https://www.regulations.gov/docket/FTC-2022-0015

Chairwoman Khan and FTC Commissioners,

Pharmacists United for Truth and Transparency (PUTT) respectfully submits the following letter and select examples of PBM practices that adversely impact primary stakeholders in the U.S. healthcare system, notably patients, employers, providers (physicians and non-PBM owned pharmacies) and taxpayers.

There are literally hundreds of publicly-available examples of how PBM business practices have shaped Americans' access to medication, the result of PBMs' ability to design and sell benefits plans; require drug maker payment for product inclusion on formularies; and direct patients to PBM-owned pharmacies over the community pharmacies they are required by law to contract with in order to achieve "network adequacy".

Concentration among 3 major PBMs, owned by health insurers whose size and reach across the breadth of healthcare delivery modalities has ranked them among the top 10 largest corporations in the world, is ensuring a closed market in which competition and innovation are stifled while prices continue to rise.

For far too long, PBMs' lack of transparency, in concert with state and federal governments' inability (or perhaps unwillingness) to conduct oversight of these organizations receiving billions in taxpayer-funded revenues, has resulted in a system so complex that not even the finest business minds can unravel – let alone fix – the problem.

To that end, we appreciate the efforts of the FTC to pull back the opaque shroud enfolding PBM practices so that Americans can begin to understand why their healthcare premiums and drug prices have risen at record pace, while access to care and agency in the matter of their own health have shrunk at an equally, perhaps correlated, rate.

Yours in advocacy,

Monique Whitney
Executive Director
Pharmacists United for Truth and Transparency
www.truthrx.org

Pharmacists United for
Truth & Transparency
TruthRx.org

May 20, 2022

The Honorable Lina M. Khan
Chair
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, D.C. 20580

Re: How Pharmacy Benefit Managers are Gaming the System to Their Advantage, Creating Obstacles for Patients and Creating a Real and Present Danger to non-PBM owned Pharmacies

Dear Chair Khan:

Thank you for the work the FTC is undertaking to study the impact that Pharmacy Benefit Managers (PBMs) have on the entire healthcare system, independent pharmacies, and most importantly, American patients and taxpayers. This is an incredibly critical undertaking and one that we hope you will continue to pursue.

Pharmacists United for Truth and Transparency (PUTT) is a non-profit advocacy organization founded by independent pharmacists and pharmacy owners. Ours is a grassroots effort that includes doctors and patient advocates in addition to pharmacists. Our mission is to fight the egregious practices constantly and regularly employed by PBMs that harm local businesses, employers, and American consumers.

As described in more detail below, PBMs employ these tactics through a number of draconian policies that adversely affect not only patients, but also the ability of local healthcare providers to act in the best interests of their patients. We expect that further study by the Federal Trade Commission will assist in shining a bright light on these problems and demonstrate the dire need for transparency and regulatory action within the industry.

Within the current market there are multiple inequities and roadblocks to patient access and care. The largest PBMs either own or are owned by giant, vertically integrated insurance conglomerates, putting them in the questionable position of controlling not only prescription drug rebates and pricing, but also patient care protocols and the reimbursements of their competitors, not to mention the vast majority of patient data which they use to their profit advantage through practices like patient steering.

Pharmacies are regularly forced to enter into non-negotiable, one-sided contracts with the largest PBMs in order to keep serving their patients. Many of these contracts, which PBMs often adjust or change without notice, are not only skewed in favor of corporate profits, they additionally disallow price concessions or local services by the pharmacy that would be in the best interests of the patient – often including threats of fines, clawbacks, or removal from the PBM's "preferred network" if the pharmacy engages in the simple act of counseling a patient on lower cost options or providing delivery for a local patient in need.

Some PBM policies that continually cause pharmacies, providers, and their patients harm are:

Gag Clauses:

While outlawed at the federal level in 2018, some PBM contracts still contain language that prohibits pharmacists from telling a patient that they could pay less for specific medications if they pay directly out of pocket, instead of filing the prescription through their insurance. It may sound counterintuitive, but it unfortunately happens more than anyone would expect.

Here's how it works: A customer goes to the pharmacy and is charged a $20 copay for their medication. But the actual cost to the pharmacy is only $5 - the extra $15 goes to the Pharmacy Benefit Manager. Many local pharmacists risk retaliation to save their patients money, but contractually, the PBM's gag clause puts them in a precarious situation for retribution – including the possibility of being removed from that PBM's pharmacy network.

Spread Pricing:

As contracted entities, PBMs charge states and employers for the cost of dispensing a medication to a patient. Unfortunately, the costs that PBMs charge are often much higher than what pharmacies are paid for a prescription, or even the actual cost of a medication. That extra money, or "spread", is charged to the plan payer and structured as a revenue source for the PBM. These spread tactics can translate into billions of dollars per year, and in the case of state Medicaid programs studies have shown billions of taxpayer dollars going directly to PBM profits, not to offset premiums nor to lower patients' out of pocket costs at the pharmacy counter.

Co-Pay Accumulators

Many patients living with chronic illnesses utilize pharmaceutical manufacturer copay assistance programs to be able to afford their life-saving medications. Until recently, the total cost of those medications including the copay assistance dollars was applied to a patient's prescription drug deductible. As certain plans require the patient to meet high medication deductibles before insurance kicks in, these programs have ensured that lower and fixed income patients are able to afford the medication they need on a monthly basis.

The inclusion of copay accumulators in many patient's prescription drug plans means that only the amount a patient pays out of pocket now applies to their deductible. Once copay assistance runs out, a patient may not be able to afford the cost of their medication at all, in addition to still not receiving insurance benefits from the inability to reach their deductible threshold. Furthermore, the PBM continues to retain the dollar amount contributed by the manufacturer. It's a double-dipping move by the PBM/insurance company to receive payment twice for the same prescription medication while ensuring they will never have to pay on the patient's behalf at the pharmacy counter.

Exclusionary Formularies

PBMs purport that their creation of plan formularies is an effort to lower prescription drug costs for both patients and plan payers.

Unfortunately, formulary choices are not driven by science or patient outcomes. PBMs routinely exclude lifesaving medications from their formularies based on the failure of drug manufacturers to pay sufficiently high rebates. Manufacturers have little choice but to "pay to play" in an effort to get their medications to the patients that need them most.

Patients can be forced to wait extended periods of time while they and their doctors appeal for coverage of a medication, or are forced to endure multiple rounds of fail first therapies that are in direct conflict with their physician's orders before an appeal for coverage will even be considered. The recent case of the removal of Eliquis from CVS Caremark formularies despite pleading from multiple medical organizations resulted in millions of patients experiencing adverse effects from non-medical switching requirements. In these cases, effective medications that a PBM keeps out of reach could prevent further physical damage or worsening of a patient's condition - so as coverage continues to be denied, the patient's health continues to decline.

Rebates as Revenue Sources, Not Drug Cost Diminishers:

As previously stated, PBMs demand that manufacturers offer discounted pricing on the medications they produce in order to have placement on an insurer's drug formulary. These rebates, initially intended to lower costs for patients, instead have been proven to drive costs up. Studies show that commercially insured patients are often and unknowingly paying significantly more for medication than their insurance company. Estimates show that 1 in 5 brand name prescription cost sharing is based on the original list price, not the rebated price.

Patient Steering:

PBMs regularly attempt to steer patients away from in-network independently owned pharmacies to PBM-owned or affiliated corporate chain pharmacies. Our members have sent proof of letters, and collected stories of phone calls using misinformation, trickery, and threats to drive patients away from their preferred local pharmacy to PBM owned or affiliated chains and mail-order.

Patient steering is an unconscionable and anti-competitive practice that is not only unethical, but additionally results in the spread of pharmacy deserts and reduced access to care - especially in our nation's rural and lower income areas where chains don't exist and internet access can be hard to come by.

PBM abuse of the system must be brought to light and stopped. We encourage the FTC to engage in a full study review of this industry, which has been allowed to operate with little oversight and no regulation for far too long. American patients deserve health care, not a broken system controlled by corporate illicit practices that benefit shareholders instead of patients.

Thank you for your consideration.

Sincerely,

M Whitney

Monique M. Whitney, MBA
Executive Director

encl.

Pharmacists United for
Truth & Transparency
TruthRx.org

Name Bethany Holmes State AL Date 4.21.2026

Signature Bethany Holmes

Name FRANCIS CHAN State TX Date 4/21/2022

Signature

Name Kristin Glezman State TX Date 4-21-2022

Signature

Name Joseph Glezman State Tx Date 4.21.2022

Signature

Name Paul Franchi State FL Date 4/21/22

Signature

Name Dave Shakespeare State VT Date 4-21-22

Signature

Name George Warren State Fl Date 4.21.2022

Signature

Pharmacists United for
Truth & Transparency
TruthRx.org

Signatures of Support

Name Parthiv Waghwala State TX Date 4/21/22

Signature (Birdsongs Pharmacy)

Name Bharti Waghwala State TX Date 4/21/22

Signature (Birdsongs Pharmacy)

Name Hossein Malekí State TX Date 4-21-22

Signature

Name Saadi Neamati State TX Date 4/21/22

Signature

Name Sierra McCamey State AL Date 4/21/22

Signature Sierra McCamey

Name Rebekah Neel State AL Date 4/21/22

Signature

Name Lynda Harding State AL Date 4/21/22

Signature Lynda Harding

Pharmacists United for
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TruthRx.org

Name Deborah Keavey State MN Date 4-21-22

Signature

Name NATHAN I. MOUTON State LA Date 04-21-22

Signature

Name Dawn Butterfield State FL Date 4/21/22

Signature

Name James A Burky State FL Date 4/21/22

Signature JAMES A. BURKY, JR.

Name Sonia Martinez State FL Date 4/21/22

Signature

Name [illegible] State FL Date 4/21/22

Signature BEN LEVENE

Name Lauren Denbski State CA Date 4.21.22

Signature

Pharmacists United for
Truth & Transparency
TruthRx.org

Name Philip Hammerdings State MN Date 4/21/22

Signature

Name James Haye State MN Date 4/21/22

Signature

Name Lynn Loggering State MN Date 4/21/22

Signature

Name Sarah Hammerding State MN Date 4/21/22

Signature

Name BEN COAKLEY State SC Date 4/21/22

Signature

Name Michael J Donohue State WA Date 4/22/22

Signature

Name Vikram Rao State FL Date 4/22/22

Signature

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Truth & Transparency
TruthRx.org

Name Nidhi Rao State FL Date 4/22/22

Signature N. V Rao

Name Duchi Jones State AL Date 4/22/22

Signature Duchi Jones

Name JAMES JONES State AL Date 4/22/22

Signature

Name Dalsha a Patel State MI Date 4/22/22

Signature

Name Atul Gandhi State MI Date 04/22/22

Signature

Name Gautam Thakkar State FL Date 04/22/22

Signature

Name BHANU VASOYA State CA Date 4/22/22

Signature Bhanu Vasoya

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TruthRx.org

Name DACSHA MISTRY State CA Date 4/22/22

Signature

Name K PATEL State CA Date 4/22/22

Signature

Name V Gandhy State CA Date 4/22/22

Signature

Name GEETA SINGH State CA Date 4/22/2022

Signature

Name Zonia H Rivas FNPc APRN State TX Date 4/22/22

Signature

Name Tom Dembski State ca Date 4-22-22

Signature

Name Jimin Patel State FL Date 4/22/2022

Signature

Pharmacists United for
Truth & Transparency
TruthRx.org

Name Yvette Resendez State TX Date 4/22/2022

Signature _____

Name _____ State _____ Date _____

Signature _____

Name _____ State _____ Date _____

Signature _____

Name _____ State _____ Date _____

Signature _____

Name _____ State _____ Date _____

Signature _____

Name _____ State _____ Date _____

Signature _____

Name _____ State _____ Date _____

Signature _____

Pharmacists United for Truth & Transparency
TruthRx.org

Name & Title	I am a
Vipul Mamtora, owner	Pharmacy or Practice Owner
Shannon Wightman-Girard	Patient, Taxpayer
Dr Robert C Henslee	Pharmacy or Practice Owner
Allison Lucas, RPh	Healthcare Provider, Pharmacy or Practice Owner, Employer, Taxpayer
Nario Rene Cantu	Pharmacy or Practice Owner
Joe Maxwell Rph President Maxwell Pharmacy Inc	Patient, Healthcare Provider, Pharmacy or Practice Owner, Employer, Taxpayer
Yordi Ponce de Leon Pharmacist	Healthcare Provider, Pharmacy or Practice Owner
Jeffrey Mayo R.Ph.	Pharmacy or Practice Owner
S Robinson manager	Pharmacy or Practice Owner
Mark Whittier Pharmacist/Owner	Pharmacy or Practice Owner
Jim Morisoli RPH	Pharmacy or Practice Owner
Deborah Suggs, Pharm.D.	Healthcare Provider, Taxpayer
Umesh Patel, Pharmacist	Pharmacy or Practice Owner
Kathleen Elliott Owner/Pharmacist	Pharmacy or Practice Owner
Matthew Perkins, PharmD	Healthcare Provider, Pharmacy or Practice Owner, Employer
terry perkins pharmacist	Healthcare Provider, Pharmacy or Practice Owner, Employer, Taxpayer
Arun tandon , President	Patient, Healthcare Provider, Pharmacy or Practice Owner, Employer, Taxpayer
Patrick K Brian	Pharmacy or Practice Owner
Elizabeth M. Caveness, PharmD	Patient, Healthcare Provider, Pharmacy or Practice Owner, Employer, Taxpayer
Karen Hekeler, Pharmacy Consultant	Taxpayer
David Bagot RPh	Patient, Pharmacy or Practice Owner, Employer, Taxpayer
Brandon Cooper, Pharm.D.	Pharmacy or Practice Owner
Scott Popyk	Pharmacy or Practice Owner
Dave Falk Owner	Pharmacy or Practice Owner, Employer, Taxpayer
Dr. Ben Harris Pharmacist/Owner	Pharmacy or Practice Owner
Jesse Brashear, CEO	Pharmacy or Practice Owner
Ervin Counts, PIC	Pharmacy or Practice Owner
Dr. Nicholas Abernathy	Patient, Healthcare Provider, Employer, Taxpayer
William Cobb PharmD	Pharmacy or Practice Owner
Charles Brumer PD	Pharmacy or Practice Owner
Anita Roberts PharmD, Consultant	Pharmacy or Practice Owner

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Name & Title	I am a
Sara Buscher	Taxpayer
DHAVAL ZAVERI, PHARMACIST	Pharmacy or Practice Owner
Michael Aksamit, President	Pharmacy or Practice Owner
John Bannister	Pharmacy or Practice Owner
Jerry Callahan RPh, Owner	Patient, Healthcare Provider, Pharmacy or Practice Owner, Employer, Taxpayer
Sean Mullally, co-owner	Patient, Healthcare Provider, Pharmacy or Practice Owner, Employer, Taxpayer
Kaylee St John, PharmD	Healthcare Provider, Pharmacy or Practice Owner, Taxpayer
DENNIS E MILLER RPH	Patient, Healthcare Provider, Pharmacy or Practice Owner, Employer, Taxpayer
Heather Callaway CPhT	Patient, Healthcare Provider, Employer, Taxpayer
Joseph Grana	Healthcare Provider, Taxpayer
Ilsa Corredeira, Pharmacy Manager	Pharmacy or Practice Owner
K. Scott Nunnelee, RPh	Pharmacy or Practice Owner
kathleen rothrock	Healthcare Provider, Pharmacy or Practice Owner
James A Fields PD	Patient, Healthcare Provider, Pharmacy or Practice Owner, Employer, Taxpayer
Lee Ann Hampton, Pharm D. Pharmacy owner	Patient, Healthcare Provider, Pharmacy or Practice Owner, Employer, Taxpayer
RK CAMPBELL PHARMACY OWNER	Pharmacy or Practice Owner
Peter Wolfe owner	Pharmacy or Practice Owner
Merry Schmittgens	Patient, Healthcare Provider, Pharmacy or Practice Owner, Employer, Taxpayer
Lynn Hostetler, R.ph. pharmacy owner and consumer	Patient, Healthcare Provider, Pharmacy or Practice Owner, Employer, Taxpayer
Janet Trainham , PharmD	Pharmacy or Practice Owner
Walt Cwietniewicz RPh	Healthcare Provider, Pharmacy or Practice Owner
Gary R.Ickes	Pharmacy or Practice Owner
Bernard LeBas	Patient, Healthcare Provider, Pharmacy or Practice Owner, Employer, Taxpayer
william H. Burch, RPh	Pharmacy or Practice Owner
Rosemary C. Smith, RPh	Patient, Healthcare Provider, Pharmacy or Practice Owner, Employer, Taxpayer
Kevin Minassian, President Datascan	Patient, Employer, Taxpayer
Jenna Hawkins, Pharmacist In Charge	Pharmacy or Practice Owner
Pete Powers RPH.	Pharmacy or Practice Owner
George Warren, RPh Pharmacist/Owner	Pharmacy or Practice Owner
Vijay Desai	Healthcare Provider, Pharmacy or Practice Owner, Taxpayer

Pharmacists United for Truth & Transparency
TruthRx.org

Name & Title	I am a
Ramila Desai	Pharmacy or Practice Owner, Taxpayer
Shobha Patel	Pharmacy or Practice Owner, Taxpayer
Mital Patel	Healthcare Provider, Taxpayer
Manish Goswami	Healthcare Provider, Pharmacy or Practice Owner
Narsinh Desai	Healthcare Provider, Pharmacy or Practice Owner, Employer, Taxpayer
Ajay Desai, Pharmacist	Pharmacy or Practice Owner
Vignya Patel, Supervising Pharmacy	Pharmacy or Practice Owner
Brianna Trevorah, Cashier	Pharmacy or Practice Owner
Patricia Reed, Pharmacy Technician	Pharmacy or Practice Owner
Jean Murphy, Pharmacist	Pharmacy or Practice Owner
Dhvani Desai	Healthcare Provider
Clark boyd	Pharmacy or Practice Owner
Bhupendra Patel (Pharmacist in Charge)	Pharmacy or Practice Owner
KETAN DESAI	Taxpayer
Pranav Gaglani	Healthcare Provider, Pharmacy or Practice Owner, Taxpayer
MARK TRIPLETT OWNER/PIC	Pharmacy or Practice Owner
Brian Key, Pharmacist/Owner	Pharmacy or Practice Owner
Walter M. Hughes, Jr. President	Pharmacy or Practice Owner
Charles Thompson	Healthcare Provider
Amy Union (PIC)	Pharmacy or Practice Owner
Jerid Maddox, Pharm.D.	Pharmacy or Practice Owner
Hope Mullally, Pharmacist	Pharmacy or Practice Owner
Dr. Kaylee St. John-Bean, PharmD	Healthcare Provider, Pharmacy or Practice Owner, Employer, Taxpayer
Chandra Patel, Pharmacist	Pharmacy or Practice Owner
Curt Schaefer, Regional Sales Director	Taxpayer

FTC Comments Attachment 1A
Index of Attachments

Attachment 1: Evidence that PBMs do not negotiate contracts. PCMA and PBMs frequently and publicly say they are open and willing to negotiate contract terms, however this is never true. The example provided is from a pharmacy owner in rural Minnesota whose situation is such that she can only attempt to negotiate with PBMs, she doesn't have an entity to do it for her. Time and again she's been told the contract is not negotiable, that she must accept the contract terms or not join the PBM network.

Attachment 2: 2021 Drug Pricing Transparency report by Janssen Pharmaceuticals. We ask you to review pages 1-8, which not only classify and quantify rebates by dollar amount, but also directly draw a line between the increasing demand for drug rebates and the higher price consumers pay (because rebates are based on list price, consumers pay list price, but PBMs negotiate a net price for themselves, then charge a higher price back to health plan payers. Consumers do not receive the benefit of a drug rebate and don't even know they aren't receiving that benefit, in spite of the publicity PCMA and PBMs generate by taking credit for "negotiating lower drug prices".

Attachment 3: Examples of Patient Steering Letters Received by Patients. Identifying information has been redacted, but these are letters patients received that were sent to them by name, falsely indicating their independent pharmacy was no longer in-network. These kinds of letters make their way to patients all the time, and the most vulnerable ones (usually seniors) do not know to check with their current pharmacy to see if the letter is accurate. The accompanying email to the photographed letters explains the circumstances of one such vulnerable patient. In state policy stakeholder meetings where patient steering is on the table for discussion, PCMA and the PBM lobbyists threaten over and over that if they are not allowed to direct patients to their owned pharmacies then patients will see higher drug prices. But we have tracked examples for years showing how independent pharmacies often have better pricing and better service. We've collected stories from patients who were led to believe under false circumstances that they needed to switch pharmacies, only to find out they were lied to.

Attachment 4: Examples of Contract Terms that Prohibit Pharmacies from Taking Certain Actions, but not PBMs. Contract examples are as follows: (2) pharmacy prohibition on soliciting patients to come to their pharmacy (patient steering); prohibition against accepting discount cards as a form of payment; and a requirement that the pharmacy must refer to mail order, specialty pharmacy or other providers as appropriate to the design of the benefit plan.

Attachment 5: Example of How PBM Mail Order is Not Less Expensive than In-Person Pharmacy. This is a snapshot from a public hearing by the Collin County Commissioners re: changing their pharmacy benefits plan away from the PBM's mail order pharmacy program. In the powerpoint slide, the 3rd bullet shows Collin County paid an average of *$29.09 per prescription* for mail order vs. in-person pharmacy.

Fwd: Reminder: Waiting for you to sign Updated Offer for Aetna Medicare Retail Network P3 - 2426737

1 message

Deborah Keaveny <[redacted]> Wed, Sep 2, 2020 at 10:39 PM
To: Shannon Wightman-Girard <shannon@truthrx.org>

Sent from my iPhone

Begin forwarded message:

From: Pharmacy Network Services <pharmnetwrksrvc@aetna.com>
Date: May 20, 2020 at 5:49:22 AM CDT
To: [redacted]
Subject: RE: Re: Reminder: Waiting for you to sign Updated Offer for Aetna Medicare Retail Network P3 - [redacted]

Deborah,

Thanks for your response. Unfortunately the terms of this agreement are non-negotiable. Please decline the amendment otherwise you will receive reminder notifications until it expires 30 days from the date sent. Please note refusal to sign the amendment will result in termination from the P3 network effective 12/31/2020. Your pharmacy does not meet the Rural requirements.

Thanks,

Pharmacy Network Services

Proprietary

From: Aetna Pharmacy Auto Responder <AetnaPharmacyAutoResponder@AETNA.com>
Sent: Tuesday, May 19, 2020 12:51 PM
To: Pharmacy Network Services <PharmNetwrkSrvc@aetna.com>
Subject: FW: [EXTERNAL] Re: Reminder: Waiting for you to sign Updated Offer for Aetna Medicare Retail Network P3 - [redacted]

From: Deborah Keaveny <[redacted]>
Sent: Tuesday, May 19, 2020 12:42 PM
To: Aetna Pharmacy Auto Responder <AetnaPharmacyAutoResponder@AETNA.com>
Subject: [EXTERNAL] Re: Reminder: Waiting for you to sign Updated Offer for Aetna Medicare Retail Network P3 - 2426737

**** External Email - Use Caution ****

I am a small rural pharmacy, the only pharmacy in town and cannot accept these reimbursement rates. Please contact me with new rates. Without my pharmacy you do not meet TriCare standards.

Deborah Keaveny

Keaveny Drug

[redacted]

[redacted]

[redacted]

On Tue, May 19, 2020 at 9:38 AM Aetna Pharmacy Network Operations <echosign@echosign.com> wrote:

Please sign Updated Offer for Aetna Medicare Retail Network P3 - [redacted]

Click here to review and sign **Updated Offer for Aetna Medicare Retail Network P3 -** [redacted]

After you sign **Updated Offer for Aetna Medicare Retail Network P3 -** [redacted], all parties will receive a final PDF copy by email.

Aetna Pharmacy Network Operations has requested that this reminder be sent. This reminder will be re-sent every day until completed. Click here if you wish to stop receiving reminders about this agreement.

*Please note: Completion of an application and agreement does not indicate our acceptance of your agreement and does not guarantee your participation in our network. We will evaluate your application according to our business and credentialing processes and standards and will notify you of the status of your application and agreement.

--

Deborah Keaveny, RPh

Centene Medicare P

The undersigned hereby enrolls as a provider in the Medicare Part D Retail Network stated below, effective January 1, and agrees to accept the AWP Discount and Dispensing Fee and the other participation requirements as set forth here

For the purposes of Section 4.3 or Schedule A of the Caremark Provider Agreement, whichever is applicable, the AWP Discount for brands and generics and Dispensing Fees are as follows:

Network Name	AWP Discount		Dispensing Fee
	Brand	Generic	
Medicare Part D Retail Centene Medicare Part D Performance Network Program: Standard 1	**10.50%***	**25.0%**	**$0.50**
1-90 Days Supply			

* In the event changes are made to the Medicare Part D rules that impact this Medicare Part D Retail Network Performance Network Program, and Caremark determines in its sole discretion that such changes make the continuation of the Program infeasible, Caremark reserves the right to discontinue the Program for this and any other reason and, unless otherwise notified, the **AWP Brand Discount above will no longer apply and the new AWP Brand Discount will be 22.14%,** and the network variable rate, the associated Retail Performance Network Program Information, the attached Specialty Drug Reimbursement Addendum (SDRA) will all no longer apply, and a replacement SDRA will be issued.

- This Network Enrollment Form may be utilized by Centene's Medicare Part D plans, including Medicare Part D plans for legacy WellCare plans, Fidelis, Health Net, Centene plans and any other Medicare Part D plans that are owned or affiliated with Centene (collectively, "Centene Medicare Part D Plans").
- Other reimbursement terms may apply as set forth in an addendum to the Provider Agreement for a pharmacy that is not a **"Retail Pharmacy"** (as that term is defined in the *"Standards of Operation"* section of the Provider Manual) participating in this retail network.
- For Caremark contracted affiliations/PSAOs (Pharmacy Services Administration Organization), the above reimbursement rates and program terms apply to all retail pharmacies.
- To ensure adequate access to network pharmacies for Part D Enrollees, Provider agrees to participate in the Medicare Part D network identified above for the entire applicable Part D plan year and may only terminate network participation as in accordance with the *"Termination"* section of the Provider Manual and the *"Network Participation"* sub-section of the *"Medicare Part D"* section of the Provider Manual.
- By its enrollment in this Performance Network Program, Provider also agrees that the terms and conditions of participation herein are reasonable and relevant to the Provider.

Retail Performance Network Program Information

Provider will be charged a network variable rate to the Plan Sponsors that will range from **12% to 14%** for each brand product total ingredient cost paid and **39% to 41%** for each generic product total ingredient cost paid based on Provider's performance on the performance criteria outlined in Exhibit A during the measurement period. The network variable rate amount and the annual performance payment will be calculated individually for each pharmacy.

Provider may be eligible for a performance payment after the plan year based on Provider's annual performance score with respect to the performance criteria. The Retail Performance Network Program is based on two parts – performance effort (Pay per Intervention – **PPI**) and performance outcome (Performance Payment - **PP**) with the end result focused **solely** on performance outcome. PPI payments (excluding CMR payments) made for effort that exceed the annual PP may be recovered from pharmacies as part of the final plan year collection period. If the PP exceeds the PPI payments, the PP will be paid approximately after the final collection period which occurs in the first half of the next plan year.

Caremark may modify the performance criteria and/or criteria weighting to align with a change in CMS Star measures.

_____Initial

TRUTHRX.ORG [redacted]

FW: Attached Image

[redacted] Thu, Sep 2, 2021 at 8:48 AM

Hi Everyone,

Attached is an email from Humana stating it is preparing to respond to the Minnesota Department of Health's upcoming RFP to serve Minnesota Managed Medicaid enrollees. Mailings have gone out to MN pharmacies, but I suspect as pharmacies in neighboring states (IA, SD, ND, WI) you may also have received the mailing or will be receiving the mailing. The attachment I am sending is dated August 16, 2021.

I have read through the agreement and here are some areas where I urge extreme caution:

1. This is yet another silent acceptance clause. That means no response from your pharmacy back to Humana by their self-imposed deadline means "you're in!"

2. The deadline is 52 calendar days (not business days) from the date of the letter, so in the case of this attachment you MUST respond no later than October 7, 2021 to either their fax number or email address. My recommendation based on your decision: ***DO BOTH*** and save your proof of delivery either as the fax and save your email in a specific Humana file. If you do not receive an "unable to deliver" message from your internet service provider (ISP) Humana DID receive your email.

3. Reimbursement – there is no mention of reimbursement, or how reimbursements will be calculated. Another good example of "turning over your checkbook to a PBM." Should that not be a part of a contract when a store receives such a letter.

4. What are the rescission terms if you agree to this letter and later on want to walk away? Are you locked in with no possibility of removing your store(s) from this Humana agreement? Be ultra cautious! Know what those termination clauses are.

5. Inability for a patient to pay cost sharing (copay, co-insurance) means you are stuck as a provider. Ex: $300 cost on insulin which you will likely be paid at or below cost, and then a patient tells you he/she can't afford the $35 copay – you get to absorb that as well! Why does Humana not step up to the plate? After all, Humana is the PBM engaging in spread pricing to the state of MN (yours and my taxpayer dollars).

We all know the difficulties with Humana in trying to negotiate at all; theirs is a take-it or leave-it proposition as I discovered yesterday with a number of northern MN pharmacies yesterday (most of you were copied on that as well).

I certainly cannot tell each of you what to do when you receive the attached letter from Humana, and that is what it is – a letter, not an offering to participate. Unilateral as predictable. Heed my cautions above; there are likely others I have missed.

Be in touch with any questions you may have.

Thanks.

Humana.

Reimbursement?

August 16, 2021

Humana Pharmacy Solutions
309/73290
515 West Market Street/5th FL
Louisville, KY 40202

[redacted]

RE: CONTRACT AMENDMENT FOR THE MINNESOTA MEDICAID PLANS

Dear Pharmacy Owner,

Humana is preparing to respond to Minnesota Department of Health's (MDH) upcoming Request for Proposals (RFP) to serve Minnesota's Managed Medicaid enrollees. The purpose of this letter is to extend to you the opportunity to participate in the Humana designated plans offered in the State of Minnesota should Humana be awarded a Medicaid Managed Care contract with MDH (Contract).

In accordance with the *Modification of this Agreement* section of your Pharmacy Provider Agreement, an amendment is enclosed. If you wish to participate, you do not need to do anything. The provisions in this Amendment shall be effective upon Humana's designation of Medicaid Plans offered in the State of Minnesota, if any.

If you wish not to participate, please fax or email a signed letter of correspondence utilizing company letterhead and reference your NCPDP/NPI and tax identification number to the contact information below. Any letter of correspondence must be remitted no later than fifty-two (52) calendar days from the date of this letter. (October 7th)

FAX: 1-877-650-2334
EMAIL: pharmacycontracting@humana.com (Subject Line: Humana MN Medicaid Amendment)

In the meantime, if you have questions about this letter please contact Humana Pharmacy Solutions Contracting Support at **1-888-204-8349** or email **pharmacycontracting@Humana.com**. Thank you for the care of our members.

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Sincerely,

[redacted]
Market Vice President, Pharmacy Networks and Contracting
Humana Pharmacy Solutions

Enclosure

PHARMACY PROVIDER AGREEMENT

MINNESOTA MEDICAID NETWORK PARTICIPATION AMENDMENT

This Minnesota Medicaid Network Participation Amendment ("**Amendment**") to the Pharmacy Provider Agreement ("**Agreement**") is made and entered into by and between Humana Pharmacy Solutions, Inc. (a pharmacy benefit manager) (hereinafter "**Humana**") and Provider as identified in preamble of the Agreement (hereinafter "**Provider**").

WITNESSETH

WHEREAS, Humana and Provider entered into the Agreement pursuant to which Provider agreed to provide and/or arrange for the provision of Covered Services to individuals enrolled in the Humana designated Medicaid Plans ("**Members**") at negotiated rates; and

WHEREAS, in accordance with the terms and conditions pursuant to Section 9.9, *Modification of Agreement*, Humana desires to amend the Agreement to include the terms and conditions for Provider's participation in the Humana designated Medicaid Plans offered in the State of Minnesota ("**State**") and provision of Covered Services to the Members under such Medicaid Plans.

NOW THEREFORE, in consideration of the premises and the mutual promises and covenants herein contained, the Agreement is amended as follows:

A. Section 10.2, *Scope of Agreement*, of the Agreement is modified to include Provider's participation in all Humana designated Medicaid Plans offered in the State of Minnesota.

B. The Agreement is amended to add the text set forth in Attachment #1 hereto to **EXHIBIT H**, *Regulatory Requirements: Minnesota-Specific Requirements*.

C. Except as specifically amended hereby, the terms and conditions of the Agreement remain the same.

D. Capitalized terms used herein but not otherwise defined shall have the meanings ascribed to them in the Agreement.

E. This Amendment shall be effective upon Humana's designation of Medicaid Plans offered in the State of Minnesota.

ATTACHMENT #1

EXHIBIT H

MINNESOTA-SPECIFIC REQUIREMENTS

The following additional provisions apply specifically to Minnesota Medicaid products and plans and are hereby incorporated by reference into the Agreement solely to the extent specifically required to ensure compliance with applicable Minnesota laws, rules, and/or regulations. In the event of a conflict between the terms and conditions of the Agreement and this Minnesota-Specific Requirements Appendix ("Appendix"), the terms and conditions of this Appendix shall control as they apply to Minnesota Medicaid products and plans. To the extent this Agreement covers any commercial or Medicare line(s) of business, the parties further agree that none of the provisions of this Appendix apply to same. Any terms capitalized but not otherwise defined in this Appendix or the Agreement will have the meaning set forth in the Medicaid Managed Care Contracts between the State of Minnesota ("State") on behalf of the Minnesota Department of Human Services ("Department") and Humana Health Plan, Inc., including the Contract for Prepaid Medical Assistance and MinnesotaCare ("Minnesota Families Contract"), the Contract for Minnesota Senior Health Options and Minnesota Senior Care Plus Services ("Minnesota Seniors Contract"), and the Contract for Special Needs BasicCare Program Services for People with Disabilities ("Minnesota Special Needs Contract," and, together with the Minnesota Families Contract and the Minnesota Seniors Contract, the "Minnesota Medicaid Contracts"). In the event of any differences in the definitions set forth in the Minnesota Medicaid Contracts, the applicable definition shall apply when used in the context of the applicable contract.

Terms Applicable to All Minnesota Medicaid Contracts

1. Provision of Covered Services. Provider agrees to provide Covered Services to Members in accordance with all applicable federal and state laws, rules, regulations, and policies and procedures relating to the provision of medical services rendered to such Members. For purposes of this Appendix, the term "Covered Services" means those Medically Necessary Services that Provider is authorized to provide pursuant to the Agreement. The Agreement shall not be construed to require Provider to participate or accept other plans or products offered by Humana unrelated to providing Covered Services to Members.

2. Medicaid Contract. Provider agrees and acknowledges that Humana is bound by, and the obligations under this Appendix shall be performed in accordance with, the terms of the Minnesota Medicaid Contracts, and Provider shall meet all terms and requirements of the Minnesota Medicaid Contracts that apply to Provider and its subcontractors. Humana shall monitor Provider's performance under the Agreement on an ongoing basis and subject Provider to formal review on the schedule established by the Department and consistent with industry standards or federal or state laws and regulations. Humana shall identify any deficiencies or areas for improvement related to Provider's performance related to the Minnesota Medicaid Contracts, and upon request of the Department, Provider shall provide evidence to Humana, that Humana may share with the Department, to demonstrate that corrective action has been taken to address such deficiency.

3. Data Exchanges. Humana and Provider shall electronically perform data exchanges containing eligibility data, claims data, and payment data and remittance advice. Further, Humana may require Provider to use the state's Electronic Verification System ("EVS") or MN-ITS system.[1]

4. Member Rights. When providing services to Members, Provider shall consider the Member's right to: (i) receive information pursuant to 42 C.F.R. § 438.10; (ii) be provided with services under the Minnesota Medicaid Contracts in accordance with 42 C.F.R. §§ 438.206 through 438.210; (iii) be treated with respect and with due consideration for the Member's dignity and privacy (42 C.F.R. § 438.100(b)(2)(ii)); (iv) receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand (42 C.F.R. § 438.100(b)(2)(iii)); (v) participate in decisions regarding his or her health care, including the right to refuse treatment (42 C.F.R. §438.100(b)(2)(iv)); (vi) be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion (42 C.F.R. § 438.100(b)(2)(v)); (vii) request and receive a copy of his or her medical records, and request to amend or correct the record (45 C.F.R. §§ 160 and 164, subparts A and E); and (viii) have freedom to exercise his or her rights, and the exercise of these rights must not adversely affect the way the Member is treated (42 C.F.R. § 438.100(c)). To the extent applicable, Provider shall not specify confidential services, as defined by the State, in notices sent to the Member and must not be sent to the Member if the only service furnished was confidential.[2]

5. Communications. Provider shall comply with the recommendations of the revised Policy Guidelines published on August 4, 2003 by the Office of Civil Rights of DHHS, titled "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (hereinafter "Guidance") and take reasonable steps to ensure meaningful access to Humana's programs and services by limited English proficiency ("LEP") persons, pursuant to the Guidance. Provider shall apply the four factors described in the Guidance to the various kinds of contacts they have with the public to assess language needs, and decide what reasonable steps, if any, they should take to ensure meaningful access for LEP persons.[3]

6. Marketing. Provider acknowledges that all marketing materials that Provider plans to use during the applicable Minnesota Medicaid Contract period must be approved by the State. Provider also acknowledges that it is restricted from marketing on Humana's behalf. Provider acknowledges that, if Provider distributes brochures or displays posters at its office and clinics informing patients that Provider is part of Humana's network, such materials require approval by Humana and, if applicable, the state, and Provider agrees that all managed care organizations contracted with Provider have an equal opportunity to be represented.[4]

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[1] Minnesota Families Contract §§ 3.5.2, 3.5.3; Minnesota Seniors Contract §§ 3.6.2, 3.6.3; Minnesota Special Needs Contract §§ 3.8.2, 3.8.3.

[2] Minnesota Families Contract § 3.7.1; Minnesota Seniors Contract § 3.8.1; Minnesota Special Needs Contract § 3.10.1; 42 C.F.R. §§ 438.10, 438.100, 438.116, 438.206-210; 45 C.F.R. §§ 160 and 164, subparts A and E.

[3] Minnesota Families Contract § 3.8.1.1; Minnesota Seniors Contract § 3.10.1.1; Minnesota Special Needs Contract § 3.11.2.1.

[4] Minnesota Families Contract §§ 3.9.1 & 3.9.2; Minnesota Seniors Contract §§ 3.11.3, 3.11.4; Minnesota Special Needs Contract §§ 3.12.2, 3.12.3; 42 C.F.R. §§ 438.104(b)(1)(i); 438.700(c); 438.104.

7. Provider Directory. Provider agrees to be included in Humana's provider directory and agrees to provide such information as is necessary for the provider directory.[5]

8. Significant Events. Provider shall notify Humana of any significant events affecting the level of service that it provides to Members.[6]

9. Inability to Pay Cost-Sharing. Provider shall not deny Covered Services to a Member because of the Member's inability to pay cost-sharing.[7] Another donation by pharmacy. Should not the plan administrator (HUMANA) be responsible?

10. Records. Provider shall maintain and make available to other providers copies of the Member's medical records, as appropriate and in compliance with federal and state law. In the event of a termination of this Agreement, Provider shall assist in the transfer of records and data required to facilitate the transition of care of Members, upon request and at no cost to Members, the State, or the receiving managed care organization.[8]

11. Medical Equipment and Supplies. To the extent that Provider is a vendor of durable medical equipment, Provider shall be enrolled as a Medicare provider, unless exempted by the State.[9]

12. Prescribing, Electronic. Provider shall conform to the electronic prescribing standards, including the standards in Minnesota Statutes § 62J.497, for transmitting prescription or prescription-related information.[10]

13. Cost-Sharing. Provider must reimburse Members for cost-sharing erroneously charged by Provider.[11]

14. Provider Enrollment. Provider shall be enrolled with the State as a Minnesota Health Care Programs ("MHCP") provider. Provider must comply with the provider disclosure, screening, and enrollment requirements in 42 C.F.R. § 455.[12]

15. Sanction Review. Provider attests that it (i) has not been sanctioned for fraudulent use of federal or state funds by DHHS, pursuant to 42 USC §1320 a-7(a) or by the State; (ii) is not debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 (51 FR 6370, February 18, 1986) or

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[5] Minnesota Families Contract § 3.10.6; Minnesota Seniors Contract § 3.12.6; Minnesota Special Needs Contract § 3.13.6; 42 C.F.R. § 438.10(h)(1).

[6] Minnesota Families Contract § 3.11; Minnesota Seniors Contract § 3.13; Minnesota Special Needs Contract § 3.14.

[7] Minnesota Families Contract § 4.12.6; Minnesota Seniors Contract § 4.11.5; Minnesota Special Needs Contract § 4.12.4; 42 C.F.R. § 447.52.

[8] Minnesota Families Contract §§ 5.2.4.1, 6.18.6; Minnesota Seniors Contract §§ 5.2.4.1, 6.13.6; Minnesota Special Needs Contract §§ 5.2.4.2, 6.16.6.

[9] Minnesota Families Contract § 6.1.25.2; Minnesota Seniors Contract § 6.1.32.2; Minnesota Special Needs Contract § 6.1.29.2; Minnesota Statutes, § 256B.0625, subd. 31(b) and (c).

[10] Minnesota Families Contract § 6.1.40; Minnesota Seniors Contract § 6.1.44; Minnesota Special Needs Contract § 6.1.44.

[11] Minnesota Families Contract § 6.11.3; Minnesota Seniors Contract § 6.6.3; Minnesota Special Needs Contract § 6.8.3; 42 C.F.R. §§ 447.25, 438.704(c).

[12] Minnesota Families Contract § 6.12.1.1; Minnesota Seniors Contract § 6.7.1.1; Minnesota Special Needs Contract § 6.9.1.1; 42 C.F.R. § 455.

under guidelines interpreting such order; and (iii) is not an affiliate of a provider described (i) or (ii).[13]

16. Access Standards. Provider shall meet the access standards required under the Minnesota Medicaid Contracts and applicable state and federal laws. Humana shall monitor, on a periodic or continuous basis, but no less than every twelve (12) months, Provider's adherence to these standards.[14]

17. Health Records. Provider shall maintain and share a Member health record in accordance with professional standards.[15]

18. Patient-Centered Decision-Making. Provider shall participate in Humana's efforts to (i) identify key conditions warranting shared decision-making based on potential to improve health outcomes and heath care value and (ii) encourage use of shared decision-making for the identified conditions.[16]

19. Grievance and Appeal. Provider shall comply with Humana's grievance and appeal system and respect and comply with the rights of Members to grievances, appeals, and state fair hearings. Provider can file a grievance on a matter regarding a Member's dissatisfaction about any matter other than a Humana action, if acting on behalf of the Member with the Member's written consent.[17]

20. Compliance Monitoring and Overpayments. Provider shall comply with Humana's compliance plan and internal monitoring and auditing standards. Further, if Provider receives an overpayment, Provider shall report the overpayment to Humana, return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and notify Humana of the reason for the overpayment.[18]

21. State Audits. Provider acknowledges that the State has the right to audit and investigate Provider. Further, Provider acknowledges that the Department may direct Humana to monitor Provider or take corrective action as the State deems appropriate when, in the opinion of the State, good cause exists. Provider shall comply with all such monitoring or corrective action.[19]

22. Suspension of Payments. Humana may suspend all payments to Provider under the Agreement related to the Minnesota Medicaid Contracts if (i) the State has suspended all payments under a Minnesota Medicaid Contract to Provider based on a determination there is credible allegation

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[13] Minnesota Families Contract § 6.7.3; Minnesota Seniors Contract § 6.12.3; Minnesota Special Needs Contract § 6.9.3.

[14] Minnesota Families Contract § 6.12.7; Minnesota Seniors Contract § 6.7.7; Minnesota Special Needs Contract § 6.9.7; 42 C.F.R. § 438.206(c)(1).

[15] Minnesota Families Contract § 6.12.8; Minnesota Seniors Contract § 6.7.8; Minnesota Special Needs Contract § 6.9.8; 42 C.F.R. § 438.208(b)(5).

[16] Minnesota Families Contract § 7.11; Minnesota Seniors Contract § 7.14; Minnesota Special Needs Contract § 7.14; Minnesota Statutes § 256B.69, subd. 9, (c).

[17] Minnesota Families Contract §§ 8.1.4, 8.2.1; Minnesota Seniors Contract §§ 8.1.4, 8.2.1; Minnesota Special Needs Contract §§ 8.1.4, 8.2.1.

[18] Minnesota Families Contract § 9.4 Minnesota Seniors Contract § 9.4; Minnesota Special Needs Contract § 9.4; Section 1128J(d) of the Social Security Act; 42 C.F.R. § 438.608(d).

[19] Minnesota Families Contract §§ 9.4.5.2, 9.4.5.3; Minnesota Seniors Contract §§ 9.4.5.2, 9.4.5.3; Minnesota Special Needs Contract §§ 9.4.5.2, 9.4.5.3.

of fraud against Provider for which an investigation of payments made under the program is pending or (ii) Humana determines there is a credible allegation of fraud against Provider for which an investigation is pending under the program. This suspension will be temporary and will not continue after either (i) the State or Humana or the prosecuting authorities determine there is insufficient evidence of fraud by Provider and the State or Humana has notified the other party of the lack of evidence or (ii) legal proceedings relating to Provider's alleged fraud are completed. Provider acknowledges that the State has the right to direct Humana to suspend payments from Provider.[20]

23. Compliance with Federal, State, and Local Law. Provider shall comply with all applicable federal and state statutes and regulations, as well as local ordinances and rules now in effect and hereinafter adopted, including but not limited to Minnesota Statutes, §§62J.695 through 62J.76 (Minnesota Patient Protection Act), Minnesota Statutes, §62Q.47 (Alcoholism, Mental Health, and Substance Use Disorder Services), Minnesota Statutes, §62Q.53 (Mental Health Coverage; Medically Necessary Care), Minnesota Statutes, §62Q.58 (Standing Referral for Access To Specialty Care), Minnesota Statutes, §62Q.19 (Essential Community Providers); and Minnesota Statutes, §256.969, subds. 3b and 4a, with 42 CFR §438.3(g) and 42 CFR §447.26, (Provider-Preventable Conditions).[21]

24. Hold Harmless. Provider shall (i) notify Members in writing of Member liability for non-Covered Services and (ii) prior to performance of the non-Covered Service, receive written authorization from the Member for the non-Covered Service. Further, except for cost-sharing allowed under the applicable Minnesota Medicaid Contract, Provider shall not hold Member liable for any charges associated with the Member's care received from Provider. Provider may only seek payment from a Member for non-covered services (not otherwise eligible for payment) under the circumstances described in Minnesota Statutes, § 256B.0625, subd. 55. This includes that Provider shall not hold Member liable for payment if Provider fails to receive payment for Covered Services for Humana. [22]

25. Medical Necessity. For purposes of Covered Services provided pursuant to the Minnesota Medicaid Contracts, Provider agrees that medically necessary or medical necessity means a health service that is: 1) consistent with the Member's diagnosis or condition; 2) recognized as the prevailing standard or current practice by Provider's peer group; and 3) rendered: (i) in response to a life threatening condition or pain, (ii) to treat an injury, illness, or infection, (iii) to treat a condition that could result in physical or mental disability, (iv) to care for the mother and unborn child through the maternity period, (v) to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition, or (vi) as a preventive health service defined under Minnesota Rules, Part 9505.0355.[23]

26. Patient Safety. Provider shall (i) report through Leapfrog, a national patient safety initiative and (ii) develop and implement patient safety policies to systematically reduce medical errors. Such

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[20] Minnesota Families Contract §§ 9.4.6.7-9.4.6.9; Minnesota Seniors Contract §§ 9.4.6.7-9.4.6.9; Minnesota Special Needs Contract §§ 9.4.6.7-9.4.6.9.

[21] Minnesota Families Contract § 12.4; Minnesota Seniors Contract § 12.4; Minnesota Special Needs Contract § 12.4.

[22] Minnesota Families Contract §§ 12.8.6, 6.11.2.1; Minnesota Seniors Contract §§ 12.8.5, 6.6.2.1; Minnesota Special Needs Contract §§ 12.8.7, 6.8.2.1; MHCP Provider Manual.

[23] Minnesota Families Contract §§ 12.8.7, 2.88; Minnesota Seniors Contract §§ 12.8.6, 2.107; Minnesota Special Needs Contract §§ 12.8.8, 2.112; Minnesota Rules, Part 9505.0175, subpart 25.

policies may include systems for reporting errors, and systems analysis to discover and implement error-reducing technologies.[24]

27. Patient Advocacy. This Agreement shall not be interpreted to prohibit, or otherwise restrict, Provider acting within the lawful scope of practice from advising or advocating on behalf of a Member, with respect to: (i) the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (ii) any information the Member needs in order to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or non-treatment; or (iv) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.[25]

Additional Terms Applicable to Both Minnesota Seniors Contract and Minnesota Special Needs Contract

1. Medicare Provider Requirements. Provider and Humana shall comply with all applicable requirements imposed on providers in 42 CFR Part 422, subpart E, including, but not limited to: 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, Medicare cost-sharing, and limits on physician incentive plans.[26]
2. Hold Harmless. Provider shall not hold the Member liable for Medicare Part A and B cost sharing. Provider shall accept the payment from Humana as payment in full.[27]

Additional Terms Applicable Only to Minnesota Seniors Contract

1. Elderly Waiver. Provider shall not deny services because of non-payment of a waiver obligation without proper notice to the Member and Humana.[28]
2. Coordinated Benefits Education. Provider acknowledges and understands the integrated Medicare and Medicaid benefits available under the Minnesota Seniors Contract and will participate in any education from Humana regarding such benefits.[29]

Additional Terms Applicable Only to Minnesota Special Needs Contract

1. Member Rights. Provider acknowledges and shall consider that Members have the right to be free from any form of aversion or deprivation procedures as described in Minnesota Rules, parts 9525.2700 through 9525.2810.[30]
2. Service Accessibility. Provider shall cooperate with any trainings and orientations about mitigating systemic barriers and arranging for services or devices to lessen communication barriers for Members who need access to Covered Services.[31]

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[24] Minnesota Families Contract § 12.8.8; Minnesota Seniors Contract § 12.8.8; Minnesota Special Needs Contract § 12.8.10.
[25] Minnesota Families Contract § 12.8.10; Minnesota Seniors Contract § 12.8.10; Minnesota Special Needs Contract § 12.8.12; 42 C.F.R. § 438.102.
[26] Minnesota Seniors Contract § 3.19.8; Minnesota Special Needs Contract § 12.8.13; 42 C.F.R. § 422, subpart E.
[27] Minnesota Seniors Contract § 6.6.2.1; Minnesota Special Needs Contract § 6.8.2.1; 42 C.F.R. § 422.504(g)(1)(iii).
[28] Minnesota Seniors Contract § 4.12.4.
[29] Minnesota Seniors Contract § 9.2.2.
[30] Minnesota Special Needs Contract § 3.10.1; Minnesota Rules, parts 9525.2700-9525.2810.

EMERGENCY CONTRACT

On this __ day of August, 2020, the State of Louisiana, Office of Group Benefits, 1201 N. 3rd Street, Suite G-159, Baton Rouge, LA 70802, hereinafter sometimes referred to as the "OGB" or "State", and CaremarkPCS Health, L.L.C. ("CVS Caremark"), a wholly owned direct subsidiary of CaremarkPCS, L.L.C., a subsidiary of Caremark Rx, L.L.C., whose parent company is CVS Health Corporation, One CVS Drive, Woonsocket, RI 02895, hereinafter sometimes referred to as the "Contractor," do hereby enter into an Emergency Contract under the following terms and conditions.

WHEREAS, OGB is an agency of the State of Louisiana given statutory responsibility to provide health and accident benefits to state employees, retirees, and their dependents, which offers self-funded plan of health care benefits; and

WHEREAS, CVS Caremark is a pharmacy benefits manager that provides pharmacy drug benefit management and administrative services to employer groups and other plan sponsors, including Medicare Part D employer group waiver plan sponsors; and

WHEREAS, on February 21, 2020 OGB issued a Request for Proposals ("RFP") for Pharmacy Benefit Management and administrative services with a commercial wrap for Medicare Part D Employer Group Waiver Plan ("EGWP") for a contract effective January 1, 2021; and

WHEREAS, on July 9, 2020 OGB issued a notice of intent to award contract for PBM services to CVS Caremark; and

WHEREAS, there are currently statutory and practical impediments to proceeding with the contract award pursuant to the RFP; and

WHEREAS, in order to ensure the continuity of care for OGB state employees, retirees, and their dependents the Office of State Procurement, Division of Administration, has authorized OGB to proceed with an emergency procurement of PBM services, including EGWP administrative services effective January 1, 2021; and

WHEREAS, OGB has determined the best interest of the State, OGB, and the state employees, retirees, and their dependents would be served by contracting with CVS Caremark for PBM services, including EGWP administrative services; and CVS Caremark has agreed to perform such services, and to provide Medicare Part D EGWP services through its affiliate SilverScript Insurance Company ("SilverScript");

Commented [TD1]: SilverScript just announced they are eliminating all pharmacies/psao's from their network except for CVS Not sure if it will appy to EGWP plans as well, but very important to ask!

WHEREAS, the OGB and CVS Caremark wish to enter into and be bound by the terms contained in this emergency contract.

NOW THEREFORE, in consideration of the mutual promises and agreement herein contained, OGB and CVS Caremark hereby agree as follows:

1 SCOPE OF SERVICES

1.1 CONCISE DESCRIPTION OF SERVICES

CVS Caremark shall provide Pharmacy Benefit Manager ("PBM") services to support certain self-funded plans offered by OGB. These services shall include, at a minimum, all services specified in Section 1.2 and the attachments referenced therein.

1.2 STATEMENT OF WORK

The Statement of Work consists of the following and/or any subsequent addendum:

Attachment I: Scope of Work/Services

Attachment II: Pricing

Attachment III: Business Associate Addendum

Attachment IV: Records Retention Schedule

Attachment V: Imaging System Survey Compliance and Records Destruction

Attachment VI: Clinical Management Programs

1.3 GOALS AND OBJECTIVES

1. To fulfill OGB's delegated responsibility to serve the State of Louisiana by managing prescription drug cost and utilization while improving the quality of health for those served by OGB.
2. To provide quality, cost-effective healthcare services to Plan Participants.

1.4 PERFORMANCE MEASURES

The performance of the Emergency Contract, including but not limited to Attachment I, Scope of Services, and/or any subsequent addendum including performance criteria and corresponding monetary penalties for Contractor's failure to comply with the identified criteria in Section 3.6, Performance Guarantees, will be measured by the OGB Contract Monitor. The OGB Contract Monitor is authorized to evaluate the Contractor's performance against these criteria.

1.5 MONITORING PLAN

The Contract Monitor will be the OGB Medical and Pharmacy Group Benefits Administrator, who will monitor the services and performance provided by the Contractor and the expenditure of funds under this Emergency Contract. The monitoring plan is as follows:

1. The Contractor will submit various monthly, quarterly, and annual reports to the Contract Monitor as specified in Attachment I: Scope of Services.
2. The Contract Monitor will ensure all deliverables are submitted timely and perform subsequent review and acceptance.
3. The Contract Monitor will provide oversight of the implementation of the Scope of Services to ensure quality, efficiency, and effectiveness in fulfilling the goals and objectives of OGB.

1.6 CONTRACTOR PROJECT MANAGEMENT

Contractor Project Management is as follows:

A. Account Management Team. Contractor will provide an Account Management Team for the duration of the engagement including a dedicated Account Executive, Implementation Manager, Employer Group Waiver Plan ("EGWP")/Retiree Manager, Operational Account Manager, Clinical Program Manager, Clinical Pharmacy Manager (must be a resident of Louisiana), Financial Analyst, Analytics and Data Lead, Privacy

Officer, and Customer Service Manager. The Account Executive must have at least one (1) back-up staff member designated to handle the overall responsibility of OGB.

B. Substitution of Key Personnel. The Contractor's personnel assigned to this Emergency Contract shall not be replaced without the prior written consent of OGB/State. Such consent shall not be unreasonably withheld or delayed provided an equally qualified replacement is offered. In the event that any Contractor personnel become unavailable due to resignation, illness, or other factors, excluding assignment to projects outside this Emergency Contract, outside of the Contractor's reasonable control, as the case may be, the Contractor shall be responsible for providing an equally qualified replacement in time to avoid delays in providing services. When possible, Contractor will give OGB a minimum of sixty (60) days' advance notice of any changes in OGB's account management team, and a description of the training requirements for new team members. Reasonable exceptions would apply in situations beyond Contractor's control (i.e., resignation/termination with less than 60 days' notice). OGB reserves the right to request changes to any of the assigned personnel based on unsatisfactory performance levels as determined by OGB. Additionally, OGB will be provided with the opportunity to interview any new team member(s).

C. Account Management Team Support. The Account Management Team will provide support around account strategy, Plan Participant inquiries, issue resolution, reports and other requested projects and deliverables. Contractor will provide an annual service cycle plan as well as an ongoing task log with timelines for all deliverables and weekly status update meetings in person, via video conference, or via teleconference.

D. Quarterly Meetings. All of the Account Management Team will attend all on-site quarterly meetings at OGB. The meetings shall be held no later than forty-five (45) days following quarter end. The Account Management Team will provide a draft agenda for OGB approval at least ten (10) business days in advance of a meeting to allow changes to the agenda and a reasonable opportunity to prepare for the meeting. The meeting presentation should be provided seven (7) days in advance to the meeting. At minimum, during the quarterly meeting, the Account Management Team should discuss the following: goals, expectations and priorities; review the quarterly report and other issues such as performance guarantees, quality assurance, operations, network pharmacy status and access; benefit and program changes or enhancements; legislative issues; audits; cost trends; utilization; program outcomes; customer service issues; future goals and planning; and other issues reasonably related to the Emergency Contract.

E. Minutes. Within three (3) business days after any meeting, Contractor shall provide OGB with a draft of detailed and well-documented, meeting minutes. OGB shall review and revise the draft minutes as appropriate and return to the Contractor. Final minutes must be provided within three (3) business days after receipt of the revised minutes from OGB. Minutes shall include a list of and description of all tasks and/or deliverables, identify the responsible party, and provide a projected delivery date.

F. Documentation. Contractor will maintain an ongoing process log that will document all benefit and system programming changes, which will be provided to OGB within five (5) business days of any change.

G. Coordination with other OGB Vendor(s). Contractor will coordinate and cooperate with OGB's administrative services provider(s) for OGB's self-insured medical plans, actuary, and other vendors as needed on integration of information to or from other service providers relative to the services addressed in this Emergency Contract.

1.7 DELIVERABLES

The Emergency Contract will be considered complete when the entire scope of work has been completed and Contractor has delivered and OGB has accepted all deliverables specified in the Emergency Contract.

1.8 VETERAN-OWNED AND SERVICE-CONNECTED SMALL ENTREPRENEURSHIPS (VETERAN INITIATIVE) AND LOUISIANA INITIATIVE FOR SMALL ENTREPRENEURSHIPS (HUDSON INITIATIVE) PROGRAMS REPORTING REQUIREMENTS

During the term of the Emergency Contract and at expiration, the Contractor will be required to report Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurship subcontractor or distributor participation and the dollar amount of each.

2 DEFINITIONS

Account Management Team – Contractor's staff for PBM services assigned to OGB which shall include an Account Executive, Implementation Manager, Employer Group Waiver Plan ("EGWP")/Retiree Manager, Operational Account Manager, Clinical Program Manager, Clinical Pharmacy Manager (must be a resident of Louisiana), Financial Analyst, Data and Analytics Lead, Privacy Officer and Customer Service Manager.

AWP – the Average Wholesale Price.

Brand – a product that is being marketed post patent expiration by the original manufacturer and is subject to generic competition.

Brand Drug – a prescription drug that is 1) protected by a patent, supplied by one company and marketed under the manufacturer's brand name or 2) a multi-source brand product which was once a Brand product.

CDHP – a Consumer Driven Health Plan.

CMS – the Centers for Medicare and Medicaid Services.

COB – the Coordination of Benefits.

Commercial Prescription Drug Plan – OGB's prescription drug plan(s) covering active employees and non-Medicare eligible retirees.

Covered Benefit(s) – outpatient drugs (including those that under state or federal law require a prescription, or over the counter drugs), products, services, or supplies made available as a covered benefit to Plan Participants as set forth in the Plan.

CSR – a Customer Service Representative.

DAW – prescription drugs dispensed as written.

Commented [TD2]: This allows CVS full control over creating and administering their own AWP, essentially making the discounts they've guaranteed meaningless It should be tied to an independent source for AWP (MEDISPAN) and to the 11 digit NDC

Commented [TD3]: Allows CVS to arbitrarily designate multi-source as brand for the purposes of pricing/reconciliation This erodes pricing as proposed Should be tied to Medispan MONY codes of "M,O,N"

DEA – Drug Enforcement Administration.

DUR – a Drug Utilization Review.

DMR – a Direct Member Reimbursement.

EGWP – an Employer Group Waiver Plan.

EOB – an Explanation of Benefits.

ERRP – the Early Retiree Reinsurance Program.

FDA – the Federal Drug Administration.

Formulary – the list of prescription drugs that are considered as Covered Benefits. The Formulary may contain preferred and non-preferred tiers.

Generic Drug – any drug that is not a Brand.

Commented [TD4]: BIG RED FLAG Generics should have a clear definition and tied to Medispan MONY code "Y"

HIPAA – the Health Insurance Portability and Accountability Act.

Identification Cards ("ID Cards") – printed identification cards containing specific information about the Covered Benefits to which Plan Participants are entitled. All ID Cards shall have the applicable pharmacy network logo or other method, agreed upon by both parties in writing, of identifying the fact that the Contractor is the PBM.

IVR – Interactive Voice Response, an automated telephony system that interacts with callers, gathers information and routes calls to the appropriate recipients.

MAC – the Maximum Allowable Cost.

Commented [TD5]: As determined by ?

MBI – Medicare Beneficiary Identifier.

Multisource – a drug that is manufactured by more than one labeler.

Commented [TD6]: Again should be tied to Medispan

NDC – the National Drug Code.

Commented [TD7]: Should be 11 digit NDC, otherwise Caremark will play NDC repackaging games and promote higher discounted but higher overall cost generics

OGB CEO – the Office of Group Benefit's Chief Executive Officer.

OTC – Over The Counter drugs.

PBM – the Pharmacy Benefit Manager.

PDP – a CMS approved Prescription Drug Plan.

PHI – Protected Health Information.

PII – Personally-Identifiable Information.

Plan – OGB's defined benefit plan pursuant to which Covered Benefits are provided to Plan Participants.

Plan Participant(s) – the person(s) who are entitled to benefits through OGB as identified in the eligibility data file prepared, maintained and as determined by OGB, and delivered to the Contractor.

Primary Plan Participant(s) – the Plan Participant whose relationship with OGB or the employee/retiree governs the coverage under the Plan.

PPACA – the Patient Protection and Affordable Care Act.

Proposal – a response to a request for proposals.

Proposer - An individual or organization submitting a proposal in response to an RFP.

Rebates – will include rebates and other manufacturer revenues, which is defined as all revenue you receive from outside sources related to the Plan's utilization or enrollment in programs. These would include but are not limited to access fees, market share fees, rebates, formulary access fees, inflation protection/penalty payments, administrative fees and marketing grants from pharmaceutical manufacturers, wholesalers and data warehouse vendors.

Commented [TD8]: They must have had one person that knew something about rebates this definition isn't bad but they just squeezed the balloon which inflated elsewhere

RFP – a Request for Proposals.

ROI – a Return On Investment.

Shall, Must, Will – a mandatory requirement.

Should, May, Can – an advisable or permissible action.

Single Source – a drug that is manufactured by one labeler.

Commented [TD9]: Again, Medispan, not Caremark defined!

U&C – Usual and Customary.

3 ADMINISTRATIVE REQUIREMENTS

3.1 TERM OF CONTRACT

The term of this Contract shall begin on January 1, 2021, and is anticipated to end on December 31, 2021, subject to written extension(s) of this Emergency Contract by agreement of the parties and as provided by the Office of State Procurement. Notwithstanding any other provision of this emergency contract, this emergency contract shall not become effective until approved as required by statutes and regulations of the State of Louisiana. Prior to the extension of the contract beyond the twelve (12)-month term, prior approval by the Joint Legislative Committee on the Budget (JLCB) and/or other approval authorized by law shall be obtained. The continuation of this Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract.

3.2 OGB FURNISHED RESOURCES

OGB shall appoint a Contract Monitor for this Contract who will provide oversight of the activities conducted hereunder. The assigned Contract Monitor shall be the principal point of contact on behalf of OGB and will be the principal point of contact for the Contractor concerning Contractor's performance under this Contract.

3.3 TAXES AND FEES

Contractor is responsible for payment of all taxes and fees on Contractor's income, property, and entity status (i.e., permits, licenses, etc.). Contractor's federal tax identification number is 75-2882129. Contractor's seven-digit Louisiana Department of Revenue account number is 2419795. In accordance with La. R.S. 39:1624(A)(10), the Louisiana Department of Revenue ("LDR") must determine that the prospective Contractor is current in the filing of all applicable tax returns and reports and in payment of all taxes, interest, penalties, and fees owed to the State and collected by the Department of Revenue prior to the approval of this Contract by the Office of State Procurement. The Contractor hereby attests to its current and/or compliance,

and agrees to provide its seven-digit LDR Account Number to the contracting agency so that the contractor's tax payment compliance status may be verified. The Contractor further acknowledges understanding that issuance of a tax clearance certificate by the Louisiana Department of Revenue is a necessary precondition to the approval and effectiveness of this Contract by the Office of State Procurement. The contracting agency reserves the right to withdraw its consent to this Contract without penalty and proceed with alternate arrangements should the Contractor fail to resolve any identified apparent outstanding tax compliance discrepancies with the Louisiana Department of Revenue within seven (7) days of notification of such discrepancies.

3.4 PAYMENT TERMS

In consideration of the services required by this Contract, OGB hereby agrees to pay to Contractor a maximum fee of $481,289,300.00 for work performed during the term of this Contract. This fee is inclusive of travel and all Contract-related expenses. Payments are predicated upon successful completion by Contractor and written approval by OGB of the described services and deliverables as provided in the Contract. Contractor will not be paid more than the maximum amount of the Contract. **No payments will be made by OGB on banking or State holidays.**

Commented [TD10]: Interesting I'm not sure if this is a reasonable amount based on how big their plan is and what they spent last year but it's a lot of money!

OGB will monitor total expenditures under the Contract and, should the maximum fee stated above be exceeded, OGB shall seek additional appropriations to continue the Contract in effect, or terminate the Contract pursuant to Section 4.3 of this Contract.

Claims Payments. OGB will not provide advance funding for payment of claims. The Contractor shall submit weekly invoices for reimbursement of claims no later than 12:00 p.m. CT on the established billing day, with an accompanying check register (claims disbursements) showing all paid claims and any other supporting documentation necessary to substantiate invoiced costs. Separate invoices shall be prepared with respect to claims for each Plan offering. Upon receipt and validation of each claims invoice, OGB shall wire the undisputed amount within seven (7) business days of receipt. If the invoice(s) and electronic check register(s) do not reconcile, payment of the disputed amount will be made within seven (7) business days of successful reconciliation. If OGB questions the amount, OGB will notify the Contractor of its questions regarding said amount, and Contractor shall make a reasonable effort to respond to such questions within five (5) business days.

Contractor may not suspend or fail to render payments to participating pharmacies or to OGB Plan Participants within the timeframes provided by applicable law because of non-payment or late payment by OGB. Such payments by Contractor shall not constitute a waiver of any of Contractor's remedies with respect to non-payment. Should Contractor fail to make payments within the timeframes provided by applicable law, Contractor shall be liable to OGB for any penalties or fees that OGB may incur as a result of such inaction by Contractor.

Administrative Fees. Contractor will invoice OGB monthly for all fees and charges earned by Contractor set forth in Attachment II: Pricing, which may be included on the same invoice as claims payments or reflected in a separate invoice. Upon receipt and validation of Contractor's invoice for administrative fees, OGB shall pay undisputed fees by wire transfer within seven (7) business days of receipt. Any monthly fees will be charged the month following the month in which the service is provided. If OGB questions the amount, OGB will

notify the Contractor of its questions regarding said amount, and Contractor shall make a reasonable effort to respond to such questions within five (5) business days.

During the term of the Contract and at expiration, the Contractor will be required to report Veteran-Owned and Service-Connected Disabled Veteran-Owned and Hudson Initiative small entrepreneurship subcontractor or distributor participation and the dollar amount of each, if applicable.

3.5 PERFORMANCE BOND

Unless issuance of such bond is against applicable law, Contractor shall provide a performance (surety) bond in an amount determined by OGB of no more than one hundred percent (100%) of the annual contracted fees to ensure the successful performance under the terms and conditions of the Contract. The performance bond shall be written by a surety or insurance company currently on the U.S. Department of the Treasury Financial Management Services list of approved companies which is published annually in the Federal Register, or by a Louisiana-domiciled insurance company with at least an A-rating to write individual bonds up to ten percent (10%) of policyholders' surplus as shown in the latest A.M. Best's Key Rating Guide. In addition, any performance bond furnished shall be written by a surety or insurance company that is currently licensed to do business in the State of Louisiana.

The performance bond is to be provided at least thirty (30) working days prior to the effective date of the Contract. Failure to provide within the time specified may cause the Contract to be cancelled.

3.6 PERFORMANCE GUARANTEES

Contractor agrees to provide its operational performance guarantees on a client-specific basis and report OGB's results on a quarterly basis. OGB shall have the ability to modify the performance guarantees each contract year. OGB, at its sole discretion, will allocate amounts at risk for performance guarantees, provided no more than thirty percent (30%) of the total amount at risk is allocated to one performance guarantee excluding financial guarantees (i.e., AWP discounts, dispensing fees, rebates, etc.). OGB may allocate 0% to a guarantee, which would indicate that the performance guarantee will only be reported on with no amounts at risk. Contactor will be subject to per day fees for certain performance guarantees.

All guarantees must be reconciled annually and reported to OGB within sixty (60) days after the close of the period being measured and any penalties owed to OGB shall be paid within forty-five (45) days after reported reconciliation. Implementation performance guarantees will be measured and reported within ninety (90) days after the agreed upon implementation date. Payment of any due and owing implementation performance penalty shall be paid within sixty (60) days of notification of the penalty to the Contractor.

Performance Guarantees: The Contractor will be subject to negotiated performance standards and those detailed in Attachment I: Scope of Services.

Financial guarantees will be covered dollar for dollar on any shortfall with no limit to the amount at risk. Any surplus on financial guarantees will be retained 100% by OGB. In addition, the amount at risk will be the full value of the missed performance, not a calculation of OGB's net plan cost impact. All guarantees, with the exception of rebate minimum guarantees, which will be reconciled in the aggregate, will be trued up individually, meaning

Commented [TD11]: Rebate guarantee is allowing off-set

no guarantees can be cross-subsidized (i.e., surplus on one guarantee offsetting another, etc.). This includes no cross-subsidization between delivery channels, or within a delivery channel. Note: Retail and retail extended supply networks are considered separate delivery channels.

Audit: OGB reserves the right to audit performance guarantee reports on an annual basis. A third party may be utilized to perform this audit.

Measurement Periods: The period to be measured shall be January 1, 2021 through December 31, 2021. If the performance guarantees are effective for less than a full calendar year, the payment amounts will be prorated for the portion of the Measurement Period.

Commented [TD12]: This whole section is meaningless With the definitions outlined above, Caremark has the ability to hit these guarantees no matter what or the client will overpay and they'll show a "missed guarantee" and make it seem like they are giving money back which never should dhave been spent in the first place

3.7 FINANCIAL GUARANTEES

Commented [TD13]: Same comment as 3 6

Financial guarantees provided by Contractor will be covered dollar for dollar on any shortfall with no limit to the amount at risk. Any surplus on financial guarantees will be retained 100% by OGB. In addition, the amount at risk will be the full value of the financial guarantee(s) not achieved and not a calculation of OGB's net Plan cost impact. All financial guarantees , with the exception of rebate minimum guarantees, which will be reconciled in the aggregate, will be trued up individually, meaning no guarantees can be cross-subsidized (i.e., surplus on one guarantee offsetting another, etc.). This includes no cross-subsidization between delivery channels, or within a delivery channel. Note: Retail and retail extended supply networks are considered separate delivery channels.

Contractor will report financial guarantee performance to OGB on a quarterly basis, including the effective AWP discounts, dispensing fees, and rebates. This reporting will include all prior quarters covered by this Contract. All financial guarantees must be reconciled annually and any shortfalls owed to OGB shall be paid within one hundred twenty (120) days after the end of the Measurement Period.

Audit: OGB reserves the right to audit financial guarantees after the end of each Measurement Period. A third party of OGB's choosing may be utilized to perform this audit with no limitation in the scope of the audit.

Measurement Periods: The period to be measured shall be January 1, 2021 through December 31, 2021.

4 TERMINATION

4.1 TERMINATION FOR CAUSE

State may terminate this Contract for cause based upon the failure of the Contractor to comply with the terms and/or conditions of the Contract; provided the State shall give the Contractor written notice specifying the Contractor's failure. If within thirty (30) calendar days after receipt of such notice, the Contractor shall not have either corrected such failure or, in the case of failure which cannot be corrected in thirty (30) calendar days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction, then the State may, at its option, place the Contractor in default, and the Contract shall terminate on the date specified in such notice. Failure to perform within the time agreed upon in the contract may constitute default and may cause cancellation of the contract.

4.2 TERMINATION FOR CONVENIENCE

OGB/State may terminate the Contract at any time by giving at least thirty (30) days' written notice to Contractor of such termination or negotiating with Contractor an effective date for termination. Contractor shall be entitled to payment for services completed prior to receipt of such notice and deliverables in progress, to the extent work has been performed to OGB's satisfaction.

4.3 TERMINATION FOR NON-APPROPRIATION OF FUNDS

The continuation of this Contract is contingent upon the appropriation of funds by the Louisiana Legislature to fulfill the requirements of the Contract, as applicable. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the Contract, or if such appropriation is reduced or eliminated by the veto of the Governor or by any means provided in the Appropriations Act of Title 39 of the Louisiana Revised Statutes of 1950 to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the Contract, the Contract shall terminate on the date of the beginning of the first fiscal year for which funds have not been appropriated.

5 INDEMNIFICATION AND DEFENSE

(a) Contractor shall be fully liable for its own actions and the actions of its agents, employees, partners and subcontractors and shall fully protect, defend, and indemnify the State, all State departments, Agencies, Boards, and Commissions, its officers, trustees, employees, servants, subcontractors, agents, and volunteers (collectively the "State"), from and against any and all losses, claims, demands, liabilities, suits, actions, damages, costs, fines, penalties, judgments, forfeitures, assessments, expenses, obligations (including attorneys' fees), and other liabilities of every name and description ("Claims/Costs") relating to personal injury or death to any person or damages, loss, or destruction of any real or tangible property which may occur, or in any way arise out of, any act or omission of Contractor, its employees, agents, partners, or subcontractors/vendors. Contractor shall not be required to indemnify for that portion of any Claim/Cost arising due solely to the negligent or intentional act or failure to act of the State.

(b) Contractor shall further indemnify and defend the State from and against any Claims/Costs resulting from any violation of or failure to comply with any state or federal law, or other legal or Contract requirement to the extent caused by Contractor, its agents, employees, partners or subcontractors. Contractor shall not be required to indemnify for that portion of any Claim/Cost arising due solely to the negligent or intentional act or failure to act of the State.

(c) Contractor shall fully protect, defend, and indemnify, the State from and against all adverse federal and state tax consequences, loss, liability, damage, expense, attorneys' fees or other obligations resulting from, or arising out of, any act or omission by Contractor in connection with this Contract, including but not limited to other obligations resulting from or arising out of any premium charge, tax, or similar assessment by federal, state, and local governmental authorities, for which Contractor is liable.

(d) If applicable, Contractor will protect, defend, and indemnify, the State, its officers, trustees, employees, servants, subcontractors, agents, and volunteers, from and against all

Claims/Costs which may be assessed against the State in any action for infringement of a United States Letter Patent with respect to the products furnished, or of any copyright, trademark, trade secret or intellectual property right, in relation to the Contract provided that the State shall give Contractor: (i) prompt written notice of any action, claim or threat of infringement suit, or other suit; (ii) the opportunity to take over, settle or defend such Claim/Cost at Contractor's sole expense; and (iii) reasonable assistance in the defense of any such action at the expense of Contractor. Where a Claim/Cost arises relative to a real or anticipated infringement, the State, its officers, trustees, employees, servants, subcontractors, agents, and/or volunteers, may require Contractor, at its sole expense, to submit such information and documentation, including formal patent attorney opinions, as to such infringement claim as the State deems necessary.

(e) In addition to the foregoing remedies for patent infringement Claims/Costs, if the use of the product, material, or service or part(s) thereof shall be enjoined for any reason or if Contractor believes that such use may be enjoined, Contractor shall have the right, at its own expense and sole discretion to take action in the following order of precedence: (i) to procure for the State the right to continue using such product, material, or service or part(s) thereof, as applicable, under the same terms and conditions as provided in the Contract; (ii) to modify the product, material, or service so that it becomes a non-infringing product, material, or service of at least equal quality and performance, in the State's sole opinion; (iii) to replace the product, material, or service or part(s) thereof, as applicable, with non-infringing components of at least equal quality and performance, in the State's sole opinion; or (iv) if none of the foregoing is commercially reasonable, provide monetary compensation to the State.

(f) Contractor agrees to indemnify and defend the State from all Claims/Costs relating to Contractor's or its subcontractors' fault or negligence, including, but not limited to, any claims relating to the failure of Contractor to provide services or fulfill obligations as specified in the Contract due to financial hardship or insolvency.

(g) Contractor agrees to investigate, handle, respond to, provide defense for and defend any Claims/Costs at its sole expense and agrees to bear all other costs and expenses related thereto, even if the Claims/Costs are groundless, false or fraudulent.

(h) The State may, in addition to other remedies available to the State, its officers, trustees, employees, servants, subcontractors, agents, and/or volunteers at Law or equity and upon notice to Contractor, retain such monies from amounts due Contractor as may be necessary to satisfy any Claims/Costs asserted by or against the State, its officers, trustees, employees, servants, subcontractors, agents, and/or volunteers, for which Contractor owes indemnification and/or defense pursuant to this Section.

6 FORCE MAJEURE

Neither party shall be liable for any delay or failure in performance beyond its control resulting from acts of God or force majeure. Whether a delay or failure results from a force majeure is ultimately determined by the State based on a review of all facts and circumstances. The parties shall use reasonable efforts to eliminate or minimize the effect of such events upon performance of their respective duties under Contract.

7 CONTRACT CONTROVERSIES

Any claim or controversy arising out of the Contract shall be resolved by the provisions of La. R.S. 39:1672.2-1672.4.

8 FUND USE

Contractor agrees not to use Contract proceeds to urge any elector to vote for or against any candidate or proposition on an election ballot, nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the Louisiana Legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition on any election ballot or a proposition or matter having the effect of law being considered by the Louisiana Legislature or any local governing authority.

9 ASSIGNMENT

Contractor shall not assign any interest in this Contract by assignment, transfer, novation, or otherwise without prior written consent of the OGB CEO or his/her delegee. This provision shall not be construed to prohibit Contractor from assigning to a bank, trust company, or other financial institution any money due or to become due from approved contracts without such prior written consent. Notice of any such assignment, transfer, or novation shall be furnished promptly to the State Contract Monitor and shall not be binding upon the State until actually received by the State.

10 RIGHT TO AUDIT

The State Legislative Auditor, federal auditors, internal auditors of the Division of Administration and its designated agents, the State, OGB, or others so designated by the State/OGB shall be entitled to audit all accounts, procedures, matters, and records of any Contractor or subcontractor under any negotiated Contract or subcontract directly pertaining to the Contract for a period of five (5) years after final payment under the Contract and for the subcontractor/vendor for a period of five (5) years from the date of final payment under the subcontract or such longer period as required by applicable state and federal Law. Records, including direct read access to databases and all tables, shall be made available during normal business hours for this purpose.

The State has the right to hire an independent third-party auditor, if the State deems necessary, to review all accounts, procedures, matters, and records, and Contractor and/or subcontractor/vendor shall provide access to all files, information system access, and space access upon request of the State for the third-party auditor selected to perform the indicated audit. Third-party auditors selected by OGB shall execute Contractor's form of confidentiality agreement prior to performance of any audit functions. OGB acknowledges that if any independent auditor it retains to conduct any Rebate audit also performs consulting services, such auditor must maintain a firewall between its consulting activities and its audit activities. OGB agrees that, to promote efficiency, full Claims and Rebate audits will be conducted for full-year periods, not more frequently than annually.

In the event that an examination of records results in a determination that previously paid invoices included charges which were improper or beyond the scope of the Contract, Contractor agrees that the amounts paid to the Contractor shall be adjusted accordingly, and

that the Contractor shall within thirty (30) days of notification of such finding issue a remittance to the State of any payments declared to be improper or beyond the scope of the Contract. In combination therewith, or alternatively, the State, at its option, may offset the amounts deemed improper or beyond the scope of the Contract against Contractor's outstanding or subsequent invoices, if any.

10.1 RECORDS

All records, reports, documents, or other material related to this Contract, delivered or transmitted to the Contractor by the State or its employees, agents, or authorized vendors, and/or obtained or prepared by Contractor or its subcontractors/vendors in connection with the performance of the services under the Contract, shall become records of the State and are referred to herein as "Records."

Contractor agrees to retain all Records in accordance with all Louisiana and federal laws and regulations. Further, Contractor agrees to retain all Records in accordance with OGB's official retention schedules (the "Schedules"), Attachment IV, until such time as the Records are returned to the State or other disposition is agreed. In the event the applicable Law and the Schedules contain different retention periods, the Records shall be kept for the longer period. Records shall be in a format and media as required by applicable law or as agreed upon by the parties in writing if allowed by applicable law. The Schedules in place as of the effective date of this Contract are contained in Attachment IV, Records Retention Schedule, and may be amended from time to time as deemed necessary by the State. To further ensure compliance with the Schedules and Louisiana retention laws, Contractor agrees to abide by the processes outlined in Attachment V, Imaging System Survey Compliance and Records Destruction. Contractor shall return the Records to the State, at Contractor's expense, within seven (7) days of request or in the specific instance of termination or expiration of the Contract, within sixty (60) days after the termination or expiration of this Contract, and shall retain no copies of the Records unless required by applicable law, provided, the confidentiality and security requirements of this Contract shall apply to such Records as long as they are retained by the Contractor. Additionally, all State data must be sanitized from Contractor's (and its vendors') systems in compliance with the most current revision of NIST SP 800-66.

10.2 CONTRACTOR'S COOPERATION

Contractor has the duty to fully cooperate with the State and provide any and all requested information, documentation, or other such requested support to the State when requested. This applies even if the Contract is terminated and/or litigation ensues. Specifically, Contractor shall not limit or impede OGB's right to audit or withhold Records.

11 CONTRACT MODIFICATIONS

No amendment or variation of the terms of this Contract shall be valid unless made in writing, signed by the parties, and approved as required by applicable law. No oral understanding or agreement not incorporated in the Contract shall be binding on any of the parties.

12 CONFIDENTIALITY OF DATA

Commented [TD14]: Can they use PBM obtained data to solicit patients for their mail and specialty pharmacies?

All financial, statistical, personal, technical, and other data and information relating to the State's operation or the Contract which are made available to the Contractor in order to carry

out this Contract, or which become available to the Contractor in carrying out this Contract, shall be protected by the Contractor from unauthorized use and disclosure through the observance of the same or more effective security and procedural requirements as are applicable to OGB and the State. The Contractor shall not be required under the provisions of this paragraph to keep confidential any data or information (other than protected health information) which is or becomes publicly available through no fault of Contractor or its subcontractors, vendors, agents, or employees, is already rightfully in the Contractor's possession, is independently developed by the Contractor outside the scope of the Contract, or is rightfully obtained from third parties without breach of the Contract.

Under no circumstance shall the Contractor discuss and/or release information to the media concerning this Contract or any Plan Participant without prior express written approval of the OGB CEO or his/her delegee.

OGB acknowledges that Contractor has asserted that certain information of Contractor relating to Contractor's operations, systems, programs, costs, and pricing data ("Contractor Confidential Information") is Contractor's confidential, proprietary and trade secret information that is exempt from disclosure under the Louisiana Public Records Law. OGB agrees that, to the extent feasible, it will notify Contractor of any request it receives for Contractor Confidential Information, including a request made pursuant to the Louisiana Public Records Law, and provide Contractor a reasonable opportunity to redact or otherwise designate Contractor Confidential Information from any requested records. Should OGB or other State agency with responsibility for responding to records requests disagree with Contractor's request for non-disclosure of such identified Contractor Confidential Information, OGB shall notify Contractor of its intent to disclose such information and, to the extent legally permitted, allow Contractor to seek judicial relief to prevent such disclosure.

12.1 SECURITY/DUTIES TO MONITOR AND REPORT SECURITY EVENTS

The Contractor and its subcontractors/vendors shall maintain safeguards and take commercially reasonable technical, physical, and organizational/administrative precautions to ensure that the State's data is protected from unauthorized access, use, and disclosure, in accordance with the State's current and published Information Security Policy found at https://www.doa.la.gov/OTS/InformationSecurity/LA-InfoSecPolicy-v1.01.pdf. The Contractor shall implement and maintain safeguards and monitoring plans to detect unauthorized access to or use of confidential information and any attempts to gain unauthorized access to confidential information. The Contractor, on behalf of itself and its subcontractors/vendors, shall provide the Contract Monitor with immediate notification (not more than forty-eight (48) hours) of the Contractor's awareness of any Security Event, as defined in the Information Security Policy ("Security Event"), involving confidential information under this Contract and also report such Security Event to Louisiana's Information Security Team at 1.844.692.8019 (open 24 hours a day, 7 days a week) as soon as feasibly possible, not to exceed 48 hours following discovery of the Security Event. The reference to Security Event herein may include, but not be limited to, the following: attempts at gaining unauthorized access to confidential information or the unauthorized use of a system for the processing or storage of confidential information, or the unauthorized use or disclosure, whether intentional or otherwise, of confidential information. The Parties acknowledge the

ongoing existence of pings, port scans, and other routine unsuccessful attempts at accessing and/or interfering with Contractor's information system that do not pose a threat or hazard to the integrity of the State's data and about which no further notification is necessary.

In the event of a Security Event, the Contractor shall consult and cooperate fully with the State regarding the necessary steps to address the factors giving rise to the Security Event and to address the consequences of such Security Event. Contractor shall also provide assistance performing a risk assessment of any Security Event that occurs, if requested by the State.

Nothing in this Contract shall be deemed to affect or limit any rights an individual participant may have under any applicable state or federal law concerning privacy rights or the unauthorized access, use, or disclosure of protected health information.

12.2 THIRD PARTY REQUESTS FOR RELEASE OF INFORMATION

Should third parties request the Contractor to submit confidential information to them pursuant to an audit or other request not initiated by the Contractor, public records request, subpoena, summons, search warrant or governmental order, the Contractor will notify the State immediately upon receipt of such request. Notice shall be forwarded via e-mail to the Chief Executive Officer of OGB. The Contractor shall cooperate with the State with respect to defending against any such requested release of information or obtaining any necessary judicial protection against such release if, in the opinion of the State, the information contains confidential information which should be protected against such disclosure. The reasonable legal fees and related expenses incurred by the Contractor or its subcontractor in resisting the release of information under this provision shall constitute reimbursable expenses under this Contract.

Legal service fees of law firms engaged pursuant to this Section may not be "marked up" (i.e., invoiced cost-plus) by the Contractor.

13 SUBCONTRACTORS

The Contractor may enter into subcontracts with third parties for the performance of any part of the Contractor's duties and obligations, with the express prior written approval of the OGB CEO or his/her designee. In no event shall the existence of a subcontract operate to release or reduce the liability of the Contractor to the State for any breach or deficiency in the performance of the Contractor's duties. The Contractor will be the single point of contact for all subcontractor work. The Contractor shall require subcontractors/vendors who are performing any key internal control to undergo independent assurance project/program review.

14 COMPLIANCE WITH LAWS

The Contractor must comply with all applicable laws while providing services under this Contract. Specifically, Contractor agrees to abide by the requirements of the following as applicable: Title VI and Title VII of the Civil Rights Act of 1964, as amended by the Equal Opportunity Act of 1972, Federal Executive Order 11246, the Federal Rehabilitation Act of 1973, as amended, the Vietnam Era Veteran's Readjustment Assistance Act of 1974, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and the Americans with Disabilities Act of 1990 as amended.

Contractor agrees not to discriminate in its employment practices, and will render services under this Contract without regard to race, color, religion, sex, national origin, veteran status,

political affiliation, or disabilities. Any act of discrimination committed by Contractor or its subcontractors, or failure to comply with these statutory obligations when applicable, shall be grounds for immediate termination of this Contract.

15 INSURANCE

Contractor's Insurance: The Contractor shall not commence work under the resulting Contract until it has obtained all insurance required herein, and Contractor shall maintain the required insurance for the duration of the Contract or as further indicated herein. The date of the inception of the policy must be no later than the first date of anticipated work under the Contract. Certificates of Insurance shall be filed with the State for approval. If so requested, the Contractor shall also submit copies of insurance policies for inspection and approval of the State before work is commenced.

Workers' Compensation Insurance: Before any work is commenced, Contractor must have in place and shall maintain during the life of the Contract, Workers' Compensation Insurance for all of Contractor's employees and other persons for whom Contractor is required to provide Workers' Compensation Insurance under applicable law. In case any work is sublet, Contractor shall require the subcontractor similarly to provide Workers' Compensation Insurance for all the latter's employees, unless such employees are covered by the protection afforded by the Contractor. Workers' Compensation Insurance shall be in compliance with the Workers' Compensation law of the state of the Contractor's headquarters. Employer's Liability Insurance shall be included with a minimum limit of $500,000 per accident/per disease/per person. If work is to be performed over water and involves maritime exposure, applicable LHWCA, Jones Act, or other maritime law coverage shall be included and the Employer's Liability limit increased to a minimum of $1,000,000 per accident/per disease/per person. A.M. Best's insurance company rating requirement may be waived for workers' compensation coverage only.

Workers' Compensation Indemnity: In the event Contractor is not required to provide or elects not to provide workers' compensation coverage, the parties hereby agree that Contractor, its owners, agents, and employees will have no cause of action against, and will not assert a claim against, the State of Louisiana, its departments, agencies, agents and employees as an employer, whether pursuant to the Louisiana Workers' Compensation Act or otherwise, under any circumstance. The parties also hereby agree that the State of Louisiana, its departments, agencies, agents and employees shall in no circumstance be, or considered as, the employer or statutory employer of Contractor, its owners, agents, and employees. The parties further agree that Contractor is a wholly-independent contractor and is exclusively responsible for its employees, owners, and agents. Contractor hereby agrees to protect, defend, and indemnify the State of Louisiana, its departments, agencies, agents, and employees from any such assertion or claim that may arise from the performance of this Contract.

Commercial General Liability Insurance: Contractor shall maintain during the life of the Contract such Commercial General Liability Insurance, including but not limited to Personal and Advertising Injury Liability, which shall protect it, and the State, its officers, trustees, employees, servants, and/or agents, from losses, claims, demands, liabilities, suits, actions, damages, costs, fines, penalties, judgments, forfeitures, assessments, expenses, obligations (including attorneys' fees), and other liabilities relating to personal injury, general negligence, violation of or failure to comply with any state or federal law, regulation, or other legal

mandate, and damage to real or personal tangible property to the extent caused by Contractor, its employees, officers, agents, partners or, subject to the subsection titled "Subcontractor's Insurance", below, subcontractors, and which may arise from operations or services under the Contract, whether such operations or services be by Contractor or by a subcontractor, or by anyone directly or indirectly employed or procured by either of them, or in such manner as to impose liability on the State, its officers, trustees, employees, servants, and/or agents. Such insurance shall name the State of Louisiana, its officers, trustees, employees, servants, and agents as additional insureds. The amount of coverage shall be as follows: Commercial General Liability insurance, including Personal and Advertising Injury Liability, with policy limits of not less than $1,000,000 per occurrence and $2,000,000 in the aggregate, and Umbrella Liability insurance, with policy limits of not less than $5,000,000 per occurrence and $10,000,000 in the aggregate.

The Insurance Services Office (ISO) Commercial General Liability occurrence coverage form CG 00 01 (or current form approved for use in Louisiana), or equivalent, is to be used in the policy. Claims-made form is unacceptable.

Professional Liability (Errors & Omissions) Insurance: Contractor shall maintain professional liability insurance, which covers the professional errors, acts, or omissions of the Contractor, with minimum policy limit of $1,000,000 for the purpose of providing coverage for claims arising out of the performance of its services under this Contract. Claims-made coverage is acceptable. Coverage shall be provided for the duration of the Contract and shall have an expiration date no earlier than thirty (30) days after the anticipated completion of the Contract. The policy shall provide an extended reporting period of not less than thirty-six (36) months, with full reinstatement of limits, from the expiration date of the policy, if the policy is not renewed.

Cyber/Data Breach Liability Insurance: Contractor shall have in place before commencing work under the Contract and maintain during the life of the Contract and for the extended reporting period herein, cyber/data breach liability insurance, including first-party costs, for any data breach that compromises the State's confidential data with a minimum policy limit of $25,000,000 or self-insurance limit of $25,000,000 for the purpose of providing coverage for claims arising out of the performance of its services under the Contract. Claims-made coverage is acceptable. Such insurance policy shall name the State of Louisiana, its officers, trustees, employees, servants, and agents as additional insureds. If self-insured, evidence of self-insurance must be provided to and accepted by the State. Coverage shall be provided for the duration of the Contract and shall have an expiration date no earlier than thirty (30) days after the anticipated completion of the Contract. The policy shall provide an extended reporting period of not less than twenty-four (24) months from the expiration date of the policy, if the policy is not renewed. The policy shall not be cancelled for any reason, except non-payment of premiums.

Owned, Non-Owned and Hired Motor Vehicles/Automobile Liability: Contractor shall maintain during the life of the Contract, Automobile Liability Insurance in an amount not less than combined single limits of $1,000,000 per occurrence for bodily injury/property damage. ISO form number CA 00 01 (or current form approved for use in Louisiana), or equivalent, is to be used in the policy. Such insurance shall cover and include third-party bodily injury and property damage liability for any owned, non-owned, and hired motor vehicles engaged in

operations within the terms of the Contract, unless such coverage is included in insurance elsewhere specified.

Subcontractor's Insurance: Contractor shall include all subcontractors performing work required by this Contract as insureds under its policies OR shall be responsible for verifying and maintaining the Certificates of Insurance provided for any and all subcontractors, which are not protected under the Contractor's own insurance policies, of the same nature and in the same amounts as required of Contractor. Subcontractors shall be subject to all of the requirements stated herein. The State reserves the right to request copies of subcontractor's Certificates of Insurance at any time.

Deductibles and Self-Insured Retentions: Any deductibles or self-insured retentions must be declared to and accepted by the State. The Contractor shall be responsible for all deductibles and self-insured retentions.

Other Insurance Provisions: The policies are to contain, or be endorsed to contain, the following provisions:

1. General Liability and Automobile Liability Coverages

    a. The State, OGB, its officers, agents, employees, and volunteers shall be named as an additional insured as regards negligence by the Contractor. ISO Form CG 20 10 (or current form approved for use in Louisiana), or equivalent, is to be used when applicable. The coverage shall contain no special limitations on the scope of protection afforded to the State.

    b. The Contractor's insurance shall be primary as respects the State, OGB, its officers, agents, employees, and volunteers. Any insurance or self-insurance maintained by the State/OGB shall be excess and non-contributory of the Contractor's insurance.

    c. Any failure of the Contractor to comply with reporting provisions of the policy shall not affect coverage provided to the State/OGB, its officers, agents, employees, and volunteers.

    d. The Contractor's insurance shall apply separately to each insured against whom claim is made or suit is brought, except with respect to the policy limits.

2. Workers' Compensation and Employer's Liability Coverage

The insurer shall agree to waive all rights of subrogation against the State/OGB, its officers, agents, employees, and volunteers for losses arising from work performed by the Contractor for the State/OGB under the Contract.

3. All Coverages

    a. Coverage shall not be cancelled, suspended, or voided by either the Contractor or the insurer or reduced in coverage or in limits, except after 30 days' written notice has been given to the OGB/State. Ten-day written notice of cancellation is acceptable for non-payment of premium. Notifications shall comply with the standard cancellation provisions in the Contractor's policy.

b. Neither the acceptance of the completed work nor the payment thereof shall release the Contractor from the obligations of the insurance requirements or indemnification agreement.

c. The insurance companies issuing the policies shall have no recourse against the OGB/State for payment of premiums or for assessments under any form of the policies.

d. Any failure of the Contractor to comply with reporting provisions of the policy shall not affect coverage provided to the State/OGB, its officers, agents, employees, and volunteers.

Acceptability of Insurers: All required insurance shall be provided by a company or companies lawfully authorized to do business in the jurisdiction(s) in which the Project is performed. Insurance shall be placed with insurers with a A.M. Best's rating of A-:VI or higher. This rating requirement may be waived for worker's compensation coverage only.

If at any time an insurer issuing any such policy does not meet the minimum A.M. Best rating, the Contractor shall obtain a policy with an insurer that meets the A.M. Best rating and shall submit another Certificate of insurance as required in the Contract.

Verification of Coverage: Contractor shall furnish the OGB/State with Certificates of Insurance reflecting proof of required coverage. The Certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf. The Certificates are to be received and approved by the OGB/State before work commences and upon any Contract renewal thereafter.

In addition to the Certificates, Contractor shall submit the declarations page and the cancellation provision endorsement for each insurance policy. The OGB/State reserves the right to request complete certified copies of all required insurance policies at any time.

Upon failure of the Contractor to furnish, deliver, or maintain such insurance as above provided, the Contract, at the election of the OGB/State, may be suspended, discontinued, or terminated. Failure of the Contractor to purchase and/or maintain any required insurance shall not relieve the Contractor from any liability or indemnification under the Contract.

16 APPLICABLE LAW

This Contract shall be governed by and enforced in accordance with the laws of the State of Louisiana, including but not limited to La. R.S. 39:1551-1736 (Louisiana Procurement Code, as applicable) (collectively referred to as the "Law"). After exhaustion of any available administrative remedies, the exclusive venue of any action brought with regard to this Contract shall be in the Nineteenth (19th) Judicial District Court, Parish of East Baton Rouge, State of Louisiana.

17 CODE OF ETHICS

Contractor acknowledges that Chapter 15 of Title 42 of the Louisiana Revised Statutes (La. R.S. 42:1101, *et. seq.*, Code of Governmental Ethics) applies to the contracting parties in the performance of services called for in this Contract. Contractor agrees to immediately notify the OGB's CEO if violations or potential violations of the Code of Governmental Ethics by or

through Contractor or its subcontractors/vendors under this Contract arise at any time during the term of this Contract.

18 SEVERABILITY

If any term or condition of this Contract or the application thereof is held invalid, such invalidity shall not affect other terms, conditions, or applications which can be given effect without the invalid term, condition, or application; to this end, the terms and conditions of this Contract are declared severable.

19 INDEPENDENT ASSURANCES

Contractor shall submit, and cause its subcontractors who perform key internal controls to submit, to certain independent audits to ascertain that processes and controls related to the contracted service are operating properly. Independent assurances may be in the form of a Service Organization Control ("SOC") 1, Type II and/or SOC 2, Type II report resulting from an independent annual SSAE 18 engagement of the operations. The SSAE 18 engagement will be performed at least annually by an audit firm that will conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. The audit firm that will conduct the SSAE 18 engagement will submit a final report on controls placed in operation for the project and include a detailed description of the audit firm's tests of the operating effectiveness of controls. The Contractor shall supply the State with an exact copy of the SOC report resulting from the SSAE 18 engagement within the specified timeframe. Contractor shall also provide a bridge letter to OGB for the period of January 1-June 30 of the following independent assurance reporting period no later than July 31 of each calendar year. The OGB will not sign a non-disclosure agreement in order to obtain any of the independent assurances referenced herein.

The cost of such independent assurances will be borne solely by Contractor. Such independent assurances shall be performed at least annually during the term of the Contract. Contractor may review any audit report before delivery to the State and include with the report a supplementary statement containing facts that Contractor considers pertinent to the audit or engagement. Contractor shall implement recommendations as suggested by the program review and/or audit, within three (3) months of report issuance and at no cost to the State.

20 NOTICE

Any notice required or permitted by this Contract, unless otherwise specifically provided for in this Contract, shall be in writing and shall be deemed given upon receipt following delivery by: (i) an overnight carrier or hand delivery to the State/OGB; or, (ii) registered or certified mail return receipt requested, and addressed as follows:

To CVS Caremark: CVS Caremark

Northbrook, Illinois 60062
Attn: Vice President and Senior Counsel, Healthcare Services
Fax No: (847) 559-4879

With a copy to:

CVS Caremark
9501 E. Shea Blvd.
Scottsdale, AZ 85260
Attn: Senior Vice President, Health Care Services
Fax No: (480) 314-8231

To OGB: [redacted]
Office of Group Benefits
Post Office Box 44036
Baton Rouge, LA 70804

Or

[redacted]
Office of Group Benefits
1201 N. 3rd Street, Suite G-159
Baton Rouge, LA 70802
For hand delivery

The U.S. Postal Service does not make deliveries to OGB's physical location.

At any time, either party may change its addressee and/or address for notification purposes by mailing a notice stating the change and setting forth the new address.

21 HEADINGS

Descriptive headings in this Contract are for convenience only and shall not affect the construction or meaning of Contractual language.

22 ENTIRE AGREEMENT

This Contract, together with the RFP and addenda issued thereto by the State, the Proposal submitted by the Contractor in response to the applicable RFP, and any exhibits incorporated herein by reference, shall constitute the entire agreement between the parties with respect to the subject matter hereof.

23 ORDER OF PRECEDENCE

In the event of any inconsistent or incompatible provisions, this signed Contract (excluding the RFP and the Contractor's Proposal) shall take precedence, followed by the provisions of the RFP, and then by the terms of the Contractor's Proposal.

24 BUSINESS ASSOCIATE ADDENDUM

A Business Associate Addendum, Attachment III, shall be executed between the parties to this Contract to protect the privacy and provide security of Protected Health Information ("PHI") and personally-identifiable information ("PII") in compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and regulations promulgated thereunder, as amended from time to time.

OGB is a "Covered Entity" under HIPAA/HITECH. For the purposes of this Contract, Contractor is deemed to be a "Business Associate" of OGB as such term is defined by HIPAA and regulations promulgated thereunder, including in the Privacy Standard of the Federal Register, published on December 28, 2000, and the parties have executed a Business Associate Addendum attached to this Contract as Attachment III, and made a part of this Contract. The parties understand and agree that if additional agreements are required to be compliant as required under HIPAA and applicable law, the parties will execute such agreements in a timely manner. Contractor agrees that its processes, systems, and reporting will be in full compliance with federal and state requirements, including but not limited to HIPAA, throughout the term of the Contract. Any fines or penalties imposed on any party related to Contractor's or its subcontractors' non-compliance will be the sole responsibility of Contractor. Contractor shall require its subcontractors' and any other vendors' processes, systems, and reporting to be in full compliance with federal and state requirements, including but not limited to HIPAA. Further, Contractor agrees that its organization, and that it requires that its subcontractors/vendors, will comply with all HIPAA regulations throughout the term of the Contract with respect to any issue related to the OGB Contract, plans, or participants involving PHI/PII, including but not limited to participant services, complaints, appeals determinations, notification of rights, and confidentiality. Contractor shall require that all agreements with subcontractors or other vendors providing services for this Contract include the provisions of this Section and any Attachments referenced herein. OGB shall be provided copies of such subcontractor/vendor agreements upon request.

Notwithstanding any provision to the contrary, major delegated functions involving PHI and PII, including but not limited to claims processing, customer service, and any other services as provided by applicable Law, shall not be sourced outside of the territorial and jurisdictional limits of the fifty (50) United States of America.

25 CONTRACTOR ELIGIBILITY

At the time of execution, Contractor, and each tier of subcontractors/vendors, certifies that it is not on the List of Parties Excluded from Federal Procurement or Non-procurement Programs promulgated in accordance with Executive Orders 12549 and 12689, "Debarment and Suspension" as set forth in 24 CFR Part 24. Contractor has a continuing obligation to disclose any suspensions, debarment, or investigations by any government entity, including but not limited to General Services Administration (GSA). Failure to disclose may constitute grounds for suspension and/or termination of the Contract and debarment from future contracting opportunities.

26 CONTINUING OBLIGATIONS

Notwithstanding any provisions to the contrary herein, upon the termination of this Contract for any reason, the provisions of this Contract which by their nature require some action or forbearance after such termination, including but not limited to confidentiality, PHI, reporting, indemnity, insurance, records retention, and performance guarantees, shall survive such termination and be binding until any actions, obligations, and/or rights provided therein have been satisfied or released.

27 MARKET CHECK PROVISION

Commented [TD15]: 1 year contract so this doesn't hold a lot of water

OGB reserves the right to exercise an annual market check at any time during the Contract term to assess and verify the competitiveness of the pricing and other terms set forth in the Contract in comparison to that available in the marketplace at that time. OGB may designate a third party of its choosing that will compare the aggregate value of the upcoming Contract year pricing and other terms to what they may receive under a competitive procurement. Benchmarks chosen in the analysis shall be groups with similar plan design, membership and utilization patterns as OGB, to the extent possible. Should the comparison find current market conditions would yield greater than 1.0% savings, the parties will discuss in good faith a revision to the current pricing and other terms that will at least match the best offer in the marketplace and will go into effect the first day of the upcoming Contract year. If the parties are unable to reach agreement on revised pricing terms or other applicable provisions within sixty (60) days from the market check report, OGB may terminate the Contract without penalty (e.g., no loss of rebates earned but not yet paid) as indicated in Section 4.2.

28 PREFERRED CLIENT

Commented [TD16]: Pricing is meaningless due to definitions Sounds good though Also, how does OGB know/audit this?

OGB should be recognized as a preferred client relationship and should benefit from yearly pricing improvements provided to any other clients in Contractor's "book of business". Essentially, if Contractor offers better pricing to another client during the Contract term, OGB will benefit from the lesser pricing arrangement and receive the benefit of any offered enhancements.

29 CENTERS FOR MEDICARE AND MEDICAID SERVICES

Contractor shall make its books and records in connection with any Medicare business available to CMS and/or its designees in accordance with 42 CFR 423.504(d) and 42 CFR 423.505(d) and (e). In this regard, CMS and/or its designees shall have the right to audit, evaluate, and inspect any books, contracts, records, computer and/or other electronic systems, including medical records and documentation involving transactions related to the Plan and/or Medicare business provided under this Contract (including coverage costs, low income subsidies, and privacy and security of PHI and other personally identifiable information, enrollment and disenrollment) and any additional relevant information that CMS may require, and these rights shall continue for a period of ten (10) years, or longer if required by CMS, from the final date of the Contract period or from the date of completion of any audit, whichever is later. CMS and/or its designees shall have direct access (i.e., on-site access) to the Contractor, and the Contractor will make such books, records, computer and/or other electronic systems, directly available to CMS and/or its designee(s) for such inspection, evaluation, and audit.

30 TRANSITION OF SERVICES AND DATA

Contractor shall comply with the provisions of this Contract, and other requests of OGB/State, to accomplish a timely transition of services without interruption of services to participants. During any such transition, Contractor will provide all of the same Records and data in the same format as provided during the term of the Contract, to OGB/State or its designee. Contractor further agrees that no dispute or objection it may have regarding the propriety of any transition of services by OGB/State will relieve Contractor of these obligations.

31 PROHIBITION OF DISCRIMINATORY BOYCOTTS OF ISRAEL

In accordance with La. R.S. 39:1602.1, for any contract for $100,000 or more and for any Contractor with five or more employees, Contractor, including any subcontractor, shall certify it is not engaging in a boycott of Israel, and shall, for the duration of this Contract, refrain from a boycott of Israel.

The State reserves the right to terminate this Contract if the Contractor, or any subcontractor, engages in a boycott of Israel during the term of the Contract.

(Signature page to follow)

THUS DONE AND SIGNED on the date(s) noted below:

STATE OF LOUISIANA **OFFICE OF GROUP BENEFITS**	**CAREMARKPCS HEALTH, L.L.C.**
BY: _____	**BY:** _____
NAME: [redacted]	**NAME:** _____
TITLE: Chief Executive Officer	**TITLE:** _____
DATE: _____	**DATE:** _____

ATTACHMENT I: SCOPE OF WORK/SERVICES

The Contractor must possess the knowledge, capability, and resourcefulness to effectively provide PBM services in accordance with all federal, state, and any other applicable laws, regulations, policies, OGB requirements, etc. The Contractor will be responsible for successfully transitioning (in conjunction with OGB and the incumbent contractor) to being the Contractor responsible for completing all required services. The Contractor shall provide competent and qualified staff to work on the scope of services under the Contract.

The Contractor will be responsible for ensuring the accuracy, timeliness, and completion of all tasks assigned under the Contract. OGB reserves the right to modify or delete the tasks and services listed prior to and during the term of the Contract, subject to the approval of the OGB CEO, Office of State Procurement, and any other approval required by law.

At a summary level, these tasks include:

1. Implementation services
2. General Support Services
3. Pharmacy Benefit Manager Services

Below is a list of minimum services the Contractor shall be responsible for providing under the Contract:

Task (1): Implementation

- Assign a dedicated implementation team to manage the implementation process and the transition of services from the incumbent contractor.
- Work with OGB and incumbent contractor to transfer competencies and operational expertise essential to administering OGB's pharmacy benefits program with minimal interruption to Plan Participants.
- Perform all tasks necessary to complete the pre-implementation audit (including follow-up test claims) at least ten (10) days prior to the effective date. This assumes OGB will sign off on the benefit set up at least thirty (30) days in advance of the Plan effective date.
- Provide an implementation credit to OGB to offset OGB's expense associated with the RFP, transition, and ongoing services in the following amounts for commercial and EGWP:
    - Commercial implementation credit $6.50 Per Net New Member ("PNNM") for the emergency contract;
    - EGWP implementation credit $6.50 PNNM for the emergency contract; and,
    - Pre-Implementation audit credit is included in the $6.50 PNNM for the emergency contract for Commercial and EGWP.

  In no case shall OGB be required to repay all or a portion of the used or unused implementation credit. Contractor will track such services and provide OGB a quarterly report, upon request, of current utilization and remaining balance, if any, of the implementation credit. Any remaining balance will not expire and be available for use during the term of this Contract. It is the intention of the parties that, for purposes of the

Commented [TD17]: This is BIG money How much is going to OGB and how much is going to Consultant (Buck)

Federal Anti-Kickback Statute, these credits shall constitute and shall be treated as discounts against the price of drugs within the meaning of 42 U.S.C. 1320a 7b(b)(3)(A).

- Contractor will provide administrative funds, which will be funds that OGB may use to offset "ongoing expenses," and at no point will OGB be required to pay for used or unused portions of the credit offered by your organization. Contractor will provide the following administrative funds:
    - Commercial administrative fund in the amount of $3.50 Per Member Per Year ("PMPY") for the emergency contract term; and,
    - EGWP administrative fund in the amount of $3.50 PMPY for the emergency contract term.

  It is the intention of the parties that, for purposes of the Federal Anti-Kickback Statute, these Client Credits shall constitute and shall be treated as discounts against the price of drugs within the meaning of 42 U.S.C. 1320a 7b(b)(3)(A).
- Establish and implement data utilization edits that identify and deny duplicate claims, claims filed too soon, claims requiring authorization when such authorization is not in place, as well as messages to the pharmacist for review and approval or denial of the claim(s) due to safety issues.
- Facilitate system programming including, but not limited to, data collection from OGB; file transfer set-up between OGB and Contractor; and data transfer and mapping. If Contractor requires file mapping and/or subsequent updates, this service will be provided by Contractor at no additional cost to OGB. **Files must be sent electronically to the OTS MOVEit DMZ Secure FTP server utilizing a security file transport protocol; the preference is FTPS. All files must be encrypted using Public Key Infrastructure (PKI) with a prior exchange of Public Key(s), commonly referred to as PGP encryption. The encrypted file(s) must have an extension of "pgp". The encryption key must have an expiration of no longer than five (5) years from the creation date and be approved by the OTS InfoSec Team. All files must be encoded as an ASCII text file prior to encryption.**
- Provide file data in a layout format designated by OGB to include, but not be limited to, Drug Claims File, Prior Authorization Review File, Appeals Determination File, and Out of Pocket Maximum. The Contractor must accept OGB's designated file layout. File layouts will be provided at no cost to OGB. **Files must be sent electronically to the OTS MOVEit DMZ Secure FTP server utilizing a security file transport protocol; the preference is FTPS. All files must be encrypted using Public Key Infrastructure (PKI) with a prior exchange of Public Key(s), commonly referred to as PGP encryption. The encrypted file(s) must have an extension of "pgp". The encryption key must have an expiration of no longer than five (5) years from the creation date and be approved by the OTS InfoSec Team. All files must be encoded as an ASCII text file prior to encryption.**
- Mail identification cards ("ID Cards") to the homes of newly enrolled EGWP Plan Participants within four (4) calendar days of receipt of the eligibility. Contractor will be responsible for cost of reproducing ID Cards and priority mail shipping in the event of Contractor errors and/or initiated changes.
- Mail welcome kits to the homes of newly enrolled Plan Participants within four (4) calendar days upon receipt of eligibility.

Commented [TD18]: Caremark is paying the OGB to off-set their admin expenses

- Integrate with selected contractor(s) accurately and timely for the administration of the Plan, including the health claims administrator and COBRA administrator, for the purpose of out-of-pocket maximum accumulation. **Ensure that out-of-pocket maximum accumulation integration with selected contractor(s) as defined by OGB is successful prior to the "Go-Live" date, at no additional cost**.
- Provide ten (10) read only access codes to the online eligibility, claims payment and/or standard and ad hoc reporting systems(s) (collectively, the "System") which will allow OGB's specified personnel to view and/or extract information residing in the System on an individual, Plan level, and account structure basis. Training to OGB personnel will be provided by the Contractor's Account Management Team on-site at OGB.
- Conduct project status implementation meetings with the Contract Monitor on-site, or via teleconference.
- Perform comprehensive systems testing and quality assurance audits, with results reported to OGB prior to the "Go-Live" date, at no additional cost.
- Ensure successful and timely completion of all tasks necessary to begin performance of the Contract on January 1, 2021, 12:00 am CT.

Task (2): General Support Services

- Adhere to all provisions outlined and requested in the Pharmacy Benefit Manager for Self-Funded Health Plan RFP #3000014397, Attachment III: Technical Questionnaire.
- Provide a dedicated Account Executive and/or Operational Account Manager that will provide day-to-day management of project tasks and activities, coordination of Contractor's employees, and possess the technical and functional knowledge to direct all aspects of the project. Also, the Account Executive must have at least one (1) back-up staff member designated to handle the overall responsibility of OGB. Assist OGB in complying with grievance and appeal procedures adopted by OGB as outlined in the Plan. The Contractor will be responsible for resolution of appeals specific to Covered Benefits, medical necessity, and external reviews consistent with the appeals program and Plan Participant requested reviews of prescription drug denials as allowed by and in accordance with all applicable Law.
- Account team members will attend open-enrollment and benefit fairs throughout Louisiana (up to 30) either virtually or on-site, as requested.
- Account Manager will work on site at OGB headquarters for the first 30- 60 days post implementation at OGB request.
- Provide support around account strategy, Plan Participant inquiries, issue resolution, reports and other requested projects and deliverables.
- Provide an annual service cycle plan as well as an ongoing task log with timelines for all deliverables and weekly status update meetings in person or via teleconference.
- Attend all on-site quarterly meetings four times per calendar year at OGB. The meetings shall be held no later than sixty (60) days following quarter end. The Account Management Team will provide for OGB approval a draft agenda at least ten (10) business days in advance of a meeting to allow changes to the agenda and a reasonable opportunity to prepare for the meeting.
- Maintain an ongoing process log that will document all benefit and system programming changes, which will be provided to OGB within five (5) business days of any change.

- Upon OGB request, the Contractor will be required to work with the appointed OGB actuary, other selected OGB contractors, employees from the Division of Administration, and the OGB staff for management of the program.
- Investigate any activity, prescription related or otherwise relating to the Plan, which it believes to be fraudulent or abusive whenever detected by the Contractor or brought to the attention of the Contractor by OGB or other persons. The Contractor shall have established procedures and system edits to aggressively monitor and proactively search for cases and potential cases of fraud and abuse including providing OGB with a quarterly report of fraud activities and discoveries relating to the Contract.
- Assist OGB in responding to inquiries received from Plan Participants, pharmacy providers, or other persons. Such requests shall be 1) given priority status; 2) subject to a method of tracking approved by OGB; and 3) result in the delivery of all requested information, documentation, etc. When immediate responses are required, the Contractor shall assist OGB in preparing its reply including providing data and documentation within the timeframes prescribed by OGB for a specific inquiry.
- Provide immediate online real-time manual eligibility updates for urgent requests by OGB staff.
- Make available all necessary resources to assist OGB in responding to legislative inquiries and requests including, but not limited to, the Account Management Team, analytics and outcomes, and government relations department. The Contractor shall respond within the timeframe set by OGB, which will be determined at the time of the inquiry depending upon the scope and complexity of the request.
- Provide knowledgeable staff to attend statewide annual/special enrollments and any other informational meetings as scheduled by OGB as well as prepare, print, and distribute communication materials.
- Provide advisory services to OGB regarding actual or pending state and federal laws, regulations, policies, procedures, and rules specific to self-funded plans for pharmacy benefit management, pharmacy and prescription drugs, other topics related to the provisions of this Plan and provide OGB with interpretation as to the impact of such laws or regulations on the Plan.
- Subject to OGB's customization and approval, the Contractor will be responsible for the development of pharmacy benefit information including, but not limited to 1) annual and special enrollment brochures and promotions; 2) other Plan-related printed materials (i.e., promotional, Plan Participant education, ID Cards, benefit brochures, claim forms, clinical program notices and letters, pre-formatted letters, system generated letters and notifications, correspondence forms, and other written materials and forms). The Contractor will be responsible for all costs associated with designing, writing, printing, distributing, and mailing all such information.
- Upon request of the Plan Participant, provide printed materials in a medium widely accepted and in compliance with all applicable anti-discrimination Laws.
- Provide website that is specific to OGB and that is in compliance with all applicable anti-discrimination Laws.
- Provide all printed material in electronic format with final version submitted to OGB in PDF file format.
- Provide dedicated Customer Service Representatives ("CSR") to research and resolve, to the satisfaction of OGB, benefits, Claims payment, denial inquiries and complaints

submitted by Plan Participants, pharmacies, and OGB. CSR must have the ability to gather and analyze data, create an historical picture, including a timeline of Claim activity for the individual Plan Participant, and develop appropriate correspondence for complicated Claim issues that are appealed to OGB

- Furnish a dedicated toll-free number for incoming customer service calls, including telephone technology for the hearing impaired and multi-lingual support. The dedicated call center for pharmacies, Plan Participants, and account management must be staffed and available to receive calls 24/7.
- Upon request, provide digital recordings of phone calls within two (2) business days of request.
- Document and maintain a service disruption/continuity of operations plan or procedure to continue customer service activities and all other business operations when existing service is temporarily unavailable due to either scheduled or unforeseen events (i.e., repairing/restoring utility or power supply, upgrading phone systems, and other events). OGB must be notified in advance for scheduled disruptions and within twenty-four (24) hours of occurrence for other events.
- Written communications to Plan Participants that have not been previously approved by OGB will be subject to OGB's approval prior to distribution. Such changes are subject to OGB approval prior to implementation. OGB will review prior approvals annually to ensure no change in information, legal requirements as to OGB, etc.
- Conduct annual Plan Participant(s) and OGB satisfaction surveys and report results to OGB. The survey tools are subject to OGB's approval.
- Meet with OGB staff in person or via teleconference, on at least a weekly basis to review and evaluate Contract administration. This schedule may be modified by OGB.
- Notify OGB within five (5) business days of receipt of any class action notice and/or knowledge of other lawsuits related to the services provided hereunder in which the Contractor determines OGB could have an interest and provide copy of such to OGB. Contractor is not authorized to file such claims on behalf of OGB without OGB's express written consent. Contractor will provide claims data and reporting to use in filing for refunds or to participate in any such action or litigation at no additional costs.
- Contractor must notify the applicable state authority (i.e., state treasurer, etc.) and escheat any unclaimed property upon the expiration of the statutory time period for escheatment.

Task (3): Pharmacy Benefit Manager Services

- Provide prescription benefit management services including, but not necessarily limited to, general support and advisory services regarding pharmacy benefit design and implementation, Formulary management, network and rebate management, administrative and claims processing services, clinical management programs, reporting, marketing, customer service, quality management, and utilization management functions.
- Provide network access to licensed and in good standing Louisiana pharmacies without an access fee.
- Perform all aspects of Claims processing, coordination of benefits including non-Medicare and Medicare, Claims reimbursement, point-of-sale transactions, adjudication, and payment. The Contractor shall verify benefits and eligibility before authorizing prescriptions and paying Claims.

- Provide a process for reimbursing Plan Participants through electronic submission and paper reimbursement form.
- Provide a full Claims file feed to all vendors designated by OGB including, but not limited to, OGB's actuary and third-party claims administrator of self-insured health plans, as requested by OGB at no additional cost and in the format specified by OGB. File layouts will be provided at no cost to OGB.
- Modify Formulary as requested by OGB and communicate such modifications as necessary by transmitting disruption letters to those Plan Participants impacted by Formulary changes.
- Manage the current pharmacy benefit plan design and any changes implemented by OGB. Benefit design and coverage for supplies and prescriptions can be modified as needed and requested by OGB to align with associated health/medical programs, such as disease management and diabetic care.
- Provide innovative savings solutions for the prescription drug plan, including a detailed overview of the design and scope of the solution.
- Provide a process flow of the solution, from identification of potential savings, outreach to plan participants and providers, and data regarding savings realized by the plan and participants.
- Provide retail network (30 and 90 day), mail order, and specialty pharmacy services.
- Through Contractor's affiliate, SilverScript Insurance Company ("SilverScript"), provide comprehensive management of the EGWP, including the ability to maintain benefits for OGB retirees who are awaiting EGWP approval by CMS with 100% adherence to all CMS guidelines. Any funds received applicable to Plan Participants in Medicare Part D will be remitted to OGB within ten (10) business days of receipt from CMS and the appropriate files will be provided for purposes of reconciliation. Accordingly, OGB hereby delegates to Contractor the authority to enter into an agreement with SilverScript to provide the EGWP services to eligible Plan Participants as described in this Agreement and the contract between Contractor and SilverScript. OGB authorizes Contractor to provide to SilverScript any information available through this Agreement which is required in connection with the provision of EGWP services, in each case, in accordance with applicable law.
- Review, clarify, edit as necessary, and confirm the accuracy of all prescription drug program information included in the annual benefit guide and website as requested by OGB. The Contractor shall respond within the timeframe set by OGB, which will be determined at the time of the request.
- Communicate as necessary with those Plan Participants on Plan Participant disruption letters to those impacted by quarterly Formulary changes.
- Perform all aspects of claims processing, coordination of benefits including non-Medicare and Medicare, claims reimbursement, point-of-sale transactions, adjudication, and payment. The Contractor shall verify benefits and eligibility before authorizing prescriptions and paying claims.
- Support any deductible or out-of-pocket maximum cross accumulation in a mutually agreed format to ensure compliance with the Patient Protection and Affordable Care Act ("PPACA").
- Process run-on Claims for eligible OGB Plan Participants incurred prior to but not processed as of the effective date of the Contract at OGB's request.

Commented [TD19]: PBM owns

- Process claims for eligible OGB Plan Participants incurred prior to but not processed as of the termination of the Contract and received not more than one (1) year following Contract termination ("run-off services"). At OGB's request, the handling of such claims may be transitioned to a successor appointed by OGB prior to the end of the run-off period, and the Contractor shall cooperate in transitioning such services to any successor appointed by OGB. Further, Contractor will continue to process all claims and appeals for claims incurred prior to termination of the Contract during the one (1) year run-off period following termination, unless otherwise transitioned to a successor appointed by OGB.
- Provide membership eligibility/enrollment, co-payment/coinsurance and benefit coverage information, supplied by OGB or its designated agent in mutually agreed format, available to network Pharmacies on a weekly basis at the time of dispensing through the online electronic transmission link maintained between the Contractor and pharmacies to assure claims are processed appropriately
- Provide 24/7 access to online portal, except for scheduled maintenance, to Plan Participants for activities such as Claim submission, account monitoring, communications requested and approved by OGB, Formulary, and any other information required by state and federal Laws. All outages in excess of one (1) hour should be promptly reported to the Contract Monitor.
- Provide web-based tools that will help educate Plan Participants on the benefit plan design and assist in calculating and tracking the cost and utilization of their prescribed drug through all delivery channels (i.e., retail 30, retail 90, specialty, and mail service). The tool(s) must also provide alternative suggestions for more cost-effective medication within the same therapeutic class.
- Unless Louisiana Law requires greater notice, provide advance written notice to OGB no later than ninety (90) days prior to any anticipated Formulary change, with written notice also to be sent to the address of impacted Plan Participants no later than sixty (60) days prior to the effective date of any change. For purposes of this requirement, Plan Participant shall include any Plan Participant who has had a prescription filled for the impacted medication(s) within the last ninety (90) calendar days or has an active refill on file. Written communications to Plan Participants will be subject to OGB's approval prior to distribution. Such changes are subject to OGB approval prior to implementation.
- Unless Louisiana Law requires greater notice, provide advance written notice to OGB no later than ninety (90) days prior to any anticipated material change(s) to the retail pharmacy network, mail order pharmacy, and/or specialty pharmacy with written notice also to be sent to the address of impacted Plan Participants by no later than sixty (60) days prior to the effective date of any change. For purposes of this requirement, Plan Participant shall include any Plan Participant who has had a prescription filled within the last ninety (90) calendar days or has an active refill on file with the terminating pharmacy. Written communications to Plan Participants will be subject to OGB's approval prior to distribution. Such changes are subject to OGB approval prior to implementation.
- Provide Plan Participant notice of any delays beyond three (3) days in the delivery of prescription to the Plan Participant.
- Implement a specialty pharmacy program that will provide cost-effective care and positive patient outcomes through increased adherence, as well as provide an enhanced patient experience through the convenience of scheduled delivery, disease management programs and compliance monitoring employing a care coordination model.

Commented [TD20]: Caremark controls formulary as well

- Provide predictive and plan design modeling capabilities and tools that will assist OGB in assessing the financial impact and/or return on investment ("ROI") of OGB's current benefit plan design and any proposed benefit changes.
- Provide benchmark comparison for clients similar to OGB as well as national comparisons.
- Perform audits of individual pharmacies not located in the State of Louisiana prior to their entering the provider network and as requested by OGB for the purpose of determining pharmacy accuracy. For pharmacies located in the State of Louisiana that are seeking entrance into the network, the Contractor may accept the formal application of the pharmacy along with a copy of the on-site inspection report completed by the Louisiana Pharmacy Board in lieu of an audit.
- Maintain criteria to establish when and how a utilized participating pharmacy may be selected for audit (i.e., desk audit, on-site audit, client specific on-site participating pharmacy audit requests, etc.) and/or audited to determine compliance with its contract with the Contractor. Audits will be conducted by the Contractor's internal auditors or its subcontracted auditors at the utilized participating pharmacy. The Contractor will be required to institute action to collect overpayments and return 100% of the recoveries to OGB. Overpayments will be remitted to OGB within thirty (30) days after the close of each Contract quarter via check or wire unless otherwise specified. Contractor will provide reporting at no cost to validate overpayments and recoveries.
- Pharmacy Claims Audit and/ or Rebate Audit: Contractor agrees to pay up to a total annual allowance of $75,000.00 for OGB or OGB's designated third party's fees and out-of-pocket expenses related to performing a Pharmacy Claims Audit and/ or Rebate Audit and at no point will OGB be required to pay for used or unused portions of the audit credit offered by your organization.
- Render payment to OGB for all rebates within one hundred twenty (120) days after termination of the Contract. In addition, all pricing guarantees will be trued up and any shortfalls will be paid to OGB within one hundred twenty (120) days after said termination.
- Provide immediate notification upon receipt by Contractor of any non-routine CMS-related inquiries regarding OGB's pharmacy benefits program and prepare response to such inquiries for OGB approval within the specified timeframe mutually agreed upon by the parties; and submit such response upon OGB approval.
- Perform and/or process subrogation of prescription Claims and other government agency recoveries on behalf of OGB in accordance with the timeframes specified by Law or such other periods requested by OGB. Government agencies include but are not limited to the Centers for Medicaid and Medicare Services ("CMS"), Office of Inspector General ("OIG"), Health and Human Services ("HHS"), state Medicaid agencies, Veteran's Administration ("VA") facilities, Indian Health Services and Bureau of Indian Affairs ("IHS"), and Department of Defense military treatment facilities (or other similar facilities) ("DOD"), or the agencies' or facilities' third-party representatives.
- Remit applicable fees to pharmacies as required by Louisiana law.
- For disaster declarations and or catastrophic events, Contractor should have the ability to limit the "refill too soon" edit to either the parish/county of residence or the zip code of residence of Plan Participants.

Commented [TD21]: More money offered to OGB for expenses associated with managing/auditing/etc

Task (4) Clinical Management Services

- Perform Formulary management, rebate sharing and other clinical services described herein. These services will include, but not limited to, prior authorization, step-therapy, concurrent and retrospective drug utilization review and other measures that are deemed appropriate to effectuate Formulary management. All Formulary changes are subject to OGB's approval prior to implementation.
- Develop and implement clinical intervention and cost-saving programs. All such initiatives are subject to OGB's approval prior to implementation and/or discontinuance.
- Provide clinical resources (i.e., dedicated pharmacist, etc.) to OGB to assist in interpreting pharmacy data and developing cost management strategies.

Commented [TD22]: Hope they have a pharmacist on staff Formulary managed by caremark will be rebate driven, not clinically driven

1.1 Deliverables

The deliverables listed in this section are the minimum required from the Contractor for both Commercial & EGWP. Additional deliverables may be included as mutually agreed between both parties.

Deliverable	Description	Frequency of Submission
Independent Assurances		
Independent Assurances	Contractor shall supply OGB with an exact copy of the annual SOC 1, Type II and/or SOC 2, Type II (as agreed by OGB) resulting from the SSAE18 engagement or any other independent assurances approved by OGB for the period of January 1 – December 31. Contractor shall also provide a bridge letter to OGB for the period of January 1- June 30 of the following independent assurance reporting period.	March 31, 2022 and each calendar year thereafter. Contractor shall provide bridge letter for the period of January 1- June 30 no later than July 31 of each calendar year.
Performance Guarantees		
Performance Guarantee Report	A detailed comprehensive monthly report including metrics for the performance guarantees set forth in the Contract.	Within sixty (60) calendar days after close of each month and calendar year.
Financial Guarantee Report	A comprehensive quarterly report, including the effective AWP discounts, dispensing fees, and rebates.	Within thirty (30) calendar days after the close of each quarter.
Account Satisfaction		
Plan Participant Satisfaction Survey	Conduct annual Plan Participant satisfaction survey and report results to OGB.	Within thirty (30) calendar days after end of each calendar year.

OGB Satisfaction Survey	Conduct annual OGB satisfaction survey and report results to OGB.	Within thirty (30) calendar days after end of each calendar year.
Market Check		
Market Check Report	Provide comments on the market check audit report provided by OGB or its designee.	Within thirty (30) calendar days of receipt.
Operational Activities		
Ad Hoc Reports	Provide client-specific reports that include data related to Contractor's operating performance and health outcomes of OGB Plan Participants.	Within ten (10) business days of request.
Weekly Status Meeting Agenda	A document that provides a high level overview of agenda topics, new and current issues requiring resolution, and any other necessary discussions.	Within twenty-four (24) hours in advance of the scheduled meeting for review and comments.
Service Log	A log detailing open and resolved issues to include, but not limited to, description of issue, date identified, recommended and/or agreed upon course of action, anticipated completion date, responsible party for resolution, notes from meeting discussions regarding the issue, and any other applicable comments.	Within fifteen (15) calendar days after end of each month.
Meeting Minutes	Provide detailed and well-documented draft meeting minutes for review and comment. Final minutes must be provided within three (3) business days after receipt of revisions from OGB.	Within three (3) days after any meeting and/or receipt of revisions from OGB.
Quarterly Meeting Agenda	A document that provides a high level overview of agenda topics, new and current issues requiring resolution, and any other necessary discussions.	Within ten (10) business days in advance of the scheduled quarterly meeting.
Process Log	A comprehensive document including a detailed description of all benefit and system programming changes.	Within five (5) business days of any change.

Drug Type Summary	A summary of claims by drug type, broken out by Plan & level of coverage (employee ("EE"), employee + spouse ("EE+SP"), etc.), drug type (Generic/Brand), prescription count, days' supply, paid amount, total Plan Participant Out of Pocket ("OOP").	Within fifteen (15) calendar days after end of each month.
Paid Claims Summary	A summary of paid claims, broken out by Plan & level of coverage, prescription count, Plan paid amount, Plan Participant paid amount, total claims, and year to date total.	Within fifteen (15) calendar days after end of each month.
Direct Member Reimbursement ("DMR") Summary	A summary of DMR claims by Plan to include DMR flag, in/out network, prescription count, relationship code, paid amount, total Plan Participant OOP, and year to date total.	Within fifteen (15) calendar days after end of each month.
Specialty Utilization by Drug within Disease Summary	A summary of specialty drug utilization to include, but not limited to, Rheumatoid Arthritis, Multiple Sclerosis, and Hepatitis C broken out by disease state, drug name, number of prescriptions, Plan/Plan Participant cost, Plan/Plan Participant cost per fill, average total cost per fill.	Within fifteen (15) calendar days after end of each month.
Clinical Pipeline Report	A summary of specialty products in Phase III trials that are expected to receive Federal Drug Administration ("FDA") approvals within the next twelve (12) months. This report is to include information by drug, manufacturer, therapeutic category, main use/description, expected approval, efficacy and safety data, predicted place in therapy, and financial impact. As specialty products are released to market a drug review will be performed that includes efficacy, safety data, place in therapy, comparative cost analysis, Formulary placement recommendation, and prior authorization guideline recommendation.	Last day of the month following end of each quarterly reporting period.

OGB Claims by Therapeutic Class	A description of the top 25 therapeutic classes by Plan paid claims. This report is to include total paid, Plan paid, patient paid, and percentage of Generic of each, number of claims, percentage of total claims, percentage of Generic drugs utilized, Plan paid/day, Plan paid/claim, and per Plan Participant per month. Commercial and EGWP claims must be separated.	Last day of the month following end of each quarterly reporting period.
Drug Utilization Review ("DUR") Activity Report	A description of the total monthly drug utilization. To include total DUR activity, rejected claims, and reversed claims broken out by conflict description, summarized by total DUR count, ingredient cost, paid and percentage of alerts, total overall claims, claims with alerts, and claims sent summary. Commercial and EGWP claims must be separated.	Last day of the month following end of each quarterly reporting period.
Grievance report	A description of Plan Participant reported grievances, both oral and written broken out by number of type: Plan (co-pays, coinsurance, coverage gap, prescription exclusions/limitations); appeals/formal grievances; customer service (i.e., Plan materials not received, mail order vendor, pharmacy staff, service plan operations, service plan staff); disenrollment (i.e., disenrollment not processed), fraud and abuse; marketing; quality of care; other/misc.	Last day of the month following end of each quarterly reporting period.
Plan Summary	A summary of issues, changes to Formulary, communications, and recommendations, to be presented at quarterly meetings.	Ten (10) days prior to the occurrence of each quarterly meeting.
Maximum Allowable Cost ("MAC")	A listing of MAC pricing list (i.e., OGB retail pricing).	Within fifteen (15) calendar days after end of each month.
Pharmacy Audits	Detailed results of any pharmacy audit including recommendations for identified deficiencies and plan of action as needed.	Last day of the month following end of each quarterly reporting period.
Plan Participant Communications	Prepare talking points and communications necessary for Plan/Formulary updates and changes.	Within the specified timeframe identified by OGB at time of request.

Commented [TD23]: Multiple lists are traditionally deployed Which list is going to be provided to OGB?

CMS Reporting	Prepare and submit all CMS mandated and ad hoc reports.	Within the specified timeframe identified at the time of request.
Payment of Rebates	Render payment to OGB for rebates	Within ninety (90) days following the end of each quarter.
Reconciliation and Payment of Financial Guarantees	Render payment to OGB for reconciliation of financial guarantees.	Within ninety (90) days following the end of each quarter.
Unclaimed Property	Detailed listing in a mutually agreeable format of any unclaimed property of OGB Plan Participants held by Contractor.	No later than June 30 of each calendar year.

1.2 Performance Guarantees

The following performance guarantees are the minimum acceptable standards for the Contract. These metrics shall be reported quarterly and reconciled on an annual basis unless another time period is agreed to between OGB and Contractor. OGB shall have the ability to modify the performance guarantees each Contract year. OGB, at its sole discretion, will allocate amounts at risk for performance guarantees, provided no more than thirty (30%) of the total amount at risk is allocated to one performance guarantee excluding financial guarantees (i.e., AWP discounts, dispensing fees, rebates, etc.). OGB may allocate 0% to a guarantee, which would indicate that the performance guarantee will only be reported on with no amounts at risk. Contactor will also be subject to per day fees for Independent Assurance Reporting performance guarantees.

Any penalties owed to OGB shall be reported within sixty (60) days after the close of the period being measured, and will not need to be requested. Any penalties owed to OGB shall be paid within forty-five (45) days after reported. Implementation performance guarantees will be measured and reported within ninety (90) days after the agreed upon implementation date. Payment of any due and owing implementation performance penalty shall be paid within sixty (60) days of notification of the penalty to the Contractor.

Performance Guarantees: The Contractor will be subject to the performance standards and those detailed in Attachment I, Scope of Service.

Financial guarantees will be covered dollar for dollar on any shortfall with no limit to the amount at risk. Any surplus on financial guarantees will be retained 100% by OGB. All guarantees will be trued up individually, meaning no guarantees can be cross-subsidized (i.e., surplus on one guarantee offsetting other, etc.). This includes not being able to cross-subsidize between delivery channels, or within a delivery channel. For example, retail and retail extended supply networks are considered separate delivery channels.

Audit: OGB reserves the right to audit performance guarantee reports on an annual basis. A third party may be utilized to perform this audit without limitation of the scope of the audit.

Measurement Periods: The period to be measured shall be January 1, 2021 through December 31, 2021. If the performance guarantees are effective for less than a full calendar year, the payment amounts will be prorated for the portion of the Measurement Period.

Commercial

Performance Guarantee	Measurement	Penalty Percent at Risk Annually
Implementation		
Implementation Satisfaction Survey	Provide an implementation satisfaction guarantee that is separate from all other guarantees. The guarantee will be at the sole discretion of OGB, meaning OGB can determine, in good faith, a "yes" or "no" if they were satisfied with the implementation, or a percentage of satisfaction.	20%
Pre-Implementation Audit	Complete the pre-implementation audit, including follow-up test claims, at least ten (10) days prior to the established implementation date.	10%
Group Structure, Benefit Plan Design - Timeliness	The group structure and benefit plan design will be entered and tested in the PBM system at least five (5) Business Days prior to open enrollment materials being mailed; such that, Vendor Call Center representatives can answer client-specific questions. Any corrections needed, including those that may be identified during a pre-implementation audit, with be made within five (5) Business Days. This guarantee is dependent on receiving final sign-off from Client on the Benefit Plan Design Summary Documents by a mutually agreed upon date when the implementation plan is baselined within 30 days of kickoff.	15%
Group Structure, Benefit Plan Design - Accuracy	The group structure(s) and the respective benefit plan design(s) coded into the PBM system will be 100% accurate at least one (1) Business Day prior to open enrollment materials being mailed; such that, Vendor Call Center representatives can answer client-specific questions. This guarantee is dependent on receiving final sign-off from Client on the Benefit Plan Design Summary Documents at least ten (10) Business Days prior to the "effective date.", provided Client signs off on testing to certify we meet 100% accuracy prior to opening open enrollment phone lines.	15%

Eligibility Load - Timeliness	Participant eligibility will be loaded by the date mutually agreed upon in the Implementation Project Plan (which should be enough time for participants to receive ID cards by the date agreed upon in the Implementation Project Plan, but at least fifteen (15) Business Days in advance of the Go-live/Effective Date. This guarantee is dependent upon Vendor receiving a test file ten (10) Business Days in advance of the date for the "Live Eligibility" load date mutually agreed upon in the Implementation Project Plan.	5%
Eligibility Load - Accuracy	Participant eligibility loaded into the PBM system will be 100% accurate (i.e., in accordance with the plans/agreements made during implementation with the eligibility supplier).	5%
Member ID Cards/Welcome Kit - Mailing Timeliness	Vendor guarantees that 100% of members will be mailed ID cards and/or Welcome Booklets by the date agreed upon in the Implementation Project Plan, but at least fifteen (15) Business Days prior to the Go-Live/Effective Date.	5%
Member ID Cards/Welcome Kit - Accuracy	Vendor guarantees that 100% of all ID cards and Welcome Booklets mailed to members will be 100% accurate in terms of plan and member information (e.g. member identification number, plan number, etc.).	5%
Customer Service during Open Enrollment - Timeliness	A dedicated toll-free telephone number for member questions/assistance will be established by the date agreed upon in the Implementation Project Plan, but at least five (5) Business Days before open enrollment materials are mailed, and maintained during open enrollment.	5%
Customer Service Call Accuracy	100% of all calls reviewed at the request of OGB (typically based on participant complaints) will include no inaccurate coverage information. Measurement to begin only after (a) 24 hours after Contractor's receipt of an initial eligibility file in the agreed upon format and (b) Contractor's completion of benefits set-up in its adjudication system, in accordance with the implementation timeline.	3%

Implementation Updates	The Implementation Project Manager will provide regular weekly updates to Client, tracking the status of the implementation.	1%
Member Call Tracking	The Implementation Project Manager will provide member call stats by call category to Client for every day of open enrollment for the first fifteen (15) days after the effective date (reporting during the weekend is not required), and then weekly thereafter by a mutually agreed upon date when the implementation plan is baselined within 30 days of kickoff.	2%
Claim Tracking Report - Timeliness	Vendor will provide to Client claim stat reports (e.g. paid vs rejected) every day for the first month of implementation for purposes of identifying any trends or errors.	1%
Claim Tracking Report	Vendor will provide to Client claim stat reports (e.g. paid vs rejected) that include reasons for claim rejections and will provide the additional research requested to determine whether there are any transition issues that need to be addressed.	1%
Post-Implementation Review Meeting	Vendor will conduct a post-implementation review meeting with Client within sixty (60) days after the effective date or a later time if requested by Client.	1%
Client Inquiries - Response Timeliness	Vendor representative will acknowledge 100% of inquiries/concerns raised from Client, and/or their designees, within one (1) Business Day from when the requests are sent (documented via email), and provide a date when the next update will be provided.	2%
Inquiry/Issue Resolution Timeliness	Vendor representative will work to resolve any implementation questions/issues raised by Client within five (5) Business Day from when the inquiry/requests are sent (documented via email), or a later date if mutually agreed upon.	2%
Contract Change Requests - Timeliness	Vendor will respond to the first contract review (contract change requests/inquiries) within ten (10) Business Days from its receipt and will respond to follow-up inquiries about the same items initially	2%

	identified within five (5) Business Days. The response times may be extended if mutually agreed upon in writing in advance.	
Post Implementation		
Pharmacy Network Disruption	At least 98% of Plan Participants shall reside within one and one half (1.5) miles of a network pharmacy for urban areas, within three (3) miles for suburban areas, and ten (10) miles for rural areas.	1%
Retail Direct Reimbursement Claims	100% of retail direct reimbursement claims processed for payment or rejected and responded to within five (5) business days.	1%
Retail Point-of-Sale Claims Adjudication Accuracy	Adjudication accuracy rate of at least 99.5% for all claims processed at point of sale.	1%
Mail Order Turnaround for Prescription Drugs Requiring No Intervention	99% of mail orders for prescription drugs requiring no intervention (i.e., clinical verification, prior authorization, etc.) will be shipped within two (2) business days. (Measured in business days from the date the prescription drug claim is received by the vendor either paper, phone, fax or e-prescribed.)	1%
Mail Order Turnaround for Prescription Drugs Requiring Administrative/Clinical Intervention	100% of mail orders for prescription drugs requiring administrative/clinical intervention will be shipped within five (5) business days.	1%
Mail Order Dispensing Accuracy	99.8% or greater accuracy of mail order prescriptions dispensed with no errors.	1%
Wait Time for Pharmacist/Clinical Support Supervisor	100% of Plan Participant calls that are transferred to a pharmacist or supervisor will be answered within five (5) minutes.	1%
Specialty Pharmacy Dispensing Accuracy	99.8% or greater of specialty pharmacy prescriptions filled with no errors.	1%
Specialty Adherence Rate	Adherence rate for patients using specialty pharmacy of at least 90%. Conditions to be measured include, but are not limited to, Rheumatoid Arthritis, Multiple Sclerosis, Growth Hormones, HIV/AIDS, and Hepatitis C. Conditions will be measured for each condition separately.	2%

Commented [TD24]: This is good for independent's but a very small penalty for not meeting Does this apply to EGWP? Might help with silverscript discussion

Commented [TD25]: How's adherence measured? Just that CVS specialty shipped the med? That's NOT adherence

Average Speed to Answer	100% of calls will be answered by a live voice within twenty (20) seconds. The amount of time that elapses between the time a call is received into a Plan Participant service queue to the time the phone is answered by a Customer Service Representative ("CSR"). Measurement excludes calls routed to Interactive Voice Response ("IVR").	0%
Abandoned Call Rate	2% or less of calls will be abandoned before call is answered by CSR. (Measurement excludes calls abandoned within the first thirty (30) seconds and calls routed to IVR.)	0%
First Call Resolution	98% of all calls will be resolved at first point of contact.	3%
Prior Authorizations	Promptly review and respond to request for prior approval for specific drugs following receipt of all required information, but in any case will respond in no more than two (2) business days.	3%
Plan Participant Written Inquiry Timeliness	97% of all Plan Participant written inquiries will be responded to and resolved within five (5) business days and 100% within ten (10) business days.	3%
Plan Participant Satisfaction Survey	Satisfaction rate must be 85% or greater, using metrics mutually agreed by Contractor and OGB prior to January 1, 2022 and each subsequent contract year.	5%
OGB Satisfaction Survey	Satisfaction rate must be 85% or greater, using metrics mutually agreed by Contractor and OGB prior to January 1, 2022 and each subsequent contract year.	10%
Standard Reporting	Within the specified timeframe, deliver standard financial and clinical reports detailed in the deliverables section.	10%
Benefit Plan Review	Conduct an annual benefit plan review forty–five (45) days prior to effective date of any plan benefit changes, i.e. co-payments, coinsurance, clinical rules, etc.	3%
Plan Participant Identification Card Timeliness	Issue at least 100% of all new Plan Participant identification cards within five (5) business days following receipt of a clean eligibility file.	3%

Reporting Requirements	Provide OGB all reports specified in Attachment I:, Scope of Services within the specified timeframes. Additionally, Contractor must prepare a written summary analysis and orally present results to OGB annually.	5%
On-site Pharmacy Audits	At least 3% of pharmacies with greater than 150 OGB Plan Participant prescriptions will be audited on-site on a quarterly basis.	2%
Point-of-Sale Network System Downtime	System downtime will be 0.5% or less, measured monthly.	1%
Eligibility Processing Accuracy	100% of electronically transmitted eligibility processed accurately within one (1) business day without error.	2%
Reconciliation	Reconciliation of all financial settlements (i.e. performance guarantees, Formulary guarantee true-up, generic guarantees, rebates, etc.) to OGB within one hundred twenty (120) days from the close of each reporting period.	15%
True-up Payments	Payment of all financial settlements (i.e. performance guarantees, Formulary guarantee true-up, generic guarantees, rebates, etc.) to OGB within one hundred twenty (120) days from the close of each reporting period	5%
Independent Assurances	Contractor shall supply OGB with an exact copy of the annual SOC 1, Type II and/or SOC 2, Type II (as agreed by OGB) resulting from the SSAE18 engagement or any other independent assurances approved by OGB for the period of January 1 – December 31 for each calendar year of the contract.	$1,000 per day
Audit Response Time and Reconciliation	Audit response and reconciliation of findings will be provided within 60 days of the close of the audit. If a response is not received and the vendor requires the audit be reopened than the vendor will pay for additional audit fees.	10%

Commented [TD26]: Oh good, something for independents to look forward to

Audit Errors	If a claims or rebate audit results in errors that express more than 1% of drug costs then the vendor will reimburse OGB those costs plus interest, as well as the applicable audit fees.	10%

EGWP

Performance Guarantee	Measurement	Penalty Percent at Risk Annually
Implementation		
Implementation Satisfaction Survey	Provide an implementation satisfaction guarantee that is separate from all other guarantees. The guarantee will be at the sole discretion of OGB, meaning OGB can determine, in good faith, a "yes" or "no" if OGB is satisfied with the implementation, or a percentage of satisfaction.	20%
Pre-Implementation Audit	Complete the pre-implementation audit, including follow up test claims, at least thirty (30) days prior to the established implementation date.	10%
Plan Design Coding	Client standard plan designs will be implemented within mutually agreed upon dates in the implementation project plan.	15%
Plan Design Accuracy	Plan Design will be completed with 100% accuracy by the effective date based on Client signed documents, including changes identified during a pre-implementation audit. Client must sign off on test output to confirm accuracy.	15%
Eligibility Load	Participant eligibility will be loaded by the mutually agreed upon date but no later than 30 days prior to the start date, provided Client has delivered test file with sufficient lead team in accordance with implementation project plan.	10%
ID Cards & CMS Welcome Kit	100% of members will be sent accurate ID cards and other CMS required materials within 10 days of approval from CMS.	10%
Customer Service Number	A dedicated toll-free telephone number for member assistance will be established and fully functioning by the date established in the implementation timeline (before open enrollment begins) and maintained in	10%

	operation during the first part of the plan year	
Implementation Manager Updates	The Implementation Project Manager will provide regular weekly updates to Client , tracking the status of the implementation, including one face-to-face kickoff meeting as well as additional face-to-face meetings, as needed throughout implementation.	2%
Claim Stat Reporting	Claim stat (e.g. paid vs. rejected) reports will be provided to Client every day for the first month of implementation for purposes of identifying trends and errors.	2%
Client Agreement	Draft agreement will be provided to Client at least 60 Days prior to the effective date.	2%
Post-Implementation Review Meeting	Implementation Project Manager will conduct a post- implementation review meeting with Client within (30) days after the effective date.	2%
Resolution of Implementation Issues	Implementation issues will be resolved within five (5) or as otherwise mutually agreed upon business days from identification.	2%
Post Implementation (ongoing)		
Pharmacy Network Disruption	In accordance with CMS requirements.	2%
Retail Direct Reimbursement Claims	100% of retail direct reimbursement claims processed for payment or rejected and responded to within five (5) business days.	1%
Retail Point-of-Sale Claims Adjudication Accuracy	Adjudication accuracy rate of at least 99.5% for all claims processed at point of sale.	1%
Mail Order Turnaround for Prescription Drugs Requiring No Intervention	99% of mail orders for prescription drugs requiring no intervention (i.e., clinical verification, prior authorization, etc.) will be shipped within two (2) business days. (Measured in business days from the date the prescription drug claim is received by the vendor either paper, phone, fax or e-prescribed.)	1%

Commented [TD27]: SHOULD be good for independents but you'd want to verify

Mail Order Turnaround for Prescription Drugs Requiring Administrative/Clinical Intervention	100% of mail orders for prescription drugs requiring administrative/clinical intervention will be shipped within five (5) business days.	1%
Mail Order Dispensing Accuracy	99.8% or greater accuracy of mail order prescriptions dispensed with no errors.	1%
Wait Time for Pharmacist/Clinical Support Supervisor	100% of Plan Participant calls that are transferred to a pharmacist or supervisor will be answered within five (5) minutes.	1%
Specialty Pharmacy Dispensing Accuracy	99.8% or greater of specialty pharmacy prescriptions filled with no errors.	1%
Specialty Adherence Rate	Adherence rate for patients using specialty pharmacy of at least 90%. Conditions to be measured include, but are not limited to, Rheumatoid Arthritis, Multiple Sclerosis, Growth Hormones, HIV/AIDS, and Hepatitis C. Conditions will be measured for each condition separately.	1%
Average Speed to Answer	On average 100% of calls will be answered by a live voice within twenty (20) seconds or less. The amount of time that elapses between the time a call is received into a Plan Participant service queue to the time the phone is answered by a CSR. Measurement excludes calls routed to IVR.	0%
Abandoned Call Rate	2% or less of calls will be abandoned before call is answered by CSR. (Measurement excludes calls abandoned within the first thirty (30) seconds and calls routed to IVR.)	0%
First Call Resolution	98% of all calls will be resolved at first point of contact.	3%
Prior Authorizations	Promptly review and respond to request for prior approval for specific drugs following receipt of all required information, but in any case will respond in no more than two (2) business days.	3%
Plan Participant Written Inquiry Timeliness	97% of all Plan Participant written inquires will be responded to and resolved within five (5) business days and 100% within ten (10) business days.	3%

Plan Participant Satisfaction Survey	Satisfaction rate must be 85% or greater, using metrics mutually agreed upon by Contractor and OGB prior to January 1, 2022.	5%
OGB Satisfaction Survey	Satisfaction rate must be 85% or greater, using metrics mutually agreed upon by Contractor and OGB prior to January 1, 2022.	10%
Standard Reporting	Deliver within the specified timeframe standard financial and clinical reports detailed in the deliverables section.	10%
Plan Participant Identification Card Timeliness	Issue at least 99% of all new Plan Participant identification cards within four (4) business days following receipt of notification of approval from CMS.	3%
Reporting Requirements	Provide OGB all reports specified in Attachment I: Scope of Services within the specified timeframes. Additionally, Contractor must prepare a written summary analysis and orally present results to OGB annually.	9%
On-site Pharmacy Audits	At least 3% of pharmacies with greater than 150 OGB Plan Participant prescriptions will be audited on-site on a quarterly basis.	2%
Point-of-Sale Network System Downtime	System downtime will be 0.5% or less, measured monthly.	0%
Eligibility Processing Accuracy	100% of electronically transmitted eligibility files processed accurately within one (1) business day without error.	2%
Reconciliation	Reconciliation of all financial settlements (i.e. performance guarantees, Formulary guarantee true-up, generic guarantees, rebates, etc.) to OGB within one-hundred and twenty (120) days from the close of each reporting period.	10%
True-up Payments	Payment of all financial settlements (i.e. performance guarantees, Formulary guarantee true-up, generic guarantees, rebates, etc.) to OGB within one-hundred and twenty (120) days from the close of each reporting period.	10%

Independent Assurances	Contractor shall supply OGB with an exact copy of the annual SOC 1, Type II and/or SOC 2, Type II (as agreed by OGB) resulting from the SSAE18 engagement or any other independent assurances approved by OGB for the period of January 1 – December 31.	$1,000 per day
Audit Response Time and Reconciliation	Audit response and reconciliation of findings will be provided within 60 days of the close of the audit. If a response is not received and the vendor requires the audit be reopened than the vendor will pay for additional audit fees.	10%
Audit Errors	If a claims or rebate audit results in errors that express more than 1% of drug costs then the vendor will reimburse OGB those costs plus interest, as well as the applicable audit fees.	10%

Performance Guarantees Total Dollar at Risk	**January 1, 2021 through December 31, 2021**
Commercial Implementation Performance Guarantees: Total dollar at risk for the Implementation Performance Guarantees	$1,757,000 00
Commercial Ongoing Performance Guarantees: Total dollar at risk for the Ongoing (annual) Performance Guarantees	$1,757,000 00
EGWP Implementation Performance Guarantees: Total dollar at risk for the Implementation Performance Guarantees	$1,757,000 00
EGWP Ongoing Performance Guarantees: Total dollar at risk for the Ongoing (annual) Performance Guarantees	$1,757,000 00

ATTACHMENT II: PRICING

COMMERCIAL

Commented [TD28]: Meangingless based on definitions

Retail Network Pricing - Broad	Contract Year 1
Brand Discount: The annual average Brand effective discount guarantee rate.	19.20%
Generic Discount: The annual overall Generic discount guarantee, as defined within this RFP.	85.50%
Dispensing Fee: The overall annual guarantee.	$0.15 per claim
Retail 90 Network Pricing - Broad	**Contract Year 1**
Brand Discount: The annual average Brand effective discount guarantee rate.	23.00%
Generic Discount: The annual overall Generic discount guarantee, as defined within this RFP.	87.75%
Dispensing Fee: The overall annual guarantee.	$0.00 per claim
Mail Pricing	**Contract Year 1**
Brand Discount: The value of "X" in the lower of AWP - X% or MAC.	24.50%
Generic Discount: The annual overall Generic discount guarantee, as defined within this RFP.	88.00%
Dispensing Fee: It is expected this will be zero for all claims.	$0.00 per claim
Specialty and Retail Specialty Pricing	**Contract Year 1**
Minimum discount for all new products in new therapeutic classes	15.00%
Aggregate annual discount guarantee across all specialty drugs (not filled through retail). This will include all specialty products, including bio-generics, biosimilars, limited distribution, etc.	19.50%
Aggregate annual discount guarantee across all specialty drugs filled through retail. This will include all specialty products, including bio-generics, biosimilars, limited distribution, etc.	19.20%
Dispensing fee for specialty claims filled through specialty pharmacy	$0.00 per claim

Commented [TD29]: Not very good since they are blending specialty generics

Dispensing fee for specialty claims filled through retail pharmacy	$0.15 per claim
Minimum Rebate Guarantees (Exclusion Formulary)	**Contract Year 1**
Name of Formulary	CVS Health Standard Control Formulary with Advanced Control Specialty Formulary
Minimum annual rebate guarantee per retail network Brand claim	$195.84 per Brand claim
Minimum annual rebate guarantee per retail 90 network extended supply Brand claim	$565.28 per Brand claim
Minimum annual rebate guarantee per mail Brand claim	$378.43 per Brand claim
Minimum annual rebate guarantee per retail specialty network claim	$2,256.65 per Brand Claim
Minimum annual rebate guarantee per specialty claim	$2,256.65 per Brand Claim
Admin Fee per final net paid claim	**Contract Year 1**
Admin fee per final net paid retail claim	$0.98 per claim
Admin fee per final net paid retail 90 extended supply claim	$0.98 per claim
Admin fee per final net paid mail claim	$0.98 per claim
Admin fee per final net paid specialty pharmacy claim	$0.98 per claim
Admin fee per final net paid retail specialty claim	$0.98 per claim

Commented [TD30]: Should be same as retail 90

Commented [TD31]: About double market, but that's because the specialty discount pricing is so bad

Commented [TD32]: Why the HECK is there an admin fee? This is a traditional spread model?! This is just gravy for CVS

Commented [TD33]: CVS owns specialty and mail AND getting admin fee on each claim

Commercial	Contract Year 1
Monthly Administrative Service Fee	$0.00

EGWP

Retail Network Pricing (Base Retail Network)	Contract Year 1
Brand Discount: The annual average Brand effective discount guarantee rate.	AWP - 20.80% Long Term Care (LTC): AWP - 12.25% Home Infusion (HIF): AWP - 12.80% Indian Health Service, Tribal and Urban (IHS): AWP - 12.80% Territory (TER): AWP - 10.50%
Generic Discount: The annual overall Generic discount guarantee, as defined within this RFP.	AWP - 85.50% Long Term Care (LTC): AWP - 85.50% Home Infusion (HIF): MAC or AWP - 15.38% Indian Health Service, Tribal and Urban

	(IHS): AWP - 15.38% Territory (TER): MAC or AWP - 10.50%
Dispensing Fee: The overall annual guarantee.	Brand & Generic: $0.50 per claim Long Term Care (LTC): Brand: $3.80 per claim Generic: $3.70 per claim Home Infusion (HIF): Brand: $1.50 per claim Generic: $2.00 per claim Indian Health Service, Tribal and Urban (IHS): Brand: $1.95 per claim Generic: $2.65 per claim Territory (TER): $2.20 per claim
Retail 90 Network Pricing - Broad	**Contract Year 1**
Brand Discount: The annual average Brand effective discount guarantee rate.	20.80%
Generic Discount: The annual overall Generic discount guarantee, as defined within this RFP.	87.75%
Dispensing Fee: The overall annual guarantee.	$0.50 per claim
Mail Pricing	**Contract Year 1**
Brand Discount: The value of "X" in the lower of AWP - X% or MAC.	24.50%
Generic Discount: The annual overall Generic discount guarantee, as defined within this RFP.	88.00%
Dispensing Fee: It is expected this will be zero for all claims.	$0.00 per claim
Specialty and Retail Specialty Pricing	**Contract Year 1**
Minimum discount for all new products in new therapeutic classes	15.00%
Aggregate annual discount guarantee across all specialty drugs (not filled through retail). This will include all specialty products, including bio-generics, biosimilars, limited distribution, etc.	19.00%
Aggregate annual discount guarantee across all specialty drugs filled through retail. This will include all specialty products, including bio-generics, biosimilars, limited distribution, etc.	20.80%

Dispensing fee for specialty claims filled through specialty pharmacy	$0.00 per claim
Dispensing fee for specialty claims filled through retail pharmacy	$0.50 per claim
Minimum Rebate Guarantees (Exclusion Formulary w closed wrap)	**Contract Year 1**
Name of Formulary	Platinum Formulary with Closed Wrap
Minimum annual rebate guarantee per retail network Brand claim	$248.74 per Brand claim
Minimum annual rebate guarantee per retail 90 network extended supply Brand claim	$750.44 per Brand claim
Minimum annual rebate guarantee per mail Brand claim	$796.88 per Brand claim
Minimum annual rebate guarantee per retail specialty network claim	$610.79 per Brand claim
Minimum annual rebate guarantee per specialty claim	$610.79 per Brand claim
Admin Fee per final net paid claim	**Contract Year 1**
Admin fee per final net paid retail claim	$0.98 per claim (PBM Admin Fee) + $5.50 PMPM (Self-funded EGWP Admin Fee)
Admin fee per final net paid retail 90 extended supply claim	$0.98 per claim (PBM Admin Fee) + $5.50 PMPM (Self-funded EGWP Admin Fee)
Admin fee per final net paid mail claim	$0.98 per claim (PBM Admin Fee) + $5.50 PMPM (Self-funded EGWP Admin Fee)
Admin fee per final net paid specialty pharmacy claim	$0.98 per claim (PBM Admin Fee) + $5.50 PMPM (Self-funded EGWP Admin Fee)
Admin fee per final net paid retail specialty claim	$0.98 per claim (PBM Admin Fee) + $5.50 PMPM (Self-funded EGWP Admin Fee)

EGWP	**Contract Year 1**
Monthly Administrative Service Fee	$0.00

Clinical Management Fees	**Contract Year 1**
All-inclusive total Clinical Management Fee for Commercial	$0.04 PMPM
All-inclusive total Clinical Management Fee for EGWP	$0.00 PMPM

Commented [TD34]: What's being done for this?

Commercial Therapeutic Prior Authorization Administration (Non-POS Edits)	$30.00 per review
Commercial Appeals Administration	Firsl Level Appeals: $100.00 per request Second Level Appeals: $500.00 per request Urgent Appeals (Combination of 1st and 2nd Level Appeals): $600.00 per request
EGWP Therapeutic Prior Authorization Administration (Non-POS Edits)	No additional cost
EGWP Appeals Administration	No additional cost

Brand Guarantees will apply to and include the following in the reconciliation:	**Response**
Single Source Brands	Included
Multi Source Brands not adjudicated with a DAW-5 code	Included
Exclusive Distribution Drugs	Excluded
Limited Distribution Drugs	Excluded
Glucometer test strips	Included
OTC Brand Drugs - (if covered by Plan)	Included
Generic Guarantees will apply to and include the following in the reconciliation:	**Response**
Single Source Generics	Included
Multi Source Generics (both MAC and non-MAC'd)	Included
Brands adjudicated with a DAW-5 code	Included
Patent Litigated products	Included
Limited Supply Generic Drugs	Included
Biosimilars (Specialty Generics) dispensed at retail pharmacies (not at the PBM specialty pharmacies)	Included
Exclusive Distribution Drugs	Excluded
Limited Distribution Drugs	Excluded
Glucometer test strips	Included
OTC Generics - (if covered by Plan)	Included
Effective rate guarantees shall exclude the following from the guarantee reconciliation:	**Response**
Claims where Vendor negotiated rate was NOT the basis for adjudication (i.e. U&C claims)	Confirmed.
Compound Claims	Confirmed.

Commented [TD35]: Including OTC for guarantees only helps the PBM

Commented [TD36]: Good for PBM, nobody else DAW-5 should be defined somewhere

Commented [TD37]: Shouldn't be in generic bucket

Commented [TD38]: Only benefits pbm

Direct Member Reimbursement/Paper Claims	Confirmed.
Claims with calculated discount of greater than 95% (must be explained to and accepted by Client prior to including)	Confirmed.
Secondary/COB claims (including subrogation)	Confirmed.
In-house or 340b pharmacy	Confirmed.
Vaccines	Confirmed.
Claims through Department of Veterans Affairs (VA) pharmacies	Confirmed.

Rebate Guarantees	Response
Confirm that the following are counted in the baseline for rebates guarantee calculation:	
Single Source Brands	Confirmed.
Multi Source Brands	Confirmed with the exception of DAW 5
Biosimilars	Confirmed.
OTC Brand Drugs (if covered by Plan)	Confirmed.
Provide any exclusions to the rebate guarantees:	CVS Health will exclude the following from rebate guarantees: • 340B Claims; • Compound drug Claims; • Paper or Member submitted Claims; • Coordination of Benefits (COB) or secondary payor Claims; • Vaccine and vaccine administration Claims; As it pertains to wrap claims they will be excluded from minimum guarantees, but 100% of rebates earned will be passed through to the client.
Provide a disclosure of all pharmaceutical manufacturer contract provisions by completing the table below and indicate if each item will be included in the pass-through of rebates to Client. Please provide additional revenue sources if not captured in the table below.	

Commented [TD39]: Define

Formulary/Access rebates	Included
Market Share rebates	Included
Performance/Incentive rebates	Included
Data fees	Included
Manufacturer administration fees	Included
Inflation caps / price protection	Included
Compliance program funding	Excluded
Clinical program support/funding	Excluded
Therapeutic intervention funding	Not applicable - we do not engage in this program
Specialty drug rebates/point of service discounts	Included
Specialty clinical/case management funding	Excluded
Specialty compliance program funding	Excluded
Mail Order volume discounts	Excluded
Other (please describe)	Not applicable

Commented [TD40]: Wonder how much this and compliance program equate to!

ENHANCED/OPTIONAL CLINICAL MANAGEMENT PROGRAMS

COMMERCIAL

Commented [TD41]: All a waste of money

Name of Clinical Management Programs	Description		Proposer' Per Plan Participant Per Month Cost
Transform Diabetes Care	Our Transform Diabetes Care™ program is intended to address the increasing costs and unique clinical needs associated with the growing prevalence of diabetes. This program can help plans control their trend and improve outcomes for their members with diabetes to optimize health care savings:	Will target an aggregate, 1 point decrease in A1C among the uncontrolled (A1C >7%) portion of a client's diabetic population	Quoted upon request.
Drug Savings Review (Enhanced Concurrent and	Retrospective and Concurrent at Mail focus clinical appropriateness and managing drug trend	Client savings can vary depending on drug mix and utilization. A typical	$0.30 PMPM or $0.50 per all Rx

Commented [TD42]: Calculation of Return on Investment should be clear Appears most of these programs are designed to drive utilization at CVS pharmacies

Retrospective DUR)		client can expect savings of 3-5%.	
Condition Alerts Complete	Identifies evidence-based opportunities for improved pharmacy and medical care for more than 100 conditions through ongoing review and analysis of pharmacy and medical claims, and lab values.	Savings are attributed to total health care cost avoidance due to optimizing treatment in accordance with credible clinical guidelines, and will vary due to individual client characteristics	$0.45 PMPM
Condition Alerts Select Commercial	Identifies evidence-based opportunities for improved pharmacy and medical care for the more prevalent & costly conditions through ongoing review and analysis of pharmacy and medical claims, and lab values	Savings are attributed to total health care cost avoidance due to optimizing treatment in accordance with credible clinical guidelines, and will vary due to individual client characteristics	$0.25 PMPM
Condition Alerts Select Medicare	Identifies evidence-based opportunities for improved pharmacy and medical care for the more prevalent & costly conditions through ongoing review and analysis of pharmacy and medical claims, and lab values.	Savings are attributed to total health care cost avoidance due to optimizing treatment in accordance with credible clinical guidelines, and will vary due to individual client characteristics	$0.25 PMPM
Condition Alerts Quality	Identifies evidence-based opportunities for improved pharmacy and medical care for conditions linked to select 2015 HEDIS measures through ongoing review and analysis of pharmacy and	Savings are attributed to total health care cost avoidance due to optimizing treatment in accordance with credible clinical guidelines, and will vary due to individual client characteristics	$0.20 PMPM

	medical claims, and lab values.		
Condition Alerts HIV	Identifies evidence-based opportunities for improved pharmacy and medical care for HIV through ongoing review and analysis of pharmacy and medical claims, and lab values.	Savings are attributed to total health care cost avoidance due to optimizing treatment in accordance with credible clinical guidelines, and will vary due to individual client characteristics	$0.20 PMPM
Pharmacy Advisor Counseling	Provides one-on-one pharmacist counseling, face to face or by phone to improve adherence and close gaps in care for members with targeted conditions.	Client-specific (Medical savings based on PCEM model)	Pricing for Commercial Rate Card: Pharmacy Advisor Counseling at CVS: $0.25 PMPM Pharmacy Advisor Counseling all channels: $0.60 PMPM
Specialty Guideline Management	Utilization management for specialty medications under the pharmacy benefit.	Up to 7% cost avoidance of specialty spend under the pharmacy benefit	$30 per review, No additional cost under an Exclusive Specialty arrangement.
Care Management/ Disease Management	AccordantCare Rare is our nurse care management solution for members across 17 rare conditions. The conditions include the AccordantCare Specialty conditions listed above plus the following nine additional conditions: amyotrophic lateral sclerosis,	The program generates on average an estimated 2.5:1 ROI after program fees are considered each year. CVS Health guarantees a client's fees paid into the program via 20% Fees at Risk for ROI % 10%	$132 Per Engaged Member Per Month

	chronic inflammatory demyelinating polyradiculoneuropathy, dermatomyositis, epilepsy, myasthenia gravis, Parkinson's disease, polymyositis, scleroderma and sickle cell disease. For CVS/specialty patients, a care management nurse is embedded into the Specialty CareTeams	Fees at Risk for Clinical/Operational Metrics.	

EGWP

Name of Clinical Management Programs	Description	Description of the Cost Savings	Proposer' Per Plan Participant Per Month Cost
Condition Alerts Complete	Identifies evidence-based opportunities for improved pharmacy and medical care for more than 100 conditions through ongoing review and analysis of pharmacy and medical claims, and lab values.	Savings are attributed to total health care cost avoidance due to optimizing treatment in accordance with credible clinical guidelines, and will vary due to individual client characteristics	$0.45 PMPM
Condition Alerts Select Medicare	Identifies evidence-based opportunities for improved pharmacy and medical care for the more prevalent & costly conditions through ongoing review and analysis of pharmacy and medical claims, and lab values.	Savings are attributed to total health care cost avoidance due to optimizing treatment in accordance with credible clinical guidelines, and will vary due to individual client characteristics	$0.25 PMPM
Condition Alerts Quality	Identifies evidence-based opportunities for improved pharmacy and medical	Savings are attributed to total health care cost avoidance due to	$0.20 PMPM

	care for conditions linked to select 2015 HEDIS measures through ongoing review and analysis of pharmacy and medical claims, and lab values.	optimizing treatment in accordance with credible clinical guidelines, and will vary due to individual client characteristics	
Condition Alerts HIV	Identifies evidence-based opportunities for improved pharmacy and medical care for HIV through ongoing review and analysis of pharmacy and medical claims, and lab values.	Savings are attributed to total health care cost avoidance due to optimizing treatment in accordance with credible clinical guidelines, and will vary due to individual client characteristics	$0.20 PMPM
Transform Diabetes Care	Our Transform Diabetes Care™ program is intended to address the increasing costs and unique clinical needs associated with the growing prevalence of diabetes. This program provides comprehensive and personalized diabetes care management.	2:1 guaranteed ROI based on medical claims data	$0.63 PMPM (price subject to change for clients with a diabetes prevalence greater than 15% of the total population)
Care Management/ Disease Management	AccordantCare Rare is our nurse care management solution for members across the following rare conditions: multiple sclerosis, rheumatoid arthritis, Crohn's disease, ulcerative colitis, hemophilia, cystic fibrosis, systemic lupus erythematosus, Gaucher disease, amyotrophic lateral	The program generates on average an estimated 2.5:1 ROI after program fees are considered each year. CVS Health guarantees a client's fees paid into the program via 20% Fees at Risk for ROI & 10% Fees at Risk for	$132 Per Engaged Member Per Month (15,000 lives minimum)

	sclerosis, chronic inflammatory demyelinating polyradiculoneuropathy, dermatomyositis, epilepsy, myasthenia gravis, Parkinson's disease, polymyositis, scleroderma and sickle cell disease. For CVS/specialty patients, a care management nurse is embedded into the Specialty CareTeams.	Clinical/Operational Metrics.	
Pharmacy Advisor Counseling			$2.00 PMPM

ADMINISTRATION FEE SCHEDULE FOR SELF-FUNDED INDIRECT WAIVER PDP

Administration Fee Schedule for Self-Funded Indirect Waiver PDP			
	Services	**Pricing Metric**	**Price**
	Fee for Self-Funded EGWP Services 1-8	**PMPM**	**$5.50**
1	**Core Administrative Service Package:** Includes: • Implementation and maintenance of Medicare specified benefit set-up parameters (e.g. TrOOP) • Incremental programming and associated maintenance/management requirements relating to unique Medicare electronic claims adjudication (Accumulations Management, Vaccine processing, Automated TrOOP Transfer, etc.) • Varied claims adjustment activities inherent in Medicare Part D program (retro LICS, eligibility, COB, etc) • Prescription Drug Event file submission and response file administration (reject resolution and resubmission) • Pre-Enrollment contact center support • Application processing and eligibility management services • Standard PDP Pre-Enrollment website **Required Clinical Programs** Includes: • POS Safety Edits • Retrospective DUR • Core Retrospective Safety Review • Core Safety and Monitoring • Enhanced Safety and Monitoring • Medication Therapy Management Program • High Risk Medication (Medicare Part D) **Standard SilverScript EGWP Clinical Programs** Includes: • Pharmacy Advisor Support – Gaps in Care – Adherence to Drug Therapy – ReadyFill at Mail (may opt-out) • Drug Savings Review (Retrospective only) • Diabetic Meter (may opt-out)		
2	**Explanation of Benefits** • Includes 1 monthly statement produced and mailed to each utilizing beneficiary, and a final statement for any beneficiary whose enrollment is terminated, as per CMS requirements		
3	**Standard PDP Pre-Enrollment Materials** • Includes: Summary benefit packet, cover letter and group enrollment, all based on private labeled version of SSI Std templates w/variable fields for plan design and other specified client specific information		

4	**PDP Post-enrollment Materials:** • Includes: production and distribution of Standard enrollment materials; including a welcome kit for the initial plan year comprised of acknowledgement letter, EOC, abridged formulary, pharmacy listing, ID card, as well as other correspondence associated as needed with the receipt and processing of enrollment. Also includes ANOC for all subsequent years for existing beneficiaries, beginning year 2.		
5	**Replacement ID Cards and Pharmacy Directories:** • ID cards direct shipped to beneficiary		
6	**Transition Rx Communication Services to Beneficiaries** • Individualized letters mailed direct to each beneficiary for transition fills, as required by CMS		
7	**Medicare Post-enrollment Calls** • Incremental Medicare D service requirements associated with Post Enrollment Customer Care Calls (increased call volume and handle time)		
8	**Other Programs:** • Prior Authorizations (includes clinical Prior Authoriza ion and B vs. D coverage determinations) • Grievances: (all non-drug related grievance) – includes non-escalated (resolved in call center) and escalated (resolved in Service Recovery Center) • Coverage Determinations including formulary exceptions, tiering exceptions and non-Med D coverage issues (first level appeals) • Re-determination of coverage (second level appeals) – Medical: Requires physician intervention for re-determination – Administrative re-determination (does not require physician intervention).		
Optional Services			
9	**Paper Applications Processing** • Receipt and handling of paper enrollment applications	per application	$10 00
11	**Low Income Premium Subsidy (LIPS) Refund Checks** • LIPS refund checks sent directly to members	Per refund check	$3.50

ATTACHMENT III: BUSINESS ASSOCIATE ADDENDUM

State of Louisiana, Office of Group Benefits

HIPAA Business Associate Addendum

THIS HIPAA BUSINESS ASSOCIATE ADDENDUM (the "Addendum") is entered into effective the _____ day of August, 2020 (the "Effective Date"), by and between CaremarkPCS Health, L.L.C. ("CVS Caremark"), a wholly owned direct subsidiary of CaremarkPCS, L.L.C., a subsidiary of Caremark Rx, L.L.C., whose parent company is CVS Health Corporation ("Business Associate") and the State of Louisiana, Office of Group Benefits, on behalf of itself and its affiliates, if any (individually and collectively, the "Covered Entity"), and adds to the Agreement or Emergency Contract dated _____, 2020, entered into between Covered Entity and Business Associate (the "Agreement").

WHEREAS, pursuant to the Agreement, Business Associate performs functions or activities or arranges for such on behalf of Covered Entity involving the use and/or disclosure of protected health information that Business Associate accesses, creates, receives, maintains or transmits on behalf of Covered Entity ("PHI"); and

WHEREAS, Covered Entity and Business Associate intend to protect the privacy and provide for the security of PHI in compliance with the Health Insurance Portability and Accountability Act of 1996, and regulations promulgated thereunder by the U.S. Department of Health and Human Services ("HHS"), as amended from time to time including by the Health Information Technology for Economic and Clinical Health Act ("HITECH") (collectively "HIPAA").

Business Associate, therefore, agrees to the following terms and conditions set forth in this Addendum.

1. *Definitions*. Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms are defined under HIPAA.

2. *Compliance with Applicable Law*. The parties acknowledge and agree that, beginning with the Effective Date, Business Associate shall comply with its obligations under this Addendum and with all obligations of a business associate under HIPAA and other applicable laws, regulations, and record retention policies, as they exist at the time this Addendum is executed and as they are amended, for so long as this Addendum is effective.

3. *Uses and Disclosures of PHI*. Except as otherwise limited in the Agreement or this Addendum, Business Associate may, and shall ensure that its directors, officers, employees, contractors, subcontractors, vendors, and agents use or disclose PHI only as follows:

(a) Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

(b) Business Associate may disclose PHI for the proper management and administration, or to carry out the legal responsibilities, of the Business Associate, provided that disclosures are required by HIPAA, or Business Associate obtains reasonable written assurances from the person or entity to whom the PHI is disclosed that it will remain confidential and be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person or entity, and the person or entity notifies the Business Associate of any instances of which it is aware or suspects in which the confidentiality of the PHI has been breached. In such case, Business Associate shall report such known or suspected breaches to Covered Entity as soon as possible and in accordance with timeframes set forth in this Addendum.

(c) Business Associate, upon written request by Covered Entity, may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 CFR 164.504(e)(2)(i)(B). For purposes of this Section, Data Aggregation means, with respect to PHI, the combining of such PHI by Business Associate with the PHI received by Business Associate in its capacity as a Business Associate of another Covered Entity to permit data analyses that relate to the health care operations of the respective Covered Entities. It is not contemplated that Business Associate will perform Data Aggregation services with PHI received from Covered Entity without express prior written permission of Covered Entity.

(d) Business Associate may completely de-identify any and all PHI created or received by Business Associate under this Agreement; provided, however, that the de-identification conforms to the requirements of HIPAA and in accordance with any guidance issued by the Secretary. Such resulting de-identified information would not be subject to the terms of this Addendum.

(e) Business Associate may create a Limited Data Set, as defined in HIPAA, and use such Limited Data Set pursuant to a Data Use Agreement that meets the requirements of HIPAA, provided Covered Entity agrees to such creation and use of a Limited Data Set.

(f) Business Associate may use and disclose PHI to respond to requests for PHI either accompanied by an authorization that meets the requirements of 45 CFR 164.508 or from a covered entity or health care provider in accordance with 45 CFR 164.506(c); or to report violations of law to federal and state agencies consistent with 45 CFR 164.502(i)(1).

4. *Required Safeguards To Protect PHI*. Business Associate shall implement appropriate safeguards in accordance with HIPAA to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of the Agreement. To the extent that Business Associate creates, receives, maintains, or transmits electronic PHI ("ePHI") on behalf of Covered Entity, Business Associate shall comply with the HIPAA Security Rule as of the relevant effective date and further, shall implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI.

5. *Reporting to Covered Entity*. Business Associate shall report to Covered Entity any use or disclosure of PHI not provided for by this Addendum. Business Associate shall immediately report to Covered Entity breaches of unsecured PHI in accordance with the Breach Notification Rule (45 CFR Subpart D). Business Associate shall also report any security incident resulting in an actual or suspected breach of Business Associate's information security system of which it becomes aware. Business Associate shall cooperate with Covered Entity's investigation, analysis, notification and mitigation activities, and shall be responsible for all costs incurred by Covered Entity for those activities. In addition to the reporting required by this section, Business Associate agrees to report to Covered Entity upon request any use or disclosure of PHI not provided for by this Addendum of which Covered Entity becomes aware.

6. *Mitigation of Harmful Effects*. Business Associate agrees to mitigate, to the extent practicable, any harmful effect of a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum, including, but not limited to, compliance with any state law or contractual data breach requirements.

7. *Agreements with Third Parties*. Business Associate understands and agrees that any agent or subcontractor that may create, receive, maintain or transmit PHI on behalf of Business Associate must comply with all applicable laws and regulations as are applicable to Covered Entity in regard to PHI. Business Associate shall enter into a written agreement with any agent or subcontractor of Business Associate that will create, receive, maintain, or transmit PHI on behalf of Business Associate. Pursuant to such agreement, the agent or subcontractor shall agree to be bound by the same restrictions, terms, and conditions that apply to Business Associate under this Addendum with respect to such PHI. Such agreements with Business Associates agents and subcontractors shall be provided to Covered Entity upon request and subject to audit hereunder.

8. *Access to Information*. Within ten (10) days of a request by Covered Entity for access to PHI about an individual contained in a Designated Record Set, Business Associate shall make available to Covered Entity such PHI for so long as such information is maintained by Business Associate in the Designated Record Set, as required by 45 CFR 164.524. In the event any individual delivers directly to Business Associate a request for access to PHI, Business Associate shall within five (5) days forward such request to Covered Entity.

9. *Availability of PHI for Amendment*. Within ten (10) days of receipt of a request from Covered Entity for the amendment of an individual's PHI or a record regarding an individual contained in a Designated Record Set (for so long as the PHI is maintained in the Designated Record Set), Business Associate shall provide such information to Covered Entity for amendment and incorporate any such amendments in the PHI as required by 45 CFR 164.526.

10. *Documentation of Disclosures*. Business Associate agrees to document disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528. At a minimum, Business Associate shall provide Covered Entity with the following information: (i) the date of the disclosure; (ii) the name of the entity or person who received the PHI, and if known, the address of such entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure.

11. *Accounting of Disclosures*. Within ten (10) days of notice by Covered Entity to Business Associate that it has received a request for an accounting of disclosures of PHI regarding an individual, Business Associate shall make available to Covered Entity information collected in accordance with Section 10 of this Addendum, to permit Covered Entity to respond to the request for an accounting of disclosures of PHI in accordance with 45 CFR 164.528. In the event the request for an accounting is delivered directly to Business Associate, Business Associate shall within five (5) days forward such request to Covered Entity. Business Associate hereby agrees to implement an appropriate record keeping process to enable it to comply with the requirements of this Section.

12. *Other Obligations*. To the extent that Business Associate is to carry out Covered Entity's obligation under HIPAA, Business Associate shall comply with the requirements of HIPAA that apply to the Covered Entity in the performance of such obligation.

13. *Availability of Books and Records*. Business Associate hereby agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to Covered Entity and to

the Secretary for purposes of determining Covered Entity's compliance with HIPAA for the term of this Agreement and for six years following the final payment under the Agreement.

14. *Effect of Termination of Agreement*. Upon the termination of the Agreement or this Addendum for any reason, Business Associate shall return to Covered Entity, at its expense and within sixty (60) days of the termination, all PHI owned by or belonging to Covered Entity as provided in the Agreement, and shall retain no copies of the PHI unless required by law. In the event that the law requires Business Associate to retain copies of PHI, Business Associate shall extend the protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes required by law, for so long as Business Associate maintains such PHI. This provision includes, but is not limited to, PHI: (a) received from Covered Entity; (b) created or received by Business Associate on behalf of Covered Entity; and, (c) in the possession of subcontractors or agents of Business Associate. This provision includes PHI in any form, recorded on any medium, or stored in any storage system. In addition, the Business Associate shall return any books, records, or other documents required by the Agreement.

15. *Breach of Contract by Business Associate*. In addition to any other rights Covered Entity may have in the Agreement, this Addendum or by operation of law or in equity, Covered Entity may (i) immediately terminate the Agreement if Covered Entity determines that Business Associate has violated a material term of this Addendum, or (ii) at Covered Entity's option, permit Business Associate to cure or end any such violation within the time specified by Covered Entity. Covered Entity's exercise of its option to permit Business Associate to cure a breach of this Addendum shall not be construed as a waiver of any other rights Covered Entity has in the Agreement, this Addendum or by operation of law or in equity.

16. *Indemnification*. Business Associate shall defend, indemnify and hold harmless Covered Entity and its officers, trustees, employees, subcontractors and agents from and against any and all claims, penalties, fines, costs, liabilities or damages, including but not limited to reasonable attorney fees, incurred by Covered Entity arising from a violation by Business Associate or its subcontractors of Business Associate's obligations under this Addendum or HIPAA. This Section 16 of the Addendum shall survive the termination of the Agreement or this Addendum.

17. *Exclusion from Limitation of Liability*. To the extent that Business Associate has limited its liability under the terms of the Agreement, whether with a maximum recovery for direct damages or a disclaimer against any consequential, indirect or punitive damages, or other such limitations, all limitations shall exclude any damages to Covered Entity arising from Business Associate's breach of its obligations relating to the use and disclosure of PHI. This Section 17 of the Addendum shall survive the termination of the Agreement and this Addendum.

18. *Injunctive Relief*. Business Associate acknowledges and stipulates that the unauthorized use or disclosure of PHI by Business Associate or its subcontractors while performing services pursuant to the Agreement or this Addendum would cause irreparable harm to Covered Entity, and in such event, Covered Entity shall be entitled, if it so elects, to institute and prosecute proceedings in any court of competent jurisdiction, either in law or in equity, to obtain damages and injunctive relief, together with the right to recover from Business Associate costs, including reasonable attorneys' fees, for any such breach of the terms and conditions of the Agreement or this Addendum.

19. *Third Party Rights*. The terms of this Addendum are not intended, nor should they be construed, to grant any rights to any parties other than Business Associate and Covered Entity.

20. *Owner of PHI*. Under no circumstances shall Business Associate be deemed in any respect to be the owner of any PHI used or disclosed by or to Business Associate pursuant to the terms of the Agreement.

21. *Changes in the Law*. Covered Entity may amend either the Agreement or this Addendum, as appropriate, to conform to any new or revised federal or state legislation, rules, regulations, and records retention policies to which Covered Entity is subject now or in the future including but not limited to HIPAA.

22. *Judicial and Administrative Proceedings*. In the event Business Associate receives a subpoena, court, or administrative order, or other discovery request or mandate for release of PHI associated with this contract, other than a standard medical records request/medical records subpoena, Business Associate shall notify Covered Entity of such within five (5) business days by providing a copy of such and any applicable comments. Covered Entity shall have the right to control Business Associate's response to such request.

23. *Conflicts*. If there is any direct conflict between the Agreement and this Addendum, the terms and conditions of this Addendum shall control.

IN WITNESS WHEREOF, the parties have executed this Addendum effective the day and year first above written.

STATE OF LOUISIANA **OFFICE OF GROUP BENEFITS**	**CAREMARKPCS HEALTH, L.L.C.**
By: _____ *Signature*	By: _____ *Signature*
Tommy Teague *Printed Name*	_____ *Printed Name*
Title: Chief Executive Officer	Title: _____
Date: _____	Date: _____

ATTACHMENT IV: RECORDS RETENTION SCHEDULE

Records Retention Schedule

SS ARC 932 (10/19)

Louisiana Secretary of State
Division of Archives, Records Management and History
Post Office Box 94125, Baton Rouge, LA 70804
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Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Executive

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Internal Audit Records/Reports	ACT + 2 FY	3 FY	ACT + 5 CY	M	S	Y	V	ACT = until the end of the FY in which the audit report is issued. ^^
2	LLA Audit Records/Reports	ACT + 2 FY	3 FY	ACT + 5 CY	M	S	Y	V	ACT = until the end of the FY in which the audit report is issued. ^^
3	Group Benefits Policy and Planning Board Meeting Presentations	ACT + 10 CY	0	ACT + 10 CY	P	S	N	I	ACT = until the end of the CY in which the presentations were created. ^^
4	Group Benefits Policy & Planning Board Reports	ACT + 10 CY	0	ACT + 10 CY	M	S	N	V	ACT= Until end of CY in which OGB ceases to exist. **
5	Group Benefits Policy & Planning Board Meeting Minutes	PERM	0	PERM	M	R	N	V	
6	Group Benefits Estimating Conference Meeting Presentations	ACT + 10 CY	0	ACT + 10 CY	P	S	N	I	ACT = until the end of the CY in which the presentations were created. ^^
7	Group Benefits Estimating Conference Meeting Minutes	PERM	0	PERM	M	R	N	V	
8	OGB 5-year Strategic Plan	ACT + 5 FY	0	ACT + 5FY	P	S	N	V	ACT = until the end of the FY in which the Strategic plan was drafted. ^^
9	OGB HIPAA Compliance Records	ACT + 6 CY	0	ACT + 6 CY	M	S	N	V	ACT = until the end of the CY in which the records were created or received. ^^

Permitted Retention Period Abbreviations
ACT – Active Period (when used define term in remarks column)
FY- Fiscal Year (July 1- June 30)
CY – Calendar Year (Jan 1 – Dec 31)
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FFY – Federal Fiscal Year (Oct 1 - Sept 30)
MO – Months WK – Week (Mon-Sun) DY - Day(s)
PERM – Permanent
** = May be part of an Imaging/Electronic Exception.
^^ = May be part of an Imaging/Electronic Survey.

Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
D- Review by State Archives/Electronic
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
LLA = Louisiana Legislative Auditor
OGB = Office of Group Benefits
HIPAA = Health Insurance Portability and Accessibility Act

Tommy Teague
Agency Approval

1-7-2020
Date Signed

Susan E. Hipple, CRM
Secretary of State, State Archives & Records Services

1-8-2020
Date Approved

Records Retention Schedule

SS ARC 932 (10/19)

Louisiana Secretary of State
Division of Archives, Records Management and History
Post Office Box 94125, Baton Rouge, LA 70804
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Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Administration – Finance

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	OGB Budget Request Documents/Records	ACT + 5 FY	0	ACT + 5 FY	P	R	N	V	ACT = until the end of the FY in which created^^
2	Actuarial Revenue/Expenditure Line-item Projections	ACT + 5 FY	0	ACT + 5 FY	M	S	N	V	ACT = until the end of the FY in which received^^
3	Actuarial Premium Rate Schedules	ACT + 5 CY	0	ACT + 5 CY	P	S	N	V	ACT = until the end of the FY in which received^^
4	Official Premium Rate Schedules	ACT + 10 CY	0	ACT+ 10 CY	P	S	N	V	ACT= until end of the CY in which the OGB ceases to exist**
5	Monthly OTS Invoices & Supporting Documents	ACT + 1 FY	3 FY	ACT + 4 FY	M	S	Y	V	ACT = until the end of the FY in which the document was received^^
6	Annual IAT Agreements & Supporting Documents	ACT + 1 FY	3 FY	ACT + 4 FY	M	S	Y	V	ACT = until the end of the FY in which the document was received^^
7	Miscellaneous/One-time Invoices & Supporting Documents	ACT + 1 FY	3 FY	ACT + 4 FY	M	S	Y	V	ACT = until the end of the FY in which the document was received^^
8	OGB Fiscal Note Worksheets & Supporting Documents	ACT + 5 CY	0	ACT + 5 CY	M	S	N	V	ACT = until the end of the CY in which the document was created^^
9	DOA Analysis Sheets & Supporting Documents	ACT + 5 CY	0	ACT + 5 CY	M	S	N	V	ACT = until the end of the CY in which the document was created^^
10	Fuel Invoices & Supporting Documents	ACT + 1 FY	3 FY	ACT + 4 FY	M	S	Y	V	ACT = until the end of the FY in which the document was received^^

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Security Status Codes
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M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
D- Review by State Archives/Electronic
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N – No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB – Office of Group Benefits
OTS – Office of Technology Services
IAT- Inter Agency Transfers
DOA – Division of Administration

[redacted] 1-7-2020
Agency Approval* Date Signed

[redacted] 1-8-2020
Secretary of State, State Archives & Records Services Date Approved

Records Retention Schedule

SS ARC 932 (10/19)

Louisiana Secretary of State
Division of Archives, Records Management and History
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Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Administration -- Communications

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Annual Enrollment Member Guides	ACT + 10 CY	0	ACT + 10 CY	P	D	N	I	ACT = until the end of the CY in which OGB ceases to exist**
2	Annual Enrollment Member Presentations	ACT + 10 CY	0	ACT + 10 CY	P	S	N	I	ACT = until the end of the CY in which the presentations were created^^
4	Annual Enrollment HR Presentations	ACT + 10 CY	0	ACT + 10 CY	P	S	N	I	ACT = until the end of the CY in which the presentations were created**
5	Agency/Member Memos on OGB Policies/Procedures Changes	ACT + 10 CY	0	ACT + 10 CY	P	D	N	V	ACT = until the end of the CY in OGB ceases to exist**
6	Medicare Part D Creditable Coverage Notices	ACT + 6 CY	0	ACT + 6 CY	M	S	N	V	ACT = until the end of the CY in which the notices were created^^
7	Publications	ACT + 10 CY		ACT + 10 CY	M	S	N	I	ACT = until end of CY in which OGB ceases to exist**

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O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
HR – Human Resources
OGB – Office of Group Benefits

[redacted] 1-7-2020
Agency Approval — Date Signed

[redacted] 1-8-2020
Secretary of State, State Archives & Records Services — Date Approved

Records Retention Schedule

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Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Administration – General

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	OGB Employee Driver Authorization Forms	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	V	ACT = until the end of the FY in which the employee separates from agency**
2	OGB Employee Safety Meetings Training Materials & Sign-in Sheets	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	V	ACT = until the end of the FY in which the documents were created or received**
3	OGB Employee PES Evaluations and Planning Session Documents	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	V	ACT = until the end of the FY in which supervision ends**
4	OGB Employee Time & Attendance Reports	ACT + 2 CY	3 CY	ACT + 5 CY	M	S	Y	V	ACT = until the end of the CY in which the reports were created or received^^
5	Vehicle Logs & Supporting Documents	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	V	ACT = until the end of the FY in which the documents were created or received^^
6	SOF & Supporting Documents	ACT + 2 FY	1 FY	ACT + 3 FY	M	S	Y	V	ACT = until the end of the FY in which the documents were created or received^^
7	OGB Visitor Logs/Sign-in Sheets	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	U	ACT = until the end of the FY in which the logs were created^^
8	Daily Documents/Mail Assignments Logs	ACT + 2 FY	3 FY	ACT + 5 FY	M	S	Y	U	ACT = until the end of the FY in which the logs were created^^
9	Records Management Files (Retention Schedules, disposal requests, Transmittals, Surveys and Exceptions)	ACT + 10 CY		ACT + 10 CY	M	S	N	V	ACT = until end of CY in which OGB ceases to exist. **

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State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
SOF –Special order Form
OGB= Office of Group Benefits
PES = Personnel Evaluation System

[redacted] 1-7-2020
Agency Approval — Date Signed

[redacted] 1-8-2020
Secretary of State, State Archives & Records Services — Date Approved

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Louisiana Secretary of State
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Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Contracts Management

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	OGB Contracts, Contract Amendments, & Supporting Documents	ACT + 3 CY	7 CY	ACT + 10 CY	M	S	Y	V	ACT = Until the end of the CY in which the contract expires or is terminated**
2	OGB Contract Solicitations (RFP, ITB, RFI) & Supporting Documents	ACT + 3 CY	0	ACT + 3 CY	M	S	Y	V	ACT = Until the end of the CY in which the solicitations deadline ends^^

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N - No

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U= Useful

Agency Abbreviations
OGB= Office of Group Benefits
RFP = Request for Proposal
ITB = Intent to Bid
RFI = Request for Information

[redacted] 1-7-2020
Agency Approval — Date Signed

[redacted] 1-8-2020
Secretary of State, State Archives & Records Services — Date Approved

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Louisiana Secretary of State
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Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Agency Services

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	OGB Member Participation Schedules	ACT + 10 CY	0	ACT + 10 CY	C	S	N	V	ACT= Until end of CY in which OGB ceases to exist**
2	OGB Member Collections Notices & Supporting Documents	ACT + 10 CY	0	ACT + 10 CY	C	S	N	V	ACT= Until end of CY in which OGB ceases to exist**
3	OGB Member Appeals & Supporting Documents	ACT + 10 CY	0	ACT + 10 CY	C	S	N	V	ACT= Until end of CY in which OGB ceases to exist**
4	OGB-participating Agency Administrative Error Appeals & Supporting Documents	ACT + 10 CY	0	ACT + 10 CY	C	S	N	V	ACT= Until end of CY in which OGB ceases to exist**

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O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

[redacted] 1-7-2020
Agency Approval — Date Signed

[redacted] 1-8-2020
Secretary of State, State Archives & Records Services — Date Approved

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Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Customer Service

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Enrollment Change Forms & Supporting Eligibility Documents (GB-01)	ACT + 10 CY		ACT + 10 CY	C	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **
2	Designation Forms (OBG Coordinator, Agency Master User, Invoice Contact) (GB-74, GB-75, GB-78)	ACT + 10 CY		ACT + 10 CY	M	S	N	I	ACT = until the end of the CY in which OGB ceases to exist. **
3	OGB Member Correspondence	ACT + 10 CY		ACT + 10 CY	C	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **
4	Daily Work Papers (includes printed copies of imaged documents and non-essential notes with PHI or OGB member contact info, produced by OGB Customer Service section staff)	ACT	0	ACT	M	S	N	U	ACT = until the end of the day in which the work papers were created ^^

Permitted Retention Period Abbreviations
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FFY – Federal Fiscal Year (Oct 1 – Sept 30)
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PERM – Permanent
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Security Status Codes
P – Public Record
M – May Contain Confidential Information
C – Confidential Information

Archival Processing Codes
A – Transfer to State Archives
R – Retain in Agency Archives
S – Review by State Archives
D- Review by State Archives/Electronic
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB= Office of Group Benefits
PHI = Personal Health Information

[redacted] 1-7-2020
Agency Approval — Date Signed

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Secretary of State, State Archives & Records Services — Date Approved

Records Retention Schedule

SS ARC 932 (10/19)

Louisiana Secretary of State
Division of Archives, Records Management and History
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Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Medical and Pharmacy Benefits Administration – Health Insurance

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Self-funded Health Plan Medical TPA Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received ^^
2	Self-funded Health Plan Pharmacy TPA Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received ^^
3	Fully Insured Health Plan Vendors Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received ^^
4	Capitated Primary Care Network Vendor Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received ^^
5	IMMEHRA Vendor Invoices and Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received ^^
6	Health Plan Vendors Reports & Contract Deliverables	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	U	ACT = until the end of the CY in which the report or deliverable was received ^^
7	Health Savings Account Enrollment & Payroll Deduction Election/Changes (GB-79 Forms)	ACT + 10 CY		ACT + 10 CY	C	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **
8	TPA Health and Pharmacy Claims (including supplemental Claims)	ACT + 10 CY		ACT + 10CY	C	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **

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C – Confidential Information

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R – Retain in Agency Archives
S – Review by State Archives
D- Review by State Archives/Electronic
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V– Vital
I = Important
U= Useful

Agency Abbreviations
TPA = Third party administrator
IMMEHRA = Individual Medicare Market Exchange with Health Reimbursement Arrangements
OGB = Office of Group Benefits

[redacted] 12-2020
Agency Approval — Date Signed

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Secretary of State, State Archives & Records Services — Date Approved

Records Retention Schedule

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Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Medical and Pharmacy Benefits Administration – Life Insurance

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Fully Insured Basic and Supplemental Life Insurance Vendor Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	U	ACT = until the end of the CY in which the document was received ^^
2	Fully Insured Basic and Supplemental Life Insurance Vendor Reports & Contract Deliverables	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	U	ACT = until the end of the CY in which the report or deliverable was received ^^
3	Fully Insured Basic and Supplemental Life Insurance Member Beneficiary Designation/Change Forms	ACT+ 10 CY	0	ACT + 10 CY	C	S	N	V	ACT= Until end of the CY in which OGB ceases to exist **

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C – Confidential Information

Archival Processing Codes
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R – Retain in Agency Archives
S – Review by State Archives
D- Review by State Archives/Electronic
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

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Agency Approval — Date Signed

[redacted] 1-8-2020
Secretary of State, State Archives & Records Services — Date Approved

Records Retention Schedule

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Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Medical and Pharmacy Benefits Administration – Flexible Benefits & COBRA

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	FSA & COBRA TPA Vendor Invoices & Supporting Documents	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the document was received ^^
2	FSA & COBRA TPA Vendor Reports & Contract Deliverables	ACT + 1 CY	3 CY	ACT + 4 CY	M	S	Y	V	ACT = until the end of the CY in which the report or deliverable was received ^^
3	Flexible Spending Arrangement Enrollment/Stop Form (GB-2)	ACT+ 10 CY	0	ACT + 10 CY	M	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **

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Archival Processing Codes
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R – Retain in Agency Archives
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D- Review by State Archives/Electronic
O – Other (Specify in Remarks)

State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
V= Vital
I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

[redacted] 1-7-2020
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Records Retention Schedule

SS ARC 932 (10/19)

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Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits ; Discontinued Programs

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
1	Filing Deadline Mail Records	ACT + 3 CY		ACT + 3 CY	M	S	N	I	ACT = until the end of the CY in which the document was created or received ^^
2	Live and Event Claims Records	ACT + 10 CY		ACT + 10CY	C	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **
3	Field and Audit Reports	ACT + 5 CY		ACT + 5 CY	M	S	N	I	ACT = until the end of the CY in which Report was issued. ^^
4	Health Claims (including supplemental Claims)	ACT + 10 CY		ACT + 10CY	C	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **
5	Explanation of Benefits (EOBs)	ACT + 10 CY		ACT + 10CY	C	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **
6	Medical Records	ACT + 10 CY		ACT + 10CY	C	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **
7	Pre-determinations	ACT + 10 CY		ACT + 10CY	C	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **
8	Case Management	ACT + 10 CY		ACT + 10CY	C	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **
9	Medical Necessities	ACT + 10 CY		ACT + 10CY	C	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **

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Archival Processing Codes
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D- Review by State Archives/Electronic
O – Other (Specify in Remarks)

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N - No

Vital Record Identification Code
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I = Important
U= Useful

Agency Abbreviations
OGB = Office of Group Benefits

[redacted] 1-7-2020
Agency Approval — Date Signed

[redacted] 1-8-2020
Secretary of State, State Archives & Records Services — Date Approved

Records Retention Schedule

SS ARC 932 (10/19)

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Division of Archives, Records Management and History
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Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Discontinued Programs

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
10	Paid In Vouchers	ACT + 10 CY		ACT + 10CY	C	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **
11	Flexible Benefit Master File	ACT + 10 CY		ACT + 10CY	C	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **
12	Hospital Audits, Statistical Reports and Work Papers	ACT + 5 CY		ACT+ 5 CY	M	S	N	I	ACT = until the end of the CY in which Report was issued. ^^
13	Fraud and Abuse Case Files and Logs	ACT + 10 CY		ACT + 10CY	C	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **
14	Health Claim Audits and work papers (including over $500 plan Member check Audits)	ACT + 5 CY		ACT + 5CY	C	S	N	I	ACT = until the end of the CY in Audit is completed. ^^
15	Special Reports (Outlier, Check Cycle)	ACT + 10 CY		ACT + 10CY	M	S	N	I	ACT = until the end of the CY in which report is run. ^^
16	Reviews (Medical and Chiropractic)	ACT + 10 CY		ACT + 10CY	C	S	N	I	ACT = until the end of the CY in which OGB ceases to exist. **
17	Case Management	ACT + 10 CY		ACT + 10CY	C	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **
18	Medical Necessities	ACT + 10 CY		ACT + 10CY	C	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **

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Agency Abbreviations
OGB = Office of Group Benefits

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Secretary of State, State Archives & Records Services — Date Approved 1-8-2020

Records Retention Schedule

SS ARC 932 (10/19)

Louisiana Secretary of State
Division of Archives, Records Management and History
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Agency No	Agency / Division / Section
003.005	Division of Administration / Office of Group Benefits / Discontinued Programs

Item Number	Records Series Title	Retention Period			Security	Archival	State Records Center	Vital	Remarks
		In Office	In Storage	Total Retention					
19	Preferred Provider Option/Exclusive Provider Option Contracts	ACT + 5 CY		ACT + 5CY	M	S	N	V	ACT = until the end of the CY in which OGB ceases to exist. **
20	Logic Approvals	ACT + 3 CY	7CY	ACT + 10CY	M	S	N	V	ACT = until the end of the CY in which plan expires. **
21	Adjusted Batch Listings	ACT + 7 CY		ACT+ 7CY	M	S	N	I	ACT = until the end of the CY in which plan expires. **

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N - No

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OGB = Office of Group Benefits

[redacted]
Agency Approval

1-7-2020
Date Signed

[redacted]
Secretary of State, State Archives & Records Services

1-8-2020
Date Approved

ATTACHMENT V: IMAGING SYSTEM SURVEY COMPLIANCE AND RECORDS DESTRUCTION

In connection with OGB's electronic records retention requirements and within thirty (30) days of the Contract's effective date, Contractor shall complete a State Archives Imaging System Survey ("System Survey") and forward to OGB.Records@la.gov[1], or as otherwise directed by OGB. According to LAC 4:XVII.1305(A), the System Survey must contain the following information:

1. A list of all OGB records series[2] maintained/managed by Contractor's system;
2. The hardware and software used including model number, version number and total storage capacity;
3. The type and density of media used by Contractor's system;
4. The type and resolution of images being produced (TIFF class 3 or 4 and dpi);
5. Contractor's quality control procedures for image production and maintenance;
6. Contractor's system's back up procedures including location of back-up (on or off-site) and number of existing images; and
7. Contractor's migration plan for purging images from the system that have met their retention period.

OGB shall review the System Survey to make an initial determination of conformity with LAC 4:XVII.1305(A). Once OGB determines that Contractor's System Survey contains the requisite information, OGB will forward the System Survey to the Secretary of State. As a continuing requirement, any system changes necessitating a revised System Survey response must be submitted to the Secretary of State within ninety (90) days of the change. To ensure compliance with this rule, Contractor shall notify the Records Officer of these changes within sixty (60) days so that he or she may forward the appropriate information to the Secretary of State.

Further, to ensure compliance with OGB's Records Retention Schedule (Attachment IV) and applicable laws, Contractor shall not destroy any OGB records unless records are converted to digital images and thereafter approved for destruction or other disposition by the Secretary of State. Contractor shall request expedited authority to destroy or otherwise dispose of converted records by email to disposals@sos.louisiana.gov with "EDR_I2014-009 OGB [CaremarkPCS Health, L.L.C.]" in the subject line, carbon copy to the Records Officer and OGB.Records@la.gov, and a description of the subject records per the OGB Schedules (such as "Documents, scanned and inspected, for the week/month of X") in the body. Upon receiving approval of the Secretary of State to destroy or otherwise dispose of the requested records, Contractor shall commence destruction or other approved disposition of said records. Contemporaneously therewith, Contractor shall complete a Certificate of Destruction (SSARC 933) form which shall be forwarded to the Records Officer. All SSARC forms can be found on the Louisiana Secretary of State's website http://www.sos.la.gov/HistoricalResources/ManagingRecords/GetForms/Pages/default.aspx.

[1] If OGB makes a different designation, OGB will notify Contractor of the change and provide updated contact information

[2] A records series is a group of related or similar records that may be filed together as a unit, used in a similar manner, and typically evaluated as a unit for determining retention periods LAC 4:XVII 301(A) The records series listed in Contractor's imaging survey should correspond to the records series listed on the OGB official Record Retention Schedule, Attachment IV

ATTACHMENT VI: CLINICAL MANAGEMENT PROGRAMS

ALL INCLUSIVE CLINICAL ADMINISTRATION FEE SERVICES

COMMERCIAL

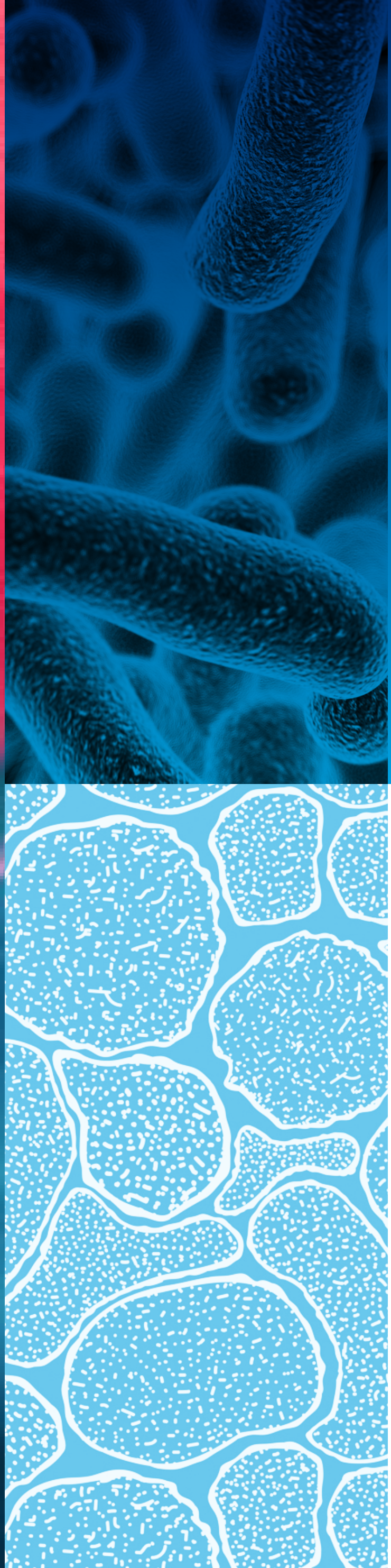
Clinical Management Program	Description
POS Safety Edits (Concurrent POS DUR/therapeutic interchange, Retrospective Safety Review) **(Aligns to Standard DUR review)**	Flags potential medication safety concerns at the point of sale. Additionally, reviews claims within 72 hours of adjudication to identify potential medication safety concerns.
Opioid Core MME Strategy **(Aligns to Opioid Cumulative Dosing and APAP Safety Controls)**	Enhanced opioid utilization management criteria that are aligned with the CDC Guideline recommendations to help improve management of opioid use and reduce potential misuse and abuse. This stricter criteria uses Morphine Milligram Equivalent (MME) to limit quantity of opioid products. Prior Authorization requests can be made if prescribers believe their pa ients should exceed the MME within the CDC recommendation. Not intended for patients with cancer or receiving palliative or end-of-life care.
Core & Enhanced Safety and Monitoring Solution **(Aligns to Polypharmacy DUE Program)**	Reduces instances of prescription fraud, waste, and abuse through regular claims monitoring and imely interventions. Includes an extensive range of provider and member interventions to address more complex cases related to opioid abuse, controlled substance medications and top chronic classes at risk of abuse and misuse.
Formulary Management Strategy and Exclusions **(Aligns to High Cost Generic, Formulary Exclusions, 510K management, Patent Exclusivity management)**	Designed to increase appropriate u ilization of generics, provide hyperinflation protection, and control new-to-market product launch spend for specialty and non-specialty medications. Includes our Tier 1 strategy, which allows coverage of certain branded medications at the tier 1 generic copay, while blocking the generic equivalent, in order to deliver the lowest net cost for clients and their members.
Dose Optimization	Point-of-sale identification of opportunities where a higher- strength, single daily dose can be used in place of multiple daily doses, when available and clinically appropriate.
Quantity Limits **(Aligns to Clinical Edit Package)**	Establishes a maximum quantity allowed over a period of time for medications with potential for overuse and misuse.
Step Therapy **(Aligns to Clinical Edit Package)**	Automated step therapy edits that review a member's drug history to verify that a first-line therapy was attempted before he claim can be approved at the point of sale.
Diabetic/Disease Management Program	Plan design set-up which allows members to have OOP waived and applicable tiered copays apply.

(Aligns to Diabetic/OGB DM Program)	Additionally, our dedicated Diabetic meter team can support members in ordering a free Accu-Chek blood glucose meter, at no cost to the member or the plan. Members are able to order and select a meter via the website (www.caremark.com/managingdiabetes), via email or over the phone (1-877-418-4746 Mon.–Fri., 8 am–6 pm (CT)). The team can also assist members with obtaining a new or updated prescription for their diabetic testing supplies.
Pharmacy Advisor Support: Adherence (Compliance)	Promotes optimal adherence by providing tailored messages to meet the needs of members with top 10 chronic, common conditions at key points in therapy.
Pharmacy Advisor Support: Closing Gaps in care	Targeted recommendations to prescribers, in line with key clinical guidelines, that have been shown to reduce future medical complications by closing gaps in care.

EGWP

Clinical Management Program	Description
POS Safety Edits (Concurrent POS DUR/therapeutic interchange) **(Aligns to Standard DUR review)**	Flags potential medication safety concerns at point of sale (more than 500 plan design and safety edits).
Retrospective Safety Review **(Aligns to Standard DUR review)**	Reviews claims wi hin 72 hours of adjudication to identify potential medication safety concerns.
Drug Savings Review (Retrospective DUR)	Identifies opportunities for improved prescribing and utilization according to accepted evidence-based prescribing criteria. Retrospective prescrip ion claims reviews identify drug safety concerns and opportunities for more cost-effective therapy to maximize savings and member safety
Core & Enhanced Safety and Monitoring Solution **(Aligns to Care Quality and High Risk Safety Management DUE Program)**	Reduces instances of prescription fraud, waste, and abuse through regular claims monitoring and timely interventions. Includes an extensive range of provider and member interventions to address more complex cases related to opioid abuse, controlled substance medications and top chronic classes at risk of abuse and misuse.
Opioid Utilization Management Strategy **(Aligns to Opioid Cumulative Dosing, Overutilization and APAP Safety Controls)**	Enhanced opioid utilization management criteria that are aligned with CMS recommendations to help improve management of opioid use and reduce potential misuse and abuse.
Quantity Limits **(Aligns to Clinical Edit Package)**	Establishes a maximum quantity allowed over a period for medications wi h potential for overuse and misuse.
Step Therapy **(Aligns to Clinical Edit Package)**	Automated step therapy edits that review a member's drug history to verify that a first-line therapy was attempted before the claim can be approved at the point of sale.
Prior Authorization **(Aligns to Clinical Edit Package)**	A drug class management technique that requires select prescriptions meet defined criteria before

	they are covered by the plan, requires prescribers to confirm medical necessity and allows members to appeal a denied claim.
Formulary Management Strategy and Standard Exclusions **(Aligns to Formulary Exclusions, 510K management)**	The EGWP formulary selected is designed to increase appropriate utilization of generics and provide hyperinflation protection for specialty and non-specialty medications.
Medication Therapy Management (**Aligns to MTMP)**	The Medication Therapy Management program is designed to optimize Part D beneficiaries' understanding of medication use, provide better therapeutic outcomes for targeted enrollees by improving medication adherence, and reduce adverse drug events.
Diabetic Supply Coverage **(Aligns to Diabetic Supply Coverage)**	Plan design set-up for diabetic supplies including test strips that adjudicate through the Part D benefit for $0 copay.
Pharmacy Advisor® Support: Improving Adherence (Compliance)	Designed to improve adherence to medications in the CMS Stars classes (Diabetes, Hypertension, and Cardiovascular). Program is mainly member focused with letters explaining the importance of adherence and contacting members who at risk of non-adherence.
Pharmacy Advisor® Support: Closing Gaps in Care	Reviews pharmacy claims and identifies poten ial gaps in medication therapy for compliance with clinical guidelines that have been shown to reduce future medical complica ions.



The 2021 Janssen U.S. Transparency Report

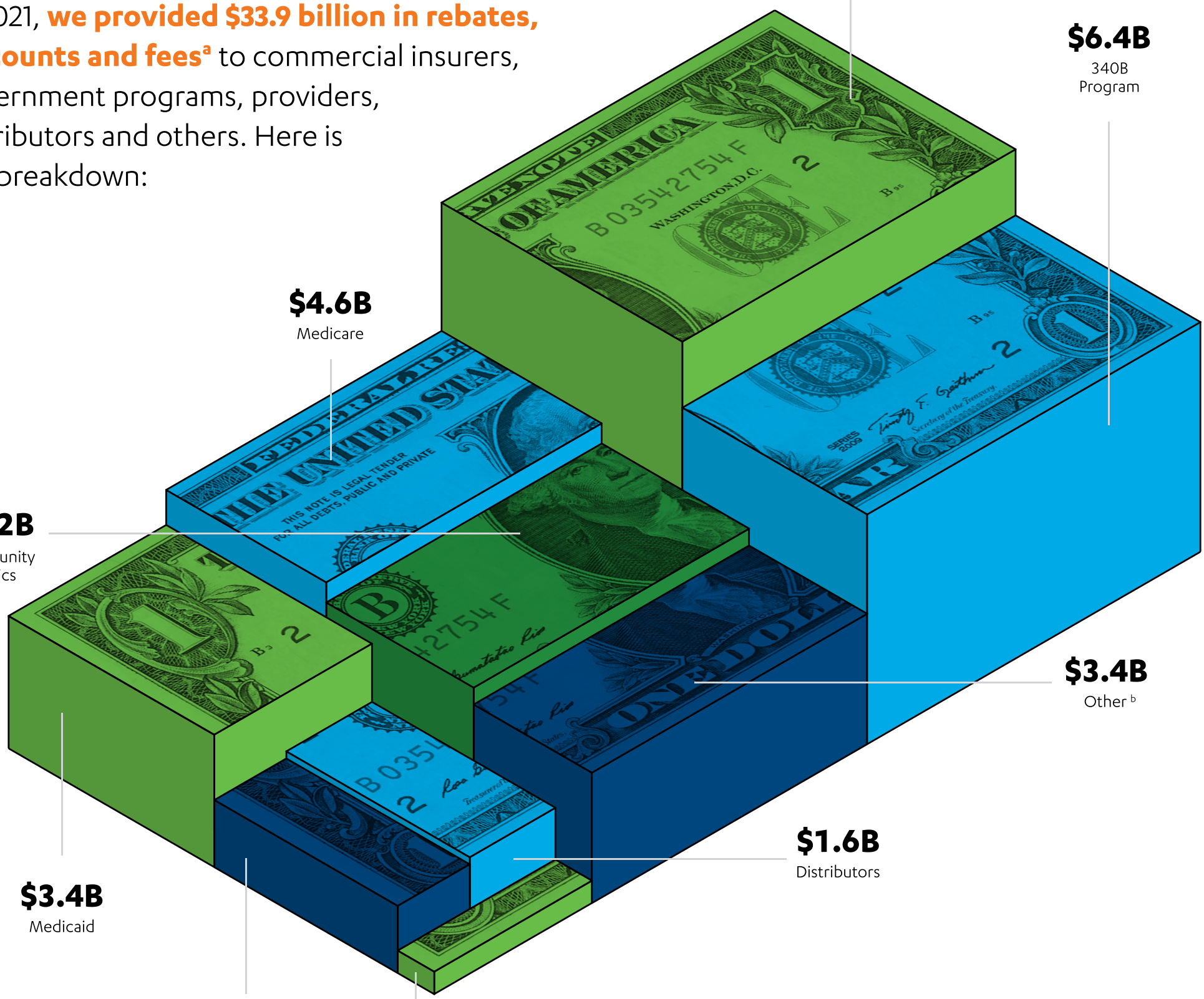
Upper Left: 3D render of bacteria under a microscope.

Bottom Left: Microscopic photograph of virus cells and microbes.

Janssen | PHARMACEUTICAL COMPANIES OF Johnson & Johnson

$33.9 Billion Paid in Rebates, Discounts & Fees: Breaking It Down

In 2021, **we provided $33.9 billion in rebates, discounts and fees**[a] to commercial insurers, government programs, providers, distributors and others. Here is the breakdown:



Government programs benefit from vigorous negotiation as well as legally required price concessions. Medicaid discounts also reflect the extra, "supplemental," rebates states negotiate with manufacturers.

a. All figures according to Janssen internal financial accounting.

b. Other: Includes Coupons/Co-Pay, programs such as Long-Term Care, ADAP (a program specific to HIV and AIDS) and other disease-specific sites of care/insurers.

2021 at a Glance

In 2021, our net prices declined for the fifth year in a row. Yet even as the net prices paid by commercial insurers, pharmacy benefit managers (PBMs) and government programs continue to decrease, **patients face ever-increasing cost-sharing burdens.**

1 Net Prices for Our Medicines Have Declined for the Fifth Year in a Row

-2.8%

Average net price decline of Janssen medicines in 2021[a] (compared to the 2021 consumer inflation rate of 7%)[b]

2 Rebates and Discounts to Commercial Insurers, PBMs and Government Programs Have Grown

$33.9B

Total amount Janssen paid in **rebates, discounts and fees** to commercial insurers, government programs and others in the healthcare system in 2021[a]

3 Insurance Design Shifts More Costs to Sicker Patients

64% of covered U.S. workers face an **in-network out-of-pocket cost maximum above $3,000**– an all-time high, up 83% since 2010 (then 35%)[c]

$28.1B

Total annual patient costs for coinsurance[d]

3X

Increase in average deductible since 2006[c]

4 Our Investments in R&D Continue to Grow

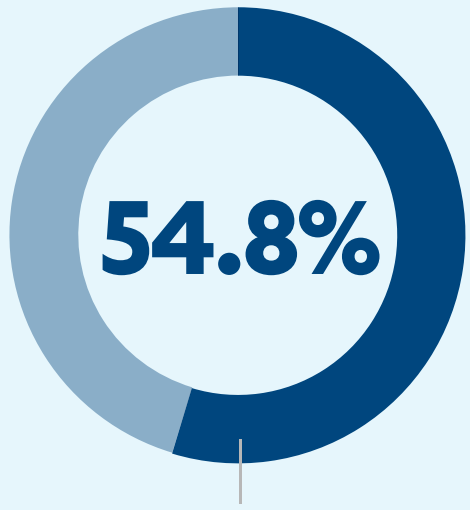
$11.9B

Dedicated in 2021 to the **discovery and development of new treatments and cures**[a]

11.2%

Average annual increase in R&D investment from 2016–2021[a]

3 Facts to Know



Of the **list prices of our medicines** went to commercial insurers and others in the healthcare system[a]

$54.1B

In total R&D spending since 2016[a]

1.1M

Patients who were helped with support to afford their medicines through the **Janssen CarePath Program**[a]

a. Figures according to Janssen internal financial accounting.

b. Bureau of Labor Statistics. "Consumer Price Index: 2021 in Review." January 14, 2022. https://www.bls.gov/opub/ted/2022/consumer-price-index-2021-in-review.htm.

c. Kaiser Family Foundation, *2021 Employer Health Benefits Survey*, p. 100. November 10, 2021. https://www.kff.org/report-section/ehbs-2021-summary-of-findings.

d. Howell, S., Yin, P. and Robinson, J. "Quantifying the Economic Burden of Drug Utilization Management on Payers, Manufacturers, Physicians, and Patients." *Health Affairs*. August 2021. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.00036.

Protecting Progress for Patients

The U.S. healthcare innovation ecosystem stands out across the world as a beacon of promise for patients. This is because the remarkable pace of innovation, applied research and advanced clinical development is enabling transformative outcomes for patients.

Recent years have seen dramatic advancements in targeted treatments for cancers, gene and novel cell-based therapies and advances in treating childhood and rare diseases. Yet, for many American families, employers and individuals, the transformational progress made to address existing and unmet medical needs is not easily or affordably accessible.

Our responsibility as a leader in the healthcare system is to bring forward actionable ideas, data and insights to help create a sustainable healthcare system. This has been a paramount principle since our first Transparency Report was released in 2016. These data and insights are critical to help inform the ongoing debate surrounding rising out-of-pocket costs for patients.

Rising costs for patients is the right issue to focus on because patients deserve affordable access to needed care and treatments. However, in specific instances, federal and state policy proposals do not address the growing "affordability gap" for patients. This gap exists because commercial insurers have increased out-of-pocket costs for patients through inadequate insurance benefit design, despite the lower net prices paid by commercial insurers and pharmacy benefit managers (PBMs).

These same policy proposals could have other unintended consequences, including:

- Directly undermining doctor-patient decision-making.
- Limiting patients' access to needed medicines.
- Stifling research and discovery that will lead to lifesaving treatments.

This year's report demonstrates our responsible approach to pricing, enduring investments in research and development and our continuing efforts to support affordable access to our medicines.

In this year's report we provide updated disclosures to continue advancing the national dialogue on healthcare costs and innovation, including these six key facts:

-2.8%
In 2021, our net prices declined for the **fifth consecutive year.**[1]

$33.9B
Our negotiated rebates, discounts and fees grew to **$33.9 billion** – a **15.2%** increase year-over-year.[2]

55%
Our rebates, discounts and fees represent **more than half** of our list prices.[3]

>100%
R&D spending was **more than double** our spending on sales and marketing.[4]

$11.9B
R&D spending grew to **$11.9 billion** – a **24%** increase from 2020.[5]

$54.1B
Our **total R&D** investments since 2016.[6]

With this data and evidence, we are providing actionable information, insights and analysis critical to helping inform policies that address the growing affordability gap, foster a patient-centric healthcare system and enable our unique ecosystem of innovation.

At Janssen, our mission is to make disease a thing of the past, and we carry this mission forward by developing and providing medicines that are safe, effective and accessible. It is our responsibility to do so, and our 50,000 U.S.-based Johnson & Johnson employees dedicate themselves to this mission each day.

Sincerely,

Scott White
Company Group Chairman
North America Pharmaceuticals
Johnson & Johnson

Anastasia G. Daifotis, M.D.
Chief Scientific Officer
Janssen North America
Pharmaceuticals

1. Janssen's Responsible Approach to Pricing

In 2021, our net prices declined for the fifth year in a row – **declining by -2.8%,[7] and nearly -17%[8] when compounded over the last six years.**

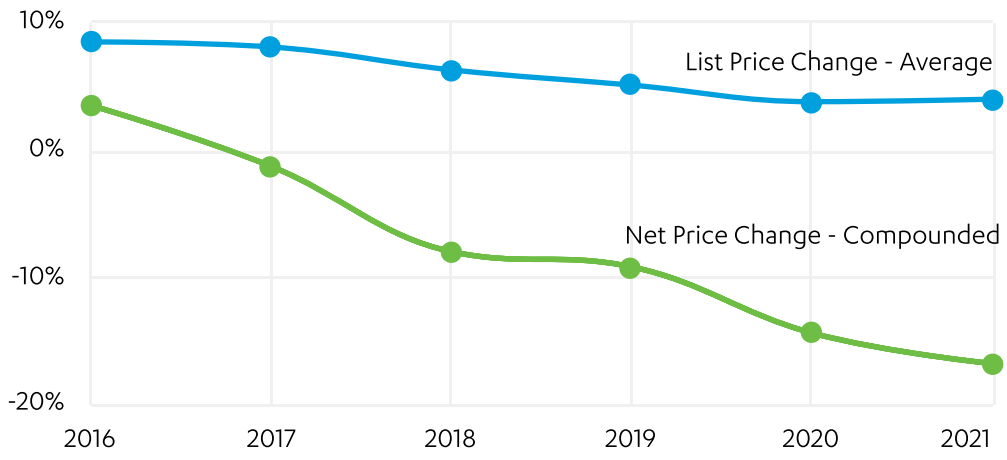
Even as the net prices paid by commercial insurers, pharmacy benefit managers (PBMs) and government programs, on average, have declined over the past five years,[9] **individuals and families face ever-increasing cost-sharing burdens,** especially for prescription drugs, due to the design and growing use of high-deductible benefit plans.[10]

Highlights:

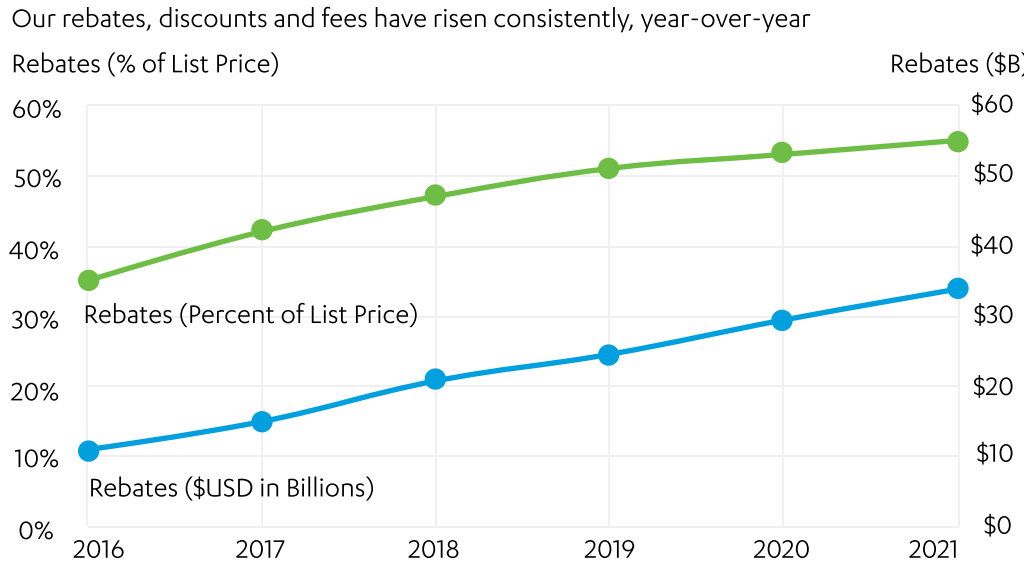
- Janssen paid $33.9 billion[11] in rebates, discounts and fees in 2021, up 15.2% compared to 2020.[12]
- Nearly 55% of the list price of our medicines went to commercial insurers and others in the healthcare system as rebates, discounts and fees.[13]
- In 2021, Janssen CarePath provided access and affordability support to nearly 1.1 million patients.[14]

Janssen U.S. Pricing Overview[15]

Our net list prices have been falling consistently over the past five years



Our rebates, discounts and fees have risen consistently, year-over-year



Our Responsibility—Today's patients need affordable access to medicines. Tomorrow's patients count on us to deliver treatments and cures for future health challenges and diseases. In setting a list price for a medicine, we balance:

1. **The medicines' value to patients, the healthcare system and society.** We assess how our medicines and vaccines improve individual health and allow a person to live their life to the fullest, as well as the potential to lower healthcare costs throughout the system and advance existing standards of care.
2. **The importance of supporting affordable access to our medicines and vaccines.** We negotiate with insurers, PBMs and governments, as well as hospitals, physicians and other providers of care, so patients who are prescribed our medicines or need our vaccines can get access to them.
3. **The importance of preserving our ability to develop future ground-breaking vaccines, treatments and cures.** Sales from our existing innovations provide us with the necessary resources to meet the growing costs of R&D to address unmet medical needs, better help underserved populations and remain prepared for emerging health threats.

2. From Rebates to Insurance Benefit Design: What It Means for Patients & the Healthcare System

In 2021, nearly 55% of the list prices of our medicines[16] – **$33.9 billion**[17] – went to commercial insurers and others in the healthcare system as rebates, discounts and fees. Rebates and discounts resulted in lower net prices for commercial insurers and PBMs.

Since 2016, the first year covered by the Transparency Report, **the discounts we have provided have more than tripled**,[18] as PBMs and commercial insurers have grown in size and power (the three largest PBMs process nearly 80% of all prescription claims[19]).

U.S. Prescription Drug Spending & Overall Healthcare Costs

Despite the continuous decline in net prices driven by the growth in rebates, discounts and fees, there are still many misconceptions about overall prescription drug costs within the U.S. healthcare system.

In 2020 (the most recent data available) the Centers for Medicare and Medicaid Services (CMS) found that spending on **retail prescription drugs across the entire healthcare system accounted for 8.4% of overall healthcare spending in the U.S.** – or about $348.4 billion[20] – down from 9.9% in 2015. Government experts find that, **when all costs for medicines in non-retail settings are added, the U.S. drug percentage of healthcare spending is no more than 14% – which is projected to remain consistent.**[21]

Comparatively, when examining total U.S. healthcare spending, which was $4.1 trillion in 2020[22], spending on medicines is less than what is spent across many other sectors, such as on hospitals ($1.3 trillion.)[23]

One recent analysis noted, "Real net per capita spending – adjusting for net prices, population and economic growth – declined in 2020 to $1,085 and has increased only $56 since 2010."[24] **This is less than $6 per year.**

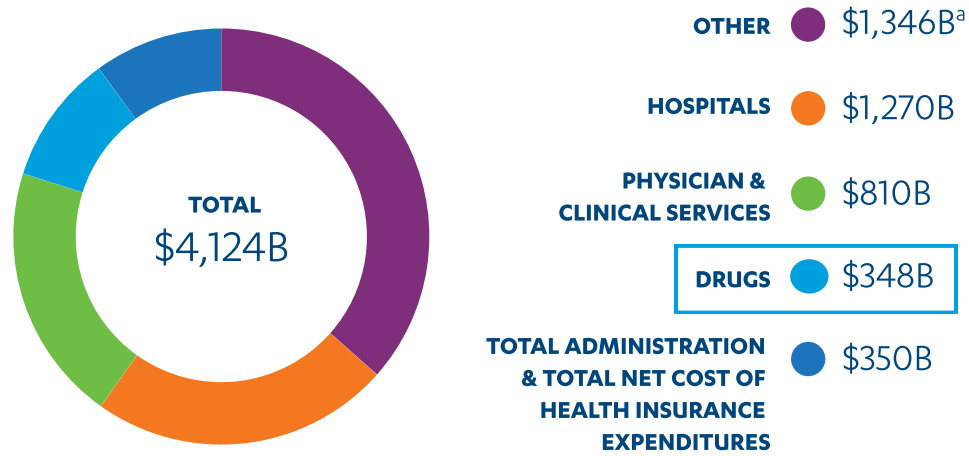
340B: Explosive Growth, but Who's Benefiting? The Federal 340B Drug Discount Program, established in 1992, was intended to restore discounts on drugs to certain hospitals and clinics that provided care to underserved or vulnerable communities. This program has grown considerably in the past 30 years without transparency of who is benefiting from the growth in discounts.[25]

As the Congressional Budget Office (CBO) noted recently, "Nationwide per capita spending on prescription drugs has generally held steady or declined since the mid-2000s – other than the increase from 2013 to 2015 – whereas use of prescription drugs has most likely increased over that period."[26] **The CBO notes spending most likely increased because of the aging of the nation's population.**[27]

Other research shows that a growing share of healthcare spending is on low-value care or administrative spending, with estimates of such healthcare spending on waste ranging from $760 billion to $935 billion.[28] The University of Michigan identified over $340 billion in unnecessary spending on low-value care that could be eliminated by designing insurance to be value-based.[29]

Healthcare Spending on Retail Drugs Is Less Than Spending on Other Sectors

2020 Spending on Retail Drugs, Percent of U.S. Health Expenditures (Sections in Billions USD)[30]



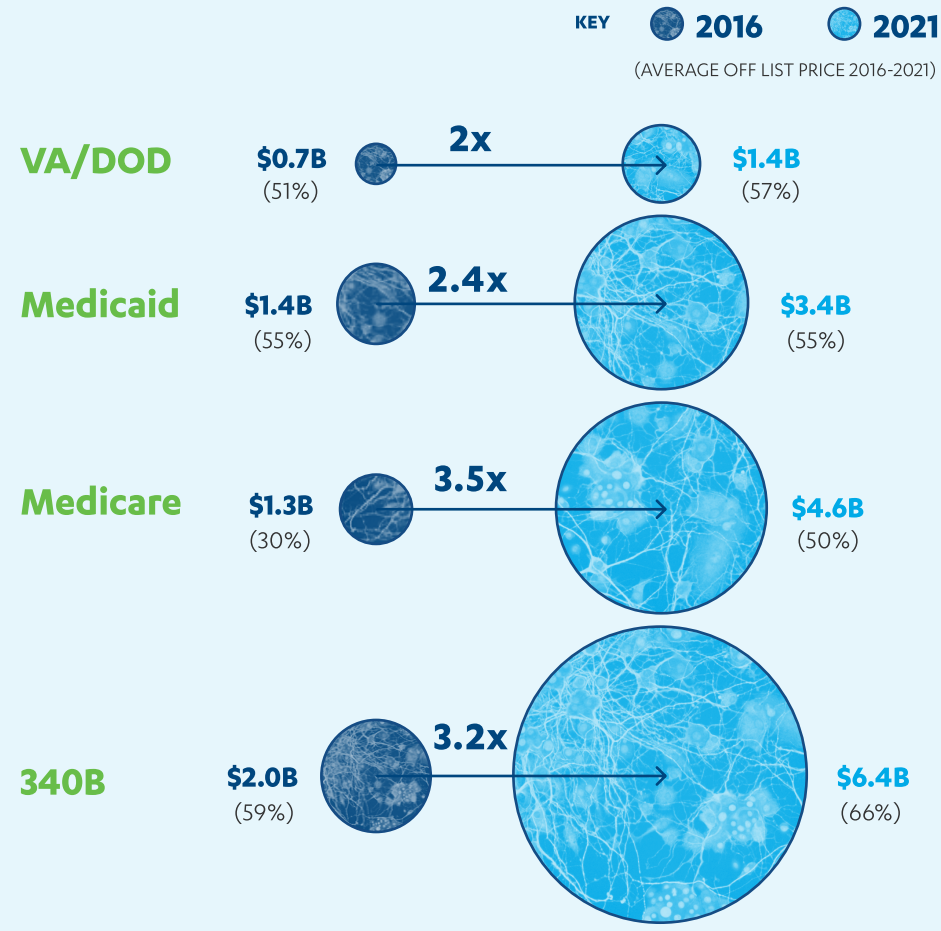
a. Note: Per NHE Definitions, Total of Combined Other includes: Investment, Nursing Care Facilities and Continuing Care Retirement Communities, Other Professional Services, Dental Services and Other.

2. From Rebates to Insurance Benefit Design
Insurers Determine Patient Out-of-Pocket Costs

Growing Discounts and Rebates in Government Programs[31]

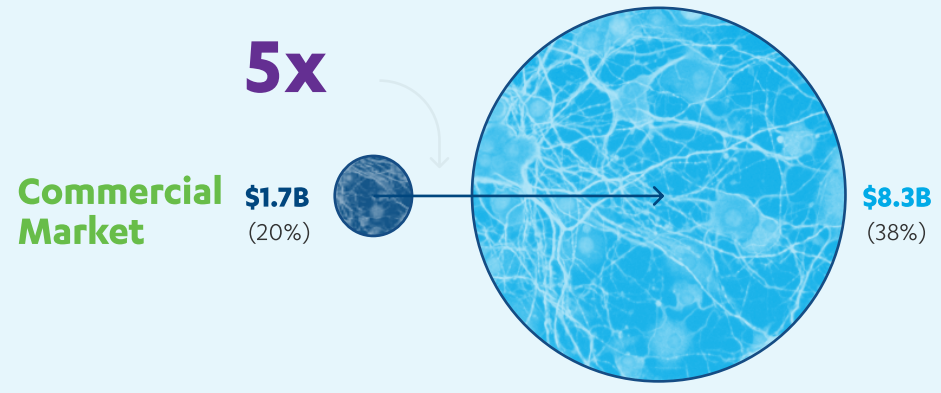
There are four primary drivers of the recent growth in rebates and discounts Janssen has provided since 2016 to various government programs, including:

- Benefits of vigorous negotiations with private insurance companies administering Medicare Part D benefits
- Increases in statutory required price concessions to government programs
- Supplemental discounts negotiated with individual states
- Exponential growth of 340B Drug Pricing Discount Program



From 2016 – 2021, Our Rebates, Discounts and Fees to Commercial Insurers and PBMs Have Increased

Since 2016, the first year covered by the Transparency Report, the rebates, discounts and fees we have provided to commercial insurers and PBMs have increased almost fivefold.



Commercial Insurers' Utilization Management Programs Impact Patient Treatment Options

The CBO recently acknowledged that "it is unlikely that the average net price of a prescription has increased considerably in recent years...,"[32] yet patients face growing cost-sharing (or out-of-pocket costs) obligations because of insurance benefit design, and in some instances, are getting less access to needed medicines. Commercial insurers and PBMs often, and more increasingly, base patient cost-sharing on list price and not the lower net price negotiated with drug companies. There is a growing gap between the lower net prices paid by commercial insurers and the higher out-of-pocket costs they set for patients, which is leading patients to stop filling their prescriptions and taking their medicines.

This is especially acute for patients with multiple chronic conditions or who are prescribed specialty drugs in areas like oncology and immunology.[33]

Commercial insurers and PBMs are also implementing more restrictive utilization management programs.[34] One such example is the increasing use of "exclusion lists," which in some instances, prevents patients from accessing a growing list of medicines. Since 2014, these "exclusion lists" have grown more than 675%[35] to include more than 846 unique products.[36] These exclusions are also being leveraged with specialty drugs, which could disproportionately affect patients with very acute and specialized treatment needs.[37]

2. From Rebates to Insurance Benefit Design
The Ways Insurance Benefit Design Drives Up Patient Out-of-Pocket Costs

The financial burden for patients is growing as formularies become more complex through multiple tiers and various cost-sharing arrangements based on class of drug. For instance, co-insurance alone now costs patients nearly $30 billion per year.[38]

At the same time, commercial insurers' utilization management tactics create access requirements for patients, which may affect patient outcomes:

- **Expanded Tiered Lists with Varying Cost-Sharing:** Commercial insurers continue to incorporate "more complex [insurance] benefit designs for prescriptions drugs... with multiple cost-sharing tiers as well as other management approaches."[39] This can be especially harmful for patients needing specialty drugs, (e.g., cancer treatment) as these drugs are often placed on higher cost-sharing tiers.
- **Co-Pay Adjustment Programs:** Commercial insurers are increasingly using accumulator and maximizer adjustment programs to prevent co-pay assistance provided to patients by manufacturers from applying toward patient out-of-pocket maximums or deductibles. They can lead to additional and unexpected costs for patients and consequently reduce medication adherence.
- **Non-Medical Switching:** This happens when commercial insurers and PBMs switch clinically stable patients on any product to other therapies for non-medical reasons. This creates significant barriers to decision-making for patients, with one study noting that 73% of patients surveyed felt commercial insurers' non-medical switching disrupted the care decisions made between a patient and doctor.[40]
- **Step Therapy:** Commercial insurers can require patients to fail treatment on the insurer's preferred medicine before trying another medicine. Beyond the burden this type of policy places on physicians, there is a growing concern that step therapy is preventing patients, especially those with very chronic conditions such as rheumatoid arthritis (RA), from taking their prescribed medicines.[41] This also creates extra work for providers and doctors who must manage and maintain up-to-date lists of commercial insurers' approved drug lists.
- **Prior Authorization:** This is a requirement that providers submit documentation to commercial insurers before the commercial insurer approves coverage of a specific treatment and is a key driver of administrative cost growth in the U.S. It is estimated that physicians spend more than $26 billion per year managing commercial insurers' prior authorization requirements for prescription drugs.[42] One recent study noted that prior authorization could be the cause of prescription abandonment for more than 150 million patients.[43]

Utilization Management Challenges Doctors, Too: Prior authorization can be disconnected from clinical care, with one recent study noting that only 34% of step therapy protocols deployed by the largest 17 U.S. health plans are consistent with clinical guidelines.[44] Doctors and their support staff are also spending almost two full business days each week processing prior authorization – which means delays in patients receiving medications they need and less time for delivering care.[45]

Co-Pay Adjustment Programs
—Who Benefits: Patients or Commercial Insurers?

Commercial insurers deploy a growing array of aggressive tactics to undermine the co-pay assistance drug manufacturers provide patients. They prevent that assistance from counting toward a patient's deductible, sometimes leaving patients with sudden and often unexpected increases in out-of-pocket costs. Often these commercial insurer tactics are deployed to capture maximum economic value of the patient co-pay assistance for the commercial insurers' benefit while patients unknowingly face higher out-of-pocket costs as a result.

This makes it harder for patients to stay on their medicines and leads to worse health outcomes. The American Society of Clinical Oncology (ASCO) recently noted that these types of programs "have the potential to harm patients by discouraging the appropriate utilization of specialty therapies and reducing adherence to recommended treatment."

There is growing concern among policymakers about these tactics' effects on patients. In fact, 12 states and Puerto Rico have passed legislation prohibiting the use of co-pay adjustment programs.

The full report document can be found at https://transparencyreport.janssen.com/

Have Your Prescriptions Been Poached or Rerouted by a PBM?

User: [redacted] / Email: [redacted] / Phone: [redacted]

Survey answered on: 7/20/2020 10:43 AM

1. Have your or your pharmacy's prescriptions been poached or rerouted by a major PBM?
Please share your story and include as much information as possible below. We will keep your identifying information anonymous.
For additional questions, please contact us at info@truthrx.org (answer type: Long Text)

We have had multiple instances where PBMs (primarily Humana) have targeted our Dual Eligible patients and promised 90-day mail order fills because their generic copays are $0 on their "plan" (not available at the retail level). They then call the prescribers directly for new prescriptions. They [Humana] have also been exceedingly aggressive when contacting our elderly dual eligible patients during COVID-19 telling our patients that mail order would be a better option because the patient won't need to leave their home and many of their medication would be $0.

We've also had recent issues with Caremark and our retired mine workers. Caremark issues a reject at the retail level requiring the patient (not pharmacy) call Caremark because the patient is showing up as being a "black lung" candidate. When the patient calls to remedy the issue, they are then told that they would save money if they were to get their medication through Caremark mail order. Interestingly, the patients where we have seen this issue have never been diagnosed with black lung.

2. As the person providing information, please choose which option describes you most accurately. (answer type: Multiple Options With Single Answer)

Pharmacy Owner

3. May we contact you for additional information? (answer type: Yes/No)

Yes

4. If we may contact you, please provide us with your email address or phone number (whichever is preferred). (answer type: Short Text)

[redacted]

CVS caremark

There's an important change coming to your prescription benefit plan that affects the medications you take regularly (such as medication for high blood pressure or diabetes).

What's changing? **Starting January 1, 2020, you'll need to fill prescriptions for these medications in 90-day supplies at CVS Pharmacy® or through CVS Caremark® Mail Service Pharmacy. If you fill them anywhere else, or in 30-day supplies, they will no longer be covered and you'll pay 100 percent of the cost.**

Is it easy to make the change? Yes, you can do it online with just a few clicks.

Here's how (in two simple steps):

1. Decide whether you want to pick up your medications at CVS Pharmacy (including locations inside Target stores) or have them delivered by mail to your door.
2. Transfer your prescriptions. Go to Caremark.com/MoveMyMeds and enter your Member ID (found on your member ID card). Select the medications you take regularly and we'll transfer them to the new pharmacy for you – no need to type in each prescription. It's that easy.

Be sure you make this important change by **January 1, 2020.** If you have any questions about your copay or coinsurance*, visit **Caremark.com.**

We have your best health at heart,
Your CVS Caremark Team

Do you fill prescriptions with the CVS Pharmacy app?

If so, you can have your 90-day supplies delivered, along with short-term medications (such as antibiotics).

You can choose:

On-Demand Delivery - delivered within four hours for a small fee.

1-2 Day Delivery - delivered in 1-2 days from USPS at no extra cost to you.

Download the CVS Pharmacy app to learn more. Turn this letter over for important delivery information.

Caremark.com/MoveMyMeds

*Copayment, copay or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

[redacted]

TDD: 1-800-863-5488
[redacted]

TRUTHRX.ORG

Moniue Whitney moniuetruthr.org

Wellcare

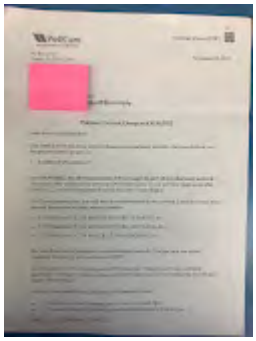
[redacted] <[redacted]> Wed, Nov 17, 2021 at 5:13 PM
To: Monique Whitney <monique@truthrx.org>

Hi

I'm being told you are collecting these letters. A few patients have brought in these letters that we are no longer in network.
We did sign this contract. We even called today and we're verbally told we are a pharmacy patients can go to. They couldn't tell us why these letters are being sent out stating such a thing.

[redacted]
Sent from my iPhone

2 attachments



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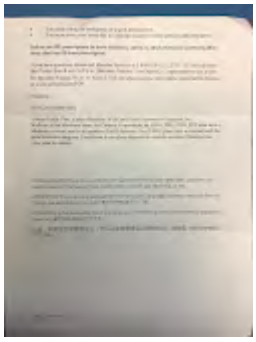

image1.peg
1635K

TRUTHRX.ORG

Monique Whitney <monique@truthrx.org>

Wellcare

[redacted] <[redacted]> Wed, Nov 17, 2021 at 5:22 PM
Reply-To: [redacted]
To: "monique@truthrx.org" <monique@truthrx.org>

I forgot to mention.....
This adult patient needs extra care and her mom takes care of her. They got a call from CVS today that CVS is starting the process of contacting the prescriber to get new prescriptions to start filling at CVS. The mom said it was a local number, she couldn't tell if it was the local store, mail order, corporate.

The mom is willing to talk to someone about what they are doing to them.
I also told her to call the local CMS office Kelly Valente number 617-565-1271 and I also left Kelly a voicemail myself that my patients are getting these letters.

Thanks
Marc

[redacted]

[Quoted text hidden]
[redacted]
Sent from my iPhone

2 attachments

image0.jpeg
1497K

image1.jpeg
1635K

421

WellCare
Beyond Healthcare. A Better You.

WellCare Classic (PDP)

PO Box 31411
Tampa, FL 33631-3341

November 02, 2021

[redacted]

022

Pharmacy Network Change as of 01/01/2022

Dear [redacted]:

This letter is to let you know about a change to our pharmacy network. Our records show you bought prescription drug(s) at:

- [redacted] PHARMACY

As of 01/01/2022, the above pharmacies will no longer be part of our pharmacy network. This means they will be out-of-network (OON) pharmacies. If you use these pharmacies after 01/01/2022, you will be responsible for the full cost of your drug(s).

To fill your prescriptions, you will need to use pharmacies in our network. Listed below are three network pharmacies you may want to consider:

- CVS PHARMACY, 501 BOSTON POST RD, SUDBURY, MA
- CVS PHARMACY, 313 BOSTON POST RD, WAYLAND, MA
- CVS PHARMACY, 774 WATER ST, FRAMINGHAM, MA

We have thousands of pharmacies in our nationwide network. You can view our online pharmacy directory at www.wellcare.com/PDP.

In most cases, we only cover drugs at an OON pharmacy when you can't use a network pharmacy. If we approve drug coverage at an OON pharmacy, you can only get up to a 30-day supply of your drug(s).

We may cover prescriptions filled at an OON pharmacy when:

- There is no network pharmacy that is close to you and open.
- You need a drug that you can't get at a network pharmacy close to you.

[redacted]

- You need a drug for emergency or urgent medical care.
- You must leave your home due to a federal disaster or other public health emergency.

Before you fill prescriptions in these situations, call us to check if there is a network pharmacy that can fill your prescription.

If you have questions please call Member Services at 1-888-550-5252, TTY: 711 for help Monday-Friday from 8 a.m. to 8 p.m. (Between October 1 and March 31, representatives are available Monday-Sunday, 8 a.m. to 8 p.m.). You can always access our online searchable directory at www.wellcare.com/PDP.

Sincerely,

WellCare Health Plans

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.
Wellcare is the Medicare brand for Centene Corporation, an HMO, PPO, PFFS, PDP plan with a Medicare contract and is an approved Part D Sponsor. Our D-SNP plans have a contract with the state Medicaid program. Enrollment in our plans depends on contract renewal. Please contact your plan for details.

WellCare Health Plans, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-877-374-4056** (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-374-4056** (TTY: **711**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-374-4056** (TTY: **711**)。

[redacted]

Patient #1

Pg (1)

Arkansas Blue MEDICARE

January 25, 2022

[redacted]

Member ID:

No - they paid the copay that you sent.

Our records indicate the following prescriptions were paid incorrectly. Blue Medicare Rx (PDP) is required to make adjustments based on correct plan information. As a result, we have determined that the additional costs for the following prescriptions must be paid to Blue Medicare Rx (PDP). We are required by Medicare to recover these amounts.

Please send payment with a copy of this letter to Arkansas Blue Medicare, P.O. Box 2099, Little Rock, AR 72203-2099.

We regret any inconvenience this may cause. If you have any questions or concerns regarding this letter or making payment, please contact Customer Service at 1-866-230-7264 (TTY 711), 24 hours a day/7 days a week.

Thank you,

Blue Medicare Rx (PDP)

Arkansas Blue Medicare is an affiliate of Arkansas Blue Cross and Blue Shield. Arkansas Blue Medicare offers PDP plans with Medicare contracts. Enrollment in Arkansas Blue Medicare depends on contract renewal.

Y0083_Negative Balance Letter

Fill Date	Pharmacy Name	Drug Name	Amount You Paid	Amount You Should Have Paid	Difference
2021-05-17	[redacted]	DULOXETINE CAP 60MG	8.00	20.00	-12.00
2021-04-19	[redacted]	TRAZODONE TAB 150MG	2.00	10.00	-8.00
2021-04-19	[redacted]	SIMVASTATIN TAB 20MG	2.00	5.53	-3.53
2021-04-19	[redacted]	POT CHLORIDE TAB 20MEQ ER	8.00	13.17	-5.17
2021-05-10	[redacted]	ALPRAZOLAM TAB 0.5MG	2.00	9.72	-7.72
2021-05-10	[redacted]	DOXYCYCL HYC TAB 100MG	8.00	20.00	-12.00
2021-05-17	[redacted]	POT CHLORIDE TAB 20MEQ ER	8.00	13.99	-5.99
2021-06-08	[redacted]	POT CHLORIDE TAB 20MEQ ER	8.00	13.99	-5.99
2021-05-17	[redacted]	TRAZODONE TAB 150MG	2.00	10.00	-8.00
2021-06-07	[redacted]	SIMVASTATIN TAB 20MG	2.00	6.35	-4.35
2021-06-08	[redacted]	ALPRAZOLAM TAB 0.5MG	2.00	6.04	-4.04
2021-06-08	[redacted]	TRAZODONE TAB 150MG	2.00	10.00	-8.00
2021-06-08	[redacted]	DULOXETINE CAP 60MG	8.00	11.94	-3.94
2021-04-08	[redacted]	DOXYCYCL HYC TAB 100MG	8.00	20.00	-12.00

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2021-06-08	[redacted]	BUPROPION TAB 75MG	8.00	14.93	-6.93
2021-06-08	[redacted]	LISINOP/HCTZ TAB 20-25MG	2.00	7.29	-5.29
2021-04-19	[redacted]	DULOXETINE CAP 60MG	8.00	20.00	-12.00
2021-01-18	[redacted]	SIMVASTATIN TAB 20MG	2.00	5.73	-3.73
2021-04-08	[redacted]	ALPRAZOLAM TAB 0.5MG	2.00	8.90	-6.90
2021-02-19	[redacted]	SIMVASTATIN TAB 20MG	2.00	5.53	-3.53
2021-01-04	[redacted]	ALPRAZOLAM TAB 0.5MG	2.00	6.89	-4.89
2021-03-22	[redacted]	POT CL MICRO TAB 20MEQ ER	8.00	13.17	-5.17
2021-01-18	[redacted]	POT CL MICRO TAB 20MEQ ER	8.00	13.17	-5.17
2021-01-18	[redacted]	TRAZODONE TAB 150MG	2.00	10.00	-8.00
2021-01-27	[redacted]	DOXYCYCL HYC TAB 100MG	8.00	20.00	-12.00
2021-02-01	[redacted]	ALPRAZOLAM TAB 0.5MG	2.00	8.90	-6.90
2021-01-18	[redacted]	DULOXETINE CAP 60MG	8.00	20.00	-12.00
2021-02-19	[redacted]	DULOXETINE CAP 60MG	8.00	20.00	-12.00
2021-02-19	[redacted]	TRAZODONE TAB 150MG	2.00	10.00	-8.00
2021-03-08	[redacted]	DOXYCYCL HYC TAB 100MG	8.00	20.00	-12.00

2021-03-09	[redacted]	ALPRAZOLAM TAB 0.5MG	2.00	8.90	-6.90
2021-03-22	[redacted]	DULOXETINE CAP 60MG	8.00	20.00	-12.00
2021-03-22	[redacted]	SIMVASTATIN TAB 20MG	2.00	5.53	-3.53
2021-03-22	[redacted]	TRAZODONE TAB 150MG	2.00	10.00	-8.00
2021-02-19	[redacted]	POT CL MICRO TAB 20MEQ ER	8.00	13.17	-5.17
				Amount You Owe:	**-260.84**

[redacted]

Pg (1)

Patient #2

P.O. Box 52115, Phoenix, AZ 85072-2115

1 problem - FTC allowing companies to Merge!

Dear Beneficiary,

Thank you for allowing SilverScript® Insurance Company to provide your Medicare Part D prescription drug coverage.

We regularly review Medicare Part D prescription drug claims and payments made. During a recent review, we found one or more of your prior claims was not processed correctly. As a result, the copayment that you paid was incorrect. As part of this process, your Explanation of Benefits was adjusted to account for this activity.

Your claims were adjusted for one or more of the following reasons:

- To reflect changes in your Low Income Subsidy (Extra Help) status
- To reflect plan TrOOP and Drug Spend changes due to a change in coverage by a prior Med D plan
- To reflect plan TrOOP and Drug Spend changes due to a change in coverage by a secondary payer

An invoice is attached that details the claims which were adjusted. We are asking for you to pay the amount stated on your invoice at this time. The balance owed will carry over to future invoices.

If you have questions about this amount please contact Customer Care toll-free at 1-866-235-5660, 24 hours a day, 7 days a week. TTY users should call 1-866-236-1069.

Sincerely,

SilverScript Customer Care

This information is available for free in other languages. Please call our Customer Care number at 1-866-235-5660 (TTY: 1-866-236-1069), 24 hours a day, 7 days a week. Esta información está disponible gratuitamente en otros idiomas. Llame a nuestro Cuidado al Cliente, al 1-866-235-5660 (teléfono de texto (TTY): 1-866-236-1069), las 24 horas del día, los 7 días de la semana.

SilverScript is a Prescription Drug Plan with a Medicare contract offered by SilverScript Insurance Company. Enrollment in SilverScript depends on contract renewal.

aetna

PO Box 52066
Phoenix AZ 85072-2066

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Forwarding Service Requested

[redacted]

CLAIM ADJUSTMENT STATEMENT

Your claim adjustment account at a glance...

Member ID:

Account Summary		Year-to-date Totals
Previous Balance	$0.00	
Payments & Other Activites	$0.00	
New Adjustments (details below)	$0.01	
Total Balance Due	$0.01	

Payments & Other Activites Since Last Statement

Type	Date Received	Amount

Missing a payment? Payments received in the last 10 days may appear on your next statement.

New Adjustments

Date of Service	Rx Number	Drug Name	Original Payment	New Payment	Adjustment Amount
04/04/2022		PROPAFENONE TAB 150MG	$15.72	$24.53	$8.81
04/14/2022		LINZESS CAP 72MCG	$201.70	$192.90	-$8.80
				Total Adjustment Amount	$0.01

Aetna told our customer that it was OUR FAULT! Sending him a bill for 1 penny!

Understanding Your Statement

Thank you for your membership in a prescription drug plan offered by Medicare D insurance plan. Caremark processes prescription drug copayments on behalf of your Medicare D insurance plan. We are sending you this Claim Adjustment Statement because your Medicare Part D prescription drug co-pay changed to reflect updated claim information we have received. If you have questions or concerns about your statement, please call the number on the back of your member ID card.

Bottom of Statement
Billing Date: This is the date your Statement was produced. Transactions posted after this date will be reflected on your next Statement.

Past Due After mm/dd/yyyy: This is your payment due date.

Total Balance Due: This is the full amount payable to Caremark at the time the Statement was produced.

Member ID: This number is your individual Caremark Member ID. Please reference this number when inquiring about your account and include it on your check if paying by check.

Account Summary
Previous Balance: This is the balance from your last Statement. Listed below this will be any recent payments or adjustments and any recent activity on your account.

Year-to-Date Totals
Reflects all claim adjustments activity posted to your account in the current calendar year.

New Adjustments
Date of Service: The date you received your prescription drug.

Original Payment: The co-pay amount you paid for the prescription drug.

New Payment: The co-pay amount you should pay after the retroactive change.

Adjustment Amount: A negative amount represents an amount Caremark owes you. A positive amount represents an amount you owe to Caremark.

Payment Options: Caremark provides you the option to pay your outstanding balance using a check or money order, or Electronic Funds Transfer (EFT) from your bank account. Regardless of what payment option you choose, Caremark would like to make it easy and convenient.

NOTE: If you are paying online through your bank or financial institution, you must include your Member ID on the payment. If we do not have a Member ID, this may result in inaccurate or delayed posting of your payment. Also, please submit a payment stub and separate payment for each member if you are paying more than one member.

† Other Pharmacies available in our Network

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aetna®

INVOICE #:

CLAIM ADJUSTMENT STATEMENT

BILL DATE	PAST DUE DATE	TOTAL BALANCE DUE	MEMBER ID
05/11/2022	06/10/2022	$0.01	

3. Pharmacy Services and Standards

In the event Provider and/or its agents, including outside counsel acting on Provider's behalf, breaches any terms and conditions outlined in this chapter of the Provider Manual, Provider may not seek reimbursement from Eligible Person, and Caremark, on its own behalf, or on behalf of a Plan Sponsor, may terminate the Provider Agreement (or Provider's participation in specific Plans or networks) and may exercise other remedies available to Caremark as may be set forth herein or otherwise available at Law or equity, including chargeback of applicable claims.

Pharmacies are an important part of Caremark's services and our goal to help people on their path to better health. Our Plan Sponsors, which include insurance companies, managed care organizations, third-party administrators, federal and state entities, employers, and union-sponsored benefit plans, entrust us with serving their diverse membership and we are committed to providing them with innovative and quality services and measures to control healthcare spending and improve health outcomes. Through our health services, plans, and community pharmacists, we are pioneering a bold new approach to total health, making quality care more affordable, accessible, simple and seamless, to not only help people get well, but help them stay well in body, mind and spirit.

3.01 Providing Pharmacy Services to Eligible Persons

3.01.01 Professional Judgment and Conduct

All Pharmacy Services must be provided by or under the direct supervision of a Licensed Pharmacist and in accordance with Prescriber directions and applicable Law. Provider must at all times exercise professional judgment in providing Pharmacy Services to an Eligible Person. Provider may refuse to provide Pharmacy Services to an Eligible Person based on professional judgment.

3.01.02 Verification of Eligible Persons

Caremark or Plan Sponsors may provide Eligible Persons with identification cards. Eligible Persons must present an identification card to Provider when having a prescription filled. Provider must utilize the information on the Eligible Person's identification card to submit claims through the claims adjudication system. If an identification card is unavailable at the point of service, Provider must make reasonable efforts to obtain the necessary information for claim submission. Provider will not be reimbursed for providing Pharmacy Services to an Eligible Person whose eligibility was incorrectly submitted.

3.01.03 Identification Cards

In most cases, the identification card will be produced in the most current NCPDP format and will contain the Eligible Person's identification number, RXBIN, RXPCN, and RXGRP. Some Plan Sponsors produce identification cards that may not include this information.

An identification card may show coverage for the Eligible Person only or it may show coverage for the Eligible Person and his or her dependents.

3.01.04 Nondiscrimination

Provider must not discriminate against an Eligible Person on the basis of race, color, national origin, gender, age, religion, disability, medical condition, political convictions, sexual orientation, Eligible Person's enrollment in a Plan, source of payment, marital or family status, or any other basis prohibited by Law. Unless professional judgment dictates otherwise, Provider must deliver Pharmacy Services related to Covered Items to all Eligible Persons.

3.01.05 Eligible Person Solicitation

Provider must not directly or indirectly obtain prescriptions for Eligible Persons via marketing activities including, but not limited to, (1) contacting Eligible Person or Prescriber without a previously existing relationship; (2) obtaining an Eligible Person's primary care provider or billing information through unsolicited methods; and/or (3) contacting or offering to contact a Prescriber on an Eligible Person's behalf without the Eligible Person's express knowledge and authorization for each specific claim. Provider shall not obtain a prescription from a Prescriber not expressly requested by the Eligible Person or by suggesting to an Eligible Person that his or her Prescriber or health plan wants the Eligible Person to receive the medication without the prescriber's express knowledge and authorization. Nothing herein is intended to prohibit Provider from engaging in documented clinical initiatives including, but not limited to, adherence initiatives, gaps-in-care management, or comprehensive medication reviews with Eligible Persons.

Pharmaceutical Manufacturer Coupons that are only eligible to be used at specific pharmacies are not allowed. Certain Pharmaceutical Manufacturer Programs are specifically disallowed including, but not limited to, those from Affordable Medication Solutions, RetainRx, RxData Resources PBM, Phoenix PBM and all associated programs, including, but not limited to, The Association for Precision Pharmacy Services and Arena Health Foundation.

Provider's application of a Pharmaceutical Manufacturer Coupon to reduce a Patient Pay Amount in violation of this section constitutes a prohibited waiver of the Patient Pay Amount.

3.03.04 Proof of Payment

Provider must maintain proof of payment by Eligible Person of the Patient Pay Amount [e.g., copies of cancelled checks (front and back), proof of credit card transactions, or bank deposits for Patient Pay Amounts paid in cash], which shall be subject to Caremark audit and/or compliance review.

Provider must maintain proof of payment of the Patient Pay Amount [e.g., copies of cancelled checks (front and back), proof of credit card transactions, or bank deposits for Patient Pay Amounts paid in cash], by other persons, organizations, foundations, charities, etc., on Eligible Person's behalf, which shall be subject to Caremark audit and/or compliance review.

If the Patient Pay Amount is reduced due to a coordination of benefits (COB), Provider must provide evidence of the COB claim payment by other payer(s), which shall be subject to Caremark audit and/or compliance review.

3.03.05 Excess Collections

If Caremark determines that Provider has charged or collected from an Eligible Person in excess of the Patient Pay Amount communicated by the claims adjudication system, Provider must promptly reimburse Eligible Person for the excess amount upon Caremark request; otherwise, Caremark reserves the right to recover the excess amount from Provider (including by offset against other amounts owing to Provider) and return the recovered amounts to the Eligible Person.

3.03.06 Limitation on Collection

Except for the Patient Pay Amount, Provider cannot bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person for the provision of Pharmacy Services related to a Covered Item in any event, including non-payment by or bankruptcy of a Plan Sponsor or Caremark or where such amount is disallowed or not permitted by a governmental body. For claims of Plan Sponsors who are Medicare Advantage organizations providing Medicare Part C services, Provider must not hold any Eligible Person liable for payment of any fees that are the legal obligation of such Medicare Advantage organization.

3.03.07 Patient Inducements

Provider may not offer or provide any item of value including, but not limited to, gift cards, coupons, or free goods or services, to an Eligible Person to induce or reward the purchase of Pharmacy Services or Covered Items from Provider, unless such items are nominal in value (meaning a value of $15 or less) and the aggregate value of items given to an Eligible Person does not exceed $75 per year, as documented in Provider's records that are subject to audit. Further, notwithstanding the foregoing, Provider may not offer or provide any inducement to an Eligible Person that is prohibited by any applicable Law. This section does not apply to Pharmaceutical Manufacturer Coupons which are addressed in section **3.03.03 Coupons and Other Programs** of the Provider Manual.

3.03.08 Waivers

Provider must promptly collect from the Eligible Person the full Patient Pay Amount as communicated by the claims adjudication system unless otherwise authorized in writing by Caremark or except for a non-routine, unadvertised waiver of a Patient Pay Amount that does not violate applicable Law and is either:

- A waiver based on an individualized determination of financial need made under a Financial Hardship Program that meets the Financial Hardship Program requirements set forth below; or
- A waiver made following exhaustion of reasonable collection efforts, such as invoices, billing letters, and collection calls.

Provider must document its reasonable collection efforts, and such documentation must include, at minimum, the date the collection effort was sent or contact made, the Patient Pay Amount owed by Eligible Person, results of each collection effort, and final disposition.

If a payment plan is agreed to by Provider with an Eligible Person for the payment of a Patient Pay Amount, all terms of the payment plan, including the total amounts subject to the payment plan and repayment terms, must be documented and written confirmation of such terms must be sent to the Eligible Person. The payment plan must be reasonable and expected to result in full collection of outstanding Patient Pay Amounts owed and must be readily retrievable upon request from Caremark.

3.05.03 Prescription Information

All prescription documentation (including electronic records within Provider system and written, faxed, telephoned, and computer-generated orders) for Covered Items written by the Prescriber and dispensed to the Eligible Person, must fulfill the requirements as set forth within applicable Law and contain additional information necessary for proper submission and adjudication of a claim transaction such as:

- Full name of the Eligible Person for whom the prescription was written by the Prescriber and the address at which the Eligible Person resides
- Full name, address, telephone number, and NPI (or other required identification number) of the Prescriber
- Name, quantity, and strength of the medication prescribed
- Specific dosage directions
- Generic substitution instructions (if applicable)
- Notation when Eligible Person requests that a multi-source brand medication be dispensed
- If prescription is changed, notation of the changed prescription element, time, date, name of authorizing person, and affiliation with Prescriber
- Refill instructions
- Miscellaneous or other information as required in accordance with applicable Law
- Prescription hard copies or electronic prescription records for insulin and diabetic supplies must contain complete documentation of items, quantities dispensed and directions for use

Documentation for a vaccine claim transaction, which includes vaccine administration, must be maintained on the prescription hard copy or electronic prescription record, or in the form of a vaccination administration record (when the administration was included within the claim transaction). Documentation must include:

- Detail regarding the administration (e.g., lot number, expiration)
- Date of the administration
- Name and NPI of Provider directly responsible for administration of the vaccine (if the Provider does not have an NPI, provide the NPI of the pharmacy)
- NPI of the Prescriber of the vaccine, following applicable state and federal Law (this may be the same as the Provider administering the vaccine where applicable Law allows)
- Acknowledgement that confirms the Eligible Person received both the medication and the administration

Prescription records must be updated at least annually, or such shorter period as required by applicable Law, and updates include contacting the Prescriber to authorize the prescription order and documenting on the hard copy, electronic prescription record, or Provider systems where it can be readily retrievable. In the case of a long-term care pharmacy's standing medication order, Provider must maintain written record of the prescriber's review and continuation of the standing order within one (1) year prior to the fill date, or such shorter period as required by applicable Law.

During an audit, it may be difficult to remember the circumstances surrounding a particular prescription. Therefore, Caremark recommends that Provider document as much information as possible on the prescription itself, outlining any unusual circumstances that occurred while dispensing the medication. A notation on the prescription may eliminate a question from the Caremark auditor or help to resolve an audit discrepancy.

3.06 Referrals

3.06.01 Referral Fees

Provider shall not offer or pay to any healthcare provider or its affiliates or representatives, directly or indirectly, any payment, commission, kickback, or other consideration, whether in the form of money or otherwise, as compensation or inducement for the referrals of patients or other individuals to Provider for the provision of any pharmacy or other healthcare service.

Provider shall not solicit or receive from any healthcare provider or its affiliates or representatives, directly or indirectly, any payment, commission, kickback, or other consideration, whether in the form of money or otherwise, as compensation or inducement for Provider's referral of patients or other individuals for the provision of any pharmacy or other healthcare service.

3.06.02 Referrals to Non-Retail Participating Providers

Provider must refer Eligible Persons to mail order, specialty, and/or other specified pharmacies for certain Pharmacy Services as appropriate for his or her plan benefit design and in compliance with applicable Law.

Network Pharmacy Providers encounters abusive and disruptive Members, please see Pharmacy help desk service contact information provided in Section III of this PM.

As a Network Pharmacy Provider, Administrator encourages that you keep notes and any documentation concerning abusive and disruptive contact as you may be asked to provide this information at the time you report abusive and disruptive Members.

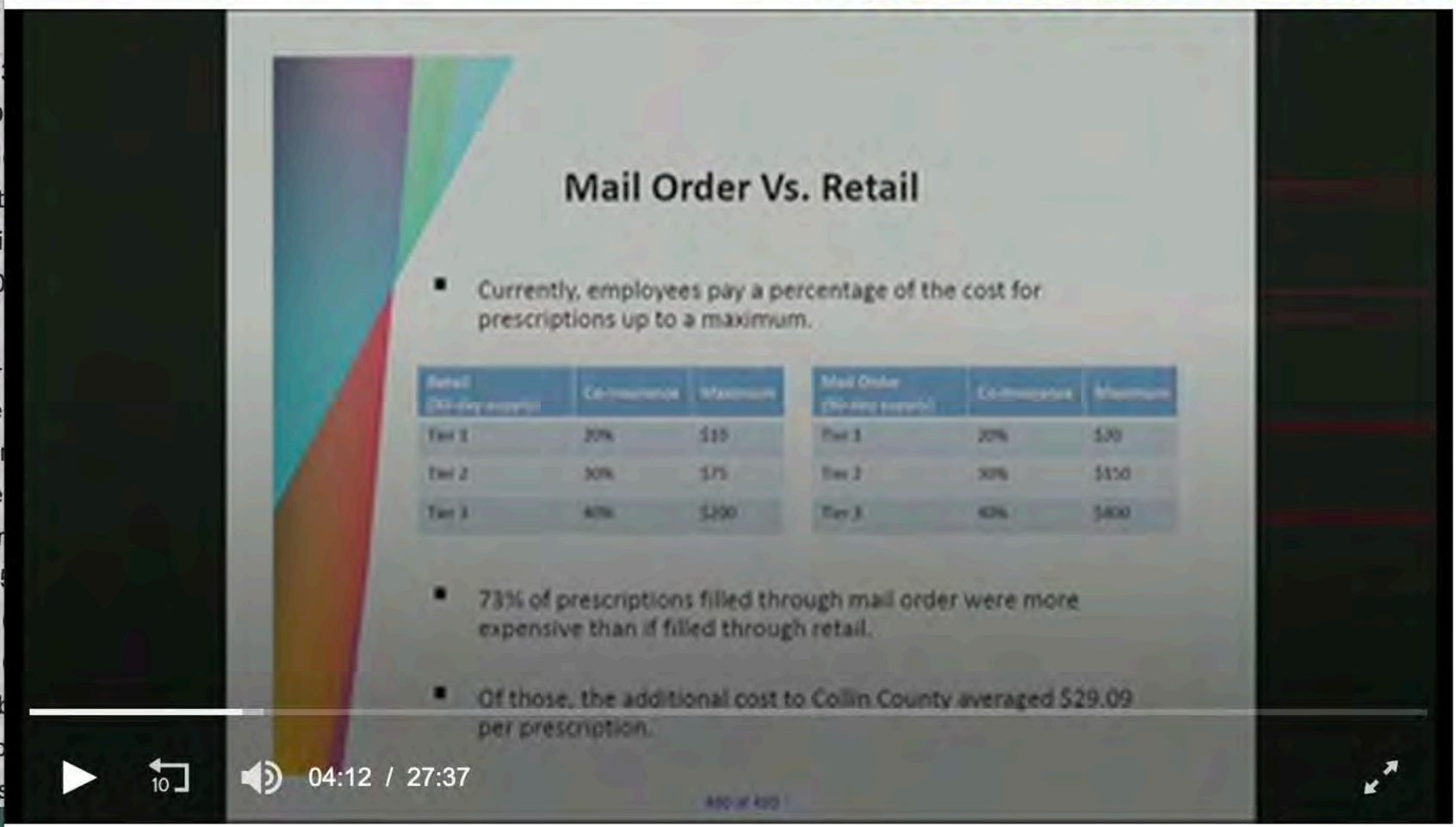
K. National Plan and Provider Enrollment System (NPPES) Updates

Network Pharmacy Providers are strongly encouraged to update their information, including all taxonomy codes, on the
National Plan and Provider Enrollment System (NPPES) at the following location: https://nppes.cms.hhs.gov
The information on NPPES, including your pharmacy's taxonomy information, may be used for network and contract validation by Administrator, Clients and CMS.

L. Termination

Administrator may immediately terminate or suspend the Agreement or any applicable Addendum or Amendment (in whole or in part with respect to an applicable Client, network and/or Network Pharmacy Provider location) pursuant to business needs, Client-specific network design, for, in the opinion of Administrator, actions detrimental to the provider network(s) or for cause, regardless of the network in which the Network Pharmacy Provider participates for reasons including, but not limited to:

- Rejecting Members at the point of sale for a non-clinical reason, including to improve reimbursement;
- Implementing any systematic or other block of a Client's Benefits Plan(s);
- Attempts to steer or redirect Members to other coverage (including other discount card plans);
- Loss of required licensure by a Network Pharmacy Provider or individual location;
- Administrator reasonably believes that Network Pharmacy Provider or Pharmacist is or has been engaged in fraudulent activity of federal/state law;
- Network Pharmacy Provider's insurance required hereunder being canceled, lapsed, terminated or otherwise suspended without replacement coverage;
- Network Pharmacy Provider solicits or attempts to solicit or steer any client of Administrator to terminate its relationship with Administrator or to enter into a direct agreement with Network Pharmacy Provider;
- Network Pharmacy Provider engages in conduct or communication(s), including, but not limited to, contact with any third party, including any Client, Plan and/or a Client or Plan's Member, which disparages Administrator;
- Any attempt by Network Pharmacy Provider to institute an automated reversal process;
- Any attempt by Network Pharmacy Provider to circumvent any security measure that is part of the POS System;
- Network Pharmacy Provider or Pharmacist provides substandard, inferior, contaminated or adulterated Drug Product(s) to any Member;
- Network Pharmacy Provider engages in Mail fulfillment in violation of the Agreement without Administrator's written authorization;
- Administrator determines in its sole and absolute discretion that Network Pharmacy Provider or Pharmacist has violated Administrator's policies and procedures, including without limitation those included in this PM in the provision of Covered Prescription Services;
- Governmental Authority directs Administrator to terminate its relationship with Network Pharmacy Provider;
- Network Pharmacy Provider is otherwise non-compliant with the PM;
- Network Pharmacy Provider violates any law or regulation relevant to performance under the Agreement and with the Network Pharmacy Provider's operations in general;



Video Index | Share

1. Call to order. The board will convene in open session for consideration of the following business matters:

2. Consent agenda to approve:

a. Disbursements for the period ending November 10, 2019, Auditor.

b. Personnel Appointments, Human Resources.

EXECUTIVE SESSION

Executive Session, in accordance with Chapter 551 of the Government Code.

The board reserves the right to convene into executive session throughout this meeting.

Any action resulting from the executive session.

Adjourn.

THE TRUE COST OF FILLING A PRESCRIPTION AND HOW PHARMACIES ARE SUBSIDIZING PBM PROFITS.

ACCORDING TO DISPENSING DATA FROM 16,000 PHARMACIES EVERY PRESCRIPTION COSTS THE PHARMACY

$12.40

BEFORE A PILL EVEN HITS THE BOTTLE

DRUG "X" COSTS THE PHARMACY

+ *$2

*Most drugs cost more than $2, but this example is to show other fixed costs pharmacies have in each prescription

= $14.40

TO FILL THIS PRESCRIPTION

PBM'S "NEGOTIATE" dispensing "Drug X" medication for just $3 in a "TAKE IT OR LEAVE IT" contract.

The pharmacy has $14.40 invested minus the $3 the patient paid.

PHARMACY LOSES $11.40

On this claim PBM's tell plan sponsors they saved the plan $11.40, but in fact the pharmacy subsidized the PBM profit by taking an $11.40 loss.

PHARMACISTS UNITED FOR TRUTH AND TRANSPARENCY

INDEPENDENT *Pharmacy* RECEIPT

INSURANCE PAYS $0.00
PATIENT PAYS $6.00

PHARMACY SUBSIDY $6.00
WITH NO PROFIT & COST OF DRUG NOT FACTORED IN

HOMETOWN *Drug* RECEIPT

INSURANCE PAYS $4.40
PATIENT PAYS $0.00

PHARMACY SUBSIDY $8.00

Thank You

IF YOUR COPAY + THE INSURANCE PAYMENT IS LESS THAN $12.40 YOUR PHARMACY IS SUBSIDIZING YOUR HEALTHCARE & SENDING HEALTHCARE DOLLARS TO OUT-OF-STATE PBMS INSTEAD OF CIRCULATING IT IN YOUR LOCAL ECONOMY.