CONTRACT WITH ELIGIBLE MEDICARE ADVANTAGE (MA) ORGANIZATION PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A MEDICARE ADVANTAGE COORDINATED CARE PLAN(S)

CONTRACT (H4007)

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as CMS)

and

HUMANA HEALTH PLANS OF PUERTO RICO, INC.
(hereinafter referred to as the MA Organization)

CMS and the MA Organization, an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR §422.503, agree to the following for the purposes of §§ 1851 through 1859 of the Social Security Act (hereinafter referred to as the Act):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the regulatory authority for certain contract provisions. All references to Part 422 are to 42 CFR Part 422.)

Article I
Term of Contract

The term of this contract shall be from the date of signature by CMS' authorized representative through December 31, 2020, after which this contract may be renewed for successive one-year periods in accordance with 42 CFR §422.505(c) and as discussed in Paragraph A of Article VII below. **[422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above, and supersedes any prior agreements between the MA Organization and CMS as of such date. MA organizations offering Part D benefits also must execute an Addendum to the Medicare Managed Care Contract Pursuant to §§ 1860D-1 through 1860D-43 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereafter the "Part D Addendum"). For MA Organizations offering MA-PD plans, the Part D Addendum governs the rights and obligations of the parties relating to the provision of Part D benefits, in accordance with its terms, as of its effective date.

Article II
Coordinated Care Plan

A. The MA Organization agrees to operate one or more coordinated care plans as defined in 42 CFR §422.4(a)(1)(iii)), including at least one MA-PD plan as required under 42 CFR §422.4(c), as described in its final Plan Benefit Package (PBP) bid submission (benefit and price bid) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan and Price, and in compliance with the requirements of this contract and applicable Federal statutes, regulations, and policies (e.g., policies as described in the Call Letter, Medicare Managed Care Manual, etc.).

B. Except as provided in paragraph (C) of this Article, this contract is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations or policies implementing or interpreting such statutory provisions.

C. CMS will not implement, other than at the beginning of a calendar year, requirements under 42 CFR Part 422 that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute. **[422.521]**

D. If the MA Organization had a contract with CMS for Contract Year 2019 under the contract ID number designated above, this document is considered a renewal of the existing contract. While the terms of this document supersede the terms of the 2019 contract, the parties' execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2019 or prior year contracts.

E. This contract is in no way intended to supersede or modify 42 CFR, Part 422. Failure to reference a regulatory requirement in this contract does not affect the applicability of such requirements to the MA organization and CMS.

Article III
Functions To Be Performed By Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. The MA Organization agrees to provide enrollees in each of its MA plans the basic benefits as required under 42 CFR §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final benefit and price bid proposal as approved by CMS and listed in the MA Organization Plan Attestation of Benefit Plan and Price, which is attached to this contract. The MA Organization agrees to provide access to such benefits as required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in 42 CFR §422.112.

2. The MA Organization agrees to provide post-hospital extended care services, should an MA enrollee elect such coverage, through a home skilled nursing facility, as defined at 42 CFR §422.133(b), according to the requirements of § 1852(l) of the Act and 42 CFR §422.133. **[422. 133; 422.504(a)(3)]**

B. ENROLLMENT REQUIREMENTS

1. The MA Organization agrees to accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in 42 CFR Part 422, Subpart B.

2. The MA Organization shall comply with the provisions of 42 CFR §422.110 concerning prohibitions against discrimination in beneficiary enrollment, other than in enrolling eligible beneficiaries in a CMS-approved special needs plan that exclusively enrolls special needs individuals as consistent with 42 CFR §§422.2, 422.4(a)(1)(iv) and 422.52. **[422.504(a)(2)]**

C. BENEFICIARY PROTECTIONS

1. The MA Organization agrees to comply with all requirements in 42 CFR Part 422, Subpart M governing coverage determinations, grievances, and appeals. **[422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in 42 CFR §422.118.

3. Beneficiary Financial Protections. The MA Organization agrees to comply with the following requirements:

(3.a) Each MA Organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the MA Organization. To meet this requirement the MA Organization must—

(3.a.i) Ensure that all contractual or other written arrangements with providers prohibit the Organization's providers from holding any beneficiary enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(3.a.ii) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the MA Organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA Organization, to provide services to the organization's beneficiary enrollees.

[422.504(g)(1)]

(3.a.iii) Ensure that the enrollee does not have any financial liability for services, items, or drugs furnished, ordered, or prescribed to the enrollee by an MA contracting individual or entity on the preclusion list, as defined and described in 42 CFR § 422.2 and 422.222. [422.504(g)(1))iv)]

(3.b) The MA Organization must provide for continuation of enrollee health care benefits-

(3.b.i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(3.b.ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of the MA Organization's insolvency, through the date of discharge. **[422.504(g)(2)]**

(3.c) In meeting the requirements of this paragraph, other than the provider contract requirements specified in subparagraph 3(a) of this paragraph, the MA Organization may use—

(3.c.I) Contractual arrangements;

(3.c.II) Insurance acceptable to CMS;

(3.c.III) Financial reserves acceptable to CMS; or

(3.c.iv) Any other arrangement acceptable to CMS. **[422.504(g)(3)]**

D. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable provider requirements in 42 CFR Part 422 Subpart E, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, limits on physician incentive plans, and preclusion list requirements in 42 CFR §§422.222, 422.224. **[422.504(a)(6)]**

2. The MA Organization agrees to ensure that the plan's provider agreement contains a provision stating that after the expiration of the 60-day period specified in 42 CFR §422.222:

(2.a) The provider will no longer be eligible for payment from the plan and will be prohibited from pursuing payment from the beneficiary as stipulated by the terms of the contract between CMS and the plan per 42 CFR §422.504(g)(1)(iv); and

(2.b) The provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period, at which point the provider will have already received notification of the preclusion. [422.504(g)(1)(v)]

3. Prompt Payment.

(3.a) The MA Organization must pay 95 percent of "clean claims" within 30 days of receipt if they are claims for covered services that are not furnished under a written agreement between the organization and the provider.

(2.a.i) The MA Organization must pay interest on clean claims that are not paid within 30 days in accordance with §§ 1816(c)(2) and 1842(c)(2) of the Act.

(2.a.ii) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request. **[422.520(a)]**

(3.b) Contracts or other written agreements between the MA Organization and its providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA Organization and the relevant provider. **[422.520(b)]**

(3.c) If CMS determines, after giving notice and opportunity for hearing, that the MA Organization has failed to make payments in accordance with subparagraph (2)(a) of this paragraph, CMS may provide-

(2.c.I) For direct payment of the sums owed to providers; and

(2.c.II) For appropriate reduction in the amounts that would otherwise be paid to the MA Organization, to reflect the amounts of the direct payments and the cost of making those payments. **[422.520(c)]**

4. Agreements with Federally Qualified Health Centers (FQHC)

(4.a) The MA Organization agrees to pay an FQHC a similar amount to what it pays other providers for similar services.

(4.b) Under such a contract, the FQHC must accept this payment as payment in full, except for allowable cost sharing which it may collect.

(4.c) Financial incentives, such as payments or bonuses, and financial withholdings are not considered in determining the payments made by CMS under 42 CFR §422.316(a). [42 CFR §422.527]

E. QUALITY IMPROVEMENT PROGRAM

1. The MA Organization agrees to operate, for each plan that it offers, an ongoing quality improvement program in accordance with § 1852(e) of the Social Security Act and 42 CFR §422.152.

2. The MA Organization agrees to develop and operate a chronic care improvement program in accordance with the requirements of 42 CFR §422.152(c).

3. Performance Measurement and Reporting: The MA Organization shall measure performance under its MA plans using standard measures required by CMS, and report (at the organization level) its performance to CMS. The standard measures required by CMS during the term of this contract will be uniform data collection and reporting instruments, to include the Health Plan and Employer Data Information Set (HEDIS), Consumer Assessment of Health Plan Satisfaction (CAHPS) survey, and Health Outcomes Survey (HOS). These measures will address clinical areas, including effectiveness of care, enrollee perception of care and use of services; and non-clinical areas including access to and availability of services, appeals and grievances, and organizational characteristics. **[422.152 & 422.162(c)]**

4. Utilization Review:

(4.a) An MA Organization for an MA coordinated care plan must use written protocols for utilization review and policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and have in effect mechanisms to detect both underutilization and over utilization of services. **[422.152(b)]**

(4.b) For MA regional preferred provider organizations (RPPOs) and MA local preferred provider organizations (PPOs) that are offered by an organization that is not licensed or organized under State law as an HMOs, if the MA Organization uses written protocols for utilization review, those policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and include mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation. **[422.152(e)]**

5. Information Systems:

(5.a) The MA Organization must:

(5.a.i) Maintain a health information system that collects, analyzes and integrates the data necessary to implement its quality improvement program;

(5.a.ii) Ensure that the information entered into the system (particularly that received from providers) is reliable and complete;

(5.a.iii) Make all collected information available to CMS. **[422.152(f)(1)]**

6. External Review: The MA Organization will comply with any requests by Quality Improvement Organizations to review the MA Organization's medical records in connection with appeals of discharges from hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and home health agencies.

7. The MA Organization agrees to address complaints received by CMS against the MA Organization by:

(7.a) Addressing and resolving complaints in the CMS complaint tracking system; and

(7.b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the MA plan's main Web page.**[422.504(a)(15)]**

F. COMPLIANCE PLAN

The MA Organization agrees to implement a compliance plan in accordance with the requirements of 42 CFR §422.503(b)(4)(vi). **[422.503(b)(4)(vi)]**

G. COMPLIANCE DEEMED ON THE BASIS OF ACCREDITATION

CMS may deem the MA Organization to have met the quality improvement requirements of §1852(e) of the Act and 42 CFR §422.152, the confidentiality and accuracy of enrollee records requirements of §1852(h) of the Act and 42 CFR §422.118, the anti-discrimination requirements of §1852(b) of the Act and 42 CFR §422.110, the access to services requirements of §1852(d) of the Act and 42 CFR §422.112, the advance directives requirements of §1852(l) of the Act and 42 CFR §422.128, the provider participation requirements of §1852(j) of the Act and 42 CFR Part 422, Subpart E, and the applicable requirements described in 42 CFR §423.156, if the MA Organization is fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by CMS and the accreditation organization used the standards approved by CMS for the purposes of assessing the MA Organization's compliance with Medicare requirements. The provisions of 42 CFR §422.156 shall govern the MA Organization's use of deemed status to meet MA program requirements.

H. PROGRAM INTEGRITY

1. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS of any integrity items related to payments from governmental entities, both federal and state, for healthcare or prescription drug services. These items include any investigations, legal actions or matters subject to arbitration brought involving the MA Organization (or MA Organization's firm if applicable) and its subcontractors (excluding contracted network providers), including any key management or executive staff, or any major shareholders (5% or more), by a government agency (state or federal) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. In providing the notice, the sponsor shall keep the government informed of when the integrity item is initiated and when it is closed. Notice should be provided of the details concerning any resolution and monetary payments as well as any settlement agreements or corporate integrity agreements.

2. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS in the event the MA Organization or any of its subcontractors is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services.

I. MARKETING

1. The MA Organization may not distribute any marketing materials, as defined in 42 CFR §422.2260 and in the Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans and Prescription Drug Plans (Medicare Marketing Guidelines), unless they have been filed with and not disapproved by CMS in accordance with 42 CFR §422.2264. The file and use process set out at 42 CFR §422.2262 must be used, unless the MA organization notifies CMS that it will not use this process.

2. CMS and the MA Organization shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The MA Organization bears full responsibility for the accuracy of its marketing materials. CMS, in its sole discretion, may order the MA Organization to print and distribute the agreed upon marketing materials, in a format approved by CMS. The MA Organization must disclose the information to each enrollee electing a plan as outlined in 42 CFR §422.111.

3. The MA Organization agrees that any advertising material, including that labeled promotional material, marketing materials, or supplemental literature, shall be truthful and not misleading. All marketing materials must include the Contract number. All membership identification cards must include the Contract number on the front of the card.

4. The MA Organization must comply with all applicable statutes and regulations, including and without limitation § 1851(h) of the Act and 42 CFR § 422.111, 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V, consistent with guidance provided in the Medicare Communication and Marketing Guidelines. Failure to comply may result in sanctions as provided in 42 CFR Part 422 Subpart O.

Article IV
CMS Payment to MA Organization

A. The MA Organization agrees to develop its annual benefit and price bid proposal and submit to CMS all required information on premiums, benefits, and cost sharing, as required under 42 CFR Part 422 Subpart F. **[422.504(a)(10)]**

B. METHODOLOGY

CMS agrees to pay the MA Organization under this contract in accordance with the provisions of § 1853 of the Act and 42 CFR Part 422 Subpart G. **[422.504(a)(9)]**

C. ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM PAYMENTS

The MA Organization agrees to abide by the requirements in 42 CFR §§495.200 et seq. and §1853(l) and (m) of the Act, including the fact that payment will be made directly to MA-affiliated hospitals that are certified Medicare hospitals through the Medicare FFS hospital incentive payment program.

D. ATTESTATION OF PAYMENT DATA (Attachments A, B, and C).

As a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G, the MA Organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on the forms attached hereto as Attachment A (enrollment attestation) and Attachment B (risk adjustment data) which attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data identified on these attachments. The Medicare Advantage Plan Attestation of Benefit Plan and Price must be signed and attached to the executed version of this contract.

(NOTE: The forms included as attachments to this contract are for reference only. CMS will provide instructions for the completion and submission of the forms in separate documents. MA Organizations should not take any action on the forms until appropriate CMS instructions become available.)

1. Attachment A requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization. The MA Organization shall submit completed enrollment attestation forms to CMS, or its contractor, on a monthly basis.

2. Attachment B requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the risk adjustment data it submits to CMS under 42 CFR §422.310 are accurate, complete, and truthful. The MA Organization shall make annual attestations to this effect for risk adjustment data on Attachment B and according to a schedule to be published by CMS. If such risk adjustment data are generated by a related entity, contractor, or subcontractor of an MA Organization, such entity, contractor, or subcontractor must <u>also</u>*attest to (based on best knowledge, information, and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data. **[422.504(l)]**

3. The Medicare Advantage Plan Attestation of Benefit Plan and Price (an example of which is attached hereto as Attachment C) requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposed bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposed bid submission. This document is being sent separately to the MA Organization and must be signed and attached to the executed version of this contract, and is incorporated herein by reference. **[422.504(i)]**

Article V
MA Organization Relationship with Related Entities, Contractors, and Subcontractors

A. Notwithstanding any relationship(s) that the MA Organization may have with first tier, downstream, or related entities, the MA Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. **[422.504(i)(1)]**

B. The MA Organization agrees to require all first tier, downstream, and related entities to agree that—

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of the first tier, downstream, and related entities related to CMS' contract with the MA organization;

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph B (1) of this Article directly from any first tier, downstream, or related entity;

3. For records subject to review under paragraph B(2) of this Article, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated; and

4. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. **[422.504(i)(2)]**

C. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with first tier, downstream, and related entities shall contain the following elements:

1. Enrollee protection provisions that provide—

(1.a) Consistent with Article III, paragraph C, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(1.b) Consistent with Article III, paragraph C, provision for the continuation of benefits.

2. Accountability provisions that indicate that the MA Organization may only delegate activities or functions to a first tier, downstream, or related entity in a manner consistent with requirements set forth at paragraph D of this Article.

3. A provision requiring that any services or other activity performed by a first tier, downstream, and related entity in accordance with a contract or written agreement will be consistent and comply with the MA Organization's contractual obligations.**[422.504(i)(3)]**

D. If any of the MA Organization's activities or responsibilities under this contract with CMS is delegated to other parties, the following requirements apply to any related entity, contractor, subcontractor, or provider:

1. Each and every contract must specify delegated activities and reporting responsibilities.

2. Each and every contract must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA Organization determine that such parties have not performed satisfactorily.

3. Each and every contract must specify that the performance of the parties is monitored by the MA Organization on an ongoing basis.

4. Each and every contract must specify that either-

(4.a) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA Organization; or

(4.b) The credentialing process will be reviewed and approved by the MA Organization and the MA Organization must audit the credentialing process on an ongoing basis.

5. Each and every contract must specify that the first tier, downstream, or related entity comply with all applicable Medicare laws, regulations, and CMS instructions. **[422.504(i)(4)]**

E. If the MA Organization delegates selection of the providers, contractors, or subcontractors to another organization, the MA Organization's contract with that organization must state that the CMS-contracting MA Organization retains the right to approve, suspend, or terminate any such arrangement. **[422.504(i)(5)]**

F. As of the date of this contract and throughout its term, the MA Organization

1. Agrees that any physician incentive plan it operates meets the requirements of 42 CFR §422.208, and

2. Has assured that all physicians and physician groups that the MA Organization's physician incentive plan places at substantial financial risk have adequate stop-loss protection in accordance with 42 CFR §422.208(f). **[422.208]**

Article VI
Records Requirements

A. MAINTENANCE OF RECORDS

1. The MA Organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that-

(1.a) Are sufficient to do the following:

(1.a.i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the benefit and price bid) of the MA Organization.

(1.a.ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the MA Organization.

(1.a.iii) Enable CMS to audit and inspect any books and records of the MA Organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(1.a.iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the benefit and price bid proposal.

(1.a.v) Establish component rates of the benefit and price bid for determining additional and supplementary benefits.

(1.a.vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(1.b) Include at least records of the following:

(1.b.i) Ownership and operation of the MA Organization's financial, medical, and other record keeping systems.

(1.b.ii) Financial statements for the current contract period and ten prior periods.

(1.b.iii) Federal income tax or informational returns for the current contract period and ten prior periods.

(1.b.iv) Asset acquisition, lease, sale, or other action.

(1.b.v) Agreements, contracts (including, but not limited to, with related or unrelated prescription drug benefit managers) and subcontracts.

(1.b.vi) Franchise, marketing, and management agreements.

(1.b.vii) Schedules of charges for the MA Organization's fee-for-service patients.

(1.b.viii) Matters pertaining to costs of operations.

(1.b.ix) Amounts of income received, by source and payment.

(1.b.x) Cash flow statements.

(1.b.xi) Any financial reports filed with other Federal programs or State authorities.**[422.504(d)]**

2. Access to facilities and records. The MA Organization agrees to the following:

(2.a) The Department of Health and Human Services (HHS), the Comptroller General, or their designee may evaluate, through inspection or other means—

(2.a.i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(2.a.ii) Compliance with CMS requirements for maintaining the privacy and security of protected health information and other personally identifiable information of Medicare enrollees;

(2.a.iii) The facilities of the MA Organization; and

(2.a.iv) The enrollment and disenrollment records for the current contract period and ten prior periods.

(2.b) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, documents, papers, patient care documentation, and other records of the MA Organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(2.c) The MA Organization agrees to make available, for the purposes specified in paragraph A of this Article, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require.

(2.d) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the final date of the contract period or completion of audit, whichever is later unless-

(2.d.i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA Organization at least 30 days before the normal disposition date;

(2.d.ii) There has been a termination, dispute, or fraud or similar fault by the MA Organization, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(2.d.iii) HHS, the Comptroller General, or their designee determines that there is a reasonable possibility of fraud, in which case they may inspect, evaluate, and audit the MA Organization at any time. **[422.504(e)]**

B. REPORTING REQUIREMENTS

1. The MA Organization shall have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor patient relationship, statistics and other information as described in the remainder of this paragraph. **[422.516(a)]**

2. The MA Organization agrees to submit to CMS certified financial information that must include the following:

(2.a) Such information as CMS may require demonstrating that the organization has a fiscally sound operation, including:

(2.a.i) The cost of its operations;

(2.a.ii) A description, submitted to CMS annually and within 120 days of the end of the fiscal year, of significant business transactions (as defined in 42 CFR §422.500) between the MA Organization and a party in interest showing that the costs of the transactions listed in subparagraph (2)(a)(v) of this paragraph do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(2.a.iii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(2.a.iv) A combined financial statement for the MA Organization and a party in interest if either of the following conditions is met:

(2.a.iv.aa) Thirty five percent or more of the costs of operation of the MA Organization go to a party in interest.

(2.a.iv.bb) Thirty five percent or more of the revenue of a party in interest is from the MA Organization. **[422.516(b)]**

(2.a.v) Requirements for combined financial statements.

(2.a.v.aa) The combined financial statements required by this subparagraph must display in separate columns the financial information for the MA Organization and each of the parties in interest.

(2.a.v.bb) Inter-entity transactions must be eliminated in the consolidated column.

(2.a.v.cc) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(2.a.v.dd) Upon written request from the MA Organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in this subparagraph with respect to a particular entity. **[422.516(c)]**

(2.a.vi) A description of any loans or other special financial arrangements the MA Organization makes with contractors, subcontractors, and related entities. **[422.516(e)]**

(2.b) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA Organization. **[422.504(f)]**

(2.c) Patterns of utilization of the MA Organization's services. **[422.516(a)(2)]**

3. The MA Organization agrees to participate in surveys required by CMS and to submit to CMS all information that is necessary for CMS to administer and

evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(3.a) The benefits covered under the MA plan;

(3.b) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan.

(3.c) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(3.d) Plan quality and performance indicators for the benefits under the plan including —

(3.d.I) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(3.d.II) Information on Medicare enrollee satisfaction;

(3.d.III) The patterns of utilization of plan services;

(3.d.Iv) The availability, accessibility, and acceptability of the plan's services;

(3.d.v) Information on health outcomes and other performance measures required by CMS;

(3.d.vi) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(3.d.vII) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;

(3.d.viii) Information about beneficiary appeals and their disposition;

(3.d.Ix) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(3.d.x) Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program. **[422.504(f)(2)]**

4. The MA Organization agrees to provide to its enrollees and upon request, to any individual eligible to elect an MA plan, all informational requirements under 42 CFR §422.64 and, upon an enrollee's, request, the financial disclosure information required under 42 CFR §422.516. **[422.504(f)(3)]**

5. Reporting and disclosure under ERISA —

(5.a) For any employees' health benefits plan that includes an MA Organization in its offerings, the MA Organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the MA Organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(5.b) The MA Organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA. **[422.516(d)]**

6. Electronic communication. The MA Organization must have the capacity to communicate with CMS electronically. **[422.504(b)]**

7. Risk Adjustment data. The MA Organization agrees to comply with the requirements in 42 CFR §422.310 for submitting risk adjustment data to CMS. **[422.504(a)(8)]**

8. The MA Organization acknowledges that CMS releases to the public the following data, consistent with 42 CFR Part 422, Subpart K, and 42 CFR Part 423, Subpart K:

(8.a) summary reconciled Part C and Part D payment data after the reconciliation of Part C and Part D payments, as provided in 42 CFR §422.504(n)(1) and 42 CFR §423.505(o)(1);

(8.b) MA bid pricing data submitted during the annual bidding process, as described at 42 CFR §422.272;

(8.c) Part C Medical Loss Ratio data for the contract year, as described at 42 CFR §422.2490, and, for Part D plan sponsors, Part D Medical Loss Ratio data for the contract year, as described at 42 CFR §423.2490.

9. The MA Organization agrees that it must subject information collected pursuant to 42 CFR §422.516(a) to a yearly independent audit to determine their reliability, validity, completeness, and comparability in accordance with specifications developed by CMS. [422.516(g)]

Article VII
Renewal of the MA Contract

A. RENEWAL OF CONTRACT

In accordance with 42 CFR §422.505, following the initial contract period, this contract is renewable annually only if-

1. The MA Organization has not provided CMS with a notice of intention not to renew; **[422.506(a)]**

2. CMS and the MA Organization reach agreement on the bid under 42 CFR Part 422, Subpart F; and **[422.505(d)]**

3. CMS informs the MA Organization that it authorizes a renewal.

B. NONRENEWAL OF CONTRACT

1. In accordance with 42 CFR §422.506, the MA Organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason, provided it meets the time frames for doing so set forth in this subparagraph.

2. If the MA Organization does not intend to renew its contract, it must notify—

(2.a) CMS, in writing, by the first Monday in June of the year in which the contract would end, pursuant to 42 CFR §422.506

(2.b) Each Medicare enrollee by mail, at least 90 calendar days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area including alternative MA plans, MA-PD plans, Medigap options, and original Medicare and prescription drug plans and must receive CMS approval prior to issuance.

3. If the organization submits a request to end the term of its contract after the deadline in 42 CFR §422.506, CMS may mutually consent to terminate the contract pursuant to 42 CFR §422.508 when a nonrenewal notice is submitted after the applicable annual non-renewal notice deadline if—

(3.a) The contract termination does not negatively affect the administration of the Medicare program; and

(3.b) The MA Organization notifies its Medicare enrollees and the public in accordance with subparagraph 1(b)(ii) of this paragraph; and

4. If the MA Organization does not renew a contract under this subparagraph, CMS may deny an application for a new contract or a service area expansion from the Organization or with any organization whose covered persons, as defined at 42 CFR §422.506(a)(4), also served as covered persons for the non-renewing MA Organization for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS. This prohibition may apply regardless of

the product type, contract type, or service area of the previous contract. [422.506(a) & 422.508(c)]

Article VIII
Modification or Termination of the Contract

A. MODIFICATION OR TERMINATION OF CONTRACT BY MUTUAL CONSENT

1. This contract may be modified or terminated at any time by written mutual consent.

(1.a) If the contract is modified by written mutual consent, the MA Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within time frames specified by CMS. **[422.508(a)(2)]**

(1.b) If the contract is terminated by written mutual consent, except as provided in subparagraph 2 of this paragraph, the MA Organization must provide notice to its Medicare enrollees and the general public as provided in paragraph B, subparagraph 2(b) of this Article. **[422.508(a)(1)]**

2. If this contract is terminated by written mutual consent and replaced the day following such termination by a new MA contract, the MA Organization is not required to provide the notice specified in paragraph B of this Article.**[422.508(b)]**

3. As a condition of the consent to a mutual termination, CMS will require as a provision of the termination agreement language prohibiting the MA organization from applying for new contracts or service area expansions for a period of 2 years, absent circumstances warranting special consideration. This prohibition may apply regardless of the product type, contract type, or service area of the previous contract. **[422.508(c)]**

B. TERMINATION OF THE CONTRACT BY CMS OR THE MA ORGANIZATION

1. Termination by CMS.

(1.a) CMS may at any time terminate a contract if CMS determines that the MA Organization meets any of the following: [42 CFR §422.510(a)(1)-(3)]

(1.a.i) has failed substantially to carry out the terms of its contract with CMS.

(1.a.ii) is carrying out its contract in a manner that is inconsistent with the efficient and effective implementation of 42 CFR Part 422.

(1.a.iii) no longer substantially meets the applicable conditions of 42CFR Part 422.

(1.b) CMS may make a determination under paragraph B(1)(a)(i), (ii), or (iii) of this Article if the MA Organization has had one or more of the conditions listed in 42 CFR §422.510(a)(4) occur.

(1.c) Notice. If CMS decides to terminate a contract , it will give notice of the termination as follows: [42 CFR §422.510(b)(1)]

(1.c.i) CMS will notify the MA Organization in writing at least 45 calendar days before the intended date of the termination.

(1.c.ii) The MA Organization will notify its Medicare enrollees of the termination by mail at least 30 calendar days before the effective date of the termination.

(1.c.iii) The MA Organization will notify the general public of the termination at least 30 calendar days before the effective date of the termination by releasing a press statement to news media serving the affected community or county and posting the press statement prominently on the organization's Web site.

(1.c.iv) In the event that CMS issues a termination notice to an MA Organization on or before August 1 with an effective date of the following December 31, the MA Organization must issue notification to its Medicare enrollees at least 90 days prior to the effective date of termination.

(1.d) Expedited termination of contract by CMS. [42 CFR §422.510(b)(2)]

(1.d.i) For terminations based on violations prescribed in 42 CFR §422.510(a)(4)(i) or if CMS determines that a delay in termination would pose an imminent and serious threat to the health of the individuals enrolled with the MA Organization, CMS will notify the MA Organization in writing that its contract has been terminated on a date specified by CMS. If a termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA Organization covering the period of the month following the contract termination.

(1.d.ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS' decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the plan of its decision to terminate this contract. CMS will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA Organizations in a similar geographic area and original Medicare.

(1.d.iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS' decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(1.e) Corrective action plan [42 CFR §422.510(c)]

(1.e.i) General. Before providing a notice of intent to terminate a contract for reasons other than the grounds specified in subparagraph 1(d)(i) of this paragraph, CMS will provide the MA Organization with notice specifying the MA Organization's deficiencies and a reasonable opportunity of at least 30 calendar days to develop and implement an approved corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(1.e.ii) Exceptions. If a contract is terminated under subparagraph 1(d)(i) of this paragraph, the MA Organization will not be provided with the opportunity to develop and implement a corrective action plan.

(1.f) Appeal rights. If CMS decides to terminate this contract, it will send written notice to the MA Organization informing it of its termination appeal rights in accordance with 42 CFR Part 422 Subpart N. **[422.510(d)]**

2. Termination by the MA Organization [42 CFR §422.512]

(2.a) Cause for termination. The MA Organization may terminate this contract if CMS fails to substantially carry out the terms of the contract.

(2.b) Notice. The MA Organization must give advance notice as follows:

(2.b.i) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA Organization is requesting contract termination.

(2.b.ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA and MA-PD plans, PDP plans, Medigap options, and original Medicare and must receive CMS approval.

(2.b.iii) To the general public at least 60 days before the termination effective date by publishing a CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA Organization's geographic area.

(2.c) Effective date of termination. The effective date of the termination will be determined by CMS and will be at least 90 days after the date CMS receives the MA Organization's notice of intent to terminate.

(2.d) CMS' liability. CMS' liability for payment to the MA Organization ends as of the first day of the month after the last month for which the contract is in effect, but CMS shall make payments for amounts owed prior to termination but not yet paid.

(2.e) Effect of termination by the organization. CMS may deny an application for a new contract or service area expansion from the MA Organization or with

an organization whose covered persons, as defined in 42 CFR §422.512(e)(2), also served as covered persons for the terminating MA Organization for a period of two years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by CMS. This prohibition may apply regardless of the product type, contract type, or service area of the previous contract. **[422.512]**

Article IX
Requirements of Other Laws and Regulations

A. The MA Organization agrees to comply with—

1. Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 USC §§3729 et seq.) , and the anti-kickback statute (§ 1128B(b) of the Act): and

2. HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.**[422.504(h)]**

B. Pursuant to § 13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), the MA Organization agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by § 13101 of the ARRA.

C. The MA Organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors. **[422.504(i)]**

D. In the event that any provision of this contract conflicts with the provisions of any statute or regulation applicable to an MA Organization, the provisions of the statute or regulation shall have full force and effect.

E. The MA Organization agrees to comply with the requirements relating to Nondiscrimination in Health Programs and Activities in 45 CFR Part 92, including submitting assurances that the MA Organization's health programs and activities will be operated in compliance with the nondiscrimination requirements, as required in 45 CFR §92.5.

Article X
Severability

The MA Organization agrees that, upon CMS' request, this contract will be amended to exclude any MA plan or State-licensed entity specified by CMS, and a separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made. **[422.504(k)]**

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
20 - 004

Article XI
Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 422.

B. ALTERATION TO ORIGINAL CONTRACT TERMS

The MA Organization agrees that it has not altered in any way the terms of this contract presented for signature by CMS. The MA Organization agrees that any alterations to the original text the MA Organization may make to this contract shall not be binding on the parties.

C. MA Organization agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 CFR § 422.504(a)(14).

D. MA Organization agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality improvement activities related to the delivery of Part C services as required by 42 CFR §422.504(a)(16).

E. MA Organization agrees to maintain a Part C summary plan rating score of at least 3 stars under the 5-star rating system specified in 42 CFR Part 422 subpart D, as required by 42 CFR §422.504(a)(17).

F. CMS may determine that an MA organization is out of compliance with a Part C requirement when the organization fails to meet performance standards articulated in the Part C statutes, regulations, or guidance. If CMS has not already articulated a measure for determining noncompliance, CMS may determine that an MA organization is out of compliance when its performance in fulfilling Part C requirements represents and outlier relative to the performance of other MA organizations. **[422.504(m)]**

G. **Business Continuity:** The MA organization agrees to develop, maintain, and implement a business continuity plan as required by 42 CFR §422.504(o).

ATTACHMENT A

ATTESTATION OF ENROLLMENT INFORMATION
RELATING TO CMS PAYMENT
TO A MEDICARE ADVANTAGE ORGANIZATION

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution. This attestation shall not be considered a waiver of the MA Organization's right to seek payment adjustments from CMS based on information or data which does not become available until after the date the MA Organization submits this attestation.

1. The MA Organization has reported to CMS for the month of (INDICATE MONTH AND YEAR) all new enrollments, disenrollments, and appropriate changes in enrollees' status with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

2. The MA Organization has reviewed the CMS monthly membership report and reply listing for the month of (INDICATE MONTH AND YEAR) for the above-stated MA plans and has reported to CMS any discrepancies between the report and the MA Organization's records. For those portions of the monthly membership report and the reply listing to which the MA Organization raises no objection, the MA Organization, through the certifying CEO/CFO, will be deemed to have attested, based on best knowledge, information, and belief as of the date indicated below, to its accuracy, completeness, and truthfulness.

ATTACHMENT B

ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO
CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization

acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS during the period of (INDICATE DATES) all (INDICATE TYPE - DIAGNOSIS/ENCOUNTER) risk adjustment data available to the MA Organization with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

ATTACHMENT C - Medicare Advantage Plan Attestation of Benefit Plan and Price

In witness whereof, the parties hereby execute this contract.

This document has been electronically signed by:

FOR THE MA ORGANIZATION

BRIAN KANE

Contracting Official Name

8/28/2019 10:24:28 AM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

9/19/2019 8:34:18 AM

Date

Kathryn A. Coleman
Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
20 - 004

MEDICARE MARK LICENSE AGREEMENT

THIS AGREEMENT is made and entered into 8/28/2019 10:24:28 AM

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter "Licensor"),
with offices located at 7500 Security Blvd.,Baltimore, MD 21244

and

HUMANA HEALTH PLANS OF PUERTO RICO, INC. (hereinafter "Licensee"),
with offices located at 383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

CMS Contract ID: H4007

WITNESSETH

WHEREAS, Licensor is the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

WHEREAS, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning October 15, 2019.

WHEREAS, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Agreement, Licensor hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.
2. Licensee acknowledges Licensor's exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Agreement with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.
3. Licensor retains the right to use the Mark in the manner or style it has done so prior to this Agreement and in any other lawful manner.
4. This Agreement and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.
5. Licensor, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensor may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensor. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Medicare Marketing Guidelines. Licensee shall not take any action inconsistent with the Licensor's ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensor.
6. This agreement shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2020, concurrent with the execution of the Part D contract (or Part D addendum to a Medicare Managed Care contract). This Agreement may be terminated by either party upon written notice at any time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark immediately. Starting December 31, 2020, this agreement shall be renewable for successive one-year periods running concurrently with the term of the Licensee's Part D contract. This agreement shall terminate, without written notice, upon the effective date of termination or non-renewal of the Licensee's Part D contract (or Part D addendum to a Medicare Managed Care contract).
7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.
8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Agreement even if Licensor has been advised of the possibility of such damages.
9. This Agreement is the entire agreement between the parties with respect to the subject matter hereto.
10. Federal law shall govern this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement by their duly authorized officers as of the date first set forth above.

This document has been electronically signed by:

FOR THE LICENSEE

BRIAN KANE

Contracting Official Name

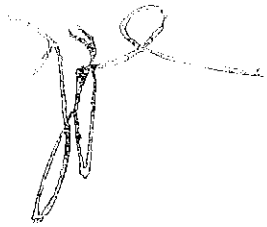
8/28/2019 10:24:28 AM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

FOR THE LICENSOR



H4007

9/19/2019 8:34:18 AM

Amy Lamick Chavez-Valdez
Director
Medicare Drug Benefit
and C & D Data Group,
Center for Medicare

Date

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
20 - 004

H4007

EMPLOYER/UNION-ONLY GROUP PART C ADDENDUM TO CONTRACT WITH APPROVED ENTITY PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A MEDICARE ADVANTAGE PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and HUMANA HEALTH PLANS OF PUERTO RICO, INC., a Medicare Advantage Organization (hereinafter referred to as the "MA Organization") agree to amend the contract H4007 governing the MA Organization's operation of a Medicare Advantage plan described in §1851(a)(2)(A) or §1851(a)(2)(C) of the Social Security Act (hereinafter referred to as "the Act"), including all attachments, addenda, and amendments thereto, to include the provisions contained in this Addendum (collectively hereinafter referred to as the "contract"), under which the MA Organization shall offer Employer/Union-Only Group MA-Only Plans (hereinafter referred to as "employer/union-only group health plans") in accordance with the waivers granted by CMS under §1857(i) of the Act. The terms of this Addendum shall only apply to MA-only health plans offered by the MA Organization exclusively to eligible individuals enrolled in employment-based health coverage under a contract between the MA Organization and the employer/union sponsor of the employment-based health coverage.

This Addendum is made pursuant to Subpart K of 42 CFR Part 422.

Article I
Employer/Union-Only Group Medicare Advantage Health Plan

A. MA Organization agrees to operate one or more employer/union-only group health plans in accordance with the Medicare Advantage contract (as modified by this Addendum), which incorporates in its entirety the *2020 Part C-Medicare Advantage and 1876 Cost Plan Expansion Application* (released on January 9, 2019) and any employer/union-only group waiver guidance, including, but not limited to those requirements contained in Chapter 9 of the Medicare Managed Care Manual).

B. This Addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract, and any regulations and policies implementing or interpreting such statutory provisions.

C. In the event of any conflict between the employer/union-only group waiver guidance issued prior to the execution of the contract and this Addendum, the provisions of this Addendum shall control. In the event of any conflict between the employer/union-only group waiver guidance issued after the execution of the contract and this Addendum, the provisions of the employer/union-only group guidance shall control.

D. This Addendum is in no way intended to supersede or modify 42 CFR Part 422 or §§1851 through 1859 of the Act, except as specifically provided in applicable employer/union-only group waiver guidance and/or in this Addendum. Failure to reference a statutory or regulatory requirement in this Addendum does not affect the applicability of such requirement to the MA Organization and CMS.

E. The provisions of this Addendum apply to all employer/union-only group health plans offered by MA Organization under this contract number. In the event of any conflict between the provisions of this Addendum and any other provision of the contract, the terms of this Addendum shall control.

Article II
Functions to be Performed by the Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. MA Organization agrees to provide enrollees in each of its employer/union-only group health plans the basic benefits (hereinafter referred to as "basic benefits") as required under 42 CFR §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final plan benefit package proposal as approved by CMS.

2. MA Organization acknowledges and agrees that payment under Part C of Title XVIII for Part A and B services, including rebates under section 1854 of the Social Security Act, provided to enrollees in its employer/union-only group MA-PDs will be governed by the CY 2020 Rate Announcement issued on April 1, 2019.

3. The requirements in §1852 of the Act and 42 CFR §422.100(c)(1) pertaining to the offering of benefits covered under Medicare Part A and in §1851 of the Act and 42 CFR §422.50(a)(1) pertaining to who may enroll in an MA plan are waived for employer/union-only group health plan enrollees who are not entitled to Medicare Part A.

4. For employer/union-only group health plans offering non-calendar year coverage, MA Organization may determine basic and supplemental benefits (including deductibles, out-of-pocket limits, etc.) on a non-calendar year basis subject to the following requirements:

(4.a) Applications, plan benefit packages, bids, and other submissions to CMS must be submitted on a calendar year basis; and

(4.b) CMS payments will be determined on a calendar year basis.

5. For employer/union-only group MA-only plans that have a monthly beneficiary rebate described in 42 CFR §422.266:

(5.a) MA Organization may vary the form of rebate for a particular plan benefit package so that the total monthly rebate amount may be credited differently for each employer/union group to whom MA Organization offers the plan benefit package; and

(5.b) MA Organization must retain documentation that supports the use of all of the rebates on a detailed basis for each employer/union group within the plan benefit package and must provide access to this documentation in accordance with the requirements of 42 CFR §422.504(e).

B. ENROLLMENT REQUIREMENTS

1. MA Organization agrees to restrict enrollment in an employer/union-only group health plan to those individuals eligible for the employer's/union's employment-based group coverage.

2. MA Organization will not be subject to the requirement to offer the employer/union-only group health plan to all eligible beneficiaries residing in the plan's service area as set forth in 42 CFR §422.50.

3. If an employer/union elects to enroll eligible individuals eligible for its employer/union-only group health plan through a group enrollment process, MA Organization will not be subject to the individual enrollment requirements set forth in 42 CFR §422.60. MA Organization agrees that it will comply with all the requirements for group enrollment contained in CMS guidance, including those requirements contained in Chapter 2 of the Medicare Managed Care Manual.

C. BENEFICIARY PROTECTIONS

1. Except as provided in subparagraph 2 of this paragraph, CMS agrees that with respect to any employer/union-only group health plans, MA Organization will not be subject to the prior review and approval of marketing materials and election forms requirements set forth in 42 CFR Part 422 Subpart V. MA Organization will be subject to all other disclosure requirements contained in 42 CFR §422.111 and that are conditions on any waivers for EGWPs provided in CMS guidance in Chapter 9 of the Medicare Managed Care Manual.

2. CMS agrees that the disclosure requirements set forth in 42 CFR §422.111 will not apply with respect to any employer/union-only group health plan when the employer/union is subject to alternative disclosure requirements (e.g., the Employee Retirement Income Security Act of 1974 ("ERISA")) and fully complies with such alternative requirements. As a condition of this waiver, MA Organization must:

(2.a) Provide summary plan descriptions and all other beneficiary communications required by the alternative disclosure requirements on a timely basis;

(2.b) Provide these materials to CMS, upon request, in the event of beneficiary complaints, or for any other reason CMS requests, so that CMS may ensure

the information accurately and adequately informs Medicare beneficiaries about their rights and obligations under the plan.

(2.c) Retain these dissemination materials and provide access to these written materials to CMS (or its designees) in accordance with 42 CFR 422.503(d) and 422.504(d) and (e).

3. MA Organization agrees to comply with the requirements for this waiver contained in employer/union-only group waiver guidance, including those requirements contained in Chapter 9 of the Medicare Managed Care Manual.

D. SERVICE AREA

1. CMS agrees that local employer/union-only group health plans that provide coverage to individuals in any part of a State may offer coverage to individuals eligible for the employer/union-only group throughout that State provided the MA Organization has properly designated (in accordance with CMS operational requirements) its employer/union-only group service areas in CMS's Health Plan Management System (HPMS) as including those areas outside of its individual service area(s) to allow for enrollment of these beneficiaries in CMS enrollment systems.

2. Notwithstanding 42 CFR § 422.50(a)(3), CMS agrees that those Local Coordinated Care Health MA-PDs that provide coverage to individuals in any part of a State can offer coverage to beneficiaries eligible for the employer/union-only group plan that reside outside of the State provided it meets the requirements designated in the Medicare Managed Care Manual.

In witness whereof, the parties hereby execute this contract.

This document has been electronically signed by:

FOR THE MA ORGANIZATION

BRIAN KANE

Contracting Official Name

8/28/2019 10:24:28 AM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

9/19/2019 8:34:18 AM

Date

Kathryn A. Coleman
Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
20 - 004

H4007

ADDENDUM TO MEDICARE MANAGED CARE CONTRACT PURSUANT TO SECTIONS 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and HUMANA HEALTH PLANS OF PUERTO RICO, INC., a Medicare managed care organization (hereinafter referred to as MA-PD Sponsor) agree to amend the contract H4007 governing MA-PD Sponsor's operation of a Part C plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as "the Act") or a Medicare cost plan to include this addendum under which MA-PD Sponsor shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

This addendum is made pursuant to Subpart L of 42 CFR Part 417 (in the case of cost plan sponsors offering a Part D benefit) and Subpart K of 42 CFR Part 422 (in the case of an MA-PD Sponsor offering a Part C plan).

NOTE: For purposes of this addendum, unless otherwise noted, reference to an "MA-PD Sponsor" or "MA-PD Plan" is deemed to include a cost plan sponsor or a MA private fee-for-service contractor offering a Part D benefit.

Article I
Voluntary Medicare Prescription Drug Plan

A. MA-PD Sponsor agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including but not limited to all the attestations contained therein and all supplemental guidance, and in compliance with the provisions of this addendum, which incorporates in its entirety the *Solicitation for Applications for Medicare Prescription Drug Plan 2020 Contracts*, released on January 9, 2019 (hereinafter collectively referred to as "the addendum"). MA-PD Sponsor also agrees to operate in accordance with the regulations at 42 CFR Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable Federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.

B. CMS agrees to perform its obligations to MA-PD Sponsor consistent with the regulations at 42 CFR Part423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable Federal statutes, regulations, and policies.

C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 CFR Part 423 that impose new, significant regulatory requirements on MA-PD Sponsor. This provision does not apply to new requirements mandated by statute.

D. If MA-PD Sponsor had an MA-PD Addendum with CMS for Contract Year 2019 under the contract ID number designated above, this document is considered a renewal of the existing addendum. While the terms of this document supersede the terms of the 2019 addendum, the parties' execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2019 or prior year addendums.

E. This addendum is in no way intended to supersede or modify 42 CFR, Parts 417, 422 or 423. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to MA-PD Sponsor and CMS.

Article II
Functions to be Performed by MA-PD Sponsor

A. ENROLLMENT

1. MA-PD Sponsor agrees to enroll in its MA-PD plan only Part D-eligible beneficiaries as they are defined in 42 CFR §423.30(a) and who have elected to enroll in MA-PD Sponsor's Part C or §1876 benefit.

2. If MA-PD Sponsor is a cost plan sponsor, MA-PD Sponsor acknowledges that its §1876 plan enrollees are not required to elect enrollment in its Part D plan.

B. PRESCRIPTION DRUG BENEFIT

1. MA-PD Sponsor agrees to provide the required prescription drug coverage as defined under 42 CFR §423.100 and, to the extent applicable, supplemental benefits as defined in 42 CFR §423.100 and in accordance with Subpart C of 42 CFR Part 423. MA-PD Sponsor also agrees to provide Part D benefits as described in MA-PD Sponsor's Part D bid(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).

2. MA-PD Sponsor agrees to calculate and collect beneficiary Part D premiums in accordance with 42 CFR §§423.286 and 423.293.

3. If MA-PD Sponsor is a cost plan sponsor, it acknowledges that its Part D benefit is offered as an optional supplemental service in accordance with 42 CFR §417.440(b)(2)(ii).

4. MA-PD Sponsor agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, communication, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 CFR §423.505(b)(25).

5. MA-PD Sponsor agrees to provide applicable beneficiaries applicable discounts on applicable drugs in accordance with the requirements of 42 CFR Part 423 Subpart W.

C. DISSEMINATION OF PLAN INFORMATION

1. MA-PD Sponsor agrees to provide the information required in 42 CFR §423.48.

2. MA-PD Sponsor acknowledges that CMS releases to the public the following data, consistent with 42 CFR Part 423, Subpart K:

(a) summary reconciled Part D payment data after the reconciliation of Part D payments, as provided in 42 CFR §423.505(o)(1);

(b) Part D Medical Loss Ratio data for the contract year, as described at 42 CFR §423.2490.

3. MA-PD Sponsor agrees to disclose information related to Part D benefits to beneficiaries in the manner and the form specified by CMS under 42 CFR §§423.128 and 423 Subpart V, consistent with the guidance provided in the Medicare Communication and Marketing Guidelines.

D. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. MA-PD Sponsor agrees to operate quality assurance, drug utilization management, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart D of 42 CFR Part 423.

2. MA-PD Sponsor agrees to address complaints received by CMS against the Part D sponsor as required in 42 CFR §423.505(b)(22) by:

(a) Addressing and resolving complaints in the CMS complaint tracking system; and

(b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the Part D plan's main Web page.

3. MA-PD Sponsor agrees to maintain a Part D summary plan rating score of at least 3 stars as required by 42 CFR §423.505(b)(26).

4. MA-PD Sponsor agrees to pass an essential operations test prior to the start of the benefit year. This provision only applies to new sponsors that have not previously entered into a Part D contract with CMS and neither it, nor another subsidiary of the applicant's parent organization, is offering Part D benefits during the

current year. 42 CFR §423.505(b)(27).

E. APPEALS AND GRIEVANCES

MA-PD Sponsor agrees to comply with all requirements in Subpart M of 42 CFR Part 423 governing coverage determinations, grievances and appeals, and formulary exceptions and the relevant provisions of Subpart A governing reconsiderations. MA-PD Sponsor acknowledges that these requirements are separate and distinct from the appeals and grievances requirements applicable to MA-PD Sponsor through the operation of its Part C or cost plan benefits.

F. PAYMENT TO MA-PD SPONSOR

MA-PD Sponsor and CMS agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 CFR Part 423.

G. BID SUBMISSION AND REVIEW

If MA-PD Sponsor intends to participate in the Part D program for the next program year, MA-PD Sponsor agrees to submit the next year's Part D bid, including all required information on premiums, benefits, and cost-sharing, by the applicable due date, as provided in Subpart F of 42 CFR Part 423 so that CMS and MA-PD Sponsor may conduct negotiations regarding the terms and conditions of the proposed bid and benefit plan renewal. MA-PD Sponsor acknowledges that failure to submit a timely bid under this section may affect the sponsor's ability to offer a Part C plan, pursuant to the provisions of 42 CFR §422.4(c).

H. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. MA-PD Sponsor agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 CFR Part 423.

2. MA-PD Sponsor agrees to comply with Medicare Secondary Payer procedures as stated in 42 CFR §423.462.

I. SERVICE AREA AND PHARMACY ACCESS

1. MA-PD Sponsor agrees to provide Part D benefits in the service area for which it has been approved by CMS to offer Part C or cost plan benefits utilizing a pharmacy network and formulary approved by CMS that meet the requirements of 42 CFR §423.120.

2. MA-PD Sponsor agrees to provide Part D benefits through out-of-network pharmacies according to 42 CFR §423.124.

3. MA-PD Sponsor agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 CFR §423.100), and long-term care pharmacies (as defined in 42 CFR §423.100) according to 42 CFR §423.505(b)(17).

4. MA-PD Sponsor agrees to contract with any pharmacy that meets MA-PD Sponsor's reasonable and relevant standard terms and conditions according to 42 CFR §423.505(b)(18), including making standard contracts available on request in accordance with the timelines specified in the regulation.

(a) If MA-PD Sponsor has demonstrated that it historically fills 98% or more of its enrollees' prescriptions at pharmacies owned and operated by MA-PD Sponsor (or presents compelling circumstances that prevent the sponsor from meeting the 98% standard or demonstrates that its Part D plan design will enable the sponsor to meet the 98% standard during the contract year), this provision does not apply to MA-PD Sponsor's plan. 42 CFR§423.120(a)(7)(I)

(b) The provisions of 42 CFR §423.120(a) concerning the retail pharmacy access standard do not apply to MA-PD Sponsor if the Sponsor has demonstrated to CMS that it historically fills more than 50% of its enrollees' prescriptions at pharmacies owned and operated by MA-PD Sponsor. MA-PD Sponsors excused from meeting the standard are required to demonstrate retail pharmacy access that meets the requirements of 42 CFR §422.112 for a Part C contractor and 42 CFR §417.416(e) for a cost plan contractor. 42 CFR§423.120(a)(7)(i)

J. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

MA-PD Sponsor agrees that it will develop and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 CFR §423.504(b)(4)(vi).

K. LOW-INCOME SUBSIDY

MA-PD Sponsor agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 CFR Part 423.

L. BENEFICIARY FINANCIAL PROTECTIONS

MA-PD Sponsor agrees to afford its enrollees protection from liability for payment of fees that are the obligation of MA-PD Sponsor in accordance with 42 CFR §423.505(g).

M. RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

1. MA-PD Sponsor agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.

2. MA-PD Sponsor shall ensure that any contracts or agreements with first tier, downstream, and related entities performing functions on MA-PD Sponsor's behalf related to the operation of the Part D benefit are in compliance with 42 CFR §423.505(i).

N. CERTIFICATION OF DATA THAT DETERMINE PAYMENT

MA-PD Sponsor must provide certifications in accordance with 42 CFR §423.505(k).

O. MA-PD SPONSOR REIMBURSEMENT TO PHARMACIES

1. If MA-PD Sponsor uses a standard for reimbursement of pharmacies based on the cost of a drug, MA-PD Sponsor will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

2. If the source for any prescription drug pricing standard is not publicly available, MA-PD Sponsor will disclose all individual drug prices to be updated to the applicable pharmacies in advance for their use for the reimbursement of claims.

3. MA-PD Sponsor will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 days of receipt of an electronically submitted claim or within 30 days of receipt of a claim submitted otherwise.

4. MA-PD Sponsor must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than 30 days (but not more than 90 days) to submit claims to MA-PD Sponsor for reimbursement.

Article III
Record Retention and Reporting Requirements

A. RECORD MAINTENANCE AND ACCESS

MA-PD Sponsor agrees to maintain records and provide access in accordance with 42 CFR §§ 423.505 (b)(10) and 423.505(I)(2).

B. GENERAL REPORTING REQUIREMENTS

MA-PD Sponsor agrees to submit information to CMS according to 42 CFR §§423.505(f) and 423.514, and the "Final Medicare Part D Reporting Requirements," a document issued by CMS and subject to modification each program year.

C. CMS LICENSE FOR USE OF PLAN FORMULARY

MA-PD Sponsor agrees to submit to CMS each plan's formulary information, including any changes to its formularies, and hereby grants to the Government, and any person or entity who might receive the formulary from the Government, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

Article IV
HIPAA Provisions

A. MA-PD Sponsor agrees to comply with the confidentiality and enrollee record accuracy requirements specified in 42 CFR §423.136.

B. MA-PD Sponsor agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of-pocket costs.

Article V
Addendum Term and Renewal

A. TERM OF ADDENDUM

This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2020. This addendum shall be renewable for successive one-year periods thereafter according to 42 CFR §423.506.

B. QUALIFICATION TO RENEW ADDENDUM

1. In accordance with 42 CFR §423.507, MA-PD Sponsor will be determined qualified to renew this addendum annually only if MA-PD Sponsor has not provided CMS with a notice of intention not to renew in accordance with Article VII of this addendum.

2. Although MA-PD Sponsor may be determined qualified to renew its addendum under this Article, if MA-PD Sponsor and CMS cannot reach agreement on the Part D bid under Subpart F of 42 CFR Part 423, no renewal takes place, and the failure to reach agreement is not subject to the appeals provisions in Subpart N of 42 CFR Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article VI
Nonrenewal of Addendum by MA-PD Sponsor

A. MA-PD Sponsor may non-renew this addendum in accordance with 42 CFR 423.507(a).

B. If MA-PD Sponsor non-renews this addendum under this Article, CMS cannot enter into a Part D addendum with the organization or with an organization whose covered persons, as defined in 42 CFR §423.507(a)(4), also served as covered persons for the nonrenewing sponsor for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS.

Article VII
Modification or Termination of Addendum by Mutual Consent

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 CFR 423.508. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article VIII
Termination of Addendum by CMS

CMS may terminate this addendum in accordance with 42 CFR 423.509. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article IX
Termination of Addendum by MA-PD Sponsor

A. MA-PD Sponsor may terminate this addendum only in accordance with 42 CFR 423.510.

B. CMS will not enter into a Part D addendum with an MA-PD Sponsor that has terminated its addendum or with an organization whose covered persons, as defined in 42 CFR §423.508(f), also served as covered persons for the terminating sponsor within the preceding 2 years unless there are circumstances that warrant special consideration, as determined by CMS.

C. If the addendum is terminated under section A of this Article, MA-PD Sponsor must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article X
Relationship between Addendum and Part C Contract or 1876 Cost Contract

A. MA-PD Sponsor acknowledges that, if it is a Medicare Part C contractor, the termination or nonrenewal of this addendum by either party may require CMS to terminate or non-renew the Sponsor's Part C contract in the event that such non-renewal or termination prevents MA-PD Sponsor from meeting the requirements of 42 CFR §422.4(c), in which case the Sponsor must provide the notices specified in this contract, as well as the notices specified under Subpart K of 42 CFR Part 422. MA-PD Sponsor also acknowledges that Article IX.B. of this addendum may prevent the sponsor from entering into a Part C contract for two years following an addendum termination or non-renewal where such non-renewal or termination prevents MA-PD Sponsor from meeting the requirements of 42 CFR §422.4(c).

B. The termination of this addendum by either party shall not, by itself, relieve the parties from their obligations under the Part C or cost plan contracts to which this document is an addendum.

C. In the event that MA-PD Sponsor's Part C or cost plan contract (as applicable) is terminated or nonrenewed by either party, the provisions of this addendum shall also terminate. In such an event, MA-PD Sponsor and CMS shall provide notice to enrollees and the public as described in this contract as well as 42 CFR Part 422, Subpart K or 42 CFR Part 417, Subpart K, as applicable.

Article XI
Intermediate Sanctions

Consistent with Subpart O of 42 CFR Part 423, MA-PD Sponsor shall be subject to sanctions and civil money penalties.

Article XII
Severability

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Severability of the addendum shall be in accordance with 42 CFR §423.504(e).

Article XIII
Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 CFR Part 423 or, as applicable, 42 CFR Part 422 or Part 417.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS

MA-PD Sponsor agrees that it has not altered in any way the terms of the MA-PD addendum presented for signature by CMS. MA-PD Sponsor agrees that any alterations to the original text MA-PD Sponsor may make to this addendum shall not be binding on the parties.

C. ADDITIONAL CONTRACT TERMS

MA-PD Sponsor agrees to include in this addendum other terms and conditions in accordance with 42 CFR §423.505(j).

D. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), MA-PD Sponsor agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

E. MA-PD sponsor agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 CFR §423.505(b)(23).

F. **Business Continuity:** MA-PD Sponsor agrees to develop, maintain, and implement a business continuity plan as required by 42 CFR §423.505(p).

G. The MA-PD sponsor agrees to comply with the requirements relating to Nondiscrimination in Health Programs and Activities in 45 CFR Part 92, including submitting assurances that the MA-PD sponsor's health programs and activities will be operated in compliance with the nondiscrimination requirements, as required in 45 CFR §92.5.

In witness whereof, the parties hereby execute this contract.

This document has been electronically signed by:

FOR THE MA ORGANIZATION

BRIAN KANE

Contracting Official Name

8/28/2019 10:24:28 AM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

9/19/2019 8:34:18 AM

Date

Amy Larrick Chavez-Valdez
Director
Medicare Drug Benefit
and C & D Data Group,
Center for Medicare

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
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H4007

ADDENDUM TO MEDICARE MANAGED CARE CONTRACT PURSUANT TO SECTIONS 1851 THROUGH 1859 AND 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF AN EMPLOYER GROUP ONLY A MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and HUMANA HEALTH PLANS OF PUERTO RICO, INC., a Medicare Advantage Organization (hereinafter referred to as the "MA Organization") agree to amend the contract H4007 governing the MA Organization's operation of a Medicare Advantage plan described in § 1851(a)(2)(A) or § 1851(a)(2)(C) of the Social Security Act (hereinafter referred to as "the Act"), including all attachments, addenda, and amendments thereto, to include the provisions contained in this addendum (collectively hereinafter referred to as the "contract"), under which the MA Organization shall offer Employer/Union-Only Group MA-PD Plans (hereinafter referred to as "employer/union-only group MA-PDs") in accordance with the waivers granted by CMS under section 1857(i) of the Act. The terms of this Addendum shall only apply to MA-PD plans offered exclusively to Medicare Advantage-eligible individuals enrolled in employment-based health coverage under a contract between the MA Organization and the employer/union sponsor of the employment-based health coverage, pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

This addendum is made pursuant to Subpart K of 42 CFR Parts 422 and 423.

ARTICLE I
EMPLOYER/UNION-ONLY GROUP MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS

A. MA Organization agrees to operate one or more employer/union-only group MA-PDs in accordance with the Medicare Advantage contract (as modified by this addendum), which incorporates in its entirety the *Solicitation for Applications for Medicare Prescription Drug Plan 2020 Contracts and 2020 Part C – Medicare Advantage and 1876 Cost Plan Expansion Application* (both released on January 9, 2019) and any employer/union-only group waiver guidance issued by CMS, including, but not limited to, those requirements set forth in Chapter 12 of the Medicare Prescription Drug Benefit Manual and Chapter 9 of the Medicare Managed Care Manual (hereinafter referred to as "employer/union group waiver guidance"). This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.

B. In the event of any conflict between the employer/union-only group waiver guidance issued prior to the execution of the contract and this Addendum, the provisions of this Addendum shall control. In the event of any conflict between the employer/union-only group waiver guidance issued after the execution of the contract and this Addendum, the provisions of the employer/union-only group guidance shall control.

C. This Addendum is in no way intended to supersede or modify 42 CFR Parts 422 and 423 or sections 1851 through 1859 and 1860D-1 through D-43 of the Act, except as specifically provided in applicable employer/union-only group waiver guidance and/or in this Addendum. Failure to reference a statutory or regulatory requirement in this Addendum does not affect the applicability of such requirement to the MA Organization and CMS.

D. The provisions of this Addendum apply to all employer/union-only group MA-PDs offered by MA Organization under this contract number. In the event of any conflict between the provisions of this Addendum and any other provision of the contract, the terms of this Addendum shall control.

ARTICLE II
FUNCTIONS TO BE PERFORMED BY THE MEDICARE ADVANTAGE ORGANIZATION

A. PROVISION OF MA BENEFITS

1. MA Organization agrees to provide enrollees in each of its employer/union-only group MA-PDs the basic benefits (hereinafter referred to as "basic benefits") as required under 42 CFR §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final benefit as approved by CMS.

2. The requirements in section 1852 of the Act and 42 CFR §422.100(c)(1) pertaining to the offering of benefits covered under Medicare Part A and in section 1851 of the Act and 42 CFR §422.50(a)(1) pertaining to who may enroll in an MA-PD are waived for employer/union-only group MA-PD enrollees who are not entitled to Medicare Part A.

3. For employer/union-only group MA-PDs offering non-calendar year coverage, MA Organization may determine basic and supplemental benefits (including deductibles, out-of-pocket limits, etc.) on a non-calendar year basis subject to the following requirements:

(3.a) Applications, plan benefit packages, bids, and other submissions to CMS must be submitted on a calendar year basis; and

(3.b) CMS payments will be determined on a calendar year basis.

4. For employer/union-only group MA-PDs that have a monthly beneficiary rebate described in 42 CFR §422.266:

(4.a) MA Organization may vary the form of rebate for a particular plan benefit package so that the total monthly rebate amount may be credited differently for each employer/union group to whom MA Organization offers the plan benefit package and

(4.b) MA Organization must retain documentation that supports the use of all of the rebates on a detailed basis for each employer/union group within the plan benefit package and must provide access to this documentation for inspection or audit by CMS (or its designee) in accordance with the requirements of 42 CFR 422.503(d) and (e).

5. MA Organization agrees it shall obtain written agreements from each employer/union that provide that the employer/union may determine how much of an enrollee's Part C monthly beneficiary premium it will subsidize, subject to the restrictions set forth in II.A.5(a) through (c). MA Organization agrees to retain these written agreements with employers/unions and must provide access to this documentation for inspection or audit by CMS (or its designee) in accordance with the requirements of 42 CFR 422.503(d) and 422.504(d) and (e)

(5.a) The employer/union can subsidize different amounts for different classes of enrollees in the employer group health plan provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried v. hourly).

(5.b) The employer/union cannot vary the premium subsidy for individuals within a given class of enrollees.

(5.c) The employer/union cannot charge an enrollee for coverage provided under the employer group health plan more than the sum of his or her monthly beneficiary premium attributable to basic benefits provided under the plan as defined in 42 CFR §422.2 (i.e., all Medicare-covered benefits, except hospice services) and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part C benefits (if any). MA Organization must pass through the monthly payments described under 42 CFR 422.304(a) received from CMS to reduce the amount that the enrollee pays (or, in those instances where the subscriber to or participant in the employer plan pays premiums on behalf of a Medicare eligible spouse or dependent, the amount the subscriber or participant pays).

B. PROVISION OF PRESCRIPTION DRUG BENEFIT

1. Except as provided in this subsection, MA Organization agrees to provide basic prescription drug coverage, as defined under 42 CFR §423.100, under any employer/union-only group MA-PD, in accordance with Subpart C of 42 CFR Part 423.

(1.a) CMS agrees that MA Organization will not be subject to the actuarial equivalence requirement set forth in 42 CFR §423.104(e)(5) with respect to any employer/union-only group MA-PD and may provide less than the defined standard coverage between the deductible and initial coverage limit. MA Organization agrees that its basic prescription drug coverage under any employer/union-only group MA-PD will satisfy all of the other actuarial equivalence standards set forth in 42 CFR §423.104, including but not limited to the requirement set forth in 42 CFR §423.104(e)(3) that the plan has a total or gross value that is at least equal to the total or gross value of defined standard coverage.

2. CMS agrees that nothing in this Addendum prevents MA Organization from offering prescription drug benefits in addition to basic prescription drug coverage to employers/unions. Such additional benefits offered pursuant to private agreements between MA Organization and employers/unions will be considered non-Medicare

Part D benefits ("non-Medicare Part D benefits"). MA Organization agrees that such additional benefits may not reduce the value of basic prescription drug coverage (e.g., additional benefits cannot impose a cap that would preclude enrollees from realizing the full value of such basic prescription drug coverage).

3. MA Organization agrees that enrollees of employer/union-only group MA-PDs shall not be charged more than the sum of his or her monthly beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part D benefits (if any). MA Organization must pass through the direct subsidy payments received from CMS to reduce the amount that the beneficiary pays (or, in those instances where the subscriber to or participant in the employer plan pays premiums on behalf of an eligible spouse or dependent, the amount the subscriber or participant pays).

4. MA Organization agrees that any additional non-Medicare Part D benefits offered to an employer/union will always pay primary to the subsidies provided by CMS to low-income individuals under Subpart P of 42 CFR Part 423 (the "Low-Income Subsidy").

5. MA Organization agrees enrollees of employer/union-only group MA-PDs will not be permitted to make payment of premiums under 42 CFR §423.293(a) through withholding from the enrollee's Social Security, Railroad Retirement Board, or Office of Personnel Management benefit payment.

6. MA Organization agrees it shall obtain written agreements from each employer/union that provide that the employer/union may determine how much of an enrollee's Part D monthly beneficiary premium it will subsidize, subject to the restrictions set forth in this subsection. MA Organization agrees to retain these written agreements with employers/unions, including any written agreements related to items (d) through (f) of this subsection, and must provide access to this documentation for inspection or audit by CMS (or its designee) in accordance with the requirements of 42 CFR §§423.504(d) and 423.505(d) and (e).

(6.a) The employer/union can subsidize different amounts for different classes of enrollees in the employer/union-only group MA-PD provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried v. hourly). Different classes cannot be based on eligibility for the Low Income Subsidy.

(6.b) The employer/union cannot vary the premium subsidy for individuals within a given class of enrollees.

(6.c) The employer/union cannot charge an enrollee for prescription drug coverage provided under the plan more than the sum of his or her monthly beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part D benefits (if any). The employer/union must pass through direct subsidy payments received from CMS to reduce the amount that the beneficiary pays (or, in those instances where the subscriber to or participant in the employer plan pays premiums on behalf of an eligible spouse or dependent, the amount the subscriber or participant pays).

(6.d) For all enrollees eligible for the Low Income Subsidy, the low income premium subsidy amount will first be used to reduce any portion of the MA-PD monthly beneficiary premium paid by the enrollee (or in those instances where the subscriber to or participant in the employer plan pays premiums on behalf of a low-income eligible spouse or dependent, the amount the subscriber or participant pays), with any remaining portion of the premium subsidy amount then applied toward any portion of the MA-PD monthly beneficiary premium (including any MA premium) paid by the employer/union. However, if the sum of the enrollee's MA-PD monthly premium (or the subscriber's/participant's MA-PD monthly premium, if applicable) and the employer's/union's MA-PD monthly premiums (i.e., total monthly premium) are less than the monthly low-income premium subsidy amount, any portion of the low-income subsidy premium amount above the total MA-PD monthly premium must be returned directly to CMS. Similarly, if there is no MA-PD monthly premium charged the beneficiary (or subscriber/participant, if applicable) or employer/union, the entire low-income premium subsidy amount must be returned directly to CMS and cannot be retained by the MA Organization, the employer/union, or the beneficiary (or the subscriber/participant, if applicable).

(6.e) If the Part D sponsor does not or cannot directly bill an employer group's beneficiaries, CMS will permit the Part D sponsor to directly refund the amount of the low-income premium subsidy to the LIS beneficiary. This refund must meet the above requirements concerning beneficiary premium contributions; specifically, that the amount of the refund not exceed the amount of the monthly premium contribution by the enrollee and/or the employer. In addition, the sponsor must refund these amounts to the beneficiary within a reasonable time period. However, under no circumstances may this time period exceed forty five (45) days from the date that the Part D sponsor receives the low-income premium subsidy amount payment for that beneficiary from CMS.

(6.f) The MA Organization and the employer/union may agree that the employer/union will be responsible for reducing up-front the MA-PD premium contribution required for enrollees eligible for the Low Income Subsidy. In those instances where the employer/union is not able to reduce up-front the MA-PD premiums paid by the enrollee (or, the subscriber/participant, if applicable), the MA Organization and the employer/union may agree that the employer/union shall directly refund to the enrollee (or subscriber/participant, if applicable) the amount of the low-income premium subsidy up to the MA-PD monthly premium contribution previously collected from the enrollee (or subscriber/participant, if applicable). The employer/union is required to complete the refund on behalf of the MA Organization within forty-five (45) days of the date the MA Organization receives from CMS the low-income premium subsidy amount payment for the low-income subsidy eligible enrollee.

(6.g) If the low income premium subsidy amount for which an enrollee is eligible is less than the portion of the Part D monthly beneficiary premium paid by the enrollee (or subscriber/participant, if applicable), then the employer/union should communicate to the enrollee (or subscriber/participant) the financial consequences of the low-income subsidy eligible individual enrolling in the employer/union-only group MA-PD as compared to enrolling in another Part D plan with a monthly beneficiary premium equal to or below the low income premium subsidy amount.

7. For non-calendar year employer/union-only group MA-PDs, MA Organization may determine benefits (including deductibles, out-of-pocket limits, etc.) on a non-calendar year basis subject to the following requirements:

(7.a) Applications, formularies, bids and other submissions to CMS must be submitted on a calendar year basis;

(7.b) The prescription drug coverage under the employer/union-only group MA-PD must be at least actuarially equivalent to defined standard coverage for the portion of its plan year that falls in a given calendar year. An employer/union-only group MA-PD will meet this standard if its prescription drug coverage is at least actuarially equivalent for the calendar year in which the plan year starts and no design change is made for the remainder of the plan year. In no event can MA Organization increase during the plan year the annual out-of-pocket threshold;

(7.c) After an enrollee's incurred costs exceed the annual out-of-pocket threshold, the employer/union-only group MA-PD must provide prescription drug coverage that is at least actuarially equivalent to that provided under standard prescription drug coverage; eligibility for such coverage can be determined on a plan year basis.

8. MA Organization agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 CFR §423.505(b)(25).

9. MA Organization agrees to provide applicable beneficiaries applicable discounts on applicable drugs in accordance with the requirements of 42 CFR Part 423 Subpart W.

10. MA Organization agrees to pass an essential operations test prior to the start of the benefit year. This provision only applies to new sponsors that have not previously entered into a Part D contract with CMS and neither it, nor another subsidiary of the applicant's parent organization, is offering Part D benefits during the current year. 42 CFR §423.505(b)(27).

C. CMS ENROLLMENT REQUIREMENTS

1. MA Organization agrees to restrict enrollment in an employer/union-only group MA-PD to those individuals eligible for the employer's/union's employment-based group coverage.

2. MA Organization will not be subject to the requirement to offer the employer/union-only group MA-PD to all Medicare eligible beneficiaries residing in its service area as set forth in 42 CFR §422.50.

3. If an employer/union elects to enroll eligible individuals eligible for its employer/union-only group MA-PDs through a group enrollment process, MA Organization will not be subject to the individual enrollment requirements set forth in 42 CFR §422.60. MA Organization agrees that it will comply with all the requirements for group enrollment contained in CMS guidance, including those requirements contained in Chapter 2 of the Medicare Managed Care Manual.

D. BENEFICIARY PROTECTIONS

1. Except as provided in II.D.2., CMS agrees that, with respect to any employer/union-only group MA-PDs, MA Organization will not be subject to the information requirements set forth in 42 CFR §423.48 and the prior review and approval of marketing materials and election forms requirements set forth in 42 CFR Part 422, subpart V and Part 423, subpart V. MA Organization will be subject to all other disclosure and dissemination requirements contained in 42 CFR §422.111, §423.128 and that are conditions on any waivers for EGWPs provided in CMS guidance in Chapter 9 of the Medicare Managed Care Manual.

2. CMS agrees that the disclosure requirements set forth in 42 CFR §422.111 will not apply with respect to any employer/union-only group health plan when the employer/union is subject to alternative disclosure requirements (e.g., the Employee Retirement Income Security Act of 1974 ("ERISA")) and fully complies with such alternative requirements. As a condition of this waiver, MA Organization must:

(2.a) Provide summary plan descriptions and all other beneficiary communications required by the alternative disclosure requirements on a timely basis;

(2.b) Provide these materials to CMS, upon request, in the event of beneficiary complaints, or for any other reason CMS requests, so that CMS may ensure the information accurately and adequately informs Medicare beneficiaries about their rights and obligations under the plan.

(2.c) Retain these dissemination materials and provide access to these written materials to CMS (or its designees) in accordance with 42 CFR 422.503(d) and 422.504(d) and (e).

3. MA Organization agrees to comply with the requirements for this waiver contained in employer/union-only group waiver guidance in Chapter 9 of the Medicare Managed Care Manual.

E. SERVICE AREA, FORMULARIES AND PHARMACY ACCESS

1. CMS agrees that Local employer/union-only group MA-PDs that provide coverage to individuals in any part of a State may offer coverage to retirees eligible for the employer/union-only group MA-PD throughout that State provided the MA Organization has properly designated (in accordance with CMS operational requirements) its employer/union-only group service areas in CMS's Health Plan Management System (HPMS) as including those areas outside of its individual service area(s) to allow for enrollment of these beneficiaries in CMS enrollment systems. CMS also agrees that employer/union-only group Regional MA-PDs that provide coverage to individuals in any part of a Region can offer coverage to retirees eligible for the employer/union-only group MA-PD throughout that Region.

2. Notwithstanding 42 CFR § 422.50(a)(3), CMS agrees that those Local Coordinated Care Health MA-PDs that provide coverage to individuals in any part of a State can offer coverage to beneficiaries eligible for the employer/union-only group plan that reside outside of the State provided it meets the requirements designated in the Medicare Managed Care Manual.

3. CMS agrees that Private Fee-for-Service employer/union-only group MA-PDs may offer coverage beyond their designated individual service areas to all enrollees of a particular employer/union-only group plan, regardless of where they reside in the nation, provided the MA Organization has properly designated (in accordance with CMS operational requirements) its employer/union-only group service area in CMS' HPMS as including areas outside of its individual plan service area(s) to allow for the enrollment of these beneficiaries in CMS enrollment systems.

4. MA Organization agrees to utilize, as the formulary for any employer/union-only group MA-PD, a base formulary that has received approval from CMS, in accordance with CMS formulary guidance, for use in a non-group MA-PD offered by MA Organization. Except as set forth in 42 CFR §423.120(b) and sub-regulatory guidance, MA Organization may not modify the approved base formulary used for any employer/union-only group MA-PD by removing drugs, adding additional utilization management restrictions, or increasing the cost-sharing status of a drug from the base formulary. Enhancements that are permitted to the base formulary include adding additional drugs, removing utilization management restrictions, and improving the cost-sharing status of drugs.

5. For any employer/union-only group MA-PD, MA Organization agrees to provide Part D benefits in the plan's service area utilizing a pharmacy network and formulary that meets the requirements of 42 CFR §423.120, with the following exception: CMS agrees that the retail pharmacy access requirements set forth in 42 CFR §423.120(a)(1) will not apply when the employer/union-only group MA-PD's pharmacy network is sufficient to meet the needs of its enrollees throughout the employer/union-only group MA-PD's service area, as determined by CMS. CMS may periodically review the adequacy of the employer/union-only group MA-PD's pharmacy network and require the employer/union-only group MA-PD to expand access if CMS determines that such expansion is necessary in order to ensure that the employer/union-only group MA-PD's network is sufficient to meet the needs of its enrollees.

F. PAYMENT TO MA ORGANIZATION

1. MA Organization is not required to submit a Part C bid pricing tool; MA Organization acknowledges and agrees that payment under Part C of Title XVIII for Part A and B services, including rebates under section 1854 of the Social Security Act, provided to enrollees in its employer/union-only group MA-PDs will be governed by the CY 2020 Rate Announcement issued on April 1, 2019. Except as provided in this subsection, payment under this Addendum will be governed by the rules of Subparts G and J of 42 CFR Part 423.

(1.a) MA Organization acknowledges that the risk sharing, plan entry and retention bonus provisions of section 1858 of the Act and 42 CFR §422.458 shall not apply to any employer/union-only group Regional MA-PDs.

(1.b) MA Organization acknowledges that the risk-sharing payment adjustment described in 42 CFR §423.336 is not applicable for any employer/union-only group MA-PD enrollee.

(1.c) MA Organization is not required to submit a Part D bid and will receive a monthly direct subsidy under 42 CFR Subpart G for each employer/union-only group MA-PD enrollee equal to the amount of the national average monthly bid amount (not its approved standardized bid), adjusted for health status (as determined under 42 CFR §423.329(b)(1)) and reduced by the base beneficiary premium for the employer/union-only group MA-PD, as adjusted under 42 CFR §423.286(d)(3), if applicable. The further adjustments to the base beneficiary premium contained in 42 CFR §423.286(d)(1) and (2) will not apply.

(1.d) MA Organization will not receive monthly reinsurance payment or low-income cost-sharing subsidy amounts in the manner set forth in 42 CFR §423.329(c)(2)(i) and 42 CFR §423.329(d)(2)(I) for any employer/union-only group MA-PD enrollee, but instead will receive the full reinsurance and low-income cost-sharing subsidy payments following the end of year reconciliation as described in 42 CFR §423.329(c)(2)(II) and 42 CFR §423.329(d)(2)(II) respectively.

2. For non-calendar year plans:

(2.a) CMS payments will be determined on a calendar year basis;

(2.b) Low income subsidy payments and reconciliations will be determined based on the calendar year for which the payments are made; and

(2.c) MA Organization acknowledges that it will not receive reinsurance payments under 42 CFR §423.329(c).

G. MA ORGANIZATION REIMBURSEMENT TO PHARMACIES

1. If an MA Organization uses a standard for reimbursement of pharmacies based on the cost of a drug, MA Organization will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

2. If the source for any prescription drug pricing standard is not publicly available, MA Organization will disclose all individual drug prices to be updated to the applicable pharmacies in advance for their use for the reimbursement of claims.

3. MA Organization will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 days of receipt of an electronically submitted claim or within 30 days of receipt of a claim submitted otherwise.

4. MA Organization must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than 30 days (but not more than 90 days) to submit claims to MA Organization for reimbursement.

H. PUBLIC HEALTH SERVICE ACT

Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), MA Organization agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation

specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

In witness whereof, the parties hereby execute this contract.

This document has been electronically signed by:

FOR THE MA ORGANIZATION

BRIAN KANE

Contracting Official Name

8/28/2019 10:24:28 AM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

9/19/2019 8:34:18 AM

Date

Amy Lanick Chavez-Valdez
Director
Medicare Drug Benefit
and C & D Data Group,
Center for Medicare

9/19/2019 8:34:18 AM

Date

Kathryn A. Coleman
Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
20 - 004

H4007

Medicare Advantage Attestation of Benefit Plan

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

H4007

Date: 08/28/2019

I attest that I have examined the Plan Benefit Packages (PBPs) identified below and that the benefits identified in the PBPs are those that the above-stated organization will make available to eligible beneficiaries in the approved service area during program year 2020. I further attest that we have reviewed the bid pricing tools (BPTs) with the certifying actuary and have determined them to be consistent with the PBPs being attested to here.

I attest that I have examined the employer/union-only group waiver ("800 series") PBPs identified below and that these PBPs are those that the above-stated organization will make available only to eligible employer/union-sponsored group plan beneficiaries in the approved service area during program year 2020. I further attest we have reviewed any MA bid pricing tools (BPTs) associated with these PBPs (no Part D bids are required for 2020 "800 series" PBPs) with the certifying actuary and have determined them to be consistent with any MA PBPs being attested to here.

I attest that our MA plan(s) are implementing Part B step therapy under the direction of its P&T committee consistent with CMS regulatory and sub-regulatory guidance.

I further attest that these benefits will be offered in accordance with all applicable Medicare program authorizing statutes and regulations and program guidance that CMS has issued to date and will issue during the remainder of 2019 and 2020, including but not limited to, the 2020 Call Letter, the 2020 Solicitations for New Contract Applicants, the Medicare Prescription Drug Benefit Manual, the Medicare Managed Care Manual, and the CMS memoranda issued through the Health Plan Management System (HPMS).

Plan ID	Segment ID	Version	Plan Name	Plan Type	Transaction Type	MA Premium	Part D Premium	CMS Approval Date	Effective Date
012	0	6	Humana Gold Plus H4007-012 (HMO)	HMO	Renewal	0.00	0.00	08/21/2019	01/01/2020
013	0	4	Humana Gold Plus H4007-013 (HMO)	HMO	Renewal	0.00	0.00	08/21/2019	01/01/2020
016	0	3	Humana Gold Plus SNP-DE H4007-016 (HMO D-SNP)	HMO	Renewal	0.00	0.00	08/21/2019	01/01/2020
018	0	2	Humana Gold Plus SNP-DE H4007-018 (HMO D-SNP)	HMO	Renewal	0.00	0.00	08/21/2019	01/01/2020
019	0	3	Humana Gold Plus SNP-DE H4007-019 (HMO D-SNP)	HMO	Renewal	0.00	0.00	08/21/2019	01/01/2020
020	0	3	Humana Gold Plus H4007-020 (HMO)	HMO	Renewal	0.00	0.00	08/21/2019	01/01/2020
801	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	N/A	N/A	08/16/2019	01/01/2020
802	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	N/A	N/A	08/16/2019	01/01/2020
811	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	N/A	N/A	08/16/2019	01/01/2020
812	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	N/A	N/A	08/16/2019	01/01/2020
813	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	N/A	N/A	08/16/2019	01/01/2020
814	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	N/A	N/A	08/16/2019	01/01/2020

BRIAN KANE

Contracting Official Name

8/28/2019 10:24:28 AM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

Address

DATA USE ATTESTATION

The sponsor shall restrict its use and disclosure of Medicare data obtained from CMS information systems (listed in Attachment A) to those purposes directly related to the administration of the Medicare managed care and/or outpatient prescription drug benefits for which it has contracted with the Centers for Medicare & Medicaid Services (CMS) to administer. The sponsor shall only maintain data obtained from CMS information systems that are needed to administer the Medicare managed care and/or outpatient prescription drug benefits that it has contracted with CMS to administer. The sponsor (or its subcontractors or other related entities) may not re-use or provide other entities access to the CMS information system, or data obtained from the system, to support any line of business other than the Medicare managed care and/or outpatient prescription drug benefit for which the sponsor contracted with CMS.

The sponsor further attests that it shall limit the use of information it obtains from its Medicare plan members to those purposes directly related to the administration of such plan. The sponsor acknowledges two exceptions to this limitation. First, the sponsor may provide its Medicare members information about non-health related services after obtaining consent from the members. Second, the sponsor may provide information about health-related services without obtaining prior member consent, as long as the sponsor affords the member an opportunity to elect not to receive such information.

CMS may terminate the sponsor's access to the CMS data systems immediately upon determining that the sponsor has used its access to a data system, data obtained from such systems, or data supplied by its Medicare members beyond the scope for which CMS has authorized under this agreement. A termination of this data use agreement may result in CMS terminating the sponsor's Medicare contract(s) on the basis that it is no longer qualified as a Medicare sponsor. This agreement shall remain in effect as long as the sponsor remains a Medicare managed care organization and/or outpatient prescription drug benefit sponsor. This agreement excludes any public use files or other publicly available reports or files that CMS makes available to the general public on our website.

Attachment A

The following list contains a representative (but not comprehensive) list of CMS information systems to which the Data Use Attestation applies. CMS will update the list periodically as necessary to reflect changes in the agency's information systems

Automated Plan Payment System (APPS)
Common Medicare Environment (CME)
Common Working File (CWF)
Coordination of Benefits Contractor (COBC)
Drug Data Processing System (DDPS)
Electronic Correspondence Referral System (ECRS)
Enrollment Database (EDB)
Financial Accounting and Control System (FACS)
Front End Risk Adjustment System (FERAS)
Health Plan Management System (HPMS), including Complaints Tracking and all other modules
HI Master Record (HIMR)
Individuals Authorized Access to CMS Computer Services (IACS)
Integrated User Interface (IUI)
Medicare Advantage Prescription Drug System (MARx)
Medicare Appeals System (MAS)
Medicare Beneficiary Database (MBD)
Payment Reconciliation System (PRS)
Premium Withholding System (PWS)
Prescription Drug Event Front End System (PDFS)
Retiree Drug System (RDS)
Risk Adjustments Processing Systems (RAPS)

This document has been electronically signed by:

BRIAN KANE

Contracting Official Name

8/28/2019 10:24:28 AM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

Address

H4007

SIGNATURE ATTESTATION

Contract ID: H4007
Contract Name: HUMANA HEALTH PLANS OF PUERTO RICO, INC.

I understand that by signing and dating this form, I am acknowledging that I am an authorized representative of the above named organization and that I am the contracting official associated with the user ID used to log on to the Health Plan Management System (HPMS) to sign the 2020 Medicare contracting documents. I also acknowledge that in accordance with the HPMS Rule of Behavior, sharing user IDs is strictly prohibited.

This document has been electronically signed by:

BRIAN KANE

Contracting Official Name

8/28/2019 10:24:28 AM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

Address

CONTRACT WITH ELIGIBLE MEDICARE ADVANTAGE (MA) ORGANIZATION PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A MEDICARE ADVANTAGE COORDINATED CARE PLAN(S)

CONTRACT (H4007)

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as CMS)

and

HUMANA HEALTH PLANS OF PUERTO RICO, INC.
(hereinafter referred to as the MA Organization)

CMS and the MA Organization, an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR §422.503, agree to the following for the purposes of §§ 1851 through 1859 of the Social Security Act (hereinafter referred to as the Act):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the regulatory authority for certain contract provisions. All references to Part 422 are to 42 CFR Part 422.)

Article I
Term of Contract

The term of this contract shall be from the date of signature by CMS' authorized representative through December 31, 2020, after which this contract may be renewed for successive one-year periods in accordance with 42 CFR §422.505(c) and as discussed in Paragraph A of Article VII below. **[422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above, and supersedes any prior agreements between the MA Organization and CMS as of such date. MA organizations offering Part D benefits also must execute an Addendum to the Medicare Managed Care Contract Pursuant to §§ 1860D-1 through 1860D-43 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereafter the "Part D Addendum"). For MA Organizations offering MA-PD plans, the Part D Addendum governs the rights and obligations of the parties relating to the provision of Part D benefits, in accordance with its terms, as of its effective date.

Article II
Coordinated Care Plan

A. The MA Organization agrees to operate one or more coordinated care plans as defined in 42 CFR §422.4(a)(1)(iii)), including at least one MA-PD plan as required under 42 CFR §422.4(c), as described in its final Plan Benefit Package (PBP) bid submission (benefit and price bid) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan and Price, and in compliance with the requirements of this contract and applicable Federal statutes, regulations, and policies (e.g., policies as described in the Call Letter, Medicare Managed Care Manual, etc.).

B. Except as provided in paragraph (C) of this Article, this contract is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations or policies implementing or interpreting such statutory provisions.

C. CMS will not implement, other than at the beginning of a calendar year, requirements under 42 CFR Part 422 that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute. **[422.521]**

D. If the MA Organization had a contract with CMS for Contract Year 2019 under the contract ID number designated above, this document is considered a renewal of the existing contract. While the terms of this document supersede the terms of the 2019 contract, the parties' execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2019 or prior year contracts.

E. This contract is in no way intended to supersede or modify 42 CFR, Part 422. Failure to reference a regulatory requirement in this contract does not affect the applicability of such requirements to the MA organization and CMS.

Article III
Functions To Be Performed By Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. The MA Organization agrees to provide enrollees in each of its MA plans the basic benefits as required under 42 CFR §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final benefit and price bid proposal as approved by CMS and listed in the MA Organization Plan Attestation of Benefit Plan and Price, which is attached to this contract. The MA Organization agrees to provide access to such benefits as required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in 42 CFR §422.112.

2. The MA Organization agrees to provide post-hospital extended care services, should an MA enrollee elect such coverage, through a home skilled nursing facility, as defined at 42 CFR §422.133(b), according to the requirements of § 1852(l) of the Act and 42 CFR §422.133. **[422. 133; 422.504(a)(3)]**

B. ENROLLMENT REQUIREMENTS

1. The MA Organization agrees to accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in 42 CFR Part 422, Subpart B.

2. The MA Organization shall comply with the provisions of 42 CFR §422.110 concerning prohibitions against discrimination in beneficiary enrollment, other than in enrolling eligible beneficiaries in a CMS-approved special needs plan that exclusively enrolls special needs individuals as consistent with 42 CFR §§422.2, 422.4(a)(1)(iv) and 422.52. **[422.504(a)(2)]**

C. BENEFICIARY PROTECTIONS

1. The MA Organization agrees to comply with all requirements in 42 CFR Part 422, Subpart M governing coverage determinations, grievances, and appeals. **[422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in 42 CFR §422.118.

3. Beneficiary Financial Protections. The MA Organization agrees to comply with the following requirements:

(3.a) Each MA Organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the MA Organization. To meet this requirement the MA Organization must--

(3.a.I) Ensure that all contractual or other written arrangements with providers prohibit the Organization's providers from holding any beneficiary enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(3.a.II) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the MA Organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA Organization, to provide services to the organization's beneficiary enrollees.

[422.504(g)(1)]

(3.a.iii) Ensure that the enrollee does not have any financial liability for services, items, or drugs furnished, ordered, or prescribed to the enrollee by an MA contracting individual or entity on the preclusion list, as defined and described in 42 CFR § 422.2 and 422.222. [422.504(g)(1))iv)]

(3.b) The MA Organization must provide for continuation of enrollee health care benefits-

(3.b.i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(3.b.ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of the MA Organization's insolvency, through the date of discharge. **[422.504(g)(2)]**

(3.c) In meeting the requirements of this paragraph, other than the provider contract requirements specified in subparagraph (3)(a) of this paragraph, the MA Organization may use—

(3.c.i) Contractual arrangements;

(3.c.ii) Insurance acceptable to CMS;

(3.c.iii) Financial reserves acceptable to CMS; or

(3.c.iv) Any other arrangement acceptable to CMS. **[422.504(g)(3)]**

D. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable provider requirements in 42 CFR Part 422 Subpart E, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice to plans, limits on provider indemnification, rules governing payments to providers, limits on physician incentive plans, and preclusion list requirements in 42 CFR §§422.202 & 422.224. **[422.504(a)(6)]**

2. The MA Organization agrees to ensure that the plan's provider agreement contains a provision stating that after the expiration of the 60-day period specified in 42 CFR §422.222:

(2.a) The provider will no longer be eligible for payment from the plan and will be prohibited from pursuing payment from the beneficiary as stipulated by the terms of the contract between CMS and the plan per 42 CFR §422.504(g)(1)(iv); and

(2.b) The provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period, at which point the provider will have already received notification of the preclusion. [422.504(g)(1)(v)]

3. Prompt Payment.

(3.a) The MA Organization must pay 95 percent of "clean claims" within 30 days of receipt if they are claims for covered services that are not furnished under a written agreement between the organization and the provider.

(2.a.i) The MA Organization must pay interest on clean claims that are not paid within 30 days in accordance with §§ 1816(c)(2) and 1842(c)(2) of the Act.

(2.a.ii) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request. **[422.520(a)]**

(3.b) Contracts or other written agreements between the MA Organization and its providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA Organization and the relevant provider. **[422.520(b)]**

(3.c) If CMS determines, after giving notice and opportunity for hearing, that the MA Organization has failed to make payments in accordance with subparagraph (2)(a) of this paragraph, CMS may provide-

(2.c.i) For direct payment of the sums owed to providers; and

(2.c.ii) For appropriate reduction in the amounts that would otherwise be paid to the MA Organization, to reflect the amounts of the direct payments and the cost of making those payments. **[422.520(c)]**

4. Agreements with Federally Qualified Health Centers (FQHC)

(4.a) The MA Organization agrees to pay an FQHC a similar amount to what it pays other providers for similar services.

(4.b) Under such a contract, the FQHC must accept this payment as payment in full, except for allowable cost sharing which it may collect.

(4.c) Financial incentives, such as payments or bonuses, and financial withholdings are not considered in determining the payments made by CMS under 42 CFR §422.316(a). [42 CFR §422.527]

E. QUALITY IMPROVEMENT PROGRAM

1. The MA Organization agrees to operate, for each plan that it offers, an ongoing quality improvement program in accordance with § 1852(e) of the Social Security Act and 42 CFR §422.152.

2. The MA Organization agrees to develop and operate a chronic care improvement program in accordance with the requirements of 42 CFR §422.152(c).

3. Performance Measurement and Reporting: The MA Organization shall measure performance under its MA plans using standard measures required by CMS, and report (at the organization level) its performance to CMS. The standard measures required by CMS during the term of this contract will be uniform data collection and reporting instruments, to include the Health Plan and Employer Data Information Set (HEDIS), Consumer Assessment of Health Plan Satisfaction (CAHPS) survey, and Health Outcomes Survey (HOS). These measures will address clinical areas, including effectiveness of care, enrollee perception of care and use of services; and non-clinical areas including access to and availability of services, appeals and grievances, and organizational characteristics. **[422.152 & 422.162(c)]**

4. Utilization Review:

(4.a) An MA Organization for an MA coordinated care plan must use written protocols for utilization review and policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and have in effect mechanisms to detect both underutilization and over utilization of services. **[422.152(b)]**

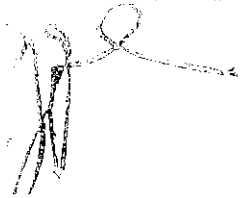
(4.b) For MA regional preferred provider organizations (RPPOs) and MA local preferred provider organizations (PPOs) that are offered by an organization that is not licensed or organized under State law as an HMOs, if the MA Organization uses written protocols for utilization review, those policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and include mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation. **[422.152(e)]**

5. Information Systems:

(5.a) The MA Organization must:

(5.a.i) Maintain a health information system that collects, analyzes and integrates the data necessary to implement its quality improvement program;

(5.a.ii) Ensure that the information entered into the system (particularly that received from providers) is reliable and complete;



(5.a.iii) Make all collected information available to CMS. **[422.152(f)(1)]**

6. External Review: The MA Organization will comply with any requests by Quality Improvement Organizations to review the MA Organization's medical records in connection with appeals of discharges from hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, and home health agencies.

7. The MA Organization agrees to address complaints received by CMS against the MA Organization by:

(7.a) Addressing and resolving complaints in the CMS complaint tracking system; and

(7.b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the MA plan's main Web page.**[422.504(a)(15)]**

F. COMPLIANCE PLAN

The MA Organization agrees to implement a compliance plan in accordance with the requirements of 42 CFR §422.503(b)(4)(vi). **[422.503(b)(4)(vi)]**

G. COMPLIANCE DEEMED ON THE BASIS OF ACCREDITATION

CMS may deem the MA Organization to have met the quality improvement requirements of §1852(e) of the Act and 42 CFR §422.152, the confidentiality and accuracy of enrollee records requirements of §1852(h) of the Act and 42 CFR §422.118, the anti-discrimination requirements of §1852(b) of the Act and 42 CFR §422.110, the access to services requirements of §1852(d) of the Act and 42 CFR §422.112, the advance directives requirements of §1852(i) of the Act and 42 CFR §422.128, the provider participation requirements of §1852(j) of the Act and 42 CFR Part 422, Subpart E, and the applicable requirements described in 42 CFR §423.156, if the MA Organization is fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by CMS and the accreditation organization used the standards approved by CMS for the purposes of assessing the MA Organization's compliance with Medicare requirements. The provisions of 42 CFR §422.156 shall govern the MA Organization's use of deemed status to meet MA program requirements.

H. PROGRAM INTEGRITY

1. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS of any integrity items related to payments from governmental entities, both federal and state, for healthcare or prescription drug services. These items include any investigations, legal actions or matters subject to arbitration brought involving the MA Organization (or MA Organization's firm if applicable) and its subcontractors (excluding contracted network providers), including any key management or executive staff, or any major shareholders (5% or more), by a government agency (state or federal) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. In providing the notice, the sponsor shall keep the government informed of when the integrity item is initiated and when it is closed. Notice should be provided of the details concerning any resolution and monetary payments as well as any settlement agreements or corporate integrity agreements.

2. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS in the event the MA Organization or any of its subcontractors is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services.

I. MARKETING

1. The MA Organization may not distribute any marketing materials, as defined in 42 CFR §422.2260 and in the Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans and Prescription Drug Plans (Medicare Marketing Guidelines), unless they have been filed with and not disapproved by CMS in accordance with 42 CFR §422.2264. The file and use process set out at 42 CFR §422.2262 must be used, unless the MA organization notifies CMS that it will not use this process.

2. CMS and the MA Organization shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The MA Organization bears full responsibility for the accuracy of its marketing materials. CMS, in its sole discretion, may order the MA Organization to print and distribute the agreed upon marketing materials, in a format approved by CMS. The MA Organization must disclose the information to each enrollee electing a plan as outlined in 42 CFR §422.111.

3. The MA Organization agrees that any advertising material, including that labeled promotional material, marketing materials, or supplemental literature, shall be truthful and not misleading. All marketing materials must include the Contract number. All membership identification cards must include the Contract number on the front of the card.

4. The MA Organization must comply with all applicable statutes and regulations, including and without limitation § 1851(h) of the Act and 42 CFR § 422.111, 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V, consistent with guidance provided in the Medicare Communication and Marketing Guidelines. Failure to comply may result in sanctions as provided in 42 CFR Part 422 Subpart O.

Article IV
CMS Payment to MA Organization

A. The MA Organization agrees to develop its annual benefit and price bid proposal and submit to CMS all required information on premiums, benefits, and cost sharing, as required under 42 CFR Part 422 Subpart F. **[422.504(a)(10)]**

B. METHODOLOGY

CMS agrees to pay the MA Organization under this contract in accordance with the provisions of § 1853 of the Act and 42 CFR Part 422 Subpart G. **[422.504(a)(9)]**

C. ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM PAYMENTS

The MA Organization agrees to abide by the requirements in 42 CFR §§495.200 et seq. and §1853(l) and (m) of the Act, including the fact that payment will be made directly to MA-affiliated hospitals that are certified Medicare hospitals through the Medicare FFS hospital incentive payment program.

D. ATTESTATION OF PAYMENT DATA (Attachments A, B, and C).

As a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G, the MA Organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on the forms attached hereto as Attachment A (enrollment attestation) and Attachment B (risk adjustment data) which attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data identified on these attachments. The Medicare Advantage Plan Attestation of Benefit Plan and Price must be signed and attached to the executed version of this contract.

(NOTE: The forms included as attachments to this contract are for reference only. CMS will provide instructions for the completion and submission of the forms in separate documents. MA Organizations should not take any action on the forms until appropriate CMS instructions become available.)

1. Attachment A requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization. The MA Organization shall submit completed enrollment attestation forms to CMS, or its contractor, on a monthly basis.

2. Attachment B requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the risk adjustment data it submits to CMS under 42 CFR §422.310 are accurate, complete, and truthful. The MA Organization shall make annual attestations to this effect for risk adjustment data on Attachment B and according to a schedule to be published by CMS. If such risk adjustment data are generated by a related entity, contractor, or subcontractor of an MA Organization, such entity, contractor, or subcontractor must <u>also</u>*attest to (based on best knowledge, information, and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data. **[422.504(l)]**

3. The Medicare Advantage Plan Attestation of Benefit Plan and Price (an example of which is attached hereto as Attachment C) requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposed bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposed bid submission. This document is being sent separately to the MA Organization and must be signed and attached to the executed version of this contract, and is incorporated herein by reference. **[422.504(l)]**

Article V
MA Organization Relationship with Related Entities, Contractors, and Subcontractors

A. Notwithstanding any relationship(s) that the MA Organization may have with first tier, downstream, or related entities, the MA Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. **[422.504(i)(1)]**

B. The MA Organization agrees to require all first tier, downstream, and related entities to agree that—

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of the first tier, downstream, and related entities related to CMS' contract with the MA organization;

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph B (1) of this Article directly from any first tier, downstream, or related entity;

3. For records subject to review under paragraph B(2) of this Article, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated; and

4. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. **[422.504(i)(2)]**

C. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with first tier, downstream, and related entities shall contain the following elements:

1. Enrollee protection provisions that provide—

(1.a) Consistent with Article III, paragraph C, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(1.b) Consistent with Article III, paragraph C, provision for the continuation of benefits.

2. Accountability provisions that indicate that the MA Organization may only delegate activities or functions to a first tier, downstream, or related entity in a manner consistent with requirements set forth at paragraph D of this Article.

3. A provision requiring that any services or other activity performed by a first tier, downstream, and related entity in accordance with a contract or written agreement will be consistent and comply with the MA Organization's contractual obligations.**[422.504(i)(3)]**

D. If any of the MA Organization's activities or responsibilities under this contract with CMS is delegated to other parties, the following requirements apply to any related entity, contractor, subcontractor, or provider:

1. Each and every contract must specify delegated activities and reporting responsibilities.

2. Each and every contract must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA Organization determine that such parties have not performed satisfactorily.

3. Each and every contract must specify that the performance of the parties is monitored by the MA Organization on an ongoing basis.

4. Each and every contract must specify that either-

(4.a) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA Organization; or

(4.b) The credentialing process will be reviewed and approved by the MA Organization and the MA Organization must audit the credentialing process on an ongoing basis.

5. Each and every contract must specify that the first tier, downstream, or related entity comply with all applicable Medicare laws, regulations, and CMS instructions. **[422.504(i)(4)]**

E. If the MA Organization delegates selection of the providers, contractors, or subcontractors to another organization, the MA Organization's contract with that organization must state that the CMS-contracting MA Organization retains the right to approve, suspend, or terminate any such arrangement. **[422.504(i)(5)]**

F. As of the date of this contract and throughout its term, the MA Organization

1. Agrees that any physician incentive plan it operates meets the requirements of 42 CFR §422.208, and

2. Has assured that all physicians and physician groups that the MA Organization's physician incentive plan places at substantial financial risk have adequate stop-loss protection in accordance with 42 CFR §422.208(f). **[422.208]**

ADMINISTRACIÓN DE SEGUROS DE SALUD
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Article VI
Records Requirements

A. MAINTENANCE OF RECORDS

1. The MA Organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that-

(1.a) Are sufficient to do the following:

(1.a.I) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the benefit and price bid) of the MA Organization.

(1.a.II) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the MA Organization.

(1.a.iii) Enable CMS to audit and inspect any books and records of the MA Organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(1.a.iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the benefit and price bid proposal.

(1.a.v) Establish component rates of the benefit and price bid for determining additional and supplementary benefits.

(1.a.vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(1.b) Include at least records of the following:

(1.b.i) Ownership and operation of the MA Organization's financial, medical, and other record keeping systems.

(1.b.ii) Financial statements for the current contract period and ten prior periods.

(1.b.iii) Federal income tax or informational returns for the current contract period and ten prior periods.

(1.b.iv) Asset acquisition, lease, sale, or other action.

(1.b.v) Agreements, contracts (including, but not limited to, with related or unrelated prescription drug benefit managers) and subcontracts.

(1.b.vi) Franchise, marketing, and management agreements.

(1.b.vii) Schedules of charges for the MA Organization's fee-for-service patients.

(1.b.viii) Matters pertaining to costs of operations.

(1.b.ix) Amounts of income received, by source and payment.

(1.b.x) Cash flow statements.

(1.b.xi) Any financial reports filed with other Federal programs or State authorities.**[422.504(d)]**

2. Access to facilities and records. The MA Organization agrees to the following:

(2.a) The Department of Health and Human Services (HHS), the Comptroller General, or their designee may evaluate, through inspection or other means—

(2.a.i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(2.a.ii) Compliance with CMS requirements for maintaining the privacy and security of protected health information and other personally identifiable information of Medicare enrollees;

(2.a.iii) The facilities of the MA Organization; and

(2.a.iv) The enrollment and disenrollment records for the current contract period and ten prior periods.

(2.b) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, documents, papers, patient care documentation, and other records of the MA Organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(2.c) The MA Organization agrees to make available, for the purposes specified in paragraph A of this Article, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require.

(2.d) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the final date of the contract period or completion of audit, whichever is later unless-

(2.d.i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA Organization at least 30 days before the normal disposition date;

(2.d.ii) There has been a termination, dispute, or fraud or similar fault by the MA Organization, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(2.d.iii) HHS, the Comptroller General, or their designee determines that there is a reasonable possibility of fraud, in which case they may inspect, evaluate, and audit the MA Organization at any time. **[422.504(e)]**

B. REPORTING REQUIREMENTS

1. The MA Organization shall have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor patient relationship, statistics and other information as described in the remainder of this paragraph. **[422.516(a)]**

2. The MA Organization agrees to submit to CMS certified financial information that must include the following:

(2.a) Such information as CMS may require demonstrating that the organization has a fiscally sound operation, including:

(2.a.i) The cost of its operations;

(2.a.ii) A description, submitted to CMS annually and within 120 days of the end of the fiscal year, of significant business transactions (as defined in 42 CFR §422.500) between the MA Organization and a party in interest showing that the costs of the transactions listed in subparagraph (2)(a)(v) of this paragraph do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(2.a.iii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(2.a.iv) A combined financial statement for the MA Organization and a party in interest if either of the following conditions is met:

(2.a.iv.aa) Thirty five percent or more of the costs of operation of the MA Organization go to a party in interest.

(2.a.iv.bb) Thirty five percent or more of the revenue of a party in interest is from the MA Organization. **[422.516(b)]**

(2.a.v) Requirements for combined financial statements.

(2.a.v.aa) The combined financial statements required by this subparagraph must display in separate columns the financial information for the MA Organization and each of the parties in interest.

(2.a.v.bb) Inter-entity transactions must be eliminated in the consolidated column.

(2.a.v.cc) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(2.a.v.dd) Upon written request from the MA Organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in this subparagraph with respect to a particular entity. **[422.516(c)]**

(2.a.vi) A description of any loans or other special financial arrangements the MA Organization makes with contractors, subcontractors, and related entities. **[422.516(e)]**

(2.b) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA Organization. **[422.504(f)]**

(2.c) Patterns of utilization of the MA Organization's services. **[422.516(a)(2)]**

3. The MA Organization agrees to participate in surveys required by CMS and to submit to CMS all information that is necessary for CMS to administer and

evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(3.a) The benefits covered under the MA plan;

(3.b) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan.

(3.c) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(3.d) Plan quality and performance indicators for the benefits under the plan including —

(3.d.i) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(3.d.ii) Information on Medicare enrollee satisfaction;

(3.d.iii) The patterns of utilization of plan services;

(3.d.iv) The availability, accessibility, and acceptability of the plan's services;

(3.d.v) Information on health outcomes and other performance measures required by CMS;

(3.d.vi) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(3.d.vii) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;

(3.d.viii) Information about beneficiary appeals and their disposition;

(3.d.ix) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(3.d.x) Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program. **[422.504(f)(2)]**

4. The MA Organization agrees to provide to its enrollees and upon request, to any individual eligible to elect an MA plan, all informational requirements under 42 CFR §422.64 and, upon an enrollee's, request, the financial disclosure information required under 42 CFR §422.516. **[422.504(f)(3)]**

5. Reporting and disclosure under ERISA —

(5.a) For any employees' health benefits plan that includes an MA Organization in its offerings, the MA Organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the MA Organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(5.b) The MA Organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA. **[422.516(d)]**

6. Electronic communication. The MA Organization must have the capacity to communicate with CMS electronically. **[422.504(b)]**

7. Risk Adjustment data. The MA Organization agrees to comply with the requirements in 42 CFR §422.310 for submitting risk adjustment data to CMS. **[422.504(a)(8)]**

8. The MA Organization acknowledges that CMS releases to the public the following data, consistent with 42 CFR Part 422, Subpart K, and 42 CFR Part 423, Subpart K:

(8.a) summary reconciled Part C and Part D payment data after the reconciliation of Part C and Part D payments, as provided in 42 CFR §422.504(n)(1) and 42 CFR §423.505(o)(1);

(8.b) MA bid pricing data submitted during the annual bidding process, as described at 42 CFR §422.272;

(8.c) Part C Medical Loss Ratio data for the contract year, as described at 42 CFR §422.2490, and, for Part D plan sponsors, Part D Medical Loss Ratio data for the contract year, as described at 42 CFR §423.2490.

9. The MA Organization agrees that it must subject information collected pursuant to 42 CFR §422.516(a) to a yearly independent audit to determine their reliability, validity, completeness, and comparability in accordance with specifications developed by CMS. [422.516(g)]

Article VII
Renewal of the MA Contract

A. RENEWAL OF CONTRACT

In accordance with 42 CFR §422.505, following the initial contract period, this contract is renewable annually only if-

1. The MA Organization has not provided CMS with a notice of intention not to renew; **[422.506(a)]**

2. CMS and the MA Organization reach agreement on the bid under 42 CFR Part 422, Subpart F; and **[422.505(d)]**

3. CMS informs the MA Organization that it authorizes a renewal.

B. NONRENEWAL OF CONTRACT

1. In accordance with 42 CFR §422.506, the MA Organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason, provided it meets the time frames for doing so set forth in this subparagraph.

2. If the MA Organization does not intend to renew its contract, it must notify—

(2.a) CMS, in writing, by the first Monday in June of the year in which the contract would end, pursuant to 42 CFR §422.506

(2.b) Each Medicare enrollee by mail, at least 90 calendar days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area including alternative MA plans, MA-PD plans, Medigap options, and original Medicare and prescription drug plans and must receive CMS approval prior to issuance.

3. If the organization submits a request to end the term of its contract after the deadline in 42 CFR §422.506, CMS may mutually consent to terminate the contract pursuant to 42 CFR §422.508 when a nonrenewal notice is submitted after the applicable annual non-renewal notice deadline if—

(3.a) The contract termination does not negatively affect the administration of the Medicare program; and

(3.b) The MA Organization notifies its Medicare enrollees and the public in accordance with subparagraph 1(b)(ii) of this paragraph; and

4. If the MA Organization does not renew a contract under this subparagraph, CMS may deny an application for a new contract or a service area expansion from the Organization or with any organization whose covered persons, as defined at 42 CFR §422.506(a)(4), also served as covered persons for the non-renewing MA Organization for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS. This prohibition may apply regardless of

the product type, contract type, or service area of the previous contract. [422.506(a) & 422.508(c)]

Article VIII
Modification or Termination of the Contract

A. MODIFICATION OR TERMINATION OF CONTRACT BY MUTUAL CONSENT

1. This contract may be modified or terminated at any time by written mutual consent.

(1.a) If the contract is modified by written mutual consent, the MA Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within time frames specified by CMS. **[422.508(a)(2)]**

(1.b) If the contract is terminated by written mutual consent, except as provided in subparagraph 2 of this paragraph, the MA Organization must provide notice to its Medicare enrollees and the general public as provided in paragraph B, subparagraph 2(b) of this Article. **[422.508(a)(1)]**

2. If this contract is terminated by written mutual consent and replaced the day following such termination by a new MA contract, the MA Organization is not required to provide the notice specified in paragraph B of this Article.**[422.508(b)]**

3. As a condition of the consent to a mutual termination, CMS will require as a provision of the termination agreement language prohibiting the MA organization from applying for new contracts or service area expansions for a period of 2 years, absent circumstances warranting special consideration. This prohibition may apply regardless of the product type, contract type, or service area of the previous contract. **[422.508(c)]**

B. TERMINATION OF THE CONTRACT BY CMS OR THE MA ORGANIZATION

1. Termination by CMS.

(1.a) CMS may at any time terminate a contract if CMS determines that the MA Organization meets any of the following: [42 CFR §422.510(a)(1)-(3)]

(1.a.i) has failed substantially to carry out the terms of its contract with CMS.

(1.a.ii) is carrying out its contract in a manner that is inconsistent with the efficient and effective implementation of 42 CFR Part 422.

(1.a.iii) no longer substantially meets the applicable conditions of 42CFR Part 422.

(1.b) CMS may make a determination under paragraph B(1)(a)(i), (ii), or (iii) of this Article if the MA Organization has had one or more of the conditions listed in 42 CFR §422.510(a)(4) occur.

(1.c) Notice. If CMS decides to terminate a contract , it will give notice of the termination as follows: [42 CFR §422.510(b)(1)]

(1.c.i) CMS will notify the MA Organization in writing at least 45 calendar days before the intended date of the termination.

(1.c.ii) The MA Organization will notify its Medicare enrollees of the termination by mail at least 30 calendar days before the effective date of the termination.

(1.c.iii) The MA Organization will notify the general public of the termination at least 30 calendar days before the effective date of the termination by releasing a press statement to news media serving the affected community or county and posting the press statement prominently on the organization's Web site.

(1.c.iv) In the event that CMS issues a termination notice to an MA Organization on or before August 1 with an effective date of the following December 31, the MA Organization must issue notification to its Medicare enrollees at least 90 days prior to the effective date of termination.

(1.d) Expedited termination of contract by CMS. [42 CFR §422.510(b)(2)]

(1.d.i) For terminations based on violations prescribed in 42 CFR §422.510(a)(4)(i) or if CMS determines that a delay in termination would pose an imminent and serious threat to the health of the individuals enrolled with the MA Organization, CMS will notify the MA Organization in writing that its contract has been terminated on a date specified by CMS. If a termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA Organization covering the period of the month following the contract termination.

(1.d.ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS' decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the plan of its decision to terminate this contract. CMS will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA Organizations in a similar geographic area and original Medicare.

(1.d.iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS' decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(1.e) Corrective action plan [42 CFR §422.510(c)]

(1.e.i) General. Before providing a notice of intent to terminate a contract for reasons other than the grounds specified in subparagraph 1(d)(i) of this paragraph, CMS will provide the MA Organization with notice specifying the MA Organization's deficiencies and a reasonable opportunity of at least 30 calendar days to develop and implement an approved corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(1.e.ii) Exceptions. If a contract is terminated under subparagraph 1(d)(i) of this paragraph, the MA Organization will not be provided with the opportunity to develop and implement a corrective action plan.

(1.f) Appeal rights. If CMS decides to terminate this contract, it will send written notice to the MA Organization informing it of its termination appeal rights in accordance with 42 CFR Part 422 Subpart N. **[422.510(d)]**

2. Termination by the MA Organization [42 CFR §422.512]

(2.a) Cause for termination. The MA Organization may terminate this contract if CMS fails to substantially carry out the terms of the contract.

(2.b) Notice. The MA Organization must give advance notice as follows:

(2.b.i) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA Organization is requesting contract termination.

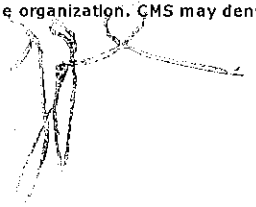
(2.b.ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA and MA-PD plans, PDP plans, Medigap options, and original Medicare and must receive CMS approval.

(2.b.iii) To the general public at least 60 days before the termination effective date by publishing a CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA Organization's geographic area.

(2.c) Effective date of termination. The effective date of the termination will be determined by CMS and will be at least 90 days after the date CMS receives the MA Organization's notice of intent to terminate.

(2.d) CMS' liability. CMS' liability for payment to the MA Organization ends as of the first day of the month after the last month for which the contract is in effect, but CMS shall make payments for amounts owed prior to termination but not yet paid.

(2.e) Effect of termination by the organization. CMS may deny an application for a new contract or service area expansion from the MA Organization or with



an organization whose covered persons, as defined in 42 CFR §422.512(e)(2), also served as covered persons for the terminating MA Organization for a period of two years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by CMS. This prohibition may apply regardless of the product type, contract type, or service area of the previous contract. **[422.512]**

Article IX
Requirements of Other Laws and Regulations

A. The MA Organization agrees to comply with—

1. Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 USC §§3729 et seq.) , and the anti-kickback statute (§ 1128B(b) of the Act): and

2. HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.**[422.504(h)]**

B. Pursuant to § 13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), the MA Organization agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by § 13101 of the ARRA.

C. The MA Organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors. **[422.504(i)]**

D. In the event that any provision of this contract conflicts with the provisions of any statute or regulation applicable to an MA Organization, the provisions of the statute or regulation shall have full force and effect.

E. The MA Organization agrees to comply with the requirements relating to Nondiscrimination in Health Programs and Activities in 45 CFR Part 92, including submitting assurances that the MA Organization's health programs and activities will be operated in compliance with the nondiscrimination requirements, as required in 45 CFR §92.5.

Article X
Severability

The MA Organization agrees that, upon CMS' request, this contract will be amended to exclude any MA plan or State-licensed entity specified by CMS, and a separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made. **[422.504(k)]**

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
20 - 004

Article XI
Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 422.

B. ALTERATION TO ORIGINAL CONTRACT TERMS

The MA Organization agrees that it has not altered in any way the terms of this contract presented for signature by CMS. The MA Organization agrees that any alterations to the original text the MA Organization may make to this contract shall not be binding on the parties.

C. MA Organization agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 CFR § 422.504(a)(14).

D. MA Organization agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality improvement activities related to the delivery of Part C services as required by 42 CFR §422.504(a)(16).

E. MA Organization agrees to maintain a Part C summary plan rating score of at least 3 stars under the 5-star rating system specified in 42 CFR Part 422 subpart D, as required by 42 CFR §422.504(a)(17).

F. CMS may determine that an MA organization is out of compliance with a Part C requirement when the organization fails to meet performance standards articulated in the Part C statutes, regulations, or guidance. If CMS has not already articulated a measure for determining noncompliance, CMS may determine that an MA organization is out of compliance when its performance in fulfilling Part C requirements represents and outlier relative to the performance of other MA organizations. **[422.504(m)]**

G. **Business Continuity:** The MA organization agrees to develop, maintain, and implement a business continuity plan as required by 42 CFR §422.504(o).

ATTACHMENT A

ATTESTATION OF ENROLLMENT INFORMATION
RELATING TO CMS PAYMENT
TO A MEDICARE ADVANTAGE ORGANIZATION

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution. This attestation shall not be considered a waiver of the MA Organization's right to seek payment adjustments from CMS based on information or data which does not become available until after the date the MA Organization submits this attestation.

1. The MA Organization has reported to CMS for the month of (INDICATE MONTH AND YEAR) all new enrollments, disenrollments, and appropriate changes in enrollees' status with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

2. The MA Organization has reviewed the CMS monthly membership report and reply listing for the month of (INDICATE MONTH AND YEAR) for the above-stated MA plans and has reported to CMS any discrepancies between the report and the MA Organization's records. For those portions of the monthly membership report and the reply listing to which the MA Organization raises no objection, the MA Organization, through the certifying CEO/CFO, will be deemed to have attested, based on best knowledge, information, and belief as of the date indicated below, to its accuracy, completeness, and truthfulness.

ATTACHMENT B

ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO
CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization

acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS during the period of (INDICATE DATES) all (INDICATE TYPE - DIAGNOSIS/ENCOUNTER) risk adjustment data available to the MA Organization with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

ATTACHMENT C - Medicare Advantage Plan Attestation of Benefit Plan and Price

In witness whereof, the parties hereby execute this contract.

This document has been electronically signed by:

FOR THE MA ORGANIZATION

BRIAN KANE

Contracting Official Name

8/28/2019 10:24:28 AM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

9/19/2019 8:34:18 AM

Date

Kathryn A. Coleman
Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

H4007

MEDICARE MARK LICENSE AGREEMENT

THIS AGREEMENT is made and entered into 8/28/2019 10:24:28 AM

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter "Licensor"),
with offices located at 7500 Security Blvd.,Baltimore, MD 21244

and

HUMANA HEALTH PLANS OF PUERTO RICO, INC. (hereinafter "Licensee"),
with offices located at 383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

CMS Contract ID: H4007

WITNESSETH

WHEREAS, Licensor is the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

WHEREAS, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning October 15, 2019.

WHEREAS, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Agreement, Licensor hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.
2. Licensee acknowledges Licensor's exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Agreement with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.
3. Licensor retains the right to use the Mark in the manner or style it has done so prior to this Agreement and in any other lawful manner.
4. This Agreement and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.
5. Licensor, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensor may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensor. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Medicare Marketing Guidelines. Licensee shall not take any action inconsistent with the Licensor's ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensor.
6. This agreement shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2020, concurrent with the execution of the Part D contract (or Part D addendum to a Medicare Managed Care contract). This Agreement may be terminated by either party upon written notice at any time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark immediately. Starting December 31, 2020, this agreement shall be renewable for successive one-year periods running concurrently with the term of the Licensee's Part D contract. This agreement shall terminate, without written notice, upon the effective date of termination or non-renewal of the Licensee's Part D contract (or Part D addendum to a Medicare Managed Care contract).
7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.
8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Agreement even if Licensor has been advised of the possibility of such damages.
9. This Agreement is the entire agreement between the parties with respect to the subject matter hereto.
10. Federal law shall govern this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement by their duly authorized officers as of the date first set forth above.

This document has been electronically signed by:

FOR THE LICENSEE

BRIAN KANE

Contracting Official Name

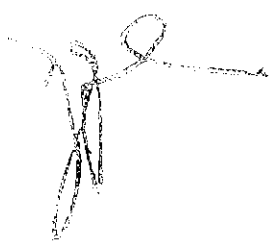
8/28/2019 10:24:28 AM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

FOR THE LICENSOR



H4007

9/19/2019 8:34:18 AM

Amy Larrick Chavez-Valdez
Director
Medicare Drug Benefit
and C & D Data Group,
Center for Medicare

Date

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
20 - 004

H4007

EMPLOYER/UNION-ONLY GROUP PART C ADDENDUM TO CONTRACT WITH APPROVED ENTITY PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A MEDICARE ADVANTAGE PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and HUMANA HEALTH PLANS OF PUERTO RICO, INC., a Medicare Advantage Organization (hereinafter referred to as the "MA Organization") agree to amend the contract H4007 governing the MA Organization's operation of a Medicare Advantage plan described in §1851(a)(2)(A) or §1851(a)(2)(C) of the Social Security Act (hereinafter referred to as "the Act"), including all attachments, addenda, and amendments thereto, to include the provisions contained in this Addendum (collectively hereinafter referred to as the "contract"), under which the MA Organization shall offer Employer/Union-Only Group MA-Only Plans (hereinafter referred to as "employer/union-only group health plans") in accordance with the waivers granted by CMS under §1857(i) of the Act. The terms of this Addendum shall only apply to MA-only health plans offered by the MA Organization exclusively to eligible individuals enrolled in employment-based health coverage under a contract between the MA Organization and the employer/union sponsor of the employment-based health coverage.

This Addendum is made pursuant to Subpart K of 42 CFR Part 422.

Article I
Employer/Union-Only Group Medicare Advantage Health Plan

A. MA Organization agrees to operate one or more employer/union-only group health plans in accordance with the Medicare Advantage contract (as modified by this Addendum), which incorporates in its entirety the *2020 Part C-Medicare Advantage and 1876 Cost Plan Expansion Application* (released on January 9, 2019) and any employer/union-only group waiver guidance, including, but not limited to those requirements contained in Chapter 9 of the Medicare Managed Care Manual).

B. This Addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract, and any regulations and policies implementing or interpreting such statutory provisions.

C. In the event of any conflict between the employer/union-only group waiver guidance issued prior to the execution of the contract and this Addendum, the provisions of this Addendum shall control. In the event of any conflict between the employer/union-only group waiver guidance issued after the execution of the contract and this Addendum, the provisions of the employer/union-only group guidance shall control.

D. This Addendum is in no way intended to supersede or modify 42 CFR Part 422 or §§1851 through 1859 of the Act, except as specifically provided in applicable employer/union-only group waiver guidance and/or in this Addendum. Failure to reference a statutory or regulatory requirement in this Addendum does not affect the applicability of such requirement to the MA Organization and CMS.

E. The provisions of this Addendum apply to all employer/union-only group health plans offered by MA Organization under this contract number. In the event of any conflict between the provisions of this Addendum and any other provision of the contract, the terms of this Addendum shall control.

Article II
Functions to be Performed by the Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. MA Organization agrees to provide enrollees in each of its employer/union-only group health plans the basic benefits (hereinafter referred to as "basic benefits") as required under 42 CFR §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final plan benefit package proposal as approved by CMS.

2. MA Organization acknowledges and agrees that payment under Part C of Title XVIII for Part A and B services, including rebates under section 1854 of the Social Security Act, provided to enrollees in its employer/union-only group MA-PDs will be governed by the CY 2020 Rate Announcement issued on April 1, 2019.

3. The requirements in §1852 of the Act and 42 CFR §422.100(c)(1) pertaining to the offering of benefits covered under Medicare Part A and in §1851 of the Act and 42 CFR §422.50(a)(1) pertaining to who may enroll in an MA plan are waived for employer/union-only group health plan enrollees who are not entitled to Medicare Part A.

4. For employer/union-only group health plans offering non-calendar year coverage, MA Organization may determine basic and supplemental benefits (including deductibles, out-of-pocket limits, etc.) on a non-calendar year basis subject to the following requirements:

(4.a) Applications, plan benefit packages, bids, and other submissions to CMS must be submitted on a calendar year basis; and

(4.b) CMS payments will be determined on a calendar year basis.

5. For employer/union-only group MA-only plans that have a monthly beneficiary rebate described in 42 CFR §422.266:

(5.a) MA Organization may vary the form of rebate for a particular plan benefit package so that the total monthly rebate amount may be credited differently for each employer/union group to whom MA Organization offers the plan benefit package; and

(5.b) MA Organization must retain documentation that supports the use of all of the rebates on a detailed basis for each employer/union group within the plan benefit package and must provide access to this documentation in accordance with the requirements of 42 CFR §422.504(e).

B. ENROLLMENT REQUIREMENTS

1. MA Organization agrees to restrict enrollment in an employer/union-only group health plan to those individuals eligible for the employer's/union's employment-based group coverage.

2. MA Organization will not be subject to the requirement to offer the employer/union-only group health plan to all eligible beneficiaries residing in the plan's service area as set forth in 42 CFR §422.50.

3. If an employer/union elects to enroll eligible individuals eligible for its employer/union-only group health plan through a group enrollment process, MA Organization will not be subject to the individual enrollment requirements set forth in 42 CFR §422.60. MA Organization agrees that it will comply with all the requirements for group enrollment contained in CMS guidance, including those requirements contained in Chapter 2 of the Medicare Managed Care Manual.

C. BENEFICIARY PROTECTIONS

1. Except as provided in subparagraph 2 of this paragraph, CMS agrees that with respect to any employer/union-only group health plans, MA Organization will not be subject to the prior review and approval of marketing materials and election forms requirements set forth in 42 CFR Part 422 Subpart V. MA Organization will be subject to all other disclosure requirements contained in 42 CFR §422.111 and that are conditions on any waivers for EGWPs provided in CMS guidance in Chapter 9 of the Medicare Managed Care Manual.

2. CMS agrees that the disclosure requirements set forth in 42 CFR §422.111 will not apply with respect to any employer/union-only group health plan when the employer/union is subject to alternative disclosure requirements (e.g., the Employee Retirement Income Security Act of 1974 ("ERISA")) and fully complies with such alternative requirements. As a condition of this waiver, MA Organization must:

(2.a) Provide summary plan descriptions and all other beneficiary communications required by the alternative disclosure requirements on a timely basis;

(2.b) Provide these materials to CMS, upon request, in the event of beneficiary complaints, or for any other reason CMS requests, so that CMS may ensure

the information accurately and adequately informs Medicare beneficiaries about their rights and obligations under the plan.

(2.c) Retain these dissemination materials and provide access to these written materials to CMS (or its designees) in accordance with 42 CFR 422.503(d) and 422.504(d) and (e).

3. MA Organization agrees to comply with the requirements for this waiver contained in employer/union-only group waiver guidance, including those requirements contained in Chapter 9 of the Medicare Managed Care Manual.

D. SERVICE AREA

1. CMS agrees that local employer/union-only group health plans that provide coverage to individuals in any part of a State may offer coverage to individuals eligible for the employer/union-only group throughout that State provided the MA Organization has properly designated (in accordance with CMS operational requirements) its employer/union-only group service areas in CMS's Health Plan Management System (HPMS) as including those areas outside of its individual service area(s) to allow for enrollment of these beneficiaries in CMS enrollment systems.

2. Notwithstanding 42 CFR § 422.50(a)(3), CMS agrees that those Local Coordinated Care Health MA-PDs that provide coverage to individuals in any part of a State can offer coverage to beneficiaries eligible for the employer/union-only group plan that reside outside of the State provided it meets the requirements designated in the Medicare Managed Care Manual.

In witness whereof, the parties hereby execute this contract.

This document has been electronically signed by:

FOR THE MA ORGANIZATION

BRIAN KANE

Contracting Official Name

8/28/2019 10:24:28 AM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

9/19/2019 8:34:18 AM

Date

Kathryn A. Coleman
Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
20 - 004

H4007

ADDENDUM TO MEDICARE MANAGED CARE CONTRACT PURSUANT TO SECTIONS 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and HUMANA HEALTH PLANS OF PUERTO RICO, INC., a Medicare managed care organization (hereinafter referred to as MA-PD Sponsor) agree to amend the contract H4007 governing MA-PD Sponsor's operation of a Part C plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as "the Act") or a Medicare cost plan to include this addendum under which MA-PD Sponsor shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

This addendum is made pursuant to Subpart L of 42 CFR Part 417 (in the case of cost plan sponsors offering a Part D benefit) and Subpart K of 42 CFR Part 422 (in the case of an MA-PD Sponsor offering a Part C plan).

NOTE: For purposes of this addendum, unless otherwise noted, reference to an "MA-PD Sponsor" or "MA-PD Plan" is deemed to include a cost plan sponsor or a MA private fee-for-service contractor offering a Part D benefit.

Article I
Voluntary Medicare Prescription Drug Plan

A. MA-PD Sponsor agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including but not limited to all the attestations contained therein and all supplemental guidance, and in compliance with the provisions of this addendum, which incorporates in its entirety the *Solicitation for Applications for Medicare Prescription Drug Plan 2020 Contracts*, released on January 9, 2019 (hereinafter collectively referred to as "the addendum"). MA-PD Sponsor also agrees to operate in accordance with the regulations at 42 CFR Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable Federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.

B. CMS agrees to perform its obligations to MA-PD Sponsor consistent with the regulations at 42 CFR Part423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable Federal statutes, regulations, and policies.

C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 CFR Part 423 that impose new, significant regulatory requirements on MA-PD Sponsor. This provision does not apply to new requirements mandated by statute.

D. If MA-PD Sponsor had an MA-PD Addendum with CMS for Contract Year 2019 under the contract ID number designated above, this document is considered a renewal of the existing addendum. While the terms of this document supersede the terms of the 2019 addendum, the parties' execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2019 or prior year addendums.

E. This addendum is in no way intended to supersede or modify 42 CFR, Parts 417, 422 or 423. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to MA-PD Sponsor and CMS.

Article II
Functions to be Performed by MA-PD Sponsor

A. ENROLLMENT

1. MA-PD Sponsor agrees to enroll in its MA-PD plan only Part D-eligible beneficiaries as they are defined in 42 CFR §423.30(a) and who have elected to enroll in MA-PD Sponsor's Part C or §1876 benefit.

2. If MA-PD Sponsor is a cost plan sponsor, MA-PD Sponsor acknowledges that its §1876 plan enrollees are not required to elect enrollment in its Part D plan.

B. PRESCRIPTION DRUG BENEFIT

1. MA-PD Sponsor agrees to provide the required prescription drug coverage as defined under 42 CFR §423.100 and, to the extent applicable, supplemental benefits as defined in 42 CFR §423.100 and in accordance with Subpart C of 42 CFR Part 423. MA-PD Sponsor also agrees to provide Part D benefits as described in MA-PD Sponsor's Part D bid(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).

2. MA-PD Sponsor agrees to calculate and collect beneficiary Part D premiums in accordance with 42 CFR §§423.286 and 423.293.

3. If MA-PD Sponsor is a cost plan sponsor, it acknowledges that its Part D benefit is offered as an optional supplemental service in accordance with 42 CFR §417.440(b)(2)(ii).

4. MA-PD Sponsor agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, communication, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 CFR §423.505(b)(25).

5. MA-PD Sponsor agrees to provide applicable beneficiaries applicable discounts on applicable drugs in accordance with the requirements of 42 CFR Part 423 Subpart W.

C. DISSEMINATION OF PLAN INFORMATION

1. MA-PD Sponsor agrees to provide the information required in 42 CFR §423.48.

2. MA-PD Sponsor acknowledges that CMS releases to the public the following data, consistent with 42 CFR Part 423, Subpart K:

(a) summary reconciled Part D payment data after the reconciliation of Part D payments, as provided in 42 CFR §423.505(o)(1);

(b) Part D Medical Loss Ratio data for the contract year, as described at 42 CFR §423.2490.

3. MA-PD Sponsor agrees to disclose information related to Part D benefits to beneficiaries in the manner and the form specified by CMS under 42 CFR §§423.128 and 423 Subpart V, consistent with the guidance provided in the Medicare Communication and Marketing Guidelines.

D. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. MA-PD Sponsor agrees to operate quality assurance, drug utilization management, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart D of 42 CFR Part 423.

2. MA-PD Sponsor agrees to address complaints received by CMS against the Part D sponsor as required in 42 CFR §423.505(b)(22) by:

(a) Addressing and resolving complaints in the CMS complaint tracking system; and

(b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the Part D plan's main Web page.

3. MA-PD Sponsor agrees to maintain a Part D summary plan rating score of at least 3 stars as required by 42 CFR §423.505(b)(26).

4. MA-PD Sponsor agrees to pass an essential operations test prior to the start of the benefit year. This provision only applies to new sponsors that have not previously entered into a Part D contract with CMS and neither it, nor another subsidiary of the applicant's parent organization, is offering Part D benefits during the

current year. 42 CFR §423.505(b)(27).

E. APPEALS AND GRIEVANCES

MA-PD Sponsor agrees to comply with all requirements in Subpart M of 42 CFR Part 423 governing coverage determinations, grievances and appeals, and formulary exceptions and the relevant provisions of Subpart U governing reopenings. MA-PD Sponsor acknowledges that these requirements are separate and distinct from the appeals and grievances requirements applicable to MA-PD Sponsor through the operation of its Part C or cost plan benefits.

F. PAYMENT TO MA-PD SPONSOR

MA-PD Sponsor and CMS agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 CFR Part 423.

G. BID SUBMISSION AND REVIEW

If MA-PD Sponsor intends to participate in the Part D program for the next program year, MA-PD Sponsor agrees to submit the next year's Part D bid, including all required information on premiums, benefits, and cost-sharing, by the applicable due date, as provided in Subpart F of 42 CFR Part 423 so that CMS and MA-PD Sponsor may conduct negotiations regarding the terms and conditions of the proposed bid and benefit plan renewal. MA-PD Sponsor acknowledges that failure to submit a timely bid under this section may affect the sponsor's ability to offer a Part C plan, pursuant to the provisions of 42 CFR §422.4(c).

H. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. MA-PD Sponsor agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 CFR Part 423.

2. MA-PD Sponsor agrees to comply with Medicare Secondary Payer procedures as stated in 42 CFR §423.462.

I. SERVICE AREA AND PHARMACY ACCESS

1. MA-PD Sponsor agrees to provide Part D benefits in the service area for which it has been approved by CMS to offer Part C or cost plan benefits utilizing a pharmacy network and formulary approved by CMS that meet the requirements of 42 CFR §423.120.

2. MA-PD Sponsor agrees to provide Part D benefits through out-of-network pharmacies according to 42 CFR §423.124.

3. MA-PD Sponsor agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 CFR §423.100), and long-term care pharmacies (as defined in 42 CFR §423.100) according to 42 CFR §423.505(b)(17).

4. MA-PD Sponsor agrees to contract with any pharmacy that meets MA-PD Sponsor's reasonable and relevant standard terms and conditions according to 42 CFR §423.505(b)(18), including making standard contracts available on request in accordance with the timelines specified in the regulation.

(a) If MA-PD Sponsor has demonstrated that it historically fills 98% or more of its enrollees' prescriptions at pharmacies owned and operated by MA-PD Sponsor (or presents compelling circumstances that prevent the sponsor from meeting the 98% standard or demonstrates that its Part D plan design will enable the sponsor to meet the 98% standard during the contract year), this provision does not apply to MA-PD Sponsor's plan. 42 CFR§423.120(a)(7)(I)

(b) The provisions of 42 CFR §423.120(a) concerning the retail pharmacy access standard do not apply to MA-PD Sponsor if the Sponsor has demonstrated to CMS that it historically fills more than 50% of its enrollees' prescriptions at pharmacies owned and operated by MA-PD Sponsor. MA-PD Sponsors excused from meeting the standard are required to demonstrate retail pharmacy access that meets the requirements of 42 CFR §422.112 for a Part C contractor and 42 CFR §417.416(e) for a cost plan contractor. 42 CFR§423.120(a)(7)(I)

J. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

MA-PD Sponsor agrees that it will develop and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 CFR §423.504(b)(4)(vi).

K. LOW-INCOME SUBSIDY

MA-PD Sponsor agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 CFR Part 423.

L. BENEFICIARY FINANCIAL PROTECTIONS

MA-PD Sponsor agrees to afford its enrollees protection from liability for payment of fees that are the obligation of MA-PD Sponsor in accordance with 42 CFR §423.505(g).

M. RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

1. MA-PD Sponsor agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.

2. MA-PD Sponsor shall ensure that any contracts or agreements with first tier, downstream, and related entities performing functions on MA-PD Sponsor's behalf related to the operation of the Part D benefit are in compliance with 42 CFR §423.505(I).

N. CERTIFICATION OF DATA THAT DETERMINE PAYMENT

MA-PD Sponsor must provide certifications in accordance with 42 CFR §423.505(k).

O. MA-PD SPONSOR REIMBURSEMENT TO PHARMACIES

1. If MA-PD Sponsor uses a standard for reimbursement of pharmacies based on the cost of a drug, MA-PD Sponsor will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

2. If the source for any prescription drug pricing standard is not publicly available, MA-PD Sponsor will disclose all individual drug prices to be updated to the applicable pharmacies in advance for their use for the reimbursement of claims.

3. MA-PD Sponsor will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 days of receipt of an electronically submitted claim or within 30 days of receipt of a claim submitted otherwise.

4. MA-PD Sponsor must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than 30 days (but not more than 90 days) to submit claims to MA-PD Sponsor for reimbursement.

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Article III
Record Retention and Reporting Requirements

A. RECORD MAINTENANCE AND ACCESS

MA-PD Sponsor agrees to maintain records and provide access in accordance with 42 CFR §§ 423.505 (b)(10) and 423.505(i)(2).

B. GENERAL REPORTING REQUIREMENTS

MA-PD Sponsor agrees to submit information to CMS according to 42 CFR §§423.505(f) and 423.514, and the "Final Medicare Part D Reporting Requirements" document issued by CMS and subject to modification each program year.

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C. CMS LICENSE FOR USE OF PLAN FORMULARY

MA-PD Sponsor agrees to submit to CMS each plan's formulary information, including any changes to its formularies, and hereby grants to the Government, and any person or entity who might receive the formulary from the Government, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

Article IV
HIPAA Provisions

A. MA-PD Sponsor agrees to comply with the confidentiality and enrollee record accuracy requirements specified in 42 CFR §423.136.

B. MA-PD Sponsor agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of-pocket costs.

Article V
Addendum Term and Renewal

A. TERM OF ADDENDUM

This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2020. This addendum shall be renewable for successive one-year periods thereafter according to 42 CFR §423.506.

B. QUALIFICATION TO RENEW ADDENDUM

1. In accordance with 42 CFR §423.507, MA-PD Sponsor will be determined qualified to renew this addendum annually only if MA-PD Sponsor has not provided CMS with a notice of intention not to renew in accordance with Article VII of this addendum.

2. Although MA-PD Sponsor may be determined qualified to renew its addendum under this Article, if MA-PD Sponsor and CMS cannot reach agreement on the Part D bid under Subpart F of 42 CFR Part 423, no renewal takes place, and the failure to reach agreement is not subject to the appeals provisions in Subpart N of 42 CFR Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article VI
Nonrenewal of Addendum by MA-PD Sponsor

A. MA-PD Sponsor may non-renew this addendum in accordance with 42 CFR 423.507(a).

B. If MA-PD Sponsor non-renews this addendum under this Article, CMS cannot enter into a Part D addendum with the organization or with an organization whose covered persons, as defined in 42 CFR §423.507(a)(4), also served as covered persons for the nonrenewing sponsor for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS.

Article VII
Modification or Termination of Addendum by Mutual Consent

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 CFR 423.508. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article VIII
Termination of Addendum by CMS

CMS may terminate this addendum in accordance with 42 CFR 423.509. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article IX
Termination of Addendum by MA-PD Sponsor

A. MA-PD Sponsor may terminate this addendum only in accordance with 42 CFR 423.510.

B. CMS will not enter into a Part D addendum with an MA-PD Sponsor that has terminated its addendum or with an organization whose covered persons, as defined in 42 CFR §423.508(f), also served as covered persons for the terminating sponsor within the preceding 2 years unless there are circumstances that warrant special consideration, as determined by CMS.

C. If the addendum is terminated under section A of this Article, MA-PD Sponsor must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article X
Relationship between Addendum and Part C Contract or 1876 Cost Contract

A. MA-PD Sponsor acknowledges that, if it is a Medicare Part C contractor, the termination or nonrenewal of this addendum by either party may require CMS to terminate or non-renew the Sponsor's Part C contract in the event that such non-renewal or termination prevents MA-PD Sponsor from meeting the requirements of 42 CFR §422.4(c), in which case the Sponsor must provide the notices specified in this contract, as well as the notices specified under Subpart K of 42 CFR Part 422. MA-PD Sponsor also acknowledges that Article IX.B. of this addendum may prevent the sponsor from entering into a Part C contract for two years following an addendum termination or non-renewal where such non-renewal or termination prevents MA-PD Sponsor from meeting the requirements of 42 CFR §422.4(c).

B. The termination of this addendum by either party shall not, by itself, relieve the parties from their obligations under the Part C or cost plan contracts to which this document is an addendum.

C. In the event that MA-PD Sponsor's Part C or cost plan contract (as applicable) is terminated or nonrenewed by either party, the provisions of this addendum shall also terminate. In such an event, MA-PD Sponsor and CMS shall provide notice to enrollees and the public as described in this contract as well as 42 CFR Part 422, Subpart K or 42 CFR Part 417, Subpart K, as applicable.

Article XI
Intermediate Sanctions

Consistent with Subpart O of 42 CFR Part 423, MA-PD Sponsor shall be subject to sanctions and civil money penalties.

Article XII
Severability

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Severability of the addendum shall be in accordance with 42 CFR §423.504(e).

Article XIII
Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 CFR Part 423 or, as applicable, 42 CFR Part 422 or Part 417.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS

MA-PD Sponsor agrees that it has not altered in any way the terms of the MA-PD addendum presented for signature by CMS. MA-PD Sponsor agrees that any alterations to the original text MA-PD Sponsor may make to this addendum shall not be binding on the parties.

C. ADDITIONAL CONTRACT TERMS

MA-PD Sponsor agrees to include in this addendum other terms and conditions in accordance with 42 CFR §423.505(j).

D. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), MA-PD Sponsor agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

E. MA-PD sponsor agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 CFR §423.505(b)(23).

F. **Business Continuity:** MA-PD Sponsor agrees to develop, maintain, and implement a business continuity plan as required by 42 CFR §423.505(p).

G. The MA-PD sponsor agrees to comply with the requirements relating to Nondiscrimination in Health Programs and Activities in 45 CFR Part 92, including submitting assurances that the MA-PD sponsor's health programs and activities will be operated in compliance with the nondiscrimination requirements, as required in 45 CFR §92.5.

In witness whereof, the parties hereby execute this contract.

This document has been electronically signed by:

FOR THE MA ORGANIZATION

BRIAN KANE

Contracting Official Name

8/28/2019 10:24:28 AM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

9/19/2019 8:34:18 AM

Date

Amy Larrick Chavez-Valdez
Director
Medicare Drug Benefit
and C & D Data Group,
Center for Medicare

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ADDENDUM TO MEDICARE MANAGED CARE CONTRACT PURSUANT TO SECTIONS 1851 THROUGH 1859 AND 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF AN EMPLOYER GROUP ONLY A MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and HUMANA HEALTH PLANS OF PUERTO RICO, INC., a Medicare Advantage Organization (hereinafter referred to as the "MA Organization") agree to amend the contract H4007 governing the MA Organization's operation of a Medicare Advantage plan described in § 1851(a)(2)(A) or § 1851(a)(2)(C) of the Social Security Act (hereinafter referred to as "the Act"), including all attachments, addenda, and amendments thereto, to include the provisions contained in this addendum (collectively hereinafter referred to as the "contract"), under which the MA Organization shall offer Employer/Union-Only Group MA-PD Plans (hereinafter referred to as "employer/union-only group MA-PDs") in accordance with the waivers granted by CMS under section 1857(i) of the Act. The terms of this Addendum shall only apply to MA-PD plans offered exclusively to Medicare Advantage-eligible individuals enrolled in employment-based health coverage under a contract between the MA Organization and the employer/union sponsor of the employment-based health coverage, pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

This addendum is made pursuant to Subpart K of 42 CFR Parts 422 and 423.

ARTICLE I
EMPLOYER/UNION-ONLY GROUP MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS

A. MA Organization agrees to operate one or more employer/union-only group MA-PDs in accordance with the Medicare Advantage contract (as modified by this addendum), which incorporates in its entirety the *Solicitation for Applications for Medicare Prescription Drug Plan 2020 Contracts and 2020 Part C – Medicare Advantage and 1876 Cost Plan Expansion Application* (both released on January 9, 2019) and any employer/union-only group waiver guidance issued by CMS, including, but not limited to, those requirements set forth in Chapter 12 of the Medicare Prescription Drug Benefit Manual and Chapter 9 of the Medicare Managed Care Manual (hereinafter referred to as "employer/union group waiver guidance"). This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.

B. In the event of any conflict between the employer/union-only group waiver guidance issued prior to the execution of the contract and this Addendum, the provisions of this Addendum shall control. In the event of any conflict between the employer/union-only group waiver guidance issued after the execution of the contract and this Addendum, the provisions of the employer/union-only group guidance shall control.

C. This Addendum is in no way intended to supersede or modify 42 CFR Parts 422 and 423 or sections 1851 through 1859 and 1860D-1 through D-43 of the Act, except as specifically provided in applicable employer/union-only group waiver guidance and/or in this Addendum. Failure to reference a statutory or regulatory requirement in this Addendum does not affect the applicability of such requirement to the MA Organization and CMS.

D. The provisions of this Addendum apply to all employer/union-only group MA-PDs offered by MA Organization under this contract number. In the event of any conflict between the provisions of this Addendum and any other provision of the contract, the terms of this Addendum shall control.

ARTICLE II
FUNCTIONS TO BE PERFORMED BY THE MEDICARE ADVANTAGE ORGANIZATION

A. PROVISION OF MA BENEFITS

1. MA Organization agrees to provide enrollees in each of its employer/union-only group MA-PDs the basic benefits (hereinafter referred to as "basic benefits") as required under 42 CFR §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final benefit as approved by CMS.

2. The requirements in section 1852 of the Act and 42 CFR §422.100(c)(1) pertaining to the offering of benefits covered under Medicare Part A and in section 1851 of the Act and 42 CFR §422.50(a)(1) pertaining to who may enroll in an MA-PD are waived for employer/union-only group MA-PD enrollees who are not entitled to Medicare Part A.

3. For employer/union-only group MA-PDs offering non-calendar year coverage, MA Organization may determine basic and supplemental benefits (including deductibles, out-of-pocket limits, etc.) on a non-calendar year basis subject to the following requirements:

(3.a) Applications, plan benefit packages, bids, and other submissions to CMS must be submitted on a calendar year basis; and

(3.b) CMS payments will be determined on a calendar year basis.

4. For employer/union-only group MA-PDs that have a monthly beneficiary rebate described in 42 CFR §422.266:

(4.a) MA Organization may vary the form of rebate for a particular plan benefit package so that the total monthly rebate amount may be credited differently for each employer/union group to whom MA Organization offers the plan benefit package and

(4.b) MA Organization must retain documentation that supports the use of all of the rebates on a detailed basis for each employer/union group within the plan benefit package and must provide access to this documentation for inspection or audit by CMS (or its designee) in accordance with the requirements of 42 CFR 422.503(d) and (e).

5. MA Organization agrees it shall obtain written agreements from each employer/union that provide that the employer/union may determine how much of an enrollee's Part C monthly beneficiary premium it will subsidize, subject to the restrictions set forth in II.A.5(a) through (c). MA Organization agrees to retain these written agreements with employers/unions and must provide access to this documentation for inspection or audit by CMS (or its designee) in accordance with the requirements of 42 CFR 422.503(d) and 422.504(d) and (e)

(5.a) The employer/union can subsidize different amounts for different classes of enrollees in the employer group health plan provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried v. hourly).

(5.b) The employer/union cannot vary the premium subsidy for individuals within a given class of enrollees.

(5.c) The employer/union cannot charge an enrollee for coverage provided under the employer group health plan more than the sum of his or her monthly beneficiary premium attributable to basic benefits provided under the plan as defined in 42 CFR §422.2 (i.e., all Medicare-covered benefits, except hospice services) and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part C benefits (if any). MA Organization must pass through the monthly payments described under 42 CFR 422.304(a) received from CMS to reduce the amount that the enrollee pays (or, in those instances where the subscriber to or participant in the employer plan pays premiums on behalf of a Medicare eligible spouse or dependent, the amount the subscriber or participant pays).

B. PROVISION OF PRESCRIPTION DRUG BENEFIT

1. Except as provided in this subsection, MA Organization agrees to provide basic prescription drug coverage, as defined under 42 CFR §423.100, under any employer/union-only group MA-PD, in accordance with Subpart C of 42 CFR Part 423.

(1.a) CMS agrees that MA Organization will not be subject to the actuarial equivalence requirement set forth in 42 CFR §423.104(e)(5) with respect to any employer/union-only group MA-PD and may provide less than the defined standard coverage between the deductible and initial coverage limit. MA Organization agrees that its basic prescription drug coverage under any employer/union-only group MA-PD will satisfy all of the other actuarial equivalence standards set forth in 42 CFR §423.104, including but not limited to the requirement set forth in 42 CFR §423.104(e)(3) that the plan has a total or gross value that is at least equal to the total or gross value of defined standard coverage.

2. CMS agrees that nothing in this Addendum prevents MA Organization from offering prescription drug benefits in addition to basic prescription drug coverage to employers/unions. Such additional benefits offered pursuant to private agreements between MA Organization and employers/unions will be considered non-Medicare

Part D benefits ("non-Medicare Part D benefits"). MA Organization agrees that such additional benefits may not reduce the value of basic prescription drug coverage (e.g., additional benefits cannot impose a cap that would preclude enrollees from realizing the full value of such basic prescription drug coverage).

3. MA Organization agrees that enrollees of employer/union-only group MA-PDs shall not be charged more than the sum of his or her monthly beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part D benefits (if any). MA Organization must pass through the direct subsidy payments received from CMS to reduce the amount that the beneficiary pays (or, in those instances where the subscriber to or participant in the employer plan pays premiums on behalf of an eligible spouse or dependent, the amount the subscriber or participant pays).

4. MA Organization agrees that any additional non-Medicare Part D benefits offered to an employer/union will always pay primary to the subsidies provided by CMS to low-income individuals under Subpart P of 42 CFR Part 423 (the "Low-Income Subsidy").

5. MA Organization agrees enrollees of employer/union-only group MA-PDs will not be permitted to make payment of premiums under 42 CFR §423.293(a) through withholding from the enrollee's Social Security, Railroad Retirement Board, or Office of Personnel Management benefit payment.

6. MA Organization agrees it shall obtain written agreements from each employer/union that provide that the employer/union may determine how much of an enrollee's Part D monthly beneficiary premium it will subsidize, subject to the restrictions set forth in this subsection. MA Organization agrees to retain these written agreements with employers/unions, including any written agreements related to items (d) through (f) of this subsection, and must provide access to this documentation for inspection or audit by CMS (or its designee) in accordance with the requirements of 42 CFR §§423.504(d) and 423.505(d) and (e).

(6.a) The employer/union can subsidize different amounts for different classes of enrollees in the employer/union-only group MA-PD provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried v. hourly). Different classes cannot be based on eligibility for the Low Income Subsidy.

(6.b) The employer/union cannot vary the premium subsidy for individuals within a given class of enrollees.

(6.c) The employer/union cannot charge an enrollee for prescription drug coverage provided under the plan more than the sum of his or her monthly beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part D benefits (if any). The employer/union must pass through direct subsidy payments received from CMS to reduce the amount that the beneficiary pays (or, in those instances where the subscriber to or participant in the employer plan pays premiums on behalf of an eligible spouse or dependent, the amount the subscriber or participant pays).

(6.d) For all enrollees eligible for the Low Income Subsidy, the low income premium subsidy amount will first be used to reduce any portion of the MA-PD monthly beneficiary premium paid by the enrollee (or in those instances where the subscriber to or participant in the employer plan pays premiums on behalf of a low-income eligible spouse or dependent, the amount the subscriber or participant pays), with any remaining portion of the premium subsidy amount then applied toward any portion of the MA-PD monthly beneficiary premium (including any MA premium) paid by the employer/union. However, if the sum of the enrollee's MA-PD monthly premium (or the subscriber's/participant's MA-PD monthly premium, if applicable) and the employer's/union's MA-PD monthly premiums (i.e., total monthly premium) are less than the monthly low-income premium subsidy amount, any portion of the low-income subsidy premium amount above the total MA-PD monthly premium must be returned directly to CMS. Similarly, if there is no MA-PD monthly premium charged the beneficiary (or subscriber/participant, if applicable) or employer/union, the entire low-income premium subsidy amount must be returned directly to CMS and cannot be retained by the MA Organization, the employer/union, or the beneficiary (or the subscriber/participant, if applicable).

(6.e) If the Part D sponsor does not or cannot directly bill an employer group's beneficiaries, CMS will permit the Part D sponsor to directly refund the amount of the low-income premium subsidy to the LIS beneficiary. This refund must meet the above requirements concerning beneficiary premium contributions; specifically, that the amount of the refund not exceed the amount of the monthly premium contribution by the enrollee and/or the employer. In addition, the sponsor must refund these amounts to the beneficiary within a reasonable time period. However, under no circumstances may this time period exceed forty five (45) days from the date that the Part D sponsor receives the low-income premium subsidy amount payment for that beneficiary from CMS.

(6.f) The MA Organization and the employer/union may agree that the employer/union will be responsible for reducing up-front the MA-PD premium contribution required for enrollees eligible for the Low Income Subsidy. In those instances where the employer/union is not able to reduce up-front the MA-PD premiums paid by the enrollee (or, the subscriber/participant, if applicable), the MA Organization and the employer/union may agree that the employer/union shall directly refund to the enrollee (or subscriber/participant, if applicable) the amount of the low-income premium subsidy up to the MA-PD monthly premium contribution previously collected from the enrollee (or subscriber/participant, if applicable). The employer/union is required to complete the refund on behalf of the MA Organization within forty-five (45) days of the date the MA Organization receives from CMS the low-income premium subsidy amount payment for the low-income subsidy eligible enrollee.

(6.g) If the low income premium subsidy amount for which an enrollee is eligible is less than the portion of the Part D monthly beneficiary premium paid by the enrollee (or subscriber/participant, if applicable), then the employer/union should communicate to the enrollee (or subscriber/participant) the financial consequences of the low-income subsidy eligible individual enrolling in the employer/union-only group MA-PD as compared to enrolling in another Part D plan with a monthly beneficiary premium equal to or below the low income premium subsidy amount.

7. For non-calendar year employer/union-only group MA-PDs, MA Organization may determine benefits (including deductibles, out-of-pocket limits, etc.) on a non-calendar year basis subject to the following requirements:

(7.a) Applications, formularies, bids and other submissions to CMS must be submitted on a calendar year basis;

(7.b) The prescription drug coverage under the employer/union-only group MA-PD must be at least actuarially equivalent to defined standard coverage for the portion of its plan year that falls in a given calendar year. An employer/union-only group MA-PD will meet this standard if its prescription drug coverage is at least actuarially equivalent for the calendar year in which the plan year starts and no design change is made for the remainder of the plan year. In no event can MA Organization increase during the plan year the annual out-of-pocket threshold;

(7.c) After an enrollee's incurred costs exceed the annual out-of-pocket threshold, the employer/union-only group MA-PD must provide prescription drug coverage that is at least actuarially equivalent to that provided under standard prescription drug coverage; eligibility for such coverage can be determined on a plan year basis.

8. MA Organization agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 CFR §423.505(b)(25).

9. MA Organization agrees to provide applicable beneficiaries applicable discounts on applicable drugs in accordance with the requirements of 42 CFR Part 423 Subpart W.

10. MA Organization agrees to pass an essential operations test prior to the start of the benefit year. This provision only applies to new sponsors that have not previously entered into a Part D contract with CMS and neither it, nor another subsidiary of the applicant's parent organization, is offering Part D benefits during the current year. 42 CFR §423.505(b)(27).

C. CMS ENROLLMENT REQUIREMENTS

1. MA Organization agrees to restrict enrollment in an employer/union-only group MA-PD to those individuals eligible for the employer's/union's employment-based group coverage.

2. MA Organization will not be subject to the requirement to offer the employer/union-only group MA-PD to all Medicare eligible beneficiaries residing in its service area as set forth in 42 CFR §422.50.

3. If an employer/union elects to enroll eligible individuals eligible for its employer/union-only group MA-PDs through a group enrollment process, MA Organization will not be subject to the individual enrollment requirements set forth in 42 CFR §422.60. MA Organization agrees to comply with all the requirements for group enrollment contained in CMS guidance, including those requirements contained in Chapter 2 of the Medicare Managed Care Manual.

D. BENEFICIARY PROTECTIONS

1. Except as provided in II.D.2., CMS agrees that, with respect to any employer/union-only group MA-PDs, MA Organization will not be subject to the information requirements set forth in 42 CFR §423.48 and the prior review and approval of marketing materials and election forms requirements set forth in 42 CFR Part 422, subpart V and Part 423, subpart V. MA Organization will be subject to all other disclosure and dissemination requirements contained in 42 CFR §422.111, §423.128 and that are conditions on any waivers for EGWPs provided in CMS guidance in Chapter 9 of the Medicare Managed Care Manual.

2. CMS agrees that the disclosure requirements set forth in 42 CFR §422.111 will not apply with respect to any employer/union-only group health plan when the employer/union is subject to alternative disclosure requirements (e.g., the Employee Retirement Income Security Act of 1974 ("ERISA")) and fully complies with such alternative requirements. As a condition of this waiver, MA Organization must:

(2.a) Provide summary plan descriptions and all other beneficiary communications required by the alternative disclosure requirements on a timely basis;

(2.b) Provide these materials to CMS, upon request, in the event of beneficiary complaints, or for any other reason CMS requests, so that CMS may ensure the information accurately and adequately informs Medicare beneficiaries about their rights and obligations under the plan.

(2.c) Retain these dissemination materials and provide access to these written materials to CMS (or its designees) in accordance with 42 CFR 422.503(d) and 422.504(d) and (e).

3. MA Organization agrees to comply with the requirements for this waiver contained in employer/union-only group waiver guidance in Chapter 9 of the Medicare Managed Care Manual.

E. SERVICE AREA, FORMULARIES AND PHARMACY ACCESS

1. CMS agrees that Local employer/union-only group MA-PDs that provide coverage to individuals in any part of a State may offer coverage to retirees eligible for the employer/union-only group MA-PD throughout that State provided the MA Organization has properly designated (in accordance with CMS operational requirements) its employer/union-only group service areas in CMS's Health Plan Management System (HPMS) as including those areas outside of its individual service area(s) to allow for enrollment of these beneficiaries in CMS enrollment systems. CMS also agrees that employer/union-only group Regional MA-PDs that provide coverage to individuals in any part of a Region can offer coverage to retirees eligible for the employer/union-only group MA-PD throughout that Region.

2. Notwithstanding 42 CFR § 422.50(a)(3), CMS agrees that those Local Coordinated Care Health MA-PDs that provide coverage to individuals in any part of a State can offer coverage to beneficiaries eligible for the employer/union-only group plan that reside outside of the State provided it meets the requirements designated in the Medicare Managed Care Manual.

3. CMS agrees that Private Fee-for-Service employer/union-only group MA-PDs may offer coverage beyond their designated individual service areas to all enrollees of a particular employer/union-only group plan, regardless of where they reside in the nation, provided the MA Organization has properly designated (in accordance with CMS operational requirements) its employer/union-only group service area in CMS' HPMS as including areas outside of its individual plan service area(s) to allow for the enrollment of these beneficiaries in CMS enrollment systems.

4. MA Organization agrees to utilize, as the formulary for any employer/union-only group MA-PD, a base formulary that has received approval from CMS, in accordance with CMS formulary guidance, for use in a non-group MA-PD offered by MA Organization. Except as set forth in 42 CFR §423.120(b) and sub-regulatory guidance, MA Organization may not modify the approved base formulary used for any employer/union-only group MA-PD by removing drugs, adding additional utilization management restrictions, or increasing the cost-sharing status of a drug from the base formulary. Enhancements that are permitted to the base formulary include adding additional drugs, removing utilization management restrictions, and improving the cost-sharing status of drugs.

5. For any employer/union-only group MA-PD, MA Organization agrees to provide Part D benefits in the plan's service area utilizing a pharmacy network and formulary that meets the requirements of 42 CFR §423.120, with the following exception: CMS agrees that the retail pharmacy access requirements set forth in 42 CFR §423.120(a)(1) will not apply when the employer/union-only group MA-PD's pharmacy network is sufficient to meet the needs of its enrollees throughout the employer/union-only group MA-PD's service area, as determined by CMS. CMS may periodically review the adequacy of the employer/union-only group MA-PD's pharmacy network and require the employer/union-only group MA-PD to expand access if CMS determines that such expansion is necessary in order to ensure that the employer/union-only group MA-PD's network is sufficient to meet the needs of its enrollees.

F. PAYMENT TO MA ORGANIZATION

1. MA Organization is not required to submit a Part C bid pricing tool; MA Organization acknowledges and agrees that payment under Part C of Title XVIII for Part A and B services, including rebates under section 1854 of the Social Security Act, provided to enrollees in its employer/union-only group MA-PDs will be governed by the CY 2020 Rate Announcement issued on April 1, 2019. Except as provided in this subsection, payment under this Addendum will be governed by the rules of Subparts G and J of 42 CFR Part 423.

(1.a) MA Organization acknowledges that the risk sharing, plan entry and retention bonus provisions of section 1858 of the Act and 42 CFR §422.458 shall not apply to any employer/union-only group Regional MA-PDs.

(1.b) MA Organization acknowledges that the risk-sharing payment adjustment described in 42 CFR §423.336 is not applicable for any employer/union-only group MA-PD enrollee.

(1.c) MA Organization is not required to submit a Part D bid and will receive a monthly direct subsidy under 42 CFR Subpart G for each employer/union-only group MA-PD enrollee equal to the amount of the national average monthly bid amount (not its approved standardized bid), adjusted for health status (as determined under 42 CFR §423.329(b)(1)) and reduced by the base beneficiary premium for the employer/union-only group MA-PD, as adjusted under 42 CFR §423.286(d)(3), if applicable. The further adjustments to the base beneficiary premium contained in 42 CFR §423.286(d)(1) and (2) will not apply.

(1.d) MA Organization will not receive monthly reinsurance payment or low-income cost-sharing subsidy amounts in the manner set forth in 42 CFR §423.329(c)(2)(I) and 42 CFR §423.329(d)(2)(I) for any employer/union-only group MA-PD enrollee, but instead will receive the full reinsurance and low-income cost-sharing subsidy payments following the end of year reconciliation as described in 42 CFR §423.329(c)(2)(II) and 42 CFR §423.329(d)(2)(II) respectively.

2. For non-calendar year plans:

(2.a) CMS payments will be determined on a calendar year basis;

(2.b) Low income subsidy payments and reconciliations will be determined based on the calendar year for which the payments are made; and

(2.c) MA Organization acknowledges that it will not receive reinsurance payments under 42 CFR §423.329(c).

G. MA ORGANIZATION REIMBURSEMENT TO PHARMACIES

1. If an MA Organization uses a standard for reimbursement of pharmacies based on the cost of a drug, MA Organization will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

2. If the source for any prescription drug pricing standard is not publicly available, MA Organization will disclose all individual drug prices to be updated to the applicable pharmacies in advance for their use for the reimbursement of claims.

3. MA Organization will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 days of receipt of an electronically submitted claim or within 30 days of receipt of a claim submitted otherwise.

4. MA Organization must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than 30 days (but not more than 90 days) to submit claims to MA Organization for reimbursement.

H. PUBLIC HEALTH SERVICE ACT

Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), MA Organization agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation

specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

In witness whereof, the parties hereby execute this contract.

This document has been electronically signed by:

FOR THE MA ORGANIZATION

BRIAN KANE

Contracting Official Name

8/28/2019 10:24:28 AM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

Amy Larrick Chavez-Valdez
Director
Medicare Drug Benefit
and C & D Data Group,
Center for Medicare

9/19/2019 8:34:18 AM

Date

Kathryn A. Coleman
Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

9/19/2019 8:34:18 AM

Date

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
20 - 004

Medicare Advantage Attestation of Benefit Plan

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

H4007

Date: 08/28/2019

I attest that I have examined the Plan Benefit Packages (PBPs) identified below and that the benefits identified in the PBPs are those that the above-stated organization will make available to eligible beneficiaries in the approved service area during program year 2020. I further attest that we have reviewed the bid pricing tools (BPTs) with the certifying actuary and have determined them to be consistent with the PBPs being attested to here.

I attest that I have examined the employer/union-only group waiver ("800 series") PBPs identified below and that these PBPs are those that the above-stated organization will make available only to eligible employer/union-sponsored group plan beneficiaries in the approved service area during program year 2020. I further attest we have reviewed any MA bid pricing tools (BPTs) associated with these PBPs (no Part D bids are required for 2020 "800 series" PBPs) with the certifying actuary and have determined them to be consistent with any MA PBPs being attested to here.

I attest that our MA plan(s) are implementing Part B step therapy under the direction of its P&T committee consistent with CMS regulatory and sub-regulatory guidance.

I further attest that these benefits will be offered in accordance with all applicable Medicare program authorizing statutes and regulations and program guidance that CMS has issued to date and will issue during the remainder of 2019 and 2020, including but not limited to, the 2020 Call Letter, the 2020 Solicitations for New Contract Applicants, the Medicare Prescription Drug Benefit Manual, the Medicare Managed Care Manual, and the CMS memoranda issued through the Health Plan Management System (HPMS).

Plan ID	Segment ID	Version	Plan Name	Plan Type	Transaction Type	MA Premium	Part D Premium	CMS Approval Date	Effective Date
012	0	6	Humana Gold Plus H4007-012 (HMO)	HMO	Renewal	0.00	0.00	08/21/2019	01/01/2020
013	0	4	Humana Gold Plus H4007-013 (HMO)	HMO	Renewal	0.00	0.00	08/21/2019	01/01/2020
016	0	3	Humana Gold Plus SNP-DE H4007-016 (HMO D-SNP)	HMO	Renewal	0.00	0.00	08/21/2019	01/01/2020
018	0	2	Humana Gold Plus SNP-DE H4007-018 (HMO D-SNP)	HMO	Renewal	0.00	0.00	08/21/2019	01/01/2020
019	0	3	Humana Gold Plus SNP-DE H4007-019 (HMO D-SNP)	HMO	Renewal	0.00	0.00	08/21/2019	01/01/2020
020	0	3	Humana Gold Plus H4007-020 (HMO)	HMO	Renewal	0.00	0.00	08/21/2019	01/01/2020
801	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	N/A	N/A	08/16/2019	01/01/2020
802	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	N/A	N/A	08/16/2019	01/01/2020
811	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	N/A	N/A	08/16/2019	01/01/2020
812	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	N/A	N/A	08/16/2019	01/01/2020
813	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	N/A	N/A	08/16/2019	01/01/2020
814	0	1	Humana Medicare Employer (HMO)	HMO	Renewal	N/A	N/A	08/16/2019	01/01/2020

BRIAN KANE

Contracting Official Name

8/28/2019 10:24:28 AM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

Address

DATA USE ATTESTATION

The sponsor shall restrict its use and disclosure of Medicare data obtained from CMS information systems (listed in Attachment A) to those purposes directly related to the administration of the Medicare managed care and/or outpatient prescription drug benefits for which it has contracted with the Centers for Medicare & Medicaid Services (CMS) to administer. The sponsor shall only maintain data obtained from CMS information systems that are needed to administer the Medicare managed care and/or outpatient prescription drug benefits that it has contracted with CMS to administer. The sponsor (or its subcontractors or other related entities) may not re-use or provide other entities access to the CMS information system, or data obtained from the system, to support any line of business other than the Medicare managed care and/or outpatient prescription drug benefit for which the sponsor contracted with CMS.

The sponsor further attests that it shall limit the use of information it obtains from its Medicare plan members to those purposes directly related to the administration of such plan. The sponsor acknowledges two exceptions to this limitation. First, the sponsor may provide its Medicare members information about non-health related services after obtaining consent from the members. Second, the sponsor may provide information about health-related services without obtaining prior member consent, as long as the sponsor affords the member an opportunity to elect not to receive such information.

CMS may terminate the sponsor's access to the CMS data systems immediately upon determining that the sponsor has used its access to a data system, data obtained from such systems, or data supplied by its Medicare members beyond the scope for which CMS has authorized under this agreement. A termination of this data use agreement may result in CMS terminating the sponsor's Medicare contract(s) on the basis that it is no longer qualified as a Medicare sponsor. This agreement shall remain in effect as long as the sponsor remains a Medicare managed care organization and/or outpatient prescription drug benefit sponsor. This agreement excludes any public use files or other publicly available reports or files that CMS makes available to the general public on our website.

Attachment A

The following list contains a representative (but not comprehensive) list of CMS information systems to which the Data Use Attestation applies. CMS will update the list periodically as necessary to reflect changes in the agency's information systems

Automated Plan Payment System (APPS)
Common Medicare Environment (CME)
Common Working File (CWF)
Coordination of Benefits Contractor (COBC)
Drug Data Processing System (DDPS)
Electronic Correspondence Referral System (ECRS)
Enrollment Database (EDB)
Financial Accounting and Control System (FACS)
Front End Risk Adjustment System (FERAS)
Health Plan Management System (HPMS), including Complaints Tracking and all other modules
HI Master Record (HIMR)
Individuals Authorized Access to CMS Computer Services (IACS)
Integrated User Interface (IUI)
Medicare Advantage Prescription Drug System (MARx)
Medicare Appeals System (MAS)
Medicare Beneficiary Database (MBD)
Payment Reconciliation System (PRS)
Premium Withholding System (PWS)
Prescription Drug Event Front End System (PDFS)
Retiree Drug System (RDS)
Risk Adjustments Processing Systems (RAPS)

This document has been electronically signed by:

BRIAN KANE

Contracting Official Name

8/28/2019 10:24:28 AM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

Organization

383 F.D. Roosevelt Avenue, 3rd Floor
San Juan, PR 009182131

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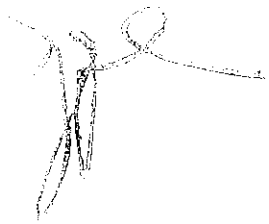

H4007

SIGNATURE ATTESTATION

Contract ID: H4007
Contract Name: HUMANA HEALTH PLANS OF PUERTO RICO, INC.

I understand that by signing and dating this form, I am acknowledging that I am an authorized representative of the above named organization and that I am the contracting official associated with the user ID used to log on to the Health Plan Management System (HPMS) to sign the 2020 Medicare contracting documents. I also acknowledge that in accordance with the HPMS Rule of Behavior, sharing user IDs is strictly prohibited.

This document has been electronically signed by:

BRIAN KANE

Contracting Official Name

8/28/2019 10:24:28 AM

Date

HUMANA HEALTH PLANS OF PUERTO RICO, INC.

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