrollees to access community-based social service resources instead of covered benefits.

22-10 Disease and Case Management

Insurer shall provide disease and case management services. Insurer shall provide FHKC a list of disease and case management programs, to the extent any case management is condition-specific, by the date established in the approved implementation plan. Insurer shall inform FHKC of any addition or removal of such programs sixty (60) Calendar Days prior to the change.

Insurer shall have policies and procedures in place for identifying and enrolling Enrollees likely to benefit from such services.

Insurer shall provide a quarterly disease and case management report that includes the number of Enrollees identified as eligible for disease or case management, the number of Enrollees enrolled in the quarter, the percentage of eligible Enrollees engaged in disease or case

management, Insurer's definition of "engagement" and a breakdown of such information by program.

22-11 Coordination; Transition of Care

Insurer shall coordinate, or provide for the coordination of, services between settings of care, including appropriate discharge planning for short and long-term hospital and institutional stays, with services Enrollees receive from other health care coverage or liable third-parties and with services Enrollees receive from community and social support Providers.

Insurer shall implement a transition of care policy consistent with the transition of care policy adopted by FHKC. FHKC's transition of care policy shall be made publicly available. Insurer will provide a copy of Insurer's transition of care policy to FHKC during implementation of the Contract, by the date established in the approved implementation plan, and prior to any proposed changes. Changes to Insurer's transition of care policy are subject to FHKC's approval. Summaries of the transition of care policy shall be included in the Enrollee handbook and relevant notices.

Notwithstanding any other provision of this Contract, as of the Effective Date of this Contract, Insurer shall be liable for the cost of any previously authorized, ongoing course of treatment provided to an Enrollee by any provider, regardless of whether such provider has a contract with Insurer, without any further authorizations, for an additional sixty (60) Calendar Days after termination or expiration of any prior insurer's contract covering such Enrollees.

22-12 Dental Coordination

Insurer shall coordinate care with Enrollees' Florida Healthy Kids dental insurance carriers. Insurer shall enter into data sharing agreements and shall exchange data with FHKC's contracted dental insurance carriers as directed by FHKC, including sharing medical encounters for fluoride varnish services.

Section 23 Grievances and Appeals

Insurer shall have a Grievance and Appeal system in place for Enrollees in compliance with 42 CFR 457.1260. The Grievance and Appeal system shall be the same for Title XXI Enrollees and Full-pay Enrollees. Insurer shall establish and maintain policies and procedures for the Grievance and Appeal system, including procedures for expedited Appeals.

Insurer shall provide its Grievance and Appeal policies and procedures to FHKC by the date established in the approved implementation plan and at least sixty (60) Calendar Days prior to any proposed changes. The initial policy and procedures and any subsequent changes are subject to approval by FHKC. Insurer shall provide its Grievance and Appeal policies and procedures to Providers and Subcontractors when Insurer enters into a written agreement with such entities or individuals and after any approved changes.

Insurer shall ensure individuals making decisions about Grievances and Appeals:

a. Were not involved in any previous level of review or decision-making and are not the subordinate of any such individual;
b. Have the appropriate clinical expertise in treating the Enrollee's condition or disease when:
    i. An Appeal is based on lack of Medical Necessity;
    ii. A Grievance is about the denial of an expedited resolution of an Appeal; and
    iii. A Grievance or Appeal involves clinical issues.
c. Take all comments, documents, records and other information submitted by the Enrollee or Enrollee's representative into account without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

Insurer shall maintain a record of all Grievances and Appeals that includes the following information for each Grievance and Appeal:

a. Date received;
b. Date of each review or review meeting, as applicable;
c. Enrollee name;
d. Nature or general description of the reason for the Grievance or Appeal;
e. Disposition of each level of the Grievance and Appeal process, as applicable;
f. Date of resolution at each level, as applicable; and
g. Documents relevant to each Grievance and Appeal.

Insurer shall accurately maintain these records in a manner accessible to FHKC and, upon request, CMS.

Insurer shall provide FHKC with a quarterly Grievances and Appeals report. The Grievances and Appeals report shall include:

a. A summary analysis of the Grievances and Appeals that includes:
    i. Appeal response timeliness as a percentage of Appeals in the reporting quarter that were closed timely. Appeals closed in the quarter includes Appeals that were received in a different quarter and closed in the reporting quarter.

ii. Grievance response timeliness as a percentage of Grievances in the reporting quarter that were closed timely. Grievances closed in the quarter includes Grievances that were received in a different quarter and closed in the reporting quarter.

b. Line item records of Grievances and Appeals received in the quarter that includes:

   i. The date received;

   ii. Identification as a Grievance or an Appeal;

   iii. Nature or general description of the reason for the Grievance or Appeal;

   iv. The disposition, as applicable;

   v. The date of the disposition, as applicable;

   vi. If a Subcontractor handles the Grievance or Appeal, the name of the Subcontractor responsible; and

   vii. An indicator showing whether the Grievance or Appeal is for a Title XXI Enrollee or a Full-pay Enrollee.

c. Line item records of Grievances and Appeals closed in the quarter that includes:

   i. The date received;

   ii. Identification as a Grievance or an Appeal;

   iii. Nature or general description of the reason for the Grievance or Appeal;

   iv. The disposition;

   v. The date of the disposition;

   vi. If a Subcontractor handles the Grievance or Appeal, the name of the Subcontractor responsible; and

   vii. An indicator showing whether the Grievance or Appeal is for a Title XXI Enrollee or a Full-pay Enrollee.

Insurer shall provide an annual summary analysis Grievance and Appeals report that includes:

a. Appeal response timeliness as a percentage of Appeals in the reporting Contract Year that were closed timely. Appeals closed in the Contract Year includes Appeals that were received in a different Contract Year for this Contract and closed in the reporting Contract Year.

b. Grievance response timeliness as a percentage of Grievances in the reporting Contract Year that were closed timely. Grievances closed in the Contract Year includes Grievances

that were received in a different Contract Year for this Contract and closed in the reporting Contract Year.

c. Summary of any Appeal trends. At a minimum Insurer shall consider whether any trends may be found regarding benefits appealed, Provider specialty types involved (as a function of the benefit, not related to Provider involvement in the Appeal process), and similarities in overturned Appeals.

d. A description of activities Insurer has taken to address avoidable Appeals as well as any planned activities.

e. Summary of any Grievance trends. At a minimum Insurer shall consider whether any trends may be found regarding Grievance topic and Providers involved (as a component of the Grievance, not related to Provider involvement in the Grievance process).

f. A description of activities Insurer has taken to address avoidable Grievances as well as any planned activities.

Insurer shall provide this information in the aggregate and broken out in the manner requested by FHKC. Insurer's performance in this subject to the performance guarantees established in Attachment C.

Insurer shall provide Enrollees with reasonable assistance completing forms and taking other procedural steps related to Grievances and Appeals, upon request. Such assistance shall include providing auxiliary aids and services, interpretation services and toll-free numbers with TTY/TTD and interpreter capability. Insurer shall follow the requirements of 42 CFR 457.1207 which incorporates 42 CFR 438.10 and any method(s) established by FHKC when notifying Enrollees about any aspect of the Grievance and Appeal process.

An Enrollee's authorized representative, including Providers, may file Grievances and Appeals on the Enrollee's behalf with the written consent of the Enrollee. Insurer shall not take punitive action against any Provider for filing an Appeal, requesting an expedited Appeal, or supporting an Enrollee's request for an expedited Appeal.

23-1 Grievances

Enrollees may file a Grievance with Insurer orally or in writing at any time. Insurer shall acknowledge receipt of the Grievance in writing within five (5) Business Days.

Insurer shall provide Enrollees a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.

Insurer shall resolve each Grievance, and provide notice of the resolution, as expeditiously as the Enrollee's health condition requires within the timeframes required in this Contract and 42 CFR 457.1260. Standard resolution and notice of Grievances shall not exceed ninety (90) Calendar Days from the date of Grievance receipt, unless extended appropriately.

The standard resolution timeframe for a Grievance may be extended by up to fourteen (14) Calendar Days if:

a. The Enrollee requests the extension; or

b. Insurer shows that there is need for additional information and that such an extension is in the Enrollee's interest. FHKC may choose to request the basis for Insurer's decision to extend the timeframe. In such instances, the basis for Insurer's decision is subject to FHKC's satisfaction.

If a Grievance timeframe has been extended other than at the request of an Enrollee, Insurer shall make reasonable efforts to give the Enrollee:

a. Prompt oral notice of the delay;

b. Written notice of the decision to extend the timeframe within two (2) Calendar Days; and

c. Notice of the Enrollee's right to file a Grievance regarding this decision.

Insurer shall resolve the Grievance as expeditiously as the Enrollee's health condition requires, but no later than the date the extension expires.

23-2 Appeals

Enrollees may file an Appeal orally or in writing within sixty (60) Calendar Days of the date of notification of an Adverse Benefit Determination. Oral requests for Appeal must be followed by a signed, written Appeal unless the request is for an expedited Appeal. Such oral requests shall be used to establish the earliest possible filing date for the Appeal. Insurer shall acknowledge receipt of the Appeal in writing within five (5) Business Days. Appeals are limited to a single level. Enrollees wishing to further appeal Insurer's decision to uphold an Appealed decision may proceed to the independent external review process.

Insurer shall provide Enrollees a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. Such reasonable opportunity includes informing the Enrollee of the limited time available for these actions sufficiently in advance of the resolution timeframes for Appeals. Insurer shall also provide Enrollees with the Enrollee's case file, including medical records, other documents and records and any new or additional evidence considered, relied upon or generated by Insurer in connection with the Appeal of the Adverse Benefit Determination, free of charge and sufficiently in advance of the resolution timeframe for Appeals.

Insurer shall resolve each Appeal, and provide notice, as expeditiously as the Enrollee's health condition requires within the timeframes required in this Contract and 42 CFR 457.1260.

a. Standard resolution and notice of Appeals shall not exceed thirty (30) Calendar Days from the date of Appeal receipt, unless extended appropriately.

b. Expedited resolution and notice of Appeals shall not exceed seventy-two (72) hours from the Appeal receipt, unless extended appropriately.

When an Enrollee requests an expedited Appeal, Insurer shall determine whether taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function. Providers may also request, or support an Enrollee's request for, an expedited Appeal.

The standard resolution timeframe for an Appeal may be extended by up to fourteen (14) Calendar Days if:

a. The Enrollee requests the extension; or

b. Insurer shows that there is need for additional information and that such an extension is in the Enrollee's interest. FHKC may choose to request the basis for Insurer's decision to extend the timeframe. In such instances, the basis for Insurer's decision is subject to FHKC's satisfaction.

If an Appeal timeframe has been extended other than at the request of an Enrollee, Insurer shall make reasonable efforts to give the Enrollee:

a. Prompt oral notice of the delay;

b. Written notice of the decision to extend the timeframe within two (2) Calendar Days; and

c. Notice of the Enrollee's right to file a Grievance regarding this decision.

Insurer shall resolve the Appeal as expeditiously as the Enrollee's health condition requires, but no later than the date the extension expires.

Insurer shall provide written notice of resolution for Appeals and shall additionally make reasonable efforts to provide oral notice of resolution of an expedited Appeal. Appeal determination notices must include:

a. The result of the Appeal process;

b. The date the Appeal was resolved;

c. For Appeal determinations not wholly in the Enrollee's favor, the right to request an independent external review, and instructions on how to make such a request.

In the event Insurer fails to adhere to the Appeal decision or notice requirements, the Enrollee shall be deemed to have exhausted the Appeal process and may request an independent external review.

In the event Insurer overturns an Adverse Benefit Determination, Insurer shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours from the Appeal resolution date.

23-3 Independent External Review

Enrollees may request an independent external review within one hundred twenty (120) Calendar Days of notification that an appealed Adverse Benefit Determination has been upheld or when the Appeal process has been deemed exhausted by way of Insurer's failure to adhere to the notification and timing requirements of 42 CFR 457.1260 which incorporates 42 CFR 438.408.

Insurer shall maintain a contract with an Independent Review Organization (IRO) for the provision of Enrollees' option to have a post-appeal independent review. Such contract shall specify and meet all state and federal laws, regulations and guidance applicable to CHIP Grievance and Appeal process requirements and subcontractor requirements, including FHKC's audit rights.

Insurer shall provide a quarterly report listing all independent reviews the IRO handled in the quarter, including the date the independent review was requested, the date the IRO made a final decision, the outcome of the review, whether Insurer has since received any Grievances related to the independent review and any other information requested by FHKC.

Enrollees and the Enrollee's representative or the legal representative of a deceased Enrollee's estate shall be included as parties to the review.

In the event the independent external review overturns an Adverse Benefit Determination, Insurer shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours from the independent external review determination date.

Insurer is responsible for the full cost of all independent reviews.

Section 24 Access to Care

24-1 General Network Requirements

Insurer shall maintain a network of Providers sufficient to meet the requirements of this Contract and to adequately serve the needs of the Enrollees. Insurer shall allow Enrollee choice of network Providers to the extent possible and appropriate.

Insurer's Provider network shall be supported by written agreements.

Insurer shall establish mechanisms to:

a. Ensure network Provider compliance with required terms;

b. Monitor Providers regularly to determine compliance;

c. Take corrective action should a network Provider fail to comply; and

d. Handle Provider complaints.

Insurer shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification, including Providers that serve high-risk populations or specialize in conditions that require costly treatment. This provision does not:

a. Require Insurer to contract with Providers beyond the number necessary to meet the needs of the Enrollees;

b. Preclude Insurer from using different reimbursement amounts for different specialties or different Providers of the same specialty; or

c. Preclude Insurer from establishing measures designed to maintain quality of services or control costs and are consistent with Insurer's responsibilities to Enrollees.

Insurer shall promptly notify FHKC when Insurer receives information about a change in a network Provider's information that may affect the Provider's eligibility to participate in the Program.

Insurer shall provide FHKC with a monthly list of Providers leaving and entering the network the previous month. The monthly network change report shall include each Provider's NPI, name, address(es), specialty type, telephone number, whether the Provider is entering or leaving the network, an indicator showing whether the Provider should appear in the Provider director or be suppressed, and indicators for any Providers removed from the network for ineligibility to participate in Medicare, Medicaid or CHIP or for Fraud or Abuse.

Upon FHKC request, Insurer shall provide its complete network Provider data in the format, timeframe and frequency required by FHKC.

Insurer shall provide FHKC with sixty (60) Calendar Days advance written notice of any anticipated termination of large Provider groups, hospitals, or any independently practicing Provider if the independently practicing Provider has at least fifty (50) Enrollees on its patient panel.

24-2 Provider Credentialing

Insurer shall establish and follow policies and procedures for credentialing and recredentialing Providers. Such policies and procedures shall, at a minimum, comply with the uniform credentialing and recredentialing policy adopted by FHKC. Insurer may adopt credentialing and

recredentialing policies and procedures that are more robust than FHKC's uniform credentialing and recredentialing policy requires.

In the event Insurer declines to contract with a Provider or Provider group, Insurer shall provide affected Providers with written notice of the reason for Insurer's decision.

24-3 Participating Provider Requirements

Insurer shall require each network Provider to have a National Provider Identifier (NPI).

Insurer shall ensure all network Providers have an active Medicaid ID.

Insurer's network shall not include any Providers excluded for participation by Medicare, Medicaid or CHIP. Insurer shall not enter into or authorize any agreements with such excluded Providers that would otherwise require Insurer to pay for out-of-network services, except for Emergency Services.

Insurer shall ensure that all network Providers are enrolled in Medicaid or CHIP consistent with the Provider disclosure, screening and enrollment requirement of 42 CFR part 455, subparts B and E as incorporated in 42 CFR 438.608(b). Insurers may execute temporary Provider Contracts pending the outcome of the Medicaid or CHIP provider enrollment process of up to one hundred twenty (120) Calendar Days but must terminate a Network Provider Immediately upon notification that the Network Provider cannot be enrolled, or the expiration of one (1) 120 Calendar Day period without enrollment of the Provider. Insurer shall provide assistance to AHCA, FHKC and any other agency as requested to facilitate the enrollment process.

24-3-1 Medical Records

Insurer shall require Providers to maintain and share, as appropriate, medical records for each Enrollee under this Contract in accordance with professional standards and applicable federal and state law.

24-3-2 Health Information Technology Participation

24-3-3 Florida SHOTS

Insurer shall require and ensure that network PCPs provide all covered immunizations to Enrollees, are enrolled with Florida's statewide online immunization registry, the Florida State Health Online Tracking System (SHOTS), and continue to keep the Enrollee's immunization record updated in the SHOTS database. Insurer may allow immunizations to be administered at locations other than a PCP's office so long as Insurer ensures the treating Provider submits the information to SHOTS or notifies the Enrollee's PCP of the immunization administration. This provision shall not allow a PCP to refuse to proactively offer or administer immunizations at the PCP's office.

Insurer shall confirm to FHKC annually that Insurer is in compliance with these provisions.

24-3-4 Electronic Health Records

Insurer shall promote and support the use of electronic health records (EHRs) among its network Providers.

By the end of the second Contract Year and annually thereafter, Insurer shall provide evidence to FHKC that:

a. At least fifty percent (50%) of eligible professionals and eligible hospitals, as defined under the HITECH Act, use certified EHRs in a meaningful manner, as described in the Florida Medicaid EHR Incentive Program; and

b. At least sixty-five percent (65%) of Enrollees are assigned to PCPs using certified EHRs in a meaningful manner, as described in the Florida Medicaid EHR Incentive Program.

This provision does not require Insurer's Providers meeting EHR use standards to participate in or receive incentives from the Florida Medicaid EHR Incentive Program.

24-3-5 Electronic Notification System

Insurer shall participate in the Event Notification System (ENS) of the Florida Health Information Exchange. Insurer shall use the hospital encounter data it receives through the ENS in its case and disease management and care coordination programs to identify, develop, and implement interventions that reduce avoidable emergency department visits, hospital admissions, and hospital readmissions for its Enrollees. Insurer shall also implement programs to share its ENS encounter data with its network Providers to collaborate on these same goals.

24-3-6 Primary Care Providers

PCPs are limited to:

a. Board-certified pediatricians;

b. Board-certified family physicians;

c. Providers who have recently completed a residency program in pediatrics or family practice approved by the National Board for Certification of Training Administrators of Graduate Medical Education Programs and who are eligible for board certification but have not yet achieved board certification;

    i. If the Provider does not achieve board certification within three (3) years of initial credentialing for the Florida Healthy Kids program, Insurer shall remove the Provider from its Florida Healthy Kids network or request a board-certification exemption for the provider.

d. Physician extenders working under the direct supervision of a board-certified pediatrician or board-certified family physician; and

e. Exempt Providers, as described in this Contract.

24-3-6-1 Board-certified PCP Exemptions

Insurer may request an exemption to the board-certification requirement for individual pediatricians and family physicians in writing. Insurer shall provide the reason for such request and include the proposed Provider's curriculum vitae and other information required by FHKC. Insurer shall not make board-certification exemption requests for the sole or primary purpose of avoiding normal business costs associated with board-certified PCPs. FHKC shall review the exemption requests on a case-by-case basis provide a written response to Insurer. Board-certification exemptions are provided on a per Insurer basis for any specific Provider. Insurer must submit an exemption request to FHKC for a Provider even if that Provider has an active exemption with another Florida Healthy Kids insurer. Exemptions expire after two (2) years unless a Renewal is approved by FHKC.

24-3-7 Facility Standards

Network facilities shall meet applicable accreditation, licensure requirements and facility regulations specified by AHCA.

24-3-8 Behavioral Health and Substance Use Disorder Providers

Behavioral health, including substance use disorder, Providers shall be limited to those Providers delivering behavioral health services within the scope of their licensure and Insurer's credentialing and recredentialing requirements.

In addition to qualified, licensed behavioral health Providers, Insurer may allow services to be provided by provider agencies eligible to provide Florida Medicaid behavioral health overlay services in the manner described in Rule 59G-4.027, Florida Administrative Code. This allowance is limited to the provider and staff qualifications and does not allow Insurer to adopt Florida Medicaid's behavioral health overlay services as Covered Services under this Contract.

Behavioral health Provider qualifications and requirements for entry into the network are subject to mental health/substance use disorder parity requirements.

24-3-9 Federally Qualified Health Centers; Rural Health Centers

A Federally Qualified Health Center (FQHC) is an entity that is receiving a grant under Section 330 of the Public Health Service Act and Section 1905(1)(2)(B) of the Social Security Act.

A Rural Health Clinic (RHC) is a facility meeting the requirements of section 1861(aa)(2) of the Social Security Act, 42 CFR 405.2401 and 42 CFR 491.2.

Insurer shall reimburse FCHCs and RHCs at or above the reimbursement amounts provided under the Medicaid Prospective Payment System for such entities.

No supplemental payments from FHKC will be provided for these payments under any circumstances. Insurer is responsible for the entire amount.

Insurer shall provide a quarterly report identifying all network FQHCs and RHCs and attesting to Insurer's compliance with these reimbursement requirements.

This provision does not require Insurer to contract with FQHCs or RHCs.

24-3-10 Indian Health Care Providers

Insurer shall maintain sufficient numbers of Indian Health Care Providers (IHCPs) in Insurer's Provider network to ensure timely access to services from such Providers to Enrollees eligible to receive such services. Insurer shall provide a quarterly attestation and supporting documentation to FHKC demonstrating compliance with this requirement.

Insurer shall allow any Enrollee who is eligible to receive services from a network IHCP to choose the IHCP as his or her PCP so long as the IHCP has the capacity to provide the services. Insurer must also allow any Enrollee who is eligible to receive services from an IHCP to obtain services covered under the Contract from an out-of-network IHCP. Insurer shall allow out-of-network IHCPs to refer Enrollees to a network Provider.

Should there be too few IHCPs in the State to ensure timely access to Covered Services, Enrollees who are eligible to receive such services shall be permitted to access out-of-state IHCPs.

Insurer shall pay for Covered Services provided to eligible Enrollees by IHCPs, whether participating in the network or not, at either the rate negotiated between Insurer and the IHCP or at a rate not less than the level and amount of payment Insurer would make for services to a non-IHCP network Provider. Insurer shall make all payments to network IHCP's in a timely manner, as required by 42 CFR 447.45 and 447.46.

When an IHCP is also an FQHC, but is not a network Provider, Insurer shall pay the IHCP an amount equal to the amount Insurer would pay a participating FQHC that is not an IHCP.

When an IHCP is not an FQHC, regardless of network participation status, the IHCP has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of such published encounter rate, the amount it would receive if the services were provided by the State's Medicaid fee for service payment methodology.

Insurer shall pay IHCPs the full amount an IHCP is eligible to be paid. No supplemental payments from FHKC will be provided for these payments under any circumstances. Insurer is responsible for the entire amount.

24-4 Network Adequacy

Insurer shall maintain and monitor a Provider network sufficient to meet Enrollee needs and the requirements of this Contract. Insurer shall take into consideration Enrollees with limited English proficiency, physical and mental disabilities, or other barriers to care and Insurer's ability to meet such needs through the Provider network when determining network adequacy.

Insurer shall provide a certification attesting to, and documentation supporting, Insurer's capacity to serve the expected enrollment in its service area in accordance with the terms of this Contract. Supporting documentation must demonstrate that Insurer offers an appropriate range of preventive, primary care and specialty services for the anticipated number of Enrollees in the Service Area and that Insurer maintains a network of Providers sufficient in number, mix and geographic distribution to meet the needs of the anticipated Enrollees. Insurer shall submit this documentation in the format specified by FHKC.

Documentation shall be submitted when:

a. Insurer enters into this Contract with FHKC;
b. On an annual basis, when submitting the annual premium report; and
c. Any time there has been a significant change in Insurer's operations that may affect the adequacy of capacity and services, including changes in:
    i. Services;
    ii. Benefits;
    iii. Geographic service area;
    iv. Composition of Provider network;
    v. Payments to Provider network; or
    vi. Enrollment of a new population in plan.

Insurer understands and agrees that such documentation may be posted on FHKC's website in accordance with 42 CFR 457.1285.

Insurer shall also provide any documentation needed by FHKC's EQRO to conduct an annual network adequacy validation or any other activity required by FHKC.

FHKC may add network access requirements, such as Provider to Enrollee ratios, urgent care center or telehealth services access requirements, or revise existing network access requirements to meet Enrollee needs, reflect Enrollee utilization patterns, reflect availability of Providers, or for other similar reasons.

Failure to provide access as required in this Contract may constitute a material breach, as determined by FHKC in its sole discretion. Such material breach shall entitle FHKC to unilaterally terminate this Contract pursuant to Section 34-4 Termination for Lack of Performance or Breach.

24-4-1 Access to Family Planning Providers; Women's Health Specialists

Insurer shall demonstrate that the Provider network includes sufficient access to family planning Providers to ensure timely access to Covered Services.

Insurer shall provide female Enrollees with direct access to a network women's health specialist. Such direct access is in addition to the Enrollee's PCP if the PCP is not a women's health specialist.

24-4-2 Geographical Access

Insurer shall maintain a network that meets the following standards:

Provider Type	Time (in minutes)		Distance (in miles)	
	Rural	Urban	Rural	Urban
PCP – Pediatrician	30	20	30	20
PCP – Family Physician	20	20	20	20
OB/GYN	30	30	30	30
Behavioral Health – Pediatric	60	30	45	30
Behavioral Health – Other	60	30	45	30
Allergy/immunology	60	30	45	30
Dermatology	60	30	45	30
Optometry	60	30	45	30
Otolaryngology (ENT)	60	30	45	30
Specialist – Pediatric	40	20	30	20
Specialist – Other	20	20	20	20
Hospital	30	30	30	20
Pharmacy	15	15	10	10
Urgent Care Center	Report	Report	Report	Report
Telehealth Services	Report			

"Other" means providers in the specified provider type who do not hold a pediatric subspecialty.

For urgent care centers, Insurer shall report Enrollees' access to such facilities. FHKC may choose to use such reports and other information available to create minimum geographic access standards for urgent care centers.

For telehealth services, Insurer shall report Enrollee's access to telehealth services in the manner and format determined by FHKC. FHKC may choose to use such reports and other information available to create access standards for telehealth services or to create a methodology to supplement the geographic network access standards.

Insurer shall provide FHKC with a quarterly geographic access report demonstrating Insurer's compliance with these requirements and the performance guarantees in Attachment C.

24-4-2-1 Geographic Access Exemptions

Insurer may request a service area exemption to waive time and/or distance network adequacy standards for a given geographical area. To request a service area exemption, Insurer must submit a written request for an exemption accompanied by supporting documentation. These requests shall include:

a. Identification of the service area, provider type(s), and specific standard(s) the request for exemption covers;

b. The reason for the request, which may include:

    i. No providers exist in the area.

    ii. No providers exist in the area that are able to pass Insurer's credentialing or recredentialing standards.

    iii. Limited providers exist in the area and all refuse to contract with Insurer despite Insurer's documented good faith efforts to contract.

c. The number of providers in the area;

d. The distance to the nearest network provider;

e. Documentation of Insurer's efforts to find providers in the area as well as proof of existing providers' inability to be credentialed/recredentialed or proof of Insurer's failed good faith efforts to contract, as appropriate. Insurer must provide the practice address and phone number of any provider refusing to contract;

f. Certification attesting that documentation is complete and accurate;

g. Insurer's plan to monitor the area and take action should any change occur;

h. Explanation of how Insurer will provide timely services to enrollees in the area; and

i. Any other information FHKC deems necessary to make a determination.

Once a service area exemption has been granted, Insurer must monitor and report on enrollee access to the relevant provider type as well as activity relating to Insurer's monitoring plan on a quarterly basis.

Exemptions expire and must be re-approved every two years unless withdrawn by Insurer or revoked by FHKC. Exemptions may be revoked for the following reasons:

a. The situation in the area has changed and Insurer can reasonably be expected to meet access requirements;

b. Failure to provide continuing evidence that the exemption is appropriate; and

c. Failure to adequately monitor, take action or report as required by Insurer's documented plan, the contract or state or federal law.

Information regarding service area exemptions may be reported to CMS as required by federal law.

24-4-3 Appointment Access

Insurer shall require network Providers to offer hours of operation and appointment times that are no less than the hours of operation and appointment times offered to commercial enrollees.

Insurer shall provide timely treatment for Enrollees in accordance with the following standards:

a. Emergency care shall be provided immediately.

b. Urgently needed care shall be provided within twenty-four (24) hours.

c. Routine care shall be provided within seven (7) Calendar Days of the Enrollee's request for services.

d. Well-child visits, as recommended by the American Academy of Pediatrics, shall be provided within four (4) weeks of the Enrollee's request.

e. Follow-up care shall be provided as medically appropriate.

Insurer shall report on network Providers offering routine After-hours Services as required by FHKC.

24-4-4 Out-of-Network Access

In the event an Enrollee requires access to Covered Services and Insurer has failed to provide adequate access to such Covered Services, as determined by FHKC or Insurer, Insurer shall provide access to the relevant Covered Services outside the network. In the event Insurer has materially failed to provide adequate access for an Enrollee's ongoing health care needs, including access to an out-of-network Provider, FHKC may direct Enrollees to seek related

Covered Services from an out-of-network Provider. Should FHKC direct such action, Insurer shall be financially responsible for such services to the extent Insurer would be responsible if the services had been provided by a network Provider.

24-5 Physician Incentive Plans

Insurer shall comply with 42 CFR 457.1201(h) incorporating through 42 CFR 438.3(i) references to 42 CFR 422.208 and 42 CFR 422.210, as well as any other applicable federal or state laws and regulations related to physician incentive plans.

Insurer shall not make specific payment(s), directly or indirectly (including offerings of monetary value measured in the present or future), to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an Enrollee.

If a physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, Insurer shall ensure that all physicians and physician groups at financial risk have sufficient aggregate or per-patient stop-loss protection.

Substantial financial risk is determined as defined in 42 CFR 422.208 and this Contract. Substantial financial risk is when risk is based on the use or costs of referral services and that risk exceeds the risk threshold of twenty-five percent (25%) of potential payments. Payments based on other factors are not considered in determining whether substantial financial risk exists.

The following arrangements cause substantial financial risk to exist for physicians or physician groups with patient panel sizes not greater than twenty-five thousand (25,000) patients:

a. Withholds greater than twenty-five percent (25%) of potential payments;

b. Withholds less than twenty-five percent (25%) of potential payments if the physician or physician group is potentially liable for amounts exceeding twenty-five percent (25%) of potential payments;

c. Bonuses that are greater than thirty-three percent (33%) of potential payments minus the bonus;

d. Withholds plus bonuses if the withholds plus bonuses equal more than twenty-five percent (25%) of potential payments. The threshold bonus percentage for a particular withhold percentage may be calculated using the formula described in 42 CFR 422.208(d)(3)(iv);

e. Capitation arrangements if the difference between the maximum potential payments and the minimum potential payments is more than twenty-five percent (25%) of the maximum potential payments or the maximum and minimum potential payments are not clearly explained in the contract with the physician or physician group; and

f. Any other incentive arrangements that have the potential to hold the physician or physician group liable for more than twenty-five percent (25%) of potential payments.

Stop-loss protection required for physicians and physician groups at substantial financial risk must cover ninety percent (90%) if aggregate stop-loss protection is used. If per-patient stop-loss protection is used, the stop-loss limit per patient must be determined based on the size of the patient panel in accordance with 42 CFR 422.208(g) and must cover ninety percent (90%) of the costs of referral services that exceed the per patient Deductible limit in accordance with 42 CFR 422.208(f)(2)(iii).

Insurer shall provide Enrollees with a disclosure that includes whether the Insurer uses a physician incentive plan that affects the use of referral services, the type of incentive arrangement and whether stop-loss protection is provided, upon request.

Insurer shall notify FHKC of any physician incentive plans used for Healthy Kids Enrollees and provide documentation to FHKC assuring that insurer is meeting contractual and regulatory requirements. Such documentation shall also include a copy of the Enrollee disclosure notice Insurer intends to provide to Enrollees.

24-6 Integrity of Professional Advice to Enrollees

Insurer shall comply with 42 CFR 457.985 prohibiting Insurer from interfering with the advice of health care professionals to Enrollees and requiring that professionals engaged in the performance of Insurer's duties under this Contract give information about treatments to Enrollees as provided by law.

Insurer shall not prohibit, or otherwise restrict, a Provider acting within the lawful scope of practice from advising or advocating on behalf of an Enrollee who is his or her patient regarding:

a. The Enrollee's health status, medical care or treatment options, including any alternative treatment that may be self-administered;

b. Any treatment the Enrollee needs to decide among all relevant treatment options;

c. The risks, benefits and consequences of treatment or non-treatment; and

d. The Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preference about future treatment decisions.

Insurer shall be subject to intermediate sanctions, as described in 42 CFR Part 457, Subpart I, for any violations of this prohibition.

24-7 Provider Payments

24-7-1 Claims

Insurer shall provide FHKC with the address from which claims are paid.

Insurer shall receive and process claims in accordance with the terms of this Contract and industry best practices and nationally recognized standards, including the use of electronic transmission of claims, payments and related documents.

Insurer shall pay clean claims submitted electronically within fifteen (15) Calendar Days of receipt. For all other claims submitted electronically, Insurer shall deny or request any additional information needed to process the claim within fifteen (15) Calendar Days and deny or pay within ninety (90) Calendar Days of claim receipt.

Insurer shall pay clean claims not submitted electronically within twenty (20) Calendar Days of receipt. For all other claims not submitted electronically, Insurer shall deny or request any additional information needed to process the claim within fifteen (15) Calendar Days and ultimately deny or pay within ninety (90) Calendar Days of receipt.

Insurer shall also process and pay claims in accordance with the performance guarantees required in Attachment C.

A clean claim is a claim completed in accordance with Insurer's guidelines, accompanied by all documentation required for payment and that may be processed and adjudicated without obtaining additional information from the Provider or a third party or Medical Necessity review. Claims from Providers under investigation for Fraud, Abuse or violation of state or federal laws or regulations are not considered clean claims.

Information pertaining to claims and payment data provided to FHKC shall be accompanied by an attestation attesting to the accuracy, completeness and truthfulness of the data under penalty of perjury.

24-7-2 Capitated Arrangements

Insurer shall monitor and assess any capitated arrangements in place on a routine basis to ensure that such arrangements continue to provide appropriate value in cost savings or avoidance.

Annually, or upon request, Insurer shall provide FHKC with a report listing the types of services provided under capitated arrangements, the percent of encounters that are capitated, the total amount paid for capitated services broken out as required by FHKC and, for those services provided by a mix of capitated and other payment arrangements, the percentage of providers under a capitated agreement.

24-7-3 Provider Overpayments

Insurer shall provide an annual report listing all overpayments to Providers, including overpayments made related to Fraud, Waste and Abuse and all other overpayments.

a. Such policies and procedures must include:

   i. A mechanism for a network Provider to report in writing to Insurer that an overpayment has been received and the reason why the overpayment was received; and

   ii. Require Provider to return the overpayment to Insurer within sixty (60) Calendar Days after the date on which the overpayment was identified.

Section 25 Fraud and Abuse

Insurer shall have administrative and management arrangements and procedures to detect and prevent Fraud, Waste and Abuse that comply with all state and federal laws and regulations, including 42 CFR 457.1285.

Insurer’s arrangements and procedures shall include:

a. A compliance program that includes:

   i. Written policies, procedures and standards of conduct detailing Insurer’s commitment to comply with all applicable requirements and standards;

   ii. A compliance officer responsible for developing and implementing the policies, procedures and practices designed to ensure compliance with the Contract. The compliance officer shall have sufficient experience in healthcare and shall report directly to the CEO and Insurer’s board of directors;

   iii. A regulatory compliance committee on the board of directors and at the senior management level charged with overseeing Insurer’s compliance program and its compliance with the Contract;

   iv. A system for training and educating the compliance officer, senior management and Insurer’s employees about state, federal and contractual requirements;

   v. Effective lines of communication between the compliance officer and Insurer’s employees, as evidenced by some formal policy;

   vi. Enforcement of standards through well-publicized disciplinary guidelines;

   vii. Non-retaliation policies against any individual that reports violations of Insurer’s Fraud and Abuse policies and procedures or suspected Fraud and Abuse; and

viii. A system, and related procedures, with dedicated staff for routine internal monitoring, auditing of compliance risks, prompt response to, investigation of, and correction of compliance issues, actions to reduce the potential for recurrence of compliance issues, and ongoing compliance with the requirements of the Contract.

b. A method used to verify services that were represented to have been delivered by network Providers were received by Enrollees. Such verification process shall be conducted on a regular basis;

c. The distribution of written policies to Insurer's employees, and of any Subcontractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about the rights of employees to be protected as whistleblowers;

d. Prompt reporting to FHKC of information Insurer obtains indicating Fraud or potential Fraud by a Provider, Subcontractors, Applicant or Enrollee;

e. Suspension of payments to a network Provider when FHKC or AHCA determines there is a credible allegation of Fraud in accordance with 42 CFR 455.23; and

f. Policies and procedures to maintain adequate staffing and resources to investigate unusual incidents and to develop corrective action plans to assist Insurer with preventing and detecting potential Fraud and Abuse activities.

Insurer shall provide its Fraud, Waste and Abuse policies to FHKC for approval during implementation of this Contract, by the date established in the approved implementation plan, and prior to any changes. Changes to Insurer's Fraud, Waste and Abuse policies are subject to FHKC approval.

Insurer shall provide FHKC with a quarterly Fraud, Waste and Abuse report detailing prevention activities conducted by Insurer, potential offenses being investigated and any confirmed instances of Fraud or Abuse. Insurer may report information on violations of law by Subcontractors, Providers, Enrollees or other relevant individuals to FHKC and/or to CMS, as appropriate. Insurer may only report such information regarding Enrollees when the information pertains to enrollment in the plan or Covered Services.

Insurer shall cooperate in any investigation by FHKC or any state or federal entities and any subsequent legal action that may result from such an investigation.

Section 26 Quality Management

26-1 Accreditation

Insurer shall inform FHKC of any accreditations received by a private independent accrediting entity. Insurer shall authorize the private independent accrediting entity to provide FHKC with a copy of its most recent accreditation review. Such review includes the following information:

a. Accreditation status;

b. Accreditation survey type;

c. Accreditation level, as applicable;

d. Accreditation results, including

   i. Recommended actions or improvements

   ii. Corrective action plans; and

   iii. Summaries of findings

e. Expiration date of the accreditation

In accordance with the requirements of 42 CFR 457.1240(c), FHKC will make Insurer's accreditation status available on the Florida Healthy Kids website. Such accreditation status will include the name of the accrediting entity, accreditation program and accreditation level, as applicable.

Insurer shall provide FHKC with a report listing the accrediting entity, accreditation program and accreditation level of all accreditations during implementation of the Contract, by the date established in the approved implementation plan, and annually thereafter by December 15th. Insurer shall inform FHKC of any change in accreditation status within thirty (30) Calendar Days of such change.

26-2 Quality Assessment and Performance Improvement

Insurer shall maintain a quality assessment and performance improvement (QAPI) program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes.

At a minimum, the QAPI program shall include:

a. Performance improvement projects (PIPs) focusing on clinical and non-clinical areas;

b. Collection and submission of performance measurement data;

c. Mechanisms to detect underutilization and overutilization of services;

d. Mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs;

e. Written policies and procedures that address components of effective health care management including anticipation, identification, monitoring, measurement, evaluation of Enrollees' health care needs, and effective action to promote quality of care; and

f. Any performance measures and PIPs that are required by CMS during the term of this Contract.

Insurer's QAPI shall incorporate an annual quality improvement plan (QIP). Insurer's QIP shall:

a. Include an executive summary describing the structure of Insurer's QAPI, Insurer's approach to quality improvement and how Insurer evaluates the QIP and QAPI to determine new or improved quality improvement activities;

b. Define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest-level of success;

c. Implement specific interventions to better manage Enrollee care and promote improved health outcomes; and

d. Identify performance goals supporting the QAPI program.

Insurer shall submit its QIP to FHKC during implementation of the Contract, by the date established in the approved implementation plan, and annually thereafter by July 1st. Insurer's QIP is subject to FHKC approval. Insurer shall use the results of the QIP to assess and report on the overall QAPI program to FHKC annually.

Insurer shall have a quality improvement committee that develops and is responsible for the oversight of the QIP. The quality improvement committee shall be chaired or co-chaired by Insurer's medical director, meet at least quarterly and include provider representation.

26-3 External Quality Review

FHKC shall contract with an EQRO to conduct annual external quality review activities during the Contract term.

Insurer shall cooperate in all such activities. Cooperation with EQR-activities includes, but is not limited to:

a. Responsiveness to requests for discussion and feedback, including requests for PIP-topic preferences;

b. Provision of data, documentation and other information in an accurate and timely manner;

c. Reviews and evaluation of Insurer's PIPs, whether such review is a review of the format and initial methodology, progress review or the EQRO's validation review;

d. Participation in any EQR-related training made available to Insurer by FHKC;

e. Monitoring of activities by FHKC; and

f. Corrective action plans or quality improvement activities required of Insurer by FHKC as a result of EQR-activity findings.

Insurer shall calculate results for and report the performance measures identified by FHKC on an annual basis as part of FHKC's external quality review activities. Insurer shall also provide FHKC with data, as specified by FHKC, which enables FHKC to validate or calculate Insurer's performance using the standard measures. FHKC may choose to independently calculate, or have calculated, the performance measures. Insurer remains responsible for calculating the performance measures regardless of whether FHKC is independently calculating these performance measures.

Insurer shall conduct PIPs as part of the QAPI program in accordance with the written guidance for PIPs released by CMS. Each PIP must be designed to:

a. Achieve significant improvement, sustained over time, in health outcomes and/or Enrollee satisfaction; and

b. Must include measurement of performance using:

   i. Objective quality indicators;

   ii. Implementation of interventions to achieve improvement in access and quality of care;

   iii. Evaluate the effectiveness of the interventions; and

   iv. Planning and initiation of activities for increasing or sustaining improvement.

PIPs specific to Insurer and/or to the overall Program resulting from FHKC's monitoring, the EQR-activities or industry trends or emerging issues may also be required from Insurer. FHKC may choose to either dictate any or all of the PIP topics or allow Insurer to choose any or all of its PIP topics, subject to FHKC approval.

26-4 Managed Care Quality Rating System

FHKC may adopt the quality rating system developed by CMS or may adopt an alternative quality rating system as allowed in 42 CFR 457.1240 which incorporates 42 CFR 438.334. FHKC will notify Insurer of any such quality rating system.

Insurer shall cooperate with FHKC in the implementation and maintenance, including data submission, of such quality rating system.

26-5 CAHPS Survey

Insurer shall conduct NCQA's Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.0H, or its successor, annually for the Florida Healthy Kids population. Insurer shall conduct the annual CAHPS survey in a manner that allows Insurer to report on the Florida Healthy Kids results separately from the results of any other group. FHKC may publish Insurer's Florida Healthy Kids CAHPS survey results.

26-6 FHKC Quality Initiatives

FHKC may implement quality initiatives other than those types of quality activities considered in this Contract and may require Insurer to participate in such initiatives. In the event a quality initiative requires substantial and material efforts by Insurer beyond the scope of the Contract, FHKC shall amend the Contract to include the quality initiative. The Parties agree to negotiate such amendments in good faith.

Insurer shall engage in preliminary discussions, research assistance, basic consultation and other activities of a similar nature and such activities shall not require a Contract amendment.

26-6-1 Value-Based Payments

Insurer shall report on its value-based payment arrangements, including Provider participation, Enrollee participation, type of value-based payment and planned contracting activities as required by FHKC. FHKC may require Insurer to implement a value-based payment arrangement development plan. The value-based payment arrangement development plan, including measure indicators and outcome targets, shall be subject to approval by FHKC.

Section 27 Reporting Requirements

Insurer shall comply with all reporting requirements under this Contract in the manner and timeframes specified in the Contract, as listed under Attachment D or as otherwise required by FHKC. For this section, the term "reports" encompasses reports, documents, deliverables and other information provided to FHKC.

Insurer shall provide reports to FHKC electronically. Insurer shall provide physical copies upon request.

Reports submitted to FHKC must be clearly named and must include, at a minimum, Insurer's name and a short descriptive document title. Such descriptive document titles should be intelligible by an individual familiar with CHIP and general health insurance, but unfamiliar with Insurer and Insurer's internal document management system and processes. FHKC may

occasionally dictate a specific naming convention for certain documents. Insurer shall adhere to any prescribed naming convention.

In the event a routine report is required for which Insurer has no data to report for the reporting period, Insurer shall populate relevant fields in the report with a statement indicating the lack of reportable information. Insurer shall not fail to submit any report because of lack of reportable data.

Insurer may be required to provide FHKC information or data that is not specified under this Contract. Insurer shall have at least thirty (30) Calendar Days to fulfill such ad hoc reporting requests unless otherwise required by FHKC.

Insurer shall provide supporting evidentiary documentation with all reports unless otherwise required by FHKC.

Insurer shall provide reports in accordance with the requirements described in this Contract or requested by FHKC. Insurer shall be liable for financial consequences in the amount of five hundred dollars ($500) per Calendar Day, limited to fifteen thousand dollars ($15,000) per incident, for failure to provide reports in an acceptable format by the required due date. Financial consequences apply to each Calendar Day beyond the due date until provided to FHKC, inclusive of the day provided to FHKC. Financial consequences apply to the initial due date and to subsequent due dates should the report require revisions prior to FHKC approval.

Insurer shall be liable for financial consequences in the amount of five hundred dollars ($500) per incident for failure to adhere to any reporting requirement other than timeliness.

FHKC shall not assess both Calendar Day and per incident financial consequences for the same instance of noncompliance nor shall FHKC assess such financial consequences when FHKC has assessed other financial consequences for an equivalent reason for the instance of noncompliance.

Section 28 Encounter Data

Insurer shall provide a quarterly encounter and claims data for all services rendered under this Contract. Insurer shall submit the encounter and claims data using a format and following a process established by FHKC. The quarterly encounter and claims data shall include the level of detail specified by FHKC using standardized ASC X12N 837, NCPDP formats and the ASC X12N 835 or another standardized format, as required by FHKC. Encounter data reports must comply with HIPAA security and privacy standards and shall be submitted in a format required by the Medicaid Statistical Information System or successor system.

FHKC anticipates requiring Insurer to submit the quarterly encounter and claims data to FHKC’s contracted EQRO and AHCA’s contracted vendor responsible for the annual Florida KidCare Evaluation Report.

Insurer shall provide the quarterly Encounter and Claims Data by the due dates listed below:

Encounters and Claims Processed During:	Data Due to FHKC by:
January 1st – March 31st	April 15th
April 1st – June 30th	July 15th
July 1st – September 30th	October 15th
October 1st – December 31st	January 15th

FHKC may amend the process, format or other requirements during the Contract term without amending this Contract. Insurer shall implement such changes by the date required by FHKC.

Insurer shall be liable for financial consequences in the amount of one thousand dollars ($1,000) per Calendar Day for failure to provide a complete file of all claims/encounter data to FHKC's contracted EQRO and/or AHCA's contracted vendor on a quarterly basis in the format and timeframe specified by FHKC. Financial consequences apply to each Calendar Day beyond the due date until such complete file is submitted to FHKC's EQRO and/or AHCA's contracted vendor in the format specified, inclusive of the date Insurer provides the file.

Insurer shall assist FHKC in complying with any state or federal encounter data reporting requirements, including correcting accuracy, completeness or other compliance issues.

Access to Enrollee claims data by FHKC, the State of Florida, the federal Centers for Medicare and Medicaid Services and the Department of Health and Human Services Inspector General shall be allowed to the extent permitted by law.

Section 29 Attestations

Insurer shall provide a written attestation signed by Insurer's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual reporting directly to the CEO or CFO with delegated authority to sign for the aforementioned individual. The attestation shall certify based on best information, knowledge and belief, that the data, documentation or information provided is accurate, complete and truthful when submitting the information listed in this provision.

The CEO or CFO is ultimately responsible for attestations provided by an individual with delegated authority. Insurer shall provide an organizational chart upon execution of this Contract and within one (1) week of any changes.

This provision is applicable to the following specified data, documentation and information:

a. Encounter Data;

b. Data FHKC may use to determine Insurer's compliance with MLR requirements;

c. Data FHKC may use to determine Insurer has made adequate provision against the risk of insolvency;

d. Documentation related to Insurer's compliance with requirements for availability and accessibility of services, including Provider network adequacy;

e. Information on ownership and control of Insurer and Subcontractors;

f. Annual overpayment recoveries report; and

g. Any other data, documentation or information for which FHKC requests an attestation.

Attestations must be submitted concurrently with the submission of data, documentation or information.

Insurer shall attest to the accuracy, completeness and truthfulness of claims and payment data submitted to FHKC under penalty of perjury.

Section 30 Governing Law

Insurer shall comply with all applicable federal and state laws and regulations, including:

a. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq.;

b. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794;

c. Title IX of the Education Amendments of 1972, as amended 20, U.S.C. 1681 et seq.;

d. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq.;

e. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849;

f. The American Disabilities Act of 1990, P.L. 101-336;

g. Section 274A (e) of the Immigration and Nationalization Act;

h. Title XXI of the federal Social Security Act;

i. HIPAA, and any other federal or state laws regarding disclosure of protected health information as specified in Attachment B.

j. The Immigration Reform and Control Act of 1986

k. All applicable federal and state laws regarding advertising, marketing and promotional activities of health care services or otherwise related to the offering of health care services and items and services including: (i) the Federal Anti-Kickback Law, 42 U.S.C. § 1320a-7b; (ii) the Civil Monetary Penalty Law, 42 U.S.C. § 1320a-7a; (iii) the Civil and Criminal False Claims Acts, 31 U.S.C. §§ 3729-3733; (iv) the Stark Law, 42 U.S.C.

§1395nn; (v) the Health Care Fraud Statute, 18 U.S.C. § 1347, Federal; and (f) to the extent applicable, the respective state law counterparts of any of the federal laws described in (i) through (v) above.

Insurer further agrees that all contractors, Subcontractors, sub-grantees or others with whom it arranges to provide goods, services or benefits in connection with any of its programs and activities are not discriminating against either those whom they employ nor those to whom they provide goods, services or benefits in violation of the above statutes, regulations, guidelines and standards.

It is expressly understood that evidence of Insurer's refusal or failure to substantially comply with this section or such failure by Insurer's subcontractors or anyone with whom Insurer affiliates in performing under this Contract shall constitute a material breach and renders this Contract subject to unilateral cancellation by FHKC.

Section 31 Notice

All Notices required under this Contract shall be in writing and shall be delivered by any of the following methods:

a. Certified mail with return receipt requested;

b. Facsimile with proof of receipt;

c. Email with proof of receipt; or

d. In person with proof of delivery.

Notices shall be directed to:

For FHKC:

Austin Noll, Chief Operating Officer
Florida Healthy Kids Corporation
1203 Governor's Square Blvd., Suite 400
Tallahassee, Florida 32301

For Insurer:

Lupe Rivero, SVP of Government Programs
Community Care Plan
1643 Harrison Parkway, Bldg. H, Suite 200
Sunrise, Florida 33323

In the event that different contact persons are designated by either Party after execution of this Contract, Notice of the name and address of the new contact will be sent to the other Party. A change in contact for this section does not require an amendment to the Contract.

31-1-1 Notification Requirements

Insurer shall notify FHKC in writing within one (1) Business Day, of:

a. Any judgment, decree or order rendered by any court of any jurisdiction or Florida administrative agency enjoining Insurer from the sale or provision of services.

b. Any petition by Insurer in bankruptcy or for approval of a plan of reorganization or arrangement under the Bankruptcy Act; Chapter 631, Florida Statutes; or any other Florida Statute; or an admission seeking relief provided therein.

c. Any petition or order of rehabilitation or liquidation as provided in Chapters 631 or 641, Florida Statutes or any other Florida Statute.

d. Any order revoking Insurer's Certificate of Authority or license issued by an agency of the State of Florida.

e. Any administrative action taken by the Department of Financial Services, Office of Insurance Regulation or the Agency for Health Care Administration in regard to Insurer.

f. Any medical malpractice action filed in a court of law in which an Enrollee is a party (or in which Enrollee's allegations are to be litigated).

g. The filing of an application for merger or other change in structure or ownership.

h. Any pending litigation or commencement of legal action involving Insurer in which liability for or Insurer's obligation to pay could exceed five hundred thousand dollars ($500,000.00) or ten percent (10%) of Insurer's surplus, whichever is lower.

Section 32 Administrative and Legal Proceedings

"Legal action" is defined to include administrative proceedings.

32-1-1 Venue

The exclusive forum and venue for any legal action that arises out of or relates to the Contract for which there is no administrative remedy shall be a state court of competent jurisdiction in Leon County, Florida, or, on appeal, the first district court of appeal. Florida law will apply to any legal action, without giving effect to Florida's choice of law principles. Further, any hearings and depositions for any legal action shall be held in Leon County, Florida. FHKC, in its sole discretion, may waive this venue for depositions.

32-1-2 Attorney Fees

In the event of any legal action, dispute, litigation or other proceeding in relation to this Contract, FHKC is entitled to recover its attorney fees and other costs incurred from Insurer, whether or not suit is filed, and if filed, at both trial and appellate levels.

The Parties agree the intent of this provision is to protect the enrollees who receive medical benefits through Florida KidCare and rely upon the continuation of FHKC's duties authorized in section 624.91, Florida Statutes.

Section 33 Severability

If any provision of this Contract is held to be unenforceable by a court of competent jurisdiction, such provision shall be severed from the remaining provisions of the Contract, which shall remain in effect.

Section 34 Survival

The provisions of the following sections shall survive any termination of this Contract:

a. Record Retention;

b. Indemnification;

c. Attorney Fees;

d. Confidentiality;

e. Public Records;

f. Conflicts of Interest;

g. Non-Solicitation;

h. Governing Law;

i. Venue;

j. Contract Termination Transition Plan;

k. Contract Termination; and

l. Any other sections that specify survival of Contract termination that are not listed in this section.

Section 35 Contract Termination

35-1 Termination for Lack of Funding

This Contract is subject to the continuation and approval of funding to FHKC from state, federal and other sources. FHKC has the right, at its sole discretion, to terminate this Contract if funding for the Program is to be changed or terminated to the extent that this Contract cannot be sustained. FHKC shall provide Insurer a Notice of termination at least thirty (30) Calendar Days prior to the date of termination.

35-2 Termination for Lack of Payment

In the event FHKC fails to make payments in accordance with the schedule included in this Contract, Insurer may suspend work and pursue the appropriate remedies for FHKC's breach of its payment obligations. Insurer shall provide FHKC at least thirty (30) Calendar Days written Notice of its intent to suspend work because of lack of payment and allow FHKC an opportunity to correct the default prior to suspension of work.

35-3 Termination for Insolvency or Bankruptcy

In the event of Insurer's insolvency or filing a petition for bankruptcy, FHKC may immediately terminate this Contract, either in its entirety or any part herein, at its sole discretion. Insurer shall notify FHKC within one (1) Business Day of the Insolvency or the filing of a petition for bankruptcy. Consistent with section 9 above, in no event shall FHKC or Enrollees be held liable for Insurer's debt.

35-4 Termination for Lack of Performance or Breach

The continuation of this Contract is contingent upon the satisfactory performance of Insurer. If Insurer breaches or fails to adequately meet the terms of this Contract, FHKC reserves the right to terminate this Contract, or any part herein, at its discretion. Such termination shall be effective on the date determined by FHKC and provided by written Notice to Insurer. FHKC, in its sole discretion, may allow Insurer to cure any performance deficiencies prior to termination of the Contract.

35-5 Termination upon Revision of Applicable Law

In the event federal or state revisions of any applicable laws or regulations restrict FHKC's ability to comply with the Contract, make such compliance impracticable, frustrate the purpose of the Contract or place the Contract in conflict with FHKC's ability to adhere to its statutory purpose, FHKC may unilaterally terminate this Contract. FHKC shall provide Insurer a Notice of termination at least thirty (30) Calendar Days prior to the termination date.

35-6 Termination upon Mutual Agreement

Upon mutual agreement of the Parties, this Contract, or any part herein, may be terminated on an agreed date prior to the end of the Contract without penalty to either Party.

35-7 Termination by FHKC

Notwithstanding any other termination provisions, FHKC may terminate this Contract or any part of this Contract, without penalty or cost to FHKC, at its convenience, and such termination will be effective at such time as is determined by FHKC. FHKC shall provide at least thirty (30) Calendar Days Notice of such termination unless a shorter period of time is mutually agreed upon by the Parties.

IN WITNESS WHEREOF, the parties have caused this Contract, to be executed by their undersigned officials as duly authorized.

FOR:
SOUTH FLORIDA COMMUNITY CARE NETWORK, LLC D/B/A COMMUNITY CARE PLAN

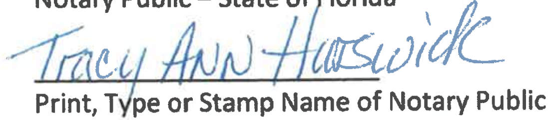
NAME: Jessica Lerner
TITLE: President & CEO.
DATE SIGNED: 08/02/2019

STATE OF Florida

COUNTY OF Broward

The foregoing instrument was acknowledged before me before this 2nd day of Aug 2019, by Jessica Lerner, as Pres/CEO on behalf of the CCP.
He/She is personally known to me or has produced ____________ as identification.

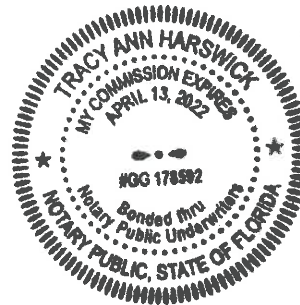
Signature
Notary Public – State of Florida



Print, Type or Stamp Name of Notary Public

8/13/2022

My Commission Expires



APPROVED—As to legal form by counsel for Community Care Plan 8/1/2019 3:13 PM

FOR
FLORIDA HEALTHY KIDS CORPORATION:

____
NAME: JEFF DYKES
TITLE: INTERIM CHIEF EXECUTIVE OFFICER
DATE SIGNED: 8-6-19

STATE OF FLORIDA
COUNTY OF LEON
The foregoing instrument was acknowledged before me before this 6th day of August, 2019, by Jeff Dykes, as Interim Chief Executive Officer, on behalf of the Florida Healthy Kids Corporation. He is personally known to me or has produced ________________ as identification.

____
Signature
Notary Public – State of Florida

Laura M Kreps
Print, Type or Stamp Name of Notary Public

June 20, 2020
My Commission Expires

Attachment A: Benefit Schedule

All covered services are subject to Medical Necessity and all other applicable requirements for coverage.

Lifetime Limit

Once an Enrollee has accumulated $1 million in claims paid under the Program, the Enrollee's eligibility for the Program ends effective after the last day of the Enrollee's continuous eligibility period, or the functional equivalent for Full-pay Enrollees, unless extended in accordance with any applicable notification, eligibility dispute, or Appeal requirements, as determined by FHKC. Insurer shall not limit, reduce payment, or deny claims solely because an Enrollee has accumulated $1 million or more in paid claims.

Cost Sharing

Certified American Indians or Alaskan Natives shall not be subject to any cost sharing.

Out-of-pocket Maximum

Title XXI Enrollees: Cost sharing, including premium, is limited to no more than five (5) percent of an Enrollee's family's income per Contract Year.

Full-pay Enrollees: copayments count toward the annual out-of-pocket maximum. Premiums do not count toward the annual out-of-pocket maximum for Full-pay Enrollees.

Covered Services

Behavioral Health Services; Substance Use Disorder Services

Enrollee Cost Share: $5 copayment per office visit; $0 for inpatient services

Covered services include:

a. Inpatient and outpatient care for psychiatric evaluation, diagnosis and treatment;
b. Inpatient and outpatient care for drug and alcohol abuse, including evaluation, diagnosis, treatment, counseling and placement assistance.

Durable Medical Equipment (DME) and Prosthetic Devices

Enrollee Cost Share: $0

Covered services include prescribed equipment and devices that are medically indicated to assist in the treatment of a medical condition. Covered prosthetic devices include artificial eyes, limbs, braces and other artificial aids.

Low-vision and telescopic lenses are not included.

Hearing aids are covered only when medically indicated to assist in the treatment of a medical condition.

Equipment and devices shall be provided by Insurer's participating supplier.

Emergency Services

Enrollee Cost Share: $10 copayment per visit, waived if admitted or authorized by PCP

Covered services include visits to an emergency room, hospital or other healthcare setting within the U.S. if needed to treat an Emergency Medical Condition.

Insurer shall comply with Section 641.513, Florida Statutes, and 42 CFR 438.114. Insurer shall not:

a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms;

b. Use terms such as "life threatening" or "bona fide" to qualify the type of emergency that is covered;

c. Indicate that emergencies are covered only if care is secured within a certain period of time;

d. Deny payment based on the Enrollee's failure to provide Insurer advanced notification of seeking treatment;

e. Refuse to cover emergency services based on the treating Provider or facility not notifying the Enrollee's PCP of the Enrollee's screening and treatment within ten (10) Calendar Days of presentation for emergency services or based on the Enrollee's failure to provide Insurer notification within a certain period of time after care is provided;

f. Hold Enrollees liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee; or

g. Require prior authorization for emergency transportation or emergency services.

Post-stabilization Services

Insurer is responsible for any post-stabilization services administered to maintain, improve or resolve the Enrollee's stabilized position, regardless of the facility or Provider's Network status when:

a. Such services were pre-approved by Insurer or Insurer's representative; or

b. The treating facility or Provider sought approval for such services; and

c. Insurer failed to respond within one (1) hour of the request.

Insurer's financial responsibility for post-stabilization services that Insurer has not pre-approved ends when:

a. A Network Provider with privileges at the treating facility assumes responsibility for the Enrollee’s care;

b. A Network Provider assumes responsibility for the Enrollee’s care through transfer; or

c. The Enrollee is discharged.

The attending emergency physician or the Provider treating the Enrollee is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge.

Emergency Transportation Services
Enrollee Cost Share: $10 copayment per service

Covered services include emergency transportation in response to an emergency medical condition.

Home Health Services
Enrollee Cost Share: $5 copayment per visit

Covered services include prescribed home visits by registered or licensed practical nurses to provide skilled nursing services on a part-time intermittent basis.

Limited to skilled nursing services only. Meals, housekeeping and personal comfort items are excluded.

Private duty nursing is limited to circumstances where such care is medically necessary.

Hospice Services
Enrollee Cost Share: $5 copayment per visit; $0 for inpatient services

Covered services include reasonable and necessary services for palliation or management of an Enrollee’s terminal illness.

Once hospice care is elected, other services that treat the terminal condition shall not be covered.

Services required for conditions totally unrelated to the terminal condition are covered to the extent that such services are otherwise Covered Services.

Inpatient Services
Enrollee Cost Share: $0

Except for purposes of mental health/substance use disorder parity, inpatient services mean all covered services provided for the medical care and treatment of an Enrollee who is admitted as an inpatient to a hospital licensed under Part I of Chapter 395, Florida Statutes.

Covered Benefits for Inpatient services are those items and services ordinarily furnished by the hospital for the care and treatment of inpatients, including:

a. Bed and board in a semi-private room except when a private room is considered medically necessary or semi-private accommodations are not available;

b. Drugs, biologicals, supplies, appliances and equipment for use in the hospital;

c. Medical or surgical services;

d. Medical social services;

e. Nursing services and other related services;

    i. Private duty nursing is covered only when such care is medically necessary.

f. Other diagnostic or therapeutic services; and

g. Use of hospital facilities.

Admissions for rehabilitation or physical therapy are limited to fifteen (15) Calendar Days per Contract Year.

Inpatient admissions shall be authorized by Insurer.

Maternity Services and Newborn Care
Enrollee Cost Share: $0

Covered services include:

a. Maternity and newborn care;

b. Prenatal and postnatal care;

c. Vaginal and Cesarean section deliveries;

d. Initial inpatient care of an Enrollee’s infant, including:

    i. Nursery charges

    ii. Initial pediatric or neonatal examination

Infants are covered up to three (3) Calendar Days following birth.

Nursing Facility Services
Enrollee Cost Share: $0

Covered services include:

a. Routine nursing services;

b. Rehabilitation services;

    i. Admissions for rehabilitation and physical therapy are limited to fifteen (15) Calendar Days per Contract Year.

c. Drugs and biologicals;

d. Medical supplies;

e. The use of appliances and equipment furnished by the facility; and

f. Room and board

    i. Limited to semi-private accommodations unless a private room is considered medically necessary or semi-private accommodations are not available.

Enrollees must require and receive skilled services on a daily basis, as ordered by a Network Provider. The length of the Enrollee's stay shall be determined by medical necessity, but shall be limited to no more than one hundred (100) Calendar Days per Contract Year.

Specialized treatment centers and independent kidney disease treatment centers are excluded.

Private duty nurses, television and custodial care are excluded.

Organ Transplantation Services

Enrollee Cost Share: $0

Coverage is available for transplants and medically related services if deemed necessary and appropriate by AHCA's Organ Transplant Advisory Council or the U.S. Department of Health and Human Services' Bone Marrow Transplant Advisory Council, as applicable.

Covered services include:

a. Pre-transplant services;

b. Transplant services;

c. Post-discharge services; and

d. Treatment of complications after transplantation.

Outpatient Services

Enrollee Cost Share: $5 copayment per visit; $0 for preventive services

Outpatient services means covered services provided to an Enrollee:

a. In the outpatient portion of a health facility licensed under Chapter 395, Florida Statutes;

b. Admitted as outpatient to a health care facility as defined by Section 408.07, Florida Statutes;

c. At the service location of an office-based Provider; or

d. By telemedicine; and

e. Excluding emergency care.

Covered services include:

a. Preventive health services, including:
    i. Well-child care, including those services recommended in the Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents as produced by the American Academy of Pediatrics;
    ii. Immunizations and injections;
    iii. Health education counseling and clinical services;
    iv. Vision screening; and
    v. Hearing screening provided by the PCP.
b. Family planning services limited to one (1) annual visit and one (1) supply visit every ninety (90) Calendar Days;
c. Clinical radiological, laboratory and other outpatient diagnostic tests;
d. Ambulatory surgical procedures;
e. Splints and casts;
f. Consultation and treatment by referral physicians;
g. Radiation and chemotherapy;
h. Chiropractic services provided in the same manner as in the Florida Medicaid program;
i. Podiatric services limited to one (1) visit per day and a total of two (2) visits per month for specific foot disorders; and
j. Dental services limited to services provided by an oral surgeon for medically necessary reconstructive dental surgery due to injury.

Treatment for temporomandibular joint dysfunction is specifically excluded from covered outpatient services.

Prescription Drugs

Enrollee Cost Share: $5 copayment per prescription, up to a thirty-one (31) Calendar Day supply

Covered services include prescribed drugs for the treatment of illness or injury. Covered prescription drugs shall include all prescription drugs covered under the Florida Medicaid program.

Brand name prescription drugs are covered if a generic drug is not available or the prescribing Provider indicates that a brand name is medically necessary.

Vision Services

Enrollee Cost Share: $5 copayment per visit; $10 copayment for corrective lenses

Covered services include examination to determine the need for and to prescribe corrective lenses as medically necessary.

Corrective lenses and frames are limited to one (1) pair every two (2) years unless the Enrollee's head size or prescription changes.

Insurer shall follow the Florida Medicaid Visual Aid Services fee schedule laid out in Rule 59G-4.340, Florida Administrative Code, and its successors, insofar as it relates to the criteria for covered eyeglasses and contact lenses. In the event this rule conflicts with this benefit schedule or the Contract, the benefit schedule or Contract shall prevail.

Second Opinions

Enrollee Cost Share: $0

Insurer shall provide a second opinion from a network Provider or arrange for a second opinion from an out-of-network Provider at no cost to the Enrollee, upon Enrollee request.

Short-term Rehabilitation Therapies

Enrollee Cost Share: $5 copayment per visit

Covered services include the following short-term rehabilitation therapies when such therapies are expected to result in significant improvement in the Enrollee's condition, limited to no more than twenty-four (24) treatment sessions within a sixty (60) Calendar Day period per episode or injury:

a. Physical therapy;

b. Occupational therapy;

c. Respiratory therapy; and

d. Speech therapy.

The sixty (60) Calendar Day period begins with the first treatment.

Value-added Services

Insurer may voluntarily provide additional services in accordance with section 22-7 of the Contract.

Medically-related Lodging

Insurer shall provide reimbursement for lodging related to medical care outside of Insurer's Service Area.

Enrollee Eligibility: Must receive prior authorization from Insurer

Additional Limitations: Benefit limited to $150 per episode of care. Reimbursement is only available when services are not available within Insurer's network. Enrollees must provide proof of relevant expenditures to receive reimbursement.

CVS ExtraCare Health Card

Insurer shall provide one (1) CVS ExtraCare Health Card to each Enrollee's household by mail upon enrollment. The CVS ExtraCare Health Card provides a twenty percent (20%) discount on CVS brand over-the-counter health-related items available in CVS retail stores or online.

Enrollee Eligibility: All Enrollees eligible

Additional Limitations: One (1) CVS ExtraCare Health Card per household

Sports/School Physical Copay Waiver

Insurer shall waive the copay for an annual school or sports physical provided by the Enrollee's PCP.

Enrollee Eligibility: All Enrollees eligible

Additional Limitations: One physical per Enrollee per year

PCP Office Visit Copay Waiver

Insurer shall waive the copay for PCP visits.

Enrollee Eligibility: All Enrollees eligible

Additional Limitations: None

Hypoallergenic Bedding

Insurer shall provide up to one hundred dollars ($100) for hypoallergenic bedding to Enrollees with an appropriate diagnosis of allergies or asthma.

Enrollee Eligibility: Enrollees with a diagnosis of allergies or asthma and for whom hypoallergenic bedding is medically necessary

Additional Limitations: Up to $100 per year

Transportation for Medical and Dental Preventive Services

Insurer shall provide non-emergent transportation to Enrollees, and up to two (2) companions, to medical or dental preventive exams.

Enrollee Eligibility: All Enrollees eligible

Additional Limitations: Reservations must be made at least seventy-two (72) hours prior to the appointment. Trips over twenty-five (25) miles require prior authorization.

Water Safety Classes

Insurer shall collaborate with a local agency to provide water safety and drowning prevention classes to Enrollees.

Enrollee Eligibility: All Enrollees eligible

Additional Limitations: One set of classes per Enrollee per lifetime

Healthy Behavior Coaching

Insurer shall offer six (6) month individualized, in-person coaching program for tobacco cessation, substance use disorder and medically necessary supervised nutrition counseling for Enrollees in need of weight management.

Enrollee Eligibility: Enrollees in need of coaching in any of the three categories

Additional Limitations: None

Provider House Calls

Insurer shall offer to provide up to twenty (20) home visits per year by a licensed Provider to Enrollees who are homebound or who are not engaged with a PCP and are in need of an emergency department follow-up visit.

Enrollee Eligibility: Prior authorization for medical necessity required

Additional Limitations: None

Health Risk Assessment (HRA) Incentive

Insurer shall provide:

- A twenty-five-dollar ($25) gift card for completing the HRA within thirty (30) Calendar Days of enrollment;
- A twenty-dollar ($20) gift card for completing the HRA within sixty (60) Calendar Days of enrollment; or
- A fifteen-dollar ($15) gift card for completing the HRA within ninety (90) Calendar Days of enrollment

Enrollee Eligibility: All Enrollees

Additional Limitations: One-time benefit

Obesity Program

Insurer shall offer a series of three (3) education workshops utilizing a family-centered approach to address childhood obesity and partnerships with community organizations to educate Enrollees and their families on healthy eating and lifestyles. This program includes the following components: concierge case management, nutritionist visits, exercise education and resources, behavioral health, community group education classes, social work services, and linkage to food, housing and finance services. Insurer shall provide a Bluetooth®-enabled digital scale as an incentive. This program is tailored to each participating Enrollee and will include a self-management assessment tool upon enrollment in the program, at three (3), six (6) and twelve (12) months enrollment.

Enrollee Eligibility: Ages 5-19 with a BMI at or above the 95th percentile for children and teens the same age and sex, as defined by the CDC and the American Academy of Pediatrics.

Additional Limitations: One-time benefit

Additional Service Commitments

Insurer shall provide the following additional service commitments in accordance with section 22-8 of the Contract. The provision of an additional service commitment does not guarantee access or availability of the specified additional service commitment to any Enrollee; access and availability may be dependent upon a variety of variables including location and eligibility requirements.

No additional service commitments apply.

Exclusions

Covered services shall not include:

a. Experimental or investigational procedures defined as a drug, biological product, device, medical treatment or procedure that meets any of the following criteria, as determined by Insurer:

    i. Reliable evidence shows the drug, biological product, device, medical treatment or procedure when applied to the Enrollee's circumstances is the subject of ongoing phase I, II or III clinical trials;

    ii. Reliable evidence shows the drug, biological product, device, medical treatment or procedure when applied to the Enrollee's circumstances is under study with a written protocol to determine maximum tolerated dose, toxicity, safety, efficacy or efficacy in comparison to conventional alternatives; or

iii. Reliable evidence shows the drug, biological product, device, medical treatment or procedure when applied to the Enrollee's circumstances is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board as required and defined by federal regulations, particularly those of the U.S. Food and Drug Administration or the Department of Health and Human Services.

b. Abortions except when provided in the following situations:

i. When the pregnancy is the result of an act of rape or incest; or

ii. When a physician has found that the abortion is necessary to save the life of the mother.

c. Services performed for cosmetic purposes only; or

d. Services for the convenience of the Enrollee, unless designated and approved as a Value-Added Service.

ATTACHMENT B: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 COMPLIANCE: BUSINESS ASSOCIATE (BA) AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT ("AGREEMENT") is entered into by and between Florida Healthy Kids Corporation, a Florida non-profit corporation, ("FHKC" or "Covered Entity") and South Florida Community Care Network, LLC d/b/a Community Care Plan (the "BA"), and is incorporated in the Contract or other Ancillary Agreement ("Contract") between FHKC and South Florida Community Care Network, LLC d/b/a Community Care Plan.

A. HIPAA Compliance

FHKC and BA agree to comply with the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, codified at 42 U.S.C. §1320d through d-9, as amended from time to time ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH"). BA recognizes and agrees that it is directly obligated by law, through the Contract, and through any other written agreement and this Agreement to meet the applicable provisions of HIPAA and HITECH.

B. Definitions for Use in this Attachment

Terms used but not otherwise defined in this Agreement and the Contract shall have the same meaning as those terms in 45 C.F.R. Parts 160, 162 and 164.

C. Obligations and Activities of Business Associate (Privacy Rule)

1. Operation on Behalf of FHKC

The BA shall use and disclose Protected Health Information ("PHI") only as shall be permitted by the Contract, this Agreement or as required by law. BA shall have the same duty to protect FHKC's PHI as such term is defined in the Contract and under HIPAA, and in furtherance of the duties therein.

2. Compliance with the Privacy Rule

BA agrees to fully comply with the requirements under the Standards for Privacy of Individually Identifiable Health Information ("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 the Contract, this Agreement or as required by law.

BA shall create and/or adopt policies and procedures to periodically audit BA's adherence to all HIPAA regulations. BA acknowledges and promises to perform such audits pursuant to the terms and conditions set out herein. BA shall make such audit policies and procedures available to FHKC for review.

To the extent BA is to carry out one or more of FHKC's obligations under the Privacy Rule, BA agrees to comply with the requirements of the Privacy Rule that apply to FHKC in the performance of such obligations. Except as otherwise allowed in this Agreement and under HIPAA, BA shall not directly or indirectly receive remuneration in exchange for any PHI of an individual unless the individual has provided a valid authorization compliant with HIPAA and state law.

3. Privacy Safeguards and Policies

BA agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by the Contract, any Ancillary Agreement(s), this Agreement, or as required by law.

4. Mitigation of Harmful Effect of Violations

BA agrees to inform FHKC without unreasonable delay and mitigate, to the extent practicable, any harmful effect that is known to BA of a use or disclosure of PHI by BA, or by a subcontractor or agent of BA, resulting from a violation of the requirements of this Agreement.

5. Privacy Obligations Breach and Security Incidents

5.1 Privacy Breach

BA will report to FHKC, immediately following discovery and without unreasonable delay, any use or disclosure of FHKC's PHI not permitted by HIPAA, this Agreement or in writing by FHKC. In addition, BA will report, immediately following discovery and without unreasonable delay, but in no event later than seven (7) business days following discovery, any "Breach" of "Unsecured Protected Health Information" as these terms are defined by HIPAA, notwithstanding whether BA has made an internal risk assessment and determined that no notification is required. BA shall cooperate with FHKC in investigating the Breach and in meeting FHKC's obligations under HIPAA and any other security breach notification laws. In the event of a breach, BA and FHKC will work together to comply with any required regulatory filings.

Any such report shall include the identification (if known) of each individual whose Unsecured PHI has been, or is reasonably believed by BA to have been, accessed, acquired, used or disclosed during such Breach. BA will make the report to FHKC's Privacy Officer not more than seven (7) business days after BA discovers such non-permitted use or disclosure.

Any items not known at the time of the initial report will be subsequently reported to FHKC as answers are determined. All elements will be reported no later than 30 days after the date of the initial report, or as soon as feasible, whichever is sooner.

5.2 Access of Individual to PHI and other Requests to Business Associate

If BA receives PHI from FHKC in a designated record set, BA agrees to provide access to such PHI to FHKC in order for FHKC to meet its requirements under 45 CFR § 164.524. If BA receives a

request from an individual for a copy of the individual's PHI, and the PHI is in the sole possession of the BA, BA will provide the requested copies to the individual in compliance with 45 CFR § 164.524, and notify FHKC of such action within five (5) business days of completion of the request. If BA receives a request for PHI in the possession of FHKC, or receives a request to exercise other individual rights as set forth in the Privacy Rule, BA shall promptly forward the request to FHKC within two (2) business days. BA shall then assist FHKC as necessary in responding to the request in a timely manner. If a BA provides copies of PHI to the individual, it may charge a reasonable fee for hard copies as the regulations shall permit. If requested, BA shall provide electronic copies as required by law.

6. Recording of Designated Disclosures of PHI

BA agrees to maintain and make available information required to provide an accounting of disclosures to FHKC as necessary to satisfy FHKC's obligations under 45 CFR § 164.528. BA agrees to provide to FHKC, within fifteen (15) days and in a secure manner, information collected in accordance with this provision, to permit FHKC to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528 and applicable state law.

7. Requests to Make an Amendment to the PHI

BA agrees to make any amendments to PHI in a designated record set as agreed to by FHKC pursuant to 45 CFR § 164.526, or take other measures as necessary to satisfy FHKC's obligations under 45 CFR § 164.526.

8. Security and Privacy Compliance Review upon Request

8.1 HHS Inspection

BA shall make its internal practices, books and records relating to the Use and Disclosure of PHI available to the HHS for purposes of determining Covered Entity's compliance with HIPAA. Except to the extent prohibited by law, BA agrees to notify FHKC of all requests served upon BA for information or documentation by or on behalf of the HHS. BA shall provide to FHKC a copy of any PHI that BA provides to the HHS concurrently with providing such PHI to the HHS.

8.2 FHKC Inspection

Upon written request, BA agrees to make available to FHKC during normal business hours BA's internal practices, books, and records relating to the use and disclosure of PHI or EPHI received from, or created or received on behalf of, FHKC in a time and manner designated by FHKC for the purposes of FHKC determining compliance with the HIPAA Privacy and Security Requirements.

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D. Obligations and Activities of Business Associate (Security Rule)

1. Compliance with Security Rule

BA shall ensure compliance with the HIPAA Security Standards for the Protection of Electronic Protected Health Information ("EPHI"), 45 C.F.R. Part 160 and Part 164, Subparts A and C (the "Security Rule"), with respect to EPHI covered by the Contract and this Agreement.

2. Security Safeguards and Policies

BA agrees to 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 FHKC as required by the Security Rule. The BA will maintain appropriate documentation of its compliance with the Security Rule. These safeguards will include, but shall not be limited to:

- Annual training to relevant employees, contractors and subcontractors on preventing improper use or disclosure of PHI, updated as appropriate;
- Adopting policies and procedures regarding the safeguarding of PHI, updated and enforced as necessary;
- Implementing appropriate technical and physical safeguards to protect PHI, including access controls, transmission security, workstation security, etc.

3. Security Provisions in Business Associate Contracts

In accordance with 45 CFR §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, BA shall ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of BA agree in writing to the same restrictions and conditions that apply to BA with respect to such information.

4. Florida Consumer Notice of Breach

BA understands that FHKC or its customers may be a "covered entity" (as may be BA) under the terms of section 501.171, Florida Statutes, and that in the event of a breach of system as defined by that statute, the BA shall indemnify and hold FHKC harmless for expenses and/or damages related to the breach. Such obligation shall include, but is not limited to, the mailed notification to a governmental agency and any Florida resident whose personal information is reasonably believed to have been accessed as a result of the breach. In the event that the BA discovers circumstances requiring notification of more than one thousand (1,000) persons at one time, BA shall also notify, without unreasonable delay, all consumer reporting agencies that compile and maintain files on consumers on a nationwide basis, as in the Fair Credit Reporting Act, 15 U.S.C. § 1681a(p), of the timing, distribution and content of the notices. Substitute notice, as specified in section 501.171(4)(f), Florida Statutes, shall not be permitted except as approved in writing in advance by FHKC. The parties agree that PHI includes data elements in addition to those included described as "personal information" under section 501.171, Florida

Statutes, and agree that BA's responsibilities under this paragraph shall include all PHI. BA also agrees to pay all costs of any associated mitigation as a result of a breach under HIPAA or section 501.171, Florida Statutes, including the provision of, at a minimum, one (1) year of credit monitoring and identity theft protection for such affected individuals. FHKC, in its sole discretion, shall determine if the breach is significant enough to warrant such measures and the length of time such mitigation measures shall be offered to the affected individuals.

5. Reporting of Security Incidents

The BA shall track all "Security Incidents" as defined by HIPAA and shall report any Security Incident that results in the unauthorized access, acquisition, use or disclosure of PHI, including any Breach of Unsecured PHI, of which it becomes aware. The Parties acknowledge and agree that this section constitutes notice by BA to FHKC of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined below) for which no additional notice to FHKC shall be required. "Unsuccessful Security Incidents" shall include, but not be limited to, pings and other broadcast attacks on BA's firewall, port scans, unsuccessful long-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, acquisition, use or disclosure of PHI.

The BA shall reasonably use its own vulnerability assessment of damage potential and monitoring to define levels of Security Incidents and responses for BA's operations. However, the BA shall expediently notify FHKC's Privacy Officer of any "Security Incident" , including any "breach of security " under section 501.171*,* Florida Statutes*,* in a preliminary report within two (2) business days, with a full report of the incident not less than five (5) business days of the time it became aware of the incident. The BA shall likewise notify FHKC in a preliminary report within two (2) business days of any unauthorized acquisition including but not limited to internal user access to non-test records reported to BA's privacy manager, and any use, disclosure, modification, or destruction of PHI by an employee or otherwise authorized user of its system of which it becomes aware with a full report of the incident not less than five (5) business days from the time it became aware of the incident.

BA shall identify in writing key contact persons for administration, data processing, marketing, information systems and audit reporting within thirty (30) days of the execution of this Agreement. BA shall notify FHKC of any reduction of in-house staff during the term of this Agreement, in writing, within ten (10) business days.

6. Unsecured Protected Health Information

BA shall notify each individual whose Unsecured PHI has been accessed, acquired, used, or disclosed in a manner not permitted under the HIPAA Privacy Rule which compromises the security and privacy of the PHI, except when law enforcement requires a delay pursuant to 45 CFR 164.412.

On behalf of FHKC, BA shall notify such individuals without unreasonable delay, and in no case later than sixty (60) days after discovery of the breach. However, where applicable state law, such as section 501.171, Florida Statutes, requires notification to be sent within a shorter time period, BA agrees to comply with such state laws in notifying the affected individuals. The notice required under HIPAA shall be made as follows:

- By written notice in plain language including, to the extent possible:
  - A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;
  - A description of the types of Unsecured PHI involved in the breach (including but not limited to items such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);
  - Any steps individuals should take to protect themselves from potential harm resulting from the breach;
  - A brief description of what BA and FHKC are doing to investigate the breach, to mitigate the harm to individuals, and to protect against further breaches; and
  - Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, website or postal address.
- BA must use a method of notification that meets the requirements of 45 CFR 164.404(d).
- BA must provide notice to the media when required under 45 CFR 164.406, and to HHS pursuant to 45 CFR 164.408.

E. Electronic Transaction and Code Sets

To the extent that the services performed by BA pursuant to the Agreement involve transactions that are subject to the HIPAA Standards for Electronic Transactions and Code Sets, 45 C.F.R. Parts 160 and 162, with respect to EPHI covered by the Contract and this Agreement, BA shall conduct such transactions in conformance with such regulations as amended from time to time. Without limiting the generality of the foregoing, BA also agrees that it will, in accordance with 45 C.F.R. § 162.923(c), comply with all applicable requirements of 45 C.F.R. Part 162, and require any agent or subcontractor to comply with all applicable requirements of 45 C.F.R. Part 162.

F. Permitted Uses and Disclosures by BA – General Use and Disclosure Provisions

1. Use of PHI for Operations on Behalf of FHKC

Except as otherwise limited by this Agreement, BA may use or disclose PHI to perform functions, activities, or services for, or on behalf of, FHKC as specified in the Contract and this Agreement, provided that such use or disclosure would not violate HIPAA if done by FHKC, or violate other policies and procedures of FHKC. BA may use or disclose PHI as required by law.

Except as otherwise provided in the Contract or this Agreement, BA is prohibited from further using or disclosing any information received from FHKC, or from any other business associate of FHKC for any commercial purposes of the BA, including, by way of example, "data mining."

BA shall only request, use and disclose the minimum amount of PHI necessary to accomplish the purposes of the request, use or disclosure.

G. Permitted Uses and Disclosures by BA – Specific Use and Disclosure Provisions

1. Proper Management and Administration of BA

BA may use PHI for the proper management and administration of BA or to carry out the legal responsibilities of BA.

2. Third Party Disclosure Confidentiality

Except as otherwise limited in the Contract or this Agreement, BA may disclose PHI for the proper management and administration of the BA or to carry out the legal responsibilities of BA, provided that disclosures are required by law, or, if permitted by law, this Agreement, the Contract and any Ancillary Agreements, provided that, if BA discloses any PHI to a third party for such a purpose, BA 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 BA of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the PHI is breached in a preliminary report within two (2) business days with a full report of the incident not less than five (5) business days from the time it became aware of the incident.

3. Data Aggregation Services

Except as otherwise limited in this Agreement, BA may use PHI to provide Data Aggregation Services to FHKC as permitted by 42 CFR § 164.504(e)(2)(i)(B).

H. Provisions for FHKC to Inform BA of Privacy Practices and Restrictions

1. Notice of Privacy Practices

FHKC shall provide BA with the Notice of Privacy Practices produced by FHKC or provided to FHKC as a result of FHKC's obligations with other organizations in accordance with 45 CFR § 164.520, as well as any changes to such Notice.

2. Notice of Changes in Individual's Access or PHI

FHKC shall provide BA with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect BA's permitted or required uses.

3. Notice of Restriction in Individual's Access or PHI

FHKC shall notify BA of any restriction to the use or disclosure of PHI that FHKC has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect BA's use of PHI.

I. Term and Termination

1. Term

The Term of this Agreement shall be effective concurrent with the Contract, and shall terminate when all of the PHI provided by FHKC to BA, or created or received by BA on behalf of FHKC, is destroyed or returned to FHKC, or, if it is not feasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this section.

2. Termination for Cause

This Agreement authorizes and BA acknowledges and agrees FHKC shall have the right to immediately terminate this Agreement in the event BA fails to comply with, or violates a material provision of this Agreement or any provision of the Privacy and Security Rules. Notwithstanding the aforementioned, BA shall not be relieved of liability to FHKC for damages sustained by virtue of any breach of this Agreement by BA.

3. Effect of Termination; Return of Protected Health Information

Upon termination of this Agreement for any reason, except as provided in subsections below, BA shall, at its own expense, either return and/or destroy all PHI and other confidential information received from FHKC or created or received by BA on behalf of FHKC. This provision applies to all confidential information regardless of form, including but not limited to electronic or paper format. This provision shall also apply to PHI and other confidential information in the possession of subcontractors or agents of BA.

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

The BA shall notify FHKC whether it intends to return and/or destroy the confidential information with such additional detail as requested. In the event BA determines that returning or destroying the PHI and other confidential information received by or created for FHKC at the end or other termination of this Agreement is not feasible, BA shall provide to FHKC notification of the conditions that make return or destruction not feasible, and BA shall:

a) Retain only that PHI which is necessary for BA to continue its proper management and administration or to carry out its legal responsibilities;
b) Return to FHKC (or, if agreed to by FHKC, destroy) the remaining PHI that the BA still maintains in any form;

c) Continue to use appropriate safeguards and comply with the Security Rule with respect to EPHI to prevent use or disclosure of the PHI, other than as provided for in this section, for as long as BA retains the PHI;
d) Not use or disclose the PHI retained by BA other than for the purposes for which such PHI was retained and subject to the same conditions set out under "Permitted Uses and Disclosures by BA – Specific Use and Disclosure Provisions" which applied prior to termination; and
e) Return to FHKC (or, if agreed to by FHKC, destroy) the PHI retained by BA when it is no longer needed by BA for its proper management and administration or to carry out its legal responsibilities.

J. Miscellaneous

1. Severability

If any of the provisions of this Agreement shall be held by a court of competent jurisdiction to be no longer required by HIPAA, the parties shall exercise their best efforts to determine whether such provisions shall be retained, replaced or otherwise modified.

2. Cooperation

The parties agree to cooperate and to comply with procedures mutually agreed upon to facilitate compliance with HIPAA, including procedures designed to mitigate the harmful effects of any improper use or disclosure of PHI.

3. Regulatory Reference

Any reference in this Agreement to a section in the HIPAA regulations means those provisions currently in effect or as may be amended in the future.

4. Modification and Amendment

This Agreement may be modified only by express written amendment executed by all Parties hereto. The Parties agree to take such action to amend this Agreement from time to time as is necessary for FHKC to comply with the requirements of HIPAA and applicable state law.

5. Survival

The respective rights and obligations of BA under "Term and Termination" of this Agreement shall survive the termination of this Agreement and the Contract.

6. Interpretation

Any ambiguity in this Agreement or the Contract shall be resolved so as to permit FHKC to comply with HIPAA.

7. No Third Party Rights/Independent Contractors

The Parties to this Agreement do not intend to create any rights in any third parties. The Parties agree that they are independent contractors and not agents of each other, except nothing herein affects whether BA is an "agent" for purposes of compliance with 42 CFR § 1001.952(d).

8. State Law

BA acknowledges and agrees that it has implemented and will maintain appropriate privacy and security measures to protected personal information consistent with state laws and regulations to the extent those state laws and regulations are applicable to the PHI. The confidentiality obligations hereunder are independent of and do not limit or otherwise affect the Parties' other confidentiality obligations under this Agreement.

9. Governing Law

To the extent not preempted by federal law, this Agreement shall be governed and construed in accordance with the state laws governing the Contract, without regard to conflicts of law provisions that would require application of the law of another state.

10. Assignment, Binding Nature and Benefits

This Agreement binds and benefits the Parties, and their respective successors, and their permitted assigns. BA may not assign or subcontract rights or obligations under this Agreement without the express written consent of FHKC. FHKC may assign its rights and obligations under this Agreement under this Agreement to any successor or affiliated entity.

11. Counterparts

This Agreement may be executed in multiple counterparts, which shall constitute a single agreement, and by facsimile or pdf signatures, which shall be treated as originals.

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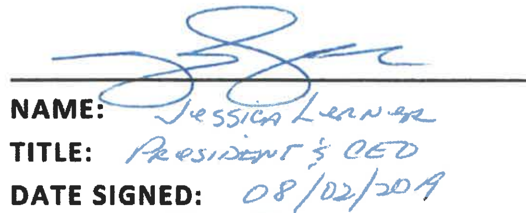
TWO (2) SIGNATURE PAGES FOLLOW

IN WITNESS WHEREOF, the Parties have caused this BUSINESS ASSOCIATE AGREEMENT, to be executed by their undersigned officials as duly authorized.

FOR
ENTITY: SOUTH FLORIDA COMMUNITY CARE NETWORK, LLC D/B/A COMMUNITY CARE PLAN



NAME: Jessica Lerner
TITLE: President & CEO
DATE SIGNED: 08/02/2019

WITNESS #1 SIGNATURE

Lupe Rivero

WITNESS #1 PRINT NAME

WITNESS #2 SIGNATURE

Alec Salceda

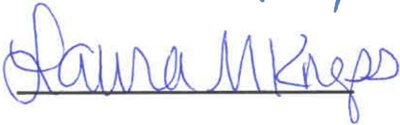
WITNESS #2 PRINT NAME

APPROVED - As to legal form by counsel for Community Care Plan 8/1/2019 3:13 PM

FOR

FLORIDA HEALTHY KIDS CORPORATION:

NAME: JEFF DYKES
TITLE: INTERIM CHIEF EXECUTIVE OFFICER
DATE SIGNED: 8-6-19



WITNESS #1 SIGNATURE

WITNESS #1 PRINT NAME

WITNESS #2 SIGNATURE

WITNESS #2 PRINT NAME

NOTIFICATION TO THE FHKC OF BREACH OF UNSECURED PROTECTED HEALTH INFORMATION

Contract Information	
Contract Number	**Contract Title**
Contract Contact Information	
Contact Person for This Incident:	
Contact Person's Title:	
Contact's Address	
Contact's Email:	
Contact's Telephone No:	

Business Associate hereby notifies FHKC that there has been a Breach of Unsecured (unencrypted) Protected Health Information that Business Associate has used or has had access to under the terms of the Business Associate Agreement, as described in detail below:

Breach Detail	
Date of Breach	**Date of Discovery of Breach**
Information about the Breach	
Type of Breach: ☐ **Lost or stolen laptop, computer, flash drive, disk, etc.** ☐ **Stolen password or credentials** ☐ **Unauthorized access by an employee or contractor** ☐ **Unauthorized access by an outsider** ☐ **Other (describe)**	
Detailed Description of the Breach	

<table>
<tr><th colspan="3">Types of Unsecured Protected Health Information involved in the breach (such as Full Name, SSN, Date of Birth, Address, Account Number, Disability Code, etc).</th></tr>
<tr><td>Personal Information:

☐ Name
☐ Address
☐ Date of birth
☐ Social Security number
☐ Drivers license or identification card number
☐ Financial insurance information (credit card number, bank account number, etc.)
☐ Health insurance information (insurance carrier, insurance card number, etc.)
☐ Other Personal or Health Information (describe):</td><td colspan="2">Health Information:

☐ Basic information (age, sex, height, etc.)
☐ Disease or medical conditions
☐ Medications
☐ Treatments or procedures
☐ Immunizations
☐ Allergies
☐ Information about children
☐ Test results
☐ Hereditary conditions
☐ Mental health information
☐ Information about diet, exercise, weight, etc.)
☐ Correspondence between patient, or medical power of attorney
☐ Organ donor authorization</td></tr>
<tr><th colspan="3">What steps are being taken to investigate the breach, mitigate losses, and protect against any further breaches?</th></tr>
<tr><td colspan="3"></td></tr>
<tr><th colspan="3">List any law enforcement agencies you’ve contacted about the b</th></tr>
<tr><td colspan="3"></td></tr>
<tr><th>Number of Individuals Impacted</th><th colspan="2">If over 500, do individuals live in multiple states?</th></tr>
<tr><td></td><td>Yes</td><td>No</td></tr>
</table>

<table>
<tr><th colspan="3">Breach Notification</th></tr>
<tr><th colspan="2">Have you made the breach public?</th><th>If YES, when did you make it public</th></tr>
<tr><td>Yes</td><td>No</td><td></td></tr>
<tr><td colspan="3">Have you notified the people whose information was breached?

☐ YES. We notified them on:
Attach a copy of the letter to this form. Don’t include any personally identifiable information, other than your own contact information.

☐ NO. Our investigation isn’t complete.</td></tr>
<tr><td colspan="3">Comments</td></tr>
<tr><td colspan="3">1.
2.</td></tr>
</table>

Submitted By: **Date of Submission:**

_______________________________ ___________________________

Attachment C: Performance Guarantees

Insurer agrees the services provided under this Contract are critical to the success of FHKC's provision of quality services to Enrollees and the administration of the Program as part of Florida's CHIP.

The failure to meet the following performance guarantees (PGs) shall be deemed a default. For each such default, Insurer shall be liable to FHKC for financial consequences in addition to any other remedies available under the Contract. FHKC shall inform Insurer in writing, by email or mail, of any financial consequences incurred and how the amounts owed to FHKC should be remitted. Financial consequences shall be calculated, reported and paid for each PG's specified frequency.

FHKC may waive financial consequences, in whole or in part, for any reason in its sole discretion. The waiver of financial consequences in one instance does not provide Insurer any right or expectation to future waived financial consequences under the same, or any other, circumstances.

When reporting PG results, Insurer shall round the results at the tenth decimal place to the nearest whole number.

- For percentages with numbers zero through four (0-4) in the tenth decimal place, round down.
- For percentages with numbers five through nine (5-9) in the tenth decimal place, round up.

PG-1: Average Speed to Answer

Ninety percent (90%) of inbound calls received by Insurer's Enrollee services call center shall be answered by a live agent within thirty (30) seconds.

Reporting Frequency: Monthly

Financial Consequences: one thousand dollars ($1,000) per percentage point below guarantee.

Calculation Methodology

- The answer time measurement threshold begins when the call is presented in the call queue for an agent to answer.
    - The time the caller spends navigating any automated systems is not included in the measurement time.

- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of inbound calls answered within thirty (30) seconds. Performance reported in any other manner, including the average number of seconds for ninety percent (90%) of inbound calls to be answered is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 21

PG-2: Call Abandonment Rate

The percentage of calls received that are terminated by the caller before a live person answers shall not exceed three percent (3.0%).

Reporting Frequency: Monthly

Financial Consequences: one thousand dollars ($1,000) per percentage point below guarantee.

Calculation Methodology

- The abandonment measurement threshold begins when the call is presented in the call queue for an agent to answer.
    - Callers who terminate while navigating any automated systems are not included in the measurement.

Related Contract Reference: Section 21

PG-3: Blocked Calls

The percentage of inbound calls blocked from entering the call center system and those that are forced disconnects shall be zero percent (0.0%).

Reporting Frequency: Monthly

Financial Consequences: five hundred dollars ($500) per percentage point above the guarantee.

Calculation Methodology

- The percentage of blocked calls shall be calculated by the number of calls blocked by Insurer's telecom provider and the number of calls that are forced disconnects divided by the total number of calls.

Related Contract Reference: Section 21

PG-4: First Call Resolution

Insurer's Enrollee service representatives shall ensure that at least eighty-five percent (85%) of calls are resolved within the first call during the first Contract Year and at least ninety percent (90%) thereafter.

Reporting Frequency: Monthly

Financial Consequences: five hundred dollars ($500) per percentage point below the guarantee

Calculation Methodology

- Insurer shall audit a statistically valid random sample of all Florida Healthy Kids calls each month.
    - Insurer shall determine if the call is the first call the caller has made about the issue and if the Enrollee services representative answering the call resolved the call during that initial call.
    - Resolution includes providing complete and clear information to the extent a call or other communication back to or from the caller is not needed. Insurer shall also review the caller's record to ensure no follow up calls were placed to Insurer about the same issue.

Related Contract Reference: Section 21

PG-5: Call Quality Assurance Monitoring

Insurer shall ensure that the average call quality monitoring score resulting from call monitoring of all call center Enrollee service representatives working on the Florida Healthy Kids account is at least ninety-five percent (95%).

Reporting Frequency: Monthly

Financial Consequences: five hundred dollars ($500) per percentage point below the guarantee

Calculation Methodology

- Insurer shall conduct quality assurance monitoring of all call center Enrollee service representatives working on the Florida Healthy Kids account each month using an established review methodology for which the highest score possible is one hundred percent (100%). Insurer shall divide the sum of all quality assurance monitoring review scores by the total number of quality assurance monitoring reviews conducted during the month.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report performance based on the average score. Performance reported in any other manner, including the number of quality assurance monitoring reviews to meet ninety-five percent (95%) is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 21

PG-6: Enrollment Files

Insurer shall accurately process one hundred (100%) of enrollment files, including supplemental enrollment files within two (2) Business Days of receipt.

Reporting Frequency: Monthly

Financial Consequences: two thousand dollars ($2,000) per Calendar Day

Calculation Methodology

- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of enrollment files accurately processed within two (2) Business Days. Performance reported in any other manner, including the number of days to process one hundred percent (100%) of enrollment files is insufficient to meet the requirements of this PG.
- Financial consequences apply to each Calendar Day beyond the due date until accurately processed, inclusive of the date processed.

Related Contract Reference: Section 18

PG-7: Ad hoc Enrollment Data

Insurer shall accurately process one hundred percent (100%) of ad hoc enrollment requests, including changes in demographic information, within one (1) Business Day.

Reporting Frequency: Monthly

Financial Consequences: two thousand dollars ($2,000) per incident per Calendar Day

Calculation Methodology

- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of ad hoc enrollment requests accurately processed within one (1) Business Day. Performance reported in any other manner, including the number of days to process one hundred percent (100%) of ad hoc enrollment requests, is insufficient to meet the requirements of this PG.
- Financial consequences apply to each Calendar Day beyond the due date until accurately processed, inclusive of the date processed for each ad hoc enrollment request.

Related Contract Reference: Section 18

PG-8: Enrollment Packages

Insurer shall provide complete enrollment packages, including ID cards, to one hundred percent (100%) of new Enrollees within five (5) Business Days of receipt of the enrollment information.

Reporting Frequency: Monthly

Financial Consequences: two thousand dollars ($2,000) per percentage point below guarantee.

Calculation Methodology

- “Provide” is used in the same manner as 42 CFR 438.10(g)(3) except that a physical ID card must be mailed to each Enrollee.
- Enrollment packages returned undeliverable due to no fault of Insurer are not included in the measurement.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of enrollment packages provided to Enrollees within five (5) Business Days. Performance reported in any other manner, including the number of days to process one hundred percent (100%) of enrollment packages is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 18; Section 21

PG-9: Appeal and Grievance Resolution Timeframes

Insurer shall resolve one hundred percent (100%) of Appeals and Grievances within the timeframes below. Any of the timeframes below may be extended by fourteen (14) Calendar Days if the conditions of 42 CFR 438.408(c) are met.

- Standard Grievances: Ninety (90) Calendar Days
- Standard Appeals: Thirty (30) Calendar Days
- Expedited Appeals: Seventy-two (72) hours

Reporting Frequency: Quarterly

Financial Consequences: two thousand five hundred dollars ($2,500) per percentage point below guarantee.

Calculation Methodology

- When determining the percentage of Appeals and Grievances resolved timely, the denominator includes all Appeals and Grievances received for which the latest acceptable resolution date fell within the reporting period, regardless of when the Appeal or Grievance was actually resolved. For example, an Appeal or Grievance for which the latest acceptable resolution date falls in quarter B shall be included in the

denominator for quarter B regardless of the quarter during which the Appeal or Grievance was resolved.

  - The “latest acceptable resolution date” includes the fourteen (14) Calendar Days extension only if the required conditions for the extension were met **and** the extension was taken for the Appeal or Grievance.

- When determining the percentage of Appeals and Grievances resolved timely, the numerator includes all Appeals and Grievances included in the denominator that were resolved timely.

Related Contract Reference: Section 23

PG-10: Independent Review Timeframes

Insurer shall ensure that Insurer’s contracted IRO completes one hundred percent (100%) of the independent reviews within the timeframes below.

- Standard Review: Ninety (90) Calendar Days
- Expedited Review: Seventy-two (72) hours

Reporting Frequency: Quarterly

Financial Consequences: two thousand five hundred dollars ($2,500) per percentage point below guarantee.

Calculation Methodology

- When determining the percentage of reviews resolved timely, the denominator includes all reviews received for which the latest acceptable resolution date fell within the reporting period, regardless of when the review was actually resolved. For example, a review for which the latest acceptable resolution date falls in quarter B shall be included in the denominator for quarter B regardless of the quarter during which the review was resolved.
- When determining the percentage of reviews resolved timely, the numerator includes all reviews included in the denominator that were resolved timely.

Related Contract Reference: Section 23

PG-11: Electronic Claims Processing

Insurer shall process ninety percent (90%) of electronic claims within fifteen (15) Calendar Days.

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars ($1,000) per percentage point below guarantee.

Calculation Methodology

- The measurement for electronic claims includes clean claims and claims for which all information requested by Insurer to continue processing the claim has been received.
- The measurement begins on the date a clean claim is received or on the date stamped on information received for non-clean claims. The measurement ends on either the date a payment is made or the date the claim is denied as indicated by the date on the EDI 835 Electronic Remittance Advice, paper check, or denial notice, as applicable.
- Claims currently pending response from Providers are not included in this measurement.
- Claims related to investigations for potential fraud, waste or abuse are not included in this measurement.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of electronic claims processed within fifteen (15) Calendar Days. Performance reported in any other manner, including the number of days to process ninety percent (90%) of electronic claims is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-12: Paper Claims Processing

Insurer shall process ninety percent (90%) of paper claims within twenty (20) Calendar Days.

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars ($1,000) per percentage point below guarantee.

Calculation Methodology

- The measurement for paper claims includes clean claims and claims for which all information requested by Insurer to continue processing the claim has been received.
- The measurement begins on the date a clean claim is received or on the date stamped on information received for non-clean claims. The measurement ends on either the date a payment is made or the date the claim is denied as indicated by the date on the EDI 835 Electronic Remittance Advice, paper check, or denial notice, as applicable.
- Claims currently pending response from Providers are not included in this measurement.
- Claims related to investigations for potential fraud, waste or abuse are not included in this measurement.

- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of paper claims processed within twenty (20) Calendar Days. Performance reported in any other manner, including the number of days to process ninety percent (90%) of paper claims is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-13: Claims Payment Financial Accuracy

Ninety-eight percent (98%) of claims Insurer audits in a statistically valid quarterly audit of Florida Healthy Kids claims using representative sampling shall be free from financial errors.

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars ($1,000) per percentage point below guarantee.

Calculation Methodology

- Financial accuracy shall be measured as (the number of claims free from financial error divided by the number of claims in the audit sample) multiplied by (the number of claims in the strata population divided by the number of claims in the population).

- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of claims free from financial error. Performance reported in any other manner, including the percentage of paid dollars that were for claims free from financial error is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 12

PG-14: Non-financial Claims Processing Accuracy

Ninety-five percent (95%) of claims Insurer audits in a statistically valid quarterly audit of Florida Healthy Kids claims using representative sampling shall be free from non-financial errors.

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars ($1,000) per percentage point below guarantee.

Calculation Methodology

- Non-financial claims processing accuracy shall be measured as (the number of claims free from non-financial error divided by the number of claims in the audit sample) multiplied by (the number of claims in the strata population divided by the number of claims in the population).

- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of claims free from non-financial error. Performance reported in any other manner, including the percentage of paid dollars that were for claims free from non-financial error is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 12

PG-15: Provider Overpayment Recovery

Insurer shall recover eighty percent (80%) of overpayments to Providers within sixty (60) Calendar Days of identification as required by 42 CFR 457.1285 which incorporates 42 CFR 438.608(d).

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars ($1,000) per percentage point below guarantee.

Calculation Methodology

- The measurement timeframe begins the date a payment is determined to be an overpayment and ends the date Insurer receives full compensation for the overpaid amount.
- When determining the percentage of overpayments recovered timely, the denominator includes all identified overpayments for which the latest acceptable recovery date fell within the reporting period regardless of when the overpayment was actually recovered.
    - The "latest acceptable recovery date" means sixty (60) Calendar Days from the date the overpayment was identified, as determined by Insurer.
- Overpayments recovered by netting the overpaid amount from amounts owed to a Provider may be considered recovered only if payments of funds owed to the Provider sufficient to recover the entire overpaid amount have been fully processed by Insurer.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of overpayments recovered from Providers within sixty (60) Calendar Days. Performance reported in any other manner, including the number of Calendar Days to recover eighty percent (80%) of Provider overpayments is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-16: Standard, Medical Services Prior Authorization Processing Timeliness

Insurer shall process 100 percent (100%) of all standard, medical services prior authorizations within fourteen (14) Calendar Days.

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars ($1,000) per percentage point below guarantee.

Calculation Methodology

- The measurement begins from the date Insurer receives the request and ends the date Insurer makes a final decision and communicates such decision to the requesting Provider.
  - Requests for prior authorization pending additional information from the requesting Provider are not included in the measurement so long as the prior authorization was extended appropriately as described in 42 CFR 438.210.
  - Prior authorizations for which Insurer extended beyond the fourteen (14) Calendar Days as permitted by law are excluded from this measurement.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of prior authorizations processed within fourteen (14) Calendar Days. Performance reported in any other manner, including the number of Calendar Days to process one hundred percent (100%) of prior authorizations is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 22

PG-17: Expedited, Medical Services Prior Authorization Processing Timeliness

Insurer shall process 100 percent (100%) of all expedited, medical services prior authorizations within seventy-two (72) hours.

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars ($1,000) per percentage point below guarantee.

Calculation Methodology

- The measurement begins from the date and time Insurer receives the request and ends the date and time Insurer makes a final decision and communicates such decision to the requesting Provider.
  - Requests for prior authorization pending additional information from the requesting Provider are not included in the measurement so long as the prior authorization was extended appropriately as described in 42 CFR 438.210.

  - Prior authorizations for which Insurer extended beyond the seventy-two (72) hours as permitted by law are excluded from this measurement.

- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of prior authorizations processed within seventy-two (72) hours. Performance reported in any other manner, including the number of Calendar Days or hours to process one hundred percent (100%) of prior authorizations is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 22

PG-18: Prescription Drug Prior Authorization Processing Timeliness

Insurer shall process 100 percent (100%) of all outpatient prescription drug prior authorizations within twenty-four (24) hours.

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars ($1,000) per percentage point below guarantee.

Calculation Methodology

- The measurement begins from the date and time Insurer receives the request and ends the date and time Insurer makes a final decision and communicates such decision to the requesting Provider by telephone or other telecommunication device.
  - Prescription drugs not subject to the prior authorization requirements of section 1927(d)(5)(A) of the Act are excluded from this measurement.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of prior authorizations processed within twenty-four (24) hours. Performance reported in any other manner, including the number of Calendar Days or hours to process one hundred percent (100%) of prior authorizations is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 22

PG-19: Systems Availability

Insurer shall maintain availability, which includes standard accessibility, of systems critical to Enrollees and Providers, including the public and private plan website(s), any Provider portal or website, and enrollment system, twenty-four hours a day, seven days a week (24/7) except during scheduled maintenance. Insurer shall resolve unscheduled unavailability of these systems within forty-eight (48) hours of identification of the unavailability, when such unavailability is within Insurer’s direct or indirect control.

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars ($1,000) per Calendar Day that Insurer's system(s) is not available

Calculation Methodology

- Financial consequences apply to each Calendar Day beyond the allowable forty-eight (48) hours, including the date the system(s) regains availability.

Related Contract Reference: Section 6

PG-20: Network Access

Insurer shall provide ninety percent (90%) of Enrollees residing in Insurer's Service Area with access to one Provider for each of the provider types below within the timeframe and distance listed for rural and urban counties.

Provider Type	Time (in minutes)		Distance (in miles)	
	Rural	**Urban**	**Rural**	**Urban**
PCP – Pediatrician	30	20	30	20
PCP – Family Physician	20	20	20	20
OB/GYN	30	30	30	30
Behavioral Health – Pediatric	60	30	45	30
Behavioral Health – Other	60	30	45	30
Allergy/Immunology	60	30	45	30
Dermatology	60	30	45	30
Optometry	60	30	45	30
Otolaryngology (ENT)	60	30	45	30
Specialist – Pediatric	40	20	30	20
Specialist – Other	20	20	20	20
Hospital	30	30	30	20
Pharmacy	15	15	10	10

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars ($1,000) per percentage point below guarantee per measurement. Financial consequences are capped at the following amounts for this performance guarantee based on Insurer's enrollment range as of the last day of the reporting quarter:

Enrollment	Quarterly Financial Consequences Cap
<25K	$40,000
25-50K	$60,000
50-75K	$80,000
75K+	$100,000

Calculation Methodology

- Network access shall be calculated separately for each provider type and access type (time or distance) and geographical location type (rural or urban).
    - This PG requires fifty-two (52) separate measurements.
    - Financial consequences shall be assessed for each of the fifty-two (52) measurements, including each access and geographical type and for each Provider type, for which Insurer fails to meet the guarantee.
    - Insurer shall be assessed total financial consequences for the PG based on the sum of the financial consequences for provider type, access type, and geographical location type measurements.
    - The quarterly financial consequences cap applies to the PG and not to the fifty-two (52) separate measurements.
- The most recent U.S. census data available is used to determine whether a county is rural or urban.
- For rural measurements, all rural counties in Insurer's Service Area are included in the measurement, regardless of whether the counties are all in the same Region.
- For urban measurements, all urban counties in Insurer's Service Area are included in the measurement, regardless of whether the counties are all in the same Region
- Insurer shall use estimates of actual driving time and actual driving distance to determine access.
    - Insurer may not use "as-the-crow-flies" methodology for determining driving time or mileage.
- The PCP measurements should include any non-board-certified PCP for whom FHKC has granted an exception for Insurer's Network.
- The measurements should exclude geographical areas for which Insurer has a current network access waiver for the specified provider type.

- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of Enrollees with access within the standard. Performance reported in any other manner, including the percentage or number of Providers within the access standard for ninety percent (90%) of Enrollees is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-21: Appointment Access Standards

Ninety percent (90%) of network Providers maintain appointment availability within the timeframes required below:

Appointment Types	Timeframe
Emergency	Immediately
Urgent	Within twenty-four (24) hours
Routine	Seven (7) Calendar Days
Well-child	Within four (4) weeks of request

Reporting Frequency: quarterly

Financial Consequences: one thousand dollars ($1,000) per percentage point below guarantee per measurement.

Calculation Methodology

- Appointment access shall be determined by Insurer's internal audit and quality assurance activities, using appropriate stratification to avoid over or under representation of any appointment type.
- Appointment access shall be calculated by dividing the sum of network Providers maintaining appointments within the specified timeframes by the total number of network Providers evaluated. This measure is a single calculation encompassing all appointment types.
- Financial consequences shall be calculated as the difference between the guarantee and the actual result, multiplied by one thousand dollars ($1,000).

Related Contract Reference: Section 24

Attachment D: Reports and Deliverables

The following reports and deliverables are due from Insurer to FHKC by the dates indicated in the chart below. This chart is not an exhaustive list of reports and deliverables required by the Contract. In the event of any conflict between Attachment D and the Contract, the Contract supersedes.

Report/Deliverable Name	Contractual Reference	Frequency and Due Dates
Implementation plan	12-1	One-time; within five (5) Business Days of Contract execution
Performance Bond	4-13	Within fifteen (15) Business Days of Contract execution
Fidelity Bond	4-14	Within fifteen (15) Business Days of Contract execution
Premium rate adjustment request package	3-3-2-2	Annually; July 1
Prohibited affiliations disclosure	4-4-1	Annually; January 15
Ownership and control disclosures	4-4-3	Upon Contract execution, renewal or extension Within thirty-five (35) Calendar Days of any change in ownership
Conflict of interest disclosure form	4-6	Within five (5) Business Days of Insurer's receipt of executed Contract Within ten (10) Business Days after becoming aware of any potential conflicts of interest Annually; January 15
Lobbying disclosure	4-7	Upon Contract execution Annually; January 15

Proof of insurance coverage	4-10	Within ten (10) Business Days of Contract execution Annually; December 31 or by certificate of insurance expiration date
Subcontractor requests	5	Date established in approved implementation plan 90 Calendar Days prior to proposed effective date
Subcontractor monitoring schedule	5-2	Date established in approved implementation plan Annually; December 1
Subcontractor contingency plan	5-2	Date established in approved implementation plan Upon submission of new Subcontractor requests
NIST compliant information security risk assessment attestation	6	One-time; January 31, 2021
Audited financial statements	9-1	Annually; July 1
Other coverage liability report	9-4-2	Monthly; by the 15th
MLR report	9-5-1	Quarterly; see section 9-5-1 for specific dates
Annual MLR report	9-5-1	Annually; July 1
Experience adjustment report	9-5-2	Annually; December 31, beginning on December 31, 2021
MLR Rebate	9-5-2	Annually; March 1, beginning on March 1, 2022
SOC 2 Type II	11-1	Date established in approved implementation plan Annually; date required by FHKC

Account management team contact information	12-2	Upon Contract execution
Key experience metrics report	12-4	Quarterly; by the 15th of the second month following the reporting quarter.
Contract termination transition plan	12-6	90 Calendar Days' prior to Contract termination
Quarterly marketing event report	17-7	Quarterly; 15th of the month following the reporting quarter
Annual marketing event report	17-7	Annually; February 28
Enrollment file discrepancy report	18-2-1-1	Monthly; 5 Business Days after receipt of supplemental enrollment file
Enrollee rights policies	19	Date established in approved implementation plan
Cultural competency plan	20	Date established in approved implementation plan Annually; November 1
Parity assessment	22-3	Date established in approved implementation plan
Lifetime limit report	22-4	Monthly; 5th of the month following the reporting month
Disease and case management report	22-8	Quarterly; by the 15th of the second month following the reporting quarter.
Transition of care policy	22-9	Date established in approved implementation plan
Grievances and Appeals Report	23	Quarterly; 15th of the month following the reporting quarter
Network add/term report	24-1	Monthly; 5th of the month following the reporting month

Florida SHOTS compliance report	24-3-3	Annually; July 1
Electronic health record meaningful use report	24-3-4	Annually; July 1, beginning July 1 2021
FQHC/RHC report	24-3-8	Quarterly; 15th of the month following the reporting quarter
IHCP report	24-3-9	Quarterly; 15th of the month following the reporting quarter
Adequate capacity to serve	24	Upon Contract execution Annually; July 1 Upon significant change in Insurer's operations
Geographic network access report	24-4-2	Quarterly; by the 15th of the second month following the reporting quarter.
Service area exemption reports	24-4-2-1	Quarterly; 20th of the month following the reporting quarter
Claims payment address(es)	24-7-1	Date established in approved implementation plan
Claims processing report	24-7-1	Quarterly; 15th of the month following the reporting quarter
Capitated arrangements report	24-7-2	Annually; February 1
Provider overpayment report	24-7-3	Annually; July 1
Fraud and Abuse policies	25	Date established in approved implementation plan
Fraud and Abuse report	25	Quarterly; 15th of the month following the reporting quarter
Accreditation report	26-1	Date established in approved implementation plan Annually; December 15

Quality Improvement Plan	26-2	Date established in approved implementation plan Annually; July 1
Quality Improvement Plan Assessment	26-2	Annually; July 1, beginning Jul 1, 2021
Encounter and claims data	28	Quarterly; see section 26-5 for specific dates
Attestation organizational chart	29	Upon Contract execution; within 1 week of any changes
Encounter data attestation	29	Concurrent with submission of encounter data
MLR-related attestation	29	Concurrent with submission of documentation FHKC may use to determine Insurer's compliance with MLR requirements
Financial solvency-related attestation	29	Concurrent with submission of documentation FHKC may use to determine Insurer has made adequate provision against the risk of insolvency
Availability and accessibility of services attestation	29	Concurrent with submission of documentation related to Insurer's compliance with requirements for availability and accessibility of services, including Provider network adequacy
Ownership and control disclosures attestation	29	Concurrent with submission of documentation
Annual overpayment recoveries report attestation	29	Concurrent with submission of annual overpayment recoveries report

Attachment E: Enrollment File Layout

This attachment contains the enrollment file layout as described in section 18-2-1 of the Contract. This attachment is subject to change without a Contract amendment.

The enrollment file is provided in the standard benefit enrollment and maintenance transaction (ANSI 834) file format. The information below is a companion guide.

HIPAA TXN: 834 Benefit Enrollment and Maintenance 5010

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
HDR	ISA	INTERCHANGE CONTROL HEADER			R	1			
HDR	ISA01	Authorization Information Qualifier	ID	2/2	R		00, 03	**00**	Set to “00”
HDR	ISA02	Authorization Information	AN	10/10	R			**spaces**	Set to spaces
HDR	ISA03	Security Information Qualifier	ID	2/2	R		00, 01	**00**	Set to “00”
HDR	ISA04	Security Information	AN	10/10	R			**spaces**	Set to spaces
HDR	ISA05	Interchange ID Qualifier	ID	2/2	R		01, 14, 20, 27, 28, 29, 30, 33, ZZ	Values provided in final file definition	Set to “ZZ” unless specified in the columns.
HDR	ISA06	Interchange Sender ID	AN	15/15	R			Values provided in final file definition	PSI Tax ID = 20-8412317
HDR	ISA07	Interchange ID Qualifier	ID	2/2	R		01, 14, 20, 27, 28, 29, 30, 33, ZZ	Values provided in final file definition	Set to “ZZ” unless specified in the corresponding partner columns.
HDR	ISA08	Interchange Receiver ID	AN	15/15	R			Values provided in final file definition	Set to “<mco receiver id>” as shown in each program column (I, J, K, L)
HDR	ISA09	Interchange Date	DT	6/6	R		YYMMDD	Current system date	Current system date
HDR	ISA10	Interchange Time	TM	4/4	R		HHMM	Current system time	Current system time
HDR	ISA11	Repetition Separator	AN	1/1	R		Need mutual agreement with Translator Vendor	Hardcode to ‘^’	Default to Caret “^”
HDR	ISA12	Interchange Control Version Number	ID	5/5	R		00501	00501	Set to "00501"
HDR	ISA13	Interchange Control Number	N0	9/9	R		Translator generated	Translator generated	System generated 9 digit control number
HDR	ISA14	Acknowledgement Requested	ID	1/1	R		0, 1	**0**	Set to “0”
HDR	ISA15	Usage Indicator	ID	1/1	R		P, T	**T or P**	Set to “P” for Production, "T" for Test
HDR	ISA16	Component Element Separator	AN	1/1	R			Hardcode to ‘>’	Default to '>'
HDR	GS	FUNCTIONAL GROUP HEADER			R	≥1			
HDR	GS01	Functional Identifier Code	ID	2/2	R		00	BE	Send “BE"
HDR	GS02	Application Sender Code	AN	2/15	R			Values provided in final file definition	PSI Tax ID = 20-8412317
HDR	GS03	Application Receiver Code	AN	2/15	R			Values provided in final file definition	Set to “<mco receiver id>”
HDR	GS04	Date	DT	8/8	R		CCYYMMDD	Current system date	Current system date
HDR	GS05	Time	TM	4/8	R		HHMM	Current system time	Current system time

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
HDR	GS06	Group Control Number	N0	1/9	R			System generated 9 digit control number	System generated 9 digit control number
HDR	GS07	Responsible Agency Code	ID	1/2	R		X	Set to “X”	Set to “X”
HDR	GS08	Version/ Release/ Industry Identifier Code	AN	1/12	R		005010X220A1	Set to"005010X220A1"	Set to"005010X220A1"
HDR	ST	TRANSACTION SET HEADER		1/1	R	≥1			
HDR	ST01	Transaction Set Identifier Code	ID	3/3	R		834	Set to 834	Set to 834
HDR	ST02	Transaction Set Control Number	AN	4/9	R			Set automatically by map set (begins with 0001)	Map sets automatically Set automatically by map set (begins with 1000) - 2/27/13 - MAXIMUS will be beginning with 0001, not 1000
HDR	ST03	Implementation Convention Reference	AN	1/35	R		005010X220A1	Set to "005010X220A1"	Set to "005010X220A1"
HDR	BGN	BEGINNING SEGMENT		1/1	R	1			
HDR	BGN01	Transaction Set Purpose Code	ID	2/2	R		00, 15, 22	00	Set to "00"
HDR	BGN02	Transaction Set Reference Number	AN	1/50	R		This is a Translator DB named field.	sequential numbering starting with ‘123000’	Set same std Maintained by Translator. (sequential numbering starting with ‘123000’)
HDR	BGN03	Transaction Set Creation Date	DT	8/8	R		CCYYMMDD	Current system date	Current system date
HDR	BGN04	Transaction Set Creation Time	TM	4/8	R		HHMM, HHMMSS, HHMMSSD, HHMMSSDD	Current system time HHMM	Current system time HHMM
HDR	BGN05	Time Zone Code	ID	2/2	S		01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, AD, AS, AT, CD, CS, CT, ED, ES, ET, GM, HD, HS, HT, LT, MD, MS, MT, ND, NS, NT	MT	Set to 'PT' - 2/27/13 - Given that the 834 is being processed out of Denver, timezone is MT
HDR	BGN06	Original Transaction Set Reference Number	AN	1/35	S			**N/A**	Original Transaction Set Reference Number; Required when there is a previously sent transaction to cross-reference. If not required by this implementation guide, do N2not send.
HDR	BGN07	Transaction Type Code			not used			**N/A**	IGNORE
HDR	BGN08	Action Code	ID	1/2	R		2 = Change/Update 4 = Verify; Used to identify a full enrollment transaction to verify that the sponsor’s and payer’s systems are synchronized RX = Replace; Used to identify a full enrollment transmission to be used to identify additions, terminations and changes that need to be applied to the payer’s enrollment system.	**2**	Set to "2" = Change/Update Used to identify a transaction of additions, terminations and changes to the current enrollment
HDR	BGN09	Security Level Code			not used			**N/A**	IGNORE

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
HDR	REF	TRANSACTION SET POLICY NUMBER		1/1	S				
HDR	REF01	Reference Identification Qualifier	ID	2/3	R		38	**38**	Set to "38" = Master Policy Number
HDR	REF02	Master Policy Number	AN	1/50	R			"FKIDCARE834"	"FKIDCARE834"
HDR	DTP	FILE EFFECTIVE DATE		>1	S				IGNORE this segment
HDR	DTP01	Date Time Qualifier	ID	3/3	R		007, 090, 091, 303, 382, 388	**N/A**	IGNORE
HDR	DTP02	Date Time Period Format Qualifier	ID	2/3	R		D8	**N/A**	IGNORE
HDR	DTP03	Date Time Period	AN	1/35	R		CCYYMMDD	**N/A**	IGNORE
HDR	QTY	TRANSACTION SET CONTROL TOTALS		1/3	S				IGNORE this segment
HDR	QTY01	Quantity Qualifier	ID	2/2	R		DT, ET TO	**N/A**	IGNORE
HDR	QTY02	Record Totals	R	1/15	R			**N/A**	IGNORE
1000A	N1	SPONSOR NAME		1/1	R	1			For each person/row in the Translator table with the same Plan ID being processed, create the following segments.
1000A	N101	Entity Identifier Code	ID	2/3	R		P5	**P5**	Set to "P5" - Plan Sponsor
1000A	N102	Plan Sponsor Name	AN	1/60	S			Values provided in final file definition	Insurer Name: Name of the MCO
1000A	N103	Identification Code Qualifier	ID	1/2	R		24, 94, FI	**FI**	Set to "FI". - Federal Taxpayer ID
1000A	N104	Sponsor Identifier	AN	2/80	R			Values provided in final file definition	<Tax Id for each partner>
1000A	N105	Entity Relat Code	ID	2/2	not used			**N/A**	IGNORE
1000A	N106	Entity ID Code	ID	2/3	not used			**N/A**	IGNORE
1000B	N1	PAYER		1/1	R	1			
1000B	N101	Entity Identifier Code	ID	2/3	R		IN	IN	Set to IN – Insurer
1000B	N102	Insurer Name	AN	1/60	S			Florida Healthy Kids	Florida Healthy Kids
1000B	N103	Identification Code Qualifier	ID	1/2	R		94, FI, XV	FI	Set to FI.
1000B	N104	Insurer Identification Code	AN	2/80	R			20-8412317	NOTE: CG = Sponsor Identifier, "00-0000000" - based on sample files, the PSI Tax ID should be used which is shown in columns I through L.
1000B	N105			2/2	not used			**N/A**	IGNORE
1000B	N106			2/3	not used			**N/A**	IGNORE
1000C	N1	TPA/BROKER NAME		1/1	S	1			IGNORE this segment
1000C	N101	Entity Identifier Code	ID	2/3	R		BO, TV	**N/A**	IGNORE
1000C	N102	TPA or Broker Name	AN	1/60	R			**N/A**	IGNORE
1000C	N103	Identification Code Qualifier	ID	1/2	R		94, FI, XV	**N/A**	IGNORE
1000C	N104	TPA or Broker Identification Code	AN	2/80	R			**N/A**	IGNORE

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
1000C	N105	Entity Relat Code		2/2	not used			**N/A**	IGNORE
1000C	N106	Entity ID Code		2/3	not used			**N/A**	IGNORE
1000C	ACT	TPA/BROKER ACCOUNT INFORMATION		1/1	S	1			IGNORE this segment
1000C	ACT01	Account Number	AN	1/35	R			**N/A**	IGNORE
1000C	ACT02	Name	AN	1/60	not used			**N/A**	IGNORE
1000C	ACT03	ID Code Qualifier	AN	1/2	not used			**N/A**	IGNORE
1000C	ACT04	ID Code	ID	1/80	not used			**N/A**	IGNORE
1000C	ACT05	Acct Number Qualifier	AN	1/3	not used			**N/A**	IGNORE
1000C	ACT06	TPA or Broker Account Number	AN	1/35	not used			**N/A**	IGNORE
1000C	ACT07	Description	AN	1/80	not used			**N/A**	IGNORE
1000C	ACT08	Payment Method Code	ID	1/2	not used			**N/A**	IGNORE
1000C	ACT09	Benefit Status Code	AN	1/35	S			**N/A**	IGNORE
2000	INS	SUBSCRIBER RELATIONSHIP		1/1	R	>1	A Subscriber is a person who elects the benefits and is affiliated with the employer or the insurer. A Dependent is a person who is affiliated with the subscriber, such as a spouse, child, etc., and is therefore entitled to benefits. Subscriber information must come before dependent information. The INS segment is used to note if information being submitted is subscriber information or dependent information.		
2000	INS01	Member Indicator	ID	1/1	R		Y, N	**Y**	Set to "Y". = Insured is a Subscriber
2000	INS02	Individual Relationship Code	ID	2/2	R		01, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 23, 24, 25, 26, 31, 38, 53, 60, D2, G8, G9	**18**	Set to 18-Self.
2000	INS03	Maintenance Type Code	ID	3/3	R		001 – Change 021 – Addition 024 – Cancellation or Termination 025 – Reinstate-ment 030 – Audit or Compare	On Regular and Supplemental: 001 – Continuous Enrollment 021 – Addition 024 – Cancellation or Termination 025 – Reinstatement	Click here for additional information on the Maintenance Type Codes
2000	INS04	Maintenance Reason Code	ID	2/3	S		01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 14, 15, 16, 17, 18, 20, 21, 22, 25, 26, 27, 28, 29, 31, 32, 33, 37, 38, 39, 40, 41, 43, 59, AA, AB, AC, AD, AE, AF, AG, AH, AI, AJ, AL, EC, XN, XT	"07" = Termination of Benefits, "28" = Initial Enrollment, "41" = Re-enrollment	Click here for additional information on the Maintenance Type Codes
2000	INS05	Benefit Status Code	ID	1/1	R		A, C, S, T	"A"	Set to "A" A -Active (even on cancellations)
2000	INS06	MEDICARE STATUS CODE			S				
2000	INS06-1	Medicare Plan Code	ID	1/1	R		A, B, C, D, E	**N/A**	IGNORE
2000	INS06-2	Medicare Eligibility Reason Code	ID	1/1	S		0 Age 1 Disability 2 End Stage Renal Disease (ESRD)	**N/A** **N/A** **N/A**	IGNORE

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2000	INS07	Consolidated Omnibus Budget Reconciliation Act (COBRA) Qualifying **Event Code**	ID	1/2	S		1, 2, 3, 4, 5, 6, 7, 8, 9,10, ZZ	**N/A**	IGNORE
2000	INS08	Employment Status Code	ID	2/2	S		AC, AO, AU, FT, L1, PT, RT, TE	“FT"	Set to "FT" = Full Time (This really indicates the status of the subscriber in the program, since FHKC in not the employer)
2000	INS09	Student Status Code	ID	1/1	S		F, N, P	**N/A**	IGNORE
2000	INS10	Handicap Indicator	ID	1/1	S		N, Y	**N/A**	IGNORE
2000	INS11	Date Time Period Format Qualifier	ID	2/3	S		D8	**N/A**	IGNORE
2000	INS12	Member Individual Death Date	AN	1/35	S				IGNORE
2000	INS13	Confidentiality Code	ID	1/1	S		R Restricted Access U Unrestricted Access	**N/A**	IGNORE
2000	INS17	Birth Sequence Number	N0	1/9	S			**N/A**	IGNORE
2000	REF	SUBSCRIBER IDENTIFIER		1/1	R				
2000	REF01	Reference Identification Qualifier	ID	2/3	R		0F	**0F**	Set to "0F" - Subscriber Number
2000	REF02	Subscriber Identifier	AN	1/50	R			BCBS = SSN (if NULL, populate with MEDICAL_INS_NUM); All other MCOs = MEDICAL_INS_NUM	Set to Child's Medical Insurance Number: NOTE: per the RFP this number is assigned to each enrollee in the eligibility system and is transmitted to the enrollee's health care insurer.
2000	REF	MEMBER POLICY NUMBER		1/1	S				
2000	REF01	Reference Identification Qualifier	ID	2/3	R		1L	**1L**	**1L**
2000	REF02	Member Group or Policy Number	AN	1/50	R			Set to Individual ID (Person Number)	The unique randomly generated 10- digit number assigned to each enrollee that remains with the child without regard to a change to the child's status. That number assigned to each enrollee in the eligibility system that is transmitted to the enrollee's health care insurer. Currently, this field is nine digits and the numbering logic is established by the enrollee's health care insurer for those enrolled in Healthy Kids.
2000	REF	MEMBER SUPPLEMENTAL IDENTIFIER		1/13	S		Occurrence 1		Change segment name

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2000	REF01	Reference Identification Qualifier	ID	2/3	R		17, 23, 3H, 4A, 6O, ABB, D3, DX, F6, P5, Q4, QQ, ZZ	3H	Set same std "3H" (Household Number / Case Number)
2000	REF02	Member Supplemental Identifier	AN	1/50	R			Account Number	Set to Family Account ID (Child's Family Account Number): The unique sequential 10 digit number that identifies a household's account. New applicants are currently assigned numbers sequences starting with 100.
2000	REF	MEMBER SUPPLEMENTAL IDENTIFIER		1/13	S		Occurrence 2		
2000	REF01	Reference Identification Qualifier	ID	2/3	R		17, 23, 3H, 4A, 6O, ABB, D3, DX, F6, P5, Q4, QQ, ZZ	23	Set to "23" = Client ID - Payer specific identifier for a member (person_number)
2000	REF02	Member Supplemental Identifier	AN	1/50	R			Child's Individual Id	Set to Child's Individual ID (person_number)
2000	REF	MEMBER SUPPLEMENTAL IDENTIFIER		1/13	S		Occurrence 3		
2000	REF01	Reference Identification Qualifier	ID	2/3	R		f2310	ZZ	Set to "ZZ" Mutually Defined (Disenrollment Reason Code)
2000	REF02	Member Supplemental Identifier	AN	1/50	R		see allowed values and disenrollment reasons tab	Click Here for valid code	Send the appropriate Allowed Disenrollment Reason value. Click here for valid codes
2000	REF	MEMBER SUPPLEMENTAL IDENTIFIER		1/13	S		Occurrence 4		IGNORE this segment
2000	REF01	Reference Identification Qualifier	ID	2/3	R		17, 23, 3H, 4A, 6O, ABB, D3, DX, F6, P5, Q4, QQ, ZZ	**N/A**	IGNORE
2000	REF02	Member Supplemental	AN	1/50	R		Not applicable for MAX	**N/A** **N/A**	IGNORE
2000	REF	MEMBER SUPPLEMENTAL IDENTIFIER		1/13	S		Occurrence 5		IGNORE this segment
2000	REF01	Reference Identification Qualifier	ID	2/3	R		17, 23, 3H, 4A, 6O, ABB, D3, DX, F6, P5, Q4, QQ, ZZ	**N/A**	IGNORE
2000	REF02	Member Supplemental	AN	1/50	R		Not applicable for MAX	**N/A** **N/A**	IGNORE
2000	DTP	MEMBER LEVEL DATES		1/24	S		Occurrence 1		
2000	DTP01	Date Time Qualifier	ID	3/3	R		050, 286, 296, 297, 300, 301, 303, 336, 337, 338, 339, 340, 341, 350, 351, 356, 357, 383, 385, 386, 393, 394, 473, 474	356'	If the child is being reported as enrolled for the following month, populate with "356".
2000	DTP02	Date Time Period Format Qualifier	ID	2/3	R		D8	**D8**	Set to D8.
2000	DTP03	Status Information Effective Date	AN	1/35	R		CCYYMMDD	Next Coverage Date	For DTP01 = 356. Reformat date to CCYYMMDD If the child is being reported as enrolled for the following month, populate these fields with the Next Coverage Date in CCYYMMDD format.
2000	DTP	MEMBER LEVEL DATES		1/24	S		Occurrence 2		

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2000	DTP01	Date Time Qualifier	ID	3/3	R		050, 286, 296, 297, 300, 301, 303, 336, 337, 338, 339, 340, 341, 350, 351, 356, 357, 383, 385, 386, 393, 394, 473, 474	357 = If child is being reported as cancelled at the end of the current month	Set to 357 If End Date NOT = spaces (NOTE: END date is not persisted in VIDA - it is derived) NOTE: When there is a disenrollment or voided coverage record, the 834 will not have a 356 qualifier.
2000	DTP02	Date Time Period Format Qualifier	ID	2/3	R		D8	**D8**	Set to D8.
2000	DTP03	Status Information Effective Date	AN	1/35	R		CCYYMMDD	Next Coverage Date - 1 day	For DTP01 = 357. Reformat date to CCYYMMDD If the child is being reported as cancelled at the end of the current month, populate with the Next Coverage Date - 1 day in CCYYMMDD format.
2100A	NM1	MEMBER NAME		1/1	R	1			
2100A	NM101	Entity Identifier Code	ID	2/3	R		74, 1L	**IL**	Set same std “IL” = Insured or Subscriber
2100A	NM102	Entity Type Qualifier	ID	1/1	R		1	**1**	Set to "1" (Person)
2100A	NM103	Member Last Name	AN	1/60	R			**Child's Last Name + Suffix**	Child's Last Name + Suffix
2100A	NM104	Member First Name	AN	1/35	R			**Child's First Name**	Set to Child's First Name
2100A	NM105	Member Middle Name	AN	1/25	S			**Child's Middle Initial**	Set to Child's Middle Initial
2100A	NM106	Member Name Prefix	AN	1/10	S			**N/A**	IGNORE
2100A	NM107	Member Name Suffix	AN	1/10	S			**N/A**	IGNORE
2100A	NM108	Identification Code Qualifier	ID	1/2	R		34, ZZ	**34**	Set to 34
2100A	NM109	Member Identifier	AN	2/80	R			SSN can be blank	Set to Child's SSN If missing, default to 000000000. If EQ spaces set to 9 zeros left justified
2100A	PER	MEMBER COMMUNICATION S NUMBERS		1/1	R				IGNORE
2100A	PER01	Contact Function Code	ID	2/2	R		IP	**N/A**	IGNORE
2100A	PER03	Communication Number Qualifier	ID	2/2	R		AP, BN, CP, EM, EX, FX, HP, TE, WP	**N/A**	IGNORE
2100A	PER04	Communication Number	AN	1/256	R			**N/A**	IGNORE
2100A	PER05	Communication Number Qualifier	ID	2/2	S		AP, BN, CP, EM, EX, FX, HP, TE, WP	**N/A**	IGNORE
2100A	PER06	Communication Number	AN	1/256	S			**N/A**	IGNORE
2100A	PER07	Communication Number Qualifier	ID	2/2	S		AP, BN, CP, EM, EX, FX, HP, TE, WP	**N/A**	IGNORE
2100A	PER08	Communication Number	AN	1/256	S			**N/A**	IGNORE
2100A	N3	MEMBER RESIDENCE STREET ADDRESS		1/1	S				Map to member level address.

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2100A	N301	Member Address Line	AN	1/55	R			**Home Address Line 1**	Send Residential Address Line 1
2100A	N302	Member Address Line	AN	1/55	S			**Home Address Line 2**	Send Residential Address Line 2
2100A	N4	MEMBER CITY, STATE, ZIP CODE		1/1	S				Map to member level address.
2100A	N401	Member City Name	AN	2/30	R			**Home Address City**	Send Residential City
2100A	N402	Member State or Province Code	ID	2/2	S			**Home Address State**	Send Residential State - 2 char
2100A	N403	Member Postal Zone or ZIP Code	ID	3/15	S			**Home Address Zip**	Send Residential Zip
2100A	N404	Country Code	ID	2/3	S			**N/A**	IGNORE
2100A	N405	Location Qualifier	ID	1/2	R		60 Area CY County/Parish	**CY**	Set to "CY"
2100A	N406	Location Identifier	AN	1/30	R			**Home County**	Name of County of Residence of the Childl if blank, defaiult to 'UNKNOWN'
2100A	N407	Country Subdivision Code	ID	1/3	S			**N/A**	IGNORE
2100A	DMG	MEMBER DEMOGRAPHICS		1/1	S				
2100A	DMG01	Date Time Period Format Qualifier	ID	2/3	R		D8	D8	Set to D8.
2100A	DMG02	Member Birth Date	AN	1/35	R		CCYYMMDD	Date of Birth	Send Date of Birth
2100A	DMG03	Member Gender Code	ID	1/1	R		F, M, U	only M, F	F = female; set if gender unknown or U M = maile
2100A	DMG04	Marital Status Code	ID	1/1	S		B, D, I, M, R, S, U , W, X	**N/A**	IGNORE
2100A	DMG05	Composite Race or Ethnicity Information			S				
2100A	DMG05-1	Race or Ethnicity Code	ID	1/1	S		7, 8, A, B, C, D, E, F, G, H, I, J, N, O, P, Z	Values provided in final file definition	CG includes the field with no explanation
2100A	DMG05-2	Code List Qualifier Code	ID	1/3	S		RET - Classification of Race or Ethnicity	**N/A**	IGNORE
2100A	DMG05-3	Race or Ethnicity Code	AN	1/30	S			**N/A**	IGNORE
2100A	DMG06	Citizenship Status Code	ID	1/2	S		1 - U.S. Citizen 2 - Non-Resident Alien 3 - Resident Alien 4 - Illegal Alien 5 - Alien 6 - U.S. Citizen - Non-Resident 7 - U.S. Citizen - Resident	**N/A**	IGNORE
2100A	DMG10	Code List Qualifier Code	ID	1/3	S		REC - Race or Ethnicity Collection Code	**N/A**	IGNORE
2100A	DMG11	Race or Ethnicity Collection Code	AN	1/30	S			**N/A**	IGNORE
2100A	EC	EMPLOYMENT CLASS		>1	S				IGNORE this segment

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2100A	EC01	Employment Class Code	ID	2/3	R		01 - Union 02 - Non-Union 03 - Executive 04 - Non-Executive 05 - Management 06 - Non-Management 07 - Hourly 08 - Salaried 09 - Administrative 10 - Non-Administrative 11 - Exempt 12 - Non-Exempt 17 - Highly Compensated 18 - Key-Employee 19 - Bargaining 20 - Non-Bargaining 21 - Owner 22 - President 23 - Vice President	**N/A**	IGNORE
2100A	EC02	Employment Class Code	ID	2/3	**S**		01 - Union 02 - Non-Union 03 - Executive 04 - Non-Executive 05 - Management 06 - Non-Management 07 - Hourly 08 - Salaried 09 - Administrative 10 - Non-Administrative 11 - Exempt 12 - Non-Exempt 17 - Highly Compensated 18 - Key-Employee 19 - Bargaining 20 - Non-Bargaining 21 - Owner 22 - President 23 - Vice President	**N/A**	IGNORE

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2100A	EC03	Employment Class Code	ID	2/3	S		01 - Union 02 - Non-Union 03 - Executive 04 - Non-Executive 05 - Management 06 - Non-Management 07 - Hourly 08 - Salaried 09 - Administrative 10 - Non-Administrative 11 - Exempt 12 - Non-Exempt 17 - Highly Compensated 18 - Key-Employee 19 - Bargaining 20 - Non-Bargaining 21 - Owner 22 - President 23 - Vice President	**N/A**	IGNORE
2100A	ICM	MEMBER INCOME		1/1	S				IGNORE this segment
2100A	ICM01	Frequency Code	ID	1/1	R		1 - Weekly 2 - Biweekly 3 - Semimonthly 4 - Monthly 6 - Daily 7 - Annual 8 - Two Calendar Months 9 - Lump-Sum Separation Allowance B - Year-to-Date C - Single H - Hourly Q - Quarterly S - Semiannual U - Unknown	**N/A**	IGNORE
2100A	ICM02	Wage Amount	R	1/18	R			**N/A**	IGNORE
2100A	ICM03	Work Hours Count	R	1/15	S			**N/A**	IGNORE
2100A	ICM04	Location Identification Code	AN	1/30	S			**N/A**	IGNORE
2100A	ICM05	Salary Grade Code	AN	1/5	S			**N/A**	IGNORE
2100A	AMT	MEMBER POLICY AMOUNTS		1/7	S				IGNORE this segment
2100A	AMT01	Amount Qualifier Code	ID	1/3	R		B9 - Co-insurance - Actual C1 - Co-Payment Amount D2 - Deductible Amount EBA - Expected Expenditure Amount FK - Other Unlisted Amount P3 - Premium Amount R - Spend Down	**N/A**	IGNORE
2100A	AMT02	Contract Amount	R	1/18	R			**N/A**	IGNORE
2100A	HLH	MEMBER HEALTH INFORMATION		1/1	S				IGNORE this segment

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2100A	HLH01	Health-Related Code	ID	1/1	R		N - None S - Substance Abuse T - Tobacco Use U - Unknown X - Tobacco Use and Substance Abuse	N/A	IGNORE
2100A	HLH02	Member Height	R	1/8	S			N/A	IGNORE
2100A	HLH03	Member Weight	R	1/10	S			N/A	IGNORE
2100A	LUI	MEMBER LANGUAGE		>1	S				
2100A	LUI01	Identification Code Qualifier	ID	1/2	S		LD - NISO Z39.53 Language Codes LE - ISO 639 Language Codes	LE	Set to "LE"
2100A	LUI02	Language Code	AN	2/80	S		ENG = English CPF = Creole SPA = Spanish	ENG = English CPF = Creole SPA = Spanish	
2100A	LUI03	Language Description	AN	1/80	S			N/A	IGNORE
2100A	LUI04	Language Use Indicator	ID	1/2	S		5 - Language Reading 6 - Language Writing 7 - Language Speaking 8 - Native Language	N/A	IGNORE
2100B	NM1	INCORRECT MEMBER NAME		1/1	S	1			IGNORE this segment
2100B	NM101	Entity Identifier Code	ID	2/3	R		70 - Prior Incorrect Insured	N/A	IGNORE
2100B	NM102	Entity Type Qualifier	ID	1/1	R		1 - Person	N/A	IGNORE
2100B	NM103	Prior Incorrect Member Last Name	AN	1/60	R			N/A N/A N/A	IGNORE
2100B	NM104	Prior Incorrect Member First Name	AN	1/35	R			N/A N/A	IGNORE
2100B	NM105	Prior Incorrect Member Middle	AN	1/25	R			N/A N/A	IGNORE
2100B	NM106	Prior Incorrect Member Name Prefix	AN	1/10	S			N/A	IGNORE
2100B	NM107	Prior Incorrect Member Name Suffix	AN	1/10	S			N/A	IGNORE
2100B	NM108	Identification Code Qualifier	ID	1/2	R		34, ZZ	N/A	IGNORE
2100B	NM109	Prior Incorrect Insured Identifier	AN	2/1	R			N/A N/A	IGNORE
2100B	DMG	INCORRECT MEMBER DEMOGRAPHICS		1/1	S				IGNORE this segment
2100B	DMG01	Date Time Period Format Qualifier	ID	2/3	S		D8	N/A	IGNORE
2100B	DMG02	Prior Incorrect Insured Birth Date	AN	1/35	S		CCYYMMDD	N/A	IGNORE

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2100B	DMG03	Prior Incorrect Insured Gender Code	ID	1/1	S		F, M, U	N/A	IGNORE
2100B	DMG04	Marital Status Code	ID	1/1	S		B, D, I, M, R, S, U , W, X	N/A	IGNORE
2100B	DMG05	Composite Race or Ethnicity Information			S				IGNORE this segment
2100B	DMG05-1	Race or Ethnicity Code	ID	1/1	S		7, 8, A, B, C, D, E, F, G, H, I, J, N, O, P, Z	N/A	IGNORE
2100B	DMG05-2	Code List Qualifier Code	ID	1/3	S		RET - Classification of Race or Ethnicity	N/A	IGNORE
2100B	DMG05-3	Race or Ethnicity Code	AN	1/30	S			N/A	IGNORE
2100B	DMG06	Citizenship Status Code	ID	1/2	S		1 - U.S. Citizen 2 - Non-Resident Alien 3 - Resident Alien 4 - Illegal Alien 5 - Alien 6 - U.S. Citizen - Non-Resident 7 - U.S. Citizen - Resident	N/A N/A N/A N/A N/A N/A N/A	IGNORE
2100B	DMG10	Code List Qualifier Code	ID	1/3	S		REC - Race or Ethnicity Collection Code	N/A	IGNORE
2100B	DMG11	Race or Ethnicity Collection Code	AN	1/30	S			N/A	IGNORE
2100C	NM1	Race or Ethnicity Collection Code		1/1	S	1			IGNORE
2100C	NM101	Entity Identifier Code	ID	2/3	R		31 - Postal Mailing Address	N/A	IGNORE IGNORE
2100C	NM102	Entity Type Qualifier	ID	1/1	R		1 - Person	N/A	IGNORE IGNORE
2100C	N3	MEMBER MAIL STREET ADDRESS		1/1	R				IGNORE this segment
2100C	N301	Member Address Line	AN	1/55	R			N/A	IGNORE
2100C	N302	Member Address Line	AN	1/55	S			N/A	IGNORE
2100C	N4	MEMBER MAIL CITY, STATE, ZIP CODE		1/1	R				IGNORE
2100C	N401	Member Mail City Name	AN	2/30	R			N/A	IGNORE
2100C	N402	Member Mail State Code	ID	2/2	R			N/A	IGNORE
2100C	N403	Member Mail Postal Zone or ZIP Code	ID	3/15	R			N/A	IGNORE
2100C	N404	Country Code	ID	2/3	S			N/A	IGNORE
2100C	N407	Country Subdivision Code	ID	1/3	S			N/A	IGNORE
2100D	NM1	MEMBER EMPLOYER		1/1	S	3			IGNORE this segment
2100D	NM101	Entity Identifier Code	ID	2/3	R		36 - Employer	N/A	IGNORE

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2100D	NM102	Entity Type Qualifier	ID	1/1	R		1 - Person 2 - Non-Person Entity	N/A N/A	IGNORE
2100D	NM103	Member Employer Name	AN	1/60	R			N/A	IGNORE
2100D	NM104	Member Employer First Name	AN	1/35	S			N/A	IGNORE
2100D	NM105	Member Employer Middle Name	AN	1/25	S			N/A	IGNORE
2100D	NM106	Member Employer Name Prefix	AN	1/10	S			N/A	IGNORE
2100D	NM107	Member Employer Name Suffix	AN	1/10	S			N/A	IGNORE
2100D	NM108	Identification Code Qualifier	ID	1/2	R		24, 34	N/A	IGNORE
2100D	NM109	Member Employer Identifier	AN	2/80	R			N/A	IGNORE
2100D	PER	MEMBER EMPLOYER COMMUNICATION S NUMBERS		1/1	S				IGNORE this segment
2100D	PER01	Contact Function Code	ID	2/2	R		EP - Employer Contact	N/A	IGNORE
2100D	PER02	Member Employer Communications Contact Name	AN	1/60	S			N/A	IGNORE
2100D	PER03	Communication Number Qualifier	ID	2/2	R		AP, BN, CP, EM, EX, FX, TE,	N/A	IGNORE
2100D	PER04	Communication Number	AN	1/256	R			N/A	IGNORE
2100D	PER05	Communication Number Qualifier	ID	2/2	S		AP, BN, CP, EM, EX, FX, TE,	N/A	IGNORE
2100D	PER06	Communication Number	AN	1/256	S			N/A	IGNORE
2100D	PER07	Communication Number Qualifier	ID	2/2	S		AP, BN, CP, EM, EX, FX, TE	N/A	IGNORE
2100D	PER08	Communication Number	AN	1/256	S			N/A	IGNORE
2100D	N3	MEMBER EMPLOYER STREET ADDRESS		1/1	S				IGNORE this segment
2100D	N301	Member Employer Address Line	AN	1/1	R			N/A	IGNORE
2100D	N302	Member Employer Address Line	AN	1/1	S			N/A	IGNORE

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2100D	N4	MEMBER EMPLOYER CITY, STATE, ZIP CODE		1/1	S			**N/A**	IGNORE this segment
2100D	N401	Member Employer City Name	AN	2/1	R			**N/A**	IGNORE
2100D	N402	Member Employer State Code	ID	2/2	**R**			**N/A**	IGNORE
2100D	N403	Member Employer Postal Zone or ZIP Code	ID	3/15	**R**			**N/A**	IGNORE
2100D	N404	Country Code	ID	2/3	S			**N/A**	IGNORE
2100D	N407	Country Subdivision Code	ID	1/3	S			**N/A**	IGNORE
2100E	NM1	MEMBER SCHOOL		1/1	S	3			IGNORE this segment
2100E	NM101	Entity Identifier Code	ID	2/3	R		M8 - Educational Institution	**N/A**	IGNORE
2100E	NM102	Entity Type Qualifier	ID	1/1	R		2 - Non-Person Entity	**N/A**	IGNORE
2100E	NM103	School Name	AN	1/1	R			**N/A**	IGNORE
2100E	PER	MEMBER SCHOOL COMMUNICATION S NUMBERS		1/1	R				IGNORE this segment
2100E	PER01	Contact Function Code	ID	2/2	R		SK - School Clerk	**N/A**	IGNORE
2100E	PER02	Member School Communications Contact Name	AN	1/1	S			**N/A**	IGNORE
2100E	PER03	Communication Number Qualifier	ID	2/2	R		EM - Electronic Mail EX - Telephone Extension FX - Facsimile TE - Telephone	**N/A** **N/A** **N/A** **N/A**	IGNORE
2100E	PER04	Communication Number	AN	1-256	R			**N/A**	IGNORE
2100E	PER05	Communication Number Qualifier	ID	2/2	S		EM - Electronic Mail EX - Telephone Extension FX - Facsimile TE - Telephone	**N/A** **N/A** **N/A** **N/A**	IGNORE
2100E	PER06	Communication Number	AN	1-256	S			**N/A**	IGNORE
2100E	PER07	Communication Number Qualifier	ID	2/2	S		EM - Electronic Mail EX - Telephone Extension FX - Facsimile TE - Telephone	**N/A** **N/A** **N/A** **N/A**	IGNORE
2100E	PER08	Communication Number	AN	1-256	S			**N/A**	IGNORE
2100E	N3	MEMBER SCHOOL STREET ADDRESS		1/1	S				IGNORE this segment
2100E	N301	School Address Line	AN	1/1	R			**N/A**	IGNORE

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2100E	N302	School Address Line	AN	1/1	S			N/A	IGNORE
2100E	N4	MEMBER SCHOOL CITY, STATE, ZIP CODE		1/1	S				IGNORE this segment
2100E	N401	Member School City Name	AN	2/1	R			N/A	IGNORE
2100E	N402	Member School State Code	ID	2/2	R			N/A	IGNORE
2100E	N403	Member School Postal Zone or ZIP Code	ID	3/15	R			N/A	IGNORE
2100E	N404	Country Code	ID	2/3	S			N/A	IGNORE
2100E	N407	Country Subdivision Code	ID	1/3	S			N/A	IGNORE
2100F	NM1	CUSTODIAL PARENT		1/1	S	1			IGNORE this segment
2100F	NM101	Entity Identifier Code	ID	2/3	R		S3 - Custodial Parent	N/A	IGNORE
2100F	NM102	Entity Type Qualifier	ID	1/1	R		1 - Person	N/A	IGNORE
2100F	NM103	Custodial Parent Last Name	AN	1/1	R		Map “X” Constant ‘X’	N/A N/A N/A	IGNORE
2100F	NM104	Custodial Parent First Name	AN	1/1	R		Map “X” Constant ‘X’ (MAX)	N/A N/A N/A	IGNORE
2100F	NM105	Custodial Parent Middle Name	AN	1/25	S			N/A	IGNORE
2100F	NM106	Custodial Parent Name Prefix	AN	1/10	S			N/A	IGNORE
2100F	NM107	Custodial Parent Name Suffix	AN	1/10	S			N/A	IGNORE
2100F	NM108	Identification Code Qualifier	ID	1/2	R		34 - Social Security Number ZZ - Mutually Defined	N/A N/A	IGNORE
2100F	NM109	Custodial Parent Identifier	AN	2/1	R			N/A	IGNORE
2100F	PER	CUSTODIAL PARENT COMMUNICATION S NUMBERS		1/1	S				IGNORE this segment
2100F	PER01	Contact Function Code	ID	2/2	R		PQ - Parent or Guardian	N/A	IGNORE
2100F	PER03	Communication Number Qualifier	ID	2/2	R		AP - Alternate Telephone BN - Beeper Number CP - Cellular Phone EM - Electronic Mail EX - Telephone Extension FX - Facsimile HP - Home Phone Number TE - Telephone WP - Work Phone Number	N/A N/A N/A N/A N/A N/A N/A N/A N/A	IGNORE

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2100F	PER04	Communication Number	AN	1-256	R			**N/A**	IGNORE
2100F	PER05	Communication Number Qualifier	ID	2/2	S		AP - Alternate Telephone BN - Beeper Number CP - Cellular Phone EM - Electronic Mail EX - Telephone Extension FX - Facsimile HP - Home Phone Number TE - Telephone WP - Work Phone Number	**N/A** **N/A** **N/A** **N/A** **N/A** **N/A** **N/A** **N/A** **N/A**	IGNORE
2100F	PER06	Communication Number	AN	1-256	S			**N/A**	IGNORE
2100F	PER07	Communication Number Qualifier	ID	2/2	S		AP - Alternate Telephone BN - Beeper Number CP - Cellular Phone EM - Electronic Mail EX - Telephone Extension FX - Facsimile HP - Home Phone Number TE - Telephone WP - Work Phone Number	**N/A** **N/A** **N/A** **N/A** **N/A** **N/A** **N/A** **N/A** **N/A**	IGNORE
2100F	PER08	Communication Number	AN	1-256	S			**N/A**	IGNORE
2100F	N3	CUSTODIAL PARENT STREET ADDRESS		1/1	S				IGNORE this segment
2100F	N301	Custodial Parent Address Line	AN	1/1	R			**N/A**	IGNORE
2100F	N302	Custodial Parent Address Line	AN	1/1	S			**N/A**	IGNORE
2100F	N4	CUSTODIAL PARENT CITY, STATE, ZIP CODE		1/1	S				IGNORE this segment
2100F	N401	Custodial Parent City Name	AN	2/1	R			**N/A**	IGNORE
2100F	N402	Custodial Parent State Code	ID	2/2	**R**			**N/A**	IGNORE
2100F	N403	Custodial Parent Postal Zone or ZIP Code	ID	3/15	**R**			**N/A**	IGNORE
2100F	N404	Country Code	ID	2/3	S			**N/A**	IGNORE
2100F	N407	Country Subdivision Code	ID	1/3	S			**N/A**	IGNORE
2100G	NM1	RESPONSIBLE PERSON		1/1	S	13			

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2100G	NM101	Entity Identifier Code	ID	2/3	R		6Y - Case Manager 9K - Key Person E1 - Person or Other Entity Legally Responsible for a Child EI - Executor of Estate EXS - Ex-spouse GB - Other Insured GD - Guardian J6 - Power of Attorney LR - Legal Representative QD - Responsible Party S1 - Parent TZ - Significant Other X4 - Spouse	**QD**	Set same std to map "QD" If NM103 <> spaces (Loop 2100A). QD - Responsible Party
2100G	NM102	Entity Type Qualifier	ID	1/1	R		1 - Person	**1**	Set same std to map "1" If NM103 <> spaces (loop 2100A).
2100G	NM103	Responsible Party Last or Organization Name	AN	1 / 60	R			Parent 1. Last Name + Suffix	Parent 1. Last Name + Suffix
2100G	NM104	Responsible Party First Name	AN	1/1	S			Parent 1. First Name	Set to Parent 1 First Name
2100G	NM105	Responsible Party Middle Name	AN	1/25	S			Parent 1. Middle Initial.	Set to Parent 1 Middle Initial
2100G	NM106	Responsible Party Name Prefix	AN	1/10	S			**N/A**	IGNORE
2100G	NM107	Responsible Party Name Suffix	AN	1/10	S			**N/A**	IGNORE
2100G	NM108	Identification Code Qualifier	ID	1/2	S		34 - Social Security Number ZZ - Mutually Defined	**34**	Set to "34"
2100G	NM109	Responsible Party Employer Identifier	AN	2/80	S			**Parent 1 SSN**	
2100G	PER	RESPONSIBLE PERSON COMMUNICATIONS NUMBERS		1/1	S				7/14/14 - NOTE: Up to 3 communication numbers are possible. If the home phone, work phone and email address are all available, populate the PER elements in the order shown below. However, if not all 3 are available, populate what is available and correlate the communication number with its qualifier. For example, if all that is available is the email address, populate PER03 = EM and PER04 = email address. If home phone and email address are available, populate PER03 = HP and PER04 = home phone, PER05 = EM and PER06 = email address, etc.
2100G	PER01	Contact Function Code	ID	2/2	**R**		RP - Responsible Person	**RP**	Set to "RP" - Responsible Person

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2100G	PER03	Communication Number Qualifier	ID	2/2	R		AP - Alternate Telephone BN - Beeper Number CP - Cellular Phone EM - Electronic Mail EX - Telephone Extension FX - Facsimile HP - Home Phone Number TE - Telephone WP - Work Phone Number	**HP**	Set to "HP"
2100G	PER04	Communication Number	AN	1-256	R			**Home Phone**	Set to Responsible Person Home Phone
2100G	PER05	Communication Number Qualifier	ID	2/2	S		AP - Alternate Telephone BN - Beeper Number CP - Cellular Phone EM - Electronic Mail EX - Telephone Extension FX - Facsimile HP - Home Phone Number TE - Telephone WP - Work Phone Number	**WP**	Set to "WP"
2100G	PER06	Communication Number	AN	1-256	S			**Work Phone**	Set to Responsible Person Work Phone
2100G	PER07	Communication Number Qualifier	ID	2/2	S		AP - Alternate Telephone BN - Beeper Number CP - Cellular Phone EM - Electronic Mail EX - Telephone Extension FX - Facsimile HP - Home Phone Number TE - Telephone WP - Work Phone Number	**EM**	Set to "EM"
2100G	PER08	Communication Number	AN	1-256	S			**Email address**	Set to Responsible Person Email
2100G	N3	RESPONSIBLE PERSON STREET ADDRESS		1/1	S			If no mailing Address line 1 is defined for the case, replicate the residence address into the mailing address	
2100G	N301	Responsible Party Address Line	AN	1/55	R			Mailing Address Line 1	Set to Responsible Person Mailing Address Line 1
2100G	N302	Responsible Party Address Line	AN	1/55	S			Mailing Address Line 2	Set to Responsible Person Mailing Address Line 2
2100G	N4	RESPONSIBLE PERSON CITY, STATE, ZIP CODE		1/1	R				
2100G	N401	Responsible Party City Name	AN	2/1	R			Mailing Address City	Set to Responsible Person City
2100G	N402	Responsible Party State Code	ID	2/2	S			Mailing Address State	Set to Responsible Person State
2100G	N403	Responsible Party Postal Zone or ZIP Code	ID	3/15	S			Mailing Address Zip	Set to Responsible Person Zip
2100G	N404	Country Code	ID	2/3	S			**N/A**	IGNORE
2100G	N407	Country Subdivision Code	ID	1/3	S			**N/A**	IGNORE

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2100H	NM1	DROP OFF LOCATION		1/1	S	1			IGNORE this segment
2100H	NM101	Entity Identifier Code	ID	2/3	R		45 - Drop-off Location	**N/A**	IGNORE
2100H	NM102	Entity Type Qualifier	ID	1/1	R		1 - Person	**N/A**	IGNORE
2100H	NM103	Name Last or Organization Name	AN	1/1	**S**			**N/A**	IGNORE
2100H	NM104	First Name	AN	1/1	S			**N/A**	IGNORE
2100H	NM105	Middle Name	AN	1/25	S			**N/A**	IGNORE
2100H	NM106	Name Prefix	AN	1/10	S			**N/A**	IGNORE
2100H	NM107	Name Suffix	AN	1/10	S			**N/A**	IGNORE
2100H	N3	DROP OFF LOCATION STREET ADDRESS		1/1	S				IGNORE this segment
2100H	N301	Drop Off Location Address Line	AN	1/1	R			**N/A**	IGNORE
2100H	N302	Drop Off Location Address Line	AN	1/1	S			**N/A**	IGNORE
2100H	N4	RESPONSIBLE PERSON CITY, STATE, ZIP CODE		1/1	**S**				IGNORE this segment
2100H	N401	Drop Off Location City Name	AN	2/1	R			**N/A**	IGNORE
2100H	N402	Drop Off Location State Code	ID	2/2	S			**N/A**	IGNORE
2100H	N403	Drop Off Location Postal Zone or ZIP Code	ID	3/15	S			**N/A**	IGNORE
2100H	N404	Country Code	ID	2/3	S			**N/A**	IGNORE
2100H	N407	Country Subdivision Code	ID	1/3	S			**N/A**	IGNORE
2200	DSB	DISABILITY INFORMATION		1/1	S	>1			IGNORE this segment
2200	DSB01	Disability Type Code	ID	1/1	R		1 - Short Term Disability 2 - Long Term Disability 3 - Permanent or Total Disability 4 - No Disability	**N/A**	IGNORE
2200	DSB07	Product or Service ID Qualifier	ID	2/2	S		DX - International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) - Diagnosis ZZ - Mutually Defined	**N/A**	IGNORE
2200	DSB08	Diagnosis Code	AN	1/15	S			**N/A**	IGNORE
2200	DTP	DISABILITY ELIGIBILITY DATES		1/2	S				IGNORE this segment
2200	DTP01	Date Time Qualifier	ID	3/3	R		360 - Initial Disability Period Start 361 - Initial Disability Period End	**N/A**	IGNORE

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2200	DTP02	Date Time Period Format Qualifier	ID	2/3	R		D8	**N/A**	IGNORE
2200	DTP03	Disability Eligibility Date	AN	1/1	R		CCYYMMDD	**N/A**	IGNORE
2300	HD	HEALTH COVERAGE		1/1	S	99			
2300	HD01	Maintenance Type Code	ID	3/3	R		001 - Change 002 - Delete 021 - Addition 024 - Cancellation or Termination 025 - Reinstatement 026 - Correction 030 - Audit or Compare 032 - Employee Information Not Applicable	On Regular & Supplemental: 001 – Change 021 – Addition 024 – Cancellation or Termination 025 – Reinstatement	Click here for additional information on the Maintenance Type Codes
2300	HD03	First Name	ID	2/3	R		AG - Preventative Care/Wellness AH - 24 Hour Care AJ - Medicare Risk AK - Mental Health DCP - Dental Capitation DEN - Dental EPO - Exclusive Provider Organization FAC - Facility HE - Hearing HLT - Health HMO - Health Maintenance Organization LTC - Long-Term Care LTD - Long-Term Disability MM - Major Medical MOD - Mail Order Drug PDG - Prescription Drug POS - Point of Service PPO - Preferred Provider Organization PRA - Practitioners STD - Short-Term Disability UR - Utilization Review VIS - Vision	"HMO"	Set same std “HMO”

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2300	HD04	Plan Coverage Description	AN	1/50	S			**For HK** Bytes / Field Value: 1 = Z IF American Indian, Alaskan Native and premium category is subsidy; else 1 = blank	MCO's: 1/ Z or space If child is American Indian / Alaskan Native and premium category is subsidy, populate with "Z" If child is American Indian / Alaskan Native and premium category is Full Pay, populate with a 'space' If child is not American Indian / Alaskan Native, populate with a 'space'
								43 - 50 / YYYYMMDD (KidCare Renewal Date)	If ACCOUNT_RENEWAL.RENEWAL_DATE IS NULL, populate with '99999999'
2300	HD05	Coverage Level Code	ID	3-3	S		CHD - Children Only DEP Dependents Only E1D Employee and One Dependent E2D Employee and Two Dependents E3D Employee and Three Dependents E5D Employee and One or More Dependents E6D Employee and Two or More Dependents E7D Employee and Three or More Dependents E8D Employee and Four or More Dependents E9D Employee and Five or More Dependents ECH Employee and Children EMP Employee Only ESP Employee and Spouse FAM Family IND Individual SPC Spouse and Children SPO Spouse Only TWO Two Party	**N/A**	IGNORE
2300	HD09	Late Enrollment Indicator	ID	1/1	S			**N/A**	IGNORE
2300	DTP	HEALTH COVERAGE DATES		1/6	R				

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2300	DTP01	Date Time Qualifier	ID	3/3	R		300 - Enrollment Signature Date 303 - Maintenance Effective 343 - Premium Paid to Date End 348 - Benefit Begin 349 - Benefit End 543 - Last Premium Paid Date 695 - Previous Period	348 = Enrolled in next coverage month	Set to "348" - Always populate (applies to Coverage Date) - per FHKC Companion Guide
2300	DTP02	Date Time Period Format Qualifier	ID	2/3	R		D8 - Date Expressed in Format CCYYMMDD RD8 - Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	**D8**	Set same std of “D8”
2300	DTP03	Coverage Period	AN	1 / 35	R			If 348, EFFECTIVE_DATE for next coverage month.	Next Coverage Date Format CCYYMMDD Next Coverage Date minus 1 day Format CCYYMMDD
2300	AMT	HEALTH COVERAGE POLICY		1/9	S				IGNORE this segment
2300	AMT01	Amount Qualifier Code	ID	1/3	R		B9 - Co-insurance - Actual C1 - Co-Payment Amount D2 - Deductible Amount EBA - Expected Expenditure Amount FK - Other Unlisted Amount P3 - Premium Amount R - Spend Down	**N/A**	IGNORE
2300	AMT02	Contract Amount	R	1/18	R			**N/A**	IGNORE
2300	REF	HEALTH COVERAGE		1/14	S				IGNORE this segment
2300	REF01	Reference Identification Qualifier	ID	2/3	R		17 - Client Reporting Category 1L - Group or Policy Number 9V - Payment Category CE - Class of Contract Code E8 - Service Contract (Coverage) Number M7 - Medical Assistance Category PID - Program Identification Number RB - Rate code number X9 - Internal Control Number XM - Issuer Number XX1 - Special Program Code XX2 - Service Area Code ZX - County Code ZZ - Mutually Defined	**N/A**	IGNORE
2300	REF02	Reference Identification	AN	1/50	R			**N/A**	IGNORE

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2300	REF	PRIOR COVERAGE MONTHS		1/1	S				IGNORE this segment
2300	REF01	Reference Identification Qualifier	ID	2/3	R		QQ	**N/A**	IGNORE
2300	REF02	Prior Coverage Month Count	AN	1/50	R			**N/A**	IGNORE
2300	IDC	IDENTIFICATION CARD		1/3	S				IGNORE this segment
2300	IDC01	Plan Coverage Description	AN	1/1	R			**N/A**	IGNORE
2300	IDC02	Identification Card Type Code	ID	1/1	R		D - Dental Insurance H - Health Insurance P - Prescription Drug Service Drug Insurance	**N/A**	IGNORE
2300	IDC03	Identification Card Count	R	1/15	S			**N/A**	IGNORE
2300	IDC04	Action Code	ID	1/2	S		1 - Add 2 - Change (Update) RX - Replace	**N/A**	IGNORE
2310	LX	PROVIDER INFORMATION		**1**	S	**30**			IGNORE this segment
2310	LX01	Assigned Number	N0	1/6	R			**N/A**	Not Used by FHK
2310	NM1	PROVIDER NAME		1/1	R	13			IGNORE this segment
2310	NM101	Entity Identifier Code	ID	2/3	R		1X - Laboratory 3D - Obstetrics and Gynecology Facility 80 - Hospital FA - Facility OD - Doctor of Optometry P3 - Primary Care Provider QA - Pharmacy QN - Dentist Y2 - Managed Care Organization	**N/A**	IGNORE
2310	NM102	Entity Type Qualifier	ID	1/1	R		1 - Person 2 - Non-Person Entity	**N/A** **N/A**	IGNORE
2310	NM103	Provider Last or Organization Name	AN	1/1	S			**N/A** **N/A**	IGNORE
2310	NM104	Provider First Name	AN	1/1	S			**N/A**	IGNORE
2310	NM105	Provider Middle Name	AN	1/25	S			**N/A**	IGNORE
2310	NM106	Provider Name Prefix	AN	1/10	S			**N/A**	IGNORE
2310	NM107	Provider Name Suffix	AN	1/10	S			**N/A**	IGNORE
2310	NM108	Identification Code Qualifier	ID	1/2	S		34 - Social Security Number FI - Federal Taxpayer Identification Number SV - Service Provider Number XX - Centers for Medicare and Medicaid Services National Provider Identifier	**N/A** **N/A** **N/A** **N/A**	IGNORE
2310	NM109	Provider Identifier	AN	2/1	S			**N/A**	IGNORE

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2310	NM110	Entity Relationship Code	ID	2/2	R		25 - Established Patient 26 - Not Established Patient 72 - Unknown	N/A N/A N/A	IGNORE
2310	N3	PROVIDER ADDRESS		1/2	S				IGNORE this segment
2310	N301	Provider Address Line	AN	1/1	R			N/A	IGNORE
2310	N302	Provider Address Line	AN	1/1	S			N/A	IGNORE
2310	N4	PROVIDER CITY, STATE, ZIP CODE		1/1	S				IGNORE this segment
2310	N401	Provider City Name	AN	2/1	R			N/A	IGNORE
2310	N402	Provider State Code	ID	2/2	S			N/A	IGNORE
2310	N403	Provider Postal Zone or ZIP Code	ID	3/15	S			N/A	IGNORE
2310	N404	Country Code	ID	2/3	S			N/A	IGNORE
2310	N405	Location Qualifier	ID	1/2	S		60 - Area CY - County/Parish RJ - Region	N/A N/A N/A	IGNORE
2310	N406	Location Identification Code	AN	1/30	S			N/A	IGNORE
2310	N407	Country Subdivision Code	ID	1/3	S			N/A	IGNORE
2310	PER	PROVIDER COMMUNICATIONS NUMBERS		1/2	S				IGNORE this segment
2310	PER01	Contact Function Code	ID	2/2	**R**		IC - Information Contact	N/A	IGNORE
2310	PER03	Communication Number Qualifier	ID	2/2	R		AP - Alternate Telephone BN - Beeper Number CP - Cellular Phone EM - Electronic Mail EX - Telephone Extension FX - Facsimile HP - Home Phone Number TE - Telephone WP - Work Phone Number	N/A N/A N/A N/A N/A N/A N/A N/A N/A	IGNORE
2310	PER04	Communication Number	AN	1-256	R			N/A	IGNORE
2310	PER05	Communication Number Qualifier	ID	2/2	S		AP - Alternate Telephone BN - Beeper Number CP - Cellular Phone EM - Electronic Mail EX - Telephone Extension FX - Facsimile HP - Home Phone Number TE - Telephone WP - Work Phone Number	N/A N/A N/A N/A N/A N/A N/A N/A N/A	IGNORE
2310	PER06	Communication Number	AN	1-256	S			N/A	IGNORE

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2310	PER07	Communication Number Qualifier	ID	2/2	S		AP - Alternate Telephone BN - Beeper Number CP - Cellular Phone EM - Electronic Mail EX - Telephone Extension FX - Facsimile HP - Home Phone Number TE - Telephone WP - Work Phone Number	N/A N/A N/A N/A N/A N/A N/A N/A N/A	IGNORE
2310	PER08	Communication Number	AN	1-256	S			N/A	IGNORE
2310	PLA	PROVIDER CHANGE REASON		1/1	S				IGNORE this segment
2310	PLA01	Action Code	ID	1/2	R		2 - Change (Update)	N/A	IGNORE
2310	PLA02	Entity Identifier Code	ID	**2/3**	R		1P - Provider	N/A	IGNORE
2310	PLA03	Provider Effective Date	DT	8/8	R		CCYYMMDD	N/A	IGNORE
2310	PLA05	Maintenance Reason Code	ID	2/3	R		14 - Voluntary Withdrawal 22 - Plan Change 46 - Current Customer Information File in Error AA - Dissatisfaction with Office Staff AB - Dissatisfaction with Medical Care/Services Rendered AC - Inconvenient Office Location AD - Dissatisfaction with Office Hours AE - Unable to Schedule Appointments in a Timely Manner AF - Dissatisfaction with Physician's Referral Policy AG - Less Respect and Attention Time Given than to Other Patients AH - Patient Moved to a New Location AI - No Reason Given AJ - Appointment Times not Met in a Timely Manner	N/A N/A N/A N/A N/A N/A N/A N/A N/A N/A N/A N/A N/A	IGNORE
2320	COB	COORDINATION OF BENEFITS		1/1	S	5			IGNORE this segment
2320	COB01	Payer Responsibility Sequence Number Code	ID	1/1	R		P - Primary S - Secondary T - Tertiary U – Unknown “P” for MAX	N/A	IGNORE
2320	COB02	Member Group or Policy Number	AN	1/1	S			N/A	IGNORE
2320	COB03	Coordination of Benefits Code	ID	1/1	R		1 - Coordination of Benefits 5 - Unknown 6 - No Coordination of Benefits Constant ‘1’ (MAX)	N/A	IGNORE

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2320	COB04	Service Type Code	ID	1/2	S		1 - Medical Care 35 - Dental Care 48 - Hospital - Inpatient 50 - Hospital - Outpatient 54 - Long Term Care 89 - Free Standing Prescription Drug 90 - Mail Order Prescription Drug A4 - Psychiatric AG - Skilled Nursing Care AL - Vision (Optometry) BB - Partial Hospitalization (Psychiatric	**N/A**	IGNORE
2320	REF	ADDITIONAL COORDINATION OF BENEFITS IDENTIFIERS		1/4	S				IGNORE this segment
2320	REF01	Reference Identification Qualifier	ID	2/3	R		60 - Account Suffix Code 6P - Group Number SY - Social Security Number ZZ - Mutually Defined	**N/A**	IGNORE
2320	REF02	Member Group or Policy Number	AN	1/1	R			**N/A**	IGNORE
2320	DTP	COORDINATION OF BENEFITS ELIGIBILITY DATES		1/2	S			**N/A**	IGNORE this segment
2320	DTP01	Date Time Qualifier	ID	3/3	R		344 - Coordination of Benefits Begin 345 - Coordination of Benefits End	**N/A**	IGNORE
2320	DTP02	Date Time Period Format Qualifier	ID	2/3	R		D8 - Date Expressed in Format CCYYMMDD	**N/A**	IGNORE
2320	DTP03	Coordination of Benefits Date	AN	1/1	R			**N/A**	IGNORE
2330	NM1	COORDINATION OF BENEFITS RELATED ENTITY		1/1	S	3			IGNORE this segment
2330	NM101	Entity Identifier Code	ID	2/3	R		36 - Employer GW - Group IN – Insurer	**N/A**	IGNORE
2330	NM102	Entity Type Qualifier	ID	1/1	R		2 - Non-Person Entity	**N/A**	IGNORE
2330	NM103	Coordination of Benefits Insurer	AN	1/1	S			**N/A**	IGNORE
2330	NM108	Identification Code Qualifier	ID	1/2	S		FI, NI, XV	**N/A**	IGNORE
2330	NM109	Coordination of Benefits Insurer Identification Code	AN	2/1	S				IGNORE
2330	N3	COORDINATION OF BENEFITS RELATED ENTITY ADDRESS		1/1	S				IGNORE this segment
2330	N301	Address Information	AN	1/1	R			**N/A**	IGNORE
2330	N302	Address Information	AN	1/1	S			**N/A**	IGNORE

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2330	N4	COORDINATION OF BENEFITS OTHER INSURANCE COMPANY CITY, STATE, ZIP CODE		1/1	S		Note: Carrier information supplied in proprietary format		IGNORE this segment
2330	N401	Coordination of Benefits Other Insurance Company City Name	AN	2/1	R			**N/A**	IGNORE
2330	N402	Coordination of Benefits Other Insurance Company State Code	ID	2/2	S			**N/A**	IGNORE
2330	N403	Coordination of Benefits Other Insurance Company Postal Zone or ZIP Code	ID	3/15	S			**N/A**	IGNORE
2330	N404	Country Code	ID	2/3	S			**N/A**	IGNORE
2330	N407	Country Subdivision Code	ID	1/3	S			**N/A**	IGNORE
2330	PER	PER - ADMINISTRATIVE COMMUNICATIONS CONTACT		1/1	S				IGNORE this segment
2330	PER01	Contact Function Code	ID	2/2	**R**		CN - General Contact	**N/A**	IGNORE
2330	PER03	Communication Number Qualifier	ID	2/2	R		TE - Telephone	**N/A**	IGNORE
2330	PER04	Communication Number	AN	1-256	R			**N/A**	IGNORE
2000	LS	ADDITIONAL REPORTING CATEGORIES **Member Level Detail**		1/1	S				IGNORE this segment
2000	LS01	Loop Identifier Code	AN	1/4	R			**N/A**	IGNORE
2700	LX	MEMBER REPORTING CATEGORIES		1/1	S	>1			IGNORE this segment
2700	LX01	Assigned Number	N0	1/6	R			**N/A**	IGNORE
2750	N1	REPORTING CATEGORY		1/1	S	1			IGNORE this segment
2750	N101	Entity Identifier Code	ID	2/3	R		75 - Participant	**N/A**	IGNORE
2750	N102	Member Reporting Category Name	AN	1/1	R			**N/A**	IGNORE

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
2750	REF	REPORTING CATEGORY REFERENCE		1/1	S				IGNORE this segment
2750	REF01	Reference Identification Qualifier	ID	2/3	R		00 - Contracting District Number 17 - Client Reporting Category 18 - Plan Number 19 - Division Identifier 26 - Union Number 3L - Branch Identifier 6M - Application Number 9V - Payment Category 9X - Account Category GE - Geographic Number LU - Location Number PID - Program Identification Number XX1 - Special Program Code XX2 - Service Area Code YY - Geographic Key ZZ - Mutually Defined	N/A	IGNORE
2750	REF02	Member Reporting Category Reference ID	AN	1/1	R			N/A	IGNORE
2750	DTP	REPORTING CATEGORY DATE		1/1	S				IGNORE this segment
2750	DTP01	Date Time Qualifier	ID	3/3	R		007 - Effective	N/A	IGNORE
2750	DTP02	Date Time Period Format Qualifier	ID	2/3	R		D8 - Date Expressed in Format CCYYMMDD RD8 - Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	N/A N/A	IGNORE
2750	DTP03	Member Reporting Category Effective Date(s)	AN	1/1	R			N/A	IGNORE
2000	LE	ADDITIONAL REPORTING CATEGORIES LOOP TERMINATION		1/1	S				IGNORE this segment
2000	LE01	Loop Identifier Code	AN	1/4	R			N/A	IGNORE
TLR	SE	TRANSACTION SET TRAILER		1/1	R	≥1			
TLR	SE01	Transaction Segment Count	N0	1/10	R			Set at End of File.	Set at End of File.
TLR	SE02	Transaction Set Control Number	AN	4/9	R		Note: must match transaction set control number in ST02	Set at End of File.	Set at End of File.
TLR	GE	FUNCTION GROUP TRAILER			R	1			
TLR	GE01	Number of Transaction Sets Included	N0	1/6	R			Set at End of File. Hardcode to '1'	Set at End of File. Hardcode to '1'
TLR	GE02	Group Control Number	N0	1/9	R		Note: must match transaction set control number in GS06	Set at End of File.	Set at End of File.

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Allowed Values	Medical MCOS	Requirement Description (Use Unless otherwise specified in the columns I - M)
TLR	IEA	INTERCHANGE CONTROL TRAILER			R	1			
TLR	IEA01	Number of Included Functional Groups	N0	1/5	R			Set at End of File.	Set at End of File.
TLR	IEA02	Interchange Control Number	N0	9/9	R		Note: must match transaction set control number in ISA13	Set at End of File.	Set at End of File.

Rules for Populating Maint Type and Maint Reason

Maintenance Reason Code
"07" = Termination of Benefits,
"28" = Initial Enrollment,
"41" = Re-enrollment

REGULAR File		2000/INS03		2000/INS04		2300/HD01		VIDA Mapping		
Type of Enrollment	**Description (FROM IG)**	**Maintenance Type**	**Partner(s)**	**Maintenance Reason Code**	**Partner(s)**	**Maintenance Type**	**Partner(s)**	**TABLE.FIELD**	**Value**	
Initial enrollment into Plan X for a member:	Use this code to add a subscriber or dependent	021	MCO	28 XX	MCO	021	MCO	COVERAGE.COVERAGE_STATUS	NEWLY_ENROLLED	
Continuous enrollment; member is enrolled current month and next month	Use this code to indicate a change to an existing subscriber/dependent record. [AFJ] - in XEROX MCO REG and SUPL doc: This value is to be used for continuous enrollment (The child was enrolled in the MCO the previous month)	001	MCO	N/A	N/A	001	MCO	COVERAGE.COVERAGE_STATUS	ENROLLED	
Member who is Cancelled/Disenrolled	Use this code for cancellation, termination, or deletion of a subscriber or dependent.	024	MCO	07	MCO	024	MCO	COVERAGE.COVERAGE_STATUS	VOIDED or DISENROLLED	
Reinstated member:	Use this code for reinstatement of a cancelled subscriber/dependent record.	025	MCO	41	MCO	025	MCO	COVERAGE.COVERAGE_STATUS	REINSTATED	7/30/14 - Changed per CR151

SUPPLEMENTAL File(s)		2000/INS03		2000/INS04		2300/HD01		VIDA Mapping		
Type of Enrollment	**Description (FROM IG)**	**Maintenance Type**	**Partner(s)**	**Maintenance Reason Code**	**Partner(s)**	**Maintenance Type**	**Partner(s)**	**TABLE.FIELD**	**Value**	
Initial enrollment into Plan X for a member:	Use this code to add a subscriber or dependent	021	MCO	28 XX	MCO	021	MCO	COVERAGE.COVERAGE_STATUS	NEWLY_ENROLLED	
Continuous enrollment; member is enrolled current month and next month	Use this code to indicate a change to an existing subscriber/dependent record. [AFJ] - in XEROX MCO REG and SUPL doc: This value is to be used for continuous enrollment (The child was enrolled in the MCO the previous month)	001	MCO	N/A	N/A	001	MCO	COVERAGE.COVERAGE_STATUS	ENROLLED	
Member who is Cancelled/Disenrolled	Use this code for cancellation, termination, or deletion of a subscriber or dependent.	024	MCO	07	MCO	024	MCO	COVERAGE.COVERAGE_STATUS	VOIDED or DISENROLLED	
Reinstated member:	Use this code for reinstatement of a cancelled subscriber/dependent record.	025	MCO	41	MCO	025	MCO	COVERAGE.COVERAGE_STATUS	REINSTATED	7/30/14 - Changed per CR151

ACS Definitions

Enrolled Child Defiition	1. Open HMO_REG_EXPORT_STDs exists for the case 2. Eligibility Program Id = "Healthy Kids" 3. Enrollment Plan = "HMO" 4. Enrollment Sent For Date < Next Coverage Date (batch parameter) 5. Enrollment End Date = NULL 6. Enrollment Effective Date <= Next Coverage Date (batch parameter) 7. PPS Financial Status = Current
Cancelled Children Definition (Voluntarily or due to loss of eligibility)	1. Open HMO_REG_EXPORT_STDs exists for the case 2. Eligibility Program Id = "Healthy Kids" 3. Enrollment Plan = "HMO" 4. Disenrollment Sent For Date = NULL or < Next Coverage Date - 1 5. Enrollment End Date = Next Coverage Date – 1 6. If there are no longer any active children for the case, close the HMO_REG_EXPORT_STDs
Cancelled Children (Currently enrolled, but financial status Past Due)	1. Open HMO_REG_EXPORT_STDs exists for the case 2. Eligibility Program Id = "Healthy Kids" 3. Enrollment Plan = "HMO" 4. Disenrollment Sent For Date = NULL or < Next Coverage Date - 1 5. Enrollment End Date = NULL 6. PPS Financial Status = Past Due 7. If there are no longer any active children for the case, close the HMO_REG_EXPORT_STDs

INS03_2000 and HD01_2300 segments

from ACS-MCO docs

Translator Table Column	Business Rule	X12 Values
INS03_2000 and HD01_2300	Enrolled Child (BR #5.1.1) and the Enrollment Effective Date = Next Coverage Date.	"021" - Addition
INS03_2000 and HD01_2300	Enrolled Child (BR #5.1.1) and the Enrollment Effective Date < Next Coverage Date.	"001" – This value is to be used for continuous enrollment (The child was enrolled in the MCO the previous month)
INS03_2000 and HD01_2300	Cancelled Child (BR #5.1.2 & 5.1.3)	"024" – Cancellation or termination
INS03_2000 and HD01_2300	Enrolled Child (BR #5.1.1) with Reinstatement and the Enrollment Effective Date = Next Coverage Date.	"025" - Reinstatement

Disenrollment Reasons Hierarchy - mapped to VIDA disenrollment reasons

COVERAGE RECORD will be populated with the following STATUS for the "not enrolled" state along with the reason noted:

- **DISENROLLED:** If member was enrolled in a plan in the previous coverage month and is being disrenrolled in the next coverage month

- **VOIDED:** If member was sent as Enrolled in the Regular run and then loses eligibility before the final supplemental, the Coverage record will have a STATUS of VOIDED for the upcoming month

COVERAGE_REASON_REF Values	R834_CODE values	PRECEDENCE_ORDER	UI_REASON_CODE
MDCD_TRANSITION	X	1	Not Eligible
DECEASED	Z	1	Not Eligible
SCHIP_OVER_AGE	A	2	Not Eligible
OUT_OF_STATE	R	4	Not Eligible
MOVED_OUT_OF_HOUSEHOLD	V	5	Moved Out
VOLUNTARY_DISENROLLMENT	M	6	Family Request
MEDICAID_ENROLLED	D	7	Not Eligible
MEDICAID_NON_COMPLIANT	U	8	Not Eligible
HAS_OTHER_INSURANCE	O	9	Not Eligible
MASS_TRANSFER	Q	10	Mass Transfer
PLAN_CHANGE	Q	10	Transfer
INELIGIBLE_NON_CITIZEN	C	11	Not Eligible
HK_FULLPAY_TRANSFER	I	13	Transfer
OVER_INCOME	I	13	Not Eligible
NON_COMPLIANT_RENEWAL	N	14	Not Eligible
NON_COMPLIANT_VIC	S	14	Not Eligible
NON_PAYMENT	H	15	Non-Payment
STATE_EMPL_DEPENDENT	G	16	Not Eligible

SEPARATORS	**Value**
Segment Separator	~
Element Separator	*
Compound Element Separator	>
Repetition Separator	^

Attachment F: Capitation File Layout

This attachment contains the capitation file layout as described in section 18-2-1-2 of the Contract. This attachment is subject to change without a Contract amendment.

The capitation file is provided in the standard ASC X12N 820 file format for health plan premiums. The information below is a companion guide.

HIPAA TXN: Payroll Deducted and Other Group Premium Payment for Insurance Products (820)

System sends the capitation file to Medical MCOs showing payments made by FHKC to a specific MCO for all enrollments from current coverage month. Also included are all retroactive enrollments and retroactive disenrollments entered in the prior calendar month.

These files are formatted in a HIPAA compliant x12 format and include one record with information for each currently enrolled child and any adjustments from the prior calendar month for a child.

Comments

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Implementation Guide Description	Allowed Values	Medical MCOS	Requirement Description
HDR	ISA	INTERCHANGE CONTROL HEADER			R	1				
HDR	ISA01	Authorization Information Qualifier	ID	2/2	R			00, 03	00	Set to "00"
HDR	ISA02	Authorization Information	AN	10/10	R				spaces	Set to spaces
HDR	ISA03	Security Information Qualifier	ID	2/2	R			00, 01	00	Set to "00"
HDR	ISA04	Security Information	AN	10/10	R				spaces	Set to spaces
HDR	ISA05	Interchange ID Qualifier	ID	2/2	R			01, 14, 20, 27, 28, 29, 30, 33, ZZ	Values provided in final file definition	
HDR	ISA06	Interchange Sender ID	AN	15/15	R				Values provided in final file definition	
HDR	ISA07	Interchange ID Qualifier	ID	2/2	R			01, 14, 20, 27, 28, 29, 30, 33, ZZ	Values provided in final file definition	
HDR	ISA08	Interchange Receiver ID	AN	15/15	R				Values provided in final file definition	Set to "<mco receiver id>"
HDR	ISA09	Interchange Date	DT	6/6	R			YYMMDD	Current system date	Current system date
HDR	ISA10	Interchange Time	TM	4/4	R			HHMM	Current system time	Current system time
HDR	ISA11	Repetition Separator	AN	1/1	R			Need mutual agreement with Translator Vendor	Hardcode to '^'	Default to Caret "^"
HDR	ISA12	Interchange Control Version Number	ID	5/5	R			00501	00501	Set to "00501"
HDR	ISA13	Interchange Control Number	N0	9/9	R			Translator generated	Translator generated	System generated 9 digit control number
HDR	ISA14	Acknowledgement Requested	ID	1/1	R			0, 1	**0**	Set to "0"
HDR	ISA15	Usage Indicator	ID	1/1	R			P, T	**T or P**	Set to "P" for Production, "T" for Test
HDR	ISA16	Component Element Separator	AN	1/1	R				Hardcode to '>'	Default to '>'
HDR	GS	FUNCTIONAL GROUP HEADER			R	≥1				
HDR	GS01	Functional Identifier Code	ID	2/2	R			RA	RA	Send "RA"
HDR	GS02	Application Sender Code	AN	2/15	R				Values provided in final file definition	
HDR	GS03	Application Receiver Code	AN	2/15	R				Values provided in final file definition	Set to "<mco receiver id>"
HDR	GS04	Date	DT	8/8	R			CCYYMMDD	Current system date	Current system date
HDR	GS05	Time	TM	4/8	R			HHMM	Current system time	Current system time
HDR	GS06	Group Control Number	N0	1/9	R				System generated 9 digit control number	System generated 9 digit control number
HDR	GS07	Responsible Agency Code	ID	1/2	R			X	X	Set to "X"
HDR	GS08	Version/ Release/ Industry Identifier Code	AN	1/12	R			005010X220A1	005010X218	Set to"005010X218"
HDR	ST	TRANSACTION SET HEADER		1/1	R	≥1				
HDR	ST01	Transaction Set Identifier Code	ID	3/3	R			820 = Payment Order/Remittance Advice	820	820 Payment Order/Remittance Advice
HDR	ST02	Transaction Set Control Number	AN	4/9	R				Set automatically by map (begins with 0001)	
HDR	ST03	Implementation Convention Reference	AN	1/35	R				005010X218	The value in ST03 must be the same as the value in GS08.
HDR	BPR	Beginning Segment for Payment Order/Remittance Advice		1/1	R					
HDR	BPR01	Transaction Handling Code	ID	1/2	R		Code designating whether and how money and information are to be processed.	C = Payment Accompanies Remittance Advice D = Make Payment Only I = Remittance Information Only P = Prenotification of Future Transfers U = Split Payment and Remittance X = Handling Party's Option to Split Payment and Remittance	I	Default to I - Remittance Information Only
HDR	BPR02	Monetary Amount	R	1/18	R		Total Premium Payment Amount		Rolled up amount for all captitations included in the file from the 2300B RMR segment	Calculated from Detail Records in the 2300B RMR segment. Format = 999999999999999.99
HDR	BPR03	Credit/Debit Flag Code	ID	1/1	R		This indicates a credit to the payee's account, and a debit to the Payer's account.	C = Credit; D = Debit	C or D	If Credit (positive) = C If Debit (negative) = D

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Implementation Guide Description	Allowed Values	Medical MCOS	Requirement Description
HDR	BPR04	Payment Method Code	ID	3/3	R		Code identifying the method for the movement of payment instructions	ACH = Automated Clearing House (ACH) BOP = Financial Institution Option CHK = Check FWT = Federal Reserve Funds/Wire Transfer - Nonrepetitive NON = Non-Payment Data SWT = Society for Worldwide Interbank Financial Telecommunications (S.W.I.F.T.)	NON	Default to NON = Non-Payment Data
HDR	BPR05	Payment Format Code	ID	1/10	S		Code identifying the payment format to be used	CCP = Cash Concentration/Disbursement plus Addenda (CCD+) (ACH) CTX = Corporate Trade Exchange (CTX) (ACH)	N/A	SITUATIONAL RULE: Required when payment is made using an ACH network.
HDR	BPR06	Depository Financial Institution ID Number Qualifier	ID	2/2	S		Code identifying the type of identification number of Depository Financial Institution (DFI)	01 = ABA Transit Routing Number Including Check Digits (9 digits) 02 = Swift Identification (8 or 11 characters) 04 = Canadian Bank Branch and Institution Number	N/A	SITUATIONAL RULE: Required when payment is made using an ACH network.
HDR	BPR07	(DFI) Identification Number	AN	3/12	S		This is the identifying number of the Originating Depository Financial Institution sending the transaction into the ACH network.		N/A	Required when BPR01 is not equal to "I".
HDR	BPR08	Account Number Qualifier	ID	1/3	S		Code indicating the type of account	DA = Demand Deposit	N/A	Required when BPR01 is not equal to "I".
HDR	BPR09	Account Number	AN	1/35	S		Sender Bank Account Number		N/A	Required when BPR01 is not equal to "I".
HDR	BPR10	Payer Identifier	AN	10/10	R		Payer Identifier - shall be mutually established between the originating depository financial institution (ODFI) and the company originating the payment.		59-3032613	Clarification Received during meeting with FHKC meeting held on 3/26/2013. Use FHKC tax id which is 59-3032613.
HDR	BPR11	Originating Company Supplemental Code	AN	9/9	S		A code defined between the originating company and the originating depository financial institution (ODFI) that uniquely identifies the company initiating the transfer instructions		N/A	This data must be identical to the value sent in the TRN04 data element. Required when identification of a subdivision within a company is necessary.
HDR	BRP12	(DFI) ID Number Qualifier	ID	2/2	S		Code identifying the type of identification number of Depository Financial Institution (DFI)	01 = ABA Transit Routing Number Including Check Digits (9 digits) 02 = Swift Identification (8 or 11 characters) 04 = Canadian Bank Branch and Institution Number	N/A	Required when BPR04 is ACH, BOP, FWT, or SWT. BPR12 THROUGH BPR15 relate to the Receiving Depository Financial Institution and the premium receiver's bank account. BPR12 - BPR15 are required if the 820 transaction set initiates a funds transfer.
HDR	BPR13	Receiving Depository Financial Institution (DFI) Identifier	AN	3/12	S		This is the identifying number of the Receiving Depository Financial Institution receiving the transaction into the ACH network.		N/A	Required when BPR04 is ACH, BOP, FWT, or SWT.
HDR	BPR14	Account Number Qualifier	ID	1/3	S		Code indicating the type of account - BPR14 identifies the type of account in BPR15.	DA = Demand Deposit SG = Savings	N/A	Required when BPR04 is ACH, BOP, FWT, or SWT.
HDR	BPR15	Account Number	AN	1/1	S		This is the premium receiver's bank account at the Receiving Depository Financial Institution.		N/A	Required when BPR04 is ACH, BOP, FWT, or SWT.
HDR	BPR16	Check Issue or EFT Effective Date	DT	8/8	R				YYYYMMDD - 15th day of the coverage month	For check payment, this data element specifies the check issuance date. For payments other than check this data element specifies the date the originator (premium payer) intends to provide funds to the receiver (premium receiver). RP32 reports sent to FHKC on the 5th of the month. FHKC pays the plans around the 15th of the month. Default to the 15th of the coverage month noted in 2300B / DTM06
HDR	TRN	**REASSOCIATION TRACE NUMBER**		**1/1**	**R**		**The purpose of this segment is to uniquely identify this transaction set and aid in the reassociating payment and remittance data that have been separated.**			
HDR	TRN01	Trace Type Code	ID	1/2	R		Code identifying which transaction is being referenced	1 = Current Transaction Trace Numbers (The payment and remittance have not been separated.) 3 = Financial Reassociation Trace Number (The payment and remittance information have been separated and need to be reassociated by the receiver.)	3	Default to 3 = Financial Reassociation Trace Number (The payment and remittance information have been separated and need to be reassociated by the receiver.)

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HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Implementation Guide Description	Allowed Values	Medical MCOS	Requirement Description
HDR	TRN02	Check or EFT Trace Number	AN	1/50	R		This field is used to re-associate the payment with the remittance information.		Plan Short Name + _Coverage Month (MM) + _Year (YYYY)	Concatenate HEALTH PLAN SHORT NAME with Coverage Month and Year, e.g., AMG_04_2013
HDR	TRN03	Originating Company Identifier	AN	10/10	S		A unique identifier designating the company initiating the funds transfer instructions, business transaction or assigning tracking reference identification.		N/A	Required when the receiver needs an originating company identification to reassociate a payment to a remittance.
HDR	TRN04	Originating Company Supplemental Code	AN	1/50	S		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		N/A	Required when the Payer is sending multiple premium payments for multiple group plans and the receiver needs an additional identifier for re-association. If provided, TRN04 and BPR11 must be identical.
HDR	CUR	FOREIGN CURRENCY INFORMATION		1/1	S		To specify the currency (dollars, pounds, francs, etc.) used in a transaction	Required when the payment is not being made in US Dollars.	N/A	IGNORE THIS SEGMENT
HDR	CUR01	Entity Identifier Code	ID	2/3	R		This data element identifies the party using the currency defined in Currency Code CUR02.	2B = Third-Party Administrator PR = Payer	N/A	
HDR	CUR02	Currency Code	ID	3/3	R		Code (Standard ISO) for country in whose currency the charges are specified	MXP = Mexican Pesos CAD = Canadian Dollars	N/A	
HDR	REF	PREMIUM RECEIVERS IDENTIFICATION KEY		1/1	S					Required when specified by the terms of the trading partner agreement.
HDR	REF01	Reference Identification Qualifier	ID	2/3	R			14 = Master Account Number 17 = Client Reporting Category 18 = Plan Number 2F = Consolidated Invoice Number 38 = Master Policy Number 72 = Schedule Reference Number LB = Lockbox	18	18 = Plan Number
HDR	REF02	Premium Receiver Reference Identifier	AN	1/50	R		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		Internal Health Plan ID from VIDA	VIDA assigned ID for the Health Plan
HDR	DTM	PROCESS DATE		1	S		This segment is used to relay the date the payment was processed by the premium payer.	Required when specified by the terms of the trading partner agreement.	N/A	IGNORE THIS SEGMENT
HDR	DTM01	Date Time Qualifier	ID	3/3	R			009 = Process	N/A	
HDR	DTM02	Payer Process Date	ID	8/8	R				N/A	
HDR	DTM	DELIVERY DATE		1	S		Relays the date the payment was delivered to the Originating Depository Financial Institution by the premium payer or a third party processor.	Required when specified by the terms of the trading partner agreement.	N/A	IGNORE THIS SEGMENT
HDR	DTM01	Date Time Qualifier	ID	3/3	R			035 = Delivered	N/A	
HDR	DTM02	Premium Delivery Date	ID	8/8	R				N/A	
HDR	DTM	COVERAGE PERIOD		1	S		This segment communicates the start and end date of the coverage period associated with this premium payment.			Required when the premium payer is not paying from an invoice, but paying on account for a coverage period.
HDR	DTM01	Date Time Qualifier	ID	3/3	R			582 = Report Period	582 = Report Period	
HDR	DTM05	Date Time Period Format Qualifier	ID	2/3	R			RD8 =Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	RD8 = Range of Dates Expressed in Format CCYYMMDD - CCYYMMDD	
HDR	DTM06	Coverage Period	AN	1/35	R				Coverage Begin - End Date CCYYMMDD - CCYYMMDD	Coverage begin and end date for the current coverage month based on the selection criteria
HDR	DTM	CREATION DATE		1	S		This segment is used to relay the date that the premium payment was created.	Required when specified by the terms of the trading partner agreement	N/A	IGNORE THIS SEGMENT
HDR	DTM01	Date Time Qualifier	ID	3/3	R			097 = Transaction Creation	N/A	
HDR	DTM02	Date	ID	8/8	R		Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year		N/A	
1000A	N1	PREMIUM RECEIVER'S NAME		1/1	R	1	To identify a party by type of organization, name, and code			
1000A	N101	Entity Identifier Code	ID	2/3	R		Code identifying an organizational entity, a physical location, property or an individual	PE = Payee	PE	Default to PE = Payee
1000A	N102	Premium Receiver's Last or Organization Name	AN	1/60	S		Free-Form Name		N/A	N/A

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HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Implementation Guide Description	Allowed Values	Medical MCOS	Requirement Description
1000A	N103	Identification Code Qualifier	ID	1/2	S			1 = D-U-N-S Number, Dun & Bradstreet 9 = D-U-N-S+4, D-U-N-S Number with Four Character Suffix EQ = Insurance Company Assigned Identification Number FI = Federal Taxpayer's Identification Number XV = Centers for Medicare and Medicaid Services PlanID	FI	Required when a value is not being sent in N102 and a value is being reported in the N104 element. Default to FI = Federal Taxpayer's Identification Number
1000A	N104	Premium Receiver's Identification Code	AN	2/80	S				Values provided in final file definition	Required when specified by the terms of the trading partner agreement.
1000A	N2	PREMIUM RECEIVER ADDITIONAL NAME		1/1	S	1	Additional Name Information	Required when the sender needs more characters than are available in the N102 or secondary line information is needed.	N/A	IGNORE THIS SEGMENT
1000A	N201	Premium Receiver's Additional Name	AN	1/60	R		Premium Receiver's Additional Name		N/A	
1000A	N3	PREMIUM RECEIVER'S ADDRESS		1/1	S	1	Party location	Required when specified by the terms of the Originating Financial Institution, or 3rd Party Processor, with the payment Originator.	N/A	IGNORE THIS SEGMENT
1000A	N301	Premium Receiver's Address Line	AN	1/55	R		Premium Receiver's Additional Name		N/A	
1000A	N302	Address Information	AN	1/55	S				N/A	Required if a second address line exists.
1000A	N4	PREMIUM RECEIVER'S CITY, STATE, AND ZIP CODE		1/1	S	1	Geographic Location	Required when specified by the terms of the Originating Financial Institution, or 3rd Party Processor, with the payment Originator.	N/A	IGNORE THIS SEGMENT
1000A	N401	Premium Receiver's City Name	AN	2/30	R		Premium Receiver's City Name		N/A	
1000A	N402	Premium Receiver's State Code	ID	2/2	S		Code (Standard State/Province) as defined by appropriate government agency		N/A	Required when the address is in the United States of America, including its territories, or Canada.
1000A	N403	Premium Receiver's Postal Zone or Zip Code	ID	3/15	S		Code defining international postal zone code excluding punctuation and blanks (zip code for United States)		N/A	Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404.
1000A	N404	Country Code	ID	2/3	S		Use the alpha-2 country codes from Part 1 of ISO 3166.		N/A	Required when the address is outside the United States of America.
1000A	N407	Country Subdivision Code	ID	1/3	S		Code identifying the country subdivision		N/A	Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc.
1000A	RDM	PREMIUM RECEIVER'S REMITTANCE DELIVERY METHOD		1/1	S			Required when specified by the terms of the agreement between originator and financial institution or 3rd party processor.	N/A	IGNORE THIS SEGMENT
1000A	RDM01	Remittance Delivery Method Code	ID	1/2	R		Code defining timing, transmission method or format by which reports are to be sent	BM = By Mail EM = E-Mail FT = File Transfer FX = By Fax IA = Electronic Image OL = On-Line	N/A	
1000A	RDM02	Premium Receiver's Last or Organization Name	AN	1/60	S		RDM02 is used to contain the name of a third party processor if needed, who would be the first recipient of the remittance.		N/A	Required when specified by the terms of the trading partner agreement.
1000A	RDM03	Premium Receiver's Communication Number	AN	1/256	S		Complete communications number including country or area code when applicable		N/A	Required when RDM01 is not equal to "BM" and when specified by the terms of the originating financial institution, or 3rd party processor, with the payment originator.
1000B	N1	PREMIUM PAYER'S NAME		1/1	R	1	To identify a party by type of organization, name, and code			
1000B	N101	Entity Identifier Code	ID	2/3	R		Code identifying an organizational entity, a physical location, property or an individual	PR = Payer	PR	Default to PR = Payer
1000B	N102	Premium Payer Name	AN	1/60	S		Free-Form Name	N/A	N/A	N/A
1000B	N103	Identification Code Qualifier	ID	1/2	S			1 = D-U-N-S Number, Dun & Bradstreet 9 = D-U-N-S+4, D-U-N-S Number with Four Character Suffix 24 = Employer's Identification Number 75 = State or Province Assigned Number EQ = Insurance Company Assigned Identification Number FI = Federal Taxpayer's Identification Number PI = Payor Identification	FI	Required when a value is not being sent in N102 and a value is being reported in the N104 element. Default to FI = Federal Taxpayer's Identification Number

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HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Implementation Guide Description	Allowed Values	Medical MCOS	Requirement Description	Comments
1000B	N104	Premium Payer Identifier	AN	2/80	S				59-3032613	Required when specified by the terms of the trading partner agreement. Use FHKC Tax ID of 59-3032613	
1000B	N2	PREMIUM PAYER ADDITIONAL NAME		1/1	S	1	Additional Name Information	Required when the sender needs more characters than are available in the N102 or secondary line information is needed.	N/A	IGNORE THIS SEGMENT	
1000B	N201	Premium Receiver's Additional Name	AN	1/60	R		Premium Payer Additional Name		N/A		
1000B	N3	PREMIUM PAYER'S ADDRESS		1/1	S	1	Party location	Required when specified by the terms of the Originating Financial Institution, or 3rd Party Processor, with the payment Originator.	N/A	IGNORE THIS SEGMENT	
1000B	N301	Premium Payer Address Line	AN	1/55	R		Premium Payer Additional Name		N/A		
1000B	N302	Premium Payer Address Line	AN	1/55	S				N/A	Required when a second line of the Premium Payer's Address exists.	
1000B	N4	PREMIUM PAYER'S CITY, STATE, AND ZIP CODE		1/1	S	1	Geographic Location	Required when specified by the terms of the Originating Financial Institution, or 3rd Party Processor, with the payment Originator.	N/A	IGNORE THIS SEGMENT	
1000B	N401	Premium Payer City Name	AN	2/30	R		Premium Payer City Name		N/A		
1000B	N402	Premium Payer State Code	ID	2/2	S		Code (Standard State/Province) as defined by appropriate government agency		N/A	Required when the address is in the United States of America, including its territories, or Canada.	
1000B	N403	Premium Payer Postal Zone or Zip Code	ID	3/15	S		Code defining international postal zone code excluding punctuation and blanks (zip code for United States)		N/A	Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404.	
1000B	N404	Country Code	ID	2/3	S		Use the alpha-2 country codes from Part 1 of ISO 3166.		N/A	Required when the address is outside the United States of America.	
1000B	N407	Country Subdivision Code	ID	1/3	S		Code identifying the country subdivision		N/A	Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc.	
1000B	PER	PREMIUM PAYER'S ADMINISTRATIVE CONTACT		>1	S	1	Administrative Communications Contact	Required when specified by the terms of the trading partner agreement.	N/A	IGNORE THIS SEGMENT	
1000B	PER01	Contact Function Code	ID	2/2	R		Code identifying the major duty or responsibility of the person or group named	IC = Information Contact	N/A		
1000B	PER02	Premium Payer Contact Name	AN	1/60	R				N/A		
1000B	PER03	Communication Number Qualifier	ID	2/2	R		Code identifying the type of communication number	EM = Electronic Mail FX = Facsimile TE = Telephone	N/A	This is required when the sender needs to relay communication information.	
1000B	PER04	Communication Number	AN	1/256	R		Complete communications number including country or area code when applicable		N/A		
1000B	PER05	Communication Number Qualifier	ID	2/2	S			EM = Electronic Mail EX = Telephone Extension FX = Facsimile TE = Telephone	N/A	Required when additional communication numbers are available.	
1000B	PER06	Communication Number	AN	1/256	S		Complete communications number including country or area code when applicable		N/A	Required when additional communication numbers are available.	
1000B	PER07	Communication Number Qualifier	ID	2/2	S		Code identifying the type of communication number	EM = Electronic Mail EX = Telephone Extension FX = Facsimile TE = Telephone	N/A	Required when additional communication numbers are available.	
1000B	PER08	Communication Number	AN	1/256	S		Complete communications number including country or area code when applicable		N/A	Required when additional communication numbers are available.	
1000C	N1	INTERMEDIARY BANK INFORMATION		1/1	S	14	To identify a party by type of organization, name, and code	Required when specified by the terms of the Originating Financial Institution, or 3rd Party Processor, with the payment Originator.	N/A	IGNORE THIS SEGMENT	

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Implementation Guide Description	Allowed Values	Medical MCOS	Requirement Description
1000C	N101	Entity Identifier Code	ID	2/3	R		Code identifying an organizational entity, a physical location, property or an individual	04 = Asset Account Holder 0B = Interim Funding Organization 8W = Payment Address AK = Party to Whom Acknowledgment Should Be Sent BE = Beneficiary BK = Bank C1 = In Care Of Party no. 1 C2 = In Care Of Party no. 2 IAT = Party Executing and Verifying MJ = Financial Institution RB = Receiving Bank Z6 = Transferring Party ZB = Party to Receive Credit ZL = Party Passing the Transaction	N/A	
1000C	N102	Intermediary Bank Name	AN	1/60	S		Free-Form Name		N/A	Required when a value is not being sent in N103.
1000C	N103	Identification Code Qualifier	ID	1/2	S			31 = Bank Identification Code 57 = Department 94 = Code assigned by the organization that is the ultimate destination of the transaction set A3 = Assigned by Third Party A4 = Assigned by Clearinghouse A6 = Financial Identification Numbering System (FINS) Number CF = Canadian Financial Institution Routing Number G = Payee Identification Number PA = Secondary Agent Identification	N/A	Required when a value is not being sent in N102 and a value is being reported in the N104 element.
1000C	N104	Intermediary Bank Identifier	AN	2/80	S				N/A	Required when specified by the terms of the trading partner agreement.
1000C	N2	INTERMEDIARY BANK ADDITIONAL NAME		1/1	S	1	Additional Name Information	Required when the sender needs more characters than are available in the N102 or secondary line information is needed.	N/A	IGNORE THIS SEGMENT
1000C	N201	Intermediary Bank Additional Name	AN	1/60	R		Intermediary Bank Additional Name		N/A	
1000C	N3	INTERMEDIARY BANK'S ADDRESS		1/1	S	1	Party location	Required when specified by the terms of the Originating Financial Institution, or 3rd Party Processor, with the payment Originator.	N/A	IGNORE THIS SEGMENT
1000C	N301	Intermediary Bank Address Line	AN	1/55	R		Premium Payer Additional Name		N/A	
1000C	N302	Intermediary Bank Address Line	AN	1/55	S				N/A	Required when a second line of the Premium Payer's Address exists.
1000C	N4	INTERMEDIARY BANK'S CITY, STATE, AND ZIP CODE		1/1	S	1	Geographic Location	Required when specified by the terms of the Originating Financial Institution, or 3rd Party Processor, with the payment Originator.	N/A	IGNORE THIS SEGMENT
1000C	N401	Intermediary Bank City Name	AN	2/30	R		Intermediary Bank City Name		N/A	
1000C	N402	Intermediary Bank State Code	ID	2/2	S		Code (Standard State/Province) as defined by appropriate government agency		N/A	Required when the address is in the United States of America, including its territories, or Canada.
1000C	N403	Intermediary Bank Postal Zone or Zip Code	ID	3/15	S		Code defining international postal zone code excluding punctuation and blanks (zip code for United States)		N/A	Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404.
1000C	N404	Country Code	ID	2/3	S		Use the alpha-2 country codes from Part 1 of ISO 3166.		N/A	Required when the address is outside the United States of America.
1000C	N407	Country Subdivision Code	ID	1/3	S		Code identifying the country subdivision		N/A	Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc.
1000C	PER	INTERMEDIARY BANK'S ADMINISTRATIVE CONTACT		>1	S	1	Administrative Communications Contact	Required when specified by the terms of the trading partner agreement.	N/A	IGNORE THIS SEGMENT
1000C	PER01	Contact Function Code	ID	2/2	R		Code identifying the major duty or responsibility of the person or group named	IC = Information Contact	N/A	
1000C	PER02	Intermediary Bank Contact Name	AN	1/60	R				N/A	
1000C	PER03	Communication Number Qualifier	ID	2/2	R		Code identifying the type of communication number	EM = Electronic Mail FX = Facsimile TE = Telephone	N/A	This is required when the sender needs to relay communication information.

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HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Implementation Guide Description	Allowed Values	Medical MCOS	Requirement Description
1000C	PER04	Communication Number	AN	1/256	R		Complete communications number including country or area code when applicable		N/A	
1000C	PER05	Communication Number Qualifier	ID	2/2	S			EM = Electronic Mail EX = Telephone Extension FX = Facsimile TE = Telephone	N/A	Required when additional communication numbers are available.
1000C	PER06	Communication Number	AN	1/256	S		Complete communications number including country or area code when applicable		N/A	Required when additional communication numbers are available.
1000C	PER07	Communication Number Qualifier	ID	2/2	S		Code identifying the type of communication number	EM = Electronic Mail EX = Telephone Extension FX = Facsimile TE = Telephone	N/A	Required when additional communication numbers are available.
1000C	PER08	Communication Number	AN	1/256	S		Complete communications number including country or area code when applicable		N/A	Required when additional communication numbers are available.
2000A	ENT	ORGANIZATION SUMMARY REMITTANCE		1/1	S	1	To designate the entities which are parties to a transaction and specify a reference meaningful to those entities	Required when providing company remittance line items that pertain to group level premium or contribution payments.	N/A	IGNORE THIS SEGMENT
2000A	ENT01	Assigned Number	N0	1/6	R				N/A	ENT01 must b+L139e a sequential number within the transaction set, starting with one and incrementing by one.
2000A	ENT02	Entity Identifier Code	ID	2/3	R		Code identifying an organizational entity, a physical location, property or an individual	2L = Corporation AG = Agent/Agency NH = Association RGA = Responsible Government Agency UN = Union	N/A	
2000A	ENT03	Identification Code Qualifier	ID	1/2	R			1 = D-U-N-S Number, Dun & Bradstreet 9 = D-U-N-S+4, D-U-N-S Number with Four Character Suffix 24 = Employer's Identification Number FI = Federal Taxpayer's Identification Number	N/A	
2000A	ENT04	Organization Identification Code	AN	2/80	R				N/A	
2200A	ADX	ORGANIZATION SUMMARY REMITTANCE LEVEL ADJUSTMENT FOR PREVIOUS PAYMENT		1/1	S	>1	To convey accounts-payable adjustment information for the purpose of cash application, including payer-generated debit/credit memos	Required when the paid amount reflects adjustments related to previous payments.	N/A	IGNORE THIS SEGMENT
2200A	ADX01	Premium Payment Adjustment Amount	R	1/18	R				N/A	
2200A	ADX02	Premium Payment Adjustment Reason	ID	2/2	R		Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment	52 = Credit for Overpayment 53 = Remittance for Previous Underpayment 80 = Overpayment 81 = Credit as Agreed 86 = Duplicate Payment BJ I= nsurance Charge H1 = Information Forthcoming H6 = Partial Payment Remitted RU = Interest WO = Overpayment Recovery WW = Overpayment Credit	N/A	
2300A	RMR	ORGANIZATION SUMMARY REMITTANCE DETAIL		1/1	R	>1	To specify the accounts receivable open item(s) to be included in the cash application and to convey the appropriate detail	The RMR segment is essential to fulfilling the balancing requirements.	N/A	IGNORE THIS SEGMENT
2300A	RMR01	Reference Identification Qualifier	ID	2/3	R			11 = Account Number 1L = Group or Policy Number CT = Contract Number IK = Invoice Number	N/A	Parties using this segment should agree on the content of RMR01 and RMR02 prior to initiating communication.
2300A	RMR02	Contract, Invoice, Account, Group, or Policy Number	AN	1/50	R		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		N/A	Required when specified by the terms of the trading partner agreement
2300A	RMR03	Payment Action Code	ID	2/2	S		It specifies how the cash is to be applied	PA = Payment in Advance PI = Pay Item PO = Payment on Account PP = Partial Payment	N/A	Required when specified by the terms of the trading partner agreement.
2300A	RMR04	Detail Premium Payment Amount	R	1/18	R		The amount being paid on this remittance item.		N/A	

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HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Implementation Guide Description	Allowed Values	Medical MCOS	Requirement Description
2300A	RMR05	Billed Premium Amount	R	1/18	S		the amount of invoice (including charges, less allowance) before terms discount (if discount is applicable) or debit amount or credit amount of referenced items.		N/A	This is required when the Insurer sent an Invoice and the paid amount is different than the amount invoiced.
2300A	REF	ORGANIZATION SUMMARY REMITTANCE DETAIL		>1	S			Required when the premium receiver needs additional identifying information pertaining to the organizational remittance details.	N/A	IGNORE THIS SEGMENT
2300A	REF01	Organizational Reference Identification Qualifier	ID	2/3	R		Code qualifying the Reference Identification	14 = Master Account Number 17 =Client Reporting Category 18 = Plan Number 2F = Consolidated Invoice Number 38 = Master Policy Number E9 = Attachment Code LB = Lockbox LU = Location Number ZZ = Mutually Defined	N/A	
2300A	REF02	Organizational Reference Identifier	AN	1/50	R				N/A	
2300A	DTM	ORGANIZATIONAL COVERAGE PERIOD		1	S		This segment relays the start and end date of the organizational coverage period associated with the premium payment in the current RMR segment when the date range indicator 582 is used. This segment relays the due date of the organizational coverage period associated with the premium payment in the currnent RMR segment when the due date indicator AAG is used.	Required when the premium payer is not paying from an invoice, but paying on account for a coverage period. The 2300A DTM overrides the DTM in the header when DTM01 = 582.	N/A	IGNORE THIS SEGMENT
2300A	DTM01	Date Time Qualifier	ID	3/3	R			582 = Report Period AAG = Due Date	N/A	
2300A	DTM02	Date	DT	8/8	S				N/A	Required when DTM01 is AAG.
2300A	DTM05	Date Time Period Format Qualifier	ID	2/3	R			RD8 = Range of Dates Expressed in Format CCYYMMDDCCYYMMDD	N/A	Required when DTM01 is 582.
2300A	DTM06	Coverage Period	AN	1/35	R				N/A	Required when DTM01 is 582.
2310A	IT1	Baseline Item Data		1	S	1	To specify the basic and most frequently used line item data for the invoice and related transactions	Required when additional charges exist, or when member counts are specified by the terms of the trading partner agreement.	N/A	IGNORE THIS SEGMENT
2310A	IT101	Line Item Control Number	AN	1/20	R		Assigned for uniqueness. Start with "1" and increment by "1" for every occurrence of the segment within a specific transaction.		N/A	
2312A	SAC	SERVICE, PROMOTION, ALLOWANCE, OR CHARGE INFORMATION		1/1	S	4	To request or identify a service, promotion, allowance, or charge; to specify the amount or percentage for the service, promotion, allowance, or charge	Required when additional charges exist, or when member counts are specified by the terms of the trading partner agreement.	N/A	IGNORE THIS SEGMENT
2312A	SAC01	Allowance or Charge Indicator	ID	1/1	R		Code which indicates an allowance or charge for the service specified	C = Charge	N/A	Required when additional charges must be reported.
2312A	SAC02	Service, Promotion, Allowance, or Charge Code	ID	4/4	R		Code identifying the service, promotion, allowance, or charge	A172 = Administrative B680 = Contract Service Charge D940 = Insurance Premium G740 = Service Charge	N/A	
2312A	SAC05	Amount	N2	1/15	R		The total amount for the service, promotion, allowance, or charge.		N/A	
2315A	SLN	MEMBER COUNT		1/1	S	3	The member count is the total number of members included in the summary line item payment (2300A/RMR)	Required when member counts are specified by the terms of the trading partner agreement.	N/A	IGNORE THIS SEGMENT
2315A	SLN01	Line Item Control Number	AN	1/20	R		SLN01 is related to (but not necessarily equivalent to) the baseline item number.		N/A	Assigned for uniqueness. Start with "1" and increment by "1" for every occurrence of the segment within a specific transaction.
2315A	SLN03	Information Only Indicator	ID	1/1	R		It is the configuration code indicating the relationship of the subline item to the baseline item.	O = Information Only	N/A	
2315A	SLN04	Head Count	R	1/5	R		This is the number of contract holders with the type of coverage identified in SLN05-1.		N/A	
2315A	SLN05	COMPOSITE UNIT OF MEASURE							N/A	

Comments

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Implementation Guide Description	Allowed Values	Medical MCOS	Requirement Description
2315A	SLN05-1	Unit or Basis for Measurement Code	ID	2/2	R		Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken	**10 = Group** (Used to identify that the value in SLN04 represents the number of contract holders with Family coverage.) **IE = Person (**Used to identify that the value of SLN04 represents the number of contract holders with Individual coverage.) **PR = Pair** (Used to identify that the value in SLN04 represents the number of contract holders with Self and Spouse Only coverage.)	N/A	
2320A	ADX	ORGANIZATION SUMMARY REMITTANCE LEVEL ADJUSTMENT FOR CURRENT PAYMENT		1	S	>1	To convey accounts-payable adjustment information for the purpose of cash application, including payer-generated debit/credit memos	Required when the paid amount differs from the billed amount (RMR05 is present) in the related RMR segment and the difference is not completely accounted for by amounts in related SAC segments, position 5.	N/A	IGNORE THIS SEGMENT
2320A	ADX01	Adjustment Amount	R	1/18	R		It specifies the amount of the adjustment and must be signed if negative. If negative, it reduces the payment amount; if positive, it increases the payment amount.		N/A	
2320A	ADX02	Adjustment Reason Code	ID	2/2	R		This segment specifies the reason for claiming the adjustment	**20 = Balance Due Declined** (Indicates the entire balance due is being disputed.) **52 = Credit for Overpayment** **53 = Remittance for Previous Underpayment** **AA = Prepaid Benefit or Advances** **AX = Person No Longer Employed** **H1 = Information Forthcoming** (Detailed information related to the adjustment will be provided through a separate mechanism.) **H6 = Partial Payment Remitted** **IA = Invoice Amount Does Not Match Account Analysis Statement** **J3 = Promised Adjustment Not Received**	N/A	
2000B	ENT	INDIVIDUAL REMITTANCE		1	S	>1	To designate the entities which are parties to a transaction and specify a reference meaningful to those entities			Required when providing remittance line items that pertain to an individual enrolled in a group plan.
2000B	ENT01	Assigned Number	N0	1/6	R		Number assigned for differentiation within a transaction set		Set automatically by map (begins with 1)	Number assigned to each child detailed in the 2000B loop
2000B	ENT02	Entity Identifier Code	ID	2/3	R		Code identifying an organizational entity, a physical location, property or an individual	2J = Individual	2J	Default to 2J = Individual
2000B	ENT03	Identification Code Qualifier	ID	1/2	R			34 = Social Security Number EI = Employee Identification Number II = Standard Unique Health Identifier for each Individual in the United States	34	Default to 34 = Social Security Number
2000B	ENT04	Receiver's Individual Identifier	AN	2/80	R		This is the identification number of the individual used by the receiver.		SSN	Member's SSN
2100B	NM1	INDIVIDUAL NAME		1/1	S	1				
2100B	NM101	Entity Identifier Code	ID	2/3	R			DO = Dependent Name EY = Employee Name IL = Insured or Subscriber QE = Policyholder	IL	Default to IL = Insured or Subscriber
2100B	NM102	Entity Type Qualifier	ID	1/1	R			1 = Person	1	Default to 1 = Person
2100B	NM103	Individual Last Name	AN	1/60	S				Last Name	This is required when the sender needs to relay the individual's last name.
2100B	NM104	Individual First Name	AN	1/35	S				First Name	This is required when the sender needs to relay the individual's first name.
2100B	NM105	Individual Middle Name	AN	1/25	S				Middle Name	This is required when the sender needs to relay the individual's middle name.
2100B	NM106	Individual Name Prefix	AN	1/10	S				N/A	This is required when the sender needs to relay the individual's prefix
2100B	NM107	Individual Name Suffix	AN	1/10	S				Suffix	This is required when the sender needs to relay the individual's Suffix
2100B	NM108	Identification Code Qualifier	ID	1/2	R			34 = Social Security Number EI = Employee Identification Number N = Insured's Unique Identification Number	N 34 = Social Security Number	This is required when the sender needs to relay a unique identifier that is associated to the individual. Default to N = Insured's Unique Identification Number

Comments

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Implementation Guide Description	Allowed Values	Medical MCOS	Requirement Description	Comments
2100B	NM109	Individual Identifier	AN	2/80	R				All other MCOs = PERSON_NUMBER (length 10, left pad zero)	Required when the sender needs to relay a unique identifier that is associated to the individual.	
2200B	ADX	INDIVIDUAL PREMIUM ADJUSTMENT FOR PREVIOUS PAYMENT		1	S	>1	To convey accounts-payable adjustment information for the purpose of cash application, including payer-generated debit/credit memos	Required when the paid amount reflects adjustments related to previous payments.	N/A	IGNORE THIS SEGMENT	
2200B	ADX01	Premium Payment Adjustment Amount	R	41292	R			Contract Rate as positive value if for type of enrollment; (along with ADX02 = 53) Contract Rate as negative value if for type of disenrollment/void; (along with ADX02 = 52)	N/A	N/A	
2200B	ADX02	Premium Payment Adjustment Reason	ID	41307	R		Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment	52 = Credit for Overpayment 53 = Remittance for Previous Underpayment 80 = Overpayment 81 = Credit as Agreed 86 = Duplicate Payment BJ = Insurance Charge H1 = Information Forthcoming H6 = Partial Payment Remitted RU = Interest WO = Overpayment Recovery WW = Overpayment Credit	N/A	N/A	
2300B	RMR	INDIVIDUAL PREMIUM REMITTANCE DETAIL		1	R	>1	To specify the accounts receivable open item(s) to be included in the cash application and to convey the appropriate detail			This loop includes detailed remittance information related to an employee or member of a group plan. Included are all enrollments, reinstatements, new enrollments for the coverage month shown in 2300B/DTM06 and/or retro disenrolllments or enrollments from a prior coverage month.	In the previoius implementation, MAXIMUS was creating an RMR segment with a zero amount when a child ONLY had a retro row and was not covered in the current coverage month. This will no long be the case. Only actual coverages will be represented in the 2300B loop.
2300B	RMR01	Reference Identification Qualifier	ID	2/3	R			11 = Account Number 9J = Pension Contract AZ = Health Insurance Policy Number B7 = Life Insurance Policy Number CT = Contract Number ID = Insurance Certificate Number IG = Insurance Policy Number IK = Invoice Number KW = Certification	AZ (if not BCBC) IG (If BCBC)	Parties using this segment should agree on the content of RMR01 and RMR02 prior to initiating communication. AZ = Health Insurance Policy Number	
2300B	RMR02	Insurance Remittance Reference Number	AN	1/50	R		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		Insurance Number (if not BCBC) See Reference Data for BCBC numbers by county to set	Health Plan Assignment Insurance Number assigned by VIDA	
2300B	RMR03	Payment Action Code	AN	2/2	S		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		Else, omit		
2300B	RMR04	Detail Premium Payment Amount	R	1/18	R		The amount being paid on this remittance item.		Capitation amount	Contract Rate in assigned Health Plan County Format = S99999999999999.99	
2300B	RMR05	Billed Premium Amount	R	1/18	S		the amount of invoice (including charges, less allowance) before terms discount (if discount is applicable) or debit amount or credit amount of referenced items.		N/A	Required when the Insurer sent an Invoice and the paid amount is different than the amount invoiced.	
2300B	REF	INDIVIDUAL PREMIUM REMITTANCE DETAIL		>1	S				N/A	Required when the premium receiver needs additional identifying information pertaining to the Individual remittance details.	
2300B	REF01	Organizational Reference Identification Qualifier	ID	2/3	R		Code qualifying the Reference Identification	14 = Master Account Number 18 = Plan Number 2F = Consolidated Invoice Number 38 = Master Policy Number E9 = Attachment Code LU = Location Number ZZ = Mutually Defined	14	Family Account Number	
2300B	REF02	Organizational Reference Identifier	AN	1/50	R				Family Account Number	Populate the child's family account number	

HDR / Loop / TRL	Segment / Element Identifier	Element Name	ID	Segment Rpt / Element Min-Max	Req / Sit	Envelope Rpt / Loop Rpt	Implementation Guide Description	Allowed Values	Medical MCOS	Requirement Description	Comments
2300B	REF	INDIVIDUAL PREMIUM REMITTANCE DETAIL		>1	S				N/A	Required when the premium receiver needs additional identifying information pertaining to the Individual remittance details.	
2300B	REF01	Organizational Reference Identification Qualifier	ID	2/3	R		Code qualifying the Reference Identification	14 = Master Account Number 18 = Plan Number 2F = Consolidated Invoice Number 38 = Master Policy Number E9 = Attachment Code LU = Location Number ZZ = Mutually Defined	ZZ	Default to ZZ = Mutually Defined	
2300B	REF02	Organizational Reference Identifier	AN	1/50	R				Child's county;	Populate the Child's County	
2300B	DTM	INDIVIDUAL COVERAGE PERIOD		1	S		This segment relays the start and end date of the organizational coverage period associated with the premium payment in the current RMR segment when the date range indicator 582 is used. This segment relays the due date of the organizational coverage period associated with the premium payment in the currnent RMR segment when the due date indicator AAG is used.			Required when the premium payer is not paying from an invoice, but paying on account for a coverage period. The 2300A DTM overrides the DTM in the header when DTM01 = 582.	
2300B	DTM01	Date Time Qualifier	ID	3/3	R			582 = Report Period AAG = Due Date	582	Default to 582 = Report Period	
2300B	DTM02	Date	DT	8/8	S				N/A	Required when DTM01 is AAG.	
2300B	DTM05	Date Time Period Format Qualifier	ID	2/3	R			RD8 = Range of Dates Expressed in Format CCYYMMDDCCYYMMDD	RD8 = Range of Dates Expressed in Format CCYYMMDD - CCYYMMDD	Required when DTM01 is 582.	
2300B	DTM06	Coverage Period	AN	1/35	R				Coverage Begin - End Date CCYYMMDD - CCYYMMDD	Coverage begin and end date for the current coverage month based on the selection criteria	
2320B	ADX	INDIVIDUAL PREMIUM ADJUSTMENT FOR CURRENT PAYMENT		1	S	>1	To convey accounts-payable adjustment information for the purpose of cash application, including payer-generated debit/credit memos	Required when the paid amount differs from the billed amount (RMR05 is present) in the related RMR segment.	N/A	IGNORE THIS SEGMENT	
2320B	ADX01	Adjustment Amount	R	1/18	R		It specifies the amount of the adjustment and must be signed if negative. If negative, it reduces the payment amount; if positive, it increases the payment amount.		N/A		
2320B	ADX02	Adjustment Reason Code	ID	2/2	R		This segment specifies the reason for claiming the adjustment	**20 = Balance Due Declined** (Indicates the entire balance due is being disputed.) **52 = Credit for Overpayment** **53 = Remittance for Previous Underpayment** **AA = Prepaid Benefit or Advances** **AX = Person No Longer Employed** **H1 = Information Forthcoming** (Detailed information related to the adjustment will be provided through a separate mechanism.) **H6 = Partial Payment Remitted** **IA = Invoice Amount Does Not Match Account Analysis Statement** **J3 = Promised Adjustment Not Received**	N/A		
TLR	SE	TRANSACTION SET TRAILER		1/1	R	≥1					
TLR	SE01	Transaction Segment Count	N0	1/10	R				Set at End of File.	Calculated	
TLR	SE02	Transaction Set Control Number	AN	4/9	R				Set at End of File.		
TLR	GE	FUNCTION GROUP TRAILER			R	1					
TLR	GE01	Number of Transaction Sets Included	N0	1/6	R				Set at End of File. Hardcode to '1'		
TLR	GE02	Group Control Number	N0	1/9	R				Set at End of File.		
TLR	IEA	INTERCHANGE CONTROL TRAILER			R	1					
TLR	IEA01	Number of Included Functional Groups	N0	1/5	R				Set at End of File.		
TLR	IEA02	Interchange Control Number	N0	9/9	R				Set at End of File.		

As of Sept. 2015, each FL county is associated to a region. FI41 / 820 file sends the member's county in the 2300B/REF02 element which can be used to cross reference to the Region noted in this tab.

Sort by County			
County	Region	County	Region
ALACHUA	3	LEE	8
BAKER	4	LEON	2
BAY	2	LEVY	3
BRADFORD	3	LIBERTY	2
BREVARD	7	MADISON	2
BROWARD	10	MANATEE	6
CALHOUN	2	MARION	3
CHARLOTTE	8	MARTIN	9
CITRUS	3	MIAMI_DADE	11
CLAY	4	MONROE	11
COLLIER	8	NASSAU	4
COLUMBIA	3	OKALOOSA	1
DESOTO	8	OKEECHOBEE	9
DIXIE	3	ORANGE	7
DUVAL	4	OSCEOLA	7
ESCAMBIA	1	PALM_BEACH	9
FLAGLER	4	PASCO	5
FRANKLIN	2	PINELLAS	5
GADSDEN	2	POLK	6
GILCHRIST	3	PUTNAM	3
GLADES	8	SANTA_ROSA	1
GULF	2	SARASOTA	8
HAMILTON	3	SEMINOLE	7
HARDEE	6	SAINT_JOHNS	4
HENDRY	8	SAINT_LUCIE	9
HERNANDO	3	SUMTER	3
HIGHLANDS	6	SUWANNEE	3
HILLSBOROUGH	6	TAYLOR	2
HOLMES	2	UNION	3
INDIAN_RIVER	9	VOLUSIA	4
JACKSON	2	WAKULLA	2
JEFFERSON	2	WALTON	1
LAKE	3	WASHINGTON	2
LAFAYETTE	3		

Sort by Region/County			
County	Region	County	Region
ESCAMBIA	1	BAKER	4
OKALOOSA	1	CLAY	4
SANTA_ROSA	1	DUVAL	4
WALTON	1	FLAGLER	4
BAY	2	NASSAU	4
CALHOUN	2	SAINT_JOHNS	4
FRANKLIN	2	VOLUSIA	4
GADSDEN	2	PASCO	5
GULF	2	PINELLAS	5
HOLMES	2	HARDEE	6
JACKSON	2	HIGHLANDS	6
JEFFERSON	2	HILLSBOROUGH	6
LEON	2	MANATEE	6
LIBERTY	2	POLK	6
MADISON	2	BREVARD	7
TAYLOR	2	ORANGE	7
WAKULLA	2	OSCEOLA	7
WASHINGTON	2	SEMINOLE	7
ALACHUA	3	CHARLOTTE	8
BRADFORD	3	COLLIER	8
CITRUS	3	DESOTO	8
COLUMBIA	3	GLADES	8
DIXIE	3	HENDRY	8
GILCHRIST	3	LEE	8
HAMILTON	3	SARASOTA	8
HERNANDO	3	INDIAN_RIVER	9
LAFAYETTE	3	MARTIN	9
LAKE	3	OKEECHOBEE	9
LEVY	3	PALM_BEACH	9
MARION	3	SAINT_LUCIE	9
PUTNAM	3	BROWARD	10
SUMTER	3	MIAMI_DADE	11
SUWANNEE	3	MONROE	11
UNION	3		