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

NOTICE OF INTENT TO CONTRACT (NIC)

FOR

PHARMACY BENEFITS MANAGEMENT (PBM) SERVICES FOR GROUP HEALTH PLAN

AND

MEDICARE (PART D) EMPLOYER GROUP WAIVER PLAN (EGWP) PDP

ISSUED

May 29, 2013

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SECTION I

GENERAL INFORMATION AND INSTRUCTIONS OF PROPOSAL FORMAT

A. Background

The State of Louisiana through OGB is authorized 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 systems that elect to participate and certain political subdivisions. Eligibility does not include local government entities, parishes, or municipalities.

Approximately eighty-five percent (85%) of OGB plan participants are enrolled in one of two self-insured plans:

- The PPO plan, which retains deductible and co-insurance features of a traditional indemnity plan; or
- The HMO plan, which include co-payments as opposed to deductibles in most instances.

Enrollment as of May 12, 2013 is as follows:

OGB Plan of Benefits	Employees/Retirees	Covered Lives
PPO	36,204	52,923
HMO	89,470	169,736
TOTALS	**125,674**	**222,659**

The self-insured PPO and HMO plans are administered by Blue Cross and Blue Shield of Louisiana (BCBSLA), including provider network and services, behavioral health services claims administration, customer services, medical management (medical necessity and utilization review, case management), and disease management.

Medicare eligible retirees may enroll in the PPO or HMO plan as a Medicare supplement, with prescription drug coverage through the EGWP.

In addition to the PPO and HMO plans, OGB also offers a self-insured consumer driven health plan (CDHP) with a health savings account (HSA), administered by BCBSLA, which also provides the pharmacy benefits for that plan. This NIC does not include PBM services for the CDHP plan.

For Medicare eligible retirees, OGB offers three employer-sponsored Medicare Advantage HMO plans provided by Louisiana HMOs. Medicare eligible retirees also have the option to select an individual market Medicare plan through an exchange, together with a Health Reimbursement Arrangement (HRA). The individual market Medicare exchange and HRA

are administered by Extend Health.

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.

B. Purpose and OGB Expectations

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

- Pharmacy Benefits Management (PBM) services for its self-insured group health plans, including retail network management and auditing, account management, billing management, rebate management and client reporting; and

- For OGB's eligible retirees, a Centers for Medicare and Medicaid Services (CMS) approved prescription drug plan (PDP) in accordance with CMS regulations implementing the Medicare Prescription Drug Benefit ("Part D") established by Section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which regulations allow for a CMS-approved Employer Group Waiver Plan (EGWP) PDP, to be administered consistent with applicable requirements. In addition, OGB will provide EGWP PDP participants with self-insured non-part D wrap-around coverage that supplements the EGWP PDP benefit to make it substantially the same as the pharmacy benefits provided to all other PPO and HMO plan participants. This NIC includes all PBM services related to the EGWP PDP and wrap-around coverage.

OGB seeks a contractual relationship with a PBM that agrees to act as a <u>fiduciary</u> 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 payable to OGB. The term "rebates" as used herein includes all utilization based incentives.

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 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.

C. GB Information Technology Architecture

Desktop: Dell 200 Workstations running Windows XP
LAN: 10/100/1000 Ethernet using Cisco switches
Servers: Windows servers, AIX UNIX servers, and LINUX servers
WAN: Frame Relay using Cisco routers, switches, and firewalls. In addition, Fujitsu scanners, and various laser printers are used

OGB computer applications include: Impact (customer services and eligibility processes), Discoverer (Oracle report writer), MS Office, FileNet (Oracle based imaging and document management system). OGB uses Oracle databases as its standard.

OGB uses Imprivata OneSign – a centralized security appliance which provides services for bio-login and single-sign-on.

D. Term of Contract

The effective date of the contract will be January 1, 2014, for a term of three years, ending December 31, 2016. 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. Market Check Provision

OGB reserves right to exercise a market check anytime during the first and second contract year to assess and verify the competitiveness of the pricing term set forth in the agreement in comparison to that available in the marketplace at that time. OGB will designate a third party independent consultant of its choosing that will compare the aggregate value of the upcoming contract year pricing terms to what they may receive under a competitive procurement. Should the comparison find current market conditions would yield greater than 1.0% savings (i.e. including the impact of administrative fees and rebate guarantees), then the parties will discuss in good faith a revision to the current pricing terms that will at least match the best offer in the marketplace and will go into effect the first day of the upcoming contract year. If parties are unable to reach agreement on revised pricing terms or other applicable provisions within 60 days from the market check report, then OGB may terminate the agreement without penalty (e.g., no loss of rebates earned but not yet paid) upon 90 days prior written notice prior to the second and third contract year, respectively. Benchmarks chosen in the analysis shall be groups with similar plan design, membership and utilization

patterns as OGB, to the extent possible.

F. Standard Contract Provisions

See Exhibit 5 for the standard contract provisions, business associate addendum and reporting requirements. 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.

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

G. 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 ten (10) 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

   Section VI
   Tab 2 - Mandatory Signature Page

   Section VIII
   (See Exhibit 6, Excel Workbook to be provided.

(A) Rx Pricing Pass-Thru
(B) Administrative Fees
(C) EGWP and Wrap Pricing
(D) EGWP Administrative Fees
(E) Retail Network Disruption
(F) Formulary Description
(G) Specialty Drug Pricing
(H) Generic Drugs

Section VII - Cost Quotation Proposal Form
Option 1
Option 2

4. Answer questions directly. Where you cannot 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.**

H. 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

NIC Issued - Public Notice by Advertising in the Official Journal of the State/Posted OGB Website/Posted to LAPAC……..	Wednesday, May 29, 2013
NIC Mailed or Available to Prospective Proposers Posted to OGB Website; Posted to LAPAC…….	Wednesday, May 29, 2013
Deadline to Notify OGB of Interest to Submit a Proposal (MANDATORY) …….	Wednesday, June 5, 2013
Electronic Data Sent to Interested Proposers……..	Thursday, June 6, 2013
Deadline to Receive Written Questions……..	Tuesday, June 11, 2013
Response to Written Questions……..	Friday, June 14, 2013
Proposer Conference- Attendance in Person (MANDATORY) …….	Tuesday, June 18, 2013
Deadline to Receive Additional Written Questions……..	Thursday, June 20, 2013
Response to Additional Written Questions……..	Friday, June 21, 2013
Proposals Due to OGB……..	Wednesday, July 3, 2013
Finalist's Interviews/Site Visits……..	TBD
Probable Selection and Notification of Award……..	TBD
Contract Effective Date……..	January 1, 2014

NOTE: 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 the date listed in the Schedule of Events. Notification should be sent to:

Patty Rahl
Contract Reviewer 3
Office of Group Benefits
Post Office Box 44036
Baton Rouge, LA 70804

7389 Florida Blvd., Suite 400
Baton Rouge, LA. 70806

Fax: (225) 925-4207
E-Mail: patty.rahl@la.gov

C. Written Questions

Written questions regarding the NIC are to be submitted to and received on or before 4:00 p.m., Central Time (CT) 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 10: 00 AM at the following location:

Office of Group Benefits
7389 Florida Blvd., Suite 400
Baton Rouge, LA. 70806

A representative of your organization must participate in person at the Mandatory Proposers Conference scheduled for approximately 10:00 AM., 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.

E. Proposal Due Date

The original proposal must be signed by an authorized representative of your firm/organization and delivered, together with ten (10) numbered copies and two (2) CDs, between the hours of 8:00 a.m. and 4:00 p.m. Central Time (CT) 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 following formula:

$$\frac{X}{N} \quad x \quad 500 \quad = \quad Z$$

Where: X = Lowest computed cost among all proposals
N = Actual computed cost of the proposal
Z = Points Awarded

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.

OGB, in its sole discretion, after evaluation of proposals, will determine whether to proceed with Option 1 or Option 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 response 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 primary proposer is an approved CMS-contracted prescription drug plan ("PDP") sponsor for an Employer Group Waiver Plan PDP in accordance with CMS regulations. The EGWP PDP may not be provided by or through a subcontractor.

7. You will pay guaranteed rebates to OGB not later than 30 days following the end of each quarter.

8. The PBM and/or Company (Vendor) shall cooperate with the administrative services provider for OGB's PPO and HMO plans (currently Blue Cross and Blue Shield of Louisiana) and share costs, as necessary, to produce and distribute durable member I.D. cards that include applicable information relative to the prescription drug plan. A copy of OGB current member identification card, which identifies the required data elements, is included in Exhibit 4 of this NIC. Any costs associated with 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 Vendor'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.

9. OGB requires direct on-line access to the Vendor'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 Vendor at OGB's office. All associated costs for the CRT interface are to be included in the PBM or Company's quoted fees.

10. The proposing Vendor 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 Vendor 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.

11. 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 Vendor 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.

12. The executive account manager for the Vendor 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 Vendor 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 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.

13. 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 of the proposal for the purpose of evaluation.

14. 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.

15. 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.

16. 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.

17. 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.

18. 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.

19. 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.

20. 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.

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

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 the three (3) most recent references that left your organization. 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 2012 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				
EGWP				

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	
EGWP administration	Yes or No	

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.

	Retail
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.			
	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 final six months of 2012 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 (2012)	
Desktop (2012)	

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

Mail Service

using a credit card.

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 Sandy or other regional or local disasters.

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 2012

	Single Source Brands		Multi-Source Brands		Generic		Specialty	
Retail 2012	#	%	#	#	%	%	#	%
Mail Service 2012	#	%	#	#	%	%	#	%

11. What was your book-of-business generic substitution rate (GSR) at mail service during the final six months of 2012?

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	2012	YTD 2013
Total number of prescriptions dispensed		
Utilization as a percent (%) of capacity		
Average turn-around time (no intervention required)		

Mail Order Facility Statistics	2012	YTD 2013
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	2012	YTD 2013
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 not 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. Please describe any specialized programs you offer to improve quality of care and/or control costs of care. Your response should include:

(a) A description of the program;
(b) Deliverables;
(c) Actual results from experience;
(d) Additional cost should OGB opt to include the Program.

Note: OGB retains full discretion regarding implementation of any such program(s), including whether such program(s) would be implemented as part of the pharmacy benefits or the existing disease management program.

5. 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 January 1, 2014.

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

15. **Option 2 Only:** 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. **Option 2 Only:** Complete the "Formulary Disruption" worksheet (Exhibit 6) with the formulary status of OGB's top 200 brand name drugs using your proposed formulary as of April 1, 2013.

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. **Option 2 Only:** Complete the following table based on your proposed formulary for OGB as of April 1, 2013:

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 2012.

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		
	Yes	No	NA
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	Yes	No	NA

your book of business and/or similar industry clients.

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		
FTP File Transfer	Yes	No	NA
Paper	Yes	No	NA
Floppy disk/CDROM	Yes	No	NA
Internet	Yes	No	NA
Other	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.

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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	**2012**	**YTD 2013**
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 final six months of 2012 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 final six			

months of 2012.			
19. What percent of calls received a busy signal during the final six months of 2012.			
20. You maintain a dedicated individual or staff responsible for resolving escalated member issues.	Yes	No	NA
21. During the final six months of 2012, 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
FTP File Transfer	Yes	No	NA
Electronic feed via a modem	Yes	No	NA
Paper	Yes	No	NA
Other (Explain)	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		
1. Identification cards, EOBs, and enrollment forms can be customized at no charge.	Yes	No	NA
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 30 days of the effective date of member's coverage	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 2012 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 <u>the pharmacy network you are proposing</u> for OGB.

<u>Table 1 – YOUR PROPOSED PHARMACY NETWORK</u>

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 electronically per the Schedule of Events) 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 <u>not</u> included in geo-access analysis				
D. Percent of participants with network access within standards				
E. Percent of participants <u>without</u> 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, complete the retail network disruption worksheet (Exhibit 6).

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. Employer Group Waiver Plan Administration

1. For any Medicare Part D services that your organization currently subcontracts, or intends to subcontract for future business delivery, please provide an attachment outlining, at a minimum, all the information requested below, including any services that are subcontracted to domestic or offshore companies:
   a. Name of Subcontractor
   b. Location(s)
   c. Contract Period
   d. Description of Services Provided
   e. Certification/Compliance required for services provided (if applicable)

2. Is your Medicare PDP product wholly owned?
   a. If your Medicare PDP product is not wholly owned, please provide 1) Legal definition of relationship, 2) the company's name, 3) the headquartered city and state of the company, 4) tenure of current relationship, and 5) Contractual term period of relationship.

3. Please confirm you agree OGB will review and may make edits to all communications to retirees prior to release?

4. Describe how you honor repayment demands or requests for reimbursement that are made within the time period mandated by Medicare for recovery of improper payments.

5. Describe the training you provide to client's staff and other health vendors who could take calls from Medicare retired members.

6. Describe any clinical programs over and above the minimum CMS requirements. Please provide as attachment with detailed information on each one, including cost, if any.

7. Please confirm you will allow OGB to remove prior authorizations, quantity limits or step therapies on an individual drug level?

8. Please populate for the self funded with regard to your EGWP offering for the provisions in the table below:

Question	**Vendor Response**
Does year end reconciliation on claim experience occur?: Self Funded	
Who is responsible for distributing required communication per CMS rules including but not limited to Welcome Kit, Annual Notice of Change, and Evidence of Coverage?: Self Funded	
Who pays for co-branding and customization costs for communications materials?: Self Funded	
Who performs LIS premium subsidy administration?: Self Funded	

Who takes the claim risk (distinguish between standard plan benefit and enhanced plan benefit)?: Self Funded	
Who receives / retains rebates?: Self Funded	
Who receives / retains subsidies from CMS?: Self Funded	
Who is responsible for the eligibility process and dealing with CMS?: Self Funded	
How is nonpayment of retiree premium handled and who takes the risk of claims incurred during period of non-payment if payment is never captured?: Self Funded	
Who is responsible for reporting that may be requested by CMS?: Self Funded	
Who is responsible for audits that may be requested by CMS?: Self Funded	
Who is responsible for PDE reporting required by CMS?: Self Funded	

9. Do you allow clients to elect to cover non-formulary drugs via a prior authorization exceptions process?

10. Do you allow clients to offer a customized specialty program for its EGWP?

11. Please confirm you will administer a supplemental wrap plan using a single transaction coordination of benefits through one identification card?

12. Describe the assistance you provide in acquiring Health Insurance Claim Numbers (HICNs for Medicare retired members) and associated costs (if applicable).

13. Describe how your organization helps self-insured EGWP Plus Wrap plans achieve the lowest cost alternative in their program.

14. Please complete the retail network disruption analysis for your Medicare business versus the participating pharmacy composition you propose for the Commercial business, and please confirm you will customize the network, if requested by OGB, to ensure uniformity throughout both networks?

15. If the retail network you propose for the EGWP Plus Wrap Plan is different in participating pharmacy composition than what you propose for the Commercial Plan, please propose a plan to get Commercial network pharmacies in the Part D network prior to 1/1/2014.

16. How many CMS-compliant retail pharmacy networks do you offer?

17. Describe your process for handling eligibility feeds.

18. What is your resolution process for handling eligibility outliers?

19. What are your reporting capabilities with respect to utilization metrics? Please include your process for reporting of Part B drugs. Please provide example of full reporting package.

20. Please describe the elements of flexibility your Medicare Part D support brings to employer-sponsored groups?

21. Are you willing to agree to a 3-year commitment for Medicare Part D support?

22. Please indicate how your capabilities to match your standard employer-sponsored PDP plan design and utilization management options to OGB's current EGWP Plus Wrap current plan design and utilization management programs.

23. Are you able to manage and adhere to all mandated CMS policies and procedures regarding compliance, formulary submission, fraud, waste and abuse, and transition fills?

24. Are you capable of managing the coverage determinations, re-determinations, appeals and grievance procedures and processes and be compliant with CMS?

25. Please provide a flow chart of your ERISA compliant prior authorization/appeals process.

26. Please provide an attachment outlining information on your MTM program, not limited to how retirees are identified and the specific program communication and timeline you adhere to.

27. Describe how Direct Member Reimbursement is handled.

28. How are LIS members reported to the employer plan sponsor?

29. Is your company willing to passback Low Income Subsidy on behalf of the employer?

    a. If your company is willing to passback Low Income Subsidy on behalf of the employer, please confirm there is no fee for this service. If there a fee associated with this service, please state below.

30. Describe how Direct Member Reimbursement is handled

31. Does your organization offer Medicare B billing solution through the retail network?

32. Please confirm there are no additional charges for the Medicare B Billing solution. If there is a charge, please provide.

33. If a client wishes to coordinate benefits with Medicare B in the retail network, please confirm there is not a fee for this service. If there is a fee, please provide below.

34. What is your STAR rating?

35. What is the minimum number of lives for a self-insured plan without wrap?

36. What customization is available for your B vs D determination process?

37. Describe your process to make sure that PDE's are handled in a manner that would ensure that the maximum number of PDE's are approved.

38. Vendor must provide an administrative fee rebate guarantee PMPM following annual reconciliation if the Prescription Drug Event (PDE) error/reject rate exceeds 1%. Please provide in your response what your proposed PMPM administrative fee rebate guarantee will be.

39. How many CMS-compliant Part-D formularies do you offer?

40. Describe the differences between the CMS-compliant Part-D formularies you offer.

41. Does your organization contract with any other organization for formulary development and/or administration?

    a. If your organization contracts with any other organization for formulary development and/or administration, please list 1) the organization and describe its role, 2) Fees that your organization pays for formulary development/administration, including formulary administration fees, and 3) The percent of rebates that are retained by the contracting organization.

42. How often are your CMS compliant Part D formularies reviewed?

43. Describe the committee(s)/team(s) involved in developing and managing your formularies?

44. Do you have a separate P&T Committee (from your commercial committee) that makes decisions or recommendations for the Part D formularies and coverage rules you offer?

45. What is the composition of your P&T Committee, and their credentials?

46. Describe the P & T Committee's formulary drug review and decision-making process.

47. What are the criteria for evaluating an existing drug's formulary status?

48. What are the criteria for adding a drug to your formulary?

49. What are the criteria for deleting single-source brand drugs from your Part-D formulary?

50. Do you allow clients the option to delay single-source brand deletions from the Part-D

formulary until the next plan year?

51. How do you communicate formulary changes to your clients and their members?

52. Describe the transition supply process you will utilize for members who are currently using nonformulary prescription drugs, drugs requiring prior authorization, step therapy, and quantity level limits.

53. Describe your process for keeping abreast of current CMS rules and criteria for PDP formularies.

54. What percentage of your formulary consists of multi-source brand drugs?

55. What percentage of your formulary are extended release versions of medications?

56. "Medicare Part D Formulary Analysis" - Please provide a copy of your Medicare Part D formulary. Using the current formulary provided (Exhibit 3), complete the formulary disruption worksheet (Exhibit 6).

57. "Medicare Part D Specialty Drug Formularies" - If you have developed formularies for Specialty Drugs, attach the formulary with your response.

58. Will you allow the employer to perpetually grandfather retirees for tier changes and utilization management programs? (other than B vs D)

59. Complete the EGWP Administrative Fees worksheet (Exhibit 6)

60. 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.

61. Please confirm your company does not have any administrative, regulatory, judicial actions, or investigations regarding past or current activities? If you answer “No” please describe the administrative, regulatory, judicial actions, or investigations regarding past or current actions.

62. Have there been any governmental investigations of your organization due to Medicare fraud? If so please describ

K. Implementation

1. Provide an implementation work plan to outline all key steps for plan implementation. 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, 2013 and the size of each account. How many implementations is this person anticipated to manage for January 1, 2014?

L. Account Management

1. Provide an organizational chart for the account management team proposed for all services (PBM and EGWP) 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 cannot 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.

a. Penalties associated with Performance Guarantees must be settled annually within 90 calendar days from the end of the contract year, depending on the guarantee.

b. OGB is allowed to allocate amounts at risk for both Implementation and Annual Performance Guarantees, provided no more than 25% of total amount at risk shall be allocated to one performance guarantee. Annual performance guarantees may be

reallocated annually.

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

Total Aggregate Amount at Risk for Ongoing Performance Standards:

A. For the EGWP is $_____
B. For all other services is $_____

Ongoing Performance Standards

Performance Category	Performance Guarantee	Agree (Y/N)
a. Identification cards	**99% of identification cards will be produced and mailed within 5 business days of receipt of complete and accurate eligibility information.** **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.**	

Performance Category	Performance Guarantee	Agree (Y/N)
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 97% of all member inquiries will be responded to within 5 business days, and 100% will be responded to within 10 business days.**	
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 93% 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 30 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.**	

Performance Category	Performance Guarantee	Agree (Y/N)
Penalty and Method of Measurement	**Percent of usable, error-free program eligibility transactions received and loaded by the PBM or Company within 24 hours 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.**	
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.**	

Performance Category	Performance Guarantee	Agree (Y/N)
m. Administration of Non-Network Claims	**PBM and/or Company must agree that at least 96% 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 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 Dispensing Accuracy	**Mail order dispensing accuracy will be equal to or greater than 99.995%.**	
Penalty and Method of Measurement	**Percent of all mail order pharmacy claims dispensed accurately with no errors according to the prescription written and the OGB plan design. Calculated as the total number of conformance**	

Performance Category	Performance Guarantee	Agree (Y/N)
	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 4business 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 four (4) 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.	
Penalty and Method of Measurement		
u. Account Management Satisfaction	Based on survey results, an overall satisfaction rate of 4 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 4 on a 5-point scale (5 is the best rating). Designated members of OGB benefits staff will complete the report card to	

Performance Category	Performance Guarantee	Agree (Y/N)
	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 **Penalty and Method of Measurement**	**All member communication material must be accurate and pre-approved by OGB in writing.**	
w. Specialty Dispensing Accuracy **Penalty and Method of Measurement**	Specialty pharmacy dispensing accuracy will be equal to or greater than 99.95%. Percent of all 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.	
x. Specialty Adherence **Penalty and Method of Measurement**	The adherence rate for patients using specialty pharmacy will be 90 or higher. Adherent will be defined as having a MPR of 90% or higher. The conditions to be measured will include the following: Rheumatoid Arthritis, Multiple Sclerosis, and Hepatitis C and will be measured for each individual condition separately.	
y. Specialty Medication Approvals	Information, including pricing and coverage recommendations, on new specialty drugs being evaluated will be provided to OGB 90 days, when possible, before the new drug enters	

Performance Category	Performance Guarantee	Agree (Y/N)
	the market.	
Penalty and Method of Measurement	Based on the information provided and the timeframe provided relative to when the new specialty drug enters the market.	

Total Aggregate Amount at Risk for Implementation Performance Standards is $_____.

Implementation Performance Standards

Performance Category	Performance Guarantee	Agree (Y/N)
a. Plan Design Coding	**OGB standard plan designs will be implemented within 7 days of receiving sign-off on the plan documents**	
Penalty and Method of Measurement		
b. Plan Design Accuracy	**Plan Design will be completed with 100% accuracy by the effective date based on OGB signed documents, including changes identified during a pre-implementation audit.**	
Penalty and Method of Measurement	**For errors not corrected on or before the effective date vendor will credit Client the amount at risk allocated for this guarantee.**	
c. Eligibility Load	**Participant eligibility will be loaded by the mutually agreed upon date but no later than 30 days prior to the start date.**	
Penalty and Method of Measurement	**Performance Standard dependent upon receiving a test file 45 days prior to the start date with all corrections, if necessary, completed and re-tested by 40 days prior to the start date with the final eligibility file to be received from OGB 35 days prior to the start date.**	
d. ID Cards	**100% of members will be mailed accurate ID cards and/or Welcome Booklets by the mutually agreed upon date but no later than ten (10) days prior to the effective date.**	

Performance Category	Performance Guarantee	Agree (Y/N)
Penalty and Method of Measurement	**To be measured based on the mailing date to OGB participants and accuracy of member and plan information (e.g. member identification number, plan number, etc).**	
e. Customer Service Number	**A dedicated toll-free telephone number for member assistance will be established and fully functioning by the date established in the implementation timeline (before open enrollment begins) and maintained in operation during the first part of the plan year.**	
Penalty and Method of Measurement		
f. Implementation Manager Updates	**The Implementation Project Manager will provide regular weekly updates to OGB, tracking the status of the implementation, including one face-to-face kickoff meeting as well as additional face-to-face meetings, as needed throughout implementation**	
Penalty and Method of Measurement		
g. Claim Stat Reporting	**Claim stat (e.g. paid vs rejected) reports will be provided to OGB every day for the first month of implementation for purposes of identifying trends and errors.**	
Penalty and Method of Measurement		
h. Implementation Satisfaction Survey	**An implementation performance survey will be provided to the OGB, no later than forty-five (45) days after the program effective date.**	

Performance Category	Performance Guarantee	Agree (Y/N)
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 4 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 performance on implementation. Guarantee will be measured using a mutually agreed upon survey tool.**	
i. Client Agreement	**Draft agreement will be provided to OGB at least 60 Days prior to the effective date.**	
Penalty and Method of Measurement		
j. Post-Implementation Review Meeting	**Implementation Project Manager will conduct a post-implementation review meeting with OGB within (30) days after the effective date**	
Penalty and Method of Measurement		
k. Resolution of Implementation Issues	**Implementation issues will be resolved within five (5) business days from identification**	
Penalty and Method of Measurement	**To be measured and based on a mutually developed Implementation Plan**	

N. Vendor Innovation – Lowest Cost

In conjunction with providing a response to the questions below, please provide your companies capabilities around innovative solutions that you can offer OGB to drive cost savings in addition to the standard pricing and programs shared as part of this RFP.

1. With the market becoming primarily Generics and Specialty medications, risk-sharing between drug companies and PBMs is becoming a more expected methodology for product/service pricing. What ways is your organization working to grow this kind of model focused on ensuring clinical outcomes for a negotiated or contracted price?
   a. Are you currently piloting any programs to address this?
   b. Would you be willing to work with OGB to establish and promote such a program with

its participants?

2. What clinical programs focused on outcomes and cost reduction are you willing and able to provide to OGB?
   a. Are you willing to provide a Return on Investment (ROI) for these programs?
   b. If yes, please provide the methodology for measuring such guarantee.

3. How does Risk Evaluations and Mitigation Strategy (REMS) results factor into the drugs purchased and sold through your pharmacies?

4. Are you willing to provide an average cost per script guarantee for retail, mail, and specialty claims, separately, using the following formulas:
   a. (Ingredient Cost plus Dispensing Fees minus rebates for all retail scripts) / Total Retail Scripts
   b. (Ingredient Cost plus Dispensing Fees minus rebates for all mail scripts) / Total Mail Scripts
   c. (Ingredient Cost plus Dispensing Fees minus rebates for all specialty scripts) / Total Specialty Scripts

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. Ten (10) 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 - Retail	Vendor must adjudicate all retail 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) or on a minimum copayment amount and retail pharmacies will not be allowed to collect a minimum copayment.	
Lowest Cost/Zero Balance Claims - Mail	All mail order claims will be adjudicated according to the "lowest of" logic such that members always pay the lowest of the applicable copayment or the discounted price. 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) or on a minimum copayment amount through mail order.	
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.	

Financial Component	Proposal Requirements	Confirm (Y/N)
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.	
Pass-Through Definition	"Transparency" or “Pass-Through” will mean that the amount you pay the pharmacies in the retail network may not be different from the amount paid to you for retail network pharmacy claims by OGB (thus, prices will vary by pharmacy) and you are required to pass-through 100% of Rebates and Other Manufacturer Revenue to OGB in addition to offering minimum guarantees for the rebates on a per brand basis that OGB will receive. This also includes full disclosure of rebate revenue and any fees paid by third parties made by the claims processor through a specific client's business, and disclosures of any relationships that are or may appear to be conflicts of interest to OGB and disclosure of any activity that it not in alignment with OGB's financial and/or clinical goals.	
PBM Revenue	The Vendor will not earn revenues from any hidden source, including but not limited to rebates, discounts, credits, incentives, grants, chargebacks, reimbursements, health management fees paid by pharmaceutical manufacturers and other third parties to the Vendor, or other financial benefits of any sort. Vendor will be required to pass-through to OGB all such financial benefits.	
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)
Drug Classification	A product's brand or generic status will be determined using information available from only one nationally recognized source (e.g., MediSpan) and you have proved this source to the right of this question. Vendor will not change this source throughout the duration of the contract, unless mutually agreed in written documentation between OGB and Vendor.	
Single-Source ("SS") Brands Definition	Single-Source ("SS") Brands will be defined as products that have not lost their patent protection (i.e., a product available from the innovator, the manufacturer with the New Drug Application approval) or are available from only one manufacturer.	
Multi-Source ("MS") Brands Definition	Multi-Source ("MS") Brands, for purposes of pricing term offers and guarantees in this RFP, will be defined as innovator products that have lost their patent protection and are available from at least two sources: the innovator (one with the New Drug Application approval) and at least one other with either an Abbreviated New Drug Application approval or a marketing agreement for an authorized / branded generic.	
Single-Source ("SS") Generics Definition	Single-Source ("SS") Generics, for purposes of pricing term offers and guarantees in this RFP, will be defined as the non-innovator product that is available from two: the innovator (one with the New Drug Application approval) and another with either an Abbreviated New Drug Application approval or a marketing agreement for an authorized / branded generic.	
Multi-Source ("MS") Generics Definition	Multi-Source ("MS") Generics, for purposes of pricing term offers and guarantees in this RFP, will be defined as non-innovator products that are available from three or more: the innovator (the manufacturer with the New Drug Application approval) and two or more manufacturers with Abbreviated New Drug Application approvals or marketing agreements for an authorized / branded generic.	

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, but inclusive of all other single-source brands and multi-source brands.	
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, including multi and single-source generics, MAC'd and Non-MAC'd generics, limited supply generics, patent litigated generics	
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.	
Compounds	In the pass-thru pricing arrangement, compounds (i.e., claims for a prescription that requires the pharmacy to create the medication by combining two or more ingredients) will be priced at the exact rate you negotiated with the pharmacy.	
Mail Order Pricing	Vendor must agree to offer consistent pricing for all mail order prescriptions regardless of the days' supply.	
Mail Order Pricing	Vendors will not be allowed to adjudicate based on a minimum copayment amount through mail order.	

Financial Component	Proposal Requirements	Confirm (Y/N)
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.	
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) on an annual basis. (Generic Dispensing Rate = Generic Rxs / Total Rxs)	
Audit Rights	Vendor must agree to provide unrestrictive operational and financial audit rights, including the right to audit any data necessary to ensure the Vendor is complying with all contract terms. This may include but is not limited to: 100% of pharmacy claims data, including at least all NCPDP fields from the most current version and release; pharmaceutical manufacturer and wholesaler agreements; approved and denied utilization management reviews; clinical program outcomes; appeals; information related to the reporting and measurement of performance guarantees; appropriate access to MAC rates and the formulary rebate program (as appropriate) including the processes for reporting data to manufacturers, accounting for rebates earned, and allocating rebate payments to OGB, etc.	
Audit Rights	OGB requires the ability to conduct these audits at any time during the contract term without limitation to the time period of paid claims to be audited In addition, OGB has the right to audit post termination.	

Financial Component	Proposal Requirements	Confirm (Y/N)
Audit Rights	OGB will not be responsible for any Vendor expenses related to an operation or financial audit, including the provision of records. Furthermore, OGB has the right to one annual audit at no charge to the OGB with the only charge for any additional audits performed on an annual basis being the direct pass-through of any data retrieval fees, which may be required if the data requested has already been stored.	
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. Your fees must include all costs associated with the attendance of 100% of the scheduled annual enrollment meetings statewide on an annual basis.	
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 brand claim basis only, inclusive of all brand prescriptions at retail, mail order, and specialty.	
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 fees, marketing grants 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	Vendor agrees to pay all minimum per brand	

Financial Component	Proposal Requirements	Confirm (Y/N)
Payments	guaranteed rebates within 30 days after the end of each quarter and to reconcile to the total amount paid to OGB per the minimum guarantees against the total rebates received (100% pass-through) 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 and clearly noted on the invoice. Rebates must be accompanied by the appropriate back-up to substantiate rebate amounts.	
AWP Source	The AWP used to price the claim must be from only one nationally recognized source (e.g., MediSpan) and are based on current AWPs (Post-Rollback, September 26, 2009) and AWP discounts are applied directly to this AWP, with no further adjustments.	
AWP Retail	The AWP used to price retail pharmacy claims will be the actual National Drug Code (NDC)-11 submitted by the pharmacy as the one the pharmacy used to fill the prescription.	
AWP Mail	The AWP used to price mail pharmacy claims will be the actual National Drug Code (NDC)-11 submitted by the pharmacy as the one the pharmacy used to fill the prescription.	
AWP Specialty	The AWP used to price specialty pharmacy claims will be the actual National Drug Code (NDC)-11 submitted by the pharmacy as the one the pharmacy used to fill the prescription.	
AWP Guarantees	The AWPs used in the guaranteed AWP discount calculation will be the same AWP used to price the claim	
AWP Market Change	In the event there are changes in the marketplace to the baseline measure used for the ingredient costs of drugs (e.g. AWP), the terms will be adjusted accordingly to provide an equivalent price; OGB must not bear any economic harm. Vendor will provide as much advanced notice as possible to OGB and sufficient details to support any changes being propose.	

Financial Component	Proposal Requirements	Confirm (Y/N)
AWP Market Change	In the event there are changes in the marketplace to the baseline measure used for the ingredient costs of drugs (e.g. AWP) and you propose changes to OGB's pricing terms in order to account for the changes, changes will be agreed upon before any changes are made. If changes are not agreeable either party has the right to terminate the agreement without financial consequences (e.g., loss of rebates earned but not yet paid).	
Implementation Audit	By submitting a proposal, your organization agrees that, if selected by OGB as its PBM, you will pay the full cost of OGB's designated third party's fees and out-of-pocket expenses related to a post-implementation audit for the commercial lives and a pre-implementation audit for the EGWP lives. At no point shall OGB be required to pay for used or unused portions of the audit amount offered by your organization.	
EGWP Reconciliation	Pricing guarantees and reconciliations for the EGWP Plus lives (discounts, dispensing fees) do not differ for those claims administered while under the primary coverage and those in the wrap.	

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 worksheets "Rx Pricing Pass-Thru" and "EGWP and Wrap Pricing

(Exhibit 6).

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 above.

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. 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 April 1, 2013.

MAC Pricing		**Retail**	**Mail**
A.	Name of MAC List		

MAC Pricing		Retail	Mail
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 April 1, 2013.

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

5. Confirm that you will apply a lowest-net-cost cost, single MAC price list across all channels (retail, mail order, specialty pharmacy).

6. The MAC list at Mail will include the same medications or more and will use the same prices or lower prices as the most aggressive retail pharmacy MAC list.

7. The MAC list at specialty pharmacies will include the same medications or more and will use the same prices or lower prices as the most aggressive retail pharmacy MAC list.

8. Confirm you will provide OGB the updated MAC list on a quarterly basis.

9. The MAC lists used to price claims will be updated no less frequently than 4 times throughout each contract year term of the contract to remain competitive; however, you will proactively communicate, identify and explain, to OGB any deletions and any unit price increases over 8% per quarter.

10. Confirm that the MAC List and associated pricing applied to claims from network pharmacies is 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 Adjudication Guarantee	Lower of AWP - _____% or MAC
B. Overall Effective Brand Discount Guarantee	AWP - _____%
B. Brand Dispensing Fee (per claim) Guarantee	$_____ per Rx
C. Non Generic Adjudication Guarantee	Lower of AWP - _____% or MAC
D. Overall Effective Generic Discount	AWP - _____%
E. Generic Dispensing Fee (per claim) Guarantee	$_____ 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. 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.

E. Specialty Drug Pricing

a. Complete the worksheet "Specialty Drug Pricing" (Exhibit 6) with your proposed Specialty Pharmacy pricing.

b. 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.

c. Confirm that you will provide OGB with at least 90 days notice in advance of new medications being added to your "specialty drug list" whenever feasible; OGB reserves right to exclude the medication from coverage if the medication is in a category that is currently excluded (e.g., growth hormones).

d. The AWP used to price specialty pharmacy claims will be the actual NDC-11 submitted by the pharmacy as the one the pharmacy used to fill the prescription.

e. All specialty pharmacy claims must be adjudicated at the lowest of: (a) the contracted discount plus dispensing fee; or (b) MAC plus dispensing fee. Vendors may not assess a "minimum charge" through specialty pharmacy.

f. All specialty pharmacy claims will be adjudicated according to the “lowest of” logic such that members always pay the lowest of the applicable copayment or the discounted price. Vendors will not be allowed to adjudicate based on a minimum copayment amount through specialty pharmacy.

g. Vendor will price all claims processed by the specialty pharmacy for medications that are not on your specialty drug list at the mail-order pharmacy rates.

h. Confirm that OGB will not be responsible for any member contributions (e.g., deductible, coinsurance, copays) owed to you through the specialty pharmacy. Collecting such fees will be the sole responsibility of your organization

i. The advance notification must include your criteria/rationale for adding the drug to the Specialty list and should include the proposed pricing if available. If the pricing is not available, it must be provided at least five (5) business days in advance of the specialty medication being added to OGB’s specialty list;

j. Confirm you will provide guaranteed minimum AWP discount pricing and dispensing fees per Rx for newly approved Specialty drugs similar to those already available to treat the same condition and pricing will not automatically be set at a default rate.

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 worksheet “Administrative Fees” (Exhibit 6)

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 (2013) and proposed (2014) 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.).

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

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

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. Vendor must provide a an implementation credit and a competitive and

annual/ongoing financial credits to offset OGB's expense associated with the RFP, transition, and ongoing services; Vendors are requested to provide credit as outlined below, and may offer credit amounts separately for the Commercial and EGWP population, respectively, provided that overages/unused credits for one population may be used for expenses in another population, if needed. In no case shall OGB be required to repay all or a portion of the used or unused Implementation Credit.

(a) Amount ($):
    a. Commercial Population:
    b. EGWP Population:
    c. Total Population:
(b) When and how it will these be paid; and
(c) Required documentation from the client.

2. Vendor agrees that the implementation credit can be used for any ERISA approved expenses, including the following services:
   (a) File conversions;
   (b) Claims history loads;
   (c) Auditing;
   (d) Prior authorization loads;
   (e) Physician loads;
   (f) Facility loads;
   (g) Report customization;
   (h) Letter customization;
   (i) Development of prior authorization letter customization;
   (j) Customization or development of prior authorization guidelines;
   (k) Custom edits (including but not limited to benefit plan design edits or standard or custom benefit changes);
   (l) On-site training; and
   (m)Non-standard ID Cards
   (n) Benefit or clinical management programs
   (o) Client-engaged consultants
   (p) Mailing(s) and postage
   (q) For the EGWP population, member implementation and welcome materials, if applicable

3. 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, 2014 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 April 1, 2013) 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. Ten (10) 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. Your fees must also include your cost to attend 100% of the annual enrollment meetings conducted by OGB at no additional cost to OGB.	
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 pricing worksheets (Exhibit 6).

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 pricing worksheets (Exhibit 6).

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

4. 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 pricing worksheets (Exhibit 6).

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 the worksheet "Specialty Pharmacy Pricing" (Exhibit 6).

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 worksheets “Admin Fees” and “EGWP Admin Fee” (Exhibit 6)

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 (2013) and proposed (2014) 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:
   (r) The amount;
   (s) How it can be used;
   (t) When and how it will be paid; and
   (u) 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, 2014 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 April 1, 2013) 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 Benefits Data
- A. Pharmacy Claims Experience
- B. Top 200 Brand Drugs
- C. Top 200 Generic Drugs
- D. Specialty Drug Data

EXHIBIT 4 Current Member ID Card

EXHIBIT 5 Standard Contract Provisions
Addendum A – Business Associate Agreement
Addendum B – Reporting/Data Requirements

EXHIBIT 6 Excel Workbook
- A. Rx Pricing Pass-Thru
- B. Administrative Fees
- C. EGWP and Wrap Pricing
- D. EGWP Administrative Fees
- E. Retail Network Disruption
- F. Formulary Description
- G. Specialty Drug Pricing
- H. Generic Drugs

EXHIBIT 1
PLAN OF BENEFITS – PRESCRIPTION DRUG BENEFIT

	Option 1 (Current)	Option 2
Generic	50%, Maximum $50 per 31 day supply	50%, Maximum of $30 per 31 day supply
Preferred brand	50%, Maximum $50 per 31 day supply	50%, Maximum of $55 per 31 day supply
Non preferred brand	50%, Maximum $50 per 31 day supply	65%, Maximum of $80 per 31 day supply
Specialty	50%, Maximum $50 per 31 day supply	50%, Maximum $80.00 Limit of 31 days
Maximum out of pocket	$1,200	$1,500
Copays after Maximum out of pocket met	$0.00 for generic, $15 for brand	$0.00 for generic, $20 for preferred brand, $30 for non- preferred brand and specialty
Note:	No retail/mail differential	No retail/mail differential

CENSUS INFORMATION

TO BE PROVIDED ELECTRONICALLY PER THE SCHEDULE OF EVENTS

EXHIBIT 3

OGB PHARMACY BENEFITS DATA

TO BE PROVIDED ELECTRONICALLY PER THE SCHEDULE OF EVENTS

A. Pharmacy Claims Experience
B. Top 200 Brand Drugs
C. Top 200 Generic Drugs
D. Specialty Drug Data

EXHIBIT 4

CURRENT ID CARD
(ATTACHED)

OGB PPO - 04BA0039A 10/08 - 08102012

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BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross and Blue Shield Association.

Office of Group Benefits
P. O. Box 66678
Baton Rouge, Louisiana 70896

Welcome to Blue Cross and Blue Shield of Louisiana!

John Q. Smith
101 Main Street
Anytown, ST 11111-1111

Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company

04BA0039A 10/08

DRAFT

BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross and Blue Shield Association.

PreferredCare.

Member Name **John Q. Smith** Member ID **OGS123456789**	**Office of Group Benefits** **OGB PPO Plan**
Grp/Subgroup **ST222ERC/000** RxMbr ID **123456789** RxBIN **005947** **PCN CLAIMCR** RxGrp **STLA** **BC PLAN 170 BS PLAN 670**	Deductible Active **$500** Coinsurance: Preferred **90/10** All other providers **70/30**

04BA0039 10/08

PPO℠

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Member Name **John Q. Smith** Member ID **OGS123456789**	**Office of Group Benefits** **OGB PPO Plan**
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04BA0039 10/08

PPO℠

IMPORTANT INFORMATION ON YOUR NEW ID CARD

As a Blue Plan member, you have access to the BlueCard Program which offers you convenient access to health care outside of Louisiana. If you are outside of Louisiana and need emergency medical services, please go directly to the nearest hospital. For non-emergency care, please follow these steps.

1) Call 1-800-810-BLUE (2583) for information on the nearest doctors and hospitals.
2) Use a designated physician or hospital to receive the highest level of benefits.
3) Present your ID card to the doctor or hospital, who will verify coverage and file your claim for you.
4) Obtain prior authorization for services requiring authorization as outlined in your Schedule of Benefits.

NOTICE:

YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

By accepting this card and any benefits to which this card entitles the holder, the holder acknowledges that the policy/agreement, as applicable, pursuant to which this card is issued constitutes a contract solely between subscriber/group subscriber/participant, as applicable, and Blue Cross and Blue Shield of Louisiana, and that Blue Cross and Blue Shield of Louisiana is an independent corporation operating under a license from the Blue Cross and Blue Shield Association which permits Blue Cross and Blue Shield of Louisiana to use the Blue Cross and Blue Shield names and service marks in Louisiana.

BlueCross BlueShield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association

Hospitals and Physicians: File claims with your local BlueCross and/or BlueShield Plan.

Authorization required on some services.

File Medicare primary claims with Medicare.

Blue Cross and Blue Shield of Louisiana provides administrative services only and does not assume any financial risk for claims.

catamaran

www.bcbsla.com

Customer Service	800-392-4089
BlueCard Access	800-810-2583
Authorizations	800-523-6435
Catamaran Rx Inquiries*	866-358-9530
MHSA Authorizations	800-523-6435

*Contracts Directly with Group

Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 70898-9029

Printed: XX/XX/XXXX

Pharmacy Benefits Administrator

BlueCross BlueShield of Louisiana
An independent licensee of the Blue Cross and Blue Shield Association

Hospitals and Physicians: File claims with your local BlueCross and/or BlueShield Plan.

Authorization required on some services.

File Medicare primary claims with Medicare.

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Baton Rouge, LA 70898-9029

Printed: XX/XX/XXXX

Pharmacy Benefits Administrator

Proof

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EXHIBIT 5

STANDARD CONTRACT PROVISIONS

1. Contractor agrees that the contract (the "Agreement") begins on the effective date (January 1, 2014) and will expire three years from that date, unless terminated earlier pursuant to this Agreement. 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) Contractor 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.

2. Contractor agrees a Party may terminate the Agreement upon notice to the other Party if the other Party: (a) is in bankruptcy or insolvency proceedings, whether voluntary or involuntary; 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.

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

4. Contractor agrees that upon termination of this Agreement, Contractor will continue to process run-out claims for Plan benefits that were incurred prior to but not processed as of the termination date which are received by Contractor 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-out period Contractor 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-out claims. Benefit payments processed by Contractor with respect to such claims which are pended or disputed will be handled to their conclusion by Contractor 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.

5. Contractor agrees that if it is determined that any payment has been made by Contractor 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, Contractor 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.

6. Contractor agrees that during the term of the Agreement, and for up to three (3) years 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 Contractor and during regular business hours, to audit Contractor's books, records, electronic data, co-payments, rebates and other evidence related to services provided, claims paid, ingredient costs and fees charged, by Contractor to determine compliance with financial terms; other items as outlined by OGB. Contractor 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. Contractor 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.

25. Upon the request of OGB, the Office of the Governor, Division of Administration, and/or the Legislative Auditor, the Contractor shall provide copies of its internal audits and quality assurance reports and shall obtain and provide a Standards for Attestation Engagements (SSAE)-16, Type II. The SSAE-16, Type II must be received by OGB not later than September 30 of each year of the contract term. The contractor will be subject to a $1,000 per day penalty until receipt by OGB. In addition, the Contractor 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.

26. Contractor 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 Contractor's data processing systems (but shall extend to any claim or payment data recorded for, or otherwise integrated into such systems), information which Contractor reasonably deems to be proprietary in nature, or information which Contractor reasonably believes it cannot divulge due to applicable law. All data and records shall be maintained by Contractor 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 Contractor in connection with its own business.

27. The Contractor 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 Contractor 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 Contractor 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 Contractor 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.

22. Contractor agrees that, except with OGB's prior written consent in each instance, Contractor 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 Contractor's assets or ownership. OGB reserves the right to require each approved subcontractor to enter into a contract substantially similar to the Agreement and Contractor remains fully liable for its obligations under the Agreement.

23. Contractor 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 Contractor must maintain an ongoing issues log and document all benefit and systems programming changes, subject to OGB's review and approval.

24. Contractor 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.

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

26. Contractor 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.

27. Contractor 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.

28. Contractor 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).

29. Contractor 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.

30. Contractor 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 Contractor's control (e.g., resignation/termination with less than 60 day notice).

31. Contractor 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.

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

33. Contractor 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.

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

35. Contractor agrees to provide its operational performance guarantees on a client-specific basis and report OGB's results on a quarterly basis. OGB shall have the ability to 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.

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

37. Contractor warrants that all Contractors' Personnel performing any of Contractor's obligations under the Agreement will have employment authorization that complies with all applicable Laws. Contractor warrants that no Contractor Personnel performing any of Contractor'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.

38. The 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 act or omission of the 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 act or omission of OGB, the State of Louisiana, State Departments, Agencies, Boards, Commission, their officers, directors, agents, servants and/or employees. The Contractor 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 Contractor's position with respect to the resolution or defense of the claim or cause of action.

39. Claims payments shall be processed through an account or accounts owned by Contractor.

40. The Contractor 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 January 1, 2014, multiplied by the monthly fee, multiplied by three.

41. 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.

42. 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.

43. The Contractor 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.

44. 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 Contractor for OGB in connection with this Contract or in the performance hereof.

45. The Contractor warrants that all materials and/or products produced by the Contractor 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 Contractor, and the Contractor shall defend such claim, in OGB's name, but at the Contractor's expense, and shall indemnify OGB against any loss, expense, or liability arising out of such claim, whether or not such claim is successful.

46. 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.

47. The Contractor and the Contractor'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 Contractor. Materials belonging to OGB will be safeguarded by the Contractor to at least

the same extent as the Contractor safeguards proprietary information relating to its own business.

48. The 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 the PBM and/or Company agrees to abide by the requirements of the Americans with Disabilities Act of 1990.

    The Contractor 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, or disabilities

49. 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 Contractor, shall be refunded in full to OGB by the Contractor.

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

51. No provision of the Contract is intended to create nor shall it be deemed or construed to create any relationship between the Contractor 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.

52. 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.

53. The Contractor, 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.

54. 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.

55. 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.

56. 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.

57. 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.

58. 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.

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

60. 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.

61. The Contractor will comply with the provisions of statute La.R.S. 22:226, regarding mail order prescription service. .

62. The Contractor 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.

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

64. Contractor agrees to share pharmacy information as requested with OGB's Disease Management program Contractor who provides for the management of OGB members with diabetes, asthma, COPD, heart failure and/or coronary artery disease (CAD).

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 _____, 20__, pursuant to which Business Associate is to provide certain services to OGB involving the use or disclosure of PHI, as defined below.
c) "ARRA" shall mean the American Recovery and Reinvestment Act of 2009, Public Law 111-5.
d) "Business Associate" shall mean _____.
e) "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.
f) "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.
g) "HIPAA Regulations" shall mean the Privacy Rule, the Security Rule, and the regulations promulgated pursuant to ARRA.
h) "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).
i) "OGB" shall mean the State of Louisiana, Division of Administration, Office of Group Benefits, which is a covered entity under HIPAA, ARRA and the HIPAA Regulations, as defined below.
j) "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.
k) "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.
l) "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.
m) "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103.
n) "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.
o) "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR § 164.304.

p) “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.
q) “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.
r) Any other terms used in this Addendum that are not defined herein but are defined in the HIPAA Regulations or ARRA shall have the same meaning as given in the HIPAA Regulations or ARRA.

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 an ARRA.

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 Associate shall immediately notify OGB when Business Associate receives a subpoena related to PHI and shall cooperate with OGB, at OGB's expense, in any attempt to obtain a protective order. Business Associate shall immediately notify OGB when Business Associate discloses PHI in response to a subpoena. Such notice shall include all information that would be required for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
p) 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.
r) Business Associate shall report to OGB any unauthorized acquisition, access, use or disclosure of PHI by Business Associate or its workforce or subcontractors immediately, but no later than five (5) business days after discovery or the date the breach should have

been known to have occurred, and include with that report the remedial action taken or proposed to be taken with respect to such use or disclosure and account for such disclosure. Business Associate is responsible for any and all costs related to notification of individuals or next of kin (if the individual is deceased) of any security or privacy breach reported by Business Associate to OGB.

s) In the event of a breach of PHI, Business Associate shall provide a report to OGB including the date the breach was discovered, the plan participant(s) name(s), contact information, nature/cause of the breach, PHI breached and the date or period of time during which the breach occurred. Business Associate understands that such a report must be provided to OGB immediately but no later than five (5) business dates from the date of the breach or the date the breach should have been known to have occurred.

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).

f) Business Associate may not use PHI to make any communications about a product or service that encourages recipients of the communication to purchase or use the product or service unless the communication is made as described in subparagraph (i), (ii) or (iii) of the definition of “Marketing” in 45 CFR 164.501. Such communication must be permitted under and consistent with the Agreement, including this Addendum.

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, ARRA 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, ARRA 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, ARRA 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, ARRA 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: _____

Name: _____

Title: _____

CONTRACTOR

By: _____

Name: _____

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 200 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.

Appendix A – File requirements and layout

The Contractor shall send and receive data files and act on the received data files as outlined in this section (Appendix A):

Files to be sent by the contractor to OGB:

The contractor shall provide files 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. All files are examples of data exchanged with current vendor. Layouts are to be finalized with vendor after award of the contract. The file shall be sent electronically using FTP (File Transfer Protocol) and MUST be encrypted using PGP (Pretty Good Privacy).

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

2. **Clinical Fees Per Enrollee per Month(Appendix A-2)**
   This file shall be received by OGB at the beginning of a month for the Per enrollee per month Clinical fees that were charged to OGB for the Previous month.

3. **Prior Authorization Review file(Appendix A-3)**
   This file shall be received by OGB at the beginning of a month for Prior Authorization Reviews that were charged to OGB for the previous month. This file contains the four type drug records of the drug claims as originally sent to OGB with the addition of Authorization reason and description on the end of each record.

4. **Appeals Determination file (Appendix A-4)**
   This file shall be received by OGB quarterly, April, July, October and January. This will be an Excel file containing information about first and second level appeal determinations for which OGB will have an accompanying invoice.

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 Appendix A-5 thru A-6. Files shall be sent electronically using FTP (File Transfer Protocol) and MUST be encrypted using PGP (Pretty Good Privacy).

5. **Pharmacy Eligibility File (Appendix A-5)**
   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.

6. **Pharmacy Group File (Appendix A-6)**
   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.

7. Administrative Fee Billing File (Appendix A-7)

Two files shall be received monthly by the contractor and will contain the amount per contract holder that OGB will pay for administrative fee. One file will contain EGWP Administrative fees, the other will contain Commercial Plans (HMO/PPO,etc) Admin Fees. OGB will pay Catalyst based on this file. The file will contain adjustments to prior months billing resulting from retro terms and enrollment.

8. Shared Accumulator File (Appendix A-8)

This file shall be received bi-monthly by the contractor and will contain the old and new information on people who have been assigned a new member id by OGB. OGB will only be sending those people who have had a new member id assigned to them on or after July 1, 2011 and OGB will keep track of the members they have already sent so as not to send duplicates on the subsequent files.

Appendix A-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

Appendix A-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

Appendix A-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	01=AWP (contracted netwrok discount) 06=MAC 07=USUAL AND CUSTOMARY Required field when not an adjustment
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”

Appendix A-1 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
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 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	THE PROVIDER’S USUAL AND CUSTOMARY AMT 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	

Appendix A-1 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
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	235-249	
31	FILLER	A/N	12	250-261	
32	RESUBMISSION CYCLE COUNT	A/N	2	262-263	0 = ORIGINAL SUBMISSION 1 = FIRST RE-SUBMISSION 2 = SECOND RE-SUBMISSION
33	DATE PRESCRIPTION WRITTEN	A/N	8	264-271	DATE PRESCRIPTION WAS WRITTEN
34	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
35	ELIGIBILITY CLARIFICATION CODE	A/N	1	273-273	CODE INDICATING THAT THE PHARMACY IS CLARIFYING ELIGIBILITY BASED ON DENIAL

Appendix A-1 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					0 = NOT SPECIFIED 1 = NOT OVERRIDE 2 = OVERRIDE 3 = FULL TIME STUDENT 4 = DISABLED DEPENDENT 5 = DEPENDENT PARENT
36	COMPOUND CODE	A/N	1	274-274	CODE INDICATING WHETHER OR NOT THE PRESCRIPTION IS A COMPOUND 0=NOT SPECIFIED 1=NOT A COMPOUND 2=COMPOUND
37	NUMBER OF REFILLS AUTHORIZED	N	2	275-276	NUMBER OF REFILLS AUTHORIZED BY PRESCRIBER
38	DRUG TYPE	A/N	1	277-277	CODE TO INDICATE THE TYPE OF DRUG DISPENSED (Must be specified (1-3) if an amount is paid) 0=Not Specified 1=SINGLE SOURCE BRAND 2=BRANDED GENERIC 3=GENERIC 4=O.T.C. (OVER THE COUNTER)
39	PRESCRIBER LAST NAME	A/N	15	278-292	PRESCRIBER LAST NAME
40	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”
41	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
42	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
43	FILLER	A/N	35	304-338	RESERVED FOR FUTURE NCPDP CONTINGENCIES
44	CONTRACT SSN	A/N	9	339-347	(Contract Holder’s SSN)- RxClaim map from 1st nine digits of member ID number
45	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

Appendix A-1 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					negative Example: 123.45 would be expressed as “0000123.45” -123.45 would be expressed as “-000123.45”
46	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”
47	PAID DATE	A/N	8	368-375	Date of payment FORMAT = CCYYMMDD
48	FILLER	A/N	2	376-377	Spaces
49	Prescribe First Name	A/N	15	378-392	
50	Prescribe Last Name	A/N	25	393-417	
51	Prescribe MI	A/N	1	418-418	
52	Prescribe Address-1	A/N	55	419-473	
53	Prescribe Address-2	A/N	55	474-528	
54	Prescribe City	A/N	20	529-548	
55	Prescribe State	A/N	2	549-550	
56	Prescribe Zip Code	A/N	10	551-560	
57	GPI Number	N	14	561-574	Map from extract file field – “GPINUMBER”
58	Care Facility	A/N	6	575-580	From the RCMCF file (field HAAPCD)
59	Care Qualifier	A/N	10	581-590	From the RCMCF file (filed HAPNC2)
60	Care From Date	N	7	591-597	From the RCMCF file (field HACRDA) format = CYYMMDD
61	Care Thru Date	N	7	598-604	From the RCMCF file (field HACSDA) format = CYYMMDD
62	Family ID	A/N	20	605-624	Map from extract file field MBRFAMLYID
63	Alternate Insurance ID	A/N	10	625-634	Map from extract file filed MBRALTINCD
64	Submitted PA Type	N	1	635-	Map from extract file filed PAMCCDE

Appendix A-1 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
				635	
65	Submitted PA Number	A/N	11	636-646	Map from extract file field PAMCNBR
66	Member PA Number	A/N	11	647-657	Map from extract file field PRAUTHNBR
67	Member PA Reason Code	A/N	2	658-659	Map from extract file field PRAUTHRSN
68	Therapeutic Class Code	N	6	660-665	From the RCPRD file (field SZEBC4)
69	Therapeutic Class Name	A/N	25	666-690	From the RCAHF file (field SMBVT3)
70	RxClaim #	N	15	691-705	Map from extract file field RXCLAIMNBR
71	Claim Sequence #	N	3	706-708	Map from extract file field CLMSEQNBR
72	Medicare D Eligible Indicator	A/N	1	709-709	Y = Medicare D eligible N = NOT Medicare D eligible
73	Date Processed	N	8	710-717	Format YYYYMMDD Map from DATESBM
74	Time Processed	N	6	718-723	Format HHMMSS Map from TIMESBM
75	Diabetic Sense Vendor Indicator	A/N	1	724-724	If RXNETWORK = “DIABET” then Y, else N
76	Mail Order Indicator	A/N	1	725-725	If RXNETWORK = “CTMAIL” then Y, else N
77	Brand/Generic Indicator	A/N	1	726-726	Map from MULTSRCCDE: values M, O, N, Y
78	Brand/Generic Override	A/N	1	727-727	Map from GENINDOVER: values M, O, N, Y
79	Claim Origin	A/N	1	728-728	Map from CLMORIGIN: values T = Electronic B = Batch M = Manual
80	Retrospective DUR Program	A/N	1	729-729	Run-time parameter: values Y/N
81	Quantity Limit Program	A/N	1	730-730	Run-time parameter: values Y/N
82	Prior Authorization Program	A/N	1	731-731	Run-time parameter: values Y/N
83	Therapeutic Interchange Program	A/N	1	732-732	Run-time parameter: values Y/N
84	Decimal Qty	N	13	733-745	Format -9.999; Map from DECIMALQTY
85	Cost Type Unit Cost	N	14	746-759	Format 9.99999; Map from CTYPEUCOST: will contain unit cost or cost type (AWP, MAC)

Appendix A-1 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
86	Cost Basis	A/N	10	760-769	Map from CLTPRCTYPE: values SD = Submitted Drug Cost SM = Submitted Amount Due U = Usual and Customary AWP = Average Wholesale Price HCFA = HCFA MAC MAC* = Catalyst RX MAC price
87	Avg Wholesale Price Unit	N	14	770-783	Format 9.99999; Map from AWPUNITCST
88	DMR Method/Cust Location	A/N	2	784-785	Map from CUSTLOC; Added to indicate if DMR pricing is used: 91 indicates DMR is submitted value less copay,, 94 indicates adjustment, 93 indicates pass thru rate less copay
89	Prescription Number (12-byte)	A/N	12	786-797	12-byte Prescription Number

Appendix A-2 Clinical Fees Per Enrollee Per Month File					
No.	**Name**	**Type**	**Length**	**Position**	**Description**
1	Record ID	N	8	1-8	As sent to vendor in eligibility file
2	Contract Holder's SSN	N	9	9-17	
3	First Name	A/N	15	18-32	
4	Last Name	A/N	20	33-52	
5	Middle Initial	A/N	1	53-53	
6	Month/year of charge	A/N	6	54-59	ccyymm
7	Clinical Type	A/N	1	60-60	D= Diabetic Sense,

Appendix A-3 Prior Authorization Review 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	01=AWP (contracted netwrok discount) 06=MAC 07=USUAL AND CUSTOMARY Required field when not an adjustment
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”

Appendix A-3 Prior Authorization Review File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
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 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	THE PROVIDER’S USUAL AND CUSTOMARY AMT 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	

Appendix A-3 Prior Authorization Review File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
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	235-249	
30	FILLER	A/N	12	250-261	
31	RESUBMISSION CYCLE COUNT	A/N	2	262-263	3 = ORIGINAL SUBMISSION 4 = FIRST RE-SUBMISSION 5 = 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	10 = NO PRODUCT SELECTION INDICATED 11 = SUBSTITUTION NOT ALLOWED BY PRESCRIBER 12 = SUBSTITUTION ALLOWED - PATIENT REQUESTED PRODUCT DISPENSED 13 = UBSTITUTION ALLOWED PHARMACIST SELECTED PRODUCT DISPENSED 14 = SUBSTITUTION ALLOWED - GENERIC DRUG NOT IN STOCK 15 = SUBSTITUTION ALLOWED - BRAND DRUG DISPENSED AS A GENERIC 16 = OVERRIDE 17 = SUBSTITUTION NOT ALLOWED - BRAND DRUG MANDATED BY LAW 18 = SUBSTITUTION ALLOWED - GENERIC DRUG NOT AVAILABLE IN MARKETPLACE 19 = OTHER
34	ELIGIBILITY CLARIFICATION CODE	A/N	1	273-273	CODE INDICATING THAT THE PHARMACY IS CLARIFYING ELIGIBILITY BASED ON DENIAL

Appendix A-3 Prior Authorization Review File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					6 = NOT SPECIFIED 7 = NOT OVERRIDE 8 = OVERRIDE 9 = FULL TIME STUDENT 10 = DISABLED DEPENDENT 11 = DEPENDENT PARENT
35	COMPOUND CODE	A/N	1	274-274	CODE INDICATING WHETHER OR NOT THE PRESCRIPTION IS A COMPOUND 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 (Must be specified (1-3) if an amount is paid) 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

Appendix A-3 Prior Authorization Review File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					negative Example: 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	Mail/Retail Indicator	A/N	1	562-562	M = Mail Order R or spaces = Retail
58	Filler	A/N	5	563-567	
59	Authorization Switch	A/N	1	568-568	D- Part D drug coverage determination B- Part B versus Part D covered drugs determination
60	Authorization Description	A	30	569-598	Description of what caused the review
61	Filler	A/N	111	598-708	Spaces

Appendix A-4 Appeals Determinations (Excel) File					
No.	**Name**				
1	Plan Member Name				
2	Patient Name				
3	Impact Record ID				
4	First Level Appeal Date Received				
5	First Level Description of issue				
6	First Level Drug Name (if applicable)				
7	First Level Doctor				
8	First Level Date initial letter sent				
9	First Level Number of business days elapsed				
10	First Level Appeal/ Grievance Decision				
11	Second Level Appeal Date Received				
12	Second Level Description of issue				
13	Second Level Drug Name (if applicable)				
14	Second Level Doctor				
15	Second Level Date initial letter sent				
16	Second Level Number of business days elapsed				
17	Second Level Appeal/ Grievance Decision				

Pharmacy Eligibility Appendix A-5					
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 of the file sent for that day – “01”
9	Contact E-Mail	A/N	30	57-86	Load issues contact
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, HMO & 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
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

Pharmacy Eligibility Appendix A-5					
No.	**Name**	**Type**	**Length**	**Position**	**Description**
					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 Medicare
25	Care Qualifier	A/N	10	276-285	Level of Coverage Values: EC = Employee With Children 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 "*"
27	Accumulated Amount	N	10	287-296	FORMAT- 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative;

Pharmacy Eligibility Appendix A-5					
No.	**Name**	**Type**	**Length**	**Position**	**Description**
					Example: 123.45 would be expressed as “0000123.45” -123.45 would be expressed as “-000123.45”
28	Disease Management Code	A/N	3	297-299	Non-null value indicates participation
29	Multiple Birth Indicator	A/N	1	300-300	“Y” or blank
30	HIC Number	A/N	12	301-312	
31	EGWP Effective Date	D	8	313-320	
32	EGWP Term Reason	A/N	2	321-322	
33	Physical Address1	A/N	35	323-357	
34	Physical Address 2	A/N	35	358-392	
35	Physical Add-City	A/N	30	393-422	
36	Physical Add-State	A/N	2	423-424	
37	Physical Add-ZipCode	A/N	5	425-429	
38	Filler	A/N	71	430-500	For later use
	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 Appendix A-6					
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 CATALYSTRX
2	Account (PRODUCT)	A/N	15	10-24	Value: EPO, PPO, MCO, HMO & 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”

Pharmacy Group Appendix A-6					
No.	**Name**	**Type**	**Length**	**Position**	**Description**
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 “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 “#### “

Pharmacy Group Appendix A-6					
No.	**Name**	**Type**	**Length**	**Position**	**Description**
5	Filler	A/N	678	29-706	

APPENDIX A-7 ADMINISTRATIVE FEE BILLING FILE					
	FIELD NAME	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	Invoice Date	N	8	001-008	CCYYMMDD
2	Enrollee SSN	N	9	009-017	SOCIAL SECURITY NUMBER
3	Enrollee Last Name	A	20	018-037	Last Name
4	Enrollee First Name	A	20	038-057	First Name
5	Enrollee Middle Initial	A	1	058-058	Initial
6	Enrollee Plan	A	10	059-068	“CSTLAEP007” = United EPO “CSTLAPP007” = OGB PPO “CSTLAHM007” = Humana ASO
8	Billing OR Coverage	N	8	069-076	CCYYMMDD
9	Admin Fee Amount	N	7	077-83	

APPENDIX A-8 SHARED ACCUMULATOR FILE					
	FIELD NAME	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	Old Date of Birth	N	8	001-008	CCYYMMDD
2	Old Enrollee Last Name	A	25	009-033	Last Name
3	Old Enrollee First Name	A	15	034-048	First Name
4	Old Enrollee Middle Initial	A	1	049-049	Initial
5	Old Member ID	N	18	050-067	Primary's SSN + Record ID
6	Old Enrollee Plan	A/N	15	068-082	"HMO" = Blue Cross "PPO" = OGB PPO "CHV" = LaChip
7	Old Group (Agency Number)	A/N	15	083-097	Example = "0701 " (Plan Member's True Agency; i.e., no R96 or R97) Reference: 3 in File Detail Of Drug Claim Daily Eligibility
8	New Enrollee Last Name	A	25	098-122	Last Name
9	New Enrollee First Name	A	15	123-137	First Name
10	New Enrollee Middle Initial	A	1	138-138	Initial
11	New Member ID	N	18	139-156	Primary's SSN + Record ID
12	New Enrollee Plan	A/N	15	157-171	"HMO" = Blue Cross "PPO" = OGB PPO "CHV" = LaChip
13	New Group (Agency Number)	A/N	15	172-186	Example = "0701 " (Plan Member's True Agency; i.e., no R96 or R97) Reference: 3 in File Detail Of Drug Claim Daily Eligibility

EXHIBIT 6

TO BE PROVIDED ELECTRONICALLY PER THE SCHEDULE OF EVENTS

A. Rx Pricing Pass-Thru
B. Administrative Fees
C. EGWP and Wrap Pricing
D. EGWP Administrative Fees
E. Retail Network Disruption
F. Formulary Description
G. Specialty Drug Pricing
H. Generic Drugs