Purchase Order #2000231042
Amendment # 2

Amendment to Agreement Between

State of Louisiana
Division of Administration
Office of Group Benefits (OGB)

And

MedImpact Healthcare Systems, Inc.
10181 Scripps Gateway Court
San Diego, CA 92131

REPLACE ATTACHMENT III: PRICING with the attached REVISED ATTACHMENT III: PRICING.

Effective Date of Amendment: January 1, 2019

Justification for Amendment: To allow OGB to receive better pharmacy network discounts that have been negotiated by MedImpact with major retail pharmacy chains than are currently provided for in the existing contract.

No Amendment shall be valid until it has been executed by all parties and approved by the Office of State Procurement, Division of Administration.

All other provisions of the Contract shall remain in full force and effect. Any conflict between the Contract and this Amendment regarding the subject matters of this Amendment shall be resolved in favor of this Amendment.

This Amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this Amendment is signed and entered into on the date(s) stated below.

MEDIMPACT HEALTHCARE SYSTEMS, INC.	**STATE OF LOUISIANA DIVISION OF ADMINISTRATION OFFICE OF GROUP BENEFITS**
BY:	**BY:**
NAME: Greg Watanabe	**NAME:** Tommy Teague
TITLE: President and COO	**TITLE:** Chief Executive Officer
DATE: 11-12-2018	**DATE:**

MedImpact

ATTACHMENT III: PRICING (REVISED)

I. Pricing Information

Retail Network Pricing
As of May 16, 2016, 65,834 stores participate nationally in the network.
Return 100% of all retail/mail pharmacy audit overpayments to OGB on a quarterly basis within thirty (30) days from the close of the Contract quarter. In addition, Contractor will provide reporting at no cost to validate overpayments and recoveries.
OGB will always benefit from any Contractor re-contracting with retail pharmacies during any given Contract year, i.e. if rates improve during any Contract year, those rates will be passed through to OGB assuming they are better than the current Contract rates.
Both OGB and Plan Participant will receive the financial benefit of U&C pricing.
The retail billing formula and Contract will include a formula that is calculated as the lower of AWP – X% + dispensing fee, U&C, or MAC + dispensing fee, where X% will be a pass through of Proposer as the lower of discounts pharmacy contract rate with each pharmacy.
The Plan Participant will always pay the "lesser of 3" (discounted price, Copay, U&C). A "minimum charge at retail" shall not apply to any transaction for any stores.
Plan Participant Copayments will not be included in any discount calculation (billing, guarantee or otherwise). To clarify the above, if the AWP of a Generic product is $10, the discounted cost is $6 and the Plan Participant Copay is also $6 (leaving a zero balance due from the Plan), the discount % off of AWP for both billing and guarantee purposes would be 40% off of AWP.
Any billing formula and all related financial guarantees will be based on the AWP and associated discount on the date of service of each individual prescription.
Excess Copays (i.e., Plan Participant pays the difference amounts or any other ancillary charges) will not be included in any billing or guaranteed discount.
All billing discounts and related guarantees will be calculated using only the billing formula used to process the Claim. No other monies (i.e. audit savings, clinical savings, therapeutic interchange savings, DUR savings, etc.) will be included in any billed amounts, guarantees or otherwise.
Mail and Retail 90 day pricing applies to Claims filled with 84 days' supply or greater.
Usual & customary Claims are included in the measurement of network guarantees.
Zero balance Claims are included in the measurement of network guarantees at the discounted price (not at 100% discount).
The following Claims are excluded from network performance measurements: over the counter (OTC) drug Claims, compound Claims, paper Claims (DMR), pharmacy submitted paper Claims, discount card programs Claims, Claims where the Contractor negotiated rate was not the basis for adjudication, prescription subrogation Claims, limited distribution drug ("LDD") Claims, and Claims submitted by OGB-contracted Participating Pharmacies.
Bio-similar products will be included in the Brand guarantee.
Pricing is based upon the eligible Plan Participants provided at the time of the Proposal. If the number of eligible Plan Participants changes by ten percent (10%) or more after the first month of the term of this Contract, or any subsequent month of the term, resulting in a material impact on the ability to achieve financial guarantees, pricing contained herein is subject to change.
Network performance guarantees proposed are based on the Plan design and clinical programs as outlined in the Proposal.
Network guarantees are based on OGB's Formulary and benefit design. Changes to either may cause a negative impact to network performance. Patent expiration products will not have an impact.
In the event OGB makes any modification to Contractor's standard Formulary (including but not limited to prior authorization guidelines or utilization management edits), it may be considered and treated as a custom

Retail Network Pricing
Formulary and may be subject to additional fees and custom Formulary requirements. Any such Formulary modifications may impact network performance and a new network performance guarantee may be required.

Formulary Rebates
Contractor will pass through 100% of all rebates (base, incentive, administrative fee rebate & all other monies received from pharmaceutical manufacturers, including any inflation cap guarantees), with a minimum guarantee per Brand claim, measured as set forth in the Contract.
Rebate guarantees are for real rebates received from pharmaceutical manufacturers and do not include other amounts (i.e. therapeutic interchange savings, etc.).
For the avoidance of doubt, all Brand claims (single source, multi-source, Formulary, non-formulary etc.) will be included in the Formulary guarantee.
Brand claims where the Plan Participant paid 100% of the cost of the transaction will be included in the calculation.
Rebate payments and guarantees proposed are based on the Plan design and clinical programs as outlined in this RFP.
Rebate guarantee amounts will be fixed for the term of the Contract and cannot be altered for any reason other than a change in government legislation which materially impacts the current economics of the rebating process between pharmaceutical manufacturers and managed care organizations and has a material adverse impact on rebates that OGB receives or if a Generic product is unexpectedly introduced to the market ahead of the anticipated Generic date as long as OGB does not make Formulary or benefit changes that negatively impact yield.
In the event OGB makes any modification to Contractor's standard Formulary (including but not limited to prior authorization guidelines or utilization management edits), it may be considered and treated as a custom Formulary and may be subject to additional fees and custom Formulary requirements. Any such Formulary modifications may reduce rebate return and a new rebate guarantee may be required.
The rebate credit will not be conditioned on the days of supply performance averaging a defined target during the Contract term. Said differently, as long as the Plan allows up to a thirty (30)-day supply at retail and up to a ninety (90)-day supply at retail, the full rebate credit will be provided to OGB. The Proposer cannot pro-rate guarantees based on the achieved utilization performance, nor set a floor days of supply performance amount that needs to be achieved to be eligible for the guarantees.
If the number of retail pharmacies in the Contractor's network is reduced by more than 5% cumulatively before the Effective Date and or at any point during the Contract term, Contractor will provide OGB with an improved pricing offer for the proposed smaller retail network at least ninety (90) days prior to the effective date of such change. Pharmacies that close are excluded from this stipulation.
Rebates are based on Formulary and benefit design. Changes to either may cause a negative impact to rebate yield. Patent expiration products will not have an impact to rebate guarantee offers.
Rebate guarantees are based on national trend and growth assumptions derived from statistics compiled by leading academic centers and research institutes such as Centers for Disease Control or National Medical Association. Rebate guarantees may be adjusted if OGB utilization varies from national statistics used in assumptions. Compound drug Claims and vaccine Claims are excluded from the rebate guarantees.
The rebate guarantees are based on Brand Drug Claims.

General Information
A full replacement Consumer Driven Health Plan ("CDHP") will not change pricing.
All pricing guarantees will be trued up and any shortfalls will be paid to OGB within one hundred eighty (180) days after said termination.

General Information
Upon termination of the Contract, Contractor will provide all necessary documentation, Claims files, prescription history and other data needed for the successful transition of the program to the appointed vendor within a mutually agreed reasonable timeframe at no additional cost to OGB. This includes, but is not limited to, all open mail orders and specialty pharmacy refills, prior authorizations, accumulators used in all Plan options, and at least six (6) months of historical Claims data. In addition, Contractor will furnish information for any governmental programs that may be audited (ERRP and/or EGWP). Standard file layouts will be provided at no cost to OGB. If custom file layouts are needed, programming charges may be applied toward OGB's implementation credit. Additionally, open mail order and specialty refill file charges from the vendors may be applied toward OGB's implementation credit.
Contractor will provide and support OGB after termination of this Contract with any and all required data feeds for class action settlements with drug manufacturers. These files will be provided at no cost to OGB.
OGB has the right to audit any data necessary to ensure Contractor is complying with all Contract terms and guarantees, which includes but is not limited to the following: 100% of pharmacy claims data, pharmaceutical manufacturer and wholesaler agreements, mail and specialty pharmacy contracts to the extent they exist with other vendors, approved and denied utilization management reviews, clinical program outcomes, appeals, information related to the reporting and measurement of performance guarantees set forth herein as well as any other accounts, procedures, matters, and records directly pertaining to the Contract, for a period of five (5) years after final Contract payment or such longer period as required by applicable state and federal Law. Contractor will provide all documentation necessary for OGB and/or its consultant to audit all data and items within the timeframe specified at the time of request.
Contractor will provide OGB and/or its consultant a copy of the actual MAC list used for audits upon request.
For compound drugs, each ingredient is calculated based on the AWP discount or MAC price, summed, and then the standard fill fee is added.
Contractor is able to reject or add a prior authorization to compound drugs at point of sale at no additional cost.
Contractor will not charge for the integration of medical and pharmacy data to manage PPACA OOP requirements when standard files are exchanged regardless if Contractor has a current connection with OGB's ASO vendor. Custom files may incur programming fees that can be applied towards implementation credit.
Contractor will provide a detailed analysis describing OGB savings and Plan Participant disruption, with all underlying assumptions to OGB at least ninety (90) days prior to the effective date of the proposed network change if it impacts more than 5% of pharmacies in the network (add, drop, etc.) and is proposed before the Effective Date and/or during the Contract term.
A dispensing fee applies to U&C Claims; however, it is not additive. The discounted AWP is netted down so that the ingredient cost plus the dispensing fee equals the U&C price.
Contractor shall pass through the amount paid to the Participating Pharmacy, which shall be the same amount that Contractor will invoice OGB. The pharmacy network guarantees specified are representative pharmacy reimbursement amounts (including AWP discount and MAC) and dispensing fees. However, OGB will pay hereunder, the actual reimbursement rate, MAC and dispensing fee paid to the applicable Participating Pharmacy. The actual reimbursement paid to a Participating Pharmacy may be greater or less than the guarantees identified.

Specialty
New products in existing classes will be priced at the default rate of AWP – 14.5%.
Specialty Claims filled through retail will be priced at no less than the standard network discount.

Mail Service Pricing
Contractor will offer MAC for mail transactions, and the MAC list and price schedule used will be the same (or better) as the MAC list and pricing schedule used for retail transactions.
The mail billing formula and Contract will include a formula that is calculated as the lower of AWP - X% + dispensing fee or MAC + dispensing fee, where "X%" will be a documented minimum fixed discount for all Claims in the Contract if the MAC price is not better; i.e., the billing formula must include a minimum fixed discount for all transactions. There should be no need for any type of "effective Brand average".
Excess Copay from the Plan Participant, meaning the Plan Participant will always pay the lesser of the discounted price or Copay at mail, will not be retained.
Plan Participant Copayments will not be included in any discount calculation (billing, guarantee or otherwise). To clarify the above, if the AWP of a Generic product is $10, the discounted cost is $6 and the Plan Participant Copay is also $6 (leaving a zero balance due from the Plan), the discount percentage off of AWP for both billing and guarantee purposes would be 40% off of AWP.
The billing formula and all related financial guarantees will be based on the AWP and associated discount on the date of service of each individual prescription.
Excess Copays (i.e., Plan Participant pays the difference amounts or any other ancillary charges) will not be included in any billing or guaranteed discount.
All billing discounts and related guarantees will be calculated using only the billing formula used to process the Claim. No other monies (i.e. audit savings, clinical savings, therapeutic interchange savings, DUR savings, etc.) will be included in any billed amounts, guarantees or otherwise.
Pricing will be fixed for all Claims, regardless of the days of supply of the individual prescription. For example, Contractor cannot price mail Claims below a certain days of supply threshold at the retail rate.
A minimum charge at mail will not apply to any prescription.
The mail service dispensing fee will be fixed at $0.00 for the duration of the Contract, and will not be subject to any types of increase (postage increases, handling increases, etc.).

II.

Retail Network Pricing (Base Retail Network)	Contract Year 1 (2017)	Contract Year 2 (2018)	Contract Year 3 (2019)
Brand Discount: The annual average Brand effective discount guarantee rate.	17.00%	17.10%	18.25%
Generic Discount: The annual overall Generic discount guarantee.	80.60%	80.85%	82.50%
Dispensing Fee: The overall annual guarantee.	$0.90	$0.90	$0.65

Retail 90 Network Pricing (Extended Supply Network - ONLY IF REQUESTED)	Contract Year 1 (2017)	Contract Year 2 (2018)	Contract Year 3 (2019)
Brand Discount: The annual average Brand effective discount guarantee rate.	21.50%	21.60%	22.50%
Generic Discount: The annual overall Generic discount guarantee.	84.00%	84.25%	86.50%
Dispensing Fee: The overall annual guarantee.	$0.00	$0.00	$0.00

Mail Pricing	Contract Year 1 (2017)	Contract Year 2 (2018)	Contract Year 3 (2019)
Brand Discount: The value of "X" in the lower of AWP - X% or MAC.	24.00%	24.00%	24.50%
Generic Discount: The annual overall Generic discount guarantee.	84.00%	84.25%	86.50%
Dispensing Fee: It is expected this will be zero.	$0.00	$0.00	$0.00

Specialty and Retail Specialty Pricing	Contract Year 1 (2017)	Contract Year 2 (2018)	Contract Year 3 (2019)
Minimum discount for all new products in new therapeuticclasses	14.50%	14.50%	18.00% (Exclusive) 15.25% (Open)
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.	15.25%	15.25%	16.00%
Dispensing fee for Specialty Claims filled through specialty pharmacy	$0.00	$0.00	$0.00 (Central Fill) $1.00 (Retail)
Dispensing fee for Specialty Claims filled through retail pharmacy	Contracted retail dispensing fee applies	Contracted retail dispensing fee applies	Contracted retail dispensing fee applies

EGWP

Retail Network Pricing (Base Retail Network)	Contract Year 1 (2017)	Contract Year 2 (2018)	Contract Year 3 (2019)
Brand Discount: The annual average Brand effective discount guarantee rate.	17.55%	17.65%	19.10%
Generic Discount: The annual overall Generic discount guarantee.	81.75%	82.00%	83.00%
Dispensing Fee: The overall annual guarantee.	$0.80	$0.80	$0.60

Retail 90 Network Pricing (Extended Supply Network - ONLY IF REQUESTED)	Contract Year 1 (2017)	Contract Year 2 (2018)	Contract Year 3 (2019)
Brand Discount: The annual average Brand effective discount guarantee rate.	22.30%	22.40%	23.00%
Generic Discount: The annual overallGeneric discount guarantee.	85.00%	85.25%	86.50%
Dispensing Fee: The overall annual guarantee.	$0.00	$0.00	$0.00

Mail Pricing	Contract Year 1 (2017)	Contract Year (2018)	Contract Year 3 (2019)
Brand Discount: The value of "X" in the lower of AWP - X% or MAC.	24.00%	24.00%	24.50%
Generic Discount: The annual overall Generic discount guarantee.	85.00%	85.25%	86.50%
Dispensing Fee: It is expected this will be zero for all Claims.	$0.00	$0.00	$0.00

Specialty and Retail Specialty Pricing	Contract Year 1 (2017)	Contract Year 2 (2018)	Contract Year 3 (2019)
Minimum discount for all new products in new therapeutic classes	14.50%	14.50%	17.00% (Exclusive) 15.25% (Open)
Aggregate annual discount guarantee across all Specialty Drugs (not filled throughretail). This will include all specialty products, including bio- generics, biosimilars, limited distribution, etc.	15.25%	15.25%	17.00% (Exclusive) 15.25% (Open)
Dispensing fee for Specialty Claims filled through specialty pharmacy	$0.00	$0.00	$0.00
Dispensing fee for Specialty Claims filled through retail pharmacy	Contracted retail dispensing fee applies	Contracted retail dispensing fee applies	Contracted retail dispensing fee applies

III. Rebates

Commercial

Minimum Rebate Guarantees (Broad	Contract Year 1 (2017)	Contract Year 2 (2018)	Contract Year 3 (2019)
Minimum annual rebate guarantee per retail network Brand Claim	$58.00	$64.37	$71.63
Minimum annual rebate guarantee per retail 90 network extended supply Brand Claim (if requested)	$144.41	$162.06	$178.79
Minimum annual rebate guarantee per mail Brand Claim	$159.49	$177.19	$199.83
Minimum annual rebate guarantee per retail Specialty network Claim	$406.56	$449.97	$494.97
Minimum annual rebate guarantee per Specialty Claim	$406.56	$449.97	$494.97

Minimum Rebate Guarantees (MedPerform Exclusionary Formulary)	Contract Year 1 (2017)	Contract Year 2 (2018)	Contract Year 3 (2019)
Minimum annual rebate guarantee per retail network Brand Claim	$83.23	$92.73	$110.00
Minimum annual rebate guarantee per retail 90 network extended supply Brand Claim (if requested)	$231.66	$258.13	$300.00
Minimum annual rebate guarantee per mail Brand Claim	$275.78	$307.28	$350.00
Minimum annual rebate guarantee per retail Specialty network Claim	$752.84	$836.33	$1,000.00
Minimum annual rebate guarantee per Specialty Claim	$752.84	$836.33	$1,000.00

Rebate Caveats

Rebate guarantees require the following conditions:

- Specialty is defined as a drug cost of $670 or higher
- Follow MedPerform in entirety (including PCSK9 drugs)
- Non Drugs, Vaccines, OTC, Compound drugs, Claims where the member paid greater than 50% of the cost of the claim, claims not meeting minimum day supply criteria are excluded
- Day Supply Minimum - Retail 30 & Specialty = 30; Retail 90 & Mail = 90
- A change to utilization by 10% or more would allow for reevaluation of rebate guarantees

EGWP

Minimum Rebate Guarantees	Contract Year 1 (2017)	Contract Year 2 (2018)	Contract Year (2019)
Minimum annual rebate guarantee per retail network Brand Claim	$56.28	$63.56	$120.00
Minimum annual rebate guarantee per retail 90 network extended supply Brand Claim (if requested)	$131.58	$148.60	$220.00

Minimum annual rebate guarantee per mail Brand Claim	$145.05	$163.81	$450.00
Minimum annual rebate guarantee per retail Specialty network Claim	$492.63	$556.32	$850.00
Minimum annual rebate guarantee per Specialty Claim	$492.63	$556.32	$850.00

Rebate Caveats

Rebate guarantees require the following conditions:

- Specialty is defined as a drug cost of $670 or higher
- Follow Standard Closed formulary in entirety
- Non Drugs, Vaccines, OTC, Compound drugs, Claims where the member paid greater than 50% of the cost of the claim, claims not meeting minimum day supply criteria are excluded
- Day Supply Minimum - Retail 30 & Specialty = 30; Retail 90 & Mail = 90
- A change to utilization by 10% or more would allow for reevaluation of rebate guarantees

IV. Claims Processing Administrative Fees

Commercial

Admin Fee per final net paid Claim	Contract Year 1 (2017)	Contract Year 2 (2018)	Contract Year 3 (2019)
Admin fee per final net paid retail Claim*	$0.68	$0.68	$0.68
Admin fee per final net paid retail 90 extended supply Claim	$0.68	$0.68	$0.68
Admin fee per final net paid mail Claim	$0.68	$0.68	$0.68
Admin fee per final net paid Specialty pharmacy Claim	$0.68	$0.68	$0.68
Admin fee per final net paid retail Specialty Claim	$0.68	$0.68	$0.68

*Includes vaccine Claims.

EGWP

Admin Fee per final net paid Claim	Contract Year 1 (2017)	Contract Year 2 (2018)	Contract Year 3 (2019)
Admin fee per final net paid retail Claim*	$1.65	$1.65	$1.65
Admin fee per final net paid retail 90 extended supply Claim	$1.65	$1.65	$1.65
Admin fee per final net paid mail Claim	$1.65	$1.65	$1.65
Admin fee per final net paid Specialty pharmacy Claim	$1.65	$1.65	$1.65
Admin fee per final net paid retail Specialty Claim	$1.65	$1.65	$1.65

*Includes vaccine Claims.

V. Clinical Management Fees

Below are the clinical management programs offered by Contractor. Programs will be implemented as selected by OGB. OGB and Contractor agree to modify clinical management programs as needed based on OGB Plan Participant health needs. For new clinical management programs and/or initiatives not currently implemented by OGB, or beyond those described in this Contract, the role of the Contractor, scope of services, and price will be mutually agreed prior to implementation and subject to the approval of the OGB CEO or as applicable Office of State Procurement, and any other approval required by Law.

Commercial

Comprehensive Trend Management Package:

Clinical Trend Management Services	Per Plan Participant Per Month Cost
Comprehensive Clinical Trend Management Package: • Point of Service Clinical Management Edits	$0.34

Clinical Trend Management Services	Per Plan Participant Per Month Cost
o Step Therapy Package o Quantity Limit Package o Prior Authorization Package o Age Edit Package o Standard Retrospective Drug Use Evaluation (DUE) Programs o MedFocus® • Standard Concurrent Drug Utilization Review • Enhanced Retrospective Drug Use Evaluation (DUE) Programs o High Risk Safety Management Programs (Polypharmacy) • Overutilization & Safety Controls Programs o Safety Controls at POS Interventions o Opiate Overutilization Intervention Program • Patent Exclusivity Management (Brand over Generic) • Drug Exclusions • Compound Strategy • Dispense as Written Difference • Diabetic Management Program	

Clinical Trend Management Services:

Clinical Trend Management Services	Per Plan Participant Per Month Cost
Prior Authorization – Full Service Therapeutic PA Request Administration	$45/Therapeutic PA Request No additional charge for operational PA requests
Prior Authorization – Appeals Administration	$100/administrative appeal $225/first level clinical appeal
Utilization Management 13 Delegation UM13 Element C is the NCQA standard on patient safety. This is included as Contractor's Claims processing in the form of DUR processing if there is a safety related class 1 or class 2 medication recall. Contractor will provide reporting to OGB of utilizing Plan Participants and their prescribers for notification.	Included in Claims Administration Fee

Optional Cost Containment Programs:

Optional Cost Containment Programs	Per Plan Participant Per Month Cost
Prior Authorization Notification via IVR Interactive Voice Recognition (IVR) automated phone calls are made on all finalized prior authorizations to the Plan Participant to notify of the PA decision.	$1.50 added to basic PA fee

Optional Cost Containment Programs	Per Plan Participant Per Month Cost
MedResults® Plan Participant/Prescriber Preferred Medication Communication Program Physician and/or Plan Participant outreach programs are designed to help OGB achieve the following goals: increase generic utilization, increase Formulary compliance, improve clinical management and improve quality. Claims are targeted at the point of sale and letters are generated the next business day.	$5,000 Implementation Fee Per Program +
MedResults® - Cost Focused Programs • Formulary Alignment/Formulary Compliance – This program targets non-formulary Brand medications and sends letters to either physicians or Plan Participants encouraging them to switch to a Formulary Brand or Formulary Generic alternative.	$0.08 PMPM per Therapeutic Class
• Dose Optimization (aka Strength) - This program identifies patients who may benefit from modifying the dosing strength of a drug. It delivers education messages to physicians asking them to move Plan Participants from twice daily dosing to once daily dosing. This program can also target moving Plan Participants from one tablet to half tablet.	$0.04 PMPM per Therapeutic Class
MedResults® - Quality Focused Programs • Drug-Drug Interaction (DDI) – This program identifies Plan Participants who are potentially taking medications inappropriately by targeting Claims that have been filled after being flagged as a Level 1 drug interaction. The letter requests a response from the physician (for example, physician will discontinue an interacting medication, physician previously aware of the drug interaction, or physician will evaluate for an alternative medication).	$0.04 PMPM Minimum $8,000/year per program per Therapeutic class $225/hour for scope changes (any modifications to the program post implementation)
High Cost Generic Performance Management A comprehensive set of service and intervention programs designed to optimize the utilization of generic products within a plan sponsor's membership that delivers significant cost savings and enhances the overall cost-effective utilization of prescription drugs within pharmacy benefit programs: • Clinical Consultative Services to identify target HCGs and appropriate alternative medications • Plan Participant and physicians communication campaigns • Active prescription conversion program • Implementation and coordination of all services • Reporting and performance management services	Implementation fee: $10,000 + Monthly Program Fee: $0.25 PMPM *Program estimates, including fees, subject to change if any other exclusions to target population of OGB01, OGB02, OGB03, OGB04

Optional Reporting and Analytics:

Optional Reporting and Analytics:	Per Plan Participant Per Month Cost
QPMP Dashboard Quality Performance Monitoring Program (QPMP) is a competitive analysis and clinical targeting tool. By identifying care and adherence gaps and suggesting pharmacy based solutions, QPMP provides plans with an opportunity to mitigate performance issues that could affect end of year quality measurements and thus marketplace perception and rankings. This monitoring program version provides: • Tabular quarterly summary reports • Benchmarking against average Book of Business Modifications to any of the standard QPMP components set forth herein will be quoted upon request. Note: Quarterly reports are delivered 4 weeks after close of quarter. The full report is contingent on availability 12 months of historical Claims and eligibility data.	Set-up Fee: $2,500 + Program Fee: $25,000/year
QPMP Data File Program: Monthly Reports Program that leverages advanced analytics to determine patterns of patient behavior for targeted intervention strategies. This program supports plans with actionable information for use by care management and pharmacy teams. Program includes: • Monthly data files contain Plan Participant-level and Claim-level information and detailed prescriber and pharmacy information. • Prioritization for intervention efforts using variables known to be predictive of medication adherence. Factors include: o Plan Participants with more than 1 adherence issue o Plan Participants' adherence levels o Use of 30 versus 90 day Claims o New start to therapy o Plan Participants with 2 and 1 High-Risk Medications o Plan Participants with Diabetes not on a Statin Information contained in this program is specific to the Medicare Part D Star Ratings (or display measures where applicable).	$5,000 Set-up Fee + A la carte Program Fee: $12,000 annually per individual measure
Custom data file orientation including formatting, sorting, and flagging to meet OGB's needs. Technical specification must be set up prior to program launch in order to maximize efficiencies with services for Contractor and OGB.	Included
Physician Access Physician Access is a web-based tool that allows physicians to view online patient prescriptions fulfillment and compliance data over the previous twelve (12) months. All medications are shown on this report unless restricted by state, federal or plan regulations. The tool is designed to allow physicians to improve their awareness of patients' use of prescription drugs in order to	$5,000 one-time set-up fee + $2,000 monthly maintenance fee

Optional Reporting and Analytics:	Per Plan Participant Per Month Cost
increase compliance, decrease the incidence of escalating dosages and prevent drug interactions. Within the Contractor Physician Portal, the tool allows for access to reports that can be made a part of the patient medical record: • Generates a detailed report outlining a patient's drug history. Charts related compliance rates for the medications in the report.	
Personal Health Report Card Contractor's Personal Health Report Card is a Plan Participant engagement tool designed to help Plan Participants monitor their drug utilization, increase awareness of medication costs, and improve medication adherence. The standard Personal Health Report Card for Plan Participants is based upon pharmacy Claims and includes the following components: • A comprehensive listing of all prescription Claims for the last six months • An adherence rating with the number of fills and a generic identifier • Medication cost information including the total cost of the medication, the Plan Participant's cost share, and the amount the plan has saved the Plan Participant. • General reminders to all Plan Participants, such as reminders for lab tests, screening and immunizations The Personal Health Report Card is a simple, easy-to-understand report that can serve as a valuable tool for Plan Participants in managing their health. Plan Participants are encouraged to share their report card with their physician or pharmacist. The PHRC can help Plan Participants take an active role in managing their health and can improve overall Plan Participant satisfaction with their Plan.	Implementation fee: $5,000 + $10.00 per report

Optional Care Quality and Safety Management Programs:

<table>
<tr><th>Optional Care Quality and Safety Management Programs</th><th>Per Plan Participant Per Month Cost</th></tr>
<tr><td>Enhanced Retrospective Drug Use Evaluation (DUE) Programs
Physician outreach programs focused on care quality along with safety management interventions incorporating the identification of Plan Participants utilizing medications in a manner suggesting less than optimum drug therapy utilization with written communication to prescriber requesting a reassessment of therapy.

Care Quality Programs
Quarterly Claims sweep on a three month rotating basis with follow-up communication to prescriber no more often than quarterly.
Migraine – Prophylaxis in Severe Disease
Statin Use in People with Diabetes (SUPD)
Cardiovascular – Lipid Medication Use in Diabetics
Asthma - Controller Use in Asthma
Osteoporosis – Fracture Prophylaxis

High Risk Safety Management Programs
Monthly Claims sweep with follow-up communication to prescriber monthly. Potentially Inappropriate Medications in Elderly/Beers. Includes outreach fees.</td><td>Bundled Fee
$0.14 PMPM
Minimum
$25,000/year

Individual Program Fees

$0.02 PMPM
$0.02 PMPM
$0.03 PMPM
$0.03 PMPM
$0.02 PMPM

$0.02 PMPM

$6,000 Set Up Per Program Minimum
$8,000/year each program selected.</td></tr>
<tr><td>Custom Retrospective Drug Use Evaluation (DUE) Programs
Physician outreach programs focused on care quality and safety management incorporating the identification of Plan Participants utilizing medications in a manner suggesting less than optimum drug therapy utilization with written communication to prescriber requesting a reassessment of therapy.

Fully Customized Programs
• Customized Intervention Program
• Develop customized communication program based upon unique utilization patterns in consultation with OGB.</td><td>Quoted upon
request and receipt of business requirements, minimum
$30,000/year</td></tr>
<tr><td>Refill Reminder Program
Plan Participant outreach program focused on medication non-adherence incorporating the identification of Plan Participants whose refill patterns suggest less than optimal medication utilization with communication to the Plan Participant reminding him/her to refill medications.
Letter-based or automated telephonic (IVR) interventions available to improve adherence in the following therapeutic classes:
• Oral Diabetes Agents
• Hypertension (ACE/ARB/DRI)
• Hypercholesterolemia (Statins)
Additional features of the IVR program include collection of Plan Participant response data identifying reasons for</td><td>Letter Program: $3,000 set-up fee
+
$0.30 PMPM, minimum $30,000 annually
IVR:
$7,500 set-up Plus Eligibility PMPM
0-99,000: $0.49
100K -500K: $0.37
>500K: $0.24
Minimum $30,000 annually

Additional classes available at $0.04 PMPM each, minimums above apply</td></tr>
</table>

Optional Care Quality and Safety Management Programs	Per Plan Participant Per Month Cost
non-adherence for further plan sponsor intervention (i.e., "I'm having side effects" or "I don't believe I need to take it").	
Choice 90 Optimization Program Provider outreach program focused on medication non-adherence incorporating the identification of Plan Participants filling 30 day supply at a 90 day retail pharmacy with communication and pre-populated prescription to the prescriber to encourage 90 day fill. Daily interventions are available to improve adherence to maintenance medications.	$5,000 Set Up Fee + $0.30 PMPM Minimum $30,000/year per program

Prescriber Q-Card™ Program
Prescribers are often not aware of how their patients take their medications on a day to day basis. By raising the awareness to the prescriber of how patients are taking their chronic medication(s) the prescriber is able to better address potential barriers that were otherwise not apparent to them. The purpose of Contractor's Prescriber Q-Card Program is to engage the prescribing community to help facilitate an understanding of how their patients are taking specific medications for key chronic conditions.
 	
The Q-Card is a prescriber-specific report that:
• Highlights a summary of their patient(s) sub-optimal medication use
    o e.g. poor adherence, gaps in care, high risk medication use
• Contrasts the prescribers' patients performance to their peers
    o e.g. a cardiology specialist is compared to all other patients prescribed by other cardiologist
• Identifies individual patient's opportunities for improved medication use
    o Additionally, the program can identify prescribers and their patients with optimal medication use
The Q-Card can be delivered via direct mailing to the prescriber or be made available as a data file format for OGB use. In some cases, OGB can use internal staff including care managers or pharmacists to provide direct consultation to large provider groups that treat many patients. The data file format can be designed as a flexible tool that can be filtered to provide a summary, benchmark and detailed performance of any prescriber; or used to focus only on prescribers with Plan Participants having suboptimal medication use; or to target prescribers who care for Plan Participants with multiple medication use issues.
	$10,000 implementation fee
	+
	$0.10 PMPM or $45,000 annual minimum
	
	Program fee includes:
	• Identification of target prescribers and their patients
	• Comparative benchmarks that may include Contractor's market segment-specific Book of Business data, all of OGB-specific performance data or prescriber specialty-specific data
	• Up to 3 target measures will be included in the prescriber report (e.g., adherence to 3 medication categories, or 2 adherence and 1 gap in care measure, etc.)
	• Selection of measures are available from the suite of QPMP Dashboard measures
	• Data Files used to prepare the Prescriber Q-Cards - monthly provided
	• Limited custom consideration to [OGB] physician information
	*Same target measure within a 1 year cycle (4 quarterly reports)

Mango Health A mobile health application using consumer design expertise and gaming concepts to engage Plan Participants	$3.00 per active user per month (active user defined as using the app once per month)

Optional Care Quality and Safety Management Programs	Per Plan Participant Per Month Cost
in daily medication management, a positive first step toward health for those suffering from chronic diseases. As Plan Participants build positive daily habits around medication management, they become healthier, happier and more productive.	

EGWP

Comprehensive Clinical Trend Management Package:

Clinical Trend Management Services	Per Plan Participant Per Month Cost

Comprehensive Clinical Trend Management Package:
• Point of Service Clinical Management Edits
    o Prior Authorization Pack age
    o Step Therapy Package
    o Quantity Restriction Package
• Standard Concurrent Drug Utilization Review
• Standard Retrospective Drug Use Evaluation (DUE) Programs
• Overutilization & Safety Controls Programs
    o Safety Controls at POS Interventions
    o Opiate Overutilization Intervention Program
• MTM Program (MTMP) Full Service
• Patent Exclusivity Management (Brand over Generic)
• Drug Exclusions
• Compound Strategy
• Dispense as Written Difference
• Diabetic Management Program
• High Risk Medications in the Elderly
• Diabetes/Lipids
	Included in Claims Administration Fee

Clinical Trend Management Services:

Clinical Trend Management Services	Per Plan Participant Per Month Cost
Prior Authorization – Full Service Therapeutic PA Request Administration	$45/Therapeutic PA Request No additional charge for operational PA requests
Prior Authorization – Appeals Administration	$100/administrative appeal $225/first level clinical appeal

Optional Cost Containment Programs:

Optional Cost Containment Services	Per Plan Participant Per Month Cost
Prior Authorization Notification via IVR Interactive Voice Recognition automated phone calls are made on all finalized prior authorizations to the Plan Participant to notify of the PA decision	$1.50 added to basic PA fee
MedResults® Plan Participant/Prescriber Preferred Medication Communication Program Physician and/or Plan Participant outreach programs are designed to help OGBs achieve the following goals:	$5,000 Implementation Fee Per Program +

Optional Cost Containment Services	Per Plan Participant Per Month Cost
increase generic utilization, increase Formulary compliance, improve clinical management and improve quality. Claims are targeted at the point of sale and letters are generated the next business day.	
MedResults® - Cost Focused Programs • Formulary Alignment/Formulary Compliance – This program targets non-formulary Brand medications and sends letters to either physicians or Plan Participants encouraging them to switch to a Formulary Brand or Formulary Generic alternative.	$0.08 PMPM per Therapeutic Class
• Dose Optimization (aka Strength) - This program identifies patients who may benefit from modifying the dosing strength of a drug. It delivers education messages to physicians asking them to move Plan Participants from twice daily dosing to once daily dosing. This program can also target moving Plan Participants from one tablet to half tablet.	$0.04 PMPM per Therapeutic Class
MedResults® - Quality Focused Programs • Drug-Drug Interaction (DDI) – This program identifies Plan Participants who are potentially taking medications inappropriately by targeting Claims that have been filled after being flagged as a Level 1 drug interaction. The letter requests a response from the physician (for example, physician will discontinue an interacting medication, physician previously aware of the drug interaction, or physician will evaluate for an alternative medication).	$0.04 PMPM Minimum $8,000/year per program per Therapeutic class $225/hour for scope changes (any modifications to the program post implementation)

Optional Reporting and Analytics:

Optional Reporting and Analytics:	Per Plan Participant Per Month Cost
QPMP Dashboard Quality Performance Monitoring Program (QPMP) is a competitive analysis and clinical targeting tool. By identifying care and adherence gaps and suggesting pharmacy based solutions, QPMP provides plans with an opportunity to mitigate performance issues that could affect end of year quality measurements and thus marketplace perception and rankings. This monitoring program version provides: • Tabular quarterly summary reports • Benchmarking against average Book of Business	Set-up Fee: $2,500 + Program Fee: $25,000/year

<table>
<tr><th>Optional Reporting and Analytics:</th><th>Per Plan Participant Per Month Cost</th></tr>
<tr><td>Modifications to any of the standard QPMP components set forth herein will be quoted upon request.

Note: Quarterly reports are delivered 4 weeks after close of quarter. The full report is contingent on availability 12 months of historical Claims and eligibility data.</td><td></td></tr>
<tr><td>Quality Performance Monitoring Program (QPMP) Data File Program: Member Priority List Program
Program that utilizes advanced data analytics critical for clinical targeting. Program identifies and prioritizes Plan Participants based on their calculated adherence level and a number of risk factors including comorbidity, number of target medication categories, new start Plan Participants, etc.
Program provides a quick and accurate method to:
1. Improve overall plan adherence rate by stratifying Plan Participants based on risk
2. Prioritizes care management outreach to Plan Participants by identifying several key predictors for medication adherence issues

Primary targeted medication measures include, but are not limited to:
• Medication Adherence for Diabetes
• Medication Adherence for Hypertension (RAS Antagonists)
• Medication Adherence for Hypercholesterolemia (statins)
Note: This program is delivered and only available at year end and can be bundled with QPMP Data File Program: Monthly Reports. Reports are provided monthly starting 5 months before the end of the calendar year.</td><td>$5,000 Set-up fee

+

A la carte Program Fee: $8,000 annually per individual measure

Or

$5,000 Set-up fee Plus

Bundled Program Fee: $20,000 annually for all 3 adherence measures</td></tr>
<tr><td>QPMP Data File Program: Monthly Reports Program that leverages advanced analytics to determine patterns of patient behavior for targeted intervention strategies. This program supports plans with actionable information for use by care management and pharmacy teams. Program includes:
• Monthly data files contain Plan Participant-level and Claim-level information and detailed prescriber and pharmacy information.
• Prioritization for intervention efforts using variables known to be predictive of medication adherence. Factors include:
o Plan Participants with more than 1 adherence issue
o Plan Participants' adherence levels
o Use of 30 versus 90 day Claims</td><td>$5,000 Set-up Fee
+
A la carte Program Fee:
$12,000
annually per individual measure

Or

$5,000 Set-up Fee
+
Bundled Program Fee:
$45,000
annually for all 5 measures</td></tr>
</table>

Optional Reporting and Analytics:	Per Plan Participant Per Month Cost
○ New start to therapy ○ Plan Participants with 2 and 1 High-Risk Medications ○ Plan Participants with Diabetes not on a Statin Information contained in this program is specific to the Medicare Part D Star Ratings (or display measures where applicable). Star Rating Package Targeted medication measures include: • High Risk Medications in Elderly • Statin Use in Persons with Diabetes (CMS Patient Safety Measure) • Medication Adherence for Hypertension (RAS Antagonists) • Medication Adherence for Hypercholesterolemia (statins) Custom data file orientation including formatting, sorting and flagging to meet OGB needs. Technical specifications must be set up prior to program lunch in order to maximize efficiencies with services for Contractor and OGB.	Included

Optional Reporting and Analytics:	Per Plan Participant Per Month Cost
Physician Access Physician Access is a web-based tool that allows physicians to view online patient prescriptions fulfillment and compliance data over the previous twelve (12) months. All medications are shown on this report unless restricted by state, federal or plan regulations. The tool is designed to allow physicians to improve their awareness of patients' use of prescription drugs in order to increase compliance, decrease the incidence of escalating dosages and prevent drug interactions. Within the Contractor Physician Portal, the tool allows for access to reports that can be made a part of the patient medical record: • Generates a detailed report outlining a patient's drug history. Charts related compliance rates for the medications in the report.	$5,000 one-time set-up fee + $2,000 monthly maintenance fee
Personal Health Report Card Contractor's Personal Health Report Card is a Plan Participant engagement tool designed to help Plan Participants monitor their drug utilization, increase awareness of medication costs, and improve medication adherence. The standard Personal Health Report Card for Plan Participants is based upon pharmacy Claims and includes the following components: • A comprehensive listing of all prescription Claims for the last six months • An adherence rating with the number of fills and a generic identifier • Medication cost information including the total cost of the medication, the Plan Participant's cost share, and the amount the plan has saved the Plan Participant. • General reminders to all Plan Participants, such as reminders for lab tests, screening and immunizations The Personal Health Report Card is a simple, easy-to-understand report that can serve as a valuable tool for Plan Participants in managing their health. Plan Participants are encouraged to share their report card with their physician or pharmacist. The PHRC can help Plan Participants take an active role in managing their health and can improve overall Plan Participant satisfaction with their Plan.	Implementation fee: $5,000 + $10.00 per report

Optional Care Quality and Safety Management Programs:

Optional Care Quality and Safety Management Programs	Per Plan Participant Per Month Cost
Custom Retrospective Drug Use Evaluation (DUE) Programs Physician outreach programs focused on care quality and safety management incorporating the identification of Plan Participants utilizing medications in a manner suggesting	Quoted upon request and receipt of business requirements, minimum $30,000/year

Optional Care Quality and Safety Management Programs	Per Plan Participant Per Month Cost
less than optimum drug therapy utilization with written communication to prescriber requesting a reassessment of therapy. **Fully Customized Programs** • Customized Intervention Program • Develop customized communication program based upon unique utilization patterns in consultation with OGB.	
Star Forecaster® (for Medicare OGBs Only) Contractor's Star Forecaster program is an early warning system that addresses Medicare Part D Plan sponsors need to know if there is a problem before it is too late. The Star Forecaster services use advanced analytics and a statistical model to estimate year-end performance and overall program value including return on investment (ROI). Services are tiered into 3 Levels to meet a variety of OGBs' needs. **Level 1: "Modeling the Value of Star Ratings"** • Annual consultation on total value contributions that make up Star Ratings • Annual assessment of the total value (or risk) associated with the Star Rating program • Model value contribution of Star Ratings as they relate to Quality Bonus Payments and membership growth/loss **Level 2 (includes Level 1): "Measuring and Forecasting Specific Star Measure Performance"** • Forecast of specific Part D clinical Star Rating measures using pharmacy Claims data and membership eligibility data • Accurate estimate of Star Rating measurements for 5 of the Part D Star Rating measures • Simulate calculation for Final Star Ratings which are otherwise not available or incomplete until PDE data is used to calculate performance • Comparative assessment of current year against prior year performance for 5 of the Part D Star Rating measures Star Rating Performance Measures included are: High Risk Medications in Elderly, Diabetes Treatment - Anti-Hypertensive Use in Diabetics, Oral Diabetes Agents Adherence, Hypertension (ACE/ARB/DRI) Adherence, Statin Adherence.	**Level 1 Only Fee:** $10,000 annually **Levels 1 and 2 Combined Fee:** $30,000 annually
Mango Health A mobile health application using consumer design expertise and gaming concepts to engage Plan Participants in daily medication management, a positive first step toward health for those suffering from chronic diseases. As	$3.00 per active user per month (active user defined as using the app once per month)

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