STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS (OGB)

NOTICE OF INTENT TO CONTRACT (NIC)

FOR

PHARMACY BENEFIT MANAGEMENT (PBM) SERVICES

ISSUED

October 2, 2006

TABLE OF CONTENTS

SECTION			PAGES
SECTION I	GENERAL INFORMATION AND INSTRUCTIONS OF PROPOSAL FORMAT		3
SECTION II	SCHEDULE OF EVENTS		8
SECTION III	PROPOSAL EVALUATION		10
SECTION IV	PROPOSER REQUIREMENTS		12
SECTION V	PROPOSER INFORMATION/QUALIFICATION/EXPERIENCE		25
SECTION VI	MANDATORY SIGNATURE PAGE		66
SECTION VII	COST QUOTATIONS		
	OPTION 1		67
	OPTION 2		81
SECTION VIII	EXHIBITS		95
	EXHIBIT 1	Plan of Benefits	96
	EXHIBIT 2	Census Information	97
	EXHIBIT 3	Pharmacy Claims Experience	98
	EXHIBIT 4	Current Member ID Card	99
	EXHIBIT 5	Top 100 Brand Drugs (Excel Spread Sheet)	101
	EXHIBIT 6	Top 200 Generic Drugs (Excel Spread Sheet)	102
	EXHIBIT 7	Specialty Drug Pricing (Excel Spread Sheet)	103
	EXHIBIT 8	Contract	104
		Addendum A – Business Associate Agreement (BAA)	112
		Addendum B – Reporting/Data Requirements	118
	EXHIBIT 9	Pertinent State Statues	136

SECTION I

GENERAL INFORMATION AND INSTRUCTIONS OF PROPOSAL FORMAT

A. Introduction/Purpose

The State of Louisiana, Office of Group Benefits (hereinafter called "OGB" or the "Program") invites proposals from any qualified Pharmacy Benefit Management Organization (hereinafter called "PBM" or PBMs") any other company that meet all of the requirements outlined in this Notice of Intent to Contract (NIC).

OGB seeks a contractual relationship with a PBM that agrees to act as a fiduciary for OGB. As such, the PBM shall place and hold the financial interests of OGB and its members above those of third parties.

This NIC anticipates proposals from PBMs that will pay OGB all rebates generated through the sale of prescription medicines to OGB members under this contract. Therefore, each proposer shall base its fee proposal on the fact that all rebates shall be passed on to OGB. Fees quoted by the proposers shall not anticipate the retention of any rebates by the PBM. All rebates shall be collected by the PBM on OGB's behalf and the PBM shall make all efforts to collect and account for any rebates accrued and payble to OGB.

All fees related to administering the core PBM services, including, but not limited to maintenance of a network, maintenance of a POS payment system, development and supply of educational materials, accounting for, collection of and payment of rebates to OGB and other services should all be included in the fees proposed by the proposer.

Proposals are requested for Option 1 and Option 2 Plan of Benefits. Please see Exhibit 1 (page 96) for the Plan of Benefits. OGB reserves the right to choose the Option which best serves the State and OGB. Only one Option will be chosen.

B. General Information

The State of Louisiana through OGB is required by statute to provide health and accident benefits and life insurance to state employees, retirees and their dependents. Plan member eligibility includes employees of state agencies, institutions of higher education, local school boards that elect to participate and certain political subdivisions. Eligibility does not include local government entities, parishes, or municipalities.

The term covered contract as used in this NIC is defined as any class of coverage in which a plan member is enrolled, whether single, employee + spouse, employee + child(ren) and/ or family. Therefore, a covered contract includes the employee or retiree and any covered dependents.

Enrollment as of September 1, 2006 is as follows:

OGB Plan of Benefits	Employee/Retiree	Covered Lives
Preferred Provider Organization (PPO)	51,525	81,951
Exclusive Provider Organization (EPO)	9,900	18,064
Health Maintenance organization (HMO)	47,094	91,710
Managed Care Option (MCO)	19,155	37,568
TOTAL	127,674	229,293

The Mental Health and Substance Abuse (MHSA) benefits are carved out of the basic benefits plan and are currently provided by United Behavioral Health (UBH) on a fully insured basis.

The Utilization Management Services (UM) are provided by Patients Infosystems for the PPO Plan of Benefits. The ASOs provide these services for their plan members.

OGB currently contracts with APS Healthcare for a Disease Management Program for its PPO, EPO and MCO Plan of Benefits. In the current plan year the HMOs are providing these services for their plan members; however, effective July 1, 2007 this will be provided by OGB's Disease Management Program Contractor.

The Pharmacy Benefits Management Services (PBM) are currently provided by Catalyst Rx. In the current plan year the HMOs are providing these services for their plan members; however, July 1, 2007 this will be provided by OGB's PBM Contractor.

All Proposals must be prepared in accordance with the provisions of this Notice of Intent to Contract (NIC). Proposer must agree to meet the Proposer Requirements as delineated in the Proposer Requirements section of the NIC.

C. GB Information Technology Architecture

Desktop: Dell 450 Workstations running Windows 2000 and Window XP
LAN: 10/100/1000 Ethernet using Cisco switches
Servers: Windows servers and AIX UNIX serves
WAN: Frame Relay using Cisco routers switches, and firewall. In addition, Kodak scanners, and various laser printers are used

D. Term of Contract

The effective date of the contract will be July 1, 2007. The contract will expire one year from that date. The contract may be extended for up to two additional years. If marketplace dynamics change, OGB has the right to review current contract terms and pricing at the end of each 12 month period, subject to more favorable contract terms for OGB.

E. Standard Contract Provisions

See Exhibit 8 for the State of Louisiana, Office of Group Benefits Contract/Business Associate Agreement. Any deviation sought by a Proposer from these contract terms should be specifically and completely set forth to be considered by OGB. The provisions of the NIC and the winning proposal will be incorporated by reference into the contract. Any additional clauses or provisions, required by the Federal or State law or regulation in effect at the time of execution of the contract, will be included.

F. Instructions on Proposal Format

Proposers should respond thoroughly, clearly and concisely to all of the points and questions set forth in the Notice of Intent to Contract (NIC). Answers should specifically address current capabilities separately from anticipated capabilities.

1. Submit an original (clearly marked "original") and eight (8) copies of a completed, numbered proposal placing each in a three-ring binder. Note: You must also submit a redacted version of your proposal as outlined in G.3. In addition, provide 2 CDs of your proposal.

2. Use tabs to divide each section and each attachment. The tabs should extend beyond the right margin of the paper so that they can be read from the side and are not buried within the document.

3. Order of presentation:

   Cover Letter & Executive Summary:
   Your Executive Summary should not exceed three (3) pages. Please highlight in your Executive Summary what sets you apart from your competitors and state the reason(s) you believe you are qualified to partner with OGB.

   Section V
   Tab 1 - Proposer Information/Qualifications/Experience (Page 25).

   Section VI
   Tab 2 - Mandatory Signature Page (Page 66).

Section VIII (page 98)

(See Exhibits 5,6,7 which will be provided at the Proposer Conference)

Tab 3 - Top 100 Brand Drugs (Excel Spread Sheet)
Tab 4 - Top 200 Generic Drugs (Excel Spread Sheet)
Tab 5 - Specialty Drug Pricing (Excel Spread Sheet)

Section VII - Cost Quotation Proposal Form - Submit an original and eight (8) numbered copies and two (2) CDs, **in a separate, (do not include in three ring binder) sealed envelope clearly marked, "PBM NIC Cost Proposals"** on the outside of such envelope. Proposal must be received on or before 4:00 pm CST on the date listed in the Schedule of Events.

Option 1 – Pages 67-80
Option 2 – Pages 81-94

4. Answer questions directly. Where you can not provide an answer, indicate not applicable or no response.

5. Do not answer a question by referring to the answer of a previous question; restate the answer or recopy the answer under the new question. If however, the question asks you to provide a copy of something; you may indicate where this copy can be found by an attachment/exhibit number, letter or heading. You are to state the question, then answer the question. Do not number answers without providing the question.

6. **Proposers must submit their Best and Final offer. OGB will not negotiate contract terms or fees outside of this NIC and no consideration will be given to revised quotes.**

G. Ownership, Public Release and Costs of Proposals

1. All proposals submitted in response to this NIC become the property of the OGB and will not be returned to the Proposers.

2. Costs of preparation, development and submission of the response to this NIC are are entirely the responsibility of the Proposer and will not be reimbursed in any manner.

3. Proprietary, Privileged, Confidential Information in Proposals: After award of the Contract, all proposals will be considered public record and will be available for public inspection during regular working hours.

   As a general rule, after award of the Contract, all proposals are considered public record and are available for public inspection and copying pursuant to the Louisiana Public Records Law, La. R.S. 44.1 et. seq. OGB recognizes that proposals submitted in response to the NIC may contain trade secrets and/or privileged commercial or financial information that the Proposer does not want used or disclosed for any purpose other than evaluation of the proposal. The use and disclosure of such data

may be restricted, provided the Proposer marks the cover sheet of the proposal with following legend, specifying the pages of the proposal which are to be restricted in accordance with the conditions of the legend:

"Data contained in Pages of the proposal have been submitted in confidence and contain trade secrets and/or privileged or confidential information and such data shall only be disclosed for evaluation purposes, provided that if a contract is awarded to this Proposer as a result of or in connection with the submission of this proposal, the OGB shall have the right to use or disclose the data therein to the extent provided in the contract. This restriction does not limit the right of OGB to use or disclose data obtained from any other source, including the Proposer without restrictions".

Further, to protect such data, each page containing such data shall be specifically identified and marked **"CONFIDENTIAL".**

You are advised to use such designation only when appropriate and necessary. A blanket designation of an entire proposal as Confidential is NOT appropriate. Your fee proposal may not be designated as Confidential.

It should be noted, however, that data bearing the aforementioned legend shall be subject to release under the provision of the Louisiana Public Records Law, L.R.S. 44.1 et. seq. The OGB assumes no liability for disclosure or use of unmarked data and may use or disclose such data for any purpose. It should be noted that any resultant contract will become a matter of public record.

The OGB reserves the right to make any proposal, including proprietary information contained therein, available to the Office of the Governor, Division of Administration, Office of Contractual Review, or other state agencies or organizations for the purpose of assisting the OGB in its evaluation of the Proposal. The OGB will require such individuals to protect the confidentiality of any specifically identified proprietary information or privileged business information obtained as a result of their participation.

In addition, you are to provide a redacted version of your proposal omitting those responses (or options thereof) and attachments that you determine are within the scope of the exception to the Louisiana Public Records Law. In a separate document, please provide the justification for each omission.

The Louisiana Office of Group Benefits (OGB) will make the edited proposal available for inspection and/or copying upon the request of any individual pursuant to the Louisiana Public Records Law without notice to you.

SECTION II

SCHEDULE OF EVENTS

A. Time Line

Event	Date
NIC Issued - Public Notice by Advertising in the Official Journal of the State/Posted OGB Website/Posted to LAPAC	October 2, 2006
NIC Mailed or Available to Prospective Proposers Posted to OGB Website; Posted to LAPAC	October 2, 2006
Deadline to Notify OGB of Interest to Submit a Proposal **(MANDATORY)**	October 10, 2006
Deadline to Receive Written Questions	October 10, 2006
Response to Written Questions	October 17, 2006
Proposer Conference- Attendance in Person **(MANDATORY)**	October 17, 2006
Response to Additional Questions (if necessary)	October 20, 2006
Proposals Due to OGB	November 14, 2006
Finalist's Interviews/Site Visits	**TBD**
Probable Selection and Notification of Award	**TBD**
Contract Effective Date	July 1, 2007

NOTE: The OGB reserves the right to deviate from this schedule.

B. Mandatory – Notification to OGB of Interest to Submit a Proposal

All interested Proposers shall notify OGB of its interest in submitting a proposal on or before date listed in the Schedule of Events. Notification should be sent to:

Tommy D. Teague
Chief Executive Officer
Office of Group Benefits
Post Office Box 44036
5825 Florida Blvd. 2nd Floor
Baton Rouge, LA 70804
Fax: (225) 925-4721
E-Mail: bstromain@ogb.state.la.us

C. Written Questions

Written questions regarding the NIC are to be submitted to and received on or before 4:00 p.m., Central Standard Time (CST) on the date listed in the Schedule of Events. Written questions should be directed to the address listed above (Section B).

D. Mandatory - Proposers Conference

The Proposers Conference will be held in the boardroom at l: 00 PM at the following location:

Office of Group Benefits
5825 Florida Boulevard
2nd Floor
Baton Rouge, LA. 70806

A representative of your organization must participate in person at the Mandatory Proposers Conference scheduled for approximately 1:00 PM., Central Time on the date listed in the Schedule of Events. OGB staff will be available to discuss the proposal specifications with you, answer any questions you may have in regards to submitted questions and distribute Exhibits.

Proposals will only be accepted from Proposers that have met this mandatory requirement. Attendance by a subcontractor is welcome, but will not be an acceptable substitute for a representative of the primary proposing firm/organization.

E. Proposal Due Date

The original proposal must be signed by an authorized representative of your firm/organization and delivered, together with eight (8) numbered copies and two (2) CDs, between the hours of 8:00 a.m. and 4:00 p.m. Central Standard Time (CST) on or before the date listed in the Schedule of Events at the address listed above (Section B).

SECTION III

PROPOSAL EVALUATION

A. Proposal Evaluation

Proposals will be evaluated by a Selection Committee. Each proposal will be evaluated to insure all requirements and criteria set forth in the NIC have been met. Failure to meet all of the Proposer Requirements will result in rejection of the proposal.

After initial review and evaluation the Selection Committee may invite those firms whose proposals are deemed reasonably susceptible of being selected for award for interviews and discussions at the Program's offices in Baton Rouge, Louisiana, or the Committee may make site visits to the firm's office and conduct interviews and discussions on site. The interviews and/or site visits will allow the Committee to substantiate and clarify representations contained in the written proposals, evaluate the capabilities of each firm and discuss each firm's understanding of the Program's needs. The results of the interviews and/or site visits, if held, will be incorporated into the final scoring for each firm selected as a finalist.

Following interviews and discussions, scoring will be finalized in accordance with the mandatory requirements and evaluation criteria below. The proposal receiving the highest total score will be recommended for contract award.

B. Evaluation Criteria

After determining that a proposal satisfies the minimum requirements stated in the NIC, an assessment of the relative benefits and deficiencies of each proposal, including information obtained during the interviews and discussions and/or site visits, shall be made using the following criteria:

Financial Analysis	500 Points
Qualitative Analysis	500 Points
TOTAL POINTS	1,000 Points

C. Cost Evaluation

The Proposer that provides the lowest cost proposal will be awarded the full points for the Financial Analysis.

Points for other proposals shall be prorated based on the amount (percent) more costly they are compared to the lowest cost Proposer.

Points awarded within each category will be rounded to the nearest whole point. Fractional points of 0.5 or greater will be rounded up.

All expenses (personal compensation, travel, office supplies, copies, etc) should be included in your proposed administrative fee.

This same formula will be used for both Option 1 and 2.

SECTION IV

PROPOSER REQUIREMENTS

A. Proposer's Requirements

To be eligible for consideration, a Proposer must confirm agreement to each of the following requirements:

1. Have a minimum of five (5) years of operation experience in providing PBM Services to a client organization with a group size of twenty-five thousand (25,000) or more covered employees/retirees (not counting dependents).

2. Must have a representative of your organization attend the Mandatory Proposer's Conference.

3. Must submit (within your reponse to this NIC) your firm's audited financial statements for your most recent fiscal year and copy of your organization's most recent Annual Report.

4. Must be able to submit the required reporting information.

5. You agree to provide pharmacy benefit management services, as specified in this NIC, recognizing the unique benefit plan design of OGB's program including, but not limited to, lifetime maximum accumulators, a mail order program, point-of-sale adjudication system that can handle OGB's claim volume, and the ability to administer "paper claim" transactions.

6. The PBM and/or Company shall produce and distribute durable plastic member I.D. cards that include applicable information relative to the prescription drug plan, as well as the medical plan, mental health & substance abuse carve-out plan, out-of-area PPO plan, and utilization management services. A copy of OGB current member identification card, which identifies the required data elements, is included in Exhibit 4 of this NIC. At a minimum, the successful proposer shall produce and issue ID Cards for the PPO plan. MCO, HMO and EPO administrators currently produce and distribute cards for their respective plans. The cost of the member I.D. card, including mailing cost to issue initial I.D. cards as well as any replacement and/or additional cards directly to plan members is to be included in the PBM or Company's quoted fees. Any employee with dependent coverage is to receive two (2) I.D. cards, with additional I.D. cards for family members issued upon request. It is anticipated that cards will be mailed and in members' mailboxes at least ten days prior to the effective date of a plan year.

7. OGB requires direct on-line access to the PBM or Company's system for the purpose of updating eligibility and member enrollment verification by terminal connection via modem. Training on the system must be provided by the PBM and/or Company at OGB's office. All associated costs for the CRT interface are to be included in the PBM or Company's quoted fees.

8. The proposing PBM and/or Company should assume continuation of the clinical services and should include the cost for these services in its fees. If, during the term of the contract, OGB determines that additional drugs are to be subject to prior authorization, the cost for these services should also be included in the quoted fees. The PBM and/or Company will not be able to "renegotiate" its contract with OGB or charge additional fees for adding drugs to or deleting drugs from a prior-authorization status.

9. Provide access to a data reporting system to allow OGB and its consultants and auditors to review OGB claims information. Both OGB and its consultants must have the ability to generate reports from this system. The PBM and/or Company will be responsible for conducting training relative to the reporting system for OGB. The fee for this service must be incorporated into the PBM or Company's proposed pricing.

10. The executive account manager for the PBM and/or Company shall be available for monthly management meetings with OGB staff. These meetings are sometimes on an ad-hoc basis with short notice, and the executive account manager and PBM and/or Company need to be aware of this.

    Vendor agrees to meet with OGB's benefits staff in-person on a quarterly basis to review program results, trend metrics, and benefit strategy recommendations.

    Attendance by the executive account manager or back-up PBM and/or Company personnel at OGB Policy and Planning Board meetings (9-10 per year) is mandatory. At Board meetings, the executive account manager and/or back-up staff member should be prepared to discuss any aspect of its PBM and/or Company or OGB's pharmacy program. Discussions may include an in-depth review of management reports and suggestions for program changes.

11. The contents of this NIC and of the successful proposal will become contractual obligations if a contract ensues.

12. Vendor agrees to be bound by its proposal from the date submitted until the effective date of the contract, during which time OGB may request clarification or correction of the proposal for the purpose of evaluation. Amendments or clarifications shall affect only that portion of the proposal so amended or clarified.

13. Vendor agrees that upon notification of a contract award, an agreement to provide the services requested herein must be fully executed before work can begin. Further, Vendor agrees to work collaboratively with OGB to complete and approve the contractual agreement prior to the contract effective date.

14. Vendor agrees that OGB assumes no responsibility or liability for any costs Vendors may incur in responding to this NIC, including attending meetings or site visits. Any costs incurred by Vendors in preparing or submitting proposals are the Vendor's sole responsibility. Vendors will not be reimbursed for these costs.

15. Vendor agrees that any contact with an OGB employee or contractor, other than the individual(s) designated to receive proposal copies in **Section II** regarding this NIC or the evaluation of proposals prior to completion of the procurement is prohibited and is grounds for disqualification.

16. Vendor agrees that it is solely responsible for ensuring that all pertinent and required information is included in its proposal. Failure to adhere to the described format and to include the required information could result in disqualification or a low evaluation of the bidder's proposal. OGB reserves the sole right to determine if a proposal is incomplete or non-responsive.

17. Vendor agrees that its processes, systems and reporting will be in full compliance with federal and state requirements, including changes related to the Health Information Portability & Accountability Act (HIPAA), throughout the term of the agreement. Any fines or penalties related to non-compliance will be the sole responsibility of the Vendor.

18. Vendor agrees that its organization and its subcontracted Vendors will comply with all HIPAA regulations throughout the term of the agreement with respect to member services, complaints, appeals determinations, notification of rights, and confidentiality.

19. Vendor agrees that the contract (the "Agreement") begins on the effective date (July 1, 2007) and will expire one year from that date, unless terminated earlier pursuant to this Agreement. The contract may be extended for up to two additional years. If marketplace dynamics change, OGB has the right to review current contract terms and pricing at the end of each 12 month period, subject to more favorable contract terms for OGB. At the Term's end (regardless of cause): (a) a Party will not be relieved of any remaining unfulfilled obligations; (b) Vendor will perform its claim run-off obligations; and (c) all warranties, indemnifications, and other provisions will survive and be enforceable to the extent necessary to protect the Party in whose favor they run.

20. Vendor agrees a Party may terminate the Agreement upon notice to the other Party if the other Party: (a) is bankrupt or insolvent; or (b) breaches any of its obligations and fails to cure that breach within 30 days after written notice thereof. In addition, the Agreement will terminate if: (a) the Plan terminates; or (b) the Parties agree in writing to terminate the Agreement.

21. Vendor agrees that OGB may terminate the Agreement without cause with at least 30 days written notice.

22. Vendor agrees that upon termination of this Agreement, Vendor will continue to process run-off claims for Plan benefits that were incurred prior to but not processed as of the termination date which are received by Vendor not more than 12 months following the termination date; provided, however, that at OGB's request the handling of such benefits may be transitioned to a successor agent appointed by OGB; and further provided, that during any run-off period Vendor shall cooperate in the transitioning of services to any successor agent appointed by OGB. The procedures and obligations described in the Agreement, to the extent applicable, shall survive the termination of the Agreement and remain in effect with respect to run-off claims. Benefit payments processed by Vendor with respect to such claims which are pended or disputed will be handled to their conclusion by Vendor except as otherwise provided herein, and the procedures and obligations described in the Agreement, to the extent applicable, shall survive the expiration of the 12 month period. Requests for benefit payments received after such 12 month period will be returned to OGB or, upon its direction, to a successor administrator.

23. Vendor acknowledges and agrees that in providing the claims administration services, it is acting as a fiduciary to the Plan, and that it will be identified as the named claims fiduciary in the Summary Plan Description. OGB delegates to Vendor full and final authority and discretion over all claims and appeals determinations made under the Plan, and to interpret and construe the provisions of the Plan, as necessary. In addition to any other indemnification provided under this Agreement, Vendor will defend, indemnify and hold harmless the Plan and their trusts, OGB, the Plan Administrator, the Employer, and its employees, directors and officers acting within the scope of their employment and not as Plan participants, with respect to any demands, causes of action, litigation, decrees, judgments, awards, expenses and/or associated legal fees which result from or arise out of any fiduciary duty which Vendor will specifically assume under the Agreement.

24. Vendor agrees that if it is determined that any payment has been made by Vendor to or on behalf of an ineligible person or, if it is determined that more than the appropriate amount has been paid or an amount to which the recipient is not entitled under the Plan has been paid, Vendor shall undertake good faith efforts to recover the erroneous payment and, regardless of the success of its recovery effort, will be liable to OGB and Plan for any such overpayment.

25. Vendor agrees that during the term of the Agreement, and for up to one year after termination of the Agreement, OGB (including the Legislative Auditor of the State of Louisiana and/or the Office of the Governor, Division of Administration Auditors, and/or the OGB's Quality Assurance Division, or any third party designated by OGB) shall have the right, upon reasonable prior written notice to Vendor and during regular business hours, to audit Vendor's books, records, electronic data, co-payments, rebates and other evidence related to services provided, claims paid, ingredient costs and fees charged, by Vendor to determine compliance with financial terms; other items as outlined by OGB. Vendor shall fully cooperate with OGB in the conduct of such audit and shall provide OGB with access to the items within the scope of the audit. Vendor shall allow OGB unrestricted audit rights using any reasonable method of audit selected by OGB and its auditors. OGB reserves the right to use external auditors to conduct the audits.

27. Upon the request of the Legislative Auditor, the PBM and/or Company shall provide copies of its internal audits and quality assurance reports and shall obtain and provide an annual report on controls placed in operation and tests of operating effectiveness from an independent audit conducted pursuant to Statement on Auditing Standards (SAS) 70, service organizations. In addition, the PBM and/or Company must perform audits of individual pharmacies requested by OGB for the purpose of determining pharmacy accuracy and adherence to the PBM and/or Company contract. These audits must be conducted and the results reported to OGB within 60 days.

28. Vendor agrees that all documents, records and data relating to the payment of claims shall be the property of the Plan and OGB, except that such property interest shall not extend to Vendor's data processing systems (but shall extend to any claim or payment data recorded for, or otherwise integrated into such systems), information which Vendor reasonably deems to be proprietary in nature, or information which Vendor reasonably believes it cannot divulge due to applicable law. All data and records shall be maintained by Vendor for the same period of time, but in no event less than 7 years or as described in 45 CFR 74.21(B), whichever is longer, and subject to the same privacy and confidentiality safeguards, unless a more restrictive or protective standard is required by the Agreement (in which case such standard shall apply), as similar data maintained by Vendor in connection with its own business.

29. The PBM and/or Company shall procure and maintain, at its own expense, for the duration of the agreement: (a) liability insurance with a combined single limit liability of not less than Ten Million ($10,000,000.00) Dollars (b) commercial general liability insurance (including contractual liability) of at least $2,000,000 per occurrence; (c) if available for the type of service Vendor is providing, professional liability insurance (including errors and omissions coverage) of at least $2,000,000 per occurrence; (d) worker's compensation insurance that meets statutory requirements or satisfactory evidence that Vendor is authorized to self-insure; and (e) employer's liability insurance of at least $500,000 per occurrence. The State of

Louisiana, Division of Administration, OGB must be named as a loss payee and each insurance policy must provide that it cannot be cancelled or changed without 30 days' prior written notice to OGB.

The PBM and/or Company shall, on request, furnish OGB with certificate(s) of insurance affecting coverage required by this Contract. The certificate(s) for each insurance policy is to be signed by a person authorized by that insurer to bind coverage on its behalf. OGB reserves the right to require complete, certified copies of all required insurance policies, at any time.

30. Vendor agrees that, except with OGB's prior written consent in each instance, Vendor will not assign or transfer any of its rights or obligations under the Agreement, including any subcontracting of any services to another party or any transfer of at least fifty percent (50%) of Vendor's assets or ownership. OGB reserves the right to require each approved subcontractor to enter into a contract substantially similar to the Agreement and Vendor remains fully liable for its obligations under the Agreement.

31. Vendor agrees that "Personal Information" shall mean information about a particular individual that, on its own or in combination with other information, identifies an individual (including but not limited to medical information, names, addresses, telephone numbers, social security numbers, and dates of birth of covered persons), in any form and any media, which OGB may provide Vendor or which Vendor may obtain as a result of performing services under this Agreement. Vendor shall: (a) keep all Personal Information strictly confidential and shall exercise the same degree of care, but no less than a reasonable degree of care, to protect and secure the confidential nature of the Personal Information as Vendor uses to protect and secure its own confidential information; (b) use Personal Information only as necessary to perform its obligations under this Agreement and, in such cases, shall limit its use of Personal Information to the minimum necessary to accomplish its purpose; (c) not disclose Personal Information to a third party without the express written permission of OGB; (d) implement security measures to protect all Personal Information from unauthorized access, use, disclosure, alteration or destruction; (e) disclose or provide access to Personal Information to OGB or third party upon direction from OGB; (f) create, obtain, process and use Personal Information only in compliance with all applicable Laws; (g) restrict access to Personal Information to only those Vendor employees and OGB-approved subcontractors as is necessary to perform Vendor's obligations under this Agreement; (h) ensure that all employees and OGB-approved subcontractors with such access have obligations as strict as Vendor's obligations under this Section and that all employees have been informed of those obligations and all OGB-approved subcontractors have acknowledged those in writing; (i) maintain any records that include Personal Information in accurate and current form; (j) on OGB's request, provide reasonable assistance with updating, correcting, verifying, and providing individuals with access to their Personal Information; (k) promptly

notify OGB if any unauthorized person accesses, uses, or discloses any Personal Information, or if any individual requests access to, correction of, or revokes consent for, Personal Information; (l) promptly notify OGB of any judicial process that might require its disclosure and allow OGB a reasonable time to oppose such process; and (m) on OGB's request, notify affected parties at Vendor's expense of any unauthorized access, use or disclosure of Personal Information or other such breach of the confidentiality of a party's Personal Information. Vendor acquires no rights to Personal Information due to the Agreement or the services it provides under the Agreement. Vendor will, at OGB's option, either return or destroy all Personal Information on request or at the Term's end.

32. Vendor agrees to maintain a documented internal quality control process, including pertinent system information, to ensure accurate administration of OGB's pharmacy benefit program. In addition, the Vendor must maintain an ongoing issues log and document all benefit and systems programming changes, subject to OGB's review and approval.

33. Vendor acknowledges and agrees that OGB reserves the right to contract with an outside third party for specialty/biotech pharmacy services at any time during the contract period without penalty.

34. Vendor agrees to immediately notify OGB of any impending litigation involving its company, officers, subsidiaries or subcontractors.

35. Vendor agrees, if applicable, to transfer all open mail order and specialty drug refills, prior authorization approvals, and at least six (6) months of historical claims data at no additional cost to OGB during the implementation process if at such a time OGB terminates its relationship with your organization.

36. Vendor agrees to provide account management representation on-site, if desired by OGB, as of the effective date of the contract and a reasonable time thereafter to assist OGB staff with member inquiries.

37. Vendor agrees to provide a dedicated account management team, including a daily operational account manager supported by an executive account director, eligibility specialist, member services manager, implementation manager and clinical manager. Your account management team is subject to OGB review and approval.

    The executive account manager will have at least one (1) back-up staff member to handle the overall responsibility of the OGB program. The individual who serves as executive account manager must be experienced in working with large public sector accounts (50,000+ employees). Additionally, this representative must assist

with program implementation and ongoing account support and must not be an Account Executive to more than 2 employer accounts (15,000+ employees) including OGB (i.e., the Account Executive can only represent one other account in addition to OGB).

38. Vendor agrees to provide dedicated clinical pharmacist support, which will interact with OGB's benefits staff and local physicians and pharmacists in key geographic areas, as appropriate. The pharmacist must be licensed and in good standing with national/state Boards of Pharmacy.

39. Vendor agrees to offer a key personnel clause, which requires a minimum of 60 days advance notice of any changes to OGB's account team, a description of training requirements for new team members, and a clause that would allow OGB the right to refuse any proposed account management team changes. Reasonable exceptions would apply in situations beyond the Vendor's control (e.g., resignation/termination with less than 60 day notice).

40. Vendor agrees that all customer service centers (e.g., member service center, provider support for technical or administrative issues) will be located in the United States.

41. Vendor agrees to keep OGB informed of any class action lawsuits related to covered prescription drugs. In addition, Vendor will provide claims data and reporting to use in filing for refunds and judgments at no additional cost.

42. Vendor agrees to allow OGB to review and approve all standard communication materials before distribution to plan members. All production costs, including postage, for any plan member communications must be provided at no additional cost.

43. Vendor agrees to provide administrative support for OGB's Medicare Part D drug program, including, but not limited to, eligibility maintenance and reconciliation, drug cost reporting and submission to CMS, preparing and distributing letters of creditable coverage, and ensuring compliance with all CMS and Retiree Drug Subsidy (RDS) requirements.

44. Vendor agrees to arrange and pay for a short-term retail supply of a delayed mail order prescription caused by the Vendor. In addition, Vendor agrees that neither OGB nor its members will be charged for expedited shipping costs as a result of such delays.

45. Vendor 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 re-allocate the penalty dollars at the beginning of each contract year with no more than 20% of the total amount at risk assigned to any one guarantee. All guarantees must be reconciled annually and any penalties owed to OGB shall be paid within 90 days after the end of the year.

46. Vendor agrees to coordinate and share data with OGB's other health care vendors as needed for health plan operations, and at no additional cost.

47. Vendor warrants that all vendors' Personnel performing any of vendor's obligations under the Agreement will have employment authorization that complies with all applicable Laws. Vendor warrants that no vendor Personnel performing any of vendor's obligations under the Agreement is on the U.S. government's "Restricted Parties Lists," which are: (a) the Commerce Department's Entity List, Denied Persons List, and Unverified List; (b) Treasury Department Specially Designated Nationals & Blocked Persons List; and (c) State Department Debarred Parties List.

48. The PBM and/or Company agrees to protect, defend, indemnify and hold harmless OGB, the State of Louisiana, all State Departments, Agencies, Boards and Commissions, their respective officers, directors, agents, servants and employees, including volunteers (each a State Affiliated Indemnified Party), from and against any and all claims, demands, expense and liability arising out of or in any way growing out of any act or omission of the PBM and/or Company, its agents, servants, and employees, together with any and all costs, expenses and/or attorney fees reasonably incurred as a result of any such claim, demands, and/or causes of action <u>except</u> those claims, demands and/or causes of action arising out of the act or omission of OGB, the State of Louisiana, State Departments, Agencies, Boards, Commission, their officers, directors, agents, servants and/or employees. The PBM and/or Company agrees to investigate, handle, respond to, provide defense for and defend any such claims, demand, or suit at its sole expense, even if it (claims, etc.) is groundless, false or fraudulent, provided that (a) the State Affiliated Indemnified Party has given reasonable notice to the PBM and/or Company of the claim or cause of action, and (b) no State Affiliated Indemnified Party has, by act or failure to act, compromised the PBM or Company's position with respect to the resolution or defense of the claim or cause of action.

49. Claims payments shall be processed through an account or accounts owned by Vendor.

50. Your mail service facilities, and your pharmacists, pharmacy technicians and other applicable employees meet all state and federal pharmacy licensing requirements. You also require all your contracted network pharmacies to meet all state and federal pharmacy licensing requirements.

51. You dispense only "AB" rated generic drugs, as approved by the FDA and documented in the Orange Book.

52. The PBM and/or Company shall furnish a performance bond in the amount of three (3) months Administrative Fees to assure performance under the Contract. The amount of the performance bond shall be determined using the number of enrolled employees and retirees on July 1, 2007, multiplied by the monthly fee, multiplied by three.

53. This NIC and any ensuing contract shall be construed in accordance with and governed by the laws of the State of Louisiana, and the exclusive venue of any action brought in connection with the NIC and/or contract will be the 19th Judicial District Court, in and for the Parish of East Baton Rouge, State of Louisiana.

54. The continuation of the Contract is contingent upon the appropriation of funds to fulfill the requirements of the contract by the legislature of the State of Louisiana. If the legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act 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 are not appropriated.

55. The PBM and/or Company acknowledges that OGB is a primary responsibility of the organization, and that such acknowledgement places the Louisiana OGB in a high priority position relative to other clients of the organization.

56. Subject to the confidentiality obligations as set forth in the Contract, OGB shall have unrestricted authority to reproduce, publish, distribute, and otherwise use, in whole or in part, any reports, data, studies, or surveys prepared by the PBM and/or Company for OGB in connection with this Contract or in the performance hereof.

57. The PBM and/or Company warrants that all materials and/or products produced by the PBM and/or Company hereunder will not infringe upon or violate any patent, copyright, or trade secret right of any third party. In the event of any such claim by any third party against OGB, OGB shall promptly notify the PBM and/or Company, and the PBM and/or Company shall defend such claim, in OGB's name, but at the PBM or Company's expense, and shall indemnify OGB against any loss, expense, or liability arising out of such claim, whether or not such claim is successful.

58. Neither party shall be responsible for delays or failure in performance resulting from acts beyond the control of such party. Such acts shall include but not be limited to acts of God, strikes, riots, lockouts, acts of war, epidemics, governmental regulations superimposed after the fact, fire, communication line failures, power failure, earthquakes, or other disasters, or by reason of judgment, ruling, or order of any court or agency of competent jurisdiction.

59. The PBM and/or Company and the PBM or Company's personnel will at all times comply with all security requirements in effect at OGB's facilities which are made known in writing by OGB to the PBM and/or Company. Materials belonging to OGB will be safeguarded by the PBM and/or Company to at least the same extent as the PBM or Company safeguards proprietary information relating to its own business.

60. The PBM and/or Company agrees to abide by the requirements of the following as applicable: Title VI and 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 Act of 1972, and the PBM and/or Company agrees to abide by the requirements of the Americans with Disabilities Act of 1990.

    The PBM and/or Company agrees not to discriminate in its employment practices, and will render services under the Contract without regard to race, color, religion, sex, national origin, veteran status, political affiliation, disabilities, or because of an individual's sexual orientation.

61. Expenditures under the Contract which are ineligible for reimbursement and are determined by audit or review to be ineligible for reimbursement and for which payment has been made to the PBM and/or Company, shall be refunded in full to OGB by the PBM and/or Company.

62. The PBM and/or Company agrees that the responsibility for payment of taxes from the funds thus received under the Contract and/or legislative appropriation shall be the PBM and/or Company's obligation and shall provide its Federal Tax Identification Number upon request.

63. No provision of the Contract is intended to create nor shall it be deemed or construed to create any relationship between the PBM and/or Company and OGB other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of the Contract. This includes both entities and includes the following: all officers, directors, agents, employees or servants of each party.

64. Any notice, demand, communication or payment required under this Contract shall be deemed effectively given when personally delivered or mailed, postage prepaid, as designated in the contract.

65. The PBM and/or Company, if a corporation, shall secure and attach to the contract a formal, dated Board resolution indicating the Signatory is a corporate representative and authorized to sign said contract.

66. No amendment to the Contract shall be effective unless in writing and signed by duly authorized representatives of both parties and approved as required by statutes and regulations of the State of Louisiana.

67. The Contract, together with the attached and referenced Exhibits, constitutes the sole agreement between the parties regarding pharmacy benefits management services, and that no other representations, either oral or written, are binding upon either party.

68. The waiver by either party of a breach or violation of any provision of the Contract shall not operate as, or be construed to be, a waiver of any subsequent breach of the Contract.

69. The invalidity or unenforceability of any terms or conditions of the Contract shall in no way effect the validity or enforceability of any other terms or provisions. Any provision of the contract is severable if it is determined by the parties or by a court or agency of competent jurisdiction to be in violation of the laws of the State of Louisiana or of the United States or of rules or regulations promulgated pursuant to law, or if such provision becomes inoperative due to changes in state or federal law, or applicable state or federal rules or regulations.

70. Notwithstanding any other provision of the Contract, the Contract shall not become effective until approved as required by statutes and regulations of the State of Louisiana.

71. In the event of any inconsistent or incompatible provisions, the signed Contract (excluding the NIC and the PBM and/or Company's proposal) shall take precedence, followed by the provisions of the NIC, and then by the terms of the PBM and/or Company's proposal.

72. Any claims or controversy arising out of this Contract shall be resolved in accordance with the provisions of La R.S. 39:1524 and 1525. A copy of the statute is included as Exhibit 9 of this NIC.

73. The PBM and/or Company will comply with the provisions of statute La.R.S. 22:226, regarding mail order prescription service. A copy of the statute is included as Exhibit 9 of this NIC.

74. The PBM and/or Company will comply with the provisions of La.R.S. 22:1214 regarding unfair methods of competition or unfair or deceptive acts or practices. Specifically, paragraph 15(a) of the statute concerns pharmacies. A copy of the statute is included as Exhibit 9of this NIC.

75. All of your business practices comply with applicable state and federal laws and regulations.

SECTION V

PROPOSER INFORMATION/QUALIFICATIONS/EXPERIENCE

TAB 1

PBM or Company Client References
Please provide three (3) references for your organization's three largest existing clients that utilize both your retail and mail services. Two of the 3 existing references must be for clients with at least 25,000 or more covered employees and retirees (not counting dependents).

Existing Reference #1

Company Name	
Industry	
Contact Person(s)/Title	
Address/City/State/Zip Code	
Telephone	
Facsimile	
Your Organization's Account Manager Assigned to this Account	
How Long Has This Account Been With Your Organization?	*(Provide # of years)*
Which Network Is This Account Using?	*Please provide the name of the network.*
Total # of Employees and Total # of Members	
Plan Design Currently in Place	*(Include copayments, deductibles, Rx exclusions, limits, drugs on prior-authorization, etc.)*

Existing Reference #2

Company Name	
Industry	
Contact Person(s)/Title(s)	
Address/City/State/Zip Code	
Telephone	
Facsimile	
Your Organization's Account Manager Assigned to this Account	
How Long Has This Account Been With Your Organization?	*(Provide # of years)*
Which Network Is This Account Using?	*Please provide the name of the network.*
Total # of Employees and Total # of Members	
Plan Design Currently in Place	*(Include copayments, deductibles, Rx exclusions, limits, drugs on prior-authorization, etc.)*

Existing Reference #3

Company Name	
Industry	
Contact Person(s)/Title(s)	
Address/City/State/Zip Code	
Telephone	
Facsimile	
Your Organization's Account Manager Assigned to this Account	
How Long Has This Account Been With Your Organization?	*(Provide # of years)*
Which Network Is This Account Using?	*Please provide the name of the network.*
Total # of Employees and Total # of Members	
Plan Design Currently in Place	*(Include copayments, deductibles, Rx exclusions, limits, drugs on prior-authorization, etc.)*

Please provide two (3) references that left your organization in 2005. Please state the reason(s) why.

Terminated Reference #1

Company Name	
Industry	
Contact Person(s)/Title(s)	
Address/City/State/Zip Code	
Telephone	
Facsimile	
Your Organization's Account Manager Assigned to this Account	
How Long Was This Client With Your Organization?	*(Provide # of years)*
What Network Was This Account Using?	
Total # of Employees and Total # of Members	
Why Did This Client Leave?	

Terminated Reference #2

Company Name	
Industry	
Contact Person(s)/Title(s)	
Address/City/State/Zip Code	
Telephone	
Facsimile	
Your Organization's Account Manager Assigned to this Account	
How Long Was This Client With Your Organization?	*(Provide # of years)*
What Network Was This Account Using?	
Total # of Employees and Total # of Members	
Why Did This Client Leave?	

Terminated Reference #3

Company Name	
Industry	
Contact Person(s)/Title(s)	
Address/City/State/Zip Code	
Telephone	
Facsimile	
Your Organization's Account Manager Assigned to this Account	
How Long Was This Client With Your Organization?	*(Provide # of years)*
What Network Was This Account Using?	
Total # of Employees and Total # of Members	
Why Did This Client Leave?	

Questionnaire
Please respond to all questions outlined in this section. Each question must be answered specifically. Reference should not be made to a prior response.

A. General background

1. Please complete the following information:

PBM or Company Name	
Name of Parent Company	
Ownership Structure	
Operational Date	
Tax Identification Number	
Street Address	
City	
State	
Zip Code	
Web Address	
Contact for This Proposal	
Title	
Telephone #	
Facsimile #	
Year Network(s) Established	
Name of Network Proposed for OGB	
Covered Lives (including all networks) - 3 Years Prior (average monthly) - 1 Year Prior (average monthly) Current	
Number of Group Plans Currently Administered	
Number of Group Plans Terminated in past 24 months	
Number of Groups Plans Currently Administered in Louisiana	
Number of Groups Plans Terminated in past 24 months in Louisiana	

2. Complete the following table with information reflecting your 2005 book-of-business with self-funded employers:

Employer Plan Sponsor	Total Number of Clients	Total Covered Lives	Number of Paid Claims	Retention Rate
Commercial				
Government/Public Sector				

3. Please identify any anticipated changes in ownership or business developments, including but not limited to mergers, stock issues, and the acquisition of new venture capital.

4. 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?

5. 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.) and describe the type of revision or enhancement to each system.

6. Are there any major changes, upgrades, or modifications of your systems scheduled in the next 36 months? If yes, describe your product changes (i.e., enhancement, upgrades, etc.), processes and procedures.

7. Please list any companies to which you subcontract services.

Service	Response	If Yes, Name of Subcontractor
Claims Processing	Yes or No	
Utilization Review	Yes or No	
Disease Management	Yes or No	
Credentialing/Re-credentialing	Yes or No	
Pharmacy Auditing	Yes or No	
Claim Auditing	Yes or No	
Mail Order Services	Yes or No	
Pharmacy On-Site Auditing	Yes or No	
List Other:	Yes	

8. Report on your entire book of business

Employer Size (# of employees/retirees)	# of Accounts	# of Lives	Total Claim Dollars Paid Annually
<500			$
500 – 15,000			$
15,001 – 30,000			$
30,001 – 50,000			$
>50,000			$

9. What amount of professional liability insurance do you maintain?

a. Does your professional liability coverage protect all clients against liability arising from your activities?

b. What is the amount of E&O liability insurance maintained for PBM or Company operations?

10. Provide your company's most recent financial rating or filing (identify date) from each of the following:

Rating Agency	Rating	Date
A.M. Best		
Moody's		
Duff & Phelps		
Standard & Poor's		

11. Indicate if your rating has changed within the past 12 months for any of the rating agencies:

Rating Agency	Rating	Date
A.M. Best		
Moody's		
Duff & Phelps		
Standard & Poor's		

12. Please describe any past or pending litigation proceedings with contingent liability over $500,000 and judgments or settlements involving your firm's prescription drug retail and/or mail order services.

13. Please describe the process available to members who need to file an appeal or grievance against your company.

B. Retail Network.

1. All pharmacies are required by contract to maintain adequate professional liability coverage to cover all risks associated with dispensing errors, patient counseling, and quality assurance activities.

Retail		
Yes	No	NA

2. All pharmacies are required by contract to submit claims electronically via point-of-sale devices.

Retail		
Yes	No	NA

3. The pharmacy must make an effort to collect DEA number or other provider identifier and submit it to support DUR.

Retail		
Yes	No	NA

4. All pharmacies are required by contract to accept "lesser of" pricing – the lower of U&C, MAC or eligible charge.

Retail		
Yes	No	NA

5. All pharmacies are required by contract to review concurrent DUR messages and take action as appropriate.

Retail		
Yes	No	NA

6. All pharmacies are required by contract to actively encourage generic substitution.

Retail		
Yes	No	NA

7. 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.

Retail		
Yes	No	NA

8. All pharmacies are required by contract to cooperate in health management/ disease management programs offered through the network.

Retail		
Yes	No	NA

9. All pharmacies are required by contract to dispense generic drugs whenever possible and abide by the pricing of the MAC program.

Retail		
Yes	No	NA

10. All pharmacies are required by contract to hold OGB members harmless in the event of an overcharge.

Retail		
Yes	No	NA

11. All pharmacies are required by contract to counsel patients about their medications and their compliance with therapy.

Retail		
Yes	No	NA

12. You will add a pharmacy where access does not meet OGB standards.

Retail		
Yes	No	NA

13. You have the ability to offer multiple networks for OGB.

Retail		
Yes	No	NA

14. You perform on-site audits of 20% or more of your pharmacies on a quarterly basis.

Retail		
Yes	No	NA

15. All audit recoveries will be returned to OGB.

Retail		
Yes	No	NA

16. Each of the following factors are included in your on-site audits:

	Retail		
Physician Dispense as Written (DAW) use	Yes	No	NA
Concurrent DUR intervention	Yes	No	NA
Package size submitted	Yes	No	NA
Usual and Customary pricing	Yes	No	NA
Generic dispensing	Yes	No	NA
Controlled substance dispensing	Yes	No	NA
Compound dispensing	Yes	No	NA
Days supply	Yes	No	NA
Return to stock	Yes	No	NA
Claim cost	Yes	No	NA
Claim volume	Yes	No	NA
Refill Rate	Yes	No	NA
Units per claim	Yes	No	NA
DEA (physician ID) submission	Yes	No	NA
Historical audit results	Yes	No	NA
Other	Yes	No	NA

17. If requested by OGB, you will perform an on-site audit of the specified pharmacy.

Retail		
Yes	No	NA

18. Your pharmacy relations department will provide on behalf of OGB:

	Retail		
Ongoing network pharmacy newsletter communication	Yes	No	NA
Pharmacy help-desk toll-free number	Yes	No	NA
Local continuing education programs	Yes	No	NA
Written continuing education programs	Yes	No	NA

19. To identify a local pharmacy in your network, the following tools are available to OGB employees at no charge:

	Retail		
Directories	Yes	No	NA
Toll-free customer service line	Yes	No	NA
Internet look up via zip code	Yes	No	NA

20. You have a pharmacy report card available for OGB that shows in detail the performance of specific pharmacies. Provide a sample report card with your proposal.

Retail		
Yes	No	NA

21. You pay your pharmacies from reserve funds and then replace the funds with OGB invoicing (rather than waiting to receive the funds from OGB before paying the pharmacies).

Retail		
Yes	No	NA

22. Please provide a copy of your survey questionnaire, documentation of the survey methodology, and the results of the most recent network pharmacy satisfaction survey.

23. How many contracted pharmacies were terminated during the first six months of 2006 because of unacceptable audit or performance results? Explain reason for terminations.

# Terminated	

24. Pharmacies are paid:

Weekly	
Bi-weekly	
Twice Monthly	
Monthly	
Varies By Client	
Other	

25. What percent of contracted retail pharmacies have on-site audits conducted? Desktop audits? In addition, indicate frequency of each audit type.

Onsite (2005)	
Desktop (2005)	

26. What is the total number of pharmacies included in your:

Select Network	
Broad Network	

27. Provide the location and operating hours of your proposed call center that will handle inquiries from pharmacy providers regarding technical or administrative claims processing issues.

C. Mail Service/Specialty Pharmacy

1. Your policies prevent you from dispensing any prescriptions using medication within 120 days of the medication's expiration date.

Mail Service		
Yes	No	NA

2. You allow mail service prescription refills by telephone using a credit card.

Mail Service		
Yes	No	NA

3. You allow mail service prescriptions refills by the Internet using a credit card.

Mail Service		
Yes	No	NA

4. The following mechanisms are available to notify participants of their next refill date:

	Mail Service		
At time of initial fill	Yes	No	NA
Through proactive phone call	Yes	No	NA
Internet email	Yes	No	NA
Post card/letter	Yes	No	NA
Other	Yes	No	NA

5. If a patient reports that a prescription drug is lost in the delivery process, you will replace the drug at no cost to the payer (i.e., OGB).

Mail Service		
Yes	No	NA

6. OGB employees can purchase the following at their expense through the mail facility:

	Mail Service		
OTCs	Yes	No	NA
Vitamins	Yes	No	NA
Nutritional supplements	Yes	No	NA
DME	Yes	No	NA
Other	Yes	No	NA

7. When auditing your mail service facilities, your audit criteria are more stringent and detailed than your retail audit criteria. Explain.

Mail Service		
Yes	No	NA

8. You have a disaster recovery plan, which would be used in the event of a mail service facility closure or local disaster where members reside. Provide details and explain how you handled the effects of Hurricane Katrina.

Mail Service		
Yes	No	NA

9. Please provide copies of all materials mailed to members receiving mail service prescriptions.

10. Provide your book-of-business drug mix over the past year separately for mail and retail. Provide number of single source brands, multi-source brands, generic, and specialty. Please provide numbers and percentages.

Drug Mix Percentage for 2005

	Single Source Brands		Multi-Source Brands		Generic		Specialty	
Retail 2005	#	%	#	#	%	%	#	%
Mail Service 2005	#	%	#	#	%	%	#	%

11. What was your book-of-business generic substitution rate (GSR) at mail service during the first six months of 2006?

Brand to Generic	

12. Indicate the location, percent capacity, and hours of operation of the mail order and specialty facility you are proposing for OGB.

	Location (City, State)	**Percent Capacity**	**Hours of Operation (i.e., dispensing)**
Mail			
Specialty			

13. Please outline the procedure for tracking/replacing prescriptions sent to patients that are reported lost or stolen.

14. Using the table below, provide your Mail Order performance statistics over the past two years:

Mail Order Facility Statistics	**2005**	**YTD 2006**
Total number of prescriptions dispensed		
Utilization as a percent (%) of capacity		
Average turn-around time (no intervention required)		
Target turn-around time (no intervention required)		
Average turn-around time (intervention required)		
Target turn-around time (intervention required)		

15. Are specialty/biotech drugs dispensed from your mail order pharmacy or at a separate facility? If at a separate facility, briefly describe your routing procedures if a prescription for a specialty/biotech drug is sent to the standard mail order pharmacy.

16. Using the table below, provide your Specialty Pharmacy performance statistics over the past two years:

Specialty Pharmacy Facility Statistics	**2004**	**2005**

Specialty Pharmacy Facility Statistics	2004	2005
Total number of prescriptions dispensed		
Utilization as a percent (%) of capacity		
Average turn-around time (no intervention required)		
Average turn-around time (intervention required)		

17. How do you define and classify "specialty/biotech" drugs for dispensing purposes (i.e., determining what products are filled at the Specialty Pharmacy). Is this definition consistent with your pricing of specialty/biotech drugs?

18. Do you (or any subcontractors) repackage drugs for your mail order/specialty dispensing operations? If yes, how is the Average Wholesale Price (AWP) determined for the repacked product and does it match the unit AWP of the source labeler?

19. Will you provide postage-paid return envelopes for refill orders to OGB members along with their filled mail order/specialty prescription?

20. What is the minimum length of time (in days) that a mail order/specialty prescription would have to be delayed before a short-term retail supply is offered to the member? In addition, please explain:
    a) What criteria are used to determine whether or not a short-term retail supply is authorized?
    b) Under what circumstances is the member contribution <u>not</u> waived for the short-term retail supply?

21. How are members notified when a mail order/specialty prescription is delayed due to the following circumstances?
    a) A prescription requiring clarification from the physician or physician's agent (e.g., missing quantity, illegible drug name)?
    b) A clean prescription where the delay is due to the vendor's operational, capacity, or drug supply issues?
    c) A clean prescription where the delay is a result of the vendor's therapeutic switch intervention?

22. Describe your shipping procedures and protocols for medications that are temperature sensitive.

23. How do you manage wholesale drug shortages, including the process for seeking alternative procurement or adjusting dispensing levels?

24. What is the standard days' supply for specialty drugs dispensed at the mail order/specialty pharmacy? Can OGB customize the allowable supply, and are there any other plan design requirements or parameters specific to specialty drugs?

25. Discuss your capabilities for ensuring that all specialty/biotech drugs are appropriately processed through OGB's pharmacy program rather than its medical benefit. Provide a recent case study where you were successful in "carving out" specialty drug claims from a medical plan that helped achieve measurable savings for the plan sponsor.

26. Confirm your willingness to lock out all artificial (i.e., 'dummy') DEA numbers, including your own mail facility DEA number, and describe your ability to ensure that the correct physician DEA number is included with each mail order claim.

27. Confirm your willingness and ability to print claim price information (e.g., total claim cost and member/plan cost share) on mail order/specialty pharmacy invoices or offer other services to accomplish this objective.

D. Clinical Programs

		Check One		
1.	You provide emergency access to a registered pharmacist 24 hours a day.	Yes	No	NA
2.	You provide educational information to members with asthma, diabetes, circulatory problems, and cardiac problems.	Yes	No	NA
3.	Your registered pharmacists consult directly with prescribing physicians. Describe.	Yes	No	NA

4. Your concurrent DUR program includes edits for:

	Retail			Mail Service		
Duplicate claim	Yes	No	NA	Yes	No	NA
Early refill	Yes	No	NA	Yes	No	NA
Drug-drug interaction	Yes	No	NA	Yes	No	NA
Duplicate therapy	Yes	No	NA	Yes	No	NA
Late refill	Yes	No	NA	Yes	No	NA
Drug age	Yes	No	NA	Yes	No	NA
Drug gender	Yes	No	NA	Yes	No	NA
Drug pregnancy	Yes	No	NA	Yes	No	NA
High dose	Yes	No	NA	Yes	No	NA
Low dose	Yes	No	NA	Yes	No	NA
Maximum duration	Yes	No	NA	Yes	No	NA
Drug disease interaction	Yes	No	NA	Yes	No	NA

Allergies	Yes	No	NA	Yes	No	NA
Others (explain)	Yes	No	NA	Yes	No	NA

5. You perform a daily audit of transactions and contact the pharmacist and/or physician if potentially life-threatening therapies are identified.

Check One		
Yes	No	NA

6. Retrospective DUR is done for each individual client and not by consolidating multiple employers into one group.

Check One		
Yes	No	NA

7. Provide an example of DUR for SSRIs including physician letter, clinical information, and rule set.

8. How do you substantiate DUR savings? Provide the specific DUR savings report, including methodology and assumptions.

9. Your DUR system requires pharmacist input in order to bypass DUR messaging. (i.e., "active participation").

Retail			**Mail Service**		
Yes	No	NA	Yes	No	NA
Yes	No	NA	Yes	No	NA

10. OGB may customize any system edits.

Retail			**Mail Service**		
Yes	No	NA	Yes	No	NA

11. What are your criteria for denying claims for early refill and duplicate claims?

12. Complete the following tables with the requested information about your current clinical and utilization management programs. Note: do not provide information for programs that are not guaranteed to be operational by July 1, 2007.

Program Type:	**Basic Concurrent DUR**
Program Name & Description:	
Program Cost (if any):	
Anticipated Savings:	
Guaranteed Savings (if any):	

Program Type:	**Retrospective DUR**
Program Name & Description:	
Program Cost (if any):	
Anticipated Savings:	
Guaranteed Savings (if any):	

Program Type:	**Formulary Management/Therapeutic Interchange**
Program Name & Description:	
Program Cost (if any):	
Anticipated Savings:	
Guaranteed Savings (if any):	
Other information:	

Program Type:	**Traditional Prior Authorization**
Program Name & Description:	
Program Cost (if any):	
Anticipated Savings:	
Guaranteed Savings (if any):	
Other information:	

Program Type:	**Automated Prior Authorization (e.g., drug history and patient demographic information used to reduce member disruption)**
Program Name & Description:	

Program Cost (if any):

Anticipated Savings:

Guaranteed Savings (if any):

Other information:

Program Type:	**Enhanced Concurrent DUR: Step Therapy Edits**
Program Name & Description:	
Program Cost (if any):	
Anticipated Savings:	
Guaranteed Savings (if any):	
Other information:	

Program Type:	**Enhanced Concurrent DUR: Rx Quantity Limits**
Program Name & Description:	
Program Cost (if any):	
Anticipated Pharmacy Savings:	
Guaranteed Pharmacy Savings (if any):	
Other information:	

Program Type:	**Enhanced Concurrent DUR: Dose/Duration of Therapy Edits**
Program Name & Description:	
Program Cost (if any):	
Anticipated Pharmacy Savings:	
Guaranteed Pharmacy Savings (if any):	
Other information:	

Program Type:	**Other Programs**
Program Name & Description:	
Program Cost (if any):	
Anticipated Pharmacy Savings:	
Guaranteed Pharmacy Savings (if any):	
Other information:	

13. For programs with guaranteed savings in Question 12 above, provide a description of your savings methodology, including an illustrative calculation on a 'per Rx' basis. Additionally, indicate how savings due to market events (e.g., Vioxx withdrawal) would be factored out of the reported savings.

14. **<u>Option 2 Only (see Exhibit 1; Option 1 does not have a formulary):</u>** What formulary are you proposing? What elements of your financial proposal in Section VII are contingent upon OGB implementing this formulary?

15. **<u>Option 2 Only:</u>** Confirm that OGB will have the ability to customize the formulary upon request and that you will provide a detailed cost impact analysis (including specific drug-level rebates) for any proposed change.

16. **<u>Option 2 Only:</u>** Complete Exhibit 5 with the formulary status of OGB's top 100 brand name drugs using your proposed formulary as of September 1, 2006.

17. Describe your operational processes, including member and prescriber notification, for formulary interventions and other therapeutic switches. Detail any differences between your retail and mail order processes.

18. For therapeutic switches, detail any cases where the AWP of the preferred/formulary drug is higher than the AWP of the targeted non-preferred/non-formulary drug, exclusive of rebate considerations. Differentiate these cases between retail and mail order protocols, and confirm that OGB will have the option to "turn off" any specific therapeutic switches with no financial impact.

19. **<u>Option 2 Only:</u>** Complete the following table based on your proposed formulary for OGB as of September 1, 2006:

Formulary Name:

Total number of unique formulary products (brand and generic), regardless of strength, form, or manufacturer ______

Percent of single-source brands on formulary ____%

Percent of multi-source brands on formulary ____%

Percent of generics on formulary ____%

Total Average Unit AWP of formulary $______

20. Describe any programs you offer as a standard service that profiles physician prescribing patterns and how this information is used to promote higher generic and/or formulary utilization.

21. Confirm your willingness to provide counter-detailing support to OGB in key geographic areas where there is a large concentration of employees/utilization. Describe your approach to physicians, your staffing requirements, and any additional costs associated with this service.

22. Detail any formal program in place to notify plan sponsors of new drug developments (e.g., anticipated launch of a blockbuster drug, patent expirations, etc.). Please provide one to two examples of this type of notification from 2006.

23. Provide a flow chart of your compliant appeals process, including:
    (a) The standard response time guidelines;
    (b) Notification of denial and appeal rights; and
    (c) Qualifications for determining the need for pharmacist/physician review.

24. Your P&T committee meets:

Check One		
Quarterly	**Monthly**	**Annually**

25. You can administer an:

	Check One		
Open formulary	Yes	No	NA
Closed formulary	Yes	No	NA
Restrictive formulary (top 5-10 categories closed)	Yes	No	NA
Incentive-based formulary using copay differentials	Yes	No	NA
Other	Yes	No	NA

26. **Option 2 Only:** Your formulary is developed in-house rather than being a private label of another PBM or Company.

Check One		
Yes	No	NA

27. You communicate formulary changes to MDs, PTs, and RPhs via:

	Check One		
Online messaging to RPhs	Yes	No	NA
Physician newsletter quarterly	Yes	No	NA
DUR communication	Yes	No	NA
Academic detailing	Yes	No	NA
Patient newsletters	Yes	No	NA
Fliers in mail services deliveries	Yes	No	NA
Others (elaborate in Explain.doc)	Yes	No	NA

	Check One		
28. **Option 2 Only:** You offer a separate formulary program for Seniors/Retirees/Medicare.	Yes	No	NA

29. **Option 2 Only:** Your formulary is supported through:

	Check One		
Therapeutic substitution at mail service	Yes	No	NA
Patient education	Yes	No	NA
Retail therapeutic substitution program	Yes	No	NA
Performance based network	Yes	No	NA
Other (explain)	Yes	No	NA

30. **Option 2 Only:** Provide a copy of the formulary you are proposing for OGB.

31. Who is on your P&T committee? Please elaborate on who the "Others" are.

	Insert #
# of MDs (indicate specialties)	
# of Pharmacists	
# of Other	

32. Are members of the P&T Committee compensated?

Check One		
Yes	No	NA

How are they compensated:

Salary (if employees)	Yes	No	NA
Company stock	Yes	No	NA
Consulting fees	Yes	No	NA
Expenses	Yes	No	NA
Honorarium per meeting	Yes	No	NA
Other	Yes	No	NA

33. Your standard for responding to prior authorization requests is less than two hours. If not, what is your standard?

Retail			Mail Service		
Yes	No	NA	Yes	No	NA

E. Data, Systems, and Reporting

	Check One		
1. You will provide semi-annual written evaluations of cost and utilization with recommendations for improvement.	Yes	No	NA
2. Customized reports are available at the request of OGB at no additional cost including a full claims file on a frequency to be determined by OGB.	Yes	No	NA
3. You will provide OGB with a comparison of financial data to your book of business and/or similar industry clients.	Yes	No	NA
4. OGB and its consultants will have access through PC based software to access OGB claims experience. This access will be at no charge to OGB or to its consultants, and training by the PBM and/or Company will be provided to OGB and consultants' personnel. **OGB:**	Yes	No	NA
Consultants:	Yes	No	NA

5. You provide your reports on the following applications:

	Check One		
Magnetic tape	Yes	No	NA
Paper	Yes	No	NA
Floppy disk/CDROM	Yes	No	NA
On-line access	Yes	No	NA

6. Provide samples of your quarterly and annual Executive Summary reporting package. Please detail regarding when and in what format (i.e., hard copy, electronic) these reports will be delivered after each quarter end.

7. Will OGB have access to your claims processing system to review specific drug edits, adjudication logic, and pricing information? If yes, will OGB be able to access this information remotely or only during on-site visits and/or audits?

8. What is your proposed cost and turnaround time for installing system programming changes (e.g., clinical edits, formulary or plan design changes, or custom step therapies/quantity limits)?

9. Please provide a temporary login/password or an interactive demonstration of your online reporting tool. How many user licenses will you offer OGB at no additional cost?

10. How frequently is your online reporting system updated with new claim information that could be viewed or queried by OGB?

11. Detail any enhancements or changes you have made to your online reporting tool within the past 6-12 months.

12. Confirm that you will provide OGB's benefits staff with pharmacy claims data at no additional cost at a frequency determined by OGB.

F. Member Services

1. Provide the location and operating hours of your proposed call center that will handle OGB's member inquiries. Will all member calls regarding retail, mail order, and specialty/biotech prescriptions be supported in the same location?

2. Are you willing to propose a dedicated customer service team for OGB, and if so, what percent of member calls will be answered by this team?

3. Briefly describe your call routing procedures and supply sample materials from your customized staffing and training programs.

4. OGB requires its PBM to record member calls to the customer service call center. What software system do you use for monitoring and recording incoming calls to the member call center and how long are call records archived? What percentage are recorded?

5. Provide a sample report on call center metrics and performance guarantees that will be provided to OGB on a quarterly basis.

6. Complete the table below regarding your customer service representative (CSR) turnover at the proposed call center for each calendar year.

Turnover Reason	**2005**	**YTD 2006**
Number of promotions or transfers		
Number of resignations or terminations		
Other (please detail)		
Total		
Percent of Total CSR Staff		

7. Provide the URL for your member service website and a temporary login and password for viewing its capabilities.

8. Is the member website directly linked to your adjudication platform to accurately provide members with cost share amounts, formulary status, drug coverage and other related information for specific prescriptions?

9. Describe any new developments to your member service site that have been implemented within the past 6-8 months.

10. Confirm your willingness to allow OGB to customize the questions included in your annual member satisfaction survey and the delivery method (i.e., phone, mailing, email, etc.) at no additional cost.

11. Member satisfaction surveys are conducted at least annually.

Retail			Mail Service		
Yes	No	NA	Yes	No	NA

	Check One		
12. There is a single, toll-free member service telephone number for addressing claims payment, general questions, and any appeals.	Yes	No	NA
13. The member service is available 24 hours a day, 365 days per year. If not, indicate member service hours.	Yes	No	NA
14. Your member service unit is the same for mail and retail. If no, explain.	Yes	No	NA

15. The following information is available to member service representatives at all times:

	Check One		
Claim history	Yes	No	NA
Pharmacy location	Yes	No	NA
Claim status	Yes	No	NA
Benefit design	Yes	No	NA
Explanation of benefits	Yes	No	NA
Identification card status	Yes	No	NA
Eligibility	Yes	No	NA
Drug Information	Yes	No	NA
Other	Yes	No	NA

16. Claims submitted via point-of-sale are available to member service representatives within 24 hours of being processed.	Yes	No	NA
17. In the first six months of 2006 what percent of member service calls were answered by a representative in 20 seconds or less.			

18. What was your call abandonment rate during the first six months of 2006.

19. What percent of calls received a busy signal during the first six months of 2006.

20. You maintain a dedicated individual or staff responsible for resolving escalated member issues.

Yes	No	NA

21. During the first six months of 2006, what percent of new members received their identification cards by the effective date of coverage.

22. Member identification cards will be issued within 48 hours of receiving eligibility information.

Yes	No	NA

23. Please include a copy of your member satisfaction survey and the results of your most recent company-wide survey.

24. Where is the member service center you are proposing located?

G. Claim Administration/Eligibility

	Check One		
1. Mail order and retail claims are processed through an integrated claim processing system prior to being dispensed.	Yes	No	NA
2. Your system maintains on-line eligibility files that are updated on a real-time or nightly batching basis.	Yes	No	NA
3. Your system captures dependent-specific claim and eligibility information.	Yes	No	NA

4. You can administer the following plan provisions:

	Check One		
Annual individual deductible	Yes	No	NA
Annual family deductible	Yes	No	NA
Flat dollar copayment	Yes	No	NA
Triple tiered copay based on gen/msb/ssb status	Yes	No	NA
Triple tiered copay based on formulary status	Yes	No	NA
Quadruple tiered copay based o gen/msb/ssb/specialty status	Yes	No	NA

Percentage coinsurance	Yes	No	NA
Individual maximum out-of-pocket amounts	Yes	No	NA
Family maximum out-of-pocket amounts	Yes	No	NA
Annual benefit maximums	Yes	No	NA
Integrated pharmacy ad medical deductibles	Yes	No	NA
Other (explain)	Yes	No	NA

	Check One		
5. You have available a mechanism for online input of individual eligibility records or, alternatively, the immediate processing of claims (within 15 minutes) for individuals not on the eligibility file.	Yes	No	NA
6. You can accept other electronic transfer of eligibility (e.g. tape transfer).	Yes	No	NA

7. You provide the following mechanisms allowing the customer to audit eligibility records:

	Check One		
Internet	Yes	No	NA
Tape transfer	Yes	No	NA
Electronic feed via a modem	Yes	No	NA
Paper	Yes	No	NA
Other (axplain)	Yes	No	NA

	Check One		
8. All charges associated with the eligibility transfer and updates (initially or subsequent) are included in your fees.	Yes	No	NA
9. You have the capability to administer a coordination of benefits (COB) plan provision.	Yes	No	NA
10. You can administer COB by rejecting a claim and referring patient to other insurance.	Yes	No	NA
11. You can administer COB retrospectively by providing reports/invoices that can be sent to patients or other insurers.	Yes	No	NA
12. You have a current client administering a COB program with measured savings.	Yes	No	NA
13. You have the capability to interface with a medical plan for purposes of utilization reporting.	Yes	No	NA
14. Your system allows for full file eligibility loads if required.	Yes	No	NA

15. Will members using network pharmacies ever need to submit claim forms?

Yes	No	NA

16. Will a member's termination be in your system within 24 hours of notification?

Yes	No	NA

17. If a full file of eligibility is received at noon on a Friday, indicate the date/time it will be loaded on:

18. Briefly outline your eligibility capabilities, including file frequency, full file versus update file, electronic versus manual, etc. Detail any limitations or charges associated with manual eligibility maintenance. Will OGB representatives have the capability to access your online system and edit their eligibility records?

H. Communications

	Check One		
	Yes	No	NA
1. Identification cards, EOBs, and enrollment forms can be customized at no charge.			
2. You are willing to include OGB's logo on customized materials at no additional cost.	Yes	No	NA
3. Booklets/certificates will be provided within 60 days of the effective date.	Yes	No	NA

4. Confirm your willingness to assist OGB in developing and/or reviewing information on the pharmacy program in its Summary Plan Description (SPD). Describe the costs, if any, associated with this service.

5. OGB is committed to empowering its members to be well-informed consumers of prescription drugs. Please provide one (1) sample communication piece your organization developed in 2006 that you believe most effectively met this objective.

6. OGB will require its PBM to design and deliver customized communication materials for its members. Describe your process for developing custom communications and detail the costs, if any, which would be charged to OGB for this service.

I. Network Access

1. For purposes of this NIC, OGB has established nine major service areas which are defined by the first three digits of the zip codes. The nine major service areas are as follows:

Major Service Areas	Three Digit Zip Code
1. New Orleans	700 - 701
2. Houma/Thibodaux	703
3. Hammond	704
4. Lafayette	705
5. Lake Charles	706
6. Baton Rouge	707 - 708
7. Alexandria	713 - 714
8. Shreveport	710 - 711
9. Monroe	712

Based on these nine service areas, complete Table 1 with regard to the pharmacy network you are proposing for OGB.

Table 1 – YOUR PROPOSED PHARMACY NETWORK

Major Service Areas	Total # of Independent Network Pharmacies	Total # of Chain Network Pharmacies	Total # of Pharmacies w/24 Hour Access
1. New Orleans			
2. Houma/ Thibodaux			
3. Hammond			
4. Lafayette			
5. Lake Charles			
6. Baton Rouge			
7. Alexandria			
8. Shreveport			
9. Monroe			
Total State of Louisiana			

Indicate N/A where not applicable (i.e., you are only quoting one network)

2. Complete a standard Geo-Access analyses using the OGB census data provided in Exhibit 2 (to be provided at the Proposer Conference) and include copies of the reports with your response.

3. Based on the results of the Geo-Access analyses, complete the following table Note: The sum of items (D) and (E) should equal 100%.

Broad National Network	**Mileage Standard as Measured by Driving Distance**			
	Urban (1 mile)	**Suburban (3 miles)**	**Rural (10 miles)**	**Total**
A. Total number of network pharmacies				
B. Number of plan participants included in geo-access analysis				
C. Number of plan participants not included in geo-access analysis				
D. Percent of participants with network access within standards				
E. Percent of participants without network access within standards				
F. Avg. distance to nearest network pharmacy for participants without standard access				
G. Key geographic areas (cities) where greater than 40% of participants do not have standard network access.				

4. Explain why the participants in item C were not included in the analysis.

5. Using the pharmacy claims data provided in Exhibit 3, what percent of OGB's calendar year 2005 retail claims were filled at pharmacies outside your proposed network?

6. Describe the process that allows OGB or its members to recommend pharmacies for addition to the network. How quickly do you contact pharmacies after they are recommended to you?

J. Medicare Part D Administration

1. What percent of your 2006 self-funded, commercial book-of-business do you support with Medicare Part D administrative services? Of these clients, what percent have filed for the CMS Retiree Drug Subsidy (RDS)?

2. Complete the following table with the list of services that are included in your standard or core Medicare Part D administration fee.

Core Service	Included in Standard Fee (Yes/No)	If No, Additional Fee(s)
A. Medicare RDS application assistance		
B. Medicare eligibility maintenance		
C. Upload of monthly eligibility data and reconciliation of weekly/monthly response files from CMS		
D. Separate data tracking and drug cost reporting		
E. Financial and plan design modeling relative to Medicare Part D standard plan to determine actuarial equivalence		
F. Submission and reconciliation of retiree drug costs, including quarterly or annual rebate adjustments		
G. Analytic support for valuing subsidy payments versus alternative coverage options		
H. Standard quarterly reporting to OGB		

Core Service	Included in Standard Fee (Yes/No)	If No, Additional Fee(s)
I. Custom or ad hoc reporting requests		
J. Quarterly updates on Medicare program changes, legislative issues, employer responses and recommendations for OGB		
K. Prior Authorization reviews (Part D drug coverage determination)		
L. Prior Authorization reviews (Part B versus Part D covered drugs)		
M. Annual Letters of Creditable Coverage		
N. Retention of claim records and supporting documentation for a minimum of six (6) years		
O. Other (please specify)		

3. What is your required timeframe for receiving approved eligibility and drug cost reporting files from OGB for submission to CMS?

4. OGB requires the ability to audit the vendor administering its Medicare Part D drug program. Describe any audit requirements or restrictions regarding your services and confirm that OGB will not be responsible for any audit expenses incurred by your organization.

K. Implementation

1. Provide an implementation work plan to outline all key steps for plan implementation, effective January 1, 2007 through July 1, 2007. Please use a GANTT chart or similar tool to indicate the number of person-hours allocated to each task and the estimated resources, from the vendor and OGB, needed for each task.

2. Please provide the number of implementations that the assigned implementation manager handled for January 1, 2006 and the size of each account. How many implementations is this person anticipated to manage for July 1, 2007?

L. Account Management

1. Provide an organizational chart for the account management team proposed for OGB with name, title, and office location of each team member. At a minimum, the proposed account team should consist of the following personnel:
- Account Director
- Account Manager
- Implementation Manager
- Pharmacist/Clinical Program Director

2. Attach a brief resume (including education, experience, years with company, and years in current position) for each account team member.

3. How many clients and total covered lives do the proposed team members currently support, respectively? Would these assignments change if awarded a contract with OGB?

4. Describe how your account management team is compensated (e.g., straight salary, bonuses for up-selling products/services, client retention, client satisfaction, etc.).

5. Identify which team member is responsible for day-to-day account issues and communication with OGB; please confirm that this person will respond to all inquiries from the OGB benefits staff within one business day.

6. Describe your process for documenting all account service issues and escalating issues that cannot be appropriately handled by the Account Manager/Director.

M. Performance Standards and Penalties

Each PBM and/or Company must agree to abide by the Performance Standards specified on the following tables; if you can not meet these performance standards, indicate any deviations below. All guarantees must be measured on a client-specific basis. The OGB reserves the right to reduce or waive any performance penalties if, in OGB's sole discretion, the failure of the PBM and/or Company to meet a performance standard was due to extraordinary circumstances.

The annual minimum aggregate amount payable for performance guarantees not met is three times the proposed Administrative Fee.

Total Aggregate Amount at Risk is $________.

Amount at Risk for each Performance Standard is $_______.

Performance Standards

Performance Category	Performance Guarantee	Agree (Y/N)
a. Identification cards	95% of identification cards will be produced and mailed within 15 business days of receipt of complete and accurate eligibility information.	
b. Client Agreement	Draft agreement will be provided to OGB at least 60 Days prior to the effective date.	
c. Satisfaction Survey	Satisfactory result of at least 95% from Annual Member Satisfaction Survey.	
Penalty and Method of Measurement	To be measured by results of a customized, annual survey to OGB's members with a statistically valid number of respondents from the entire OGB population. Measured as the number of "satisfied" to "highly satisfied" survey ratings divided by the total number of survey responses.	
d. Call Answering Time	100% answered within 30 seconds.	
Penalty and Method of Measurement	To be measured based on OGB-specific data. Calculated as the amount of time that elapses once a call is placed in to the customer service queue to the time the call is answered by a Customer Service Representative (CSR). Measurement excludes calls routed through an Interactive Voice Response (IVR) system. Member Service Call Answer statistics to be reported quarterly to OGB.	
e. Call Abandonment Rate	Less than 2% of calls will be abandoned.	
Penalty and Method of Measurement	To be measured based on OGB-specific data, the percent of calls that are abandoned after being connected for at least 20 seconds (i.e., participant hangs up before the call is answered by a CSR). Calculated as the number of calls that are abandoned divided by the number of calls received in queue. Abandonment statistics to be reported quarterly to OGB.	
f. Response to Member Written Inquiries	Greater than 95% of all member inquiries will be responded to within 5 business days, and 100f% will be responded to within 10 business days.	

Performance Category	Performance Guarantee	Agree (Y/N)
Penalty and Method of Measurement	Percent of member written inquiries (including e-mail) that are responded to within 5 business days and 10 business days, respectively. Response time for all member-written inquiries will be based on the number of business days subtracting the date received by the PBM and/or Company from the date the response was sent.	
g. First Call Resolution	Greater than 90% of inquiries will be resolved on the first call.	
Penalty and Method of Measurement	Percent of OGB calls resolved during initial CSR call, as defined by the number of ensuing calls by the same member with the same "reason for call" within a five-day period. Calculated as the percent of calls resolved divided by the total number of calls answered by a CSR.	
h. Wait Time for Pharmacist/Clinical Support ASA	Wait time will be less than 45 seconds.	
Penalty and Method of Measurement	Measured by the time elapsed once a participant requests to speak to a pharmacist from a CSR or selects this option from the IVR menu to the time the call is answered by a pharmacist.	
i. Eligibility Posting	100% of electronically transmitted eligibility updates posted within 24 hours.	
Penalty and Method of Measurement	Percent of usable, error-free program eligibility transactions received and loaded by the PBM or Company within 24 ours of receipt. Calculated as the number of eligibility files received and loaded within 24 hours divided by the number of eligibility files received in the reporting period. To be determined at the end of each contract year.	
j. Eligibility Processing Accuracy	100% of electronically transmitted eligibility is processed accurately.	
Penalty and Method of Measurement	Percent of usable, error-free program eligibility transactions received and loaded by the PBM or Company without error. Calculated as the number of eligibility files audited and found to be processed and loaded without error divided by the total number of eligibility files received.	
k. Network Access	PBM and/or Company must provide access to at least 98.5% of all plan members.	

Performance Category	Performance Guarantee	Agree (Y/N)
Penalty and Method of Measurement	Measured by the number of OGB members with access to a network pharmacy within three (3) miles of their home zip code (where a pharmacy exists), divided by the total number of OGB members. To be measured by GeoAccess reports produced by the PBM and/or Company one month prior to implementation and twice annually for each contract year. The parameters used to prepare the GeoAccess report will be specified by OGB at the time of the request (at implementation and in subsequent contract years).	
l. On-site Pharmacy Audits	20% of pharmacies	
Penalty and Method of Measurement	As measured by the number of network pharmacies audited on-site each year divided by the total number of network pharmacies that dispense more than 500 prescriptions on an annual basis for OGB.	
m. Administration of Non-Network Claims	PBM and/or Company must agree that at least 95% of "clean" Rx claims will be processed within 5 working days of receipt.	
Penalty and Method of Measurement	Penalty calculated at end of each contract year based on the average claims turnaround time for the year. To be measured by claims turnaround reports produced by PBM and/or Company or independent audit by OGB or its designee.	
n. Reporting Requirements	PBM and/or Company must agree to provide OGB all the reports specified in this NIC within the stated time periods. Additionally, PBM and/or Company must prepare a written summary analysis and orally present results to OGB annually.	
o. Point-of-Sale Network System Downtime	PBM and/or Company must agree that system downtime will be less than 0.5%.	
Penalty and Method of Measurement	The percent of time the claims processing system is unavailable to retail pharmacies as measured by the number of hours the system is unavailable divided by the total number of hours within the reporting period, excluding regularly scheduled maintenance.	
p. Retail Point-of-Sale Claims Adjudication Accuracy	PBM and/or Company must agree to a financial accuracy rate of at least	

Performance Category	Performance Guarantee	Agree (Y/N)
	99.9% for all claims processed at point-of-sale.	
Penalty and Method of Measurement	To be determined at end of each contract year. Percent of claims processed and paid accurately based on the applicable coverage, pricing, and plan design. Calculated as the number of claims audited and found to be processed and paid without error divided by the total number of claims paid.	
q. Mail Order/Specialty Pharmacy Dispensing Accuracy	Mail order and specialty pharmacy dispensing accuracy will be equal to or greater than 99.95%.	
Penalty and Method of Measurement	Percent of all mail order and specialty pharmacy claims dispensed accurately with no errors according to the prescription written and the OGB plan design. Calculated as the total number of conformance events divided by the total number of prescriptions dispensed.	
r. Mail Order Turnaround Time – Clean Rx	100% of clean mail order prescriptions will be processed within 2 business days.	
Penalty and Method of Measurement	Measured in business days from the date the prescription is received by the PBM and/or Company (either via paper, phone, fax or Internet) to the date it is shipped. Calculated as the number of "clean" prescription claims processed within two (2) business days divided by the total number of clean prescription claims received.	
s. Mail Order Turnaround Time – Non-Clean Rx	100% of non-clean mail order prescriptions will be processed within 5 business days.	
Penalty and Method of Measurement	Measured in business days from the date the prescription is received by the PBM and/or Company (either via paper, phone, fax or Internet) to the date it is shipped. Calculated as the number of prescription claims requiring intervention processed within five (5) business days divided by the total number of prescription claims received that require intervention.	
t. Response to OGB regarding invoicing, fees and/or formulary rebates	OGB shall submit any issues or questions regarding the accuracy of any invoice for claim reimbursement, fees and/or formulary rebates in writing to the PBM and/or Company. The PBM and/or Company shall have 10 working days to respond to OGB concerns.	

Performance Category	Performance Guarantee	Agree (Y/N)
Penalty and Method of Measurement		
u. Account Management Satisfaction	Based on survey results, an overall satisfaction rate of 3.5 points out of 5 must be reached.	
Penalty and Method of Measurement	Based on the results of the PBM and/or Company's annual survey or report card submitted to OGB benefits staff. Measured based on overall satisfaction rating of at least 3.5 on a 5-point scale (5 is the best rating). Designated members of OGB benefits staff will complete the report card to evaluate the PBM and/or Company's account team, or the overall service performance. Guarantee will be measured using a mutually agreed upon survey tool to be developed and modified, if necessary, on an annual basis. Account team may be scored on: technical knowledge, accessibility, interpersonal skills, communication skills, and overall performance. PBM and/or Company's overall service may be scored on such dimensions as proactive communication of issues and recommendations, timeliness and accuracy of reports, responsiveness to day-to-day needs, adequacy of staffing and training, and overall ability to meet performance expectations.	
v. Communication Material Accuracy	All member communication material must be accurate and pre-approved by OGB in writing.	
Penalty and Method of Measurement		

SECTION VI

MANDATORY SIGNATURE PAGE

Tab 2 of Proposal

This proposal, together with all attachments and the fee proposal form, is submitted on behalf of:

Proposer:____

I hereby certify that:

1. This proposal complies with all requirements of the NIC. In the event of any ambiguity or lack of clarity, the response is intended to be in compliance.
2. This proposal was not prepared or developed using assistance or information illegally or unethically obtained.
3. I am solely responsible for this proposal meeting the requirements of the NIC.
4. I am solely responsible for its compliance with all applicable laws and regulations to the preparation, submission and contents of this proposal.
5. All information contained in this proposal is true and accurate.

Date:____________________ Printed Name:________________________

Title:____________________ Signature:__________________________

SECTION VII

OPTION 1

SEE EXHIBIT 1 FOR PLAN OF BENEFITS

COST QUOTATION /PROPOSAL FORM

Cost Proposal Form is to be submitted in a separate envelope marked "PBM Cost Proposal – Option 1" on the outside of the envelope. Eight (8) copies and two (2) CDs need to be submitted.

Do not include this Fee Proposal Form in the three-ring binder with the other required portions of your proposal.

Financial Proposal

Please complete all tables in this section using the formats provided. Use footnote references to clearly explain all qualifications or conditions.

Responses that do not use this format will not be evaluated.

A. Minimum Requirements

The table below contains a list of OGB's minimum financial requirements for this NIC. Vendors must indicate their agreement to these requirements by completing the table below. Please clearly explain any exceptions. If necessary, OGB will make adjustments to the financial proposals of vendors that do not adhere to these guidelines.

Financial Component	Proposal Requirements	Confirm (Y/N)
Financial Disclosure	Vendor must agree to disclose all sources of revenue for managing OGB's pharmacy program, including the percentage of total revenue coming from specific PBM programs, administrative fees, manufacturers and prescription delivery channels (retail, mail, specialty pharmacies).	

Financial Component	Proposal Requirements	Confirm (Y/N)
Claims Processing	Vendor must process all OGB claims at the lesser of: A. The contracted network discount + dispensing fee; B. MAC + dispensing fee; or C. The provider's usual & customary (U&C) amount.	
Lowest Cost/Zero Balance Claims	Vendor must adjudicate all claims according to the "lowest of" logic such that OGB members always pay the lowest claim cost based on the applicable copayment, eligible/allowed charge, and the pharmacy's U&C amount. Vendors will not be allowed to process claims using "zero balance logic" where the stated discount is 100% (i.e., $0.00 due from OGB).	
Financial Guarantees	Vendor agrees to reconcile its financial guarantees and report OGB-specific experience on a quarterly basis, including effective AWP discounts, dispensing fees, and rebates. All guarantees must be reconciled against actual results on an annual basis and any penalties owed to OGB must be paid within 90 days after the end of the year. In addition, Vendor must agree that all pricing guarantees are effective over the entire contract term.	
Component Guarantees	Vendor must agree that all of its proposed guarantees shall be reconciled annually against actual results and shall be backed dollar-for-dollar such that OGB is made whole if any guarantee fails to be met. Shortfalls in one component guarantee may not be offset by overages in other areas.	
Retail Network	Vendor must agree to propose pricing based on its Broad National retail network. OGB may elect to engage vendors on narrow or custom network options during the finalist phase.	
Retail Pricing	Vendor must agree that all retail pricing will be on a pass-through basis with minimum guarantees.	

Financial Component	**Proposal Requirements**	**Confirm (Y/N)**
Brand Discounts	Vendor must offer brand AWP discount guarantees, exclusive of usual and customary (U&C) claims and the impact of MAC on multi-source brand claims.	
Generic Discounts	Vendor must offer overall effective generic AWP discount guarantees, excluding claims priced at U&C but inclusive of the vendor's MAC pricing. Guarantees must include all generics, regardless of the number of manufacturers (i.e., single source generics) or availability issues.	
Overall Effective Discounts	Vendor must be willing to offer overall effective discount (OED) guarantees for all brand and generic drugs priced at retail and mail order, respectively.	
Retail Dispensing Fees	Vendor must offer per claim dispensing fee guarantees for retail brand and generic drugs priced at the discounted ingredient cost or MAC rate.	
U&C Pricing	Vendor must agree to adjudicate all claims priced at U&C with the drug ingredient cost equal to the submitted U&C price and a $0.00 dispensing fee.	
Mail Order Pricing	Vendor must agree to offer consistent pricing for all mail order prescriptions regardless of the days' supply.	
Mail Order Shipping Costs	Vendor must underwrite all mail order shipping costs into the proposed mail order pricing and dispensing fees for the life of the contract. Fees may not be adjusted during the contract term for postage rate increases.	
Specialty Pharmacy Pricing	Vendor must agree to allow OGB to review and modify (if necessary) the Specialty Pharmacy pricing schedule on an annual basis as new drugs are introduced and competition increases in specialty drug therapy classes.	

Financial Component	Proposal Requirements	Confirm (Y/N)
Generic Dispensing Rate Guarantees	Vendor must agree to offer generic dispensing rate (GDR) guarantees for retail and mail order prescriptions, respectively. GDR shall be defined as the number of generic prescriptions dispensed divided by the total number of prescriptions dispensed (brand & generic).	
Audit Rights	Vendor must agree to provide unrestrictive operational and financial audit rights, including the ability to audit paid claims data, the vendor's claims processing system, performance guarantees and rebate agreements, as appropriate. OGB requires the ability to conduct these audits at any time during the contract term.	
Administrative Fees	Vendor must quote all claims processing fees on a per employee/retiree per month (PEPM) basis only.	
Administrative Fees	Your fees must include your cost to develop, print and disseminate to all employees, retirees and providers, communication materials necessary to effectively implement and manage the drug program for OGB. This communication material shall be subject to OGB's advance approval. Your fees must also include your cost to produce and mail member I.D. cards and any replacement cards directly to plan members.	
Commissions	Commissions or finders fees are <u>not</u> payable under this contract.	
Rebates	Vendor must agree to pass <u>all</u> rebates (see definition below) to OGB with a minimum rebate guarantee on a per claim basis only, inclusive of <u>all</u> brand and generic prescriptions at retail and mail order.	
Rebate Definition	Vendor must agree that "all pharmaceutical rebates" refers to base, formulary, incentive, and market share rebates, as well as related considerations, such as administrative and data fees, received from manufacturers in relation to the provision of OGB's utilization data to manufacturers for rebating, marketing, and related purposes.	

Financial Component	Proposal Requirements	Confirm (Y/N)
Rebate Payments	Vendor agrees to pay all guaranteed rebates within 90 days after the end of each quarter and to reconcile the total amount paid to OGB against the total rebates received on an annual basis within 120 days after the end of each contract year. Any additional rebates owed to OGB must be paid within 150 days after the end of the year.	

B. Retail Network Pricing

1. Complete the following table based on your proposed Broad National network.

Retail Pharmacy Network	
Name of Network	
Number of Retail Pharmacies	
List Major Chains NOT in Network	
Length of Pricing Guarantees	
Confirm Pass-Through Pricing	

2. Complete the following table with your proposed retail pricing.

Brand Drugs		
A.	Brand discount & dispensing fee guarantees	Lower of AWP - ___% **OR** MAC + $______ dispensing fee **OR** U&C
Generic Drugs		
B.	Generic discount & dispensing fee guarantee	Lower of AWP - ___% **OR** MAC + $______ dispensing fee **OR** U&C
C.	Overall effective Generic discount guarantee (MAC & non-MAC)	AWP – _%

D.	Detail any generic dispensing incentive that will be paid to providers, if any, in addition to the dispensing fees identified above.	$______
Overall Effective Discount Guarantee		
E.	Overall Effective Discount guarantee (all retail claims, excluding U&C)	AWP – _%

3. Confirm that specialty drugs dispensed at retail network pharmacies will be priced according to the same formulas above and included in the guaranteed rates to OGB.

4. Provide a sample report that will be provided to OGB to demonstrate satisfaction of the component guarantees above and to calculate any penalties owed. Confirm that this report will be provided to OGB quarterly.

5. Please complete the following table indicating the amount that would be collected from the member for each prescription claim scenario. *Note: This adjudication logic must be reflected in the network contracts and provider reimbursement language.*

Pricing Element	**Scenario 1**	**Scenario 2**	**Scenario 3**	**Scenario 4**
Eligible Charge	$12.00	$12.00	$60.00	$60.00
Copay/Coinsurance	$16.00	$16.00	20%	20%
U&C	$20.00	$13.00	$20.00	$10.00
Amount Collected from Member				

6. Confirm that if a member pays 100 percent of the cost of a prescription, OGB will not be billed for any portion of the claim exclusive of any applicable administrative fees.

7. Confirm that retail drug pricing will be based on the AWP of the drug and package size dispensed (i.e., NDC-11) on the date of service as submitted by the retail pharmacy. Additionally, if the methodology by which AWP is measured or reported changes during the term of the contract, will you agree to mutually re-negotiate the pricing terms to preserve the economics of the program?

8. Detail your source document or service that provides wholesale pricing information and indicate the frequency of AWP updates to your drug file. Is this the same source that determines brand and generic drug indicators? If no, what is your source for identifying a drug as a brand or generic for pricing purposes?

C. Maximum Allowable Cost (MAC) Pricing

1. Describe how your MAC program is developed and maintained and how frequently it is updated with new drug and pricing information.

2. Please complete the following table with the information regarding this list effective September 1, 2006.

MAC Pricing		Retail	Mail
A.	Name of MAC List		
B.	Number of Generic Code Numbers (GCNs) on the MAC list[1]		
C.	For those generic drugs subjected to MAC pricing, what is the average effective discount off AWP, excluding multi-source brands?		
D.	Will you guarantee this effective MAC discount (B) for OGB?		
E.	Estimated % of generic claims (Rx) that will be MAC'd.		
F.	Estimated % of generic dollars (AWP) that will MAC'd.		

3. Complete Exhibit 6 based on OGB's top 200 generic drugs using your proposed MAC prices effective as of September 1, 2006.

4. Disclose any exceptions or differences in how MAC pricing is administered from pharmacy to pharmacy.

5. Is the MAC List and associated pricing applied to claims from network pharmacies identical to the MAC List and associated pricing invoiced to OGB (i.e., no positive 'spread')?

1 If the proposed MAC list is GPI-based, use a GCN crosswalk to convert the number of GPIs to GCNs.

D. Mail Order Pricing

1. Complete the following table based on your proposed mail order pricing.

Mail Order Pricing	
A. Brand AWP Discount	Lower of AWP - _______% or MAC
B. Brand Dispensing Fee (per claim)	$_________ per Rx
C. Non Generic AWP Discount	Lower of AWP - _______% or MAC
D. Overall Effective Generic Discount	AWP - _______%
E. Generic Dispensing Fee (per claim)	$_________ per Rx
F. Overall Effective Discount (all Mail Rx)	AWP - _______%

2. OGB is interested in a "cost plus" pricing model at mail order using Actual Acquisition Costs (AAC). Are you willing to provide pricing on this basis?

3. If you are willing to provide "cost plus" pricing at mail order, what is your proposed professional fee for OGB on a per Rx basis, inclusive of shipping/postage charges for the duration of the contract?

4. Based on your experience, will a cost plus pricing model offer OGB financial savings? What are the pros and cons of this pricing model as you see them? Provide a case study example.

5. What is the package size basis for calculating your mail order AWP discounts and do you use the manufacturer's full 11-digit NDC as of the date the drug is dispensed?

6. If your mail order pricing is based upon the actual package size purchased from the manufacturer or wholesaler, provide an estimate to demonstrate the value compared to discounts based on a fixed package size of 100s or pints.

7. What amount is collected from the member when the mail order copay is greater than the discounted ingredient cost? Do you typically charge a minimum mail order copay? If yes, confirm that you will waive this copay requirement for OGB based on its requirement that members always pay the "lowest" claim cost.

E. Specialty Drug Pricing

1. Complete Exhibit 7 with your proposed Specialty Pharmacy pricing.

2. If OGB elects to institute a retail lockout or mandatory mail provision for specialty/biotech drugs, indicate what impact, if any, this would have on your proposed pricing.

3. Confirm that you will provide OGB with a 30-day notice of new drug additions and price changes on mail order specialty products.

F. Generic Dispensing Rate Guarantees

Complete the following table with your proposed retail generic dispensing rate guarantees (GDRs).

Retail GDR	Year 1	Year 2	Year 3

Complete the following table with your proposed mail order GDRs.

Mail Order GDR	Year 1	Year 2	Year 3

G. Administrative Fee

1. Complete the following table with your proposed base administrative fees.

Base Administrative Fees		
A.	Network Claims Processing	$____ PEPM
B.	Mail Order Claims Processing	$____ PEPM
C.	Specialty Pharmacy Claims Processing	$____ PEPM
D.	Out of Network and Paper Claims	$____ PEPM
E.	Ad Hoc/Custom Reporting	

Base Administrative Fees		
F.	Online Reporting Tool	
G.	Additional User Licenses for Online Reporting	$____ per user
H.	Scheduled Pharmacy Data Extracts to Third-Party Vendors	
I.	Standard COB Administration	
J.	Medicare COB Administration	
K.	Standard Program Enrollment Materials (welcome packet, member handbook, formulary guide, pharmacy listing, and ID cards)	
L.	Replacement ID Cards	$____ per card
M.	Benefit Design/Coverage Change Notification	$____ per mailing
N.	Clinical Program Update/Change Notification	$____ per mailing
O.	Custom Communication Materials	
P.	Explanation of Benefits (EOB) Statements	$____ per EOB
Q.	Medicare Part D Claims Administration	$____ per Medicare participant per month
R.	Medicare RDS Eligibility Maintenance	$____ per Medicare participant per month
S.	Notices of Creditable Coverage	$____ per mailing
T.	Other (please specify)	

2. Complete the following table with your proposed base clinical fees.

Base Clinical Fees		
A.	Concurrent DUR	
B.	Retrospective DUR	
C.	Quantity Limitation System Edits & Support	
D.	Prior Authorization (PA) Edits & Support	
E.	Duration of Therapy Edits & Support	
F.	Step Therapy Edits & Support	
G.	Administrative/Technical PA Reviews/Overrides	
H.	Clinical PA Reviews/Overrides for Quantity limits, Step Therapy, Prior Authorization, etc.	
I.	Preferred Drug Education/Compliance	
J.	First Level Appeal Determinations	
K.	Second Level Appeal Determinations, if required	
L.	Physician Profiling Report Cards	
M.	Therapeutic Interchange	
N.	Other (please specify)	

3. Confirm you will subsidize a pool of 100 hours of customized ad-hoc reporting per year at no charge.

H. Rebates

1. Based on OGB's contractual definition of "all pharmaceutical rebates," confirm that 100% of the total rebates collected will be shared or passed through to OGB?

2. Complete the following table with your proposed rebate guarantees based on OGB's current (2006) and proposed (2007) plan designs.

Rebate Guarantees		Year 1	Year 2	Year 3
A.	Retail rebate per claim: Incentive2 Non-incentive	 $____ per Rx $____ per Rx	 $____ per Rx $____ per Rx	 $____ per Rx $____ per Rx
B.	Mail order rebate per claim: Incentive Non-incentive	$____ per Rx $____ per Rx	$____ per Rx $____ per Rx	$____ per Rx $____ per Rx
C.	Specialty rebate per claim: Incentive Non-incentive	$____ per Rx $____ per Rx	$____ per Rx $____ per Rx	$____ per Rx $____ per Rx
D.	Confirm these are minimum rebate guarantees and 100% of rebates will be passed on to OGB			

3. Are the rebate guarantees outlined above contingent upon OGB implementing specific formulary management programs (e.g., therapeutic interventions)? If so, please describe.

4. Attach a sample rebate report that will be provided to OGB on a quarterly basis.

5. Discuss your willingness and ability to provide reporting detail to OGB by drug, manufacturer, unit amount, and type of rebate received (e.g., base, formulary, incentive, market share, other, etc.).

[2] Incentive designs are defined by a minimum $15 copay or 20% coinsurance differential between Tier 2 (preferred) and Tier 3 (non-preferred) drugs.

6. State your willingness to allow OGB's representatives or a third party designated by OGB to audit your formulary rebate program, including the processes for reporting data to manufacturers, accounting for rebates earned, and allocating rebate payments to OGB. The designated auditor shall operate under a confidentiality agreement covering all external parties, as well as other divisions of its firm. Clearly explain any conditions to which the audit process will be subjected.

7. How many different manufacturers do you have rebate contracts with?

8. Describe in detail your procedures for the following activities:

a) Accounting for the accrual of rebates due a plan,

b) Collections of accrued rebates (with aging estimates)

c) Payments of rebates to plans.

I. Financial Disclosure

1. Complete the following table based on your proposed pricing for OGB.

PBM Service/Delivery Channel	Percent of Total (Net) Revenue or Margin
Retail Claims Processing	
Mail Order Pharmacy	
Specialty Pharmacy	
Administrative Fees	
Clinical/Utilization Management Programs	
Formulary Management/Rebate Administration	
Other (please specify)	
TOTAL	**100%**

J. Implementation Credit or Allowance

1. Detail any implementation credit or allowance that you are proposing. Include the following information in your proposal:
   (a) The amount;
   (b) How it can be used;
   (c) When and how it will be paid; and
   (d) Required documentation from the client.

2. Confirm that OGB may use the implementation credit, if any, to offset consulting fees associated with this procurement, including fees incurred prior to the January 1, 2007 implementation date.

K. Funding and Contracting

1. What are your standard payment terms (i.e., reimbursement) in your retail network contracts?

2. Describe any additional cost to OGB due to taxes and specify the:
   (a) Type of tax (e.g., sales, usage, service, etc.);
   (b) Level of taxes;
   (c) Applicability of taxes (e.g., state of prescribing, dispensing, or shipment); and
   (d) Estimate of annual tax.

3. Confirm that OGB will not be subject to any advance deposit requirements.

Certification

The undersigned certifies that the figures stated above are based upon an application of the proposer's current (as of September 1, 2006) contracts with pharmacies, suppliers, manufacturers, and any other relevant parties to the utilization data supplied by the Office of Group Benefits.

_______________________	_______________________
Proposer	**Date**
_______________________	_______________________
Printed Name (Authorized to Sign)	**Signature**
_______________________	
Title	

SECTION VII

OPTION 2

SEE EXHIBIT 1 FOR PLAN OF BENEFITS

COST QUOTATION /PROPOSAL FORM

Cost Proposal Form is to be submitted in a separate envelope marked "PBM Cost Proposal – Option 2" on the outside of the envelope. Eight (8) copies and two (2) CDs need to be submitted.

Do not include this Fee Proposal Form in the three-ring binder with the other required portions of your proposal.

Financial Proposal

Please complete all tables in this section using the formats provided. Use footnote references to clearly explain all qualifications or conditions.

Responses that do not use this format will not be evaluated.

A. Minimum Requirements

The table below contains a list of OGB's minimum financial requirements for this NIC. Vendors must indicate their agreement to these requirements by completing the table below. Please clearly explain any exceptions. If necessary, OGB will make adjustments to the financial proposals of vendors that do not adhere to these guidelines.

Financial Component	Proposal Requirements	Confirm (Y/N)
Financial Disclosure	Vendor must agree to disclose all sources of revenue for managing OGB's pharmacy program, including the percentage of total revenue coming from specific PBM programs, administrative fees, manufacturers and prescription delivery channels (retail, mail, specialty pharmacies).	

Financial Component	Proposal Requirements	Confirm (Y/N)
Claims Processing	Vendor must process <u>all</u> OGB claims at the lesser of: A. The contracted network discount + dispensing fee; B. MAC + dispensing fee; or C. The provider's usual & customary (U&C) amount.	
Lowest Cost/Zero Balance Claims	Vendor must adjudicate all claims according to the "lowest of" logic such that OGB members always pay the lowest claim cost based on the applicable copayment, eligible/allowed charge, and the pharmacy's U&C amount. Vendors will not be allowed to process claims using "zero balance logic" where the stated discount is 100% (i.e., $0.00 due from OGB).	
Financial Guarantees	Vendor agrees to reconcile its financial guarantees and report OGB-specific experience on a quarterly basis, including effective AWP discounts, dispensing fees, and rebates. All guarantees must be reconciled against actual results on an annual basis and any penalties owed to OGB must be paid within 90 days after the end of the year. In addition, Vendor must agree that all pricing guarantees are effective over the entire contract term.	
Component Guarantees	Vendor must agree that all of its proposed guarantees shall be reconciled annually against actual results and shall be backed dollar-for-dollar such that OGB is made whole if any guarantee fails to be met. Shortfalls in one component guarantee may <u>not</u> be offset by overages in other areas.	
Retail Network	Vendor must agree to propose pricing based on its Broad National retail network. OGB may elect to engage vendors on narrow or custom network options during the finalist phase.	
Retail Pricing	Vendor must agree that all retail pricing will be on a pass-through basis with minimum guarantees.	

Financial Component	**Proposal Requirements**	**Confirm (Y/N)**
Brand Discounts	Vendor must offer brand AWP discount guarantees, exclusive of usual and customary (U&C) claims and the impact of MAC on multi-source brand claims.	
Generic Discounts	Vendor must offer overall effective generic AWP discount guarantees, excluding claims priced at U&C but inclusive of the vendor's MAC pricing. Guarantees must include all generics, regardless of the number of manufacturers (i.e., single source generics) or availability issues.	
Overall Effective Discounts	Vendor must be willing to offer overall effective discount (OED) guarantees for all brand and generic drugs priced at retail and mail order, respectively.	
Retail Dispensing Fees	Vendor must offer per claim dispensing fee guarantees for retail brand and generic drugs priced at the discounted ingredient cost or MAC rate.	
U&C Pricing	Vendor must agree to adjudicate all claims priced at U&C with the drug ingredient cost equal to the submitted U&C price and a $0.00 dispensing fee.	
Mail Order Pricing	Vendor must agree to offer consistent pricing for all mail order prescriptions regardless of the days' supply.	
Mail Order Shipping Costs	Vendor must underwrite all mail order shipping costs into the proposed mail order pricing and dispensing fees for the life of the contract. Fees may not be adjusted during the contract term for postage rate increases.	
Specialty Pharmacy Pricing	Vendor must agree to allow OGB to review and modify (if necessary) the Specialty Pharmacy pricing schedule on an annual basis as new drugs are introduced and competition increases in specialty drug therapy classes.	

Financial Component	Proposal Requirements	Confirm (Y/N)
Generic Dispensing Rate Guarantees	Vendor must agree to offer generic dispensing rate (GDR) guarantees for retail and mail order prescriptions, respectively. GDR shall be defined as the number of generic prescriptions dispensed divided by the total number of prescriptions dispensed (brand & generic).	
Audit Rights	Vendor must agree to provide unrestrictive operational and financial audit rights, including the ability to audit paid claims data, the vendor's claims processing system, perform ance guarantees and rebate agreements, as appropriate. OGB requires the ability to conduct these audits at any time during the contract term.	
Administrative Fees	Vendor must quote all claims processing fees on a per employee/retiree per month (PEPM) basis only.	
Administrative Fees	Your fees must include your cost to develop, print and disseminate to all employees, retirees and providers, communication materials necessary to effectively implement and manage the drug program for OGB. This communication material shall be subject to OGB's advance approval. Your fees must also include your cost to produce and mail member I.D. cards and any replacement cards directly to plan members.	
Commissions	Commissions or finders fees are not payable under this contract.	
Rebates	Vendor must agree to pass all rebates (see definition below) to OGB with a minimum rebate guarantee on a per claim basis only, inclusive of all brand and generic prescriptions at retail and mail order.	

Financial Component	Proposal Requirements	Confirm (Y/N)
Rebate Definition	Vendor must agree that "all pharmaceutical rebates" refers to base, formulary, incentive, and market share rebates, as well as related considerations, such as administrative and data fees, received from manufacturers in relation to the provision of OGB's utilization data to manufacturers for rebating, marketing, and related purposes.	
Rebate Payments	Vendor agrees to pay all guaranteed rebates within 90 days after the end of each quarter and to reconcile the total amount paid to OGB against the total rebates received on an annual basis within 120 days after the end of each contract year. Any additional rebates owed to OGB must be paid within 150 days after the end of the year.	

B. Retail Network Pricing

1. Complete the following table based on your proposed Broad National network.

Retail Pharmacy Network	
Name of Network	
Number of Retail Pharmacies	
List Major Chains NOT in Network	
Length of Pricing Guarantees	
Confirm Pass-Through Pricing	

2. Complete the following table with your proposed retail pricing.

Brand Drugs		
A.	Brand discount & dispensing fee guarantees	Lower of AWP - ___% **OR** MAC + $______ dispensing fee **OR** U&C
Generic Drugs		
B.	Generic discount & dispensing fee guarantee	Lower of AWP - ___% **OR** MAC + $______ dispensing fee **OR** U&C
C.	Overall effective Generic discount guarantee (MAC & non-MAC)	AWP – _%
D.	Detail any generic dispensing incentive that will be paid to providers, if any, in addition to the dispensing fees identified above.	$______
Overall Effective Discount Guarantee		
E.	Overall Effective Discount guarantee (all retail claims, excluding U&C)	AWP – _%

9. Confirm that specialty drugs dispensed at retail network pharmacies will be priced according to the same formulas above and included in the guaranteed rates to OGB.

10. Provide a sample report that will be provided to OGB to demonstrate satisfaction of the component guarantees above and to calculate any penalties owed. Confirm that this report will be provided to OGB quarterly.

11. Please complete the following table indicating the amount that would be collected from the member for each prescription claim scenario. *Note: This adjudication logic must be reflected in the network contracts and provider reimbursement language.*

Pricing Element	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Eligible Charge	$12.00	$12.00	$60.00	$60.00
Copay/Coinsurance	$16.00	$16.00	20%	20%
U&C	$20.00	$13.00	$20.00	$10.00
Amount Collected from Member				

12. Confirm that if a member pays 100 percent of the cost of a prescription, OGB will not be billed for any portion of the claim exclusive of any applicable administrative fees.

13. Confirm that retail drug pricing will be based on the AWP of the drug and package size dispensed (i.e., NDC-11) on the date of service as submitted by the retail pharmacy. Additionally, if the methodology by which AWP is measured or reported changes during the term of the contract, will you agree to mutually re-negotiate the pricing terms to preserve the economics of the program?

14. Detail your source document or service that provides wholesale pricing information and indicate the frequency of AWP updates to your drug file. Is this the same source that determines brand and generic drug indicators? If no, what is your source for identifying a drug as a brand or generic for pricing purposes?

C. Maximum Allowable Cost (MAC) Pricing

1. Describe how your MAC program is developed and maintained and how frequently it is updated with new drug and pricing information.

2. Please complete the following table with the information regarding this list effective September 1, 2006.

MAC Pricing		Retail	Mail
A.	Name of MAC List		
B.	Number of Generic Code Numbers (GCNs) on the MAC list[3]		
C.	For those generic drugs subjected to MAC pricing, what is the average effective discount off AWP, <u>excluding</u> multi-source brands?		

1 If the proposed MAC list is GPI-based, use a GCN crosswalk to convert the number of GPIs to GCNs.

MAC Pricing		Retail	Mail
D.	Will you guarantee this effective MAC discount (B) for OGB?		
E.	Estimated % of generic claims (Rx) that will be MAC'd.		
F.	Estimated % of generic dollars (AWP) that will MAC'd.		

3. Complete Exhibit 6 based on OGB's top 200 generic drugs using your proposed MAC prices effective as of September 1, 2006.

4. Disclose any exceptions or differences in how MAC pricing is administered from pharmacy to pharmacy.

5. Is the MAC List and associated pricing applied to claims from network pharmacies identical to the MAC List and associated pricing invoiced to OGB (i.e., no positive 'spread')?

D. Mail Order Pricing

1. Complete the following table based on your proposed mail order pricing.

Mail Order Pricing	
A. Brand AWP Discount	Lower of AWP - _______% or MAC
B. Brand Dispensing Fee (per claim)	$_________ per Rx
C. Non Generic AWP Discount	Lower of AWP - _______% or MAC
D. Overall Effective Generic Discount	AWP - _______%
E. Generic Dispensing Fee (per claim)	$_________ per Rx
F. Overall Effective Discount (all Mail Rx)	AWP - _______%

2. OGB is interested in a "cost plus" pricing model at mail order using Actual Acquisition Costs (AAC). Are you willing to provide pricing on this basis?

3. If you are willing to provide "cost plus" pricing at mail order, what is your proposed professional fee for OGB on a per Rx basis, inclusive of shipping/postage charges for the duration of the contract?

4. Based on your experience, will a cost plus pricing model offer OGB financial savings? What are the pros and cons of this pricing model as you see them? Provide a case study example.

5. What is the package size basis for calculating your mail order AWP discounts and do you use the manufacturer's full 11-digit NDC as of the date the drug is dispensed?

6. If your mail order pricing is based upon the actual package size purchased from the manufacturer or wholesaler, provide an estimate to demonstrate the value compared to discounts based on a fixed package size of 100s or pints.

7. What amount is collected from the member when the mail order copay is greater than the discounted ingredient cost? Do you typically charge a minimum mail order copay? If yes, confirm that you will waive this copay requirement for OGB based on its requirement that members always pay the "lowest" claim cost.

E. Specialty Drug Pricing

1. Complete Exhibit 7 with your proposed Specialty Pharmacy pricing.
2. If OGB elects to institute a retail lockout or mandatory mail provision for specialty/biotech drugs, indicate what impact, if any, this would have on your proposed pricing.
3. Confirm that you will provide OGB with a 30-day notice of new drug additions and price changes on mail order specialty products.

F. Generic Dispensing Rate Guarantees

1. Complete the following table with your proposed retail generic dispensing rate guarantees (GDRs).

Retail GDR	**Year 1**	**Year 2**	**Year 3**

2. Complete the following table with your proposed mail order GDRs.

Mail Order GDR	**Year 1**	**Year 2**	**Year 3**

G. Administrative Fee

1. Complete the following table with your proposed base administrative fees.

Base Administrative Fees		
A.	Network Claims Processing	$____ PEPM
B.	Mail Order Claims Processing	$____ PEPM
C.	Specialty Pharmacy Claims Processing	$____ PEPM
D.	Out of Network and Paper Claims	$____ PEPM
E.	Ad Hoc/Custom Reporting	
F.	Online Reporting Tool	
G.	Additional User Licenses for Online Reporting	$____ per user
H.	Scheduled Pharmacy Data Extracts to Third-Party Vendors	
I.	Standard COB Administration	
J.	Medicare COB Administration	
K.	Standard Program Enrollment Materials (welcome packet, member handbook, formulary guide, pharmacy listing, and ID cards)	
L.	Replacement ID Cards	$____ per card
M.	Benefit Design/Coverage Change Notification	$____ per mailing
N.	Clinical Program Update/Change Notification	$____ per mailing
O.	Custom Communication Materials	
P.	Explanation of Benefits (EOB) Statements	$____ per EOB
Q.	Medicare Part D Claims Administration	$____ per Medicare participant per month

Base Administrative Fees		
R.	Medicare RDS Eligibility Maintenance	$____ per Medicare participant per month
S.	Notices of Creditable Coverage	$____ per mailing
T.	Other (please specify)	

2. Complete the following table with your proposed base clinical fees.

Base Clinical Fees		
A.	Concurrent DUR	
B.	Retrospective DUR	
C.	Quantity Limitation System Edits & Support	
D.	Prior Authorization (PA) Edits & Support	
E.	Duration of Therapy Edits & Support	
F.	Step Therapy Edits & Support	
G.	Administrative/Technical PA Reviews/Overrides	
H.	Clinical PA Reviews/Overrides for Quantity limits, Step Therapy, Prior Authorization, etc.	
I.	Preferred Drug Education/Compliance	
J.	First Level Appeal Determinations	
K.	Second Level Appeal Determinations, if required	
L.	Physician Profiling Report Cards	
M.	Therapeutic Interchange	
N.	Other (please specify)	

3. Confirm you will subsidize a pool of 100 hours of customized ad-hoc reporting per year at no charge.

H. Rebates

1. Based on OGB's contractual definition of "all pharmaceutical rebates," confirm that 100% of the total rebates collected will be shared or passed through to OGB?

2. Complete the following table with your proposed rebate guarantees based on OGB's current (2006) and proposed (2007) plan designs.

Rebate Guarantees		Year 1	Year 2	Year 3
A.	Retail rebate per claim: Incentive Non-incentive	$____ per Rx $____ per Rx	$____ per Rx $____ per Rx	$____ per Rx $____ per Rx
B.	Mail order rebate per claim: Incentive Non-incentive	$____ per Rx $____ per Rx	$____ per Rx $____ per Rx	$____ per Rx $____ per Rx
C.	Specialty rebate per claim: Incentive Non-incentive	$____ per Rx $____ per Rx	$____ per Rx $____ per Rx	$____ per Rx $____ per Rx
D.	Confirm these are minimum rebate guarantees and 100% of rebates will be passed on to OGB			

3. Are the rebate guarantees outlined above contingent upon OGB implementing specific formulary management programs (e.g., therapeutic interventions)? If so, please describe.

4. Attach a sample rebate report that will be provided to OGB on a quarterly basis.

5. Discuss your willingness and ability to provide reporting detail to OGB by drug, manufacturer, unit amount, and type of rebate received (e.g., base, formulary, incentive, market share, other, etc.).

6. State your willingness to allow OGB's representatives or a third party designated by OGB to audit your formulary rebate program, including the processes for reporting data to manufacturers, accounting for rebates earned, and allocating rebate payments

to OGB. The designated auditor shall operate under a confidentiality agreement covering all external parties, as well as other divisions of its firm. Clearly explain any conditions to which the audit process will be subjected.

7. How many different manufacturers do you have rebate contracts with?

8. Describe in detail your procedures for the following activities:

a) Accounting for the accrual of rebates due a plan,

b) Collections of accrued rebates (with aging estimates)

c) Payments of rebates to plans.

I. Financial Disclosure

1. Complete the following table based on your proposed pricing for OGB.

PBM Service/Delivery Channel	**Percent of Total (Net) Revenue or Margin**
Retail Claims Processing	
Mail Order Pharmacy	
Specialty Pharmacy	
Administrative Fees	
Clinical/Utilization Management Programs	
Formulary Management/Rebate Administration	
Other (please specify)	
TOTAL	**100%**

J. Implementation Credit or Allowance

1. Detail any implementation credit or allowance that you are proposing. Include the following information in your proposal:
   (e) The amount;
   (f) How it can be used;
   (g) When and how it will be paid; and
   (h) Required documentation from the client.

2. Confirm that OGB may use the implementation credit, if any, to offset consulting fees associated with this procurement, including fees incurred prior to the January 1, 2007 implementation date.

K. Funding and Contracting

1. What are your standard payment terms (i.e., reimbursement) in your retail network contracts?

2. Describe any additional cost to OGB due to taxes and specify the:
   (e) Type of tax (e.g., sales, usage, service, etc.);
   (f) Level of taxes;
   (g) Applicability of taxes (e.g., state of prescribing, dispensing, or shipment); and
   (h) Estimate of annual tax.

3. Confirm that OGB will not be subject to any advance deposit requirements.

Certification

The undersigned certifies that the figures stated above are based upon an application of the proposer's current (as of September 1, 2006) contracts with pharmacies, suppliers, manufacturers, and any other relevant parties to the utilization data supplied by the Office of Group Benefits.

Proposer	**Date**
Printed Name (Authorized to Sign)	**Signature**
Title	

SECTION VIII

EXHIBITS

EXHIBIT 1	Plan of Benefits
EXHIBIT 2	Census Information
EXHIBIT 3	Pharmacy Claims Experience
EXHIBIT 4	Current Member ID Card
EXHIBIT 5	Top 100 Brand Drugs (Excel Spread Sheet) Tab 3 of Proposal
EXHIBIT 6	Top 200 Generic Drugs (Excel Spread Sheet) Tab 4 of Proposal
EXHIBIT 7	Specialty Drug Pricing (Excel Spread Sheet) Tab 5 of Proposal
EXHIBIT 8	Contract (Includes Addendum A - Business Associate Agreement (BAA) and Addendum B – Reporting/Data Requirements
EXHIBIT 9	Pertinent State Statutes

EXHIBIT 1
PLAN OF BENEFITS – PRESCRIPTION DRUG BENEFIT

Option 1

In Network	Co-pay/Co-insurance
Lifetime Maximum	$250,000 per person
Member pays 50%	Maximum $50 per 30 day fill
After $1,200 per person per plan year	Co-Pay Brand - $15 Generic - $0
Mail Order	
Member pays 50%	Maximum $150 per 90 day fill
After $1,200 per person per plan year	Co-Pay Brand - $45 Generic - $0

Option 2

In Network	Co-pay/Co-insurance
Lifetime Maximum	$250,000 per person

Formulary Tier	Co-pay/Coinsurance
Formulary Brand Member pays 50%	Maximum $40
Non-Formulary Brand Member pays 50%	Maximum $80
Generics	$5

Mail Order (90 day supply)

Formulary Tier	Co-pay/Coinsurance
Formulary Brand Member pays 50%	Maximum $80
Non-Formulary Brand Member pays 50%	Maximum $160
Generics	$10

EXHIBIT 2

CENSUS INFORMATION

A CD WITH THIS INFORMATION Will BE DISTRIBUTED AT THE MANDATORY PROPOSERS CONFERENCE

EXHIBIT 3

PHARMACY CLAIMS EXPERIENCE

A CD WITH THIS INFORMATION WILL BE DISTRIBUTED AT THE MANDATORY PROPOSERS CONFERENCE

EXHIBIT 4

CURRENT ID CARD (ATTACHED)

Health and Pharmacy Benefits ID Card

PPO

The cardholder's Social Security number must be provided at the point of service

Rx Bin#: 005947

Rx Group#: STLA

PCN: CLAIMCR

Name: JOHN SAMPLE

Present this card when visiting a participating pharmacy or health care provider.
It identifies you as an Office of Group Benefits Member.
This ID card does not guarantee medical coverage or benefits.

A Nationwide PPO and Affiliated Networks:

Call to pre-authorized Beech Street affiliated services
For out of state emergencies only

Member Customer Service:	1-800-272-8451 or 225-925-6625
Provider Customer Service:	1-800-215-1093- or 225-922-0218
Provider Right Fax:	1-800-233-8156
TDD:	1-800-259-6771
Website address:	www.groupbenefits.org
Mailing address for claims:	Office of Group Benefits P.O. Box 44036 Baton Rouge, LA 70804

Important Phone Numbers Concerning your benefits:

Hospital Pre-Admission: 1-800-432-3432
(For emergency hospitalization/surgery, you must call within 72 hours)

Mental Health/Substance Abuse Pre-certification 1-866-492-7143
(For in-patient and out-patient treatment and therapy)

For drug claims information/locate participating pharmacy 1-866-358-9530 or 1-877-362-3933

LV7050

EXHIBIT 5

TAB 3 OF PROPOSAL

TOP 100 BRAND DRUGS (EXCEL SPREAD SHEET)

A CD WITH THIS INFORMATION Will BE DISTRIBUTED AT THE MANDATORY PROPOSERS CONFERENCE

EXHIBIT 6

TAB 4 OF PROPOSAL

TOP 200 GENERIC DRUGS (EXCEL SPREAD SHEET)

A CD WITH THIS INFORMATION WiII BE DISTRIBUTED AT THE MANDATORY PROPOSERS CONFERENCE

EXHIBIT 7

TAB 5 OF PROPOSAL

SPECIALTY DRUGS PRICING (EXCEL SPREAD SHEET)

A CD WITH THIS INFORMATION WiII BE DISTRIBUTED AT THE MANDATORY PROPOSERS CONFERENCE

EXHIBIT 8

CONTRACT (INCLUDES ADDENDUMS: BUSINESS ASSOCIATE AGREEMENT (BAA)/ PERFORMANCE STANDARDS/ REPORTING REQUIREMENTS

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS (OGB)

CONTRACT

(ATTACHED)

STANDARD CONTRACT

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS (OGB)

The STATE OF LOUISIANA, DIVISION OF ADMINISTRATION, OFFICE OF GROUP BENEFITS (hereinafter sometimes referred to as the OGB) located at 5825 Florida Blvd., Baton Rouge, LA 70806 and (NAME OF CONTRACTOR) (hereinafter sometimes referred to as "Contractor") located at ________do hereby enter into a contract under the following terms and conditions:

1.0 SCOPE OF SERVICES/DELIVERABLES

(To Be Determined pursuant to NIC and Proposal).

2.0 TERM OF CONTRACT

This contract shall begin _________ and end _________________.

This contract is not effective until approved by the Director of the Office of Contractual Review in accordance with La. R.S. 39:1502.

3.0 PAYMENT TERMS

In consideration of the services described in this contract the maximum the OGB will pay Contractor is $________________________.

NOTE: All other payment terms will be completed at contract negotiation.

4.0 STAFF INSURANCE

Contractor shall procure and maintain for the duration of this contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by the Contractor, his agents, representatives, employees or subcontractors.

5.0 TAXES

Contractor hereby agrees that the responsibility for payment of taxes from the funds thus received under this contract and/or legislative appropriation shall be contractor's obligation and identified under Federal Tax Identification Number ________________.

6.0 SECURITY

Contractor personnel will always comply with all security regulations in effect at the OGB's premises, and externally for materials belonging to the OGB or to the project. Contractor is responsible for reporting any breach of security to the OGB promptly.

7.0 CONFIDENTIALITY

The parties, their agents, staff members and employees agree to maintain as confidential all individually identifiable information regarding Louisiana Office of Group Benefits plan members, including but not limited to patient records, demographic information and claims history. All information obtained by contractors from the OGB shall be maintained in accordance with state and federal law, specifically including but not limited to the Health Insurance Portability and Accountability Act of 1996, and any regulations promulgated thereunder (collectively, "HIPAA"). To that end, the parties have executed and hereby make a part of this Agreement a Protected Health Information (Business Associate) Addendum to be in full compliance with all relevant provisions of HIPAA, including but not limited to all provisions relating to Business Associates.

Further, the parties agree that all financial, statistical, personal, technical and other data and information relating to either party's operations which are designated confidential by such party and made available to the other party in carrying out this contract, shall be protected by the receiving party from unauthorized use and disclosure through the observance of the same or more effective procedural requirements as are applicable to the OGB and/or Contractor. Neither party shall be required to keep confidential any data or information which is or becomes publicly available, is already rightfully in the party's possession, is independently developed by the party outside the scope of this contract, or is rightfully obtained from third parties.

8.0 PROJECT MANAGEMENT/MONITORING PLAN

(To Be Determined)

9.0 PERFORMANCE MEASURES

Contractor will assign a Project Account Manager to work with OGB's assigned Contract Supervisor. OGB's Contract Supervisor will be responsible for the Performance Evaluation Report in regards to the scope of services provided by the Contractor pursuant to this contract. The performance evaluation will be based on the following: the quality of services performed in accordance with services required; the submission of required reports/reporting and other measurements as determined by the Contract Supervisor.

10.0 TERMINATION FOR CAUSE

OGB may terminate this contract for cause based upon the failure of Contractor to comply with the material terms and/or conditions of the contract; provided that the OGB shall give the Contractor written notice specifying the Contractor's failure. If within thirty (30) 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) days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction, then the OGB may,
at its option, place the Contractor in default and this contract shall terminate on the date specified in such notice.

Contractor may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of the OGB to comply with the terms and conditions of this contract; provided that the Contractor shall give the OGB written notice specifying the OGB's failure. Furthermore, the Contractor shall be entitled to suspend any and all services until such time as when the OGB is not in default of its obligations under this contract.

10.1 TERMINATION FOR CONVENIENCE

The OGB may terminate the contract at any time without penalty by giving thirty (30) days written notice to Contractor. Upon any termination of this contract the Contractor shall be entitled to payment for deliverables in progress, to the extent work has been performed satisfactorily.

10.2 REMEDIES FOR DEFAULT

Any claims or controversy arising out of this contract shall be resolved in accordance with the provisions of La R.S. 39:1524 – 1526.

The validity of this contract and any of its terms or provisions, as well as the rights and duties of the parties hereunder, shall be construed pursuant to, and in accordance with, the laws of the State of Louisiana and venue of any action brought under this contract shall be the Nineteenth (19th) Judicial District Court.

11.0 INDEMNIFICATION

Contractor agrees to protect, defend, indemnify and hold harmless OGB, the State of Louisiana, all State Departments, Agencies, Boards and Commissions, their respective officers, directors, agents, servants and employees, including volunteers (each a State Affiliated Indemnified Party), from and against any and all claims, demands, expense and liability arising out of or in any way growing out of any negligent act or omission of Contractor, its agents, servants, and employees, together with any and all costs, expenses and/or attorney fees reasonably incurred as a result

of any such claim, demands, and/or causes of action, **except** those claims, demands and/or causes of action arising out of the negligent act or omission of a State Affiliated Indemnified Party. Contractor agrees to investigate, handle, respond to, provide defense for and defend any such claim, demand or suit at its sole expense, even if such claim, demand or suit is groundless, false or fraudulent, provided that (a) the State Affiliated Indemnified Party has give reasonable notice to Contractor of the claim or cause of action, and (b) no State Affiliated Indemnified Party has, by act, compromised Contractor's position with respect to the resolution or defense of the claim or cause of action.

OGB agrees to protect, defend, indemnify and hold harmless Contractor, its affiliates, contractors, shareholders, directors, officers, employees, and agents (each a Contractor Indemnified Party), from and against any and all claims, demands, expense and liability arising out of or in any way growing out of any negligent act or omission of OGB, its agents, servants, and employees, or arising out of the actions or inactions of OGB, its agents, servants, and employees, or arising out of the actions or inactions of Contractor taken or not taken at the direction of the OGB, together with any and all costs, expenses and/or attorney fees reasonably incurred as a result of any such claim, demands, and/or causes of action, **except** those claims, demand and/or causes of action arising out of the negligent act or omission of a Contractor Indemnified Party. OGB agrees to investigate, handle, respond to, provide defense for and defend any such claim, demand or suit at its sole expense, even if such claim, demand or suit is groundless, false or fraudulent, provided that (a) the Contactor Indemnified Party has given reasonable notice to OGB of the claim or cause of action, and (b) no Contractor Indemnified Party has, by act or failure to act, compromised OGB's position with respect to the resolution or defense of the claim or cause of action.

12.0 OWNERSHIP OF PRODUCT

All records, reports, documents and other material delivered or transmitted to Contractor by OGB shall remain the property of OGB, and shall be returned by Contractor to OGB, at Contractor's expense, at termination or expiration of this contract. Contractor may retain one copy of such records, documents or materials for archival purposes and to defend its work product. All records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor specifically and exclusively for the OGB in connection with the performance of the services contracted for herein shall become the property of the OGB, and shall, upon request, be returned by Contractor to OGB, at Contractor's expense, at termination or expiration of this contract.

13.0 ASSIGNMENT

Contractor shall not assign any interest in this contract and shall not transfer any interest in same (whether by assignment or novation), without prior written consent of the OGB, provided however, that claims for money due or to become due to the

Contractor from the OGB may be assigned to a bank, trust company, or other financial institution without such prior written consent. Notice of any such assignment or transfer shall be furnished promptly to the OGB and to the Office of Contractual Review, Division of Administration.

14.0 RIGHT TO AUDIT

Contractor grants to the Office of the Legislative Auditor, Inspector General's Office, the Federal Government, and any other duly authorized agency of the State the right to inspect and review all books and records pertaining to services rendered under this contract. Contractor shall comply with federal and/or state laws authorizing an audit of Contractor's operation as a whole, or of specific program activities. Any audit shall be conducted during ordinary business hours and upon reasonable advance notice to the Contractor.

15.0 RECORD RETENTION

Contractor agrees to retain all books, records, and other documents relevant to this contract and the funds expended hereunder for at least three years after project completion of contract, or as required by applicable Federal law, whichever is longer.

16.0 AMENDMENTS IN WRITING

Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when it has been reduced to writing, duly signed. No amendment shall be valid until it has been executed by all parties and approved by the Director of the Office of Contractual Review, Division of Administration.

17.0 WAIVER OF BREACH

The waiver by either party of a breach or violation of any provision of the contract shall not operate as, or be construed to be, a waiver or any subsequent breach of the contract.

18.0 SEVERABILITY

The invalidity or unenforceability of any terms or conditions of the contract shall in no way effect the validity or enforceability of any other terms or provisions.

19.0 FUND USE

Contractor agrees not to use funds received for services rendered under this contract 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.

20.0 NON-DISCRIMINATION

Contractor agrees to abide by the requirements of the following as applicable: Title VI and 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 Act of 1972, and Contractor agrees to abide by the requirements of the Americans with Disabilities Act of 1990. 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, disabilities, or because of an individual's sexual orientation. Any act of discrimination committed by Contractor, or failure to comply with these obligations when applicable shall be grounds for termination of this contract.

21.0 AVAILABILITY OF FUNDS

The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract. If the legislative fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by veto of the Governor or by any means provided in the appropriation act 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 reductions 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. Such termination shall be without penalty or expense to the OGB except for payments which have been earned prior to the termination.

22.0 HEADINGS

Descriptive headings in this contract are for convenience only and shall not affect the Construction or meaning of contractual language.

23.0 ENTIRE AGREEMENT AND ORDER OF PRECEDENCE

This contract (together with the NIC issued thereto by the OGB, the Proposal submitted by the Contractor in response to the OGB's NIC, and any exhibits specifically incorporated herein by reference) constitutes the entire agreement between the parties with respect to the subject matter.

This contract shall, to the extent possible, be constructed to give effect to all provisions contained therein: however, where provisions are in conflict, first priority shall be given to the provisions of the contract, excluding the NIC and the Proposal; second priority shall be given to the provisions of the NIC and amendments thereto; and third priority shall be given to the provisions of the Proposal.

BY SIGNING BELOW, THE PARTIES AGREE TO ALL OF THE TERMS AND CONDITIONS SET FORTH ABOVE.

THUS DONE AND SIGNED ON THE DATE(S) LISTED BELOW:

STATE OF LOUISIANA OFFICE OF GROUP BENEFITS	**CONTRACTOR**
SIGNATURE____________________	**SIGNATURE**____________________
NAME **Tommy D. Teague**	**NAME**____________________
TITLE **Chief Executive Officer**	**TITLE**____________________

ADDENDUM - A
State of Louisiana, Division of Administration
Office of Group Benefits
Protected Health Information Addendum

I. Definitions

a) "Administrative Safeguards" shall mean administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic protected health information and to manage the conduct of the covered entity's workforce in relation to the protection of that information., as more particularly set forth in 45 CFR § 164.308.
b) "Agreement" shall mean the agreement between Business Associate and OGB, dated , pursuant to which Business Associate is to provide certain services to OGB involving the use or disclosure of PHI, as defined below.
c) "Business Associate" shall mean .
d) "ePHI" shall have the same meaning as the term "electronic protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of OGB.
e) "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
f) "HIPAA Regulations" shall mean the Privacy Rule and the Security Rule.
g) "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
h) "OGB" shall mean the State of Louisiana, Division of Administration, Office of Group Benefits, which is a covered entity under HIPAA and the HIPAA Regulations, as defined below.
i) "PHI" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of OGB.
j) "Physical Safeguards" shall mean physical measures, policies, and procedures to protect a covered entity's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion as more particularly set forth in 45 CFR § 164.310.
k) "Privacy Rule" shall mean the regulations promulgated pursuant to HIPAA regarding Privacy of Individually Identifiable Health Information at 45 CFR, Part 160 and Part 164, Subparts A and E.
l) "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103.
m) "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.
n) "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR § 164.304.

o) "Security Rule" shall mean the regulations promulgated pursuant to HIPAA regarding Security Standards for Electronic Protected Health Information at 45 CFR, Part 160 and Part 164, Subparts A and C.
p) "Technical Safeguards" shall mean the technology and the policy and procedures for its use that protect electronic protected health information and control access to it, as more particularly set forth in 45 CFR § 164.312.
q) Any other terms used in this Addendum that are not defined herein but are defined in the HIPAA Regulations shall have the same meaning as given in the HIPAA Regulations.

II. Obligations and Activities of Business Associate

a) Business associate agrees to comply with OGB policies and procedures regarding the use and disclosure of PHI.
b) Business Associate agrees to not use or further disclose PHI other than as permitted or required by this Addendum, or as Required by Law.
c) Business Associate agrees to limit all requests to OGB for PHI to the minimum information necessary for Business Associate to perform functions, activities, or services for or on behalf of OGB as specified in the Agreement.
d) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Addendum.
e) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum.
f) Business Associate agrees to report to OGB any use or disclosure of the PHI not provided for by this Addendum of which it becomes aware. Such report shall be made within two (2) business days of Business Associate learning of such use or disclosure.
g) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of, OGB agrees to the same restrictions and conditions that apply through this Addendum to Business Associate with respect to such information. However, Business Associate shall not enter into any subcontractor or other agency relationship with any third party that involves use or disclosure of such PHI without the advance written consent of OGB.
h) Business Associate agrees to provide access, at the request of OGB, and in the time and manner designated by OGB, to PHI maintained by Business Associate in a Designated Record Set, to OGB or, as directed by OGB, to an Individual in order to meet the requirements under 45 CFR § 164.524.
i) Business Associate agrees to make any amendment(s) to PHI maintained by Business Associate in a Designated Record Set that OGB directs or agrees to pursuant to 45 CFR § 164.526 at the request of OGB or an Individual, and in the time and manner designated by OGB.
j) Business Associate 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, OGB available to OGB, or at the request of OGB to the Secretary, in a time and manner designated by OGB or the Secretary, for purposes of the Secretary determining OGB's compliance with the HIPAA Regulations.

k) Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for OGB to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
l) Business Associate agrees to provide to OGB or an Individual, in a time and manner designated by OGB, information collected in accordance with Section II.j of this Addendum, to permit OGB to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
m) At any time(s) requested by OGB, Business Associate agrees to return to OGB or destroy such PHI in its possession as directed by OGB.
n) Business Associate shall defend and indemnify OGB from and against any and all claims, costs, and/or damages arising from a breach by Business Associate of any of its obligations under this Addendum. Any limitation of liability provision set forth in the Agreement, including but not limited to any cap on direct damage liability and any disclaimer of liability for any consequential, indirect, punitive, or other specified types of damages, shall not apply to the defense and indemnification obligation contained in this Addendum.
o) Business Associates shall relinquish to OGB all control over responses to subpoenas Business Associate receives related to PHI.
p) Not later than April 20, 2005, the compliance date for the Security Rule, Business Associate shall:
    1. Implement and document Administrative Safeguards, Physical Safeguards, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of OGB, specifically including, but not limited to, the following:
        i) Ensuring the confidentiality, integrity, and availability of all ePHI that it creates, receives, maintains, or transmits on behalf of OGB;
        ii) Protecting against any reasonably anticipated threats or hazards to the security or integrity of such information;
        iii) Protecting against any reasonably anticipated uses or disclosures of such information that are not permitted or required by this Addendum or Required by Law; and
        iv) Ensuring compliance with these requirements by its workforce;
    2. Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate safeguards to protect it;
    3. Report to OGB any Security Incident of which it becomes aware. If no Security Incidents are reported, Business Associate shall certify to OGB in writing within ten (10) days of each anniversary date of the Agreement that there have been no Security Incidents during the previous twelve months.
q) Business Associate shall not permit PHI to be disclosed to or used by any individual or entity outside of the territorial and jurisdictional limits of the fifty United States of America.

III. Permitted Uses and Disclosures by Business Associate

a) Except as otherwise limited in this Addendum, Business Associate may use or disclose PHI to perform functions, activities, or services for or on behalf of OGB as specified in the Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by OGB or the minimum necessary policies and procedures of OGB.
b) Except as otherwise limited in this Addendum, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.
c) Except as otherwise limited in this Addendum, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that such disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person 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, and the person promptly notifies the Business Associate of any known instances of breach of the confidentiality of the PHI
d) Except as otherwise limited in this Addendum, Business Associate may use PHI to provide Data Aggregation services to OGB as permitted by 45 CFR § 164.504(e)(2)(i)(B), provided that such services are contemplated by the Agreement.
e) Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR § 164.502(j)(1).

IV. Obligations and Activities of OGB

a) With the exception of Data Aggregation services as permitted by 45 CFR § 164.504(e)(2)(i)(B), OGB shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by OGB.
b) OGB shall notify Business Associate of any limitation(s) in OGB's Notice of Privacy Practices in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
c) OGB shall notify Business Associate of any changes in, or revocation of, permission by any Individual to use or disclose PHI, to the extent such changes may affect Business Associate's use or disclosure of PHI.
d) OGB shall notify Business Associate of any restriction to the use or disclosure of PHI that OGB has agreed to in accordance with 45 CFR § 164.522, to the extent such restriction may affect Business Associate's use or disclosure of PHI.

V. Term and Termination

a) Term. The Term of this Addendum shall commence on the effective date set forth below, and shall terminate when all of the PHI provided by OGB to Business Associate, or created or received by Business Associate on behalf of OGB, is destroyed or returned to OGB, or, if it is not feasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.
b) Termination of Agreement for Cause. In the event that OGB learns of a material breach of this Addendum by Business Associate, OGB shall, in its discretion:

1. Provide a reasonable opportunity for Business Associate to cure the breach to OGB's satisfaction. If Business Associate does not cure the breach within the time specified by OGB, OGB may terminate the Agreement for cause; or
2. Immediately terminate the Agreement if Business Associate has breached a material term of this Addendum and cure is not possible; or
3. If neither termination nor cure is feasible, OGB may report the violation to the Secretary.

c) Effect of Termination.
1. Except as provided in paragraph (2) below, upon termination of the Agreement for any reason, Business Associate shall return or destroy all PHI received from OGB, or created or received by Business Associate on behalf of OGB. Business Associate shall retain no copies of the PHI. This provision shall also apply to PHI that is in the possession of subcontractors or agents of Business Associate.
2. In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to OGB written notification of the conditions that make return or destruction not feasible. Upon mutual agreement of the parties that return or destruction of PHI is not feasible, Business Associate shall extend the protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction not feasible, for so long as Business Associate maintains such PHI.

VI. Miscellaneous

a) A reference in this Addendum to a section in the HIPAA Regulations means the section as in effect or as amended, and for which compliance is required.
b) The parties agree to amend this Addendum from time to time as necessary for OGB to comply with the requirements of HIPAA and the HIPAA Regulations.
c) If applicable, the obligations of Business Associate under Section V.c.2 of this Addendum shall survive the termination of this Addendum.
d) Any ambiguity in this Addendum shall be resolved in favor of a meaning that permits OGB to comply with HIPAA and the HIPAA Regulations. It is the intent of the parties that neither this Addendum, nor any provision in this Addendum, shall be construed against either party pursuant to the common law rule of construction against the drafter.
e) Except as expressly stated herein, the parties to this Addendum do not intend to create any rights in any third parties. Nothing in this Addendum shall confer upon any person other that the parties and their respective successors or assigns any rights, remedies, obligations, or liabilities whatsoever.
f) In the event of any conflict between the terms of the Agreement and the terms of this Addendum, the terms of this Addendum will control, with the exception that if the Agreement contains any provisions relating to the use or disclosure of PHI that are more protective of the confidentiality of PHI than the provisions of this Addendum, then the more protective provisions will control. The provisions of this Addendum are intended to establish the minimum limitations on Business Associate's use and disclosure of PHI.
g) The terms of this Addendum shall be construed in light of any applicable interpretation or guidance on HIPAA and/or the HIPAA Regulations issued from time to time by the Department of Health and Human Services or the Office for Civil Rights.

h) This Addendum may be modified or amended only by a writing signed by the party against which enforcement is sought.
i) Neither this Addendum nor any rights or obligations hereunder may be transferred or assigned by one party without the other party's prior written consent, and any attempt to the contrary shall be void. Consent to any proposed transfer or assignment may be withheld by either party for any or no reason.
j) Waiver of any provision hereof in one instance shall not preclude enforcement thereof on future occasions.
k) For matters involving the HIPAA and the HIPAA Regulations, this Addendum and the Agreement will be governed by the laws of the State of Louisiana, without giving effect to choice of law principles.

In witness whereof, the parties have executed this Addendum through their duly authorized representatives. This Addendum shall be effective as of the _________ day of _________, 20_________.

State of Louisiana,
Division of Administration
Office of Group Benefits

By:______________________________	By:______________________________
Name: Tommy D. Teague	Name:______________________________
Title: Chief Executive Officer	Title:______________________________

CONTRACT ADDENDUM - B

REPORTING/DATA REQUIREMENTS

Reporting Requirements

The Program will require a number of regular monthly, quarterly and annual claim reports. All reports should show data separately for actives, retirees and in total.

The required reports and their frequency are noted below:

A monthly paid claims summary for all benefit payments made during the month. The summary should show separately for employees and dependents the eligible charges submitted, amount paid during the month, and the number of claims paid. (i.e., the number of checks or drafts issued).

Monthly in-network and out-of-network utilization showing data noted above (a).

Monthly Ingredient Cost Savings report by individual claimant, listing the NDC #, submitted charge, allowable charge, zip code and Tax Identification # of the prescribing physician.

A monthly communication piece identifying new drugs approved by the FDA. This communication piece must include the following components:

- Drug Name (including brand name and generic name);
- Therapeutic Class;
- FDA approval date;
- Manufacturer name;
- Available strength(s);
- Date of availability;
- Comparative costs (including drug name, dosage, and cost (AWP);
- Recommended dose;
- Indication(s) and Contraindications/Warnings;
- Description of the drugs clinical effectiveness;
- Description of the Side Effects/Drug Interactions;
- Your PBM or Company's opinions of the drug (i.e., effectiveness, determination of coverage under your formulary and identification of which tier would it reside.);
- Your PBM or Company's recommendation on how employers should cover this drug and why;
- Prevalence factors you can apply to this drug (if applicable)

Gross submitted charge amounts, amounts determined to be ineligible, amounts applied to copayments and coinsurance. This report is required quarterly.

Claims paid by therapeutic category showing total number of claims, eligible charges and claim payments for each category. This report is required quarterly.

Annual report of high amount pharmacy claimants.

Number of prescriptions submitted by single source brand, multisource brand and generic drugs, including average cost per prescription and average days supply, by month.

Average discounted ingredient cost per prescription for the top 100 drugs dispensed (sorted by total benefits paid). This report is required annually.

Quarterly Drug Utilization Review activity and savings report by type of edit.

Annual report listing the gross claims and payment made to each pharmacy. Chain outlets should be shown separately and in total for the chain.

Annual report on non-network claims processing turnaround time showing total number of claims processed and number of claims processed within 10 working days as measured by date on which claim is received, according to date stamp, versus date check is issued.

Annual claims report showing total number of network claims processed and number of claims processed with network providers for which there was a payment error. Payment errors include payments made for ineligible expenses, payments on ineligible plan members, incorrect copayments collected at point-of-sale, and payment errors with regard to ingredient cost or dispensing fee.

Semi-annual plan member access reports prepared based on OGB census as of June 30 and December 31 of each contract year. (At OGB's discretion, this report may be requested annually.)

A rebate report must be delivered monthly to OGB and must include rebates collected by PBM and/or Company from manufacturer by drug claim. The report should also include the number of prescriptions filled, and the dollar amount of rebates received for each drug on the formulary, with an annual reconciliation/report of all activity for each contract year.

A specialty drug report delivered monthly to OGB and must include top drugs by drug and by class, ingredient cost, discount cost, total amount paid and number of claims. The report must be customizable.

All reports are due as follows:

Monthly reports are due no later than 10 days following month end.

Quarterly reports are due no later than 45 days following the end of the quarter.

Annual reports are due 60 days following the end of the contract year.

Ad hoc reports may be required from time to time and shall be in a format with a due date agreed upon by OGB and the PBM and/or Company.

ADDENDUM B – File requirements and layout

The Contractor shall send and receive data files and act on the received data files as detailed in this section (ADDENDUM B):

Files to be sent by the contractor to OGB:

The contractor shall provide the following file to OGB for drug claims paid on a bimonthly basis. The paid period end dates shall be the Friday closest to the middle of the month and the end of the month. OGB shall receive the claims file no later than 10 days after the end of the period. This claims file should have all information needed to balance to the invoice for paid claims. The file shall be constructed using strictly the layout as described in ADDENDUM B-1. The file shall be sent electronically using FTP (File Transfer Protocol) and MUST be encrypted using PGP (Pretty Good Privacy).

1. **Drug Claims File (ADDENDUM B-1)**
   This file contains all drugs for which prescriptions were filled during the period.

Files to be sent to the contractor by OGB:

The contractor shall receive the following four files from OGB. All files shall be constructed using strictly the layout as described in ADDENDUM B-2 thru B-5. Files shall be sent electronically using FTP (File Transfer Protocol) and MUST be encrypted using PGP (Pretty Good Privacy).

2. **Accumulator File (ADDENDUM B-2)**
   This file shall be received once by the contractor and will contain lifetime pharmacy accumulators for member that the contractor must keep track of during their contract with OGB. The contractor is not to pay for drugs for the patient when that patient's lifetime maximum is reached.

3. **Pharmacy Eligibility File (ADDENDUM B-3)**
   This file shall be received the evening of every work day by the contractor and posted to their system before the next day. It will contain the contract membership plus any terminations.

4. **Pharmacy Group File (ADDENDUM B-4)**
   This file shall be received the evening of every work day by the contractor in conjunction with the Eligibility file above. The groups that are referenced in the Eligibility file above are to be loaded to the contractor's system prior to using the eligibility.

5. **Pharmacy Accumulator Cross Reference File (ADDENDUM B-5)**
   This file shall be received by the contractor the first of every month. There is a from member and to memberid in this file. The id that is referenced is the same internal id referenced in the Eligibilityfile. (field number 4). Each record in this file represents OGB's communication to the contractors that these two members are the same. The contractor, therefore; should paid for claims as iftheir lifetime accumulators were the same.

ADDENDUM B-1 Drug Claims File					
	FIELD NAME	TYPE	LEN	LOC	DESCRIPTION
1	RECORD IDENTIFIER	N	1	001-001	0=PROCESSOR RECORD
2	PROCESSOR NUMBER	N	10	002-011	THIS NUMBER IS ASSIGNED BY NCPDP TO IDENTIFY THE SOURCE OF THE TAPE, I.E. PHARMACY, WHOLESALER, HOSPITAL, SERVICE BUREAU, ETC.
3	BATCH NUMBER	N	5	012-016	THIS NUMBER IS ASSIGNED BY THE PROCESSOR. FORMAT=YYDDD YY=YEAR DDD=JULIAN DATE I.E. 92252=SEPT. 8, 1992
4	PROCESSOR NAME	A/N	20	017-036	PROCESSOR NAME
5	PROCESSOR ADDRESS	A/N	20	037-056	PROCESSOR ADDRESS
6	PROCESSOR LOCATION CITY	A/N	18	057-074	PROCESSOR CITY
7	PROCESSOR LOCATION STATE	A/N	2	075-076	PROCESSOR STATE
8	PROCESSOR ZIP CODE	A/N	9	077-085	PROCESSOR ZIP CODE, EXPANDED
9	PROCESSOR TELEPHONE NUMBER	N	10	086-095	TELEPHONE NUMBER FORMAT=AAAEEENNNN AAA=AREA CODE EEE=EXCHANGE CODE NNNN=NUMBER
10	RUN DATE	A/N	8	096-103	DATE ON WHICH TAPE WAS GENERATED BY CARRIER FORMAT=CCYYMMDD
11	THIRD PARTY TYPE	A/N	1	104-104	TYPE OF CLAIM M=GOVERNMENT P=PRIVATE
12	VERSION/RELEASE NUMBER	N	2	105-106	A NUMBER TO IDENTIFY THE FORMAT OF THE TRANSACTION SENT OR RECEIVED 10=1981 FORMAT TAPE 20=1991 FORMAT TAPE

13	EXPANSION AREA	A/N	187	107-293	RESERVED FOR FUTURE NCPDP CONTINGENCIES
14	UNIQUE FREE FORM	A/N	415	294-708	FILLER

ADDENDUM B-1 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	RECORD IDENTIFIER	N	1	001-001	2=PHARMACY RECORD
2	PROCESSOR NUMBER	N	10	002-011	THIS NUMBER IS ASSIGNED BYNCPDP TO IDENTIFY THE SOURCE OF THE TAPE, I.E. PHARMACY, WHOLESALER, HOSPITAL, SERVICE BUREAU, ETC.
3	BATCH NUMBER	N	5	012-016	THIS NUMBER IS ASSIGNED BY THE PROCESSOR. FORMAT=YYDDD YY=YEAR DDD=JULIAN DATE I.E. 92252=SEPT. 8, 1992
4	PHARMACY NUMBER	A/N	12	017-028	ID ASSIGNED TO A PHARMACY
5	PHARMACY NAME	A/N	20	029-048	NAME OF PHARMACY
6	PHARMACY ADDRESS	A/N	20	049-068	ADDRESS OF PHARMACY
7	PHARMACY LOCATION CITY	A/N	18	069-086	CITY OF PHARMACY
8	PHARMACY LOCATION STATE	A/N	2	087-088	STATE OF PHARMACY
9	PHARMACY ZIP CODE	A/N	9	089-097	ZIP CODE OF PHARMACY EXPANDED
10	PHARMACY TELEPHONE NUMBER	A/N	10	098-107	TELEPHONE NUMBER OF PHARMACY
11	EXPANSION AREA	A/N	211	108-318	RESERVED FOR FUTURE NCPDP CONTINGENCIES
12	UNIQUE FREE FORM	A/N	390	319-708	FILLER

ADDENDUM B-1 Drug Claims File					
NO	FIELD NAME	TYPE	LEN	LOC	DESCRIPTION
1	RECORD IDENTIFIER	N	1	1-1	4=CLAIM RECORD
2	PROCESSOR NUMBER	N	10	2-11	THIS NUMBER IS ASSIGNED BY NCPDP TO IDENTIFY THE SOURCE OF THE TAPE, I.E. PHARMACY, WHOLESALER, HOSPITAL, SERVICE BUREAU, ETC.
3	BATCH NUMBER	N	5	12-16	THIS NUMBER IS ASSIGNED BY THE PROCESSOR. FORMAT=YYDDD YY=YEAR DDD=JULIAN DATE I.E. 92252=SEPT. 8, 1992
4	PHARMACY NUMBER	A/N	12	17-28	ID ASSIGNED TO A PHARMACY
5	PRESCRIPTION NUMBER	A/N	7	29-35	
6	DATE FILLED	A/N	8	36-43	DISPENSING DATE OF RX **FORMAT=CCYYMMDD**
7	NDC NUMBER	N	11	44-54	FOR LEGEND COMPOUNDS USE: 99999999999 SCHEDULE II: 99999999992 SCHEDULE III: 99999999993 SCHEDULE IV: 99999999994 SCHEDULE V: 99999999995 COMPOUNDS: 99999999996
8	DRUG DESCRIPTION	A/N	30	55-84	LABELNAME
9	NEW/REFILL CODE	N	2	85-86	00=NEW PRESCRIPTION 01-99=NUMBER OF REFILLS
10	METRIC QUANTITY	N	6	87-92	NUMBER OF METRIC UNITS OF MEDICATION DISPENSED (LEADING SIGN IF NEGATIVE)
11	DAYS SUPPLY	N	4	92-96	ESTIMATED NUMBER OF DAYS THE PRESCRIPTION WILL LAST
12	BASIS OF COST DETERMINATION	A/N	2	97-98	00=NOT SPECIFIED 01=AWP 02=LOCAL WHOLESALER 03=DIRECT 04=EAC 05=ACQUISITION

ADDENDUM B-1 Drug Claims File					
NO	FIELD NAME	TYPE	LEN	LOC	DESCRIPTION
					06=MAC 6X=BRAND MEDICALLY NECESSARY 07=USUAL AND CUSTOMARY 08=UNIT DOSE 09=OTHER USED ON TAPE AND DISKETTE ONLY
13	INGREDIENT COST	N	10	99-108	COST OF THE DRUG DISPENSED. FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as "0000123.45" -123.45 would be expressed as "-000123.45"
14	DISPENSING FEE SUBMITTED	N	10	109-118	FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as "0000123.45" -123.45 would be expressed as "-000123.45"
15	CO-PAY AMOUNT	N	10	119-128	CORRECT CO-PAY FOR PLAN BILLED FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as "0000123.45" -123.45 would be expressed as "-000123.45"
16	SALES TAX	N	10	129-138	SALES TAX FOR THE PRESCRIPTION DISPENSED FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit

NO	FIELD NAME	TYPE	LEN	LOC	DESCRIPTION
					decimal point and leading sign only when negative Example: 123.45 would be expressed as "0000123.45" -123.45 would be expressed as "-000123.45"
17	AMOUNT BILLED	N	10	139-148	FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as "0000123.45" -123.45 would be expressed as "-000123.45"
18	PATIENT FIRST NAME	A/N	12	149-160	FIRST NAME OF PATIENT
19	PATIENT LAST NAME	A/N	15	161-175	LAST NAME OF PATIENT
20	DATE OF BIRTH	A/N	8	176-183	DATE OF BIRTH OF PATIENT **FORMAT=CCYYMMDD**
21	SEX CODE	A/N	1	184-184	0=NOT SPECIFIED 1=MALE 2=FEMALE
23	EMPLOYEE SSN	A/N	9	185-193	
24	OGB Internal Id-	A/N	8	194-201	See Appendix E (Eligibility File) Field number-33
25	FILLER	A/N	1	202-202	
26	RELATIONSHIP CODE	A/N	1	203-203	1=CARDHOLDER 2=SPOUSE 3=CHILD 4=OTHER
27	GROUP NUMBER	A/N	15	204-218	ID ASSIGNED TO CARDHOLDER GROUP OR EMPLOYER GROUP
28	PRESCRIBER ID	A/N	10	219-228	IDENTIFICATION ASSIGNED TO THE PRESCRIBER
29	DIAGNOSIS CODE	A/N	6	229-234	ICD-9 STANDARD DIAGNOSIS CODES
30	Document number	A/N	15	235-	

ADDENDUM B-1 Drug Claims File					
NO	FIELD NAME	TYPE	LEN	LOC	DESCRIPTION
				249	
30	FILLER	A/N	12	250-261	
31	RESUBMISSION CYCLE COUNT	A/N	2	262-263	0 = ORIGINAL SUBMISSION 1 = FIRST RE-SUBMISSION 2 = SECOND RE-SUBMISSION
32	DATE PRESCRIPTION WRITTEN	A/N	8	264-271	DATE PRESCRIPTION WAS WRITTEN
33	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	A/N	1	272-272	0 = NO PRODUCT SELECTION INDICATED 1 = SUBSTITUTION NOT ALLOWED BY PRESCRIBER 2 = SUBSTITUTION ALLOWED - PATIENT REQUESTED PRODUCT DISPENSED 3 = UBSTITUTION ALLOWED PHARMACIST SELECTED PRODUCT DISPENSED 4 = SUBSTITUTION ALLOWED - GENERIC DRUG NOT IN STOCK 5 = SUBSTITUTION ALLOWED - BRAND DRUG DISPENSED AS A GENERIC 6 = OVERRIDE 7 = SUBSTITUTION NOT ALLOWED - BRAND DRUG MANDATED BY LAW 8 = SUBSTITUTION ALLOWED - GENERIC DRUG NOT AVAILABLE IN MARKETPLACE 9 = OTHER
34	ELIGIBILITY CLARIFICATION CODE	A/N	1	273-273	CODE INDICATING THAT THE PHARMACY IS CLARIFYING ELIGIBILITY BASED ON DENIAL 0 = NOT SPECIFIED 1 = NOT OVERRIDE 2 = OVERRIDE 3 = FULL TIME STUDENT 4 = DISABLED DEPENDENT 5 = DEPENDENT PARENT
35	COMPOUND CODE	A/N	1	274-274	CODE INDICATING WHETHER OR NOT THE PRESCRIPTION IS A COMPOUND

ADDENDUM B-1 Drug Claims File					
NO	FIELD NAME	TYPE	LEN	LOC	DESCRIPTION
					0=NOT SPECIFIED 1=NOT A COMPOUND 2=COMPOUND
36	NUMBER OF REFILLS AUTHORIZED	N	2	275-276	NUMBER OF REFILLS AUTHORIZED BY PRESCRIBER
37	DRUG TYPE	A/N	1	277-277	CODE TO INDICATE THE TYPE OF DRUG DISPENSED 0=NOT SPECIFIED 1=SINGLE SOURCE BRAND 2=BRANDED GENERIC 3=GENERIC 4=O.T.C. (OVER THE COUNTER)
38	PRESCRIBER LAST NAME	A/N	15	278-292	PRESCRIBER LAST NAME
39	POSTAGE AMOUNT CLAIMED	N	4	293-296	DOLLAR AMOUNT OF POSTAGE CLAIMED FORMAT- Field should be 4 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 1.23 would be expressed as "01.23" -1.23 would be expressed as "-1.23"
40	UNIT DOSE INDICATOR	A/N	1	297-297	CODE INDICATING THE TYPE OF UNIT DOSE DISPENSING DONE 0=NOT SPECIFIED 1=NOT UNIT DOSE 2=MANUFACTURER UNIT DOSE 3=PHARMACY UNIT DOSE
41	OTHER PAYOR AMOUNT	N	6	298-303	DOLLAR AMOUNT OF PAYMENT KNOWN BY THE PHARMACY FROM OTHER SOURCES FORMAT=positive 123.56 negative -12.45
42	FILLER	A/N	35	304-338	RESERVED FOR FUTURE NCPDP CONTINGENCIES
43	CONTRACT SSN	A/N	9	339-347	(Contract Holder's SSN)- RxClaim map from 1st nine digits of member ID number
44	COVERED AMOUNT	N	10	348-357	FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example:

ADDENDUM B-1 Drug Claims File					
NO	FIELD NAME	TYPE	LEN	LOC	DESCRIPTION
					123.45 would be expressed as "0000123.45" -123.45 would be expressed as "-000123.45"
45	PAID AMOUNT	N	10	358-367	FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as "0000123.45" -123.45 would be expressed as "-000123.45"
46	PAID DATE	A/N	8	368-375	Date of payment FORMAT = CCYYMMDD
47	FILLER	A/N	2	376-377	Spaces
48	Prescribe First Name	A/N	15	378-392	
49	Prescribe Last Name	A/N	25	393-417	
50	Prescribe MI	A/N	1	418-418	
51	Prescribe Address-1	A/N	55	419-473	
52	Prescribe Address-2	A/N	55	474-528	
53	Prescribe City	A/N	20	529-548	
54	Prescribe State	A/N	2	549-550	
55	Prescribe Zip Code	A/N	10	551-560	
56	Medicare D Eligible Indicator	A/N	1	561-561	Y = Medicare D eligible N = NOT Medicare D eligible
57	Filler	A/N	147	562-708	Spaces

ADDENDUM B-2 ACCUMULATOR FILE					
	FIELD NAME	TYPE	LEN	LOC	DESCRIPTION
1	Enrollee SSN	A/N	9	001-009	Subscriber SSN
2	Relation Code	A/N	2	010-011	"01" – Employee "02" – Spouse "03" – Child "05" – Grandchild "07" – StepChild "24" – Minor Child of a Minor Child
3	Member ID	A/N	8	012-019	OGB Impact ID
4	Accum Type	A/N	4	020-023	*"DEDU" – Deductible (used for mid-year changes only)* "DRUG" – Pharmacy-life time "LIFE" – Life time(Medical)
5	Effective From Date	D	8	024-031	Prior month start (ccyymmdd)
6	Effective Thru Date	D	8	032-039	Prior month end (ccyymmdd)
7	Accum Amount	A/N	10	040-049	Accum Amount (7.2)
8	Member First Name	A/N	15	050-064	Member First Name
9	Member Last Name	A/N	20	065-084	Member Last Name
10	Member Date of Birth	N	8	085-092	Ccyymmdd
11	Member Gender Code	A/N	1	093-093	"1" – Male "2" – Female "0" – Unknown
12	Member SSN	A/N	9	094-102	Patient SSN

Pharmacy Eligibility ADDENDUM B-3					
No.	Name	Type	Length	Position	Description
	File Header				
1	Company ID	A/N	3	01-03	Value = "SLA" – Assigned by Catalystrx
2	Create Date	A/N	8	04-11	Value = "CCYYMMDD"
3	Create Time	A/N	8	12-19	Value = "HHMMSS"
4	File Type	A/N	1	20-20	Value = "M" = Member File
5	Format	A/N	3	21-23	Value = "26 " =Designates Member File format v2.6
6	Trans Type	A/N	1	24-24	Value = "R" = Refresh/Full file
7	Profile	A/N	3	25-54	Value = "CTRSTLA/*ALL/*ALL
8	Sequence Number	A/N	2	55-56	Sequence number of the file sent for that day – "01"
9	Contact E-Mail	A/N	30	57-86	Load issues contact "it-operations@ogb.state.la.us"
10	Contact Fax	A/N	10	87-96	"0000000000"
11	Filler	A/N	190	97-286	
	File Detail				
1	Carrier	A/N	9	01-09	Value = "CTRSTLA " – Assigned by CATALYSTRX
2	Account (PRODUCT)	A/N	15	10-24	Value: EPO, PPO, MCO, & EPO REGION 6
3	Group (Agency Number)	A/N	15	25-39	Example = "0701 " (Plan Member's True Agency; i.e., no R96 or R97)
4	Member ID	A/N	18	40-57	Primary's SSN + Record ID
5	Relationship Code	A/N	1	58-58	Values: Blank 0 = Not Specified 1 = Cardholder 2 = Spouse 3 = Child 4 = Other
6	Member Last Name	A/N	25	59-83	Value = Last name of dep. If no dep. last name is available, use enrollee's last name
7	Member First Name	A/N	15	84-98	
8	Member Middle Initial	A/N	1	99-99	
9	Member Sex Code	A/N	1	100-100	
10	Member Birthday	A/N	8	101-108	Format = CCYYMMDD – Must be zero-filled if blank

Pharmacy Eligibility ADDENDUM B-3					
No.	Name	Type	Length	Position	Description
11	Member Type	A/N	1	109-109	Values: Blank 1 = Dependent 2 = Disabled Dependent 3 = Spousal Equivalent 4 = Student
12	Language Code	A/N	1	110-110	Values: 1 = USA 2 = FRENCH 3 = SPANISH
13	Member SSN	A/N	9	111-119	999999999
14	Address 1	A/N	35	120-154	
15	Address 2	A/N	35	155-189	
16	City	A/N	30	190-219	
17	State	A/N	2	220-221	
18	Zip	A/N	5	222-226	Must be zero-filled if blank
19	Phone	A/N	10	227-236	Must be zero-filled if blank
20	Family Type	A/N	1	237-237	Values: Blank 1 = Family 2 = Cardholder 3 = Cardholder & Spouse 4 = Cardholder & Dependents 5 = Spouse & Dependents 6 = Dependents 7 = Spouse Only 8 = Member + 1
21	Family ID	A/N	18	238-255	Primary's SSN
22	Member Effective Date	A/N	7	256-262	Format = CYYMMDD (19??:C=0 | 20??:C=1)
23	Member Termination Date	A/N	7	263-269	Format = CYYMMDD (19??:C=0 | 20??:C=1)
24	Care Facility (Billing Rate)	A/N	6	270-275	Values: AC = Active CB = Cobra CD = Cobra Disability R1 = Retired Medicare 1 R2 = Retired Medicare 2 RN = Retired, No Medicare S1 = Surviving Dep 1 Medicare S2 = Surviving Dep 2 Medicare SA = Surviving Dep (Active) SN = Surviving Dep, No

Pharmacy Eligibility ADDENDUM B-3					
No.	Name	Type	Length	Position	Description
					Medicare
25	Care Qualifier	A/N	10	276-285	Level of Coverage Values: EC = Employee With Childre EE = Employee Only ES = Employee + Spouse FM = Family Coverage
26	Send Term Indicator	A/N	1	286-286	This indicator is for terminations sent on more than one file. On the subsequent files the value is "*"
	File Trailer				
1	Company ID	A/N	3	01-03	Value = "SLA"
2	Create Date	A/N	8	04-11	Value = "CCYYMMDD'
3	Create Time	A/N	8	12-19	Value = "HHMMSS"
4	Number Detail	A/N	9	20-28	Number of detail records
5	Filler	A/N	9	29-286	

Pharmacy Group ADDENDUM B-4					
No.	Name	Type	Length	Position	Description
	Group File Header				
1	Company ID	A/N	3	01-03	Value = "SLA" – Assigned by CATALSTRX
2	Create Date	A/N	8	04-11	Value = "CCYYMMDD"
3	Create Time	A/N	8	12-19	Value = "HHMMSS"
4	File Type	A/N	1	20-20	Value = "G" = Group File
5	Format	A/N	3	21-23	Value = "24B " = Designates Member File format 24B
6	Trans Type	A/N	1	24-24	Value = "R" = Refresh/Full file
7	Profile	A/N	30	25-54	Value = "CTRSTLA/*ALL/*ALL
8	Sequence Number	A/N	2	55-56	Sequence number of the file sent for that day – "01"
9	Contact E-Mail	A/N	30	57-86	Load issues contact "it-operations@ogb.state.la.us"
10	Contact Fax	A/N	10	87-96	"0000000000"
11	Filler	A/N	610	97-706	
	Group File Detail				
1	Carrier	A/N	9	01-09	Value = "CTRSTLA " – Assigned by

No.	Name	Type	Length	Position	Description
Pharmacy Group ADDENDUM B-4					
					CATALYSTRX
2	Account (PRODUCT)	A/N	15	10-24	Value: EPO, PPO, MCO, & EPO REGION 6
3	Group (Agency Number)	A/N	15	25-39	Example = "0701 " (Plan Member's True Agency; i.e., no R96 or R97) Reference: 3 in File Detail Of Drug Claim Daily Eligibility
4	Group Name	A/N	25	40-64	
5	Address 1	A/N	25	65-89	
6	Address 2	A/N	15	90-104	
7	City	A/N	20	105-124	
8	State	A/N	2	125-126	
9	Zip	A/N	5	127-131	
10	Zip2	A/N	4	132-135	
11	Zip3	A/N	2	136-137	
12	Country	A/N	4	138-141	Values: "USA"
13	Phone Number	A/N	10	142-151	
14	Contact	A/N	25	152-176	
15	Original From Date	A/N	7	177-183	Original From Date – FORMAT = CYYMMDD (19??: C=0 | 20??: C=1) Value = "0010101"
16	Benefit Reset Date	A/N	7	184-190	Format = CYYMMDD (19?? : C=0 | 20?? : C=1) Value = "0000000"
17	Sic Code	A/N	4	191-194	Value = "0000"
18	Language Code	A/N	1	195-195	Value = "1"
19	From Date	A/N	7	196-202	Format = CYYMMDD (19?? | C=0 | 20??| C=1) Value = "0010101"
20	Thru Date	A/N	7	203-209	Format = CYYMMDD (19?? | C=0 | 20??| C=1) If current, use "1391231" otherwise, report what on file
21	Plan	A/N	10	210-219	Values: "CSTLAEPO-R" = EPO & EPO REGION6 "CSTLAPP0-R" = PPO "CSTLAMCO-R" = MCO "CSTLAAST-R" = ASO – Houma "CSTLAASW-R" = ASO – Lafayette

Pharmacy Group ADDENDUM B-4					
No.	Name	Type	Length	Position	Description
					"CSTLAASZ-R" = ASO - Fara/Baton Rouge
22	Plan Effective Date	A/N	7	220-226	Format = CYYMMDD (19??: C=) | 20??:C=1) Value = "0910101"
23	Brand (COPAY)	A/N	5	227-231	Format = 999v99 – Value = "00000"
24	Generic (COPAY)	A/N	5	232-236	Format = 999v99 - Value = "00000"
25	Copay 3	A/N	5	237-241	Format = 999v99 – Value = "00000"
26	Copay 4	A/N	5	242-246	Format = 999v99 - Value = "00000"
27	Copay 5	A/N	5	247-251	Format = 999v99 – Value = "00000"
28	Copay 6	A/N	5	252-256	Format = 999v99 - Value = "00000"
29	Copay 7	A/N	5	257-261	Format = 999v99 – Value = "00000"
30	Copay 8	A/N	5	262-266	Format = 999v99 - Value = "00000"
31	Benefit Code	A/N	10	267-276	Value = Blanks
32	Numeric Filler	A/N	14	277-290	Value = Zero-Filled
33	Alpha/Numeric Filler	A/N	5	291-295	Value = Blanks
34	Numeric Filler	A/N	26	296-321	Value = Zero-Filled
35	Alpha/Numeric Filler	A/N	2	322-323	Value = Blanks
36	Numeric Filler	A/N	2	324-325	Value = Zero-Filled
37	Alpha/Numeric Filler	A/N	2	326-327	Value = Blanks
38	Numeric Filler	A/N	2	328-329	Value = Zero-Filled
39	Alpha/Numeric Filler	A/N	7	330-336	Value = Blanks
40	Numeric Filler	A/N	14	337-350	Value = Zero-Filled
41	Alpha/Numeric Filler	A/N	356	351-706	Value = Blanks
	Group File Trailer				
1	Company ID	A/N	3	01-03	Value = "SLA" - Assigned by CATALYSTRX
2	Create Date	A/N	8	04-11	Value = "CCYYMMDD"
3	Create Time	A/N	8	12-19	Value = "HHMMSS "
4	Number Detail	A/N	9	20-28	Number of detail records "#### "
5	Filler	A/N	678	29-706	

Pharmacy Accumulator Cross Reference ADDENDUM B-5					
No.	Name	Type	Length	Position	Description
	Member Header				
1	Create Date	A/N	8	01-08	
2	Create Time	A/N	6	09-14	
3	Filler	A/N	20	15-34	
	Member Detail				
1	From Record ID	A/N	8	01-08	
2	From Family SSN	A/N	9	09-17	
3	To Record ID	A/N	8	18-25	
4	To Family SSN	A/N	9	26-34	

EXHIBIT 9

PERTINENT STATE STATUTES

La. RS 22:1214

Methods, acts, and practices which are defined herein as unfair or deceptive

The following are declared to be unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies. Making, issuing, circulating, or causing to be made, issued, or circulated any estimate, illustration, circular or statement, sales presentation, omission, or comparison that does any of the following:

(a) Misrepresents the benefits, advantages, conditions, or terms of any policy issued or to be issued.

(b) Misrepresents the dividends or share of the surplus to be received on any policy.

(c) Makes a false or misleading statement as to the dividends or share of surplus previously paid on similar policies.

(d) Makes any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates.

(e) Misrepresents to any policyholder insured by any insurer for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance.

(f) Uses any name or title of any policy or class of policies misrepresenting the true nature thereof.

(g) Is a misrepresentation for the purpose of effecting a pledge or assignment or effecting a loan against any policy.

(h) Misrepresents any policy as being shares of stock.

(2) False information and advertising generally. Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

(3) Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(4) Boycott, coercion and intimidation. Entering into any agreement to commit or by any concerted action committing any act of boycott, coercion or intimidation resulting or tending to result in unreasonable restraint of, or a monopoly in, the business of insurance.

(5) False financial statements and false entries.

(a) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of any insurer.

(b) Knowingly making any false entry of a material fact in any book, report, or statement of any insurer or knowingly omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer, or knowingly making any false material statement to any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to which such insurer is required by law to report, or which has authority by law to examine into its condition or into any of its affairs.

(6) Stock operations and advisory board contract. Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any corporation, or securities or any special advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insure.

(7) Unfair discrimination. (a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract, provided that, in determining the class, consideration may be given to the nature of the risk, plan of insurance, the actual or expected expense of conducting the business or any other relevant factor.

(b) Making or permitting any unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, or rates charged for any policy or contract of health or accident insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever, provided that, in determining the class, consideration may be given to the nature of the risk, plan of insurance, the actual or expected expense of conducting the business or any other relevant factor.

(c) Violating the provisions of R.S. 22:652.

(d) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazard by refusing to insure, refusing to renew, cancelling, or limiting the amount of insurance coverage on a property or casualty risk solely because of the geographic location of the risk, unless such action is a result of the application of sound underwriting and actuarial principles related to actual or reasonably anticipated loss experience.

(e) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to insure, refusing to renew, cancelling, or limiting the amount of insurance coverage on the residential property risk, or the personal property contained therein, solely because of the age of the residential property.

(f) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual solely because of the sex, marital status, race, religion, or national origin of the individual. However, nothing in this Subsection shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits. Nothing in this Section shall prohibit or limit the operation of fraternal benefit societies.

(g) Terminating or modifying coverage, or refusing to issue or refusing to renew any property or casualty policy solely because the applicant or insured or employee of either is mentally or physically impaired, unless the applicant, insured, or employee is mentally and physically incapable of

operating an automobile and does not possess a valid operator's license issued by the state. However, this Subsection shall not apply to accident health insurance sold by a casualty insurer and shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract.

(h) Refusing to insure solely because another insurer has refused to write a policy, or has cancelled or has refused to renew an existing policy in which that person was the named insured. Nothing herein contained shall prevent the termination of an excess insurance policy on account of the failure of the insured to maintain any required underlying insurance.

(i) With regard to automobile liability insurance, terminating or modifying coverage, or refusing to issue or refusing to renew any policy solely because the applicant or insured filed for bankruptcy. This Subparagraph shall not apply where the refusal to continue to insure is based upon nonpayment of premium.

(j) With regard to automobile liability insurance, refusing to issue insurance coverage or increasing insurance premiums solely based upon a lapse in insurance coverage where the insured is serving in the military and has been deployed and has performed military services out of state and where the individual has previously surrendered his automobile license number plate to the office of motor vehicles in compliance with R.S. 47:505(B). This Paragraph shall apply to all existing and new insurance policies as well as renewals of existing policies.

(8) Rebates. Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of insurance including life insurance, life annuity or health and accident insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance or annuity or in connection therewith, any stock, bonds, or other securities of any insurer or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

Nothing in paragraph (7) or this paragraph (8) of this Sub-section shall be construed as including within the definition of discrimination or rebates any of the following practices:

(a) Paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interest of the insurer and its policyholders;

(b) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have paid premiums in advance or continuously for a specified period made premium payment directly to an office of the insurer in an amount which fairly represents the saving in collection expense;

(c) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first year or of any subsequent year of insurance thereunder, which may be made retroactive only for such policy year;

(d) Agents accepting on their own responsibility, notes for the first premiums.

(9) Requiring as a condition precedent to lending money upon the security of a mortgage on movable or immovable property that the borrower negotiate any policy of insurance covering such property through a particular insurance agent or agents, company or companies, type of company or

types of companies, broker or brokers. Provided, however, that this provision shall not prevent the exercise by any mortgagee of his right to approve the insurer selected by the borrower on a reasonable non-discriminatory basis related to the solvency of the company and its ability to service the policy. The mortgagee may require that the amount of insurance be at least in an amount to protect the amount of the loan on a type of policy furnishing reasonable protection to the mortgagee in a form selected by the borrower which may include additional coverages not inuring to the benefit of the mortgagee and reasonably associated or connected with the property which is the subject of the loan or mortgage. Notwithstanding the provisions of R.S. 22:1212, any lender either directly or indirectly requiring a borrower to furnish insurance upon such property shall be subject to the conditions and prohibitions of this paragraph.

(10) Tying, which shall mean the following:

(a) The requirement by a health and accident agent or group health and accident insurer, individual health and accident insurer, or health maintenance organization, as a condition to the offer or sale of a health benefit plan to a group or individual insured, that such insured purchase any other insurance policy.

(b) Tying of a purchase of a health and life insurance policy or policies to another insurance product. "Tying" is the requirement by any small employer health insurance carrier or individual health insurance carrier, as a condition to the offer or sale of a health benefit plan, health maintenance organization, or prepaid limited health care service plan to a small employer, as defined by this Code, or to an individual, that such employer or individual purchase any other insurance product.

(c) Tying does not include the joint sale of group life and group health coverages or the joint sale of group life and/or group health and any other employee benefit plan.

(11) No person, as defined in R.S. 22:5(6), shall directly or indirectly participate in any plan to offer or effect any kind or kinds of life or health insurance and annuities as an inducement to or in connection with the purchase by the public of any goods, securities, commodities, services or subscriptions to periodicals. This paragraph shall not apply to such insurance, written in connection with an indebtedness, one of the purposes of which is to pay the indebtedness in case of the death or disability of the debtor. Nor shall this paragraph apply to the sale by life insurance agents, or by life insurance companies of equity products, including equities, mutual funds, shares of investment companies, variable annuities, and including face amount certificates of regulated investment companies under offerings registered with the Federal Securities and Exchange Commission.

(12) Any violation of any prohibitory law of this state.

(13) Fraudulent insurance act. A fraudulent insurance act is one committed by a person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker, or any agent thereof, any written statement as part of, or in support of, or in opposition to an application for the issuance of, or the rating of an insurance policy for commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which he knows to contain materially false information concerning any fact material thereto; or conceal for the purpose of misleading information concerning any fact material thereto.

(14) Unfair claims settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following:

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue.

(b) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(c) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(d) Refusing to pay claims without conducting a reasonable investigation based upon all available information.

(e) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

(f) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(g) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds.

(h) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(i) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured.

(j) Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made.

(k) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(l) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(m) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(n) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(o) Failing to provide forms necessary to present claims within fifteen calendar days of a request with reasonable explanations regarding their use, if the insurer maintains the forms for that purpose.

(15)(a) The issuance, delivery, issuance for delivery, or renewal of, or execution of a contract for, a health benefits policy or plan which:

(i) Prohibits or limits a person who is an insured or other beneficiary of the policy or plan from selecting a pharmacy or pharmacist of the person's choice to be a provider under the policy or plan to furnish pharmaceutical services or pharmaceutical products offered or provided by that policy or plan or in any manner interferes with that person's selection of a pharmacy or pharmacist, provided that the chosen pharmacy or pharmacist agrees in writing to provide pharmaceutical services and pharmaceutical products that meet all the terms and requirements, including the same administrative, financial, and professional conditions and a minimum contract term of one year if requested, that apply to all other pharmacies or pharmacists who have been designated as providers under the policy or plan or as participating providers in a pharmacy network established by the policy or plan.

(ii) Denies a pharmacy or pharmacist the right to participate as a contract provider of pharmaceutical services or pharmaceutical products under the policy or plan, or under a pharmacy

network established by the policy or plan, if the pharmacy or pharmacist agrees in writing to provide pharmaceutical services and pharmaceutical products that meet all the terms and requirements, including the same administrative, financial, and professional conditions and a minimum contract term of one year, if requested, which apply to pharmacies and pharmacists which have been designated as providers under the policy or plan or as participating providers in a pharmacy network established by the policy or plan.

(b) This Paragraph shall not, however, require a health benefits policy or plan to provide pharmaceutical services or pharmaceutical products.

(c) As used in this Paragraph, the following terms shall be given these meanings:

(i) "Drug" and "prescription" have the meanings assigned by R.S. 37:1171 and regulations of the Louisiana Board of Pharmacy.

(ii) "Health benefits policy or plan" means any and all health and accident insurance policies or contracts, including but not limited to individual, group, family, family group, blanket, and association health and accident insurance policies, as well as health maintenance organizations and preferred provider organizations, and any and all other third-party payment plans or contracts, and any and all other health care or health benefits plans, policies, contracts, or funds that either in whole or in part provide benefits for pharmaceutical services and pharmaceutical products that are necessary as a result of or to prevent an accident or sickness.

(iii) "Interferes" or "interferes with" means and includes but is not limited to the charging to or imposing on an insured or other beneficiary who does not utilize a specified or designated pharmacy or pharmacist, a copayment fee or other condition not equally charged to or imposed on all insureds or other beneficiaries in or under the same program or policy or plan. However, "interferes" or "interferes with" does not mean or include the advertisement, or periodic dissemination, to all insureds or other beneficiaries of current lists of all pharmacies or pharmacists who have agreed to participate as a contract provider pursuant to the requirements of R.S. 22:1214(15)(a)(ii).

(iv) "Pharmaceutical product" means a "drug" and "prescription", as defined in this Paragraph, and home intravenous therapies.

(v) "Pharmaceutical services" means services that are ordinarily and customarily rendered by a pharmacy or pharmacist, including the preparation and dispensing of pharmaceutical products.

(vi) "Pharmacist" means a person licensed to practice pharmacy under the Pharmacy Law and Board of Pharmacy regulations of the state of Louisiana.

(vii) "Pharmacy" has the meaning assigned by R.S. 37:1171 and regulations of the Louisiana Board of Pharmacy.

(d) This Paragraph shall be cited as the "Patient Pharmacy Preference Act".

(16) Failure to maintain marketing and performance records. Failure of an insurer to maintain its books, records, documents, and other business records in such an order that data regarding complaints, claims, rating, underwriting, and marketing are accessible and retrievable for examination by the insurance commissioner. Data for at least the current calendar year and the two preceding years shall be maintained.

(17) Failure to maintain adequate complaint handling procedures. Failure of any insurer to maintain a complete record of all the complaints that it received since the date of its last examination. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this Paragraph, "complaint" shall mean any written communication primarily expressing a grievance received by the insurer from the Department of Insurance.

(18) Misrepresentation in insurance application. Making false or fraudulent statements or representations on or relative to an application for a policy, for the purpose of obtaining a fee, commission, money, or other benefit from any provider or individual person.

(19) Unfair financial planning practices. An insurance producer:

(a) Holding himself out, directly or indirectly, to the public as a "financial planner", "investment adviser", "consultant", "financial counselor", or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters, or trust and estate matters when such person is in fact engaged only in the sale of policies.

(b)(i) Engaging in the business of financial planning without disclosing to the client prior to the execution of the agreement provided for in Subparagraph (c) or solicitation of the sale of a product or service that:

(aa) He is also an insurance salesperson.

(bb) That a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case.

(ii) The disclosure requirement under this Paragraph may be met by including it in any disclosure required by federal or state securities law.

(c)(i) Charging fees other than commissions for financial planning by insurance producer, unless such fees are based upon a written agreement, signed by the party to be charged in advance of the performance of the services under the agreement. A copy of the agreement shall be provided to the party to be charged at the time the agreement is signed by the party.

(aa) The services for which the fee is to be charged shall be specifically stated in the agreement.

(bb) The amount of the fee to be charged or how it will be determined or calculated shall be specifically stated in the agreement.

(cc) The agreement shall state that the client is under no obligation to purchase any insurance product through the insurance agent, broker, or consultant.

(ii) The insurance producer shall retain a copy of the agreement for not less than three years after completion of services, and a copy shall be available to the commissioner upon request.

(20) Failure to provide claims history.

(a) Loss information - property and casualty. Failure of a company issuing property and casualty insurance to provide the following loss information for the three previous policy years to the first named insured within thirty days of receipt of the first named insured's written request:

(i) On all claims, date, and description of occurrence, and total amount of payments.

(ii) For any occurrence not included in Item (i) of this Paragraph, the date and description of occurrence.

(b) Should the first named insured be requested by a prospective insurer to provide detailed loss information in addition to that required under Subparagraph (a), the first named insured may mail or deliver a written request to the insurer for the additional information. No prospective insurer shall request more detailed loss information than reasonably required to underwrite the same line or class of insurance. The insurer shall provide information under this Subparagraph to the first named insured as soon as possible, but in no event later than twenty days of receipt of the written request.

Notwithstanding any other provision of this Section, no insurer shall be required to provide loss reserve information, and no prospective insurer may refuse to insure an applicant solely because the prospective insurer is unable to obtain loss reserve information.

(c) The commissioner may promulgate regulations to exclude the providing of the loss information as outlined in Subparagraph (a) for any line or class of insurance where it can be shown that the information is not needed for that line or class of insurance or where the provision of loss information otherwise is required by law.

(d) Information provided under Subparagraph (b) shall not be subject to discovery by any party other than the insured, the insurer, and the prospective insurer.

(21) The issuance of any line of health insurance in the state by an insurer, self-insurer, or other entity that provides health and accident insurance policies or plans within five years after the entity has ceased writing insurance or issuing plans in the state.

(22) The discrimination against an insured, enrollee, or beneficiary in the issuance, payment of benefits, withholding of coverage, cancellation, or nonrenewal of a policy, contract, plan, or program based upon the results of a prenatal test.

(23) The discrimination against an insured, enrollee, or beneficiary in the issuance, payment of benefits, withholding of coverage, cancellation or nonrenewal of a policy, contract, plan, or program based upon the results of a genetic test or receipt of genetic information. Actions of an insurer or third parties dealing with an insurer taken in the ordinary course of business in connection with the sale, issuance or administration of a life, disability income, or long-term care insurance policy are exempt from the provisions of this Paragraph.

(24) Requiring an agent or broker or offering any incentive for agents or brokers who represent more than one company to limit information provided to consumers on limited benefit plans. Failure to comply with the provisions of this Paragraph shall subject the insurer to a penalty, of not less than two thousand five hundred dollars nor more than five thousand dollars, payable to the agent or broker and shall not be subject to the penalties provided for in R.S. 22:1217.

(25) Requiring an agent or broker or offering any incentive for agents or brokers, who represent more than one insurance company, to limit the number of other insurance companies they may represent. This prohibition shall not apply to captive insurance agents or brokers. Failure to comply with the provisions of this Paragraph shall subject the insurer to a penalty up to ten thousand dollars and shall not be subject to the penalties provided for in R.S. 22:1217.

Acts 1958, No. 125. Amended by Acts 1960, No. 402, §1; Acts 1964, No. 371, §1; Acts 1968, No. 351, §1; Acts 1986, No. 744, §1; Acts 1989, No. 638, §1; Acts 1992, No. 22, §1, eff. May 18, 1992; Acts 1993, No. 139, §1; Acts 1993, No. 663, §2, eff. June 16, 1993; Acts 1993, No. 953, §1; Acts 1995, No. 966, §1; Acts 1997, No. 1418, §1; Acts 1999, No. 748, §1, eff. July 2, 1999; Acts 2003, No. 129, §1, eff. May 28, 2003; Acts 2004, No. 770, §1.
{{NOTE: SEE ACTS 1989, NO. 638, §2.}}

La. RS 22:226

Employer-provided health plan; limitation to specific pharmacies prohibited; penalty

A. No employer who provides pharmacy services including prescription drugs to any employee or retiree of such employer, as part of any health insurance or health maintenance program, shall knowingly:

(1) Require the employee or retiree to obtain prescription drugs from a mail order pharmacy as a condition of obtaining payment for such drugs; or

(2) Impose upon an employee or retiree who does not utilize a designated mail order pharmacy a copayment fee or other condition not imposed upon employees or retirees who utilize the designated mail order pharmacy.

B. The provisions of this Section shall not apply to any policies, contracts, programs, or plans which are provided by an employer to its employees pursuant to any agreement, whether or not in the form of a binding collective bargaining agreement.

C. Any person violating the provisions of this Section, upon conviction shall be fined not more than five hundred dollars.

Acts 1988, No. 481, §1.

LaR.S. 39:1524 and 1525

SUBPART B. SETTLEMENT OF CONTROVERSIES

§1524. Authority of the commissioner of administration

Prior to the institution of any action in a court concerning any contract, claim or controversy, the commissioner of administration with the concurrence of the attorney general is authorized to compromise, pay, or otherwise adjust the claim by or against or a controversy with a contractor relating to a professional, personal, consulting, or social service contract entered into with the state under their respective authority, including a claim or controversy based on breach of contract, mistake, misrepresentation, or other cause for contract modification or rescission. Nothing herein shall limit the authority of the commissioner of administration, pursuant to rules and regulations to issue, negotiate, or accept changes in the terms and conditions of a contract. When authorized, such compromise, payments, or adjustments shall be promptly paid; however, subject to any limitations or conditions imposed by rule or regulation, the commissioner of administration shall charge back all or any portion of such payments to the department or departments for whose benefit the contract was let.
Added by Acts 1978, No. 772, §1; Acts 1985, No. 673, §1.

RS 39: 1525

§1525. Action on contract claims

This Section applies to a claim by or controversy between the state and a contractor arising out of a contract for professional, personal, consulting, or social services. If such a claim or controversy is not resolved by mutual agreement, the commissioner of administration, or his designee, shall promptly issue a decision in writing. A copy of that decision shall be mailed or otherwise furnished to the contractor, shall state the reasons for the action taken, and shall inform the contractor of his right to judicial relief as provided in this Part. The decision shall be final and conclusive unless fraudulent, or unless the contractor institutes suit pursuant to R.S. 39:1526. If the commissioner of administration, or his designee, does not issue a written decision within one hundred twenty days after written request for a final decision, or within such longer period as may be established in writing by the parties to the contract, then the contractor may proceed as if an adverse decision had been received.
Added by Acts 1978, No. 772, §1; Acts 1985, No. 673, §1.