STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS

July 29, 2020

Ms. Pamela Rice
Assistant Director, Professional Contracts
DOA-Office of State Procurement
P.O. Box 94095
Capital Annex – Room 207
Baton Rouge, Louisiana 70804-9095

Re: Request for Emergency Contract for Pharmacy Benefit Manager Services effective 1/1/2021 through 12/31/2021

Dear Ms. Rice:

The Office of Group Benefits is required by R.S. 42:821 to administer a health benefits program on behalf of its plan participants and their covered dependents. Pursuant to that mandate, OGB issued an RFP to contract for pharmacy benefit manager services. (Solicitation RFP 3000014397) Five proposals were received. It was determined that the proposal submitted by Clutch Health, LLC did not meet mandatory requirements of the RFP. After the review and evaluation of the remaining proposals, the evaluation committee selected CaremarkPCS Health, LLC ("CVS") for the pharmacy benefits manager services contract. CVS was provided the Notice of Intent to Award on July 9, 2020. CVS was the proposer with the highest evaluation score and the lowest cost. On July 23, 2020, Clutch Holdings, LLC., and MedImpact Healthcare Systems, Inc., (the incumbent vendor) filed protests and, as a result thereof, the Office of State Procurement on July 23, 2020, decided to stay the award of Solicitation No. RFP 3000014397 in compliance with La R.S. 39:1671.

Due to the time sensitive nature of the contract approval process, the pharmacy benefit manager services implementation process, and OGB's need to provide all eligible plan participants information regarding the pharmacy benefit plan for calendar year 2021, OGB is requesting approval to enter into an emergency contract with CaremarkPCS Health, LLC ("CVS") effective January 1, 2021. OGB is requesting that the emergency contract be effective for the duration of January 1, 2021 through December 31, 2021, in order to prevent any service, benefit, and formulary disruption to the OGB plan participants that elected coverage in the OGB self-funded

health plans for calendar year 2021. The current contract with the incumbent vendor expires December 31, 2020. It is in the best interest of the state enter into an emergency contract, to ensure that OGB plan participants and their covered dependents have pharmacy benefit coverage for the OGB self-funded health plan offerings. OGB must provide all necessary information to plan participants regarding the PBM contract that will be in place January 1, 2021.

There are approximately 207,831 OGB plan participants in the OGB self-funded health plans and the pharmacy benefits (PBM services) included in that health benefit offering. The participants in the self-funded health plans, (with the exception of Pelican HSA plan) depend on OGB to have a pharmacy benefit manager contract in place. Time is of the essence, OGB must notify all of the OGB plan participants of the PBM contractor's benefit plan, provide information on the pharmacy network, and formulary related with the offering. The OGB annual enrollment period begins on October 1, 2020. Plan participants will need to elect the plan offering of their choice within the annual enrollment period. OGB submits that not having known pharmacy benefits in place for October 1, 2020, would cause delay to annual enrollment as to pharmacy benefits, and will cause confusion for plan participants. Failure to provide pharmacy benefits information to eligible plan participants would result in an inefficient annual enrollment.

OGB is also requesting an emergency contract because implementation of a pharmacy benefit manager services contract cannot be delayed. The implementation of a PBM services contract must begin as soon as possible due to the nature of the contract, specifically getting the formulary and benefits in place for calendar year 2021. A PBM emergency contract being approved and timely implemented will ensure that pharmacy benefit coverage to OGB plan participants and their covered dependents remains in place. It is imperative that we have an emergency contract in place for pharmacy services in order to have information by the annual enrollment start date and to allow for sufficient implementation time.

OGB must have an emergency contract for the pharmacy benefit manager services. OGB is requesting that you issue a determination that an emergency contract be issued under R.S. 39:1600(E). OGB's annual enrollment period begins October 1, 2020. OGB submits that not having known the pharmacy benefits in place for October 1, 2020, would cause a delay to annual enrollment as to pharmacy benefits for the self-funded health plans and will cause confusion for plan participants, resulting in an inefficient annual enrollment. Additionally, a pharmacy benefit services contract must implemented timely to be in place by January 1, 2021. Again, there are approximately 207,831 OGB plan participants in the OGB self-funded health plans and the pharmacy benefits (PBM services) that depend upon these pharmacy benefits. There is an imminent threat to the public health and welfare of this group if a contract is not in place by January 1, 2021.

Additionally, we ask that this request be expedited due to the timeline for contract approval. The OGB contract approval requirement for contracts includes submitting the PBM contract to OGB's Board and Estimating Conference and Joint Legislative Committee on the Budget for review and approval (a two month process).

I look forward to working with you and your staff on this emergency contract.

Sincerely,

Tommy Teague
Chief Executive Officer
Office of Group Benefits

RS 39:1598

§1598. Emergency procurements

A. Conditions for use. The chief procurement officer or his designee above the level of procurement officer may make or authorize others to make emergency procurements when there exists an imminent threat to the public health, welfare, safety, or public property under emergency conditions as defined in accordance with regulations.

B. Written quotations. Every effort shall be made to obtain quotations from three or more vendors when supplies, services, or major repairs are to be purchased on an emergency basis, except for standard equipment parts for which prices are established. Immediate purchasing shall be discouraged as much as is practicable. When supplies, services, or major repairs are urgently required and time does not permit the obtaining of written quotations, the procurement officer may obtain quotations by telephoning or otherwise, but such quotations shall be made on the relative purchase requisitions. So far as practicable, quotations shall be secured from institutions of the state as provided by law.

C. Determination required. The chief procurement officer shall make a written determination of the basis of the emergency that includes the facts and circumstances leading to the conclusion that such procurement was necessary as well as a written determination detailing the steps taken prior to selecting a particular contractor and the basis for the final selection. The written determination shall be included in the contract file either prior to contracting or as soon thereafter as practicable.

Added by Acts 1979, No. 715, §1, eff. July 1, 1980; Acts 2014, No. 864, §2, eff. Jan. 1, 2015.

EMERGENCY CONTRACT

On this __ day of September, 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");

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.

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.

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.

MBI – Medicare Beneficiary Identifier.

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

NDC – the National Drug Code.

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.

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.

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.

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.**

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

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.

3.7 FINANCIAL GUARANTEES

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

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 LEGAL REQUIREMENTS

17. 1 ACT 124 OF THE 2019 REGULAR LEGISLATIVE SESSION

The Contractor shall comply with all laws of the State of Louisiana, including but not limited to, Act 124 (Senate Bill 41) of the 2019 Regular Legislative Session, as applicable to Contractor and the services provided pursuant to this Contract.

17.2 LA. R.S. 40:2870, ACT 124 OF THE 2019 REGULAR LEGISLATIVE SESSION

The Contractor shall comply with all laws of the State of Louisiana, including but not limited to La. R.S. 40:2870, Act 124 (Senate Bill 41) of the 2019 Regular Legislative Session, as applicable to Contractor and the services provided pursuant to this Contract. In adhering to La. R.S. 40:2870, Contractor shall not:

(1) Commit any unfair and deceptive trade practice prohibited by R.S. 22:1964(15).

(2) Perform any act that violates the duties, obligations, and responsibilities imposed under the Louisiana Insurance Code on a pharmacy benefit manager.

(3) Buy, sell, transfer, or provide personal healthcare or contact information of any beneficiary to any other party for any purpose with one exception. A pharmacy benefit manager may provide such information regarding beneficiaries of a health plan to that health plan provider if requested by the health plan provider.

(4) Conduct or participate in spread pricing as defined in R.S. 22:1863(9) without providing the notice required by R.S. 22:1867.

(5)(a) Directly or indirectly engage in patient steering to a pharmacy in which the pharmacy benefit manager maintains an ownership interest or control without making a written disclosure and receiving acknowledgment from the patient. The disclosure required by this Paragraph shall provide notice that the pharmacy benefit manager has an ownership interest in or control of the pharmacy, and that the patient has the right under the law to use any alternate pharmacy that they choose. The pharmacy benefit manager is prohibited from retaliation or further attempts to influence the patient, or treat the patient or the patient's claim any differently if the patient chooses to use the alternate pharmacy.

(b) The provisions of this Paragraph shall not apply to employers, unions, associations, or other persons who employ, own, operate, control, or contract directly with a pharmacy or pharmacist for the purpose of managing or controlling prescription costs paid for the benefit of an employee or member or those covered by the employee or member's plan, or when the persons contract with a pharmacy benefit manager to steer employees or members to pharmacists or pharmacies which the person owns, operates, or controls.

(6)(a) Penalize a beneficiary or provide an inducement to the beneficiary for the purpose of getting the beneficiary to use specific retail, mail order pharmacy, or another network pharmacy provider in which a pharmacy benefit manager has an ownership or controlling interest or that has an ownership or controlling interest in a pharmacy benefit manager.

(b) For purposes of this Paragraph, “inducement” means the providing of financial incentives, including variations in premiums, deductibles, copayments, or coinsurance.

(c) The provisions of this Paragraph shall not apply to employers, unions, associations, or other persons who employ, own, operate, control, or contract directly with a pharmacy or pharmacist for the purpose of managing or controlling prescription costs paid for the benefit of an employee or member or those covered by the employee or member's plan, or when the persons contract with a pharmacy benefit manager to steer employees or members to pharmacists or pharmacies which the person owns, operates, or controls.

(7) Retroactively deny or reduce a claim of a pharmacist or pharmacy for payment or demand repayment of all or part of a claim after the claim has been approved by the pharmacy benefit manager as authorized by R.S. 22:1856.1.

(8) Reimburse a local pharmacist or local pharmacy, as defined in R.S. 46:460.36(A), less than the amount it reimburses chain pharmacies, mail-order pharmacies, specialty pharmacies, or affiliates of the pharmacy benefit manager for the same drug or device or for the same pharmacy service in this state.

(9) Fail to update prices as required by R.S. 22:1857.

(10)(a) Fail to honor maximum allowable cost (MAC) prices as set forth in R.S. 22:1863 et seq.

(b) Shall not require a pharmacist or pharmacy to purchase drugs from any particular wholesaler. However, if Contractor recommends or provides a wholesaler, then that wholesaler must be willing and able to honor the Contractor's MAC price, ship the order, and have receipt of the order within two business days with no additional charge to the pharmacist.

(c) If the wholesaler chooses not to sell the drug to the pharmacist or pharmacy, then the MAC price set by Contractor must be adjusted to the price available to the pharmacist or pharmacy through another wholesaler.

(11) Fail to meet the payment standards established in R.S. 22:1856.

(12) Fail to provide detailed remittance advice to pharmacists and pharmacies in compliance with R.S. 22:1856.

(13)(a) Fail to pay any state or local sales tax imposed on any drug, device, or pharmacy services or to remit the sales tax to the appropriate pharmacist or pharmacy for the tax proceeds to be forwarded to the sales tax authority.

(b) As provided in La. R.S. 40:2870, if Contractor does not pay the sales tax, Contractor shall be liable to the taxing authority for the tax, interest, penalties, and any other fees or costs imposed by law for failure to pay sales taxes.

(c) Contractor shall not deduct the taxes from any amount due to a pharmacist or pharmacy for a drug, device, or pharmacy service or charge or pay anyone a fee or surcharge for paying any sales tax or remitting any sales tax proceeds to a pharmacist or pharmacy if that fee or surcharge would be imposed directly or indirectly on the pharmacist or pharmacy.

(d) If Contractor pays any out-of-state pharmacist or pharmacy for drugs or devices shipped to a beneficiary in this state or for pharmacy services rendered to a beneficiary which is taxable in this state, Contractor shall remit the tax directly to the appropriate taxing authority.

(e) State or local sales taxes and other applicable state-imposed taxes or fees shall be considered as part of the allowable cost and shall be included in the claim submitted by a pharmacist or pharmacy.

(14) Restrict early refills on maintenance drugs to an amount less than seven days for a prescription of at least a thirty-day supply.

(15) Require a beneficiary to follow a plan's step therapy protocol if the prescribed drug is on the health plan's prescription drug formulary, the beneficiary has tried the step therapy required

prescription drug while under his current or previous health plan, and the provider has submitted a justification and supporting clinical documentation that such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse effect or event.

(16) Delay a decision on a request for authorization to dispense a prescription drug for more than seventy-two hours, or twenty-four hours in exigent circumstances in which the patient, in the opinion of the prescribing provider, pharmacy, or pharmacist submitting the authorization request, is suffering from a health condition that may seriously jeopardize the patient's life, health, or ability to regain maximum function. A request for authorization shall include relevant data or appropriate documentation to render a decision on a request for authorization.

(17) Exploit prescription drug information obtained from beneficiaries for monetary gain or economic power over beneficiaries, pharmacists, or pharmacies.

(18) Sell, exchange, or use in any manner prescription drug information regarding a beneficiary obtained through a beneficiary's use of a prescription for purposes of marketing, solicitation, consumer steering, referral, or any other practice or act, except as otherwise provided for in this Section, that provides the pharmacy benefit manager or any of its affiliates or subsidiaries economic power or control over pharmacists or pharmacies or interferes in the free choice of a beneficiary.

(19) Engage in drug repackaging and markups. If Contractor owns or controls a mail-order pharmacy, Contractor shall not allow the mail-order pharmacy to repackage drugs and sell the repackaged items at higher prices than the original average wholesale price unless beneficiaries who may buy the repackaged drugs are informed in writing that the drugs have been repackaged and are being sold at the higher price.

(20) Operate in Louisiana without either being registered with and in good standing with the Louisiana secretary of state to do business in Louisiana or being licensed by and in good standing with the commissioner of insurance, as provided by this Chapter.

18 MAIL ORDER

The Contractor shall not steer OGB plan participants to use a mail order pharmacy by penalizing plan participants for not selecting mail order or by offering any inducement for the purposes of increasing plan participants' usage of mail order. The Contractor shall not solicit OGB plan participants' usage of mail order pharmacies by advertising, marketing, or promoting its mail order pharmacy, either orally or in writing, including online messaging. This provision does not prohibit the Contractor from including the mail order pharmacy option with other annual enrollment and general information that includes all options of obtaining pharmaceuticals.

19 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.

20 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.

21 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, 2021 no later than July 31, 2021. 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.

22 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: Ms. Renita Ward Williams, Interim CEO
Office of Group Benefits
Post Office Box 44036
Baton Rouge, LA 70804

Or

Ms. Renita Ward Williams, Interim CEO
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.

23 HEADINGS

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

24 ENTIRE AGREEMENT

This is the complete Contract between the parties with respect to the subject matter and all prior discussions and negotiations are merged into this Contract. This Contract is entered into with neither party relying on any statement or representation made by the other party not embodied in this Contract and there are no other agreements or understanding changing or modifying the terms. This Contract shall become effective upon final statutory approval**.**

25 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.

26 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.

27 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.

28 MARKET CHECK PROVISION

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.

29 PREFERRED CLIENT

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.

30 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.

31 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.

32 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: Renita Ward Williams	**NAME:** _____
TITLE: Interim 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 transition and ongoing services in the following amounts for commercial and EGWP:
    - Commercial implementation credit [redacted] Per Net New Member ("PNNM") for the emergency contract;
    - EGWP implementation credit [redacted] PNNM for the emergency contract; and,
    - Pre-Implementation audit credit is included in the [redacted] 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 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 [redacted] Per Member Per Year ("PMPY") for the emergency contract term; and,
    - EGWP administrative fund in the amount of [redacted] 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.
- 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 included in attachment I (A): Supplemental Scope of Work/Services.
- 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.
- 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.
- 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 [redacted] 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.

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.

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, 2021. Contractor shall also provide a bridge letter to OGB for the period of January 1-June 30, 2021.	The Contractor's SOC 1, Type II shall be provided on or before March 31, 2022. Contractor shall provide bridge letter for the period of January 1-June 30, 2021 no later than July 31, 2021.
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 the calendar year.
OGB Satisfaction Survey	Conduct annual OGB satisfaction survey and report results to OGB.	Within thirty (30) calendar days after end of the 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.
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 December 31, 2021.

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 [redacted] 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 [redacted] 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 [redacted] 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 [redacted] 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 [redacted] 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	5%

	Implementation Project Plan, but at least [redacted] 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.	
Eligibility Load - Accuracy	Participant eligibility loaded into the PBM system will be [redacted] 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 [redacted] of members will be mailed ID cards and/or Welcome Booklets by the date agreed upon in the Implementation Project Plan, but at least [redacted] Business Days prior to the Go-Live/Effective Date.	5%
Member ID Cards/Welcome Kit – Accuracy	Vendor guarantees that [redacted] of all ID cards and Welcome Booklets mailed to members will be [redacted] 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 [redacted] Business Days before open enrollment materials are mailed, and maintained during open enrollment.	5%
Customer Service Call Accuracy	[redacted] 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 [redacted] 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 [redacted] 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 [redacted] of inquiries/concerns raised from Client, and/or their designees, within [redacted] 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 [redacted] 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 [redacted] Business Days from its receipt and will respond to follow-up inquiries about the same items initially identified within [redacted] Business Days. The response times may be extended if mutually agreed upon in writing in advance.	2%
Post Implementation		

Pharmacy Network Disruption	At least [redacted] 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	[redacted] of retail direct reimbursement claims processed for payment or rejected and responded to within [redacted] business days.	1%
Retail Point-of-Sale Claims Adjudication Accuracy	Adjudication accuracy rate of at least [redacted] for all claims processed at point of sale.	1%
Mail Order Turnaround for Prescription Drugs Requiring No Intervention	[redacted] of mail orders for prescription drugs requiring no intervention (i.e., clinical verification, prior authorization, etc.) will be shipped within [redacted] 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	[redacted] of mail orders for prescription drugs requiring administrative/clinical intervention will be shipped within [redacted] business days.	1%
Mail Order Dispensing Accuracy	[redacted] or greater accuracy of mail order prescriptions dispensed with no errors.	1%
Wait Time for Pharmacist/Clinical Support Supervisor	[redacted] of Plan Participant calls that are transferred to a pharmacist or supervisor will be answered within [redacted] minutes.	1%
Specialty Pharmacy Dispensing Accuracy	[redacted] or greater of specialty pharmacy prescriptions filled with no errors.	1%
Specialty Adherence Rate	Adherence rate for patients using specialty pharmacy of at least [redacted]. 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%
Average Speed to Answer	[redacted] of calls will be answered by a live voice within [redacted] 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	0%

	excludes calls routed to Interactive Voice Response ("IVR").	
Abandoned Call Rate	[redacted] 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	[redacted] 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 [redacted] business days.	3%
Plan Participant Written Inquiry Timeliness	[redacted] of all Plan Participant written inquiries will be responded to and resolved within [redacted] business days and [redacted] within [redacted] business days.	3%
Plan Participant Satisfaction Survey	Satisfaction rate must be [redacted] or greater, using metrics mutually agreed by Contractor and OGB prior to January 1, 2022.	5%
OGB Satisfaction Survey	Satisfaction rate must be [redacted] or greater, using metrics mutually agreed by Contractor and OGB prior to January 1, 2022.	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 [redacted] of all new Plan Participant identification cards within [redacted] 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 [redacted] 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 [redacted] or less, measured monthly.	1%
Eligibility Processing Accuracy	[redacted] of electronically transmitted eligibility processed accurately within [redacted] 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, 2021.	$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 represent more than [redacted] 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 [redacted] 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 [redacted] 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 [redacted] 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	[redacted] of members will be sent accurate ID cards and other CMS required materials within [redacted] 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 operation during the first part of the plan year	10%
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	2%

	as well as additional face-to-face meetings, as needed throughout implementation.	
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 [redacted] 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 [redacted] business days.	1%
Retail Point-of-Sale Claims Adjudication Accuracy	Adjudication accuracy rate of at least [redacted] for all claims processed at point of sale.	1%
Mail Order Turnaround for Prescription Drugs Requiring No Intervention	[redacted] of mail orders for prescription drugs requiring no intervention (i.e., clinical verification, prior authorization, etc.) will be shipped within [redacted] 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	[redacted] of mail orders for prescription drugs requiring administrative/clinical intervention will be shipped within [redacted] business days.	1%
Mail Order Dispensing Accuracy	[redacted] or greater accuracy of mail order prescriptions dispensed with no errors.	1%

Wait Time for Pharmacist/Clinical Support Supervisor	[redacted] of Plan Participant calls that are transferred to a pharmacist or supervisor will be answered within [redacted].	1%
Specialty Pharmacy Dispensing Accuracy	[redacted] or greater of specialty pharmacy prescriptions filled with no errors.	1%
Specialty Adherence Rate	Adherence rate for patients using specialty pharmacy of at least [redacted]. 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 [redacted] of calls will be answered by a live voice within [redacted] 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	[redacted] 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	[redacted] 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 [redacted] business days.	3%
Plan Participant Written Inquiry Timeliness	[redacted] of all Plan Participant written inquires will be responded to and resolved within [redacted] business days and [redacted] within [redacted] business days.	3%
Plan Participant Satisfaction Survey	Satisfaction rate must be [redacted] or greater, using metrics mutually agreed upon by Contractor and OGB prior to January 1, 2022.	5%
OGB Satisfaction Survey	Satisfaction rate must be [redacted] 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 [redacted] of all new Plan Participant identification cards within [redacted] 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 [redacted] 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 [redacted] or less, measured monthly.	0%
Eligibility Processing Accuracy	[redacted] of electronically transmitted eligibility files processed accurately within [redacted] 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, 2021.	$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 represent more than [redacted] 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.	[redacted]
Commercial Ongoing Performance Guarantees: Total dollar at risk for the Ongoing (January 1, 2021-December 31, 2021) Performance Guarantees.	[redacted]
EGWP Implementation Performance Guarantees: Total dollar at risk for the Implementation Performance Guarantees.	[redacted]
EGWP Ongoing Performance Guarantees: Total dollar at risk for the Ongoing (January 1, 2021-December 31,2021) Performance Guarantees.	[redacted]

ATTACHMENT I (A): SUPPLEMENTAL SCOPE OF WORK/SERVICES

This Supplemental Scope of Work/Services is hereby made a part of Attachment I: Scope of Work/Services and provides additional clarification and detail regarding the manner in which the Contractor shall provide the Emergency Contract services. In the columns below, OGB has presented various questions regarding Contractor and the services, and Contractor has provided its response and, as applicable, related explanations. In this Attachment I.A, all references to "CVS Caremark" shall mean Contractor.

#	Question	Response	Explanation
A	**GENERAL INFORMATION BACKGROUND**		
A1	Are you currently in the process of any system conversions (i.e., adjudication platform, reporting tools including web-based, phone, clinical, mail order, website, etc.)? If yes, which systems and when is completion expected?	No. CVS Caremark is not in the process of any system conversions that would impact services to OGB.	
A2	Provide the date (month and year) of the last major system revision (i.e., adjudication platform, reporting tools including web-based, phone, clinical, mail order, website, etc.), how long it took to implement, and describe the type of revision or enhancement to each system.	CVS Caremark completed migration of all existing client business to our RxClaim platform in January 2017, the project took approximately 5 years. All new business is implemented on this adjudication platform. RxClaim is a single, next-generation claims adjudication platform that incorporates features to support our clients' plan design requirements and is presented through an enhanced user interface. Our single platform strategy allows us more efficient delivery of product innovations for all our clients.	
A3	Are there any major changes, upgrades, or modifications of your systems scheduled in the next thirty-six (36) months? If yes, describe your product changes (i.e., enhancement, upgrades, etc.), processes and procedures, and implementation schedule.	We are not planning on any major changes, upgrade, or modification to our systems in the next thirty-six (36) months.	

A4	Provide OGB with a list of all entities or persons to which you intend to subcontract any work required under this Contract or utilize in connection with providing services to OGB. Subcontractors should include, but not be limited to, any third-party mail order pharmacy, third-party specialty drug pharmacy, re-packager, rebate aggregator, call center, service center, and/or pharmacy auditor.	We directly furnish the core PBM services through our PBM subsidiaries or affiliates and do not have a strategic alliance or subcontract arrangement for such core PBM services. For support or ancillary services, we have provided a list of the vendors that assist in the provision of such services.	

A5	Provide an overview of your top three (3) cost containment initiatives scheduled for implementation during the life of this proposed Contract that could align with OGB's population and Plan design. For each initiative, provide details on how the program works or will work, impact to the Plan Participant, and how OGB would benefit from this initiative.	*The answer provided in response to this question contains confidential information that is proprietary to, and constitutes trade secrets of, CVS Caremark. CVS Caremark's trade secret and/or proprietary information is exempt from disclosure under applicable public records laws.* 1) Real-Time Benefits To help prescribers and provide members to have convenient access to affordable and cost transparency to medications, CVS Caremark offers real-time benefits across all key points of care. CVS Caremark is committed to transparency wherever the member is on the health care continuum. Real-time benefits further build on our connections with electronic health records, bringing the system closer to true, seamless interoperability. Using our technology and data sharing capabilities, we are able to connect providers with real-time information to ensure more informed decision-making and coordinated care, leading to lower costs and a better member experience. With our solution, all of the information is integrated into the e-prescribing workflow, enabling prescribers to make more informed decisions and select a clinically appropriate medication that may be more affordable for the member. If the selected drug has any restrictions, connected prescribers will also be able to immediately submit an electronic PA (ePA) request. With real-time benefits, even before a prescription is written, the provider will have member-specific information available at their fingertips, including: - Cost of a selected drug based on the member's plan coverage, deductible, and how much of the deductible the member has met. - Up to five clinically appropriate therapeutic	2) Pharmacy Advisor Our Next Generation Pharmacy Advisor® solution is designed to better engage members in the management of prevalent and costly chronic conditions, leading to improved health outcomes. The method of engagement occurs at the retail pharmacy setting within our national network, as well as through telephonic outreach as well as through text, email, and interactive voice response. Medication management is a critical component of an overall health management strategy, and pharmacists are uniquely suited to help members achieve optimal therapy. In addition, we use predictive analytics to identify and stratify highest risk members. Pharmacy Advisor provides targeted interventions for members who are receiving an initial prescription to treat a chronic condition, are non-adherent to prescribed medications, or who may have gaps in their drug therapy. Pharmacy Advisor has a [redacted] ROI, and the performance will be measured on an annual basis. 3) Health Advisor Health Advisor is a new product that empowers smarter care decisions by delivering individualized next best actions through digital channels, provider outreach, 1:1

		alternatives, that may also be at a lower cost, generated from our database of drug classes, mapped for clinical substitution and specific to the member's formulary. - Restrictions on the selected drug, such as prior authorization (PA), step therapy requirements, or quantity limits. - Whether the selected pharmacy is in network. When the member takes a prescription to the pharmacy, our integrated technology will enable the pharmacist to see the same list of clinically appropriate formulary alternatives. At CVS Pharmacy, the information will be integrated into the pharmacist's workflow, making it easy to engage patients and inform them about potentially lower-cost alternatives, based on formulary coverage. If the member's prescription is for a medication not on the formulary, the CVS pharmacist will be able to request a prescription change from the provider at the click of a button. Increasing connectivity through interoperability, eliminating blind spots, and providing transparent access to information at critical decision points will help members get the medications they need faster, more easily, and affordably, enabling them to be more engaged in their own care and benefits. Through the Check Drug Cost tool on Caremark.com and the Caremark app. CVS Caremark views this as a great way to engage prescribers at the right time and also provide cost transparency to OGB members. Real-Time Benefits information and access includes, but not limited to, the following health systems in Louisiana: - Franciscan Missionaries of Our Lady Health System and Its Subsidiaries and Affiliates	pharmacist counseling to improve health outcomes and reduce medical costs. Health Advisor leverages enterprise capabilities and medical claims, pharmacy claims and lab data to drive higher engagement and better care delivery through a comprehensive behavior change platform. Based on a member's risk profile, low-touch and high-touch channels are used to deliver next best actions. Low-touch channels include provider fax, direct mail, email, SMS/text, interactive voice response (IVR). High-touch channels include Pharmacist Panel – The high-touch delivery channel intensifies outreach for the top 5 percent of high-risk members by providing proactive, ongoing support by a pharmacist to deliver better outcomes. Pharmacist Panel leverages behavioral insights and analytics to provide tailored education to members. Intervenes proactively, up to 6 health interviews/consultations annually (face-to-face and/or telephonically) for those high-risk members filling at CVS retail. Health Advisor has a [redacted] ROI, and the performance will be measured on an annual basis.

		- LCMC Health - North Oaks Health System - Ochsner Health System and Its Subsidiaries and Affiliates - University Health	

A6	Provide an overview and the resources assigned to the steps your organization is taking to comply with HIPAA regulations. Identify the name and title of the individual within your organization responsible for HIPAA compliance.	We are in compliance with federal and state laws and regulations that are applicable to the services to be provided by CVS Caremark under the Contract. We have a robust library of privacy and security policies which are reviewed annually to help ensure compliance with all regulation changes and provide training to all employees upon hire and annually thereafter. Additionally, our annual corporate training program includes a module that provides all employees with an overview of HIPAA and employee responsibilities. The Privacy Office is responsible for overseeing compliance with our company-wide privacy policies and assisting business areas, as necessary, in resolving privacy issues. Tracey Scraba is our vice president and chief privacy officer, heads the Privacy Office, and reports to executives of CVS Caremark's Law Department. The Privacy Office has assigned a privacy advisor/privacy manager to each business area. The privacy advisor/privacy manager is responsible for day-to-day enforcement of our company-wide privacy policies and the procedures that support them and serves as the initial point of contact for the business area.	
A7	Confirm that all employees in your organization have been HIPAA trained and trained on how to report a HIPAA security incident or potential breach.	Confirmed.	
A8	What is the latest date you would be comfortable beginning the implementation of OGB's business?	September 1, 2020.	
A9	Confirm that you will accept eligibility files in OGB's standard format and will support any customized files at no additional cost.	Confirmed.	
A10	*Reserved*		

A11	Confirm that you will support a pre-implementation audit funded by the implementation credit.	Confirmed.	
A12	Confirm that you will provide a per month budget to be used at the direction and discretion of OGB toward transparency and validation initiatives such as third-party auditing, program review, and external reporting.	Confirmed.	
A13	Confirm that you will provide a full claims file feed to all vendors as requested by OGB at no additional cost and in the format specified by OGB.	Confirmed.	
A14	Confirm that you will allow for implementation of new strategic and cost containment programs in each year of the Contract as they are developed and rolled out to other populations serviced by your organization.	Confirmed.	
A15	What is the cure period allowed for late payments?	10 days	
B	**ACCOUNT MANAGEMENT**		
B1	Is there a reporting system that is available to OGB for use via the Internet for standard and ad hoc reporting? If not, an allowance must be provided to establish a data warehouse.	Yes.	
B2	Contractor should provide detailed information about the experience and qualifications of the Contractor's Account Management Team, including but not limited to, the assigned 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 as well as any other assigned personnel considered key to the success of the project. This includes the Contractor's own staff and staff from any subcontractor to be used. Account Executive ("AE") and Operational Account Manager assigned to OGB must be dedicated solely to OGB and have a minimum of two (2) years tenure with the Contractor.	Confirmed. Information provided.	

B3	Contractor must provide a Clinical Pharmacy Manager to advise on drug-related issues and trends, clinical programs and utilization rules, among other issues, specific to OGB's plan. The Clinical Pharmacy Manager assigned should have a minimum of one (1) year tenure with the Contractor. The Clinical Pharmacy Manager must be a resident of Louisiana and will participate in in-person performance review meetings and will be generally available between 7 a.m. to 5 p.m. Central Standard Time, M - F, to address OGB issues that may arise.	Confirmed.	
B4	Provide name, title, and immediate superior of the Account Executive assigned to OGB and indicate how the organization evaluates the performance of this individual when considering compensation for the relevant period.	'Tracy Fields, Strategic Account Director Immediate Superior: Diane Galo Tracy brings over 24 years of PBM service experience supporting large and complex accounts. Account team members' individual employee evaluations and overall CVS Caremark evaluations are based on client feedback regarding the value-added service performance provided. We continually evaluate our staff performance to ensure a positive customer experience, conducting ongoing client satisfaction surveys.	
B5	Provide the location of the office that will manage the OGB account.	'750 W John Carpenter Fwy #1200 Irving, Texas 75039	
B6	Confirm that OGB will have the ability to request a change in any of the assigned personnel and teams based on unsatisfactory performance levels as determined by OGB. In addition, OGB will be provided the opportunity to interview any new team member(s).	Confirmed.	
B7	Confirm that your entire Account Management Team will be in attendance (in person) at all quarterly OGB meetings unless an absence is pre-approved by OGB.	Confirmed.	
C	**Administration**		

C1	Provide sample Plan Participant communications materials, including request letters for clinical programs, switching programs, and explanation of benefits ("EOBs").	Sample member communication materials provided.	
C2	Provide a detailed utilization management program list, including specific drug names in each program.	Utilization Management Programs list provided.	
C3	Provide a detailed description of how your organization determines which drugs are preferred versus non-preferred.	Our independent Pharmacy & Therapeutics (P&T) Committee evaluates the formulary on an on-going basis, evaluating new and existing drugs in the marketplace to determine their placement in therapy. We remain focused on the highest levels of clinical efficacy and care for members. We target classes with sufficient generic availability and clinically interchangeable brands. Additionally, we evaluate opportunities in appropriate specialty classes where there is similarity between chemical entities. Newly introduced products and line extensions will be reviewed to determine if addition to the formulary is warranted, taking into consideration both clinical and economic factors. Selection criteria sources include but are not limited to: peer-reviewed literature; recognized compendia; consensus documents; nationally sanctioned guidelines and other publications of the National Institutes of Health, Agency for Healthcare Research and Quality, and other organizations or government agencies; drug labeling approved by the U.S. Food and Drug Administration (FDA); and input from medical specialty practitioners.	
C4	Identify which of the following are performed at the point of service:		
	a) Ineligible Plan Participant	Confirmed.	
	b) Ineligible Drug	Confirmed.	

	c) Incorrect Average Wholesale Price ("AWP")	Confirmed.	
	d) Usual, Customary, Reasonable ("UCR") input	Confirmed.	
	e) Duplicate Prescription	Confirmed.	
	f) Refill too soon	Confirmed.	
	g) Incorrect Dosage	Confirmed.	
	h) Prescription Splitting	Confirmed.	
	i) Drug Interactions	Confirmed.	
	j) Over Utilization	Confirmed.	
	k) Under Utilization	Confirmed.	
	l) Coordination of Benefits ("COB")	Confirmed.	
	m) Drug is inappropriate for the patient due either to age or sex	Confirmed.	
	n) Other (specify)	Our system can perform up to 500 concurrent DUR edits on every prescription – in real time, at mail and retail – to help ensure the prescription meets both administrative and member safety criteria. Some additional edits include formulary compliance and conforming to OGB's plan designs.	

C5	Describe the methods currently in place to influence prescribing behavior of physicians, if any. Does OGB have the option to opt-in or opt-out of these programs?	CVS Caremark is committed to transparency wherever the member is on the health care continuum. Real-time benefits further build on our connections with electronic health records, bringing the system closer to true, seamless interoperability to prescribers. Using our technology and data sharing capabilities, we are able to connect providers with real-time information to ensure more informed decision-making and coordinated care, leading to lower costs and a better member experience. With our solution, all of the information is integrated into the e-prescribing workflow, enabling prescribers to make more informed decisions and select a clinically appropriate medication that may be more affordable for the member. If the selected drug has any restrictions, connected prescribers will also be able to immediately submit an electronic PA (ePA) request. With real-time benefits, even before a prescription is written, the provider will have member-specific information available at their fingertips, including: • Cost of a selected drug based on the member's plan coverage, deductible, and how much of the deductible the member has met • Up to five clinically appropriate therapeutic alternatives, that may also be lower cost, generated from our database of drug classes, mapped for clinical substitution and specific to the member's formulary • Restrictions on the selected drug, such as prior authorization (PA), step therapy requirements, or quantity limits • Whether the selected pharmacy is in network. OGB has the choice to opt-out of this offering.	

		Additionally we can help reduce costs by targeting physicians who may not be meeting practice standards and intervening through several of our clinical solutions - which OGB may opt into or out of as well. Through our programs such as Pharmacy Advisor, we provide member-specific feedback and alternative therapy suggestions for specific prescribing issues. Interventions are evidence-based and encourage compliance with national clinical guidelines. Our advanced analytics allow us to identify physician outliers for intervention and partner with our clients on creating solutions that can influence physician behavior.	
C6	Describe how the Contractor will monitor and increase Plan Participant's prescription compliance.	Adherence Program details provided separately.	
C7	What is the process for handling a non-preferred drug claim?	Our clinical intervention and cost-containment program, designed to increase the use of generic and preferred brand drugs, includes online messaging to the pharmacist at the point of service across our all 68k pharmacies in our network. If an opportunity for substituting a generic or preferred brand-name drug presents itself, and OGB has opted for our intervention program, our online claims processing system generates a message to the pharmacist. Additionally, specifically at CVS Pharmacy, the information will be integrated into the pharmacist's workflow, making it easy to engage patients and inform them about potentially lower-cost alternatives, based on formulary coverage. If the member's	

		prescription is for a medication not on the formulary, the CVS pharmacist will be able to request a prescription change from the provider at the click of a button.	
C8	How will the mix between retail and mail order prescriptions be optimized?	With proper education and incentives, clients can reduce overall costs and engage members into making the most appropriate decisions regarding their prescription benefit by optimizing the mix between retail and mail prescriptions. Length of prescription therapy serves as one of the main drivers of retail utilization. Members should obtain short-term prescriptions (e.g., for 30 days or fewer) in a retail pharmacy, since mail service's cost efficacies materialize when filling long-term, maintenance medication prescriptions. In addition, if a member's physician tries different drug therapies, obtaining a short-term supply of the medication at retail avoids wasting a long-term supply through mail service if the medication does not work. Members must have the proper financial/copay incentives to choose the best distribution channel that meets their needs, as well as the client's. For those situations in which mail service makes the most sense, we offer several options to maximize appropriate mail service use. Some clients also implement a stepped copay/coinsurance option based on days' supply to produce savings. We can work with you to minimize disruption to your	

		members' routines but optimize the cost-effectiveness of the plan.	
C9	Describe the programs implemented to expedite conversion to newly-released generic medications. Provide examples.	One of the ways we can help you increase the use of generics among your members is to educate them through personalized communication materials, informative website content, plan design parameters, and face-to-face consultation. We will proactively consult with you in developing a comprehensive plan to promote generic products well in advance of market release, which can include targeted patient mailings and messaging on member counseling information. Some examples include: • Caremark.com - We have developed online tools including: -Interactive Savings Tools -Check Drug Cost -Save with alternative medications -eAlerts (text and email) with embedded savings messages. • DAW 2 Calls - Targeted phone calls alerting brand users of generic availability • DAW 2 Letters - Targeted, personalized	

		educational letters alerting brand users of generic availability • OGB Dedicated Customer Care Team - Proactive education of lower cost alternatives (e.g. generic availability) to members • Member-Specific Reporting – A personalized summary based on a member's prescription history which highlights opportunities to save money on future purchases. This report visually illustrates opportunities for potential generic alternatives, preferred drug list medications, and mail service, when appropriate, complete with the potential savings that could be realized when a change towards generics is made. All messaging is personalized in Member-Specific Reporting. • We also offer several initiatives such as our Pharmacy Advisor program and Real-Time Benefits program to promote and increase generic drug use through face-to-face, personalized communication with pharmacist.	
C10	How are out-of-network claims processed?		

C11	Do you currently have e-prescribing capabilities? If yes, describe the process and note any additional fees for these services. If not, describe any future plans for implementing e-prescribing capabilities.	[redacted]	***The answer provided in response to this question contains confidential information that is proprietary to, and constitutes trade secrets of, CVS Caremark. CVS Caremark's trade secret and/or proprietary information is exempt from disclosure under applicable public records laws.***

		[redacted]	
C12	Confirm that OGB has the right to accept or reject any and all Formulary changes.	Confirmed.	
C13	Confirm that OGB has the right to accept or reject any and all clinical programs.	Confirmed.	
C14	Confirm that OGB (and any selected audit firm of choice) will have full audit rights, including, but not limited to the following: conducting an on-site audit of 100% of all claims each year of the Contract, on-site rebate contract review, clinical management programs, operational assessments, performance guarantees, etc.	Confirmed.	
C15	Confirm that OGB will have the option to create its own Formulary. Describe how your organization would partner with OGB in Pharmacy & Therapeutics ("P&T") support from both a clinical and analytical support perspective. In addition, confirm whether any additional charges would apply, and if so, specify.	Confirmed.	CVS Caremark currently supports over 1,000 custom formularies across our book of business and we are certainly able to support custom changes to the formulary at your request. We will provide you with our standard formulary changes, as developed by our P&T committee for your consideration. In addition, through the use of our advanced analytics as well as comprehensive consultative recommendations that align with current clinical information your account team will provide OGB an opportunity to maximize savings for the plan and your members. Products recommended for inclusion will be

			identified after careful consideration of current market dynamics as well as future introductions to ensure the most appropriate and/or cost effective products are recommended. There may be potential rebate loss for those not aligned to our standard formulary; however, specifics relating to areas of customization would be required for the impact to be determined. Rebate impact and, if required, adjustments to pricing will be evaluated for client-specific customization. Additionally, we will recommend potential strategies that influence rebate value when selecting products for inclusion to produce the lowest net cost.
C16	Confirm that you are able to provide a monthly report of patients that have utilized a patient assistance program at a specialty pharmacy. The report should detail patient name, drug name, amount paid by patient assistance program, amount paid by Plan, and amount paid by patient (after assistance program). In addition, OGB requires a quarterly report of all available patient assistance programs. Please confirm your ability to comply.	Confirmed.	
C17	Do you have the ability, and will accept open prior authorizations, open mail refill and historical claims files at no additional cost?	Yes.	
C18	Confirm that the 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.	Confirmed.	
C19	Contractor is willing and able to work with OGB and its consultants on development and execution of targeted drug interventions at no cost. (For example,	Confirmed.	

	high cost generics, high trend drugs, lower cost providers)		
C20	Confirm that OGB will not be required to adopt any programs or modifications to the Plan or Formulary in place as of the start of the Contract term. This includes recommendations on prior authorizations and inclusion/exclusion of drugs. OGB will be given full and custom discretion on how and when to apply program modifications.	Confirmed.	
C21	Confirm that you have a mature program for ensuring that all Plan Participants' information, including but not limited to PHI, will be handled in accordance with all applicable Laws and this Contract and provide a copy of your Privacy Practices and other documentation that supports your privacy program.	Confirmed.	
C22	Confirm that you are willing and able to 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.	Confirmed.	
a	Contractor will 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.	Confirmed.	
b	Contractor will continuously monitor maximum accumulations and pass back maximum out of pocket dollars if member has overpaid.	Confirmed.	
C23	OGB is looking for innovative concepts to manage their prescription benefit plan and provide savings solutions. Provide a detailed overview of the design and scope of your proposed solutions.	We offer a suite of clinical solutions, such as, Pharmacy Advisor, Health Advisor, Specialty Copay Plan Design, and AccordantCare, to help improve member health and reduce total costs for clients. We reach out and intervene with members and physicians using a combination of integrated technology and extensive clinical resources in order to improve safety, reduce inappropriate drug utilization and promote adherence to evidence-based care.	

a	Provide a process flow of how your proposed solution works: from identification of potential savings, to outreach to plan participants and providers, to cost savings realized for the plan and participants.	We offer OGB a wide array of proven clinical and specialty pharmacy management solutions. Your dedicated account, clinical, and analytics team will work closely with you to demonstrate and educate OGB on plan recommendations, potential savings value and member outreach communication plan. The following outlines the process flow of how your dedicated team will service OGB's needs. • Service Materials – Your account and clinical team will work collaboratively with OGB and your consultant to provide specifics on recommended plan solutions based on utilization/trend patterns. • Analyses – Your account team will provide the appropriate specialty utilization analyses, along with recommendations for managing current experience and trend. • Identify Opportunities and Make Recommendations – Your account team will also work with you to understand OGB's strategic needs and desires, and align those recommendations accordingly. • Reporting – OGB will receive member impact and savings reports that demonstrate the outcomes of the recommended solutions.	
b	Will you guarantee a return on investment (ROI)? If so, provide and explain in detail the ROI guarantees to be provided on an annual basis. List the savings and measurements that are included in the ROI provided.	***The answer provided in response to this question contains confidential information that is proprietary to, and constitutes trade secrets of, CVS Caremark. CVS Caremark's trade secret and/or proprietary information is exempt from disclosure under applicable public records laws.*** Confirmed. CVS Caremark offers an ROI on many of their solutions, which are typically measured and reported on an annual basis.	More details will be provided upon request.

	Provide an overview of the methodology to determine savings	***The answer provided in response to this question contains confidential information that is proprietary to, and constitutes trade secrets of, CVS Caremark. CVS Caremark's trade secret and/or proprietary information is exempt from disclosure under applicable public records laws.*** Savings associated with our core clinical solutions is expected to be 3% to 4% of your total drug spend. Since no single clinical solution is effective in all circumstances, our core clinical solutions are designed to provide optimal savings when all programs are employed. Savings generated from our enhanced solutions all vary by offering, but most come with a [redacted] ROI.	More details will be provided upon request.
d	Provide a specific example of your company's program at the participant level and how it provides cost savings.	***The answer provided in response to this question contains confidential information that is proprietary to, and constitutes trade secrets of, CVS Caremark. CVS Caremark's trade secret and/or proprietary information is exempt from disclosure under applicable public records laws.*** A 350,000-life client implemented Pharmacy Advisor Counseling for diabetes and experienced a [redacted] improvement in optimal adherence over one year. After discontinuing Pharmacy Advisor Counseling, improvements from the first year began to reverse, with a [redacted] decrease in optimal adherence within nine months. Over time, members became less adherent to their medication. Based on a published study of our pilot data, we expect clinical metrics will return to pre-Pharmacy Advisor Counseling levels without ongoing monitoring and	

		intervention. Pharmacy Advisor Counseling interventions are necessary to sustain positive member adherence behavior.	
D	**Customer Service**		
D1	What facility will handle customer service for OGB's Plan Participants and where will it be located?	We are providing a dedicated Customer Care team based in our Knoxville, Tennessee call center.	
D2	Will you provide OGB with a dedicated customer service unit and toll-free line, i.e., customer service representatives who will only handle calls from OGB Plan Participants? How many call center representatives will be employed by the proposed call center for OGB? How many of these representatives will be dedicated to handling calls from OGB Plan Participants?	Confirmed. CVS Caremark is pleased to provide a fully dedicated Customer Care team to support both Commercial and EGWP plan participants. The OGB dedicated team will be made up of 50 Customer Care Representatives, 6 Senior Reps, and 3 Supervisors.	
D3	What will the hours of operation be for customer service provided to OGB's Plan Participants? How will customer service be handled after hours of operation (if hours of operation are not 24/7)?	We provide customer service 24 hours a day, seven days per week, 365 days a year.	

D4	What was the customer service representative turnover rate for the last calendar year for the facility and/or dedicated team you are providing to OGB?	The turnover rate for the entire Knoxville facility was 14.25% in 2019.	
D5	Confirm that you are willing to extend customer service hours for potential participants during OGB's annual enrollment period, special enrollments, and/or as requested by OGB. Provide the extended hours of operation proposed.	Confirmed.	Extended hours are not necessary as we provide customer service 24 hours a day, seven days a week, 365 days a year.
D6	How are calls segmented (i.e., routing of inquiries by Plan, inquiries about claims, requests to identify network providers, generalized Plan Participant services questions, etc.)?	By dialing the client-specific, toll-free number, members are routed to the appropriate self service option (depending on your plan set-up), some of which include: • Order prescription refills • Check the status of an order • Check the cost of a particular drug • Request plan balance information (OOP, etc.) • Check eligibility • Request a new ID card • Locate a convenient retail network pharmacy • Obtain an order form or claim form • Request to speak to a live representative.	
D7	What methodologies (i.e., silent call monitoring) are employed to monitor and control the quality of service provided?	In an effort to further establish CVS Caremark as a pre-eminent service provider in the health care industry, our Customer Care uses the Behavioral Analytics tool from Mattersight™. Behavioral Analytics allows us to record, analyze, and interpret unstructured call content into structured, usable call data, which is then used for coaching and training opportunities. The application also provides an objective view of our service levels. We are able to analyze our member interactions based on substantial data, resulting in reduced service escalations through proactive servicing. We can also utilize data from calls to enhance the member's experience and improve the Customer Care Representative's performance. Quality assurance performance tracking is an	

		important element in coaching and development for the individual representative. Daily, weekly, monthly, and quarterly data is disseminated to enable ongoing assessment and intervention. This data also helps identify customer and client trends. Accuracy measurement is present throughout call monitoring that is conducted by both our Quality Assurance Team and Supervisors. A combined minimum of eight calls are monitored for each Customer Care Representative. Supervisors utilize reporting from Behavior Analytics that may present challenges to the Customer Care Representative such as First Call Resolution results, call back rate, and silent time along with behavior specific components. Their review is based on the coaching needs of the Customer Care Representative while our Quality Team's reviews are random. Targeting calls that have been identified as resulting in a call back or struggles interacting with a specific behavior has allowed us to coach and develop our Customer Care Representatives to provide personalized customer service.	
D8	Confirm that you will digitally record all customer service calls at no additional cost to OGB. How long are the recordings kept?	Confirmed.	Our current recording applications provide full audio recording and retention for a total of 10 years.
D9	Provide a sample of the proposed OGB-specific management reports of telephone inquiry performance. General book of business statistics are not acceptable.	Sample Client Call Stats Report provided.	
D10	Do you offer a smartphone app to Plan Participants to order refills, locate pharmacies, etc.? In addition, confirm that your phone application will include the	Yes. Confirmed.	

	ability to check the price of a medication at both retail and mail order pharmacies.		
D11	Is your website available in languages other than English? If yes, please detail what languages are supported.	Yes.	The translated version of Caremark.com allows members to manage their prescriptions online in Spanish. With this version, members can: • Refill mail service prescriptions; • Check order status; • View prescription history; • Request a new prescription; • Find savings and opportunities; • Check drug costs; • Find a local pharmacy; • View drug lists; • Access prescription plan information; • Print forms and ID cards; and • Manage accounts and family member prescriptions.
D12	Do you have the ability to warm transfer calls to other vendors?	Yes.	
D13	Will customer service representatives run test claims to assist with Plan Participant inquiries?	Yes.	
D14	For Commercial Business, will Contractor prepare a "Member Welcome Kit" that will include at least the following as directed by OGB: identification (ID) cards, plan design and key coverage information, and other descriptive materials/documents that may be necessary for participants to understand their core pharmacy benefits?	Yes.	
D15	For EGWP, will you allow a customized insert be included in the initial CMS required mailings (e.g., Opt out mailing and Welcome kit)?	Yes.	
D16	Contractor agrees all member communication (e.g. ID cards, general and/or targeted mailings, etc.) will be subject to prior and final approval by OGB.	Confirmed.	

E	Mail Order Management		
E1	If the Contractor owns the mail order pharmacy, are purchase discounts passed along to the Plan or kept as margin by the pharmacy benefit manager?	CVS Caremark may receive and retain purchase discounts from drug manufacturers in relation to drugs purchased to stock its mail and specialty pharmacies for its entire book of business. Therefore, unlike a PBM that contracts with a third party for mail and specialty fulfillment, CVS Caremark incurs overhead expenses for mail and specialty pharmacy fulfillment not only as a PBM, but as the pharmacy operator as well. It is also important to note that purchase discounts are not directly related to any client's specific member utilization or formulary strategy.	
E2	Describe your process for maintaining credits or issuing payments to Plan Participants for account credits on file.	If the member sends more than the appropriate copay amount, a credit will reflect on the member's mail service invoice. This credit amount can apply to future mail service orders, or the member may contact Customer Care to request a check. Upon the member's request to Customer Care, we will mail a check to them in the amount of their credit balance. Also, if there is a balance when the member terminates, a check will be mailed to them within the first 30 days of termination.	
E3	How will the Contractor assist Plan Participants with the transfer of prescriptions from the current mail order facility to your mail order facility? What documentation is required of the Plan Participant to transfer the prescription? How long does the process take on average, in your experience, to transfer a prescription to your mail order facility?	We can transfer prescription information electronically from your incumbent mail service provider during the implementation process. This approach results in a seamless transition for your members by allowing them to complete the remaining refills on their current mail prescriptions, thus eliminating the disruption caused by having to call or visit their physician to obtain new prescriptions. In order to successfully execute these transfers, we typically need 30-60 days to transfer mail prescriptions. In fact, the mail order transition	

		file process is considered a major milestone in our implementation project plan and we also have experience transitioning mail files from your incumbent PBM. Additionally, through our FastStart® program, members can register their maintenance medications via Caremark.com or by phone during the implementation period. A FastStart representative will contact the member's physician to transfer new prescriptions.	
E4	Confirm that your organization can accept and fill mail service prescriptions from any of your mail order facilities, regardless of facility to which OGB may be assigned.	Confirmed.	
E5	Confirm your organization has the ability to electronically transfer specialty prescriptions received at the mail order location to the specialty pharmacy.	Confirmed.	
E6	Confirm that you can accept e-prescribing prescriptions at your mail facility.	Confirmed.	
E7	Describe the process for ordering refills by mail and include a sample refill order form.	Members complete an order form and send it, along with their new or refill prescription and copay, to one of CVS Caremark's regional inbound mail processing centers (Regional Order Creation Centers or ROCC). All correspondence will be electronically imaged and routed to our network of mail service pharmacies for further processing. Sample Refill Order Form provided.	

E8	Describe the process for ordering refills by phone. How far in advance can Plan Participants order a refill?	Our user-friendly application enables your members to select a prescription for refill by entering the prescription number or by speaking the prescription drug name. If the prescription cannot be filled on the date the member calls, the caller is reminded that it is "too soon to refill," and the system speaks the available refill date. The caller is also informed if the prescription has expired or if there are no remaining refills, the IVR will advise the member that a request will be sent to their physician to renew the prescription. This feature helps members manage their prescription needs within the plan requirements. After each prescription is added to an order, the IVR system will advise the member of the remaining refills. If the medication requested is out of refills or if the prescription is expired, the IVR will still add them to that order but will advise the caller "we will be contacting the doctor to request a new prescription on your behalf. This may extend the normal processing time." Methods of payments include: Credit Card, Invoice, and Electronic Check. These payment types are conditional upon client approval. Refills can be charged to the credit card on file, or the caller can elect to enter an alternative credit card number. Plan members will hear the estimated cost of their refill prescription order prior to its completion. Any debit or credit amounts on file are stated to the member and calculated as part of the estimated cost. A confirmation number is provided with each refill order and can be used when checking the order status. For a typical mail order of 90 days, the member could fill as early as 13 days prior to the refill	

		expiration for non-controlled (which can be adjusted per OGB's request) and 6 days early for any refillable controlled medications.	

E9	Describe the quality controls in place to ensure accurate dispensing of prescriptions. How many levels of review take place and who conducts the reviews?	We incorporate all items below during the dispensing process to help ensure accurate dispensing and effective administration of the mail service program. • Bar Code Technology – A bar code is assigned to a prescription request upon receipt and is affixed to it as the order progresses through the mail process. After a bar code is assigned, a registered pharmacist verifies the prescription's info, including member identification, correct drug and potential interactions, dosage form, strength, quantity, therapeutic duplicates, and generic substitutes. • Mail Receipt Procedure – The number of the member's prescriptions received is identified on each mail service order form to help ensure integrity throughout the process. This initial check and notation is verified throughout the process prior to shipping, further ensuring the number of prescriptions received by our pharmacy matches the number sent to the member. • Prescription Screening – As each prescription is entered into the adjudication system, an interactive verification occurs, helping ensure compliance with your plan design. • Eligibility – Member eligibility is certified online during the input of member and physician information. Member eligibility files are updated continuously as new information is received from OGB. If a member is found to be ineligible, the computer will not allow the process to continue. • Drug Interaction – We maintain a central database on all members using mail service.	Once the order has been reviewed for quality control in the pharmacy, it is released to shipping, where final quality verification helps ensure that the right prescription is sent to the correct destination.

		All drug-to-drug interactions and drug-to-allergy interactions are detected online when a prescription is entered into the computer. If an interaction is detected, a brief description of it is provided to the pharmacist as well as reference sources for researching pharmacology before contacting the prescribing physician. • Fraud and Abuse Controls – We screen orders through our computer system to detect evidence of program fraud or abuse. Each prescription is checked online before the filling process to verify eligibility, detect potential early refill, and/or potential fraud or abuse. If there are any questions, a registered pharmacist will contact the prescribing physician for authorization before the prescription is filled. • Registered Pharmacist Quality Assurance Monitoring – All translation is verified by a registered pharmacist who confirms that the prescription image matches the info in the system: member, drug, drug strength, dosage form, instructions, prescriber, quantity, and refills. Once confirmed, the pharmacist passes the prescription to the next step in the system. Pharmacists also perform product verification in the dispensing pharmacy as well and will verify that the correct product is being dispensed either through image technology or visual inspection.	

E10	Describe online integration with retail pharmacies, if any, to prevent duplication and to identify potential adverse interactions.	Our Mail Service program fully integrates with our retail service, utilizing the same online system as all of the pharmacies in our retail networks. The basic requirements for any integrated retail and mail service program include utilization of a single eligibility file, member claims history file, plan database for claims adjudication, access to one set of drug utilization review edits, and integrated reporting and billing. • Enrollment/Eligibility - You will enjoy ease of enrolling eligible members for retail and mail service through a single submission of eligibility. We will maintain an integrated retail and mail eligibility file for you in an online system to support member verification at the point of dispensing. Every claim submitted by either the mail service pharmacy or a retail pharmacy accesses the same eligibility file for member verification. • Data Capture/Reporting - Integrated retail and mail claims data are readily available to you through our data management platforms. Our integrated claims database facilitates the storage, linkage, and rapid retrieval of prescription information and other health data, regardless of the distribution channel. We offer online and ad hoc query capabilities, drill-down options, and industry-leading reporting functions that apply in the retail and mail service environments. These tools identify management needs, target interventions, and measure program results. • Interventions - Our integrated retail and mail service pharmacy programs combine a variety of services designed to maximize cost saving opportunities and enhance member satisfaction. In addition, our ability to deliver an integrated	

		approach to therapeutic interchange in both retail and mail environments is a unique differentiator that can benefit your bottom-line. • Drug Utilization Review (DUR) - Our mail service and retail network pharmacies access a common database for concurrent DUR point-of-dispensing messages, to ensure that the member receives the most clinically appropriate drug product, regardless of distribution channel. Each member's claim history is a completely integrated drug profile that can be shared in real time with ancillary providers. This profile includes information regarding all prescriptions we process for the member. • OGB-dedicated Customer Care Service - OGB plan participants have 24-hour-a-day, 7-day-a-week access to a pharmacist or an Interactive Voice Response (IVR) unit. With one toll-free call, the member receives personalized service to locate the nearest retail pharmacy or to answer questions about retail or mail claims, including up-to-the-minute verification of a mail claim's status at any point in the dispensing process. Customer care representatives have online access to integrated retail and mail service data, claims history, eligibility (current and historical), plan guidelines, deductible status, copay levels, pharmacy participation, and mail service prescription quotes. • Account Services - We will provide you with the highest levels of support and resources. Your account services team employs a matrix organization to provide you with the appropriate level of expertise in each component of your program. • Consistent Claims Auditing Procedures - Retail and mail service claims data submitted to us are reviewed and subject to audit by our Pharmacy	

		Performance department. Auditing procedures bring considerable value to clients with recovery efforts and reliability, and to participating pharmacies with education and deterrence mechanisms. Our integrated mail and retail services reduces your overall costs while engaging your members to make better decisions about their health care. For you, this means fewer calls about prescription coverage to your benefits professionals. For your members, it means excellent clinical services in both the retail and mail service environments.	

E11	Describe drug safety policies as they relate to safe delivery of prescriptions that may have environmental limitations or be subject to environmental requirements (i.e., temperature, etc.).	Medications that require refrigeration are packaged in a moisture-barrier bag to protect the packaging and print. Cold chain shipments utilize either a packout containing frozen gels and protective pads or a combination of unfrozen and frozen gel packs. The unfrozen gel packs are placed next to each side of the medication with frozen gel packs next. This allows the medication to remain at a constant temperature throughout the shipping process. The surrounded medication is then placed in a protective bag for the combination frozen gels and foam pad packouts, or without for combination frozen and unfrozen gels; all packouts are then placed in an EPS cooler, which is included in a pre-assembled cardboard box. We currently have five sizes of coolers/cardboard boxes to help ensure the most efficient shipping. Shipping software is used that reads the package destination temperature and determines the shipping method. The system will help ensure that the package is delivered either in a one day or two day mode, depending on multiple factors The following are our guidelines regarding cold packs. SHIPPING GUIDELINES • Information is maintained from the drug manufacturers regarding storage and/or shipping requirements of specific drugs. • To help ensure drug quality and stability, drugs that have been identified as requiring cold packs are shipped that way to maintain the appropriate medication temperature for the appropriate time	

		in transit. • Cold packs are generally shipped Monday through Thursday. Exception orders with cold packs can be shipped on Friday. SPECIAL ORDER • These are temperature-sensitive items or high-dollar items (medications over $10,000). • Shipped by UPS or Express Mail for overnight delivery. PROTECTING FROM HEAT AND FREEZING • These are items that require no refrigeration; however, the manufacturer has indicated that they must be protected from extreme heat and freezing. • With the exception of temperatures above 85 degrees and below 32 degrees, special packaging is not needed to ship these medications. • Shipped delivery signature confirmation is required whenever temperature in the destination city is forecast to be above 85 degrees or below 32 degrees. Otherwise, these products are shipped by priority mail (2-3 day delivery). BENEFITS OF USING THE CURRENT PACKAGING • Confidence in packaging and medication temperature integrity across temperature and weather variability experienced across the U.S. on a daily basis. • Ease of packing for CVS Caremark staff in our pharmacies as a result of labeling, pre-	

		assembled packaging, and color-coded gel packs. • Coolers are recyclable in areas where #6 plastics are accepted.	

E12	Are on-site audits performed at mail service pharmacies? If so, describe the frequency and types of audits performed. Will the mail service pharmacy proposed for OGB's mail order program be subjected to the same audit programs as your retail network?	Yes, on-site audits are performed at mail service pharmacies. Quality audits are an integral part of our operations and are conducted by independent business areas, by registered pharmacists with the assistance of our Quality staff. Pharmacy supervisors randomly select orders at any time during the dispensing process and check for appropriate dispensing practices (e.g., quality checks completed by pharmacists indicated by an approval stamp, adherence to strict guidelines for filling controlled substances). Operational audits are conducted daily. Pharmacy and pharmacists' licenses, controlled substances inventory and related mandatory documentation, and procedural compliance are audited regularly. Quality assurance staff members observe dispensing operations and interview pharmacy supervisors to monitor compliance with standard operating procedures. Compliance audits are conducted annually. The State Pharmacy Board, the Drug Enforcement Administration (DEA), and other regulatory agencies conduct additional external audits. These audits are unannounced and are performed randomly. Designated management and quality assurance staff cooperate with these agencies to conduct and document the audits. CVS Caremark mail service pharmacies are subject to the same daily claim audits and annual on-site audits as are our retail network pharmacies.	
E13	Describe the process for notifying Plan Participants of the following:		
	a) Expiration date of their prescription	For a prescription that is about to expire or run out of refills, we will notify the member and	

		contact the prescriber to obtain a new prescription on behalf of the member. The member has the option to cancel the physician outreach if he or she is no longer taking the medication.	
	b) Next refill date and number of refills remaining	Each prescription filled through our mail service will indicate the number of remaining refills and the refill expiration date on the label. Members can also sign up to receive mail order refill reminder messages through their message center at Caremark.com or by email. If no refills remain, the reorder form sent with each order will read “NO REFILLS REMAIN – TIME TO RENEW”. When we receive a refill request through mail for a prescription that has no remaining refills, we attempt to reach the prescriber and obtain refill authorization. If we cannot reach the prescriber, we communicate the situation to the member.	
	c) Prescriptions not on Formulary	Depending on how the benefit design is set up, drugs not on the formulary will either be rejected by the adjudication system, or alternatives may pay, but generally at a higher copay. For drugs that are not covered, the pharmacy will receive a reject and will send a letter to the member with the information that the drug is not covered. The letter has the Customer Care phone number in case the member would like to discuss it further. If the non-formulary drug is covered, but at a higher copay, then the medication will be filled. If the copay causes the cost of the order to exceed the client-driven threshold, then the member will be contacted to ensure that they are aware of the charge and also to obtain permission to charge their credit card for the additional cost.	

	d) Generic substitution availability	If an opportunity for substituting a generic or preferred brand-name drug presents itself, and OGB has opted for our intervention program, our online claims processing system generates a message to the pharmacist. Our clinical intervention and cost-containment program, designed to increase the use of generic and preferred brand drugs, includes online messaging to the pharmacist at the point of service, but not a notification directly to the member.	
E14	5	All (100%) prescriptions dispensed by our Mail Service pharmacies include member counseling information for each prescription. These instructions are specific to both the member and the medication, including information on proper therapy compliance, proper drug usage, possible interactions, side effects, and applicable warnings. Each prescription filled through our mail service will indicate the number of remaining refills and the refill expiration date on the label. Samples of our patient advisory information have been provided.	
E15	How is the Plan Participant billed (i.e., before or after the prescription is filled)? How does the Plan Participant know which co-pay applies?	Pre-authorization of funds on a member's credit card takes place prior to shipment, however the actual payment is processed after filling the prescription. An invoice/receipt is included with every order. We communicate the mail service copay amount to the member as part of the initial program announcement. For ongoing support, the member can either call a toll-free telephone number to obtain plan benefit information, which includes copay information, or log on to our mail service website, Caremark.com. Following a brief registration process, the	

		member can access quotes based on his/her benefit program. For orders placed outside of the IVR, a Customer Care Representative, or the web, we will contact the member as a courtesy prior to dispensing their prescription if the copay amount exceeds the threshold set by the client if the member does not have a history of paying a similar copay, to help ensure s/he is aware of the charge (current process is to contact the member by phone). For orders placed by IVR, a Customer Care Representative, or the web, we will contact the member as a courtesy prior to dispensing his/her prescription if the copay amount exceeds $1,000.	
E16	Does the Contractor email refill reminders, savings intervention opportunity messages, and Coordination of Benefits ("COB") messages to Plan Participants?	Yes.	
E17	Confirm that your organization will absorb any unpaid Plan Participant balances associated with your mail service facility.	Confirmed.	
E18	Confirm that you will communicate any delays beyond three (3) days in the delivery of prescriptions to the Plan Participant.	Confirmed.	
E19	Confirm that you agree to arrange and pay for a short-term retail supply of a delayed or incorrectly processed mail order prescription caused by your organization. In addition, confirm you agree not to charge OGB Plan Participants for expedited delivery of the mail order prescription if the prescription delay is caused by your organization.	Confirmed.	
F	**Specialty Pharmacy**		

F1	Does your organization own a specialty pharmacy? If so, are purchase discounts passed along to the Plan or kept as margin by the PBM?	Yes, CVS Caremark and its affiliates own and operate our specialty pharmacy locations. CVS Caremark may receive and retain purchase discounts from drug manufacturers in relation to drugs purchased to stock its mail and specialty pharmacies for its entire book of business. Therefore, unlike a PBM that contracts with a third party for mail and specialty fulfillment, CVS Caremark incurs overhead expenses for mail and specialty pharmacy fulfillment not only as a PBM, but as the pharmacy operator as well. It is also important to note that purchase discounts are not directly related to any client's specific member utilization or formulary strategy.	
F2	Does your organization capture any laboratory data and treatment history at time of enrollment or thereafter?	Yes.	
F3	Do you have the capability to compound medications and to ship these products directly to a medical office?	Yes.	
F4	Confirm that your organization can assist and collaborate with another vendor on all fraud and abuse monitoring, if required.	Confirmed.	
F5	Confirm the Plan will have the ability to limit the day supply associated with prescriptions filled by the specialty pharmacy without an impact to the financials.	Confirmed.	
F6	Confirm that OGB will have the right to carve out specialty pharmacy benefits at no cost or revision/penalty to any other financial components at any time during the term of the resulting Contract.	Confirmed.	
F7	Do you offer specialty distribution services to administer physician buy-and-bill?	Yes.	
F8	In a non-exclusive specialty arrangement, is there a limit to the number of providers with whom OGB can partner?	No.	With an open specialty network, any pharmacy that participates in our National Network may be able to dispense specialty drugs.
F9	Confirm that your organization will proactively notify OGB of all products that are deemed specialty.	Confirmed.	

F10	Is the proposed specialty pharmacy part of a specialty pharmacy network? Provide the locations of the other specialty pharmacies in the network.	A list of our specialty pharmacy locations has been provided.	
F11	Does your organization offer an integrated specialty pharmacy program? If yes, describe the operations of the program and include elements describing Plan Participant outreach, case and care management abilities.	Yes. We approach the management of cost, quality and outcomes in a way that is unmatched in the industry. Our specialty pharmacy CareTeams manage all patients on a regular basis to help manage side effects and ensure adherence to their prescribed medication. We see an opportunity for a more holistic approach to management of the most complex – high cost patients. This holistic approach encompasses management of co-morbidities, self-care and other issues that are related to the patient's conditions, not just their medications. Our AccordantCare care management program offers members with rare conditions nurse support with a holistic view, in addition to medication management services through our specialty pharmacy. For rare conditions, our AccordantCare nurses are integrated with our specialty solutions to support members in managing their whole condition and co-morbidities, especially in critical disease states. We provide clinical care focused on the member and the condition vs. the drug dispensed and thus have the ability to reduce total health care costs and improve quality of life. Members benefit from an integrated specialty pharmacist and nurse experience, which result in timely and coordinated clinical interventions and lead to improved medication and care plan adherence. We are the only specialty pharmacy to provide a truly comprehensive solution by integrating, nurse-led care management for rare, complex	

		conditions with our specialty pharmacy services.	
F12	Describe the status, scope, and management strategies of your specialty pharmacy services in the following areas:		
	a) Injectable and infusion therapies	As one of the leading specialty and infusion providers, we provide and support infusion therapy in both the home and the ambulatory care settings. We support those medications that are considered specialty therapies such as hemophilia, intravenous immune globulins, enzyme replacement therapies (Cerezyme, Fabrazyme etc.), pulmonary hypertension, and other infused medications for example, the treatment of multiple sclerosis and rheumatoid arthritis. Additionally, we have the ability to support the full spectrum of home infusion therapies such as total parenteral nutrition (TPN), intravenous antibiotics, hydration, and pain management.	

	b) High-cost ($5,000 per year and up) therapies	CVS Caremark offers a range of proven cost containment solutions to better manage the unsustainable rising costs in the specialty market while preserving clinical quality and patient needs and maintaining access to limited distribution drugs. Due to the high cost of specialty drugs across classes and disease states, we recommend comprehensive specialty management strategies, some of which include the following to help manage specialty trend. • Targeted formulary strategies including indication- and outcomes- based contracting • Copay plan solutions to help minimize the impact of specialty copay cards • Innovative plan designs including tiered and cost-effectiveness, complemented by our partnership with the Institute for Clinical and Economic Review (ICER) to establish the estimated expenditure per unit benefit for new drugs at or just before the time of their introduction to the market. CVS Caremark has developed this approach to meet the needs of our clients, and we are the first PBM and managed care organization to make a direct attempt to address the launch price problem. We believe this Cost-Effectiveness Plan Design will have a tangible and demonstrable impact on drug launch prices, leading to a more sustainable and affordable drug benefit that delivers higher value to clients and their members. • Site of care optimization with Coram®* infusion care. Our Site of Care Alignment offering is specifically focused on clinician-infused medications that are primarily administered, billed, and paid for under the medical benefit. The program targets a select list of medications that may be appropriate to be administered at a lower cost site of care.	

	c) Therapies that require complex care	Specialty members relying on complex medications require personalized care and support to help ensure they are on the right drug, at the right dose, and are using and responding to their medications appropriately in order to achieve optimal therapeutic benefit. By focusing only on a limited range of conditions and a much narrower segment of the population, we have developed a significant level of clinical expertise and knowledge. Some of the key components of our specialty offering include: • CareTeam Coordination – Our approach is very personalized, focusing on the specific needs of each member. The CareTeam, available 24 hours a day, seven days a week provides a reliable link for routine follow-up to assess medication needs, insurance coverage assistance, member advocacy, training needs, and nursing or other professional health care services to aid and optimize clinical outcomes. • Proactive Refill Outreach - Every member will have a follow up assessment and their refill coordinated prior to the exhaust date of their last fill. Approximately five to seven days prior to the next shipment date, our pharmacy staff proactively contacts the member to conduct a follow-up assessment, including a discussion of the member's progress on therapy, identify any instances of non-compliance, discuss any potential issues or adverse effects that may be affecting treatment, review any changes to the member's medication regimen or dosing schedule, and arrange for the next delivery. • Focused on Specialty Therapies with Centers of Excellence - We are a leading specialty pharmacy provider for the management of more	

		than 50 therapy classes, treating more than 70 disease states/conditions and with access to more than 400 drugs. Our Centers of Excellence (COE) model incorporates best practices, tools, and technology to improve effectiveness, help ensure clinical excellence, and meet the changing needs of our clients and their members. Our COEs are comprised of dedicated interdisciplinary teams of clinical pharmacists, nurses, and technical and/or Customer Care staff with advanced training, knowledge, and expertise in the management and delivery of specialty pharmacy services. • Limited Distribution Drug Access – We have broad access to specialty drugs, including most limited distribution drugs. We have access to 95% of specialty spend and we continuously pursue access to all specialty products. • Coordination with Rare Condition Management to Manage Comorbidities – We identify members with one or more of the rare conditions and outreach to each one, develop specific, collaborative plans of care based on specific needs, implement the care plans in collaboration with each member's care providers, and personally monitor each member's success. Our pharmacists and nurses are able to seamlessly coordinate education, engagement, and management of gaps in care. For this unique population, our robust medication delivery and adherence management is encased in proactive, whole-person support, with the objective of managing total healthcare costs. We proactively coordinate the symptom management; self-care skills, care and medication optimization, and co-morbidity management that will help reduce avoidable inpatient admissions and use of the ER.	

		• Convenient Member Access – Our combined assets of more than 9,900 CVS Pharmacy locations and specialty pharmacies help improve the specialty member experience by offering expanded choice and greater access to specialty medications and services. Specialty Connect leverages our unique retail and specialty pharmacy resources to help members access specialty medications and services through CVS Pharmacy, including personalized clinical support through our specialty pharmacy CareTeams. • Nationwide Nursing Network – We have a national nursing model to deliver specialty nursing services for our members who receive infused medications. Through our Coram nurses we will provide nursing services, education, and treatment in the member's home and/or in ambulatory infusion centers. Our nursing staff coordinates home and ambulatory infusion suite visits. We work to assure high standards of therapy-specific clinical nursing expertise, timely coordination of care, contributing to high physician and member satisfaction. • Cross Benefit Utilization Management – Trend and utilization management solutions are in place to manage specialty medications under both the pharmacy and medical benefits, all utilizing evidence-based guidelines.	
	d) Major disease conditions treated	Through our comprehensive portfolio, we manage a broad spectrum of disease states and therapies, along with comprehensive services to support each therapy. We can manage more than 70 disease states.	

F13	How long has your organization had injectable and infusion therapies in place? To how many patients do you currently provide services?	For nearly 40 years, we have been helping our clients and their members with complex conditions. Through our nationwide infusion capabilities we manage infusion therapies and have strategies to help our clients address their growing specialty spend. We are one of the longest-serving home infusion companies in the nation and offer a wide range of services to the members we support. We occupy greater than 20% of the specialty infusion market share nationally and are the number one provider of home nutrition therapies. Through an experienced team of nurses, pharmacists, dietitians, hospital liaisons, and other dedicated clinical staff, we provide a wide range of therapies to more than 50,000 members each month and 170,000 unique members per year. Our clinical presence creates unparalleled presence in major acute care institution in the United States, within physician offices, and hospital staff.	
F14	Does your organization offer any of the following programs?		
	a) Package recovery program	Yes.	
	b) Vial/assay management program	Yes.	
	c) Ready to inject program	Yes.	

F15	How do you monitor and report on compliance and adherence to therapy?	We monitor adherence for each specialty member on an ongoing basis. Annually, as well as at any time upon client request, we are able to provide therapy-specific, client-level adherence, calculated as Medication Possession Ratio (MPR). Adherence information can also be provided at a member-specific level upon the client's request. We employ the following specific methodology: • Adherence is measured as a member's MPR: -Includes both new and existing utilizers in the drug class -Analysis period is generally a calendar year or 12 months -Total adherence for members with multiple conditions can be calculated as a weighted average of the adherences by drug class. • MPR is: -Defined as (total days' supply of medication received by the member/total days' exposure to therapy) -The MPR analysis period will be based on a 12-month period measured from the effective date and every contract year thereafter during the initial term -MPR will be greater than zero but cannot exceed a value of one -Days' exposure is evaluated from the member's first fill date in the 12-month analysis period to either the end of the period or until the member discontinues therapy. When a member's last fill has a days' supply that goes beyond the end of the analysis period, only the days' supply that falls within the time period should be counted. PERSISTENCY	

		Persistency is measured as a new utilizers length of therapy within the initial 12 months of service, or an alternate timeframe based on condition: • Includes only new utilizers in the drug class • Analysis period is generally a calendar year or 12 months • Persistency is: -Defined as: (total days elapsed in the measurement period that the utilizer was considered to be on medication) -The Persistency analysis period will be based on a 12-month period measured from the effective date and every contract year thereafter during the initial term -Any utilizer that has a gap within dispensed medication that exceeds 60 days is considered no longer on service or no longer persistent -Days' elapsed is evaluated from the member's first fill date in the identification period to when the member discontinues therapy within the measurement period.	
F16	How do you report on Plan Participant outcomes for specialty drug management programs (i.e., return on investment, clinical results, etc.)?	***The answer provided in response to this question contains confidential information that is proprietary to, and constitutes trade secrets of, CVS Caremark. CVS Caremark's trade secret and/or proprietary information is exempt from disclosure under applicable public records laws.*** All plan participant outcomes are measured and reported via our web-based RxNavigator reporting tool. CVS Caremark can also provide access of our RxNavigator reporting tool to OGB for [redacted].	
F17	How will new specialty products (not known today) be priced? Please provide a minimum guarantee for newly-released drugs added to the specialty list.	Specialty products will be provided a separate guaranteed discount for new to market specialty drugs.	

F18	Confirm that only newly-released drugs will be added to the specialty list. (i.e., you cannot flip drugs that are non-specialty today to specialty status later.)	Confirmed.	
F19	Confirm that OGB will have the ability to negotiate the addition of new specialty drugs to the list and the associated minimum discount offered. If agreement on price cannot be reached, confirm that OGB may carve out such products without any financial or other penalty.	Confirmed.	
F20	For products to which you do not have access, please describe the process for the Plan Participant to obtain these drugs.	Should we receive a prescription in our specialty pharmacy for an item we do not dispense, we will return the prescription to the prescriber and advise the prescriber of the specialty pharmacies with access to dispense the medication.	
F21	Please confirm HIV/AIDS medications are not included on the specialty list and that they would be subject to standard retail network and mail order pricing.	Confirmed.	
F22	Do you currently receive incentives from pharmaceutical manufacturers for any programs or services associated with your specialty program (i.e., data fees, compliance programs, etc.)? Are these incentives included in your definition of total rebates?	We may receive fees from certain manufacturers for clinical services that our specialty pharmacies provide to the manufacturer for compliance and persistency programs. These fees are based on our specialty pharmacy book-of-business, and are not tied to a specific client's utilization, therefore, this revenue is not included in our definition of total rebates.	
F23	Do you provide rebates for products dispensed under the medical benefit (i.e., certain medications dispensed during a hospital stay, specific injectable medications, etc.)?	At this time, we do not provide rebates for products dispensed under the medical benefit. However, we would be happy to work with OGB, and your medical carriers (e.g. BCBS Louisiana), to determine which medications can be carved out to the PBM to maximize savings.	
F24	How would you notify OGB of new drug rebating developments?	The pace of change in health care demands that we continue to innovate and find differentiated solutions to deliver on our commitment to driving more affordable,	

		accessible and effective care. Your dedicated account team will work with you to provide proactive updates and notification of new drug rebating developments during your regularly scheduled meetings and as these opportunities arise.	
G	**Retail Pharmacy Access and Network Management**		
G1	Provide information regarding the Contractor's network.		
	a) Describe the network proposed for OGB.	The CVS Caremark National Network currently consists of approximately 68,000 pharmacies nationwide, including the majority of walk-in pharmacies and all retail drug store chains and other large retail merchandisers, grocery chains, and independent pharmacies located within the United States, Puerto Rico, and the Virgin Islands so your members may receive greater choice and maximum convenience. Additions to the existing network occur as new pharmacies open, and solicitations for nonparticipating pharmacies are considered at the request of the client or members.	
	b) Total number of pharmacies available nationwide.	Our comprehensive National Network currently includes approximately 68,000 pharmacies, consisting of approximately 41,000 chain pharmacies and 27,000 independent pharmacies, in the United States, Puerto Rico, Guam and the Virgin Islands.	
	c) Total number of pharmacies available in Louisiana.	1,169	
	d) List the geographic locations within the United States that are NOT served by the network proposed for OGB.	Not applicable. The CVS Caremark National Network is specifically designed to provide maximum geographic coverage.	
G2	Identify any major chain pharmacies that are not part of the proposed network.	Not applicable. All major chain pharmacies are part of the National Network.	

G3	What percentage of the proposed network is made up of independent pharmacies versus major chains?	40%	
G4	List the elements of your various pharmacy audit programs. For each program, include the type of audit, frequency, and audit method.	Our pharmacy audit process involves both on-site and off-site procedures: • On-site procedures are designed to verify the accuracy of claims submitted through observation of original records including, among other things, prescription hard copies and patient signature logs. On-site auditors provide education to the pharmacy staff on CVS Caremark initiatives and proper billing methods. The on-site process also includes a review of the pharmacy for adherence to other contractual requirements, such as reviewing pharmacy computer DUR/Medication allergy screening, drug stock reviews, partial and return-to-stock procedures, compliance with Medicare Part D requirements, and more. • Off-site procedures include both Investigational and Desk audits. Investigational audits are based on utilization and cost data obtained from reports designed to identify erroneous billings. An investigational audit is a close scrutiny of pharmacy records that may include its purchases, documentation of records, and confirmation of prescriptions from prescribers. All participating pharmacies are subject to our Desk Audit process, which audits for erroneous billings including four off-site teams—Daily Review, Compound Review, Medicare Part D, and member submitted Paper Claims Review. Each team has processes to confirm that claims are properly submitted by the pharmacy or member. DAILY REVIEW AND COMPOUND REVIEW PROCESSES	

		Pharmacy Performance performs a daily review of high dollar claims as well as claims submitted with abnormal quantities or dosages. The daily review is designed to supplement the system edit processes and focuses on the reasonableness of quantity and dosage form. Keying issues are usually the source of incorrect quantity, days' supply, dosage form, or NDC numbers. When an error is suspected, a telephone call is placed to the pharmacy. Most reversals occur within one cycle before the plan sponsor pays the claim, with the remainder adjusted out of cycle. Pharmacies that have recurring or substantial billing issues are more likely to be selected for an on-site audit. The same high dollar review is performed for compound medication claims. This review helps to ensure that compound claims are paid per the contracted rates and meet the plan design requirements of the plan sponsor. RETROSPECTIVE AUDITS We are committed to identifying and eliminating drug diversion and insurance fraud. Our retrospective audit analysis, including on-site audit and investigational audits, helps identify and eliminate fraud, waste, and abuse. ON-SITE AUDIT PROCESS In addition to the auditing and monitoring techniques discussed above, our Pharmacy Performance team conducts more than 4,000 on-site pharmacy audits annually.	

		Our on-site auditing process uses a proprietary program that performs a systematic review of the claims history and automatically flags claims meeting specific criteria. The entire claim record, as transmitted by the pharmacy and subsequently adjudicated by us, is made available at the audit site allowing the auditor to deviate from the original audit plan as the situation dictates. The audit function is also educational. Auditors answer questions about CVS Caremark, inform pharmacists about our programs and policies, and relay pharmacists' concerns back to us. Educational material is provided to all pharmacies to assist in improved program performance and to prevent future point-of-service and submission issues. Approximately two weeks after an on-site or investigational audit is completed the pharmacy is sent a report listing the audit discrepancies and guidelines for documenting these discrepancies. The pharmacy is required to respond, in writing, with proper verification and documentation to support the claims in question. Our on-site auditing process includes a systematic review of the pharmacy's claims history. Specific claims to be reviewed are selected by algorithms, which identify claims that meet specific criteria. Claims may also be selected subjectively by the auditor for any number of reasons including the presence of unusual trends. INVESTIGATIONAL AUDITS Pharmacies may be selected for an	

		investigational audit if the Pharmacy Performance department's analysis indicates irregularities, whether upon receipt of a client referral, upon receipt of a tip from a regulatory agency, member/enrollee, provider/client, or whether from cases referred from other audit processes. The CVS Health Pharmacy Performance management team then determines which of the following actions may be appropriate: • Review of purchase invoices • Contacting the prescriber-of-record for validation • Contacting the patient for validation of receipt of medications.	
G5	How will audit recoveries be paid or remitted to OGB?	OGB will receive 100% of audit recoveries. These collected funds will be returned to OGB as a credit on your invoice or through the correction of the claim transaction.	

G6	Provide a copy of your survey questionnaire, documentation of the survey methodology, and the results of the most recent network pharmacy satisfaction survey.	We measure satisfaction via telephone surveys with members, clients, and pharmacists. Each group is measured in a tailored way: • Members — Members who have utilized their retail and/or mail benefits, or have used our specialty pharmacy, or if they have contacted one of our Customer Care units, are selected randomly to participate in a brief survey designed to evaluate their service experiences. This research, conducted continuously, is an important management tool that helps us assess the quality of our performance and stay abreast of member needs and problems. • Clients — Client executives are asked to participate in satisfaction surveys designed to assess performance in a number of key service areas. These surveys enable us to identify how well client expectations are being met, track the effectiveness of continuous quality improvement programs, and assist in identifying best-performing Account Services personnel. • Pharmacists — Pharmacists who recently have contacted our Pharmacy Help Desk are surveyed randomly to assess their satisfaction with our services. This research reflects our commitment to help our retail-network pharmacies provide prompt, accurate service to prescription drug members. Studies are also conducted by qualified professional research firms that specialize in customer satisfaction issues. These firms notify respondents that they are conducting the studies on behalf of CVS Caremark. MEMBER SATISFACTION RESULTS FOR	

		CAREMARK We randomly select members who have recently used their prescription drug benefits or contacted our Customer Care department, and ask them to participate in a brief survey designed to evaluate their service experience/s. This research is performed on an ongoing basis and is an important management tool for helping to ensure that we are aligned with our members' needs. In 2019, our member overall satisfaction was rated as 95% Satisfied or better. PHARMACIST SATISFACTION RESULTS Pharmacists who recently have contacted our Pharmacy Help Desk are surveyed randomly to assess their satisfaction with our services. This research reflects our commitment to assisting retail network pharmacies in providing prompt, accurate service to prescription drug members. In 2019, 96% of responding pharmacists in our contracted networks were satisfied overall with our Help Desk support service	
G7	How many contracted pharmacies were terminated during the final six months of 2019 because of unacceptable audit or performance results? Explain specific reason(s) for termination of each such pharmacy.	49 pharmacies were termed in the final six months of 2019 for audit results, none of which were in the State of Louisiana.	
G8	How often are pharmacies paid (i.e., weekly, bi-weekly, monthly, etc.)?	Payments are issued to pharmacies on a weekly basis as claims become due for payment.	

G9	Provide the location and operating hours of the proposed call center that will handle inquiries from pharmacy providers regarding technical or administrative claims processing issues.	The CVS Caremark pharmacy help desk provides retail pharmacists with access to Customer Care and is available 24 hours a day, seven days a week, 365 days a year. CVS Caremark Pharmacy Help Desk Locations: - Humble, Texas 77338 - Mobile, Alabama 36619 - Rockford, Illinois 61114 - Virginia Beach, Virginia 23462 - Henderson, North Carolina 27537 - Orlando, Florida 32809	
G10	Confirm that you do not use repackaged NDCs and will only use the NDC of the original packaging manufacturer.	Confirmed.	
G11	Confirm that you have offered your Broadest National Network that includes all chains with fifteen (15) or more stores. If any chain is excluded, please document in the response areas.	Confirmed.	
G12	As of the date you responded to the RFP, how many stores participate nationally in this network?	Our comprehensive National Network currently includes approximately 68,000 pharmacies, consisting of approximately 41,000 chain pharmacies and 27,000 independent pharmacies, in the United States, Puerto Rico, Guam and the Virgin Islands.	
G13	Confirm that OGB will always benefit from any re-contracting with retail pharmacies the PBM does 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 more beneficial than the current rates charged to OGB under the Contract.	Confirmed.	
H	**EGWP**		
H1	Detail the number of clients with self-insured EGWP that you supported in your most recently completed calendar year.	For 2019, we provided services for 105 clients with self-insured EGWP, representing 1.30M retirees.	
H2	Detail the number of clients with EGWP + wrap that you supported in your most recently completed calendar year.	For 2019, we provided services for 105 clients with EGWP + wrap, representing 1.30M retirees.	

H3	Does your organization offer a self-funded EGWP?	Yes	
H4	Do you support custom benefit designs and Formularies within the scope of CMS regulations for EGWP clients?	Yes	
H5	Describe your process for managing Part D versus Part B drugs within the EGWP administration process	We provide appropriate Part B vs. Part D assistance at the point of service (POS). CMS requires plans to implement strategies that promptly provide members access to appropriate pharmacy care. Plans are expected to process B vs. D drug coverage decisions without delay, preferably at the POS. A timely and systematic approach is needed to monitor and apply changing coverage rules to avoid member disruption, CMS complaints, and negative CMS audit findings. This enhanced solution offers clients an alternative to managing these processes in-house, which can often be a costly, and also helps to minimize beneficiary disruption by speeding access to care. Should a client want to cover a drug that is deemed to be a Part B drug after the determination process, we can ensure that drug is covered on our enhanced benefit which will eliminate member noise significantly.	
H6	Is your organization able to submit enrollment data and cost files directly to CMS on behalf of OGB?	Yes	
H7	If yes to the above, what is the frequency with which your organization submits enrollment data and cost files directly to CMS and the timing for these to go into effect?	CVS Caremark's affiliate, SilverScript Insurance Company ("SilverScript") follows CMS guidelines for enrollment. Our process is described as follows: - Receive a client batch files with new adds, changes, and disenrollments via secure connection. - Enrollment and disenrollment requests are expected to contain required data elements for successful processing. - Enrollment requests are expected to be received 45 days prior to effective date of coverage. - Process group sponsor Medicare Part D	

		batch files • Opt-Out Option – Member will be on hold for 30 days (21 days plus mailing) before releasing the transaction to CMS. • Opt-In Option – Transaction will be released to CMS without a 30-day hold.	
H8	Please explain your process used for low income subsidies and catastrophic coverage.	During the enrollment process, CMS notifies SilverScript of any Low Income Subsidy (LIS) eligibility. We use this information to properly mark the individual for the appropriate level of Low Income Copay Subsidy (LICS) and the Low Income Premium Subsidy (LIPS). Per CMS guidance, LIPS should be used to offset any premium owed by the beneficiary. For a self funded EGWP plan, you will be paid back the LIPS monthly and are required to reimburse eligible members within 45 days of the date SilverScript receives the payment from CMS, which is typically the first day of the benefit month. SilverScript will identify LIPS members within the monthly subsidy report.	CMS pays reinsurance subsidies on a PMPM (per member per month) basis. For a Self-Funded EGWP plan the PMPM reinsurance subsidies will be reconciled to actual incurred reinsurance costs as part of the annual reconciliation process for the plan year. In the event that your reinsurance subsidies exceed the actual incurred reinsurance amount calculated during annual reconciliation, the difference will be recouped by SilverScript. In the event that your reinsurance subsidies are less than the actual incurred reinsurance amount, the difference will be paid to you within 30 days.
H9	Does your organization have the capability to segregate Med-D eligible and non Med-D eligible retirees?	Yes	
H10	Will your organization petition CMS for OGB-specific waivers?	Yes	
H11	Confirm that separate reporting and billing will be provided for the EGWP-PDP group.	Confirmed	
H12	When would a decision need to be made, in order to be enrolled into the upcoming (2021) EGWP wrap plan year?	SilverScript's recommendation for a smooth and effective transition to the PDP is 150 days from initial kick-off meeting to the “go-live” date. For a January 1 plan effective date, a final decision should be made by late July (or early August at the latest) of the prior year to help ensure optimal timing for implementation planning.	

H13	Do you have a separate call center that handles EGWP calls?	The fully dedicated customer care team for OGB is cross-trained to support both Commercial and EGWP plan participants. Your dedicated team will be based in our Knoxville, TN facility.	
H14	Confirm whether the same implementation team responsible for the active membership will support the implementation process for the EGWP wrap.	Confirmed	
H15	Confirm that you will support OGB in obtaining member MBI.	Yes	
I	**MEDICARE PART D - GENERAL INFORMATION**		
I1	Is Contractor's Medicare PDP product wholly owned? If not, please provide 1) Legal definition of relationship, 2) the company's name, 3) the headquartered city and state of the company, 4) tenure of current relationship, and 5) Contractual term period of relationship	Yes	SilverScript Insurance Company (SilverScript) is a nationwide PDP sponsor and is an indirect wholly owned subsidiary of Caremark Rx, L.L.C. whose ultimate parent company is CVS Health Corporation.
I2	Do you permit OGB review and allow OGB edits of all CMS and non - CMS communications to retirees prior to release?	Yes	As part of the implementation process, OGB can review all communications. Additionally, SilverScript agrees to customize certain materials for OGB. SilverScript uses the CMS model documents for Medicare Part D communication materials and customization can be accommodated to better clarify the EGWP plan benefits. SilverScript will work with OGB to incorporate edits as appropriate for this audience. All materials are reviewed and approved by our regulatory and compliance teams to manage our contract with CMS. This may require that our two organizations work together to adopt content that meets compliance requirements.

I3	Will you allow a customized insert be included in the initial CMS required mailings (eg Opt out mailing and Welcome kit)	Yes	
I4	Describe the training you provide to OGB's staff who could take calls from Medicare retired members.	Client education on the administration of EGWP plans is a key focus of SilverScript's implementation process. Our trainings cover subjects such as enrollment/disenrollment, late enrollment penalty, creditable coverage, low income subsidy, EGWP-related subsidies, income related monthly adjustment amount (IRMAA), member communication materials, and EGWP reporting. SilverScript can provide EGWP training to OGB staff that interact with Medicare Part D members through onsite and/or live meeting presentations. We are happy to further discuss OGB's training needs and preferences.	
I5	Describe any clinical programs over and above the minimum CMS requirements. Please provide detailed information on each one, including cost, if any.	List of Recommended Clinical programs and costs provided.	
I6	Will you allow OGB to remove prior authorizations, quantity limits or step therapies on an individual drug or therapy class level?	Yes	
I7	Do you allow clients to elect to cover non-Part D drugs?	Yes	
I8	Do you allow clients to elect to cover non-formulary drugs?	Yes	
I9	If you do allow clients to elect to cover non-formulary drug, please confirm the process can be customized to allow a prior authorization exceptions process if requested.	We can accomplish this through our enhanced drug coverage program.	
I10	Are you able to administer a supplemental wrap using a single transaction coordination of benefits through one identification card?	Yes	
I11	Please provide an example of how straddle claims are calculated.	Below is a description of our standard straddle claim logic for Medicare Part D: • If the claim is cusping from a benefit phase with a fixed (flat) copay into a benefit phase	For example, an EGWP plan has a fixed copay of $25 for applicable brands in both the ICL and Gap phase, and the CMS Defined Standard catastrophic cost share

		that also applies a fixed co-pay, only the copay from the beginning benefit phase will be applied - If the claim is straddling from Gap to catastrophic, and the Gap copay is greater than the amount left to meet TrOOP, patient pay will be capped at the remaining TrOOP amount - CMS considers variable copays (i.e., percent plus flat dollar amount) to be fixed copays • If the claim is cusping and one benefit phase has a fixed copay and the other has a percent coinsurance, final patient pay will be the sum of both cost shares.	(e.g. for 2016, greater of 5% or $2.95/$7.40). On a high-dollar claim straddling from Gap to the catastrophic phase, the beneficiary would be charged both the Gap copay of $25 plus the 5% coinsurance of the claim cost falling in the catastrophic phase. The Gap discount would be calculated based on the CMS Defined Standard benefit as follows: TrOOP remaining (prior to this claim)/ (1-Plan Cost Sharing)*50% The EGWP plan would pick up the remaining cost of the drug.
I12	How do you communicate CMS changes to clients?	Your OGB dedicated account team will notify you of CMS changes as they arise. In addition, we regularly provide updates through periodic client communications.	
J	**EGWP RETAIL NETWORK**		
J1	How many CMS-compliant retail pharmacy networks do you offer?	Three	We offer the following SilverScript Medicare Part D Networks (all include a 90-Day network option): -SilverScript Medicare Part D National Network with nearly 68,000 pharmacies, including approximately 41,000 chain pharmacies and 27,000 independent pharmacies. -Medicare Part D Select Discount Network provides client savings between 1% - 3% of gross drug costs in exchange for some potential member disruption. The Select Discount Network, with more than 57,000 providers nationally, includes most pharmacy chains and independents. -Medicare Part D Preferred

			Discount Network with nearly 68,000 providers nationally, including all national and regional chains and most independents. Approximately 24,000 of those providers are Preferred Discount Network preferred pharmacies.
J2	Do you currently offer a preferred pharmacy network for your Medicare business? If yes, please provide specifics:	Yes	SilverScript offers a preferred Medicare Part D retail network with greater overall discounts. Our Medicare Part D Preferred Discount Network is a network option that provides a balance between member access and the opportunity for additional client savings. The Preferred Discount Network includes nearly 68,000 providers nationally, including all national and regional chains and most independents. Approximately 24,000 of those providers are Preferred Discount Network preferred pharmacies. The Preferred Discount Network and the pricing afforded by SilverScript due to OGB's election of the network is expressly conditioned upon a sufficient copay differential between a preferred pharmacy and nonpreferred pharmacy. Savings

			realized with the Preferred Discount Network can translate to lower premiums, lower deductibles, and lower copays.
J3	Please provide your in and out of network paper claims process. How do you determine an emergency?	The following is our claims processing workflow: • The claim is mailed to our P.O. Box address. • The mail is picked up and delivered to the Paper Claims department. • The mail is opened, sorted, counted, and scanned. • All work is date-stamped. • Processors work their claims by oldest date received. • Claims adjudicate against the client benefit for paper claims (e.g., foreign claims, COB, Medicare Part D) • Some claims require that a return letter be sent to the member asking for more information. • Quality Control audits claims through MedForce (imaging tool). Errors are returned to the claims processors for corrective action and adjustment (if needed). Quality Control is a separate department from Claims Processing. • Upon completion of scanning, the clerk picks up and stores the claims on site for approximately 30 days. • Claims are forwarded to a third-party off-site	• After 10 years, claims are destroyed by on-site shredding at the storage facility; this process is overseen by SilverScript Claims department management. • Upon claims adjudication, files are downloaded on a routine basis to a third-party vendor. • The third-party vendor produces the Paper Claims Reconciliation Statements (PCRS) and checks. • Claims run nightly. In emergencies, the member will already have their medication, so the Out of Network claim is reviewed as all other claims. Our Customer Care team will work with the member in a reasonable manner to determine and accommodate for emergency situations which would allow us to process the claim as Out of Network.

		vendor for storage. Claims can be pulled for review upon request.	**Designated Emergency:** Our operating procedures are updated to ensure we waive out of network penalties, timely limits, or similar edits, to ensure members are properly reimbursed for prescriptions paid with cash at the pharmacy. This procedure change will often stay in effect during the declared emergency/disaster (e.g. hurricane, tornado). This change is often completed in conjunction with broader benefit plan updates. **Non-Designated Emergency:** First, our clients may customize how we process and adjudicate member-submitted paper claims in specific scenarios, emergencies are unique vents. Essentially, a client may declare the conditions that warrant emergency processing, and prescribe the process and expectations to include bypassing out-of-network penalties, timely limits, or similar edits. We can also program out workflow systems to escalate member-submitted claims to Account Management where a member suggests an emergency exists, or a special circumstance led to the claim. Account Management may review the claim and circumstance with the client, and approve special overrides, or processing exceptions.
K	**EGWP REBATES**		
K1	Please confirm you will pass rebates back to OGB via check.	Yes	
L	**EGWP PART D ENROLLMENT PROCESS**		

L1	Is Contractor able to automatically group-enroll members into the EGWP program?	Yes	
L2	Is the enrollment process automated for members who 'age in' to Medicare? If no, please describe the process:	Yes	
L3	Will Contractor allow OGB and OGB's eligibility Contractor to manage 'age in' retirees if requested?	Yes	
L4	Does Contractor provide communications for transitioning retirees?	Yes	
M	**PDP/EGWP ADMINISTRATION**		
M1	Describe Contractor's process for handling eligibility feeds both to and from OGB administrator and CMS.	Medicare Part D maintenance enrollment files received must clearly identify OGB's Medicare Part D-eligible members. These files will be loaded in our system within 2 business days, providing that OGB's enrollment data is accurate and contains all required information. This turnaround ensures that SilverScript can circumvent and possible delays in letter and app processing. Once a member is entered into our system, the information is transmitted to CMS for enrollment. The member will not actually be active or terminated in our system until we receive the response file back from CMS. SilverScript produces a Feedback File (FBF) in order to communicate enrollment status for OGB's retirees. The file enables quick identification of EGWP member records and statuses from CMS (enrollments, disenrollments, CMS member data changes, incomplete/denied status), all within a single report. It is generated on a weekly basis, aligned with CMS enrollment transaction cadence and systems to ensure that CMS timeliness guidelines are met.	

M2	Please provide Contractor eligibility file layout requirements. What customization is allowed?	The following elements are CMS-required information for all members being enrolled into the EGWP plan (retirees and spouses will need to be listed separately), along with providing the completed production file to SilverScript for the initial enrollment period. The file should be provided in the DM46 file format, and each record must include the following information for successful intake: • Name • DOB • Gender • Primary address • Medicare Beneficiary Identifier (MBI) • Plan hierarchy information • Effective date • Term date • Disenrollment reason codes • Notice date Other than these CMS-required items, SilverScript has the flexibility to include other elements that are important to OGB.	
M3	What is Contractor's resolution process for handling eligibility outliers?	We manage rejects in work queues to correct and resubmit eligible transactions to CMS for resolution, and we work closely with the account team on exceptions or questions that may be outside of our view. SilverScript follows CMS guidelines for enrollment and disenrollment. When a transaction reply report (TRR) is received, an Exceptions team representative works on the data discrepancies between the Medicare Advantage Prescription Drug (MARx) application and Part D enrollment system as follows: • If the MARx application shows the same member and the enrollment system shows the last name and first name reversed, incorrect	

		date of birth, or gender mismatch, the representative will update the transaction and resubmit it to CMS. • If a reject cannot be resolved by inquiry to the enrollment system or we are unable to contact the member, our Part D Services team triggers a letter to the member seeking additional information and notifies the corresponding Account Manager.	
M4	Contractor agrees to perform multiple tests of eligibility file formats per OGB's / OGB's eligibility administrator's request.	Yes	
M5	Contractor will be required to send a file of certain CMS TRC codes to OGB eligibility administrator for processing. Can Contractor support this requirement?	Yes	
M6	Is Contractor able to manage and adhere to all mandated CMS policies and procedures regarding compliance, formulary submission, fraud, waste and abuse, and transition fills?	Yes	
M7	Is Contractor capable of managing the coverage determinations, re-determinations, appeals and grievance procedures and processes and be compliant with CMS?	Yes	
M8	Please describe Contractor's ERISA compliant and Medicare-required prior authorization/appeals process.	An overview of our coverage determinations and appeals processes has been provided.	
M9	Contractor agrees to handle all levels of appeals for Medicare retirees.	Yes	

M10	Please provide an outline of Contractor's information on Contractor's Medication Therapy Management (MTM) program, not limited to how retirees are identified and the specific program communication and timeline Contractor adheres to. Provide how many of OGB's members will be contacted for MTM by condition.	SilverScript's MTM program is CMS-approved. OGB members who meet the program criteria are automatically opted in to the program. If the qualified member does not wish to participate, a toll-free number is provided in the Explanation of Coverage and MTM program offer letters with instructions on how to disenroll. Members can disenroll at any time. Using prescription claims data, we apply proprietary algorithms to identify beneficiaries with applicable chronic diseases. Targeting for anticipated annual drug spend is performed monthly and includes the evaluation of all Medicare Part D-covered drugs. Beneficiaries are enrolled in the MTM program if they meet all three of the criteria listed below to qualify: • Chronic Conditions - 3 or more targeted chronic conditions (dependent upon the program design selected by the plan, and HIV/AIDS is included as part of the Standard Plus Program Offering only) • Maintenance Medications - 8 or more covered Part D chronic/maintenance medications • Part D drug spend - In excess of $4,255 in anticipated annual Part D Drug spend	
N	**LOW INCOME SUBSIDY (LIS) PROGRAM**		
N1	How are LIS members reported to the OGB and the timing?	Low Income Subsidy (LIS) members are identified in the SilverScript weekly enrollment feedback file we provide to OGB and the monthly subsidy report from Finance. For a Self-Funded EGWP plan, OGB will be sent associated CMS LICS reconciliation payments received by SilverScript within 30 days.	
O	**EGWP OPERATIONAL/BILLING**		
O1	What is your turn around time to provide CMS subsidies to clients once received?	Direct Subsidy, Low Income Premium Subsidy, Reinsurance Subsidy, and reduction of Late Enrollment Penalty amounts will be paid to OGB monthly. Pharmaceutical manufacturers are invoiced for Coverage Gap Discount	

		amounts on a quarterly basis and payment is remitted to OGB five (5) business days after the payments received from manufacturers have been confirmed with CMS (confirmation date is per the CMS calendar). You will be sent associated CMS LICS/reinsurance reconciliation payments received by SilverScript within 30 days. We also have a standardized reporting package to support all subsidy payments.	
O2	What is your STAR rating?	The Centers for Medicare & Medicaid Services (CMS) released its annual Star quality ratings on October 11, 2019, and SilverScript Medicare Part D Prescription Drug Plans improved from 3.5-stars to an overall 4-star rating for 2020. This rating includes all SilverScript EGWP plans. SilverScript is now the only Prescription Drug Plan (PDP) with over 500,000 members to be rated at 4 stars in 2020.	
O3	In response to recent CMS guidance, please describe how your auto-ship program has changed? Did you submit a waiver request to CMS and what impact does that have on your program?	CMS requires SilverScript to obtain consent for non-member-initiated new prescriptions received directly from the prescriber if it is the first time the member has used mail service under their current plan. These non-member-initiated prescriptions include autorenewals and provider-submitted prescriptions via phone, fax, and e-prescribing. SilverScript EGWP members do not have to provide consent for automatic refills.	
O4	Please indicate your process for handling the new CMS guidelines around Hospice and ESRD claims.	Our system is maintained annually to meet all call letter and regulatory needs, and includes the following: -Reject specific medications for members whom CMS has indicated are in hospice or receiving dialysis treatments for the appropriate coverage determination -When member-level hospice/dialysis information is retroactive, for any claims that	

		would have been subject to a coverage determination, SilverScript determines the appropriate payor, Part D or Part A (hospice) or B (dialysis/ESRD).	
O5	What is your end to end testing process for ensuring plans are set up per the clients requirements?	All of CVS Caremark's testing is conducted in a pre-production and Client Test Environment (CTE) allowing us to make changes as needed until the expected outcome is reached. When test results are confirmed as satisfactory, the plan design will be moved to our production environment. Client Benefits (CB) conducts comprehensive testing which includes three steps: • Processing Claims • Reviewing the Data • Verifying/Validating Results We can produce reports from these environments that enable OGB to review, audit, and confirm its programs prior to implementation, as required. Also, we produce standard confirmation reports of new plan setups that will be reviewed with and approved by OGB prior to production implementation of OGB's program on the CVS Caremark systems.	
O6	Contractor agrees to pass back monthly subsidies, quarterly coverage gap reimbursement, Catastrophic reinsurance, and low income cost sharing to OGB via check.	Yes	
P	**Formulary - Medicare Part D**		
P1	How many CMS-compliant Part-D formularies do you offer?	We offer four CMS compliant Part D formularies. We are providing the Platinum Formulary with Closed Wrap.	
P2	Describe the differences between the CMS-compliant Part-D formularies you offer.	For our EGWP, SilverScript offers multiple formularies based upon plan design and drug coverage needs. Our SilverScript Gold formulary focuses on lowest net cost and is the	

		most similar to our SilverScript PDP formulary. Our SilverScript Platinum formulary offers more mid-range coverage, while the SilverScript Copper formulary includes multi-source brands, driving lower net cost through strategic exclusions. Our SilverScript Bronze formulary offers the broadest drug coverage, maximizing CMS subsidies opportunities.	
P3	Does your organization contract with any other organization for formulary development and/or administration?	No	
P4	If your organization contracts with any other organization for formulary development and/or administration, please list 1) the organization and describe its role, 2) Fees that your organization pays for formulary development/administration, including formulary administration fees, and 3) The percent of rebates that are retained by the contracting organization.	Not applicable	
P5	How often are your CMS compliant Part D formularies reviewed?	The formularies utilized for EGWP plans are reviewed and approved by the Part D Services Pharmacy and Therapeutics Committee (P&T) and by the Centers for Medicare & Medicaid Services (CMS) on a monthly basis. The review includes which drugs will be covered on the formulary and any applicable utilization management edits & criteria.	
P6	Describe the committee(s)/team(s) involved in developing and managing your formularies?	Formulary development at SilverScript strictly follows CMS guidance for both new drug review timelines and P&T committee review. Our pharmacists and physicians review all new drugs and evaluate them for inclusion on our Medicare Part D formularies and appropriate tier position and utilization management edits, such as quantity limits or prior authorization, to help ensure safe and effective drug utilization. We track all new-to-market drugs and ensure that they are reviewed within the timeframes required by CMS.	

P7	What is the composition of your P&T Committee, and their credentials?	The CVS Caremark National P&T Committee, who meets face-to-face on a quarterly basis and, as needed, on an ad-hoc basis, is an independent body of 22 independent health care professionals and academicians recognized as national experts and leaders in their fields of specialty. A unique feature of the P&T Committee is the inclusion of a pharmacoeconomist, whose input includes quality-of-life considerations, and a medical ethicist who provides unbiased feedback regarding the logic and appropriateness of P&T Committee decisions. Our P&T Committee includes 18 physicians of which one (1) is a medical ethicist, one (1) is a pharmacoeconomist, and two (2) are specialists in the care of the elderly or disabled. There are also four (4) pharmacists, including two (2) specialists in the care of the elderly or disabled.	
P8	Describe the P & T Committee's formulary drug review and decision-making process.	Our P&T Committee selects drugs that will deliver high quality clinical outcomes for members. We look at many key factors when evaluating new and existing drugs for inclusion on our formulary. Some of these factors include: • Safety relative to other drugs with the same indication(s) and therapeutic action(s) • Efficacy relative to other drugs with the same FDA-approved indication(s) • Available dosage forms of the drug and the dosing interval for each approved indication. New products must meet all drug admission criteria to be considered for addition to our formulary.	
P9	Contractor confirms that committee(s)/team(s) involved in developing and managing your formulary (ies) do NOT utilize cost information	Yes	

	when determining whether the medication offers an clinically significant advantage that should provide it “preferred” status.		
P10	What are the criteria for evaluating an existing drug's formulary status?	We utilize peer-reviewed literature; recognized compendia; consensus documents; nationally sanctioned guidelines and other publications of the National Institutes of Health, Agency for Healthcare Research and Quality, and other organizations or government agencies; drug labeling approved by the Food and Drug Administration (FDA); and input from medical specialty practitioners. Market factors (i.e., upcoming generic launches, current utilization among drugs within a given therapeutic category) may also impact the drug selection process.	
P11	What are the criteria for adding a drug to your formulary?	Criteria used for adding a drug to the formulary is a based on CMS requirements and includes ensuring drugs meet the definition of a Medicare Part D eligible drug. Each drug class or category must include coverage of at least two drugs and that all or substantially all of the Protected Class drugs are covered on the formulary.	
P12	What are the criteria for deleting single-source brand drugs from your Part-D formulary?	Except in limited circumstances, such as removal from the market, new clinical guidelines, safety concerns, or a change in Medicare Part D eligibility, single-source brand drugs are generally not deleted during the plan year.	
P13	When a brand medication loses its patent protection, Contractor confirms that it is moved to “non-preferred” brand status when generics become available.	In almost all cases and subject to all CMS requirements, brand medications are either removed from the formulary or moved to non-preferred brand status when a new generic becomes available and is added to the formulary.	
P14	When a brand medication loses its patent protection, Contractor confirm that relevant step therapy programs are revisited and OGB is	Utilization management criteria developed by CVS Caremark for SilverScript are reviewed by external physicians and pharmacists and	

	provided the option to make the generic available as a step one medication.	approved by CMS as needed. We will work closely with you to determine if any current edits could be applied to the enhanced benefit.	
P15	Do you allow clients the option to delay single-source brand deletions from the Part-D formulary until the next plan year?	Except in limited circumstances, such as removal from the market, new clinical guidelines, safety concerns, or a change in Medicare Part D eligibility, single-source brand drugs are generally not deleted during the plan year. However, if these drugs are deleted from the Part-D formulary, they still may be available for coverage on the open enhanced benefit during the plan year and can be assessed for deletion from the enhanced benefit the next plan year.	
P16	How do you communicate formulary changes to your clients and their members outside of the CMS required notice?	Abridged formularies are provided to all members as part of their welcome kit materials and annually in the Annual Notice of Change (ANOC) mailing. Comprehensive formularies are available by request for members. Members also have access to their drug coverage through tools that are available on caremark.com. For our template SilverScript formularies, our practice is to make negative formulary changes, whereby brands are replaced by generics, twice a year, usually on June 1 and September 1. Changes are also made as needed for market withdrawals such as manufacturer discontinuations or FDA product safety withdrawals. Midyear negative formulary changes require a 30-day advance notice to impacted members, except for immediate generic substitution (i.e., removal or change in the tier/cost sharing of a brand name drug on the formulary when substituting a new therapeutically equivalent generic drug) and removal of drugs withdrawn	

		from the market, where notification could be retrospective.	
P17	Contractor can communicate formulary tier-status changes to OGB at least 60 days prior to changes being made.	CVS Caremark, through its affiliate, SilverScript, agrees to communicate EGWP and/or enhanced benefit formulary changes to OGB between 30-60 days in accordance with CMS rules & guidelines and enhanced benefit formulary timelines.	
P18	Contractor can communicate the impact of formulary tier-status changes (member impact and costs/savings) to OGB at least 60 days prior to changes being made.	CVS Health, through its affiliate SilverScript, agrees to communicate EGWP and/or enhanced benefit formulary changes to OGB between 30-60 days in accordance with CMS rules & guidelines and enhanced benefit formulary timelines and will include member impact information as well.	
P19	What percentage of your formulary consists of multi-source brand drugs?	Multi-source brand drugs make up approximately 21% of the drugs covered on 2020 SilverScript Copper Formulary (eff 4/1/2020).	
P20	What percentage of your formulary are extended release versions of medications?	Approximately 16% of the drugs covered on the 2020 SilverScript Copper formulary are extended release formulations.	
P21	"Medicare Part D Formularies" - Provide the formularies that you offer.	We have provided the applicable formulary lists.	

P22	Will you allow the employer to perpetually grandfather retirees for tier changes and utilization management programs? (other than B vs. D)	EGWP members new to the plan or members impacted by a negative formulary change are eligible for a temporary supply of a transition-fill eligible non-formulary drug or formulary drug with utilization management edit (i.e., prior authorization, step therapy, quantity limit, daily dose, or age requirements) with a minimum of a 30 days' supply during the first 90 days of enrollment. In addition, OGB would be allowed to grandfather coverage of tier changes and UM programs for non-Med D drugs through the enhanced benefit offering/OHI/open wrap.	
Q	**MISC**		

Q1

Retail Network	**Yes**	**No**	**Not Applicable**
a. All pharmacies are required by contract to maintain adequate professional liability coverage for all risks associated with dispensing errors, patient counseling, and quality assurance activities.	Yes.		
b. All pharmacies are required by contract to submit claims electronically via point-of-sale devices.	Yes.		
c. Pharmacy must make an effort to collect Drug Enforcement Administration ("DEA") number or other provider identifier and submit it to support Drug Utilization Review ("DUR").	Yes.		
d. All pharmacies are required by contract to accept "lesser of" pricing – the lower of Usual and Customary ("U&C") Pricing, Maximum Allowable Costs ("MAC"), or eligible charge.	Yes.		
e. All pharmacies are required by contract to review concurrent DUR messages and take action as appropriate.	Yes.		
f. All pharmacies are required by contract to actively encourage Generic substitution.	Yes.		
g. All pharmacies are required by contract to support Formulary programs by informing patients when a non-formulary drug has been prescribed and contact the physician.	Yes.		
h. All pharmacies are required by contract to cooperate in health management/disease management programs offered through the network.	Yes.		
i. All pharmacies are required by contract to dispense generic drugs whenever possible and abide by the pricing of the MAC program.	Yes.		
j. All pharmacies are required by contract to hold OGB Plan Participants harmless in the event of an overcharge.	Yes.		

k. All pharmacies are required by contract to counsel patients about their medications and their compliance with therapy.	Yes.		
l. Contractor will add pharmacies where access does not meet OGB standards.	Yes.		
m. Ability to offer multiple networks for OGB.	Yes.		
n. Perform on-site audits of 20% or more of your pharmacies on a quarterly basis.	Yes.		
o. If requested, perform an on-site audit of a specified pharmacy.	Yes.		
p. Return all audit recoveries to OGB.	Yes.		
q. Each of the following factors are included in on-site audits:			
▪ Physician Dispense as Written ("DAW") use	Yes.		
▪ Concurrent DUR Intervention	Yes.		
▪ Package Size Submitted	Yes.		
▪ U&C Pricing	Yes.		
▪ Generic Dispensing	Yes.		
▪Controlled Substance Dispensing	Yes.		
▪ Compound Dispensing	Yes.		
▪ Days of Supply	Yes.		
▪ Return to Stock	Yes.		
▪ Claim Cost	Yes.		
▪ Claim Volume	Yes.		
▪ Refill Rate	Yes.		
▪ Units per Claim	Yes.		
▪ DEA (physician ID) Submission	Yes.		
r. Contractor's pharmacy relations department will provide the following on behalf of OGB:			
▪ Ongoing network pharmacy newsletter communication	Yes.		
▪ Pharmacy help-desk toll-free number	Yes.		
▪ Local continuing education programs	Yes.		
▪ Written continuing education programs	Yes.		
s. To identify a local pharmacy in your network, the following tools are available to OGB Plan Participants at no charge:			
▪ Online and Hard Copy Directories	Yes		
▪ Toll-free customer service line	Yes		
▪ Online look up via zip code	Yes		
t. Pharmacy report card available for OGB that shows in detail the performance of specific pharmacies.	Yes.		

	u. Contractor will pay pharmacies from reserve funds and then replace funds with OGB invoicing (rather than waiting to receive funds from OGB before making payment).	Yes.		

Q2	Please confirm that OGB will 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" with similar size and plan designs. Essentially, if Contractor offers better pricing to another client with a similar size and plan design as OGB during the Contract term, OGB will benefit from the lesser pricing arrangement and receive the benefit of any offered enhancements	CVS Caremark confirms.	
Q3	Because CMS approval is required for member enrollment in an EGWP, please confirm the timing of ID Card delivery for EGWP members.	CVS Caremark or its affiliate will mail identification cards to the homes of newly enrolled EGWP Plan members within four (4) business days of notification of CMS approval of the Member's enrollment.	
Q4	Please confirm which funds received from CMS will be remitted to OGB within ten (10) business days of receipt.	CVS Caremark or its affiliate will remit any funds received applicable to Plan Participants in Medicare Part D on behalf of OGB, such as direct subsidies, coverage gap, and reinsurance, within ten (10) business days of receipt from CMS.	

ATTACHMENT II: PRICING

COMMERCIAL (NON-MED D POPULATION) PRICING

Retail Network Pricing - Broad	January 1, 2021 through December 31, 2021
Brand Discount: The annual average Brand effective discount guarantee rate.	AWP – [redacted]
Generic Discount: The annual overall Generic discount guarantee.	AWP – [redacted]
Dispensing Fee: The overall annual guarantee.	$[redacted] per Claim
Retail 90 Network Pricing - Broad	**January 1, 2021 through December 31, 2021**
Brand Discount: The annual average Brand effective discount guarantee rate.	AWP – [redacted]
Generic Discount: The annual overall Generic discount guarantee	AWP – [redacted]
Dispensing Fee: The overall annual guarantee.	$[redacted] per Claim
Mail Pricing	**January 1, 2021 through December 31, 2021**
Brand Discount: The annual average Brand effective discount guarantee rate.	AWP – [redacted]
Generic Discount: The annual overall Generic discount guarantee.	AWP – [redacted]
Dispensing Fee: It is expected this will be zero for all Claims.	$[redacted] per Claim
Specialty and Retail Specialty Pricing	**January 1, 2021 through December 31, 2021**
Minimum discount for all new products in new therapeutic classes	AWP – [redacted]
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.	AWP – [redacted]
Aggregate annual discount guarantee across all specialty drugs filled through retail. This will include all specialty products, including bio-generics, biosimilars, limited distribution, etc.	AWP – [redacted]
Dispensing fee for specialty Claims filled through specialty pharmacy	$[redacted] per Claim
Dispensing fee for specialty Claims filled through retail pharmacy	$[redacted] per Claim
Minimum Rebate Guarantees (Exclusion Formulary)	**January 1, 2021 through December 31, 2021**

Name of Formulary	CVS Caremark Standard Control Formulary with Advanced Control Specialty Formulary
Minimum annual Rebate guarantee per retail network Brand Claim	$[redacted] per Brand Claim
Minimum annual Rebate guarantee per retail 90 network extended supply Brand Claim	$[redacted] per Brand Claim
Minimum annual Rebate guarantee per mail Brand Claim	$[redacted] per Brand Claim
Minimum annual Rebate guarantee per retail specialty network Claim	$[redacted] per Brand Claim
Minimum annual Rebate guarantee per specialty Claim	$[redacted] per Brand Claim
Admin Fee per final net paid Claim	**January 1, 2021 through December 31, 2021**
Admin fee per final net paid retail Claim	$[redacted] per Claim
Admin fee per final net paid retail 90 extended supply Claim	$[redacted] per Claim
Admin fee per final net paid mail Claim	$[redacted] per Claim
Admin fee per final net paid specialty pharmacy Claim	$[redacted] per Claim
Admin fee per final net paid retail specialty Claim	$[redacted] per Claim

Commercial	January 1, 2021 through December 31, 2021
Monthly Administrative Service Fee	$[redacted]

EGWP PRICING

Retail Network Pricing (Base Retail Network) SilverScript Medicare Part D Network	January 1, 2021 through December 31, 2021
Brand Discount: The annual average Brand effective discount guarantee rate.	AWP -[redacted]% Long Term Care (LTC): AWP -[redacted]% Home Infusion (HIF): AWP -[redacted]% Indian Health Service, Tribal and Urban (IHS): AWP -[redacted]% Territory (TER): AWP -[redacted]%
Generic Discount: The annual overall Generic discount guarantee.	AWP -[redacted]% Long Term Care (LTC): AWP -[redacted]% Home Infusion (HIF): MAC or AWP -[redacted]% Indian Health Service, Tribal and Urban

	(IHS): AWP - [redacted]% Territory (TER): MAC or AWP - [redacted]%
Dispensing Fee: The overall annual guarantee.	Brand & Generic: $[redacted] per Claim Long Term Care (LTC): Brand: $[redacted] per Claim Generic: $[redacted] per Claim Home Infusion (HIF): Brand: $[redacted] per Claim Generic: $[redacted] per Claim Indian Health Service, Tribal and Urban (IHS): Brand: $[redacted] per Claim Generic: $[redacted] per Claim Territory (TER): [redacted] per Claim
Retail 90 Network Pricing – Broad – Medicare Extended Day Supply Network	**January 1, 2021 through December 31, 2021**
Brand Discount: The annual average Brand effective discount guarantee rate.	AWP – [redacted]%
Generic Discount: The annual overall Generic discount guarantee.	AWP – [redacted]%
Dispensing Fee: The overall annual guarantee.	$[redacted] per Claim
Mail Pricing	**January 1, 2021 through December 31, 2021**
Brand Discount: The annual average Brand effective discount guarantee rate.	AWP – [redacted]%
Generic Discount: The annual overall Generic discount guarantee.	AWP – [redacted]%
Dispensing Fee: It is expected this will be zero for all Claims.	$[redacted] per Claim
Specialty and Retail Specialty Pricing	**January 1, 2021 through December 31, 2021**
Minimum discount for all new products in new therapeutic classes	AWP – [redacted]%
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.	AWP – [redacted]%
Aggregate annual discount guarantee across all specialty drugs filled through retail. This will include all specialty products, including bio-	AWP – [redacted]%

generics, biosimilars, limited distribution, etc.	
Dispensing fee for specialty Claims filled through specialty pharmacy	$[redacted] per Claim
Dispensing fee for specialty Claims filled through retail pharmacy	$[redacted] per Claim
Minimum Rebate Guarantees (Exclusion Formulary w closed wrap)	**January 1, 2021 through December 31, 2021**
Name of Formulary	Platinum Formulary with Closed Wrap
Minimum annual Rebate guarantee per retail network Brand Claim	$[redacted] per Brand Claim
Minimum annual Rebate guarantee per retail 90 network extended supply Brand Claim	$[redacted] per Brand Claim
Minimum annual Rebate guarantee per mail Brand Claim	$[redacted] per Brand Claim
Minimum annual Rebate guarantee per retail specialty network Claim	$[redacted] per Brand Claim
Minimum annual Rebate guarantee per specialty Claim	$[redacted] per Brand Claim
Admin Fee per final net paid Claim	**January 1, 2021 through December 31, 2021**
Admin fee per final net paid retail Claim	$[redacted] per Claim (PBM Admin Fee) + $[redacted] per Member per month ("PMPM") (Self-funded EGWP Admin Fee)
Admin fee per final net paid retail 90 extended supply Claim	$[redacted] per Claim (PBM Admin Fee) + $[redacted] PMPM (Self-funded EGWP Admin Fee)
Admin fee per final net paid mail Claim	$[redacted] per Claim (PBM Admin Fee) + $[redacted] PMPM (Self-funded EGWP Admin Fee)
Admin fee per final net paid specialty pharmacy Claim	$[redacted] per Claim (PBM Admin Fee) + $[redacted] PMPM (Self-funded EGWP Admin Fee)
Admin fee per final net paid retail specialty Claim	$[redacted] per Claim (PBM Admin Fee) + $[redacted] PMPM (Self-funded EGWP Admin Fee)

EGWP	**January 1, 2021 through December 31, 2021**
Monthly Administrative Service Fee	$[redacted]

For the EGWP Wrap Enhanced benefit, Claims will be included in pricing discount and dispensing fee guarantees. The Wrap Enhanced benefit is a PBM service administered outside of the SilverScript Insurance Company Prescription Drug Program (PDP) by CVS Caremark.

Pricing guarantees are measured and reconciled on a component basis. MAC, if applicable, is managed to achieve pricing guarantees within each component while

maintaining a MAC unit price at mail that is equal to or lower than the MAC unit price at retail.

Brand Drug guarantees and Generic Drug guarantees for Claims processed through the tertiary networks indicated in the table above (HIF, LTC, IHS, TER) shall be reconciled in aggregate with the Brand Drug guarantees and Generic Drug guarantees, as applicable, for the broad SilverScript Medicare Part D Network.

CVS Caremark will supply a monthly MAC list by NDC and channel to OGB.

The amount billed to OGB will be equal to the amount paid to retail pharmacies. OGB will pay the lower of the retail pharmacy's usual and customary price, MAC price plus dispensing fee (if applicable), or discount price plus dispensing fee. OGB acknowledges that retail pharmacy rates and fees are variable and in a transparent arrangement Claims will process at the retail pharmacy paid rate. Any applicable sales tax will be added to the Claim cost unless OGB submits documentation confirming its exemption from applicable sales and use taxes.

The participating pharmacy will collect from the Member the lowest of the discounted cost plus dispensing fee and applicable taxes, applicable cost share, or the participating pharmacy's usual and customary price.

Reconciliation of all financial settlements (i.e. performance guarantees, Formulary guarantee true-up, generic guarantees, Rebates, etc.) will be made to OGB within one-hundred and twenty (120) days from the close of each reporting period.

CVS Caremark shall 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.

Any billing formula and all related financial guarantees stated herein will be based on the AWP and associated discount on the date of service of each individual prescription Claim.

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 the reconciliation of any billed amounts, guarantees or otherwise.

The CVS Caremark Retail-90 Network is a 90 day network comprised of many major chains and independent pharmacies providing the combination of member access and market competitive pricing. CVS Caremark Retail-90 Network pricing is applicable for non-specialty Claims equal to or greater than Client's qualified retail Plan design limits, and filled by a participating CVS Caremark Retail-90 Network pharmacy. Claims up to Client's qualified retail days' supply Plan design limits can be filled at any Participating Pharmacy. Claims greater than Client's retail Plan design limits shall only be filled by a CVS Caremark Retail-90 Network pharmacy. Implementation of CVS Caremark's Maintenance Choice Program and/or a mandatory mail plan design may limit the implementation of this network.

The Medicare Extended Days Supply Network is a subset of the SilverScript Medicare Part D Network. Extended Days Supply pricing is applicable for non-specialty Claims equal to or greater than 84 days' supply filled by a participating Extended Days Supply Network Pharmacy. Claims greater than OGB's qualified retail day supply plan design limit shall only be filled by an Extended Days Supply Network Pharmacy.

For compound drug Claims, CVS Caremark applies the NCPDP D.0 standard. For each compound drug Claim, the submitting pharmacy shall provide the following: (a) compound indicator; (b) eleven-digit NDC, quantity, and submitted ingredient cost for each component in the recipe; (c) total quantity and total Usual & Customary price; and (d) level of effort value. CVS Caremark shall determine the appropriate ingredient cost, or NDC, for each component using the lower of (1) the AWP discount; (2) MAC; or (3) the submitted ingredient cost. The level of effort charge will be applied in addition to the appropriate dispensing fee.

Brand Discount and Dispensing Fee Guarantees will based on the following reconciliation:	
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 Discount and Dispensing Fee Guarantees will based on the following reconciliation:	
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 Exclusions (Brand and Generic Claims)	
Claims where Vendor negotiated rate was NOT the basis for adjudication (i.e. U&C Claims)	Excluded
Compound Claims	Excluded

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

For purposes of the Federal Anti-Kickback Statute, Rebates paid to OGB 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).

Commercial Rebate guarantees are conditioned upon alignment with CVS Caremark Performance Drug List – Standard Control and alignment with CVS Caremark Advanced Control Specialty Formulary™.

EGWP Rebate guarantees are conditioned upon alignment with Silver Script Platinum Formulary with Closed Wrap Enhanced Benefit (which may be referred to as Other Health Insurance or "OHI" in communications).

OGB will receive the greater of the aggregate minimum Rebate guarantees or 100% of Rebates plus manufacturer administrative fees received by CVS Caremark for negotiating and administering Rebate agreements, quoted herein. For the purpose of this financial offer, the "minimum Rebate guarantee" or "Rebate" includes formulary and price protection rebates collected by CVS in its capacity as a group purchasing organization on behalf of OGB, and manufacturer administrative fees received by CVS Caremark that are attributable to the utilization of prescription drugs by OGB's Members.

Within ninety (90) days of the beginning of each calendar quarter, CVS Caremark will remit to OGB the Minimum Rebate Guarantee amounts attributable to Claims processed during the prior calendar quarter. No minimum Rebate shall be credited for any Generic Drug Claim, whether such Claim is filled with a Generic Drug or by a Brand Drug dispensed in lieu of a Generic Drug at the Generic Drug reimbursement rate. Final reconciliation between Rebates paid and Rebates collected by CVS Caremark in aggregate shall be performed annually, within ninety (90) days after the end of the calendar year.

To qualify for the minimum Rebate guarantees, the Plan Participants under this Agreement must be covered under a three-tier qualifying plan design. A three-tier qualifying plan design consists of a plan design with at least a $15.00 co-payment differential between tier 2 and tier 3 (the highest Cost Share tier) covered products, at least a $15.00 differential in the minimum co-payment for coinsurance, or a differential of coinsurance 1.5 times, or 50 percentage points, between the tier 2 and tier 3 (the highest Cost Share tier) covered products (for example, if tier 2 covered product coinsurance was 20%, tier 3 covered product would need to be 30% to qualify).

Rebate Guarantees	
Single Source Brands	Included
Multi Source Brands	Included with the exception of DAW 5
Biosimilars	Included

OTC Brand Drugs (if covered by Plan)	Included
Provide any exclusions to the Rebate guarantees:	CVS Caremark 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; Wrap Enhanced Benefit Claims will be excluded from minimum Rebate guarantees, but 100% of any Rebates earned for such Claims will be passed through to OGB.
The following discloses sources of manufacturer revenue received by CVS Caremark that are attributable to OGB Member Claims utilization and an indication of whether each item will be included in the pass-through of Rebates to OGB.	
Formulary/Access rebates	Included
Market Share rebates	Included
Performance/Incentive rebates	Included
Data fees	Not applicable (OGB Claims are excluded from deidentified data sales)
Manufacturer administration fees	Included
Inflation caps / price protection	Included
Compliance program funding	Excluded
Clinical program support/funding	Excluded
Therapeutic intervention funding	Not applicable
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

CREDITS AND ALLOWANCES

This Section sets forth various credits to be paid or credited by CVS Caremark to OGB (collectively "Client Credits"). 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). In addition, OGB acknowledges and agrees that, as a condition to its right to receive Client Credits from CVS Caremark, all Client Credits received shall be used exclusively for providing benefits to Plan Participants and defraying the reasonable expense of administering the Plan.

CVS Caremark agrees to provide OGB annual credit in the amount up to $[redacted] per Member which will be available during the term of the contract as provided in Attachment I: Scope of Work, Task (1) Implementation. The number of Members shall be based on the information provided by OGB during this process. This credit may be used to offset certain expenses incurred by OGB in the administration of OGB's prescription benefit plan or the services provided by CVS Caremark during the term. The credit, for example, may be applied to offset legitimate implementation expenses, communication expenses, Member I.D. cards, postage, special programming charges, Fees and expenses from OGB-engaged consultants associated with projects related to pharmacy benefits or specialty drug medical benefit management, Fees and expenses for third party ongoing reviews/audits or any other consulting services or applied to clinical programs offered by CVS Caremark. OGB will be requested to provide reasonable documentation of expenses incurred that are to be applied to this credit. Alternatively, OGB may elect to have this credit applied to its monthly invoices on a prorated basis. If OGB terminates this Agreement prior to the expiration of the contract term for any reason other than CVS Caremark breach, or if CVS Caremark terminates the agreement as a result of OGB's breach, OGB shall repay CVS Caremark a pro rata portion of the applied general credit amount based upon the number of months remaining in the contract term.

CVS Caremark shall provide OGB with annual audit credit of up to $[redacted] for the term of the contract as provided in in Attachment I: Scope of Work, Task (3) Pharmacy Benefits Manager Services. This annual credit provided to OGB can be applied to offset costs incurred by OGB in the administration of an audit pursuant to the terms of the Agreement. This audit credit will be credited to OGB's monthly invoices. Identification of the expenses attributable to this audit credit shall be mutually agreed upon. OGB shall provide CVS Caremark with documentation of expenses actually incurred in the form of an invoice, an account statement, or other detailed documentation. Expenses applied to this credit will not exceed fair market value of such expenses. If OGB terminates this Agreement prior to the expiration of the contract term for any reason other than CVS Caremark breach, or if CVS Caremark terminates the agreement as a result of OGB's breach, OGB shall repay CVS Caremark a pro rata portion of the applied audit credit amount based upon the number of months remaining in the contract term.

CVS Caremark shall provide OGB with one time implementation credit up to $[redacted] per net new Member implementation credits as provided in Attachment I: Scope of Work, Task (1) Implementation. This credit can be used to offset typical and/or mutually agreed upon implementation costs in transferring from the current provider to CVS Caremark. OGB shall be responsible for all transition and implementation expenses in excess of the implementation credit provided to OGB as set forth above. Examples of transition and implementation expenses include costs of customized Member I.D. cards, postage expense for direct mail of I.D. cards and other communication materials to Members, and special programming required by CVS Caremark or OGB's prior prescription benefit manager to provide data to CVS Caremark. Identification of the costs shall occur no later than six (6) months after the effective date of the Agreement. OGB shall provide CVS Caremark with documentation of eligible expenses directly incurred by OGB in the form of an invoice, an account statement, or other detailed documentation. For agreed upon implementation or transition services provided by CVS Caremark towards this credit, CVS Caremark shall provide expense detail for such items. If OGB's Agreement with CVS Caremark is terminated prior to the expiration of the contract term for any reason (other than CVS Caremark's breach), or if CVS Caremark terminates the Agreement as a result of OGB's breach, OGB will repay CVS Caremark a pro rata portion of the applied implementation credit amount based upon the number of

months remaining in the contract term. The parties acknowledge and agree that the implementation credits provided by CVS Caremark are commercially reasonable and necessary services related to the implementation of this Agreement and represent fair market value for the services provided.

GENERAL PRICING TERMS AND CONDITIONS

Shipping fees and/or postage will not be increased if CVS Caremark's third party carrier increases its charges to CVS Caremark.

The financial provisions in this emergency contract are based upon information provided by OGB (or OGB's authorized representative) during the pricing request process. Subject to written notice to OGB within 30 days and upon written agreement between OGB and Caremark, Attachment II: Pricing may be modified or amended in a manner designed to account for the impact of events identified below. Such written notice will include CVS Caremark's explanation of the manner in which the modification accounts for the impact of the event.

1. OGB-initiated change to pharmacy benefit program, plan design, or formulary alignment, provided, however, a full replacement Consumer Driven Health Plan (CDHP) will not, in and of itself, trigger any pricing adjustment.
2. Product offering decisions by drug manufacturers that result in a reduction of Rebates, including the introduction of a lower cost alternative product which may replace an existing rebatable brand product; an unexpected launch of a generic product ahead of the anticipated generic date; or a branded product converted to OTC status, recalled or withdrawn from the market;
3. Any government imposed change, including changes in CMS guidelines for government regulated programs, if applicable, which materially impacts the current economics of the rebating process with pharmaceutical manufacturers and have a material adverse impact on Rebates that CVS Caremark receives; or
4. OGB's failure to implement, maintain, or satisfy the pricing conditions set forth in the Agreement.

CLINICAL MANAGEMENT PROGRAMS

Clinical Management Fees	January 1, 2021 through December 31, 2021
All-inclusive total Clinical Management Fee for Commercial	$[redacted] PMPM
All-inclusive total Clinical Management Fee for EGWP	$[redacted] PMPM
Commercial Therapeutic Prior Authorization Administration (Non-POS Edits)	$[redacted] per review
Commercial Appeals Administration	First Level Appeals: $[redacted] per request Second Level Appeals: $[redacted] per request Urgent Appeals (Combination of 1st and 2nd Level Appeals): $[redacted] per request
EGWP Therapeutic Prior Authorization Administration (Non-POS Edits)	[redacted]
EGWP Appeals Administration	[redacted]

For the pricing of Self-Funded EGWP Medicare Services, please refer to the attached Self-Funded EGWP Part D Fee Schedule at the end of this document.

Please note that rates and fees are subject to change based on changes in CMS requirements.

COMMERCIAL (OPTIONAL)

Charges or services not identified in this Attachment II: Pricing and/or changes in pricing resulting from a change in the scope of services shall be quoted upon request.

Name of Clinical Management Programs	Description	Description of the Cost Savings	Contractor 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	Will target an aggregate, [redacted] point decrease in A1C among the uncontrolled (A1C >7%) portion of a OGB's diabetic population	Quoted upon request.

	to optimize health care savings:		
Drug Savings Review (Enhanced Concurrent and Retrospective DUR)	Retrospective and Concurrent at Mail focus clinical appropriateness and managing drug trend	OGB savings can vary depending on drug mix and utilization. A typical OGB can expect savings of [redacted]%.	$[redacted] PMPM or $[redacted] per all Rx
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 OGB characteristics	$[redacted] 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 OGB characteristics	$[redacted] 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 OGB characteristics	$[redacted] PMPM
Condition Alerts Quality	Identifies evidence-based opportunities for improved pharmacy and medical care for conditions	Savings are attributed to total health care cost avoidance due to optimizing treatment	$[redacted] PMPM

	linked to select 2015 HEDIS measures through ongoing review and analysis of pharmacy and medical claims, and lab values.	in accordance with credible clinical guidelines, and will vary due to individual OGB 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 OGB characteristics	$[redacted] 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.	OGB-specific (Medical savings based on PCEM model)	Pricing for Commercial Rate Card: Pharmacy Advisor Counseling at CVS: $[redacted] PMPM Pharmacy Advisor Counseling all channels: $[redacted] 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	$[redacted] 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	The program generates on average an estimated [redacted] ROI after program fees are considered each year. CVS	$[redacted] Per Engaged Member Per Month

	Specialty conditions listed above plus the following nine additional conditions: amyotrophic lateral 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	Caremark guarantees a OGB's fees paid into the program via [redacted]% Fees at Risk for ROI [redacted] Fees at Risk for Clinical/Operational Metrics.	

EGWP (OPTIONAL)

Name of Clinical Management Programs	Description	Description of the Cost Savings	Contractor 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 OGB characteristics	$[redacted] 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	Savings are attributed to total health care cost avoidance due to optimizing treatment in accordance with credible clinical guidelines, and will	$[redacted] PMPM

	analysis of pharmacy and medical claims, and lab values.	vary due to individual OGB characteristics	
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 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 OGB characteristics	$[redacted] PMPM
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 OGB characteristics	$[redacted] 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.	[redacted] guaranteed ROI based on medical claims data	$[redacted] PMPM (price subject to change for OGBs with a diabetes prevalence greater than 15% of the total population)
Care Management/ Disease Management	Accordant Care Rare is our nurse care management solution for Members across the following rare conditions: multiple sclerosis, rheumatoid	The program generates on average an estimated [redacted] ROI after program fees are considered each year. CVS	$[redacted] Per Engaged Member Per Month (15,000 lives minimum)

	arthritis, Crohn's disease, ulcerative colitis, hemophilia, cystic fibrosis, systemic lupus erythematosus, Gaucher disease, amyotrophic lateral 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 Care Teams.	Caremark guarantees a OGB's fees paid into the program via [redacted] Fees at Risk for ROI & [redacted] Fees at Risk for Clinical/Operational Metrics.	
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.	Guarantees are client specific (based on metric performance in the previous measurement period).	$[redacted] PMPM

ADMINISTRATION FEE SCHEDULE FOR SELF-FUNDED INDIRECT WAIVER PDP EGWP PLAN

Administration Fee Schedule for Self-Funded Indirect Waiver PDP			
	Services	**Pricing Metric**	**Price**
	Fee for Self-Funded EGWP Services 1-8	**PMPM**	**$[redacted]**
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)		included
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		included
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 OGB specific information		included

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.		included
5	**Replacement ID Cards and Pharmacy Directories:** • ID cards direct shipped to beneficiary		included
6	**Transition Rx Communication Services to Beneficiaries** • Individualized letters mailed direct to each beneficiary for transition fills, as required by CMS		included
7	**Medicare Post-enrollment Calls** • Incremental Medicare D service requirements associated with Post Enrollment Customer Care Calls (increased call volume and handle time)		included
8	**Other Programs:** • Prior Authorizations (includes clinical Prior Authorization 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).		included
Optional Services			
9	**Customized Reporting / Programming:** • Any customization to alter reporting beyond current capabilities	Any charges for customized reporting must be approved by OGB and added to the Agreement by amendment.	
10	**Paper Applications Processing** • Receipt and handling of paper enrollment applications	per application	$[redacted]
11	**Low Income Premium Subsidy (LIPS) Refund Checks** • LIPS refund checks sent directly to Members	Per refund check	$[redacted]

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 September, 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	**CAREMARKPCS HEALTH, L.L.C.**
OFFICE OF GROUP BENEFITS	
By: _____	By: _____
Signature	*Signature*
Renita Ward Williams	_____
Printed Name	*Printed Name*
Title: Interim Chief Executive Officer	Title: _____
Date: _____	Date: _____

ATTACHMENT IV: RECORDS RETENTION SCHEDULE

Louisiana Secretary of State
Division of Archives, Records Management and History
Post Office Box 94125, Baton Rouge, LA 70804

Records Retention Schedule

SS ARC 932 (10/19)

Page 1 of 13 R2019-100 CFM

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X RENEWAL
__REPLACEMENT PAGE
__ADDENDUM PAGE

Http://www.sos.la.gov

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)
AY – Academic Year (Aug 1 – July 31)
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

Agency Approval

Date Signed 1-22-20

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
Post Office Box 94125, Baton Rouge, LA 70804
Http://www.sos.la.gov

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__REPLACEMENT PAGE
__ADDENDUM PAGE

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^^

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)
AY – Academic Year (Aug 1 – July 31)
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
OGB – Office of Group Benefits
OTS – Office of Technology Services
IAT- Inter Agency Transfers
DOA – Division of Administration

Tommy League — Agency Approval
1-7-2020 — Date Signed
Susan C. Snyder, 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
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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**

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
HR – Human Resources
OGB – Office of Group Benefits

Tommy Teague
Agency Approval

1-7-2020
Date Signed

Duane C. Hopkins, CRM
Secretary of State, State Archives & Records Services

1-8-2020
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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Security Status Codes
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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
SOF –Special order Form
OGB= Office of Group Benefits
PES = Personnel Evaluation System

Tommy Teague — Agency Approval
1-7-2020 — Date Signed
Susan P. Hopper, CRM — Secretary of State, State Archives & Records Services
1-8-2020 — Date Approved

Records Retention Schedule

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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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State Records Center Use
Y – Yes
N - No

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

Tommy Teague
Agency Approval

1-7-2020
Date Signed

Susan P. Hopper, CRM
Secretary of State, State Archives & Records Services

1-8-2020
Date Approved

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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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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

Tammy Teague — Agency Approval
1-7-2020 — Date Signed
Duane E. Doyle, CRM — Secretary of State, State Archives & Records Services
1-8-2020 — Date Approved

Records Retention Schedule

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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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Security Status Codes
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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
PHI = Personal Health Information

Tammy League — Agency Approval
1-7-2020 — Date Signed
Juanne E. Doppler, CRM — Secretary of State, State Archives & Records Services
1-8-2020 — 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 – 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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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

Tommy Teague
Agency Approval

1-7-2020
Date Signed

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

1-8-2020
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 / 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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Archival Processing Codes
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State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
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Agency Abbreviations
OGB = Office of Group Benefits

Tammy Leger — Agency Approval
1-7-2020 — Date Signed
Duane E. Doyle, CRM — Secretary of State, State Archives & Records Services
1-8-2020 — 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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Security Status Codes
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Archival Processing Codes
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State Records Center Use
Y – Yes
N - No

Vital Record Identification Code
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I = Important
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Agency Abbreviations
OGB = Office of Group Benefits

Agency Approval — 1-7-2020 Date Signed — Secretary of State, State Archives & Records Services — 1-8-2020 Date Approved

Records Retention Schedule

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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 / 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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Agency Abbreviations
OGB = Office of Group Benefits

Agency Approval — 1-7-2020 Date Signed

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

Records Retention Schedule

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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
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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

Tommy Teague — Agency Approval
1-7-2020 — Date Signed
Susan E. Hopkins, CRM — Secretary of State, State Archives & Records Services
1-8-2020 — Date Approved

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Division of Archives, Records Management and History
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__REPLACEMENT PAGE
__ADDENDUM PAGE

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. **

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)
AY – Academic Year (Aug 1 – July 31)
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
OGB = Office of Group Benefits

Tommy Teague — Agency Approval
1-7-2020 — Date Signed
Duane E. Hopper, CRM — 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 patients 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 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.
Formulary Management Strategy and Exclusions **(Aligns to High Cost Generic, Formulary Exclusions, 510K management, Patent Exclusivity management)**	Designed to increase appropriate utilization 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 the 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 within 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 prescription 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 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 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 potential gaps in medication therapy for compliance with clinical guidelines that have been shown to reduce future medical complications.