NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

REQUEST FOR PROPOSALS #2012RX-1

"PHARMACY BENEFIT SERVICES for THE EMPIRE PLAN, EXCELSIOR PLAN, STUDENT EMPLOYEE HEALTH PLAN, and NEW YORK STATE INSURANCE FUND WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAMS"

RELEASE DATE: **February 22, 2012**

PROPOSAL DUE DATE: **May 8, 2012**

IMPORTANT NOTICE: A Restricted Period under the Procurement Lobbying Law is currently in effect for this Procurement and it will remain in effect until State Comptroller approval of the resultant contract. During the Restricted Period for this Procurement ALL communications must be directed, in writing, solely to the Procurement Manager as listed below and shall be in compliance with the Procurement Lobbying Law and the NYS Department of Civil Service "*Rules Governing Conduct of Competitive Procurement Process*" (refer to RFP, Section II: Procurement Protocol and Process).

Department of Civil Service Contact for Inquiries and Submissions for this Solicitation:

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Robert W. DuBois, CEBS
Director
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Employee Benefits Division

SECTION I: INTRODUCTION

A. Purpose

The purpose of this Request for Proposals (RFP or Procurement), entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs," is to secure the services of a qualified Offeror to administer The Empire Plan, Excelsior Plan, Student Employee Health Plan Prescription Drug Programs, and New York State Insurance Fund Workers' Compensation Prescription Drug Programs (collectively referred to as the "Programs").

It is the Department of Civil Service's (Department or DCS) and the New York State Insurance Fund's (Fund or NYSIF) (also hereafter collectively referred to as the "Procuring Agencies") intent to enter into separate contracts (Agreements) with one (1) Offeror selected as a result of this RFP. The Agreements will be for a term of five (5) years, commencing on January 1, 2014 through December 31, 2018, during which the selected Offeror "Contractor" shall be responsible for administering the Programs in accordance with the terms and conditions of the respective Agreements.

The Offeror must agree to be bound by its Proposal which will be explicitly incorporated by reference into the executed Agreements. After Agreements are separately executed with the Contractor and DCS and NYSIF, any change to the scope of the Agreement, including but not limited to the inclusion of any individual Network Pharmacy(ies), requested by one Procuring Agency shall have no impact on the other Procuring Agency Agreement or cost thereunder, unless the other Procuring Agency likewise agrees to said change(s). The Department and NYSIF will only contract with a single Offeror, which will be the sole contact with regard to all provisions of the Agreements. If the Offeror's Proposal includes Key Subcontractors, the Offeror will be considered the Prime Contractor, and the Offeror shall assume full responsibility for the fulfillment of all of the Contractor Responsibilities under the Agreements. This RFP and other relevant information may be reviewed at: www.cs.state.ny.us/2014RxBenefitRFP/index.cfm.

Note: Refer to Section VIII: Glossary of Terms, for definitions of terms used throughout this RFP.

B. Overview of the New York State Health Insurance Program and the New York State Insurance Fund

NYSHIP

The New York State Health Insurance Program (NYSHIP) was established by the New York State Legislature in 1957 to provide essential health insurance protection to New York State (NYS) employees, retirees, and their eligible dependents. Chapter 56 of the Laws of 2010 amended the law to allow the New York State Employee Health Insurance Plan the option to be self-funded. Specifically, the law states that the President of the Civil Service Commission "may provide health benefits directly to plan participants, in which case the president is hereby authorized to purchase a contract or contracts with one or more firms qualified to administer, on New York State health benefit plan's behalf, the plan of benefits." Public authorities, public benefit corporations, and other quasi-public entities, such as the NYS Thruway Authority and the Dormitory Authority may choose to participate in NYSHIP; those that do are called Participating Employers (PEs). Article XI of the NYS Civil Service Law also allows local units of government such as school districts, special districts, and municipal corporations to participate in NYSHIP; those local government units which choose to participate in NYSHIP are called Participating Agencies (PAs). At present, there are approximately 378 NYS agencies, 93 Participating Employers, and 811 Participating Agencies in NYSHIP. Under Article XI of the Civil Service Law, as amended, and 4 New York Code of Rules and Regulations (NYCRR) Part 73, as amended, the President of the New York State Civil Service Commission, who also serves as the Commissioner of the Department, through the Department's Employee Benefits Division (EBD), is responsible for the ongoing administration of NYSHIP.

NYSHIP currently covers over 599,000 NYS, PA and PE employees and retirees. Eligible covered Dependents bring the total number of covered lives to approximately 1,230,000.

NYSHIP currently provides health insurance coverage through The Empire Plan, a Participating Provider Organization (PPO) with managed care components, and 10 Health Maintenance Organizations (HMOs). The Excelsior Plan is a lower cost version of The Empire Plan available to PAs. Additionally, the Student Employee Health Plan (SEHP) is insured and administered through The Empire Plan contracts. SEHP is a health insurance plan for graduate student

employees of the New York State and New York City University systems. NYS and PE employees and retirees may elect to enroll in either The Empire Plan or in HMOs offered through NYSHIP. NYSHIP offers only The Empire Plan and the Excelsior Plan to PAs. PAs may, and frequently do, offer HMOs directly to their own employees and retirees as an alternative to Empire Plan coverage.

NYSIF

The New York State Insurance Fund (NYSIF) was established following enactment of the Workmen's Compensation Law in 1914. It is a self-supporting, independent state agency providing workers' compensation and disability benefits insurance to employers within New York State.

For nine decades, NYSIF has been a major insurance carrier for workers' compensation insurance, providing benefits to injured workers and their families. NYSIF's policyholders range from large construction companies, manufacturing concerns, farms, small family-owned businesses to individuals employing household help. The home office is in New York City, with district offices in Albany, Buffalo, Glendale, Melville, Rochester, Syracuse, and White Plains.

C. Overview of The Empire Plan, Excelsior Plan, and Student Employee Health Plan

The Empire Plan, Excelsior Plan, and SEHP (collectively referred to as DCS Program(s)) are comprehensive health insurance programs for New York's public employees and their families. The DCS Programs are sponsored by the Council on Employee Health Insurance (CEHI). The Council is composed of the President of the Civil Service Commission, the Director of the Governor's Office of Employee Relations (GOER), and the Director of the Division of the Budget (DOB). The Department holds the contracts with the DCS Program Insurers. Currently, the DCS Programs are fully insured. This RFP is to secure the services of a qualified Offeror under a self-funded arrangement for the DCS Programs. The Employee Benefits Division (EBD) within the Department is responsible for the administration of the DCS Programs. The Empire Plan currently has over 530,000 Enrollees with approximately 1,100,000 covered lives. The Empire Plan benefit design has four (4) main parts including:

1. Hospital Program benefits that include coverage for drugs dispensed and administered by the hospital (currently insured and administered by Empire BlueCross BlueShield [EBCBS]);

2. Medical Program benefits, that include certain prescription drugs when dispensed and administered by a physician in an office setting (currently insured and administered by UnitedHealthcare Insurance Company [UHC] of New York);

3. Managed Mental Health and Substance Abuse Program benefits (currently insured by UHC of New York with network administration, managed care services, and claims administration provided through the Behavioral Healthcare Administrator, OptumHealth, Inc. [Optum]); and

4. Prescription Drug Program benefits that include coverage for prescription drugs dispensed through retail network pharmacies, through the Mail Service Pharmacy Process, through the Specialty Pharmacy Program (currently insured through UHC of New York with its Key Subcontractor, Medco Health Solutions, Inc. (Medco) serving as Pharmacy Benefit Manager) and through non-network pharmacies.

The benefit design of The Empire Plan is the result of collective bargaining between NYS and the various unions representing its employees. Benefits are administratively extended to non-represented NYS employees, employees of PAs and PEs, and retirees. Therefore, the benefit design is subject to change from time to time as the result of those negotiations, and there are variations in The Empire Plan's benefit design among the bargaining units. The benefit design cannot deviate from that which has been collectively bargained. The majority of the active workforce is represented by various unions, and union participation in the design and oversight of NYSHIP is active and ongoing. The Excelsior Plan, available to NYS local governments who participate with NYSHIP, is a more affordable version of The Empire Plan. It offers many of the same features and benefits of The Empire Plan, with a higher degree of cost sharing by covered individuals. The collective bargaining units and the unions representing the collective bargaining units are identified in Exhibit II.C as well as the other groups that participate in The Empire Plan, the Excelsior Plan, and the SEHP.

The Empire Plan also affords benefits to members of the SEHP through the various Empire Plan contracts with the Insurers. The SEHP was established in 1994 through collective bargaining. The SEHP became part of NYSHIP in 2002 to provide basic health insurance protection to graduate student employees of the State University of New York and their eligible Dependents. This benefit was extended to the graduate student employees of the City University of New York

(CUNY) on January 1, 2009. Like The Empire Plan, the SEHP includes hospital, medical, managed mental health and substance abuse benefits, and prescription drug benefits. Up through March 31, 2010, SEHP prescription drug benefits were subject to a $2,500 annual benefit maximum which was increased to $3,000 on April 1, 2010. The current SEHP prescription drug benefit maximum was removed effective January 1, 2011 as a result of the Patient Protection and Affordable Care Act. The SEHP prescription drug benefit maximum was replaced with a combined hospital, medical, managed mental health and substance abuse, and prescription drug benefit annual limit of $1,250,000 effective January 1, 2012. The benefit maximum will be increased to $2,000,000 effective January 1, 2013 and no annual combined SEHP benefit limit is permitted for plan years beginning January 1, 2014. SEHP is administered by the EBD. SEHP covers an average of 5,600 employees; their eligible covered Dependents bring the total number of average covered lives to approximately 6,800.

D. Overview of the DCS and NYSIF Prescription Drug Programs (Amended April 4, 2012)

The Programs utilize The Empire Plan, Excelsior Plan, SEHP, and State Insurance Fund identification cards to access retail network pharmacies and the mail service pharmacy, including designated specialty pharmacy(ies). The Programs include a number of utilization management controls including mandatory generic substitution, prior authorization, physician education, and various other cost containment provisions. For a detailed description of the Programs, refer to Section IV of this RFP. The Empire Plan, Excelsior Plan, and the SEHP provides benefits to Enrollees and covered Dependents and the NYSIF provides benefits to injured workers (Claimants) for covered drugs subject to applicable copayments (DCS Programs only), days' supply limits and benefit maximums. The Programs cover up to a ninety (90) day supply of covered drugs through retail pharmacies, the mail service pharmacy, and the specialty pharmacy program, with refills up to one (1) year. For SEHP enrollees, a thirty (30) day supply limitation applies at retail network pharmacies. Exhibit II.C of this RFP provides the applicable copayments, supply limits, and benefit maximums by plan and employee group. Also for information purposes, the Department's current Empire Plan Certificate of Insurance, SEHP Summary Plan Description, Excelsior Comparison Chart and The Empire Plan At A Glance for specific employee groups are included as Exhibits II.D.1 through II.D.4 and II.E.4a through II.E.4c of this RFP.

DCS Program Enrollees who receive a covered drug from a network pharmacy incur out-of-pocket costs that are, in most instances, limited to the applicable copayment. DCS Program Enrollees who receive a covered drug from a non-network pharmacy, or who do not use their identification card and pay the full amount for a prescription at a network pharmacy, receive specific reimbursement based on whether the drug is categorized as a Level 1 (usually Generic), Level 2 (usually Preferred Brand) or Level 3 (usually Non-Preferred brand) drug. These provisions are set forth in claims processing within Section IV of this RFP. The DCS Programs currently have three (3) formulary benefit designs that the Contractor must administer:

1. **Traditional Empire Plan PDL** – The three-level open formulary benefit design generally features Generics on the first level, Preferred Brand named drugs on the second level, and Non-Preferred Brand name drugs on the third level. The Program's copayment structure offers an incentive to use Level 1 medications and Level 2 medications. In addition, copayments differ depending on whether a prescription is filled at retail or by mail order and according to the number of days' supply (currently ~~12.25%~~ less than 1% of Empire Plan enrollee contracts have this PDL);

2. **Flexible Formulary Drug Lists (2)** – The three-level Flexible Formulary was implemented effective January 1, 2009 for most Empire Plan employee groups, followed by a January 1, 2010 and April 1, 2010 implementation for several additional groups and the SEHP. The Flexible Formulary is a Preferred Drug list in which Brand Drugs may be assigned to different copayment levels based on clinical judgment and value to the Program. Drugs may be excluded from coverage if a therapeutic equivalent is on the Flexible Formulary or a therapeutically equivalent over-the-counter drug is available. It features Level 1 drugs which are assigned the lowest copayment and include all covered Generic Drugs and certain Brand-Name drugs. Level 2 drugs are assigned a higher copayment and include Preferred Brand-Name Drugs that have been selected because of their overall healthcare value. Level 3 drugs have the highest copayment and include Non-Preferred Brand-Name Drugs and Multi-Source Brand-Name drugs (with a generic equivalent). In addition, copayments differ depending on whether a prescription is filled at retail or by mail order, and according to the number of days' supply. SEHP and most Empire Plan enrollees have this plan design (currently ~~87.74~~ over 99% of enrollee contracts have this plan). In October 2011, as a result of collective

bargaining, an additional Flexible Formulary drug list or "Enhanced Flexible Formulary" was implemented with an added "Brand for Generic" feature for most Enrollees subject to the Flexible Formulary. With this feature, a brand-name drug may be placed on Level 1, or excluded, and the generic equivalent placed on Level 3, or excluded. With State approval, these placements may be revised mid-year when such changes are advantageous to the DCS Program; and

3. **Offeror's Book of Business PDL** – The three-level formulary was implemented effective January 1, 2009 for employees enrolled in the Excelsior Plan. This formulary may exclude certain drugs in a therapeutic category as well as have certain generic drugs subject to a Level 2 or 3 copayment. Under Excelsior's Plan benefit copayment design, Level 1 drugs have the lowest copayment, Level 2 drugs have the mid-range copayment, and Level 3 drugs have the highest copayment. The goal of the Excelsior Plan PDL is to offer a therapeutically sound formulary that costs 15% less than The Empire Plan formularies (currently .01% of enrollee contracts have this plan).

NYSIF

NYSIF provides prescription coverage to injured workers who are employed by individuals and companies that have workers' compensation policies with NYSIF. All medically necessary and appropriate drugs that are causally related to the loss are covered. NYSIF was created by Section 76 of the New York State Workers' Compensation Law (WCL). Responsibility for the daily operations and policy making of NYSIF rests with the Executive Director and his staff. The Board of Commissioners (Commissioners) oversees the administration of NYSIF.

NYSIF services over 50,000 Workers' Compensation claimants who fill approximately 700,000 prescriptions annually. Of this number, approximately 75% are dispensed through the services of a Pharmacy Benefits Management (PBM) provider. NYSIF Claimant does not incur copayments or out-of-pocket costs when utilizing network or non-network pharmacies. The NYSIF Program currently employs a single formulary benefit design that the Contractor must administer.

NYSIF PDL

The NYSIF PDL generally features Generic Drugs on the first level, Preferred Brand Drugs on the second level, and Non-Preferred Brand Drugs on the third level. The PDL proposed for the NYSIF

Program must include all drugs meeting the definition of Covered Drugs in this RFP. The selected Offeror is required to effectively communicate the content and requirements of the Program's PDL to Network Pharmacies, medical providers, and Enrollees. The design of the NYSIF Program does not require a Brand Drug in every therapeutic category. For the purpose of preparing a response to this RFP if an Offeror proposes a Preferred drug list which does not include a Preferred Brand Drug in every therapeutic category, the Offeror must include the clinical rationale and financial implications of the Offeror's determination. Offerors will submit cost information as required in Section V, Cost Proposal of this RFP.

E. Covered Drugs under the DCS and NYSIF Prescription Drug Programs

The DCS and NYSIF Programs cover medically necessary prescription drugs and insulin dispensed by a licensed pharmacy. The Programs cover prescription oral drugs, self-injectables and infusion drugs dispensed by a licensed pharmacy. With respect to the DCS Program, prescription drugs dispensed and billed by a physician are covered under The Empire Plan Medical Program, and prescription drugs dispensed and billed by a hospital are covered under The Empire Plan Hospital Program.

The following prescription drugs are covered when they are medically necessary and dispensed by a licensed retail pharmacy or through the mail service pharmacy:

1. **FDA Approved Drugs** that must bear the legend RX Only;

2. **State Restricted Drugs:** Drugs which can be dispensed in accordance with New York State Law (or by the laws of the state or jurisdiction in which the prescription is filled) by prescription only;

3. **Compounded Drug(s)/Medication(s) or Compounded Drug(s)/Medication(s):** A drug with two or more ingredients (solid, semi-solid, or liquid), at least one of which is a covered drug with a valid National Drug Code (NDC) and FDA approved requiring a prescription for dispensing, combined together in a method specified in a prescription issued by a medical professional. The end result of this combination must be a prescription medication for a specific patient that is not otherwise commercially available in that form or dose/strength

from a single manufacturer. The prescription must identify the multiple ingredients in the compound, including active ingredient(s), diluents(s), ratio's or amounts of product, therapeutic use, and directions for use. The act of compounding must be performed or supervised by a licensed pharmacist. Any commercially available product with a unique assigned NDC requiring reconstitution or mixing according to the FDA approved package insert prior to dispensing will not be considered a compound drug prescription by this Program;

4. **Injectable Insulin**;

5. **Oral, Injectable, or Surgically Implanted Contraceptives** that bear the legend RX Only and contraceptive devices (e.g., diaphragms and cervical caps) that require a Physician's order;

6. **Vitamins** which are FDA approved prescription drugs and bear the legend RX Only;

7. **Prescription Drugs** dispensed by on-premises pharmacies to patients in a Skilled Nursing Facility; rest home; sanitarium; extended care facility; convalescent hospital; or similar facility; and

8. **Drugs dispensed outside of the U.S.** that have an available U.S. FDA approved equivalent.

F. The DCS and NYSIF Prescription Drug Program Exclusions and Limitations

Coverage for the following drugs are excluded or limited under the Programs:

1. Drugs obtained with no prescription order, including over-the-counter products except insulin;

2. Drugs taken or given at the time and place of the prescription order and billed by the Doctor;

3. Drugs provided or required by any governmental program or statute (other than Medicaid) unless there is a legal obligation to pay;

4. Drugs for which there is no charge or legal obligation to pay in the absence of insurance;

5. Any drug refill which is more than the number approved by the Doctor;

6. Contraceptive jellies, ointments, and foams, or devices not requiring a Doctor's order, prescribed for any reason;

7. Therapeutic devices or appliances (e.g., hypodermic needles, syringes, support garments, or other non-medicinal substances) regardless of their intended use;

8. The administration of any drug or injectable insulin;

9. Any drug refill which is dispensed more than one (1) year after the original date of the prescription order;

10. Any drug labeled "Caution: Limited by Federal Law to Investigational Use," or experimental drugs except for drugs used for the treatment of cancer as specified in Section 3221(l)(12) of New York State Insurance Law as may be amended from time to time. Prescribed drugs approved by the U.S. Food and Drug Administration for the treatment of certain types of cancer shall not be excluded when the drug has been prescribed for another type of cancer. However, coverage shall not be provided for experimental or investigational drugs or for any drug which the Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed;

11. Experimental or investigational drugs shall also be covered when approved by an External Appeal Agent in accordance with an external appeal. If the External Appeal Agent approves coverage of an experimental or investigational drug that is part of a clinical trial, only the costs of the drug will be covered. Coverage will not be provided for the costs of experimental or investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs not otherwise covered by the Programs for non-experimental or non-investigational drugs provided in connection with such clinical trial;

12. Immunizing agents, biological sera, blood or blood plasma, except immune globulin;

13. Any drug which a Doctor or other health professional is not authorized by his or her license to prescribe;

14. (Exclusive to DCS) Drugs for an injury or sickness related to employment for which benefits are provided by any state or Federal Workers' Compensation, employer's liability or

occupational disease law, or under Medicare or other governmental program, except Medicaid and the Veterans Administration;

15. Drugs purchased prior to the start of coverage or after coverage ends. However, if the person is totally disabled on the date coverage ends, benefits for the disabling condition will be provided on the same basis as if coverage had continued, with no change in coverage effective until the day the person is no longer totally disabled or for three (3) months after the date his/her coverage ended, whichever is earlier;

16. Any drug prescribed and/or dispensed in violation of NYS or Federal Law;

17. Drugs furnished solely for the purpose of improving appearance rather than physical function or control of organic disease, which include, but are not limited to:

    a. Non-amphetamine anorexiants, except when prescribed for morbid obesity;
    b. Amphetamines that are prescribed for weight loss, except for morbid obesity;
    c. Products used to promote hair growth;
    d. Products (ex. Retinoic Acid) used for prevention of skin wrinkling;

18. Any non-medically necessary drugs;

19. Drugs administered to you by the facility while a patient is in a licensed hospital. This limit applies only if the hospital in which the member is a patient operates on its premises, or allows to be operated on its premises, a facility that dispenses pharmaceuticals. And dispenses such drugs administered to the member by the hospital;

20. Contraceptive Intrauterine Devices (I.U.D.) that do not contain any FDA approved hormone prescription drug products;

21. Coverage for drugs where the amount dispensed exceeds the supply limit;

22. Coverage for drugs as a replacement for a previously dispensed drug;

23. Products for which the primary use is nutrition; and

24. Foreign drugs for which there is no available US equivalent approved by the FDA.

SECTION II: PROCUREMENT PROTOCOL AND PROCESS

A. Rules Governing Conduct of Competitive Procurement Process

1. Timeline/Key Events (Amended March 8, 2012 and April 4, 2012)

RFP Release Date	February 22, 2012
Exhibit I.K Procurement Lobby Offeror's Affirmation of Understanding & Agreement Due Date	See below*
~~Request for Data Necessary to Submit a Proposal Due Date (See Section III.G. of this RFP)~~	~~March 13, 2012~~
Pre-Proposal Conference	March 14, 2012
Questions Due Date	March 20, 2012, 5:00 p.m. ET
~~Optional Re-Priced Claims Test File Due Date~~	~~April 3, 2012~~
Release Date of Official Responses to Questions	April 4, 2012
Exhibit I.J Notice of Bidding Intention Due Date	April 18, 2012
Proposals Due Date	May 8, 2012, 3:00 p.m. ET
Anticipated Contract Start Date	Upon OSC approval of the Agreement, with the Medicare Employer Group Waiver Plan (EGWP) requirements of the Agreement (DCS Agreement Only) to begin January 1, 2013 and claims adjudication for the Programs (DCS and NYSIF) to be fully implemented by January 1, 2014

***** Prior to the Offe ror's **initial** contact with the Department, the Offeror must complete and submit Exhibit I.K Procurement Lobbying Offeror's Affirmation of Understanding & Agreement to the Pharmacy Benefit Services Procurement Manager**.**

2. Procurement Lobbying Limitations

a. Pursuant to State Finance Law sections 139-j and 139-k, this Procurement imposes certain procurement lobbying limitations. Offerors are restricted from making contacts during the Procurement's "Restricted Period" (from the issuance of the RFP until the date of the Contract's final approval by the OSC) to other than designated staff of the Procuring Agencies and the Executive Branch of New York State government, unless the

contact falls within certain statutory exceptions ("permissible contacts"). For purposes of this §II.A.2 of the RFP, "Offeror" includes prospective Offerors prior to the due date for the submission of offers/bids (i.e., Proposals) in response to the RFP. Staff is required to obtain certain information from Offerors and others whenever there is a contact about the Procurement during the Restricted Period, and are required to make a determination of the Offeror's responsibility that addresses the Offeror's compliance with the statutes' requirements. Findings of non-responsibility result in rejection for contract award, and if an Offeror is subject to two non-responsibility findings within four years the Offeror also will be determined ineligible to submit a proposal on, or be awarded a contract for four years from the date of the second non-responsibility finding. The Procuring Agencies' Policy and associated procedures are included as **Exhibit I.L, "Procurement Lobbying Policy: Restrictions on Contacts During the Procurement Process"** to this RFP. Further information about these requirements can be found at: http://www.ogs.ny.gov/aboutOGS/regulations/defaultAdvisoryCouncil.html

b. In order to ensure public confidence and integrity in the procurement process, the Procuring Agencies will strictly control all communications between any Offeror and participants in the evaluation process, from the date the RFP is released until the Contracts are approved by OSC. "Offeror" means any individual or entity, or any employee, agent, consultant, or person acting on behalf of such individual or entity, who contacts the Procuring Agencies or any other State governmental entity about a governmental procurement during that procurement's restricted period, whether or not the caller has a financial interest in the outcome of the governmental procurement; provided, however, that a governmental agency or its employees that communicates with the Procuring Agencies regarding a governmental procurement in the exercise of its oversight duties shall not be considered an Offeror. "Offeror" includes prospective Offerors prior to the due date for the submission of offers/bids in response to the solicitation document. All contacts, inquires, questions, filings and submission of Proposals in regard to the RFP must be directed, in writing, by mail, facsimile or e-mail, as applicable, solely to the Pharmacy Benefit Services Procurement Manager. An Offeror's failure to comply with this requirement may result in the Offeror's disqualification from this Procurement.

Pharmacy Benefit Services Procurement Manager
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Additionally, prospective Offerors and Offerors are strictly prohibited from making any contacts or inquiries concerning the Procurement with any member, officer or employee of any NYS governmental entity other than the Procuring Agencies from the date the RFP is released until the Contracts are approved by OSC subject only to the specific exceptions listed below. Further, any Offeror shall not attempt to influence the Procurement in any manner that would result in a violation or an attempted violation of Public Officers Law sections 73(5) or 74.

c. The following contacts are exempted from the provisions of paragraph 3 of section 139-j and as such do not need to be directed to the Pharmacy Benefit Services Procurement Manager pursuant to section 139-k:

(1) the submission of written Proposals in response to the RFP;

(2) the submission of written questions by a method set forth in RFP when all written questions and responses are to be distributed to all Offerors who have expressed an interest in the Procurement;

(3) participation in a demonstration, conference or other means for exchange of information in a setting open to all potential bidders provided for in RFP;

(4) complaints by an Offeror regarding the failure of the Pharmacy Benefit Services Procurement Manager to respond to an Offeror's authorized contacts, when such complaints are made in writing to the Department's Office of the General Counsel, provided that any such written complaints shall become a part of the procurement record;

(5) communications by a successful Offeror(s) who has been tentatively awarded a contract and is engaged in communications with the Department solely for the purpose of negotiating the terms of the Contract after having been notified of tentative award;

(6) contact by an Offeror to request the review of a procurement award when done in accordance with the procedure specified in the solicitation document;

a. contacts by an Offeror in protests, appeals or other review proceedings (including the apparent successful Offeror and its representatives) before the Procuring Agencies seek a final administrative determination, or in a subsequent judicial proceeding; or

b. complaints of alleged improper conduct in the Procurement when such complaints are made to the NYS Attorney General, Inspector General, District Attorney, or to a court of competent jurisdiction; or

c. written protests, appeals or complaints to the NYS Comptroller's office during the process of contract approval, where the NYS Comptroller's approval is required provided that the NYS Comptroller shall make a record of such communications and any response thereto which shall be entered into the procurement record pursuant to State Finance Law Section 163; or

d. complaints of alleged improper conduct in a governmental procurement conducted by a municipal agency or local legislative body to the NYS Comptroller's office; and

(7) communications between Offerors and governmental entities that solely address the determination of responsibility by a governmental entity of an Offeror.

d. It is ***mandatory*** that all prospective Offerors/Offerors complete Part 1 of **Exhibit I.K**, **"Procurement Lobbying Offeror's Affirmation of Understanding and Agreement"** affirming their understanding of, and agreement to, comply with the procurement lobbying requirements set forth in State Finance Law §139-k and §139-j. A completed

Exhibit I.K must be submitted to the Pharmacy Benefit Services Procurement Manager **prior to a prospective Offeror making its initial contact with the Procuring Agencies** (e.g., attendance at the Pre-Proposal Conference, submission of a Notice of Bidding Intention Form (Exhibit I.J), submission of questions, etc. or concurrent with an Offeror's submission of its Proposal, whichever shall occur first). Offerors are advised that whenever any of the Offeror's officers, employees, agents or consultants contacts the Procuring Agencies, they should be prepared to provide their name, address, telephone number, place of principal employment, occupation, and whether they were retained, employed or designated, by or on behalf of the Offeror to appear before or contact the Procuring Agencies in regards to this Procurement. To that end and to streamline the process, Offerors are requested to complete and submit Part 1 of **Exhibit I.K** entitled, "Designated Offeror Contact" for each officer, employee, agent or consultant authorized by the Offeror to appear before or contact the Procuring Agencies in regards to this Procurement before appearing or before or at the time such contact is initiated.

Additionally, at the time a Proposal is submitted to the Procuring Agencies, the Offeror is required to provide a completed "Offeror's Certification of Compliance Pursuant to State Finance Law §139-k" form. This certification is included as **Exhibit I.P** of this RFP.

3. Notice of Bidding Intention Form

Filing of this notice is **not** mandatory; however, to assist the Procuring Agencies in better managing the procurement process, prospective Offerors, whether they intend to submit a Proposal in response to this RFP or not, are requested to complete a **"Notice of Bidding Intention Form"** (**Exhibit I.J**) and submit it to the Pharmacy Benefit Services Procurement Manager by the Notice of Bidding Intention Deadline as set forth in Section II.A.1. The completed form may be submitted either in hardcopy, at the address provided in Section II.A.2.b. or electronically at: 2014RxBenefitRFP@cs.state.ny.us.

On the Notice of Bidding Intention Form, New York State certified Minority and Women-Owned Businesses (M/WBE) may request that their firm's contact information be included on a list of M/WBE firms interested in serving as a subcontractor for this Procurement.

The listing will be publicly posted on the Procurement webpage at: www.cs.ny.gov/2014RxBenefitRFP/index.cfm for reference by the bidding community. A firm requesting inclusion on this list should send a copy of its NYS M/WBE certification with its completed Notice of Bidding Intention Form. Nothing prohibits an M/WBE vendor from proposing as a prime contractor.

4. Pre-Proposal Conference

A Pre-Proposal Conference will be held on March 14, 2012 in Room 148 of the Alfred E. Smith Office Building, Albany, NY, at 10:00 a.m. Attendance is not mandatory, but is strongly encouraged for Offerors intending to submit a Proposal.

Each Offeror is requested to send no more than three (3) representatives to the Pre-Proposal Conference. If your organization plans to attend the Pre-Proposal Conference, please notify the Pharmacy Benefit Services Procurement Manager via facsimile or e-mail at the address noted in Section II.A.2.b. at least five (5) business days before the conference with the name and affiliation of each person attending. Please be advised that due to security requirements, all visitors must be registered in the Alfred E. Smith Building's Visitors' Management System in advance of the meeting date. On the date of the conference, visitors may be required to present photo identification. Prospective Offerors are advised to allow sufficient time to go through security.

5. Submission of Errors or Omissions in the RFP Document

By participating in activities related to this Procurement, and/or by submitting a Proposal in response to this RFP, prospective Offerors agree to be bound by its terms, including, but not limited to, this process by which a prospective Offeror may submit errors or omissions for consideration. In the event that a prospective Offeror believes there is an error or omission in the RFP, the prospective Offeror may raise such issue according to the following provisions:

a. Process for Submitting Assertions of Errors or Omissions in RFP Document

(1) ***Time Frame***: Assertions of errors or omissions in the procurement process which are or should have been apparent prior to the Proposal Due Date must be received by the Procuring Agencies, in writing, five (5) business days after the Release Date of Official Responses to Questions specified in Section II.A.1.

(2) ***Content***: The submission alleging the error or omission must clearly and fully state the legal and/or factual grounds for the assertion and must include all relevant documentation.

(3) ***Format of Submission***: All submissions asserting an error or omission must be in writing and submitted to the Pharmacy Benefit Services Procurement Manager at the following address:

Pharmacy Benefit Services Procurement Manager
Employee Benefits Division, Room 641
NYS Department of Civil Service
Alfred E. Smith Office Building
Albany, New York 12239

The envelope or package must clearly and prominently display the following statement:

"Submission of Errors or Omissions for the
Pharmacy Benefit Services for The Empire Plan, Excelsior Plan,
Student Employee Health Plan, and New York State Insurance Fund
Work ers' Co mp en sation Prescription Drug
Program
Request for Proposals # 2012RX-1"

Any assertion of an error or omission which does not conform to the requirements set forth in this section shall be deemed waived by the prospective Offeror and the prospective Offeror shall have no further recourse.

b. The Review Process for Assertions of Errors or Omissions in RFP Document

The Procuring Agencies shall conduct the review process for submission of errors or omissions. The Commissioner may appoint a designee who will review the submission and make a recommendation to the Commissioner as to the disposition of the matter. The Commissioner's designee may be an employee of the Procuring Agencies but, in any event, shall be someone who has not participated in the preparation of this RFP, the evaluation of Proposals, or the selection decision. At the discretion of the Commissioner, or the Commissioner's designee, the prospective Offeror may be given the opportunity to meet with the Commissioner or the Commissioner's designee, as the case may be, to support its submission. The prospective Offeror may, but need not, be represented by

counsel at such a meeting. Any and all issues concerning the manner in which the review process is conducted shall be determined solely by the Commissioner or the Commissioner's designee.

The Commissioner, or the Commissioner's designee, shall review the matter, and the Commissioner shall issue a written decision within twenty (20) business days after the close of the review process. If additional time for the issuance of the decision is necessary, the prospective Offeror shall be advised of the delay and of the time frame within which a decision may be reasonably expected. The Commissioner's decision will be communicated to the party in writing and shall constitute the agency's final determination in the matter.

The Procuring Agencies reserve the right to determine and to act in the best interests of the State in resolving any assertion of error or omission in the RFP document. As a consequence of reviewing the assertion, the Procuring Agencies may elect to extend the Proposal Due Date as may be appropriate. Notice of any such extension will be provided to all organizations who registered via mail, facsimile or e-mail. Notice of any extension will also be posted to: www.cs.ny.gov/2014RxBenefitRFP/index.cfm.

6. Submission of Questions

In the event a prospective Offeror has any substantive or procedural questions concerning the content of the RFP document, those questions can be submitted in the following manner to:

Pharmacy Benefit Services Procurement Manager
Employee Benefits Division, Room 641
NYS Department of Civil Service
Alfred E. Smith Office Building
Albany, New York 12239
Fax: 518-402-2835
E-Mail: 2014RxBenefitRFP@cs.state.ny.us

Prospective Offerors may submit questions to the Pharmacy Benefit Services Procurement Manager, in writing, via e-mail, facsimile or mail. The Procuring Agencies strongly urges prospective Offerors to submit the questions via e-mail. Each question should cite the particular RFP section, page number and paragraph number to which it refers. All responses

will be considered unofficial until issued or confirmed in writing by the Procuring Agencies on the procurement website. Only those questions received prior to 5:00 p.m. Eastern Time (ET), on the Questions Due Date as shown in Section II.A.1. of this RFP, will be accepted.

To expedite its responses, the Procuring Agencies have provided a question template form which prospective Offerors are requested to use in submitting questions regarding the RFP (see RFP, [**Exhibit I.R**] "Question Template").

After the Questions Due Date, the Procuring Agencies will provide to all organizations who have registered, e-mail notification of the posting of all questions received and the Procuring Agencies' Official Responses to said questions. The aforementioned information will be posted to: www.cs.ny.gov/2014RxBenefitRFP/index.cfm and all registered potential Offerors will be notified of the posting to this site.

7. Submission of Proposal

a. Submission Requirements

The Offeror's Proposal must be organized and separated into three (3) separate parts: Administrative Proposal, Technical Proposal, and Cost Proposal. To facilitate the evaluation process, Offerors must submit Sixteen (16) separately bound hard copies (four (4) ORIGINALS and twelve (12) copies) and one (1) electronic copy (CD) **of each of the three (3) parts** of the Offeror's Proposal. Electronic submissions must be in Adobe Acrobat, as applicable. These forty eight (48) documents and three (3) CDs are collectively hereafter referred to as "Submissions."

Each ORIGINAL hard copy of each part must be marked "ORIGINAL," contain original signatures of an official(s) authorization to bind the Offeror to its provisions on all forms submitted that require the Offeror's signature and should be numbered sequentially, i.e. Original #1, Original #2, Original #3, Original #4. The remaining twelve (12) hard copies of each part may contain a copy of the official's signature and should be numbered sequentially (e.g. Copy #1, Copy #2, etc). Please note that for each of the three (3) parts, hard copies of each marked "Original #1" will be deemed controlling by the Procuring Agencies when viewing the Proposal.

Proposals should be placed and packaged together, by part, in sealed boxes/envelopes. Each sealed box/envelope should contain a label on the outside of the container which contains the information below.

New York State Department of Civil Service
Request for Proposals # 2012RX-1
"Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Programs"

OFFEROR NAME
OFFEROR ADDRESS

Indicate content, as applicable
ADMNISTRATIVE, TECHNICAL or COST PROPOSAL

There must be no cost information included in the Offeror's Administrative Proposal or Technical Proposal.

All Proposals must be mailed or hand-delivered to:

Pharmacy Benefit Services Procurement Manager
ATTN: Employee Benefits Division, Room 641
NYS Department of Civil Service
Alfred E. Smith Office Building
Albany, New York 12239

For those Offerors who plan to have the Proposal hand delivered to the above address, arrangements for acceptance of the package must be made in accordance with procurement security procedures. **To make such arrangements, the Procuring Agencies request that the Offeror notify the Pharmacy Benefit Services Procurement Manager forty-eight (48) hours prior to delivery. All Proposals must be received by 3:00 p.m. ET on the Proposal Due Date as set forth in Section II.A.1. of the RFP.** ***No exceptions will be made for late submission or delays in delivery of the Proposal***. If the Proposal is delivered by mail or courier, the Procuring Agencies recommend that it be sent "return receipt requested," so the Offeror obtains proof of timely delivery.

All Proposals submitted become the property of the Procuring Agencies. Any proposal received after 3:00 p.m. ET on the Proposal Due Date will not be accepted by the Procuring Agencies and may be returned to the submitting entity at the Procuring Agencies' discretion.

The Procuring Agencies will accept amendments and/or additions to an Offeror's Proposal if the request is received by the Procuring Agencies **prior** to 3:00 p.m. ET on the Proposal Due Date. All amendments to an Offeror's Proposal must be submitted in writing, in accordance with the format set forth in Section II.A.7. of this RFP, and will be included as part of the Offeror's Proposal, if accepted by the Procuring Agencies as provided above.

Offerors are cautioned to verify the content of their Proposal before submission. Except for material received from an Offeror in response to a request by the Procuring Agencies, the Procuring Agencies will not accept amendments or additions to a Proposal if such material is received after 3:00 p.m. ET on the Proposal Due Date. Offerors are encouraged to submit the Proposal Submission Checklist (**Exhibit I.A**) to facilitate verification of Proposal contents. An Offeror's request to withdraw a Proposal after the Proposal Due Date may be considered at the sole discretion of the Procuring Agencies.

b. Formatting Requirements

The Administrative Proposal, Technical Proposal, and Cost Proposal each should comply with the following formatting requirements (Failure to comply with the formatting requirements herein below may, but will not necessarily, result in the Proposal being deemed non-responsive and may, but will not necessarily, result in rejection of the Proposal):

(1) ***Binding of Proposal****:* The Administrative, Technical, and Cost Proposals must be separately bound. The official name of the organization(s) and "Pharmacy Benefit Services for The Empire Plan Prescription Drug Program, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Programs" must appear on the outside front cover of each copy of the Offeror's Administrative, Technical, and Cost Proposal. If the Proposals are

submitted in loose-leaf binders, the official name(s) of the organization(s) and "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Programs" also must appear on the spine of the binders;

(2) ***Table of Contents****:* Each Proposal must include a table of contents;

(3) ***Index Tabs****:* Each major Section of the Proposal and each Exhibit must be labeled with an index tab that completely identifies the title of the Section or Exhibit as named in the table of contents;

(4) ***Pagination****:* Each page of the Proposal, including Exhibits, must be labeled on the upper right with the Section title and Section reference, page number, and date. Pages within each Section and Exhibit must be numbered consecutively;

(5) ***Proposal Updates/Corrections****:* Each Offeror must submit its Proposal so that any update pages required by the Procuring Agencies can be easily incorporated into the Proposal. Should it be necessary for an Offeror to submit additional information in support of its Proposal, it must be submitted in accordance with the following: upon written notification by the Offeror and agreement by the Procuring Agencies, new or replacement pages may be placed in the Proposal. All new or replacement pages will show the date of the revision and indicate the portion of the page being changed. This latter requirement will be fulfilled by drawing vertical lines down both margins of all affected passages. All new/ replacement pages will be noted by the Procuring Agencies on the errata sheet to be placed at the front of the Proposal copy; and,

(6) ***Required Content of Proposals****:* The Proposal shall consist of three parts: 1) the Administrative Proposal, which must respond to the requirements set forth in Section III of this RFP; 2) the Technical Proposal, which must respond to the requirements set forth in Section IV of this RFP; and 3) the Cost Proposal, which must respond to the requirements set forth in Section V of this RFP.

c. Material Deviations

New York State Law prohibits NYS from awarding a contract based upon material deviations from the specifications, terms, and conditions set forth in the RFP. Consequently, each Offeror's Proposal must conform to the specifications, terms, and conditions set forth in this RFP and prospective Offerors are strongly advised to raise issues and/or concerns relating to this procurement during the question and answer phase rather than taking exceptions within their Proposals. Material deviations from the specifications, terms, and conditions set forth in the RFP may render the Proposal non-responsive and may result in rejection of the Proposal.

In general, a material deviation is one that would (1) impair the interests of NYS, (ii) place the successful Offeror in a position of unfair economic advantage, (iii) place other Offerors at a competitive disadvantage, or (iv) which, if it had been included in the original RFP, could have formed a reasonable basis for an otherwise qualified Offeror to change its determination concerning the submission of a Proposal. For example, a deviation that would substantially shift liability (risk) from the Offeror to NYS or substantially shift financial responsibility from the Offeror to NYS would be considered material.

Offerors are advised that Offeror's standard, pre-printed material (including but not limited to: product literature, order forms, manufacturer's license agreements, standard contracts or other pre-printed documents), which are physically attached or summarily referenced in the Offeror's Proposal, unless specifically required by the RFP to be submitted as part of the Offeror's Proposal, will not be considered as having been submitted with or intended to be incorporated as part of the official offer contained in the Proposal, but rather will be deemed by the State to have been included by Offeror for informational or promotional purposes only.

d. Proposed Alternatives or Enhancements

The Offeror's Proposal must adhere to the programmatic duties and responsibilities as described in the RFP. If the Offeror wishes to also submit an alternative approach to

addressing any duties and responsibilities of the RFP, it may do so, but any suggested modification, enhancement, and/or alternative approach must be presented in a separately bound and sealed submission marked "Alternatives." The information contained in this volume **will not be evaluated** during the procurement process. The only reference to any proposed "Alternatives" permitted in the Offeror's Technical or Cost Proposals is "(Alternative Proposed)." Any indication beyond this citation is strictly prohibited. Evaluation of all Proposals and the selection of the Successful Offeror shall be based only upon the Offeror's proposal regarding the duties and responsibilities set forth in the RFP, and shall not be based upon any such supplemental material.

8. Notification of Award

A proposed award notification letter will be sent to the selected Offeror indicating a conditional award subject to successful contract negotiations. The remaining Offerors will be notified of the conditional award and the possibility that failed negotiations could result in an alternative award. No public discussion or news releases relating to this RFP, the associated procurement process, including but not limited to the bid solicitation, proposal evaluation and award and contract negotiation processes or the Agreement shall be made by any Offeror or their agent without the prior written approval of the Procuring Agencies.

9. Debriefing

As stated in RFP, §II.A.8 above, proposed award notification letters will be sent to the selected and non-selected Offerors. At that time, Offerors will be advised of the opportunity to request a Debriefing and the timeframe by which such requests must be made, dependent upon the nature of the Debriefing, i.e., pre-award or post-award. Debriefings are subject to the Procuring Agencies' Debriefing Guidelines which are set forth in Exhibit I.H. entitled, "NYS Department of Civil Service Debriefing Guidelines." An unsuccessful Offeror's written request for a debriefing shall be submitted to:

Pharmacy Benefit Services Procurement Manager
Employee Benefits Division, Room 641
NYS Department of Civil Service
Alfred E. Smith Office Building
Albany, New York 12239
Fax: 518-402-2835
E-Mail: 2014RxBenefitRFP@cs.state.ny.us

10. Submission of Award Protests

By participating in activities related to this Procurement, and/or by submitting a Proposal in response to this RFP, all Offerors agree to be bound by its terms including, but not limited to, the process by which an Offeror may submit protests of the selection award for consideration. In the event that an Offeror decides to protest the selection decision, the Offeror may raise such issue according to the following provisions.

a. Process for Submitting Post Award Protests of the Selection Decision

(1) ***Time Frame:*** Any protest of the selection decision must be received no later than ten (10) business days after an Offeror's receipt of written notification by the Department of a conditional award.

(2) ***Content:*** The submission of the protest must clearly and fully state the legal and/or factual grounds for the protest and must include all relevant documentation.

(3) ***Format of Submission:*** All submissions of protest must be in writing and submitted to the Pharmacy Benefit Services Procurement Manager at the following address:

Pharmacy Benefit Services Procurement Manager
ATTN: Employee Benefits Division, Room 641
NYS Department of Civil Service
Alfred E. Smith Office Building
Albany, New York 12239

A protest of the selection decision must have the following statement clearly and prominently displayed on the envelope or package:

"Submission of Selection Protest for the Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Programs"

Any assertion of protest which does not conform to the requirements set forth in this section shall be deemed waived by the Offeror, and the Offeror shall have no further recourse.

b. The Review Process for Submission of Protests

The Procuring Agencies shall conduct the review process of submitted protests. The Department's Commissioner may appoint a designee to review the submission and to make a recommendation to the Commissioner as to the disposition of the matter. The Commissioner's designee may be an employee of the Procuring Agencies but, in any event, shall be someone who has not participated in the preparation of this RFP, the evaluation of Proposals, or the selection decision. At the discretion of the Commissioner, or the Commissioner's designee, the Offeror may be given the opportunity to meet with the Commissioner or her designee, as the case may be, to support its submission. The Offeror may, but need not, be represented by counsel at such a meeting. Any and all issues concerning the manner in which the review process is conducted shall be determined solely by the Commissioner, or the Commissioner's designee.

The Commissioner, or the Commissioner's designee, shall review the matter, and the Commissioner shall issue a written decision within twenty (20) business days after the close of the review process. If additional time for the issuance of the decision is necessary, the Offeror shall be advised of the delay and of the time frame within which a decision may be reasonably expected. The Commissioner's decision will be communicated to the party in writing and shall constitute the Procuring Agencies' final determination in the matter.

In the event that an Offeror protests the selection decision, the Procuring Agencies shall continue working with the selected Offeror pending the outcome of the protest. Any Offeror whose Proposal might become eligible for a conditional award in the event that the intended selection is disqualified may be asked to extend the time for which their Proposal shall remain valid.

The Procuring Agencies reserve the right to determine and to act in the best interests of the State in resolving any post award selection protest.

11. Procuring Agencies Reservation of Rights (Amended April 4, 2012)

In addition to any rights articulated elsewhere in this RFP, the Procuring Agencies reserve the right to, as applicable:

a. Make or not make a single joint award under the RFP, either in whole or in part. In addition, NYSIF further reserves the sole right not to make an award under the RFP, in whole or in part, however, a decision by NYSIF to not make an award in whole or in part, shall not preclude the Department from making an award for those components of the RFP applicable to the Department, in whole or in part. If NYSIF chooses not to make an award in whole under the RFP, but the Department does choose to make an award, in whole or in part, then the NYSIF Program shall be deemed to be withdrawn from the RFP and Offerors Proposals will be scored accordingly as provided for in the Procurement's detailed evaluation criteria;

b. Prior to the bid opening, amend the RFP. If the Procuring Agencies elect to amend any part of the RFP, notification of the amendment will be provided to all organizations who submitted a Notice of Bidding Intention Form (**Exhibit I.J**) via e-mail, facsimile or mail. Any amendments will also be posted to: www.cs.ny.gov/PharmacyBenefitRFP/index.cfm.

c. Prior to the bid opening, direct Offerors to submit Proposal modifications addressing subsequent RFP amendments;

d. Withdraw the RFP, at any time, in whole or in part, at the Procuring Agencies' sole discretion. The Department and NYSIF separately reserve the right to withdraw their respective components from the RFP, in whole or in part. Should the Department, at any time, choose to withdraw its respective components from the RFP, in whole, NYSIF's components will be deemed to be withdrawn in whole. A determination by NYSIF to withdraw its respective components, in part or in whole, regardless of when that decision is made, shall have no effect or impact on the Department or the Department's decision to withdraw or not withdraw the Department's respective components of the RFP;

e. Waive any requirements that are not material;

f. Disqualify any Offeror whose conduct and/or Proposal fails to conform to any of the mandatory requirements of the RFP;

g. Require clarification at any time during the Procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete

understanding of an Offeror's Proposal and/or to determine an Offeror's compliance with the requirements of this RFP;

h. Reject any or all Proposals received in response to this RFP, at its sole discretion;

i. Change any of the scheduled dates stated in this RFP;

j. Seek clarifications and revisions of Proposals;

k. Establish programmatic and legal requirements to meet either or both of the Procuring Agencies' needs, and to modify, correct, and/or clarify such requirements at any time during the Procurement, provided that any such modifications would not materially benefit or disadvantage any particular Offeror;

l. Eliminate any mandatory, non-material specifications that cannot be complied with by all of the Offerors;

m. For the purposes of ensuring completeness and comparability of the Proposals, analyze submissions and make adjustments or normalize submissions in the Proposal(s), including the Offeror's technical assumptions, and underlying calculations and assumptions used to support the Offeror's computation of costs, or to apply such other methods it deems necessary to make level comparisons across Proposals ~~(e.g., if prior to completion of the Business Model Assessment , NYSIF were to determine it was in NYSIF's best interests not to make a contract award);~~

n. Use the Proposal, information obtained through any site visits, management interviews, and the Procuring Agencies' own investigation of an Offeror's qualifications, experience, ability or financial standing, and any other material or information submitted by the Offeror in response to the Procuring Agencies' request for clarifying information, if any, in the course of evaluation and selection under this RFP;

o. Negotiate with the successful Offeror within the scope of the RFP in the best interests of the Department and NYSIF, or the Department or NYSIF, as applicable; and

p. Utilize any and all ideas submitted in the Proposal(s) received.

12. Limitation of Liability

The Procuring Agencies are not liable for any cost incurred by any Offeror prior to approval of the Agreement by OSC. Additionally, no cost will be incurred by the Procuring Agencies for any prospective Offeror or Offeror's participation in any procurement related activities.

The Procuring Agencies have taken care in preparing the data accompanying this RFP (hard copy Exhibits, website Exhibits, and sample document exhibits). However, the Procuring Agencies do not warrant the accuracy of the data; the numbers or statistics which appear in hardcopy Exhibits, website Exhibits, and sample document exhibits referenced throughout this RFP which are for informational purposes only and should not be used or viewed by prospective Offerors as guarantees or representations of any levels of past or future performance or participation. Accordingly, prospective Offerors should rely upon and use such numbers or statistics in preparing their Proposals at their own discretion.

B. Compliance With Applicable Rules, Laws, Regulations & Executive Orders

This Procurement is being conducted in accordance with, and is subject to, the competitive bidding laws of the State of New York (New York State Finance Law, Article 11) and it is governed by, at a minimum, the legal authorities referenced below. All Offerors must fully comply with the provisions and set forth in this Section II.B. of the RFP. The Procuring Agencies will consider for evaluation and selection purposes only those Offerors who agree to comply with these provisions whose Proposal contains the Statements, Formal Certifications, and Exhibits submissions required hereunder.

1. Public Officers Law

All Offerors and Offerors' employees and agents must be aware of and comply with the requirements of the New York State Public Officers Law ("POL"), particularly POL Sections 73 and 74, as well as all other provisions of New York State law, rules and regulations, and policy establishing ethical standards for current and former NYS employees. In signing its Proposal, each Offeror guarantees knowledge and full compliance with such provisions for purposes of this RFP and any other activities including, but not limited to, contracts, bids, offers, and negotiations. Failure to comply with these provisions may result in disqualification

from the procurement process, termination, suspension or cancellation of the Agreement and criminal proceedings as may be required by law. Per RFP §III.C, Offerors must submit an affirmative statement as to the existence of, absence of, or potential for conflict of interest on the part of the Offeror because of prior, current, or proposed contracts, engagements, or affiliations, by submitting a completed **Exhibit I.M** in the Offeror's Administrative Proposal.

2. Omnibus Procurement Act of 1994 and its 2000 Amendment

Offerors are hereby notified that, if their principal place of business is located in a foreign or domestic jurisdiction that penalizes New York State vendors, and if the goods or services they offer would be produced or performed substantially outside New York State, the Omnibus Procurement Act of 1994 and its 2000 amendments require that they be denied contracts which they otherwise could obtain.

The list of jurisdictions subject to this provision is set forth in Article 21 of Appendix A.

3. Contractor Requirements and Procedures for Business Participation Opportunities for NYS Certified Minority and Women-Owned Business Enterprises and Equal Employment Opportunities ("EEO") for Minority Group Members and Women

New York State Law:

Pursuant to New York State Executive Law Article 15-A, the Procuring Agencies recognize their obligation under the law to promote opportunities for the maximum feasible participation of certified minority and women-owned business enterprises and the employment of minority group members and women in the performance of the Procuring Agencies' contracts. By submitting a Proposal in response to this procurement, the Offeror agrees to comply with the provisions of the RFP, including but not limited to Appendix D, entitled "Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures" and the requirements set forth herein.

In 2006, the State of New York commissioned a disparity study to evaluate whether minority and women-owned business enterprises had a full and fair opportunity to participate in state contracting. The findings of the study were published on April 29, 2010, under the title "The State of Minority and Women-Owned Business Enterprises: Evidence from New York" (the

"Disparity Study"). The Disparity Study can be accessed at: http://www.esd.ny.gov/MWBE/Data/NERA_NYS_Disparity_Study_Final_NEW.pdf The report found evidence of statistically significant disparities between the level of participation of minority and women-owned business enterprises in state procurement contracting versus the number of minority and women-owned business enterprises that were ready, willing and able to participate in state procurements. As a result of these findings, the Disparity Study made recommendations concerning the implementation and operation of the statewide certified minority and women-owned business enterprises program. The recommendations from the Disparity Study culminated in the enactment and the implementation of New York State Executive Law Article 15-A, which requires, among other things, that the Procuring Agencies establish goals for maximum feasible participation of New York State Certified minority and women-owned business enterprises ("MWBE") and the employment of minority groups members and women in the performance of New York State contracts.

Business Participation Opportunities for MWBEs:

DCS - For purposes of this Procurement, the Department hereby establishes an overall goal of 20% for MWBE participation as relates only to the administrative cost component of the overall cost of the Contract.

NYSIF - For purposes of this Procurement, the NYSIF hereby establishes an overall goal of 20% for MWBE participation as relates only to the administrative cost component of the overall cost of the Contract. The Contractor must document good faith efforts to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract and Contractor agrees that the Procuring Agencies may withhold payment pending receipt of the required MWBE documentation. The directory of New York State Certified MWBEs can be viewed at: http://www.nylovesmwbe.ny.gov/cf/search.cfm.

For guidance on how the Procuring Agencies will determine the Contractor's "good faith efforts," refer to 5 NYCRR §142.8.

In accordance with 5 NYCRR §142.13, Offeror/Contractor acknowledges that if it is found to have willfully and intentionally failed to comply with the MWBE participation goals set forth in the Contract, such finding constitutes a breach of Contract and the Procuring Agencies may withhold payment from the Contractor as liquidated damages.

Such liquidated damages shall be calculated as an amount equaling the difference between: (1) all sums identified for payment to MWBEs had the Contractor achieved the contractual MWBE goals; and (2) all sums actually paid to MWBEs for work performed or materials supplied under the Contract.

By submitting a Proposal, the Offeror/Contractor agrees to submit the following documents and information as evidence of compliance with the foregoing:

a. Offerors are required to submit a MWBE Utilization Plan - Form MWBE-100 (RFP, Exhibit I.O. (A) (B)) setting forth the Offeror's proposed plan to utilize MBEs and WBEs as subcontractors and suppliers under the Contract and a Certification of Good Faith Efforts - Form MWBE-104 (RFP, Exhibit I.Q. (A) (B)) with their Proposal. Any modifications or changes to the MWBE Utilization Plan after contract award and during the term of the Contract must be reported on a revised MWBE Utilization Plan and submitted separately to DCS and/or NYSIF as applicable.

b. The Procuring Agencies will review the submitted MWBE Utilization Plan and advise the Offeror of the Procuring Agencies' acceptance or issue a notice of deficiency prior to contract award.

c. If a notice of deficiency is issued, the Offeror agrees that it shall respond to the notice of deficiency within seven (7) business days of receipt by submitting to the Pharmacy Benefit Services Procurement Manager, a written remedy in response to the notice of deficiency. If the written remedy that is submitted is not timely or is found by the Procuring Agencies to be inadequate, the Procuring Agencies shall notify the Offeror and direct the Offeror to submit, within five (5) business days, a request for a partial or total waiver of MWBE participation goals on Form MWBE-101 entitled "Request for Waiver Form" available at: http://www.cs.ny.gov/pio/mwbe-eeo-forms.cfm. Failure to

file the waiver form in a timely manner may be grounds for disqualification of the bid or proposal.

d. The Procuring Agencies may disqualify an Offeror as being non-responsive under the following circumstances:

(1) If an Offeror fails to submit a MWBE Utilization Plan;

(2) If an Offeror fails to submit a written remedy to a notice of deficiency;

(3) If an Offeror fails to submit a request for waiver, if applicable; or

(4) If the Procuring Agencies determine that the Offeror has failed to document good faith efforts.

Contractors shall attempt to utilize, in good faith, any MBE or WBE identified within its MWBE Utilization Plan, during the performance of the Contract. Requests for a partial or total waiver of established goal requirements made subsequent to contract award may be made at any time during the term of the Contract to DCS and/or NYSIF as applicable, but must be made no later than prior to the submission of a request for final payment on the Contract.

Contractors are required to submit separate Contractor's Quarterly M/WBE Contractor Compliance Reports - Form MWBE-103 to the DCS and NYSIF respective Contract Managers, as applicable, at the address set forth in the Agreements, by the 10th day following each end of quarter over the term of the Contract documenting the progress made toward achievement of the MWBE goals of the Contract. Form MWBE-103 is available at: http://www.cs.ny.gov/pio/mwbe-eeo-forms.cfm

Equal Employment Opportunity Requirements:

By submission of a Proposal in response to this procurement, the Offeror/Contractor agrees with all of the terms and conditions of Appendix A including Clause 12 - Equal Employment Opportunities for Minorities and Women. The Contractor is required to ensure that it and any subcontractors awarded a subcontract over $25,000 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements

thereon (the "Work") except where the Work is for the beneficial use of the Contractor, shall undertake or continue programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability, or marital status. For these purposes, equal opportunity shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, termination, and rates of pay or other forms of compensation. This requirement does not apply to: (i) work, goods, or services unrelated to the Contract; or (ii) employment outside New York State.

Offeror/Contractor further agrees to submit with its Proposal an EEO Staffing Plan – Form EEO-100 (RFP, Exhibit I.G(A) and (B)) identifying the anticipated work force to be utilized on the project and if awarded the contract, will, upon request, submit to DCS and/or NYSIF, as applicable, a workforce utilization report identifying the workforce actually utilized on the Contract if known.

Further, pursuant to Article 15 of the Executive Law (the "Human Rights Law"), all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor and any subcontractors will not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status, or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

Please Note: Failure to comply with the foregoing requirements may result in a finding of non-responsiveness, non-responsibility and/or a breach of the Contract, leading to the withholding of funds, suspension or termination of the Contract or such other actions or enforcement proceedings as allowed by the Contract.

Per RFP §III.C, executed copies of:
Exhibit I.G(A) and (B) entitled "EEO Staffing Plan (form EEO-100),"
Exhibit I.Q (A) and (B) entitled, "Certification of Good Faith Efforts (form MWBE-104)"; and
Exhibit I.O(A) and (B) entitled, "MWBE Utilization Plan (form MWBE-100)"

must be submitted as part of the Offeror's Administrative Proposal.

4. Americans with Disabilities Act

The Contractor will be required to assure its compliance with the Americans with Disabilities Act (42 USC§12101 et. seq.), in that any services and programs provided during the course of performance of the Agreement shall be accessible under Title II of the Americans with Disabilities Act, and as otherwise may be required under the Americans with Disabilities Act by submitting a completed Compliance with Americans with Disabilities Act form (**Exhibit I.N**) in the Offeror's Administrative Proposal.

5. MacBride Fair Employment Principles Act & Non-Collusive Bidding Certification

In accordance with Chapter 807 of the Laws of 1992, Offerors must certify whether they or any individual or legal entity in which the Offeror holds a ten percent (10%) or greater ownership interest, or any individual or legal entity that holds a ten percent (10%) or greater ownership in the Offeror have business operations in Northern Ireland. If an Offeror does have business operations in Northern Ireland, they must certify that they are taking lawful steps in good faith to conduct such business operations in accordance with the MacBride Fair Employment Opportunity Principles relating to nondiscrimination in employment and freedom of workplace opportunity regarding such operations in Northern Ireland, and shall permit independent monitoring of their compliance with such principles.

The Procuring Agencies also requires that Offerors certify that prices in their Proposal have been arrived at independently without collusion, consultation, communication or agreement for the purpose of restricting competition with any other Offeror or competitor. In addition, that unless required by law, the prices quoted in the Offeror's Proposal have not been knowingly disclosed by the Offeror and will not knowingly be disclosed by the Offeror prior to opening, directly, indirectly, to any other Offeror or to any competitor. Offerors must also certify that no attempt has been made or will be made by the Offeror to induce any person, partnership or corporation to submit or not to submit a proposal for the purpose of restricting competition. An executed copy of the combined MacBride Act statement form and Non-Collusive Bidding Certification (**Exhibit I.D**) is required to be submitted in the Offeror's Administrative Proposal.

6. Vendor Responsibility Requirements – State Finance Law §163

New York State Finance Law §163 requires contracts for services and commodities be awarded on the basis of lowest price or best value "to a responsive and responsible Offeror." Furthermore, §163(9)f requires the Procuring Agencies to make a determination of responsibility of the proposed contractor prior to making an award.

To assist the Procuring Agencies in evaluating the responsibility of Offerors, a completed **"New York State Standard Vendor Responsibility Questionnaire"** must be submitted in the Offeror's Administrative Proposal. A person legally authorized to represent the Offeror must execute the questionnaire. To the extent that the Contractor is proposing the use of Key Subcontractors (i.e., part of the Offeror's proposed Project Team), the Offeror must submit a completed "New York State Standard Vendor Responsibility Questionnaire" for each Key Subcontractor completed by a person legally authorized to represent the Key Subcontractor.

The Procuring Agencies recommend that vendors file the required Vendor Responsibility Questionnaire online via the New York State VendRep System; however, vendors may choose to complete and submit a paper questionnaire. To enroll in and use the New York State VendRep System, see the VendRep System Instructions available at: http://www.osc.state.ny.us/vendrep/vendor_index.htm or go directly to the VendRep System online at: https://portal.osc.state.ny.us.

Vendors must provide their New York State Vendor Identification Number when enrolling. To request assignment of a Vendor ID or for VendRep System assistance, contact the Office of the State Comptroller's Help Desk at 866-370-4672 or 518-408-4672 or by email at: ciohelpdesk@osc.state.ny.us

Vendors opting to complete and submit a paper questionnaire can obtain the appropriate questionnaire from the VendRep website www.osc.state.ny.us/vendrep or may contact the Office of the State Comptroller's Help Desk for a copy of the paper form. The paper form is also included in the RFP as **Exhibit I.I "New York State Standard Vendor Responsibility Questionnaire."**

7. Tax Law Section 5-a Certification Regarding Sales and Compensating Use Taxes

Section 5-a of the New York Tax Law requires that any contract valued at more than $100,000 entered into by a NYS agency shall not be valid, effective, or binding against the agency unless the Contractor certifies to the Tax Department that it is registered to collect New York State and local sales and compensating use taxes, if the Contractor made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of $300,000, measured over a specified period. In addition, the Contractor must certify to the Tax Department that each affiliate and Key Subcontractor of such Contractor exceeding such sales threshold during a specified period is registered to collect New York State and local sales and compensating use taxes. For the purpose of this requirement, "affiliate" means a person or organization which, through stock ownership or any other affiliation, directly, indirectly, or constructively controls another person or organization, is controlled by another person or organization, or is, along with another person or organization, under the control of a common parent. The Contractor also must certify to the procuring state entity that it filed the certification with the Tax Department and that the certification is correct and complete. Accordingly, in the event the value of the Agreement exceeds $100,000, the Contractor must file a properly completed Form ST-220-CA (**Exhibit I.E**) with the Procuring Agencies and a properly completed FormST-220-TD (**Exhibit I.F**) with the Department of Taxation & Finance before the Contract may take effect. In addition, after the Agreement has taken effect, the Contractor must file a properly completed Form ST-220-CA with the Procuring Agencies if the Agreement's term is renewed. Further, a new Form ST-220-TD must be filed with the Department of Taxation & Finance if no ST-220-TD has been filed by the Contractor or if a previously filed Form ST-220-TD is no longer correct and complete.

Submission of these forms (ST-220-CA and ST-220-TD) is not required at time of Proposal submission; however, the selected Offeror will be required to complete and submit these forms as a condition of contract award. These forms may also be found at: www.tax.ny.gov/forms/sales_cur_forms.htm

8. Disclosure of Proposal Contents – Freedom Of Information Law ("FOIL")

NOTICE TO OFFEROR'S LEGAL COUNSEL

All materials submitted by an Offeror in response to this RFP shall become the property of the Procuring Agencies and may be returned to the Offeror at the sole discretion of the Procuring Agencies. Proposals may be reviewed or evaluated by any person, other than one associated with a competing Offeror, designated by the Procuring Agencies. Offerors may anticipate that Proposals will be evaluated by staff and consultants retained by the Procuring Agencies and may also be evaluated by staff of other NYS agencies interested in the provision of the subject services including, but not limited to, the Division of the Budget, unless otherwise expressly indicated in this RFP. The Procuring Agencies has the right to adopt, modify, or reject any or all ideas presented in any material submitted in response to this RFP.

To request that materials be protected from FOIL disclosure, the Offeror must follow the procedures below regarding the New York State Freedom of Information Law (FOIL). If an Offeror believes that any information in its Proposal or supplemental submission(s) constitutes proprietary and/or trade secret information and desires that such information not be disclosed if requested pursuant to the New York State Freedom of Information Law, Article 6 of the Public Officers Law, the Offeror must make that assertion by completing **Exhibit I.C "Freedom of Information Law – Request for Redaction Chart."** The Offeror must complete the form specifically identifying by page number, line, or other appropriate designation, the specific information requested to be protected from FOIL disclosure and the specific reason why such information should not be disclosed. Page 2 of **Exhibit I.C** contains information regarding appropriate justification for protection from FOIL disclosure. Vague, non-specific, summary allegations that material is proprietary or trade-secret are inadequate and will not result in protection from FOIL disclosure.

Note: Offerors are advised that Exhibit I.C, as a part of the Offeror's Proposal, is subject to disclosure under FOIL. Offerors should also highlight any parts of Exhibit I.C which the Offeror wishes to protect from FOIL disclosure.

Per RFP, §III.C, the completed **Exhibit I.C** must be submitted in the Offeror's Administrative Proposal. If the Offeror chooses not to assert that any Proposal material and/or supplemental submission should be protected from FOIL disclosure, the Offeror should so advise the Procuring Agencies by checking the applicable box on **Exhibit I.C** and including the completed form in the Offeror's Administrative Proposal or with the supplemental submission, as applicable. If a completed **Exhibit I.C** form is not contained in the Offeror's Proposal or enclosed with a supplemental submission, the Procuring Agencies will assume that the Offeror chooses not to assert that any proposal material or supplemental submission, as applicable should be protected from FOIL disclosure.

The FOIL-related materials described herein will not be considered part of the Offeror's Proposal and will not be reviewed as a part of the Procurement's evaluation process.

Requested Redactions CD and Hard Copy:

In addition, at the time of Proposal submission the Offeror is requested to submit both a separately bound hardcopy and an electronic copy (on CD in Adobe Acrobat format) of the complete Proposal noting each the specific item requested to be protected from FOIL disclosure by highlighting in yellow (the Procuring Agencies' preference), each item in a manner such that the material remains visible. The electronic copy should contain no more than three pdf files; one for each part of the Proposal (Administrative Proposal, Technical Proposal, and Cost Proposal). No security should be applied to the Adobe Acrobat files. Both the hardcopy and CD should be clearly labeled "Pharmacy Benefits Services - Requested Redactions" and dated.

The Offeror must also submit an additional electronic copy (on CD in Adobe Acrobat format) with the requested redactions electronically highlighted in black ("blacked out") for, at the Procuring Agencies' sole discretion, posting to the procurement website upon completion of the procurement process. The electronic copy should contain no more than three pdf files; one for each part of the Proposal (Administrative Proposal, Technical Proposal, and Cost Proposal). This additional CD should be clearly labeled "Pharmacy Benefits Services – Redacted Version of Proposal" and dated. (Note: Offerors are advised that a copy of the redacted Agreement with the Procuring Agencies may also be posted to the website at that time.)

If, after the Proposal Due Date, if the Offeror makes any supplemental submission(s) during the procurement process that it wishes to protect from FOIL disclosure, the Offeror should submit such supplemental submission(s) with a completed **Exhibit I.C** in hardcopy and on CD in Adobe Acrobat format noting each specific item requested to be protected from FOIL disclosure by highlighting in yellow (the Procuring Agencies' preference), each item, in a manner such that the material remains visible. No security should be applied to the Adobe Acrobat file. The hardcopy should be separately bound, if applicable and both the hardcopy and CD clearly labeled "Pharmacy Benefits Services - Supplemental Submission #x - Requested Redactions" and dated. Each supplemental submission should be sequentially numbered (e.g., Supplemental Submission #1 - Requested Redactions …, Supplemental Submission #2 – Requested Redactions, etc.).

The Offeror should also submit an additional electronic copy (on CD in Adobe Acrobat format with the requested redactions electronically highlighted in black ("blacked out") for, at the Procuring Agencies' sole discretion, posting to the procurement website upon completion of the procurement process. This additional CD should be clearly labeled "Pharmacy Benefits Services – Supplemental Submission #x - Redacted Supplemental Submission #x" and dated. Each supplemental submission should be sequentially numbered (e.g., Supplemental Submission #1 - Redacted Supplemental Submission …, Supplemental Submission #2 - Redacted Supplemental Submission, etc.)

In the event any material is requested pursuant to FOIL, the Procuring Agencies will address each party's interests fully in accordance with the procedures required by Article 6 of the Public Officers Law.

9. Co mp li an ce w ith New York S tate Work e rs' Compensation Law

Sections 57 and 220 of the New York State Workers' Compensation Law (WCL) provide that the Procuring Agencies shall not enter into any contract unless proof of workers' compensation and disability benefits insurance coverage is produced. Prior to entering into a contract with the Procuring Agencies, the selected Offeror and Key Subcontractor(s), if any, will be required to verify for the Procuring Agencies, on forms authorized by the New York State Workers' Compensation Board, the fact that they are properly insured or are otherwise

in compliance with the insurance provisions of the WCL. The forms to be used to show compliance with the WCL are listed in **Exhibit I.W** – Compliance with NYS Workers' Compensation Law. Any questions relating to either workers' compensation or disability benefits coverage should be directed to the State of New York Workers' Compensation Board, Bureau of Compliance at 518-486-6307. You may also find useful information at their website: http://www.wcb.state.ny.us.

Failure to provide verification of either of these types of insurance coverage by the time the winning Offeror is selected and the Contract is ready to be executed will be grounds for disqualification of an otherwise successful Proposal.

Submission of the insurance verification information is **not** required at the time of submission; however, the Procuring Agencies would prefer the Offeror submit this insurance verification information with the Administrative Section, if possible.

To the extent that the Offeror is proposing the use of Key Subcontractors (i.e., part of the Offeror's proposed Project Team), the Offeror must verify for the Procuring Agencies, on forms authorized by the New York State Workers' Compensation Board, the fact that the Key Subcontractors" are properly insured or are otherwise in compliance with the insurance provisions of the WCL.

SECTION III: ADMINISTRATIVE PROPOSAL REQUIREMENTS

This Section of the RFP sets forth the requirements for the Offeror's Administrative Proposal submission, including the Minimum Mandatory Requirements that must be satisfied to qualify an Offeror to be considered for selection. The Procuring Agencies will accept Proposals only from qualified Offerors and will consider for evaluation and selection purposes only those Proposals that they determine to be in compliance with the requirements set forth in this Section III.

The Offeror's *Administrative Proposal* must respond to all of the following items as set forth below in the order and format specified and using the forms set forth in the RFP. Additional details pertaining to the required forms are found in Section II.B. Compliance With Applicable Rules, Laws, Regulations & Executive Orders, and Section III.

The *Administrative Proposal* must contain the following information, in the order enumerated below:

A. Formal Offer Letter (Amended April 4, 2012)

At this part of its Administrative Proposal, the Offeror must submit a formal offer in the form of the **"Formal Offer Letter"** as set forth in **Exhibit I.S**. The formal offer must be signed and executed by an individual with the capacity and legal authority to bind the Offeror in its offer to the State. Each of the ~~two~~ four copies of the Offeror's Administrative Proposal marked "ORIGINAL" requires a letter with an original signature; the remaining copies of the Offeror's Administrative Proposal may contain photocopies of the signature. The Offeror must accept the terms and conditions as set forth in RFP, Section VII and Appendices A, B (DCS), B (NYSIF), C (DCS only) and D (DCS only) and agree to enter into separate contractual agreements with the Department and NYSIF containing, at a minimum, the terms and conditions identified in the RFP section and appendices as cited herein (**Note:** Appendix A, "Standard Clauses for New York State Contracts" is basically a compilation of statutory requirements applicable to all persons and entities contracting with NYS and therefore has been deemed to be non-negotiable by the Offices of the Attorney General and the NYS Comptroller. Appendix B, "Standard Clauses for All Department Contracts," Appendix B, "Standard Clauses for All NYSIF Contracts," Appendix C (DCS only), "Third Party Connection and Data Exchange Agreement," and Appendix D, "Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and

Procedures" are compilations of standard clauses/requirements for the contracts and also are non-negotiable.) If an Offeror proposes to include the services of a Key Subcontractor(s), the Offeror shall be required to assume responsibility for those services as "Prime Contractor." The Procuring Agencies will consider only the Prime Contractor in regard to contractual matters.

B. Minimum Mandatory Requirements

The Procuring Agencies will only accept Proposals from Offerors that attest and demonstrate through current valid documentation to the satisfaction of the Procuring Agencies that the Offeror meets the Proposal's Minimum Mandatory Requirements set forth herein this Section III.B. At this part of its Administrative Proposal, the Offeror must submit a completed **Exhibit I.T "Offeror Attestations Form"** representing and warranting that the Offeror:

1. as of the Proposal Due Date, possesses the legal capacity to enter into contracts with the Procuring Agencies.

2. as of the Proposal Due Date, has the capability to dispense all covered prescriptions, including Compound Drugs, through the mail service pharmacy process. The Offeror must attest that it either owns or has subcontracted, a currently operational facility(ies) with available capacity to fully administer the Program's Mail Service Pharmacy Process. The Offeror must attest that it will be capable of processing all the Programs' mail order prescriptions as of January 1, 2014. The Programs do not require the facility(ies) processing prescriptions under the mail service pharmacy process be within New York State. Any facility serving the Programs' mail service pharmacy process must be registered with the NYS Education Department and meet all the requirements of Section 6808 of the New York State Education Law. The Offeror must recognize the full prescribing authority of medical professionals granted by NYS where allowed by state law.

3. as of the Proposal Due Date, has the capability to dispense Specialty Medications through one or more Designated Specialty Pharmacy(ies), for those Employee groups participating in the Specialty Pharmacy Program.

4. as of the Proposal Due Date, provides Point of Service prescription claims adjudication and pharmacy benefit management services for a minimum of five million (5,000,000) lives.

The Offeror must provide a list of client organizations with the number of lives served through each client to clearly demonstrate that the Offeror meets the minimum requirement of five million (5,000,000) lives. In determining lives, the Offeror should:

a. Include both at-risk and fee-for-service business;

b. Include Medicaid business;

c. Count all lives [i.e., DCS: an Enrollee, a Dependent spouse and two (2) eligible Dependent Children count as four (4) – NYSIF: Claimant (1)];

d. Exclude any non-Pharmacy benefit management business;

e. Exclude any mail service only lives; and

f. Exclude any discount card program lives.

5. as of the Proposal Due Date, has a proposed retail pharmacy network for the Programs that meets the following minimum Retail Pharmacy Network access guarantees:

a. Ninety percent (90%) of Enrollees in urban areas will have at least one (1) Network Pharmacy within two (2) miles;

b. Ninety percent (90%) of Enrollees in suburban areas will have at least one (1) Network Pharmacy within five (5) miles; and

c. Seventy percent (70%) of Enrollees in rural areas will have at least one (1) Network Pharmacy within fifteen (15) miles.

To demonstrate satisfaction of this requirement, the Offeror must submit all information required below based on the Geo-Coded Census file provided by the Procuring Agencies **(Exhibit II.A)**. Based on these files the Offeror must submit with their Administrative Proposal the following:

a. **Exhibit I.Y.4** – Offeror's Current Retail Pharmacy Network Access Prerequisite Worksheet;

b. Offeror's GeoAccess Report to Meet Minimum Mandatory Requirements (See Exhibit II.A – GeoAccess Reporting Format);

c. **Attestation** – The Offeror must attest that, as of the Proposal Due Date, it holds executed contracts with all pharmacies identified in its proposed Retail Pharmacy Network File, Exhibit I.Y.3 with a Pharmacy Status equal to "C" - contracted (See Exhibit I.Y.2 for the file layout) for participation in the Programs Retail Pharmacy Network commencing on January 1, 2014 that are consistent with the duties and responsibilities of the Offeror set forth in Section IV.B.11. of this RFP. To fulfill this requirement, the Offeror may utilize executed, specific to the Programs, pharmacy contracts contingent on award and/or existing pharmacy agreements that can be made applicable to the Programs. The Offeror must also attest that it has completed its credentialing process for all pharmacies included in that file with a Pharmacy Status equal to "C" - contracted. The Offeror must agree to provide documentation, including contracts, as required to demonstrate satisfaction of this requirement.

All Enrollees must be counted in calculating whether the Offeror meets the Retail Pharmacy Network access guarantees. No Enrollee may be excluded even if there is no pharmacy located within the minimum mandatory access requirements.

Note: The Offeror's proposed retail pharmacy network access standards will be scored as part of the evaluation of the Offeror's retail pharmacy network and the Offeror's Network Pharmacy Access Guarantees will be evaluated in accordance with the criteria specified in Section VI, entitled "Evaluation and Selection Criteria."

6. understands and agrees to comply with all specific duties and responsibilities set forth in Section IV.B.3. of this RFP, entitled "Implementation," including Section IV.B.3.b.(2) requiring the Offeror to propose a financial guarantee supporting its commitment to satisfy all implementation requirements.

Note: The Offeror's proposed Implementation and Start-Up Guarantee will be evaluated in accordance with the criteria specified in Section VI, entitled "Evaluation and Selection Criteria."

7. will maintain and make available as required by the Procuring Agencies a complete and accurate set of records related to the Agreements resulting from this RFP as required by Appendices A and B and the draft Agreements set forth in Section VII of this RFP. This includes, but is not limited to, pharmacy contracts, manufacturer's rebate agreements, detailed claim records, and any and all other financial records as deemed necessary by the Procuring Agencies to discharge their fiduciary responsibilities to the Programs' participants and to ensure that public dollars are spent appropriately.

8. will participate in a responsibility determination that will include an assessment of the Offeror's financial protections and transparency. This may require the Offeror , at the Procuring Agencies' sole discretion, to submit documentation in support of the responsibility determination. This part of the responsibility determination will evaluate compliance with, but not limited to, the following:

    a. Alignment of the Offeror's business model with the financial interests of the Programs;

    b. Adequacy of the financial protections proposed by the Offeror to address any conflicts presented between the Offeror's business model and the best financial interests of the Programs; and

    c. Transparency of all business relationships relating to the Programs. This includes but is not limited to sufficient documentation of existing business relationships to allow the Procuring Agencies to verify the reasonableness of the Offeror's Proposal.

9. has submitted as part of its Proposal, if so required by the RFP, or will submit all Transmittal letters, Statements, Formal Certifications and Exhibits as required in Section II of this RFP related to the Offeror's compliance with all rules, laws, regulations and executive orders.

10. will execute the duties and responsibilities set forth in Section IV of this RFP in strict conformance to the requirements described in that section of the RFP.

11. has the ability to adjudicate all Point of Service claims under the Programs using the applicable copayments (DCS only) for brand and generic drugs as defined in Section IV of this RFP.

12. has current URAC accreditation in the area of Pharmacy Benefit Management.

Note: Any Offeror which fails to satisfy any of the above Minimum Mandatory Requirements shall be eliminated from further consideration.

C. Exhibits

At this part of its Administrative Proposal, the Offeror must complete and submit the various Exhibits specified in Section II.B. and Section III of this RFP, in satisfaction of the regulatory requirements described therein. A listing of the required Exhibits is set forth below:

Exhibit Name	Exhibit #
Proposal Submission Requirement Checklist	**Exhibit I.A**
Freedom of Information Law – Request for Redaction Chart	**Exhibit I.C**
MacBride Statement and Non-Collusive Bidding Certification	**Exhibit I.D**
EEO Staffing Plan (form EEO-100)	**Exhibit I.G**
Debriefing Guidelines	**Exhibit I.H**
New York State Standard Vendor Responsibility Questionnaire	**Exhibit I.I**
Offeror's Affirmation of Understanding and Agreement	**Exhibit I.K**
Compliance with Public Officers Law Requirements	**Exhibit I.M**
Compliance with Americans with Disabilities Act	**Exhibit I.N**
MWBE Utilization Plan (form MWBE-100)	**Exhibit I.O**
Offeror's Certification of Compliance Pursuant to State Finance Law §139-k	**Exhibit I.P**
Certification of Good Faith Efforts (form MWBE-104)	**Exhibit I.Q**
Formal Offer Letter	**Exhibit I.S**
Offeror Attestations Form	**Exhibit I.T**
Key Subcontractors	**Exhibit I.U**
Program References	**Exhibit I.V**
Participation/Non-Participation Status of Certain Chain Pharmacies	**Exhibit I.Y.1**
Offeror's Proposed Retail Pharmacy Network File	**Exhibit I.Y.3**
Offeror's Proposed Retail Pharmacy Network Access Prerequisite Worksheet	**Exhibit I.Y.4**

Note: If not already provided to the Procuring Agencies prior to Proposal submission, the Offeror must enclose a completed Exhibit I.K "Offeror's Affirmation of Understanding and Agreement."

D. Key Subcontractors

At this part of its Administrative Proposal, the Offeror must provide a statement identifying all Key Subcontractors, if any, that the Offeror will be contracting with to provide Prescription

Drug Program services and must, for each such Key Subcontractor identify, complete and submit **Exhibit I.U "Key Subcontractors"**:

1. provide a brief description of the services to be provided by the Key Subcontractor; and

2. provide a description of any current relationships with such Key Subcontractor and the clients/projects that the Offeror and Key Subcontractor are currently servicing under a formal legal agreement or arrangement, the date when such services began and the status of the project.

   The Offeror must indicate whether or not, as of the date of the Offeror's Proposal, a subcontract has been executed between the Offeror and the Key Subcontractor for services to be provided by the Key Subcontractor relating to this RFP. If the Offeror will not be subcontracting with any Key Subcontractor(s) to provide Prescription Drug Program services, the Offeror must provide a statement to that effect.

E. Reference Checks

At this part of its Administrative Proposal, for the purpose of reference checks, the Offeror must provide four (4) references of current clients and one reference of a former client(s) for whom the Offeror has supplied prescription drug services similar to those described in this RFP. The number of covered lives covered by the Offeror for each referenced client must be at least 100,000. For each client reference provided, the Offeror must complete and submit **Exhibit I.V "Program References."** The Offeror shall be solely responsible for providing contact names, e-mail addresses and phone numbers of client references who are readily available to be contacted by the State.

F. Financial Statements

At this part of its Administrative Proposal, the Offeror must provide a copy of the Offeror's last issued GAAP annual audited financial statement. A complete set of statements, not just excerpts, must be provided. Additionally, for each Key Subcontractor, if any, that provides any of the Prescription Drug Program services; provide the most recent GAAP annual audited statement. If the Offeror, or a Key Subcontractor, is a privately held business and is unwilling to provide copies of their GAAP annual audited financial statements as part of their Proposal, the Offeror/Key

Subcontractor must make arrangements for the procurement evaluation team to review the financial statements.

Note: If financial statements have not been prepared and/or audited, the Offeror /Key Subcontractor must provide the following as part of its Administrative Proposal: a letter from a bank reference attesting to the Offeror/Key Subcontractor's financial viability and creditworthiness. (Note: For purposes of this reference, the Offeror may not give as a reference, a parent or subsidiary company, a partner or an Affiliate organization.) The letter must include the bank's name, address, contact person name and telephone number and it must address, at a minimum, the following items:

1. a brief description of the business relationship between the parties (i.e., the Offeror/Key Subcontractor and the bank), including the duration of the relationship and the Offeror's current standing with the bank. For example: "*The (Offeror/Key Subcontractor's name) is currently and has been for "x" number of years a client in good standing";*

2. a description of any ownership/partner relationship that may exist between the parties, if any. (**Note:** One party cannot be the parent, partner or subsidiary of the other, nor can one party be an affiliate of the other.); and,

3. any other facts or conclusions the bank may deem relevant to the State in regard to the bank's assessment of the Offeror /Key Subcontractor's financial viability and creditworthiness concerning the nature and scope of the Program Services, which are the subject matter of this RFP, and the Parties (i.e., Department or NYSIF, as applicable and the Offeror or the Offeror and Key Subcontractor) contractual obligations should the Offeror be awarded the resultant contract(s).

(Amended March 8, 2012)

G. Request for Data Necessary to Submit a Proposal

Offerors intending to submit a Proposal will require a DCS Program claim data file to be used to re-price claim data required in Section V.C.2. as well as a list of the current DCS Program Retail Network Pharmacies that have submitted claims during the period November 12, 2010 through October 28, 2011 to be used by the Offeror in response to Section IV.B.11. of this RFP, under subheading "Retail Pharmacy Network."

The DCS Program claims data file and Retail Network Pharmacy File can be obtained by sending a letter requesting both files and including a properly executed **Exhibit I.Z**, **Confidentiality Agreement and Certificate of Non-Disclosure** ~~and **Exhibit I.T, Offeror Attestations Form,** attesting that the prospective Offeror meets the Minimum Mandatory Requirements of Section III.B. of this RFP~~. The letter must be signed and executed by an individual with the capacity and legal authority to bind the prospective Offeror. The letter and properly executed Confidentiality Agreement and Certificate of Non-Disclosure ~~and Offeror Attestations forms~~ must be sent to:

Pharmacy Benefit Services Procurement Manager
Employee Benefits Division, Room 641
NYS Department of Civil Service
Alfred E. Smith State Office Building
Albany, New York 12239

The DCS Program claims data File Retail Network Pharmacy file will only be sent to those prospective Offerors that request said files via submission of the pre-requisite letter referred to above, accompanied by properly executed **Exhibit I.Z** ~~and **Exhibit I.T,** attesting that they meet the Minimum Mandatory Requirements of Section III.B. of this RFP~~ form~~s~~.

Additionally, a data file of NYSIF Program claims for the period November 1, 2010 through November 1, 2011 will also be provided for informational purposes to those Offeror's that request said file via submission of the letter and exhibit~~s~~ noted in the preceding paragraph.

Upon receipt of said letter and forms, the prospective Offerors will be contacted to arrange secure delivery of the Program claim files and DCS Program Network Pharmacy Data file along with the accompanying record layout and instructions for completing the Re-Priced Claims File for submission with the Offeror's Proposal.

Note: ~~Prospective Offerors are solely responsible for the delivery of the pre-requisite letter and properly executed forms by the deadline stated in Section II of this RFP.~~
Prospective Offerors should ensure the data files are provided in a timely manner.

The Procuring Agencies are not responsible for delays attributable to United States mail deliveries or any other means of transmittal, or for delays caused by the prospective Offeror due to their submission of incomplete, inaccurate or incorrect information.

H. Financial Protections and Transparency

It is the goal of the Procuring Agencies to select an Offeror that provides clinically sound Program Services in a manner that aligns the financial interests of the Programs and the Offeror. The Procuring Agencies expect a commitment to full transparency which provides a level of confidence otherwise not present as undisclosed agreements with manufacturers and/or pharmacies can create real or perceived conflicts between the interests of the Programs and the Offeror. The receipt of revenue or other non-revenue considerations not related to the Programs' utilization from pharmaceutical manufacturers or other entities involved in the provision of drugs to Program Enrollees/Claimants is not a disqualifying factor provided the Offeror 's business model protects the clinical and financial interests of the Programs and eliminates real or perceived conflicts of interests. Detailed disclosure of such relationships is necessary to fully evaluate the value of the Offeror's Proposal both for 2014 and for the remaining years of the agreement resulting from this RFP.

Note: For the purposes of this Section III.H. **and the information to be provided by Offerors in their Administrative Proposal, in regard to this Section III.H.**, the term "Offeror" shall mean the Offeror, the Offeror's Affiliate(s), Key Subcontractor(s), if any or a Key Subcontractor's Affiliate(s).

The Offeror may be required to submit documentation in support of any attestations made as part of this responsibility determination. The responsibility determination will assess, but not be limited to, the following:

1. Alignment of Financial Interests

The Offeror's business model must align itself with the financial interests of the Programs.

a. Alignment of Financial Interest Questions:

(1) In detail, please describe how the Offeror's business model aligns itself with the financial interests of the Programs.

(2) Please list and describe aspects of the Offeror's business model that may be perceived to have a conflict of interest with the Programs. For each conflict of interest identified by the Offeror, please describe what firewalls and/or other controls, policies and procedures which a reasonable person would expect to provide corrective or mitigating action to adequately safeguard or protect the Procuring Agencies against any conflict of interest which have been or will be implemented by the Offeror.

2. Pharmaceutical Manufacturer Revenue

The Contractor, under the resultant Agreements from this RFP, is required to maximize savings for the Programs through negotiation of direct discounts from manufacturers and pass along those savings to the Programs. In addition, all Pharma Revenue agreements with manufacturers and other entities applicable to the Programs must meet or exceed the Offeror's best existing Pharma Revenue agreements for all individual drugs. The Contractor must ensure that in no instance will the Programs receive less Pharma Revenue (as a percentage of claims) in any therapeutic class than other clients of the Offeror with a comparable benefit design and consistent preferred drug designations in the class provided the Programs' utilization of the drugs generating Pharma Revenue in the class is equal to or greater than those of other clients (as a percentage of claims).

The Contractor must provide to the Procuring Agencies, on an ongoing basis, access to all Pharma Revenue agreements, calculations and distribution records to fully verify contract compliance and verify proper crediting of Pharma Revenue amounts due the Programs. Please answer the following questions with respect to how the Offeror's business model generates and distributes Pharma Revenue to the Offeror's clients.

a. Pharma Revenue Questions

(1) Please describe how the Offeror's business model maximizes Pharma Revenue from manufacturers for the net financial benefit of the Programs. Please detail how the Offeror's business model ensures that these Pharma Revenue streams do not

cause a conflict with the clinical and financial interests of the Programs. What unit within the Offeror organization negotiates the Pharma Revenue agreements with manufacturers? What unit within the Offeror organization negotiates drug acquisition costs? How does the Offeror ensure that Pharma Revenue is not traded for lower acquisition costs or other cost considerations where the Offeror clients are not the primary beneficiary?

(2) Does the Offeror derive revenue or obtain other consideration or compensation from agreements with pharmaceutical manufacturers? If the Offeror derives revenue or obtains other consideration or compensation from agreements with pharmaceutical manufacturers, please identify the recipient(s) of such pharmaceutical manufacturer revenue or other consideration or compensation and explain the business relationships from which this revenue, consideration, and/or compensation is derived. If the revenue received is derived directly or indirectly from the Offeror's performance of Prescription benefit management functions, please detail the nature of the services provided in return for manufacturer funding, including, but not limited to, revenue derived from negotiated rebate sharing agreements with clients; revenues associated with administration of the rebate program; revenue derived from sharing of data gathered in the course of administering Prescription benefit plans; administration of clinical programs; and/or grant programs.

(3) Please explain in detail the process the Offeror utilizes to negotiate rebate and other revenue agreements with pharmaceutical manufacturers tied directly to specific drug utilization, including how therapeutic class is considered in the Offeror strategy to maximize the benefit of rebates on a net cost basis for the Offeror clients and how planned AWP increases are factored in. What is the process the Offeror is proposing to assure the Procuring Agencies that the Programs will not receive less Pharma Revenue in any therapeutic class than other clients of the Offeror with a comparable benefit design and consistent preferred drug designations in the class provided the Programs' utilization of the drugs generating Pharma Revenue in the class is equal to or greater than those of other clients?

(4) Please describe in detail the process the Offeror utilizes to negotiate any other pharmaceutical manufacturer revenue streams not tied directly to specific drug utilization.

(5) Does the Offeror enter into a single Pharma Revenue agreement with pharmaceutical manufacturers related to a particular drug applicable to all clients or does the Offeror have multiple Pharma Revenue agreements applicable to individual clients or groups of clients? If the Offeror has multiple agreements, please describe the basis and rationale for multiple agreements with different terms related to the same drug? Does the Offeror enter into separate agreements with manufacturers related to revenue due the Offeror and revenue due the client attributable to utilization of a particular drug by clients? If the Offeror does enter into separate agreements in the normal course of business, please describe the basis and rationale for dividing Pharma Revenue attributable to the same client utilization. Please specify which agreement(s) the Offeror is proposing to utilize in managing the Programs. Please detail the process the Offeror is proposing to confirm compliance with the provision that the Programs receive all Pharma Revenue attributable to its utilization and that the Programs shall receive the full benefit of the best Pharma Revenue agreements between the Offeror and pharmaceutical manufacturers. Please confirm the Offeror's willingness to take whatever steps are deemed necessary by the Department/NYSIF to confirm compliance with this provision.

(6) Similarly, does the Offeror have a single agreement or multiple agreements with individual manufacturers pertaining to Pharma Revenue streams not directly tied to specific drug utilization? If the Offeror has multiple agreements, please describe the basis and rationale for entering into multiple agreements. Please specify which, if any, of these agreements would be applicable to the Programs. If there are current agreements that would be applicable to the Programs, please explain the benefit of these agreements to the Programs. If there are agreements not tied directly to specific drug utilization, and not applicable to Programs, please explain how clinical and financial decisions related to the Programs are not impacted by these agreements.

(7) Does the Offeror enter into standard agreements with all manufacturers? If so please describe the basis for calculating the amount of Pharma Revenue due from the manufacturer tied directly to specific drug utilization (i.e., if on a per unit basis is the amount calculated as percentage of AWP; percentage of WAC, or other method). If the Offeror agreements with manufacturers do not utilize a standard calculation method based on dispensed units, please detail any alternative method(s) used to calculate the amount due from the manufacturer? Does the Offeror enter into agreements with manufacturers that tie rebate levels to the Programs' market share of applicable drugs? If so, please give examples of such agreements for your book of business.

(8) Describe how the Offeror will be distributing Pharma Revenue rebates to the Programs based on the Programs' Preferred Drug Lists and Flexible Formulary benefit designs. Is there a difference in the calculation of rebates between the Offeror's formulary benefit designs, including factors such as varying coverage rules and other utilization and cost management programs (e.g. drug exclusions)? If so, explain.

(9) What record is kept of the calculation and distribution of Pharma Revenue to the Offeror clients? Please explain. Please confirm that the Offeror will provide full access to these records as necessary to confirm compliance with contract terms.

(10) Does the Offeror enter into Pharma Revenue agreements with pharmaceutical manufacturers that condition or tie revenue for one or more drugs based on the assigned formulary status of other products of the manufacturer? Does the Offeror's business model allow any other pharmaceutical manufacturer revenue stream not directly tied to specific drug utilization to ever be dependent on the formulary status of one or more products of the manufacturer? If the Offeror does enter into so-called "bundling arrangements with manufacturers" please describe the analysis conducted to ensure that such agreements are in the best interests of the Offeror clients.

(11) Please detail the Offeror's timeline for negotiating Pharma Revenue agreements with pharmaceutical manufacturers. How often do the Offeror Pharma Revenue agreements change with manufacturers? Is the process done on a pre-determined scheduled basis? If so, what is the scheduled time for modifications? What are the

factors that would cause the Offeror to renegotiate the Offeror Pharma Revenue agreements? How would the Programs be notified of these changes? When do the current agreements that the Offeror Proposal is based on expire?

(12) Does the Offeror have different Pharma Revenue agreements applicable to the Offeror mail order business than the Offeror client's retail business? If the Offeror does have independent mail order Pharma Revenue agreements please detail the rationale for different agreements. Do these mail order agreements provide for higher or lower total revenue on a unit basis than agreements applicable to drugs dispensed at retail. Please state the basis for calculation of the Offeror's mail order rebate agreements. If there are different calculations utilized for mail order rebates please define these different methods. Please provide a list of all drugs that the Programs would receive less Pharma Revenue when the Prescription is filled through the Mail Service Pharmacy Process as opposed to dispensed through a Network Pharmacy.

(13) Does the Offeror have different Pharma Revenue agreements applicable to the Offeror's Specialty Drugs/Medications dispensed through the Specialty Pharmacy Program as opposed to Specialty Drugs/Medications dispensed through the Retail Pharmacy Network? If so, please detail the rationale for different agreements.

(14) Would the addition of a large client, such as NYS, affect the Offeror's Pharma Revenue agreements with manufacturers? If yes, is this priced into the Offeror's Proposal? Confirm the Offeror's agreement that the Programs would get the full benefit of any renegotiation of Pharma Revenue agreements tied directly to specific drug utilization or other Pharma Revenue agreements not directly related to specific drug utilization.

(15) Indicate whether or not the Offeror is receiving any Pharma Revenue or other manufacturer revenue based on Generic Drug utilization in the GPI/GCN; and if so, what is the amount of the manufacturer revenue?

3. <u>Retail Pharmacy Network Relationships</u>

A second critical function of the Contractor is to contract a Retail Pharmacy Network that maximizes discounts to the Programs on Prescriptions dispensed from Network Pharmacies. The Offeror must provide responses to the following questions.

a. Network Pharmacy Questions

(1) Is the network the Offeror is proposing a standard network or has it been specifically contracted to administer the Programs?

Please answer questions 2 through 7 based on the Offeror's book of business:

(2) Please detail how the Offeror's business model provides an incentive for the Offeror to negotiate the deepest discounts with chain and independent pharmacies and to offer the full benefit of those discounts to the Programs? For instance, a proposal whereby the Programs receive the same or better reimbursement rates from Network Pharmacies than the Offeror pays Network Pharmacies when it administers a self-funded benefit would tend to demonstrate alignment of financial interests.

(3) Does the Offeror's book of business model provide for a single standard contract with participating Network Pharmacies with consistent terms applied to all of the Offeror clients, including brand name discount and identical MAC pricing? If no, please describe the basis and reasons for multiple contracts and/or amendments with individual pharmacies. Please indicate if Network Pharmacies will be reimbursed for the Programs' Generic Drug Prescriptions based on the Offeror's most favorable Network Pharmacy pricing arrangement, meaning lowest overall net cost, used to
reimburse Network Pharmacies. If not, please explain.

(4) Do all of the Offeror Network Pharmacy contracts contain specific pricing terms for Brand, Generic, and Compound Drugs? Are all pricing terms and formulas incorporated into formal contracts or amendments with Network Pharmacies?

(5) How do the Offeror's contracts set forth Brand Drug pricing? How do the Offeror's contracts set forth Generic Drug pricing? Do the agreements contain aggregate discount targets or guarantees for Generic Drugs dispensed? Do the contracts set forth an agreed upon discount rate for individual Brand Drug Prescriptions? Do the contracts set forth an overall target discount rate for all drugs, brand name and generic, dispensed? Does the Offeror negotiate specific aggregate discount targets

with any Network Pharmacy? For all drugs dispensed? For Brand Drugs dispensed? For Generic Drugs dispensed?

(6) If Program specific Retail Pharmacy Network contracts, or specific amendments, are to be utilized to administer the Programs, how will these agreements differ from standard Network Pharmacy contracts? Provide a copy of the Offeror's standard contract(s) for Network Pharmacies.

(7) In addition to negotiating agreements with Network Pharmacies on behalf of clients, does the Offeror have other business arrangements with Network Pharmacies from which the Offeror have derived revenues? If the Offeror derives revenue or obtains other consideration or compensation from agreements with Network Pharmacies please identify the recipient(s) of such Network Pharmacy revenue and explain the business relationship from which the revenue is derived. Please detail how the Offeror's business model ensures that these relationships do not create a real or perceived conflict with the clinical and financial interests of the Programs?

4. Drug Pricing

The Contractor must provide the Programs with aggressive drug pricing, including pass-through pricing on all Retail Pharmacy Network prescriptions, subject to a Minimum Guaranteed Discount. One DCS/NYSIF Program MAC list must be used for Generic Drugs dispensed through the Retail Pharmacy Network or at the Mail Service Pharmacy.

a. Drug Pricing Questions

(1) Please describe in detail how the Offeror's Generic Drug pricing model maximizes Generic Drug utilization and savings accruing to the financial benefit of the Programs.

(2) Describe in detail the process the Offeror will utilize to set unit pricing for individual Generic Drugs dispensed? Please detail how the Offeror sets and periodically updates MAC pricing, including all factors considered? Please detail any and all exceptions, if any, to the standard Generic Drug pricing process described above? How does this process promote the dispensing of the most cost-effective Generic Drug NDC within a particular GPI/GCN?

(3) How are "non-MAC'd" Generic Drugs priced under the Network Pharmacy agreements that are applicable to the Programs?

(4) Is the Offeror's Generic Drug pricing process described above incorporated in formally adopted corporate policies and procedures? Please explain.

(5) Does the Offeror maintain more than one pricing list (whether referred to as a MAC list or by some other name) for purposes of billing clients? If so, please indicate the number of pricing lists maintained for client billing purposes?

(6) Does the Offeror maintain one or more pricing lists (whether referred to as a MAC list or by some other name) for purposes of reimbursing Network Pharmacies? Does the Offeror have single reimbursement arrangements, utilizing a single consistent pricing list, with individual Network Pharmacies? Or, does the Offeror have multiple reimbursement agreements with individual Network Pharmacies that are assigned and utilized based on the client?

(7) If the Offeror maintains more than one list for either clients or pharmacies please describe the purpose and rationale for maintaining multiple lists.

(8) Does the Offeror manage the Offeror's MAC list pricing to a specific overall discount target or is pricing set on a drug by drug basis without a pre-determined discount target? Describe the process that is utilized to update the Offeror's MAC list including timelines.

(9) Will the Programs' MAC list be managed as or entirely unique and independent MAC list or will it be managed based on an existing MAC list? If the Programs MAC list is to be managed based on an existing MAC list, please identify that MAC list.

(10) In what regard, if any, will the pricing on the Programs MAC list differ from the Offeror's existing MAC list and for what reasons. Is that MAC list managed to an aggregate discount target? If it is managed to an aggregate discount target, what is that target? Is that discount target based on a discount off of all MAC'd drugs or all Generic Drugs dispensed (including non-MAC'd drugs dispensed)? Is that target

based on weighted or non-weighted utilization? Is the existing MAC list the most aggressively discounted MAC list the Offeror maintains?

(11) If the Programs MAC list is to be managed as an entirely independent list, please detail the price setting rules that will be applied? Please confirm that The Programs' MAC list will be managed to achieve discounts on an aggregate basis that both exceed the Guaranteed Minimum Discounts off of the aggregate AWP for Generic Drugs and exceed the most aggressively discounted MAC list in the Offeror's book of business.

(12) The Programs require that pricing be based on discounts off of Average Wholesale Price (AWP) as reported by the Medi-Span field coded R028 entitled "AWP unit price" or Red Book as proposed by the Offeror. Are the Offeror's Network Pharmacy agreements based on AWP? Is the AWP price the Offeror uses to calculate the price to the Programs the exact same AWP price the Offeror uses to calculate payments to Network Pharmacies for each individual Prescription?

(13) Is the Offeror's pricing (including AWP discounts, MAC and dispensing fees) equal to or better than all other clients of the Offeror? If it is not, please detail the reason for the Programs not being offered the equivalent or better pricing. If it is not the Offeror's best pricing in the Offeror's book of business, please identify any chain Network Pharmacy the Offeror will be earning positive spread on for each Brand Drug script dispensed to an Enrollee/Claimant of the Programs.

(14) Many pharmacies, in particular major chain pharmacies, have the capacity to purchase and fill Prescriptions from bulk stock. If a Network Pharmacy does not dispense a Prescription drug in the original manufacturer packaging, what criteria does the Offeror apply regarding the submission of a particular NDC for reimbursement purposes? Does the Offeror always bill clients and reimburse pharmacies based on the same AWP for the same NDC? If not please explain.

(15) Please detail all steps and requirements in the Offeror's process for pricing Compound Drugs as set forth in the Offeror's standard Network Pharmacy contract as well as

any expected modifications to the current process as a result of implementation of NCPDP D.0. Is this pricing formula consistently applied to reimburse pharmacies for Compound Drug claims in the Offeror's entire book of business?

(16) Does the Offeror's claims processing system have the capacity to collect and report information on more than one component of the Compound Drug?

(17) How will the Offeror's process ensure that a Prescription submitted falls within the Programs' definition of a Compound Drug set forth in the Contract Provisions, Section VII, (see Article I, entitled "Definition of Terms") of this RFP and should be subject to Compound Drug pricing? Does the Offeror have the right under its Network Pharmacy contracts to request submission of copies of Compound Drug Prescriptions to confirm that the Prescription was filled based on the Physician's "recipe" for the particular patient?

(18) If the Offeror does not have the current capacity to confirm that the script is, in fact, for a Compound Drug within the definition of Compound Drug set forth in the Contract Provisions, Section VII, (see Article I, entitled "Definition of Terms") of this RFP, what process will the Offeror institute to protect the financial interests of the Programs?

(19) The Programs' Lesser of Logic pricing provisions apply to all claims submitted, including claims for Compound Drugs. For the Offeror's book of business, please detail the percentage of Compound Drug claims being paid pursuant to the Offeror's standard pricing formula; and the percentage of claims being paid at the Pharmacy submitted cost.

(20) The Programs are concerned that certain Compound Drug pricing formulas can result in an inflated AWP for individual Compound Drug Prescriptions. Will the Offeror agree to a mutually acceptable alternative pricing formula for Compound Drug claims? Please detail a potential alternative basis for pricing Compound Drug claims.

5. Transparency of Financial Interests

a. Post Contract Award Requirements

The Contractor must agree to be open and forthright in all matters related to the clinical management and cost management of the Programs. The State has strict standard audit provisions, subject to confidentiality requirements. Disclosure obligations include, but are not limited to:

(1) Providing full access to all subcontractor, manufacturer and Network Pharmacy agreements related to the Programs under strict confidentiality provisions including rebate and other Pharma Revenue on a per unit NDC basis;

(2) Agreeing to the standard audit provisions set forth in Contract Provisions, Section VII of this RFP (see Article XIX entitled "Audit Authority"), and Appendices A and B; and

(3) Agreement that the Offeror will disclose all agreements related to the provision, servicing and administration of Programs' Services in effect during the term of the Agreements resulting from this RFP. This includes all relationships between or among the Offeror, and relevant third parties including but not limited to, pharmaceutical manufacturers, chain and independent pharmacies, and any other entity from which the Offeror receives any form of compensation or any other consideration as a consequence of Prescription drugs purchased and reimbursed under the Programs.

b. During the Procurement Process

Offerors must provide all information the Procuring Agencies deem necessary to support the Proposal. This includes but is not limited to adequate information on the Proposal relative to Pharma Revenue; access to the MAC lists; AWP calculations; the Preferred Drug List and Flexible Formulary financial models, or to assure alignment with the financial interests of the Programs and other information as the Department/NYSIF determines is necessary to address any perceived or actual conflicts between the Offeror's business model and the financial interests of the Programs.

Notwithstanding the full transparency required in Appendices A and B of the Agreement resulting from this RFP, if the Offeror cannot or will not agree to complete transparency during this procurement process, please detail any limitations on disclosure of the above requested information. Please include in the Offeror's answer whether it is the Offeror's standard policy applicable to all clients or if the Offeror provides different levels of access depending on the client. Is the Offeror proposing the Programs receive access to relevant business agreements related to Pharma Revenue streams and Retail Pharmacy Network pricing agreements that is equal to or exceeds the level of disclosure provided to any existing client of the Offeror?

6. Financial Protections

The Contractor must have adequate financial protections in place to protect the State's financial interests.

a. Financial Protection Questions

(1) Explain the contractual and financial relationships among or between the Offeror manufacturers, and network chain and independent pharmacies. Please describe how the Offeror's proposed business model eliminates any real or potential conflicts with the clinical and financial interests of the Programs so as to comply with the intent of the Procuring Agencies and the requirements of the RFP.

(2) The State recognizes that the Offeror's business model may present potential conflicts between the financial interests of the Programs and the Offeror. List any potential conflicts in alignment of interests which would result from the Offeror's Proposal and list additional financial guarantees the Offeror proposes to address such conflicts so as to comply with the intent of the State and the requirements of the RFP.

SECTION IV: TECHNICAL PROPOSAL REQUIREMENTS

The Procuring Agencies seek to award two separate Agreements to a qualified Offeror to provide Pharmacy Benefit Services for the respective agencies prescription drug programs. The Department is seeking to secure the services of a qualified Offeror to administer The Empire Plan, Excelsior Plan, and Student Employee Health Plan Prescription Drug Programs (collectively referred to as DCS Program(s)). NYSIF is seeking to secure the services of a qualified Offeror to administer the NYS Workers' Compensation Prescription Drug Program (referred to as NYSIF Program). The purpose of this section of the RFP is to set forth the programmatic duties and responsibilities required of the Offeror and to pose questions concerning those duties and responsibilities. The Offeror's Technical Proposal must contain responses to all questions (i.e. Required Submissions) in the format requested. Each Offeror may submit only one Technical Proposal. The proposals will be evaluated based on the Offeror's responses to the questions contained in this section. Therefore, it is critical that Offerors fully respond to each of the questions presented in this section. Evaluation of all Proposals and the selection of the Successful Offeror shall be based only upon the Offeror's Proposal regarding the duties and responsibilities set forth in the RFP, and shall not be based upon any supplemental material.

Notes:

1. Unless otherwise stated, all of the requirements contained in this section pertain to both the DCS and NYSIF Programs.

2. Numbers, data, or statistics which may appear in the Exhibits referenced throughout this RFP are for informational purposes only and should not be used or viewed by prospective Offerors as guarantees or representations of any levels of past or future performance or participation.

The Procuring Agencies will accept Proposals only from qualified Offerors and will consider for evaluation and selection purposes only those Offeror Proposals that it determines to meet the Minimum Mandatory Requirements in Section III and are responsive to the duties and responsibilities set forth in Section IV of this RFP.

Please note that Offerors may not include any cost information in the Technical Proposal including exhibits or attachments. This cost information pertains to Ingredient Cost discounts, dispensing fees, discount and pharma rebate guarantees, and administrative fees requested in the Cost Proposal. Performance guarantee amounts are to be included in the Technical Proposal. Specific savings estimates (dollars or percentages) should not be quoted in the Technical Proposal or in any exhibits or attachments submitted with the Technical Proposal.

A. Program Administration

1. Executive Summary

The Offeror must describe its capacity to administer the DCS and NYSIF Prescription Drug Programs (also hereafter collectively referred to as the "Programs").

a. Required Submission

The Offeror must submit an Executive Summary that describes its capacity to administer the DCS and NYSIF Prescription Drug Programs. The Executive Summary must include:

(1) The name and address of the Offeror's main and branch offices and the name of the senior officer who will be responsible for this account;

(2) A description demonstrating its understanding of the requirements presented in the RFP, and how the Offeror can assist the Procuring Agencies in accomplishing their objectives;

(3) A statement explaining previous experience managing the Prescription drug plans of other state governments or large public entities or any other organizations with over 100,000 covered lives, as well as any previous experience managing a Self-Funded Prescription Drug Program. Detail how this experience qualifies the Offeror and, if applicable, the experience of its Key Subcontractors to undertake the functions and activities required by this RFP;

(4) An explanation of how the following administrative and operational components will be performed by the Offeror. Include an organizational chart explicitly detailing responsibility for the following functions:

(a) Network Management
(b) Specialty Pharmacy Program
(c) Mail Service Pharmacy Process
(d) Claims Processing
(e) Retrospective Coordination of Benefits
(f) Customer Service
(g) Enrollee Communication Support
(h) Enrollment Management
(i) Reporting
(j) Clinical Management/ Prior Authorization
(k) Drug Utilization Review (concurrent, retrospective and narcotics)
(l) Flexible Formulary and Preferred Drug List Development and Management
(m) Rebate Administration
(n) Account Management
(o) Consulting
(p) Mandatory Generic Substitution & Generic Appeals Process
(q) Pharmacy Audit and Responses to NYS Audits
(r) Drug Lawsuits/Settlements
(s) Medicare Part D Prescription Drug Program Administration
(t) Half Tablet Program
(u) Drug Recall Notification
(v) Financial Support Services
(w) Transition and Termination of Contract

If the proposed organizational structure has been used in administering the program of another client, provide the client's name and include the client as a reference as required in Exhibit I.V.

2. <u>General Qualifications of the Offeror</u>

The DCS Prescription Drug Programs cover over one million lives and incur costs in excess of $1.5 billion annually. Over 50,000 NYSIF Workers' Compensation claimants fill approximately 700,000 prescriptions annually and incur costs in excess of $75 million annually.

The Offeror must have the experience, reliability and integrity to ensure that each Program member's health care needs are addressed in a clinically appropriate and cost effective manner. The terms of the Offeror's proposal must demonstrate explicit acceptance of and responsiveness to the Programs duties and responsibilities set forth in this RFP, ensuring full compliance with the respective Programs Services.

a. Required Submission

The Offeror must demonstrate that it has the financial and administrative wherewithal to administer the Programs as required by this RFP. Please provide detailed responses to the following:

(1) What experience does the Offeror have in managing/supervising a Prescription drug program similar to the Programs described in this RFP?

(2) Explain how the Offeror's account team will be prepared to actively manage the administrative, operational, and clinical aspects of the Programs?

(3) What internal systems or procedures does the Offeror have in place to provide financial, legal, and audit oversight of the Programs?

B. DCS and NYSIF Prescription Drug Program Services

In this section, the Offeror must demonstrate its capacity to provide the required services for administration of the Programs.

1. Account Team

The Department expects the successful Offeror to have a proactive, experienced account leader and team(s) in place who are dedicated solely to the Programs and who have the authority and expertise to coordinate the appropriate resources to implement and administer the Programs.

a. Duties and Responsibilities

(1) The Offeror must maintain an organization of sufficient size with staff that possesses the necessary skills and experience to administer, manage, and oversee all aspects of the Programs during implementation and operation.

(a) The account team(s) must be comprised of qualified and experienced individuals who are acceptable to the Procuring Agencies and who are responsible for ensuring that the operational, clinical, and financial resources are in place to operate the Programs in an efficient manner;

(b) The Offeror must ensure that there is a process in place for the account team(s) to gain immediate access to appropriate corporate resources and senior management necessary to meet all Programs requirements and to address any issues that may arise during the performance of the separate resultant Agreements.

(2) The Offeror's dedicated account team(s) must be experienced, accessible (preferably in the New York State Capital Region district) and sufficiently staffed to:

(a) provide timely responses (within 1 to 2 Business Days) to administrative and clinical concerns and inquiries posed by the Department, or other staff on behalf of the Council of Employee Health Insurance, or NYSIF, or union representatives regarding member-specific claims issues for the duration of the separate Agreements to the satisfaction of the Procuring Agencies;

(b) immediately notify the Procuring Agencies in writing of actual or anticipated events impacting Program costs and/or delivery of services to Enrollees (for example, drug recalls and withdrawals, class action settlements, and operational issues).

(3) The Offeror's dedicated account team(s) must ensure that the Programs are in compliance with all legislative and statutory requirements. If the Offeror is unable to comply with any legislative or statutory requirements, the Procuring Agencies must be

notified in writing immediately. The Offeror is required to work with the Department to develop accurate Summary Plan Descriptions (SPDs) and/or Program material.

b. <u>Required Submission</u>

(1) Provide an organizational chart and narrative description illustrating how you propose to administer, manage, and oversee all aspects of the Programs. Include the names, qualifications, and job descriptions of the key individuals selected to comprise the account management team(s) for the Offeror. Complete Exhibit I.B of this RFP, Biographical Sketch Form, for all key members of the proposed account management team(s); where key individuals are not named, include qualifications of the individuals that you would seek to fill the positions. Include the following:

(a) Reporting relationships and the responsibilities of each key position of the account management team(s); how the team will interact with other departments such as customer service, clinical services, reporting, auditing, and network management, within your organization.

(b) Describe how the dedicated account management team(s) interfaces with senior management and ultimate decision makers within your organization to ensure that all Program requirements are met and to address any issues that may arise during the performance of the resultant Agreements;

(2) Please confirm that the account team(s) will be readily accessible to the Programs. State where the account team will be based. Describe:

(a) How will you ensure that timely responses (1 to 2 Business Days) are provided to administrative concerns and inquiries?

(b) The protocols in place to ensure the Procuring Agencies will be kept abreast of actual or anticipated events impacting Program costs and/or delivery of services to Enrollees. Provide a representative scenario.

(3) Describe the Corporate resources available to the account team(s) to ensure compliance with all legislative and statutory requirements. Confirm your commitment to notify the Procuring Agencies immediately if you are unable to comply with any legislative

or statutory requirements and to work with the Procuring Agencies to take the appropriate remedial action(s) to come into compliance as soon as practicable. Confirm your commitment to work with the Department to develop accurate SPDs and/or Program material.

2. Premium Development Services (Exclusive to DCS)

The Offeror must provide underwriting assistance and support to the Department in the development of premium rates chargeable to DCS Program participants consistent with the interests and goals of the DCS Program and the State. Premium rates must be as realistic as possible, taking into account all significant elements that can affect Program costs including, but not limited to trend factors, projected Pharma Revenue, changes in enrollment, changes in the Specialty Pharmacy drug list as well as changes in the Flexible Formularies and Traditional PDL. The development of premium rates that closely match the actual costs enables the plan to provide rate stability, one of the primary goals of the State, and to meet the budgetary needs of the State and local governments that participate in NYSHIP.

a. Duties and Responsibilities

The Offeror will be responsible for assisting and supporting the Department with all aspects of the premium rate development including, but not limited to:

(1) Providing a team of qualified and experienced individuals who are acceptable to the Department and who will assist and support the Department in developing premium rates consistent with the financial interests and goals of the DCS Program and the State;

(2) Development of claim, trend and administrative fee projections for each DCS Program Year. Analysis of all DCS Program components impacting the DCS Program cost shall be performed including, but not limited to claims, trend factors, administrative fees, projected Pharma Revenue, changes in enrollment, changes in the Specialty Pharmacy Drug list, as well as changes in the formularies including the Empire Plan's Specialty Drug list, Flexible Formularies and the Traditional PDL; and

(3) Working with the Department and its contracted actuarial consultant through the annual rate renewal process to further document and explain any premium rate

recommendation. This process includes presenting the premium rate recommendation to staff of the Department, Division of the Budget and GOER.

b. Required Submission

(1) Provide the names, qualifications and job descriptions of those key individuals who will provide premium rate development services for the DCS Programs. Describe their experience in providing financial assistance and support to other large health plans. Complete Exhibit I.B of this RFP, Biographical Sketch Form, for all key staff involved in the premium rate development.

(2) Describe the general steps that you will follow to develop the annual premium renewal recommendation for submission to the Department. Include any different steps that will be employed to develop the first year premium vs. the premium for subsequent years of the Agreement. Include a description and source of the data you will utilize, assumptions you will use and how these assumptions will be developed, as well as any resources you will utilize.

(3) Confirm your commitment to work with the Department and its contracted actuarial consultant on the annual rate renewal recommendation and your availability to present such recommendation to the Department, Division of the Budget and GOER.

Note: The responses to the above three questions should be general descriptions of the financial methodology you intend to use for the assisting and supporting the Department with the DCS Program. Responses may **NOT** include any specific cost information or values relative to the development of cost/rate projections and trends for the DCS Programs; that information must be restricted to your Cost Proposal.

3. Implementation

The Offeror must ensure that the Programs are fully functional on January 1, 2014. The Offeror's must propose two implementation plans, one for the Department and one for NYSIF. The plans must be detailed and comprehensive and exhibit a firm commitment by the Offeror to complete all implementation activities by December 31, 2013.

a. Duties and Responsibilities

(1) The Offeror must commence an implementation period beginning on or around October 1, 2012 upon approval of the resultant separate Agreements by OSC. During the implementation period, the Contractor must undertake and complete all implementation activities, including but not limited to those specific activities set forth below. Such implementation activities must be completed no later than December 31, 2013 so that the Programs are fully operational on January 1, 2014.

(2) ***Implementation and Start-up Guarantee:*** The Offeror guarantees that all Implementation and Start-up activities will be completed no later than December 31, 2013 so that, effective January 1, 2014, the Offeror can assume full operational responsibility for the Programs. For the purpose of this guarantee, the Offeror must, on January 1, 2014, have in place and operational:

(a) A contracted Retail Pharmacy Network that meets the access standards set forth in Section IV.B.11.b. of this RFP, under the subheading "Retail Pharmacy Network." Additionally, in order to meet the Offeror's implementation guarantee, the network implemented on January 1, 2014 must include all chain pharmacies with more than 20 locations and all groups of 20 or more independent pharmacies utilizing the same third party organization to collectively negotiate network participation agreements, as identified in the Offeror's Proposed Retail Pharmacy Network File, to the extent the subject chains and/or independent Pharmacy groups continue in operation on and after January 1, 2014.

The Program requires that all chain pharmacies with less than 20 locations, groups of less than 20 independent pharmacies utilizing the same third party organization to collectively negotiate network participation agreements, and all independent pharmacies, as identified in the Offeror's Proposed Retail Pharmacy Network File, be included in the Offeror's Retail Pharmacy Network implemented on January 1, 2014. Acceptable reasons for non-participation of independents, smaller chains or groups of individual pharmacies contracting collectively on January 1, 2014 include, and are limited to: a Pharmacy's violation of state and/or federal laws; a

Pharmacy's failure to meet the Offeror's credentialing criteria; or a Pharmacy's failure to fulfill its contractual obligations and no remedy can be achieved. On January 1, 2014, the Retail Pharmacy Network must meet all requirements set forth in Section IV.B.11. of this RFP, under the subheadings "Retail Pharmacy Network," "Pharmacy Credentialing" and "Pharmacy Contracting" and be available to fill Enrollee Prescriptions for all Covered Drugs including Specialty Drugs/Medications(for those Enrollees that do not participate in the Specialty Pharmacy Program);

(b) A fully operational Mail Service Pharmacy Process utilizing facilities as necessary to ensure that Enrollees have access to all Covered Drugs, including Specialty Drugs/Medications (for those Enrollees that do not participate in the Specialty Pharmacy Program) as set forth in Section IV.B.11. of this RFP, under the subheading "Mail Service Pharmacy Process." The Offeror must have a plan in place to facilitate the transfer of Prescription information, including open refills, prior authorizations and generic appeals from the previous Program administrators and outline the procedures that will be utilized to ensure a smooth mail service transition for Enrollees;

(c) A fully operational Specialty Pharmacy Program utilizing facilities as necessary to ensure that Enrollees have access to all covered Specialty Drugs/Medications (for those Enrollees that participate in the Specialty Pharmacy Program) as set forth in Section IV.B.11. of this RFP under the sub heading "Specialty Pharmacy Program." The Offeror must have a plan in place to facilitate the transfer of specialty Prescription information, including open refills and prior authorizations, from the previous Program administrator and outline the procedures that will be utilized to assure a smooth Specialty Pharmacy Program transition for affected Enrollees;

(d) A fully operational call center providing all aspects of customer support and services as set forth in Section IV.B.4. of this RFP;

(e) An on-line claims processing system that applies the Procuring Agencies' approved edits and point of service edits, including drug utilization review edits, as set forth in Section IV.B.12. of this RFP;

(f) An on-line claims processing system with real time access to the most updated, accurate enrollment and eligibility data provided by the Procuring Agencies to correctly pay claims for eligible Enrollees/Dependents consistent with the Programs benefit designs and contractual obligations; and

(g) (Exclusive to DCS) A fully functioning customized Program website with a secure dedicated link from the Department's website able to provide Enrollees with on-line access to the specific website requirements as set forth in Section IV.B.4.a.(7) of this RFP.

b. <u>Required Submission</u>

(1) Provide separate implementation plans (narrative, diagram, and timeline) upon each Agreement's approval, on or around October 1, 2012 that results in the implementation of all Program Services by the required date of December 31, 2013, indicating: roles, responsibilities, estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. Include key activities such as member and Pharmacy communications, training of customer service staff, report generation, Flexible Formulary and Preferred Drug List development, mail service and specialty Pharmacy transition, customized website design, eligibility feeds, claims testing, and EGWP approval and transition.

(2) The Offeror must guarantee that all of the Implementation and Start-Up requirements listed above in Section B.3.a.(2) will be in place on or before December 31, 2013. The Offeror shall propose, separately for each Program, the forfeiture of a percentage of the 2014 Claims Administration Fee (prorated on a daily basis) for each day that all Implementation and Start-Up requirements are not met.

The Standard Credit Amount for each day that all Implementation and Start-Up requirements for the DCS or NYSIF Program are not met is fifty percent (50%) of the 2014 Claims Administration Fees (prorated on a daily basis). However, Offerors may propose higher or lesser percentages.

The Offeror's quoted percent to be credited for each day that all Implementation and Start-up requirements are not met is _____ percent (%) of the 2014 Claims Administration Fee (prorated on a daily basis) for the DCS Program and _____ percent (%) of the 2014 Claims Administration Fee (prorated on a daily basis) for NYSIF's Program.

4. Customer Service

The Programs require that the Offeror provide quality customer service to Enrollees/Claimants. The DCS Program provides access to customer service representatives through The Empire Plan's consolidated toll-free number. Through this toll-free number members access representatives who respond to questions, complaints and appeals regarding DCS Program benefits, mail order services, Network Pharmacies, the Specialty Pharmacy Program, processing point of sale Prescriptions, drug status, claim status, etc. NYSIF's Program provides 24 hour, 7 day a week telephone support via a toll-free number, to assist its claimants with locating participating pharmacies, eligibility and benefit verification. The Offeror is required to agree to customer service performance guarantees that reflect strong commitments to quality customer service. Exhibit II.L of this RFP illustrates the current Pharmacy Benefit Manager's call center volume for the DCS Program. Exhibit II.K.1 provides the number of members who have utilized the current DCS customized Program website from October 2010 through October 2011.

a. Duties and Responsibilities (Amended April 4, 2012)

The Offeror will be responsible for all customer support and services including, but not limited to:

(1) Providing Enrollees access to information on all Prescription drug benefits and services related to the Programs through separate toll-free numbers 24 hours a day 365 Days a year.

(2) (Exclusive to DCS) The Empire Plan consolidated toll-free telephone service is provided through the AT&T voice network services under a contract with The Empire Plan's Medical Insurer and is available to callers 24 hours a Day, 365 Days a year. The Offeror is required to establish and maintain a transfer connection (currently an AT&T

T-1 line), including a back-up system which will transfer calls to the Offeror's line at their customer service site. The Offeror is required to sign a shared service agreement with The Empire Plan's Medical Insurer (currently UnitedHealthcare) and AT&T. In addition, the Offeror is also required to provide 24 hours a day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability. The TTY number must provide the same level of access to customer service as required by this Section of the RFP;

(3) Maintaining separate ~~Dedicated C~~call ~~C~~centers for the Programs located in the United States staffed by fully trained customer service representatives and supervisors available 24 hours a day 365 Days a year. The Offeror must maintain separate Dedicated Call Centers for the Programs between the hours of 7:00am and 7:00pm ET. During off hours, calls may be routed to a designated call center(s) located in the United States staffed by fully trained customer service representatives and supervisors. The ~~Dedicated~~ Ccall ~~C~~centers must also provide immediate access to Pharmacist(s) 24 hours a day 365 days a year. The ~~Dedicated C~~call ~~C~~centers must meet the Offeror's proposed customer service telephone guarantees set forth in Section.IV.4.b.(8)(a) through (d) of this RFP.

(4) Customer service staff must use an integrated system to log and track all Enrollee calls. The system must create a record of the Enrollee contacting the call center, the call type, and all customer service actions and resolutions.

(5) Customer service representatives must be trained and capable of responding to a wide range of questions, complaints and inquiries including but not limited to: Program benefit levels, refills, order status, prices and billing, point of service issues, prior authorization, eligibility, generic appeals, Mail Service Pharmacy Process, Specialty Pharmacy Process services, and Flexible Formulary and Preferred Drug List alternatives.

(6) Maintaining a backup customer service staff located in the United States with Program-specific training to handle any overflow when the dedicated customer service center is unable to meet the Offeror's proposed customer service performance guarantees. This back-up system would also be utilized in the event the primary customer service center(s) become unavailable;

(7) (Exclusive to DCS) Maintaining and timely updating a secure online customized website accessible by Enrollees, which is available 24 hours a Day, 7 Days a week, except for regularly scheduled maintenance, which will provide, at a minimum, access to information regarding: DCS Program benefits, Network Pharmacy locations, eligibility, mail service order status, Copayment information, claim status, comparative drug check functionality, Prescription drug history for both retail and mail claims, and the Flexible Formulary and Preferred Drug Lists (including alternatives for Non-Preferred Brand Name and excluded drugs). The Department shall be notified of all regularly scheduled maintenance at least one Business day prior to such maintenance being performed. The Offeror must establish a dedicated link to the customized website for the DCS Program from the Department's website with content subject to the approval of the Department and limited to information that pertains to the DCS Program. Any links should bring a viewer back to the Department website. No other links are permitted without the written approval of the Department. Access to the online Network Pharmacy locator must be available to Enrollees without requiring them to register on the website. Any costs associated with customizing and updating the website or establishing a dedicated link for the DCS Program shall be borne by the Offeror. Also, the Offeror shall fully cooperate with any Department initiatives to use new technologies, processes, and methods to improve the efficiencies of the customized website including development of an integrated Enrollee portal;

(8) ***Call Center Telephone Guarantees*:** The Offeror must provide separate guarantees for the DCS and NYSIF Programs for the following four (4) measures of service on the toll-free customer service numbers:

(a) ***Call Center Availability:*** The Programs' service level standard requires that the Offeror's telephone line will be operational and available to Enrollees, Claimants, Dependents, and pharmacies at least ninety-nine and five-tenths percent (99.5%) of the Offeror's Call Center Hours. The call center availability shall be reported monthly and calculated quarterly;

(b) ***Call Center Telephone Response Time:*** The Programs' service level standard requires that at least ninety percent (90%) of the incoming calls to the Offeror's telephone line will be answered by a customer service representative within sixty (60) seconds. Response time is defined as the time it takes incoming calls to the Offeror's telephone line to be answered by a customer service representative. The call center telephone response time shall be reported monthly and calculated quarterly;

(c) ***Telephone Abandonment Rate:*** The Programs' service level standard requires that the percentage of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service representative will not exceed three percent (3%). The telephone abandonment rate shall be reported monthly and calculated quarterly; and

(d) ***Telephone Blockage Rate:*** The Programs' service level standard requires that not more than three percent (3%) of incoming calls to the customer service telephone line will be blocked by a busy signal. The telephone blockage rate shall be reported monthly and calculated quarterly.

b. Required Submission (Amended April 4, 2012)

(1) Confirm that you will provide Enrollees access to Programs information on Claimants through separate consolidated toll-free numbers 24 hours a day 365 Days a year, as described above.

(2) (Exclusive to DCS) Confirm you will enter into a shared service agreement with the Empire Plan Medical Insurer and AT&T. Confirm you will provide 24 hours a day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability.

(3) Confirm that you will maintain separate ~~Dedicated~~ ~~C~~call ~~C~~centers for each Program located in the United States, employing ~~a staff of Pharmacists and~~ a staff of fully trained customer service representatives (CSR's) and supervisors available 24 hours a day 365 Days a year. The Offeror must maintain separate Dedicated Call Centers for the Programs between the hours of 7:00am and 7:00pm ET. During off hours,

calls may be routed to a designated call center(s) located in the United States staffed by fully trained customer service representatives and supervisors. The call centers must also provide immediate access to Pharmacist(s) 24 hours a day 365 days a year.

(4) Describe the information, resources and system capabilities that are available for the customer service representatives to address and resolve member inquiries. Include:

(a) Whether any Interactive Voice Response (IVR) system is proposed.

(b) A sample of the IVR script and a description of customizable options, if any, you propose for the Programs.

(c) A description of the management reports and information available from the system including the key statistics you propose to report.

(d) A description of the capabilities of your phone system to track call types, reasons and resolutions.

(5) Describe the training that is provided to CSR and Pharmacist staff before they go "live" on the phone with Enrollees. Include:

(a) A description of the internal reviews that are performed to ensure quality service is being provided to Enrollees;

(b) The first call resolution rate for the proposed call centers;

(c) The call center locations, average staff and turnover rate for call center employees;

(d) Ratio of management and supervisory staff to customer service representatives and;

(e) Proposed staffing levels including the logic used to arrive at the proposed staffing levels.

(6) Describe the back-up systems for your primary telephone system which would be used in the event the primary telephone system fails, is unavailable or at maximum capacity. If a back-up system is needed, explain how and in what order calls from

Enrollees will be handled. Confirm that backup staff will have DCS Program and NYSIF Program specific training. Indicate the number of times the back-up system has been utilized over the past two (2) years. Confirm that calls will be handled exclusively by your Dedicated Call Centers and that the backup call center would only be used in case of system failure or call overflow.

(7) (Exclusive to DCS) Describe the information and capabilities your website provides to members and describe the process you will utilize to develop it. Confirm that you will develop a customized website for the DCS Program. Also, confirm that the following information, at a minimum, will be available on the website: DCS Program benefits, Network Pharmacy locations, eligibility, mail service order status, Copayment information, claim status, Prescription drug history for both retail and mail claims, and the Flexible Formulary and Preferred Drug List (including alternatives for Non-Preferred Brand Name and excluded drugs). Provide the URL of your main website and provide a dummy ID and password so that the Department may view the capabilities and user-friendliness of your website.

(8) ***Call Center Telephone Guarantees:*** For each of the four (4) Call Center Telephone Guarantees above, the Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fees, for failure to meet the Offeror's proposed guarantee.

(a) ***Call Center Availability:***

The Standard Credit Amount for each .01 to .25% below the standard of ninety-nine and five-tenths percent (99.5%) that the Offeror's telephone is not operational and available to Enrollees, Claimants, Dependents and Pharmacies during the Offeror's Call Center Hours calculated on a quarterly basis, is $100,000 per quarter for DCS and $7,500 for NYSIF, respectively. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to .25% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Offeror's proposed guarantee) that the Offeror's telephone line is

not operational and available to Enrollees, Claimants, Dependents, and Pharmacies during the Offeror's Call Center Hours calculated on a quarterly basis, is $_____ per quarter for DCS and $____ per quarter for NYSIF;

(b) ***Call Center Telephone Response Time*:**

The Standard Credit Amount for each .01 to 1.0% below the standard of ninety percent (90%) of incoming calls to the Offeror's telephone line that is not answered by a customer service representative within sixty (60) seconds is $25,000 per each quarter for DCS and $7,500 for NYSIF, respectively. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line below the standard of ninety percent (90%) (or the Offeror's proposed guarantee) that is not answered by a customer service representative within sixty (60) seconds, calculated on a quarterly basis, is $_____ per quarter for DCS and $____ per quarter for NYSIF;

(c) ***Telephone Abandonment Rate:***

The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service representative in excess of the standard of three percent (3%) is $25,000 per each quarter for DCS and $7,500 for NYSIF, respectively. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service representative in excess of the standard of three percent (3%) (or the Offeror's proposed guarantee), calculated on a quarterly basis, is $_____ per quarter for DCS and $____ per quarter for NYSIF; and

(d) ***Telephone Blockage Rate*:**

The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror's telephone line that are blocked by a busy signal, in excess of the standard of three percent (3%) is $25,000 per each quarter for DCS and $7,500 for NYSIF, respectively. However, Offerors may propose higher or lesser amounts.

The Offeror's Quoted amount to be credited against the Claims Administration Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line that is blocked by a busy signal, in excess of the standard of three percent (3%) (or the Offeror's proposed guarantee), calculated on a quarterly basis, is $_____ per quarter for DCS and $____ per quarter for NYSIF.

5. Medicare Part D – Employer Group Waiver Plan PDP (Exclusive to DCS)

a. Duties and Responsibilities

The Offeror will be responsible for implementing and administering a Center for Medicare and Medicaid Services (CMS)-approved and compliant Employer Group Waiver Plan (EGWP) and Medicare D supplemental wrap Prescription Drug Plan (PDP) for the Empire Plan's Medicare-eligible retirees beginning on January 1, 2014. Such services shall include at least the following tasks and such other tasks as may be added in guidance and further regulation by CMS:

(1) Disclosing to CMS, on a timely basis and on behalf of the Department, any filings, applications, reports, formularies, and other DCS Program material necessary for the Department to comply with the requirements of an "800-series" Medicare PDP EGWP, plus Medicare D supplemental wrap;

(2) Fully supporting the Department with all operational aspects of a fully compliant Medicare PDP EGWP, plus Medicare D supplemental wrap including but not limited to:
   (a) Medicare PDP EGWP premium development
   (b) Enrollment
   (c) Enrollee Opt-Out process
   (d) Health Insurance Claim Number (HICN) administration
   (e) Formulary management
   (f) Issuing of Medicare PDP EGWP member identification cards

(g) Member Communications, including required explanation of benefits statements

(h) Claims Processing

(i) Administration of a Medicare D supplemental wrap with the goal of providing Medicare primary Enrollees with a prescription drug benefit replicating as closely as possible the prescription drug benefit design for non-Medicare primary retirees in The Empire Plan;

(j) Timely administration of catastrophe re-insurance claims

(k) Administration of Low Income Subsidy requirements

(3) Prepare timely reconciliations of administrative fees, forecast versus incurred prescription drug claims, CMS (Part D) capitated and reinsurance fees, CMS enrollee low-income subsidy payments and pharmacy rebates. The Offeror must provide such records and reports in a manner, form, and timeliness acceptable to the Department;

(4) Promptly credit the Department for all CMS premium subsidy payments and all pharmacy rebates received by the Offeror under the Medicare PDP EGWP; plus Medicare D supplemental wrap;

(5) The Department acknowledges and agrees that it shall be responsible solely (1) for providing creditable coverage notices required with respect to the EGWP; and (2) for determining whether enrolled individuals are qualifying covered retirees. The Offeror will work with the Department to obtain HICNs for all eligible Medicare-primary members enrolled in the EGWP.

(6) The Offeror acknowledges that the information furnished in connection with the administration of the Medicare PDP EGWP is being provided to obtain federal funds. The Offeror shall require all sub-contractors, including any plan administrators, if applicable, that submit information required by CMS to obtain any subsidies or payments on behalf of the DCS Program to acknowledge that information provided in connection with the key subcontract is used for the purpose of obtaining federal funds; and

(7) The Offeror acknowledges that its provision of services pursuant to this section of this RFP is subject to audit and evaluation by the U.S. Department of Health and Human Services pursuant to 42 CFR Subpart R or other authority as may be cited by the federal

government, as well as by the State of New York pursuant to Appendix A and Appendix B of the resultant Agreement. The Offeror shall comply with any record retention requirements required pursuant to 42 CFR SubPart R in this regard.

(8) The Offeror is required to act as consultant to the Department in analyzing its experience with the Medicare PDP EGWP, and recommending as well as implementing other permitted options under Medicare Part D which may be of advantage to the Department, agencies participating in NYSHIP and NYSHIP Enrollees;

(9) Upon finalization of a subrogation process by CMS, the Offeror will be required to identify and recover claim payments made by the DCS Program from other plans that should have been the primary payor.

b. Required Submission

(1) Describe your experience in implementing and administering a Medicare PDP EGWP plus Medicare D supplemental wrap for customers of similar scope and size to The Empire Plan.

(2) Confirm your understanding of the requirements to support the implementation and administration of a Medicare PDP EGWP plus Medicare D supplemental wrap for The Empire Plan on behalf of the Department, including the Offeror's proposed approach for the following:

(a) Medicare PDP EGWP premium development
(b) Enrollment
(c) Enrollee Opt-Out process
(d) Health Insurance Claim Number (HICN) administration
(e) Formulary management
(f) Issuing of Medicare PDP EGWP member identification cards
(g) Member Communications, including required explanation of benefits statements
(h) Claims Processing
(i) Administration of a Medicare D supplemental wrap with the goal of providing Medicare primary Enrollees with a prescription drug benefit replicating as

closely as possible with the prescription drug benefit design for non-Medicare primary retirees in The Empire Plan;

(j) Timely administration of catastrophe re-insurance claims

(k) Administration of Low Income Subsidy requirements

(3) Confirm that you will develop, and timely submit to, CMS and /or Enrollees all required filings and DCS Program material related to the implementation and administration of a Medicare PDP EGWP plus Medicare D supplemental wrap on behalf of the Department.

(4) Provide a copy of your proposed Medicare Part D formulary and provide a side by side comparison to the proposed Empire Plan flexible formularies included in this RFP. Comment on reasons for variances.

(5) Provide a sample member communications package, including proposed benefit card, for the EGWP PDP plus Medicare D supplemental wrap.

(6) Describe in detail the transition services you will utilize to assist members who are newly eligible for the EGWP plus Medicare D supplemental wrap, including formulary disruption, prior authorization, mail order and retail pharmacy refills, Specialty Program medications, and quantity limits.

(7) Describe the member termination process under the EGWP PDP, including the timing of termination after the termination date is received by the Department.

(8) Describe your capability to provide the consulting and accounting services necessary to support and assist the Plan Sponsor in determining what Medicare Part D option the Department should select so that the DCS Program realizes maximum savings.

(9) Confirm your understanding and describe your ability to identify and recover claim payments made by the DCS Program from other Medicare Part D plans that should have been the primary payor, upon finalization of the subrogation process by CMS.

6. <u>Enrollee Communication Support</u>

The Department regularly provides information regarding DCS Program benefits to members through various publications, the Department's website and attendance at various meetings. The successful Offeror will be required to assist the Department with the creation, review and presentation of DCS Program materials that will enhance a member's understanding of DCS Program benefits. Please see Exhibit II.N for a summary of DCS Program presentations that took place in the past 12 month period. The Offeror will also be required to assist NYSIF with various Claimant communications including the issuing of ID cards, information packets, forms and letters, as requested.

a. <u>Duties and Responsibilities</u>

(1) All Enrollee communications developed by the Offeror are subject to the Procuring Agencies' review and prior written approval, including but not limited to any regular standardized direct communication with Enrollees or their Physicians in connection with Enrollee drug utilization or the processing of Enrollee claims, either through mail, e-mail, fax or telephone. The Department or NYSIF in its sole discretion reserves the right to require any change it deems necessary.

(2) (Exclusive to DCS) The Offeror will be responsible for providing Enrollee communication support and services to the Department including, but not limited to:

(a) Developing language describing the DCS Program for inclusion in the NYSHIP General Information Book and Empire Plan SPD, subject to the Department's review and approval;

(b) Developing articles for inclusion in Empire Plan Reports and other publications on an "as needed" basis, detailing DCS Program benefit features and/or highlighting trends in drug utilization;

(c) Timely reviewing and commenting on proposed DCS Program communication material developed by the Department;

(3) (Exclusive to DCS) Upon request, subject to the approval of DCS, on an "as needed" basis, the Offeror agrees to provide staff to attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in

the United States. **The Offeror agrees that the costs associated with these services are included in the Offeror's Claims Administration Fee.**

(4) The Offeror must work with the Procuring Agencies to develop appropriate customized forms and letters for the Programs, including but not limited to mail order forms, Enrollee claim forms, prior authorization letters, generic appeal letters, Flexible Formulary and Preferred Drug List, disruption letters, etc. All such communications must be approved by the Procuring Agencies.

(5) (Exclusive to NYSIF) The Offeror must assist NYSIF in developing a customized Claimant information packet that will include information on available prescription drug services as well as a permanent ID card to be used when filling injury-related prescriptions. See sample ID card in Exhibit II.E.2d.

b. Required Submission

(1) Please describe the organizational resources currently dedicated to Enrollee communications including any changes that would occur if you were awarded the resultant Agreements. Please detail the process that will be utilized to develop Enrollee communications including, but not limited to the role of the Offeror's legal department. Provide several examples of the Programs communications you have developed for Enrollees. Confirm your understanding that all Programs communications developed by the Offeror are subject to the Procuring Agencies final approval.

Note: (Exclusive to DCS) There are specific requirements for Flexible Formulary and Preferred Drug List communications set forth in Preferred Drug List Development and Management within Section IV.B.16.a. of this RFP.

(2) (Exclusive to DCS) Describe the resources that will be available to the Department to support the Department's development of various Enrollee communications and your ability to provide input into such communications quickly.

(3) (Exclusive to DCS)Confirm that staff will be available to attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and

elsewhere in the United States. Describe the experience and qualifications of staff that will be attending these events.

(4) Confirm your commitment to work with the Procuring Agencies to develop appropriate customized forms and letters for the Programs. Provide examples of how you have worked with other large clients to produce customized communications.

(5) (Exclusive to SIF) Confirm your commitment to develop a customizable information packet that will include a permanent ID card and other prescription drug information for the NYSIF Program. Provide samples of information packets developed and customized for other clients.

7. Enrollment Management

The Programs require the Offeror to ensure the timely addition of enrollment data as well as cancellation of benefits in accordance with each of the Programs' eligibility rules.

The Employee Benefits Division of the Department of Civil Service utilizes a web-based enrollment system for the administration of Employee benefits known as the New York Benefits Eligibility & Accounting Systems (NYBEAS). NYBEAS is the source of eligibility information for all Empire Plan, Excelsior Plan, and SEHP Enrollees and Dependents. Enrollment information is set forth in Exhibits II.B through II.B.2.

Note: The enrollment counts depicted in these exhibits may vary slightly due to timing differences in exhibit generation.

When a person enrolls in The Empire Plan, Excelsior Plan, or SEHP, the Department's card contractor issues an Employee Benefit Card. An Enrollee with individual coverage will receive one card containing the Enrollee's 9-digit alternate identification number and name. An Enrollee with family coverage will receive two cards containing the Enrollee's alternate identification number and name, as well as Dependents' names. This universal card is used by Enrollees and Dependents for all components of The Empire Plan. An example of The Empire Plan Employee Benefit Card is provided in Exhibit II.E.2a. An example of the Excelsior Plan Employee Benefit Card is provided in Exhibit II.E.2c. The Department will not accept an alternative approach to ID cards, with the exception of ID cards required for the

EGWP. It is the responsibility of the Offeror to ensure that the Retail Pharmacy Network accepts The Empire Plan Employee Benefit Card as evidence of coverage and is capable of submitting claims when presented with The Empire Plan Employee Benefit Card. These cards include The Empire Plan consolidated toll free number that pharmacies may use to contact the DCS Program if they need claim submission assistance. The Offeror should not expect any modification of the current identification card as part of implementation. Separate Prescription drug cards will not be issued, with the exception of ID cards required for the EGWP.

The SEHP Employee Benefit Card displays the Enrollee's 9-digit alternate identification number and name and the expiration date of coverage. The SEHP Employee Benefit Cards are issued annually by a Department contractor and have an expiration date of August 31st of each year. An example of this card is provided in Exhibit II.E.2b.

NYSIF's Claim Eligibility process ensures that Claimants receive convenient prescription filling services and that Network Pharmacy bill the NYSIF Program with the proper Carrier Case Number (i.e. Claim Number). A sample ID card is provided in Exhibit II.E.2d.

a. Duties and Responsibilities

The selected Offeror will be responsible for the maintenance of accurate, complete, and up-to-date enrollment files, located in the United States, based on information provided by the Department and NYSIF. These enrollment files shall be used by the Offeror to process retail, mail order and specialty pharmacy claims, provide customer service, identify individuals in the enrollment files who are enrolled in the EGWP or another Medicare Part D plan, and produce management reports and data files. The Offeror is required to provide enrollment management services including but not limited to:

(1) ***Initial Testing:***

(a) Performing an initial enrollment load to commence upon receipt from the Department and NYSIF during Program implementation. The file may be EDI Benefit Enrollment and Maintenance Transaction set 834(ANSI x.12 834 standard either 834 (4010x095A1) or 834 (005010x220)), fixed length ASCII text file, or a custom file format. The determination will be made by the Procuring Agencies;

(b) Testing to determine if the enrollment file and enrollment transactions loaded correctly and that the enrollment system interfaces with the claims processing system to accurately adjudicate claims. The selected Offeror shall submit enrollment test files to the Department and NYSIF for auditing, provide the Department and NYSIF with secure, online access required to ensure accurate loading of the Programs enrollment data, and promptly correct any identified issues to the satisfaction of the Department and NYSIF;

(2) (Exclusive to DCS) Providing an enrollment system capable of receiving secure enrollment transactions (Monday through Friday) and having all transactions fully loaded to the claims processing system within twenty-four (24) hours of release of a retrievable file by the Department. The Offeror shall immediately notify the Department of any delay in loading enrollment transactions. In the event the Offeror experiences a delay due to the quality of the data supplied by the Department, the Offeror shall immediately load all records received (that meet the quality standards for loading) within twenty-four (24) hours of their release, as required. The Department will release enrollment changes to the Offeror in an electronic format daily (Monday through Friday). On occasion, the Department will release more than one enrollment file within a 24-hour period. The Offeror must be capable of loading both files within the twenty-four (24) hour performance standard. The format of these transactions will be in an EDI Benefit Enrollment and Maintenance transaction set, utilizing an ANSI x.12 834 transaction set in the format specified by the Department. The latest transaction format is contained in Exhibit II.G and II.G.1. The Offeror must also have the capability to receive alternate identification numbers and any special update files from the Department containing eligibility additions and deletions, including emergency updates, if required;

(3) (Exclusive to NYSIF) Providing an enrollment system capable of receiving secure enrollment transactions every day, including weekends and holidays, and having all transactions fully loaded to the claims processing system within twelve (12) hours of release of a retrievable file by the NYSIF. The Offeror shall immediately notify the NYSIF of any delay in loading enrollment transactions. In the event the Offeror experiences a delay due to the quality of the data supplied by the NYSIF, the Offeror

shall immediately load all records received (that meet the quality standards for loading) within twelve (12) hours of their release, as required. The NYSIF will release enrollment changes, including all additions, modifications and deletions since the previous transmission, to the Offeror in an electronic format daily (every day, including weekends and holidays). On occasion, the NYSIF will release more than one enrollment file within a 12-hour period. The Offeror must be capable of loading both files within the twelve (12) hour performance standard. The format of these transactions will be a fixed length ASCII text file. The ASCII text file is encrypted and transmitted each business day using a secure transmission protocol. Upon selection, the Offeror will be provided with the claim eligibility file specifications and the schedule for the transmission of the file. The latest transaction format for NYSIF is contained in Exhibit II.O.

(4) Ensuring the security of all enrollment information as well as the security of a HIPAA compliant computer system in order to protect the confidentiality of Enrollee/Dependent data contained in the enrollment file. Any transfers of enrollment data within the Offeror's system or to external parties must be completed via a secured process;

(5) Providing a back-up system or have a process in place where, if enrollment information is unavailable or not current at the point of service, Enrollees can obtain Prescriptions without interruption, at the point of service. Short fill policies should be included in the Pharmacy Provider manual;

(6) Cooperating fully with any State initiatives to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of the Agreement resulting from this RFP;

(7) (Exclusive to DCS) Maintaining a read only connection to the NYBEAS enrollment system for the purpose of providing the Offeror's staff with access to current Program enrollment information. Offeror's staff must be available to access enrollment information through NYBEAS, Monday through Friday, from 9:00 am to 5:00 pm, with the exception of NYS holidays as indicated on the Department's website;

(8) (Exclusive to DCS) Meeting the administrative requirements for National Medical Support Notices. A child covered by a Qualified Medical Child Support Order (QMCSO), or the child's custodial parent, legal guardian, or the provider of services to the child, or a NYS agency to the extent assigned the child's rights, may file claims and the Offeror must make payment for covered benefits or reimbursement directly to such party. An Offeror will be required to store this information in their system so that any claim payments or any other plan communication distributed by the Offeror, including access to information on the Offeror's website would go to the person designated in the QMCSO;

(9) Ability to manually load/correct an enrollment record and to contact the Pharmacy to allow the adjudication of a Prescription in an urgent or emergency situation. Occurrences of these situations are very rare; and,

(10) (Exclusive to NYSIF) The Offeror must provide an instant enrollment or "short fill" service to injured workers of NYSIF policyholders. This service should allow immediate acceptance by any pharmacy in the Offeror's Retail Pharmacy Network in order to provide a limited number of cost-effective medication benefits to the injured worker.

(11) ***Enrollment Management Guarantee:*** The Offeror must propose a performance guarantee. The Programs' service level standard requires that one hundred percent (100%) of all Program enrollment records that meet the quality standards for loading will be loaded into the Offeror's enrollment system within twenty-four (24) hours of release by the Department and within twelve (12) hours of releases by the NYSIF.

b. <u>Required Submission</u>

(1) Describe your testing plan to ensure that the initial enrollment loads for the DCS and NYSIF Programs are accurately updated to your system and that they interface correctly with your claims system.

(a) What quality controls are performed before the initial and ongoing enrollment transactions are loaded into the claims adjudication system?

(b) How does your system identify transactions that will not load into your enrollment system? What exceptions will cause enrollment transactions to fail to load into your enrollment system? What steps are taken to resolve the exceptions, and what is the turnaround time for the exception records to be added to your enrollment file?

(2) Describe your system capabilities for retrieving and maintaining enrollment information within twenty-four (24) hours of its release by the Department and within twelve (12) hours of its release by NYSIF as well as:

(a) How your system maintains a history of enrollment transactions and how long enrollment history is kept online. Is there a limit to the quantity of history transactions that can be kept on-line?

(b) How your system handles retroactive changes and corrections to enrollment data;

(c) (Exclusive to DCS) Detail how your enrollment system captures the information necessary to produce the reports entitled “Claims and Credits Paid by Agency” and “Quarterly Participating Agency Claims” required in the Reporting Section of this RFP.

(d) Confirm your enrollment and claims processing system has the capacity to administer a social security number, Employee identification number and an alternate identification number assigned by the Department or NYSIF. Does your system have any special requirements to accommodate these three identification numbers? Explain how Dependents are linked to the Enrollee in the enrollment system and claims processing system (DCS Only).

(3) Describe how your enrollment system, data transfers, and procedure for handling enrollment data are HIPAA compliant.

(4) Describe the backup system, process or policy that will be used to ensure that Enrollees receive needed Prescription drugs in the event that enrollment information is not immediately available at the point of service;

(5) (Exclusive to DCS) Confirm that you will maintain a read only connection to the NYBEAS enrollment system, and that Offeror's staff will be available to access enrollment information through NYBEAS during the required hours, Monday through Friday, from 9:00 a.m. to 5:00 p.m., with the exception of NYS holidays.

(6) (Exclusive to DCS) Describe your ability to meet the administrative requirements for National Medical Support Orders and dependents covered by a Qualified Medical Child Support Order (QMCSO), including storing this information in your system so that information about the Dependent is only released to the individual named in the QMCSO.

(7) Describe your ability and the process to manually load/correct an enrollment record and to contact the Pharmacy to allow the adjudication of a Prescription in an urgent or emergency situation.

(8) (Exclusive to NYSIF) Describe in detail how you will administer the instant enrollment or "Short Fill" service to allow immediate acceptance by any pharmacy in the Offeror's Retail Pharmacy Network in order to provide a limited number of cost-effective medications to the injured worker.

(9) ***Enrollment Management Guarantee:*** The Programs service level standard requires that one hundred percent (100%) of all Program enrollment records that meet the quality standards for loading will be loaded into the Offeror's enrollment system within twenty-four (24) hours of release by the Department and within twelve (12) hours of release by NYSIF. The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet the standards.

The Standard Credit Amount for each 24 hour period beyond twenty-four (24) hours from the release by the Department that one hundred percent (100%) of the Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system is $5,000. However, Offerors may propose higher or lesser amounts.

The Standard Credit Amount for each 24 hour period beyond twelve (12) hours from the release by the NYSIF that one hundred percent (100%) of the Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system is $375. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each 24 hour period beyond twenty-four (24) hours from the release by the Department, and for each 24 hour period beyond twelve (12) hours from the release by the NYSIF, that one hundred percent (100%) of the Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system, is $_____ for DCS and $_____ for NYSIF.

8. Reporting

(Exclusive to DCS)

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Reporting must be structured to provide assurances that member, network and account management service levels are being maintained and that claims are being paid and billed according to the terms of the agreements with pharmacies and the terms of the Agreements

resulting from this RFP. The selected Offeror may on occasion be requested to provide ad-hoc reporting and analysis within very tight time frames.

In order to fulfill its obligations to enrolled members and ensure contract compliance, the Program requires that the Offeror provide accurate claims data information on a claim processing cycle basis as well as specific summary reports concerning the DCS Program and its administration.

All electronic files received by the Department are first validated for compliance with the specified file structure. Files that fail to adhere to this structure are rejected in their entirety.

a. Duties and Responsibilities

The selected Offeror will be responsible for accurate reporting services including, but not limited to:

(1) Ensuring that all financial reports including cycle claim reports are generated from amounts billed to the DCS Program, and tie to the quarterly and annual financial experience reports, and Rebate reports;

(2) Developing, in conjunction with the Department, standard electronic management, financial, and utilization reports required by the Department for its use in the review, management, monitoring and analysis of the DCS Program. These reports must tie to the amounts billed to the DCS Program. The final format of reports is subject to the Department review and approval;

(3) Supplying reports in paper format and/or in an electronic format (Microsoft Access, Excel, Word) as determined by the Department. The primary reports and data files are listed in this section of the RFP under Annual, Semi-Annual, Quarterly, Monthly and Ad-Hoc Reports and include the time frames for submittal to the Department;

(4) Providing direct, secure access to the Offeror's claims system and any online and web-based reporting tools to the Departments' offices;

(5) Providing Ad Hoc Reports and other data analysis at no additional cost. The exact format, frequency, and due dates for such reports shall be specified by the Department. Information required in the Ad Hoc Reports may include but is not limited to providing:

(a) Forecasting and trend analysis data

(b) Data necessary to track drug pricing

(c) Utilization data on the Mail Order Pharmacy and the Special Pharmacy Program

(d) Utilization review savings

(e) Benefit design modeling analysis

(f) Reports to meet clinical program review needs

(g) Reports segregating claims experience for specific populations

(h) Reports to monitor Agreement compliance

(6) ***Management Reports and Claim File Guarantees****:* The Offeror must propose a performance guarantee. The DCS Program's service level standard requires that accurate management reports and claim files as specified in Section IV.B.8.a.(7) (DCS Reporting) of this RFP will be delivered to the Department no later than their respective due dates inclusive of the date of receipt.

(7) Supplying reports in paper format and/or in an electronic format (Microsoft Access, Excel, Word) as determined by the Department. The primary reports and data files are listed under Annual, Semi-Annual, Quarterly, Monthly, Weekly, and Ad-Hoc Reports and include the time frames for submittal to the Department:

Annual Reports

Annual Financial Summary Report: The Offeror must submit an annual report of the DCS Programs' charges and credits no later than seventy-five (75) Days after the end of each Calendar Year. These statements must detail, at minimum, claims paid during the year, claims administration costs, performance credits, audit credits, drug settlement proceeds, rebates (earned and paid), and coordination of benefit (COB) savings. Such detail must include all charges by the Offeror to the DCS Program;

Annual Rate Renewal Report: The Offeror must submit an Annual Premium Renewal no later than September 1st of each Calendar Year. This renewal package must detail all assumptions utilized to back up the rate renewal request, including, but not limited to: paid claim amounts, administrative fees, projected Pharma Revenue, COB recoveries, changes in enrollment, changes in the Specialty Pharmacy drug list as well as changes in the Flexible Formularies and the Traditional PDL;

Annual Mail Service Pharmacy Process Satisfaction Survey Summary Report: The Offeror must submit a report which details, in summary form, the results of Enrollee satisfaction surveys designed to evaluate the level of DCS Program Enrollee satisfaction with the Mail Service Pharmacy Process. The surveys should cover areas of order processing, quality of services, and timeliness. The format of the survey

instrument and reports is subject to NYS input and approval. The report is due annually, on May 1st of the year following the Calendar Year being surveyed. The report must include Enrollee comments and an accounting and resolution of any Enrollee issues;

Annual Summary Reporting: The Offeror must prepare and present an annual report that details DCS Program performance, industry trends and anticipated market developments including the introduction of generics and potential new product developments. This presentation should include comparisons of the DCS Program to book of business statistics, and other similar plan statistics. Clinical, financial and service issues as well as strategies and opportunities for plan savings are to be comprehensively addressed. In addition, the Offeror should be proactive by reporting any areas that need improvement, potential problem areas, and any solutions that can be implemented. The annual presentation and report is due each August after the end of each complete Calendar Year;

Annual Report of Claims and Credits Paid by Agency: The Offeror must submit a report that details claims and credits paid by agency. The Offeror is required to submit this report in the current format specified by the Department in Exhibit II.F unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the Calendar Year. The report must accurately reflect only Final Paid Claims.

Mail Service Pharmacy Process Accuracy Annual Report: The Offeror is required to submit an annual report that provides a breakdown of the various errors and calculates the accuracy rate of transactions processed using the Offeror's Mail Service Pharmacy Process. The Offeror is required to work out the final format of this report with the Department. The report is due thirty (30) Days after the end of the Calendar Year.

Rebate True-up File: The Offeror is required to transmit a computerized file via secure transfer containing a yearly true-up of rebate records in a format specified by the Department. The true-up rebate file must match all of the billing records provided by the Offeror in the bi-weekly pharmacy billing files. The report is due one hundred fifty (150) Days after the end of the Calendar Year.

Catastrophe Reinsurance Reconciliation Report: The Offeror is required to submit an annual reconciliation of the Catastrophe Reinsurance receipts for the EGWP by December 31st of the year following year of incurral.

Semi-Annual Reports

Top 100 Brand Name and Generic Drugs – Retail Pharmacy Report: The Offeror is required to submit a semi-annual report that details the top 100 brand name and top 100 Generic Drugs dispensed to Enrollees of the DCS Program through the Offeror's Retail Pharmacy Network sorted by drug spend and script count. The report should include fields such as: drug name, indication of use (i.e. cholesterol, diabetes, etc), preferred drug indicator, number of Rx's, number of Enrollees utilizing the drug, Rx cost, average cost per script, average Copayment, and average Days supply. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.7. The numbers should be submitted on a year-to-year comparison basis. Any trends or abnormalities should be submitted in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter;

Top 20 Therapeutic Categories Report: The Offeror is required to submit a semi-annual report that details the top 20 therapeutic categories by drug spend on the Offeror's Flexible Formularies and Preferred Drug List (broken down by drug) utilized by Enrollees of the DCS Program (combined Retail, Mail Service and Specialty Pharmacy). The report should include fields such as: drug name, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Days supply. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.8. The numbers should be submitted on a year-to-year comparison basis. Any trends or abnormalities should be submitted in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter;

Top 100 Brand Name and Generic Drugs – Mail Service Pharmacy Report: The Offeror is required to submit a semi-annual report that details the top 100 brand name and top 100 Generic Drugs dispensed to Enrollees of the DCS Program through the Offeror's Mail Service Pharmacy sorted by drug spend and script count. The report

should include fields such as: drug name, indication of use (i.e., cholesterol, diabetes, etc), preferred drug indicator, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Days supply. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.9. The numbers should be provided on a year-to-year comparison basis. Any trends or abnormalities should be provided in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter;

Top 100 Specialty Drugs – Specialty Pharmacy Report: The Offeror is required to submit a semi-annual report that details the top 100 Specialty Drugs dispensed to Enrollees of the DCS Program through the Offeror's Designated Specialty Pharmacy sorted by drug spend and script count. The report should include fields such as: drug name, indication of use (i.e., cholesterol, diabetes, etc) , preferred drug indicator, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Days supply. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.6. The numbers should be provided on a year-to-year comparison basis. Any trends or abnormalities should be provided in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter;

Quarterly Reports

Quarterly Financial Summary Reports: The Offeror must submit quarterly financial reports which present the DCS Program's experience for the most recent quarter (based on a Calendar Year) and the experience from the beginning of the Calendar Year to the end of the quarter being reported. The quarterly reports must also include projections of:

- annual financial performance;
- assessment of DCS Program costs;
- incurred claim triangles;
- Pharma Revenue;
- coordination of benefit recoveries;
- audit recoveries;

- drug settlement and litigation recoveries;
- administrative expenses;
- trend statistics; and
- such other information as the Department deems necessary.

The reports are due on a quarterly basis, fifteen (15) Days after the end of the reporting period;

Quarterly Performance Guarantee Report: The Offeror must submit quarterly the DCS Program's Performance Guarantee report that details the Offeror's compliance with all of the Offeror's proposed Performance Guarantees. The report should include the areas of: Implementation; system availability; customer service (telephone availability, response time, blockage rate, abandonment rate); claims processing; management reports and claim files; enrollment; mail service turnaround; and, Pharmacy composition and access. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.11. Documentation of compliance should be included with this report. The report is due thirty (30) Days after the end of the quarter;

Quarterly Network Access: The Offeror must submit a measurement of the Network access (using Exhibit I.Y.4) based on a "snapshot" of the network taken on the last day of each quarter. The report is due thirty (30) Days after the end of the quarter;

Quarterly Audit Report: The Offeror must submit a quarterly audit report detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Offeror. The report should include fields such as: Pharmacy name, NABP number, recovery amounts, audit method or type, and basis for and method of recovery. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.12. The report is due thirty (30) Days after the end of the quarter;

Quarterly Coordination of Benefit Report: The Offeror must submit a report that details the amount of recoveries received as a result of coordinating benefits with other Plans including Medicare. The Offeror's report should identify the COB

source, the Enrollee, the original claim amounts, and the amount received from the other insurance carriers or Medicare. The Offeror is required to work out the final format of this report with the Department. The report is due thirty (30) Days after the end of the quarter;

Quarterly Rebate and Other Pharma Revenue Report: The Offeror is required to submit a quarterly rebate and other Pharma Revenue report detailing the amount of rebates and other Pharma Revenue received from the Offeror during the quarter. The report must include breakdowns by each manufacturer and drug with quarterly and year-to-date numbers, as well as any adjustments that are performed. The Offeror should closely follow the current format specified by the Department in Exhibit II.F.13. The Offeror's process for documenting rebates and other Pharma Revenue by manufacturer and issuing the payment of rebates and other Pharma Revenue to the DCS Program should not exceed one hundred fifty (150) Days from the end of the quarter in which the initial claims were processed. This report is due at the time the rebates and other Pharma Revenue are paid to the Program;

Quarterly Participating Agency Claims: The Offeror is required to submit a quarterly report that details claims by Participating Agency. The Offeror is required to submit this report in the current format specified by DCS in Exhibit II.F unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the quarter;

Generic Appeals and Prior Authorization Quarterly Report: The Offeror is required to submit a quarterly report that provides the number of generic appeals and prior authorization requests, by individual drug. The report must include numerical breakdowns on the number of generic appeals and prior authorization requests made by the individual drug as well as the success/declination rate of these requests. The Offeror should closely follow the current format specified by the Department in Exhibits II.J and II.H.1. The report is due thirty (30) Days after the end of the quarter;

Rebate File: The Offeror is required to transmit a computerized file via secure transfer containing prescription rebate information for all earned rebates in a format specified by the Department. The pharmacy rebate records in the Rebate File must

match all prescriptions billed to the Department by the Offeror. The report is due one hundred fifty (150) Days after the end of the quarter; and

Quarterly Website Analytics Report: The Offeror is required to submit a quarterly report that provides comprehensive performance information for the Offeror's customized DCS Program website as set forth in Section IV.B.4.a.(7) of this RFP. The report must include summarized and detailed website performance information and statistics, as well as proposed modifications to the layout and design of the website to improve communications with Enrollees. The report is due thirty (30) Days after the end of the quarter.

Monthly Reports

Monthly Report of Paid Claims by Month of Incurral: The Offeror is required to submit a monthly report that provides summarized paid claims by month of incurral. The Offeror is required to submit this report in the current format specified by the Department in Exhibit II.F unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month;

Monthly Report of Paid Claims by Pharmacy and Rx Type: The Offeror is required to submit a monthly report that provides summarized paid claims by Pharmacy type by Rx type. This report must distinguish reversals and allow the Department to verify Guaranteed Discounts. The Offeror is required to submit this report in the current format as specified by the Department in Exhibit II.F unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month;

Monthly Report of DCS Program MAC List: Each month the Offeror is required to submit an updated DCS Program MAC List that details all the drugs included on the DCS Program MAC List and the corresponding prices used to charge the DCS Program. The following information shall be included: GCN, drug name, form, strength, reference product, FDA rating, date the product was initially MAC'd, initial MAC price, previous MAC price, current MAC price, effective date of current MAC price and the change in price from the previous DCS Program MAC List. Drugs that are added or deleted from the DCS Program MAC List shall be clearly marked or

highlighted. The Offeror is required to submit this report in the current format specified by DCS in Exhibit II.F.4 unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month;

MAC Saving Reports: Each month is required to submit a year-to-date and annualized savings projections of the MAC price increases and decreases based on expected utilization. The following information shall be included: GCN, Drug Name, Strength, Initial MAC Price, Current Price, Quantity Filled, Actual Savings, Annual Savings. The Offeror is required to submit this report specified by the Department in Exhibit II.F.14 unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month; and

Program Customer Service Monthly Reports: Each month the Offeror is required to submit a customer service report that measures the Offeror's customer service performance including customer service availability, customer service telephone response time, the telephone abandonment rate, the telephone blockage rate, claims processing, enrollment, and mail service turnaround. The Offeror is required to work out the final format of these reports with the Department. The reports are due fifteen (15) Days after the end of the month. For the first two months of the Agreement resulting from this RFP, these reports will be due on a weekly basis. After two months, the Department will re-examine the required frequency of these reports and establish due dates with the Selected Offeror.

Bi-Weekly Reports

Detailed Claim File Data: The Offeror must transmit to the Department and/or its Decision Support System (DSS) Vendor a computerized file via secure transfer, containing detailed claim records in the format specified by the Department in Exhibit II.F.1 unless otherwise specified by the Department, to support the bi-weekly invoice. The Department requires that all claims processed, reversed and adjusted be included in claims data. The file must facilitate reconciliation of claim payments to amounts charged to the DCS Program and include the current status of the claim (i.e. fields identifying claims as paid, adjusted, reversed). A rejected claim file is also required upon request by the Department. The Offeror is required to securely forward the

required claims data on a claims processing cycle basis to the Department and/or its DSS vendor within fifteen (15) Days after the end of each claims processing cycle, and submit a summarized report by claims processing cycle broken down by drug type (generic/brand) utilizing the fields and the format specified by the Department in Exhibit II.F.5. Based upon the analysis of the information contained in the report any important programmatic information, trends or abnormalities should be provided in a narrative.

Reports Required at Other Frequencies

Mac Alert Notice: The Offeror is required to submit a report of the financial impact of enforcing mandatory generic substitution via a "Mac Alert Notice" utilizing the current format specified by the Department in Exhibit II.F.10. This report must be submitted in accordance with the time frames specified in Section IV.B.14.a.(4) of this RFP, under the subheading "Mandatory Generic Substitution at Retail and Mail."

b. Required Submission

(1) How will reversed, rejected, and adjusted claims be reflected in the reconciliation of the cycle claim reports to the quarterly and annual financial experience statements? Will this process be the same for claims billed within the cycle or outside of the cycle? Please describe in detail how reversed or modified claims are identified within your claims data. Please describe how your system allows the Department to identify only Final Paid Claims within your claims data. Explain how a claim reversed in a different billing cycle would be identified in your claims data.

(2) The Offeror must submit examples of the financial and utilization reports that have been listed without a specified format in the reporting requirements above as well as any other reports that the Offeror is proposing to produce for the Department to be able to analyze and manage the DCS Program. Provide an overview of your reporting capabilities with the value you believe this will bring to the DCS Program.

(3) Confirm that you will provide reports in the specified format (paper and/or electronic – Microsoft Access, Excel, Word), as determined by the Department.

(4) Confirm that you will provide direct, secure access to your claims system and any online and web-based reporting tools to the Department's offices. Include a copy of the data sharing agreement you propose for Department staff to execute in order to obtain systems access.

(5) Confirm that your ability and willingness to provide Ad Hoc Reports and other data analysis. Provide examples of Ad Hoc reporting that you have performed for other clients.

(6) ***Management Reports and Claim File Guarantees*:** The DCS Program's service level standard requires that accurate management reports and claims files will be delivered to the Department no later than their respective due dates. For the management reports and claim files listed in Section IV.B.8.a.(7) of this RFP, the Offeror must propose a performance guarantee. The Offeror shall propose the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this standard.

The Standard Credit Amount for each management report or claim file that is not received by its respective due date is $1,000 per report per each Business Day. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the DCS Program's Claims Administration Fee for each management report or claim file that is not received by its respective due date, is $_____ per report for each Business Day between the due date and the date the accurate management report or claims file is received by the Department inclusive of the date of receipt.

Reporting (Exclusive to NYSIF)

Reporting must be structured to provide assurances that Claimant, network and account management service levels are being maintained and that claims are being paid and billed according to the terms of the agreements with pharmacies and the terms of the separate Agreements resulting from this RFP. The selected Offeror may on occasion be requested to provide ad-hoc reporting and analysis within very tight time frames.

In order to fulfill its obligations to enrolled members and ensure contract compliance, the NYSIF Program requires that the Offeror provide accurate claims data information on a claim processing cycle basis as well as specific summary reports concerning the NYSIF Program and its administration.

All electronic files received by NYSIF are first validated for compliance with the specified file structure. Files that fail to adhere to this structure are rejected in their entirety.

Upon selection, the contractor will be provided with detailed specifications for all files exchanged between NYSIF and the contractor. In general, these specifications include the use of:

- Either fixed length ASCII text format and/or delimited ASCII text files;
- Standard structure for all including order:
  - Header record;
  - Detail records;
  - Footer record containing defined control totals, e.g. record count, hash totals, etc.;
- Standard encryption/decryption methodology;
- Standard secure file transfer protocol.

a. <u>Duties and Responsibilities</u>

The selected Offeror will be responsible for accurate reporting services including, but not limited to:

(1) Generating and submitting monthly, quarterly, semi-annual and annual reports per NYSIF specification. Specifications will be provided upon contractor selection;

(2) Capturing and providing NYSIF with electronic files of eligibility and authorization on the GC3, or similar code level. The Offeror should have the capability to capture drug denials on the GCN and NDC code levels;

(3) Providing direct, secure access to the Contractor's claims system and any online and web-based reporting tools to NYSIF's offices;

(4) Providing NYSIF with an on-line decision support tool with ad-hoc query capability;

(5) Providing Ad Hoc Reports and other data analysis at no additional cost. The exact format, frequency, and due dates for such reports shall be specified by NYSIF. Information required in the Ad Hoc Reports may include but is not limited to providing:

(a) Forecasting and trend analysis data;

(b) Data necessary to track drug pricing;

(c) Utilization data on the Mail Order Pharmacy and the Special Pharmacy Program;

(d) Utilization review savings;

(e) Benefit design modeling analysis;

(f) Reports to meet clinical program review needs;

(g) Reports segregating claims experience for specific populations; and

(h) Reports to monitor Agreement compliance.

(6) The Offeror must work with NYSIF to resolve reporting issues according to the timeframes described in Section IV.B.8.a.(8) (NYSIF Reporting) of this RFP;

(7) ***Management Reports and Claim File Guarantees:*** The Offeror must propose a performance guarantee. The NYSIF's Program service level standard requires that accurate management reports and claim files as specified in Section IV.B.8.a.(8) (NYSIF Reports) of this RFP will be delivered to NYSIF no later than their respective due dates inclusive of the date of receipt;

(8) Supplying reports in paper format and/or in an electronic format (Microsoft Access, Excel, Word) as determined by NYSIF. The primary reports and data files are listed in this section of the RFP under Annual, Semi-Annual, Quarterly, Monthly, Weekly, and Daily Reports and include the time frames for submittal to NYSIF;

Annual Reports

Rebate True-up File: The Offeror is required to transmit a computerized file via secure transfer containing a yearly true-up of rebate records in a format specified by NYSIF. The true-up rebate file must match all of the billing records provided by the Offeror in the weekly pharmacy billing files. The report is due one hundred fifty (150) Days after the end of the Calendar Year. Issue resolution timeframe: within 1 week of the original submission.

Quarterly Reports

Rebate File: The Offeror is required to transmit a computerized file via secure transfer containing prescription rebate information for all earned rebates in a format specified by NYSIF. The pharmacy rebate records in the Rebate File must match all prescriptions billed to NYSIF by the Offeror. The report is due one hundred eighty (180) Days after the end of the quarter. Issue resolution timeframe: within 1 week of the original submission.

Monthly Reports

Card Issuance File: The Offeror is required to submit a computerized file via secure transfer with the names of all NYSIF Claimants who have been issued a permanent ID card that is used when filing their injury-related prescriptions. The Offeror is required to submit this report in the current format specified by NYSIF in Exhibit II.E.2d unless otherwise specified by NYSIF. The report is due no later than fifteen (15) calendar Days after the end of the month being reported. Issue resolution timeframe: within 1 week of the original submission.

Weekly Reports

Established Claim Billing File: The Offeror is required to transmit a computerized file via secure transfer containing only those pharmacy bills that are in accordance with the defined NYSIF business rules for pharmacy bill submission and contains only those pharmacy bills that have been successfully matched to an established

NYSIF claim. Upon Offeror selection, NYSIF will provide a comprehensive list of edit rules and rejection codes that are based on the structure or content of a pharmacy bill record, as well as the specified file format. The report is due on the Monday following the week reported. Issue resolution timeframe: prior to the next scheduled submission;

Weekly Invoice: The Vendor Invoice submission consists of two parts:

- Hard copy of the Vendor Invoice submitted to NYSIF via USPS.
- Electronic submission of a Vendor Invoice Detail file supporting the charges on the Vendor Invoice.

The Offeror must submit the Vendor Invoice Detail file in the form an ASCII text file. The purpose of the detailed invoice file is to provide NYSIF with the information needed in order to programmatically reconcile the Vendor Invoice. The report is due on the Monday following the week reported. Issue resolution timeframe: within 1 week of the original submission;

Aging Bill Report File: The Offeror is required to submit a computerized pharmacy billing file via secure transfer with bills previously submitted in the Instant Enrollment/"Short Fill" file that remain unmatched to an established NYSIF claim. In the event there are not records meeting the above criteria, an empty file should be transmitted. The report is due each Monday. Issue resolution timeframe: prior to the next scheduled submission.

Daily Reports

Short Fill Report File: The Offeror is required to submit a computerized file via secure transfer with pharmacy bills for those injured workers of NYSIF policy holders where the bill cannot be matched to an established NYSIF claim. The report is due daily. Issue resolution timeframe: prior to the next scheduled submission.

b. Required Submission

(1) Confirm your agreement to generate and submit all daily, weekly, monthly, quarterly, semi-annual, and annual reports per NYSIF specification;

(2) Confirm you will provide NYSIF with electronic file of eligibility and authorization on the GC3, or similar code level. Indicate your capability for capturing drug denials on the GCN and NDC code levels. If unable to capture denials on the GC3 code level, provide a detailed description of your denial coding system;

(3) Confirm that you will provide reports in the specified format (paper and/or electronic – Microsoft Access, Excel, Word), as determined by NYSIF;

(4) Confirm that you will provide NYSIF with an on-line decision support tool with ad-hoc query capability;

(5) Confirm that your ability and willingness to provide Ad Hoc Reports and other data analysis. Provide examples of Ad Hoc reporting that you have performed for other clients.

(6) Describe how your proposed system will accept pharmacy bills from the Offeror's network pharmacies;

(7) Describe how your proposed system will edit these pharmacy bills in accordance with NYSIF business rules;

(8) Describe how the proposed system will reject, with reason, any pharmacy bills that do not adhere to NYSIF business rules;

(9) Describe the method for notification of your network pharmacy in the event of rejection;

(10) Describe how the pharmacy bills submitted will validate against the claim eligibility information provided by NYSIF;

(11) Identify the format of your pharmacy billing file, i.e. national standard, proprietary, etc;

(12) Describe the encryption and secure transmission protocol for the pharmacy billing files;

(13) Describe how the system will be monitored for performance;

(14) Describe how NYSIF will be notified in the event of a system and/or transmission failure;

(15) Describe how it will be determined into which file Established Claim or Instant Enrollment/"Short Fill," the pharmacy bill will be placed;

(16) Describe the process for tracking Aging Bills and how it will be determined whether or not a bill is to be placed in the Aging Bill files;

(17) Describe how card issuance information is tracked in your system;

(18) Describe your encryption and secure transmission protocol for your electronic files;

(19) Confirm your agreement to create specified electronic files in the form of an ASCII text file;

(20) Describe how rebate information is tracked in your system; and

(21) Describe the process that determines when a rebate is included in the quarterly rebate and annual true-up files.

(22) ***Management Reports and Claim File Guarantees:*** The NYSIF Program's service level standard requires that accurate management reports and claims files will be delivered to the NYSIF no later than their respective due dates. For the management reports and claim files listed in Section IV.B.8.a.(8) (NYSIF Reports) of this RFP, the Offeror must propose a performance guarantee. The Offeror shall propose the forfeiture of a specific dollar amount of the NYSIF Claims Administration Fee for failure to meet this standard.

The Standard Credit Amount for each management report or claim file that is not received by its respective due date is $75 per report per each Business Day. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the NYSIF Claims Administration Fee for each management report or claim file that is not received by its respective due date, is $_____ per report for each Business Day between the due date and the date the accurate management report or claims file is received by the NYSIF inclusive of the date of receipt.

9. Consulting

The Procuring Agencies require the selected Offeror to be an expert in the Prescription drug industry. Thus, the Procuring Agencies may request the advice and recommendations of the selected Offeror to provide the Procuring Agencies with up-to-date developments in the prescription drug field. The Procuring Agencies expect the selected Offeror to proactively provide advice and recommendations that are related to the clinical quality and cost management of the Programs. Such recommendations must include preliminary analysis of financial, therapeutic and Enrollee impact of proposed and contemplated benefit design changes.

a. Duties and Responsibilities

The selected Offeror will be responsible for providing advice and recommendations regarding the Programs. Such responsibility shall include, but not be limited to:

(1) Informing the Procuring Agencies in a timely manner concerning such matters as cost containment strategies, new drugs, conversion from Brand Drugs to Generic Drugs and how it will impact cost, Flexible Formulary and Preferred Drug List configuration, technological improvements, e-prescribing, Pharmacy innovations, and state/Federal legislation (i.e., Medicare, Prescription drug mandates, etc.) that may affect the Programs. The Offeror must provide information and recommendations to the Procuring Agencies on Flexible Formulary or Preferred Drug List (PDL) placement
of new generic and biological therapies prior to release into the marketplace to the extent such information is available in the public realm. The Offeror must also make available to the Procuring Agencies one or more members of the clinical or account management team to discuss the implications of these new trends and developments.

The Procuring Agencies are not under any obligation to act on such advice or recommendation; and

(2) Assisting the Procuring Agencies with recommendations and evaluation of proposed benefit design changes and implementing any changes necessary to accommodate Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State. Recommendations must include a preliminary analysis of all associated costs, a clinical evaluation, and the anticipated impact of proposed Program modifications and contemplated benefit design changes on Enrollees.

In the event of a design change and the Offeror requests any change in compensation such change will be in accordance with Section V.C.12.a. of this RFP.

b. Required Submission

(1) What resources will you utilize to ensure the Programs are kept abreast of the latest developments in the Prescription drug field? How do you propose to communicate trends, pending legislation and industry information to the Programs?

10. Transition and Termination of Agreements

The Offeror shall ensure that upon termination of the separate Agreements, any transition to another organization be done in a way that provides Enrollees with uninterrupted access to their Prescription drug benefits and associated customer services through the final termination of the respective Agreements resulting from this RFP. This includes, but is not limited to: ensuring Enrollees/Claimants can continue to fill their Prescriptions through network pharmacies, the Mail Service Pharmacy Process and the Specialty Pharmacy Program; the processing of all non-network claims; verification of enrollment; and, providing sufficient staffing to ensure Enrollees continue to receive good customer service even after the termination date of the Agreements resulting from this RFP. It is also imperative that the Programs continue to have dialogue with key personnel of the Offeror, maintain access to online systems and receive data/reports and other information regarding the Programs after the effective end date of the Agreements. In addition, the Offeror and the selected successor shall fully cooperate with the Department and NYSIF to create and establish separate transition plans in a timely manner for each Program.

a. Duties and Responsibilities

(1) The Offeror must commit to fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the Programs.

(2) The Offeror must, within one hundred twenty (120) Days of the end of the Agreements resulting from this RFP, or within forty-five (45) Days of notification of termination, if the Agreements resulting from this RFP are terminated prior to the end of their term, provide the Procuring Agencies with separate, detailed written plans for transition, which outline, at a minimum, the tasks, milestones and deliverables associated with:

(a) Transition of Program data, including but not limited to a minimum of one year of historical Enrollee claim data, detailed COB data, report formats, Mail Service Pharmacy, Specialty Pharmacy and retail scripts with available refills, prior authorization approved through dates, generic appeal approved through dates and exceptions that have been entered into the adjudication system on behalf of the Enrollee, as well as other data the successor contractor may request and the Procuring Agencies approve during implementation of the Programs in the format acceptable to the Procuring Agencies. The transition of open refill prior authorization and generic appeal files should include but not be limited to the following:

(i) Providing a test file to the successor contractor in advance of the implementation date to allow the new contractor to address any potential formatting issues;

(ii) Providing one or more pre-production files at least four 4 weeks prior to implementation that contains Enrollee Prescription refill availability, one year of claims history and prior authorization and appeal approved-through dates as specified by the Procuring Agencies working in conjunction with the successor contractor;

(iii) Providing a second production file to the new Contractor by the close of business January 2nd (or 2 days after the Agreements resulting from this RFP terminate) that contains all Enrollee Prescription refill availability as specified

by the Procuring Agencies, working in conjunction with the selected successor contractor; and

(iv) Providing a lag file due seven (7) Days after the implementation date to capture any refills that may have been in process but not yet shipped at the Offeror's Mail Service and Designated Specialty Pharmacy(ies) after the end of the year.

(b) Transition of Enrollee information on all non-transferable compounds and controlled medications.

(3) Within fifteen (15) Business Days from receipt of the Transition Plan, the respective Procuring Agency shall either approve the Transition Plan or notify the Contractor, in writing, of the changes required to the Transition Plan so as to make it acceptable to the Department or NYSIF.

(4) Within fifteen (15) Business Days from the contractor's receipt of the required changes, the Contractor shall incorporate said changes into the respective Transition Plan and submit such revised Transition Plan to the Department or NYSIF.

(5) The selected Offeror shall be responsible for transitioning the Programs in accordance with the approved Transition Plans.

(6) To ensure that the transition to a successor contractor provides Enrollees with uninterrupted access to their Prescription Drug benefits and associated customer services, and to enable the Department or NYSIF to effectively manage the separate Agreements resulting from this RFP, the Offeror is required to provide the following Contractor-related obligations and deliverables to the Programs through the final financial settlement of the Agreements resulting from this RFP:

(a) Provide all Contractor-provided services associated with claims incurred, as applicable to the respective Programs, on or before the scheduled termination date of the Agreements resulting from this RFP, including but not limited to paying network claims, Mail Service Pharmacy claims, Specialty Pharmacy claims, manual submit claims including but not limited to: Medicaid, VA , Skilled

Nursing Facility claims, out-of-network claims, foreign claims, in-network claims, COB claims, Student Health Center Claims, and Medicare, reimbursing late filed claims if warranted, reimbursing customer credit balance accounts, resolution of Mail Service Pharmacy process and Specialty Pharmacy Process issues, repaying or recovering monies on behalf of the Program for Medicare claims, retaining NYBEAS access, continuing to provide updates on pending litigation and settlements and claims/rebate data for class action litigation that the Contractor or the NYS Attorney General's Office has/may file on behalf of the Programs. In addition, the Offeror must continue to provide the Procuring Agencies access to any online claims processing data and history and online reporting systems through the final settlement dates, unless the Procuring Agencies notify the Offeror that access may be ended at an earlier date;

(b) Complete all required reports in the reporting Section IV.B.8. of this RFP;

(c) Provide the Programs with sufficient staffing in order to address State audit requests and reports in a timely manner;

(d) Agree to fully cooperate with all the Department, NYSIF or Office of the NYS Comptroller (OSC) audits consistent with the requirements of Article XIX of the resulting Agreements and Appendices A and B;

(e) Perform timely reviews and responses to audit findings submitted by the Department, NYSIF and the Comptroller's audit unit in accordance with the requirements set forth in Article XIX "Audit Authority," Section VII, Contract Provisions;

(f) Remit reimbursement due the Program within fifteen (15) days upon final audit determination consistent with the process specified in Article XIX "Audit Authority" and Article XV "Payments/(credits) to/from the contractor" of Section VII, Contract Provisions and Appendix B; and

(g) (Exclusive to DCS) Assist the Department in all activities necessary to ensure the correct and adequate interface between NYSHIP and the Centers for Medicare and Medicaid Services (CMS) with respect to the administration of the EGWP in

accordance with Subpart R of 42CFR423 and the Medicare Prescription Drug Improvement and Modernization Act (P.L. 108-173). Such assistance includes, but is not limited to the provision of accurate data within the Offeror's control.

(7) The selected Offeror is required to reach separate agreements with the Procuring Agencies on receiving and applying enrollment updates, keeping dedicated phone lines open with adequate available staffing to provide customer service at the same levels provided prior to termination of the Agreements resulting from this RFP, adjusting phone scripts, and transferring calls to the successor contractor's lines.

(8) The selected Offeror is required to transmit point of service messaging to their Retail Pharmacy Network upon the termination date of the Agreements resulting from this RFP instructing Pharmacists to submit Enrollee claims to the appropriate RXBIN, RXPCN, RXGRP or other claim identification information as specified by the Department and NYSIF working in conjunction with the selected Offeror.

(9) If the selected Offeror does not meet all of the Transition Plan requirements in the time frame stated above, the selected Offeror **will permanently forfeit 100%** of all Claims Administration Fees (prorated on a daily basis) from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are completed to the satisfaction of the Procuring Agencies.

b. Required Submission

(1) Provide an outline of the key elements and tasks that would be included in your separate Transition Plans to ensure that all the required duties and responsibilities are completed if you were the incumbent contractor. Include a brief explanation on how you would accomplish this with the successor contractor.

(2) Please detail the level of customer service that you will provide after the termination date of the Agreements resulting from this RFP.

11. Network Management

The selected Offeror must have a comprehensive nationwide Retail Pharmacy Network in place to allow adequate access for Enrollees to obtain all Covered Drugs through the Retail

Pharmacy Network. Through this RFP, the Programs are seeking a Pharmacy Network that delivers the most aggressive discounts possible, while meeting the minimum guarantees for Network Pharmacy access. In addition, the selected Offeror is required to have a fully functioning Mail Service Pharmacy Process that allows Enrollees to obtain all Covered Drugs and is capable of handling the mail service Prescription volume of the Programs:

Retail Pharmacy Network

The current Programs include a nationwide Retail Pharmacy Network through which Enrollees can obtain all Covered Drugs including any and all drugs that could be classified as Specialty Drugs/Medications as required by Section IV.B.11. of this RFP, under the subheading "Specialty Drugs/Medications." The Offeror must propose a Retail Pharmacy Network that meets or exceeds the Programs' minimum access guarantees at the time of proposal submission that is credentialed and contracted for participation in the Programs' Retail Pharmacy Network commencing on January 1, 2014. The Offeror may choose to enter into Program-specific Pharmacy contracts that are contingent on award and/or utilize existing Pharmacy agreements that can be made applicable to the Programs to meet the Programs' requirement that the Offeror have executed contracts with all the Network Pharmacies included in the Offeror's Proposed Retail Pharmacy Network File upon the submission date of their Proposal. (**Note:** Because the Procuring Agencies provide significant purchaser volume, the Department and NYSIF expect each Offeror will present a Proposal with network contracts at reimbursement rates more favorable than the Offeror's standard pharmacy contracts.)

All Brand Drug Retail Pharmacy Network claims shall be charged to the Programs at Pass-through Pricing subject to the Offeror's proposed overall Guaranteed Minimum Discount off of AWP for all Brand Drugs dispensed, as set forth in Exhibit V.A, plus the applicable brand dispensing fee. All Generic Drug Retail Pharmacy Network claims shall be charged to the Program at Pass-through Pricing subject to the Offeror's proposed overall Guaranteed Minimum Discount off of AWP for all Generic Drugs dispensed, as set forth in Exhibit V.A plus the applicable generic dispensing fee. Retail and Mail Service Pharmacy Process claims meeting the Programs' definition of Compound Drugs shall be charged to the Programs utilizing Pass-through Pricing in accordance with the Offeror's proposed (and Procuring Agencies' approved) methodology plus the applicable compound dispensing fee. *Do not include any cost information in the technical proposal.*

a. Duties and Responsibilities

(1) The Offeror must maintain a credentialed and contracted Retail Pharmacy Network that meets or exceeds the Programs' minimum access standards throughout the term of the resultant Agreements.

(2) The Programs require that the Offeror have available to Enrollees on January 1, 2014 its proposed Retail Pharmacy Network in accordance with the requirements set forth in Section IV.B.3.a.(2)(a) guaranteeing effective implementation of their proposed Retail Pharmacy Network.

(3) The Offeror is required to include Independent Pharmacies in its Proposed Retail Pharmacy Network. In developing its proposed Retail Pharmacy Network, the Offeror is expected to use its best efforts to substantially maintain the composition of independent Network Pharmacies included in the Programs' current Retail Pharmacy Network provided such Pharmacies meet the requirements of Pharmacy Credentialing and Pharmacy Contracting of this RFP, and are willing to accept the proposed aggressive reimbursement rates.

(4) The selected Offeror shall include in its Retail Pharmacy Network any Pharmacy(ies) upon the Department's or NYSIF's request, where such inclusion is deemed necessary by the Procuring Agencies to meet the needs of Enrollees even if not otherwise necessary to meet the minimum access guarantees outlined below.

(5) The Offeror must effectively communicate the content (including any subsequent changes) and requirements of the Program's Flexible Formularies and Preferred Drug Lists to their Retail Pharmacy Network.

(6) Prior to January 1, 2014, the selected Offeror must ensure that their Network Pharmacies have the correct claim identification information (i.e. RX BIN #, RXPCN, RXGRP, effective date, phone number for questions, etc.) to facilitate accurate claims submission and uninterrupted access for Enrollees.

(7) Offerors must establish a process to provide Enrollees with access to Limited Distribution Drugs through the Retail Pharmacy Network.

(8) ***Network Pharmacy Access Guarantee*:** The selected Offeror must propose a Retail Pharmacy Network that throughout the term of the Agreements resulting from this RFP meets or exceeds the Procuring Agencies' minimum access guarantees as follows:

(a) Ninety percent (90%) of Enrollees in urban areas will have at least one (1) Network Pharmacy within two (2) miles;

(b) Ninety percent (90%) of Enrollees in suburban areas will have at least one (1) Network Pharmacy within five (5) miles; and

(c) Seventy percent (70%) of Enrollees in rural areas will have at least one (1) Network Pharmacy within fifteen (15) miles.

Note: In calculating whether the Offeror meets the minimum access guarantees, all Enrollees must be counted; no Enrollee may be excluded even if a Pharmacy is not located within the minimum access area.

Offerors should provide a guarantee, separately for each Program, for each of the three (3) measurements and areas (urban, suburban, and rural). These guarantees are based on the distance, in miles, from a Program Enrollee's home (zip code) to the nearest Network Pharmacy location.

Urban, suburban and rural are based on US Census Department classifications, as determined by GeoAccess. Offerors may guarantee better access than the minimums, but the access guarantees must follow the same structure as the above minimum (i.e., access guarantees for each of the three (3) areas based on the entire Program population).

b. Required Submission

(1) Propose access guarantees for the Programs' Retail Pharmacy Network that meet or exceed the minimums set forth above. The access guarantee must be provided in terms of actual distance from Enrollees' residences and must meet or exceed the minimum access guarantees stipulated above.

% of Enrollees with Access to Retail Pharmacies	Enrollee Location	Access Guarantee - 1 Pharmacy at least within
___%	Urban	___ miles
___%	Suburban	___ miles
___%	Rural	___ miles

(2) Complete Exhibit I.Y.1 to indicate whether certain chain pharmacies will or will not participate your Retail Pharmacy Network on January 1, 2014. The completion of Exhibit I.Y.1 must be consistent with the contents of the Offeror's Proposed Retail Pharmacy Network File, Exhibit I.Y.3.

(3) Please compare the current DCS Program network pharmacies that have submitted claims in 2010/2011 with your Proposed Retail Pharmacy Network File. Identify whether each of the Program's current network pharmacies will or will not participate in the Offeror's proposed Retail Pharmacy Network in accordance with the instructions provided in Exhibit I.Y.5, entitled "Comparison of Current Program Network Pharmacies and the Offeror's Proposed Retail Pharmacy Network." The file containing the DCS Program's current network pharmacies and instructions for completing the exhibit can be obtained by following the instructions included in Exhibit I.Y.5 and meeting the requirements specified in Section III.B.5. of this RFP.

(4) Please confirm that if selected, you will provide ~~an~~ updated Exhibits I.Y.1, I.Y.3, I.Y.4 and I.Y.5 on December 1, 2013 confirming that the Offeror's proposed Retail Pharmacy Network will be implemented as required on January 1, 2014. If necessary, the selected Offeror shall submit a second file affirmatively identifying any deviations from the proposed Retail Pharmacy Network along with a detailed explanation for all deviations.

(5) Describe the approach(es) you would use to solicit additional pharmacies to enhance your proposed Retail Pharmacy Network or to fulfill a request to add an individual independent Pharmacy.

(6) Please identify Limited Distribution Drugs and indicate the authorized distributors that will participate in the Retail Pharmacy Network proposed for the Programs. If you are unable to secure the participation of the authorized distributors in your Retail

Pharmacy Network, describe the process you will utilize to provide Enrollees with access to these drugs placing no additional steps or burdens on the Enrollee.

(7) ***Network Pharmacy Access Guarantees*:** You must guarantee that throughout the term of the Agreements resulting from this RFP, Enrollees living in urban, suburban and rural areas will have access, as proposed by the Offeror, to a Network Pharmacy. The Offeror must propose an access guarantee that meets or exceeds the minimum access guarantees set forth in the "Retail Pharmacy Network" Section of this RFP. The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet these guarantees.

The Standard Credit Amount for each .01 to 1.0% below the ninety percent (90%) minimum access guarantee, for any quarter, in which the Network Pharmacy Access for Urban Areas is not met by the Offeror, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee is $_____ for DCS and $____ for NYSIF for each .01 to 1.0% below the ninety percent (90%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Pharmacy Access-for Urban Areas Guarantee, is not met by the Offeror.

The Standard Credit Amount for each .01 to 1.0% below the ninety percent (90%) minimum access guarantee for any quarter in which the Network Pharmacy Access for Suburban Areas is not met by the Offeror, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee is $_____ for DCS and $____ for NYSIF for each .01 to 1.0% below the ninety percent (90%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Pharmacy Access-for Suburban Areas Guarantee, is not met by the Offeror.

The standard credit amount for each .01 to 1.0% below the seventy percent (70%) minimum access guarantee for any quarter in which the Network Pharmacy Access

for Rural Areas is not met by the Offeror, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee is $_____ for DCS and $____ for NYSIF for each .01 to 1.0% below the seventy percent (70%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Pharmacy Access-for Rural Areas Guarantee, is not met by the Offeror.

Measurement of compliance with each access guarantee will be based on a "snapshot" of the Retail Pharmacy Network taken on the last day of each quarter within the current plan year. The results must be provided in the format contained in Exhibit I.Y.4. The report is due thirty (30) Days after the end of the quarter.

Pharmacy Credentialing

Offerors must ensure that their Network Pharmacies meet the licensing standards required by the state in which they operate. Network pharmacies are also required to meet the credentialing criteria established by the Offeror. This criteria should be designed to ensure quality pharmaceutical care.

a. Duties and Responsibilities

(1) The selected Offeror must ensure its Retail Pharmacy Network is credentialed in accordance with all applicable federal and state laws, rules and regulations.

(2) The Offeror must credential Pharmacies in a timely manner and shall have an effective process by which to confirm Network Pharmacies continuing compliance with credentialing standards.

(3) The Offeror must maintain credentialing records and make them available for review by the Procuring Agencies upon request.

b. Required Submission

(1) Describe the Offeror's process to ensure that network pharmacies meet the applicable state licensing requirements and are in compliance with all other federal and state

laws, rules and regulations. What is the resource, data base, or other information used by your organization to verify this information?

(2) Describe your approach for credentialing Network Pharmacies.

(a) Specify if you utilize an external credentialing verification organization. When was the credentialing verification process last completed? What is your process for confirming continuing compliance with credentialing standards? How often do you conduct a complete review?

(b) What steps do you take between credentialing periods to ensure that Network Pharmacies that are officially sanctioned, disciplined, or had their licenses revoked are removed from the Retail Pharmacy Network as soon as possible? What steps, if any, do you take to advise members when a Pharmacy has been removed from the Retail Pharmacy Network?

Pharmacy Contracting

Contracts with pharmacies should be written to utilize the Programs' market strength to obtain maximum discounts while also ensuring the Programs' access guarantees are met. This could include reimbursement provisions which are lower than the Offeror's standard reimbursement rates for Network Pharmacies. Contracting staff should keep abreast of current market conditions and have the wherewithal to adjust contracts with pharmacies to reflect the best interests of the Programs. The Offeror must ensure that all Network Pharmacies contractually agree and comply with the Programs' requirements and benefit design. The Program expects Offerors to negotiate aggressive discounts off of AWP for Brand Drugs and manage a Program MAC List for Generic Drugs dispensed to Enrollees. Contracts should be consistent with and support proposed access guarantees to ensure long-term stability of the Retail Pharmacy Network.

Note: Do not include any cost information in the Technical Proposal.

a. Duties and Responsibilities

The Offeror will be responsible for providing Pharmacy contracting services including but not limited to:

(1) Ensuring that all Network Pharmacies contractually agree to and comply with all of the Programs' requirements and benefit design specifications;

(2) (Exclusive to DCS) Ensuring all Network Pharmacy contracts include a provision prohibiting the use of pharmacy manufacturer coupons that reduce or waive Enrollee Copayments;

(3) (Exclusive to DCS) Recruiting licensed Pharmacies affiliated with home care agencies that are participating providers under The Empire Plan's Home Care Advocacy Program administered by The Empire Plan's medical carrier. These licensed pharmacies are provided in Exhibit II.E.3 of this RFP;

(4) Ensuring that Network Pharmacies accept as payment-in-full the Offeror's reimbursement for all claims processed based on the Program's Lesser of Logic detailed in Section VII of the RFP, Article 12.6.0.

(5) Notifying the Department and NYSIF in writing of any plan to renegotiate the financial terms of any Network Pharmacy contract utilized by the Programs for any Pharmacy that is located in the State of New York, or for any such Pharmacy located outside the NYS that accounts for more than 0.25% of total Program final paid claim Ingredient Costs;

(6) Notifying the Procuring Agencies in writing within one (1) Business day of any changes to contracts with Retail Pharmacy Network chain Pharmacies or independent Pharmacies negotiating collectively with the Offeror, including but not limited to, those identified as participating in the Offeror's proposed network;

(7) (Exclusive to DCS) Upon the request of the Department, resoliciting the entire Pharmacy Network to obtain more aggressive reimbursement rates that would pass-through to the Program in exchange for a smaller, select network that meets proposed access guarantees, as modified;

(8) Committing to administering Pharmacy contracts consistent with all representations made in the Offeror's cost proposal, including all representations regarding the administration of generic pricing and maintenance of MAC list(s); and

(9) (Exclusive to NYSIF) Ensuring there are mechanisms in place to circumvent the referral of bills by participating pharmacies to third party billers for collection.

b. Required Submission

(1) Confirm that your agreements with Network Pharmacies require their compliance with all the Programs' requirements and benefit design specifications. Provide a copy of the Offeror's proposed Pharmacy contract, rate sheet, and provider manual.

(2) (Exclusive to DCS) Confirm that licensed Pharmacies affiliated with home care agencies that are participating providers under The Empire Plan's Home Care Advocacy Program are, or will be, recruited into your Retail Pharmacy and Specialty Pharmacy network, if applicable.

(3) Please confirm that your Network Pharmacy contracts require the Pharmacy to apply the Program's Lesser of Logic to all the Programs' claims.

(4) Please confirm that you will notify the Procuring Agencies in writing of any changes to the Network Pharmacy contracts or any plans to renegotiate the financial terms of the contracts utilized by the Programs for any New York State Pharmacy or significant out-of-state Pharmacy.

(5) (Exclusive to NYSIF) Describe in detail the mechanisms you will put in place to circumvent the referral of bills by participating pharmacies to third party billers for collection.

Pharmacy Audit

The protection of the Programs' assets must be a top priority of the selected Offeror. The selected Offeror must have a strong audit presence throughout its organization. The Offeror is responsible for the oversight and audit of pharmacies that dispense drugs for Enrollees.

Staff should be well-trained and experienced. Claims systems should have logic programmed which help to focus audit resources.

a. Duties and Responsibilities

The selected Offeror must have a staffed and trained audit unit employing a comprehensive Pharmacy audit program that includes but is not limited to:

(1) Providing ample audit resources including access to the Offeror's on-line claims processing system to the Department, NYSIF and OSC at their respective offices through the date of the final financial settlement of the Agreement resulting from this RFP;

(2) Providing the Procuring Agencies with access and monthly updates to the Prescription Drug industry pricing source material (e.g. Red Book, Medispan, other) that the Offeror will be utilizing for the Programs;

(3) Conducting routine and targeted on-site audits of Network Pharmacies, the Mail Service Pharmacy and the Specialty Pharmacy(ies). Pharmacies that deviate significantly from patterns of dispensing in terms of cost, drug selection, overrides, Days supply or utilization are to be identified and targeted for on-site and desk audits in accordance with established selection and screening criteria. On-site audits must also be conducted upon request by the Procuring Agencies, or when information is received by the Offeror that indicates a pattern of conduct by a Pharmacy that is not consistent with the respective Programs design and objectives. Periodic, on-site audits must be conducted at least once during the course of the resultant Agreements for Pharmacies that fall into the top fifty (50) in terms of total dollar spend for the Programs. Any modifications to the proposed Pharmacy audit programs must receive prior approval by the State;

(4) Providing reports to the Procuring Agencies detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Offeror. The Offeror must inform the Procuring Agencies in writing of any allegation or other indication of potential fraud and abuse identified within seven (7) Business Days of such allegations or identification. The Procuring

Agencies must be fully informed of all fraud and abuse investigations impacting the Programs upon commencement, regardless of whether the individual fraud and abuse investigation has a material financial impact to the State;

(5) The capability and contractual right to effectively audit the Programs' Retail Pharmacy Network, including the use of statistical sampling audit techniques and the extrapolation of errors;

(6) Agreement to fully cooperate with all Department, NYSIF and/or OSC audits consistent with the requirements of Appendices A and B as set forth in Section VII, Contract Provisions including provision of access to protected health information and all other confidential information when required for audit purposes as determined by the Department and/or OSC as appropriate. The Offeror must respond to all State (including OSC) audit requests for information and/or clarification within fifteen (15) Business Days. The Offeror must perform timely reviews and respond in a time period specified by the Department or NYSIF to preliminary findings submitted by the Department, NYSIF or the Comptroller's audit unit in accordance with the requirements of Article XIX "Audit Authority" in Section VII, Contract Provisions. Such audits may include, but are not limited to: mail order claims; Enrollee-submitted paper claims; and on-line Pharmacy claims. Use of statistical sampling of claims and extrapolation of findings resulting from such samples shall be acceptable techniques for identifying claims errors. The selected Offeror shall facilitate audits of network pharmacies, including on-site audits, as requested by the Department, NYSIF and/or OSC;

(7) Remitting 100% of pharmacy audit recoveries to DCS and/or NYSIF as applicable within thirty (30) Days upon final audit determination consistent with the process specified in Section V, "Payments/ (credits) to/from the Contractor" and Appendix B of Section VII, Contract Provisions;

(8) Utilizing the auditing tools and performance measures proposed by the Offeror to identify fraud and abuse by Network Pharmacies and/or Enrollees; and,

(9) Permitting the Department, NYSIF, or a designated third party to audit pharmacy bills and drug company revenues.

b. Required Submission

(1) Confirm that ample audit resources will be made available to Department, NYSIF and OSC staff to conduct audits, including access to the Offeror's on-line claims processing system.

(2) Confirm that current Prescription Drug industry pricing source material (e.g. Red Book, Medispan, other) will be made available for the duration of the Agreement resulting from this RFP by the Offeror for access up to 3 (three) Department Staff.

(3) Describe the Pharmacy audit program you would conduct for the Programs including a description of the criteria you use to select pharmacies for audit and a description of the policy that you follow when a Pharmacy audit detects possible fraudulent activity by the Pharmacy or an enrollee. Include all types of audits performed and offered by your organization.

(4) Describe the corrective action, monitoring and recovery efforts that take place when you find that a Pharmacy is billing incorrectly or otherwise acting against the interests of your clients. Please indicate whether you have a fraud and abuse unit within your organization and its role in the Pharmacy audit program. In the extreme case of potentially illegal activity, what procedures do you have in place to address illegal or criminal activities by the Pharmacy?

(5) Provide a copy of the audit language that is contained in your standard contract(s) for Network Pharmacies.

(6) Confirm that the Offeror will fully cooperate with all Department, NYSIF and/or Office of the NYS Comptroller (OSC) audits, as described in RFP Section IV.B.11.a.(6) and (7) of this RFP, under the subheading "Pharmacy Audit."

(7) Confirm that the Offeror will remit 100% of pharmacy audit recoveries to DCS and/or NYSIF as applicable within thirty (30) Days upon final audit determination consistent with the process specified in Section V, "Payments/ (credits) to/from the Contractor" and Appendix B of Section VII.

(8) Describe the Offeror's proposed auditing tools and performance measures for identifying fraud and abuse by Network Pharmacies and/or Enrollees.

(9) Confirm that you will permit the Department, NYSIF, or a designated third party to audit pharmacy bills and drug company revenues.

Mail Service Pharmacy Process

The current Programs include a Mail Service Pharmacy Process by which Enrollees can obtain all Covered Drugs through the mail including any and all drugs that could be classified as Specialty Drugs/Medications or require special preparation or handling for enrollees who do not have the Specialty Pharmacy Program benefit**. To fulfill this requirement, the Offeror may use compounding or specialty pharmacies provided that they meet all Mail Service pricing provisions and service standards with no additional steps or burdens placed on the Enrollee.** Enrollees are entitled to fill Prescriptions for up to a ninety (90) day supply with refills up to one year. The Mail Service Copay (DCS only) shall apply when the Enrollee utilizes the Mail Service Pharmacy Process to obtain medications. Exhibit II.K of this RFP presents the mail service Prescription volume from October 1, 2010 through October 28, 2011.

a. Duties and Responsibilities

The Offeror must provide all aspects of Mail Service Pharmacy Process. Such responsibility shall include, but not be limited to:

(1) Having a fully staffed and fully operational Mail Service Pharmacy Process throughout the term of the resultant Agreements, utilizing one or more Mail Service Pharmacy Process Facilities meeting all New York State legal requirements. The Mail Service Pharmacy Process must be capable of dispensing all covered, FDA approved medications including any drug that could be classified as Specialty Drugs/Medications or requires special preparation or handling for up to a 90-day supply. Offerors must establish a process to provide Enrollees with access to Limited Distribution Drugs placing no additional steps or burdens on the Enrollee. Prescriptions are considered to be "submitted through the Mail Service Process" if they are submitted by phone, fax, internet, e-prescribing or mail to any Mail Service Pharmacy Process Facility,

regardless of how the Prescription is filled. All covered Prescriptions, except for Limited Distribution Drugs, submitted through the Mail Service Pharmacy Process or through a Mail Service Pharmacy Process Facility shall be charged to the Program based on the Offeror's mail service pricing terms and dispensing fees (if any) applicable to Brand Name, Generic, and Compound Drug claims as set forth in Exhibit V.A, including Specialty Drugs/Medications for certain enrollees. Limited Distribution Drugs submitted through the Mail Service Pharmacy Process shall be charged to the Program based on the Offeror's Retail Network pricing terms and dispensing fees (if any) applicable to Brand Name, Generic and Compound Drug claims as set forth in Exhibit V.A. The Mail Service Pharmacy Process shall apply the same Programs' benefit design features as the Network Pharmacies, including but not limited to Mandatory Generic Substitution, DUR, Prior Authorization, Flexible Formulary and Preferred Drug List, and application of appropriate Copayments;

(2) Ensuring that all the Procuring Agencies' approved edits including, but not limited to, enforcing utilization edits (i.e. refill too soon, duplicate therapy, etc.) are built into the Prescription fulfillment system to protect an Enrollee's safety as well as to control Programs' costs;

(3) Ensuring that all Mail Service Pharmacy Process Facilities utilized in the Offeror's Mail Service Pharmacy Process meet all Prescription drug packaging regulatory requirements. Any facility located outside New York State that will provide service for the Program must be registered with the NYS Department of Education and meet all requirements of Section 6808-b of NYS Education Law. The Mail Service Pharmacy Process must recognize the full prescribing authority of Medical Professionals granted by NYS where allowed by state law;

(4) Providing a simple, user friendly method(s) of ordering, reordering, or transferring Prescriptions from retail to mail. Maintaining a Dedicated Call Center located in the United States employing a staff of Pharmacists, and a staff of fully trained customer service representatives, and supervisors available 24 hours a day 365 Days a year that must meet the Offeror's proposed Mail Service Pharmacy Process guarantees set forth in Section IV.B.11.b.(19) and (20) of this RFP, under the subheading "Mail Service Pharmacy Process."

(a) The Offeror must have an integrated system for customer service staff to utilize to respond to, log and track all Enrollee inquiries. The system must create a record of the Enrollee contacting the call center, the call type and all customer service actions and resolutions.

(b) Customer service representatives must be trained and capable of responding to a wide range of questions, complaints, and inquiries including but not limited to: Programs' benefit levels, refills, order status, prices and billing, point of service issues, prior authorization, eligibility, generic appeals, Mail Service Pharmacy Process, Specialty Pharmacy Process services and complaints, and Flexible Formulary and Preferred Drug List alternatives. Callers must be able to reorder and check order status through both the customized website (DCS only) and the consolidated telephone line. Enrollees must also have access to their Prescription drug history file (both retail and mail) via the customized website;

(5) Providing pre-addressed, postage-paid mail service envelopes to Enrollees, health benefit administrators and for inclusion in Empire Plan publications, at the request of the State.

(6) Having efficient procedures in place to handle routine Prescriptions, "urgent" Prescriptions, and Prescriptions that require "special" handling (i.e. temperature control, limited shelf life, high cost, etc.);

(7) Providing standard mail service delivery using packaging that is appropriate for the drug dispensed and the address it is shipped to at no additional cost to the Programs or the Enrollee. Easy open caps also must be provided to Enrollees upon request at no additional cost;

(8) Having a system in place to track all Prescriptions (both intervention and non-intervention) received for processing through the Mail Service Pharmacy Process from the date the Prescription is received to the date the mailing agent picks up the package. The Offeror must also be able to track fill accuracy rates;

(9) Maintaining a process to collect information necessary to ensure Enrollee safety. The process should collect such information as drug allergies, chronic medical conditions, and other medications taken on a regular basis;

(10) Maintaining a system that notifies Enrollees/Claimants about potential health and safety issues with their Prescriptions;

(11) Maintaining efficient procedures regarding inventory management of the Mail Service Pharmacy Process Facility(ies) including, but not limited to, backorders, inventories of high demand drugs, supplies of difficult to obtain drugs, back-up supplier contracts, etc.;

(12) Providing prompt notification to Enrollees regarding out of stock items, partial fill orders, and changes to Prescriptions (e.g., approved or required dispensing of generics instead of Brand drugs). In out of stock situations, the Offeror must have a system in place to ensure that Prescriptions are filled in the most efficient manner whether it be through an alternate facility(ies) or obtaining a re-stock from a supplier. If necessary, the Offeror shall call the Enrollee first to obtain permission to contact their Physician to offer alternative medications, or to offer to return the prescription. If the Physician authorizes use of an alternative medication, a letter notifying the Enrollee of the change must be sent to the Enrollee before the medication is shipped or must accompany the Prescription;

(13) (Exclusive to DCS) Calling the prescribing Physician when a DAW-1 is indicated on the Prescription to confirm that the Physician understands the financial impact to the Enrollee and/or the DCS Program to determine if the Physician is willing to allow the generic version of the drug to be dispensed to the Enrollee. If the Physician was previously contacted regarding the same Prescription for a particular Brand Drug for the same Enrollee and required that the Brand Drug be dispensed, no call is required. If the Physician authorizes use of the generic version of the drug, a phone call shall be made to the Enrollee to advise of the approved change before the medication is shipped or the Offeror shall include a letter with the Prescription informing the Enrollee of their Physician's approval. If the Enrollee has indicated on the mail service order form that

they do not wish their Physician to be contacted for such determinations, no call shall be made;

(14) (Exclusive to DCS) Informing the Enrollee prior to shipping if the total amount for a new Prescription order submitted through the Mail Service Pharmacy Process exceeds $100 and Enrollee has payment information (e.g. credit card) on file or Enrollee's total balance is over $100 and Enrollee has no payment information (e.g. credit card) on file. The Mail Service Pharmacy Process Facility will not be required to inform Enrollees if there is a consistent history of the acceptance of shipments of the same medication that exceed the maximum amount specified. If the brand name drug is dispensed, the Offeror shall cause the dispensing facility to collect the applicable Brand Drug Copayment plus the calculated Ancillary Charge, if any. Under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the Program.

(15) (Exclusive to DCS) The Offeror is expected to assist Enrollees, upon request, to establish a payment plan so that Prescriptions that are essential to an Enrollee's health will continue to ship when the outstanding amount exceeds the Offeror's proposed maximum limits.

(16) Notifying the Procuring Agencies of nationwide out of stock issues, including information from the manufacturer or wholesaler regarding the anticipated date that the drug will resume shipment;

(17) Utilizing best efforts to complete Physician clarification, verification, or other interventions within the five (5) Business Day service level standard. Should this require more than eight (8) Business Days, the Offeror shall call the Enrollee and offer the Enrollee the option of returning the prescription or continuing the intervention attempt;

(18) Ensuring that the consent of the Enrollee is obtained prior to calling the prescribing Physician with the exception of calls made for purposes of clarification, verification, settlement of other intervention claim issues or DAW-1 confirmations;

(19) Providing all necessary clinical and educational support to Enrollees, and/or their family/caregiver utilizing the Mail Service Pharmacy Process, including Enrollees taking injectable, infusion or other drugs requiring special handling or special administration;

(20) Having a back-up mail order facility(ies) to handle any overflow and/or situations where the primary mail order facility is unavailable;

(21) Promoting the utilization of the Mail Service Pharmacy Process through targeted mailings, Physician communications, etc., if the Department determines that such promotions are in the best financial interests of the Programs. All such activities, including mailings, are subject to change and require the prior written approval of the Procuring Agencies. Any regular direct communication with Enrollees or their Physicians in connection with Enrollee drug utilization or the processing of Enrollee claims, either through mail, e-mail, fax or telephone must be submitted for the Procuring Agencies' approval. The cost of any approved promotion shall be borne by the Offeror, unless the Procuring Agencies specifically request a particular activity not required to be performed under the resultant Agreements. The Procuring Agencies will not approve any mail order promotions that it determines will not result in a reduced net cost to the Programs;

(22) The Offeror shall act in the best interests of the Programs when dispensing Generic Drugs through the Mail Service Pharmacy Process by avoiding the dispensing of NDC's with higher AWPs unless market conditions exist making dispensing the more cost effective NDC impractical or impossible;

(23) Turnaround Time for Non-Intervention Mail Service Prescriptions Guarantee: Offerors must propose, separately for each Program, a Turnaround Time for Non-Intervention Mail Service Prescriptions performance guarantee. The Program's service level standard requires at least ninety-five percent (95%) of all non-intervention mail service Prescriptions will be turned around in two (2) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the day after the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. For example, a Prescription

order received on Monday, January 6, 2014, by the Mail Service Pharmacy, must be received by the mailing agent no later than Thursday, January 9, 2014; and

(24) Turnaround Time for Intervention Mail Service Prescriptions Guarantee: Offerors must propose, separately for each Program, a Turnaround Time for Intervention Mail Service Prescriptions performance guarantee. The Programs service level standard requires at least ninety-five percent (95%) of all intervention mail service Prescriptions will be turned around in five (5) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the day after the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. For example, a Prescription order received on Monday, January 6, 2014, by the Mail Service Pharmacy, must be received by the mailing agent no later than Tuesday, January 14, 2014.

b. <u>Required Submission</u>

(1) Identify and describe the facility(ies) that the Offeror will use in the Mail Service Pharmacy Process for the Programs including the following:

(a) Location(s) of all facilities owned, operated, or subcontracted by the Offeror that are capable of filling Prescriptions through the Mail Service Pharmacy Process including, but not limited to, any compounding or Specialty Pharmacies that fill or dispense Prescriptions through the mail;

(b) Location(s) of all other facilities including, but not limited to, any compounding or Specialty Pharmacies that the Offeror is proposing to utilize in the normal course of the Mail Service Pharmacy Process to dispense all mail order Prescriptions to Enrollees;

(c) Confirmation that the facilities listed in b.(1)(a) or (b) above that are utilized to fill any Enrollee Prescriptions submitted through the Mail Service Pharmacy Process will be priced in accordance with the Offeror's Guaranteed Mail Order Pharmacy Process pricing as proposed in Exhibit V.A;

(d) The total capacity of all facilities identified in response to question (a) including, but not limited to the total number of scripts dispensed in 2011 and customers serviced. Describe any technology changes and/or staffing changes that would be necessary to service the Mail Service Pharmacy Process Prescription volume of the Programs;

(e) Describe the backup mail order process facility(ies) that you would utilize to handle any overflow, out of stock situations and/or situations where the primary mail order facility is unavailable. Provide any other alternative methods you would utilize to meet the mail service Prescription drug delivery requirements of the Programs; and

(f) Identify the facilities listed in b.(1)(a) or (b) above that have a commercial compounding license and indicate if they compound all drugs covered by the Programs. If there are any drugs that your facilities are unable to compound or do not compound, please detail the process you will utilize to provide Enrollees with access to all Compound Drugs through the Mail Service Pharmacy Process when the Prescription is submitted through the Mail Service Pharmacy Process.

(2) Provide a flow chart describing each step in the Mail Service Pharmacy Process taken prior to dispensing the medication. Describe the system edits for eligibility, prior authorization, utilization, including refill too soon and duplicate therapy utilized to ensure Enrollee safety and Programs' cost control.

(3) (Exclusive to DCS) What steps would a member need to follow to establish their initial order and set up their billing account, when transitioning from the previous contractor's Mail Service Pharmacy? Describe the process that a member must follow when ordering, reordering Prescriptions via mail or moving Prescriptions from a retail Pharmacy to the Mail Service Pharmacy Process. How do you assist the Enrollee with this process?

(4) Describe the capabilities of the Mail Service Pharmacy call tracking system.

(5) Confirm that you will supply sufficient quantities of mail order forms and pre-paid envelopes to encourage mail service utilization.

(6) Describe the process to be utilized to handle the following types of Prescriptions including any instructions provided to the Enrollee:

(a) Urgent Prescriptions; will there be additional handling or delivery costs for these Prescriptions?

(b) Prescriptions that require "special" handling (i.e., temperature control, special preparation, controlled substances, limited shelf life, etc.);

(c) Narcotics for the original fill for an Enrollee; and

(d) Prescriptions requested to be mailed in easy open caps;

(7) Please detail the system in place to track Prescriptions received through the Mail Service Pharmacy Process. Include the time from the receipt of the order until the delivery agent picks up the package. Specifically, detail how the actual date of receipt of the Prescription and the date the delivery agent picks up the package are recorded.

(8) Please describe how your system tracks mail service fill accuracy rates including all error types tracked by the system. In addition, detail the error types your system reports and include a mail service fill accuracy report for 2011. How are member reported errors tracked and reported? What type of investigations and process modifications would you undertake to address accuracy errors that have the potential to critically impact the Enrollee's health and safety?

(9) Please detail when a Prescription is designated as requiring intervention, and how the system tracks the point at which an intervention is deemed necessary. Describe how your system tracks these Prescriptions and calculates turnaround times for intervention claims. What is the definition of a Prescription that requires external intervention? Would that ever include a Prescription for a medication that is out of stock or a Prescription that has simply aged in the processing system?

(10) Describe the process that you will utilize to provide Enrollees with access to Limited Distribution Drugs when the Prescription is submitted through the Mail Service Pharmacy Process.

(11) Please describe/present the process in place to ensure that Enrollees receive all necessary clinical information and support related to Prescriptions dispensed through the Mail Service Pharmacy Process. Please detail the role of licensed Pharmacists in the Mail Service Pharmacy Process clinical program. Is the process for providing clinical support to Enrollees utilizing the Mail Service Pharmacy Process integrated with or independent of the customer service call center?

(12) Describe the process and channels (web, phone access, hard copy, etc.) you utilize to collect the information necessary to develop and maintain an Enrollee safety profile.

(13) Describe your drug purchasing and inventory philosophy including:

(a) What are the time frames as they relate to back orders or shipment from an alternate mail order facility;

(b) What are the time frames as they relate to backorders or shipments that are from your primary supplier;

(c) What is the percentage of Prescriptions that are filled when initially submitted to the primary mail service pharmacy facility you are proposing; and

(d) How are backorders and out of stock situations handled with members?

(14) (Exclusive to DCS) Describe your Enrollee communication process for out-of-stock items, partial fill orders, when an Enrollee appears to be ineligible, when there are changes to a Prescription that would result in Ancillary Charges, and when there are billing issues that prevent a Prescription from being immediately shipped. Confirm that the Offeror will arrange payment plans with Enrollees, on request.

(15) New York State Law does not require, but permits substitution of B-rated or unrated generics. Will the Mail Service Pharmacy Process facilities utilized for the Programs fill a Prescription written for a Brand Drug with a B-rated or unrated Generic Drug or will the Enrollee have to obtain a Prescription from the prescribing Physician written for the B-rated or unrated Generic Drug in order to avoid receiving the Brand Drug and paying the higher Brand Drug Copayment?

(16) Are there any situations where a Prescription written for a Brand Drug is submitted through the Mail Service Pharmacy Process and the Mail Service Pharmacy Process facilities utilized for the Programs are prevented from substituting an A-rated or authorized Generic Drug in accordance with the Programs' benefit design?

(17) Please describe how the Days supply is determined for the following forms of Prescription Drugs, dispensed by the Mail Service Pharmacy:

- Eye/Ear Drops
- Lotions and Ointments
- Syrups

(18) Please describe what proposed strategies you would implement with your Mail Service Pharmacy to compete with Low-Cost 30 and 90 Day programs offered by Retail Pharmacies?

(19) ***Turnaround Time for Non-Intervention Mail Service Prescriptions Guarantee*:** The Programs' service level standard requires that at least ninety-five percent (95%) of all non-intervention mail service Prescriptions will be turned around in two (2) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the day after the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee, for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below the ninety-five percent (95%) of all non intervention mail service Prescriptions not turned around within two (2) Business Days, is $25,000 per each quarter for DCS and $375 for NYSIF. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to 1.0% below ninety-five percent (95%) (or the Offeror's proposed guarantee) of all non-intervention mail service Prescriptions not turned around within two (2)

Business Days, calculated on a quarterly basis, is $_____ for DCS and $_____ for NYSIF.

(20) ***Turnaround Time for Intervention Mail Service Prescriptions Guarantee*:** The Programs' service level standard requires that at least ninety-five percent (95%) of all intervention mail service Prescriptions will be turned around in five (5) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the date the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. The Offeror shall propose, separately for each Program, the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below the ninety-five percent (95%) of all intervention mail service Prescriptions not turned around within five (5) Business Days is $25,000 per each quarter for DCS and $375 for NYSIF. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to 1.0% below ninety-five percent (95%) (or the Offeror's proposed guarantee) of all intervention mail service Prescriptions not turned around within five (5) Business Days, calculated on a quarterly basis, is $_____for DCS and $_____ for NYSIF.

Specialty Drugs/Medications

The Programs provide coverage for Medically Necessary Drugs including Specialty Drugs/ Medications. Specific to the DCS Program, drugs dispensed and billed by a Physician's office or drugs dispensed in a hospital setting are not the responsibility of the DCS Program and are covered under the Medical or Hospital portion of The Empire Plan.

Enrollees in most Employee groups receive Specialty Drugs/Medications benefits through the Specialty Pharmacy Program. All other Enrollees receive Specialty Drugs/Medications through the Retail Pharmacy Network or the Mail Service Pharmacy Process. See Exhibit II.C for a breakdown of groups that participate in the Specialty Pharmacy Program and those

that receive Specialty Drugs/Medications through the Retail Pharmacy Network or the Mail Service Pharmacy Process.

Specialty Drugs/Medications Received Through the Retail Pharmacy Network or the Mail Service Pharmacy Process

For those groups that receive Specialty Drugs/Medications through the Retail Pharmacy Network or the Mail Service Pharmacy Process, the Programs make no distinction for Specialty Drugs/Medications for pricing purposes and the Offeror is strictly prohibited from proposing an alternative pricing arrangement for any FDA approved drug or class of drugs. All drugs shall be classified as either brand name, generic, or compound for pricing purposes based on the methodologies set forth in Section V of this RFP. **Proposals that exclude Specialty Drugs/Medications from proposed pricing for brand name, generic and Compound Drugs, whether by omission or by the submission of an alternate pricing proposal will be removed from consideration.** The Programs shall be entitled to all manufacturer revenue derived from Specialty Drugs/Medications.

a. Duties and Responsibilities

(1) The Offeror must provide Enrollees with access to all Medically Necessary Specialty Drugs/Medications covered by the Programs through its proposed Retail Pharmacy Network and through the Mail Service Pharmacy Process in accordance with each Enrollee group benefit design as set forth in Exhibit II.C. In the case of Limited Distribution Drugs, the Offeror shall provide Enrollees with access in accordance with the following:

(a) ***Retail Pharmacy Network Access*** **(Amended April 4, 2012)**

The Offeror shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the Programs consistent with the Offeror's contracted discount off of AWP for the Limited Distribution Drug, plus any dispensing fee. ~~If the Offeror is unable to secure the participation of the authorized distributor, the Offeror agrees to facilitate the Enrollee's receipt of the Limited Distribution Drug and bill the Program consistent with its Minimum overall Guaranteed Discounts~~

~~applicable to Brand Drugs for network pharmacies.~~ The Enrollee shall be charged the applicable retail Copayment.

(b) ***Mail Service Pharmacy Process Access*** **(Amended April 4, 2012)**

The Offeror must facilitate the Enrollee's receipt of the Limited Distribution Drug. The Offeror shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the Programs consistent with the Offeror's contracted discount off AWP for the Limited Distribution Drug, plus any dispensing fee. ~~by obtaining the drug from an authorized distributor and billing the Programs consistent with its Guaranteed Discounts applicable to Brand Drugs. for the mail service pharmacy~~. The Enrollee shall be charged the applicable mail order Copayment.

(2) (Exclusive to DCS) Individuals receiving home infusion services through the Home Care Advocacy Program (HCAP), a component of The Empire Plan's Medical/Surgical Program, have their home infusion drugs covered under the Prescription Drug Program. Currently the DCS Program has a network of licensed pharmacies affiliated with home care agencies participating in The Empire Plan's HCAP Program administered by The Empire Plan's medical carrier. The Offeror is expected to secure contracts with the licensed pharmacies provided in Exhibit II.E.3 of this RFP to ensure continued utilization of a network Prescription drug benefit for those Enrollees utilizing the HCAP Program. An Offeror may propose to utilize entities owned by or affiliated with the Offeror to serve as an HCAP Provider. The Department at its sole discretion shall determine whether it is in the best interests of the DCS Program to allow the entity to participate in the HCAP Program. The Prescription drugs dispensed to Enrollees via the entities or pharmacies owned by or affiliated with the Offeror must be charged to the DCS Program based on the Offeror's mail service pricing terms and dispensing fees applicable to brand name, generic, and Compound Drug claims as proposed in Exhibit V.A.

b. Required Submission

(1) Explain how your proposed network provides access to all medically necessary covered Specialty Drugs/Medications.

(2) Explain the mechanisms in place to facilitate the delivery of Limited Distribution Drugs to Enrollees. Confirm that Enrollees will be charged the Mail Service copayment for Limited Distribution Drugs submitted to the Mail Service Pharmacy (DCS only).

(3) (Exclusive to DCS) Confirm that you will solicit participation in the Retail Pharmacy Network all licensed pharmacies affiliated with the Empire Plan Home Care Advocacy Program. Describe the capability of the Offeror to coordinate and/or integrate services with The Empire Plan's medical insurer.

(4) (Exclusive to DCS) For those HCAP providers that do not have affiliated pharmacies, how do you propose coordinating with HCAP and supplying the medication to the Enrollee? Will you utilize the Mail Service Pharmacy Process?

(5) Confirm that necessary ancillary supplies that accompany certain Specialty Drugs/Medications will be delivered to the Enrollee at no additional cost to the Programs or Enrollee.

(6) Indicate the licensed pharmacies in Exhibit II.E.3 with whom you have a current Network Pharmacy contract.

Specialty Pharmacy Program

NYSIF Claimants and most DCS Program Employee groups participate in the Specialty Pharmacy Program, which provides an enhanced level of clinical management for Enrollees taking Specialty Drugs/Medications. Under the current plan design, after the first Specialty Drug/Medication Prescription is filled through either the Retail or Mail Service Pharmacy, future fills are subject to a Hard Edit (DCS only), meaning that Enrollees are required to obtain the drug through the Specialty Pharmacy Process, subject to the mail service copayment (DCS only) when dispensed by the designated Specialty Pharmacy. In addition to the first fill at Retail, certain Specialty Drugs/Medications available through the Specialty Pharmacy Program are also available through the Retail Pharmacy Network, because of their clinical requirements and/or urgent dispensing timeframe. All Specialty Drugs/Medications filled at a Retail Pharmacy Network are subject to the Retail Network Pharmacy Pass-through Pricing and Copayments (DCS only). For those drugs available only through the

Specialty Pharmacy Program, the Offeror may propose dispensing fees on a drug by drug basis, commensurate with the clinical services provided for each. All drugs shall be classified as either Brand name, Generic, or Compound for pricing purposes based on the methodologies set forth in Section V of this RFP. The Program shall be entitled to all manufacturer revenue derived from Specialty Drugs/Medications Drugs to be included in the Specialty Pharmacy Program, Specialty Drugs/Medications are:

1. "orphan drugs";
2. drugs requiring special handling, special administration and/or intensive Enrollee monitoring/testing;
3. biotech drugs developed from human cell proteins and DNA, targeted to treat disease at the cellular level; or,
4. other drugs identified by the Programs as used to treat Enrollees with chronic or life threatening diseases.

The Offeror must provide a Special Pharmacy Program where Enrollees receive their Specialty Drugs/Medications through one or more designated pharmacies that offer enhanced clinical management. The process must provide extensive clinical support in the most cost effective manner possible for the Programs.

a. <u>Duties and Responsibilities</u>

The Offeror must provide all aspects of the Specialty Pharmacy Program. Such responsibility must include, but not be limited to:

(1) Developing a listing of the Specialty Drugs/Medications proposed for inclusion in the Specialty Pharmacy Program;

(2) Having a fully staffed and fully operational Specialty Pharmacy Program in which Specialty Drugs/Medications are provided by one or more Designated Specialty Pharmacies. All Designated Specialty Pharmacies must meet all New York State legal requirements. Any facility located outside New York State that will provide

service for the Programs must be registered with the NYS Department of Education and meet all requirements of Section 6808-b of NYS Education Law. The Specialty Pharmacy Process must recognize the full prescribing authority of Medical Professionals granted by NYS where allowed by state law.

(Amended April 4, 2012)

(3) The Offeror must establish a process to provide Enrollees with access to Limited Distribution Drugs not available through the Designated Specialty Pharmacy(ies), which places no additional steps or burdens on the Enrollee. The Offeror shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the Programs consistent with the Offeror's contracted discount off AWP for the Limited Distribution Drug, plus any dispensing fee. The Enrollee shall be charged the applicable retail Copayment. ~~The Offeror must bill the Programs for these Prescriptions consistent with the Offeror's Minimum overall Guaranteed Discount applicable to Prescriptions dispensed at Network Pharmacies.~~

(4) Providing a fully staffed and fully operational customer support call center available to Enrollees 24 hours a day, 365 Days a year including Pharmacists, clinicians, and registered nurses trained in an Enrollee's specific Specialty Drug/Medication therapies. The Offeror must provide callers with access to customer service staff and Pharmacists through The Empire Plan consolidated line and the NYSIF Program toll-free line who are able to respond timely to questions, complaints and inquiries including but not limited to: Programs' benefit inquiries, refills, order status, price estimates, billing, point of service issues, Specialty Pharmacy Process complaints, preferred drug status, and claim status. Callers must be able to reorder and check order status through both the customized website (DCS only) and the Programs' telephone lines. Enrollees must also have web access to their Prescription drug history file (retail, mail, and specialty) via a customized website (DCS only).

(5) Administering a safety monitoring system that complies with the Food and Drug Administration (FDA) Amendments Act of 2007 which requires a Risk Evaluation and Mitigation Strategy (REMS) from the Specialty Drugs/Medications manufacturers to ensure the benefits of a drug outweigh its risks.

(6) (Exclusive to DCS) Contracting a nationwide network of appropriately licensed clinicians and/or coordinating with appropriately trained HCAP clinicians to administer the Specialty Drugs/Medications to Enrollees in a home setting and providing Enrollees with education on proper treatment regimens and possible side effects.

(7) Completing Physician consultation, coordination of care, patient care management and other interventions on a clinically appropriate and timely basis.

(8) Providing all necessary clinical and educational support to Enrollees, and/or their family/caregiver utilizing the Specialty Pharmacy Process, including but not limited to explaining the treatment plan and ancillary supplies, disease/drug education, side-effect management, compliance management and administration training.

(9) Applying the same Programs' benefit design features as the Mail Service Pharmacy Process, including but not limited to Mandatory Generic Substitution, DUR, Prior Authorization, Preferred Drug List, and application of appropriate Copayments (DCS only). Specialty Drugs/Medications that are subject to the Designated Specialty Pharmacy Passive Edit and are dispensed at a Network Pharmacy must be subject to the Network Pharmacy Copayments (DCS only).

(10) Ensuring that all the Procuring Agencies' approved edits including, but not limited to, enforcing utilization edits (e.g. refill too soon, duplicate therapy, etc.) are built into the Prescription fulfillment process system to protect an Enrollees safety as well as to control Programs' costs.

(11) Ensuring that all Designated Specialty Pharmacies utilized in the Offeror's Specialty Pharmacy Program meet all Prescription drug packaging regulatory requirements. The Offeror must ensure that Specialty Drugs/Medications are shipped to Enrollees in appropriate packing materials so that Specialty Drugs/Medications are safe and effective and delivered on time.

(12) Providing a simple, user friendly method(s) of ordering, reordering, and transferring Prescriptions from the retail and mail setting to the Designated Specialty Pharmacy(ies) including pre-addressed postage paid Specialty Pharmacy Program envelopes. The Offeror must send a Specialty Pharmacy Program letter to Enrollees who have received

a First Fill of a Specialty Drug/Medication through a Network Pharmacy. The letters must be sent within seven (7) Days of the Prescription being filled to Enrollees who have received a Specialty Drug/Medication subject to the Designated Specialty Pharmacy Hard Edit (DCS Only) and within thirty (30) Days of the Prescription being filled to Enrollees who have received a Specialty Drug/Medication subject to the Designated Specialty Pharmacy Passive Edit. Enrollees are allowed one Grace Period for Specialty Drugs/Medications.

(13) Maintaining a comprehensive system for the Offeror's staff to utilize to track all Enrollee inquiries including, but not limited to: Programs' benefits, refills, order and claim status, prices, billing, Preferred Drug List inquiries and Specialty Pharmacy Process complaints. The system shall include call type, customer service actions, and resolutions.

(14) Having a system in place to track all Prescriptions received for processing through the Specialty Pharmacy Process from the date the Prescription is received to the date the Prescription is shipped. The Offeror must also be able to track fill accuracy rates.

(15) Maintaining a process to collect information from individuals necessary to ensure Enrollee safety. The process should collect such information as drug allergies, chronic medical conditions, and other medications taken on a regular basis.

(16) Ensuring that the Designated Specialty Pharmacy(ies) have efficient procedures regarding inventory management including, but not limited to, backorders, inventories of high demand drugs, supplies of difficult to obtain drugs, back-up supplier contracts, etc.

(17) Providing notification to Enrollees as soon as possible for out of stock items, partial fill orders, and changes to Prescriptions (e.g., dosing or method of administration). In out of stock situations, the Offeror must have a system in place to ensure that Prescriptions are filled in the most efficient manner whether it be through an alternate facility(ies) or obtaining a re-stock from a supplier. The Offeror must contact the Enrollee's Physician, if necessary, to offer alternative medications or offer to return the Prescription. If the Physician authorizes use of an alternative medication, a letter

notifying the Enrollee of the change must be sent to the Enrollee before the medication is shipped or must accompany the Prescription.

(18) (Exclusive to DCS) Informing the Enrollee prior to shipping if the total amount for a new Prescription order submitted through the Specialty Pharmacy Process exceeds $100 and Enrollee has payment information (e.g. credit card) on file or Enrollee's total balance is over $100 and Enrollee has no payment information (e.g. credit card) on file. The Designated Specialty Pharmacy will not be required to inform an Enrollee if there is a consistent history of the acceptance of shipments of the same medication that exceed the $100 amount specified.

(19) (Exclusive to DCS) The Offeror is expected to assist Enrollees, upon request, to establish a payment plan so that Specialty Drug/Medication Prescriptions that are essential to an Enrollee's health will continue to ship when the outstanding amount exceeds the Offeror's proposed maximum limits.

(20) Promptly notifying the State of nationwide out of stock issues, including information from the manufacturer or wholesaler regarding the anticipated date that the drug will resume shipment.

(21) Having back-up Designated Specialty Pharmacies to handle any overflow and/or situations where the primary Specialty Program facility is unavailable.

(22) (Exclusive to DCS) The mail order Copayment shall apply to all drugs dispensed through the Specialty Pharmacy Program as well as Limited Distribution Drugs facilitated through the Special Pharmacy Program.

(23) Recommending newly launched Specialty Drugs/Medications for inclusion in the Specialty Pharmacy Program based on the established criteria/definition of Specialty Drug/Medications, in a format to be approved by the Procuring Agencies. Prior to inclusion in the Programs, or if not accepted by the Procuring Agencies to be included in the Programs, the Offeror must bill the Programs for these Prescriptions consistent with the Offeror's contracted discount off of AWP at the dispensing Network Pharmacies or the Guaranteed Discount at the Mail Service Pharmacy Process, based on where each Prescription was actually dispensed. Inclusion of new

Specialty Drugs/Medications shall have a cost-neutral or positive financial impact on the Program, and in no case shall the Ingredient Cost of a newly added Specialty Drug/Medication charged to the Program exceed the Guaranteed Discount on Specialty Pharmacy Drugs.

b. <u>Required Submission</u>

(1) Provide a listing of the Specialty Drugs/Medications that you propose for inclusion in the Specialty Pharmacy Program, along with an indication of how they meet the minimum criteria. Also, please state if you propose additional criteria. Please state whether the Designated Specialty Pharmacy(ies) you propose regularly dispense any other Specialty Drugs/Medications which you are not proposing for the Programs.

(2) Provide a detailed description of your proposed Specialty Pharmacy Program. Include the following:

(a) Customer service call center

(b) Administration of REMS

(c) (Exclusive to DCS) Whether Specialty Drugs/Medications administration will be through HCAP or a Specialty Pharmacy Program contracted network

(d) Clinical management, including demonstration of outcomes improvement

(e) Fulfillment process, including cold-chain supply and shipping logistics

(f) Transition process from First Fill at Retail or Mail

(3) Do you propose to use one dedicated Specialty Pharmacy or several different Specialty Pharmacies? What are the advantages to this approach? Indicate which of the licensed Pharmacy(ies) in Exhibit II.E.3 will participate in the Specialty Pharmacy Program.

(4) Detail the mechanisms in place to ensure the prompt, safe, and effective delivery of all Specialty Drugs/Medications in the Specialty Pharmacy Program to Enrollees. Describe the mechanisms the Offeror proposes to facilitate delivery of Limited Distribution Drugs to Enrollees. Describe override procedures the Offeror proposes to facilitate urgent or same-day delivery of Specialty Drugs/Medications in the

Specialty Pharmacy Program as well as override procedures proposed when the Designated Specialty Pharmacy is precluded from shipping the medications, i.e. to an Enrollee residing in a skilled nursing facility or foreign country.

(5) (Exclusive to DCS) Describe the capability of the Offeror to coordinate and/or integrate services with The Empire Plan's medical insurer in providing HCAP services. For those HCAP providers that do not provide medications, how do you propose supplying the medication?

(6) How does your system provide the ancillary supplies that accompany some of the Specialty Drugs/Medications?

(7) Describe the criteria you will use to evaluate new Specialty Drugs/Medications that enter the market and whether they should be included in the Specialty Pharmacy Process.

12. Claims Processing

The Offeror is required to process all claims submitted under the Programs. The selected Offeror must be capable of processing, as applicable to the respective Programs, Network Pharmacy claims and claims for scripts filled through the Mail Service Pharmacy Process and/or the Specialty Pharmacy(ies) for all Covered Drugs including Specialty Drug/Medication Claims. The Offeror must also process manual submit claims including but not limited to Medicaid , VA , Skilled Nursing Facility claims, out-of-network claims, foreign claims, in network manual claims and COB including Medicare B primary claims and Student Health Center claims. Claims for all Covered Drugs adjudicated at a chain and independent Retail Pharmacy Network Pharmacies and through the Mail Service Pharmacy Process and Specialty Pharmacy(ies) must be processed according to the applicable benefit design and contracted arrangements in place.

The claims processing system shall include controls to identify questionable claims, prevent inappropriate payments, and ensure accurate reimbursement of claims in accordance with the applicable benefit design, Programs' provisions and negotiated agreements with pharmacies. All Program provisions for drug utilization review, benefit design and other utilization or clinical management programs must be adhered to for all prescriptions.

Enrollee Submitted Claims (DCS Only) are required to be submitted to the Offeror no later than one hundred twenty (120) Days after the end of the Calendar Year in which the drugs were dispensed, or one hundred twenty (120) Days after another plan processes the claim, unless it was not reasonably possible for the Enrollee to meet this deadline. The DCS Program count of Enrollee Submitted Claims can be found in Exhibit III.B of this RFP.

a. Duties and Responsibilities

(1) The Offeror must provide all aspects of claims processing. Such responsibility shall include but not be limited to:

(a) Verifying that the Programs benefit designs have been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly;

(b) Accurate and timely processing of all claims submitted under the Programs in accordance with the benefit design applicable to the Enrollee at the time the claim was incurred as specified to the Offeror by the Procuring Agencies;

(c) Charging the Programs consistent with the Offeror's proposed pricing quotes;

(d) Developing and maintaining claim payment procedures, guidelines, and system edits that guarantee accuracy of claim payments for covered expenses only, utilizing all edits as proposed and approved by the Procuring Agencies. The Offeror shall utilize refill too soon edits and duplication of therapy edits for all claims unless exceptions are specifically approved in advance by the Procuring Agencies. The Offeror's system must ensure that refilling Prescriptions prior to use of the minimum prescribed Days supply does not result in over dispensing;

(e) Managing Flexible Formulary (two Flexible Formularies – Original and Enhanced) and Preferred Drug List placement of drugs consistent with the Programs' design and ensuring application of appropriate Copayments based on level assignment (Copayments do not apply NYSIF's Program);

(f) Maintaining claims histories for 24 months online and archiving older claim histories for 6 years and the balance of the calendar year in which they were made with procedures to easily retrieve and load claim records;

(g) Maintaining the security of the claim files and ensuring HIPAA compliance;

(Amended April 4, 2012)

(h) Reversing all attributes of claim records, e.g. AWP, quantity, Days supply, etc., processed in error ~~or due to fraud~~ including the reversal of any Claims Administration Fee associated with the original claim and crediting the Programs for all costs associated with the claim processed in error ~~or due to fraud~~ including but not limited to the Claims Administration Fee; and

(i) Agreeing that all claims data is the property of the State. Upon the request of the Department, the Offeror shall share appropriate claims data with other DCS Program carriers and consultants for various programs (e.g. Disease Management, Centers of Excellence) and the Department's DSS vendor (DCS only). The Offeror cannot share, sell, release, or make the data available to third parties in any manner without the prior consent of the Procuring Agencies. The Procuring Agencies understand that the selected Offeror will be required to share certain claims data with pharmaceutical manufacturers for purposes of obtaining for the Programs all Pharma Revenue due it under the Agreements resulting from this RFP. The Offeror shall inform the Procuring Agencies of the types of data being shared for these specific authorized purposes.

(j) Maintaining a back-up system and disaster recovery system for processing claims in the event that the primary claims payment system fails or is not accessible;

(k) Maintaining a claims processing system capable of integrating and enforcing the various utilization review components of the Programs, including, but not limited to: Mandatory Generic Substitution, Prior Authorization, messaging capability in the current NCPDP format, and a concurrent DUR program to aid the Pharmacist at the point of sale.

(l) Maintaining an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the Programs

mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the generic at the Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Retail Pharmacy Network, the Program's mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized generic in stock, mandatory generic substitution provisions will not apply and the Enrollee shall receive the Brand Drug, be charged the applicable generic Copayment (DCS only) and the Program charged based on generic pricing. The claims processing system shall reject claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW-0 code with appropriate messaging and requires resubmission of the claim since a DAW-0 code provides no indication of Generic Drug availability in the Pharmacy. The Programs' logic for the Pharmacy Submitted DAW codes is listed below:

Pharmacy Submitted DAW	**Enrollee Copay**	**Ancillary Charge**	**Pricing**
0	Brand	No	Brand
1	Brand	Yes	Generic
2	Brand	Yes	Generic
3	Generic	No	Generic
4	Generic	No	Generic
5	Generic	No	Generic
6	Generic	No	Generic
7	Brand	No	Brand
8	Generic	No	Generic
9	Generic	No	Generic

(m) Maintaining a claims processing system capable of ensuring that claims are consistently processed with the appropriate brand name/generic/compound classification in accordance with the requirements set forth in Section V.C.3.a.(6);

(n) Maintaining a Programs' MAC List for Pharmacies;

(o) (Exclusive to DCS) Processing Enrollee Submitted Claims in accordance with the following:

(i) For Prescriptions filled with a Brand Drug with no generic equivalent, the Enrollee will be reimbursed using the Offeror's Minimum overall guaranteed Discounted Ingredient Cost for the Retail Pharmacy Network and dispensing fee for Brand Drugs not to exceed the submitted charges, less the applicable Copayment;

(ii) For Prescriptions filled with a Brand Drug that has a generic equivalent, the Enrollee will be reimbursed up to the amount the DCS Program would reimburse the Retail Pharmacy Network for filling the Prescription with that drug's generic equivalent; not to exceed the submitted charges, less the applicable Copayment;

(iii) For Prescriptions filled with a Generic Drug the Enrollee will be reimbursed up to the amount the DCS Program would reimburse the Retail Pharmacy Network for that Prescription, not to exceed the submitted charges, less the applicable Copayment;

(iv) For Prescriptions filled with a Compound Drug the Enrollee will be reimbursed up to the amount the DCS Program would reimburse the Retail Pharmacy Network for that Prescription, not to exceed the submitted charges, less the applicable Copayment; and

(v) If the Enrollee has two Empire Plan coverages, the DCS Program will reimburse 100% of the copay upon submission of a paper claim form prepared by the Enrollee. For specific methodology on how the DCS Program must be charged for Enrollee Submitted Claims, see Section V.C.7. of this RFP entitled "Enrollee Submitted Claims."

(p) (Exclusive to NYSIF) Processing Non-Network Pharmacy claims submitted to the Offeror in accordance with Chapter V of title 12 NYCRR.

(q) (Exclusive to DCS) Processing claims for Employees enrolled in the SEHP who fill Prescriptions at the SUNY Stony Brook Student Health Service Pharmacy, and other SUNY pharmacies as may be requested by the Department during the term of the Agreement resulting from this RFP. Prescriptions under this

arrangement must be dispensed according to the Plan design for the SEHP (see Exhibit II.C), including required prior authorizations and, where applicable, Days supply limits. The Offeror must monitor the submission of SEHP claims and inform the Department if the SUNY Pharmacies submit charges in excess of the amounts that are paid to the Program's Retail Network Pharmacies for the same NDC's;

(r) Processing all manually submitted claims including but not limited to Medicaid, VA, Skilled Nursing Facility claims, out-of-network claims (DCS and NYSIF), foreign claims, in-network manual claims, COB claims, and Medicare B primary claims in accordance to the Offeror's proposed Claims Adjudication Guarantee;

(s) Analyzing and monitoring claim submissions to promptly identify errors, fraud and abuse and reporting to the State such information in a timely fashion in accordance with a State approved process. The Programs shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses. The Programs will be charged a Claims Administration Fee only for Final Paid Claims. The Offeror will credit the Programs the amount of any overpayment regardless of whether any overpayments are recovered from the Pharmacy and/or Enrollee in instances where a claim is paid in error due to Offeror error, or due to fraud or abuse, without additional administrative charge to the Programs. The Offeror shall report fraud and abuse to the appropriate authorities. In cases of overpayments resulting from errors only found to be the responsibility of the State, the Offeror shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the Programs upon receipt; however, the Offeror is not responsible to credit amounts that are not recovered.

(t) Establishing a process where Pharmacies can verify eligibility of Enrollees and Dependents during Call Center Hours;

(u) Requiring network pharmacies to submit to the Offeror for each drug dispensed the Pharmacy's Submitted Cost to ensure that the Programs are charged according to the Programs' Lesser of Logic. Further, if an Ancillary Charge (applicable only to DCS) is applied, it will be deducted from the total claim cost;

(v) (Exclusive to DCS) Identifying Enrollees enrolled in Medicare Part D. The Offeror's claims processing system must decline claims at the point of service for Enrollees who are enrolled in a Medicare Part D Plan other than the DCS Program EGWP. Messaging to the Pharmacy must instruct the Pharmacist to submit the claim to the Enrollee's Medicare Part D Plan.

(w) (Exclusive to DCS) Establishing a process to support, and respond, to Federal Medicare Part D audits.

(x) Having a process in place (fully staffed with ample telephone trunks) available 24 hours a Day, seven Days a week where a Pharmacist can call to quickly resolve point of service issues.

(y) (Exclusive to DCS) Processing claims pursuant to Enrollees covered under the Disabled Lives Benefit. DCS agrees to reimburse the selected Offeror for claims processed under the Disabled Lives Benefit in accordance with Section V.13 of this RFP.

(2) ***Program Claims Processing System Availability Guarantee*:** The Offeror must propose separate performance guarantees for the respective Programs. The Programs service level standard requires that the claims processing system will be available at least ninety-nine and five-tenths percent (99.5%) of the time excluding periods of scheduled down time, which shall be reported to the Department in advance and kept to a minimum, based on a 24 hours a day, 7 Days a week availability, calculated on a quarterly basis.

(3) (Exclusive to DCS) ***Turnaround Time for Claims Adjudication Guarantee*:** The Offeror must propose a performance guarantee. The Programs service level standard requires that ninety-nine and five-tenths percent (99.5%) of Enrollee Submitted Claims that require no additional information in order to be properly adjudicated that are received by the contractor will be turned around within ten (10) Business Days of receipt. Turnaround time is measured from the date the Enrollee-submitted claim is received in the Offeror's Program designated Post Office Box to the date the

Explanation of Benefits is received by the mailing agent.

(4) (Exclusive to NYSIF) ***Turnaround Time for Claims Adjudication Guarantee:*** The Offeror must propose a performance guarantee. The NYSIF Program's service level standard requires that ninety-nine and five-tenths percent (99.5%) of Non-Network Pharmacy submitted claims that require no additional information in order to be properly adjudicated that are received by the contractor will be turned around within thirty (30) Calendar Days of receipt. Turnaround time is measured from the date the Non-Network Pharmacy submitted claim is received in the Offeror's Program designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent.

b. <u>Required Submission</u>

(1) Provide a flow chart and step-by-step description of your proposed claims processing methodology for adjudicating each of the following claim types: Mail Order, Specialty Pharmacy, Network Pharmacy, Enrollee-submitted claims, and Non-Network Pharmacy claims for the NYSIF Program. Provide a description of the comprehensive edits you propose at the point of service to ensure proper claim adjudication, including a detailed description and example of how your proposed refill-too-soon (RTS) edit will operate to ensure cost effective dispensing of Drugs under the Programs. Confirm that you will implement your proposed full RTS edit on January 1, 2014.

(2) Please describe your claims processing system platform including any backup system utilized. Describe your disaster recovery plan and how Enrollee disruption will be kept to a minimum during a system failure. What is the process for Enrollees trying to get a Prescription when the claims payment system is down or is not accessible?

(3) Describe the capabilities of your claim processing system to perform, at the point of service, for each of the following required Programs' components:

(a) The Programs generic substitution requirements based on the Programs' definition of a Generic Drug as set forth in Section VIII of this RFP;

(b) A Prior Authorization Program for specific drugs that have an increased risk of inappropriate utilization;

(c) A concurrent DUR program identifying Enrollee drug therapy safety edits and Programs' benefit edits;

(d) Messaging capabilities to the Network Pharmacy;

(e) Eligibility verification;

(f) Customized edits for individual Enrollees;

(g) Utilization of some medications intended to treat conditions limited to one sex;

(h) Historic claims look up capability to reduce Enrollee disruption at the point of sale;

(i) (Exclusive to DCS) Multi-level cost sharing;

(j) Identification and pricing of compounded Prescriptions consistent with the Programs' definitions and requirements set forth in this RFP; and

(k) Recognition of Pharmacy submitted cost and ensuring the Programs receive the Lesser of Logic for all Prescriptions filled at a network and Non-Network Pharmacy or through the Mail Service and Specialty Pharmacy Processes.

(4) Please describe how your claims processing system will reject Network Pharmacy claims submitted with a DAW-0 code and send appropriate messaging to Pharmacists to ensure submission of a code that provides an indication of the Generic Drug's availability in the Pharmacy to facilitate consistent and accurate application of the Programs' mandatory generic substitution provisions.

(5) Describe how your adjudication system feeds the reporting and billing systems and any claim update data delays.

(6) Do you own the adjudication system, license the software or contract out this service?

(7) How quickly are your systems brought into compliance when a new version or capability of the standard NCPDP format for claims transmission is released?

(8) Describe the current Network Pharmacy available overrides to your claims adjudication system. How would overrides from the Retail Pharmacy Network and messaging to the retail Pharmacy network be tracked and reported to the Procuring Agencies? Describe the loading of an override within your claims processing system and confirm whether it over-rides your client's program benefit design? If so, provide the circumstances where you would load an override edit at the point of service. If applicable, describe the circumstances where you would approve the dispensing of quantities in excess of the benefit design amounts within your concurrent DUR program.

(9) Describe how the Mail Service Pharmacy Process, Specialty Pharmacy Program and Network Pharmacy Claims will be subjected to the same prior authorization/quantity limitations, Point of Service and DUR edits and how a common Enrollee profile is maintained for each Enrollee? Is this process on-line for both systems?

(10) Describe how any changes to the benefit design would be monitored, verified and tested for the Programs, and the quality assurance program to guarantee that changes to other client benefit programs do not impact the Programs.

(11) Identify the resources that are available to a Pharmacist who is having difficulty processing a claim at the point of service. How do you ensure that the Pharmacist is able to get through to a person to resolve the issue?

(12) (Exclusive to DCS) Confirm that your claims processing system has the capability to: stop claims at the point of service for Enrollees who are enrolled in a Medicare Part D; plan other than the DCS Program EGWP and send messaging to the Pharmacy to instruct the Pharmacist to submit the claim to the Enrollee's Medicare Part D Plan.

(13) Explain how your claims processing system collects overpayments from your Retail Pharmacy Network.

(14) Confirm the Offeror will reverse all attributes of claim records, e.g. AWP, quantity, Days supply, etc., processed in error or due to fraud including the reversal of any

Claim Administration Fee associated with the original claim and crediting the Programs for all costs associated with the claim processed in error, including but not limited to the Claim Administration Fee;

(15) Describe how the Offeror will analyze and monitor claim submissions to promptly identify errors, fraud and abuse and report such information in a timely fashion to the State in accordance with a State approved process. Confirm the Programs shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses and will be charged a Claims Administration Fee only for Final Paid Claims. Confirm the Offeror will credit the Programs the amount of any overpayment regardless of whether any overpayments are recovered from the Pharmacy and/or Enrollee in instances where a claim is paid in error due to Offeror error, or due to fraud or abuse. In cases of overpayments resulting from errors only found to be the responsibility of the Department, the Offeror shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the Programs upon receipt; however the Offeror, is not responsible to credit amounts that are not recovered.

(16) Can the adjudication system interact with a debit card program for flexible spending accounts?

(17) What data elements are required by your claims system to process a compound medication claim? How do you guard against inappropriate or inaccurate compound claims? How do you ensure that only those claims that meet the definition of a compound in Section VIII of this RFP are processed as compound claims thereby protecting the Program's financial interest?

(18) ***Programs' Claims Processing System Availability Guarantee*:** The Programs service level standard requires that the Programs' online claims processing system be available at least ninety-nine and five-tenths percent (99.5%) of the time excluding periods of scheduled down time which shall be reported in advance to the Department and kept to a minimum, based on a 24 hours a day, 7 Days a week availability (or the Offeror's proposed guarantee). The Offeror shall propose, separately for each Program, the

forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this guarantee.

The standard credit amount for each .01 to .25% below the ninety-nine and five-tenths percent (99.5%) that the Offeror's online claims processing system for the Programs are not available, is $100,000 per each quarter for DCS and $7,500 for NYSIF. However, the Offeror may propose higher or lesser amount.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to .25% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Offeror's proposed guarantee) that the Offeror's online claims processing system for the Programs, based on a 24 hours a day, 7 Days a week availability excluding periods of scheduled down time, which shall be reported in advance to the Department and kept to a minimum, is not available, as calculated on a quarterly basis, the Offeror shall credit against the Program's Claims Administration Fee the amount of $_____ for DCS and $_____ for NYSIF.

(19) (Exclusive to DCS) ***Turnaround Time for Claims Adjudication Guarantee*:** The DCS Program's service level standard requires that at least ninety-nine and five-tenths percent (99.5%) of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within ten (10) Business Days from the date the claim is received in the Department's Designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent. The Offeror shall propose the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this guarantee.

The standard credit amount for each .01 to .25% of the DCS Program's Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within ten (10) Business Days from the date the claim is received in the Department designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent below the standard of ninety-nine and five-tenths (99.5%) is $5,000 per each quarter for DCS. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to .25% of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within ten (10) Business Days from the date the claim is received in the Department designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent, below the standard of ninety-nine and five-tenths percent (99.5%) as calculated on a quarterly basis, is $_____ for DCS.

(20) (Exclusive to NYSIF) ***Turnaround Time for Claims Adjudication Guarantee*:** The NYSIF Program's service level standard requires that at least ninety-nine and five-tenths percent (99.5%) of Non-Network Pharmacy claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within thirty (30) Calendar Days from the date the claim is received in NYSIF's Designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent. The Offeror shall propose the forfeiture of a specific dollar amount of the Claims Administration Fee for failure to meet this guarantee.

The standard credit amount for each .01 to .25% of the NYSIF Program's Non-Network Pharmacy submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within thirty (30) Calendar Days from the date the claim is received in the FUND's designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent below the standard of ninety-nine and five-tenths (99.5%) is $375 per each quarter for NYSIF. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Claims Administration Fee for each .01 to .25% of Non-Network Pharmacy submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within thirty (30) Calendar Days from the date the claim is received in NYSIF's designated Post Office Box to the date the Explanation of Benefits is received

by the mailing agent, below the standard of ninety-nine and five-tenths percent (99.5%) as calculated on a quarterly basis, is $_____ for NYSIF.

13. Retrospective Coordination of Benefits (Exclusive to DCS)

The selected Offeror must be capable of administering a retrospective coordination of benefits (COB) recovery program. The DCS Program's current COB process is administered on a retrospective basis. A claim is not stopped at the point of service nor is there any current plan to have Prescriptions stopped at the point of service to verify COB coverage unless it is indicated that the Enrollee has enrolled in a Medicare Part D Plan other than the DCS Program EGWP. The DCS Program allows members to receive Prescriptions and have the selected Offeror seek COB recoveries after the Prescription is dispensed.

a. Duties and Responsibilities

(1) The selected Offeror is required to pursue collection of any money due the DCS Program from other payers or Enrollees who have primary Prescription drug coverage through another carrier and to credit the DCS Program's account one hundred percent (100%) of all recoveries within fifteen (15) Days after the end of the month.

(2) The selected Offeror must maintain a system capable of receiving a historical COB data file from the current contractor and benefits information obtained from Enrollee surveys. The Offeror's system must be capable of tracking the date an initial letter is sent to the Enrollee or other carrier until the point money is recovered.

(3) The selected Offeror must develop for Department review and approval COB correspondence including, but not limited to; an Enrollee questionnaire to confirm other Prescription drug coverage information, a letter(s) instructing Enrollees to file for reimbursement from the primary plan and advising that the Enrollee must reimburse the DCS Program for the cost of their claims and a collection letter(s) to other carriers who owe the DCS Program reimbursement.

(4) The selected Offeror must have a system in place to facilitate collection, without Enrollee intervention, when the primary plan claims adjudicator is the same as the selected Offeror.

Note: Offerors may choose to enter into a Key Subcontract for the provision of these services; however, the cost of this service must be included in the Offeror's proposed Claims Administration Fee with all gross recoveries credited to the DCS Program (no carve-out of Key Subcontractor fees will be permitted). The Department will not allow any alternative fee arrangement in this regard.

b. Required Submission

Provide a flow chart and step-by-step description of the process you will employ to conduct the DCS Program's retrospective coordination of benefits (COB) requirement. Specifically, please detail how you will collect, store, and investigate COB information for other insurance.

14. Utilization Management

Mandatory Generic Substitution at Retail and Mail

Appropriate utilization of cost-effective clinically equivalent Generic Drugs is an integral component of the Programs benefit design. To promote the use of Generic Drugs, the Programs have a mandatory generic substitution requirement that mandates that FDA approved generic equivalents be substituted for the equivalent Brand Drug or the Enrollee pays the Non-Preferred Brand Drug Copayment plus an Ancillary Charge (DCS only) equal to the difference in the Ingredient Cost of the Brand Drug and the Ingredient Cost of the Generic equivalent, not to exceed the cost of the drug, unless otherwise directed by the Department. Mandatory generic substitution will be applied to all specific NDC's of Brand Drugs for which there is an FDA approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc) or an authorized Generic Drug, as permissible by NYS law. Network Pharmacies shall comply with all state laws related to mandatory generic substitution. The Programs' mandatory generic substitution provisions shall apply to any claim where the A-rated or authorized Generic drug is required or permitted to be substituted under state law. Mandatory generic substitution provisions will not apply to B-rated or unrated Generic drugs or in the unlikely event that state law prohibits dispensing of the A-rated or authorized Generic Drug.

Mandatory generic substitution provisions shall apply if a Physician writes a Prescription with a Dispense as Written (DAW) code for a Brand Drug that has an A-rated or authorized

Generic Drug available. The Enrollee should be informed that an Ancillary Charge (DCS only) will be applied and the Pharmacist should offer to contact the prescribing Physician for approval to dispense the Generic Drug. Enrollees who receive a multi-source Brand Name drug because of a DAW notation are still required to pay both the applicable Brand Drug Copayment and the Ancillary Charge (DCS only). Mandatory generic substitution does not apply to the strength of a particular drug for which there is no approved Generic Drug.

The Department's Program currently has the following exceptions to the mandatory generic substitution requirement: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid, Tegretol and Tegretol XR. Because the drugs are exceptions to the mandatory generic substitution requirement, no Ancillary Charge can be imposed. The drug placement on the Offeror's proposed PDL will determine the Copayment (DCS only) for these drugs subject to the Program's benefit design which requires that a Brand Drug with a Generic equivalent be placed on the third level of the Preferred Drug List. An appeal cannot change the level status of these drugs on your proposed PDL.

a. Duties and Responsibilities

To ensure strict adherence to the Program's Mandatory Generic Substitution Requirement and protect the financial interests of the Programs, the Offeror is required to:

(1) Unless otherwise directed by the Procuring Agencies, apply mandatory generic substitution to all specific NDC's of Brand Drugs for which there is an FDA approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc) or an authorized Generic Drug as permissible by NYS law. Network Pharmacies shall comply with all state laws related to mandatory generic substitution. The Programs' mandatory generic substitution provisions shall apply to any claim where the A-rated or authorized Generic Drug is required or permitted to be substituted under state law. Mandatory generic substitution provisions will not apply to B-rated or unrated Generic Drugs or in the unlikely event that state law prohibits dispensing of the A-rated or authorized Generic Drug.

(2) (Exclusive to DCS) Establish the Ancillary Charge by calculating the difference in the Discounted Ingredient Cost of the Brand Drug and the Ingredient Cost of the equivalent A-rated Generic Drug or authorized Generic Drug based on the Programs'

MAC List price assigned when a Brand Drug for which an A-rated or authorized Generic Drug has been introduced in the market is dispensed to the Enrollee. In such cases, the Enrollee shall be responsible for paying the applicable Non-Preferred Brand Drug Copayment plus Ancillary Charge not to exceed the cost of the drug to the Programs. The Ancillary Charge shall be assessed even in the event a Physician has specifically directed a Pharmacist to dispense the Brand Drug rather than the A-rated or authorized Generic Drug through DAW notation.

(3) Monitor the pharmaceutical industry on behalf of the Department to identify Generic Drugs expected to enter the market. Prior to the actual introduction of the Generic Drug to market, the Offeror shall inform the Department of anticipated shipping dates of the first Generic Drug introduced into the market for one or more strengths of a particular Brand Drug.

(4) (Exclusive to DCS) Following the first shipment of a first Generic Drug for one or more strengths of a particular Brand Drug, the Offeror is required to:

(a) Inform the Department as soon as practicable but in no event later than 14 Days after the first date of shipment, (from manufacturer to wholesaler or retailer) of the financial impact of enforcing mandatory generic substitution via the "MAC Alert Notice" detailed in Section IV.B.8.a. of this RFP, under the subheading "Reports Required at Other Frequencies."

(b) For those drugs that will result in a lower net cost to the Program by enforcing mandatory generic substitution, the Offeror shall provide the "MAC Alert Notice" as described in (a) above. The Offeror shall add the GCN to the Programs' MAC List and begin enforcement as soon as practicable but in no event later than 14 Days after the first date of shipment provided that the majority of Retail Network Pharmacies are able to obtain the Generic Drug. In the case where a GCN is already subject to MAC pricing the Offeror is required to immediately apply the MAC price and mandatory generic substitution to any NDC added to the GCN following the first date of shipment.

(c) For those drugs that could potentially result in a higher net cost to the Programs by enforcing mandatory generic substitution, the Offeror shall provide the "MAC Alert Notice" as described in (a) above. The Department, in its sole discretion, may determine that enforcement is contrary to the best financial interests of the DCS Program and shall inform the Offeror whether mandatory substitution shall be applied. If the Offeror does not receive a formal response to the information provided via the "MAC Alert Notice," enforcement shall commence and the GCN shall be added to the Programs' MAC List effective on the 21st day after shipment of the first A-rated generic equivalent drug or authorized Generic Drug provided that the majority of pharmacies are able to obtain the Generic Drug. In the event the Department decides to exercise its discretion not to enforce mandatory generic substitution, the Offeror shall apply MAC pricing to the Generic Drug.

(d) To assist the Department in determining when mandatory generic substitution should be enforced based on an adequate supply of Generic drug being available in the market, the Offeror shall survey its Retail Pharmacy Network to identify the Pharmacies that are unable to obtain the new Generic Drug within 21 Days and weekly thereafter until the shortage resolves. The Offeror shall submit this information to the Department and provide any additional information as required by the Department to reach a determination. The Department, in its sole discretion, shall determine based on such evidence how the DCS Program's mandatory generic substitution provisions will be applied. The DCS Program will not consider and the Offeror shall not act on availability information provided by 3rd party sources, including but not limited to Medi-Span, Red Book, First Data Bank or wholesalers.

(e) For Preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall be changed from preferred to non-preferred status concurrent with the commencement of the enforcement of mandatory generic substitution. Enrollees who are prescribed strengths of the Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the Generic Drug Copayment unless the

prescribing Physician requires that the Brand Drug be dispensed. In that case, the Enrollee shall be charged the applicable Non-Preferred Brand Drug Copayment and Ancillary Charge. Enrollees who are prescribed strengths of the Preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Preferred Brand Drug Copayment;

(f) For Non-Preferred Brand Name drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall remain Non-Preferred for all strengths. Concurrent with enforcement of mandatory generic substitution, Enrollees who are prescribed strengths of the Non-Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the generic Copayment unless the prescribing Physician requires that the Brand Drug be dispensed. In that case, the Enrollee shall be charged the applicable Non-Preferred Brand Drug Copayment and Ancillary Charge. Enrollees who are prescribed strengths of the Non-Preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Non-Preferred Brand Drug Copayment;

(g) The Offeror shall require the dispensing Network Pharmacy to inform the Enrollee prior to dispensing the Brand Drug, that an Ancillary Charge will be applied in addition to the applicable Non-Preferred Brand Drug Copayment. If the prescribing Physician requires the Brand Drug be dispensed, the Offeror shall require the dispensing Network Pharmacy to collect the applicable Brand Drug Copayment plus the calculated Ancillary Charge. However, under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the DCS Program after application of the Programs' Lesser of Logic provisions;

(5) Charge the Programs based on the Programs' MAC List price assigned to the GCN of the dispensed Brand Drug subject to the Programs' Lesser of Logic plus the applicable

dispensing fee as set forth within "Program Claims Reimbursement" of the Contract Provisions, Section VII of this RFP;

(6) Promptly notify and receive the Procuring Agencies prior written approval for any and all exceptions to the Programs' mandatory substitution provisions, other than those resulting the Programs' Mandatory Substitution Appeal Process. Following commencement of mandatory generic substitution, the Offeror must receive the Procuring Agencies written approval prior to suspending enforcement of the Programs' mandatory generic substitution provisions;

(7) Maintain an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the Programs' mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the Generic Drug at the Network Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Network Pharmacy, the Programs' mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized Generic Drug in stock, mandatory generic substitution provisions will not apply and the Enrollee shall receive the Brand Drug, be charged the applicable Generic Drug Copayment (DCS only) and the Programs charged based on Generic Drug pricing. The Offeror's claims processing system must reject, with appropriate messaging, claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW-0 code requiring resubmission of the claim (since a DAW-0 code provides no indication of Generic Drug availability in the Pharmacy). Similar rules can be applied to other DAW submission codes as necessary to ensure consistent, accurate application of the Programs' mandatory generic substitution requirements;

(8) Immediately notify the Procuring Agencies of changes (from brand to generic or generic to brand) in the NDC classification submitted by the Offeror, subject to the Programs' definitions of Brand and Generic Drugs contained in Section VIII of the RFP.

(9) (Exclusive to DCS) Manage the Narrow Therapeutic Index (NTI) list of multi-source Brand Drugs not subject to Ancillary Charges, and make recommendations to the Department of suggested additions or deletions based on clinical evidence.

b. Required Submission

(1) Please explain in detail the process you will utilize to administer the Programs' mandatory generic substitution provisions in accordance with the requirements set forth in this RFP including, but not limited to, how your claims processing system will enforce the Programs' generic substitution requirement for a Generic Drug within the time limits specified above.

(2) How do your Retail Pharmacy Network contracts protect the financial interests of the Programs in the event a network Pharmacist does not have a required generic in stock when presented with a Prescription requiring dispensing of the generic under law or pursuant to the provisions of the Programs' mandatory generic substitution program after the maximum twenty-one (21) day period?

(3) Explain in detail the process you intend to follow to ensure that drugs meeting the definition of generic as set forth in this RFP are identified in your system as Generic Drugs subjecting them to the generic pricing requirements set forth in Section V and mandatory generic substitution for A-rated or authorized Generic Drugs.

(4) Please detail how your system will distinguish between A-rated and authorized Generic Drugs requiring generic substitution, A-rated generics not requiring substitution including, but not limited to Narrow Therapeutic Index (NTI) drugs (DCS only), and non-A-rated Generic Drugs. Please describe the capability of your system to apply MAC pricing but not enforce generic substitution for non-A-rated Generic Drugs, NTI drugs, or for available A-rated Generic Drugs that the Department has directed the Offeror not to enforce the Programs' mandatory generic substitution requirement.

(5) Please detail the process for updating your claims processing system upon distribution of a new Generic Drug to ensure prompt application of MAC pricing and/or mandatory generic substitution.

(6) (Exclusive to DCS) Please describe how you will manage the NTI list for the DCS Program including the parties responsible for making NTI recommendations.

Mandatory Generic Substitution Appeal Process (Exclusive to DCS)

An Enrollee may appeal the requirement to pay the Ancillary Charge. Generic appeal review is based upon the demonstrated need for the Brand Drug on an individual Enrollee basis. It is not related to the specific drug as much as it is to the ability of the Enrollee to tolerate the Generic Drug. The criteria may include: previous clinical issues with the Generic Drug, reported allergy to an inert ingredient, co-morbid conditions that require multiple drug therapies, etc. The Offeror is expected to develop a generic appeals process that would allow for exceptions based upon compelling evidence provided by the treating Physician. Each individual case should be decided upon its own merits. For the DCS Program, there must be at least one level of appeal. If an appeal is unsuccessful, an Enrollee may request an external appeal as required by the NYS Insurance Law. Exhibit II.J.1 of this RFP provides the number of generic appeals reviewed for the period of January 1, 2008 through September 17, 2010.

a. Duties and Responsibilities

The Offeror shall administer a Mandatory Generic Substitution Appeal process. The selected Offeror is required to oversee and enforce the DCS Program's generic appeal process including:

(1) Administering a clinically sound generic appeal process at no additional cost to the DCS Program or to the Enrollee. The process must include developing an appeal form and criteria for establishing medical necessity, reviewing appeals for medical necessity, preparing communications to notify Enrollees (subject to Department review and approval) of the outcome of appeals within five (5) Business Days, and integrating the decisions into the claims processing systems including reimbursing the Enrollee for any Ancillary charge paid up to 30 Days prior to receipt of the approved generic appeal; and

(2) Reporting the results of the generic appeal process for the DCS Program to the Department on a drug by drug basis in the format and frequency required in the "Reporting" section of this RFP.

(3) Following a successful generic appeal, charging the Enrollee for the Brand Drug at the Level 3 Copayment with no Ancillary Charge.

(4) Loading into your claims processing system one or more files from the incumbent contractor of the previously approved Generic Appeal requests by the January 1, 2014 implementation date, once an acceptable file is received.

(5) Interfacing with the New York State Department of Financial Services External Appeals Process that provides an opportunity for Enrollees and Dependents to appeal denied coverage on the basis that a prescription drug is not medically necessary or is an experimental or investigational drug.

b. Required Submission

(1) Describe in detail how you would administer the required generic appeal processes for the DCS Program including:

(a) The turnaround time;

(b) Qualifications of the staff that would conduct the review;

(c) A description of the criteria that would be used to determine whether the brand name medication is medically necessary. Are there any dollar thresholds within your criteria? Do you require generic appeals to be updated after a specific time period? If so, what is the process?

(d) Do you currently administer a generic appeals process? If yes, provide the number of appeals you review annually and the approval and denial rates for a client similar to the Program (for the most recent Calendar Year); and for the following list of drugs:

(~~a~~i) Prilosec
(~~b~~ii) Fosamax
(~~c~~iii) Topamax
(~~d~~iv) Keppra
(~~e~~v) Cellcept

(e) How the Enrollee's claim will be handled during the appeal processing. In the event of a successful appeal, confirm that you will retroactively adjust claims incurred within 30 Days from the date of receipt of a completed appeals form. Describe how member refunds will be handled.

(2) Confirm that you will load previously approved Generic Appeals data into your claims adjudication system.

15. Clinical Management/Drug Utilization Review (DUR)

Clinical management and drug utilization review programs help to control costs and attempt to ensure that Enrollees are receiving safe effective drug treatment. The Procuring Agencies require the selected Offeror to have clinical management/drug utilization programs including a mandatory generic substitution program, a prior authorization program, a concurrent review program and retrospective review programs. The selected Offeror is required to provide these programs; however, an Offeror is not prevented from offering other value oriented programs. No clinical management and drug utilization review programs can be funded by Pharmacy manufacturers. The Procuring Agencies reserves the right to not participate in any program offered by the selected Offeror and the right to opt out of any program at any time.

The Offeror is required to administer and enforce a comprehensive clinical management and DUR program that integrates the various Programs' components, which include at a minimum:

***A Prior Authorization Program*:** to determine the medical appropriateness of Prescription drugs that have an increased risk of inappropriate utilization;

***A Concurrent DUR Program*:** to aid the dispensing Pharmacist in identifying potential drug therapy problems at the point of sale; and

***A Retrospective DUR Program*:** to look at any long-term effects of drug treatment designed to safeguard Enrollee health and help Physicians make more informed decisions about Prescription drugs. In addition, the Procuring Agencies are interested in receiving information on Physician education/profiling and patient education programs which the Offeror believes would add value to the Programs.

NOTE: THE COST OF ALL THE PROGRAMS LISTED ABOVE IS REQUIRED TO BE IN YOUR CLAIMS ADMINISTRATION FEE.

Prior Authorization

The Programs current Prior Authorization Program determines the medical appropriateness of Prescription drugs that have an increased risk of inappropriate utilization or a high cost. Drugs currently subject to prior authorization have been recommended by the current contractor and reviewed by the Department. Exhibit II.H provides a current list of the drugs subject to prior authorization. The DCS Program allows Enrollees to appeal denied coverage on the basis that a Prescription drug is not medically necessary or is an experimental or investigational drug. Exhibit II.H.2 provides the number of Program prior authorizations reviewed and certified for the period January 1, 2008 through September 16, 2011.

The NYSIF Program also prior authorizes certain Prescription drugs. The clinical determination is made by NYSIF and conveyed to the contractor to allow dispensing at a Network Pharmacy.

a. Duties and Responsibilities

To ensure that the resources available to the DCS Program are utilized for appropriate, Medically Necessary Drug therapy, the selected Offeror is required to administer prior authorization programs for the Programs which includes, at a minimum:

(1) A Prior Authorization Program for high cost Prescription drugs that are prescribed for very specific medical indications. Only medications that have been identified by the Offeror as appropriate for Prior Authorization and reviewed by the State shall be included in the Prior Authorization Program. The Prior Authorization Program also subjects specific drugs in certain categories to clinical criteria before benefits are authorized for payment including but not limited to: anti-obesity agents; topical tretinoin; antifungal agents; Hepatitis C agents; Hepatitis B agents for interferon use; select Osteoporosis agents; Respiratory Syncytial Virus (RSV) Therapy agents, select stimulant agent; Multiple Sclerosis agents; Low Molecular Weight Heparin agents; Growth Hormones; Cancer; Pain/Arthritis; Phychosis agents and, Pulmonary Arterial Hypertension agents. Only medications that have been identified as appropriate for the

Prior Authorization Program by the Offeror and reviewed by the Procuring Agencies shall be included in the Prior Authorization Program;

(2) (Exclusive to DCS) Informing Medical Professionals who request, by phone, fax, or secure internet portal, a Prior Authorization for a Specialty Drug/Medication about the DCS Program's Specialty Pharmacy Program and providing the information necessary to utilize the Specialty Pharmacy Program to obtain the drug.

(3) Monitoring market changes and recommending deletions or additions to the list of drugs requiring Prior Authorization on an ongoing basis which must be reviewed by the Procuring Agencies prior to implementation of any changes to the list of medications;

(4) (Exclusive to DCS) Preparing and sending communications (reviewed and approved by the Department) to notify Enrollees and/or their Physicians of the outcome of their prior authorization request and notifying them of the date the Prior Authorization is approved through;

(5) Promptly loading approved prior authorizations determined by the Offeror or received from NYSIF for the NYSIF Program into the claims processing system;

(6) (Exclusive to DCS) Administering an expeditious, HIPAA compliant, internal appeals process which allows Physicians and/or Enrollees and Dependents to appeal denied coverage on the basis that a Prescription drug is not medically necessary or is an experimental or investigational drug. For the Prior Authorization Program, there must be at least one level of appeal, and it must be expeditious and PPACA compliant; and

(7) (Exclusive to DCS) Interfacing with the New York State Department of Financial Services' External Appeals Process that provides an opportunity for Enrollees and Dependents to appeal denied coverage on the basis that a Prescription drug is not medically necessary or is an experimental or investigational drug.

(8) Loading one or more files of Prior Authorization approved-through dates from the incumbent contractors, prior to the January 1, 2014 implementation date, once acceptable files are received.

b. Required Submission

(1) Referring to the drugs or the drug categories subject to Prior Authorization, describe in detail how you would propose to administer Prior Authorizations including:

(a) The process and criteria you utilize to identify drugs that the Programs should consider for prior authorization;

(b) The qualifications of each level of staff making decisions with regard to the pre-authorization process, denial, and appeal. Based on the DCS Program's number of prior authorizations, what is your projected staffing level for this unit?

(c) A description of any current prior authorization programs you manage including the list of drugs subject to prior authorization and the number of cases reviewed, approved and declined for a client similar to the DCS Program (for the most recent Calendar Year);

(d) The process you utilize to contract and collect the appropriate information from Physicians in order to make a determination. Provide a timeline for completion of approvals and denials;

(e) The methods you utilize to measure program effectiveness *(Do not include any reference to specific monetary savings).*

(f) How you will transition Enrollees with current prior authorizations and their Prescriptions into your system. Specifically address whether your system has the flexibility to grandfather benefits for Enrollees currently taking drugs that would require pre-authorization.

(2) For each of the drugs currently subject to Prior Authorization under the DCS Program, please list the time period of the authorizations that you would apply to each. Also, please confirm what steps the Offeror will perform to re-authorize at the end of the authorization period.

(3) Confirm that you will send notification letters, subject to the approval of the Department, to the Enrollee and/or Physician to advise of the outcome of the Prior Authorization review and their appeal rights.

Concurrent Drug Utilization Review (DUR)

The Programs current Concurrent DUR program aids the dispensing Pharmacist in identifying potential drug therapy safety issues at the point of sale, as well as various other point of sale edits that are related to benefit design such as "refill too soon," and Preferred/Non-Preferred Drug designation.

a. Duties and Responsibilities

To safeguard Enrollee health and ensure adherence with the Programs' benefit design, the selected Offeror must administer a concurrent DUR program which includes at a minimum:

(1) A point of service system at all Retail Pharmacy Network locations, Mail Service Pharmacy Process Facilities and Specialty Pharmacies which is continually updated with the latest patient safety edits with the capacity to "message" Pharmacists related to safety issues prior to the dispensing of the Prescription drug; and

(2) A fully integrated point of service system capable of enforcing the Programs' benefit design features.

b. Required Submission

(1) Please detail the full scope of the Concurrent DUR program that you are proposing to utilize for the Programs. Include the qualifications of the staff responsible for oversight of your Concurrent DUR program.

(2) Describe the software you will utilize to administer the Concurrent DUR program that you will implement for the Programs. Please specify if you have developed this software, purchased it from a third party source, or is it a system you purchased and have adapted for your use.

(3) ***Program Safety Edits***

(a) Within your Concurrent DUR program describe all safety edits currently enforced through your claims processing system including, but not limited to the safety edits below:

(i) drug-drug interaction including OTC drugs and herbal supplements, if applicable;

(ii) drug-allergy interaction;

(iii) drug-medical condition interaction;

(iv) minimum daily dosage;

(v) exceeding maximum dosage;

(vi) therapeutic duplication;

(vii) drug-gender interaction;

(viii) drug-age interaction;

(vix) drug-pregnancy interaction; and

(x) compliance with FDA approved drug utilization guidelines.

(b) Please describe for each edit the messaging sent to the Pharmacist including whether the edit is classified as a soft or hard edit. Describe the type of actions required by the Pharmacist at the point of service following receipt of these alerts. How do you monitor the effectiveness of the safety alerts program?

(4) ***Program Benefit Edits***

(a) Within your Concurrent DUR program describe how your program monitors the following at the point of service, including whether the edits are hard edits or soft edits, and whether the Program monitors overrides at the Pharmacy Level:

(i) refill too soon, including a description of the methodology utilized;
(ii) prior authorization; and
(iii) drug exclusions or limitations.

(5) Describe the methods you utilize to measure Program effectiveness (*Do not include any reference to specific monetary savings).*

(6) Describe any other programs the Offeror proposes to provide to administer utilization management on behalf of the Programs.

Retrospective DUR Program (Exclusive to DCS)

The DCS Program's current Retrospective DUR Program reviews Enrollee presciption profiles for drug therapy complications. In the event a potential drug complication is identified, alert letters are sent to the prescribing Physician. The DCS Program is designed to safeguard the Enrollee's health and help Physicians make more informed decisions about Prescription drugs.

a. Duties and Responsibilities

To safeguard the Enrollee's health the selected Offeror must administer a Retrospective DUR Program which:

(1) Using the Offeror's standards, evaluates the Enrollee's Prescription drug utilization against the Enrollee's profile using FDA and other evidence based guidelines to identify potential safety related concerns. The Offeror shall alert the prescribing Phyicians to drug specific, Enrollee-specific health, safety and utilization issues including potential overuse of narcotics; and

(2) Identifies potential drug therapy complications for Enrollees, develops Physician alerts (subject to Department review and approval) and sends the alerts to the prescribing Physician; and

(3) Reports the results of its Retrospective DUR Program initiatives, including outcomes, to the Department on a quarterly basis in a mutually agreed upon format.

b. Required Submission

Describe the Retrospective DUR Program that you propose to put in place for the DCS Program including:

(1) The qualifications of the staff that would perform these reviews;

(2) How you identify and select areas for retrospective review and the methods utilized to inform and educate Physicians;

(3) A timeline for these reviews.

(4) What type of follow-up you conduct after communicating the information to the Physician;

(5) How you measure the effectiveness of your Retrospective DUR Program including any statistical measures of the success of your efforts *(Do not include any reference to specific monetary savings);*

(6) Whether you currently administer a Retrospective DUR Program for other clients; and

(7) The reporting capability for your described program.

Physician Education

a. Duties and Responsibilities

Subject to review and approval by the Procuring Agencies, the Offeror must undertake a Physician education program involving communications with prescribing Physicians which includes at a minimum:

(1) Analysis of Physicians' drug or condition specific prescribing patterns;

(2) Educating Physicians about the clinical and economic aspects of their prescribing decisions. Any communication with Physicians prescribing medications for Enrollees shall make the Physician aware of the distribution channel most cost effective to the Programs and the Enrollee; and

(3) Reporting the results of its Physician Education initiatives to the State on a quarterly basis in a mutually agreed upon format.

(4) The Physician Education Program may not be funded by pharmaceutical manufacturers.

b. Required Submission

Please describe/present the Physician communication/education programs you propose for the Programs. Describe your objectives and approach to Physician profiling and education including:

(1) Whether you currently administer a Physician profiling and education program for other clients similar to the Programs;

(2) A description of the method(s) and analysis you use to select Physicians for profiling and whether your clinical programs involve peer-to-peer Physician discussions;

(3) The frequency of your educational efforts;

(4) The number of Physicians you have contacted as part of a Physician Education Program and the results of those efforts in the areas of increased compliance with recommended protocols and modifying patient Prescription utilization;

(5) How you measure the effectiveness of your Physician profiling program including any statistical measures of the success of your efforts. (*Do not include any reference to specific monetary savings*); and

(6) Whether you will adapt your Physician Education Program standards to meet the Program's needs as specified by the Department.

(7) Confirm that the Physician Education program will not be funded by pharmaceutical manufacturers.

Patient Education (Exclusive to DCS)

The Empire Plan currently includes a Patient Education Program to notify Enrollees of the cost-effective utilization of Prescription drugs through a Half Tablet Program.

a. Duties and Responsibilities

(1) Subject to State review and approval by the Department, the Offeror must develop and implement a patient education program consisting of communications to Enrollees which:

(a) Analyzes drug utilization from a clinical standpoint to identify and facilitate communication with Enrollees that have chronic diseases to maximize health benefits of drug treatment;

(b) Analyzes drug utilization to identify and facilitate communication with Enrollees not managing their drug utilization in the most cost effective manner for the Enrollee;

(c) Reports the results of its patient education initiatives to the Department on a quarterly basis in a mutually agreed upon format; and

(d) The Patient Education Program may not be funded by Pharmacy manufacturers.

(2) Offerors may propose a voluntary Half Tablet Program which will allow Enrollees to pay half the regular Copayment at the point of service for half the quantity of double strength, eligible Prescriptions. If such is the case, the Offeror's proposal shall:

(a) Establish a list of drugs that would be appropriate to include in the Half Tablet Program including, but not limited to the drugs listed in Exhibit II.M, if deemed appropriate by the Offeror;

(b) Notify Enrollees of their eligibility to participate in the Half Tablet Program. Monthly, the Offeror must use utilization data to identify Enrollees newly eligible to participate in the Half Tablet Program and mail welcome/announcement letters to those Enrollees. These letters are subject to review and approval by the Department;

(c) Provide each Enrollee newly participating in the Half Tablet Program with one tablet splitter, at no charge to the Enrollee; and

(d) Load a file to transfer current Enrollees with qualifying Prescriptions into the Half Tablet Program as of January 1, 2014.

b. Required Submission

(1) Describe your objectives and approach to patient education including:

(a) Whether you currently administer a patient education program for other clients;

(b) The identification and selection of categories of drugs to apply retrospective review and the method(s) you propose to use to educate and inform patients;

(c) The number of educational interventions and the expected Enrollee response rate;

(d) How you measure the effectiveness of your patient education program including any statistical measures of the success of your efforts. *(Do not include any reference to specific monetary savings); and*

(e) Confirm that the Patient Education Program will not be funded by Pharmacy manufacturers.

(2) If proposed, describe the Half Tablet Program for the DCS Program, including:

(a) Confirm which drugs listed in Exhibit II.M will be included in the Half Tablet Program.

(b) Detail the criteria that will be used to identify additional drugs for inclusion in the Half Tablet Program. Provide a list of additional drugs you recommend to include in the Half Tablet Program and the basis for the recommendation.

(c) Describe in detail the process to identify newly eligible Enrollees for the Half Tablet Program, including timeframes.

(d) Describe how Enrollees will enroll in the Half Tablet Program. Confirm that a table splitter will be mailed at no additional cost to the Enrollee.

(e) Confirm that if a Half Tablet Program is implemented, a half Copayment would be passed to Enrollees participating in the Programs at the point of service, upon presenting a valid script.

NOTE: THE COST OF ALL THE PROGRAMS LISTED ABOVE ARE REQUIRED TO BE IN THE CLAIMS ADMINISTRATION FEE.

Other Safety Related Programs

The Procuring Agencies are interested in any other clinical management or drug utilization review programs that are intended to promote the health and well being of Enrollees. Offerors may propose other programs of this nature, not already being utilized by the Programs as a requirement of the Contractor under duties and responsibilities set forth in the RFP. The State reserves the right, if allowed by NYS Finance Law, to participate in any such program(s) offered.

For any such program(s), the Offeror must clearly indicate whether or not there is a cost to the State for said program(s) (do not disclose the dollar amount, if any, in the Technical Proposal) and, if there is a cost, whether or not the cost is included in the Offeror's proposed Claims Administration Fee. If there is a cost for a program(s) and that cost is not included in the Offeror's proposed Claims Administrative Fee, Offerors are advised that the Department may be precluded by NYS Finance Law from participating in such program(s).

Should the State choose to participate in such program(s), the State reserves the right to opt out of any such program(s) at any time during the term of the Agreements in such case(s), the Claims Administrative Fee shall be reduced by the cost incurred by the State for that program(s).

a. Duties and Responsibilities

N/A

b. Required Submission

(1) Please describe the purpose of any other clinical management or drug utilization review programs that you are proposing to administer for the Program with the Pharmacy, Physicians, Enrollees, etc. Include a detailed description of how the program operates and its benefit to the Programs and Program's Enrollees.

(2) Identify the funding source behind any of the programs you are proposing and confirm whether or not the costs for the Program are included in the Claims Administration Fee.

16. Preferred Drug List Development and Management (Exclusive to DCS)

The selected Offeror is required to efficiently develop, administer and maintain multiple Preferred Drug Lists (PDL) that ensure Enrollee access to appropriate, quality pharmaceutical care based on sound clinical criteria. The DCS Program currently has four (4) formulary benefit designs: Traditional Empire Plan PDL, Flexible Formulary Drug List, Enhanced Flexible Formulary List, and the Excelsior Plan PDL. The DCS Program requires that all Covered Drugs be classified as preferred or non-preferred. PDL management, in particular designation of drugs as preferred (which generally means Level 1 or Level 2), non-preferred, or excluded, is critical to the clinical and financial success of the DCS Program. The Offeror must use sound clinical criteria in any decisions that are made to place or exclude drugs from the PDL's.

The PDLs generally feature Generic Drugs on the first level, Preferred Brand Drugs on the second level, and Non-Preferred Brand Drugs on the third level. The PDLs proposed for the DCS Program must include all drugs meeting the definition of Covered Drugs in this RFP. The selected Offeror is required to effectively communicate the content and requirements of the DCS Program's PDLs to Network Pharmacies, medical providers and Enrollees. The design of the DCS Program's Prescription Drug benefit does not require a Brand Drug in every therapeutic category. For the purpose of preparing a response to this RFP, if an Offeror proposes a Preferred drug list which does not include a Preferred Brand Drug in every therapeutic category, the Offeror must include the clinical rationale and financial implications of the Offeror's determination. Offerors will submit cost information as required in Section V, Cost Proposal of this RFP.

Note: Do not include any cost information in the technical proposal.

***Traditional Empire Plan PDL*:** Under the traditional Empire Plan PDL, all covered Generics are Level 1 and covered Brand Drugs are on either Level 2 or Level 3. A proposed PDL that includes Generics on Level 2 or Level 3 and/or includes Brand Drugs on Level 1 does not currently meet the Program requirements for the Traditional Empire Plan PDL and would not be acceptable. Drugs may not be excluded from the Traditional Empire Plan PDL. In addition, the current benefit design does not allow an Enrollee to appeal a drug's placement

on the second or third level of the PDL. The Traditional Empire Plan PDL is updated once a year on January 1st. Mid-year changes to the PDL are generally not acceptable. However, mid-year changes resulting from drug recalls, the introduction of new clinically superior drugs, drugs off patent, or patient safety issues are allowed.

***Flexible Formularies (two)*:** Under the Flexible Formulary, Generics may be on Level 1 or excluded. Brand Drugs may be on Level 1, 2, or 3 or excluded. A proposed PDL that includes Generics on Level 2 or Level 3 does not meet the Program requirements for the Flexible Formulary Drug List and would not be acceptable. Drugs may be excluded from the Flexible Formulary based on sound clinical and financial criteria. Proposed drug exclusions must meet the following criteria:

Access to one or more drugs in select therapeutic categories may be restricted (not covered) if the drug(s) has no clinical advantage over other generic and brand name medications in the same therapeutic class. Drugs considered to have no clinical advantage that may be excluded include any products that:

a. contain an active ingredient available in and therapeutically equivalent to another drug covered in the class;

b. contain an active ingredient which is a modified version of and therapeutically equivalent to another covered Prescription Drug Product;

c. are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent

For the 2012 Flexible Formulary, the following drugs were excluded from coverage: Acuvail, Adoxa, Amrix, Aplenzin, Asacol HD, BenzEFoam, Caduet, Clobex Shampoo, Coreg CR, Detrol LA, Dexilant (formerly Kapidex), Doryx, Edluar, Epdiuo, Extavia, Flector, Genotropin (except for the treatment of growth failure due to Prader-Willi syndrome or Small for Gestational Age), Humatrope (except for the treatment of growth failure due to SHOX deficiency or Small for Gestational Age), Iansoprazole, Metozolv ODT, Momexin Kit, Naprelan, Neobenz Micro, Nexium, Norditropin (except for the treatment of short stature associated with Noonan syndrome or Small for Gestational Age), Olux/Olux-E Complete Pack, omeprazole/sodium bicarbonate capsule (generic Zegerid), Omnitrope (except for the treatment

of growth failure due to Prader-Willi syndrome or Small for Gestational Age), Prevacid Ccapsules, Requip XL, Ryzolt, Soma 250, Terbinex, Testim, Treximet, Triaz, Twynsta, Veramyst, Xopenex Inhalation Solution, Zegerid Capsule, Ziana, Zipsor.

In addition, the current benefit design does not allow an Enrollee to appeal a drug's placement on the second or third level of the PDL, nor to appeal a drug exclusion. The Flexible Formulary is updated once a year on January 1st. Mid-year changes to the PDL are generally not acceptable. However, mid-year changes resulting from drug recalls, the introduction of new clinically superior drugs, drugs off patent, or patient safety issues are allowed.

The "Enhanced Flexible Formulary" adds a "Brand for Generic" feature to The Empire Plan's Flexible Formulary. With this feature, a brand-name drug may be placed on Level 1, or excluded, and the generic equivalent placed on Level 3, or excluded. With Department approval, these placements may be revised mid-year when such changes are advantageous to The Empire Plan. Effective January 1, 2013, a "New to You Prescriptions" program will be implemented for enrollees subject to the Enhanced Flexible Formulary. This program will require the enrollee to have two (2) 30-day fills of a newly prescribed medication at a Retail Pharmacy prior to being able to obtain a 90-day fill through the Retail Pharmacy or Mail Service Pharmacy.

Excelsior Plan PDL: Under the Excelsior Plan PDL, both Brand and Generic Drugs may be placed on Level 1, 2 or 3 or excluded. A proposed PDL that includes Generics on Level 2 or Level 3 and/or has Brand Drugs on Level 1 meets Program requirements and would be acceptable for the Excelsior Plan. Drugs may be excluded from the Excelsior Plan PDL based on sound clinical and financial criteria. In addition, the current benefit design does not allow an Enrollee to appeal a drug's placement on the second or third level of the PDL nor to appeal a drug exclusion. The Excelsior Plan PDL may be updated throughout the year. It is currently updated on January 1 and July 1 each year. The goal of the Excelsior Plan PDL is to offer a therapeutically sound formulary that result in a Plan design that costs a minimum of 15% less than The Empire Plan Flexible Formulary.

a. <u>Duties and Responsibilities</u>

The Offeror must provide PDL development and management services for the DCS Program. Such responsibility shall include but not be limited to:

(1) Developing and administering four multi-level formularies, consistent with the Program's four benefit designs. The Offeror's PDL's must be based on sound clinical criteria. The Offeror's Book of Business PDL for the Excelsior Plan PDL must include non-self administered, intravenous and intramuscular injectable drugs covered under the Excelsior benefit plan design. In designating a drug as preferred or non-preferred for the Empire Plan's Traditional PDL and Flexible Formulary drug lists, the Offeror must ensure that drugs recognized in documented medical evidence and studies as clinically superior to similar drugs in a therapeutic class be designated as preferred. In situations where there are multiple drugs in a therapeutic class of similar clinical characteristics, net costs shall be considered in determining a drug's status as preferred or non-preferred. For the Traditional Empire Plan PDL, generally, one or more single source Brand Drugs in a therapeutic category shall be designated as preferred, unless there is compelling clinical reason for not promoting the use of the Brand Drug(s). The composition of the PDL for the Flexible Formulary and the Traditional PDL will be developed by the Offeror and reviewed annually by the Department;

(2) The Offeror may recommend and the Department may, at its sole discretion, approve a mid–year change in a drug's status from non-preferred to preferred for the Flexible Formularies and Traditional PDL. Any recommended mid-year changes to the PDLs shall be provided to the Department with a summary of the clinical and financial implications to the DCS Program. In the instance when a change to a Preferred Drug List is approved outside of the annual update, the Offeror's communication responsibilities are the same as the annual PDL update. For the Excelsior Plan, the timing of up-tiers and exclusion shall be consistent with the Offeror's Book of Business PDL;

(3) Developing Preferred Drug List's for each of the four benefit designs, subject to the review and approval of the Department, for the purpose of distributing printed copies to Enrollees and medical providers. Additionally, electronic copies will be developed for posting on the Department's website and the Offeror's customized website for the DCS Program in order to inform Enrollees and providers of the placement of the most commonly prescribed medications on each Preferred Drug List. The Department shall be responsible for the distribution of the printed PDL provided by the Offeror on an

annual basis to Enrollees. The Offeror shall be responsible for producing and distributing all other copies of the printed PDL, including but not limited to supplies sent to agencies, those sent with Offeror mailings to Enrollees and individual requests by Enrollees or providers. The Offeror is required to promptly mail the Preferred Drug List to Enrollees who call requesting a copy. Printed copies of the Traditional Empire Plan PDL and Flexible Formulary Drug List from 2011 and 2012 are presented in Exhibits II.I through II.I.3. The Excelsior Plan PDL for 2012 is presented in Exhibit II.I.4.

(4) Compiling and organizing the PDLs in two versions, limited to the most commonly prescribed medications for posting and distribution: an alphabetical listing of Preferred Drugs and a listing of Preferred Drugs categorized by therapeutic category. A full listing of the PDL must be available for posting on the website. The Offeror must work with the Department on the format of the PDL. The PDL that is developed for distribution to Enrollees, and providers and posted on the website must provide notice of the pending introduction of a generic equivalent for one or more strengths of a particular Brand Drug that could result in one or more strengths of the drug being moved to non-preferred status during the year. The PDL shall also list the name of the reference product in parenthesis next to the name of the Generic Drug (i.e. simvastatin (Zocor)) unless the Department otherwise directs. The PDL shall indicate those drugs that require Prior Authorization and those drugs eligible for the Half Tablet Program. The Offeror shall inform the Department of any rebate implications to the DCS Program as a result of including this information on the PDL.

(5) Developing the PDL in a timely manner so that the Department approved, printed PDL is available to be communicated to Enrollees and posted to the website at least forty-five (45) Days before the start of the Calendar Year, to coincide with the DCS Program's option transfer period for Enrollees.

(6) Developing and mailing a Department pre-approved disruption letter, via first class mail, to Enrollees who are affected by a drug's exclusion or a Preferred Brand Drug's reclassification to a non-preferred status unless the reclassification is the result of the introduction of an equivalent generic for the Traditional Empire Plan PDL and Flexible Formulary Drug Lists. Disruption mailings for the Enrollees in the Excelsior

Plan will follow the disruption mailing plan employed for the Offeror's Book of Business PDL. Such letters must be sent to Enrollees who have utilized a medication at least once within the latest four month time period, regardless of the Days supply or whether the medication is categorized as maintenance or acute. An additional mailing must be sent to Enrollees who are new users of a medication between the date claims records were selected for the initial disruption mailing and the date that the PDL changes go into effect. Such communications should provide to the Enrollee information concerning clinically appropriate alternatives on the first and second level, when applicable, of the Preferred Drug List as of the effective date of the drug's exclusion or change from preferred to non-preferred status. In situations where Enrollees are affected by a Generic Drug's reclassification to a Brand Drug, the Offeror agrees to send a disruption letter to affected Enrollees;

(7) Notifying the Department in writing when a Class I drug recall or voluntary drug withdrawal occurs. The Offeror must take proper action to help promote patient safety. The Offeror will review with the Department the need to communicate and at the Department's discretion will notify Enrollees, Network Pharmacies and/or prescribing Physicians of the Federal Food and Drug Administration drug or device recalls and manufacturer drug or device withdrawals at no additional cost to the Program. Such notification must be timely and all written materials subject to Department review and prior written approval. The Offeror must assist the Department in collecting monies from recalled products.

(8) Using reasonable efforts to monitor the industry on behalf of the DCS Program and notifying the Department in writing of any class action lawsuits for which a class has been certified and of any proposed orders or settlements that the DCS Program may be entitled to participate in as a member of the class. Unless otherwise notified by the Department, the Offeror shall file claims on behalf of the Program and take all steps necessary to ensure the DCS Program's interests in the class action suit or proposed settlement are protected. Any recoveries collected by the Offeror on behalf of the DCS Program, net of the Offeror's actual costs in securing the DCS Program's participation in the recovery, due the DCS Program must be credited to the DCS Program within fifteen (15) Days upon the Offeror's receipt. The Offeror shall make reasonable efforts

to maximize recoveries. Distribution of recoveries, net of the Offeror's actual costs incurred on behalf of the DCS Program, shall be made consistent with the terms of the final settlement order or court decision. The Offeror shall assist the State in its recovery efforts and provide the claims and rebate data required to file a claim on behalf of the DCS Program when requested by the Department.

(9) Holding an annual meeting with the Department to review upcoming Traditional Empire Plan PDL and Flexible Formulary Drug List changes prior to the effective date of any changes. This meeting will include a review of the Offeror's Book of Business PDL strategy. Upon the Department's request the Offeror shall provide a detailed explanation of the clinical and/or financial basis for the decision to change the classification of the drug (s) on the Traditional Empire Plan PDL and Flexible Formulary Drug List as well as a detailed cost analysis of the impact of the changes to the Program.

(10**)** Assigning a new strength of a drug to the same PDL Level as the pre-existing strengths of the drug in the event a new strength of a drug already on the Traditional Empire Plan PDL or Flexible Formulary Drug List is shipped from the manufacturer or wholesaler;

(11) For the Traditional Empire Plan PDL and the Flexible Formulary Drug Lists, designating as Preferred all FDA approved Covered Drugs without therapeutically equivalent generics prescribed for the treatment of the following diseases; Cancer, Hepatitis, HIV and Diabetes. FDA approved organ transplant anti-rejection drugs shall also be designated as Preferred Brand Drugs. Post award, the Offeror may recommend other disease states where all the Covered Drugs prescribed to treat the illness would be designated as Preferred.

(12) Working with the medical carrier and the mental health and substance abuse carrier to develop communications such as, but not limited to provider newsletters to ensure that participating providers in those networks are fully apprised of the level/status of Covered Drugs.

(13) The Offeror will be responsible for ensuring the Empire Plan Flexible Formularies and the Traditional Empire Plan Preferred Drug List will be electronically available to

Medical Professionals on Rx Hub and Level 1 and Level 2 drugs will be designated as Preferred.

(14) The Offeror will be responsible for protecting the value of the DCS Program's pricing discounts by taking appropriate steps to control Prescription Drug AWP increases.

(15) The Offeror will be responsible for developing, recommending, and implementing Brand for Generic strategies for the Enhanced Flexible Formulary that are financially beneficial to the State. All Brand for Generic placements are subject to Department approval. These placements may be revised mid-year, with Department approval, when such changes are advantageous to The Empire Plan.

(16) The Offeror will be responsible for implementing and administering a "New to You Prescriptions" program. This program requires Enrollees to have two 30-day fills of a newly prescribed medication at a Retail Pharmacy prior to being able to obtain a 90-day fill through the Retail Pharmacy or Mail Service Pharmacy.

b. Required Submission

Preferred Drug List Management − General

(1) Do you currently develop, maintain and administer plans with three copay level benefit designs utilizing one or more Preferred drug lists? Detail your proposed plan and your capability to administer the Program's three different formulary benefit DCS Program designs.

(2) Describe the various preferred drug lists you have available:

(a) Do you have a standard three copay level preferred drug list used for your Book of Business?

(b) Do you maintain multiple standard and custom preferred drug lists? Provide a description of the differences.

(c) What is the goal of these alternative preferred drug lists?

(d) What role do clients play in the development of your preferred drug lists?

(e) How often are changes made for both additions and deletions?

(f) Are there special considerations for biological and specialty Pharmacy products in your preferred drug list and/or process?

(3) What Preferred Drug Lists are you proposing to use in managing the DCS Program? Please provide copies. Are there any therapeutic classes that are composed of only Non-Preferred Drugs due to documented medical evidence of inferior clinical attributes of the Brand Drugs in comparison with competing generics and/or clinically documented safety concerns? What is your clinical rationale for limiting these drugs to Level 3?

(4) Explain how you would work with the medical carrier and the mental health and substance abuse carrier to ensure that participating providers in their networks are fully apprised of the level status of Covered Drugs.

(5) Confirm that the Empire Plan Flexible Formulary and the Traditional Empire Plan Preferred Drug List will be made available on Rx Hub and Level 1 and Level 2 drugs will be designated as Preferred. Describe how Rx Hub will be utilized for the benefit of the DCS Program including how it will encourage physicians to prescribe lower cost alternative medications to Enrollees.

(6) Describe the strategy which would be implemented to control Prescription Drug AWP increases.

(7) Describe how you will develop, recommend, and implement Brand for Generic strategies for the Enhanced Flexible Formulary that are financially beneficial to the State.

(8) Do you currently administer a “New to You Prescriptions” program or one similar to this for your book of business? Detail your proposed plan and your capability to administer the “New to You Prescriptions” program.

Preferred/Non-Preferred/Excluded Determination

(1) Describe in detail the process employed to determine whether a drug is designated as preferred, non-preferred or excluded, including:

(a) All standards and criteria used in this determination;

(b) The qualifications of the current participants in the review process, as well as any requirements related to ensuring that the participants in the process are independent, objective, and free of conflict of interest;

(c) The role of net cost in this determination;

(d) Whether the designation of preferred/non-preferred or excluded status is governed by formal corporate policies and procedures detailing standards of review and criteria, is considered in reaching such determination;

(e) Whether the process is governed by formal procedures to ensure sound clinical examination resulting in quality pharmaceutical care;

(f) Whether a record is made of the process leading to preferred/non preferred or excluded designations and whether the Department will have access to either original records and/or summaries detailing the basis for designations;

(g) How often a drug's preferred/non-preferred or excluded status is reviewed and revised and is the review process done on a predetermined scheduled basis? If so, what is the schedule for the review process and are there exceptions to these scheduled meetings;

(h) Whether the process is different for innovative new therapies than for therapies that already have a competitive alternative; and

(i) The conditions that would cause a drug's preferred, non-preferred, or excluded status to change and several recent examples.

(2) Describe the type of analysis you would perform when a Preferred Brand Drug is being considered for movement to a Non-Preferred Brand Drug list and vice versa.

(3) Provide a diagrammatic illustration of the process from receipt of notification of a new drug entry into the marketplace from the manufacturer, to the Preferred Drug List decision making process, identifying any and all clinical and financial considerations impacting the placement of the product. Please include estimated time frames.

Preferred Drug List Strategy

(1) How are Generic equivalents considered in your assessment of individual therapeutic categories on your Preferred Drug List?

(2) How does your Preferred Drug List development process promote the use of the most cost effective drug within the therapeutically equivalent drugs in the class, including Generics. Provide three examples.

(3) Does your PDL strategy currently allow for drug exclusions? Do your proposed Flexible Formulary and Excelsior PDL's contain Drug exclusions? If so, please list proposed excluded drugs and rationale. Describe how you use exclusion leverage to negotiate rebates with Pharmacy manufacturers to provide the best value to the DCS Program.

(4) Describe your strategy and process for evaluating and determining the appropriate Preferred Drug List designation for the introduction of "me too" drugs including drugs with OTC equivalents. Please describe your current strategy and its rationale for the proton pump inhibitor class, statin class, and lifestyle drugs (Viagara, Levitra, etc.).

(5) Describe your strategy and process for determining the appropriate Preferred Drug List designation for the introduction of "successor drugs," including extended release products. Provide an example of this strategy.

(6) Please detail your strategy and process for determining the appropriate copay level designation for the introduction of "combination drugs" including, but not limited to any net cost analysis comparing the cost of the new combination drug and the cost of its component drugs. How does this process evaluate comparative cost when the new

combination drug does not come in all strengths available in either of the component drugs or if the single combination drug does not meet the usual dosing levels of one of the component drugs? Please provide an example of this strategy.

(7) Explain how your business model ensures that the placement of drugs on the Preferred Drug Lists will result in the best value to the DCS Program and Enrollees. Describe how manufacturer contracting is integrated into this process.

(8) Describe how the anticipated upcoming release of a new Generic drug impacts the placement of its Brand Drug equivalent on the Preferred Drug Lists. Will the rebates available for similar Brand Drugs impact its placement? Does your proposed Preferred Drug List have drugs anticipated to go generic in 2012 as non-preferred? Please explain the rationale for such classification.

Voluntary Drug Recalls, Withdrawals, and Drug Lawsuits/Settlements

(1) Describe your process for complying with the applicable Program requirements in the event of a Class I drug recall or voluntary drug withdrawal including the time notification standards you employ. Identify the services that would be provided to the Program and Enrollees. How is the Program reimbursed when a medication is recalled or withdrawn?

(2) Describe your process for identifying drug lawsuits and settlements on behalf of the Program. Confirm that the Offeror will notify the Department in a timely manner of class action lawsuits or settlements in which the Program may participate. Confirm that the Offeror will credit the Program for net recoveries within fifteen (15) Days upon receipt by the Offeror. Describe how the Offeror's actual costs incurred in the settlement will be allocated to the Program.

Preferred Drug List Development and Management (Exclusive to NYSIF)

The selected Offeror is required to efficiently develop, administer, and maintain a single Preferred Drug List (PDL) that ensures Claimant access to appropriate, quality pharmaceutical care based on sound clinical criteria. The Program requires that all Covered Drugs be classified as preferred or non-preferred. PDL management, in particular designation of drugs as preferred (which generally means Level 1 or Level 2), non-preferred or excluded, is critical to

the clinical and financial success of the Program. The Offeror must use sound clinical criteria in any decisions that are made to place or exclude drugs from the PDL.

The PDL generally features Generic Drugs on the first level, Preferred Brand Drugs on the second level, and Non-Preferred Brand Drugs on the third level. The PDL proposed for the Program must include all drugs meeting the definition of Covered Drugs in this RFP. The selected Offeror is required to effectively communicate the content and requirements of the Program's PDL to Network Pharmacies, medical providers, and Enrollees. The design of the NYSIF Program does not require a Brand Drug in every therapeutic category. For the purpose of preparing a response to this RFP if an Offeror proposes a Preferred drug list which does not include a Preferred Brand Drug in every therapeutic category, the Offeror must include the clinical rationale and financial implications of the Offeror's determination. Offerors will submit cost information as required in Section V, Cost Proposal of this RFP.

Note: Do not include any cost information in the technical proposal.

a. Duties and Responsibilities

The Offeror must provide PDL composition and management services for the NYSIF Program. Such responsibility shall include but not be limited to:

(1) Creating and maintaining a formulary that is tailored to NYSIF specifications, including the categorization of drugs, e.g. drugs requiring prior authorization, covered drugs dispensed not requiring prior authorization;

(2) Providing NYSIF with a list of therapeutic categories routinely excluded from coverage;

(3) Agreeing that the Offeror does not and will not accept payments from drug companies to promote specific products;

(4) Notifying NYSIF a minimum of three weeks prior to any additions, deletions and modifications to the existing formulary and whether or not the affected drugs are covered or require prior authorization;

(5) Notifying NYSIF a minimum of three weeks prior to the inclusion of new drugs in the formulary and specify whether or not the drugs are covered or require prior authorization; and,

(6) Providing NYSIF with an electronic file of all formulary drugs including dosages, NDC numbers, GCN and GC3 codes. The frequency of this file submission will be determined by NYSIF and will be provided upon vendor selection.

b. Required Submission

(1) Describe how you will create and maintain a formulary that is tailored to NYSIF specifications, including the categorization of drugs, e.g. drugs requiring prior authorization, covered drugs dispensed not requiring prior authorization;

(2) Provide in electronic format, preferably Excel, a list of therapeutic categories you routinely exclude from coverage;

(3) Confirm that you do not and will not accept payments from drug companies to promote specific products;

(4) Confirm you will notify NYSIF a minimum of three weeks prior to any additions, deletions and modifications to the existing formulary and whether or not the affected drugs are covered or require prior authorization;

(5) Confirm you will notify NYSIF a minimum of three weeks prior to the inclusion of new drugs in the formulary and specify whether or not the drugs are covered or require prior authorization; and,

(6) Confirm you will provide NYSIF with an electronic file of all formulary drugs including dosages, NDC numbers, GCN and GC3 codes. The frequency of this file submission will be determined by NYSIF and will be provided upon vendor selection.

Voluntary Drug Recalls, Withdrawals, and Drug Lawsuits/Settlements

(1) Describe your process for complying with the applicable Program requirements in the event of a Class I drug recall or voluntary drug withdrawal including the time

notification standards you employ. Identify the services that would be provided to the Program and Enrollees. How is the Program reimbursed when a medication is recalled or withdrawn?

(2) Describe your process for identifying drug lawsuits and settlements on behalf of the Program. Confirm that the Offeror will notify the Department in a timely manner of class action lawsuits or settlements in which the Program may participate. Confirm that the Offeror will credit the Program for net recoveries within fifteen (15) Days upon receipt by the Offeror. Describe how the Offeror's actual costs incurred in the settlement will be allocated to the Program.

SECTION V: COST PROPOSAL REQUIREMENTS

A. Introduction

The purpose of this section of the RFP is to set forth the duties and responsibilities required of the Offeror as regards to its cost quotes and to pose questions (i.e., the information and documentation required under the Confirmations and Required Submissions sections) concerning those duties and responsibilities. The Offeror's Cost Proposal must contain responses to all questions in the format requested, as well as, the cost exhibits required in Section C.1., below. The Cost Proposal evaluation will analyze the relative impact of each Offeror's Cost Proposal on the Programs' claims costs and administration costs and net savings that will result for the Offeror's Pharma Revenue Guarantee. Each Offeror may submit ONLY ONE Cost Proposal. Each Cost Proposal will be evaluated with the following goal in mind: the lowest possible total combined Program cost over the term of the Agreements resulting from this RFP while meeting Program clinical requirements, Pharmacy access requirements, and service standards.

B. Evaluation Process – General

The evaluation of Cost Proposals will be conducted by applying each Offeror's cost quotes to normalized claim data. In particular, the evaluation will involve the following:

1. Analysis of the impact of proposed Guaranteed Discounts and dispensing fees, and the Offeror's per final paid claim Pharma Revenue Guarantee on combined Program claim costs; and

2. Analysis of the impact of the Offeror's proposed Claims Administration Fees for administering the Programs.

C. Analysis of Cost Components

1. Summary of Cost Exhibits

The Offeror must complete the following cost exhibits in strict accordance with the directions set forth in this RFP and submit them as part of their Cost Proposal:

Exhibit V.A. – Offeror's Proposed Claim Reimbursement Quotes

Exhibit V.B. – Re-pricing Instructions for Exhibit V.B.2 entitled "Offeror's Re-Priced Claims Files" to be submitted in Support of the Offeror's Proposed Claim Reimbursement Quotes

Exhibit V.B.1 – Layout Specifications for Exhibit V.B.2 entitled "Offeror's Re-Priced Claims Files to be submitted in Support of the Offeror's Proposed Claim Reimbursement Quotes

Exhibit V.B.2 – Offeror's Re-priced Claims Files

Exhibit V.C. – Retail and Mail Service Generic Drugs – MAC List Costs Per GPI **(for Offerors proposing to use Medi-Span as the claims adjudication platform)**

Exhibit V.C.1 – Retail and Mail Service Generic Drugs – MAC List Costs Per GCN **(for Offerors proposing to use First Data Bank as the claims adjudication platform)**

Exhibit V.D. – Specialty Pharmacy Program Dispensing Fee

Exhibit V.E. – Pharma Revenue Guarantee Quote

Exhibit V.E.1 – Documentation to Support Pharma Revenue Guarantee Quote

Exhibit V.F. – Claims Administration Fees Quote

2. Instructions for Submitting Offeror's Re-priced Claims Files – Exhibit V.B.2

It has been the Procuring Agencies' experience that the submission of Exhibit V.B.2, Offeror's Re-Priced Claims Files, has presented difficulties for some Offerors. The Procuring Agencies will make every effort to assist Prospective Offerors in resolving issues in advance of the submission of an Offeror's actual Cost Proposal. **To assure an accurate interpretation of the requirements for completing Exhibit V.B.2, the Department**

strongly recommends Prospective Offerors take advantage of the opportunity to submit a Re-Priced Claims Test File with sample data as referenced in Section III.G. of this RFP. (Note: Do not include actual cost data in the Re-Priced Claims Test File).

In support of the Offeror's proposed claim reimbursement quotes, Offerors are required to provide their Re-priced Claim Files, Exhibit V.B.2 in strict accordance with the Re-pricing Instructions and Layout Specifications found in Exhibits V.B and V.B.1 of this RFP.

For use in preparing Exhibit V.B.2, the Department has produced a Claims Data File containing claims paid for the period 11/12/10 – 10/28/11 for the DCS Programs for Prospective Offerors that can be obtained by following the instructions and meeting the requirements specified in Section III.G. of this RFP. The NYSIF Program claims data is for informational purposes only and will not be used in the Repricing Exercise.

The Procuring Agencies make no guarantee that any Offeror will be granted an opportunity to submit a corrected Exhibit V.B.2 after the Proposal Due Date in Section II.A. of this RFP and encourages Offerors to take all steps necessary to provide accurate data in its Proposal. In addition, the Procuring Agencies reserve the right to reject any or all Proposals in which Exhibit V.B.2 is not submitted in accordance with the instructions in Exhibit V.B. and V.B.1.

3. Claim Ingredient Cost - General

The Procuring Agencies require full transparency of claim ingredient costs in the Retail Pharmacy Network. The Offeror is required to propose an overall Guaranteed Minimum Discount off the aggregate AWP of all Brand Drugs dispensed through the Retail Pharmacy Network. The Offeror is required to propose overall Guaranteed Minimum Discounts off the aggregate AWP of all Generic Drugs dispensed through the Retail Pharmacy Network and Mail Service Pharmacy Process. In addition, the Offeror is required to propose a Guaranteed Discount off Brand Drugs dispensed to Enrollees/Claimants through the Mail Service Pharmacy Process and a Guaranteed Discount off Specialty Drugs/Medications dispensed to Enrollees/Claimants through the Specialty Pharmacy Program. The Offeror must also propose a pricing methodology for Compound Drugs dispensed to Enrollees/Claimants that will be utilized for both retail claims and Mail Service Pharmacy Process claims. This section sets forth the Program requirements related to those guarantees.

a. Duties and Responsibilities – Claim Ingredient Cost – General

(Amended April 4, 2012)

(1) All proposed discounts and dispensing fees for Brand and Generic Drugs must be guaranteed for the entire term of the Agreements without qualification or condition. In addition, the selected Offeror's proposed Compound Drug pricing methodology must be guaranteed for the entire term of the Agreements without qualification or condition.

(2) All proposed discounts and dispensing fees for Specialty Drugs/Medications apply only to Enrollees/Claimants who participate in and have drugs dispensed through the Specialty Pharmacy Program and must be guaranteed for the entire term of the Agreements without qualification or condition.

(3) The Contractor shall utilize the Medi-Span field coded R028 entitled "AWP unit price" or Red Book as the source of Average Wholesale Price (AWP) information for purposes of calculating Ingredient Cost.

(4) During the term of the Agreements, in the event the national reporting service, as identified by the Contractor in its Proposal, changes its methodology related to any of the information fields used in the Procuring Agencies' classification of Brand and Generic Drugs, or its methodology for coding drugs in connection with these information fields, the Contractor shall be obligated to inform the Procuring Agencies in writing of such changes within 30 Days of learning of such changes. Upon written notification, the Contractor and the Procuring Agencies will meet and agree in writing to any Brand and/or Generic Drug classification changes that may be necessary to enable each to maintain the same economic position and obligations as are set forth in the Agreements.

(5) If, during the term of the Agreements, industry events have caused the Contractor's source of AWP to become obsolete or no longer available, the Procuring Agencies and the Contractor shall agree on revised pricing terms. In no event shall the Programs' actual costs for drugs increase as the result of new pricing terms. The Contractor shall

notify the Procuring Agencies in writing as soon as any information indicating a problem with the future use of the Contractor's AWP source is received. Within two weeks of the initial notification, the Contractor shall submit a detailed written proposal to the Procuring Agencies for effectively revising pricing terms including but not limited to a file containing the Contractor's pricing for all drugs dispensed during the prior six months utilizing the current AWP source and the Contractor's revised pricing for such drugs using the proposed methodology. The Contractor's Proposal should ensure continued alignment of the Contractor's interests with those of the Programs.

(6) To protect Enrollees/Claimants from disruption due to reclassification of drugs, during the term of the Agreements, and to assure that Offeror's Proposals are evaluated consistently, drugs shall be classified for pricing purposes in accordance with current Program Brand /Generic Drug classifications and in accordance with the definitions in the Contract Provisions, Section VII, (see Article I, entitled "Definition of Terms") of this RFP.

(7) Offerors must use the Programs current Brand/Generic classification methodology which is based on a particular set of ~~not capable of utilizing~~ Medi-Span indicators ~~to determine Brand /Generic classification of drugs, for example Offerors utilizing First Data Bank or Red Book indicators, must submit for Procuring Agency review and written approval an alternative automated or manual process intended to replicate the results of the Programs' methodology for determining the Brand /Generic classification of drugs dispensed to Program Enrollees/Claimants~~. To assist such Offerors, ~~the Procuring Agencies have created~~ Exhibit III.G ~~to provide~~ presents a listing of the NDC's dispensed to Enrollees/Claimants in 2011 and the required brand name/generic drug classification assigned to each NDC.

The following methodologies shall be used by Offerors and will be used by the Procuring Agencies in their evaluation of Offerors' Proposals to determine the appropriate Brand /Generic Drug classification so as to comply with the contractual definitions set forth in the Contract Provisions, Sections VII.A. and VII.B. (see Articles I, entitled "Definition of Terms") of this RFP.

(a) ***Brand Name Drug Determination Methodology***

A drug labeled with the identifier "M" or "O" in the Medi-Span Multi-Source code shall be processed as a Brand Drug unless the same drug is identified as "G" in the Medi-Span Brand-Name code.
In addition to drugs identified as "M" or "O" in the Medi-Span Multi-Source code, a drug that is identified as "N" in the Medi-Span Multi-Source code shall be designated a Brand Drug if the drug is identified as "T" in the Medi-Span Brand-Name code.

(b) ***Generic Drug Determination Methodology***

A drug identified as "Y" in the Medi-Span Multi-Source code shall be designated as a Generic Drug.

In addition to drugs identified as "Y" in the Medi-Span Multi-Source code, a drug identified as "N" in the Medi-Span Multi-Source Code shall be designated as a Generic Drug if the corresponding Medi-Span Brand-Name code for such drug is "B" or "G."

In addition, a drug identified as "G" in the Medi-Span Brand-Name Code shall be designated as a Generic Drug, regardless of the identifier designated in the Medi-Span Multi-Source code.

As stated in the definition, as set forth in the Contract Provisions, Sections VII.A. and VII.B., (see Articles I, entitled "Definition of Terms") of this RFP, no drug approved through an FDA Generic Drug approval process, including any FDA approval process established for approving generic equivalents of biologic drugs, shall be processed as a Brand Drug regardless of the assigned Medi-Span indicators or the result of the Offeror/Contractor's proposed methodology for determining the appropriate classification of a drug.

Offerors not capable of utilizing Medi-Span to determine Brand /Generic classification of drugs, for example Offerors utilizing First Data Bank or Red Book indicators must submit for Procuring Agency review and written approval an

alternative automated or manual process intended to replicate the results of the Programs' methodology for determining the Brand /Generic classification of drugs dispensed to Program Enrollees/Claimants.

(c) ***Compound Drug Determination Methodology***

A Compound Drug is a drug with two or more ingredients (solid, semi-solid or liquid), where the primary active ingredient is an FDA approved covered drug with a valid NDC requiring a Prescription for dispensing, combined together in a method specified in a Prescription issued by a medical professional. The end result of this combination must be a Prescription medication for a specific patient that is not otherwise commercially available in that form or dose/strength from a single manufacturer. The Prescription must identify the multiple ingredients in the Compound, including active ingredient(s), diluent(s), ratios or amounts of product, therapeutic use and directions for use. The act of compounding must be performed or supervised by a licensed Pharmacist. Any commercially available product with a unique assigned NDC requiring reconstitution or mixing according to the FDA approved package insert prior to dispensing will not be considered a Compound Prescription by the Programs.

(8) The selected Offeror shall be required to submit a file containing the NDC's dispensed to Enrollees/Claimants in 2011 and the resulting brand/generic classification of each NDC derived from application of the contractor's electronic classification process. If, at that time, the Procuring Agencies determine that the selected Offeror's proposed classification methodology does not replicate the results of the Programs' methodology for determining the brand name/generic classification of drugs, the selected Offeror must modify its classification methodology to replicate the results of the Programs' methodology, either automatically through the claims adjudication system or through an annual claims reconciliation process. The Procuring Agencies determination shall be final.

(9) The Programs' Lesser of Logic, as defined in Section VIII (Glossary of Terms), shall apply to all claims processed under the Programs.

b. Confirmation – Claim Ingredient Cost - General

(1) Offerors must confirm their agreement to perform/fulfill and comply with the Duties and Responsibilities contained within "Claim Ingredient Cost - General" section above including, but not limited to:

(a) The guarantee that all discounts and dispensing fees shall remain in effect during the entire term of the Agreements, without qualification or condition;

(b) Pricing for Specialty Drugs/Medications, shall apply only to Enrollees/Claimants who participate in and fill a prescription through the Specialty Pharmacy Program. Specialty Drugs/Medications for all other Enrollees/Claimants and/or claims shall be priced using the Offeror's proposed pricing for retail and mail service drugs;

(c) AWP will be determined by Medi-Span utilizing the field coded R028 entitled "AWP unit price" or by Red Book, as proposed by the Offeror;

(d) Confirmation that if the Procuring Agencies determine that industry events have caused the Contractor's proposed source of AWP to become inflated against new industry standards, obsolete, or unavailable, the Contractor agrees to negotiate revised pricing terms ensuring that the Programs' actual costs for drugs in no event increase as the result of new pricing terms, in accordance with Section V.C.3.a.(5) above.

(e) Drugs will be classified as brand name, generic, or compound consistent with Section V.C.3.a.(7) above;

(f) Prescriptions shall be processed consistent with the Programs' classification of drugs on an NDC basis. Confirmation that, if selected, the Offeror agrees to submit a file containing the NDC's dispensed to Enrollees/Claimants in 2011 and the resulting brand/generic classification of each NDC utilizing the Offeror's proposed methodology for determining the brand name/generic classification of drugs. Confirmation that, if the Procuring Agencies determine that the Offeror's

proposed classification methodology does not replicate the results of the Programs' methodology for determining the brand name/generic classification of drugs, the Offeror shall agree to modify its classification methodology to replicate the results of the Programs' methodology either automatically through the claims adjudication system or through an annual claims reconciliation process; and

(g) Applying the Programs' Lesser of Logic to all claims.

c. Required Submission – Claim Ingredient Cost - General

(1) The Offeror is required to specify whether they are utilizing the Medi-Span field coded R028 entitled "AWP unit price" or Red Book as the source of AWP information for calculating Ingredient Cost.

4. Mandatory Generic Substitution at Retail and Mail

Encouraging utilization of cost-effective clinically equivalent Generic Drugs is an integral component of the Programs' benefit design. To promote the use of Generic Drugs, the Programs have a mandatory generic substitution requirement that mandates that FDA approved A-rated Generic Drugs and authorized Generic Drugs be substituted for equivalent Brand Drugs or the Enrollee/Claimant pays the applicable Level 3 Drug Copayment plus an "Ancillary Charge." Under the NYSIF Program, there are no Copayments or Ancillary Charges collected from the Enrollee/Claimant. The Offeror must apply this requirement on a consistent basis at the retail network pharmacies and through the Mail Service Pharmacy Process.

a. Duties and Responsibilities

To ensure strict adherence to the Programs' Mandatory Generic Substitution Requirement and protect the financial interests of the Programs, the Contractor shall be required to:

(1) Apply mandatory generic substitution to all specific NDC's of Brand Drugs for which there is an FDA approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc) or an authorized Generic Drug as permissible by NYS law. Retail network pharmacies shall comply with all state laws related to mandatory generic substitution. The Programs' mandatory generic

substitution provisions shall apply to any claim where the A-rated or authorized Generic Drug is required or permitted to be substituted under state law. Mandatory generic substitution provisions will not apply to B-rated or unrated Generic Drugs or in the unlikely event that state law prohibits dispensing of the A-rated or authorized Generic Drug.

(2) (Exclusive to DCS) Establish the Ancillary Charge by calculating the difference in the Discounted Ingredient Cost of the Brand Drug and the Discounted Ingredient Cost of the equivalent A-rated Generic Drug or authorized Generic Drug based on the Programs' MAC List price assigned when a Brand Drug for which an A-rated or authorized Generic Drug has been introduced in the market is dispensed to the Enrollee. In such cases, the Enrollee shall be responsible for paying the applicable Level 3 Drug Copayment plus Ancillary Charge not to exceed the cost of the drug to the DCS Program. The Ancillary Charge shall be assessed even in the event a doctor has specifically directed a Pharmacist to dispense the Brand Drug rather than the A-rated or authorized Generic Drug through DAW notation.

(3) Monitor the pharmaceutical industry on behalf of the Procuring Agencies to identify Generic Drugs expected to enter the market. Prior to the actual introduction of the Generic Drug to market, the Contractor shall inform the Procuring Agencies of anticipated shipping dates of the first generic introduced into the market for one or more strengths of a particular Brand Drug.

(4) (Exclusive to DCS) Following the first shipment of a first Generic Drug for one or more strengths of a particular Brand Drug, the Contractor shall be required to:

(a) Inform the Department as soon as practicable but in no event later than fourteen (14) Days after the first date of shipment, (from manufacturer to wholesaler or retailer) of the financial impact of enforcing mandatory generic substitution via the "MAC Alert Notice" detailed in Section IV of this RFP under "Reporting";

(b) For those drugs that will result in a lower net cost to the Programs by enforcing mandatory generic substitution, the Contractor shall provide the "MAC Alert Notice" as described in (a) above. The Contractor shall add the GPI/GCN to the

Programs' MAC List and begin enforcement as soon as practicable but in no event later than fourteen (14) Days after the first date of shipment provided that the participating retail network pharmacies are able to obtain the Generic Drug;

(c) For those drugs that could potentially result in a higher net cost to the Programs by enforcing mandatory generic substitution, the Contractor shall provide the "MAC Alert Notice" as described in (a) above. The Contractor shall also notify the Department whether the drug should be included in the Brand for Generic strategy. The Department, in its sole discretion, may determine that enforcement is contrary to the best financial interests of the Programs and shall inform the Contractor whether Mandatory Substitution shall be applied. If the Contractor does not receive a formal response to the information provided via the "MAC Alert Notice," enforcement shall commence and the GPI/GCN shall be added to the Programs' MAC List effective on the 21st day after shipment of the first A-rated generic equivalent drug or authorized Generic Drug provided that the pharmacies are able to obtain the Generic Drug. In the event the Department decides to exercise its discretion not to enforce mandatory generic substitution, the Contractor shall apply MAC pricing to the Generic Drug when dispensed;

(d) To assist the Department in determining whether or not mandatory generic substitution should be enforced within 21 Days, the Contractor shall survey its Retail Pharmacy Network to identify the pharmacies that are unable to obtain the new Generic Drug within 21 Days. The Contractor shall submit this information to the Department and provide any additional information as required by the Department to reach a determination. The DCS, in its sole discretion, shall determine based on such evidence how the Programs' mandatory generic substitution provisions will be applied. The Programs will not consider and the Contractor shall not act on availability information provided by 3rd party sources, including but not limited to Medi-Span, Red Book and First Data Bank;

(e) For preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall be changed from preferred to Non-Preferred

status concurrent with the commencement of the enforcement of mandatory generic substitution. Enrollees prescribed strengths of the Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the Level 1 Copayment. If the prescribing Physician requires that the Brand Drug be dispensed, the Enrollee will be charged the applicable Level 3 Drug Copayment and Ancillary Charge. Enrollees prescribed strengths of the preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Level 2 Copayment and mandatory generic substitution provisions shall not apply;

(f) For Non-Preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall remain Non-Preferred for all strengths. Concurrent with enforcement of mandatory generic substitution, Enrollees prescribed strengths of the Non-Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the Level 1 Copayment. If the prescribing Physician requires that the Brand Drug be dispensed, the Enrollee will be charged the applicable Level 3 Drug Copayment and Ancillary Charge. Enrollees prescribed strengths of the Non-Preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Level 3 Drug Copayment and mandatory generic substitution provisions shall not apply;

(g) The Contractor shall cause the dispensing Network Pharmacy to inform the Enrollee prior to dispensing the Brand Drug, that an Ancillary Charge would be applied in addition to the applicable Level 3 Drug Copayment. If the prescribing Physician requires the Brand Drug be dispensed, the Contractor shall cause the dispensing Network Pharmacy to collect the applicable Level 3 Drug Copayment plus the calculated Ancillary Charge. However, under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have

been to the DCS Program after application of the Programs' Lesser of Logic provisions;

(5) Charge the Programs based on the Programs' MAC List price assigned to the GPI/GCN of the dispensed Brand Drug plus the applicable dispensing fee as set forth in "Programs' Claims Reimbursement" of the Contract Provisions, Sections VII.A and VII.B of this RFP;

(6) Receive written approval from the Procuring Agencies for any and all exceptions to the Programs' mandatory substitution provisions, beyond the approval of specific generic appeals. Following commencement of mandatory generic substitution, the Contractor must receive Procuring Agencies' written approval prior to suspending enforcement of the Programs' mandatory generic substitution provisions; and

(7) Maintain an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the Programs' mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the Generic Drug at the Network Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Network Pharmacy, the Programs' mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized Generic Drug in stock, mandatory generic substitution provisions will not apply and the Enrollee/Claimant shall receive the Brand Drug, be charged the applicable Generic Drug Copayment and the Plan charged based on Generic Drug pricing. Currently, the Programs reject, with appropriate messaging, claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW 0-code and require resubmission of the claim (since a DAW 0-code provides no indication of Generic Drug availability in the Network Pharmacy). Similar rules can be applied to other DAW submission codes as necessary to ensure consistent, accurate application of the Programs' mandatory generic substitution requirements.

b. <u>Confirmation - Mandatory Generic Substitution at Retail and Mail</u>

Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities contained within "Mandatory Generic Substitution at Retail and Mail" section above.

5. Retail Pharmacy Network Claims

The cost of all Covered Drugs dispensed at network pharmacies shall be charged to the Programs consistent with the requirements set forth in this RFP, including but not limited to the Lesser of Logic set forth in Section V.C.3.a.(9) above and Pass-through Pricing.

General Provisions

The following general provisions apply to all claims submitted by Retail Pharmacy Networks:

a. Duties and Responsibilities - Retail Pharmacy Network Claims - General

(1) The Contractor shall ensure that the Network Pharmacy collects the appropriate Copayment specified in Exhibit II.C (plus Ancillary Charge, if applicable) from the Enrollee/Claimant and will charge the Programs the Discounted Ingredient Cost as determined through the application of the Lesser of Logic detailed in Section V.C.3.a.(9) above plus the Contractor's applicable pharmacy contracted dispensing fee minus the applicable Copayment for all drugs dispensed through a Network Pharmacy.

(2) (Exclusive to DCS) If the current Discounted Ingredient Cost plus the dispensing fee or the submitted cost is less than the applicable Copayment, then the Contractor shall ensure that the Network Pharmacy charges the Enrollee the lesser amount.

(3) The Contractor shall implement a control process at point of service intended to protect the Programs from any inflated AWP costs associated with "repackaged" drugs charged to the Programs.

b. Confirmation – Retail Pharmacy Network Claims - General

Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities in Section V.C.5. of this RFP, under subheading "General Provisions."

c. Required Submission – Retail Pharmacy Network Claims - General

(1) The Offeror is required to provide the Offeror's Re-priced Claim Files, Exhibit V.B.2 in strict accordance with the Re-Pricing Instructions and Layout Specifications found in Exhibits V.B and V.B.1 of this RFP.

(2) The Offeror is required to describe the process it proposes to utilize to ensure that the Programs' financial interests are protected from any inflated AWP costs associated with "repackaged" drugs charged to the Program.

Retail Pharmacy Network Brand Name Drug Pricing

a. Duties and Responsibilities – Brand Name Drug Pricing

(Amended April 4, 2012)

(1) The Contractor shall charge the Program utilizing Pass-through Pricing for all Brand Name Drugs dispensed to Enrollees/Claimants through the Network Pharmacies. The Contractor's pharmacy contracted discount off of AWP and pharmacy contracted dispensing fee(s) for Brand Drugs shall be applicable to all individual Prescriptions for Brand Drugs dispensed to Enrollees/Claimants from a Network Pharmacy.

(2) Guarantee an overall minimum discount off of the aggregate AWP for all Brand Drugs dispensed at Retail Network Pharmacies as defined in the RFP. The Contractor shall guarantee the Programs that its management of Brand Drug costs dispensed by pharmacies shall result in each Program achieving the Contractor's overall Guaranteed Minimum Discounts during each Program Year as proposed by the Contractor in its Proposal. The discounts achieved off of the aggregate AWP for all Brand Drugs as a result of Pass-through Pricing will be calculated utilizing the following formula: 1 minus (Sum of Ingredient Costs of dispensed Brand Drugs divided by sum of AWP of dispensed Brand Drugs). The aggregate discount calculation will be based on Pharmacy Prescriptions filled with a Brand Drug where

the Program was the primary payer (including Enrollee submitted claims for the DCS Program). Claims submitted for secondary payer consideration, Compound Drug claims, NYSIF Program non-network claims and claims submitted by governmental entities must be excluded from the aggregate discount calculation. In addition, claims with a calculated AWP discount greater than 50% will be excluded pending receipt of supporting documentation by the Offeror and verification by the Procuring Agencies as to the validity of the calculated discount; and

(3) If the overall aggregate discounts obtained, as calculated utilizing the formula set forth in the prior paragraph, are less than the Guaranteed Minimum Discounts proposed, the Contractor shall reimburse each Program the difference between the Ingredient Cost each Program was charged utilizing Pass-through Pricing and the Ingredient Cost the Programs would have been charged if the Guaranteed Minimum Discount off of the aggregate AWP had been obtained. The Programs will be credited annually for this difference in Ingredient Cost. The Programs shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discounts off the aggregate AWP for all Brand Drugs dispensed by pharmacies.

This calculation shall be performed for each Program Year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Procuring Agencies on July 31st. If the Procuring Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Procuring Agencies reserve the right in their sole discretion to make an adjustment to the Contractor's calculations. ~~The calculations must be completed by July 1st of the following year.~~ Upon approval by the Procuring Agency, the ~~The~~ Contractor shall pay/credit each Program the applicable amount, if any, within 30 (thirty) Days. ~~following the February 15th calculations. If the Procuring Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Procuring Agencies reserve the right in their sole discretion to make an adjustment to the Contractor's calculations.~~ The Contractor shall also reflect the adjustments, if any, in the Offeror's Annual Financial Summary Report. ~~On July 31st following each Program Year, the~~

~~Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. Based on this reconciliation, the Procuring Agencies shall receive an adjustment, if necessary, within 30 Days following the date of the reconciliation and the adjustment shall be included in the following year's Annual Financial Summary Report.~~ The Programs shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discount off the aggregate AWP set forth in duties and responsibilities of Section V.C.5 entitled "Retail Pharmacy Network Claims." Any shortfall in the Guaranteed Minimum Discount set forth in Section V.C.5. cannot be recovered by the Contractor in subsequent years.

b. Confirmation – Brand Name Drug Pricing

(1) Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities Section V.C.5. of this RFP, under subheading "Retail Pharmacy Network Brand Name Drug Pricing."

(2) The Offeror agrees that it has an obligation to maximize the discount achieved on behalf of the Program for Brand Drugs dispensed by network pharmacies.

c. Required Submission – Brand Name Drug Pricing

The Offeror is required to provide its Guaranteed Minimum Discount in Exhibit V.A as a percent off of the aggregate AWP for all Brand Drugs dispensed at Network Pharmacies in Exhibit V.A.

Retail Pharmacy Network Generic Pricing

a. Duties and Responsibilities – Generic Pricing

(Amended April 4, 2012)

(1) The Contractor shall charge the Programs utilizing Pass-through Pricing for all Generic Drugs dispensed to Enrollees/Claimants through the Network Pharmacies. For purposes of the RFP and the Agreements, Pass-through Pricing is defined to mean the Programs are charged the same Ingredient Cost paid to the dispensing Network Pharmacy for the Generic Drug dispensed.

(2) To maximize savings for the Programs on Generic Drugs dispensed through a Network Pharmacy, the Contractor is required to:

(a) Create and maintain a single, Programs-specific Maximum Allowable Cost (MAC) List called the Programs MAC List for Retail and Mail Service Pharmacies, setting the Ingredient Cost ~~maximum price~~ the Programs will be charged, and the amount the dispensing Network Pharmacy will be paid, for the Ingredient Cost for the drugs required to be included on the Programs MAC List. The MAC price assigned shall not exceed the Discounted Ingredient Cost to the Programs achieved ~~through Pharmacy submitted pricing or pricing achieved~~ by using the highest contracted Retail ~~and Mail Service~~ Pharmacy Brand ~~Guaranteed Minimum~~ Discount off of AWP applied to the AWP of the dispensed Generic Drug. ~~as proposed by the Contractor in its Proposal.~~

(b) Assign a MAC price to all NDCs of drugs included within a GPI/GCN, including NDCs of all Brand Drugs, containing an A-rated or authorized Generic Drug form of the original Brand Drug in the GPI/GCN. The Contractor shall add the GPI/GCN to the Programs MAC List and set a MAC price for the GPI/GCN in accordance with Section V.C.4.a.(3)-(4). The provisions of these paragraphs require that MAC pricing be applied in no event later than 21 Days after the first shipment of the first Generic Drug from the manufacturer to a wholesaler or retailer. All A-rated or authorized Generic Drugs shall be MAC'd in all instances including, but not limited to circumstances in which the Department in its sole discretion decides not to enforce mandatory generic substitution of the Brand Drug in that GPI/GCN. There shall be one MAC price applicable to all NDCs included in the GPI/GCN on the Programs MAC List. However, depending on particular market factors, it may be in the best interests of the Programs, and therefore appropriate, for more than one MAC price to be assigned within a GPI/GCN. Such situations would require that the Contractor provide any information the Procuring Agencies deem necessary to support such action and obtain prior written approval from the Procuring Agencies.

(c) Assign a MAC price to the NDCs of B-rated or unrated Generic Drugs included within a GPI/GCN that does not include an A-rated or authorized Generic Drug. The Offeror shall add the GPI/GCN to the Programs MAC List and set a MAC price for the Generic Drug NDCs included in the GPI/GCN as soon as practicable, but in no event later than 14 Days after the first shipment of the first Generic Drug from the manufacturer to a wholesaler or retailer concurrent with transmission of the MAC alert notice. The Contractor shall not apply the MAC price to the NDC(s) for Brand Drugs dispensed in the GPI/GCN and shall not enforce the Programs' mandatory generic substitution provisions for Brand Drugs dispensed in this GPI/GCN. There shall be one MAC price applicable to all Generic Drug NDCs included in the GPI/GCN on the Programs' MAC List. However, depending on particular market factors, it may be in the best interests of the Programs, and therefore appropriate, for more than one MAC price to be assigned within a GPI/GCN. Such situations would require that the Contractor provide any information the Procuring Agencies deem necessary to support such action and obtain prior written approval from the Procuring Agencies.

(d) Charge the Programs for non-MAC'd Generic Drugs dispensed, utilizing pass-through pricing at the Contractor's pharmacy contracted discount applied to the AWP of the dispensed Generic Drug as proposed by the Contractor in its Proposal. The only Non-MAC'd Generic Drugs will be Generic Drugs included in GPIs/GCNs required to be on the Programs MAC List but which have not yet been assigned a MAC price within the required time frame;

(e) The Contractor shall inform the Department of any market based condition which makes the strict compliance with paragraphs (a)-(d) above contrary to the financial interests of the Programs. The Contractor shall agree that, in cases where the Department, at its sole discretion, determines that the above requirements are contrary to the best financial interests of the Programs, the Department may waive such requirements;

(f) Monitor the Programs MAC List pricing to ensure that NDCs contained in GPIs/GCNs subject to MAC pricing are paying at the MAC price after application

of the Programs' Lesser of Logic provisions. The Contractor shall notify the Programs of any GPIs/GCNs subject to MAC pricing in which the majority of claims are processing at a basis other than the MAC price;

(g) Agree that there shall be no increases to Programs MAC List prices where such adjustment is intended to limit the discount achieved on behalf of the Programs to the Guaranteed Minimum Discounts off of the aggregate AWP for all Generic Drugs dispensed by Network Pharmacies during the Plan Year as proposed in Exhibit V.A;

(h) Provide to the Department full access to the Programs MAC List used to price Generic Drugs dispensed by Network and Mail Service Pharmacies for the Programs. The Programs MAC List provided in the Offeror's proposal as Exhibit V.C and V.C.1 must support the Contractor's Guaranteed Minimum Discounts off of the aggregate AWP for all Generic Drugs dispensed by Retail and Mail Service Pharmacies for the Program as proposed by the Contractor in its Proposal. (**Note:** Offerors must be prepared to provide valid documented market rationale to support their Programs MAC pricing should the Procuring Agencies request this information. In order to protect the Programs' financial interests from the date of the award until the termination date of the Agreements, the selected Offeror must agree that any <u>increases</u> to the proposed Programs MAC pricing must be justified to the Procuring Agencies with valid documented market rationale. Following selection, the successful Offeror shall manage the content of the Programs MAC List consistent with the requirements of the RFP. Prices assigned to required new additions to the Programs MAC List shall be equivalent to the selected Offeror's most aggressive MAC price for that drug. To ensure compliance with these requirements, the successful Offeror shall notify the Department on a monthly basis of all changes, additions, and deletions made to the Programs MAC List in the format specified in Exhibit II.F.4 and the requirements specified in Section IV, entitled "Reporting." Compliance with these requirements as noted herein shall be a condition of contract award. Should the selected Offeror fail to comply with the requirements noted herein, the State reserves the right to deem the selected Offeror non-responsive and withdraw said

conditional award. Throughout the term of the Agreements, the Contractor shall commit to use its best efforts to maintain the aggregate effectiveness of the Programs' MAC List. The Contractor must ensure that MAC pricing is reduced to an appropriate level based on any change in market conditions such as increased competition within a GPI/GCN.

(i) The Contractor shall strictly enforce all requirements of the Programs' mandatory generic substitution provision as detailed in the duties and responsibilities of Section V.C.4. entitled "Mandatory Generic Substitution at Retail and Mail."

(j) The Contractor must guarantee an overall minimum discount off of the aggregate AWP for all Generic Drugs dispensed at Retail and Mail Service Pharmacies as defined in the RFP. The Contractor shall guarantee the Programs that its management of Generic Drug costs dispensed by pharmacies, including maintenance of the Programs MAC List, and application of pricing provisions related to Generic Drugs that do not meet the requirements for inclusion on the Programs MAC List, shall result in the Programs achieving the Contractor's overall Guaranteed Minimum Discounts during the Program Year as proposed in the Contractor's Proposal. The discount achieved off of the aggregate AWP for all Generic Drugs as a result of Pass-through Pricing will be calculated utilizing the following formula: 1 minus (Sum of Ingredient Costs of dispensed Generic Drugs at Retail and Mail Service Pharmacies divided by sum of AWP of dispensed Generic Drugs). The aggregate discount calculation will be based on Pharmacy Prescriptions filled with a Generic Drug where the Program was the primary payer (including Enrollee submitted claims). Claims submitted for secondary payer consideration, Compound Drug claims, NYSIF Program non-network claims and claims submitted by governmental entities must be excluded from the aggregate discount calculation. In addition, claims with a calculated AWP discount greater than 90% and a total AWP greater than $500 will be excluded pending receipt of supporting documentation by the Contractor and verification by the Procuring Agencies as to the validity of the calculated discounts. The setting of an overall minimum discount off of the aggregate AWP for all Generic Drugs dispensed at Network Pharmacies shall in no way modify

the Contractor's contractual obligation to maximize the NYSIF Program's aggregate discount above the Contractor's overall Guaranteed Minimum Discount off of the aggregate AWP;

(k) If the overall aggregate discount obtained, as calculated utilizing the formula set forth in the prior paragraph, is less than the Contractor's Guaranteed Minimum Discounts, the Contractor shall reimburse the Programs the difference between the Ingredient Cost the Programs were charged utilizing Pass-through Pricing and the Ingredient Cost the Programs would have been charged if the Guaranteed Minimum Discount off of the aggregate AWP had been obtained. The Programs will be credited annually for this difference in Ingredient Cost. The Programs shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discounts off the aggregate AWP for all Generic Drugs dispensed by Retail and Mail Service Pharmacies.

These calculations shall be performed for each Program Year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Procuring Agencies on July 31st. If the Procuring Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Procuring Agencies reserve the right in their sole discretion to make an adjustment to the Contractor's calculations. ~~The calculations must be completed by July 1st of the following year.~~ Upon approval by the Procuring Agency, ~~T~~the ~~calculations must be completed by February 15th of the following year. The~~ Contractor shall pay/credit each Program the applicable amount, if any, within 30 (thirty) Days. ~~following the February 15th calculations. If the Procuring Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Procuring Agencies reserve the right in their sole discretion to make an adjustment to the Contractor's calculations.~~ The Contractor shall also reflect the adjustments, if any, in the Contractor's Annual Financial Summary Report. ~~On July 31st following each Program Year, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through~~

~~June of the following Plan Year. Based on this reconciliation, the Procuring Agencies shall receive an adjustment, if necessary, within 30 Days following the date of the reconciliations and the adjustments shall be included in the following year's Annual Financial Summary Report.~~ The Programs shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discount off the aggregate AWP set forth in duties and responsibilities of Section V.C.5. entitled "Retail Pharmacy Network Claims."Any shortfall in the Guaranteed Minimum Discount set forth in Section V.C.5. cannot be recovered by the Contractor in subsequent years.

b. Confirmation – Generic Pricing

(1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in the Retail Pharmacy Network Generic Pricing in Sections V.C.5. of this RFP, under subheading "Retail Pharmacy Network – Generic Pricing."

(2) The Offeror agrees that it has an obligation to maximize the discount achieved on behalf of the Program for Generic Drugs dispensed by Retail and Mail Service pharmacies.

(3) The Offeror agrees that it will develop a Program's MAC List for Retail and Mail Service Pharmacies in order to maximize the discount achieved on behalf of the Programs for Generic Drugs.

c. Required Submission – Generic Pricing

(1) The Offeror is required to provide its Program's MAC list unit cost information in Exhibit V.C -- Retail Generic Drugs – MAC List Costs Per GPI **(for Offerors proposing Medi-Span as the claims adjudication platform)** or Exhibit V.C.1 -- Retail Generic Drugs – MAC List Costs Per GCN **(for Offerors proposing First Data Bank as the claims adjudication platform)** in accordance with the instructions provided in the files.

(2) The Offeror is required to provide its Guaranteed Minimum Discount as a percent off of the aggregate AWP for all Generic Drugs dispensed by Retail and Mail Service Pharmacies in Exhibit V.A.

Retail Pharmacy Network Compound Drug Pricing

Compound Drugs must be classified as compounds consistent with the definition in the Contract Provisions, Section VII, (see Article I, entitled "Definition of Terms"). Drugs assigned a unique NDC that require reconstitution and/or mixing prior to dispensing do not meet the Programs' definition of a Compound Drug and shall be processed in accordance with the requirements set forth in this RFP.

a. Duties and Responsibilities – Compound Drug Pricing

The Contractor shall be required to:

(1) Utilize its pricing methodology for Compound Drugs utilizing Pass-through Pricing, as proposed by the Contractor in its Proposal in Exhibit V.A, for the entire term of the Agreements. (**Note:** If an Offeror has multiple methods of pricing, the Offeror may propose each pricing method in Exhibit V.A for Procuring Agency consideration and selection.) The proposed pricing methodology(ies) for Compound Medications must be the same for retail and Mail Service Pharmacy Process claims.

(2) (Exclusive to DCS) Charge Enrollees the applicable Level 2 Drug Copayment for all Compound Medications;

(3) Process Compound Drug claims in a manner that verifies the validity of the claim as a Compound Medication according to the Programs' definition of a Compound Drug and provides appropriate claim Level control procedures to protect the financial interests of the Programs; and

(4) Conduct due diligence as well as audit Network Pharmacies to ensure that drugs are being properly classified as Compound Drugs consistent with the Programs' definition of a Compound Drug and to ensure that compound claims are priced in accordance

with the Contractor's pricing methodology for Compound Medications, as proposed by the Contractor in its Proposal, selected by the Procuring Agencies.

b. Confirmation – Compound Drug Pricing

Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities in Section V.C.5. of this RFP, under subheading "Retail Pharmacy Network Compound Drug Pricing."

c. Required Submission – Compound Drug Pricing

The Offeror is required to provide its pricing methodology(ies) utilizing Pass-through Pricing for Compound Drugs dispensed by Network Pharmacies in Exhibit V.A.

6. Mail Service Pharmacy Process Claims

The current Programs include a Mail Service Pharmacy Process by which Enrollees/Claimants can obtain all Covered Drugs through the mail including any and all drugs that could be classified as Specialty Drugs/Medications for Enrollees/Claimants who do not participate in the Specialty Pharmacy Program. Enrollees are entitled to fill Prescriptions for up to a ninety (90) day supply with refills up to one year at a cost savings to the Enrollee and the DCS Program.

General Provisions

The following provisions shall apply to all claims submitted through the Mail Service Pharmacy Process.

a. Duties and Responsibilities – General

The Contractor shall be required to:

(1) Consistently enforce and administer all provisions of the Program (including but not limited to mandatory generic substitution, drug utilization review, prior authorization, refill too-soon edits, etc.) to the claims dispensed through the Mail Service Pharmacy Process, consistent with the processing of claims through the Retail Pharmacy Network process;

(2) Charge the Programs for those drugs dispensed to the Enrollee/Claimant in original manufacturer packaging, based on the Contractor's source of AWP as proposed by the Contractor in its Proposal for the 11 digit NDC of the package size dispensed through the Mail Service Pharmacy Process, subject to MAC pricing for Generic drugs. If the drug is not dispensed to the Enrollee/Claimant in original manufacturer packaging (i.e., dispensed from bulk), the Programs shall be charged based on the Contractor's source of AWP as proposed by the Contractor in its Proposal for the 11 digit NDC of the package size from which the drug was originally dispensed by the Mail Service Pharmacy Process Facility, subject to MAC pricing for Generic drugs. If the drug is dispensed from a bulk package size for which no AWP is reported in the Contractor's proposed AWP source as proposed by the Contractor in its Proposal, the Programs will be charged based on the reported AWP for the NDC of the largest package size contained in the Contractor's AWP source as proposed by the Contractor in its Proposal. The Programs shall not be charged based on an NDC assigned to repackaged drugs or based on package sizes prepared by special arrangement with the original manufacturer, unless such packaging offers a net savings to the Programs;

(3) Charge the Programs based on the Contractor's pricing terms and dispensing fees (if any) applicable to Brand, Generic, and Compound Drug claims as set forth in Exhibit V.A of the Contractor's Proposal for all prescriptions submitted through the Mail Service Pharmacy Process. If multiple Compound Drug pricing methodologies were proposed by the Contractor in its Proposal, the Programs must be charged according to the methodology selected by the Procuring Agencies for Compound Drug claims. The Programs' Lesser of Logic shall be applied;

(4) (Exclusive to DCS) Ensure that the Mail Service Pharmacy Process Facilities collect the appropriate Copayment specified in Exhibit II.C (plus Ancillary Charge, if applicable) from the Enrollee and charge the Programs the balance of the Discounted Ingredient Cost as determined through the application of the Lesser of Logic detailed in Section V.C.3.a.(9) plus the Contractor's applicable proposed Guaranteed Dispensing Fee minus

the applicable Copayment for all drugs dispensed through the Mail Service Pharmacy Process; and

(5) (Exclusive to DCS) Inform the Enrollee prior to shipping if the total amount for a new Prescription order submitted through the Mail Service Pharmacy Process exceeds $100 and Enrollee has payment information (e.g. credit card) on file or Enrollee's total balance is over $100 and Enrollee has no payment information (e.g. credit card) on file. The Mail Service Pharmacy Process Facility will not be required to inform Enrollees if there is a consistent history of the acceptance of shipments that exceed the maximum amount specified for the same medications. If the Brand Drug is dispensed, the Contractor shall cause the dispensing facility to collect the applicable Level 3 Drug Copayment plus the calculated Ancillary Charge, if any. Under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the Program.

b. Confirmation – General Provisions

Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities in Section V.C.6. of this RFP, under subheading "General Provisions."

c. Required Submission – General Provisions

The Offeror is required to provide the Offeror's Re-priced Claim Files, Exhibit V.B.2 in strict accordance with the Re-pricing Instructions and Layout Specifications found in Exhibits V.B and V.B.1 of this RFP.

Mail Service Pharmacy Process Brand Name Drug Pricing

The Contractor must classify Brand Drugs in accordance with the definition in the Contract Provisions, Sections VII.A. and VII.B., (see Articles I, entitled "Definition of Terms") as well as the methodology outlined in Section V. of the RFP entitled "Brand Drug Determination Methodology."

a. Duties and Responsibilities – Brand Drug Pricing

The Contractor shall be required to:

(1) Utilize the Contractor's fixed contracted Guaranteed Discount off of Average Wholesale Price (AWP) as proposed by the Contractor in its Proposal to determine the Ingredient Cost of the Prescription to charge the Programs. The Contractor's fixed contracted Guaranteed Discount shall be applicable to all individual Prescriptions for Brand Drugs dispensed to Enrollees/Claimants through the Mail Service Pharmacy Process; and

(2) Ensure that the Mail Service Pharmacy Process dispensing facility collects the appropriate Brand Drug Copayment (plus Ancillary Charge if applicable) from the Enrollee and charges the Programs the balance of the Discounted Ingredient Cost plus the Contractor's guaranteed dispensing fee, if any, for Brand Drugs dispensed through the Mail Service Pharmacy Process, as proposed by the Contractor in its Proposal. If the current Discounted Ingredient Cost plus the dispensing fee (if applicable) or the submitted cost is less than the applicable Level 2 or Level 3 Drug Copayment then the Contractor shall ensure that the Enrollee/Dependent is charged the lesser amount.

b. <u>Confirmation – Brand Name Pricing</u>

Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities Section V.C.6. of this RFP, under subheading "Mail Service Pharmacy Process Brand Name Drug Pricing."

c. <u>Required Submission – Brand Name Pricing</u>

The Offeror is required to provide the Offeror's fixed contracted Guaranteed Discount off of AWP for Brand Drugs dispensed through the Mail Service Pharmacy Process on Exhibit V.A. The Offeror shall assume in its pricing that the Procuring Agencies will **<u>not</u>** allow promotion of the Mail Service Pharmacy Process. However, the Procuring Agencies reserve the right during the term of the Agreements to allow promotion of the Mail Service Pharmacy Process provided such promotion is in the best financial interests of the State and complies with all applicable state laws and regulations.

Mail Service Pharmacy Process – Generic Drug Pricing

The Contractor shall classify Generic Drugs in accordance with the definition in the Contract Provisions, Sections VII.A. and VII.B., (see Articles I, entitled "Definition of Terms") as well as the methodology outlined in Section V. of the RFP entitled "Generic Drug Determination Methodology."

a. Duties and Responsibilities – Generic Drug Pricing

The Contractor shall be required to:

(1) Utilize the Programs MAC list for Retail and Mail Service Pharmacies to determine the Ingredient Cost of each Prescription charged to the Programs. The Contractor's Programs MAC list for Retail and Mail Service Pharmacies shall be applicable to all individual Prescriptions for Generic Drugs dispensed to Enrollees/Claimants through the Mail Service Pharmacy Process;

(2) Ensure that the Mail Service Pharmacy Process dispensing facility collects the Level 1 Drug Copayment from the Enrollee and charges the Programs the balance of the Discounted Ingredient Cost plus the Contractor's guaranteed dispensing fee for Generic Drugs dispensed through the Mail Service Pharmacy Process, if any, as proposed by the Contractor in its Proposal. If the current Discounted Ingredient Cost plus the dispensing fee (if applicable) or the submitted cost is less than the applicable Level 1 Drug Copayment then the Contractor shall ensure that the Enrollee is charged the lesser amount; and

(3) Guarantee an overall minimum discount off of the aggregate AWP for all Generic Drugs dispensed through the Mail Service Pharmacy as defined in the RFP. The Contractor shall guarantee the Programs that its management of Generic Drug costs dispensed by the Mail Service Pharmacy, including maintenance of the Programs MAC List for Retail and Mail Service Pharmacies, and application of pricing provisions related to Generic Drugs that do not meet the requirements for inclusion on the Programs MAC List, shall result in the Plan achieving the Contractor's overall Guaranteed Minimum Discounts during the Plan Year, as proposed by the Contractor in its Proposal.

The discounts achieved off of the aggregate AWP for all Generic Drugs dispensed at Retail and Mail Service Pharmacies as a result of Pass-through Pricing will be calculated utilizing the following formula: 1 minus (Sum of Ingredient Costs of dispensed Generic Drugs dispensed at Retail and Mail Service Pharmacies divided by sum of AWP of dispensed Generic Drugs). The aggregate discount calculations will be based on Pharmacy Prescriptions filled with a Generic Drug where the Program was the primary payer (including Enrollee submitted claims). Claims submitted for secondary payer consideration, Compound Drug claims, house generic claims, NYSIF Program non-network claims and claims submitted by governmental entities must be excluded from the aggregate discount calculations. In addition, claims with a calculated AWP discount greater than 90% and a total AWP greater than $500 will be excluded pending receipt of supporting documentation by the Contractor and verification by the Procuring Agencies as to the validity of the calculated discounts; and

(4) If the overall aggregate discounts obtained, as calculated utilizing the formula set forth in the prior paragraph, are less than the Guaranteed Minimum Discounts as proposed by the Contractor in its Proposal, the Contractor shall reimburse the Programs the difference between the Ingredient Cost the Programs were charged utilizing Pass-through Pricing and the Ingredient Cost the Programs would have been charged if the Guaranteed Minimum Discount off of the aggregate AWP had been obtained. The Programs will be credited annually for this difference in Ingredient Cost. The Programs shall retain the benefit of any cost savings, in excess of the Contractor's proposed Guaranteed Minimum Discounts off the aggregate AWP for all Generic Drugs dispensed by pharmacies.

b. Confirmation – Generic Pricing

Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities in Section V.C.6. of this RFP, under subheading "Mail Service Pharmacy Process - Generic Drug Pricing."

c. Required Submission – Generic Pricing

(1) The Offeror is required to provide its Guaranteed Minimum Discount as a percent off of the aggregate AWP for all Generic Drugs dispensed through the Mail Service Pharmacy Process on Exhibit V.A.

(2) The Offeror is required to provide a listing of the Offeror's proposed house generics to be dispensed through the Mail Service Pharmacy Process.

Mail Service Pharmacy Process – Compound Drug Pricing

The Contractor must classify Compound Drugs in accordance with the definition in the Contract Provisions, Sections VII.A. and VII.B., (see Articles I, entitled "Definition of Terms"). Drugs assigned a unique NDC that require reconstitution and/or mixing prior to dispensing do not meet the Programs' definition of a Compound Drug and shall be processed in accordance with the requirements set forth in the RFP.

a. Duties and Responsibilities – Compound Drug Pricing

The Contractor shall be required to:

(1) Utilize its pricing methodology for Compound Drugs utilizing Pass-through Pricing, as proposed by the Contractor in Exhibit V.A of its Proposal, for the entire term of the Agreement. (**Note:** If an Offeror has multiple methods of pricing, the Offeror may propose each pricing method in Exhibit V.A for Procuring Agency consideration and selection.) The Contractor's pricing methodology(ies) for Compound Medications, as proposed by the Contractor in its Proposal, must be the same for retail and Mail Service Pharmacy Process claims.

(2) Charge Enrollees the applicable Level 2 Drug Copayment for all Compound Medications. If the current Discounted Ingredient Cost or the submitted cost is less than the applicable Level 2 Drug Copayment then the Contractor shall ensure that the Enrollee is charged the lesser amount;

(3) Process Compound Drug claims in a manner that verifies the validity of the claim as a Compound Medication according to the Programs' definition and provides appropriate claim control mechanisms to protect the financial interests of the Programs; and

(4) Conduct due diligence to ensure that drugs are being properly classified as Compound Drugs consistent with the Programs' definition of a Compound Drug and ensure that compound claims are priced in accordance with the Contractor's pricing methodology for Compound Medications, as proposed by the Contractor in its Proposal, selected by the Procuring Agencies.

b. Confirmation – Compound Drug Pricing

Confirm the Offeror's agreement to perform/fulfill and comply with the Duties and Responsibilities in Section V.C.6. of this RFP, under subheading "Mail Service Pharmacy Process – Compound Drug Pricing."

c. Required Submission – Compound Drug Pricing

The Offeror is required to provide the Offeror's proposed pricing methodology(ies) utilizing Pass-through Pricing for Compound Drugs dispensed through the mail service pharmacy in Exhibit V.A.

7. Enrollee Submitted Claims (Exclusive to DCS)

The cost to the Program for Prescriptions for which Enrollees submit direct claims for reimbursement will be charged to the DCS Program at the actual amount reimbursed by the Contractor. For the DCS Programs, such reimbursement shall be based on the lesser of the submitted cost, minus the applicable Copayment; or the Discounted Ingredient Cost, plus the applicable (brand/generic) Guaranteed Maximum Dispensing Fee, minus the applicable Copayment. In the case of an Enrollee who has dual Empire Plan coverage, the applicable copayment will not be subtracted from the reimbursement for the secondary claim.

a. Duties and Responsibilities – Enrollee Submitted Claims

The Contractor shall be required to utilize the following methodology to charge the Programs:

(1) Brand Drugs, including Specialty Drugs/Medications, must be charged to the Programs utilizing the Guaranteed Minimum Discount off of AWP for Brand Drugs

dispensed at the Retail Pharmacy Network and retail brand Guaranteed Maximum Dispensing Fee for Brand Drugs, minus the applicable Copayment;

(2) Generic Drugs, including Specialty Drugs/Medications, must be charged to the Program utilizing the Contractor's assigned MAC price for the Retail and Mail Service Pharmacies, plus the Guaranteed Maximum Dispensing Fee for Generic Drugs, minus the applicable Copayment. Generic Drugs without a MAC price must be charged to the DCS Program using the Contractor's Guaranteed Minimum Discount for Brand Drugs, as proposed by the Contractor in its Proposal, off of AWP of the dispensed Generic Drug, plus the Guaranteed Maximum Dispensing Fee for Generic Drugs, minus the applicable Copayment;

(3) Compound Drugs must be charged to the DCS Program by applying the Contractor's pricing methodology for Compound Drugs as defined in Section V,C.5. of the RFP, under the subheading "Retail Pharmacy Compound Drug Pricing," as proposed by the Contractor in its Proposal, plus the Guaranteed Maximum Dispensing Fee for Compound Drugs minus the applicable Level 2 Drug Copayment.

(4) The Program's Lesser of Logic must be applied to all Enrollee Submitted Claims; and

(5) For the NYSIF Program, all Enrollee/Dependent Submitted Claims must be charged to the Program at the submitted cost, (i.e., Enrollees/Dependents must be reimbursed 100% of their actual cost).

b. <u>Confirmation – Enrollee Submitted Claims</u>

Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in the Enrollee Submitted Claims section above.

8. <u>Non-Network Pharmacy Submitted Claims (Exclusive to NYSIF)</u>

The cost to the NYSIF Program for Prescriptions for which Non-Network Pharmacies submit direct claims for reimbursement will be charged to the NYSIF Program in accordance with New York State Worker's Compensation Board laws and regulations, specifically, Section 440 of Chapter V. of Title 12 NYCRR (New York Codes Rules and Regulations).

a. Duties and Responsibilities – Non-Network Pharmacy Submitted Claims

The Contractor shall be required to utilize the following methodology to charge the Programs:

(1) Brand Drugs, including Specialty Drugs/Medications, must be charged to the NYSIF Program at the New York State Workers' Compensation Board rates, currently a twelve percent (12%) discount off of AWP, plus a $4 Dispensing Fee;

(2) Generic Drugs, including Specialty Drugs/Medications, must be charged to the NYSIF Program at the New York State Workers' Compensation Board rates, currently a twenty percent (20%) discount off of AWP, plus a $5 Dispensing Fee;

b. Confirmation – Non-Network Pharmacy Submitted Claims

Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in the Non-Network Pharmacy Submitted Claims section above.

9. Dispensing Fee

A Dispensing Fee is the amount of money, if any, paid to the pharmacies in compensation for the services rendered for filling a Prescription under the Agreements. The level of dispensing fees should encourage appropriate dispensing and compliance with the Programs' mandatory generic substitution requirements.

a. Duties and Responsibilities – Dispensing Fees

(1) Dispensing fees at Retail Network Pharmacies shall be subject to Pass-through Pricing, up to a Guaranteed Maximum Dispensing Fee applied to aggregate claims. Dispensing fees for claims filled at the Specialty Pharmacy(ies), may be variable commensurate with the level of clinical services offered through the Specialty Pharmacy Program. (**Note:** Offerors may propose a different Guaranteed Maximum Dispensing Fee at Retail Network Pharmacies for Brand Drugs vs. Generic Drugs. Offerors shall propose a single contracted dispensing fee for the Mail Service Process.)

(2) The Contractor shall be required to guarantee its dispensing fee(s), as proposed by the Contractor in its Proposal, for the entire term of the Agreements.

(3) No dispensing fee shall be charged to the Programs for any claim that is paid on the basis of the Pharmacy's Usual and Customary price.

(4) The Contractor must guarantee the overall maximum dispensing fee for Brand, Generic and Compound claims, respectively, dispensed at Retail Network Pharmacies, as proposed by the Contractor in its Proposal. The level of dispensing fees achieved as a result of Pass-through Pricing at Retail Pharmacies will be calculated utilizing the following formula: Total Retail Network Dispensing Fees paid by each Program on an annual basis divided by the number of Final Paid Claims at Retail Network Pharmacies for each of Generic, Brand, and Compound claims.

(5) If the overall aggregate dispensing fees paid, as calculated utilizing the formula set forth in the prior paragraph, are more than the Guaranteed Maximum Dispensing Fee proposed for each of Brand, Generic, and Compound claims at Retail Network Pharmacies, the Contractor shall reimburse each Program the difference between the Dispensing Fee the Programs were charged utilizing Pass-through Pricing and the Dispensing Fee the Programs would have been charged if the Guaranteed Maximum Dispensing Fee had been obtained. The Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Procuring Agencies on July 31st. If the Procuring Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Procuring Agencies reserve the right in their sole discretion to make an adjustment to the Contractor's calculations. Upon approval by the Procuring Agency, the Contractor shall pay/credit each Program the applicable amount, if any, within 30 (thirty) Days. ~~The Programs will be credited annually for this difference by February 15th.~~ The Contactor shall also reflect the adjustment, if any, in the Contractor's Annual Financial Summary Report. The Programs shall retain the benefit of any cost savings in excess of the Guaranteed Maximum Dispensing Fees

set forth in Section V.C.9. Any shortfall in the Guaranteed Maximum Dispensing Fees set forth in Section V.C.9. cannot be recovered by the Contractor in subsequent years.

b. Confirmation – Dispensing Fees

Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in the dispensing fee section above.

c. Required Submission – Dispensing Fees

(1) The Offeror is required to provide the Offeror's proposed Guaranteed Maximum Dispensing Fees for retail Brand and Generic claims on Exhibit V.A.

(2) The Offeror is required to provide the Offeror's proposed fixed dispensing fees for mail order Brand and Generic claims on Exhibit V.A.

(3) The Offeror is required to complete Exhibit V.D listing the Offeror's proposed dispensing fees for each drug proposed to be included in the Offeror's Specialty Pharmacy Program.

10. Specialty Pharmacy Program Pricing

Certain Employee groups participate in the Specialty Pharmacy Program, whose goal is to provide an enhanced level of clinical management for Enrollees/Claimants taking Specialty Drugs/Medications in exchange for lower Copayments and restricted access. Under the current plan design for The Empire Plan and SEHP, after the first Specialty Drug/Medication Prescription is filled through Retail, future fills are subject to a Hard Edit, meaning that Enrollees are required to obtain the drug through the Specialty Pharmacy Process. In addition to the first fill at Retail, certain Specialty Drugs/Medications available through the Specialty Pharmacy Program as well as all Specialty Medications covered under the NYSIF Program are also available through the Retail Pharmacy Network, because of their clinical requirements and/or urgent dispensing timeframe or NYS laws and regulations. All drugs filled at a Retail Pharmacy Network are subject to the Retail Network Pharmacy pricing and guarantees. For those drugs available only through the Specialty Pharmacy Program, the

Offeror may propose dispensing fees on a drug by drug basis, commensurate with the clinical services provided for each. All drugs shall be classified as either Brand Name, Generic, or Compound for pricing purposes based on the classification methodologies set forth in Section V. of this RFP. The Programs shall be entitled to all manufacturer revenue derived from Specialty Drugs/Medications

Drugs to be included in the Specialty Pharmacy Program, Specialty Drugs/Medications are:

a. "orphan drugs";
b. drugs requiring special handling, special administration and/or intensive patient monitoring/testing;

c. biotech drugs developed from human cell proteins and DNA, targeted to treat disease at the cellular level; or,

d. other drugs identified by the Program as used to treat patients with chronic or life threatening diseases.

The Offeror must provide a Special Pharmacy Program where Enrollees/Claimants receive their Specialty Drugs/Medications through one or more designated pharmacies that offer enhanced clinical management. The process must provide extensive clinical support in the most cost effective manner possible for the Program.

a. <u>Duties and Responsibilities – Specialty Pharmacy Program Pricing</u>

(1) Consistently enforce and administer all provisions of the Program (including but not limited to mandatory generic substitution, drug utilization review, prior authorization, refill too-soon edits, etc.) to the claims dispensed through the Specialty Pharmacy Process, consistent with the processing of claims through the Retail and Mail Service Pharmacy Network processes.

(2) Charge the Programs for those drugs dispensed to Enrollees/Claimants in original manufacturer packaging, based on the Contractor's source of AWP for the 11 digit NDC of the package size dispensed through the Specialty Pharmacy Process. If the drug is not dispensed to the Enrollee/Claimant in original manufacturer packaging

(i.e., dispensed from bulk), the Programs shall be charged based on the Contractor's source of AWP for the 11 digit NDC of the package size from which the drug was originally dispensed by the Designated Specialty Pharmacy. If the drug is dispensed from a bulk package size for which no AWP is reported in the Contractor's AWP source, the Programs shall be charged based on the reported AWP for the NDC of the largest package size contained in the Contractor's AWP source. The Programs shall not be charged based on an NDC assigned to repackaged drugs or based on package sizes prepared by special arrangement with the original manufacturer unless such packaging offers a net savings to the Programs.

(3) Charge the Programs based on the Contractor's pricing terms and dispensing fees (if any) applicable to Brand and Generic, Specialty Drug/Medication claims as set forth in Exhibit V.A and V.D for all prescriptions submitted through the Specialty Pharmacy Program.

(4) Ensure that the Designated Specialty Pharmacy(ies) collects the appropriate Copayment specified by the Department (plus Ancillary Charge, if applicable) from the Enrollee and will charge the Programs the balance of the Discounted Ingredient Cost plus the Offeror's applicable guaranteed dispensing fee set forth in Section V.C.9. of the RFP, minus the applicable Copayment for all drugs dispensed through the Specialty Pharmacy Process.

(5) Classify Brand Drugs consistent with the definition in the Contract Provisions, Sections VII.A and VII.B, (see Articles I, entitled "Definition of Terms") as well as the methodology outlined earlier within Section V of the RFP entitled "Brand Drug Determination Methodology."

(6) Classify Generic Drugs consistent with the definition in the Contract Provisions, Sections VII.A and VII.B, (see Articles I, entitled "Definition of Terms") as well as the methodology outlined earlier within Section V of the RFP entitled "Generic Drug Determination Methodology."

(7) Propose a fixed contracted Guaranteed Discount off of Average Wholesale Price (AWP) that will be utilized to determine the Ingredient Cost of the Prescription to charge the Programs. The Offeror's Guaranteed Discount shall be applicable to all individual Prescriptions for Brand Drugs and Generic Drugs dispensed to Enrollees/Claimants through the Specialty Pharmacy Process.

(8) Act in the interests of the Programs when dispensing Generic Drugs through the Specialty Pharmacy Process by avoiding the dispensing of NDC's with higher AWPs unless market conditions exist making dispensing the more cost effective NDC impractical or impossible.

b. Confirmation – Specialty Pharmacy Program Pricing

Confirm the Offeror's agreement perform/fulfill and comply with to the Duties and Responsibilities – Section V.C.10. of this RFP, under the subheading "Specialty Pharmacy Program Pricing."

c. Required Submission – Specialty Pharmacy Program Pricing

The Offeror is required to provide the Offeror's fixed contracted Guaranteed Discount off of Average Wholesale Price (AWP) as set forth in Exhibit V.A of the RFP.

11. 100% Pharma Revenue Guarantee

The Empire Plan is one of the largest health insurance plans in the country. The DCS Program has adopted a three-level drug benefit structure for Enrollees to enhance the ability of the DCS Program to obtain direct discounts from manufacturers. The Contractor is required to manage the DCS Program's Preferred Drug List, Flexible Formulary and NYSIF Program Drug List and to negotiate, on the Programs' behalf, agreements with manufacturers for direct discounts off of the cost of drugs dispensed to Program Enrollees/Claimants. Manufacturer discounts related to Programs utilization can make a drug with a higher AWP competitive with clinically comparable drugs with lower AWPs. However, the Contractor's receipt of revenue related to the Programs' utilization can create a potential conflict of interest in the decision to classify a drug as Preferred, Non-Preferred or excluded.

Full transparency is critical to protecting the interests of the State, Participating Agencies and Enrollees/Claimants and ensuring alignment of the Programs' financial interests with those of the Contractor. This section details the Contractor's duties and responsibilities with regard to management of Pharma Revenue on the Programs' behalf.

Definitions

Pharma Revenue is defined as set forth in the "Glossary of Terms" Section VIII. Pharma Revenue is any and all revenues generated from agreements between the pharmaceutical manufacturers and the Contractor and/or its Key Subcontractor or any Affiliate of the Contractor or its Key Subcontractor which relate to Program utilization and/or Pharmacy benefit management services provided under the Agreements. Such revenues include, but are not limited to revenues described as: formulary rebates; market share rebates; administrative fees, AWP caps; or by any other name.

A Final Paid Claim is defined as set forth in the "Glossary of Terms" Section VIII. A Final Paid Claim is a claim processed and paid by the Contractor for a Prescription drug provided to an Enrollee/Claimant, including but not limited to, claims for Prescriptions filled at a retail Pharmacy or through the Mail Service Pharmacy Process or Specialty Pharmacy Program. A claim that is denied prior to processing is not considered a Final Paid Claim. In addition, a claim that is processed and paid but is subsequently voided, reversed, or otherwise adjusted is not a Final Paid Claim. Zero balance claims are considered Final Paid Claims. Consistent with the definition of a Final Paid Claim, the Pharma Revenue guarantee per Final Paid Claim quoted applies to rebateable and non-rebateable claims.

a. Duties and Responsibilities – Pharma Revenue Guarantee

The Contractor agrees to and shall:

(1) Negotiate Pharma Revenue agreements with manufacturers that maximize savings to the Programs, leveraging the significant enrollment of the Programs for each individual drug. The Contractor agrees that any Programs specific Pharma Revenue agreement shall derive total Pharma Revenue that meets or exceeds the Pharma Revenue derived from any other agreements the Contractor uses to administer its book of business for each individual drug;

(2) Pay the Programs quarterly within 150 Days of the end of each quarter, the greater of 100% Pharma Revenue received or the minimum guaranteed amount attributable to the Programs' combined utilization;

(3) Calculate and distribute Pharma Revenue to the Programs in a fully transparent and verifiable process. The Contractor agrees that all direct and indirect revenue arrangements with manufacturers, suppliers, or other vendors shall be disclosed and the revenue generated related or attributable to the Programs' utilization shall be credited to the Programs. The Contractor acknowledges and agrees that the records, methods, and calculations utilized to total and distribute these amounts to the Programs are subject to audit by the State under the audit authority set forth in Contract Provisions, Sections VII.A and VII.B, of the RFP and Appendices A and B thereto. In addition, the Contractor shall provide all agreements as necessary for the Programs to evaluate Preferred Drug List, Flexible Formulary and NYSIF Program Drug List decisions including direct access to any manufacturer contracts in unredacted form, under which the Programs is entitled to derive Pharma Revenue pursuant to the terms of the Agreements;

(4) Not enter into any agreement that has the effect of diverting, shortchanging, or trading off any form of Pharma Revenue that would otherwise be due the Programs for other consideration. There shall be no fees charged to the Programs or received from a manufacturer, separate from the Claims Administration Fees as described and authorized in the RFP, by the Contractor for rebate or other Pharma Revenue administration. The Contractor agrees that it shall not divert, shortchange, or trade off Pharma Revenue that would otherwise inure to the Programs' financial benefit for Enrollee/Claimant drug utilization in return for reduced drug acquisition costs or other monetary or non-monetary consideration from manufacturers;

(5) Upon selection of the successful Offeror and as a condition of contract award and throughout the term of the Agreements, the successful Offeror/Contractor shall provide, upon the request of the State, all information and documentation related to Pharma Revenue agreements, including but not limited to, full direct access by the

Procuring Agencies staff or their agents to complete unredacted Pharma Revenue agreements pursuant to which the Programs derives Pharma Revenue;

(6) Utilize manufacturer agreements for the Programs that meet or exceed the Contractor's best existing Pharma Revenue agreements for all individual drugs. If the Contractor's business model allows for more than one Pharma Revenue agreement with manufacturers, the Contractor agrees that in no instance will the Programs receive less Pharma Revenue in any therapeutic class than other clients of the Contractor with a comparable benefit design and consistent preferred drug designations in the class, provided the Programs' utilization of the drugs generating Pharma Revenue in the class is equal to or greater than those of other clients. The Contractor, as part of its Proposal, must propose a process satisfactory to the Procuring Agencies to confirm compliance with this provision and must implement and administer said satisfactory process under the Agreements. The Programs shall receive full pass-through of 100% of Pharma Revenue derived from any agreement with a pharmaceutical manufacturer. Where any Pharma Revenue contracts allow for higher Pharma Revenue for Mail Service Pharmacy or Specialty Pharmacy Program claims, the Programs will receive the full financial benefit of those higher rates receiving 100% of the Pharma Revenue derived from those agreements on mail order claims. If manufacturer agreements provide less Pharma Revenue for Mail Service Pharmacy or Specialty Pharmacy Program claims than retail claims for the same drug, the terms of the manufacturer agreement applicable to retail claims shall be applied to Program Mail Service Pharmacy and Specialty Pharmacy Program claims for purposes of calculating the amount of Pharma Revenue due the Programs;

(7) The Contractor, as part of its Proposal, must propose a Minimum Per Final Paid Claim Pharma Revenue Guarantee that will be utilized by the Contractor in calculating the minimum annual amount due to the Programs for Pharma Revenue. The Minimum Pharma Revenue amount due the Programs on an annual basis will be calculated according to the formula: Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee multiplied by the number of Final Paid Claims incurred for the DCS Program and the NYSIF Program for the respective Program Year;

(8) Ensure the Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee is not contingent upon the Programs' participation in any of the Contractor's formulary management or intervention programs. Nor shall the Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee be contingent or dependent on the timing of any patent expirations and/or introduction of generic equivalent drugs, including but not limited to early and/or at risk Generic Drug launches. The Programs will review the guaranteed amount only in the event of legislative, regulatory, or judicial action excluding patent litigation not specific to the Contractor's business practices that serves to void existing Pharma Revenue agreements materially compromising the Contractor's ability to obtain contracted Pharma Revenue necessary to meet the Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee;

(9) Calculate and perform an annual reconciliation of the Pharma Revenue credit to the Pharma Revenue earned. As part of this annual reconciliation the Contractor shall be required to:

(a) Calculate the Pharma Revenue guarantee on all Final Paid Claims, incurred for the respective Program Year. The Pharma Revenue guarantee shall be on the aggregate level, not separated for each therapeutic class**;**

(b) Credit the Programs an amount calculated based on the following formula: if in any Program Year, the Pharma Revenue realized and credited to the Programs by the Contractor is less than the amount due the Programs as determined utilizing the minimum Pharma Revenue credit set forth above in (7) of this Section, the amount of the credit shall be equal to the difference between the reported Pharma Revenue credited to the Programs and the Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee;

(c) Submit calculations and documentation supporting the amount of Pharma Revenue reported and credited to the Programs for the Procuring Agencies' review and written approval. The Contractor shall provide all information and documentation deemed necessary by the Procuring Agencies to verify the

Programs were credited with all Pharma Revenue due it under the terms of the Agreements;

(d) If at the close of any Plan Year, the Pharma Revenue credited to the Programs is greater than the higher of the amount derived through application of the Pharma Revenue guarantee formula or the actual Pharma Revenue realized by the Programs, upon notice and verification by the Procuring Agencies, the DCS Program and the NYSIF Program shall pay the Contractor the difference between the amount previously credited to each Program and the higher of the minimum Pharma Revenue guaranteed amount or actual Pharma Revenue realized during the Program Year;

(e) If at the close of any Program Year, the Pharma Revenue credited to the Programs is less than the actual Pharma Revenue realized by the Programs, the Contractor shall credit each Program the difference between what was previously credited and the full amount due to the Programs;

(f) Include such reconciliations as part of the Contractor's annual financial summary report. The Procuring Agencies require the Contractor's Minimum Per Final Claim Paid Pharma Revenue Guarantee be credited to the claims experience on the annual financial reports regardless of the amount of Pharma Revenue that has been received by the Contractor; and

(g) Administer the Procuring Agencies' Pharma Revenue Program in accordance with the Contract Provisions, Sections VII.A and VII.B of the RFP. In this regard, the Contractor agrees to the terms set forth in Contract Provisions, Sections VII.A and VII.B, of the RFP (see Articles XIII, entitled "100% Pharma Revenue Guarantee" and Articles XV "Payments/(Credits) to/(from) the Contractor."

b. <u>Confirmation – Pharma Revenue Guarantee</u>

Confirm the Offeror's agreement to the definitions and the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in the Pharma Revenue guarantee section above.

c. Required Submission – Pharma Revenue Guarantee

(1) The Offeror is required to provide its proposed Minimum Per Final Paid Claim Pharma Revenue Guarantee in Exhibit V.E. Offerors may provide a different Minimum Per Final Paid Claims Pharma Revenue Guarantee for each year of the Agreements. The minimum credit to the Programs for Pharma Revenue shall be the Offeror's Minimum Per Final Paid Claim Pharma Revenue Guarantee (as submitted on Exhibit V.E) times the number of Final Paid Claims paid for each Program for the respective Program Year as defined in the " "Glossary of Terms," Section VIII.").

(2) The Offeror is required to provide adequate documentation as determined by the Procuring Agencies, to support the Offeror's offer relative to Pharma Revenue. Said documentation is to be provided as Exhibit V.E.1 of the Offeror's Proposal.

12. Claims Administration Fees

The Claims Administration Fees are the fees, quoted by the Contractor in its Proposal that the Contractor shall charge the Programs to cover all of the administrative services provided by the Contractor. Three separate Claims Administration Fees must be developed and quoted by Offerors for the Programs: DCS Program Primary; EGWP Medicare Primary; and NYSIF Program. The DCS Program Primary Claims Administrative Fee covers the Contractor's administration of The Empire Plan for non-Medicare primary Enrollees, as well as the SEHP and the Excelsior Plan, as may be modified from time to time. The Contractor's EGWP Medicare Primary Claims Administrative Fee covers the Contractor's administration of The Empire Plan for Medicare primary Enrollees. The Contractor's NYSIF Program Claims Administrative Fee covers the Contractor's administration of the NYSIF Program.

a. Duties and Responsibilities – Claims Administration Fees

The Contractor shall be required to:

(1) Be bound by its Claims Administration Fees, as proposed in the Contractor's Proposal for the entire term of the Agreements;

(2) Implement any changes necessary to accommodate Programs modifications resulting from collective bargaining, legislation or within the statutory discretion of the State within 60 days of notice, or as soon as practicable;

(3) Agree not to request higher Claims Administration Fees, and the Procuring Agencies will not consider any increases to the Claims Administration Fees, that are not based on a material changes to the Programs requiring the Contractor to incur additional costs. The determination of what constitutes a material change will be at the sole discretion of the Procuring Agencies Implementation of an alternate formulary or multiple formularies shall not constitute a material change and the Contractor agrees to implement, if required, all alternative formularies at the Claims Administration Fees proposed;

(4) Manage all Programs Enrollees/Claimants based on the Contractor's associated Claims Administration Fees as proposed by the Contractor in its Proposal;

(5) Submit detailed documentation of additional administrative/clinical costs, over and above existing administrative/clinical costs, with any request for an increase in the Claims Administration Fee(s) resulting from a material change in the benefit structure of the Programs. The Procuring Agencies reserve the right to request and the Contractor agrees to provide any additional information and documentation the Procuring Agencies deem necessary to verify that the request for an increase to a Claims Administration Fee(s) is warranted. The Procuring Agencies' decision to modify the Claims Administration Fees to the extent necessary to compensate the Contractor for documented additional costs incurred shall be at the sole discretion of the Procuring Agencies, subject to the approval of a formal amendment to the Agreement(s) by the New York State Attorney General and New York State Office of State Comptroller;

(6) Implement all benefit designs as required by the Department with or without final resolution of any request for a Claims Administration Fee(s) adjustment. Refusal to implement changes will constitute a material breach of the Agreement(s) and the Procuring Agencies will seek compensation for all damages resulting; and

(7) Agree that Claims Administration Fees shall be payable only for Final Paid Claims and that the Programs will not pay a Claims Administration Fee or other charge or fees for any claim that is denied prior to processing or any claim that is subsequently voided, reversed, or otherwise modified.

b. Confirmation – Claims Administration Fees

Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in the Claims Administration Fees section above.

c. Required Submission – Claims Administration Fees

The Offeror is required to provide the Offeror's Claims Administration Fees in Exhibit V.F on a fee per Final Paid Claim basis.

13. Payments/ (Credits) to/ from the Contractor

This section presents details regarding the financial structure and timing of financial transactions related to the Agreements and the specific items Offerors must submit with their Cost Proposal and questions related to those requirements.

The following information is presented for use by Offerors in developing their Cost Proposal. Additional detail regarding each of these provisions may be found in Contract Provisions, Sections VII.A. and VII.B. of the RFP.

As of December 2011, there were 232,213 individual contracts and 291,008 family contracts with Empire Plan prescription drug coverage. Within the aforesaid contracts, there are 233,729 Empire Plan Enrollees and Dependents that have Medicare Primary coverage and would be eligible for the EGWP coverage. In addition to the Empire Plan contracts, there are 32 individual contracts and 20 family contracts with the Excelsior Plan and 4,891 individual contracts and 775 family contracts with the Student Employee Health Plan (SEHP) benefits. Under NYSIF's Program, the agency was servicing approximately 50,000 Claimants with NYSIF Program benefits. The enrollment mix and benefit characteristics are presented in Exhibits II.B through II.B.2 and Exhibits III.B through III.E4 of this RFP; however, the

Procuring Agencies cannot guarantee that, during the term of the Agreements, the same enrollment mix and benefit characteristics as those set forth in Exhibit II.B through Exhibit II.B.2 and Exhibits III.B through III.E.4 of this RFP will exist;

a. Duties and Responsibilities – Financial Structure and Timing of Financial Transactions

(1) Each Procuring Agency will separately reimburse the Contractor for claim payments and associated Claims Administration Fees no sooner than two (2) Business Days and no later than five (5) Business Days after receipt of an accurate invoice, following each claims processing cycle (weekly for the NYSIF Program and bi-weekly for the DCS Programs). The Offeror is required to submit a detailed claim file concurrent with each invoice (for the NYSIF Program) and within fifteen (15) Days after the end of each claims processing cycle (for the DCS Programs) to support the submitted invoices. The data file layout and file transmission protocol will be mutually agreed upon by the Contractor and the Procuring Agencies during Implementation, in accordance with the Contractor's Proposal.

(2) Any credit amounts due from the Contractor to the Procuring Agencies for failure of the Contractor to meet the performance guarantees set forth in the Agreements shall be applied as a credit against the Claims Administration Fees charged separately to the Programs in the ~~next~~ first invoice(s) processed after the performance guarantee has been calculated and agreed to by the Program(s).

(3) Upon final audit determination by the Procuring Agencies, any audit liability amount assessed by the Procuring Agencies shall be paid/credited to the Programs within thirty (30) Days of the date of the Procuring Agencies' final determination.

(4) (Exclusive to DCS) Coordination of Benefit recoveries collected by the Contractor shall be aggregated and paid/credited to the DCS Program within fifteen Days after the end of the month.

(5) Drug litigation recoveries and settlements shall be paid/credited to the Programs within fifteen (15) Days of receipt by the Contractor.

(6) One hundred and fifty (150) Days after the end of the first quarter, the Contractor shall pay/credit the Program the greater of (1) the actual Pharma Revenue received on behalf of the Programs or (2) the minimum Per Final Paid Claim Pharma Revenue Guarantee, set forth in the Contract Provisions, Sections VII.A. and VII.B. Articles 13.9.7, multiplied by the number of Final Paid Claims incurred for the first quarter.

(a) For each subsequent quarter of the Program Year the calculations shall be performed on a cumulative Program Year-to-Date basis. The Contractor shall pay/credit the Programs the greater cumulative amount less the amount previously paid for the Program Year.

(b) The Contractor shall perform a reconciliation by May 31st of each year and the incremental Pharma Revenue amount shall be paid/credited to the Programs within thirty (30) Days of May 31st.

(c) At the May 31st Pharma Revenue reconciliation, to the extent that any amount is owed by the Contractor, the Contractor shall pay/credit the Programs within thirty (30) Days after the Final Pharma Revenue reconciliation for the amount owed.

b. <u>Confirmation – Financial Structure and Timing of Financial Transactions</u>

(1) The Offeror is required to confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in the Details on the Financial Structure and Timing of Financial Transactions section above.

c. <u>Required Submission – Financial Structure and Timing of Financial Transactions</u>

(1) Describe in detail the Contractor's proposed invoicing process, including the timing for invoice preparation and supporting detail claims files at the end of each cycle, required payment timeframes and whether this structure is in effect for any other self-funded customers.

SECTION VI: EVALUATION AND SELECTION CRITERIA

Proposals determined by the Procuring Agencies to satisfy the submission requirements set forth in Section II and the Minimum Mandatory Requirements set forth in Section III of this RFP will be evaluated by an evaluation team composed of staff of the Procuring Agencies, the Governor's Office of Employee Relations (GOER) and/or the Division of the Budget (DOB), assisted by any person(s), other than one associated with a competing Offeror, designated by the Procuring Agencies. Proposals will be made available to representatives of NYS employee unions for review and comment. An Offeror's Proposal shall be removed from the evaluation process and not be considered for award should it be determined that the Offeror did not satisfy the Minimum Mandatory Requirements as specified in Section III, despite any attestation made regarding the Minimum Mandatory Requirements.

During the evaluation process, the Procuring Agencies may require clarifying information from an Offeror(s) for the purpose of assuring a full understanding of the Offeror's responsiveness to the RFP requirements and the duties and responsibilities set forth therein. This clarifying information must be submitted in writing in accordance with the formats set forth in Section II of this RFP and, if accepted, shall be included as a formal part of the Offeror's Proposal. Failure to provide the required information by the due date set forth in the Procuring Agencies' request for clarification may result in rejection of the Offeror's Proposal. Nothing in the foregoing shall mean or imply that it is obligatory upon the Procuring Agencies to seek or allow clarifications provided for herein. The Procuring Agencies may, at the Procuring Agencies discretion, elect to perform site visits of Offerors' facilities and have Offerors provide oral presentations pertaining to their Technical Proposal and Cost Proposal. If scheduled, representatives of NYS employee unions may also participate in site visits, Offeror oral presentations, and such other activities applicable to the evaluation of Proposals. The Pharmacy Benefit Services Procurement Manager will coordinate the necessary scheduling arrangements with the Offeror(s).

The Procuring Agencies will consider for evaluation and selection purposes only those Proposals 1) determined to have met the Minimum Mandatory Requirements specified in Section III of this RFP, and 2) determined to be responsive to the duties and responsibilities set forth in the RFP. The Procuring Agencies' desire is to select a single Offeror to administer the Programs (i.e., The Empire Plan Prescription Drug Program, the Excelsior Plan Prescription Drug Program, and the Student Employee

Health Plan Prescription Drug Program and the New York State Insurance Fund Workers' Compensation Prescription Drug Program). To this end, the Procuring Agencies intend to select that responsive and responsible Offeror whose Proposal offers the "Best Value" to the Procuring Agencies as specified in the following evaluation criteria for the purpose of entering into negotiations for two separate stand-alone contracts (i.e., one between the Offeror and the Department, and the other between the Offeror and NYSIF).

The Technical Proposal and Cost Proposal components of the evaluation process shall be based on 1,000 total available points; with 250 points available to the Technical Proposal and 750 points available to the Cost Proposal (i.e., 25% allocated to the Technical Proposal and 75% allocated to the Cost Proposal).

The Technical Proposal and Cost Proposal will be evaluated separately as described below.

A. Technical Evaluation

Each Offeror's ability and willingness to deliver the Program Services described in this RFP will be evaluated and scored based on a weighted point system. The evaluation of the Offeror's Technical Proposal will be based on that Offeror's written Technical Proposal; responses to clarifying questions, if any; information obtained through reference checks, including specific reference checks made with the Directors' of Employee Benefits at the Department, New York State Insurance Fund (NYSIF), and GOER for any Offeror, including any proposed Key Subcontractor(s) who performed services under a contract with the Procuring Agencies and, as deemed necessary by the Procuring Agencies, oral presentation(s) and/or site visits conducted to amplify and/or clarify that Offeror's proposed Technical Proposal.

1. Technical Score Ratings

Each Offeror's Technical Proposals will be evaluated based on the following rating scale and criteria as applied to each Required Submission response as required in Section IV of the RFP. A rating of "excellent" equates to a score of 5 for each evaluated Required Submission response. Each reduction in the ratings results in a one point reduction in the score such that a rating of "poor" equates to a score of 1.

a. Excellent (5)

The Offeror far exceeds the criteria. The services described indicate that the Offeror will provide very high quality services and is very pro-active and innovative.

b. Good (4)

The Offeror exceeds the criteria. The services described indicate that the Offeror will exceed the Programs' needs. The Offeror demonstrates some innovative features not shown in typical proposals.

c. Meets Criteria (3)

The Offeror meets but does not exceed the criteria. The services described indicate that the Offeror will meet the Programs' needs.

d. Fair (2)

The Offeror's answer is minimal; or the answer is very general and does not fully address the question; or the Offeror meets only some of the criteria.

e. Poor (1)

The Offeror misinterpreted or misunderstood the question; or the Offeror does not answer the question/criteria in a clear manner or the Offeror does not answer the question; or the Offeror does not meet the criteria.

The Offeror's commitment to meet the levels of standards it outlines in its proposal will be verified by reviewing responses to related Performance Guarantee questions and reviewing the Offeror's proposed credit to the administrative fee (credit amount) for its failure to meet each of its proposed performance guarantees.

2. Performance Guarantee Ratings

A rating of "excellent" equates to a score of 5 for each evaluated Service Level Standard. Each reduction in the ratings results in a one point reduction in the score such that a rating of "poor" equates to a score of 1. Offerors may propose performance guarantees that exceed the Program's service level standards presented in this RFP. Proposed Performance Guarantees

are contained within the respective technical areas and will be evaluated using the following criteria:

a. Excellent (5)

(1) The Offeror's proposed performance guarantee exceeds the Program's service level standard contained within this RFP; and

(2) The Offeror's proposed credit amount is one hundred and twenty-five percent (125%) or more of the standard credit amount stated within this RFP.

b. Good (4)

(1) The Offeror's proposed performance guarantee equals the Program's service level standard contained within this RFP, and the Offeror's proposed credit amount is one hundred and twenty-five percent (125%) or more of the standard credit amount stated within this RFP; or

(2) The Offeror's proposed performance guarantee exceeds the Program's service level standard contained within this RFP; and the Offeror's proposed credit amount is greater than one hundred percent (100%) but less than one hundred and twenty-five percent (125%) of the standard credit amount stated within this RFP.

c. Meets Criteria (3)

(1) The Offeror's proposed performance guarantee equals or exceeds the Program's service level standard contained within this RFP; and

(2) The Offeror's proposed credit amount equals the standard credit amount stated within this RFP.

d. Fair (2)

(1) The Offeror's proposed performance guarantee equals or exceeds the Program's service level standard contained within this RFP; and

(2) The Offeror's proposed credit amount is greater than fifty percent (50%) but less than one hundred percent (100%) of the standard credit amount stated within this RFP.

e. Poor (1)

(1) The Offeror's proposed performance guarantee is below the Program's service level standard contained within this RFP regardless of the credit amount proposed by the Offeror; or

(2) The Offeror's proposed credit amount is fifty percent (50%) or less of the standard credit amount stated within this RFP regardless of the level of performance the Offeror pledges.

3. Performance Guarantee Standard Credit Amounts

DCS Program

The DCS Program standard credit amount for each Offeror's proposed performance guarantee is $25,000 per quarter, assessed on a quarterly basis with the following exceptions;

a. Implementation and Start-Up (Section IV.B.3.b.(2)): Fifty percent (50%) of the Claims Administration Fee(s) (minimum mandatory requirement);

b. Program Claims Processing System Availability (Section IV.B.12.b.(18)): $100,000 per each quarter;

c. Enrollment Management (Section IV.B.7.b.(9)): $5,000 for each 24 hour period beyond 24 hours from the release of DCS Program enrollment records;

d. Management Reports and Claim File (Section IV.B.8.b.(6)): $1,000 per report per Business Day between the due date and the date the report is received by DCS inclusive of the day the report is received;

e. Network Pharmacy Access (Section IV.B.11.b.(7)), under subheading "Retail Pharmacy Network"): $100,000 per quarter for each performance guarantee in each of the three (3) areas in which the Performance Guarantee is not met;

f. Customer Service/Call Center Availability (Section IV.B.4.b.(8)(a)): $100,000 per each quarter; and

g. Turnaround Time for Claims Adjudication Guarantee (Section IV.B.12.b.(19)): $5,000 per each quarter.

NYSIF Program

The NYSIF Program standard credit amount for each Offeror's proposed performance guarantee is $7,500 per quarter, assessed on a quarterly basis with the following exceptions;

a. Implementation and Start-Up (Section IV.B.3.b.(2)): Fifty percent (50%) of the Claims Administration Fee(s) (minimum mandatory requirement);

b. Enrollment Management (Section IV.B.7.b.(9)): $375 for each 24 hour period beyond 12 hours from the release of NYSIF Program enrollment records;

c. Management Reports and Claim File (Section IV.B.8.b.(22)): $75 per report per Business Day between the due date and the date the report is received by NYSIF inclusive of the day the report is received;

d. Turnaround Time for Non-Intervention Mail Service Prescriptions Guarantee (Section IV.B.11.b.(19) "Mail Service Pharmacy Process"): $375 per each quarter;

e. Turnaround Time for Intervention Mail Service Prescriptions Guarantee (Section IV.B.11.b.(19) "Mail Service Pharmacy Process"): $375 per each quarter;

f. Turnaround Time for Claims Adjudication Guarantee (Section IV.B.12.b.(22)): $375 per each quarter.

4. Allocation of Technical Score Points

The scores referenced above shall be applied to weighted point values associated with each evaluated Required Submission response. The relative point value for each section of the Technical Proposal is as follows:

a. Program Management - 10% of Total Technical Score

Offeror will be rated on various components of Program management including Offeror qualifications, its executive summary, its account team, its premium development services, and its Program implementation plan.

b. Program Delivery and Support Services - 75% of Total Technical Score

Offeror will be rated on the various components of Program delivery including customer service, Medicare administration, enrollee communication support, enrollment management, reporting, consulting services, its transition plan, retail pharmacy network, pharmacy credentialing, pharmacy contracting, pharmacy audit, the mail service pharmacy process, Specialty Drug Program, claims processing, retrospective coordination of benefits, the mandatory generic substitution appeal process, prior authorization, concurrent DUR, retrospective DUR, physician education, patient education, and other safety related programs.

c. Flexible Formulary, Preferred Drug List and NYSIF Drug List Development and Management - 15% of Total Technical Score

Offeror will be rated on its ability to develop, administer, and maintain two Flexible Formularies, a Preferred Drug List, and a NYSIF Drug List that ensures access to quality and appropriate pharmaceutical care based on sound clinical criteria, and on the process the Offeror utilizes to communicate the Flexible Formularies, Preferred Drug List and NYSIF Drug List to Enrollees/Claimants, pharmacies and providers.

5. Technical Scoring

Qualifying Proposals will be evaluated independently by multiple evaluators based on the pre-established Evaluation Criteria. The average score for each evaluated response shall be applied to the points associated with each question such that an average score of "Excellent" for each evaluated response will result in a maximum available score of 1,000. All Offerors whose Technical Proposal is evaluated will receive a score in this manner. The technical score will then be converted to points for each Offeror such that the Offeror with the highest technical score will receive 250 points. As calculated by the Procurement Manager, all other Offerors are awarded points at a reduced level with 0.01 points being the lowest possible point value that may be assigned. The awarded points are calculated to the hundredth decimal place. The reduction in points shall be calculated in accordance with a pre-determined formula. The formula calculates the assigned points of the evaluated Offeror proportionally to the scores of the highest Technical Proposal and the lowest possible Technical Proposal score.

B. Cost Evaluation Component

The Cost Proposal of any Offeror that meets the Minimum Mandatory Requirements will be evaluated by the Procuring Agencies, and others deemed appropriate by the Procuring Agencies. The Procuring Agencies reserves the right to conduct Cost Proposal oral interviews and/or seek written responses from Offerors to clarify any aspect of the Offeror's Cost Proposal. The Procuring Agencies will then calculate a Cost Score for each Offeror as follows:

1. Cost Evaluation

The Procuring Agencies recognize that at the time the Proposal is submitted, the Cost Evaluation will be based on the Offeror's proposed claim reimbursement methodology as presented in response to Section V of this RFP, plus the Offeror's Claims Administration Fee(s), net of the savings that will result from the Offeror's guaranteed Pharma Revenue. These components will be calculated as follows:

a. Claim Costs: Claim costs will be calculated by applying the Offeror's proposed guaranteed claim discounts and dispensing fees applicable to brand and generic drugs at mail, retail and specialty pharmacies to a common aggregate AWP amount and paid claim count trended to 2014. To account for the potential cost effectiveness of the Offeror's proposed three level Preferred Drug List, Flexible Formularies, and NYSIF Drug List, the aggregated AWP amount may be adjusted for each Offeror, including, but not limited to assumed shifts in utilization from non-preferred brand drugs and excluded drugs to preferred brands or generics to account for variations in the proposed formularies. This adjustment will be based on an analysis of the Program's most significant drug therapeutic categories. Other adjustments may be made to evaluate costs associated with the Offerors' proposed Specialty Pharmacy Program drug coverage, etc.

b. Claims Administration Fee(s): DCS will apply the Claims Administration Fee(s) quoted in Exhibit V.F of this RFP against the projected number of claims; and

c. Pharma Revenue Guarantee: The Pharma Revenue Guarantee will be calculated by multiplying the Offeror's Pharma Revenue Guarantee quote(s) presented in Exhibit V.E for the period 1/1/2014 – 12/31/2018 times the normalized paid claim count.

The Procuring Agencies shall then calculate each Offeror's Total Projected Program Cost as the sum of a. through c. above. The Offeror's proposal with the lowest calculated cost will be awarded seven hundred and fifty (750) points. The points awarded to all other Offerors shall be based on a scale representing a 1 point reduction for each $400,000 the Offeror's calculated cost is higher than the calculated cost of the lowest Cost Proposal. The point value calculated and assigned shall be proportional within each $400,000 increment and calculated to the hundredth decimal place.

2. **The Procuring Agencies Reserves the Right to Analyze and/or Normalize:** The Procuring Agencies reserve the right to make other cost calculation adjustments as necessary to determine the evaluated cost of the Offeror's proposal. Any such adjustments shall be made with the intent to evaluate Offeror's proposals on a fair and consistent basis, without prejudice. These normalization adjustments may include but are not limited to:
1) the application of quoted Claims Administration Fees to the applicable normalized claims basis, 2) the adjustment of the common AWP to reflect any material differences in the Offerors' quoted source pricing, 3) unforeseen circumstances whereby the normalization of specific factors among Offerors shall result in a more accurate and fair comparison of the Offerors Cost Proposal as applied to the normalized claim base.

C. Total Combined Score of Technical and Cost

The Total Combined Score assigned for each Offeror shall be calculated by adding the Offeror's Technical Score and Cost Score.

D. Best Value Determination

It is the Procuring Agencies' desire and intent, if deemed in the best interest of the Department and NYSIF, to select, and enter into negotiations for the purpose of executing two separate stand-alone contracts, that Offeror that has accumulated the highest Total Combined Score ultimately determined by the Procuring Agencies to be responsible. (**Note:** If an Offeror's Total Combined Score is equal to or less than 1 point below the highest Total Combined Score, the Offeror's Proposal will be determined to be substantially equivalent to the Offeror holding the highest score. Among any Offerors' Proposals deemed substantially equivalent, the Procuring Agencies shall select the Offeror that has the highest Cost Score calculated pursuant to

Section VI.B.1. of this RFP.) Contract award shall be deemed made when notice of proposed contingent award is issued by the Procuring Agencies to the selected Offeror.

By submitting a Proposal in response to this RFP, the Offeror agrees that, if selected, the Offeror will enter into two separate stand-alone contracts that substantially include the terms set forth in Section VII of this RFP, Contract Provisions, and Appendices A, B, C, and D. After Agreements are separately executed with the Contractor and DCS and NYSIF, any change to the scope of the Agreement, including but not limited to the inclusion any individual independent Network Pharmacy(ies), requested by one Procuring Agency shall have no impact on the other Procuring Agency's Agreement or cost thereunder, unless the other Procuring Agency likewise agrees to said change(s).

Please note that the terms in Appendix A, "Standard Clauses for All New York State Contracts"; Appendix B, "Standard Clauses for all DCS Contracts"; Appendix B, "Standard Clauses for all NYSIF Contracts"; Appendix C, "Third Party Connection and Data Exchange Agreement (DCS Version)"; Appendix C, "Third Party Connection and Data Exchange Agreement (NYSIF Version)"; and Appendix D, "Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures," are not subject to negotiation.

In the case of a joint award, as envisioned in the RFP, if the Procuring Agencies determine that contract negotiations between the Procuring Agencies and the selected Offeror are unsuccessful because of material differences in key provision(s) as determined by the Procuring Agencies, the Procuring Agencies may invite the Offeror with the next highest Total Combined Score to enter into negotiations for purposes of executing two separate stand-alone contracts. Scores will not be recalculated for any remaining Offerors, should contract negotiations between the Procuring Agencies and the selected Offeror be unsuccessful, excepting in a case where the reason for such failure is based on a determination, made subsequent to contract award, that the Offeror is non-responsive or non-responsible.

If NYSIF determines that contract negotiations between NYSIF and the selected Offeror are unsuccessful because of material differences in key provision(s) as determined by NYSIF, but the Department does **not** make the same determination and the Department is able to successfully negotiate a contract, then proposed contract award to the selected Offeror, as regards the

Department's respective components of the RFP, shall stand, however the proposed award as regards the NYSIF components of the RFP shall be withdrawn. If the Department determines that contract negotiations between the Department and the selected Offeror are unsuccessful because of material differences in key provision(s) as determined by the Department, then contract negotiations between the Offeror and NYSIF shall be deemed unsuccessful, regardless of whether or not NYSIF and the Offeror's contract negotiations were otherwise successful, and a contract between NYSIF and the selected Offeror will be **not** be finalized or executed by NYSIF. In such case, the contract award shall be withdrawn and the Procuring Agencies may invite the Offeror with the next highest Total Combined Score to enter into negotiations for purposes of executing two separate stand-alone contracts. Scores will not be recalculated for any remaining Offerors, should contract negotiations between the Department and the selected Offeror be unsuccessful, excepting in a case where the reason for such failure is based on a determination, made subsequent to contract award, that the Offeror is non-responsive or non-responsible.

Should NYSIF decide, at any point in time prior to contract award, to withdraw its respective components from the RFP and/or not make a contract award, then the Offerors' Proposals will be evaluated and scored accordingly as provided for in the Procurement's evaluation criteria.

If an Offeror is eliminated any time prior to contract award, and that Offeror had the highest Technical score and/or Cost score, the Procuring Agencies shall recalculate the applicable Cost and/or Technical Scores for each remaining Offeror in accordance with the methodologies set forth herein.

SECTION VII: CONTRACT PROVISIONS

AGREEMENT #C000XXX

THIS Agreement is entered into by and between New York State Department of Civil Service ("Department" or "DCS"), having its principal office at the Alfred E. Smith State Office Building, Albany, NY, 12239 and _____("Contractor"), a corporation authorized to do business in the State of New York with a principal place of business located at _____, and collectively referred to as "the Parties."

WITNESSETH

WHEREAS, Civil Service Law Article XI requires the New York State Department of Civil Service to establish a health insurance plan for the benefit of State Employees, Retirees, and their Dependents, and for the benefit of Participating Employers' Employees, Retirees, and their Dependents; and

WHEREAS, Article XI requires the Department to purchase a contract or contracts to provide health benefits under the health insurance plan; and

WHEREAS, The Empire Plan Prescription Drug Program is administered by the President of the New York State Civil Service Commission, who also serves as the Commissioner of the DCS (President), subject to New York State laws and regulations including the Civil Service Law, the State Finance Law Article XI, and their respective implementing regulations; and

WHEREAS, on February 22, 2012, the Department of Civil Service issued a Request for Proposal (RFP) entitled, "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," to secure the services of a qualified organization to provide Program Services as defined in the RFP; and

WHEREAS, after thorough review and evaluation by the State of Proposals received in response to the RFP, the Contractor's Proposal was selected as representing the best value to the State; and

WHEREAS, the Department, in reliance upon the expertise of the Contractor, desires to engage the Contractor to deliver the Program Services, pursuant to the terms and conditions set forth in this Agreement;

THEREFORE, the Parties agree as follows:

ARTICLE I: DEFINITION OF TERMS

1.1.0 **Affiliate** means a person or organization which, through stock ownership or any other affiliation, directly, indirectly, or constructively controls another person or organization, is controlled by another person or organization, or is, along with another person or organization, under the control of a common parent.

1.2.0 **Ancillary Charge** means the amount in addition to the applicable Copayment an Enrollee/ Dependent will pay when purchasing a Brand Drug if an A-rated or authorized generic equivalent is available in the market. The amount represents the difference to the Program between the Discounted Ingredient Cost of the dispensed Brand Drug and the Discounted Ingredient Cost of the available generic equivalent if it had been dispensed, not to exceed the actual cost of the drug.

1.3.0 **AWP** means the [source identified in Exhibit C, Contractor's Proposal, of this Agreement] AWP Price for the eleven (11) digit NDC of the drug dispensed as of the date the Prescription was filled, unless the Parties mutually agree in writing to utilize a different source for AWP information.

1.4.0 **Brand Drug** means a Prescription drug sold under a trade name other than its chemical name that is manufactured and marketed by a single manufacturer (or single group of manufacturers pursuant to agreement among the manufacturers) where the manufacturer holds or held a patent protecting the active ingredient from generic competition. For The Empire Plan and SEHP, the Contractor shall utilize the Department's approved process to replicate the results of the methodology used by the DCS Program as of January 1, 2014 for determining the appropriate classification of drugs consistent with this definition. The Excelsior Plan will utilize the Contractor's book of business PDL classification and tier placement for generic and brand name medications.

1.5.0 **Brand for Generic** means an additional feature of the Enhanced Flexible Formulary which allows a Brand-Name drug to be placed on the lowest copayment level and the new generic equivalent to be placed on the highest copayment level, or excluded, when advantageous to the DCS Program.

1.6.0 **Business Day(s)** means every Monday through Friday, except for days designated as business holidays by the Contractor and approved as such by DCS prior to January 1 of each Calendar Year.

1.7.0 **Business Holiday(s)** means days designated by the Contractor as business holidays and approved as such by the Department prior to January 1 of each Calendar Year.

1.8.0 **Calendar Year/Annual** means a period of 12 months beginning with January 1 and ending with December 31.

1.9.0 **Call Center Hours** means 24 hours a Day, 365 days a year.

1.10.0 **Child(ren)** means children under 26 years of age, including natural children, legally adopted children, children in a waiting period prior to finalization of adoption, Enrollee stepchildren, and children of the Enrollee's domestic partner. Other children who reside permanently with the Enrollee in the Enrollee's household and are chiefly dependent on the Enrollee are also eligible, subject to a Statement of Dependence and documentation.

1.11.0 **Compound Drug(s)/Medication(s) or Compounded Drug(s)/Medication(s)** means a drug with two or more ingredients (solid, semi-solid, or liquid), at least one of which is a Covered Drug with a valid NDC requiring a Prescription for dispensing, combined together in a method specified in a Prescription issued by a medical professional. The end result of this combination must be a Prescription medication for a specific patient that is not otherwise commercially available in that form or dose/strength from a single manufacturer. The Prescription must identify the multiple ingredients in the Compound, including active ingredient(s), diluents(s), ratios or amounts of product, therapeutic use, and directions for use. The act of compounding must be performed or supervised by a licensed Pharmacist. Any commercially available product with a unique assigned NDC requiring reconstitution or mixing according to the FDA approved package insert prior to dispensing will not be considered a Compound Prescription by the Program.

1.12.0 **Contractor** means the successful Offeror selected as a result of the evaluation of Offerors' Proposals submitted in response to Exhibit B, the Request for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Student Employee Health Plan and New York State Insurance Fund Workers' Compensation Prescription Drug Programs" and who executes a contract with the Department to provide Program Services.

1.13.0 Controlled Drug means drugs designated by Federal Law or New York State law as a Class I, II, III, IV, or V substance. A Controlled Drug includes but is not limited to: some tranquilizers; stimulants; and pain medications.

1.14.0 Copayment means the amount the Enrollee/Dependent is required to pay for Covered Generic, Preferred and Non-Preferred Brand Drugs as specified by the benefit design of the DCS Program. The actual payment amount required from the Enrollee for a Prescription may not exceed the Ingredient Cost of the drug to the Plan after application of the Program's Lesser of Logic provision plus the applicable dispensing fee.

1.15.0 Covered Drug(s) means medically necessary Prescription drugs as defined in the Summary Plan Description, subject to all limitations and exclusions set forth therein.

1.16.0 Day(s) means calendar days unless otherwise noted.

1.17.0 DCS or Department means the New York State Department of Civil Service.

1.18.0 DCS Program(s)/Plan means the New York State Health Insurance Program's Empire Plan Prescription Drug Program, the Excelsior Plan Prescription Drug Program, and the Student Employee Health Program (SEHP) Prescription Drug Program.

1.19.0 DCS Program MAC List means the Program's specific Maximum Allowable Cost (MAC) List managed by the Contractor to set the maximum price the DCS Program shall be charged and the dispensing retail Network Pharmacy shall be paid on a pass through basis for the Ingredient Cost of a drug required to be included on The Empire Plan MAC List.

1.20.0 Dedicated Call Center means a group of Customer Service Representatives trained and capable of responding to a wide range of questions, complaints, and inquiries specific to the DCS Programs. The Customer Service Representatives are dedicated to the DCS Programs and do not work on any other accounts.

1.21.0 Dependent means the spouses, domestic partners, and children under twenty-six (26) years of age of an Enrollee. Young adult dependent children age twenty-six (26) or over are also eligible if they are incapable of supporting themselves due to mental or physical disability acquired before termination of their eligibility for coverage under the DCS Program.

1.22.0 Dependent Survivor means the unremarried spouse, dependent child, or domestic partner who has not acquired another domestic partner, of an Enrollee who died after having had at least ten (10) years of service, who were covered as dependents of the deceased Enrollee at the time of the Enrollee's death and who elect to continue coverage under NYSHIP following the three (3) month extended benefits period.

1.23.0 Designated Specialty Pharmacy means all facilities owned, operated, subcontracted or otherwise affiliated with the Contractor or any Key Subcontractor of the Contractor to provide certain Specialty Drugs/Medications. All facilities must meet all legal and contractual requirements as set forth in the Agreement.

1.24.0 Designated Specialty Pharmacy Hard Edit means a Network Pharmacy claims adjudication edit that will result in denial of the claim for a Specialty Drug/Medication under the Specialty Pharmacy Process after the Grace Period for Specialty Drugs has elapsed.

1.25.0 Designated Specialty Pharmacy Passive Edit means a Network Pharmacy claims adjudication edit that will prompt processing of the claim at the Designated Specialty Pharmacy but will permit continued processing and coverage for a Specialty Drug/Medication at the Network Pharmacy under the Specialty Pharmacy Process after the Grace Period for Specialty Drugs has elapsed.

1.26.0 Disabled Lives Benefit means the benefits provided to an Enrollee/Dependent who is Totally Disabled on the date coverage ends. The benefits are provided on the same basis as if coverage had continued with no change until the day the Enrollee/Dependent is no longer Totally Disabled or for ninety (90) days after the date the coverage ended, whichever is earlier.

1.27.0 Discounted Ingredient Cost(s) means the cost to the Plan for a specific drug or drugs dispensed to an Enrollee after the Contractor has applied the appropriate discount exclusive of any associated dispensing fee(s), other costs, or Copayments.

1.28.0 Employee means any person defined as an Employee as defined in 4 NYCRR Part 73, as amended, or as modified by collective bargaining agreement.

1.29.0 Employer means the State of New York in all its branches, departments and agencies, and any Participating Employer or Participating Agency.

1.30.0 Employer Group Waiver Plan (EGWP) means a Medicare Part D program in which the Contractor contracts with the Center for Medicare and Medicaid Services directly to provide prescription drug benefits, replicating the current Empire Plan prescription drug benefit structure, for Medicare primary Enrollee/Dependents.

1.31.0 Enhanced Flexible Formulary means a Flexible Formulary Drug List which includes the ability to place drugs on the appropriate Copayment level based on their economic and therapeutic value, including placement of Brand Drugs on the lowest Copayment level and to exclude Generic Drugs or place them on a higher Copayment level.

1.32.0 Enrollee means an "Employee" or "Dependent" enrolled in the DCS Programs with prescription drug benefits.

1.33.0 Enrollee Submitted Claim(s) or Subscriber Claims means a claim for benefits submitted by an Enrollee to the Contractor for direct reimbursement.

1.34.0 ET means prevailing Eastern Time.

1.35.0 Final Paid Claim means a claim processed and paid by the Contractor for a Prescription drug provided to an Enrollee, including but not limited to, claims for Prescriptions filled at a retail Pharmacy or through the Mail Service Pharmacy Process or the Specialty Pharmacy Process. A claim that is denied prior to processing is not considered a Final Paid Claim. In addition, a claim that is processed and paid but is subsequently voided, reversed, or otherwise adjusted is not a Final Paid Claim. Zero balance claims are considered Final Paid Claims.

1.36.0 First Fill means an Enrollee's initial or very first dispensing of a Specialty Drug/Medication covered under The Empire Plan Specialty Pharmacy Program.

1.37.0 Flexible Formulary Drug List means a Preferred Drug List in which Brand Drugs may be assigned to different copayment levels based on value to the DCS Program and clinical judgment. In some cases, drugs may be excluded from coverage if a therapeutic alternative or over-the-counter drug is available.

1.38.0 GCN means Generic Code Number as assigned by First Data Bank.

1.39.0 Generic Drug means a prescription drug sold under its chemical name or drug sold under a name other than its chemical name by a manufacturer other than the manufacturer that held the original patent for the active ingredient in the drug. The term Generic Drug shall include "authorized generics" marketed by or in conjunction with the manufacturer that is the holder of the original patent for the active ingredient of the drug. Any drug approved through an FDA Generic Drug approval process, including any FDA approval process established for approving generic equivalents of brand name biologic drugs, shall be classified as a Generic Drug. For The Empire Plan and SEHP, the contractor shall utilize the Department's approved process to replicate the results of the methodology used by the DCS Program as of January 1, 2012, for determining the appropriate classification of drugs. The Excelsior Plan will utilize the Contractor's book of business PDL classification and tier placement for generic and brand name medications.

1.41.0 Grace Period for Specialty Drugs means the period of time during which enrollees may receive one fill of a Specialty Drug/Medication at a Pharmacy other than the Designated Specialty Pharmacy.

1.42.0 Guaranteed Discount(s) means the Contractor's fixed, contracted, guaranteed Ingredient Cost discounts for Brand Drugs expressed as a percent off of AWP dispensed through the Mail Service Pharmacy Process. For Specialty Drug/Medications dispensed through the Specialty Pharmacy Program, Guaranteed Discounts means the Contractor's fixed, contracted, guaranteed Ingredient Cost discounts for Brand and Generic drugs expressed as a percent off of AWP.

1.43.0 Guaranteed Maximum Dispensing Fee(s) means the quoted dispensing fee(s) the Contractor guarantees that the actual average dispensing fee assessed under Pass Thru Pricing will not exceed. This Guaranteed Maximum Dispensing Fee(s) is applicable to the DCS Program for Generic, Brand, and Compound Drugs, calculated separately, for prescriptions dispensed by Retail Network Pharmacies.

1.44.0 Guaranteed Minimum Discount(s) means the guaranteed Ingredient Cost discount(s) as expressed as a percent off of the aggregate AWP and is applicable to Generic and Brand Drugs, separately, dispensed through Retail Pharmacy Network as well as Generic Drugs dispensed through the Mail Service Pharmacy Process.

1.45.0 Hard Edit means a Network Pharmacy claims adjudication edit that will result in denial of the claim.

1.46.0 **Ingredient Cost(s)** means the cost to the Plan for a specific drug, or drugs dispensed to an Enrollee exclusive of any associated dispensing fee(s), other costs, or Copayments through application of the Program's Lesser of Logic.

1.47.0 **Key Subcontractor** means those vendors with whom the Contractor subcontracts to provide DCS Program Services and incorporates as a part of the Contractor's Project Team.

1.48.0 **(Amended April 4, 2012)** **Limited Distribution Drug** means a Specialty Drug/Medication whose distribution is limited by the manufacturer to select Pharmacies and as a result of this restriction is not available to be dispensed from the Designated Specialty Pharmacy and/or Mail Service Pharmacy.

1.49.0 **Mail Service Pharmacy Process** means the method that the Contractor employs to accept, process, and dispense Prescriptions for Covered Drugs to Enrollees through the mail or other home delivery service, excluding any drug eligible under the Specialty Pharmacy Process. For those DCS employee groups not participating in the Specialty Pharmacy Process, the Mail Service Pharmacy Process means the method that the Contractor employs to accept, process, and dispense Prescriptions for Covered Drugs to Enrollees through the mail or other home delivery service including any drug that could be classified as a Specialty Drug/Medication, or that require special preparation or handling, using one or more Mail Service Pharmacy Process Facilities or other entities approved as distribution channels for dispensing Limited Distribution Drugs to Enrollees through the Mail Service Pharmacy Process. Prescriptions are considered to be submitted through the Mail Service Pharmacy Process if they are submitted by phone, fax, internet, e-prescribing or mail to any Mail Service Pharmacy Process Facility. All Prescriptions filled through the Mail Service Pharmacy Process shall be processed in strict accordance with the provisions of this Agreement including all pricing provisions related to the Mail Service Pharmacy Process. Prescriptions dispensed through the Retail Pharmacy Network and delivered to the Enrollee through the mail shall not be considered to have been filled through the Mail Service Pharmacy Process provided the Enrollee or their Physician presented the Prescription directly to the dispensing Network Pharmacy. The Contractor or its Key Subcontractor will not refer an Enrollee or their Physician to a retail Pharmacy without also making the Enrollee aware of the Mail Service Pharmacy Process.

1.50.0 Mail Service Pharmacy Process Facility(ies) means all facilities owned, operated, subcontracted or otherwise affiliated with the Contractor or any Key Subcontractor of the Contractor capable of being utilized by the Contractor in the Mail Service Pharmacy Process, including any mail service intake facility. For those DCS employee groups participating in the Specialty Pharmacy Process, the Designated Specialty Pharmacy is not considered a Mail Service Pharmacy Process Facility. All facilities must meet all legal and contractual requirements.

1.51.0 Maximum Allowable Cost means the maximum price the DCS Program shall be charged and the dispensing retail Network Pharmacy shall be paid on a pass through basis for the Ingredient Cost of a drug required to be included on the DCS Program MAC List managed by the Contractor.

1.52.0 Medically Necessary Drug means any drug which, as determined by the Contractor, is: (i) provided for the diagnosis or treatment of a medical condition; (ii) appropriate for the symptoms, diagnosis or treatment of a medical condition; (iii) within the standards of generally accepted health care practice; and (iv) not used for cosmetic purposes.

1.53.0 Medical Professional(s) means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) licensed without limitation or restriction to practice medicine. For benefits provided in this Program, and for no other purpose, Physician also means a Doctor of Dental Surgery (D.D.S.), a Doctor of Dental Medicine (D.D.M), a Podiatrist and any other health care professional licensed to prescribe medication, when he or she is acting within the scope of his or her license.

1.54.0 Narrow Therapeutic Index (NTI) Drugs means a drug that small variances in blood levels can cause changes in the effectiveness or toxicity of that drug.

1.55.0 NDC means the National Drug Code number assigned to a pharmaceutical product obtained by the manufacturer of the product through a U.S. Food and Drug Administration administered process.

1.56.0 Network Pharmacy means a Pharmacy, other than those Pharmacies meeting the definition of Mail Service Pharmacy Process Facilities or a Designated Specialty Pharmacy, which has entered into an agreement with the Contractor, or any Affiliate or Key Subcontractor of the Contractor, to provide Covered Drugs to Enrollees, including limited distribution or Specialty Drugs. The Contractor's records shall be conclusive as to whether a Pharmacy has a Network Pharmacy agreement in effect on the date a drug is dispensed.

1.57.0 **Non-Network Pharmacy** means any Pharmacy, other than a Network Pharmacy, a Mail Service Pharmacy Process Facility or a Designated Specialty Pharmacy, which has not entered into an agreement with the Contractor, or any Affiliate or Key Subcontractor of the Contractor, to provide Covered Drugs to Enrollees. The Plan has no obligation to pay the Pharmacy; the Enrollee must file a claim form with the Contractor in order to receive reimbursement for Covered Drugs.

1.58.0 **Non-Preferred Drug** means an FDA approved prescription drug that is covered by the DCS Program in accordance with the DCS Program Summary Plan Description, but is not included on the Contractor's and/or its Key Subcontractor's Preferred Drug List and will result in a higher drug Copayment for Enrollees.

1.59.0 **NYS** means New York State.

1.60.0 **NYSHIP** means the New York State Health Insurance Program.

1.61.0 **NYSIF** means the New York State Insurance Fund.

1.62.0 **Over-the-Counter Drug (OTC)** means a drug approved by the FDA, which has been determined to be safe and effective for use by the general public without a doctor's Prescription.

1.63.0 **Participating Agency (PA)** means any unit of local government such as school districts, special districts and district or municipal corporations which elects, with the approval of the President of the Civil Service Commission, to participate in the New York State Health Insurance Program.

1.64.0 **Participating Employer (PE)** means a public authority, public benefit corporation, or other public agency, subdivision, or quasi-public organization of the State which elects, with the approval of the President of the Civil Service Commission, to participate in the New York State Health Insurance Program.

1.65.0 **Pass-through Pricing** means the DCS Program is charged the same Ingredient Cost and/or dispensing fee paid to the dispensing Network Pharmacy or Mail Service Pharmacy for the Generic, Brand, or Compound Drug dispensed.

1.66.0 **Pharmacist** means a person who is legally licensed to practice the profession of Pharmacy. He or she must regularly practice such profession within the scope of their license.

1.67.0 Pharmacy or Pharmacies means any establishment, which is registered as a Pharmacy with the appropriate State licensing agency or is a Veterans Affairs Hospital Pharmacy, and regularly dispenses medications that require a Prescription from a Physician.

1.68.0 Pharmacy Benefit Services or Program Services means all of the services to be provided by the Contractor as set forth in this RFP.

1.69.0 Pharmacy Submitted Ingredient Cost or Pharmacy Submitted Pricing or Submitted Cost means the value entered by the Pharmacy in field 409, 'Ingredient Cost Submitted' of Telecommunication Standard Version 5.1 issued by the National Council for Prescription Drug Programs, Inc. For purposes of adjudication of Compound claims the value shall be no more than the total AWP of all ingredients in the Compound.

1.70.0 Pharma Revenue means any and all revenues generated from agreements between pharmaceutical manufacturers and the Contractor, or any Affiliate or Key Subcontractor of the Contractor, which relate to DCS Program utilization and/or Pharmacy benefit management services provided under this Agreement. Such revenues include revenue described by any name, but not limited to, revenues described as: formulary rebates, market share rebates, administrative fees, AWP caps or by any other name.

1.71.0 Physician means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.). He or she must be legally licensed without limitations or restrictions, to practice medicine. For benefits provided in this Program, and for no other purpose, Physician also means a Doctor of Dental Surgery (D.D.S.), a Doctor of Dental Medicine (D.D.M), a Podiatrist and any other health care professional licensed to prescribe medication, when he or she is acting within the scope of his or her license.

1.72.0 Plan/DCS Program means the New York State Health Insurance Program's Empire Plan Prescription Drug Program, the Excelsior Plan Prescription Drug Program and the Student Employee Health Program (SEHP) Prescription Drug Program.

1.73.0 Plan Sponsor means the Council on Employee Health Insurance, which is composed of the President of the Civil Service Commission, Director of the Governor's Office of Employee Relations, and the Director of the Division of Budget.

1.74.0 **Plan Year** means the period from January 1st to December 31st in each Plan Year, unless specified otherwise by the DCS.

1.75.0 **Preferred Brand Drug** means an FDA approved brand name prescription drug that is included on the Preferred Drug List developed by the Contractor for the DCS Program.

1.76.0 **Preferred Drug List or PDL** means a list of FDA approved brand name and generic prescription drugs developed by the Contractor for the Program. Unless otherwise specified, this definition applies to all three of The Empire Plan PDLs including: (1) the Traditional Empire Plan PDL (which applies to employee groups who have not agreed to implementation of a Flexible Formulary);
(2) Flexible Formulary Drug List; (3) Enhanced Flexible Formulary and the (4) Contractor's book of business PDL which applies to Enrollees/Dependents with Excelsior Plan benefits (Excelsior Plan PDL).

1.77.0 **Prescription/Prescription Order** means the written or oral request for drugs issued by a Physician duly licensed to make such a request in the ordinary course of his or her professional practice. This order must be written in the name of the person for whom it is prescribed or be an authorized refill of that order.

1.78.0 **President** means the President of the Civil Service Commission and the Commissioner of the DCS.

1.79.0 **Program Services or Pharmacy Benefit Services** means all of the services to be provided by the Contractor as set forth in this Agreement.

1.80.0 **Program Team** means the Contractor and those Key Subcontractors, if any, utilized by the Contractor who collectively undertake and perform the Program Services which are the subject of the Agreement.

1.81.0 **Proposal** means the Contractor's Administrative Proposal, Technical Proposal and Cost Proposal, including all responses to supplemental requests for clarification, information, or documentation, submitted during the course of the Procurement.

1.82.0 **Regulations of the President of the New York State Civil Service Commission** means those regulations promulgated by the President of the Civil Service Commission under the authority of

Civil Service Law, Article XI, as amended, and including, but not limited to those regulations to be promulgated as 4 New York Code of Rules and Regulations (NYCRR) Part 73.

1.83.0 **Renewal Date** means January 1, 2015, and annually thereafter up to and including January 1, 2018.

1.84.0 **Retail Pharmacy Network** means the Contractor's credentialed network of participating independent, chain Pharmacies, and specialty Pharmacies contracted to deliver services to Enrollees.

1.85.0 **Retiree** means any person defined as a Retiree pursuant to the terms of 4 NYCRR Part 73, as amended.

1.86.0 **RFP or Procurement** means the Request for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs."

1.87.0 **Specialty Drugs/Medications** means drugs that treat rare disease states; drugs requiring special handling, special administration, or intensive patient monitoring/testing; biotech drugs developed from human cell proteins and DNA, targeted to treat disease at the cellular level; or, other drugs used to treat patients with chronic or life threatening diseases identified as specialty medications through the mutual agreement of the parties.

1.88.0 **Specialty Pharmacy Process** means the method that the Contractor employs to accept, process, and dispense Prescriptions for Covered Drugs to Enrollees through the Designated Specialty Pharmacy or a Limited Distribution Drug Pharmacy, for those employee groups participating in the specialty pharmacy benefit. Prescriptions are considered to be submitted through the Specialty Pharmacy Process if they are a Limited Distribution Drug submitted directly to the Limited Distribution Drug Pharmacy, or if they are a Specialty Drug/Medication submitted directly to the Designated Specialty Pharmacy, by phone, fax, internet, e-prescribing or mail. All Prescriptions filled through the Specialty Pharmacy Process shall be processed in strict accordance with the provisions of the contract to be agreed upon by the Department and the Contractor.

1.89.0 **State** means the DCS acting in its statutory authority as the administrator of NYSHIP's Empire Plan Prescription Drug Program.

1.90.0 **Summary Plan Description(s) SPD** means the document(s) issued pursuant to and attached by reference to the Agreement. The SPD is issued to Enrollees and describes DCS Program benefits. The SPD includes the initial SPD and amendments, if any.

1.91.0 **Therapeutically Equivalent** means drugs that can be expected to produce essentially the same therapeutic outcome and toxicity.

1.92.0 **Traditional Preferred Drug List** means a list of FDA approved brand name and generic prescription drugs developed by the Contractor for the employee groups who have not agreed to implementation of the Flexible Formulary Drug List.

1.93.0 **Usual and Customary (U&C)** means the retail price charged to the general public as submitted by the dispensing Pharmacy during claims processing.

1.94.0 **Vestee** means a former Employee who is entitled to continue benefits under NYSHIP because he/she has met all the requirements for NYSHIP coverage as a Retiree, except for age eligibility for pension, at the time employment terminates.

ARTICLE II: AGREEMENT DURATION AND AMENDMENTS

2.1.0 This Agreement shall be subject to and effective upon the approval of the New York State Attorney General's Office ("AG") and the NYS Office of the State Comptroller ("OSC"). The term of the Agreement shall include an implementation period followed by five (5) years of Program Services. It is the Department's intent that this implementation period shall begin on or around October 1, 2012, upon OSC approval of the Agreement, with all other contractual responsibilities to begin on January 1, 2014, through and including December 31, 2018, and subject to the termination provisions contained herein.

2.2.0 The Agreement is subject to amendment(s) only upon mutual consent of the Parties, reduced to writing and approved by the AG and the OSC.

2.3.0 Upon termination of this Agreement the DCS shall have the right to award a new contract to another Contractor.

ARTICLE III: INTEGRATION

3.1.0 This Agreement, including all Exhibits, copies of which are attached hereto and incorporated by reference, constitutes the entire Agreement between the Parties. All prior Agreements, representations, statements, negotiations, and undertakings are superseded hereby.

3.2.0 All statements made by the DCS shall be deemed to be representations and not warranties.

ARTICLE IV: DOCUMENT INCORPORATION AND ORDER OF PRECEDENCE

4.1.0 The Agreement consists of:

4.1.1 The body of the Agreement (that portion preceding the signatures of the Parties in execution), and any amendments thereto;

4.1.2 Appendix A – Standard Clauses for All New York State Contracts;

4.1.3 Appendix B – Standard Clauses for All DCS Contracts;

4.1.4 Appendix C – Third Party Connection and Data Sharing Agreement;

4.1.5 Appendix D – Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures;

4.1.6 The following Exhibits attached and incorporated by reference to the body of the Agreement:

4.1.6a Exhibit A: which includes: the MacBride Act Statement; and the Non-Collusive Bidding Certification;

4.1.6b Exhibit B: the Request for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," and Exhibit B-1, the official Procuring Agencies response to questions raised concerning the RFP;

4.1.6c Exhibit C: the Contractor's Proposal; and, Exhibit C-1: the official transcript of the Management Interview, and related materials clarifying the Contractor's Proposal;

4.1.6d Exhibit D: the Summary Plan Descriptions; and

4.1.6e Exhibit E: Specialty Pharmacy Program Dispensing Fees.

4.1.7 In the event of any inconsistency in, or conflict among, the document elements of the Agreement identified above, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

4.1.7a First, Appendix A – Standard Clauses for All New York State Contracts;

4.1.7b Second, Appendix B – Standard Clauses for All Department of Civil Service Contracts;

4.1.7c Third, Appendix C –Third Party Data Connection and Data Exchange Agreement;

4.1.7d Fourth, Appendix D – Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures;

4.1.7e Fifth, any Amendments to the body of the Agreement;

4.1.7f Sixth, the body of the Agreement;

4.1.7g Seventh, Exhibit B, the Request for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," and Exhibit B-1, the official Procuring Agencies response to questions raised concerning the RFP;

4.1.7h Eighth, Exhibit C: the Contractor's Proposal; and, Exhibit C-1: the official transcript of the Management Interview and related materials clarifying the Contractor's Proposal; and

4.1.7i Ninth, Exhibit D, the Summary Plan Description and Benefit Summaries and Exhibit E, Specialty Pharmacy Program Dispensing Fees;

4.2.0 The terms, provisions, representations and warranties contained in the Agreement shall survive performance hereunder.

ARTICLE V: LEGAL AUTHORITY TO PERFORM

5.1.0 Contractor agrees that it shall perform its obligations under this Agreement in accordance with all applicable federal and NYS laws, rules and regulations, policies and/or guidelines now or hereafter in effect, including but not limited to the requirements set forth in Chapter 56 of the Laws of 2010.

5.2.0 The Contractor shall maintain appropriate corporate and/or legal authority, which shall include but is not limited to the maintenance of an administrative organization capable of delivering the Program Services in accordance with the Agreement and the authority to do business in the State of New York or any other governmental jurisdiction in which the Program Services are to be delivered.

5.3.0 The Contractor shall provide the Department with immediate notice in writing of the initiation of any legal action or suit which relates in any way to the Agreement, or which may affect the performance of Contractor's duties under the Agreement.

ARTICLE VI: PROGRAM SERVICES

6.1.0 The Contractor shall provide all of the Program Services as set forth herein this Article VI of the Agreement for the entire term of the Agreement pursuant to the Summary Plan Description(s) incorporated into this Agreement as Exhibit D. All Program Services shall be provided in accordance with the New York State Civil Service Law and its implementing regulations, and other NYS and Federal Law as may be applicable. In addition, the Contractor shall deliver the Program Services in such a manner so as to comply with all provisions of this Agreement. The Contractor may provide certain services through Key Subcontracts with the prior review and approval of DCS. Each subcontract entered into with a corporate entity separate from the Contractor for the purpose of delivering Program Services must be maintained throughout the term of the Agreement unless such change is approved in writing by DCS. All Key Subcontracts shall expressly name the State of New York, through the Department, as the sole intended beneficiary of any such Key Subcontract. The Contractor must maintain significant financial, legal, and audit oversight of any of its Key Subcontractors. The Contractor remains fully responsible for all services and actions performed under this Agreement. The Contractor shall submit all Key Subcontracts to DCS for its approval. The Contractor shall submit all such Key Subcontracts with no redactions to the Department before execution for its review and approval. **(Note: Costs/Fees for all services required under this Agreement shall be included in the Contractor's Claims Administrative Fee).**

6.2.0 Implementation

6.2.1 The Agreement includes an implementation period beginning on or around October 1, 2012, upon approval of the Agreement by OSC. During the implementation period, the Contractor must undertake and complete all implementation activities, including but not limited to those specific activities set forth in the Implementation and Start-up Guarantee Section 7.1.0 of the Agreement. Such implementation activities must be complete no later than December 31, 2013 so that the DCS Program is fully operational on January 1, 2014.

6.3.0 Account Team

6.3.1 The Contractor must maintain an organization of sufficient size with staff that possesses the necessary skills and experience to administer, manage, and oversee all aspects of the DCS Program during implementation and operation.

6.3.1a The account team must be comprised of qualified and experienced individuals who are acceptable to the Department and who are responsible for ensuring that the operational, clinical and financial resources are in place to operate the DCS Program in an efficient manner;

6.3.1b The Contractor must ensure that there is a process in place for the account team to gain immediate access to appropriate corporate resources and senior management necessary to meet all DCS Program requirements and to address any issues that may arise during the performance of the Agreement.

6.3.2 The Contractor's dedicated account team must be experienced, accessible (preferably in the New York State Capital Region district) and sufficiently staffed to:

6.3.2a provide timely responses (within 1 to 2 Business Days) to administrative and clinical concerns and inquiries posed by the Department or other staff on behalf of the Council of Employee Health Insurance, or union representatives regarding member-specific claims issues for the duration of the Agreement to the satisfaction of the Department; and

6.3.2b immediately notify the Department in writing of actual or anticipated events impacting DCS Program costs and/or delivery of services to DCS Program Enrollees (for example, drug recalls and withdrawals, class action settlements, and operational issues).

6.3.3 The Contractor's dedicated account team must ensure that the DCS Program is in compliance with all legislative and statutory requirements. If the Contractor is unable to comply with any legislative or statutory requirements, the Department must be notified in writing immediately. The Contractor is required to work with the Department to develop accurate Summary Plan Descriptions (SPDs) and/or DCS Program Material.

6.4.0 **Premium Development Services:** The Contractor is responsible for assisting and supporting the Department with all aspects of premium rate development, including, but not limited to:

6.4.1 Providing a team of qualified and experienced individuals who are acceptable to the Department and who will assist and support the Department in developing premium rates consistent with the financial interests and goals of the DCS Program and the State;

6.4.2 Development of claim, trend and administrative fee projections for each DCS Program Year. Analysis of all DCS Program components impacting the DCS Program cost shall be performed including, but not limited to claims, trend factors, administrative fees, projected Pharma Revenue, changes in enrollment, changes in the Specialty Pharmacy Drug list, as well as changes in the formularies including The Empire Plan's Specialty Drug list, Flexible Formularies and the Traditional PDL; and

6.4.3 Working with the Department and its contracted actuarial consultant through the annual rate renewal process to further document and explain a premium rate recommendation. This process includes presenting the premium rate recommendation to staff of the Department, Division of the Budget and GOER.

6.5.0 **Customer Service:** The Contractor is responsible for all customer support and services including, but not limited to:

6.5.1 Providing Enrollees access to information on all Prescription drug benefits and services related to The Empire Plan, Excelsior Plan, and SEHP through the Empire Plan

consolidated toll-free number 24 hours a day 365 Days a year. The Empire Plan consolidated toll-free telephone service is provided through the AT&T voice network services under a contract with The Empire Plan's Medical Insurer and is available to callers 24 hours a Day, 365 Days a year. The contractor is required to establish and maintain a transfer connection (currently an AT&T T-1 line), including a back-up system which will transfer calls to the contractor's line at their customer service site. The Contractor is required to sign a shared service agreement with The Empire Plan's Medical Insurer currently UnitedHealthcare and AT&T. In addition, the Contractor is also required to provide 24 hours a day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability. The TTY number must provide the same level of access to customer service as required by Section 6.5.0 of this Agreement;

6.5.2 Maintaining a ~~Dedicated~~ ~~C~~call ~~C~~center(s) located in the United States staffed by fully trained customer service representatives and supervisors available 24 hours a day 365 Days a year. The Contractor must maintain a Dedicated Call Center for the Program between the hours of 7:00am and 7:00pm ET. During off hours, calls may be routed to a designated call center(s) located in the United States staffed by fully trained customer service representatives and supervisors. The ~~Dedicated~~ ~~C~~call ~~C~~center(s) must also provide immediate access to Pharmacist(s) 24 hours a day 365 days a year. The ~~Dedicated~~ ~~C~~call ~~C~~center(s) must meet the Contractor's proposed customer service telephone guarantees set forth in Section 7.7.0 of this Agreement.

6.5.3 Customer service staff must use an integrated system to log and track all Enrollee calls. The system must create a record of the Enrollee contacting the call center, the call type, and all customer service actions and resolutions.

6.5.4 Customer service representatives must be trained and capable of responding to a wide range of questions, complaints and inquiries including but not limited to: DCS Program benefit levels, refills, order status, prices and billing, point of service issues, prior authorization, eligibility, generic appeals, Mail Service Pharmacy Process, Specialty Pharmacy Process services, and Flexible Formulary and Preferred Drug List alternatives.

6.5.5 Maintaining a backup customer service staff located in the United States with DCS Program-specific training to handle any overflow when the dedicated customer service

center is unable to meet the Contractor's customer service performance guarantees as set forth in Section 7.7.0 of this Agreement. This back-up system would also be utilized in the event the primary customer service center becomes unavailable; and

6.5.6 Maintaining and timely updating a secure online customized website accessible by Enrollees, which is available 24 hours a Day, 7 Days a week, except for regularly scheduled maintenance, which will provide, at a minimum, access to information regarding: DCS Program benefits, Network Pharmacy locations, eligibility, mail service order status, Copayment information, claim status, comparative price check functionality, Prescription drug history for both retail and mail claims, and the Flexible Formulary and Preferred Drug Lists (including alternatives for Non-Preferred Brand Name and excluded drugs). The Department shall be notified of all regularly scheduled maintenance at least one Business day prior to such maintenance being performed. The Contractor must establish a dedicated link to the customized website for the DCS Program from the Department's website with content subject to the approval of the Department and limited to information that pertains to the DCS Program. Any links should bring a viewer back to the Department website. No other links are permitted without the written approval of the Department. Access to the online Network Pharmacy locator must be available to Enrollees without requiring them to register on the website. Any costs associated with customizing and updating the website or establishing a dedicated link for the DCS Program shall be borne by the Contractor. Also, the Contractor shall fully cooperate with any Department initiatives to use new technologies, processes, and methods to improve the efficiencies of the customized website including development of an integrated Enrollee portal;

6.6.0 <u>Medicare Part D – Employer Group Waiver Plan PDP</u>

The Offeror will be responsible for implementing and administering a Center for Medicare and Medicaid Services (CMS) approved and compliant Employer Group Waiver Plan (EGWP) and Medicare D supplemental wrap around (wrap) Prescription Drug Plan (PDP) for the Empire Plan's Medicare-eligible retirees beginning on January 1, 2014. Such services shall include at least the following tasks and such other tasks as may be added in guidance and further regulation by CMS:

6.6.1 Disclosing to CMS, on a timely basis and on behalf of the DCS Program, any filings, applications, reports, formularies, and other DCS Program material necessary for the Department to comply with the requirements of an "800-series" Medicare PDP Employer Group Waiver Plan (EGWP), plus Medicare D supplemental wrap;

6.6.2 Fully supporting the Program with all operational aspects of a fully compliant Medicare PDP EGWP plus Medicare D supplemental wrap, including but not limited to:

6.6.2a Medicare PDP EGWP Premium Development;

6.6.1b Enrollment;

6.6.1c Enrollee Opt Out Process;

6.6.1d Health Insurance Claim Number (HICN) administration;

6.6.1e Formulary management;

6.6.1f Issuing of Medicare PDP EGWP member identification cards;

6.6.1g Member Communications, including required explanation of benefits statements;

6.6.1h Claims Processing;

6.6.1i Administration of a Medicare D supplemental wrap with the goal of providing Medicare primary Enrollees with a prescription drug benefit replicating as closely as possible the prescription drug benefit design for non-Medicare primary retirees in the Empire Plan; and,

6.6.1j Timely administration of catastrophe re-insurance claims.

6.6.3 Prepare timely reconciliations of administrative fees, forecast versus incurred prescription drug claims, CMS (Part D) capitated and reinsurance fees, CMS enrollee low-income subsidy payments and pharmacy rebates. The Contractor must provide such records and reports in a manner, form, and timeliness acceptable to the Department;

6.6.4 Promptly credit the Department for all CMS premium subsidy payments and all pharmacy rebates received by the Contractor under the Medicare PDP EGWP, plus Medicare D supplemental wrap.

6.6.5 The Department acknowledges and agrees that it shall be responsible solely (1) for providing creditable coverage notices required with respect to the EGWP; and (2) for determining whether enrolled individuals are qualifying covered retirees. The Contractor will work with the Department to obtain HICNs for all eligible Medicare-primary members enrolled in the EGWP;

6.6.6 The Contractor acknowledges that the information furnished in connection with the administration of the Medicare PDP EGWP is being provided to obtain federal funds. The Contractor shall require all sub-contractors, including any plan administrators, if applicable, that submit information required by CMS to obtain any subsidies or payments on behalf of the DCS Program to acknowledge that information provided in connection with the key subcontract is used for the purpose of obtaining federal funds; and

6.6.7 The Contractor acknowledges that its provision of services pursuant to this section of this Agreement is subject to audit and evaluation by the U.S. Department of Health and Human Services pursuant to 42 CFR Subpart R or other authority as may be cited by the federal government, as well as by the State of New York pursuant to Appendix A and Appendix B of this Agreement. The Contractor shall comply with any record retention requirements required pursuant to 42 CFR SubPart R in this regard.

6.6.8 The Contractor is required to act as consultant to the Department in analyzing its experience with the Medicare PDP EGWP, and recommending as well as implementing other permitted options under Medicare Part D which may be of advantage to the Department, agencies participating in NYSHIP and NYSHIP Enrollees; and

6.6.9 Upon finalization of a subrogation process by CMS, the Contractor will be required to identify and recover claim payments made by the DCS Program from other plans that should have been the primary payor.

6.7.0 Enrollee Communication Support

6.7.1 All Enrollee communications developed by the Contractor are subject to Department review and prior written approval, including but not limited to any regular standardized direct communication with Enrollees or their Physicians in connection with Enrollee drug utilization or the processing of Enrollee claims, either through mail, e-mail, fax or

telephone. The Department in its sole discretion reserves the right to require any change it deems necessary.

6.7.2 The Contractor will be responsible for providing Enrollee communication support and services to the Department including, but not limited to:

6.7.2a Developing language describing the DCS Program for inclusion in the NYSHIP General Information Book and Empire Plan Summary Plan Description, subject to the Department's review and approval;

6.7.2b Developing articles for inclusion in Empire Plan Reports and other publications on an "as needed" basis, detailing DCS Program benefit features and/or highlighting trends in drug utilization;

6.7.2c Timely reviewing and commenting on proposed Empire Plan communication material developed by the Department;

6.7.3 Upon request, subject to the approval of DCS, on an "as needed" basis, the Contractor agrees to provide staff to attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States. The Contractor agrees that the costs associated with these services are included in the Contractor's Claim Administration Fee.

6.7.4 The Contractor must work with the Department to develop appropriate customized forms and letters for the DCS Program, including but not limited to mail order forms, Enrollee claim forms, prior authorization letters, generic appeal letters, Flexible Formulary and Preferred Drug List, disruption letters, etc. All such communications must be approved by the Department.

6.8.0 **Enrollment Management:** The Contractor is responsible for the maintenance of an accurate, complete, and up-to-date enrollment file based on information provided by the Department. This enrollment file shall be used by the Contractor to process retail, mail order and specialty pharmacy claims, provide customer service, identify individuals in the enrollment file who are enrolled in the EGWP or another Medicare Part D plan, and produce management reports and data files. The Contractor is required to provide enrollment management services including but not limited to:

6.8.1 Initial testing

6.8.1a Performing an initial enrollment load to commence upon receipt from the Department during DCS Program implementation. The file may be EDI Benefit Enrollment and Maintenance Transaction set 834(ANSI x.12 834 standard either 834 (4010x095A1) or 834 (005010x220)) or a custom file format. The determination will be made by the Department;

6.8.1b Testing to determine if the enrollment file and enrollment transactions loaded correctly and that the enrollment system interfaces with the claims processing system to accurately adjudicate claims. The Contractor must submit enrollment test files to the Department for auditing, provide the Department with secure, online access required to ensure accurate loading of DCS Program enrollment data, and promptly correct any identified issues to the satisfaction of the Department;

6.8.2 Providing an enrollment system capable of receiving secure enrollment transactions (Monday through Friday) and having all transactions fully loaded to the claims processing system within twenty-four (24) hours of release of a retrievable file by the Department. The Contractor must immediately notify the Department of any delay in loading enrollment transactions. In the event the Contractor experiences a delay due to the quality of the data supplied by the Department, the Contractor must immediately load all records received (that meet the quality standards for loading) within twenty-four (24) hours of their release, as required. The Department will release enrollment changes to the Contractor in an electronic format daily (Monday through Friday). On occasion, the Department will release more than one enrollment file within a 24-hour period. The Contractor must be capable of loading both files within the twenty-four (24) hour performance standard. The format of these transactions will be in an EDI Benefit Enrollment and Maintenance transaction set, utilizing an ANSI x.12 834 transaction set in the format specified by the Department. The Contractor must also have the capability to receive alternate identification numbers and any special update files from the Department containing eligibility additions and deletions, including emergency updates, if required;

6.8.3 Ensuring the security of all enrollment information as well as the security of a HIPAA compliant computer system in order to protect the confidentiality of Enrollee/Dependent data contained in the enrollment file. Any transfers of enrollment data within the Contractor's system or to external parties must be completed via a secured process;

6.8.4 Providing a back-up system or have a process in place where, if enrollment information is unavailable or not current at the point of service, Enrollees can obtain Prescriptions without interruption, at the point of service. Short fill policies should be included in the Pharmacy Provider manual;

6.8.5 Cooperating fully with any Department initiatives to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of this Agreement;

6.8.6 Maintaining a read only connection to the NYBEAS enrollment system for the purpose of providing the Contractor's staff with access to current DCS Program enrollment information. Contractor's staff must be available to access enrollment information through NYBEAS, Monday through Friday, from 9:00 am to 5:00 pm, with the exception of NYS holidays as indicated on the Department's website;

6.8.7 Meeting the administrative requirements for National Medical Support Notices. A child covered by a Qualified Medical Child Support Order (QMCSO), or the child's custodial parent, legal guardian, or the provider of services to the child, or a NYS agency to the extent assigned the child's rights, may file claims and the Contractor must make payment for covered benefits or reimbursement directly to such party. A Contractor will be required to store this information in their system so that any claim payments or any other plan communication distributed by the Contractor, including access to information on the Contractor's website would go to the person designated in the QMCSO;

6.8.8 Ability to manually load/correct an enrollment record and to contact the Pharmacy to allow the adjudication of a Prescription in an urgent or emergency situation.

6.9.0 **Reporting:** The Contractor is responsible for accurate reporting services including, but not limited to:

6.9.1 Ensuring that all financial reports including cycle claim reports are generated from amounts billed to the Program, and tie to the quarterly and annual financial experience reports, and Rebate reports;

6.9.2 Developing, in conjunction with DCS, standard electronic management, financial, and utilization reports required by DCS for its use in the review, management, monitoring and analysis of the DCS Program. These reports must tie to the amounts billed to the DCS Program. The final format of reports is subject to DCS review and approval;

6.9.3 Supplying reports in paper format and/or in an electronic format (Microsoft Access, Excel, Word) as determined by the Department. This includes, but is not limited to, reports and data files listed in Article XVI of this Agreement;

6.9.4 Providing direct, secure access to the Contractor's claims system and any online and web-based reporting tools to the Department's offices;

6.9.5 Providing Ad Hoc Reports and other data analysis at no additional cost. The exact format, frequency, and due dates for such reports shall be specified by the Department. Information required in the Ad Hoc Reports may include but is not limited to providing:

6.9.5a Forecasting and trend analysis data;
6.9.5b Data necessary to track drug pricing;
6.9.5c Utilization data on the Mail Order Pharmacy and the Special Pharmacy Program;
6.9.5d Utilization review savings;
6.9.5e Benefit design modeling analysis;
6.9.5f Reports to meet clinical program review needs;
6.9.5g Reports segregating claims experience for specific populations; and
6.9.5h Reports to monitor Agreement compliance.

6.10.0 **Consulting:** The Contractor is responsible for providing advice and recommendations regarding the DCS Program. Such responsibility shall include, but not be limited to:

6.10.1 Informing the State in a timely manner concerning such matters as cost containment strategies, new drugs, conversion from Brand Drugs to Generic Drugs and how it will impact cost, Flexible Formulary and Preferred Drug List configuration, technological

improvements, e-prescribing, Pharmacy innovations, and State/Federal legislation (i.e., Medicare, Prescription drug mandates, etc.) that may affect the DCS Program. The Contractor must provide information and recommendations to the Department on Flexible Formulary or Preferred Drug List (PDL) placement of new generic and biological therapies prior to release into the marketplace to the extent such information is available in the public realm. The Contractor must also make available to the State one or more members of the clinical or account management team to discuss the implications of these new trends and developments. The Department is not under any obligation to act on such advice or recommendation; and

6.10.2 Assisting the State with recommendations and evaluation of proposed benefit design changes and implementing any changes necessary to accommodate DCS Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State. Recommendations must include a preliminary analysis of all associated costs, a clinical evaluation, and the anticipated impact of proposed DCS Program modifications and contemplated benefit design changes on Enrollees.
In the event of a design change and the Contractor requests any change in compensation such change will be in accordance with Article VIII of this Agreement.

6.11.0 Network Management

6.11.1 Retail Pharmacy Network

6.11.1a The Contractor must maintain a credentialed and contracted Retail Pharmacy Network that meets or exceeds the DCS Program's minimum access standards throughout the term of the Agreement.

6.11.1b The DCS Program requires the Contractor have available to Enrollees on January 1, 2014 the Retail Pharmacy Network it proposed in Exhibit C, Contractor's Proposal, of this Agreement, in accordance with the requirements set forth in Section 7.4.0 guaranteeing effective implementation of their Retail Pharmacy Network.

6.11.1c The Contractor is required to include Independent Pharmacies in its Retail Pharmacy Network. In developing its Retail Pharmacy Network, the Contractor is expected to use its best efforts to substantially maintain the composition of

independent Network Pharmacies included in the Programs' current Retail Pharmacy Network provided such Pharmacies meet the requirements of Sections 6.11.2 and 6.11.3 of this Agreement, and are willing to accept the proposed aggressive reimbursement rates.

6.11.1d The Contractor shall include in its Retail Pharmacy Network any Pharmacy(ies) upon the Department's request, where such inclusion is deemed necessary by the Department to meet the needs of Enrollees even if not otherwise necessary to meet the minimum access guarantees in Section 7.4.0 of this Agreement.

6.11.1e Any changes made by NYSIF to the scope of its Agreement with the Contractor for Prescription Drug Program Services after execution of this Agreement, including but not limited to the request to include any individual independent Network Pharmacy(ies), shall have no impact on this Agreement or cost thereunder, unless the change is agreed to by the Department.

6.11.1f The Contractor must effectively communicate the content (including any subsequent changes) and requirements of the Program's Flexible Formulary and Preferred Drug Lists to their Retail Pharmacy Network.

6.11.1g Prior to January 1, 2014, the Contractor must ensure that their Network Pharmacies have the correct claim identification information (i.e. RX BIN #, RXPCN, RXGRP, effective date, phone number for questions, etc.) to facilitate accurate claims submission and uninterrupted access for DCS Program Enrollees.

6.11.1h The Contractor must establish a process to provide Enrollees with access to Limited Distribution Drugs through the Retail Pharmacy Network.

6.11.2 Pharmacy Credentialing

6.11.2a The Contractor must ensure its Retail Pharmacy Network is credentialed in accordance with all applicable federal and state laws, rules and regulations.

6.11.2b The Contractor must credential Pharmacies in a timely manner and shall have an effective process by which to confirm Network Pharmacies continuing compliance with credentialing standards.

6.11.2c The Contractor must maintain credentialing records and make them available for review by the Department upon request.

6.11.3 Pharmacy Contracting: The Contractor is responsible for providing Pharmacy contracting services including, but not limited to:

6.11.3a Ensuring that all Network Pharmacies contractually agree to and comply with all of the DCS Program's requirements and benefit design specifications;

6.11.3b Ensuring all Network Pharmacy contracts include a provision for prohibiting the use of pharmacy manufacturer coupons that reduce or waive Enrollee Copayments;

6.11.3c Recruiting licensed Pharmacies affiliated with home care agencies that are participating providers under the Empire Plan's Home Care Advocacy Program administered by the Empire Plan's medical carrier, as may be updated throughout the term of the Agreement;

6.11.3d Ensuring that Network Pharmacies accept as payment-in-full, the Contractor's reimbursement for all claims processed based on the DCS Program's Lesser of Logic, as set forth in Section 12.6.0 of this Agreement;

6.11.3e Notifying the Department in writing of any plan to renegotiate the financial terms of any Network Pharmacy contract utilized by the DCS Program for any Pharmacy that is located in the State of New York, or for any such Pharmacy located outside NYS that accounts for more than 0.25% of total DCS Program final paid claim Ingredient Costs;

6.11.3f Notifying the Department in writing within 1 (one) Business day of any changes to contracts with Retail Pharmacy Network chain Pharmacies or independent

Pharmacies negotiating collectively with the Contractor, including but not limited to, those identified as participating in the Contractor's network;

6.11.3g Upon the request of the Department, resoliciting the entire Pharmacy Network to obtain more aggressive reimbursement rates that would pass-through to the DCS Program in exchange for a smaller, select network that meets proposed access guarantees, as modified; and

6.11.3h Committing to administering Pharmacy contracts consistent with all representations made in the Contractor's cost proposal, including all representations regarding the administration of generic pricing and maintenance of MAC list(s).

6.11.4 Pharmacy Audit: The Contractor must have a staffed audit unit employing a comprehensive Pharmacy audit program that includes, but is not limited to:

6.11.4a Providing ample audit resources including access to the Contractor's on-line claims processing system to the Department and the Office of the State Comptroller (OSC) at their respective offices through the date of the final financial settlement of the Agreement;

6.11.4b Providing Department with access and monthly updates to the Prescription Drug industry pricing source material (e.g. Red Book, Medispan, other) that the Contractor will be utilizing for the Program;

6.11.4c Conducting routine and targeted on-site audits of Network Pharmacies, the Mail Service Pharmacy and the Specialty Pharmacy(ies). Pharmacies that deviate significantly from patterns of dispensing in terms of cost, drug selection, overrides, Days supply or utilization are to be identified and targeted for on-site and desk audits in accordance with established selection and screening criteria. On-site audits must also be conducted upon request by the Department, or when information is received by the Contractor that indicates a pattern of conduct by a Pharmacy that is not consistent with the DCS Program's design and objectives. Periodic, on-site audits must be conducted at least once during the course of the five (5) year resultant Agreement for Pharmacies that fall into the top fifty (50)

in terms of total dollar spend for the DCS Program. Any modifications to the proposed Pharmacy audit programs must receive prior approval by the Department;

6.11.4d Providing reports to the Department detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Contractor. The Contractor must inform the Department in writing of any allegation or other indication of potential fraud and abuse identified within seven (7) Business Days of such allegations or identification. The Department must be fully informed of all fraud and abuse investigations impacting the DCS Program upon commencement regardless of whether the individual fraud and abuse investigation has a material financial impact to the State;

6.11.4e The Contractor must maintain the capability and contractual right to effectively audit the DCS Program's Retail Pharmacy Network, including the use of statistical sampling audit techniques and the extrapolation of errors;

6.11.4f Agreement to fully cooperate with all Department and/or OSC audits consistent with the requirements of Appendices A and B as set forth in this Agreement, including provision of access to protected health information and all other confidential information when required for audit purposes as determined by the Department and OSC as appropriate. The Contractor must respond to all State audit requests for information and/or clarification within fifteen (15) Business Days. The Contractor must perform timely reviews and respond in a time period specified by the Department to preliminary findings submitted by the Department and the Comptroller's audit unit in accordance with the requirements of Article XIX, "Audit Authority." Such audits may include, but are not limited to: mail order claims; Enrollee submitted paper claims; and on-line Pharmacy claims. Use of statistical sampling of claims and extrapolation of findings resulting from such samples shall be acceptable techniques for identifying claims errors. The selected Contractor shall facilitate audits of network pharmacies as requested by the Department and/or OSC;

6.11.4g Remitting 100% of pharmacy audit recoveries to the DCS Program within thirty (30) Days upon final audit determination consistent with the process specified in Article XV "Payments/(Credits) to/from the Contractor" and Appendix B of this Agreement;

6.11.4h Utilizing the auditing tools and performance measures proposed by the Contractor to identify fraud and abuse by Network Pharmacies and/or Enrollees; and,

6.11.4i Permitting the Department or a designated third party to audit pharmacy bills and drug company revenues.

6.12.0 Mail Service Pharmacy Process: The Contractor must provide all aspects of Mail Service Pharmacy Process. Such responsibility shall include, but not be limited to:

6.12.1 Having a fully staffed and fully operational Mail Service Pharmacy Process throughout the term of the Agreement, utilizing one or more Mail Service Pharmacy Process Facilities meeting all New York State legal requirements. The Mail Service Pharmacy Process must be capable of dispensing all covered, FDA approved medications including any drug that could be classified as Specialty Drugs/Medications or requires special preparation or handling for up to a 90 day supply. Contractor must establish a process to provide Enrollees with access to Limited Distribution Drugs placing no additional steps or burdens on the Enrollee. Prescriptions are considered to be "submitted through the Mail Service Process" if they are submitted by phone, fax, internet, e-prescribing or mail to any Mail Service Pharmacy Process Facility, regardless of how the Prescription is filled. All covered Prescriptions, except for Limited Distribution Drugs, submitted through the Mail Service Pharmacy Process or through a Mail Service Pharmacy Process Facility shall be charged to the DCS Program based on the Contractor's mail service pricing terms and dispensing fees (if any) applicable to Brand name, Generic, and Compound Drug claims as set forth in Article XII, "DCS Program Claims Reimbursement" of this Agreement, including Specialty Drugs/Medications for certain enrollees. Limited Distribution Drugs submitted through the Mail Service Pharmacy Process shall be charged to the DCS Program based on the Contractor's Retail Network pricing terms and dispensing fees (if any) applicable to Brand Name, Generic and Compound Drug claims as set forth in Article XII, "DCS Program Claims Reimbursement" of this Agreement. The

Mail Service Pharmacy Process shall apply the same DCS Program benefit design features as the Network Pharmacies, including but not limited to Mandatory Generic Substitution, DUR, Prior Authorization, Flexible Formulary and Preferred Drug List, and application of appropriate Copayments;

6.12.2 Ensuring that all the Department approved edits including, but not limited to, enforcing utilization edits (i.e. refill to soon, duplicate therapy, etc.) are built into the Prescription fulfillment system to protect an enrollee's safety as well as to control DCS Program costs;

6.12.3 Ensuring that all Mail Service Pharmacy Process Facilities utilized in the Contractor's Mail Service Pharmacy Process meet all Prescription drug packaging regulatory requirements. Any facility located outside New York State that will provide service for the DCS Program must be registered with the NYS Department of Education and meet all requirements of Section 6808-b of NYS Education Law. The Mail Service Pharmacy Process must recognize the full prescribing authority of Medical Professionals granted by NYS where allowed by state law;

6.12.4 Providing a simple, user friendly method(s) of ordering, reordering, or transferring Prescriptions from retail to mail. Maintaining a Dedicated Call Center located in the United States employing a staff of Pharmacists, and a staff of fully trained customer service representatives, and supervisors available 24 hours a day 365 Days a year that must meet the Contractor's Mail Service Pharmacy Process guarantees set forth in Article VII, "Performance Guarantees" of this Agreement.

6.12.4a The Contractor must have an integrated system for customer service staff to utilize to respond to, log and track all Enrollee inquiries. The system must create a record of the Enrollee contacting the call center, the call type and all customer service actions and resolutions.

6.12.4b Customer service representatives must be trained and capable of responding to a wide range of questions, complaints and inquiries including but not limited to: DCS Program benefit levels, refills, order status, prices and billing, point of service issues, prior authorization, eligibility, generic appeals, Mail Service Pharmacy Process, Specialty Pharmacy Process services and complaints, and

Flexible Formulary and Preferred Drug List alternatives. Callers must be able to reorder and check order status through both the customized website and the consolidated telephone line. Enrollees must also have access to their Prescription drug history file (both retail and mail) via the customized website;

6.12.5 Providing pre-addressed, postage-paid mail service envelopes to Enrollees, health benefit administrators for inclusion in Empire Plan publications, at the request of the Department.

6.12.6 Having efficient procedures in place to handle routine Prescriptions, "urgent" Prescriptions, and Prescriptions that require "special" handling (i.e. temperature control, limited shelf life, high cost, etc.);

6.12.7 Providing standard mail service delivery using packaging that is appropriate for the drug dispensed and the address it is shipped to at no additional cost to the Plan or the Enrollee. Easy open caps also must be provided to Enrollees upon request at no additional cost;

6.12.8 Having a system in place to track all Prescriptions (both intervention and non-intervention) received for processing through the Mail Service Pharmacy Process from the date the Prescription is received to the date the mailing agent picks up the package. The Contractor must also be able to track fill accuracy rates;

6.12.9 Maintaining a process to collect information necessary to ensure enrollee safety. The process should collect such information as drug allergies, chronic medical conditions, and other medications taken on a regular basis;

6.12.10 Maintaining a system that notifies Enrollees about potential health and safety issues with their Prescriptions;

6.12.11 Maintaining efficient procedures regarding inventory management of the Mail Service Pharmacy Process Facility(ies) including, but not limited to, backorders, inventories of high demand drugs, supplies of difficult to obtain drugs, back-up supplier contracts, etc.;

6.12.12 Providing prompt notification to Enrollees regarding out of stock items, partial fill orders, and changes to Prescriptions (e.g., approved or required dispensing of generics instead of

Brand drugs). In out of stock situations, the Contractor must have a system in place to ensure that Prescriptions are filled in the most efficient manner whether it be through an alternate facility(ies) or obtaining a re-stock from a supplier. If necessary, the Contractor shall call the Enrollee first to obtain permission to contact their Physician to offer alternative medications, or to offer to return the prescription. If the Physician authorizes use of an alternative medication, a letter notifying the Enrollee of the change must be sent to the Enrollee before the medication is shipped or must accompany the Prescription;

6.12.13 Calling the prescribing Physician when a DAW-1 is indicated on the Prescription to confirm that the Physician understands the financial impact to the Enrollee and/or the DCS Program to determine if the Physician is willing to allow the generic version of the drug to be dispensed to the Enrollee. If the Physician was previously contacted regarding the same Prescription for a particular Brand Drug for the same Enrollee and required that the Brand Drug be dispensed, no call is required. If the Physician authorizes use of the generic version of the drug, a phone call shall be made to the Enrollee to advise of the approved change before the medication is shipped or the Contractor shall include a letter with the Prescription informing the Enrollee of their Physician's approval. If the Enrollee has indicated on the mail service order form that they do not wish their Physician to be contacted for such determinations, no call shall be made;

6.12.14 Inform the Enrollee prior to shipping if the total amount for a new Prescription order submitted through the Mail Service Pharmacy Process exceeds $100 and Enrollee has payment information (e.g. credit card) on file or Enrollee's total balance is over $100 and Enrollee has no payment information (e.g. credit card) on file. The Mail Service Pharmacy Process Facility will not be required to inform Enrollees if there is a consistent history of the acceptance of shipments of the same medication that exceed the maximum amount specified. If the brand name drug is dispensed, the Contractor shall cause the dispensing facility to collect the applicable Brand Drug Copayment plus the calculated Ancillary Charge, if any. Under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the DCS Program.

6.12.15 The Contractor is expected to assist Enrollees, upon request, to establish a payment plan so that Prescriptions that are essential to an Enrollee's health will continue to ship when the outstanding amount exceeds the Contractor's proposed maximum limits.

6.12.16 Notifying the Department of nationwide out of stock issues, including information from the manufacturer or wholesaler regarding the anticipated date that the drug will resume shipment;

6.12.17 Utilizing best efforts to complete Physician clarification, verification, or other interventions within the five (5) Business Day service level standard. Should this require more than eight (8) Business Days, the Contractor shall call the Enrollee and offer the Enrollee the option of returning the prescription or continuing the intervention attempt;

6.12.18 Ensuring that the consent of the Enrollee is obtained prior to calling the prescribing Physician with the exception of calls made for purposes of clarification, verification, settlement of other intervention claim issues or DAW-1 confirmations;

6.12.19 Providing all necessary clinical and educational support to DCS Program Enrollees, and/or their family/caregiver utilizing the Mail Service Pharmacy Process, including Enrollees taking injectable, infusion or other drugs requiring special handling or special administration;

6.12.20 Having a back-up mail order facility(ies) to handle any overflow and/or situations where the primary mail order facility is unavailable;

6.12.21 Promoting the utilization of the Mail Service Pharmacy Process through targeted mailings, Physician communications, etc. if the Department determines that such promotions are in the best financial interests of the Plan. All such activities, including mailings, are subject to change and require the prior written approval of the Department. Any regular direct communication with Enrollees or their Physicians in connection with Enrollee drug utilization or the processing of Enrollee claims, either through mail, e-mail, fax or telephone must be submitted for the Department's approval. The cost of any approved promotion shall be borne by the Contractor, unless the Department specifically requests a particular activity not required to be performed under the Agreement. The Department will not approve any mail order promotions that it determines will not result in a reduced net cost to the DCS Program;

6.12.22 The Contractor shall act in the best interests of the DCS Program when dispensing Generic Drugs through the Mail Service Pharmacy Process by avoiding the dispensing of NDC's with higher AWPs unless market conditions exist making dispensing the more cost effective NDC impractical or impossible;

6.13.0 Specialty Drugs/Medications

6.13.1 The Contractor must provide Enrollees with access to all Medically Necessary Specialty Drugs/Medications covered by the DCS Program through its Retail Pharmacy Network, Mail Service Pharmacy Process and Specialty Pharmacy in accordance with each Enrollee group benefit design. In the case of Limited Distribution Drugs, the Contractor shall provide Enrollees with access in accordance with the following:

6.13.1a *Retail Pharmacy Network Access* (Amended April 4, 2012)

The Contractor shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the DCS Program consistent with the Contractor's contracted discount off of AWP for the Limited Distribution Drug, plus any dispensing fee. ~~If the Contractor is unable to secure the participation of the authorized distributor, the Contractor agrees to facilitate the Enrollee's receipt of the drug and bill the DCS Program at the Minimum overall Guaranteed Discounts applicable to Brand Drugs for network pharmacies~~. The Enrollee shall be charged the applicable retail Copayment.

6.13.1b *Mail Service Pharmacy Process Access*

~~For all Specialty Drugs including Limited Distribution Prescriptions submitted through the Mail Service Pharmacy Process, t~~The Contractor must facilitate the Enrollee's receipt of the Limited Distribution Drug. The Offeror shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the Programs consistent with the Offeror's contracted discount off AWP for the Limited Distribution Drug, plus any dispensing fee. ~~by obtaining the drug from an authorized distributor and billing the DCS Program consistent with its Guaranteed Discounts applicable to Brand Drugs for the mail service pharmacy.~~

The Enrollee shall be charged the applicable mail order Copayment.

6.13.2 Individuals receiving home infusion services through the Home Care Advocacy Program (HCAP), a component of the Empire Plan's Medical/Surgical Program, have their home infusion drugs covered under the Prescription Drug Program. Currently the DCS Program has a network of licensed pharmacies affiliated with home care agencies participating in the Empire Plan's HCAP Program administered by the Empire Plan's medical carrier. The Contractor is expected to secure contracts with the licensed pharmacies provided in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," of this Agreement, to ensure continued utilization of a network Prescription drug benefit for those Enrollees utilizing the HCAP Program. The Contractor may propose to utilize entities owned by or affiliated with the Contractor to serve as an HCAP Provider. The Department at its sole discretion shall determine whether it is in the best interests of the DCS Program to allow the entity to participate in the HCAP Program. The Prescription drugs dispensed to Enrollees via the entities or pharmacies owned by or affiliated with the Contractor must be charged to the DCS Program based on the Contractor's mail service pricing terms and dispensing fees applicable to brand name, generic, and Compound Drug claims set forth in Article XII of this Agreement.

6.13.3 Specialty Pharmacy Program (Amended April 4, 2012)

6.13.3a The Contractor must provide Enrollees with access to all Medically Necessary Specialty Drugs/Medications covered by the DCS Program through its proposed Specialty Pharmacy Program in accordance with each Enrollee group benefit design. Such responsibility must include, but not be limited to:

6.13.3a(1) Developing a listing of the Specialty Drugs/Medications proposed for inclusion in the Specialty Pharmacy Program;

6.13.3a(2) Having a fully staffed and fully operational Specialty Pharmacy Program in which Specialty Drugs/Medications are provided by one or more Designated Specialty Pharmacies. All Designated Specialty Pharmacies must meet all New York State legal requirements. Any facility located outside New York State that will provide service for

the DCS Program must be registered with the NYS Department of Education and meet all requirements of Section 6808-b of NYS Education Law. The Specialty Pharmacy Process must recognize the full prescribing authority of Medical Professionals granted by NYS where allowed by state law.

6.13.3a(3) The Contractor must establish a process to provide Enrollees with access to Limited Distribution Drugs not available through the Designated Specialty Pharmacy(ies), which places no additional steps or burdens on the Enrollee. The Offeror shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the Programs consistent with the Offeror's contracted discount off AWP for the Limited Distribution Drug, plus any dispensing fee. The Enrollee shall be charged the applicable retail Copayment. ~~The Contractor must bill the DCS Program for these Prescriptions consistent with the Contractor's Minimum Guaranteed Discount applicable to Prescriptions dispensed at Network Pharmacies.~~

6.13.3a(4) Providing a fully staffed and fully operational customer support call center available to Enrollees 24 hours a day, 365 Days a year including Pharmacists, clinicians, and registered nurses trained in an Enrollee's specific Specialty Drug/Medication therapies. The Contractor must provide callers with access to customer service staff and Pharmacists through the Empire Plan consolidated line who are able to respond timely to questions, complaints and inquiries including but not limited to: DCS Program benefit inquiries, refills, order status, price estimates, billing, point of service issues, Specialty Pharmacy Process complaints, preferred drug status, and claim status. Callers must be able to reorder and check order status through both the customized website and the consolidated telephone line. Enrollees must also have web access to their Prescription drug history file (retail, mail, and specialty) via a customized website.

6.13.3a(5) Administering a safety monitoring system that complies with the Food and Drug Administration (FDA) Amendments Act of 2007 which requires a Risk Evaluation and Mitigation Strategy (REMS) from the Specialty Drugs/Medications manufacturers to ensure the benefits of a drug outweigh its risks.

6.13.3a(6) Contracting a nationwide network of appropriately licensed clinicians and/or coordinating with appropriately trained HCAP clinicians to administer the Specialty Drugs/Medications to Enrollees in a home setting and providing Enrollees with education on proper treatment regimens and possible side effects.

6.13.3a(7) Completing Physician consultation, coordination of care, patient care management and other interventions on a clinically appropriate and timely basis.

6.13.3a(8) Providing all necessary clinical and educational support to Enrollees, and/or their family/caregiver utilizing the Specialty Pharmacy Process, including but not limited to explaining the treatment plan and ancillary supplies, disease/drug education, side-effect management, compliance management and administration training.

6.13.3a(9) Applying the same DCS Program benefit design features as the Mail Service Pharmacy Process, including but not limited to Mandatory Generic Substitution, DUR, Prior Authorization, Preferred Drug List, and application of appropriate Copayments. Specialty Drugs/Medications that are subject to the Designated Specialty Pharmacy Passive Edit and are dispensed at a Network Pharmacy must be subject to the Network Pharmacy Copayments.

6.13.3a(10) Ensuring that all the Department's approved edits including, but not limited to, enforcing utilization edits (e.g. refill to soon, duplicate therapy, etc.) are built into the Prescription fulfillment process

system to protect an Enrollee's safety as well as to control DCS Program costs.

6.13.3a(11) Ensuring that all Designated Specialty Pharmacies utilized in the Contractor's Specialty Pharmacy Program meet all Prescription drug packaging regulatory requirements. The Contractor must ensure that Specialty Drugs/Medications are shipped to Enrollees in appropriate packing materials so that Specialty Drugs/Medications are safe and effective and delivered on time.

6.13.3a(12) Providing a simple, user friendly method(s) of ordering, reordering, and transferring Prescriptions from retail and mail to the Designated Specialty Pharmacy(ies) including pre-addressed postage paid Specialty Pharmacy Program envelopes. The Contractor must send a Specialty Pharmacy Program letter to Enrollees who have received a First Fill of a Specialty Drug/Medication through a Network Pharmacy. The letters must be sent within seven (7) Days of the Prescription being filled to Enrollees who have received a Specialty Drug/Medication subject to the Designated Specialty Pharmacy Hard Edit and within thirty (30) Days of the Prescription being filled to Enrollees who have received a Specialty Drug/Medication subject to the Designated Specialty Pharmacy Passive Edit. Enrollees are allowed one Grace Period for Specialty Drugs/Medications.

6.13.3a(13) Maintaining a comprehensive system for the Contractor's staff to utilize to track all Enrollee inquiries including, but not limited to; DCS Program benefits, refills, order and claim status, prices, billing, Preferred Drug List inquiries and Specialty Pharmacy Process complaints. The system shall include call type, customer service actions and resolutions.

6.13.3a(14) Having a system in place to track all Prescriptions received for processing through the Specialty Pharmacy Process from the date the

Prescription is received to the date the Prescription is shipped. The Contractor must also be able to track fill accuracy rates.

6.13.3a(15) Maintaining a process to collect information from individuals necessary to ensure Enrollee safety. The process should collect such information as drug allergies, chronic medical conditions, and other medications taken on a regular basis.

6.13.3a(16) Ensuring that the Designated Specialty Pharmacy(ies) have efficient procedures regarding inventory management including, but not limited to, backorders, inventories of high demand drugs, supplies of difficult to obtain drugs, back-up supplier contracts, etc.

6.13.3a(17) Providing notification to Enrollees as soon as possible for out of stock items, partial fill orders, and changes to Prescriptions (e.g., dosing or method of administration). In out of stock situations, the Contractor must have a system in place to ensure that Prescriptions are filled in the most efficient manner whether it be through an alternate facility(ies) or obtaining a re-stock from a supplier. The Contractor must contact the Enrollee's Physician, if necessary, to offer alternative medications or offer to return the Prescription. If the Physician authorizes use of an alternative medication, a letter notifying the Enrollee of the change must be sent to the Enrollee before the medication is shipped or must accompany the Prescription.

6.13.3a(18) Informing the Enrollee prior to shipping if the total amount for a new Prescription order submitted through the Specialty Pharmacy Process exceeds $100 and Enrollee has payment information (e.g. credit card) on file or Enrollee's total balance is over $100 and Enrollee has no payment information (e.g. credit card) on file. The Designated Specialty Pharmacy will not be required to inform an Enrollee if there is a consistent history of the acceptance of shipments of the same medication that exceed the $100 amount specified.

6.13.3a(19) The Contractor is expected to assist Enrollees, upon request, to establish a payment plan so that Specialty Drug/Medication Prescriptions that are essential to an Enrollee's health will continue to ship when the outstanding amount exceeds the Contractor's proposed maximum limits.

6.13.3a(20) Promptly notifying the Department of nationwide out of stock issues, including information from the manufacturer or wholesaler regarding the anticipated date that the drug will resume shipment.

6.13.3a(21) Having back-up Designated Specialty Pharmacies to handle any overflow and/or situations where the primary Specialty Program facility is unavailable.

6.13.3a(22) The mail order Copayment shall apply to all drugs dispensed through the Specialty Pharmacy Program as well as Limited Distribution Drugs facilitated through the Special Pharmacy Program.

6.13.3a(23) Recommending newly launched Specialty Drugs/Medications for inclusion in the Specialty Pharmacy Program based on the established criteria/definition of Specialty Drug/Medications, in a format to be approved by the Department. Prior to inclusion in the Specialty Pharmacy Program, or if not accepted by the Department to be included in the Specialty Pharmacy Program, the Contractor must bill the DCS Program for these Prescriptions consistent with the Contractor's contracted discount off of AWP at the dispensing Network Pharmacies or the Guaranteed Discount at the Mail Service Pharmacy Process, based on where each Prescription was actually dispensed. Inclusion of new Specialty Drugs/Medications shall have a cost-neutral or positive financial impact on the DCS Program, and in no case shall the Ingredient Cost of a newly added Specialty Drug/Medication charged to the DCS Program exceed the Guaranteed Discount on Specialty Pharmacy Drugs.

6.14.0 Claims Processing

6.14.1 The Contractor must provide all aspects of claims processing. Such responsibility shall include but not be limited to:

6.14.1a Verifying that the DCS Program's benefit designs have been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly;

6.14.1b Accurate and timely processing of all claims submitted under the DCS Program in accordance with the benefit design applicable to the Enrollee at the time the claim was incurred as specified to the Contractor by the Department;

6.14.1c Charging the DCS Program consistent with the Contractor's proposed pricing quotes;

6.14.1d Developing and maintaining claim payment procedures, guidelines, and system edits that guarantee accuracy of claim payments for covered expenses only, utilizing all edits as proposed and approved by the Department. The Contractor shall utilize refill too soon edits and duplication of therapy edits for all claims unless exceptions are specifically approved in advance by the Department. The Contractor's system must ensure that refilling Prescriptions prior to use of the minimum prescribed Days supply does not result in over dispensing;

6.14.1e Managing Flexible Formulary and Preferred Drug List placement of drugs consistent with Program design and ensuring application of appropriate Copayments based on level assignment;

6.14.1f Maintaining claims histories for 24 months online and archiving older claim histories for 6 years and the balance of the calendar year in which they were made with procedures to easily retrieve and load claim records;

6.14.1g Maintaining the security of the claim files and ensuring HIPAA compliance;

6.14.1h Reversing all attributes of claim records, e.g. AWP, quantity, Days supply, etc., processed in error ~~or due to fraud~~ including the reversal of any Claim Administration Fee associated with the original claim and crediting the DCS Program for all costs associated with the claim processed in error ~~or due to fraud~~ including but not limited to the Claim Administration Fee; and

6.14.1i Agreeing that all claims data is the property of the State. Upon the request of the Department, the Contractor shall share appropriate claims data with other DCS Program carriers and consultants for various programs (e.g., Disease Management, Centers of Excellence) and the Department's Decision Support System (DSS) contractor. The Contractor cannot share, sell, release, or make the data available to third parties in any manner without the prior consent of the Department. The Department understands that the selected Contractor will be required to share certain claims data with pharmaceutical manufacturers for purposes of obtaining for the Program all Pharma Revenue due it under this Agreement. The Contractor shall inform the Department of the types of data being shared for these specific authorized purposes.

6.14.2 Maintaining a back-up system and disaster recovery system for processing claims in the event that the primary claims payment system fails or is not accessible;

6.14.3 Maintaining a claims processing system capable of integrating and enforcing the various utilization review components of the DCS Program, including, but not limited to: Mandatory Generic Substitution, Prior Authorization, messaging capability in the current NCPDP format and a concurrent DUR program to aid the Pharmacist at the point of sale;

6.14.4 Maintaining an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the DCS Program's mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the generic at the Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Retail Pharmacy Network, the DCS Program's mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized generic in stock, mandatory generic substitution provisions will not apply and the Enrollee shall receive the Brand Drug, be charged the applicable generic Copayment and the DCS Program charged based on generic pricing. The DCS Program shall reject claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW-0 code with appropriate messaging and requires resubmission of the claim since a DAW-0

code provides no indication of Generic Drug availability in the Pharmacy. The DCS Program logic for the Pharmacy Submitted DAW codes is listed below:

Pharmacy Submitted DAW	Enrollee Copay	Ancillary Charge	Pricing
0	Brand	No	Brand
1	Brand	Yes	Generic
2	Brand	Yes	Generic
3	Generic	No	Generic
4	Generic	No	Generic
5	Generic	No	Generic
6	Generic	No	Generic
7	Brand	No	Brand
8	Generic	No	Generic
9	Generic	No	Generic

6.14.5 Maintaining a claims processing system capable of ensuring that claims are consistently processed with the appropriate brand name/generic/compound classification in accordance with the requirements set forth in Article XII: "DCS Program Claims Reimbursement" of this Agreement.

6.14.6 Maintaining a Programs' MAC List for Pharmacies;

6.14.7 Processing Enrollee Submitted Claims in accordance with the following:

6.14.7a For Prescriptions filled with a Brand Drug with no generic equivalent, the Enrollee will be reimbursed using the Contractor's Minimum overall guaranteed Discounted Ingredient Cost for the Retail Pharmacy Network and dispensing fee for Brand Drugs not to exceed the submitted charges, less the applicable Copayment;

6.14.7b For Prescriptions filled with a Brand Drug that has a generic equivalent, the Enrollee will be reimbursed up to the amount the DCS Program would reimburse the Retail Pharmacy Network for filling the Prescription with that drug's generic equivalent; not to exceed the submitted charges, less the applicable Copayment;

6.14.7c For Prescriptions filled with a Generic Drug the Enrollee will be reimbursed up to the amount the DCS Program would reimburse the Retail Pharmacy Network for that Prescription, not to exceed the submitted charges, less the applicable Copayment;

6.14.7d For Prescriptions filled with a Compound Drug the Enrollee will be reimbursed up to the amount the DCS Program would reimburse the Retail Pharmacy Network for that Prescription, not to exceed the submitted charges, less the applicable Copayment; and

6.14.7e If the Enrollee has two Empire Plan coverage's, the Plan will reimburse 100% of the copay upon submission of a paper claim form prepared by the Enrollee. For specific methodology on how the DCS Program must be charged for Enrollee Submitted Claims, see Section 13.10.0, "Enrollee Submitted Claims."

6.14.8 Processing claims for Employees enrolled in the SEHP who fill Prescriptions at the SUNY Stony Brook Student Health Service Pharmacy, and other SUNY pharmacies as may be requested by the Department during the term of the Agreement. Prescriptions under this arrangement must be dispensed according to the Plan design for the SEHP, including required prior authorizations and, where applicable, Days supply limits. The Contractor must monitor the submission of SEHP claims and inform the Department if the SUNY Pharmacies submit charges in excess of the amounts that are paid to the DCS Program's Retail Network Pharmacies for the same NDC's;

6.14.9 Processing all manually submitted claims including but not limited to Medicaid, VA , Skilled Nursing Facility claims, out of network claims, foreign claims, in-network manual claims, COB claims, and Medicare B primary claims in accordance to the Contractor's proposed Claims Adjudication Guarantee;

6.14.10 Analyzing and monitoring claim submissions to promptly identify errors, fraud and abuse and reporting to the Department such information in a timely fashion in accordance with a Department approved process. The DCS Program shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses. The DCS Program will be charged a Claims Administration Fee only for Final Paid Claims. The Contractor will

credit the DCS Program the amount of any overpayment regardless of whether any overpayments are recovered from the Pharmacy and/or Enrollee in instances where a claim is paid in error due to Contractor error, or due to fraud or abuse, without additional administrative charge to the DCS Program. The Contractor shall report fraud and abuse to the appropriate authorities. In cases of overpayments resulting from errors only found to be the responsibility of the Department, the Contractor shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the DCS Program upon receipt; however the Contractor, is not responsible to credit amounts that are not recovered;

6.14.11 Establishing a process where Pharmacies can verify eligibility of Enrollees and Dependents during Call Center Hours;

6.14.12 Requiring network pharmacies to submit to the Contractor for each drug dispensed the Pharmacy's Submitted Cost to ensure that the DCS Program is charged according to the Programs' Lesser of Logic. Further, if an Ancillary Charge is applied, it will be deducted from the total claim cost;

6.14.13 Identifying Enrollees enrolled in Medicare Part D. The Contractor's claims processing system must decline claims at the point of service for Enrollees who are enrolled in a Medicare Part D Plan other than the DCS Program EGWP. Messaging to the Pharmacy must instruct the Pharmacist to submit the claim to the Enrollee's Medicare Part D Plan.

6.14.14 Establishing a process to support, and respond to Federal Medicare Part D audits; and

6.14.15 Having a process in place (fully staffed with ample telephone trunks) available 24 hours a Day, seven Days a week where a Pharmacist can call to quickly resolve point of service issues.

6.14.16 Processing claims pursuant to Enrollees covered under the Disabled Lives Benefit. DCS agrees to reimburse the selected Offeror for claims processed under the Disabled Lives Benefit in accordance with Article XV "Payments/(Credits) to/(from) the Contractor.

6.15.0 Retrospective Coordination of Benefits

6.15.1 The Contractor is required to pursue collection of any money due the DCS Program from other payers or Enrollees who have primary Prescription drug coverage through another

carrier and to credit the DCS Program's account one hundred percent (100%) of all recoveries within fifteen (15) Days after the end of the month.

6.15.2 The Contractor must maintain a system capable of receiving a historical COB data file from the current contractor and benefits information obtained from Enrollee surveys. The Contractor's system must be capable of tracking the date an initial letter is sent to the Enrollee or other carrier until the point money is recovered.

6.15.3 The Contractor must develop for Department review and approval COB correspondence including, but not limited to; an Enrollee questionnaire to confirm other Prescription drug coverage information, a letter(s) instructing Enrollees to file for reimbursement from the primary plan and advising that the Enrollee must reimburse the DCS Program for the cost of their claims and a collection letter(s) to other carriers who owe the DCS Program reimbursement.

6.15.4 The Contractor must have a system in place to facilitate collection, without Enrollee intervention, when the primary plan claims adjudicator is the same as the Contractor.

6.16.0 Utilization Management

6.16.1 Mandatory Generic Substitution at Retail and Mail

To ensure strict adherence to the DCS Program's Mandatory Generic Substitution Requirement and protect the financial interests of the DCS Program, the Contractor is required to:

6.16.1a Unless otherwise directed by the Department, apply mandatory generic substitution to all specific NDC's of Brand Drugs for which there is an FDA approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc) or an authorized Generic Drug as permissible by NYS law. Network Pharmacies shall comply with all state laws related to mandatory generic substitution. The DCS Program's mandatory generic substitution provisions shall apply to any claim where the A-rated or authorized Generic Drug is required or permitted to be substituted under state law. Mandatory generic substitution provisions will not apply to B-rated or unrated

Generic Drugs or in the unlikely event that state law prohibits dispensing of the A-rated or authorized Generic Drug.

6.16.1b Establish the Ancillary Charge by calculating the difference in the Discounted Ingredient Cost of the Brand Drug and the Ingredient Cost of the equivalent A-rated Generic Drug or authorized Generic Drug based on the Programs' MAC list price assigned when a Brand Drug for which an A-rated or authorized Generic Drug has been introduced in the market is dispensed to the Enrollee. In such cases, the Enrollee shall be responsible for paying the applicable Non-Preferred Brand Drug Copayment plus Ancillary Charge not to exceed the cost of the drug to the DCS Program. The Ancillary Charge shall be assessed even in the event a Physician has specifically directed a Pharmacist to dispense the Brand Drug rather than the A-rated or authorized Generic Drug through DAW notation.

6.16.1c Monitor the pharmaceutical industry on behalf of the Department to identify Generic Drugs expected to enter the market. Prior to the actual introduction of the Generic Drug to market, the Contractor shall inform the Department of anticipated shipping dates of the first Generic Drug introduced into the market for one or more strengths of a particular Brand Drug.

6.16.1d Following the first shipment of a first Generic Drug for one or more strengths of a particular Brand Drug, the Contractor is required to:

6.16.1d(1) Inform the Department as soon as practicable but in no event later than fourteen (14) Days after the first date of shipment, (from manufacturer to wholesaler or retailer) of the financial impact of enforcing mandatory generic substitution via the "MAC Alert Notice" detailed in Section 16.6.2 of this Agreement.

6.16.1d(2) For those drugs that will result in a lower net cost to the DCS Program by enforcing mandatory generic substitution, the Contractor shall provide the "MAC Alert Notice" as described in (1) above. The Contractor shall add the GCN to the Programs' MAC List and begin

enforcement as soon as practicable but in no event later than fourteen (14) Days after the first date of shipment provided that the majority of Retail Network Pharmacies are able to obtain the Generic Drug. In the case where a GCN is already subject to MAC pricing the Contractor is required to immediately apply the MAC price and mandatory generic substitution to any NDC added to the GCN following the first date of shipment.

6.16.1d(3) For those drugs that could potentially result in a higher net cost to the DCS Program by enforcing mandatory generic substitution, the Contractor shall provide the "MAC Alert Notice" as described in (1) above. The Department, in its sole discretion, may determine that enforcement is contrary to the best financial interests of the DCS Program and shall inform the Contractor whether mandatory substitution shall be applied. If the Contractor does not receive a formal response to the information provided via the "MAC Alert Notice," enforcement shall commence and the GCN shall be added to the Programs' MAC List effective on the 21st day after shipment of the first A-rated generic equivalent drug or authorized Generic Drug provided that the majority of pharmacies are able to obtain the Generic Drug. In the event the Department decides to exercise its discretion not to enforce mandatory generic substitution, the Contractor shall apply MAC pricing to the Generic Drug.

6.16.1d(4) To assist the Department in determining when mandatory generic substitution should be enforced based on an adequate supply of Generic drug being available in the market, the Contractor shall survey its Retail Pharmacy Network to identify the Pharmacies that are unable to obtain the new Generic Drug within 21 Days and weekly thereafter until the shortage resolves. The Contractor shall submit this information to the Department and provide any additional information as required by the Department to reach a determination. The Department, in its sole discretion, shall determine based on such

evidence how the DCS Program's mandatory generic substitution provisions will be applied. The DCS Program will not consider and the Contractor shall not act on availability information provided by 3rd party sources, including but not limited to Medi-Span, Red Book, First Data Bank or wholesalers.

6.16.1d(5) For Preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall be changed from preferred to non-preferred status concurrent with the commencement of the enforcement of mandatory generic substitution. Enrollees who are prescribed strengths of the Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the Generic Drug Copayment unless the prescribing Physician requires that the Brand Drug be dispensed. In that case, the Enrollee shall be charged the applicable Non-Preferred Brand Drug Copayment and Ancillary Charge. Enrollees who are prescribed strengths of the Preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Preferred Brand Drug Copayment;

6.16.1d(6) For Non-Preferred Brand Name drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall remain Non-Preferred for all strengths. Concurrent with enforcement of mandatory generic substitution, Enrollees who are prescribed strengths of the Non-Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the generic Copayment unless the prescribing Physician requires that the Brand Drug be dispensed. In that case, the Enrollee shall be charged the applicable Non-Preferred Brand Drug Copayment and Ancillary Charge. Enrollees who are

prescribed strengths of the Non-Preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Non-Preferred Brand Drug Copayment;

6.16.1d(7) The Contractor shall require the dispensing Network Pharmacy to inform the Enrollee prior to dispensing the Brand Drug, that an Ancillary Charge will be applied in addition to the applicable Non-Preferred Brand Drug Copayment. If the prescribing Physician requires the Brand Drug be dispensed, the Contractor shall require the dispensing Network Pharmacy to collect the applicable Brand Drug Copayment plus the calculated Ancillary Charge. However, under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the DCS Program after application of the Programs' Lesser of Logic provisions.

6.16.1e Charge the DCS Program based on the Programs MAC List price assigned to the GCN of the dispensed Brand Drug subject to the Programs' Lesser of Logic plus the applicable dispensing fee as set forth within Article XII, "DCS Program Claims Reimbursement" of this Agreement.

6.16.1f Promptly notify and receive Department prior written approval for any and all exceptions to the DCS Program's mandatory substitution provisions, other than those resulting the Program's Mandatory Substitution Appeal Process. Following commencement of mandatory generic substitution, the Contractor must receive Department written approval prior to suspending enforcement of the DCS Program's mandatory generic substitution provisions.

6.16.1g Maintain an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the DCS Program's mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the Generic Drug at the Network Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Network Pharmacy, the DCS

Program's mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized Generic Drug in stock, mandatory generic substitution provisions will not apply and the Enrollee shall receive the Brand Drug, be charged the applicable Generic Drug Copayment and the DCS Program charged based on Generic Drug pricing. The Contractor's claims processing system must reject, with appropriate messaging, claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW-0 code requiring resubmission of the claim (since a DAW-0 code provides no indication of Generic Drug availability in the Pharmacy). Similar rules can be applied to other DAW submission codes as necessary to ensure consistent, accurate application of the DCS Program's mandatory generic substitution requirements.

6.16.1h Immediately notify the Department of changes (from brand to generic or generic to brand) in the NDC classification submitted by the Contractor, subject to the DCS Program's definitions of Brand and Generic Drugs contained in Article I of this Agreement.

6.16.1i Manage the Narrow Therapeutic Index (NTI) list of multi-source Brand Drugs not subject to Ancillary Charges, and make recommendations to the Department of suggested additions or deletions based on clinical evidence.

6.16.2 Mandatory Generic Substitution Appeal Process

The Contractor shall administer a Mandatory Generic Substitution Appeal process. The selected Contractor is required to oversee and enforce the DCS Program's generic appeal process including:

6.16.2a Administering a clinically sound generic appeal process at no additional cost to the DCS Program or to the Enrollee. The process must include developing an appeal form and criteria for establishing medical necessity, reviewing appeals for medical necessity, preparing communications to notify Enrollees (subject to Department review and approval) of the outcome of appeals within five (5) Business Days, and integrating the decisions into the claims processing systems

including reimbursing the Enrollee for any Ancillary charge paid up to 30 Days prior to receipt of the approved generic appeal; and

6.16.2b Reporting the results of the generic appeal process for the DCS Program to the Department on a drug by drug basis in the format and frequency required in the Article XVI of this Agreement.

6.16.2c Following a successful generic appeal, charging the Enrollee for the Brand Drug at the Level 3 Copayment with no Ancillary Charge.

6.16.2d Loading into your claims processing system one or more files from the incumbent contractor of the previously approved Generic Appeal requests by January 1, 2014, once an acceptable file is received.

6.16.2e Interfacing with the New York State Department of Financial Services External Appeals Process that provides an opportunity for Enrollees and Dependents to appeal denied coverage on the basis that a prescription drug is not medically necessary or is an experimental or investigational drug.

6.17.0 Clinical Management/Drug Utilization Review (DUR)

6.17.1 To ensure that the resources available to the DCS Program are utilized for appropriate, Medically Necessary Drug therapy, the Contractor is required to administer a prior authorization program which includes, at a minimum:

6.17.1a A Prior Authorization Program for high cost Prescription drugs that are prescribed for very specific medical indications. Only medications that have been identified by the Contractor as appropriate for Prior Authorization and reviewed by the Department shall be included in the Prior Authorization Program. The Prior Authorization Program also subjects specific drugs in certain categories to clinical criteria before benefits are authorized for payment including but not limited to: anti-obesity agents; topical tretinoin; antifungal agents; Hepatitis C agents; Hepatitis B agents for interferon use; select Osteoporosis agents; Respiratory Syncytial Virus (RSV) Therapy agents, select stimulant agent; Multiple Sclerosis agents; Low Molecular Weight Heparin agents; Growth Hormones; Cancer;

Pain/Arthritis; Phychosis agents and, Pulmonary Arterial Hypertension agents. Only medications that have been identified as appropriate for the Prior Authorization Program by the Contractor and reviewed by the Department shall be included in the Prior Authorization Program;

6.17.1b Informing Medical Professionals who request, by phone, fax, secure internet portal, a Prior Authorization for a Specialty Drug/Medication about the DCS Program's Specialty Pharmacy Program and providing the information necessary to utilize the Specialty Pharmacy Program to obtain the drug;

6.17.1c Monitoring market changes and recommending deletions or additions to the list of drugs requiring Prior Authorization on an ongoing basis which must be reviewed by the Department prior to implementation of any changes to the list of medications;

6.17.1d Preparing and sending communications (reviewed and approved by the Department) to notify Enrollees and/or their Physicians of the outcome of their prior authorization request and notifying them of date the Prior Authorization is approved through;

6.17.1e Promptly loading approved prior authorization determined by the contractor into the claims processing system;

6.17.1f Administering an expeditious, HIPAA compliant, internal appeals process which allows Physicians and/or Enrollees and Dependents to appeal denied coverage on the basis that a Prescription drug is not medically necessary or is an experimental or investigational drug. For the Prior Authorization Program, there must be at least one level of appeal, and it must be expeditious and PPACA compliant; and

6.17.1g Interfacing with the New York State Department of Financial Services External Appeals Process that provides an opportunity for Enrollees and Dependents to appeal denied coverage on the basis that a Prescription drug is not medically necessary or is an experimental or investigational drug.

6.17.1h Loading one or more files of Prior Authorization approved-through dates from the incumbent contractor, prior to the January 1, 2014 implementation date, once an acceptable file is received.

6.17.2 Concurrent Drug Utilization Review (DUR)

To safeguard Enrollee health and ensure adherance with the DCS Program's benefit design, the Contractor must administer a concurrent DUR program which includes at a minimum:

6.17.2a A point of service system at all Retail Pharmacy Network locations, Mail Service Pharmacy Process Facilities and Specialty Pharmacies which is continually updated with the latest patient safety edits with the capacity to "message" Pharmacists related to safety issues prior to the dispensing of the Prescription drug; and

6.17.2b A fully integrated point of service system capable of enforcing the DCS Program's benefit design features.

6.17.3 Retrospective DUR Program

To safeguard the Enrollee's health the Contractor must administer a Retrospective DUR Program which:

6.17.3a Using the Contractor's standards, evaluates the Enrollee's Prescription drug utilization against the Enrollee's profile using FDA and other evidence based guidelines to identify potential safety related concerns. The Contractor shall alert the prescribing Phyicians to drug specific, Enrollee-specific health, safety and utilization issues including potential overuse of narcotics;

6.17.3b Identifies potential drug therapy complications for Enrollees, develops Physician alerts (subject to Department review and approval) and sends the alerts to the prescribing Physician; and

6.17.3c Reports the results of its Retrospective DUR Program initiatives including outcomes to the Department on a quarterly basis in a mutually agreed upon format.

6.17.4 Physician Education

6.17.4a Subject to Department review and approval, the Contractor must undertake a Physician education program involving communications with prescribing Physicians which includes at a minimum:

6.17.4a(1) Analysis of Physician's drug or condition specific prescribing patterns;

6.17.4a(2) Educating Physicians about the clinical and economic aspects of their prescribing decisions. Any communication with Physicians prescribing medications for Enrollees shall make the Physician aware of the distribution channel most cost effective to the DCS Program and the Enrollee;

6.17.4a(3) Reporting the results of its Physician Education initiatives to the Department on a quarterly basis in a mutually agreed upon format; and

6.17.4a(4) The Physician Education Program may not be funded by pharmaceutical manufacturers.

6.17.5 Patient Education

6.17.5a Subject to Department review and approval, the Contractor must develop and implement a Patient Education program consisting of communications to Enrollees which:

6.17.5a(1) Analyzes drug utilization from a clinical standpoint to identify and facilitate communication with Enrollees that have chronic diseases to maximize health benefits of drug treatment;

6.17.5a(2) Analyzes drug utilization to identify and facilitate communication with Enrollees not managing their drug utilization in the most cost effective manner for the Enrollee; and

6.17.5a(3) Reports the results of its patient education initiatives to the Department on a quarterly basis in a mutually agreed upon format.

6.17.5a(4) The Physician Education Program may not be funded by pharmaceutical manufacturers.

6.17.5b The Contractor may propose a voluntary Half Tablet Program which will allow Enrollees to pay half the regular Copayment at the point of service for half the quantity of double strength, eligible Prescriptions. The Contractor's proposal shall:

6.17.5b(1) Establish a list of drugs that would be appropriate to include in the Half Tablet Program including, but not limited to the drugs proposed by the Contractor in Exhibit C, Contractor's Proposal, of this Agreement;

6.17.5b(2) Notify Enrollees of their eligibility to participate in the Half Tablet Program. Monthly, the Contractor must use utilization data to identify Enrollees newly eligible to participate in the Half Tablet Program and mail; welcome/announcement letters to those Enrollees. These letters are subject to review and approval by the Department;

6.17.5b(3) Provide each Empire Plan Enrollee newly participating in the Half Tablet Program with one tablet splitter, at no charge to the Enrollee; and

6.17.5b(4) Load file to transfer current Enrollees with qualifying Prescriptions into the Half Tablet Program as of January 1, 2014.

6.17.5c The Patient Education Program may not be funded by pharmaceutical manufacturers.

6.18.0 Preferred Drug List Development and Management

The Contractor must provide PDL development and management services for the DCS Program. Such responsibility shall include but not be limited to:

6.18.1 Developing and administering four multi-level formularies, consistent with the DCS Program's four benefit designs as follows:

6.18.1a ***Traditional Empire Plan PDL*:** Under the Traditional Empire Plan PDL, all covered Generics are Level 1 and covered Brand Drugs are on either Level 2 or Level 3. A proposed PDL that includes Generics on Level 2 or Level 3 and/or

includes Brand Drugs on Level 1 does not currently meet the DCS Program requirements for the Traditional Empire Plan PDL and would not be acceptable. Drugs may not be excluded from the Traditional Empire Plan PDL. In addition, the current benefit design does not allow an Enrollee to appeal a drug's placement on the second or third level of the PDL. The Traditional Empire Plan PDL is updated once a year on January 1st. Mid-year changes to the PDL are generally not acceptable. However, mid-year changes resulting from drug recalls, the introduction of new clinically superior drugs, drugs off patent, or patient safety issues are allowed.

6.18.1b ***Flexible Formularies (two)*:** Under the Flexible Formulary, Generics may be on Level 1 or excluded. Brand Drugs may be on Level 1, 2, or 3 or excluded. A proposed PDL that includes Generics on Level 2 or Level 3 does not meet the Program requirements for the Flexible Formulary Drug List and would not be acceptable. Drugs may be excluded from the Flexible Formulary based on sound clinical and financial criteria, as follows: In addition, the current benefit design does not allow an Enrollee to appeal a drug's placement on the second or third level of the PDL nor to appeal a drug exclusion. The Flexible Formulary is updated once a year on January 1st. Mid-year changes to the PDL are generally not acceptable. However, mid-year changes resulting from drug recalls, the introduction of new clinically superior drugs, drugs off patent, or patient safety issues are allowed. The "Enhanced Flexible Formulary" adds a "Brand for Generic" feature to the Flexible Formulary. With this feature, a brand-name drug may be placed on Level 1, or excluded, and the generic equivalent placed on Level 3, or excluded. With State approval, these placements may be revised mid-year when such changes are advantageous to the Plan.

Access to one or more drugs in select therapeutic categories may be restricted (not covered) if the drug(s) has no clinical advantage over other generic and brand name medications in the same therapeutic class. Drugs considered to have no clinical advantage that may be excluded include any products that:

a. contain an active ingredient available in and therapeutically equivalent to another drug covered in the class;

b. contain an active ingredient which is a modified version of and therapeutically equivalent to another covered Prescription Drug Product;

c. are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent.

6.18.1c ***Excelsior Plan PDL*:** Under the Excelsior Plan PDL, both Brand and Generic Drugs may be placed on Level 1, 2 or 3 or excluded. A proposed PDL that includes Generics on Level 2 or Level 3 and/or has Brand Drugs on Level 1 meets Program requirements and would be acceptable for the Excelsior Plan. Drugs may be excluded from the Excelsior Plan PDL based on sound clinical and financial criteria. In addition, the current benefit design does not allow an Enrollee to appeal a drug's placement on the second or third level of the PDL nor to appeal a drug exclusion. The Excelsior Plan PDL may be updated throughout the year. It is currently updated on January 1 and July 1 each year. The goal of the Excelsior Plan PDL is to offer a therapeutically sound formulary that results in a Plan design that costs a minimum of 15% less than the Empire Plan Flexible Formulary.

6.18.2 The Contractor's PDL's must be based on sound clinical criteria. The Contractor's Book of Business PDL for the Excelsior Plan PDL must include non-self administered, intravenous and intramuscular injectable drugs covered under the Excelsior benefit plan design. In designating a drug as preferred or non-preferred for the Traditional Empire Plan PDL and Flexible Formulary Drug Lists, the Contractor must ensure that drugs recognized in documented medical evidence and studies as clinically superior to similar drugs in a therapeutic class be designated as preferred. In situations where there are multiple drugs in a therapeutic class of similar clinical characteristics, net costs shall be considered in determining a drug's status as preferred or non-preferred. For the Traditional Empire Plan PDL, generally, one or more single source Brand Dugs in a therapeutic category shall be designated as preferred, unless there is compelling clinical reason for not promoting the use of the Brand Drug(s). The composition of the PDL for the Flexible Formulary and the Traditional PDL will be developed by the Contractor and reviewed annually by the Department.

6.18.3 The Contractor may recommend and the Department may, at its sole discretion, approve a mid-year change in a drug's status from non-preferred to preferred for the Flexible Formularies and Traditional PDL. Any recommended mid-year changes to the PDLs shall be provided to the Department with a summary of the clinical and financial implications to the DCS Program. In the instance when a change to a Preferred Drug List is approved outside of the annual update, the Contractor's communication responsibilities are the same as the annual PDL update. For the Excelsior Plan, the timing of up-tiers and exclusion shall be consistent with the Contractor's Book of Business PDL.

6.18.4 Developing Preferred Drug List's for each of the four benefit designs, subject to the review and approval of the Department, for the purpose of distributing printed copies to Enrollees and medical providers. Additionally, electronic copies will be developed for posting on the Department's website and the Contractor's customized website for the DCS Program in order to inform Enrollees and providers of the placement of the most commonly prescribed medications on each Preferred Drug List. The Department shall be responsible for the distribution of the printed PDL provided by the Contractor on an annual basis to Enrollees. The Contractor shall be responsible for producing and distributing all other copies of the printed PDL, including but not limited to supplies sent to agencies, those sent with Contractor mailings to Enrollees and individual requests by Enrollees or providers. The Contractor is required to promptly mail the Preferred Drug List to Enrollees who call requesting a copy.

6.18.5 Compiling and organizing the PDLs in two versions, limited to the most commonly prescribed medications for posting and distribution: an alphabetical listing of Preferred Drugs and a listing of Preferred Drugs categorized by therapeutic category. A full listing of the PDL must be available for posting on the website. The Contractor must work with the Department on the format of the PDL. The PDL that is developed for distribution to Enrollees, and providers and posted on the website's must provide notice of the pending introduction of a generic equivalent for one or more strengths of a particular Brand Drug that could result in one or more strengths of the drug being moved to non-preferred status during the year, The PDL shall also list the name of the reference product in parenthesis next to the name of the Generic Drug (i.e. simvastatin (Zocor) unless the Department otherwise directs. The PDL shall indicate those drugs that require Prior Authorization

and those drugs eligible for the Half Tablet Program. The Contractor shall inform the Department of any rebate implications to the DCS Program as a result of including this information on the PDL.

6.18.6 Developing the PDL in a timely manner so that the Department approved, printed PDL is available to be communicated to Enrollees and posted to the website at least forty-five (45) Days before the start of the Calendar Year, to coincide with the DCS Program's option transfer period for Enrollees.

6.18.7 Developing and mailing a Department pre-approved disruption letter, via first class mail, to Enrollees who are affected by a drug's exclusion or a Preferred Brand Drug's reclassification to a non-preferred status unless the reclassification is the result of the introduction of an equivalent generic for the Traditional Empire Plan PDL and Flexible Formulary Drug List. Disruption mailings for the Enrollees in the Excelsior Plan will follow the disruption mailing plan employed for the Contractor's Book of Business PDL. Such letters must be sent to Enrollees who have utilized a medication at least once within the latest four month time period, regardless of the Days supply or whether the medication is categorized as maintenance or acute. An additional mailing must be sent to Enrollees who are new users of a medication between the date claims records were selected for the initial disruption mailing and the date that the PDL changes go into effect. Such communications should provide to the Enrollee information concerning clinically appropriate alternatives on the first and second level, when applicable, of the Preferred Drug List as of the effective date of the drug's exclusion or change from preferred to non-preferred status. In situations where Enrollees are affected by a Generic Drug's reclassification to a Brand Drug, the Contractor agrees to send a disruption letter to affected Enrollees.

6.18.8 Notifying the Department in writing when a Class I drug recall or voluntary drug withdrawal occurs. The Contractor must take proper action to help promote patient safety. The Contractor will review with the Department the need to communicate and at the Department's discretion will notify Enrollees, Network Pharmacies and/or prescribing Physicians of the Federal Food and Drug Administration drug or device recalls and manufacturer drug or device withdrawals at no additional cost to the DCS Program. Such notification must be timely and all written materials subject to Department review and prior

written approval. The Contractor must to assist the Department in collecting money from recalled products.

6.18.9 Using reasonable efforts to monitor the industry on behalf of the DCS Program and notifying the Department in writing of any class action lawsuits for which a class has been certified and of any proposed orders or settlements that the DCS Program may be entitled to participate in as a member of the class. Unless otherwise notified by the Department, the Contractor shall file claims on behalf of the DCS Program and take all steps necessary to ensure the DCS Program's interests in the class action suit or proposed settlement are protected. Any recoveries collected by the Contractor on behalf of the DCS Program, net of the Contractor's actual costs in securing the DCS Program's participation in the recovery, due the DCS Program must be paid to the DCS Program as set forth in Article XV of this Agreement. The Contractor shall make reasonable efforts to maximize recoveries. Distribution of recoveries, net of the Contractor's actual costs incurred on behalf of the DCS Program, shall be made consistent with the terms of the final settlement order or court decision. The Contractor shall assist the State in its recovery efforts and provide the claims and rebate data required to file a claim on behalf of the DCS Program when requested by the Department.

6.18.10 Holding an annual meeting with the Department to review upcoming Traditional Empire Plan PDL and Flexible Formulary Drug List changes prior to the effective date of any changes. This meeting will include a review of the Contractor's Book of Business PDL strategy. Upon the Department's request the Contractor shall provide a detailed explanation of the clinical and/or financial basis for the decision to change the classification of the drug (s) on the Traditional Empire Plan PDL and Flexible Formulary Drug List as well as a detailed cost analysis of the impact of the changes to the DCS Program.

6.18.11 Assigning a new strength of a drug to the same PDL Level as the pre-existing strengths of the drug in the event a new strength of a drug already on the Traditional Empire Plan PDL or Flexible Formulary Drug List is shipped from the manufacturer or wholesaler.

6.18.12 For the Traditional Empire Plan PDL and the Flexible Formulary Drug List, designating as Preferred all FDA approved Covered Drugs without therapeutically equivalent

generics prescribed for the treatment of the following diseases; Cancer, Hepatitis, and HIV. FDA approved organ transplant anti-rejection drugs shall also be designated as Preferred Brand Drugs. Post award, the Contractor may recommend other disease states where all the Covered Drugs prescribed to treat the illness would be designated as Preferred.

6.18.13 Working with the medical carrier and the mental health and substance abuse carrier to develop communications such as, but not limited to provider newsletters to ensure that participating providers in those networks are fully apprised of the level/status of Covered Drugs.

6.18.14 The Contractor will be responsible for ensuring the Empire Plan Flexible Formularies and the Traditional Empire Plan Preferred Drug List will be electronically available to Medical Professionals on Rx Hub and Level 1 and Level 2 drugs will be designated as Preferred.

6.18.15 The Contractor will be responsible for protecting the value of the DCS Program's pricing discounts by taking appropriate steps to control Prescription Drug AWP increases.

6.18.16 The Contractor will be responsible for developing, recommending and implementing Brand for Generic Strategies for the Enhanced Flexible Formulary that financially beneficial to the State. All Brand for Generic placements are subject to Department approval. These placements may be revised mid-year, with Department approval, when such changes are advantageous to the Plan.

6.18.17 The Contractor will be responsible for implementing a "New to You Prescriptions" program effective January 1, 2013. This program will require the enrollee to have two 30-day fills of a newly prescribed medication at a Retail Pharmacy prior to being able to obtain a 90-day fill through the Retail Pharmacy or Mail Service Pharmacy.

ARTICLE VII: PERFORMANCE GUARANTEES

The Parties agree that the following guarantees and the corresponding credit amounts for failure to meet the Contractor Performance Guarantees shall be implemented effective January 1, 2014. The Contractor acknowledges and agrees that failure to perform the Program Services features in such a manner which

either meets or exceeds any, and/or all of the Contractor Performance Guarantee(s) as set forth in this Article VII, and/or fails to make any payment(s) of any such credit amounts for such failure to meet any Performance Guarantee(s) does not relieve the Contractor of the performance of the activities, duties, and obligations as otherwise set forth in the Agreement. Credit amounts are cumulative. Amounts due from the Contractor to DCS for failure to perform and audit credit amounts, as determined pursuant to Article XV of this Agreement, shall be made in such amounts as determined by DCS to be final. Upon such determination, DCS shall notify the Contractor, in writing, and the Contractor shall apply such amounts as a credit against the monthly Claims Administration Fee in accordance with Article XV of this Agreement within thirty (30) Days of receiving such notification by the DCS. These amounts must also be applied as a credit against the Claim Administration Fee reported in the Annual Financial Report.

7.1.0 Implementation and Start-up Guarantees and Credit Amount

7.1.1 ***Guarantee:*** The Contractor guarantees that all Implementation and Start-up activities will be completed no later than December 31, 2013 so that, effective January 1, 2014, the Contractor can assume full operational responsibility for the DCS Program. For the purpose of this guarantee, the Contractor must, on January 1, 2014, have in place and operational:

7.1.1a a contracted Retail Pharmacy Network that meets the access standards set forth in Section 7.4.0 of this Agreement. Additionally, in order to meet the Contractor's implementation guarantee, the network implemented on January 1, 2014 must include all chain pharmacies with more than 20 locations and all groups of 20 or more independent pharmacies utilizing the same third party organization to collectively negotiate network participation agreements, as identified in the Contractor's Proposed Retail Pharmacy Network File, to the extent the subject chains and/or independent Pharmacy groups continue in operation on and after January 1, 2014.

The DCS Program requires that all chain pharmacies with less than 20 locations, groups of less than 20 independent pharmacies utilizing the same third party organization to collectively negotiate network participation agreements, and all independent pharmacies, as identified in the Contractor's Proposed Retail Pharmacy Network File, included in the Contractor's Retail Pharmacy Network

implemented on January 1, 2014. Acceptable reasons for non-participation of independents, smaller chains or groups of individual pharmacies contracting collectively on January 1, 2014 include, and are limited to: a Pharmacy's violation of state and/or federal laws; a Pharmacy's failure to meet the Contractor's credentialing criteria; or a Pharmacy's failure to fulfill its contractual obligations and no remedy can be achieved. On January 1, 2014, the Retail Pharmacy Network must meet all requirements set forth in Section 6.11.0 of this Agreement and be available to fill Enrollee Prescriptions for all Covered Drugs including Specialty Drugs/Medications(for those Enrollees that don't participate in the Specialty Pharmacy Program);

7.1.1b A fully operational Mail Service Pharmacy Process utilizing facilities as necessary to ensure that Enrollees have access to all Covered Drugs, including Specialty Drugs/ Medications (for those Enrollees that do not participate in the Specialty Pharmacy Program) as set forth in Section 6.12.0 of this Agreement. The Contractor must have a plan in place to facilitate the transfer of Prescription information, including open refills, prior authorizations and generic appeals from the previous Program administrator and outline the procedures they will utilize to assure a smooth mail service transition for Enrollees;

7.1.1c A fully operational Specialty Pharmacy Program utilizing facilities as necessary to ensure that Enrollees have access to all covered Specialty Drugs/Medications (for those Enrollees that participate in the Specialty Pharmacy Program) as set forth in Section 6.13.3 of this Agreement. The Contractor must have a plan in place to facilitate the transfer of specialty Prescription information, including open refills and prior authorizations, from the previous provider of service and outline the procedures that will be utilized to assure a smooth Specialty Pharmacy Program transition for affected Enrollees;

7.1.1d A fully operational call center providing all aspects of customer support and services as set forth in Section 6.5.0 of this Agreement;

7.1.1e An on-line claims processing system that applies DCS approved edits and point of service edits, including drug utilization review edits, as set forth in

Section 6.14.0 of this Agreement;

7.1.1f An on-line claims processing system with real time access to the most updated, accurate enrollment and eligibility data provided by DCS to correctly pay claims for eligible Enrollees/Dependents consistent with Program benefit design and contractual obligations; and

7.1.1g A fully functioning customized Program website with a secure dedicated link from DCS's website able to provide Enrollees with on-line access to the specific website requirements as set forth in Section 6.5.4 of this Agreement.

7.1.2 ***Credit Amount:*** The Contractor's quoted percent to be credited for each day that all Implementation and Start-Up requirements are not met is (TBD) percent ((TBD)%) of the 2014 Claims Administration Fee (prorated on a daily basis).

7.2.0 Enrollment Management Guarantee and Credit Amount

7.2.1 ***Guarantee:*** The Contractor guarantees that one hundred percent (100%) of all DCS Program enrollment records that meet the quality standards for loading will be loaded into the Contractor's enrollment system within twenty-four (24) hours of release by DCS.

7.2.2 ***Credit Amount*****:** For each 24 hour period beyond twenty-four (24) hours from the release by DCS that one hundred percent (100%) of the DCS Program enrollment records that meet the quality standards for loading is not loaded into the Contractor's enrollment system, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of $(TBD).

7.3.0 Management Reports and Claim Files Guarantee and Credit Amount

7.3.1 ***Guarantee:*** For each management report or claim file listed in Article XVI of this Agreement, the Contractor guarantees that accurate management reports and claims files shall be delivered to the DCS no later than their respective due dates inclusive of the date of receipt.

7.3.2 ***Credit Amount*****:** For each management report or claim file listed in Article XVI of this Agreement that is not received by its respective due date, the Contractor shall credit

against the DCS Program's Claims Administration Fee the amount of $(TBD) per report per each Business Day between the due date and the date the management report or claims file is received by the DCS inclusive of the date of receipt.

7.4.0 Retail Pharmacy Network Access Guarantee and Credit Amount

7.4.1 ***Guarantee:*** The Contractor guarantees that effective January 1, 2014 and throughout the term of the Agreement:

7.4.1a At least ninety percent (90%) of Enrollees in urban areas will have access to a Network Pharmacy. The minimum access guarantee for Enrollees in urban areas is at least one (1) Network Pharmacy, within two (2) miles of an Enrollee's home;

7.4.1b At least ninety percent (90%) of Enrollees in suburban areas will have access to a Network Pharmacy. The minimum access guarantee for Enrollees in suburban areas is at least one (1) Network Pharmacy, within five (5) miles of an Enrollee's home; and

7.4.1c At least seventy percent (70%) of Enrollees in rural areas will have access to a Network Pharmacy. The minimum access guarantee for Enrollees in rural areas is at least one (1) Network Pharmacy, within fifteen (15) miles of an Enrollee's home.

7.4.2 ***Credit Amount:***

7.4.2a The Contractor shall credit against the DCS Program's Claims Administration Fee the amount of $(TBD) for each .01 to 1.0% below the ninety percent (90%) minimum access guarantee for any quarter in which the Network Pharmacy Access for Urban Areas Guarantee is not met by the Contractor.

7.4.2b The Contractor shall credit against the DCS Program's Claims Administration Fee the amount of $(TBD) for each .01 to 1.0% below the ninety percent (90%)

minimum access guarantee for any quarter in which the Network Pharmacy Access for Suburban Areas Guarantee is not met by the Contractor.

7.4.2c The Contractor shall credit against the DCS Program's Claims Administration Fee the amount of $(TBD) for each .01 to 1.0% below the seventy percent (70%) access guarantee for any quarter in which the Network Pharmacy Access for Rural Areas Guarantee is not met by the Contractor.

7.4.3 Measurement of compliance with each access guarantee in Section 7.4 of this Agreement will be based on a "snapshot" of the Retail Pharmacy Network taken on the last Day of each quarter within the current Plan Year. The results must be provided in the format specified by DCS in Exhibit B, the Request for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," unless otherwise specified by DCS. The report is due thirty (30) Days after the end of the quarter.

7.5.0 Turnaround Time for Claims Adjudication Guarantee and Credit Amount

7.5.1 ***Guarantee:*** The Contractor guarantees that at least ninety-nine and five-tenths percent (99.5%) of Enrollee submitted claims that require no additional information in order to be properly adjudicated that are received by the Contractor shall be turned around within ten (10) Business Days. Turnaround time is measured from the date the Enrollee-submitted claim is received in the Programs designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent.

7.5.2 ***Credit Amount:*** For each .01 to .25% of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Contractor and not turned around within ten (10) Business Days from the date the claim is received in the Contractor's DCS designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent, below the standard of ninety-nine and five-tenths percent (99.5%), as calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of $(TBD).

7.6.0 Turnaround Time for Mail Service Prescriptions Guarantee and Credit Amount

7.6.1 ***Guarantee:*** The Contractor guarantees that at least ninety-five percent (95%) of all non-intervention mail service Prescriptions will be turned around in two (2) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the day after the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. For example, a Prescription order received on Monday, January 6, 2014, by the mail service Pharmacy, must be received by the mailing agent no later than Thursday, January 9, 2014;

7.6.2 ***Credit Amount:*** For each .01 to 1.0% below ninety-five percent (95%) percent of all non-intervention mail service Prescriptions not turned around within two (2) Business Days, calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of $(TBD).

7.6.3 ***Guarantee*****:** The Contractor guarantees that at least ninety-five percent (95%) of all intervention mail service Prescriptions shall be turned around in five (5) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the date the Prescription is received by the mail service Pharmacy to the date the Prescription is received by the mailing agent. For example, a Prescription order received on Monday, January 6, 2014 by the Mail Service Pharmacy must be received by the mailing agent no later than Tuesday, January 14, 2014.

7.6.4 ***Credit Amount:*** For each .01 to 1.0% below ninety-five percent (95%) of all intervention mail service Prescription not turned around within five (5) Business Days, calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of $(TBD).

7.7.0 <u>Program Call Center Telephone Guarantees and Credit Amounts</u>

7.7.1 ***Guarantees:***

7.7.1a ***Call Center Availability*****:** The DCS Program's service level standard requires that the Contractor's telephone line will be operational and available to Enrollees, Dependents, and pharmacies at least ninety-nine and five-tenths percent *(*99.5%)

of the Contractor's Call Center Hours. The call center availability shall be reported monthly and calculated quarterly;

7.7.1b ***Call Center Telephone Response Time:*** The DCS Program's service level standard requires that at least ninety percent (90%) of the incoming calls to the Contractor's telephone line will be answered by a customer service representative within sixty (60) seconds. Response time is defined as the time it takes incoming calls to the Contractor's telephone line to be answered by a customer service representative. The call center telephone response time shall be reported monthly and calculated quarterly;

7.7.1c ***Telephone Abandonment Rate*:** The DCS Program's service level standard requires that the percentage of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service representative will not exceed three percent (3%). The telephone abandonment rate shall be reported monthly and calculated quarterly; and

7.7.1d ***Telephone Blockage Rate*:** The DCS Program's service level standard requires that not more than three percent (3%) of incoming calls to the customer service telephone line will be blocked by a busy signal. The telephone blockage rate shall be reported monthly and calculated quarterly.

7.7.2 ***Credit Amounts:***

7.7.2a ***Call Center Availability*:** For each .01 to .25% below the standard of ninety-nine and five-tenths percent (99.5%) that the Contractor's telephone line is not operational and available to Enrollees, Dependents, and Pharmacies during the Contractor's Call Center Hours calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of $(TBD) per quarter;

7.7.2b ***Call Center Telephone Response Time*:** For each .01 to 1.0% of incoming calls to the Contractor's telephone line below the standard of ninety percent (90%) that is not answered by a customer service representative within sixty (60) seconds,

calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of $(TBD) per quarter;

7.7.2c ***Telephone Abandonment Rate*:** For each .01 to 1.0% of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service representative in excess of three percent (3%) calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of $(TBD) per quarter; and

7.7.2d ***Telephone Blockage Rate*:** For each .01 to 1.0% of incoming calls to the contractor's telephone line that is blocked by a busy signal, in excess of three percent (3%), calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of $(TBD) per quarter.

7.8.0 Program Claims Processing System Availability Guarantee and Credit Amount

7.8.1 ***Guarantee:*** The Contractor guarantees that the DCS Program's online claims processing system be available at least ninety-nine and five-tenths percent (99.5%) of the time excluding periods of scheduled down time which shall be reported in advance to DCS and kept to a minimum, based on a 24 hours a Day, 7 Days a week availability.

7.8.2 ***Credit Amount:*** For each .01 to .25% below the standard of ninety-nine and five-tenths percent (99.5%) that the Contractor's online claims processing system for the DCS Program, based on a 24 hours a Day, 7 Days a week availability, excluding periods of scheduled down time, which shall be reported in advance to DCS and kept to a minimum, is not available, as calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of $(TBD) per each quarter.

ARTICLE VIII: MODIFICATION OF PROGRAM SERVICES

8.1.0 In the event that laws or regulations enacted by the Federal government and/or the State have an impact upon the conduct of this Agreement in such a manner that the DCS determines that any design elements or requirements of the Agreement must be revised, the DCS shall notify the Contractor of any such revisions and shall provide the Contractor with a reasonable time within which to implement such revisions.

8.2.0 In the event that the NYS and the unions representing State Employees enter into collective bargaining agreements, or the State otherwise requires changes in Plan design elements or requirements of the Agreement, the DCS shall notify the Contractor of such changes and shall provide the Contractor with reasonable notice to implement such changes.

8.3.0 To the extent that any of the events as set forth in this Article shall take place and constitute a material and substantial change in the delivery of services that are contemplated in accordance with the terms of the DCS Program as of the Effective Date and which the Contractor is required to perform or deliver under the Agreement, the Contractor may submit a written request to the DCS to initiate review of the fee(s) received by the Contractor for services provided and guarantees made by the Contractor under the terms of the Agreement, accompanied by appropriate documentation. The DCS reserves the right to request, and the Contractor shall agree to provide additional information and documentation the DCS deems necessary to verify that an increase in the fee(s), or modification of the guarantees is warranted. The DCS will agree to modify the fee(s) to the extent necessary to compensate the Contractor for documented additional costs determined by DCS to be reasonable and necessary. The DCS will agree to modify guarantees as determined by DCS to be necessary to reflect DCS Program modifications. Should the DCS approve the Contractor's request to modify the fee(s) and/or guarantees, such approval shall be subject to written amendment and approval by OSC and the AG. The Contractor shall implement changes as required by the DCS with or without final resolution of any fee proposal.

8.4.0 Any changes made by NYSIF to the scope of its contract with the Contractor for Prescription Drug Program Services after execution of this Agreement, including but not limited to the request to include any individual independent Network Pharmacy(ies), shall have no impact on this Agreement or cost thereunder, unless the change is agreed to by DCS.

ARTICLE IX: DEVELOPMENT OF SUMMARY PLAN DESCRIPTIONS

9.1.0 The Contractor shall present to the DCS its recommendations for the development of the necessary Summary Plan Descriptions for the Empire Plan, Excelsior Plan and SEHP Prescription Drug Programs. The DCS shall review the Contractor's recommendations and shall

make the final determination regarding the manner in which the Summary Plan Descriptions shall be developed and issued by the Contractor.

ARTICLE X: ENROLLMENT INFORMATION AND RECORDS

10.1.0 The Contractor shall maintain records from which may be determined at all times the names of all Enrollees insured hereunder, and their Dependents, and the benefits in force for each such Enrollee/Dependent, together with the date when any coverage became effective and the effective date of any change in benefits.

10.2.0 The DCS shall transmit enrollment information provided by the Enrollee to the Contractor for the DCS Program in an electronic format through the New York State Benefit Eligibility and Accounting System consistent with Section 6.8.2 of this Agreement. The eligibility rules and the enrollment reports generated as a result of these eligibility rules shall be the sole means of determining valid enrollment for benefits under the DCS Program.

10.3.0 The DCS and the Enrollees/Dependents shall furnish to the Contractor all information that the Contractor may reasonably require with regard to any matters pertaining to the enrollment of Enrollees/Dependents under this Agreement. A person will not be entitled to or deprived of benefits under the Agreement due to clerical errors.

10.4.0 The DCS agrees to provide the Contractor with reasonable access to records of the DCS which may have a bearing on the benefits provided by the Contractor or calculation of the Contractor's Claims Administration Fee as set forth under Article XIV of this Agreement.

ARTICLE XI: DATA SHARING AND OWNERSHIP

11.1.0 All claims and other data related to the DCS Program is the property of the State. Upon the request of the DCS, the Contractor shall share appropriate claims data with other NYSHIP carriers.DCS consultants and the Department's DSS contractor. Except as directed by a court of competent jurisdiction, or as necessary to comply with applicable New York State or Federal law, or with the written consent of the Enrollee/Dependent, the Contractor shall not share, sell, release, or make the data available to third parties in any manner without the prior consent of the DCS. The DCS understands that the Contractor is required to share certain claims data with

pharmaceutical manufacturers for purposes of obtaining for the DCS Program all Pharma Revenue due it under the Agreement. The Contractor shall inform the DCS of the types of data being shared for these specific authorized purposes.

ARTICLE XII: DCS PROGRAM CLAIMS REIMBURSEMENT

The DCS Program shall be charged for dispensed drugs consistent with the provisions of this Article XII.

12.1.0 General Provisions

12.1.1 All discounts and dispensing fees for Brand, Generic Drugs and Specialty Drugs/ Medications are guaranteed for the entire term of this Agreement without qualification or condition. In addition, the Contractor's Compound Drug pricing methodology set forth in Article XII of this Agreement, is guaranteed for the entire term of this Agreement without qualification or condition.

12.2.0 Average Wholesale Price (AWP) Source and Brand, Generic Drug and Compound Drug Classification

The pricing formulas set forth in this Article are based on the classification of drugs as either Brand Drugs, Generic Drugs, or Compounded Drugs.

12.2.1 Throughout the term of the Agreement, the Contractor shall utilize (to be determined from the Contractor's Proposal) as the source of Average Wholesale Price (AWP) information for purposes of calculating Ingredient Cost unless the Parties mutually agree in writing to use a different source for AWP information. The AWP used for pricing purposes during claim adjudication should be the AWP in effect on the date the drug was filled.

12.2.2 In the event the national reporting service (source to be determined from the Contractor's Proposal) changes its methodology related to any of the information fields used in the Department's classification of Brand and Generic Drugs, or its methodology for coding drugs in connection with these information fields, the Contractor is obligated to inform the Department in writing of such changes within 30 Days of learning of such changes. Upon written notification, the Parties will meet and agree in writing to any Brand and/or

Generic Drug classification changes that may be necessary to enable the Parties to maintain the same economic position and obligations as are set forth in the Agreement.

12.2.3 Notwithstanding any other provision of the Agreement to the contrary, when during the term of this Agreement industry events have caused the Contractor's source of AWP to become obsolete or no longer available, the parties shall agree on revised pricing terms. In no event shall the DCS Program's actual costs for drugs increase as the result of new pricing terms. The Contractor shall notify the DCS in writing as soon as any information indicating a problem with the future use of the Contractor's AWP source is received. Within two weeks of the initial notification, the Contractor agrees to submit a detailed written proposal to DCS for effectively revising pricing terms including but not limited to a file containing the Contractor's pricing for all drugs dispensed during the prior six months utilizing the current AWP source and the Contractor's revised pricing for such drugs using the proposed methodology. The Contractor's proposal shall ensure continued alignment of the Contractor's interests with those of the DCS Program.

12.2.4 ***Classification Methodology General***

12.2.4a Drugs shall be classified for pricing purposes under this Agreement in accordance with DCS classification determinations based on the definitions contained in Article I of this Agreement. No later than November 15th of each Plan Year, the Contractor shall submit for DCS written approval a file containing all NDCs dispensed through the Program during the prior year and the classification of each NDC derived from application of the Contractor's electronic classification process. To the extent the Contractor's electronic process results in classifications inconsistent with DCS determinations, the Contractor commits to modify its classification methodology to replicate the results of the DCS determination, including the steps set forth in Section 12.2.4b below. The DCS determination shall be final.

12.2.4b To the extent the electronic process fails to comprehensively replicate drug classifications specified by the DCS Program in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and the New York State Insurance Fund

Workers' Compensation Prescription Drug Programs," of this Agreement consistent with the definitions of Brand and Generic Drugs set forth in Sections 1.4.0 and 1.39.0 of this Agreement, the Contractor agrees to modify to the extent possible its electronic processing system before January 1, 2014, including setting appropriate Copayment levels as required, and to undertake all other necessary manual steps to ensure that the result of the prescription processing process from a cost basis to both Enrollee and Plan is in accordance with the DCS determination of classification.

12.2.4c The Contractor shall conduct a year end reconciliation each Plan Year to ensure that the claim amount charged to the Plan is in accordance with the definition of Brand and Generic Drugs set forth in Sections 1.4.0 and 1.39.0 of this Agreement. The reconciliation will include claims paid during the Plan Year and is to be completed by February 15th of the following year. If DCS's review of the Contractor's reconciliation indicates an adjustment is required, then DCS reserves the right to make an adjustment to the Contractor's submitted reconciliation. The Contractor shall credit or debit the Plan as applicable no later than 30 Days following the date of reconciliation and reflect the result in the Annual Financial Statement.

12.3.0 Brand Drug Determination Methodology

12.3.1 The classification of a drug as a Brand Drug for the purpose of applying the appropriate pricing formula and Copayment level shall be based on the definition of the Brand Drug set forth in Section 1.4.0. The Contractor shall utilize an electronic process for claims processing using (TBD by Contractor's Proposal) indicators to determine classification with the results subject to the review and approval of DCS for consistency with Section 1.4.0 prior to commencement of all contractual responsibilities on January 1, 2014. The Contractor agrees that the DCS determination shall be final.

12.3.2 To the extent the electronic process fails to comprehensively replicate drug classifications proposed by the DCS Program in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs

RFP" of this Agreement consistent with the definition of Brand Drug set forth in Section 1.4.0 of this Agreement, the Contractor agrees to modify its electronic processing system before January 1, 2014, including setting appropriate Copayment levels as required, and to undertake all other necessary manual steps to ensure that the result of the prescription processing process to both Enrollee and Plan is in accordance with the correct classification.

12.3.3 To the extent the Contractor cannot process claims consistent with DCS Brand Drug determinations, the reconciliation process set forth in Section 12.2.4c above will be performed.

12.4.0 Generic Drug Determination Methodology

12.4.1 The classification of a drug as a Generic Drug for the purpose of applying the appropriate pricing formula shall be based on the definition of Generic Drug set forth in Section 1.39.0 of this Agreement. The Contractor shall utilize an electronic process using (TBD by Contractor's Proposal) indicators to establish classification with the results subject to the review and approval of DCS prior to commencement of all contractual responsibilities on January 1, 2014. The Contractor agrees that the DCS determination shall be final.

12.4.2 To the extent the electronic process fails to comprehensively replicate the drug classification proposed by the Program in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement consistent with the definition set forth in 1.34.0 of this Agreement, the Contractor agrees to modify its electronic processing system before January 1, 2014, including setting appropriate Copayment levels as required, and to undertake all other necessary manual steps to ensure that the result of the prescription processing process to both Enrollee and Plan is in accordance with the correct classification.

12.4.3 To the extent the Contractor cannot process claims consistent with DCS Generic Drug determinations, the reconciliation process set forth in Section 12.2.4c above will be performed.

12.5.0 Compound Drug Determination Methodology

The Contractor shall implement a process to review Compound Drug claim submissions for compliance with the contracted definition. The classification of a drug as a Compound Drug for the purpose of applying the appropriate pricing formula shall be based on the definition of Compound Drug set forth in Section 1.11.0 of this Agreement.

12.6.0 Program's Lesser of Logic

The Program's Lesser of Logic applies to all claims processed under the DCS Program. Retail Generic Prescriptions assigned a MAC price shall be charged to the Plan at the following Lesser of Logic: the lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee; the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is Usual and Customary); the AWP discount contracted with the Network Pharmacy plus dispensing fee; or the Maximum Allowable Cost plus dispensing fee. Retail Brand Prescriptions and Generic Prescriptions that are not assigned a MAC price shall be charged to the Plan at the following Lesser of Logic: the lowest of the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is usual and customary); the Discounted Ingredient Cost contracted with Network Pharmacy plus dispensing fee; or the Pharmacy-submitted Ingredient Cost plus dispensing fee. Mail Service Pharmacy Generic Prescriptions shall be charged to the Plan at the following Lesser of Logic: The lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee; the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is Usual and Customary; the Minimum Guaranteed Discounted Ingredient Cost off of AWP plus dispensing fee or the Maximum Allowable Cost plus dispensing fee. Mail Service Pharmacy Brand and Specialty Pharmacy Brand and Generic Prescriptions shall be charged to the Plan at the following Lesser of Logic: the lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee; the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is usual and customary); or the Guaranteed Discounted Ingredient Cost off of AWP plus dispensing fee. Once the Lesser of Logic has been applied, the pricing methodology resulting in the lowest claim cost to the Plan is determined, and to that amount any applicable sales tax is added and the applicable Copayment and any ancillary fee resulting from application of the Program's Mandatory Generic Substitution provisions are deducted.

12.7.0 Mandatory Generic Substitution at Retail and Mail

The Contractor shall:

12.7.1 Apply mandatory generic substitution to all specific NDC's of Brand Drugs for which there is an FDA approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc) or an authorized Generic Drug as permissible by NYS law. Network Pharmacies shall comply with all state laws related to mandatory generic substitution. The Contractor shall apply mandatory generic substitution to all specific NDC's (inactive or active) of Brand Drugs. The DCS Program's mandatory generic substitution provisions shall apply to any claim where the A-rated or authorized Generic Drug is required or permitted to be substituted under state law. Mandatory generic substitution provisions will not apply to B-rated or unrated Generic Drugs or in the unlikely event that state law prohibits dispensing of the A-rated or authorized Generic Drug.

12.7.2 Establish the Ancillary Charge by calculating the difference in the Discounted Ingredient Cost of the Brand Drug and the Discounted Ingredient Cost of the equivalent A-rated Generic Drug or authorized Generic Drug based on the programs' MAC List price assigned when a Brand Drug for which an A-rated or authorized Generic Drug has been introduced in the market is dispensed to the Enrollee. In such cases, the Enrollee shall be responsible for paying the applicable Non-Preferred Brand Drug Copayment plus Ancillary Charge not to exceed the cost of the drug to the DCS Program. The Ancillary Charge shall be assessed even in the event a doctor has specifically directed a Pharmacist to dispense the Brand Drug rather than the A-rated or authorized Generic Drug through DAW notation.

12.7.3 Monitor the pharmaceutical industry on behalf of DCS to identify Generic Drugs expected to enter the market. Prior to the actual introduction of the Generic Drug to market, the Contractor shall inform the DCS of anticipated shipping dates of the first Generic Drug introduced into the market for one or more strengths of a particular Brand Drug.

12.7.4 Following the first shipment of a first Generic Drug for one or more strengths of a particular Brand Drug, the Contractor is required to:

12.7.4a Inform the DCS as soon as practicable but in no event later than fourteen (14) Days after the first date of shipment, (from manufacturer to wholesaler or retailer) of the financial impact of enforcing mandatory generic substitution via the "MAC Alert Notice" detailed in Section 16.6.1 of this Agreement.

12.7.4b For those drugs that will result in a lower net cost to the DCS Program by enforcing mandatory generic substitution, the Contractor shall provide the "MAC Alert Notice" as described in Section 12.7.4a above. The Contractor shall add the GCN to the Programs' MAC List and begin enforcement as soon as practicable but in no event later than fourteen (14) Days after the first date of shipment provided that the Retail Network Pharmacies are able to obtain the Generic Drug. In the case where a GCN is already subject to MAC pricing the Contractor is required to immediately apply the MAC price and mandatory generic substitution to any NDC added to the GCN following the first date of shipment.

12.7.4c For those drugs that could potentially result in a higher net cost to the DCS Program by enforcing mandatory generic substitution, the Contractor shall provide the "MAC Alert Notice" as described in Section 12.7.4a above. DCS, in its sole discretion, may determine that enforcement is contrary to the best financial interests of the DCS Program and shall inform the Contractor whether Mandatory Generic Substitution shall be applied. If the Contractor does not receive a formal response to the information provided via the "MAC Alert Notice," enforcement shall commence and the GCN shall be added to the Programs' MAC List effective on the 21st Day after shipment (from manufacturer to wholesaler or retailer) of the first A-rated generic equivalent drug or authorized Generic Drug provided that the Pharmacies are able to obtain the Generic Drug. In the event the DCS decides to exercise its discretion not to enforce mandatory generic substitution, the Contractor shall apply MAC pricing to the Generic Drug.

12.7.4d To assist the DCS in determining whether or not mandatory generic substitution should be enforced within 21 Days, the Contractor shall survey its Retail Pharmacy Network to identify the Pharmacies that are unable to obtain the new generic within 21 Days. The Contractor shall submit this information to the DCS

and provide any additional information as required by DCS to reach a determination. The DCS, in its sole discretion, shall determine based on such evidence how the DCS Program's mandatory generic substitution provisions shall be applied. The DCS Program will not consider and the Contractor shall not act on availability information provided by 3rd party sources, including but not limited to Medi-Span, Red Book, First Data Bank or wholesalers.

12.7.4e For Preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall be changed from preferred to non-preferred status concurrent with the commencement of the enforcement of mandatory generic substitution. Enrollees prescribed strengths of the Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the Level 1 Copayment unless the prescribing Physician requires that the Brand Drug be dispensed. In that case, the Enrollee shall be charged the applicable Level 3 Copayment and Ancillary Charge. Enrollees prescribed strengths of the Preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Level 2 Copayment and mandatory generic substitution provisions shall not apply.

12.7.4f For Non-Preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall remain non-preferred for all strengths. Concurrent with enforcement of mandatory generic substitution, Enrollees prescribed strengths of the Non-Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the Level 1 Copayment unless the prescribing Physician requires that the Brand Drug be dispensed. In that case, the Enrollee shall be charged the applicable Level 3 and Ancillary Charge. Enrollees prescribed strengths of the Non-Preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Level 3 Copayment and mandatory generic substitution provisions shall not apply.

12.7.4g The Contractor shall require the dispensing Network Pharmacy to inform the Enrollee prior to dispensing the Brand Drug, that an Ancillary Charge would be applied in addition to the applicable Level 3 Copayment. If the prescribing Physician requires the Brand Drug be dispensed, the Contractor shall require the dispensing Network Pharmacy to collect the applicable Level 3 Copayment plus the calculated Ancillary Charge. However, under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the Program after application of the DCS Program's Lesser of Logic provisions.

12.7.4h Charge the DCS Program based on the Programs' MAC List price assigned to the GCN of the dispensed Brand Drug subject to the Program's Lesser of Logic set forth in Section 12.6.0 of this Agreement, plus the applicable dispensing fee as set forth in Section 12.8.3m of this Agreement.

12.7.4i Receive DCS written approval for any and all exceptions to the DCS Program's mandatory generic substitution provisions, beyond the approval of specific generic appeals. Following commencement of mandatory generic substitution, the Contractor must receive DCS approval prior to suspending enforcement of the DCS Program's mandatory generic substitution provisions.

12.7.4j Maintain an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the DCS Program's mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the Generic Drug at the Network Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Network Pharmacy, the DCS Program's mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized Generic Drug in stock, mandatory generic substitution provisions will not apply and the Enrollee shall receive the Brand Drug, be charged the applicable Level 1 Copayment and the DCS Program charged based on Generic Drug pricing. The Contractor's claims processing system must reject, with appropriate messaging, claims for Brand

Drugs subject to mandatory generic substitution that are submitted with a DAW-0 code requiring resubmission of the claim (since a DAW-0 code provides no indication of Generic Drug availability in the Pharmacy). Similar rules shall be applied to other DAW submission codes as necessary to ensure consistent, accurate application of the DCS Program's mandatory generic substitution requirements. These rules are specified in Section 6.14.4 of this Agreement.

12.7.5 Immediately notify DCS in writing of changes (from brand to generic or generic to brand) in the NDC classification submitted by the Contractor pursuant to Section 12.2.4 of this Agreement.

12.8.0 Retail Pharmacy Network Claims

12.8.1 The cost of all Covered Drugs dispensed at Network Pharmacies shall be charged to the DCS Program consistent with the requirements set forth in this section, including but not limited to application of the Lesser of Logic set forth in Section 12.6.0 of this Agreement. Under no circumstances may the Enrollee be charged costs not specifically provided for under the Plan benefit design.

12.8.1a The Contractor shall ensure that the Network Pharmacy collects the appropriate Copayment specified by DCS plus Ancillary Charge, if applicable, from the Enrollee and will charge the Program the Discounted Ingredient Cost as determined through the application of the Lesser of Logic detailed in Section 12.6.0 of this Agreement plus the Contractor's applicable pharmacy contracted dispensing fee minus the applicable Copayment for all drugs dispensed through a Network Pharmacy.

12.8.1b If the cost derived through application of the DCS Program's Lesser of Logic provision as set forth in 12.6.0 of this Agreement, plus the applicable dispensing fee and any applicable tax, is lower than the Enrollee's applicable Copayment, then the Contractor shall ensure that the Enrollee is not charged more than that cost of the drug.

12.8.1c The Contractor shall administer a control process at point of service to protect the DCS Program from any inflated AWP costs associated with "repackaged" drugs charged to the DCS Program.

12.8.2 Retail Pharmacy Network Brand Drug Pricing

12.8.2a The Contractor shall charge the DCS Program utilizing Pass-through Pricing for all Brand Drugs dispensed to Enrollees through the Network Pharmacies.

12.8.2b The Contractor shall use the following Ingredient Cost and dispensing fee, minus Copayment and applicable Ancillary Charge, if any, to charge the DCS Program for each Prescription for a covered Brand Drug dispensed by a Network Pharmacy throughout the term of the Agreement subject to application of the Lesser of Logic as set forth in Section 12.6.0 of this Agreement.

12.8.2b(1) ***Ingredient Cost of Brand Drug Dispensed at Retail Pharmacy***

Pass-through Pricing based on the terms of the Contractor's agreement with the dispensing Pharmacy related to Brand Drugs. (Pricing is subject to an overall annual minimum discount of (TBD) % off the aggregate AWP and annual maximum dispensing fee of (TBD) for all Brand Drugs dispensed through Network Pharmacies.)

12.8.2c The Contractor shall guarantee an overall minimum discount off of the aggregate AWP for all Brand Drugs dispensed at Retail Network Pharmacies as defined in the RFP. The Contractor guarantees the DCS Program that its management of Brand Drug costs dispensed by pharmacies shall result in the Plan achieving the Contractor's proposed overall Guaranteed Minimum Discounts of [TBD] during the Plan Year. The discounts achieved off of the aggregate AWP for all Brand Drugs as a result of Pass-through Pricing will be calculated utilizing the following formula: 1 minus (Sum of Ingredient Costs of dispensed Brand Drugs divided by sum of AWP of dispensed Brand Drugs). The aggregate discount calculation will be based on Pharmacy Prescriptions filled with a Brand Drug where the Plan was the primary payer (including Enrollee submit claims). Claims submitted for secondary payer consideration, Compound Drug claims, and claims submitted by governmental entities must be excluded from the aggregate

discount calculation. In addition, claims with a calculated AWP discount greater than 50% will be excluded pending receipt of supporting documentation by the Contractor and verification by the Department as to the validity of the calculated discount; and

(Amended April 4, 2012)

12.8.2d If the overall aggregate discounts obtained, as calculated utilizing the formula set forth in the prior paragraph, are less than the Guaranteed Minimum Discounts of [TBD], the Contractor shall reimburse the DCS Program the difference between the Ingredient Cost the DCS Program was charged utilizing Pass-through Pricing and the Ingredient Cost the DCS Program would have been charged if the Guaranteed Minimum Discount of [TBD] off of the aggregate AWP had been obtained. The DCS Program will be credited annually for this difference in Ingredient Cost. The DCS Program shall retain the benefit of any cost savings, in excess of the Offeror's proposed Guaranteed Minimum Discounts off the aggregate AWP for all Brand Drugs dispensed by pharmacies.

This calculation shall be performed for each Plan Year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Department on July 31st. If the Department Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Department reserves the right in their sole discretion to make an adjustment to the Contractor's calculations. ~~The calculations must be completed by February 15th of the following year.~~ Upon approval by the Department, ~~T~~the Contractor shall pay/credit the Plan the applicable amount, if any, within 30 Days. ~~following the February 15th calculation. If the Department's review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Department reserves the right in its sole discretion to make an adjustment to the Contractor's calculations.~~ The Contractor shall also reflect the adjustment, if any, in the Contractor's Annual Financial Summary Report. ~~On July 31st following each Plan Year, the Offeror shall perform a reconciliation to include claims incurred in each Plan Year and paid through June of the following Plan Year.~~

~~Based on this reconciliation, the Department shall receive an adjustment, if necessary, within 30 Days following the date of the reconciliation and the adjustment shall be included in the following year's Annual Financial Summary Report.~~ The DCS Program shall retain the benefit of any cost savings, in excess of the Offeror's Guaranteed Minimum Discount of [TBD] off the aggregate AWP. Any shortfall in the Guaranteed Minimum Discount of this Agreement cannot be recovered by the Contractor in subsequent years.

12.8.3 Retail Pharmacy Network Generic Pricing

The Contractor shall:

12.8.3a Maximize the discount achieved on behalf of the DCS Program for Generic Drugs dispensed by Network Pharmacies. The Contractor or its Key Subcontractor, if any, must manage the Programs' MAC List consistent with, or better than, their most aggressive generic pricing list used to reimburse Pharmacies. The Contractor shall charge the Program utilizing Pass-through Pricing for all Generic Drugs dispensed to Enrollees through the Network Pharmacies.

(Amended April 4, 2012)

12.8.3b Create and maintain a single Program-Specific Maximum Allowable Cost (MAC) List called the Program MAC List setting the Ingredient Cost ~~maximum price~~ the DCS Program shall be charged, and the amount the dispensing Network Pharmacy shall be paid, for the Ingredient Cost for the drugs required to be included on the Program MAC List. Under no circumstances shall the MAC price assigned exceed the Discounted Ingredient Cost to the DCS Program achieved ~~through Pharmacy submitted pricing or pricing achieved~~ by using the Contractor's highest contracted Retail ~~and Mail Service~~ Pharmacy Brand Guaranteed Minimum Discount of [TBD] off of AWP applied to the AWP of the dispensed Generic Drug.

12.8.3c Assign a MAC price to all NDCs of drugs included within a GPI/GCN, including NDCs of all Brand Drugs, containing an A-rated or authorized Generic Drug form of the original Brand Drug in the GPI/GCN. The Contractor shall add the GPI/GCN to the Programs' MAC List and set a MAC price for the GPI/GCN in

accordance with Section 6.16.1 of this Agreement. The provisions of this section require that MAC pricing be applied in no event later than 21 Days after the first shipment of the first Generic Drug from the manufacturer to a wholesaler or retailer. For those Generic Drugs with an established GPI/GCN that are already subject to MAC pricing the Contractor is required to immediately apply MAC pricing to any generic NDC added to the GPI/GCN. All A-rated or authorized Generic Drugs shall be MAC'd in all instances including, but not limited to circumstances in which the DCS in its sole discretion decides not to enforce mandatory generic substitution of the Brand Drug in that GPI/GCN. There shall be one MAC price applicable to all NDCs included in the GPI/GCN on the Programs' MAC List. The MAC price shall be consistent with the process in Section 12.8.3b. However depending on particular market factors, it may be in the best interests of the DCS Program, and therefore appropriate, for more than one MAC price to be assigned within a GPI/GCN. Such situations would require that the Contractor provide any information DCS deems necessary to support such action and obtain prior written approval from DCS.

12.8.3d Assign a MAC price to all NDCs of B-rated or unrated Generic Drugs included within a GPI/GCN that does not include an A-rated or authorized Generic Drug. The Contractor shall add the GPI/GCN to the Programs' MAC List and set a MAC price for the Generic Drug NDCs included in the GPI/GCN as soon as practicable, but in no event later than 14 Days after the first shipment of the first Generic Drug from the manufacturer to a wholesaler or retailer concurrent with transmission of the MAC alert notice. The Contractor shall not apply the MAC price to the NDC(s) for Brand Drugs dispensed in the GPI/GCN and shall not enforce the DCS Program's mandatory generic substitution provisions for Brand Drugs dispensed in this GPI/GCN. There shall be one MAC price applicable to all Generic Drug NDCs included in the GPI/GCN. However depending on particular market factors, it may be in the best interests of the DCS Program, and therefore appropriate, for more than one MAC price to be assigned within a GPI/GCN. Such situations would require that the Contractor provide any information DCS deems necessary to support such action and obtain prior written approval from DCS.

12.8.3e Charge the DCS Program for non-MAC'd Generic Drugs dispensed, utilizing pass-through pricing of the Contractor's pharmacy contracted discount applied to the AWP of the dispensed Generic Drug. The only Non-MAC'd Generic Drugs shall be Generic Drugs included in GPIs/GCNs required to be on the Programs' MAC List but which have not yet been assigned a MAC price within the required time frame.

12.8.3f The Contractor shall inform the DCS of any market based condition which makes the strict compliance with Section 12.8.3b–12.8.3e of this Agreement contrary to the financial interests of the DCS Program. The DCS in its sole discretion may waive such requirements.

12.8.3g Monitor the Programs' MAC List pricing to ensure that NDCs contained in GPIs/GCNs subject to MAC pricing are paying at the MAC price after application of the DCS Program's Lesser of Logic provisions. The Contractor shall notify the DCS Program of any GPIs/GCNs subject to MAC pricing in which the majority of claims are processing at a basis other than the MAC price.

12.8.3h Agree that there shall be no increases to Programs' MAC List prices where such adjustment is intended to limit the discount achieved on behalf of the DCS Program to the Guaranteed Minimum Discount off of the aggregate AWP as set forth in Section 12.8.3m below, for all Generic Drugs dispensed by Network Pharmacies during the Plan Year.

12.8.3i Provide to the DCS full access to the Programs' MAC List used to price Generic Drugs dispensed by Network and Mail Service Pharmacies for the DCS Program. The Contractor must be prepared to provide valid documented market rationale to support their Programs' MAC pricing should DCS request this information. In order to protect the DCS Program's financial interests from the date of the award until the termination date of the Agreement, the Contractor must agree that any <u>increases</u> to the Programs' MAC pricing must be justified to DCS with valid documented market rationale. Following selection, the Contractor shall manage the content of the Programs' MAC List consistent with the requirements

of this Agreement. Prices assigned to required new additions to the Programs' MAC List shall be equivalent to the Contractor's most aggressive MAC price for that drug. To ensure compliance with these requirements, the Contractor shall notify the DCS on a monthly basis of all changes, additions, and deletions made to the Programs' MAC List in the format specified by DCS in Section 16.4.3 of this Agreement. Compliance with these requirements as noted herein shall be a condition of contract award. Should the selected Offeror fail to comply with the requirements noted herein, the State reserves the right to deem the selected Offeror non-responsive and withdraw said conditional award. Throughout the term of the Agreement, the Contractor commits to use its best efforts to maintain the aggregate effectiveness of its Programs' MAC List. The Contractor must ensure that MAC pricing is reduced to an appropriate level based on any change in market conditions such as increased competition within a GPI/GCN.

12.8.3j The Contractor shall strictly enforce all requirements of the DCS Program's mandatory generic substitution provision as detailed in Section 12.7.0 of this Agreement.

12.8.3k The Contractor guarantees that its management of Generic Drug costs dispensed by Network Pharmacies, including maintenance of the Programs' specific MAC List, and application of pricing provisions related to Generic Drugs that do not meet the requirements for inclusion on the Programs' specific MAC List, shall result in the DCS Program achieving the Contractor's overall Guaranteed Minimum Discount off of the aggregate AWP as set forth in Section 12.8.3m below, for all Generic Drugs dispensed by Network Pharmacies during the Plan Year. The discount achieved off of the aggregate AWP for all Generic Drugs as a result of Pass-through Pricing shall be calculated utilizing the following formula: 1 minus (Sum of Ingredient Costs of dispensed Generic Drugs at Retail and Mail Service Pharmacies divided by sum of AWP of dispensed Generic Drugs). The aggregate discount calculation shall be based on Network Pharmacy Prescriptions filled with a Generic Drug where the DCS Program was the primary payer (including Enrollee submitted claims). Claims submitted for secondary payer consideration, Compound Drug claims, and claims submitted by

governmental entities are excluded from the aggregate discount calculation. In addition, claims with a calculated AWP discount greater than 90% and a total AWP greater than $500 shall be excluded pending receipt of supporting documentation by the Contractor and verification by DCS as to the validity of the calculated discount. The setting of an overall minimum discount off of the aggregate AWP for all Generic Drugs dispensed at Network and Mail Service Pharmacies shall in no way modify the Contractor's contractual obligation to maximize the DCS Program's aggregate discount above the Contractor's overall Guaranteed Minimum Discount of [TBD] off of the aggregate AWP.

12.8.3l If the overall aggregate discount obtained, as calculated utilizing the formula set forth in Section 12.8.3k, above, is less than the Guaranteed Minimum Discount set forth in Section 12.8.3m, the Contractor shall reimburse the DCS Program the difference between the Ingredient Cost the DCS Program was charged utilizing Pass-through Pricing and the Ingredient Cost the DCS Program would have been charged if the Guaranteed Minimum Discount off of the aggregate AWP set forth in Section 12.8.3m for all Generic Drugs was obtained.

This calculation shall be performed for each Plan Year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Department on July 31st. If the Department Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Department reserves the right in their sole discretion to make an adjustment to the Contractor's calculations. ~~The calculations must be completed by February 15th of the following year.~~ Upon approval of the DCS, ~~T~~the Contractor shall pay/credit the Plan the applicable amount, if any, within 30 Days. ~~following the February 15th calculation. If DCS's review of the Contractor's calculations indicates an adjustment to the calculation is required, then DCS reserves the right in its sole discretion to make an adjustment to the Contractor's calculations.~~ The Contractor shall also reflect the adjustment, if any, in the Contractor's Annual Financial Summary Report. ~~On July 31st following each Plan Year, the~~

~~Contractor shall perform a reconciliation to include claims incurred in each Plan Year and paid through June of the following Plan Year. Based on this reconciliation, the DCS Program shall receive an adjustment if necessary, within 30 Days following the date of the reconciliation and the adjustment shall be included in the following year's Annual Financial Summary Report.~~ The DCS Program shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discount off the aggregate AWP set forth in Section 12.8.3m for all Generic Drugs dispensed by Network and Mail Service Pharmacies. Any shortfall in the Guaranteed Minimum Discount set forth in Section 12.8.3m cannot be recovered by the Contractor in subsequent years.

12.8.3m The Contractor shall use the following Ingredient Cost and dispensing fee, minus applicable Copayment, to charge the DCS Program for each covered Generic Drug dispensed by Retail Network Pharmacies throughout the term of the Agreement subject to the Lesser of Logic process set forth in Section 12.6.0 of this Agreement.

12.8.3m(1) ***Ingredient Cost of Generic Drug dispensed at Retail Pharmacy:***

Pass-through Pricing based on either the Programs' MAC List or the Contractor's pharmacy contracted discount applied to the AWP of the dispensed Generic drug for Generic Drugs not assigned a MAC . (Pricing is subject to an overall annual minimum discount of (TBD)% off of the aggregate AWP and maximum annual dispensing fee of (TBD) for all Generic Drugs dispensed through Network Pharmacies.)

12.8.4 <u>Retail Pharmacy Network Compound Drug Pricing</u>

Compound Drugs must be classified consistent with the definition in Section 1.11.0 of this Agreement.

The Contractor shall:

12.8.4a Implement the pricing methodology for Compound Drugs as set forth in

Section 12.8.4e below. The Contractor's retail Brand Drug dispensing fee and the Program's "Lesser of Logic" will apply;

12.8.4b Charge Enrollees the applicable Level 2 Drug Copayment for all Compound Medications;

12.8.4c Process Compound Drug claims in a manner that verifies the validity of the claim as a Compound Medication according to the DCS Program's definition of a Compound Drug and provides appropriate claim level control procedures to protect the financial interests of the DCS Program; and,

12.8.4d Conduct due diligence as well as audit Network Pharmacies to ensure that drugs are being properly classified as Compound Drugs consistent with the DCS Program's definition of a Compound Drug and to ensure that claims are priced in accordance with the methodology for Compound Medications as set forth in Section 12.8.4e below.

12.8.4e The Contractor shall use the following methodology to charge the DCS Program for each Prescription for a covered Compound Drug/Medication dispensed by a Network Pharmacy throughout the term of the Agreement. The DCS Program shall be charged the lesser of the following:

12.8.4e(1) [Insert Contractor's proposed pricing methodology] or

12.8.4e(2) The Pharmacy Submitted Cost equaling the Total AWP of all ingredients in the Compound as submitted by the Pharmacy. (eg, AWP of NDC 1 plus AWP of NDC 2 plus AWP of NDC 3); OR

12.8.4e(3) The Pharmacy's Usual and Customary price as submitted by the Pharmacy less the dispensing fee plus the sales tax when applicable,

The DCS Program shall be charged the lowest Ingredient Cost derived through application of the above "Lesser of Logic" process plus the dispensing fee (when applicable) minus the preferred drug Copayment.

12.9.0 <u>Mail Service Pharmacy Process Pricing – Brand Drugs, Generic Drugs, and Compound Drugs</u>

The Contractor shall:

12.9.1 Consistently enforce and administer all provisions of the DCS Program (including but not limited to mandatory generic substitution, drug utilization review, prior authorization, refill too-soon edits, etc.) to the claims dispensed through the Mail Service Pharmacy Process, consistent with the processing of claims through the Retail Pharmacy Network process.

12.9.2 Charge the DCS Program for those drugs dispensed to the Enrollee in original manufacturer packaging, based on the Contractor's source of AWP for the 11 digit NDC of the package size dispensed through the Mail Service Pharmacy Process, subject to MAC pricing for Generic Drugs. If the drug is not dispensed to the Enrollee in original manufacturer packaging (i.e., dispensed from bulk), the DCS Program shall be charged based on the Contractor's source of AWP for the 11 digit NDC of the package size from which the drug was originally dispensed by the Mail Service Pharmacy Process Facility, subject to MAC pricing for Generic Drugs. If the drug is dispensed from a bulk package size for which no AWP is reported in the Contractor's AWP source, the DCS Program shall be charged based on the reported AWP for the NDC of the largest package size contained in the Contractor's AWP source, subject to MAC pricing for Generic Drugs.

The DCS Program shall not be charged based on an NDC assigned to repackaged drugs or based on package sizes prepared by special arrangement with the original manufacturer unless such packaging offers a net savings to the DCS Program.

12.9.3 Charge the DCS Program based on the Contractor's pricing terms and dispensing fees applicable to brand, generic, and Compound Drug claims as set forth in 12.9.5, 12.9.6, and 12.9.7 for all Prescriptions submitted through the Mail Service Pharmacy Process. The DCS Program's Lesser of Logic shall be applied.

12.9.4 Ensure that the Mail Service Pharmacy Process Facilities collect the appropriate Copayment specified by DCS plus Ancillary Charge, if applicable, from the Enrollee and will charge the DCS Program the balance of the Discounted Ingredient Cost as determined through the application of the Lesser of Logic detailed in Section 12.6.0 of this Agreement plus the Contractor's applicable guaranteed dispensing fee set forth in

Section 12.11.3, of this Agreement, minus the applicable Copayment for all drugs dispensed through the Mail Service Pharmacy Process.

12.9.5 Mail Service Pharmacy Process - Brand Drug Pricing

The Contractor shall:

12.9.5a Classify Brand Drugs consistent with the definition in Section 1.4.0 of this Agreement as well as the methodology outlined in Section 12.3.0 of this Agreement.

12.9.5b Implement its fixed contracted Guaranteed Discount off of Average Wholesale Price (AWP) as set forth below in Section 12.9.5d, that shall be utilized to determine the Ingredient Cost of the Prescription to charge the DCS Program. The Contractor's Guaranteed Discount shall be applicable to all individual Prescriptions for Brand Drugs dispensed to Enrollees through the Mail Service Pharmacy Process.

12.9.5c Ensure that the dispensing Mail Service Pharmacy Process Facility collects the appropriate Brand Drug Copayment plus Ancillary Charge, if applicable, from the Enrollee. If the Ingredient Cost derived through application of the DCS Program's Lesser of Logic provision as set forth in 12.6.0 of this Agreement, plus any applicable tax, is lower than the Enrollee's applicable Copayment, then the Contractor shall ensure that the Enrollee is not charged more than the cost of that drug.

12.9.5d The Contractor shall use the following Ingredient Cost and dispensing fee, minus Copayment and applicable Ancillary Charge, if any, to charge the DCS Program for each Prescription for a covered Brand Drug dispensed through the Mail Service Pharmacy Process throughout the term of the Agreement.

Brand Drug:	Ingredient Cost:	(TBD)% off AWP
	Dispensing Fee:	$(TBD)

12.9.6 Mail Service Pharmacy Process - Generic Drug Pricing

The Contractor shall:

12.9.6a Classify Generic Drugs consistent with the definition in Section 1.39.0 of this Agreement.

12.9.6b Ensure that the Mail Service Pharmacy Process dispensing facility collects the Level 1 Copayment from the Enrollee. If the Ingredient Cost derived through application of the DCS Program's Lesser of Logic provision as set forth in 12.6.0 of this Agreement, plus any applicable tax, is lower than the Enrollee's applicable Copayment, then the Contractor shall ensure that the Enrollee is not charged more than the cost of that drug.

12.9.6c The Contractor shall use the following Ingredient Cost and dispensing fee, minus Copayment, to charge the DCS Program for each Prescription for a covered Generic Drug dispensed through the Mail Service Pharmacy Process throughout the term of the Agreement subject to the Lesser of Logic process set forth in Section 12.6.0 of this Agreement:

Ingredient Cost of Generic Drug dispensed at Mail Service Pharmacy: Pass-through Pricing based on either the Programs' MAC List or the fixed, contracted Mail Service Pharmacy Guaranteed Discount off the equivalent Brand Drug as set forth in Section 12.9.5d for the dispensing of Generic Drugs not assigned a MAC. (Pricing is subject to an overall annual minimum discount of X% off of the aggregate AWP for all Generic Drugs dispensed through the Retail and Mail Services Pharmacies.)

Dispensing Fee: $(TBD)

12.9.6d The contractor must guarantee an overall minimum discount off the aggregate AWP for all Generic Drugs dispensed through the Mail Service Pharmacy, as set forth in 12.8.3 of this Agreement.

12.9.7 Mail Service Pharmacy Process - Compound Drug Pricing

The Contractor shall:

12.9.7a Classify Compound Drugs consistent with the definition in Section 1.11.0 of this Agreement;

12.9.7b Implement its Pass-through Pricing methodology for Compound Drugs as set forth below in Section 12.9.7f. The Contractor's retail Brand Drug dispensing fee and the DCS Program's Lesser of Logic will apply;

12.9.7c Charge Enrollees the applicable Level 2 Copayment for all Compound Medications. If the current Discounted Ingredient Cost or the submitted cost is less than the applicable Level 2 Copayment then the Contractor shall ensure that the Enrollee is charged the lesser amount;

12.9.7d Process Compound Drug claims in a manner that verifies the validity of the claim as a Compound Medication according to the DCS Program's definition and provides appropriate claim level control procedures to protect the financial interests of the DCS Program; and,

12.9.7e Conduct due diligence to ensure that drugs are being properly classified as Compound Drugs consistent with the Program's definition of a Compound Drug and to ensure that claims are priced in accordance with the methodology for Compound Medications as set forth below in Section 12.9.7f below.

12.9.7f The Contractor shall use the following methodology to charge the DCS Program for each Prescription for a covered Compound Drug/Medication dispensed by the Mail Service Pharmacy Process throughout the term of the Agreement. The Contractor shall charge the DCS Program the lesser of the following:

12.9.7f(1) [Insert Contractor's proposed pricing methodology] or

12.9.7f(2) The Pharmacy Submitted Cost equaling the Total AWP of all ingredients in the Compound as submitted by the Pharmacy. (eg, AWP of NDC 1 plus AWP of NDC 2 plus AWP of NDC 3); OR

12.9.7f(3) The Pharmacy's Usual and Customary price as submitted by the Pharmacy less the dispensing fee plus sales tax when applicable.

The DCS Program shall be charged the lowest Ingredient Cost derived through application of the above "Lesser of Logic" process plus the guaranteed dispensing fee (when applicable) minus the Level 2 Copayment. If the Ingredient Cost derived through application of the Compounded Drug methodology above plus the applicable taxes and dispensing fee is lower than the Enrollee's Level 2 Copayment, then the Contractor shall ensure that the Enrollee is not charged more than the cost of that drug.

Dispensing Fee: $(TBD)

12.10.0 Enrollee Submitted Claims

12.10.1 The cost to the DCS Program for Prescriptions for which Enrollees submit direct claims for reimbursement shall be charged to the DCS Program at the actual amounts reimbursed by the Contractor.

12.10.2 The Contractor shall utilize the following methodology to reimburse the Enrollee and charge the DCS Program:

12.10.2a Brand Drugs, including Specialty Drugs/Medications, must be charged to the DCS Program utilizing the Guaranteed Minimum Discount off of AWP for Brand Drugs dispensed at the Retail Pharmacy Network set forth in Section 12.8.2b(1) and retail brand Guaranteed Maximum Dispensing Fee set forth in Section 12.11.3a for Brand Drugs minus the applicable Copayment;

12.10.2b Generic Drugs, including Specialty Drugs/Medications, must be charged to the DCS Program utilizing the Contractor's assigned MAC price for the Retail and Mail Service Pharmacies plus the Guaranteed Maximum Dispensing Fee, for Generic Drugs set forth in Section 12.11.3.a of this Agreement minus the applicable Copayment. Generic Drugs without a MAC price must be charged to the DCS Program using the Contractor's Guaranteed Minimum Discount set forth in Section 12.8.2b(1) applied to the AWP of the dispensed Generic Drug, plus the Guaranteed Maximum generic dispensing fee, set forth in Section 12.11.3a of this Agreement, minus the applicable Copayment;

12.10.2c Compound Drugs must be charged to the DCS Program by applying the methodology for pricing Compound Drugs dispensed through the retail Pharmacy set forth in Section 12.8.4e of this Agreement plus the Guaranteed Maximum dispensing fee set forth in Section 12.11.3a for Compound Drugs minus the applicable Level 2 Copayment; and

12.10.2d The DCS Program's "Lesser of Logic" must be applied to all Enrollee Submitted Claims.

12.11.0 Dispensing Fee

12.11.1 The Guaranteed Dispensing Fees and Maximum Guaranteed Dispensing Fees set forth in 12.11.3 of this Section must be guaranteed for the term of this Agreement.

12.11.2 No dispensing fee shall be charged to the DCS Program for any claim that is paid on the basis of the Pharmacy's Usual and Customary price.

12.11.3 The Contractor dispensing fee for Brand Drugs, Generic Drugs and Compound Drugs dispensed by Network Pharmacies shall be Pass-through Pricing, subject to an annual aggregate Maximum Guaranteed Dispensing fee set forth below. The Contractor's Guaranteed Dispensing fees for Brand Drugs, Generic Drugs and Compound Drugs dispensed by the Mail Service Pharmacy Process and the Designated Specialty Pharmacy are set forth below:

12.11.3a Network Retail Pharmacy Guaranteed Maximum Dispensing Fee:

$(TBD) Per Brand Drug
$(TBD) Per Generic Drug
$(TBD) Per Compound Drug

12.11.3b Mail Service Pharmacy Process Guaranteed Dispensing Fee:

$(TBD) Per Brand Drug
$(TBD) Per Generic Drug
$(TBD) Per Compound Drug

12.11.3c Designated Specialty Pharmacy dispensing fees may vary based on the specific NDC of the drug dispensed. Specialty Pharmacy Program dispensing fees are set forth in Exhibit E.

12.11.4 The level of dispensing fees achieved as a result of Pass-through Pricing at Retail Pharmacies will be calculated utilizing the following formula:

Total Retail Network dispensing fees paid by the Plan on an annual basis divided by the number of Final Paid Claims at Retail Network Pharmacies for each of Generic, Brand and Compound claims.

12.11.5 If the overall aggregate dispensing fees paid, as calculated utilizing the formula set forth in Section 12.11.4 of this Agreement are more than the Guaranteed Maximum Dispensing Fee set forth in Section 12.11.3a of the Agreement, for each of Brand, Generic and Compound claims at Retail Network Pharmacies, the Contractor shall reimburse the DCS Program the difference between the Dispensing fee the DCS Program was charged utilizing Pass-through Pricing and the Dispensing Fee the DCS Program would have been charged if the Guaranteed Maximum Dispensing Fee had been obtained. The Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the DCS on July 31st. If the DCS' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the DCS reserves the right in their sole discretion to make an adjustment to the Contractor's calculations. Upon approval by the DCS, the Contractor shall pay/credit the Program the applicable amount, if any, within 30 (thirty) Days. ~~The DCS Program will be credited annually for this difference by February 15th.~~ The DCS Program shall retain the benefit of any cost savings in excess of the Guaranteed Maximum Dispensing Fees set forth in Section 12.11.3. Any shortfall in the Guaranteed Maximum Dispensing Fees set forth in Section 12.11.3 cannot be recovered by the Contractor in subsequent years..

12.12.0 Specialty Pharmacy Program Pricing

The Contractor shall:

12.12.1 Consistently enforce and administer all provisions of the DCS Program (including but not limited to mandatory generic substitution, drug utilization review, prior authorization, refill too-soon edits, etc.) to the claims dispensed through the Specialty Pharmacy Program, consistent with the processing of claims through the Retail and Mail Service Pharmacy Network processes.

12.12.2 Charge the DCS Program for those drugs dispensed to the Enrollee in original manufacturer packaging, based on the Contractor's source of AWP for the 11 digit NDC of the package size dispensed through the Specialty Pharmacy Program. If the drug is not dispensed to the Enrollee in original manufacturer packaging (i.e., dispensed from bulk), the Program shall be charged based on the Contractor's source of AWP for the 11 digit NDC of the package size from which the drug was originally dispensed by the Designated Specialty Pharmacy. If the drug is dispensed from a bulk package size for which no AWP is reported in the Contractor's AWP source, the DCS Program shall be charged based on the reported AWP for the NDC of the largest package size contained in the Contractor's AWP source. The DCS Program shall not be charged based on an NDC assigned to repackaged drugs or based on package sizes prepared by special arrangement with the original manufacturer unless such packaging offers a net savings to the DCS Program.

12.12.3 Charge the DCS Program based on the Contractor's pricing terms and dispensing fees applicable to brand and generic, Specialty Drug/Medication claims as set forth in Sections 12.12.5 through 12.12.9 for all Prescriptions submitted through the Specialty Pharmacy Program.

12.12.4 Ensure that the Designated Specialty Pharmacies collect the appropriate Copayment specified by DCS plus Ancillary Charge, if applicable from the Enrollee and will charge the DCS Program the balance of the Discounted Ingredient Cost plus the Contractor's applicable guaranteed dispensing fee set forth in Exhibit E of this Agreement, minus the applicable Copayment for all drugs dispensed through the Specialty Pharmacy Program.

12.12.5 Classify Brand Drugs consistent with the definition in Section 1.4.0 of this Agreement as well as the methodology outlined in Section 12.3.0 of this Agreement.

12.12.6 Classify Generic Drugs consistent with the definition in Section 1.39.0 of this Agreement.

12.12.7 Subject to the terms of Section 12.2.2 as amended, implement its fixed contracted Guaranteed Discount off of Average Wholesale Price (AWP) of X% to determine the Ingredient Cost of the Prescription to charge the DCS Program. The Contractor's Guaranteed Discount shall be applicable to all individual Prescriptions for Brand Drugs and Generic Drugs dispensed to Enrollees through the Specialty Pharmacy Program.

12.12.8 Act in the interests of the DCS Program when dispensing Generic Drugs through the Specialty Pharmacy Program by avoiding the dispensing of NDC's with higher AWPs unless market conditions exist making dispensing the more cost effective NDC impractical or impossible.

ARTICLE XIII: 100% PHARMA REVENUE GUARANTEE

The Contractor is required to maximize savings to the Program through negotiation of Pharma Revenue Agreements obtaining discounts or other consideration from manufacturers and passing through 100% of the value of the Pharma Revenue agreements to the Program, including any consideration that would normally flow to the Contractor or Key Subcontractor(s) based on the Plan's utilization pursuant to the terms of those Pharma Revenue Agreements. In addition, all Pharma Revenue agreements with manufacturers and other entities applicable to the Program must meet or exceed the Contractor's best existing Pharma Revenue agreements for all individual drugs ensuring that in no instance will the Program receive less Pharma Revenue in any therapeutic class than other clients of the Contractor with a comparable benefit design and consistent preferred drug designations in the class provided the Program's utilization of the drugs generating Pharma Revenue in the class is equal to or greater than those of other clients.

13.1.0 Negotiate Pharma Revenue agreements with manufacturers that maximize savings to the DCS Program, leveraging the significant enrollment of the DCS Program for each individual drug. The Contractor agrees that any Plan specific Pharma Revenue agreement shall derive total Pharma Revenue that meets or exceeds the Pharma Revenue derived from any other agreements the Contractor uses to administer its book of business for each individual drug.

13.2.0 Include the value of the guaranteed Pharma Revenue set forth in Section 13.9.7 as a credit in the development of Claims Administration Fees throughout the term of this Agreement.

13.3.0 Credit the DCS Program quarterly within 150 Days of the end of each quarter, the greater of 100% of the Pharma Revenue received or the minimum guaranteed amount set forth in Section 13.9.7.

13.4.0 Calculate and distribute Pharma Revenue to the DCS Program in a fully transparent and verifiable process. The Contractor agrees that all direct and indirect revenue arrangements with manufacturers, suppliers, or other vendors shall be disclosed and the revenue generated related or attributable to the DCS Program's utilization be credited to the DCS Program. The Contractor must agree that the records, methods and calculations utilized to total and distribute these amounts to the DCS Program are subject to audit by DCS or other State auditors with authority under Article XIX and/or Appendices A & B of this Agreement. In addition, all agreements must be provided as necessary for the DCS Program to evaluate Preferred Drug List decisions including direct access to any manufacturer contracts in unredacted form, under which the DCS Program is entitled to derive Pharma Revenue pursuant to the terms of this Agreement.

13.5.0 Not enter into any agreement that has the effect of diverting, shortchanging, or trading off any form of Pharma Revenue that would otherwise be due the DCS Program for other consideration. There shall be no fees charged to the DCS Program or received from a manufacturer, separate from the Claims Administration Fee as described and authorized in this Agreement, by the Contractor for rebate or other Pharma Revenue administration. The Contractor agrees that it will not divert, shortchange, or trade off Pharma Revenue that would otherwise inure to the DCS Program's financial benefit for Enrollee/Dependent drug utilization in return for reduced drug acquisition costs or other monetary or non-monetary consideration from manufacturers.

13.6.0 Upon selection and as a condition of contract award and throughout the term of the Agreement, the contractor shall provide upon the request of the State all information and documentation related to Pharma Revenue agreements, including but not limited to, full direct access by DCS staff or its agents to complete unredacted Pharma Revenue agreements pursuant to which the DCS Program derives Pharma Revenue**.**

13.7.0 Utilize manufacturer agreements for the DCS Program that meet or exceed the Contractor's best existing Pharma Revenue agreements for all individual drugs. If the Contractor's business model allows for more than one Pharma Revenue agreement with manufacturers, the Contractor agrees that in no instance will the DCS Program receive less Pharma Revenue in any therapeutic class than other clients of the Contractor with a comparable benefit design and consistent preferred drug designations in the class provided the DCS Program's utilization of the drugs generating Pharma Revenue in the class is equal to or greater than those of other clients. The Contractor shall have a process satisfactory to the State to confirm compliance with this provision. The DCS Program shall receive a full pass-through of 100% of Pharma Revenue derived from any agreement with a pharmaceutical manufacturer. Where any Pharma Revenue contracts allow for higher Pharma Revenue for mail order claims, the DCS Program will receive the full financial benefit of those higher rates receiving 100% of the Pharma Revenue derived from those agreements on mail order claims. If manufacturer agreements provide less Pharma Revenue for Mail Service Pharmacy or Specialty Pharmacy claims than retail claims for the same drug, the terms of the manufacturer agreement applicable to retail claims shall be applied to Program Mail Service Pharmacy and Specialty Pharmacy claims for purposes of calculating the amount of Pharma Revenue due the DCS Program.

13.8.0 Ensure the Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee, set forth in Section 13.9.7 is not contingent upon the DCS Program's participation in any of the Contractor's formulary management or intervention programs. Nor shall the Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee be contingent or dependent on the timing of any patent expirations and/or introduction of generic equivalent drugs, including but not limited to early and/or at risk Generic Drug launches. The DCS Program will review the guaranteed amount only in the event of legislative, regulatory, or judicial action excluding patent litigation not specific to the Contractor's business practices that serves to void existing Pharma Revenue agreements materially compromising the Contractor's ability to obtain contracted Pharma Revenue necessary to meet the Minimum Per Final Paid Claim Pharma Revenue Guarantee.

13.9.0 Calculate and perform an annual reconciliation of the Pharma Revenue credit to the Pharma Revenue earned. As part of this annual reconciliation the Contractor is required to:

13.9.1 Calculate the Pharma Revenue guarantee on all Final Paid Claims, incurred for the respective Plan Year. The Pharma Revenue guarantee shall be on the aggregate level, not separated for each therapeutic class.

13.9.2 Credit the DCS Program an amount calculated based on the following formula: if in any Plan Year, the Pharma Revenue realized and credited to the DCS Program by the Contractor is less than the amount due the DCS Program as determined utilizing the minimum Pharma Revenue credit set forth in Section 13.9.7, the amount of the credit shall be equal to the difference between the reported Pharma Revenue credited to the DCS Program and the Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee set forth in Section 13.9.7.

13.9.3 Submit calculations and documentation supporting the amount of Pharma Revenue reported and credited to the DCS Program for DCS review and approval. The Contractor shall provide all information and documentation deemed necessary by DCS to verify the DCS Program was credited with all Pharma Revenue due it under the terms of this Agreement.

13.9.4 If at the close of any Plan Year, the Pharma Revenue credited to the Program is greater than the higher of the amount derived through application of the Pharma Revenue guarantee formula or the actual Pharma Revenue realized by the Program, upon notice and verification by DCS, the DCS shall pay the Contractor the difference between the amount previously credited and the higher of the minimum Pharma Revenue guaranteed amount, set forth in Section 13.9.7, or actual Pharma Revenue realized during the Plan Year.

13.9.5 If at the close of any Plan Year, the Pharma Revenue credited to the Program is less than the actual Pharma Revenue realized by the Program, the Contractor shall pay the Program the difference between what was previously paid and the full amount due to the Program in accordance with Article XV, Payments/(Credits) to/(from) the Contractor, of this Agreement.

13.9.6 Include such reconciliations as part of the annual rebate report. DCS requires the Contractor's minimum Pharma Revenue guarantee, set forth in Section 13.9.7, be credited

to the claims on the annual financial settlement regardless of the amount of Pharma Revenue that has been received by the Contractor.

13.9.7 The Minimum Pharma Revenue amount due the DCS Program on an annual basis shall be calculated according to the formula: Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee multiplied by the number of Final Paid Claims incurred for the respective Plan Year. The Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee based on claims incurred for the respective Plan Year is:

13.9.7a $(TBD) for the Plan Year 2014.

13.9.7b $(TBD) for the Plan Year 2015.

13.9.7c $(TBD) for the Plan Year 2016.

13.9.7d $(TBD) for the Plan Year 2017.

13.9.7e $(TBD) for the Plan Year 2018.

ARTICLE XIV: CLAIMS ADMINISTRATION FEE

14.1.0 The Claims Administration Fee is the fee that the Contractor charges the DCS Program for all administrative services provided by the Contractor. This includes the administration of the Empire Plan, SEHP, and the Excelsior Plan, as may be modified from time to time. There are two (2) Claims Administrative Fees that apply to this Agreement: DCS Program Primary Claims Administration Fee and Medicare Primary Claims Administrative Fee. The Contractor guarantees that the Claims Administration Fees shall be $(TBD) per Final Paid Claim for DCS Program Primary and $(TBD) per Final Paid Claim for Medicare Primary Claim. The Contractor shall:

14.1.1 Agree that its Claims Administration Fees are binding for the entire term of this Agreement, unless agreed otherwise by both the State and the Contractor.

(Amended April 4, 2012)

14.1.2 Implement any changes necessary to accommodate DCS Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State within sixty (60) days of notice, or as soon as practicable.

14.1.3 Agree not to request a higher Claims Administration Fee, and the DCS will not consider any modification to the Claims Administration Fees, that is not based on a material change to the DCS Program requiring the Contractor to incur additional costs. The determination of what constitutes a material change is at the sole discretion of the DCS. Implementation of an alternate formulary or multiple formularies shall not constitute a material change and the Contractor agrees to implement, if required, all alternative formularies at the Claims Administration Fee set forth in Section 14.1.0.

14.2.4 Submit detailed documentation of additional costs, over and above existing management costs, with any request for an increase in the Claims Administration Fee resulting from a material change in the benefit structure of the DCS Program. The DCS reserves the right to request and the Contractor must agree to provide any additional information and documentation the DCS deems necessary to verify that the request for an additional Claims Administration Fee is warranted. DCS's decision to modify the Claims Administration Fee to the extent necessary to compensate the Contractor for documented additional costs incurred shall be at the sole discretion of the State.

14.2.5 Implement all benefit designs as required by the DCS with or without final resolution of any request for a Claims Administration Fee adjustment. Refusal to implement changes will constitute a material breach of this Agreement and DCS will seek compensation for all damages resulting.

14.2.6 Agree the Claims Administration Fee shall be payable only for Final Paid Claims and that the DCS Program will not pay an additional Fee(s) or other charge for any claim that is denied prior to processing or any claim that is subsequently voided, reversed, or otherwise modified.

ARTICLE XV: Payments/(Credits) to/from the Contractor

15.1.0 The Contractor agrees to manage such financial transactions in accordance with the following:

15.1.1 The Plan will reimburse the Contractor for claim payments and associated Claims Administration Fees no sooner than two (2) Business Days and no later than five (5) Business Days after receipt of an accurate invoice, following each bi-weekly claims

processing cycle. The Contractor is required to submit a detailed claim file within fifteen (15) Days after the end of each claims processing cycle to support the submitted invoices. The data file layout and file transmission protocol will be mutually agreed upon by the Contractor and the Department during the implementation period.

(Amended April 4, 2012)

15.1.2 Any credit amounts due from the Contractor to the DCS for failure of the Contractor to meet the performance guarantees set forth in this Agreement shall be applied as a credit against the Claims Administration Fees charged separately to the DCS Programs in the ~~next~~ first invoice(s) processed after the performance guarantee has been calculated and agreed to by the Department.

15.2.0 Upon final audit determination by DCS, any audit liability amount assessed by the DCS shall be paid/credited to the Plan within thirty (30) Days of the date of final determination.

15.3.0 Coordination of Benefit recoveries collected by the Contractor shall be aggregated and paid to the Plan within fifteen (15) Days after the end of the each month.

15.4.0 Drug litigation recoveries and settlements shall be paid to the Plan within fifteen (15) Days from the Contractor's receipt of such recoveries and settlements.

15.5.0 One hundred and fifty (150) Days after the end of the first quarter, the Contractor shall pay/credit the Plan the greater of (1) the actual Pharma Revenue received on behalf of the DCS Program or 2) the minimum Per Final Paid Claim Pharma Revenue Guarantee, set forth in Section 13.9.7, multiplied by the number of Final Paid Claims incurred for the first quarter.

15.5.1 For each subsequent quarter of the Plan Year the calculations must be performed on a cumulative Plan Year-to-Date basis utilizing the calculations stipulated in Section 13.9.7. The Contractor shall pay/credit the Plan the greater cumulative amount less the amount previously credited for the Plan Year.

15.5.2 The Contractor shall perform a reconciliation by May 31st of each year and the incremental Pharma Revenue amount shall be paid/credit to the Plan within thirty (30) Days.

15.5.3 At the May 31st Pharma Revenue reconciliation, to the extent that any amount is owed by the Contractor, the Contractor shall pay/credit the Plan within thirty (30) Days after the Final Pharma Revenue reconciliation for the amount owed.

15.6.0 The Plan will pay the Claims Administration Fee on a monthly basis thirty (30) Days after receipt of an accurate invoice. Any credit amounts due from the Contractor to the DCS for failure to meet the performance guarantees set forth in the Agreement shall be applied as a credit against the Claims Administration Fee charged to the DCS Program.

15.7.0 This Agreement is not subject to Article XI-A of NYS Finance Law. The Contractor agrees that Program Services provided under the Agreement shall continue in full force and effect for a minimum of at least thirty (30) days beyond the payment due date as set forth in this Article XV. If after the thirty-fifth (35) calendar day after receipt of an accurate invoice and claims data file, as set forth in this Article XV, the Contractor has not yet received payment from the State for said invoice, the Contractor may proceed under the Dispute Resolution provision in Appendix B and the Agreement shall remain in full force and effect until such final decision is made, unless the Parties can come to a mutual agreement, in which case, the Agreement shall also remain in full force and effect.

ARTICLE XVI: REPORTS AND CLAIM FILES

16.1.0 Annual Reports

16.1.1 ***Annual Financial Summary Report:*** The Contractor must submit an annual report of the DCS Program's charges and credits no later than seventy-five (75) Days after the end of each Calendar Year. These statements must detail, at minimum, the claims paid during the year, claims administration costs, performance credits, audit credits, drug settlement proceeds, rebates (earned and paid), and coordination of benefit (COB) savings. Such detail must include all charges by the Contractor to the DCS Program;

16.1.2 ***Annual Rate Renewal Report*:** The Contractor must submit an Annual Premium Renewal no later than September 1st of each Calendar Year. This renewal package must detail all assumptions utilized to back-up the rate renewal request, including, but not limited to: paid claim amounts, administrative fees, projected Pharma Revenue, COB recoveries, changes

in enrollment, changes in the Specialty Pharmacy drug list as well as changes in the Flexible Formulary and the Traditional PDL;

16.1.3 ***Annual Mail Service Pharmacy Process Satisfaction Survey Summary Report:*** The Contractor must submit a report which details, in summary form, the results of Enrollee satisfaction surveys designed to evaluate the level of DCS Program Enrollee satisfaction with the Mail Service Pharmacy Process. The surveys should cover areas of order processing, quality of services, and timeliness. The format of the survey instrument and reports is subject to NYS input and approval. The report is due annually, on May 1st of the year following the Calendar Year being surveyed. The report must include Enrollee comments and an accounting and resolution of any Enrollee issues;

16.1.4 ***Annual Summary Reporting*****:** The Contractor must prepare and present an annual report that details DCS Program performance, industry trends and anticipated market developments including the introduction of generics and potential new product developments. This presentation should include comparisons of the DCS Program to book of business statistics, and other similar plan statistics. Clinical, financial and service issues as well as strategies and opportunities for plan savings are to be comprehensively addressed. In addition, the Contractor should be proactive by reporting any areas that need improvement, potential problem areas, and any solutions that can be implemented. The annual presentation and report is due each August after the end of each complete Calendar Year;

16.1.5 ***Annual Report of Claims and Credits Paid by Agency*****:** The Contractor must submit a report that details claims and credits paid by agency. The Contractor is required to submit this report in the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the Calendar Year. The report must accurately reflect only Final Paid Claims.

16.1.6 ***Mail Service Pharmacy Process Accuracy Annual Report:*** The Contractor is required to submit an annual report that provides a breakdown of the various errors and calculates

the accuracy rate of transactions processed using the Contractor's Mail Service Pharmacy Process. The Contractor is required to work out the final format of this report with the Department. The report is due thirty (30) Days after the end of the Calendar Year.

16.1.7 ***Rebate True-Up File*:** The Contractor is required to transmit computerized file via secure transfer containing a yearly true-up of rebate records in a format specified by the Department. The true-up rebate file must match all of the billing records provided by the Contractor in the bi-weekly pharmacy billing files. The report is due one hundred fifty days (150) Days after the end of the Calendar Year.

16.1.8 ***Catastrophe Reinsurance Reconciliation Report:*** The Offeror is required to submit an annual reconciliation of the Catastrophe Reinsurance receipts for the EGWP by December 31st of the year following year of incurral.

16.2.0 Semi-Annual Reports

16.2.1 ***Top 100 Brand and Generic Drugs – Retail Pharmacy Report:*** The Contractor is required to submit a semi-annual report that details the top 100 brand name and top 100 Generic Drugs dispensed to Enrollees of the DCS Program through the Contractor's Retail Pharmacy Network sorted by drug spend and script count. The report should include fields such as: drug name, indication of use (i.e. cholesterol, diabetes, etc), preferred drug indicator, number of Rx's, number of Enrollees utilizing the drug, Rx cost, average cost per script, average Copayment, and average Days supply. The Contractor should closely follow the current format specified by the Department in Exhibit B, the Requests for Proposals entitled Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement. The numbers should be submitted on a year-to-year comparison basis. Any trends or abnormalities should be submitted in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter;

16.2.2 ***Top 20 Therapeutic Categories Report:*** The Contractor is required to submit a semi-annual report that details the top 20 therapeutic categories by drug spend on the Contractor's Flexible Formulary and Preferred Drug List (broken down by drug) utilized

by Enrollees of the DCS Program (combined Retail, Mail Service and Specialty Pharmacy). The report should include fields such as: drug name, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Days supply. The Contractor should closely follow the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement. The numbers should be submitted on a year-to-year comparison basis. Any trends or abnormalities should be submitted in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter;

16.2.3 ***Top 100 Brand Name and Generic Drugs – Mail Service Pharmacy Report*:** The Contractor is required to submit a semi-annual report that details the top 100 brand name and top 100 Generic Drugs dispensed to Enrollees of the DCS Program through the Contractor's Mail Service Pharmacy sorted by drug spend and script count. The report should include fields such as: drug name, indication of use (i.e., cholesterol, diabetes, etc), preferred drug indicator, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Days supply. The Contractor should closely follow the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement. The numbers should be provided on a year-to-year comparison basis. Any trends or abnormalities should be provided in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter; and

16.2.4 ***Top 100 Specialty Drugs – Specialty Pharmacy Report*:** The Contractor is required to submit a semi-annual report that details the top 100 Specialty Drugs dispensed to Enrollees of the Program through the Contractor's Designated Specialty Pharmacy sorted by drug spend and script count. The report should include fields such as: drug name, indication of use (i.e., cholesterol, diabetes, etc), preferred drug indicator, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Days supply. The Contractor should

closely follow the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement. The numbers should be provided on a year-to-year comparison basis. Any trends or abnormalities should be provided in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter;

16.3.0 Quarterly Reports

16.3.1 ***Quarterly Financial Summary Reports*:** The Contractor must submit quarterly financial reports which present the DCS Program's experience for the most recent quarter (based on a Calendar Year) and the experience from the beginning of the Calendar Year to the end of the quarter being reported. The quarterly reports must also include projections of:

- annual financial performance;
- assessment of DCS Program costs
- incurred claim triangles
- Pharma Revenue;
- coordination of benefit recoveries;
- audit recoveries
- drug settlement and litigation recoveries
- administrative expenses;
- trend statistics; and
- such other information as the Department deems necessary.

The reports are due on a quarterly basis, fifteen (15) Days after the end of the reporting period;

16.3.2 ***Quarterly Performance Guarantee Report:*** The Contractor must submit quarterly the DCS Program's Performance Guarantee report that details the Contractor's compliance with all of the Contractor's proposed Performance Guarantees. The report should include the areas of: Implementation; system availability; customer service (telephone availability, response time, blockage rate, abandonment rate); claims processing; management reports

and claim files; enrollment; mail service turnaround; and Pharmacy composition and access. The Contractor should closely follow the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement. Documentation of compliance should be included with this report. The report is due thirty (30) Days after the end of the quarter;

16.3.3 ***Quarterly Network Access:*** The Contractor must submit a measurement of the Network access as proposed in Exhibit C, the Contractor's Proposal of this Agreement is based on a "snapshot" of the network taken on the last day of each quarter. The report is due thirty (30) Days after the end of the quarter;

16.3.4 ***Quarterly Audit Report:*** The Contractor must submit a quarterly audit report detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Contractor. The report should include fields such as Pharmacy name, NABP number, recovery amounts, audit method or type, and basis for and method of recovery. The Contractor should closely follow the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," of this Agreement. The report is due thirty (30) Days after the end of the quarter;

16.3.5 ***Quarterly Coordination of Benefit Report:*** The Contractor must submit a report that details the amount of recoveries received as a result of coordinating benefits with other Plans including Medicare. The Contractor's report should identify the COB source, the Enrollee, the original claim amounts, and the amount received from the other insurance carriers or Medicare. The Contractor is required to work out the final format of this report with the Department. The report is due thirty (30) Days after the end of the quarter;

16.3.6 ***Quarterly Rebate and Other Pharma Revenue Report*:** The Contractor is required to submit a quarterly rebate and other Pharma Revenue report detailing the amount of rebates and other Pharma Revenue received from the Contractor during the quarter. The

report must include breakdowns by each manufacturer and drug with quarterly and year-to-date numbers, as well as any adjustments that are performed. The Contractor should closely follow the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for the Empire Plan, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Program," of this Agreement. The Contractor's process for documenting rebates and other Pharma Revenue by manufacturer and issuing the payment of rebates and other Pharma Revenue to the Program should not exceed one hundred (150) Days from the end of the quarter in which the initial claims were processed. This report is due at the time the rebates and other Pharma Revenue are paid to the Program;

16.3.7 ***Quarterly Participating Agency Claims:*** The Contractor is required to submit a quarterly report that details claims by Participating Agency. The Contractor is required to submit this report in the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for the Empire Plan, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Program," of this Agreement unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the quarter;

16.3.8 ***Generic Appeals and Prior Authorization Quarterly Report:*** The Contractor is required to submit a quarterly report that provides the number of generic appeals and prior authorization requests, by individual drug. The report must include numerical breakdowns on the number of generic appeals and prior authorization requests made by the individual drug as well as the success/declination rate of these requests. The Contractor should closely follow the current format specified by the Department in Exhibit B, the Requests for Proposals entitled Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement. The report is due thirty (30) Days after the end of the quarter;

16.3.9 ***Rebate File:*** Each quarter the Contractor is required to transmit a computerized file via secure transfer containing prescription rebate information for all earned rebates in a format specified by the Department. The pharmacy rebate records in the Rebate File

must match all prescriptions billed to the Department by the Contractor. The report is due one hundred fifty (150) Days after the end of the quarter; and

16.3.10 ***Quarterly Website Analytics Report:*** The Contractor is required to submit a quarterly report that provides comprehensive performance information for the Contractor's customized DCS Program website as set forth in Section 6.5.6 of this Agreement. The report must include summarized and detailed website performance information and statistics, as well as proposed modifications to the layout and design of the website to improve communications with Enrollees. The report is due thirty (30) Days after the end of the quarter.

16.4.0 Monthly Reports

16.4.1 ***Monthly Report of Paid Claims by Month of Incurral*:** The Contractor is required to submit a monthly report that provides summarized paid claims by month of incurral. The Contractor is required to submit this report in the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," of this Agreement unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month;

16.4.2 ***Monthly Report of Paid Claims by Pharmacy and Rx Type:*** The Contractor is required to submit a monthly report that provides summarized paid claims by Pharmacy type by Rx type. This report must distinguish reversals and allow the Department to verify Guaranteed Discounts. The Contractor is required to submit this report in the current format as specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," of this Agreement unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month;

16.4.3 ***Monthly Report of DCS Program MAC List*:** Each month the Contractor is required to submit an updated DCS Program MAC List that details all the drugs included on the DCS

Program MAC List and the corresponding prices used to charge the DCS Program. The following information shall be included: GCN, drug name, form, strength, reference product, FDA rating, date the product was initially MAC'd, initial MAC price, previous MAC price, current MAC price, effective date of current MAC price and the change in price from previous DCS Program MAC list. Drugs that are added or deleted from the DCS Program MAC list shall be clearly marked or highlighted. The Contractor is required to submit this report in the current format specified by DCS in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month; and

16.4.4 ***MAC Savings Report*:** Each month the Contractor is required to submit a year-to-date and annualized savings projection of the MAC price increases and decreases, based on expected utilization. The following information shall be included: GCN, Drug Name, Strength, Initial MAC Price, Current Price, Quantity Filled, Actual Savings, Annual Savings. The Contractor is required to submit this report specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," of this Agreement unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month; and

16.4.5 ***Program Customer Service Monthly Reports:*** Each month the Contractor is required to submit a customer service report that measures the Contractor's customer service performance including customer service availability, customer service telephone response time, the telephone abandonment rate, the telephone blockage rate, claims processing, enrollment, and mail service turnaround. The Contractor is required to work out the final format of these reports with the Department. The reports are due fifteen Days (15) after the end of the month. For the first two months of the Agreement, these reports will be due on a weekly basis. After two months, the Department will re-examine the required frequency of these reports and establish due dates with the Contractor.

16.5.0 Bi-Weekly Reports

16.5.1 ***Detailed Claim File Data*:** The Contractor must transmit to the Department and/or its Decision Support System (DSS) vendor a computerized file via secure transfer, as specified by the Department, containing detailed claim records in the format specified by the Department in Exhibit B, the Requests for Proposals entitled Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement unless otherwise specified by the Department, to support the bi-weekly invoice. The Department requires that all claims processed, reversed and adjusted be included in claims data. The file must facilitate reconciliation of claim payments to amounts charged to the DCS Program and include the current status of the claim (i.e. fields identifying claims as paid, adjusted, reversed). A rejected claim file is also required upon request by the Department. The Contractor is required to:

16.5.1a Securely forward the required claims data on a claims processing cycle basis to the Department and/or its DSS vendor within fifteen (15) Days after the end of each claims processing cycle; and

16.5.1b Submit a summarized report by claims processing cycle broken down by drug type (generic/brand) utilizing the fields and the format specified by the Department in Exhibit B, the Requests for Proposals entitled Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement. Based upon the analysis of the information contained in the report any important programmatic information, trends or abnormalities should be provided in a narrative.

16.6.0 Reports Required at Other Frequencies

16.6.1 ***Mac Alert Notice:*** The Contractor is required to submit a report of the financial impact of enforcing mandatory generic substitution via a "Mac Alert Notice" utilizing the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee

Health Plan and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," of this Agreement. This report must be submitted in accordance with the time frames specified in Section 12.7.4 of this Agreement.

ARTICLE XVIII: TRANSITION AND TERMINATION OF CONTRACT

18.1.0 The Contractor must commit to fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the DCS Program.

18.1.1 The Contractor must, within one hundred twenty (120) Days of the end of the Agreement, or within forty-five (45) Days of notification of termination, if the Agreement is terminated prior to the end of its term, provide the Department with a detailed written plan for transition, which outlines, at a minimum, the tasks, milestones and deliverables associated with:

18.1.1a Transition of DCS Program data, including but not limited to a minimum of one year of historical Enrollee claim data, detailed COB data, report formats, Mail Service Pharmacy, Specialty Pharmacy and retail scripts with available refills, prior authorization approved through dates, generic appeal approved through dates and exceptions that have been entered into the adjudication system on behalf of the Enrollee, as well as other data the successor contractor may request and the Department approves during implementation of the DCS Program in the format acceptable to the Department. The transition of open refill prior authorization and generic appeal files should include but not be limited to the following:

18.1.1a(1) Providing a test file to the successor contractor in advance of the implementation date to allow the successor contractor to address any potential formatting issues;

18.1.1a(2) Providing one or more pre-production files at least four (4) weeks prior to implementation that contains Enrollee Prescription refill availability, one year of claims history and prior authorization and appeal approved-through dates as specified by the Department working in conjunction with the successor contractor;

18.1.1a(3) Providing a second production file to the new contractor by the close of business January 2nd (or 2 days after this Agreement terminates) that contains all Enrollee Prescription refill availability as specified by the Department, working in conjunction with the selected successor contractor; and

18.1.1a(4) Providing a lag file seven (7) Days after the implementation date to capture any refills that may have been in process but not yet shipped at the Contractor's Mail Service and Designated Specialty Pharmacy(ies) after the end of the year.

18.1.2 Transition of Enrollee information on all non-transferable compounds and controlled medications.

18.1.3 Within fifteen (15) Business Days from receipt of the Transition Plan, the Department shall either approve the Transition Plan or notify the Contractor, in writing, of the changes required to the Transition Plan so as to make it acceptable to the Department.

18.1.4 Within fifteen (15) Business Days from the Contractor's receipt of the required changes, the Contractor shall incorporate said changes into the Transition Plan and submit such revised Transition Plan to the Department.

18.1.5 The Contractor shall be responsible for transitioning the DCS Program in accordance with the approved Transition Plan.

18.1.6 To ensure that the transition to a successor contractor provides Enrollee's with uninterrupted access to their Prescription drug benefits and associated customer services, and to enable the Department to effectively manage the DCS Program, the Contractor is required to provide the following Contractor-related obligations and deliverables to the DCS Program through the final financial settlement of the Agreement:

18.1.6a Provide all Contractor-provided services associated with claims incurred on or before the scheduled termination date of the Agreement, including but not limited to paying network claims, Mail Service Pharmacy claims, Specialty

Pharmacy claims, manual submit claims including but not limited to: Medicaid, VA , Skilled Nursing Facility claims, out of network claims, foreign claims, in-network claims, COB claims, Student Health Center Claims, and Medicare, reimbursing late filed claims if warranted, reimbursing customer credit balance accounts, resolution of Mail Service Pharmacy process and Specialty Pharmacy Process issues, repaying or recovering monies on behalf of the DCS Program for Medicare Part D claims, retaining NYBEAS access, continuing to provide updates on pending litigation and settlements and claims/rebate data for class action litigation that the Contractor or the AG has/may file on behalf of the DCS Program. In addition, the Contractor must continue to provide the Department access to any online claims processing data and history and online reporting systems through the final settlement dates, unless the Department notifies the Contractor that access may be ended at an earlier date;

18.1.6b Complete all required reports in Article XVI "Reports and Claim Files";

18.1.6c Provide the Program with sufficient staffing in order to address State audit requests and reports in a timely manner;

18.1.6d Agree to fully cooperate with all the Department or OSC audits consistent with the requirements of Article XIX "Audit Authority" and Appendices A and B;

18.1.6e Perform timely reviews and responses to audit findings submitted by the Department and the Comptroller's audit unit in accordance with the requirements set forth in Article XIX "Audit Authority";

18.1.6f Remit reimbursement due the DCS Program within fifteen (15) Days upon final audit determination consistent with the process specified in Article XIX "Audit Authority," Article XV "Payments/(Credits) to/from the Contractor" and Appendix B; and

18.1.6g Assist the Department in all activities necessary to ensure the correct and adequate interface between NYSHIP and the Centers for Medicare and Medicaid Services (CMS) with respect to the administration of the Medicare EGWP in accordance with Subpart R of 42CFR423 and the Medicare Prescription Drug

Improvement and Modernization Act (P.L. 108-173). Such assistance includes, but is not limited to the provision of accurate data within the Contractor's control.

18.1.7 The Contractor is required to receive and apply enrollment updates, keeping dedicated phone lines open with adequate available staffing to provide customer service at the same levels provided prior to termination of this Agreement, adjusting phone scripts, and transferring calls to the successor contractor's lines.

18.1.8 The Contractor is required to transmit point of service messaging to their Retail Pharmacy Network upon the termination date of the Agreement instructing Pharmacists to submit Enrollee claims to the appropriate RXBIN, RXPCN, RXGRP or other claim identification information as specified by the Department working in conjunction with the Contractor.

18.1.9 If the Contractor does not meet all of the Transition Plan requirements found in this Article, the Contractor **will permanently forfeit 100%** of all Claims Administrative Fees (prorated on a daily basis) from the due date of the Transition Plan requirements to the date the Transition Plan requirements are completed to the satisfaction of the Department.

ARTICLE XIX: AUDIT AUTHORITY

In addition to the Audit Authority requirements specified in Appendices A and B to this Agreement, the following provisions shall apply:

19.1.0 The Contractor acknowledges that the DCS has the authority to conduct financial and performance audits of the Contractor's delivery of DCS Program services in accordance with the Agreement and any applicable State and federal statutory and regulatory authorities;

19.2.0 Such audit activity may include, but not necessarily be limited to, the following activities:

19.2.1 Review of the Contractor's activities and records relating to the documentation of its performance under this Agreement in areas such as determination of Enrollee or Dependent eligibility and application of various DCS program administrative features (e.g., dependent survivor benefits, reasonable adjudication of disabled dependent status).

19.2.2 Comparison of the information in the Contractor's enrollment file to that on the enrollment reports issued to the Contractor by the DCS.

19.2.3 Assessment of the Contractor's information, utilization and demographic systems to the extent necessary to verify accuracy of data on the reports provided to the DCS in accordance with Article XVI "Reports and Claim Files" of this Agreement.

19.3.0 The Contractor shall maintain and make available documentary evidence necessary to perform the reviews referenced herein this Article XIX. Documentation maintained and made available by the Contractor may include, but is not limited to, source documents, books of account, subsidiary records and supporting work papers, claim documentation, pertinent contracts, key subcontracts, provider agreements, and correspondence;

19.4.0 The Contractor shall make available for audit all data in its computerized files that is relevant to and subject to the Agreement. Such data may, at DCS discretion, be submitted to the DCS in machine-readable format, or the data may be extracted by the DCS, or by the Contractor under the direction of the DCS;

19.5.0 The Contractor shall, at the DCS' request, and in a time period specified by the Department, search its files, retrieve information and records, and provide to the auditors such documentary evidence as they require. The Contractor shall make sufficient resources available for the efficient performance of audit procedures;

19.6.0 The Contractor shall comment on the contents of any audit report prepared by the DCS and transmit such comments in writing to the DCS within 30 days of receiving any audit report. The response will specifically address each audit recommendation. If the Contractor agrees with the recommendation, the response will include a work plan and timetable to implement the recommendation. If the Contractor disagrees with an audit recommendation, the response will give all details and reasons for such disagreement. Resolution of any disagreement as to the resolution of an audit recommendation shall be subject to the dispute resolution procedures set forth in Appendix B of this Agreement.

19.7.0 If the Contractor has an independent audit performed of the records relating to this Agreement, a certified copy of the audit report shall be provided to the DCS within ten (10) Days after receipt of such audit report by the Contractor.

19.8.0 The audit provisions contained herein shall in no way be construed to limit the audit authority or audit scope of the OSC as set forth in either Appendix A of this Agreement, Standard Clauses for All New York State Contracts, or Appendix B, Standard Clauses for All DCS Contracts.

ARTICLE XX: CONFIDENTIALITY

In addition to the Confidentiality requirements specified in Appendices A and B to this Agreement, the following provisions shall apply:

20.1.0 All claims and enrollment records relating to the Agreement are confidential and shall be used by the Contractor solely for the purpose of carrying out its obligations under the Agreement, for measuring the performance of the Contractor in accordance with the performance guarantees set forth in Section VII of this Agreement, and for providing the DCS with material and information as may be specified elsewhere in this Agreement;

20.2.0 Except as directed by a court of competent jurisdiction, or as necessary to comply with applicable New York State or Federal law, or with the written consent of the Enrollee/Dependent, no records may be otherwise used or released to any party other than the DCS by the Contractor, its officers, employees, agents, consultants or Key Subcontractors either during the term of the Agreement or in perpetuity thereafter. Deliberate or repeated accidental breach of this provision may, at the sole discretion of the DCS, be grounds for termination of the Agreement;

20.3.0 The Contractor, its officers, employees, agents, consultants and/or any Key Subcontractors agree to comply, during the performance of the Agreement, with all applicable Federal and State privacy, security and confidentiality statutes, including but not limited to the Personal Privacy Protection Law (New York Public Officer's Law Article 6-A, as amended), and its implementing regulations, policies and requirements, for all material and information obtained by the Contractor through its performance under the Agreement, with particular emphasis on such information relating to Enrollees and Dependents;

20.4.0 The Contractor shall be responsible for assuring that any agreement between the Contractor and any of its officers, employees, agents, consultants and/or Key Subcontractors contains a provision that strictly conforms to the various confidentiality provisions of this Agreement; and

20.5.0 The Contractor shall promptly advise the DCS of all requests made to the Contractor for information regarding the performance of services under this Agreement, including, but not limited to, requests for any material and information provided by the DCS, except as required by Key Subcontractors solely for the purpose of fulfilling the Contractor's obligations under this Agreement or as required by law.

ARTICLE XXI: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

21.1.0 For purposes of this Article, the term "Protected Health Information" ("PHI") means any information, including demographic information collected from an individual, that relates to the past, present, or future physical or mental health or condition of an individual, to the provision of health care to an individual, or to the past, present, or future payment for the provision of health care to an individual, that identifies the individual, or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. Within the context of this Agreement, PHI may be received by the Contractor from the Department or may be created or received by the Contractor on behalf of the Department. All PHI received or created by the Contractor as a consequence of its performance under this Agreement is referred to herein collectively as "Department's PHI."

21.2.0 The Contractor acknowledges that the Department administers on behalf of New York State several group health plans as that term is defined in HIPAA's implementing regulations at 45 CFR Parts 160 and 164, and that each of those group health plans consequently is a "covered entity" under HIPAA. These group health plans include NYSHIP, which encompasses the Empire Plan as well as participating health maintenance organizations; the Dental Plan, and the Vision Plan. In this capacity, the Department is responsible for the administration of these "covered entities" under HIPAA. The Contractor further acknowledges that the Department has designated NYSHIP and the Empire Plan as an Organized Health Care Arrangement (OHCA), respectively. The Contractor further acknowledges that the Contractor is a HIPAA "business associate" of the Department as a consequence of the Contractor's provision of services to and/or on behalf of the Department within the context of the Contractor's performance under this Agreement, and that the Contractor's provision of such services may involve the disclosure to the Contractor of individually identifiable health information from the Department or from other parties on behalf of the Department, and also may involve the Contractor's disclosure to the

Department of individually identifiable health information as a consequence of the services performed under this Agreement.

21.3.0 ***Permitted Uses and Disclosures of the Department's PHI*:** The Contractor may use and/or disclose the Department's PHI solely in accordance with the terms of this Agreement. In addition, the Contractor may use the Department's PHI to provide data aggregation services relating to the health care operations of the Department. Further, the Contractor may use and disclose the Department's PHI for the proper management and administration of the Contractor if such use is necessary for the Contractor's proper management and administration or to carry out the Contractor's legal responsibilities, or if such disclosure is required by law or the Contractor obtains reasonable assurances from the person to whom the information is disclosed that it shall be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Contractor of any instances of which it is aware in which the confidentiality of the information has been breached.

21.4.0 ***Nondisclosure of the Department's PHI:*** The Contractor shall not use or further disclose the Department's PHI otherwise than as permitted or required by this Agreement or as otherwise required by law. The Contractor shall limit its uses and disclosures of PHI when practical to the information comprising a Limited Data Set, and in all other cases to the minimum necessary to accomplish the intended purpose of the PHI's access, use, or disclosure.

21.5.0 ***Safeguards:*** The Contractor shall use appropriate, documented safeguards to prevent the use or disclosure of the Department's PHI otherwise than as provided for by this Agreement. The Contractor shall maintain a comprehensive written information security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities, to reasonably and appropriately protect the confidentiality, integrity and availability of any electronic PHI that it creates, receives, maintains, or that it transmits on behalf of the Department pursuant to this Agreement.

21.6.0 ***Breach Notification:***

21.6.1 ***Reporting:*** The Contractor shall report to the Department any breach of unsecured PHI, including any use or disclosure of the Department's PHI otherwise than as provided for by this Agreement, of which the Contractor becomes aware. Further, the Contractor shall report to the Department any security incident of which it becomes aware. "Security

incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations in an information system. The Contractor shall notify the Department within five (5) business days of the date the Contractor becomes aware of the event.

21.6.2 ***Required Information:*** The Contractor shall provide the following information to the Department within ten (10) business days of discovery except when, despite all reasonable efforts by the Contractor to obtain the information required, circumstances beyond the control of the Contractor necessitate additional time. Under such circumstances, the Contractor shall provide to the Department the following information as soon as possible and without unreasonable delay, but in no event later than thirty (30) Days from the date of discovery:

21.6.2a the date of the breach incident;

21.6.2b the date of the discovery of the breach;

21.6.2c a brief description of what happened;

21.6.2d a description of the types of unsecured PHI that were involved;

21.6.2e identification of each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed during the breach;

21.6.2f A brief description of what the Contractor is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches; and

21.6.2g any other details necessary to complete an assessment of the risk of harm to the individual.

21.6.3 The Department will be responsible to provide notification to individuals whose unsecured PHI has been or is reasonably believed to have been accessed, acquired or disclosed as a result of a breach, as well as the Secretary and the media, as required by 45 CFR Part 164.

21.6.4 The Contractor shall maintain procedures to sufficiently investigate the breach, mitigate losses, and protect against any future breaches, and to provide a description of these procedures and the specific findings of the investigation to the Department upon request.

21.6.5 For purposes of this Agreement, "Unsuccessful Security Incidents" include activity such as pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above, so long as no such incident results in unauthorized access, use, or disclosure of electronic PHI.

21.6.6 The Contractor shall mitigate, to the extent practicable, any harmful effects from any use or disclosure of PHI by the Contractor not permitted by this Agreement.

21.7.0 ***Associate's Agents:*** The Contractor shall require all of its agents or Key Subcontractors to whom it provides the Department's PHI, whether received from the Department or created or received by the Contractor on behalf of the Department, agree to the same restrictions and conditions on the access, use, and disclosure of PHI that apply to the Contractor with respect to the Department's PHI under this Agreement.

21.8.0 ***Availability of Information to the Department:*** The Contractor shall make available to the Department such information and documentation as the Department may require regarding any disclosures of PHI by the Contractor to fulfill the Department's obligations to provide access to, to provide a copy of, and to account for disclosures of the Department's PHI in accordance with HIPAA and its implementing regulations. The Contractor shall provide such information and documentation within a reasonable amount of time of its receipt of the request from the Department.

21.9.0 ***Amendment of the Department's PHI:*** The Contractor shall make the Department's PHI available to the Department as the Department may require to fulfill the Department's obligations to amend individuals' PHI pursuant to HIPAA and its implementing regulations. The Contractor shall, as directed by the Department, incorporate any amendments to the Department's PHI into copies of the Department's PHI as maintained by the Contractor.

21.10.0 ***Internal Practices*****:** The Contractor shall make its internal practices, policies and procedures, books, records, and agreements relating to the use and disclosure of the Department's PHI, whether received from the Department or created or received by the Contractor on behalf of the Department, available to Department and/or the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by the Department and/or the Secretary for purposes of determining the Department's compliance with HIPAA and its implementing regulations.

21.11.0 ***Termination:***

21.11.1 This Agreement may be terminated by the Department at the Department's discretion if the Department determines that the Contractor, as a business associate, has violated a material term of this Article or of the Agreement with respect to the Contractor's obligations under this Article.

21.11.2 ***Disposition of the Department's PHI:*** At the time this Agreement is terminated, the Contractor shall, if feasible, return or destroy all of the Department's PHI, whether received from the Department or created or received by the Contractor on behalf of the Department, that the Contractor still maintains in any form and retain no copies of such information. Alternatively, if such return or destruction is not feasible, the Contractor shall extend indefinitely the protections of this Agreement to the information and shall limit further uses and disclosures to those purposes that make the return or destruction of the Department's PHI infeasible.

21.12.0 ***Indemnification:*** The Contractor agrees to indemnify, defend and hold harmless the State and the Department and its respective employees, officers, agents or other members of its workforce (each of the foregoing hereinafter referred to as "Indemnified Party") against all actual and direct losses suffered by the Indemnified Party and all liability to third parties arising from or in connection with any breach of this Agreement or from any acts or omissions related to this Agreement by the Contractor or its employees, officers, Key Subcontractors, agents or other members of its workforce. Accordingly, the Contractor shall reimburse any Indemnified Party for any and all actual and direct losses, liabilities, lost profits, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be imposed upon any Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party which results from the Contractor's acts or omissions hereunder. The Contractor's obligation to indemnify any Indemnified Party shall survive the expiration or termination of this Agreement.

21.13.0 ***Miscellaneous:***

21.13.1 ***Amendments*****:** This Agreement may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed by authorized representatives of the Parties. The parties agree to take such action as is necessary to amend this Agreement from

time to time as is necessary to achieve and maintain compliance with the requirements of the Regulations.

21.13.2 ***Survival*****:** The respective rights and obligations of Business Associate and Covered Entity under HIPAA as set forth in this Business Associate Agreement shall survive termination of this Agreement.

21.13.3 ***Regulatory References*****:** Any reference herein to a federal regulatory section within the Code of Federal Regulations shall be a reference to such section as it may be subsequently updated, amended or modified.

21.13.4 ***Interpretation*****:** Any ambiguity in this Agreement shall be resolved to permit covered entities to comply with HIPAA.

ARTICLE XXII: NOTICES

22.1.0 All notices permitted or required hereunder shall be in writing and shall be transmitted either:

22.1.1 via certified or registered United States mail, return receipt requested;

22.1.2 by facsimile transmission;

22.1.3 by personal delivery;

22.1.4 by expedited delivery service; or

22.1.5 by e-mail.

Such notices shall be addressed as follows or to such different addresses as the parties may from time-to-time designate:

State of New York [Agency Name]

Name:
Title:
Address:
Telephone Number:
Facsimile Number:
E-Mail Address:

[Contractor Name]

Name:
Title:
Address:
Telephone Number:
Facsimile Number:
E-Mail Address:

22.2.0 Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or email, upon receipt.

22.3.0 The Parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this Agreement by giving fifteen (15) days written notice to the other Party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representatives for the purposes of receiving notices under this Agreement. Additional individuals may be designated in writing by the Parties for purposes of implementation and administration/billing, resolving issues and problems and/or for dispute resolution.

Contractor: _____

Contract Number: _____

Agency Certification: "In addition to the acceptance of this contract, I also certify that original copies of this signature page shall be attached to all other exact copies of this contract."

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

Date: _____ By: _____

Name: XXXXXXXXXXXX

Title: President

SELECTED CONTRACTOR

Date: _____ By: _____

Name: _____

Title: _____

STATE OF

) ss:

COUNTY OF

On the _____ day of _____, _____, before me personally came _____, to me known, and known to me to be the person who executed the above instrument, who, being duly sworn by me, did for her/himself depose and say that (s)he is the _____ of _____ the corporation or organization described in and which executed the above instrument; and that (s)he signed his/her name thereto.

My commission expires: _____ _____

NOTARY PUBLIC

Approved as to Form:

ERIC SCHNEIDERMAN
ATTORNEY GENERAL

By: _____

Date: _____

Approved:

THOMAS P. DINAPOLI
COMPTROLLER

By: _____

Date: _____

SECTION VII: CONTRACT PROVISIONS

AGREEMENT #C000XXX

THIS Agreement is entered into by and between New York State Insurance Fund, an agency of the State of New York, having its principal place of business at 199 Church Street, New York, New York 10007 (hereinafter referred to as "FUND" and _____("Contractor"), a corporation authorized to do business in the State of New York with a principal place of business located at _____, and collectively referred to as "the Parties."

WITNESSETH

WHEREAS, on [TBD], the Department of Civil Service issued a Request for Proposal (RFP) entitled, "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," to secure the services of a qualified organization to provide Program Services as defined in the RFP; and

WHEREAS, after thorough review and evaluation by the State of Proposals received in response to the RFP, the Contractor's Proposal was selected as representing the best value to the State; and

WHEREAS, the FUND, in reliance upon the expertise of the Contractor, desires to engage the Contractor to deliver the Program Services, pursuant to the terms and conditions set forth in this Agreement;

THEREFORE, the Parties agree as follows:

ARTICLE I: DEFINITION OF TERMS

1.1.0 **Affiliate** means a person or organization which, through stock ownership or any other affiliation, directly, indirectly, or constructively controls another person or organization, is controlled by another person or organization, or is, along with another person or organization, under the control of a common parent.

1.2.0 **AWP** means the [source identified in Exhibit C, Contractor's Proposal, of this Agreement,] AWP Price for the eleven (11) digit NDC of the drug dispensed as of the date the Prescription was filled, unless the Parties mutually agree in writing to utilize a different source for AWP information.

1.3.0 **Brand Drug** means a Prescription drug sold under a trade name other than its chemical name that is manufactured and marketed by a single manufacturer (or single group of manufacturers pursuant to agreement among the manufacturers) where the manufacturer holds or held a patent protecting the active ingredient from generic competition. The classification of a drug as brand or other category shall be based on indicators provided by the drug pricing reporting service that is used by the PBM, as updated regularly.

1.4.0 **Business Day(s)** means every Monday through Friday, except for days designated as business holidays by the Contractor and approved as such by the FUND prior to January 1 of each Calendar Year.

1.5.0 **Business Holiday(s)** means days designated by the Contractor as Business Holidays and approved as such by the FUND prior to January 1 of each Calendar Year.

1.6.0 **Calendar Year/Annual** means a period of 12 months beginning with January 1 and ending with December 31.

1.7.0 **Call Center Hours** means 24 hours a Day, 365 days a year.

1.8.0 **Claimant** means an injured employee who sustains an at-injury accident (loss) while in the employ of individuals or companies that have Workers' Compensation Insurance policies with NYSIF.

1.9.0 **Compound Drug(s)/Medication(s) or Compounded Drug(s)/Medication(s)** means a drug with two or more ingredients (solid, semi-solid or liquid), at least one of which is a Covered Drug with a valid NDC requiring a Prescription for dispensing, combined together in a method specified in a Prescription issued by a medical professional. The end result of this combination must be a Prescription medication for a specific patient that is not otherwise commercially available in that form or dose/strength from a single manufacturer. The Prescription must identify the multiple ingredients in the Compound, including active ingredient(s), diluents(s),

ratios or amounts of product, therapeutic use, and directions for use. The act of compounding must be performed or supervised by a licensed Pharmacist. Any commercially available product with a unique assigned NDC requiring reconstitution or mixing according to the FDA approved package insert prior to dispensing will not be considered a Compound Prescription by the NYSIF Program.

1.10.0 **Contractor** means the successful Offeror selected as a result of the evaluation of Contractors' Proposals submitted in response to Exhibit B, the Request for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and New York State Insurance Fund Workers' Compensation Prescription Drug Program and who executes a contract with the FUND to provide Program Services.

1.11.0 **Controlled Drug** means drugs designated by Federal Law or New York State law as a Class I, II, III, IV or V substance. A Controlled Drug includes but is not limited to: some tranquilizers; stimulants; and pain medications.

1.12.0 **Covered Drug(s)** means medically necessary medically necessary and appropriate drugs that are causally related to the loss.

1.13.0 **Day(s)** means calendar days unless otherwise noted.

1.14.0 **DCS** means the New York State Department of Civil Service.

1.15.0 **Dedicated Call Center** means a group of Customer Service Representatives trained and capable of responding to a wide range of questions, complaints, and inquiries specific to the NYSIF Program. The Customer Service Representatives are dedicated to the NYSIF Program and do not work on any other accounts.

1.16.0 **Designated Specialty Pharmacy** means all facilities owned, operated, subcontracted or otherwise affiliated with the Contractor or any Key Subcontractor of the Contractor to provide certain Specialty Drugs/Medications. All facilities must meet all legal and contractual requirements as set forth in the Agreement.

1.17.0 **Designated Specialty Pharmacy Hard Edit** means a Network Pharmacy claims adjudication edit that will result in denial of the claim for a Specialty Drug/Medication under the Specialty Pharmacy Process after the Grace Period for Specialty Drugs has elapsed.

1.18.0 **Designated Specialty Pharmacy Passive Edit** means a Network Pharmacy claims adjudication edit that will prompt processing of the claim at the Designated Specialty Pharmacy but will permit continued processing and coverage for a Specialty Drug/Medication at the Network Pharmacy under the Specialty Pharmacy Process after the Grace Period for Specialty Drugs has elapsed.

1.19.0 **Discounted Ingredient Cost(s)** means the cost to the NYSIF Program for a specific drug or drugs dispensed to a Claimant after the Contractor has applied the appropriate discount exclusive of any associated dispensing fee(s), other costs.

1.20.0 **Employee** means any person defined as an Employee as defined in 4 NYCRR Part 73, as amended, or as modified by collective bargaining agreement.

1.21.0 **Employer** means the State of New York in all its branches, departments and agencies..

1.22.0 **ET** means prevailing Eastern Time.

1.23.0 **Final Paid Claim** means a claim processed and paid by the Contractor for a Prescription drug provided to a Claimant, including but not limited to, claims for Prescriptions filled at a retail Pharmacy or through the Mail Service Pharmacy Process or the Specialty Pharmacy Process. A claim that is denied prior to processing is not considered a Final Paid Claim. In addition, a claim that is processed and paid but is subsequently voided, reversed, or otherwise adjusted is not a Final Paid Claim. Zero balance claims are considered Final Paid Claims.

1.24.0 **First Fill** means a Claimant's initial or very first dispensing of a Specialty Drug/Medication covered under the NYSIF Program's Specialty Pharmacy Program.

1.25.0 **FUND or NYSIF** means the New York State Insurance Fund.

1.26.0 **FUND or NYSIF Program** means the Workers' Compensation Pharmacy Benefits Management program administered by the New York State Insurance Fund.

1.27.0 **FUND or NYSIF Program MAC List** means the Programs' specific Maximum Allowable Cost (MAC) List managed by the Contractor to set the maximum price the Program shall be charged and the dispensing retail Network Pharmacy shall be paid on a pass through basis for the Ingredient Cost of a drug required to be included on the Programs MAC List.

1.28.0 **GCN** means Generic Code Number as assigned by First Data Bank.

1.29.0 **Generic Drug** means a prescription drug sold under its chemical name or drug sold under a name other than its chemical name by a manufacturer other than the manufacturer that held the original patent for the active ingredient in the drug that is therapeutically equivalent and interchangeable with drugs having the same quantity of active ingredient(s) and approved by the U.S. Food and Drug Administration. The term Generic Drug shall include "authorized generics" marketed by or in conjunction with the manufacturer that is the holder of the original patent for the active ingredient of the drug and drugs sold either after patent protection has expired or those drugs without patent protection. Any drug approved through an FDA Generic Drug approval process, including any FDA approval process established for approving generic equivalents of brand name biologic drugs, shall be classified as a Generic Drug.

1.30.0 **Grace Period for Specialty Drugs** means the period of time during which enrollees may receive one fill of a Specialty Drug/Medication at a Pharmacy other than the Designated Specialty Pharmacy.

1.31.0 **Guaranteed Discount(s)** means the Contractor's fixed, contracted, guaranteed Ingredient Cost discounts for Brand Drugs expressed as a percent off of AWP dispensed through the Mail Service Pharmacy Process. For Specialty Drug/Medications dispensed through the Specialty Pharmacy Program, Guaranteed Discounts means the Contractor's fixed, contracted, guaranteed Ingredient Cost discounts for Brand and Generic drugs expressed as a percent off of AWP.

1.32.0 **Guaranteed Maximum Dispensing Fee(s)** **Guaranteed Maximum Dispensing Fee(s)** represents the quoted dispensing fee(s) the Contractor guarantees that the actual average dispensing fee assessed under Pass Thru Pricing will not exceed. This Guaranteed Maximum Dispensing Fee(s) is applicable to the NYSIF Program for Generic, Brand and Compound Drugs, calculated separately, for prescriptions dispensed by Retail Network Pharmacies.

1.33.0 **Guaranteed Minimum Discount(s)** means the guaranteed Ingredient Cost discount(s) as expressed as a percent off of the aggregate AWP and is applicable to Generic and Brand Drugs, separately, dispensed through Retail Pharmacy Network as well as Generic Drugs dispensed through the Mail Service Pharmacy Process.

1.34.0 **Hard Edit** means a Network Pharmacy claims adjudication edit that will result in denial of the claim.

1.35.0 **Ingredient Cost(s)** means the cost to the NYSIF Program for a specific drug, or drugs dispensed to a Claimant exclusive of any associated dispensing fee(s), other costs, through application of the NYSIF Program's Lesser of Logic.

1.36.0 **Instant Enrollment/"Short Fill" Service** means allowing injured workers of NYSIF policy holders immediate acceptance by any pharmacy in the Contractor's network in order to provide a limited number of cost-effective medication benefits.

1.37.0 **Key Subcontractor** means those vendors with whom the Contractor subcontracts to provide Program Services and incorporates as a part of the Contractor's Project Team.

1.38.0 **(Amended April 4, 2012)** **Limited Distribution Drug** means a Specialty Drug/Medication whose distribution is limited by the manufacturer to select Pharmacies and as a result of this restriction is not available to be dispensed from the Designated Specialty Pharmacy and/or Mail Order Pharmacy.

1.39.0 **Mail Service Pharmacy Process** means the method that the Contractor employs to accept, process, and dispense Prescriptions for Covered Drugs to Claimants through the mail or other home delivery service, excluding any drug eligible under the Specialty Pharmacy Process. For those DCS employee groups not participating in the Specialty Pharmacy Process, the Mail Service Pharmacy Process means the method that the Contractor employs to accept, process, and dispense Prescriptions for Covered Drugs to Claimants through the mail or other home delivery service including any drug that could be classified as a Specialty Drug/Medication, or that require special preparation or handling, using one or more Mail Service Pharmacy Process Facilities or other entities approved as distribution channels for dispensing Limited Distribution Drugs to Claimants through the Mail Service Pharmacy Process. Prescriptions are considered to be submitted through the Mail Service Pharmacy Process if they are submitted by phone, fax, internet, e-prescribing or mail to any Mail Service Pharmacy Process Facility. All Prescriptions

filled through the Mail Service Pharmacy Process shall be processed in strict accordance with the provisions of this Agreement including all pricing provisions related to the Mail Service Pharmacy Process. Prescriptions dispensed through the Retail Pharmacy Network and delivered to the Claimant through the mail shall not be considered to have been filled through the Mail Service Pharmacy Process provided the Claimant or their Physician presented the Prescription directly to the dispensing Network Pharmacy. The Contractor or its Key Subcontractor will not refer a Claimant or their Physician to a retail Pharmacy without also making the Claimant aware of the Mail Service Pharmacy Process.

1.40.0 **Mail Service Pharmacy Process Facility(ies)** means all facilities owned, operated, subcontracted or otherwise affiliated with the Contractor or any Key Subcontractor of the Contractor capable of being utilized by the Contractor in the Mail Service Pharmacy Process, including any mail service intake facility. For those DCS employee groups participating in the Specialty Pharmacy Process, the Designated Specialty Pharmacy is not considered a Mail Service Pharmacy Process Facility. All facilities must meet all legal and contractual requirements.

1.41.0 **Maximum Allowable Cost** means the maximum price the NYSIF Program shall be charged and the dispensing retail Network Pharmacy shall be paid on a pass-through basis for the Ingredient Cost of a drug required to be included on the NYSIF Programs' MAC List managed by the Contractor.

1.42.0 **Medically Necessary Drug** means any drug which, as determined by the Contractor, is: (i) provided for the diagnosis or treatment of a medical condition; (ii) appropriate for the symptoms, diagnosis or treatment of a medical condition; (iii) within the standards of generally accepted health care practice; and (iv) not used for cosmetic purposes.

1.43.0 **Medical Professional(s)** means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) licensed without limitation or restriction to practice medicine. For benefits provided in the NYSIF Program, and for no other purpose, Physician also means a Doctor of Dental Surgery (D.D.S.), a Doctor of Dental Medicine (D.D.M), a Podiatrist and any other health care professional licensed to prescribe medication, when he or she is acting within the scope of his or her license.

1.44.0 **Narrow Therapeutic Index (NTI) Drugs** means a drug that small variances in blood levels can cause changes in the effectiveness or toxicity of that drug.

1.45.0 **NDC** means the National Drug Code number assigned to a pharmaceutical product obtained by the manufacturer of the product through a U.S. Food and Drug Administration administered process.

1.46.0 **Network Pharmacy** means a Pharmacy, other than those Pharmacies meeting the definition of Mail Service Pharmacy Process Facilities or a Designated Specialty Pharmacy, which has entered into an agreement with the Contractor, or any Affiliate or Key Subcontractor of the Contractor, to provide Covered Drugs to Claimants, including limited distribution or Specialty Drugs. The Contractor's records shall be conclusive as to whether a Pharmacy has a Network Pharmacy agreement in effect on the date a drug is dispensed.

1.47.0 **Non-Network Pharmacy** means any Pharmacy, other than a Network Pharmacy, a Mail Service Pharmacy Process Facility or a Designated Specialty Pharmacy, which has not entered into an agreement with the Contractor, or any Affiliate or Key Subcontractor of the Contractor, to provide Covered Drugs to Claimants.

1.48.0 **Non-Preferred Drug** means an FDA approved prescription drug that is covered by the NYSIF Program, but is not included on the Contractor's and/or its Key Subcontractor's Preferred Drug.

1.49.0 **NYS** means New York State.

1.50.0 **Over-the-Counter Drug (OTC)** means a drug approved by the FDA, which has been determined to be safe and effective for use by the general public without a doctor's Prescription.

1.51.0 **Pass-through Pricing** means the NYSIF Program is charged the same Ingredient Cost and/or dispensing fee paid to the dispensing Network Pharmacy or Mail Service Pharmacy for the Generic, Brand or Compound Drug dispensed.

1.52.0 **Pharmacist** means a person who is legally licensed to practice the profession of Pharmacy. He or she must regularly practice such profession within the scope of their license.

1.53.0 **Pharmacy or Pharmacies** means any establishment, which is registered as a Pharmacy with the appropriate State licensing agency or is a Veterans Affairs Hospital Pharmacy, and regularly dispenses medications that require a Prescription from a Physician.

1.54.0 **Pharmacy Benefit Services or Program Services** means all of the services to be provided by the Contractor as set forth in this RFP.

1.55.0 **Pharmacy Submitted Ingredient Cost or Pharmacy Submitted Pricing or Submitted Cost** means the value entered by the Pharmacy in field 409, 'Ingredient Cost Submitted' of Telecommunication Standard Version 5.1 issued by the National Council for Prescription Drug Programs, Inc. For purposes of adjudication of Compound claims the value shall be no more than the total AWP of all ingredients in the Compound.

1.56.0 **Pharma Revenue** means any and all revenues generated from agreements between pharmaceutical manufacturers and the Contractor, or any Affiliate or Key Subcontractor of the Contractor, which relate to NYSIF Program utilization and/or Pharmacy benefit management services provided under this Agreement. Such revenues include revenue described by any name, but not limited to, revenues described as: formulary rebates, market share rebates, administrative fees, AWP caps or by any other name.

1.57.0 **Physician** means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.). He or she must be legally licensed without limitations or restrictions, to practice medicine. For benefits provided in the NYSIF Program, and for no other purpose, Physician also means a Doctor of Dental Surgery (D.D.S.), a Doctor of Dental Medicine (D.D.M), a Podiatrist and any other health care professional licensed to prescribe medication, when he or she is acting within the scope of his or her license.

1.58.0 **Preferred Brand Drug** means a FDA approved brand name prescription drug that is included on the Preferred Drug List developed by the Contractor for the NYSIF Program.

1.59.0 **Preferred Drug List or PDL** means a list of FDA approved brand name and generic prescription drugs developed by the Contractor for the Program.

1.60.0 **Prescription/Prescription Order** means the written or oral request for drugs issued by a Physician duly licensed to make such a request in the ordinary course of his or her professional practice.

This order must be written in the name of the person for whom it is prescribed or be an authorized refill of that order.

1.61.0 **Program Services or Pharmacy Benefit Services** means all of the services to be provided by the Contractor as set forth in this Agreement.

1.62.0 **Program Team** means the Contractor and those Key Subcontractors, if any, utilized by the Contractor who collectively undertake and perform the Program Services which are the subject of the Agreement.

1.63.0 **Proposal** means the Contractor's Administrative Proposal, Technical Proposal and Cost Proposal, including all responses to supplemental requests for clarification, information, or documentation, submitted during the course of the Procurement.

1.64.0 **Renewal Date** means January 1, 2015, and annually thereafter up to and including January 1, 2018.

1.65.0 **Retail Pharmacy Network** means the Contractor's credentialed network of participating independent, chain Pharmacies, and specialty Pharmacies contracted to deliver services to Claimants.

1.66.0 **RFP or Procurement** means the Request for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs."

1.67.0 **Specialty Drugs/Medications** means drugs that treat rare disease states; drugs requiring special handling, special administration, or intensive patient monitoring/testing; biotech drugs developed from human cell proteins and DNA, targeted to treat disease at the cellular level; or, other drugs used to treat patients with chronic or life threatening diseases identified as specialty medications through the mutual agreement of the parties.

1.68.0 **Specialty Pharmacy Process** means the method that the Contractor employs to accept, process, and dispense Prescriptions for Covered Drugs to Claimants through the Designated Specialty Pharmacy or a Limited Distribution Drug Pharmacy. Prescriptions are considered to be submitted through the Specialty Pharmacy Process if they are a Limited Distribution Drug submitted directly to the Limited Distribution Drug Pharmacy, or if they are a Specialty Drug/Medication submitted

directly to the Designated Specialty Pharmacy, by phone, fax, internet, e-prescribing or mail. All Prescriptions filled through the Specialty Pharmacy Process shall be processed in strict accordance with the provisions of the contract to be agreed upon by the FUND and the Contractor.

1.69.0 **State** means the New York State Insurance Fund acting in its statutory authority as the administrator of the NYS Workers' Compensation Pharmacy Benefits Management Program

1.70.0 **Therapeutically Equivalent** means drugs that can be expected to produce essentially the same therapeutic outcome and toxicity.

1.71.0 **Usual and Customary (U&C)** means the retail price charged to the general public as submitted by the dispensing Pharmacy during claims processing.

1.72.0 **WCB** means the New York State Workers' Compensation Board.

ARTICLE II: AGREEMENT DURATION AND AMENDMENTS

2.1.0 This Agreement shall be subject to and effective upon the approval of the New York State Attorney General's Office ("AG") and the NYS Office of the State Comptroller ("OSC"). The term of the Agreement shall include an implementation period followed by five (5) years of Program Services. It is the FUND's intent that this implementation period shall begin on or around August 1, 2012, upon OSC approval of the Agreement, with all other contractual responsibilities to begin on January 1, 2014, through and including December 31, 2018, and subject to the termination provisions contained herein.

2.2.0 The Agreement is subject to amendment(s) only upon mutual consent of the Parties, reduced to writing and approved by the AG and the OSC.

2.3.0 Upon termination of this Agreement the FUND shall have the right to award a new contract to another Contractor.

ARTICLE III: INTEGRATION

3.1.0 This Agreement, including all Exhibits, copies of which are attached hereto and incorporated by reference, constitutes the entire Agreement between the Parties. All prior Agreements, representations, statements, negotiations, and undertakings are superseded hereby.

3.2.0 All statements made by the FUND shall be deemed to be representations and not warranties.

ARTICLE IV: DOCUMENT INCORPORATION AND ORDER OF PRECEDENCE

4.1.0 The Agreement consists of:

4.1.1 The body of the Agreement (that portion preceding the signatures of the Parties in execution), and any amendments thereto;

4.1.2 Appendix A – Standard Clauses for All New York State Contracts;

4.1.3 Appendix B – Standard Clauses for All FUND Contracts;

4.1.4 Appendix C – Third Party Connection and Data Sharing Agreement;

4.1.5 Appendix D – Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures;

4.1.6 The following Exhibits attached and incorporated by reference to the body of the Agreement:

4.1.6a Exhibit A: which includes: the MacBride Act Statement; and the Non-Collusive Bidding Certification;

4.1.6b Exhibit B: the Request for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," dated February 22, 2012, and Exhibit B-1, the official Procuring Agencies response to questions raised concerning the RFP;

4.1.6c Exhibit C: the Contractor's Proposal; and, Exhibit C-1: the official transcript of the Management Interview, and related materials clarifying the Contractor's Proposal;

4.1.6d Exhibit D: Specialty Pharmacy Program Dispensing Fees

4.1.7 In the event of any inconsistency in, or conflict among, the document elements of the Agreement identified above, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

4.1.7a First, Appendix A – Standard Clauses for All New York State Contracts;

4.1.7b Second, Appendix B – Standard Clauses for All FUND Contracts;

4.1.7c Third, Appendix D – Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures;

4.1.7c Fourth, any Amendments to the body of the Agreement;

4.1.7d Fifth, the body of the Agreement;

4.1.7e Sixth, Exhibit B, the Request for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and New York State Insurance Fund Prescription Drug Programs," dated February 21, 2012 and Exhibit B-1, the official Procuring Agencies response to questions raised concerning the RFP;

4.1.7f Seventh, Exhibit C: the Contractor's Proposal; and, Exhibit C-1: the official transcript of the Management Interview and related materials clarifying the Contractor's Proposal; and

4.1.7g Eighth, Exhibit E, Specialty Pharmacy Program Dispensing Fees;

4.1.8 The terms, provisions, representations and warranties contained in the Agreement shall survive performance hereunder.

ARTICLE V: LEGAL AUTHORITY TO PERFORM

5.1.0 Contractor agrees that it shall perform its obligations under this Agreement in accordance with all applicable federal and NYS laws, rules and regulations, policies and/or guidelines now or hereafter in effect.

5.2.0 The Contractor shall maintain appropriate corporate and/or legal authority, which shall include but is not limited to the maintenance of an administrative organization capable of delivering the Program Services in accordance with the Agreement and the authority to do business in the State of New York or any other governmental jurisdiction in which the Program Services are to be delivered.

5.3.0 The Contractor shall provide the FUND with immediate notice in writing of the initiation of any legal action or suit which relates in any way to the Agreement, or which may affect the performance of Contractor's duties under the Agreement.

ARTICLE VI: PROGRAM SERVICES

6.1.0 The Contractor shall provide all of the Program Services as set forth herein this Article VI of the Agreement for the entire term of the Agreement. All Program Services shall be provided in accordance with the New York State Workers' Compensation Law and its implementing regulations, and other NYS and Federal Law as may be applicable. In addition, the Contractor shall deliver the Program Services in such a manner so as to comply with all provisions of this Agreement. The Contractor may provide certain services through key subcontracts with the prior review and approval of the FUND. Each subcontract entered into with a corporate entity separate from the Contractor for the purpose of delivering Program Services must be maintained throughout the term of the Agreement unless such change is approved in writing by the FUND. The FUND must be explicitly identified as the intended beneficiary of the key subcontract. The Contractor must maintain significant financial, legal, and audit oversight of any of its Key Subcontractors. The Contractor remains fully responsible for all services and actions performed under this Agreement. The Contractor shall submit all key subcontracts to the FUND for its approval. The Contractor shall submit all such key subcontracts with no redactions to the FUND before execution for its review and approval. **(Note: Costs/Fees for all services required under this Agreement shall be included in the Contractor's Claims Administrative Fee).**

6.2.0 Program Implementation

6.2.1 The Agreement includes an implementation period beginning on or around October 1, 2012, upon approval of the Agreement by OSC. During this time, the Contractor must undertake and complete all implementation activities, including but not limited to those specific

activities set forth in the Implementation and Start-up Guarantee Section 7.1.0 of the Agreement. Such implementation activities must be complete no later than December 31, 2013 so that the NYSIF Program is fully operational on January 1, 2014.

6.3.0 Account Team

6.3.1 The Contractor must maintain an organization of sufficient size with staff that possesses the necessary skills and experience to administer, manage, and oversee all aspects of the NYSIF Program during implementation and operation.

6.3.1a The account team must be comprised of qualified and experienced individuals who are acceptable to the FUND and who are responsible for ensuring that the operational, clinical and financial resources are in place to operate the NYSIF Program in an efficient manner;

6.3.1b The Contractor must ensure that there is a process in place for the account team to gain immediate access to appropriate corporate resources and senior management necessary to meet all NYSIF Program requirements and to address any issues that may arise during the performance of the Agreement.

6.3.2 The Contractor's dedicated account team must be experienced, accessible (preferably in the New York State Capital Region district) and sufficiently staffed to:

6.3.2a provide timely responses (1 to 2 Business Days) to administrative and clinical concerns and inquiries posed by the FUND for the duration of the Agreement to the satisfaction of the FUND;

6.3.2b immediately notify the FUND in writing of actual or anticipated events impacting NYSIF Program costs and/or delivery of services to Claimants (for example, drug recalls and withdrawals, class action settlements, and operational issues).

6.3.3 The Contractor's assigned account team must immediately notify the FUND in writing of actual or anticipated events impacting NYSIF Program costs and/or delivery of services to NYSIF Program Claimants.

6.3.4 The Contractor's dedicated account team must ensure that the NYSIF Program is in compliance with all legislative and statutory requirements. If the Contractor is unable to comply with any legislative or statutory requirements, the FUND must be notified in writing immediately.

6.4.0 **Customer Service:** The Contractor is responsible for all customer support and services including, but not limited to:

6.4.1 Maintaining a ~~Dedicated Call Center~~ call center(s) located in the United States staffed by fully trained customer service representatives and supervisors available 24 hours a day 365 Days a year. The Contractor must maintain a Dedicated Call Center for the Program between the hours of 7:00am and 7:00pm ET. During off hours, calls may be routed to a designated call center(s) located in the United States staffed by fully trained customer service representatives and supervisors. The ~~Dedicated Call Center~~ call center(s) must also provide immediate access to Pharmacist(s) 24 hours a day, 365 days a year. The ~~Dedicated Call Center~~ call center(s) must meet the Contractor's proposed customer service telephone guarantees set forth in Section 7.7.0 of this Agreement.

6.4.2 Customer service staff must use an integrated system to log and track all Claimant calls. The system must create a record of the Claimant contacting the call center, the call type, and all customer service actions and resolutions.

6.4.3 Customer service representatives must be trained and capable of responding to a wide range of questions, complaints and inquiries including but not limited to: NYSIF Program benefit levels, refills, order status, point of service issues, prior authorization, eligibility, Mail Service Pharmacy Process, Specialty Pharmacy Process services and Preferred Drug List alternatives.

6.4.4 Maintaining a backup customer service staff located in the United States with NYSIF Program-specific training to handle any overflow when the dedicated customer service center is unable to meet the Contractor's customer service performance guarantees as set forth in Section 7.7.0 of this Agreement. This back-up system would also be utilized in the event the primary customer service center(s) become unavailable; and

6.5.0 **Enrollee Communication Support**

6.5.1 All Claimant communications developed by the Contractor are subject to FUND review and prior written approval, including but not limited to any regular standardized direct communication with Claimants or their Physicians in connection with Claimant drug utilization or the processing of Claimant claims either through mail, e-mail, fax or telephone. The FUND in its sole discretion reserves the right to require any change it deems necessary.

6.5.2 The Contractor must work with the FUND to develop appropriate customized forms and letters for the NYSIF Program, including but not limited to mail order forms, prior authorization letters, Preferred Drug List, etc. All such communications must be approved by the FUND.

6.5.3 The Contractor must assist NYSIF is developing a customized Claimant information packet that will include information on available prescription drug services as well as a permanent ID card to be used when filling injury-related prescriptions.

6.6.0 **Enrollment Management:** The Contractor is responsible for the maintenance of accurate, complete, and up-to-date enrollment files, located in the United States, based on information provided by the FUND. These enrollment files shall be used by the Contractor to process retail, mail order and specialty pharmacy claims, provide customer service, and produce management reports and data files. The Contractor is required to provide enrollment management services including but not limited to:

6.6.1 Initial testing

6.6.1a Performing an initial enrollment load to commence upon receipt from the FUND during NYSIF Program implementation. The file may be an encrypted, fixed length ASCII text file that is transmitted using a secure transmission protocol or a custom file format. The determination will be made by the FUND;

6.6.1b Testing to determine if the enrollment file and enrollment transactions loaded correctly and that the enrollment system interfaces with the claims processing system to accurately adjudicate claims. The Contractor must submit enrollment test files to the FUND for auditing, provide the FUND with secure, online access

required to ensure accurate loading of NYSIF Program enrollment data, and promptly correct any identified issues to the satisfaction of the FUND;

6.6.2 Providing an enrollment system capable of receiving secure enrollment transactions every day, including weekends and holidays, and having all transactions fully loaded to the claims processing system within twelve (12) hours of release of a retrievable file by the NYSIF. The Contractor shall immediately notify the NYSIF of any delay in loading enrollment transactions. In the event the Contractor experiences a delay due to the quality of the data supplied by the NYSIF, the Contractor shall immediately load all records received (that meet the quality standards for loading) within twelve (12) hours of their release, as required. The NYSIF will release enrollment changes, including all additions, modifications and deletions since the previous transmission, to the Contractor in an electronic format daily (every day, including weekends and holidays). On occasion, the NYSIF will release more than one enrollment file within a 24-hour period. The Contractor must be capable of loading both files within the twelve (12) hour performance standard. The format of these transactions will be a fixed length ASCII text file. The ASCII text file is encrypted and transmitted each business day using a secure transmission protocol. Upon selection, the Contractor will be provided with the claim eligibility file specifications and the schedule for the transmission of the file.

6.6.3 Ensuring the security of all enrollment information as well as the security of a HIPAA compliant computer system in order to protect the confidentiality of Claimant data contained in the enrollment file. Any transfers of enrollment data within the Contractor's system or to external parties must be completed via a secured process;

6.6.4 Providing a back-up system or have a process in place where, if enrollment information is unavailable or not current at the point of service, Claimants can obtain Prescriptions without interruption, at the point of service. Short fill policies should be included in the Pharmacy Provider manual;

6.6.5 Cooperating fully with any FUND initiatives to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of this Agreement;

6.6.6 Ability to manually load/correct an enrollment record and to contact the Pharmacy to allow the adjudication of a Prescription in an urgent or emergency situation. Occurrences of these situations are very rare; and

6.6.7 The Contractor must provide an instant enrollment or "short fill" service to injured workers of NYSIF policyholders. This service should allow immediate acceptance by any pharmacy in the Contractor's network in order to provide a limited number of cost-effective medication benefits to the Claimant.

6.7.0 **Reporting:** The Contractor is responsible for accurate reporting services including, but not limited to:

6.7.1 Generating and submitting monthly, quarterly, semi-annual and annual reports per NYSIF specification. Specifications will be provided upon vendor selection;

6.7.2 Capturing and providing the FUND with electronic file of eligibility and authorization on the GC3, or similar code level. The Contractor should have the capability to capture drug denials on the GCN and NDC code levels;

6.7.3 Supplying reports in paper format and/or in an electronic format (Microsoft Access, Excel, Word) as determined by the FUND. This includes, but is not limited to, reports and data files listed in Article XV of this Agreement;

6.7.4 Providing direct, secure access to the Contractor's claims system and any online and web-based reporting tools to the FUND's offices;

6.7.5 Providing Ad Hoc Reports and other data analysis at no additional cost. The exact format, frequency, and due dates for such reports shall be specified by the FUND. Information required in the Ad Hoc Reports may include but is not limited to providing:

6.7.5a Forecasting and trend analysis data;

6.7.5b Data necessary to track drug pricing;

6.7.5c Utilization data on the Mail Order Pharmacy and the Special Pharmacy Program;

6.7.5d Utilization review savings;

6.7.5e Benefit design modeling analysis;

6.7.5f Reports to meet clinical program review needs;

6.7.5g Reports segregating claims experience for specific populations; and

6.7.5h Reports to monitor Agreement compliance.

6.7.6 The Contractor must work with NYSIF to resolve reporting issues according to the timeframes described in Article XV.

6.8.0 **Consulting:** The Contractor is responsible for providing advice and recommendations regarding the Program. Such responsibility shall include, but not be limited to:

6.8.1 Informing the FUND in a timely manner concerning such matters as cost containment strategies, new drugs, conversion from Brand Drugs to Generic Drugs and how it will impact cost, Preferred Drug List configuration, technological improvements, e-prescribing, Pharmacy innovations, and State/Federal legislation (i.e., Prescription drug mandates, etc.) that may affect the Program. The Contractor must provide information and recommendations to the FUND on Preferred Drug List (PDL) placement of new generic and biological therapies prior to release into the marketplace to the extent such information is available in the public realm. The Contractor must also make available to the FUND one or more members of the clinical or account management team to discuss the implications of these new trends and developments. The FUND is not under any obligation to act on such advice or recommendation; and

6.8.2 Assisting the State with recommendations and evaluation of proposed benefit design changes and implementing any changes necessary to accommodate NYSIF Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State. Recommendations must include a preliminary analysis of all associated costs, a clinical evaluation, and the anticipated impact of proposed NYSIF Program modifications and contemplated benefit design changes on Claimants.

In the event of a design change and the Contractor requests any change in compensation such change will be in accordance with Article VIII of this Agreement.

6.9.0 **Network Management**

6.9.1 **Retail Pharmacy Network**

6.9.1a The Contractor must maintain a credentialed and contracted Retail Pharmacy Network that meets or exceeds the NYSIF Program's minimum access standards throughout the term of the Agreement.

6.9.1b The NYSIF Program requires the Contractor have available to Claimants on January 1, 2014 the Retail Pharmacy Network it proposed in Exhibit C, Contractor's Proposal, of this Agreement, in accordance with the requirements set forth in Section 7.4.0 guaranteeing effective implementation of their Retail Pharmacy Network.

6.9.1c The Contractor is required to include Independent Pharmacies in its Retail Pharmacy Network. In developing its Retail Pharmacy Network, the Contractor is expected to use its best efforts to substantially maintain the composition of independent Network Pharmacies included in the NYSIF Program's current Retail Pharmacy Network provided such Pharmacies meet the requirements of Sections 6.9.2 and 6.9.3 of this Agreement, and are willing to accept the proposed aggressive reimbursement rates.

6.9.1d The Contractor shall include in its Retail Pharmacy Network any Pharmacy(ies) upon the FUND's request, where such inclusion is deemed necessary by the FUND to meet the needs of Claimants even if not otherwise necessary to meet the minimum access guarantees in Section 7.4.0 of this Agreement.

6.9.1e Any changes made by DCS to the scope of its agreement with the Contractor for Prescription Drug Program Services after execution of this Agreement, including but not limited to the request to include any individual independent Network Pharmacy(ies), shall have no impact on this Agreement or cost thereunder, unless the change is agreed to by NYSIF.

6.9.1f The Contractor must effectively communicate the content (including any subsequent changes) and requirements of the NYSIF Program's Preferred Drug List to their Retail Pharmacy Network.

6.9.1g Prior to January 1, 2014, the Contractor must ensure that their Network Pharmacies have the correct claim identification information (i.e. RX BIN #, RXPCN, RXGRP, effective date, phone number for questions, etc.) to facilitate accurate claims submission and uninterrupted access for NYSIF Program Claimants.

6.9.1h The Contractor must establish a process to provide Claimants with access to Limited Distribution Drugs through the Retail Pharmacy Network.

6.9.2 Pharmacy Credentialing

6.9.2a The Contractor must ensure its Retail Pharmacy Network is credentialed in accordance with all applicable federal and state laws, rules and regulations.

6.9.2b The Contractor must credential Pharmacies in a timely manner and shall have an effective process by which to confirm Network Pharmacies continuing compliance with credentialing standards.

6.9.2c The Contractor must maintain credentialing records and make them available for review by the FUND upon request.

6.9.3 Pharmacy Contracting: The Contractor is responsible for providing Pharmacy contracting services including, but not limited to:

6.9.3a Ensuring that all Network Pharmacies contractually agree to and comply with all of the NYSIF Program's requirements and benefit design specifications;

6.9.3b Ensuring that Network Pharmacies accept as payment-in-full, the Contractor's reimbursement for all claims processed based on the NYSIF Program's Lesser of Logic, as set forth in Section 11.6.0 of this Agreement;

6.9.3c Notifying the FUND in writing of any plan to renegotiate the financial terms of any Network Pharmacy contract utilized by the NYSIF Program for any Pharmacy that is located in the State of New York, or for any such Pharmacy located outside NYS that accounts for more than 0.25% of total NYSIF Program final paid claim Ingredient Costs;

6.9.3d Notifying the FUND in writing within 1 (one) Business day of any changes to contracts with Retail Pharmacy Network chain Pharmacies or independent Pharmacies negotiating collectively with the Contractor, including but not limited to, those identified as participating in the Contractor's network; and

6.9.3e Committing to administering Pharmacy contracts consistent with all representations made in the Contractor's cost proposal, including all representations regarding the administration of generic pricing and maintenance of the NYSIF Program's MAC list; and

6.9.3f Ensuring there are mechanisms in place to circumvent the referral of bills by participating pharmacies to third party billers for collection

6.9.4 **Pharmacy Audit:** The Contractor must have a staffed audit unit employing a comprehensive Pharmacy audit program that includes, but is not limited to:

6.9.4a Providing ample audit resources including access to the Contractor's on-line claims processing system to the FUND and the OSC at their respective offices through the date of the final financial settlement of the Agreement;

6.9.4b Providing FUND access and monthly updates to the Prescription Drug industry pricing source material (e.g. Red Book, Medispan, other) that the Contractor will be utilizing for the NYSIF Program for the purposes of conducting routine audits of claims data;

6.9.4c Conducting routine and targeted on-site audits of Network Pharmacies, the Mail Service Pharmacy and the Specialty Pharmacy(ies). Pharmacies that deviate significantly from patterns of dispensing in terms of cost, drug selection, overrides, Days supply or utilization are to be identified and targeted for on-site and desk audits in accordance with established selection and screening criteria. On-site audits must also be conducted upon request by the FUND, or when information is received by the Contractor that indicates a pattern of conduct by a Pharmacy that is not consistent with the NYSIF Program's design and objectives. Periodic, on-site audits must be conducted at least once during the course of the five (5) year resultant Agreement for Pharmacies that fall into the top fifty (50)

in terms of total dollar spend for the NYSIF Program. Any modifications to the proposed Pharmacy audit programs must receive prior approval by the FUND;

6.9.4d Providing reports to the FUND detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Contractor. The Contractor must inform the FUND in writing of any allegation or other indication of potential fraud and abuse identified within seven (7) Business Days of such allegations or identification. The FUND must be fully informed of all fraud and abuse investigations impacting the NYSIF Program upon commencement regardless of whether the individual fraud and abuse investigation has a material financial impact to the State;

6.9.4e The Contractor must maintain the capability and contractual right to effectively audit the NYSIF Program's Retail Pharmacy Network, including the use of statistical sampling audit techniques and the extrapolation of errors;

6.9.4f Agreement to fully cooperate with all FUND and/or OSC audits consistent with the requirements of Appendices A and B as set forth in this Agreement, including provision of access to protected health information and all other confidential information when required for audit purposes as determined by the FUND and OSC as appropriate. The Contractor must respond to all State audit requests for information and/or clarification within fifteen (15) Business Days. The Contractor must perform timely reviews and respond in a time period specified by the FUND to preliminary findings submitted by the FUND and the Comptroller's audit unit in accordance with the requirements of Article XVII, "Audit Authority." Such audits may include, but are not limited to: mail order claims; Non-Network Pharmacy claims; and on-line Pharmacy claims. Use of statistical sampling of claims and extrapolation of findings resulting from such samples shall be acceptable techniques for identifying claims errors. The selected Contractor shall facilitate audits of network pharmacies as requested by the NYSIF and/or OSC;

6.9.4g Remitting 100% of pharmacy audit recoveries to the FUND within thirty (30) Days upon final audit determination consistent with the process specified in Article

XIV "Payments/(credits) to/from the Contractor" and Appendix B of this Agreement;

6.9.4h Utilizing the auditing tools and performance measures proposed by the Contractor to identify fraud and abuse by Network Pharmacies and/or Claimants; and

6.9.4i Permitting the FUND or a designated third party to audit pharmacy bills and drug company revenues.

6.10.0 **Mail Service Pharmacy Process:** The Contractor must provide all aspects of Mail Service Pharmacy Process. Such responsibility shall include, but not be limited to:

6.10.1 Having a fully staffed and fully operational Mail Service Pharmacy Process throughout the term of the resultant Agreement, utilizing one or more Mail Service Pharmacy Process Facilities meeting all New York State legal requirements. The Mail Service Pharmacy Process must be capable of dispensing all covered, FDA approved medications including any drug that could be classified as Specialty Drugs/Medications or requires special preparation or handling for up to a 90 day supply. Contractor must establish a process to provide Claimants with access to Limited Distribution Drugs placing no additional steps or burdens on the Claimant. Prescriptions are considered to be "submitted through the Mail Service Process" if they are submitted by phone, fax, internet, e-prescribing or mail to any Mail Service Pharmacy Process Facility, regardless of how the Prescription is filled. All covered Prescriptions, except for Limited Distribution Drugs, submitted through the Mail Service Pharmacy Process or through a Mail Service Pharmacy Process Facility shall be charged to the NYSIF Program based on the Contractor's mail service pricing terms and dispensing fees (if any) applicable to Brand name, Generic, and Compound Drug claims as set forth in Article XI, "NYSIF Program Claims Reimbursement" of this Agreement, including Specialty Drugs/Medications for certain enrollees. Limited Distribution Drugs submitted through the Mail Service Pharmacy Process shall be charged to the NYSIF Program based on the Contractor's Retail Network pricing terms and dispensing fees (if any) applicable to Brand Name, Generic and Compound Drug claims as set forth in Article XI, "NYSIF Program Claims Reimbursement" of this Agreement. The Mail Service Pharmacy Process shall apply the same Program benefit design features as the

Network Pharmacies, including but not limited to Mandatory Generic Substitution, DUR, Prior Authorization and Preferred Drug List;

6.10.2 Ensuring that all the FUND approved edits including, but not limited to, enforcing utilization edits (i.e. refill to soon, duplicate therapy, etc.) are built into the Prescription fulfillment system to protect a claimant's safety as well as to control NYSIF Program costs;

6.10.3 Ensuring that all Mail Service Pharmacy Process Facilities utilized in the Contractor's Mail Service Pharmacy Process meet all Prescription drug packaging regulatory requirements. Any facility located outside New York State that will provide service for the NYSIF Program must be registered with the NYS Department of Education and meet all requirements of Section 6808-b of NYS Education Law. The Mail Service Pharmacy Process must recognize the full prescribing authority of Medical Professionals granted by NYS where allowed by state law;

6.10.4 Providing a simple, user friendly method(s) of ordering, reordering, or transferring Prescriptions from retail to mail. Maintaining a Dedicated Call Center located in the United States employing a staff of Pharmacists, and a staff of fully trained customer service representatives, and supervisors available 24 hours a day 365 Days a year that must meet the Contractor's Mail Service Pharmacy Process guarantees set forth in Article VII, "Performance Guarantees" of this Agreement.

6.10.4a The Contractor must have an integrated system for customer service staff to utilize to respond to, log and track all Claimant inquiries. The system must create a record of the Claimant contacting the call center, the call type and all customer service actions and resolutions.

6.10.4b Customer service representatives must be trained and capable of responding to a wide range of questions, complaints and inquiries including but not limited to: NYSIF Program benefit levels, refills, order status, prices and billing, point of service issues, prior authorization and eligibility and, Mail Service Pharmacy Process, Specialty Pharmacy Process services and complaints, and Preferred

Drug List alternatives. Callers must be able to reorder and check order status through both the website and the telephone line;

6.10.5 Providing pre-addressed, postage-paid mail service envelopes to Claimants, and for inclusion in FUND publications, at the request of the FUND.

6.10.6 Having efficient procedures in place to handle routine Prescriptions, "urgent" Prescriptions, and Prescriptions that require "special" handling (i.e. temperature control, limited shelf life, high cost, etc.);

6.10.7 Providing standard mail service delivery using packaging that is appropriate for the drug dispensed and the address it is shipped to at no additional cost to the NYSIF Program or the Claimant. Easy open caps also must be provided to Claimants upon request at no additional cost;

6.10.8 Having a system in place to track all Prescriptions (both intervention and non-intervention) received for processing through the Mail Service Pharmacy Process from the date the Prescription is received to the date the mailing agent picks up the package. The Contractor must also be able to track fill accuracy rates;

6.10.9 Maintaining a process to collect information necessary to ensure claimant safety. The process should collect such information as drug allergies, chronic medical conditions, and other medications taken on a regular basis;

6.10.10 Maintaining a system that notifies Claimants about potential health and safety issues with their Prescriptions;

6.10.11 Maintaining efficient procedures regarding inventory management of the Mail Service Pharmacy Process Facility(ies) including, but not limited to, backorders, inventories of high demand drugs, supplies of difficult to obtain drugs, back-up supplier contracts, etc.;

6.10.12 Providing prompt notification to Claimants regarding out of stock items, partial fill orders, and changes to Prescriptions (e.g., approved or required dispensing of generics instead of Brand drugs). In out of stock situations, the Contractor must have a system in place to ensure that Prescriptions are filled in the most efficient manner whether it be

through an alternate facility(ies) or obtaining a re-stock from a supplier. If necessary, the Contractor shall call the Claimant first to obtain permission to contact their Physician to offer alternative medications, or to offer to return the prescription. If the Physician authorizes use of an alternative medication, a letter notifying the Claimant of the change must be sent to the Claimant before the medication is shipped or must accompany the Prescription;

6.10.13 Calling the prescribing Physician when a DAW-1 is indicated on the Prescription to confirm that the Physician understands the financial impact to the claimant and/or the FUND to determine if the Physician is willing to allow the generic version of the drug to be dispensed to the Claimant. If the Physician was previously contacted regarding the same Prescription for a particular Brand Drug for the same Claimant and required that the Brand Drug be dispensed, no call is required. If the Physician authorizes use of the generic version of the drug, a phone call shall be made to the Claimant of the approved change before the medication is shipped or the Contractor shall include a letter with the Prescription informing the Claimant of their physician's approval. If the Claimant has indicated on the mail service order form that they do not wish their Physician to be contacted for such determinations, no call shall be made;

6.10.14 Notifying the Claimant of nationwide out of stock issues, including information from the manufacturer or wholesaler regarding the anticipated date that the drug will resume shipment;

6.10.15 Utilizing best efforts to complete Physician clarification, verification, or other interventions within the five (5) Business Day service level standard. Should this require more than eight (8) Business Days, the Contractor shall call the Claimant and offer the Claimant the option of returning the prescription or continuing the intervention attempt;

6.10.16 Ensuring that the consent of the Claimant is obtained prior to calling the prescribing Physician with the exception of calls made for purposes of clarification, verification, settlement of other intervention claim issues or DAW-1 confirmations;

6.10.17 Providing all necessary clinical and educational support to NYSIF Program Claimants, and/or their family/caregiver utilizing the Mail Service Pharmacy Process, including

Claimants taking injectable, infusion or other drugs requiring special handling or special administration;

6.10.18 Having a back-up mail order facility(ies) to handle any overflow and/or situations where the primary mail order facility is unavailable;

6.10.19 Promoting the utilization of the Mail Service Pharmacy Process through targeted mailings, Physician communications, etc. if the FUND determines that such promotions are in the best financial interests of the FUND. All such activities, including mailings, are subject to change and require the prior written approval of the FUND. Any regular direct communication with Claimants or their Physicians in connection with Claimant drug utilization or the processing of Claimant claims, either through mail, e-mail, fax or telephone must be submitted for the FUND's approval. The cost of any approved promotion shall be borne by the Contractor, unless the FUND specifically requests a particular activity not required to be performed under the resultant Agreement. The FUND will not approve any mail order promotions that it determines will not result in a reduced net cost to the NYSIF Program;

6.10.20 The Contractor shall act in the best interests of the NYSIF Program when dispensing Generic Drugs through the Mail Service Pharmacy Process by avoiding the dispensing of NDC's with higher AWPs unless market conditions exist making dispensing the more cost effective NDC impractical or impossible;

6.11.0 Specialty Drugs/Medications (Amended April 4, 2012)

6.11.1 The Contractor must provide Claimants with access to all Medically Necessary Specialty Drugs/Medications covered by the Program through its Retail Pharmacy Network, Mail Service Pharmacy Process and Specialty Pharmacy. In the case of Limited Distribution Drugs, the Contractor shall provide Claimants with access in accordance with the following:

6.11.1a ***Retail Pharmacy Network Access***

The Contractor shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the Program consistent with the Contractor's

contracted discount off of AWP for the Limited Distribution Drug, plus any dispensing fee. ~~If the Contractor is unable to secure the participation of the authorized distributor, the Contractor agrees to facilitate the Claimant's receipt of the drug and bill the NYSIF Program at the Minimum overall Guaranteed Discounts applicable to Brand Drugs for network pharmacies.~~

6.11.1b ***Mail Service Pharmacy Process Access***

~~For all Specialty Drugs including Limited Distribution Prescriptions submitted through the Mail Service Pharmacy Process, the~~ The Contractor must facilitate the Claimant's receipt of the Limited Distribution Drug. The Offeror shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the Programs consistent with the Offeror's contracted discount off AWP for the Limited Distribution Drug, plus any dispensing fee. ~~by obtaining the drug from an authorized distributor and billing the NYSIF Program consistent with its Guaranteed Discounts applicable to Brand Drugs for the mail service pharmacy.~~

6.11.2 Specialty Pharmacy Program (Amended April 4, 2012)

6.11.2a The Contractor must provide Claimants with access to all Medically Necessary Specialty Drugs/Medications covered by the NYSIF Program through its proposed Specialty Pharmacy Program. Such responsibility must include, but not be limited to:

6.11.2a(1) Developing a listing of the Specialty Drugs/Medications proposed for inclusion in the Specialty Pharmacy Program;

6.11.2a(2) Having a fully staffed and fully operational Specialty Pharmacy Program in which Specialty Drugs/Medications are provided by one or more Designated Specialty Pharmacies. All Designated Specialty Pharmacies must meet all New York State legal requirements. Any facility located outside New York State that will provide service for the NYSIF Program must be registered with the NYS Department of Education and meet all requirements of Section 6808-b of NYS Education Law. The Specialty Pharmacy Process must recognize the

full prescribing authority of Medical Professionals granted by NYS where allowed by state law.

6.11.2a(3) The Contractor must establish a process to provide Claimants with access to Limited Distribution Drugs not available through the Designated Specialty Pharmacy(ies), which places no additional steps or burdens on the Claimant. The Offeror shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the Programs consistent with the Offeror's contracted discount off AWP for the Limited Distribution Drug, plus any dispensing fee. ~~The Contractor must bill the NYSIF Program for these Prescriptions consistent with the Contractor's Minimum Guaranteed Discount applicable to Prescriptions dispensed at Network Pharmacies.~~

6.11.2a(4) Providing a fully staffed and fully operational customer support call center available to Claimants 24 hours a day, 365 Days a year including Pharmacists, clinicians, and registered nurses trained in a Claimant's specific Specialty Drug/Medication therapies. The Contractor must provide callers with access to customer service staff and Pharmacists through the NYSIF Program's toll-free telephone line who are able to respond timely to questions, complaints and inquiries including but not limited to: Program benefit inquiries, refills, order status, point of service issues, Specialty Pharmacy Process complaints, preferred drug status, and claim status. Callers must be able to reorder and check order status through the too-free telephone line.

6.11.2a(5) Administering a safety monitoring system that complies with the Food and Drug Administration (FDA) Amendments Act of 2007 which requires a Risk Evaluation and Mitigation Strategy (REMS) from the Specialty Drugs/Medications manufacturers to ensure the benefits of a drug outweigh its risks.

6.11.2a(6) Completing Physician consultation, coordination of care, patient care management and other interventions on a clinically appropriate and timely basis.

6.11.2a(7) Providing all necessary clinical and educational support to Claimants, and/or their family/caregiver utilizing the Specialty Pharmacy Process, including but not limited to explaining the treatment plan and ancillary supplies, disease/drug education, side-effect management, compliance management and administration training.

6.11.2a(8) Applying the same NYSIF Program benefit design features as the Mail Service Pharmacy Process, including but not limited to Mandatory Generic Substitution, DUR, Prior Authorization, and Preferred Drug List.

6.11.2a(9) Ensuring that all the FUND's approved edits including, but not limited to, enforcing utilization edits (e.g. refill to soon, duplicate therapy, etc.) are built into the Prescription fulfillment process system to protect a claimants safety as well as to control NYSIF Program costs.

6.11.2a(10) Ensuring that all Designated Specialty Pharmacies utilized in the Contractor's Specialty Pharmacy Program meet all Prescription drug packaging regulatory requirements. The Contractor must ensure that Specialty Drugs/Medications are shipped to Claimants in appropriate packing materials so that Specialty Drugs/Medications are safe and effective and delivered on time.

6.11.2a(11) Providing a simple, user friendly method(s) of ordering, reordering, and transferring Prescriptions from retail and mail to the Designated Specialty Pharmacy(ies) including pre-addressed postage paid Specialty Pharmacy Program envelopes. The Contractor must send a Specialty Pharmacy Program letter to Claimants who have received a First Fill of a Specialty

Drug/Medication through a Network Pharmacy. The letters must be sent within thirty (30) Days of the Prescription being filled to Enrollees who have received a Specialty Drug/Medication.

6.11.2a(12) Maintaining a comprehensive system for the Contractor's staff to utilize to track all Claimant inquiries including, but not limited to; Program benefits, refills, order and claim status, Preferred Drug List inquiries and Specialty Pharmacy Process complaints. The system shall include call type, customer service actions and resolutions.

6.11.2a(13) Having a system in place to track all Prescriptions received for processing through the Specialty Pharmacy Process from the date the Prescription is received to the date the Prescription is shipped. The Contractor must also be able to track fill accuracy rates.

6.11.2a(14) Maintaining a process to collect information from individuals necessary to ensure claimant safety. The process should collect such information as drug allergies, chronic medical conditions, and other medications taken on a regular basis.

6.11.2a(15) Ensuring that the Designated Specialty Pharmacy(ies) have efficient procedures regarding inventory management including, but not limited to, backorders, inventories of high demand drugs, supplies of difficult to obtain drugs, back-up supplier contracts, etc.

6.11.2a(16) Providing notification to Claimants as soon as possible for out of stock items, partial fill orders, and changes to Prescriptions (e.g., dosing or method of administration). In out of stock situations, the Contractor must have a system in place to ensure that Prescriptions are filled in the most efficient manner whether it be through an alternate facility(ies) or obtaining a re-stock from a supplier. The Contractor must contact the Claimant's Physician, if necessary, to offer alternative medications or offer to return the Prescription. If the Physician authorizes use of an alternative medication, a letter

notifying the Claimant of the change must be sent to the Claimant before the medication is shipped or must accompany the Prescription.

6.11.2a(17) Promptly notifying the FUND of nationwide out of stock issues, including information from the manufacturer or wholesaler regarding the anticipated date that the drug will resume shipment.

6.11.2a(18) Having back-up Designated Specialty Pharmacies to handle any overflow and/or situations where the primary Specialty Program facility is unavailable.

6.11.2a(19) Recommending newly launched Specialty Drugs/Medications for inclusion in the Specialty Pharmacy Program based on the established criteria/definition of Specialty Drug/Medications, in a format to be approved by the FUND. Prior to inclusion in the NYSIF Program, or if not accepted by the FUND to be included in the NYSIF Program, the Contractor must bill the NYSIF Program for these Prescriptions consistent with the Contractor's contracted discount off of AWP at the dispensing Network Pharmacies or the Guaranteed Discount at the Mail Service Pharmacy Process, based on where each Prescription was actually dispensed. Inclusion of new Specialty Drugs/Medications shall have a cost-neutral or positive financial impact on the NYSIF Program, and in no case shall the Ingredient Cost of a newly added Specialty Drug/Medication charged to the Program exceed the Guaranteed Discount on Specialty Pharmacy Drugs.

6.12.0 Claims Processing

6.12.1 The Contractor must provide all aspects of claims processing. Such responsibility shall include but not be limited to:

6.12.1a Verifying that the NYSIF Program's benefit design has been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly;

6.12.1b Accurate and timely processing of all claims submitted under the NYSIF Program in accordance with the FUND requirements at the time the claim was incurred as specified to the Contractor by the FUND;

6.12.1c Charging the NYSIF Program consistent with the Contractor's proposed pricing quotes;

6.12.1d Developing and maintaining claim payment procedures, guidelines, and system edits that guarantee accuracy of claim payments for covered expenses only, utilizing all edits as proposed and approved by the FUND. The Contractor shall utilize refill too soon edits and duplication of therapy edits for all claims unless exceptions are specifically approved in advance by the FUND. The Contractor's system must ensure that refilling Prescriptions prior to use of the minimum prescribed Days supply does not result in over dispensing;

6.12.1e Managing Preferred Drug List placement of drugs consistent with the NYSIF Program design;

6.12.1f Maintaining claims histories for 24 months online and archiving older claim histories for up to 6 years with procedures to easily retrieve and load claim records;

6.12.1g Maintaining the security of the claim files and ensuring HIPAA compliance;

6.12.1h Reversing all attributes of claim records, e.g. AWP, quantity, Days supply, etc., processed in error ~~or due to fraud~~ including the reversal of any Claim Administration Fee associated with the original claim and crediting the NYSIF Program for all costs associated with the claim processed in error ~~or due to fraud~~ including but not limited to the Claim Administration Fee; and

6.12.1i Agreeing that all claims data is the property of the State. The Contractor cannot share, sell, release, or make the data available to third parties in any manner without the prior consent of the FUND. The FUND understands that the selected Contractor will be required to share certain claims data with pharmaceutical manufacturers for purposes of obtaining for the NYSIF

Program all Pharma Revenue due it under the Agreement. The Contractor shall inform the FUND of the types of data being shared for these specific authorized purposes.

6.12.2 Maintaining a back-up system and disaster recovery system for processing claims in the event that the primary claims payment system fails or is not accessible;

6.12.3 Maintaining a claims processing system capable of integrating and enforcing the various utilization review components of the NYSIF Program, including, but not limited to: Mandatory Generic Substitution, Prior Authorization, messaging capability in the current NCPDP format and a concurrent DUR program to aid the Pharmacist at the point of sale;

6.12.4 Maintaining an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the NYSIF Program's mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the generic at the Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Retail Pharmacy Network, the NYSIF Program's mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized generic in stock, mandatory generic substitution provisions will not apply and the Claimant shall receive the Brand Drug and the Program charged based on generic pricing. The NYSIF Program shall reject claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW-0 code with appropriate messaging and requires resubmission of the claim since a DAW-0 code provides no indication of Generic Drug availability in the Pharmacy. The NYSIF Program logic for the Pharmacy Submitted DAW codes is listed below:

Pharmacy Submitted DAW	**Pricing**
0	Brand
1	Generic
2	Generic
3	Generic
4	Generic

5	Generic
6	Generic
7	Brand
8	Generic
9	Generic

6.12.5 Maintaining a claims processing system capable of ensuring that claims are consistently processed with the appropriate brand name/generic/compound classification in accordance with the requirements set forth in Article XI: "NYSIF Program Claims Reimbursement" of this Agreement.

6.12.6 Maintaining a Program specific MAC List for Pharmacies;

6.12.7 Processing Non-Network Pharmacy claims submitted to the Contractor in accordance with Chapter V of title 12 NYCRR, as follows:

6.12.7a Brand Drugs, including Specialty Drugs/Medications, must be charged to the NYSIF Program at the New York State Workers' Compensation Board rates, currently a 12% discount off of AWP, plus a $4 Dispensing Fee.;

6.12.7b Generic Drugs, including Specialty Drugs/Medications, must be charged to the NYSIF Program at the New York State Workers' Compensation Board rates, currently a 20% discount off of AWP, plus a $5 Dispensing Fee;

6.12.8 Processing all manually submitted claims including but not limited to, out of network claims, and in-network manual claims, in accordance to the Contractor's proposed Claims Adjudication Guarantee;

6.12.9 Analyzing and monitoring claim submissions to promptly identify errors, fraud and abuse and reporting to the FUND such information in a timely fashion in accordance with a FUND approved process The NYSIF Program shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses. The NYSIF Program will be charged a Claims Administration Fee only for Final Paid Claims. The Contractor will credit the NYSIF Program the amount of any overpayment regardless of whether any overpayments are recovered from the Pharmacy and/or

Claimant in instances where a claim is paid in error due to Contractor error, or due to fraud or abuse. The Contractor shall report fraud and abuse to the appropriate authorities. In cases of overpayments resulting from errors only found to be the responsibility of the FUND, the Contractor shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the NYSIF Program upon receipt; however the Contractor, is not responsible to credit amounts that are not recovered;

6.12.10 Establishing a process where Pharmacies can verify eligibility of Claimants during Call Center Hours;

6.12.11 Requiring network pharmacies to submit to the Contractor for each drug dispensed the Pharmacy's Submitted Cost to ensure that the NYSIF Program is charged according to the NYSIF Program's Lesser of Logic; and,

6.12.12 Having a process in place (fully staffed with ample telephone trunks) available 24 hours a Day, seven Days a week where a Pharmacist can call to quickly resolve point of service issues.

6.13.0 Utilization Management

6.13.1 Mandatory Generic Substitution at Retail and Mail

To ensure strict adherence to the NYSIF Program's Mandatory Generic Substitution Requirement and protect the financial interests of the NYSIF Program, the Contractor is required to:

6.13.1a Unless otherwise directed by the FUND, apply mandatory generic substitution to all specific NDC's of Brand Drugs for which there is an FDA approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc) or an authorized Generic Drug as permissible by NYS law. Network Pharmacies shall comply with all state laws related to mandatory generic substitution. The NYSIF Program's mandatory generic substitution provisions shall apply to any claim where the A-rated or authorized Generic Drug is required or permitted to be substituted under state law. Mandatory generic substitution provisions will not apply to B-rated or unrated Generic

Drugs or in the unlikely event that state law prohibits dispensing of the A-rated or authorized Generic Drug.

6.13.1b Monitor the pharmaceutical industry on behalf of the FUND to identify Generic Drugs expected to enter the market. Prior to the actual introduction of the Generic Drug to market, the Contractor shall inform the FUND of anticipated shipping dates of the first Generic Drug introduced into the market for one or more strengths of a particular Brand Drug.

6.13.1c Charge the NYSIF Program based on the NYSIF Program MAC List price assigned to the GCN of the dispensed Brand Drug subject to the NYSIF Program's Lesser of Logic plus the applicable dispensing fee as set forth within Article XI, "NYSIF Program Claims Reimbursement," of this Agreement.

6.13.1d Promptly notify and receive FUND prior written approval for any and all exceptions to the NYSIF Program's mandatory substitution provisions. Following commencement of mandatory generic substitution, the Contractor must receive FUND written approval prior to suspending enforcement of the NYSIF Program's mandatory generic substitution provisions.

6.13.1e Maintain an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the NYSIF Program's mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the Generic Drug at the Network Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Network Pharmacy, the NYSIF Program's mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized Generic Drug in stock, mandatory generic substitution provisions will not apply and the Claimant shall receive the Brand Drug and the NYSIF Program charged based on Generic Drug pricing. The Contractor's claims processing system must reject, with appropriate messaging, claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW-0 code requiring resubmission of the claim (since a DAW-0 code provides no indication of

Generic Drug availability in the Pharmacy). Similar rules can be applied to other DAW submission codes as necessary to ensure consistent, accurate application of the NYSIF Program's mandatory generic substitution requirements.

6.13.1f Immediately notify the FUND of changes (from brand to generic or generic to brand) in the NDC classification submitted by the Contractor, subject to the NYSIF Program's definitions of Brand and Generic Drugs contained in Article I of the Agreement.

6.14.0 Clinical Management/Drug Utilization Review (DUR)

6.14.1 To ensure that the resources available to the NYSIF Program are utilized for appropriate, Medically Necessary Drug therapy, the Contractor is required to administer a prior authorization program which includes, at a minimum:

6.14.1a A Prior Authorization Program for high cost Prescription drugs that are prescribed for very specific medical indications. Only medications that have been identified by the Contractor as appropriate for Prior Authorization and reviewed by the FUND shall be included in the Prior Authorization Program. The Prior Authorization Program also subjects specific drugs in certain categories to clinical criteria before benefits are authorized for payment including but not limited to: anti-obesity agents; topical tretinoin; antifungal agents; Hepatitis C agents; Hepatitis B agents for interferon use; select Osteoporosis agents; Respiratory Syncytial Virus (RSV) Therapy agents, select stimulant agent; Multiple Sclerosis agents; Low Molecular Weight Heparin agents; Growth Hormones; Cancer; Pain/Arthritis; Phychosis agents and, Pulmonary Arterial Hypertension agents. Only medications that have been identified as appropriate for the Prior Authorization Program by the Contractor and reviewed by the FUND shall be included in the Prior Authorization Program;

6.14.1b Monitoring market changes and recommending deletions or additions to the list of drugs requiring Prior Authorization on an ongoing basis which must be reviewed by the FUND prior to implementation of any changes to the list of medications;

6.14.1c Promptly loading approved prior authorization received by the NSIF Program into the claims processing system.

6.14.1d Loading one or more files of Prior Authorization approved-through dates from the incumbent contractor, prior to the January 1, 2014 implementation date, once an acceptable file is received.

6.14.2 Concurrent Drug Utilization Review (DUR)

To safeguard claimant health and ensure adherance with the NYSIF Program's benefit design, the Contractor must administer a concurrent DUR program which includes at a minimum:

6.14.2a A point of service system at all Retail Pharmacy Network locations, Mail Service Pharmacy Process Facilities and Specialty Pharmacies which is continually updated with the latest patient safety edits with the capacity to "message" Pharmacists related to safety issues prior to the dispensing of the Prescription drug; and

6.14.2b A fully integrated point of service system capable of enforcing the NYSIF Program's benefit design features.

6.14.3 Physician Education

6.14.3a Subject to FUND review and approval, the Contractor must undertake a Physician education program involving communications with prescribing Physicians which includes at a minimum:

6.14.3a(1) Analysis of Physician's drug or condition specific prescribing patterns;

6.14.3a(2) Educating Physicians about the clinical and economic aspects of their prescribing decisions. Any communication with Physicians prescribing medications for Claimants shall make the Physician aware of the distribution channel most cost effective to the NYSIF Program;

6.14.3a(3) Reporting the results of its Physician Education initiatives to the FUND on a quarterly basis in a mutually agreed upon format; and

6.14.3a(4) The Physician Education Program may not be funded by pharmaceutical manufacturers.

6.14.4 Patient Education

6.14.4a Subject to FUND review and approval, the Contractor must develop and implement a Patient Education program consisting of communications to patients which:

6.14.4a(1) Analyzes drug utilization from a clinical standpoint to identify and facilitate communication with Claimants that have chronic diseases to maximize health benefits of drug treatment;

6.14.4a(2) Analyzes drug utilization to identify and facilitate communication with Claimants not managing their drug utilization in the most cost effective manner for the Claimant; and

6.14.4a(3) Reports the results of its patient education initiatives to the FUND on a quarterly basis in a mutually agreed upon format.

6.14.4b The Patient Education Program may not be funded by pharmaceutical manufacturers.

6.15.0 Preferred Drug List Development and Management

The Contractor must provide PDL development and management services for the NYSIF Program. Such responsibility shall include but not be limited to:

6.15.1 Creating and maintaining a formulary that is tailored to NYSIF specifications, including the categorization of drugs, e.g. drugs requiring prior authorization, covered drugs dispensed not requiring prior authorization;

6.15.2 Providing NYSIF with a list of therapeutic categories routinely excluded from coverage;

6.15.3 Agreeing that the Contractor does not and will not accept payments from drug companies to promote specific products;

6.15.4 Notifying NYSIF a minimum of three weeks prior to any additions, deletions and modifications to the existing formulary and whether or not the affected drugs are covered or require prior authorization;

6.15.5 Notifying NYSIF a minimum of three weeks prior to the inclusion of new drugs in the formulary and specify whether or not the drugs are covered or require prior authorization; and

6.15.6 Providing NYSIF with an electronic file of all formulary drugs including dosages, NDC numbers, GCN and GC3 codes. The frequency of this file submission will be determined by NYSIF and will be provided upon vendor selection.

ARTICLE VII: PERFORMANCE GUARANTEES

The Parties agree that the following guarantees and the corresponding credit amounts for failure to meet the Contractor Performance Guarantees shall be implemented effective January 1, 2014. The Contractor acknowledges and agrees that failure to perform the Program Services features in such a manner which either meets or exceeds any, and/or all of the Contractor Performance Guarantee(s) as set forth in this Article, and/or fails to make any payment(s) of any such credit amounts for such failure to meet any Performance Guarantee(s) does not relieve the Contractor of the performance of the activities, duties, and obligations as otherwise set forth in the Agreement. Credit amounts are cumulative. Amounts due from the Contractor to the FUND for failure to perform and audit credit amounts, as determined pursuant to Article XIV of this Agreement, shall be made in such amounts as determined by the FUND to be final. Upon such determination, the FUND shall notify the Contractor, in writing, and the Contractor shall apply such amounts as a credit against the monthly Claims Administration Fee in accordance with Article XIV of this Agreement within thirty (30) Days of receiving such notification by the FUND. These amounts must also be applied as a credit against the Claim Administration Fee reported in the Annual Financial Report.

7.1.0 Implementation and Start-up Guarantees and Credit Amount

7.1.1 ***Guarantee:*** The Contractor guarantees that all Implementation and Start-up activities will be completed no later than December 31, 2013 so that, effective January 1, 2014, the Contractor can assume full operational responsibility for the NYSIF Program. For the purpose of this guarantee, the Contractor must, on January 1, 2014, have in place and operational:

7.1.1a a contracted Retail Pharmacy Network that meets the access standards set forth in Section 7.4.0 of this Agreement. Additionally, in order to meet the Contractor's implementation guarantee, the network implemented on January 1, 2014 must include all chain pharmacies with more than 20 locations and all groups of 20 or more independent pharmacies utilizing the same third party organization to collectively negotiate network participation agreements, as identified in the Contractor's Proposed Retail Pharmacy Network File, to the extent the subject chains and/or independent Pharmacy groups continue in operation on and after January 1, 2014.

The NYSIF Program requires that all chain pharmacies with less than 20 locations, groups of less than 20 independent pharmacies utilizing the same third party organization to collectively negotiate network participation agreements, and all independent pharmacies, as identified in the Contractor's Proposed Retail Pharmacy Network File, included in the Contractor's Retail Pharmacy Network implemented on January 1, 2014. Acceptable reasons for non-participation of independents, smaller chains or groups of individual pharmacies contracting collectively on January 1, 2014 include, and are limited to: a Pharmacy's violation of state and/or federal laws; a Pharmacy's failure to meet the Contractor's credentialing criteria; or a Pharmacy's failure to fulfill its contractual obligations and no remedy can be achieved. On January 1, 2014, the Retail Pharmacy Network must meet all requirements set forth in Section 6.9.0 of this Agreement and be available to fill Enrollee Prescriptions for all Covered Drugs including Specialty Drugs/Medications(for those claimants that don't participate in the Specialty Pharmacy Program);

7.1.1b A fully operational Mail Service Pharmacy Process utilizing facilities as necessary to ensure that Claimants have access to all Covered Drugs, including

Specialty Drugs/ Medications (for those groups that don't participate in the Specialty Pharmacy Program) as set forth in Section 6.10.0 of this Agreement. The Contractor must have a plan in place to facilitate the transfer of Prescription information, including open refills and prior authorizations from the previous program administrator and outline the procedures they will utilize to assure a smooth mail service transition for claimants;

7.1.1c A fully operational Specialty Pharmacy Program utilizing facilities as necessary to ensure that Claimants have access to all covered Specialty Drugs/Medications as set forth in Section 6.11.2 of this Agreement. The Contractor must have a plan in place to facilitate the transfer of specialty Prescription information, including open refills and prior authorizations, from the previous provider of service and outline the procedures that will be utilized to assure a smooth Specialty Pharmacy Program transition for affected claimants;

7.1.1d A fully operational call center providing all aspects of customer support and services as set forth in Section 6.4.0 of this Agreement;

7.1.1e An on-line claims processing system that applies FUND approved edits and point of service edits, including drug utilization review edits, as set forth in Section 6.12.0 of this Agreement;

7.1.1f An on-line claims processing system with real time access to the most updated, accurate enrollment and eligibility data provided by the FUND to correctly pay claims for eligible Claimants consistent with NYSFI Program benefit design and contractual obligations; and

7.1.2 ***Credit Amount:*** The Contractor's quoted percent to be credited for each day that all Implementation and Start-Up requirements are not met is (TBD percent (TBD%) of the 2014 Claims Administration Fee (prorated on a daily basis).

7.2.0 <u>Enrollment Management Guarantee and Credit Amount</u>

7.2.1 ***Guarantee:*** The Contractor guarantees that one hundred percent (100%) of all NYSIF Program enrollment records that meet the quality standards for loading will be loaded

into the Contractor's enrollment system within twelve (12) hours of release by the FUND.

7.2.2 ***Credit Amount*:** For each 24 hour period beyond twelve (12) hours from the release by the FUND that one hundred percent (100%) of the NYSIF Program enrollment records that meet the quality standards for loading is not loaded into the Contractor's enrollment system, the Contractor shall credit against the NYSIF Program's Claims Administration Fee the amount of $(TBD).

7.3.0 Management Reports and Claim Files Guarantee and Credit Amount

7.3.1 ***Guarantee:*** For each management report or claim file listed in Article XV of this Agreement, the Contractor guarantees that accurate management reports and claims files shall be delivered to the FUND no later than their respective due dates inclusive of the date of receipt.

7.3.2 ***Credit Amount*:** For each management report or claim file listed in Article XV of this Agreement that is not received by its respective due date, the Contractor shall credit against the NYSIF Program's Claims Administration Fee the amount of $(TBD) per report per each Business Day between the due date and the date the management report or claims file is received by the FUND inclusive of the date of receipt.

7.4.0 Retail Pharmacy Network Access Guarantee and Credit Amount

7.4.1 ***Guarantee:*** The Contractor guarantees that effective January 1, 2014 and throughout the term of the Agreement:

7.4.1a At least ninety percent (90%) of Claimants in urban areas will have access to a Network Pharmacy. The minimum access guarantee for Claimants in urban areas is at least one (1) Network Pharmacy within two (2) miles of an Claimant's home;

7.4.1b At least ninety percent (90%) of Claimants in suburban areas will have access to a Network Pharmacy. The minimum access guarantee for Claimants in suburban areas is at least one (1) Network Pharmacy within five (5) miles of an Claimant's home; and

7.4.1c At least seventy percent (70%) of Claimants in rural areas will have access to a Network Pharmacy. The minimum access guarantee for Claimants in rural areas is at least one (1) Network Pharmacy within fifteen (15) miles of a Claimant's home.

7.4.2 ***Credit Amount:***

7.4.2a The Contractor shall credit against the NYSIF Program's Claims Administration Fee the amount of $(TBD) for each .01 to 1.0% below the ninety percent (90%) minimum access guarantee for any quarter in which the Network Pharmacy Access for Urban Areas Guarantee is not met by the Contractor.

7.4.2b The Contractor shall credit against the NYSIF Program's Claims Administration Fee the amount of $(TBD) for each .01 to 1.0% below the ninety percent (90%) minimum access guarantee for any quarter in which the Network Pharmacy Access for Suburban Areas Guarantee is not met by the Contractor.

7.4.2c The Contractor shall credit against the NYSIF Program's Claims Administration Fee the amount of $(TBD) for each .01 to 1.0% below the seventy percent (70%) access guarantee for any quarter in which the Network Pharmacy Access for Rural Areas Guarantee is not met by the Contractor.

7.4.3 Measurement of compliance with each access guarantee in Section 7.4 of this Agreement will be based on a "snapshot" of the Retail Pharmacy Network taken on the last Day of each quarter within the current Plan Year. The results must be provided in the format contained in Exhibit I.Y4 of the RFP. The report is due thirty (30) Days after the end of the quarter.

7.5.0 **Turnaround Time for Claims Adjudication Guarantee and Credit Amount**

7.5.1 ***Guarantee:*** The Contractor guarantees that at least ninety-nine and five-tenths percent (99.5%) of submitted claims that require no additional information in order to be properly adjudicated that are received by the Contractor shall be turned around within ten (10) Business Days from the date the claim is received in the FUND's designated post office box to the date the Explanation of Benefits is received by the mailing agent.

7.5.2 ***Credit Amount:*** For each .01 to .25% of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Contractor and not turned around within ten (10) Business Days from the date the claim is received in the Contractor's NYSIF designated post office box to the date the Explanation of Benefits is received by the mailing agent, below the standard of ninety-nine and five-tenths percent (99.5%), as calculated on a quarterly basis, the Contractor shall credit against the NYSIF Program's Claims Administration Fee the amount of $(TBD).

7.6.0 **Turnaround Time for Mail Service Prescriptions Guarantee and Credit Amount**

7.6.1 ***Guarantee:*** The Contractor guarantees that at least ninety-five percent (95%) of all non-intervention mail service Prescriptions will be turned around in two (2) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the day after the Prescription is received by the Mail Service Pharmacy to the date the Prescription is received by the mailing agent. For example, a Prescription order received on Monday, January 6, 2014, by the mail service Pharmacy, must be received by the mailing agent no later than Thursday, January 9, 2014s;

7.6.2 ***Credit Amount:*** For each .01 to 1.0% below ninety-five percent (95%) percent of all non-intervention mail service Prescriptions not turned around within two (2) Business Days, calculated on a quarterly basis, the Contractor shall credit against the NYSIF Program's Claims Administration Fee the amount of $(TBD).

7.6.3 ***Guarantee*****:** The Contractor guarantees that at least ninety-five percent (95%) of all intervention mail service Prescriptions shall be turned around in five (5) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the date the Prescription is received by the mail service Pharmacy to the date the Prescription is received by the mailing agent. For example, a Prescription order received on Monday, January 6, 2014 by the Mail Service Pharmacy must be received by the mailing agent no later than Tuesday, January 14, 2014.

7.6.4 ***Credit Amount:*** For each .01 to 1.0% below ninety-five percent (95%) of all intervention mail service Prescription not turned around within five (5) Business Days, calculated on a

quarterly basis, the Contractor shall credit against the NYSIF Program's Claims Administration Fee the amount of $(TBD).

7.7.0 Program Call Center Telephone Guarantees and Credit Amounts

7.7.1 *Guarantees:*

7.7.1a *Call Center Availability*: The NYSIF Program's service level standard requires that the Contractor's telephone line will be operational and available to Claimants and pharmacies at least ninety-nine and five-tenths percent *(*99.5%) of the Contractor's Call Center Hours. The Call Center availability shall be reported monthly and calculated quarterly;

7.7.1b *Call Center Telephone Response Time:* The NYSIF Program's service level standard requires that at least ninety percent (90%) of the incoming calls to the Contractor's telephone line will be answered by a customer service representative within sixty (60) seconds. Response time is defined as the time it takes incoming calls to the Contractor's telephone line to be answered by a customer service representative. The telephone Call Center response time shall be reported monthly and calculated quarterly;

7.7.1c *Telephone Abandonment Rate*: The NYSIF Program's service level standard requires that the percentage of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service representative will not exceed three percent (3%). The telephone abandonment rate shall be reported monthly and calculated quarterly; and

7.7.1d *Telephone Blockage Rate*: The NYSIF Program's service level standard requires that not more than three percent (3%) of incoming calls to the customer service telephone line will be blocked by a busy signal. The telephone blockage rate shall be reported monthly and calculated quarterly.

7.7.2 *Credit Amounts:*

7.7.2a *Call Center Availability*: For each .01 to .25% below the standard of ninety-nine and five-tenths percent (99.5%) that the Contractor's telephone line is not

operational and available to Claimants and Pharmacies during the Contractor's Call Center Hours calculated on a quarterly basis, the Contractor shall credit against the NYSIF Program's Claims Administration Fee the amount of $(TBD) per quarter;

7.7.2b ***Call Center Telephone Response Time*:** For each .01 to 1.0% of incoming calls to the Contractor's telephone line below the standard of ninety percent (90%) that is not answered by a customer service representative within sixty (60) seconds, calculated on a quarterly basis, the Contractor shall credit against the NYSIF's Program's Claims Administration Fee the amount of $(TBD) per quarter;

7.7.2c ***Telephone Abandonment Rate*:** For each .01 to 1.0% of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service representative in excess of three percent (3%) calculated on a quarterly basis, the Contractor shall credit against the NYSIF Program's Claims Administration Fee the amount of $(TBD) per quarter; and

7.7.2d ***Telephone Blockage Rate*:** For each .01 to 1.0% of incoming calls to the Contractor's telephone line that is blocked by a busy signal, in excess of three percent (3%), calculated on a quarterly basis, the Contractor shall credit against the NYSIF Program's Claims Administration Fee the amount of $(TBD) per quarter.

7.8.0 Program Claims Processing System Availability Guarantee and Credit Amount

7.8.1 ***Guarantee:*** The Contractor guarantees that the NYSIF Program's online claims processing system be available at least ninety-nine and five-tenths percent (99.5%) of the time excluding periods of scheduled down time which shall be reported in advance to the FUND and kept to a minimum, based on a 24 hours a Day, 7 Days a week availability.

7.8.2 ***Credit Amount:*** For each .01 to .25% below the standard of ninety-nine and five-tenths percent (99.5%) that the Contractor's online claims processing system for the NYSIF Program, based on a 24 hours a Day, 7 Days a week availability, excluding periods of scheduled down time, which shall be reported in advance to the FUND and kept to a minimum, is not available, as calculated on a quarterly basis, the Contractor shall credit

against the NYSIF Program's Claims Administration Fee the amount of $(TBD) per each quarter.

ARTICLE VIII: MODIFICATION OF PROGRAM SERVICES

8.1.0 In the event that laws or regulations enacted by the Federal government and/or the State of New York have an impact upon the conduct of this Agreement in such a manner that the FUND determines that any design elements or requirements of the Agreement must be revised, the FUND shall notify the Contractor of any such revisions and shall provide the Contractor with a reasonable time within which to implement such revisions.

8.2.0 In the event the FUND requires changes in Program design elements or requirements of the Agreement, the FUND shall notify the Contractor of such changes and shall provide the Contractor with reasonable notice to implement such changes.

8.3.0 To the extent that any of the events as set forth in this Article shall take place and constitute a material and substantial change in the delivery of services that are contemplated in accordance with the terms of the NYSIF Program as of the Effective Date and which the Contractor is required to perform or deliver under the Agreement, the Contractor may submit a written request to the FUND to initiate review of the fee(s) received by the Contractor for services provided and guarantees made by the Contractor under the terms of the Agreement, accompanied by appropriate documentation. The FUND reserves the right to request, and the Contractor shall agree to provide additional information and documentation the FUND deems necessary to verify that an increase in the fee(s), or modification of the guarantees is warranted. The FUND will agree to modify the fee(s) to the extent necessary to compensate the Contractor for documented additional costs determined by the FUND to be reasonable and necessary. The FUND will agree to modify guarantees as determined by the FUND to be necessary to reflect NYSIF Program modifications. Should the FUND approve the Contractor's request to modify the fee(s) and/or guarantees, such approval shall be subject to written amendment and approval by OSC and the AGSC. The Contractor shall implement changes as required by the FUND with or without final resolution of any fee proposal.

8.4.0 Any changes made by DCS to the scope of its contract with the Contractor for Prescription Drug Program Services after execution of this Agreement, including but not limited to the request to

include any individual independent Network Pharmacy(ies), shall have no impact on this Agreement or cost thereunder, unless the change is agreed to by NYSIF.

ARTICLE IX: ENROLLMENT INFORMATION AND RECORDS

9.1.0 The Contractor shall maintain records from which may be determined at all times the names of all Claimants insured hereunder and the benefits in force for each such Claimant, together with the date when any insurance became effective and the effective date of any change in benefits.

9.2.0 The FUND shall transmit enrollment information provided by the Claimant to the Contractor for the NYSIF Program in an electronic format consistent with Section 6.6.2 of this Agreement. The eligibility rules and the enrollment reports generated as a result of these eligibility rules shall be the sole means of determining valid enrollment for benefits under the NYSIF Program.

9.3.0 The FUND and the Claimants shall furnish to the Contractor all information that the Contractor may reasonably require with regard to any matters pertaining to the enrollment of Claimants under this Agreement. A person will not be entitled to or deprived of benefits under the Agreement due to clerical errors.

9.4.0 The FUND agrees to provide the Contractor with reasonable access to records of the FUND which may have a bearing on the benefits provided by the Contractor or calculation of the Contractor's Claims Administration Fee as set forth under Article XIV of this Agreement.

ARTICLE X: DATA SHARING AND OWNERSHIP

10.1.0 All claims and other data related to the NYISF Program is the property of the State. Upon the request of the FUND, the Contractor shall share appropriate claims data with FUND consultants. Except as directed by a court of competent jurisdiction, or as necessary to comply with applicable New York State or Federal law, or with the written consent of the Claimant, the Contractor shall not share, sell, release, or make the data available to third parties in any manner without the prior consent of the FUND. The FUND understands that the Contractor is required to share certain claims data with pharmaceutical manufacturers for purposes of obtaining for the NYSIF Program all Pharma Revenue due it under the Agreement. The

Contractor shall inform the FUND of the types of data being shared for these specific authorized purposes.

ARTICLE XI: NYSIF PROGRAM CLAIMS REIMBURSEMENT

The Program shall be charged for dispensed drugs consistent with the provisions of this Article.

11.1.0 General Provisions

11.1.1 All discounts and dispensing fees for Brand, Generic Drugs and Specialty Drugs/Medications must be guaranteed for the entire term of this Agreement without qualification or condition. In addition, the Contractor's Compound Drug pricing methodology set forth in Article XI of this Agreement must be guaranteed for the entire term of this Agreement without qualification or condition.

11.2.0 Average Wholesale Price (AWP) Source and Brand, Generic Drug, and Compound Drug Classification

The pricing formulas set forth in this Article are based on the classification of drugs as either Brand Drugs, Generic Drugs, or Compounded Drugs.

11.2.1 Throughout the term of the Agreement, the Contractor shall utilize (to be determined from the Contractor's Proposal) as the source of Average Wholesale Price (AWP) information for purposes of calculating Ingredient Cost unless the parties mutually agree in writing to use a different source for AWP information. The AWP used for pricing purposes during claim adjudication should be the AWP in effect on the date the drug was filled.

11.2.2 During the term of the Agreement, in the event the national reporting service (as identified by the Contractor in its Proposal) changes its methodology related to any of the information fields used in the FUND's classification of Brand and Generic Drugs, or its methodology for coding drugs in connection with these information fields, the Contractor is obligated to inform the FUND in writing of such changes within 30 Days of learning of such changes. Upon written notification, the Parties will meet and agree in writing to any Brand and/or

Generic Drug classification changes that may be necessary to enable the Parties to maintain the same economic position and obligations as are set forth in the Agreement.

11.2.3 Notwithstanding any other provision of the Agreement to the contrary, if, during the term of this Agreement, industry events have caused the Contractor's source of AWP to become obsolete or no longer available, the FUND and the Contractor shall agree on revised pricing terms. In no event shall the NYSIF Program's actual costs for drugs increase as the result of new pricing terms. The Contractor shall notify the FUND in writing as soon as any information indicating a problem with the future use of the Contractor's AWP source is received. Within two weeks of the initial notification, the Contractor shall submit a written detailed proposal to NYSIF for effectively revising pricing terms including but not limited to a file containing the Contractor's pricing for all drugs dispensed during the prior six months utilizing the current AWP source and the Contractor's revised pricing for such drugs using the proposed methodology. The Contractor's proposal should ensure continued alignment of the Contractor's interests with those of the NYSIF Program. Final determination of the revised pricing terms will be made by the FUND.

11.2.4 ***Classification Methodology General***

11.2.4a Drugs shall be classified for pricing purposes under this Agreement in accordance with the FUND classification determinations based on the definitions contained in Article I of this Agreement. No later than November 15th of each NYSIF Program year, the Contractor shall submit for FUND written approval a file containing all NDCs dispensed through the NYSIF Program during the prior year and the classification of each NDC derived from application of the Contractor's electronic classification process. To the extent the Contractor's electronic process results in classifications inconsistent with NYSIF determinations, the Contractor commits to modify its classification methodology to replicate the results of the FUND's determination, including the steps set forth in Section 11.2.4b below. The FUND's determination shall be final.

11.2.4b To the extent the electronic process fails to comprehensively replicate drug classifications specified by the NYSIF Program in Exhibit B, the Requests for

Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs," of this Agreement consistent with the definitions of Brand and Generic Drugs set forth in Sections 1.3.0 and 1.29.0 of this Agreement, the Contractor agrees to modify to the extent possible its electronic processing system before January 1, 2014, and to undertake all other necessary manual steps to ensure that the result of the prescription processing process from a cost basis to the NYSIF Program is in accordance with the FUND's determination of classification.

11.2.4c The Contractor shall conduct a year-end reconciliation each NYSIF Program Year to ensure that the claim amount charged to the NYSIF Program is in accordance with the definition of Brand and Generic Drugs set forth in Sections 1.3.0 and 1.29.0 of this Agreement. The reconciliation will include claims paid during the Plan Year and is to be completed by February 15th of the following year. If the FUND's review of the Contractor's reconciliation indicates an adjustment is required, then the FUND reserves the right to make an adjustment to the Contractor's submitted reconciliation. The Contractor shall credit or debit the Plan as applicable no later than 30 Days following the date of reconciliation.

11.3.0 Brand Drug Determination Methodology

11.3.1 The classification of a drug as a Brand Drug for the purpose of applying the appropriate pricing formula shall be based on the definition of the Brand Drug set forth in Section 1.3.0. The Contractor shall utilize an electronic process for claims processing using [Source to be determined by Contractor's Proposal] indicators to determine classification with the results subject to the review and approval of the FUND for consistency with Section 1.3.0 prior to commencement of the contract on January 1, 2014. The Contractor agrees that the FUND's determination shall be final.

11.3.2 To the extent the electronic process fails to comprehensively replicate drug classifications proposed by the NYSIF Program in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee

Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs," of this Agreement consistent with the definition of Brand Drug set forth in Section 1.3.0 of this Agreement, the Contractor agrees to modify its electronic processing system before January 1, 2014, and to undertake all other necessary manual steps to ensure that the result of the prescription processing process to the NYSIF Program is in accordance with the correct classification.

11.3.3 To the extent the Contractor cannot process claims consistent with the FUND's Brand Drug determinations, the reconciliation process set forth in Section 11.2.4c above will be performed.

11.4.0 Generic Drug Determination Methodology

11.4.1 The classification of a drug as a Generic Drug for the purpose of applying the appropriate pricing formula shall be based on the definition of Generic Drug set forth in Section 1.29.0 of this Agreement. The Contractor shall utilize an electronic process using [Source to be determined by Contractor's Proposal] indicators to establish classification with the results subject to the review and approval of the FUND prior to commencement of the contract on January 1, 2014. The Contractor agrees that the FUND's determination shall be final.

11.4.2 To the extent the electronic process fails to comprehensively replicate the drug classification proposed by the Program in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs," of this Agreement consistent with the definition set forth in 1.27.0 of this Agreement, the Contractor agrees to modify its electronic processing system before January 1, 2014, including setting appropriate Copayment levels as required, and to undertake all other necessary manual steps to ensure that the result of the prescription processing process to the NYSIF Program is in accordance with the correct classification.

11.4.3 To the extent the Contractor cannot process claims consistent with the FUND's Generic Drug determinations, the reconciliation process set forth in Section 11.2.4c above will be performed.

11.5.0 Compound Drug Determination Methodology

The Contractor shall implement a process to review Compound claim submissions for compliance with the contracted definition. The classification of a drug as a Compound Drug for the purpose of applying the appropriate pricing formula shall be based on the definition of Compound Drug set forth in Section 1.9.0 of this Agreement.

11.6.0 Program's Lesser of Logic

The NYSIF Program's Lesser of Logic applies to all claims processed under the NYSIF Program. Retail Generic Prescriptions assigned a MAC price shall be charged to the NYSIF Program at the following Lesser of Logic: the lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee; the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is Usual and Customary); the AWP discount contracted with the Network Pharmacy plus dispensing fee; or the Maximum Allowable Cost plus dispensing fee. Retail Brand Prescriptions and Generic Prescriptions that are not assigned a MAC price shall be charged to the NYSIF Program at the following Lesser of Logic: the lowest of the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is usual and customary); the Discounted Ingredient Cost contracted with Network Pharmacy plus dispensing fee; or the Pharmacy-submitted Ingredient Cost plus dispensing fee. Mail Service Pharmacy Generic Prescriptions shall be charged to the NYSIF Program at the following Lesser of Logic: The lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee; the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is Usual and Customary; the Minimum Guaranteed Discounted Ingredient Cost for Brand Drugs off of AWP plus dispensing fee; the Maximum Allowable Cost plus dispensing fee; or the WCB Fee Schedule. Mail Service Pharmacy Brand and Specialty Pharmacy Brand and Generic Prescriptions shall be charged to the Plan at the following Lesser of Logic: the lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee; the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is usual and customary); the Guaranteed Discounted Ingredient Cost off of AWP plus dispensing fee; or the WCB Fee Schedule. Once the Lesser of Logic has been applied, the pricing methodology resulting in the lowest claim cost to the NYSIF Program is determined, and to that amount any applicable sales tax is added.

11.7.0 Mandatory Generic Substitution at Retail and Mail

The Contractor shall:

11.7.1 Apply mandatory generic substitution to all specific NDC's of Brand Drugs for which there is an FDA approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc) or an authorized Generic Drug as permissible by NYS law. Network Pharmacies shall comply with all state laws related to mandatory generic substitution. The Contractor shall apply mandatory generic substitution to all specific NDC's (inactive or active) of Brand Drugs. The NYSIF Program's mandatory generic substitution provisions shall apply to any claim where the A-rated or authorized Generic Drug is required or permitted to be substituted under state law. Mandatory generic substitution provisions will not apply to B-rated or unrated Generic Drugs or in the unlikely event that state law prohibits dispensing of the A-rated or authorized Generic Drug.

11.7.2 Monitor the pharmaceutical industry on behalf of the FUND to identify Generic Drugs expected to enter the market. Prior to the actual introduction of the Generic Drug to market, the Contractor shall inform the FUND of anticipated shipping dates of the first Generic Drug introduced into the market for one or more strengths of a particular Brand Drug.

11.7.2a Charge the Program based on the NYSIF Program MAC List price assigned to the GCN of the dispensed Brand Drug subject to the NYSIF Program's Lesser of Logic set forth in Section 11.6.0 of this Agreement, plus the applicable dispensing fee as set forth in Section 11.8.3m of this Agreement.

11.7.2b Receive FUND written approval for any and all exceptions to the NYSIF Program's mandatory generic substitution provisions. Following commencement of mandatory generic substitution, the Contractor must receive FUND approval prior to suspending enforcement of the NYSIF Program's mandatory generic substitution provisions.

11.7.2c Maintain an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the NYSIF Program's mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the Generic Drug at the Network Pharmacy submitting the

electronic claim. If a Generic Drug is available to be dispensed by the Network Pharmacy, the NYSIF Program's mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized Generic Drug in stock, mandatory generic substitution provisions will not apply and the Enrollee shall receive the Brand Drug and the NYSIF Program charged based on Generic Drug pricing. The Contractor's claims processing system must reject, with appropriate messaging, claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW-0 code requiring resubmission of the claim (since a DAW-0 code provides no indication of Generic Drug availability in the Pharmacy). Similar rules shall be applied to other DAW submission codes as necessary to ensure consistent, accurate application of the NYSIF Program's mandatory generic substitution requirements. These rules are specified in Section 6.12.4 of this Agreement.

11.7.3 Immediately notify the FUND in writing of changes (from brand to generic or generic to brand) in the NDC classification submitted by the Contractor pursuant to Section 11.2.4a of this Agreement.

11.8.0 Retail Pharmacy Network Claims

11.8.1 The cost of all Covered Drugs dispensed at Network Pharmacies shall be charged to the NYSIF Program consistent with the requirements set forth in this section, including but not limited to application of the Lesser of Logic set forth in Section 11.6.0 of this Agreement. Under no circumstances may the Claimant be charged costs not specifically provided for under the NYSIF Program benefit design.

11.8.1a The Contractor shall ensure that the Network Pharmacy will charge the NYSIF Program the Discounted Ingredient Cost as determined through the application of the Lesser of Logic detailed in Section 11.6.0 of this Agreement plus the Contractor's applicable pharmacy contracted dispensing fee set forth in 11.11.3 for all drugs dispensed through a Network Pharmacy.

11.8.1b The Contractor shall administer a control process at point of service to protect the NYSIF Program from any inflated AWP costs associated with "repackaged" drugs charged to the NYSIF Program.

11.8.2 Retail Pharmacy Network Brand Drug Pricing

11.8.2a The Contractor shall charge the NYSIF Program utilizing Pass-through Pricing for all Brand Drugs dispensed to Claimants through the Network Pharmacies. The Contractor's contracted discount off of AWP and pharmacy contracted dispensing fee(s) for Brand Drugs shall be applicable to all individual Prescriptions for Brand Drugs dispensed to Claimants from a Network Pharmacy.

11.8.2b The Contractor shall use the following Ingredient Cost and dispensing fee to charge the NYSIF Program for each Prescription for a covered Brand Drug dispensed by a Network Pharmacy throughout the term of the Agreement subject to application of the Lesser of Logic as set forth in Section 11.6.0 of this Agreement.

11.8.2b(1) ***Ingredient Cost of Brand Drug Dispensed at Retail Pharmacy***

Pass-through Pricing based on the terms of the Contractor's agreement with the dispensing Pharmacy related to Brand Drugs. (Pricing is subject to an overall annual minimum discount of (TBD) % off the aggregate AWP and annual maximum dispensing fee of (TBD) for all Brand Drugs dispensed through Network Pharmacies.)

11.8.2c The Contractor shall guarantee an overall minimum discount off of the aggregate AWP for all Brand Drugs dispensed at Retail Network Pharmacies as defined in the RFP. The Contractor guarantees the Program that its management of Brand Drug costs dispensed by pharmacies shall result in the NYSIF Program achieving the Contractor's proposed overall Guaranteed Minimum Discounts of [TBD] during the Plan Year. The discounts achieved off of the aggregate AWP for all Brand Drugs as a result of Pass-through Pricing will be calculated utilizing the following formula: 1 minus (Sum of Ingredient Costs of dispensed Brand Drugs divided by sum of AWP of dispensed Brand Drugs). The aggregate discount calculation will be based on Pharmacy Prescriptions filled with a Brand Drug where the NYSIF Program was the primary payer. Claims submitted for

secondary payer consideration, Compound Drug claims, Non-Network claims, and claims submitted by governmental entities must be excluded from the aggregate discount calculation. In addition, claims with a calculated AWP discount greater than 50% will be excluded pending receipt of supporting documentation by the Contractor and verification by the FUND as to the validity of the calculated discount; and

(Amended April 4, 2012)

11.8.2d If the overall aggregate discounts obtained, as calculated utilizing the formula set forth in the prior paragraph, are less than the Guaranteed Minimum Discounts of [TBD], the Contractor shall reimburse the NYSIF Program the difference between the Ingredient Cost the NYSIF Program was charged utilizing Pass-through Pricing and the Ingredient Cost the NYSIF Program would have been charged if the Guaranteed Minimum Discount off of the aggregate AWP of [TBD] had been obtained. The NYSIF Program will be credited annually for this difference in Ingredient Cost. The NYSIF Program shall retain the benefit of any cost savings, in excess of the Contractor proposed Guaranteed Minimum Discounts off the aggregate AWP for all Brand Drugs dispensed by pharmacies.

This calculation shall be performed for each NYSIF Program year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the FUND on July 31st. If the FUND's review of the Contractor's calculations indicates an adjustment to the calculation is required, then the FUND reserves the right in their sole discretion to make an adjustment to the Contractor's calculations. ~~The calculations must be completed by February 15th of the following year.~~ Upon Approval by the FUND, ~~T~~the Contractor shall pay/credit the NYSIF Program the applicable amount, if any, within 30 Days. ~~following the February 15th calculation. If the FUND's review of the Contractor's calculations indicates an adjustment to the calculation is required, then the FUND reserves the right in its sole discretion to make an adjustment to the Contractor's calculations. On July 31st following each Plan Year, the Contractor shall perform a reconciliation to include claims incurred in each~~

~~NYSIF Program year and paid through June of the following Program year. Based on this reconciliation, the FUND shall receive an adjustment, if necessary, within 30 Days following the date of the reconciliation.~~ The NYSIF Program shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discount off the aggregate AWP of [TBD]. Any shortfall in the Guaranteed Minimum Discount cannot be recovered by the Contractor in subsequent years.

11.8.3 Retail Pharmacy Network Generic Pricing

The Contractor shall:

11.8.3a Maximize the discount achieved on behalf of the Program for Generic Drugs dispensed by Network Pharmacies. The Contractor or its Key Subcontractor, if any, must manage the Programs' MAC List consistent with, or better than, their most aggressive generic pricing list used to reimburse Pharmacies. The Contractor shall charge the NYSIF Program utilizing Pass-through Pricing for all Generic Drugs dispensed to Claimants through the Network Pharmacies.

(Amended April 4, 2012)

11.8.3b Create and maintain a single NYSIF Program-Specific Maximum Allowable Cost (MAC) List for called the Program MAC List setting the Ingredient Cost ~~maximum price~~ the NYSIF Program shall be charged, and the amount the dispensing Network Pharmacy shall be paid, for the Ingredient Cost for the drugs required to be included on the Program MAC List. Under no circumstances shall the MAC price assigned exceed the Discounted Ingredient Cost to the NYSIF Program achieved ~~through Pharmacy submitted pricing or pricing achieved~~ by using the Contractor's highest contracted Retail ~~and Mail Service~~ Pharmacy Brand Guaranteed Maximum Discount off of AWP of [TBD] applied to the AWP of the dispensed Generic Drug.

11.8.3c Assign a MAC price to all NDCs of drugs included within a GPI/GCN, including NDCs of all Brand Drugs, containing an A-rated or authorized Generic Drug form of the original Brand Drug in the GPI/GCN. The Contractor shall add the GPI/GCN to the Programs' MAC List and set a MAC price for the GPI/GCN in accordance with Section 6.13.1 of this Agreement. The provisions of this section

require that MAC pricing be applied in no event later than 21 Days after the first shipment of the first Generic Drug from the manufacturer to a wholesaler or retailer. For those Generic Drugs with an established GPI/GCN that are already subject to MAC pricing the Contractor is required to immediately apply MAC pricing to any generic NDC added to the GPI/GCN. All A-rated or authorized Generic Drugs shall be MAC'd in all instances including, but not limited to circumstances in which the FUND in its sole discretion decides not to enforce mandatory generic substitution of the Brand Drug in that GPI/GCN. There shall be one MAC price applicable to all NDCs included in the GPI/GCN on the Programs' MAC List. The MAC price shall be consistent with the process in Section 11.8.3b. However depending on particular market factors, it may be in the best interests of the NYSIF Program, and therefore appropriate, for more than one MAC price to be assigned within a GPI/GCN. Such situations would require that the Contractor provide any information the FUND deems necessary to support such action and obtain prior written approval from the FUND.

11.8.3d Assign a MAC price to all NDCs of B-rated or unrated Generic Drugs included within a GPI/GCN that does not include an A-rated or authorized Generic Drug. The Contractor shall add the GPI/GCN to the Programs' MAC List and set a MAC price for the Generic Drug NDCs included in the GPI/GCN as soon as practicable, but in no event later than 14 Days after the first shipment of the first Generic Drug from the manufacturer to a wholesaler or retailer. The Contractor shall not apply the MAC price to the NDC(s) for Brand Drugs dispensed in the GPI/GCN and shall not enforce the NYSIF Program's mandatory generic substitution provisions for Brand Drugs dispensed in this GPI/GCN. There shall be one MAC price applicable to all Generic Drug NDCs included in the GPI/GCN. However depending on particular market factors, it may be in the best interests of the NYSIF Program, and therefore appropriate, for more than one MAC price to be assigned within a GPI/GCN. Such situations would require that the Contractor provide any information the FUND deems necessary to support such action and obtain prior written approval from the FUND.

11.8.3e Charge the NYSIF Program for non-MAC'd Generic Drugs dispensed utilizing pass-through pricing of the Contractor's pharmacy contracted discount applied to the AWP of the dispensed Generic Drug. The only Non-MAC'd Generic Drugs shall be Generic Drugs included in GPIs/GCNs required to be on the Programs' MAC List but which have not yet been assigned a MAC price within the required time frame.

11.8.3f The Contractor shall inform the FUND of any market based condition which makes the strict compliance with Section 11.8.3b-11.8.3e of this Agreement contrary to the financial interests of the NYSIF Program. The FUND in its sole discretion may waive such requirements.

11.8.3g Monitor the Programs' MAC List pricing to ensure that NDCs contained in GPIs/GCNs subject to MAC pricing are paying at the MAC price after application of the NYSIF Program's Lesser of Logic provisions. The Contractor shall notify the NYSIF Program of any GPIs/GCNs subject to MAC pricing in which the majority of claims are processing at a basis other than the MAC price.

11.8.3h Agree that there shall be no increases to Programs' MAC List prices where such adjustment is intended to limit the discount achieved on behalf of the NYSIF Program to the Guaranteed Minimum Discount off of the aggregate AWP as set forth in Section 11.8.3m below, for all Generic Drugs dispensed by Network Pharmacies during the Program year.

11.8.3i Provide to the FUND full access to the Programs' MAC List used to price Generic Drugs dispensed by Network and Mail Service Pharmacies for the NYSIF Program. The Contractor must be prepared to provide valid documented market rationale to support their Programs' MAC pricing should the FUND request this information. In order to protect the NYSIF Program's financial interests from the date of the award until the termination date of the Agreement, the Contractor must agree that any <u>increases</u> to the Programs' MAC pricing must be justified to the FUND with valid documented market rationale. Following selection, the Contractor shall manage the content of the Programs' MAC List consistent with the requirements of this Agreement. Prices assigned to required new additions to

the Programs' MAC List shall be equivalent to the Contractor's most aggressive MAC price for that drug. Throughout the term of the Agreement, the Contractor commits to use its best efforts to maintain the aggregate effectiveness of its Programs' MAC List. The Contractor must ensure that MAC pricing is reduced to an appropriate level based on any change in market conditions such as increased competition within a GPI/GCN.

11.8.3j The Contractor shall strictly enforce all requirements of the NYSIF Program's mandatory generic substitution provision as detailed in Section 11.7 of this Agreement.

11.8.3k The Contractor guarantees that its management of Generic Drug costs dispensed by Network Pharmacies, including maintenance of the Programs' specific MAC List, and application of pricing provisions related to Generic Drugs that do not meet the requirements for inclusion on the Programs' specific MAC List, shall result in the NYSIF Program achieving the Contractor's overall Guaranteed Minimum Discount off of the aggregate AWP as set forth in Section 11.8.3m below, for all Generic Drugs dispensed by Network Pharmacies during the Program year. The discount achieved off of the aggregate AWP for all Generic Drugs as a result of Pass-through Pricing shall be calculated utilizing the following formula: 1 minus (Sum of Ingredient Costs of dispensed Generic Drugs at Retail and Mail Service Pharmacies divided by sum of AWP of dispensed Generic Drugs). The aggregate discount calculation shall be based on Network Pharmacy Prescriptions filled with a Generic Drug where the NYSIF Program was the primary payer (including Enrollee submitted claims). Claims submitted for secondary payer consideration, Compound Drug claims, and claims submitted by governmental entities are excluded from the aggregate discount calculation. In addition, claims with a calculated AWP discount greater than 90% and a total AWP greater than $500 shall be excluded pending receipt of supporting documentation by the Contractor and verification by the FUND as to the validity of the calculated discount. The setting of an overall minimum discount off of the aggregate AWP for all Generic Drugs dispensed at Network and Mail Service Pharmacies shall in no way modify the Contractor's contractual obligation to

maximize the NYSIF Program's aggregate discount above the Contractor's overall Guaranteed Minimum Discount off of the aggregate AWP.

(Amended April 4, 2012)

11.8.3l If the overall aggregate discount obtained, as calculated utilizing the formula set forth in Section 11.8.3k, above, is less than the Guaranteed Minimum Discount set forth in Section 11.8.3m, the Contractor shall reimburse the NYSIF Program the difference between the Ingredient Cost the NYSIF Program was charged utilizing Pass-through Pricing and the Ingredient Cost the NYSIF Program would have been charged if the Guaranteed Minimum Discount off of the aggregate AWP set forth in Section 11.8.3m for all Generic Drugs was obtained.

This calculation shall be performed for each Program year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the FUND on July 31st. If the FUND's review of the Contractor's calculations indicates an adjustment to the calculation is required, then the FUND reserves the right in their sole discretion to make an adjustment to the Contractor's calculations. ~~The calculations must be completed by February 15th of the following year.~~ Upon Approval by the FUND, ~~T~~the ~~The calculations must be completed by February 15th of the following year. The~~ Contractor shall pay/credit the NYSIF Program the applicable amount, if any, within 30 Days. ~~following the February 15th calculation. If the FUND's review of the Contractor's calculations indicates an adjustment to the calculation is required, then the FUND reserves the right in its sole discretion to make an adjustment to the Contractor's calculations. On July 31st following each Program Year, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. Based on this reconciliation, the NYSIF Program shall receive an adjustment, if necessary, within 30 Days following the date of the reconciliation.~~ The NYSIF Program shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discount off the aggregate AWP set forth in Section 11.8.3m for all Generic Drugs dispensed by Network and Mail

Service Pharmacies. Any shortfall in the Guaranteed Minimum Discount set forth in Section 11.8.3m cannot be recovered by the Contractor in subsequent years.

11.8.3m The Contractor shall use the following Ingredient Cost and dispensing fee to charge the NYSIF Program for each covered Generic Drug dispensed by Retail Network Pharmacies throughout the term of the Agreement subject to the Lesser of Logic process set forth in Section 11.6.0 of this Agreement.

11.8.3m(1) ***Ingredient Cost of Generic Drug dispensed at Retail Pharmacy:***

Pass-through Pricing based on either the Programs' MAC List or the Contractor's pharmacy contracted discount applied to the AWP of the dispensed Generic drug for Generic Drugs not assigned a MAC. (Pricing is subject to an overall annual minimum discount of (TBD)% off of the aggregate AWP and maximum annual dispensing fee of (TBD) for all Generic Drugs dispensed through Network Pharmacies.)

11.8.4 <u>Retail Pharmacy Network Compound Drug Pricing</u>

Compound Drugs must be classified consistent with the definition in Section 1.9.0 of this Agreement.

The Contractor shall:

11.8.4a Implement the pricing methodology for Compound Drugs as set forth in Section 11.8.4d below. The Contractor's retail Brand Drug dispensing fee and the NYSIF Programs' "Lesser of Logic" will apply;

11.8.4b Process Compound Drug claims in a manner that verifies the validity of the claim as a Compound Medication according to the NYSIF Programs' definition of a Compound Drug and provides appropriate claim level control procedures to protect the financial interests of the NYSIF Program;

11.8.4c Conduct due diligence as well as audit Network Pharmacies to ensure that drugs are being properly classified as Compound Drugs consistent with the NYSIF Programs' definition of a Compound Drug and to ensure that claims are priced in

accordance with the methodology for Compound Medications as set forth in Section 11.8.4d below; and,

11.8.4d The Contractor shall use the following methodology to charge the NYSIF Program for each Prescription for a covered Compound Drug/Medication dispensed by a Network Pharmacy throughout the term of the Agreement. The NYSIF Program shall be charged the lesser of the following:

11.8.4d(1) [Insert Contractor's proposed pricing methodology] or

11.8.4d(2) The Pharmacy Submitted Cost equaling the Total AWP of all ingredients in the Compound as submitted by the Pharmacy. (eg, AWP of NDC 1 plus AWP of NDC 2 plus AWP of NDC 3); OR

11.8.4d(3) The Pharmacy's Usual and Customary price as submitted by the Pharmacy less the dispensing fee plus the sales tax when applicable,

The NYSIF Program shall be charged the lowest Ingredient Cost derived through application of the above "Lesser of Logic" process plus the dispensing fee (when applicable).

11.9.0 <u>Mail Service Pharmacy Process Pricing – Brand Drugs, Generic Drugs, and Compound Drugs</u>

The Contractor shall:

11.9.1 Consistently enforce and administer all provisions of the NYSIF Program (including but not limited to mandatory generic substitution, drug utilization review, prior authorization, refill too-soon edits, etc.) to the claims dispensed through the Mail Service Pharmacy Process, consistent with the processing of claims through the Retail Pharmacy Network process.

11.9.2 Charge the NYSIF Program for those drugs dispensed to the Claimant in original manufacturer packaging, based on the Contractor's source of AWP for the 11 digit NDC of the package size dispensed through the Mail Service Pharmacy Process, subject to MAC pricing for Generic Drugs. If the drug is not dispensed to the Claimant in original manufacturer packaging (i.e., dispensed from bulk), the NYSIF Program shall be charged

based on the Contractor's source of AWP for the 11 digit NDC of the package size from which the drug was originally dispensed by the Mail Service Pharmacy Process Facility, subject to MAC pricing for Generic Drugs. If the drug is dispensed from a bulk package size for which no AWP is reported in the Contractor's AWP source, the NYSIF Program shall be charged based on the reported AWP for the NDC of the largest package size contained in the Contractor's AWP source, subject to MAC pricing for Generic Drugs. The NYSIF Program shall not be charged based on an NDC assigned to repackaged drugs or based on package sizes prepared by special arrangement with the original manufacturer unless such packaging offers a net savings to the NYSIF Program.

11.9.3 Charge the NYSIF Program based on the Contractor's pricing terms and dispensing fees applicable to brand, generic, and Compound Drug claims as set forth in 11.9.4, 11.9.5, and 11.9.6 for all Prescriptions submitted through the Mail Service Pharmacy Process. The NYSIF Program's Lesser of Logic shall be applied.

11.9.4 Mail Service Pharmacy Process - Brand Drug Pricing

The Contractor shall:

11.9.4a Classify Brand Drugs consistent with the definition in Section 1.3.0 of this Agreement as well as the methodology outlined in Section 11.3.0 of this Agreement.

11.9.4b Implement its fixed contracted Guaranteed Discount off of Average Wholesale Price (AWP) as set forth below in Section 11.9.4c, that shall be utilized to determine the Ingredient Cost of the Prescription to charge the NYSIF Program. The Contractor's Guaranteed Discount shall be applicable to all individual Prescriptions for Brand Drugs dispensed to Claimants through the Mail Service Pharmacy Process.

11.9.4c The Contractor shall use the following Ingredient Cost and dispensing fee to charge the NYSIF Program for each Prescription for a covered Brand Drug dispensed through the Mail Service Pharmacy Process throughout the term of the Agreement.

Brand Drug: Ingredient Cost: (TBD)% off AWP

Dispensing Fee: (TBD)

11.9.5 Mail Service Pharmacy Process - Generic Drug Pricing

The Contractor shall:

11.9.5a Classify Generic Drugs consistent with the definition in Section 1.29.0 of this Agreement.

11.9.5b The Contractor shall use the following Ingredient Cost and dispensing fee to charge the NYSIF Program for each Prescription for a covered Generic Drug dispensed through the Mail Service Pharmacy Process throughout the term of the Agreement subject to the Lesser of Logic process set forth in Section 11.6.0 of this Agreement.

Ingredient Cost of Generic Drug dispensed at Mail Service Pharmacy: Pass-through Pricing based on either the Programs' MAC List or the fixed, contracted Mail Service Pharmacy Guaranteed Discount off the equivalent Brand Drug as set forth in Section 11.9.4c for the dispensing of Generic Drugs not assigned a MAC. (Pricing is subject to an overall annual minimum discount of (TBD)% off of the aggregate AWP for all Generic Drugs dispensed through the Mail Services Pharmacy.)

Dispensing Fee: $(TBD)

11.9.5c The Contractor must guarantee an overall minimum discount off the aggregate AWP for all Generic Drugs dispensed through the Mail Service Pharmacy, as set forth in 11.8.3 of this Agreement.

11.9.6 Mail Service Pharmacy Process - Compound Drug Pricing

The Contractor shall:

11.9.6a Classify Compound Drugs consistent with the definition in Section 1.9.0 of this Agreement;

11.9.6b Implement its Pass-through Pricing methodology for Compound Drugs as set forth below in Section 11.9.6e. The Contractor's retail Brand Drug dispensing fee and the NYSIF Program's Lesser of Logic will apply;

11.9.6c Process Compound Drug claims in a manner that verifies the validity of the claim as a Compound Medication according to the NYSIF Program's definition and provides appropriate claim level control procedures to protect the financial interests of the NYSIF Program;

11.9.6d Conduct due diligence to ensure that drugs are being properly classified as Compound Drugs consistent with the NYSIF Program's definition of a Compound Drug and to ensure that claims are priced in accordance with the methodology for Compound Medications as set forth below in Section 11.9.6e below; and,

11.9.6e The Contractor shall use the following methodology to charge the NYSIF Program for each Prescription for a covered Compound Drug/Medication dispensed by the Mail Service Pharmacy Process throughout the term of the Agreement. The Contractor shall charge the NYSIF Program the lesser of the following:

11.9.6e(1) [Insert Contractor's proposed pricing methodology] or

11.9.6e(2) The Pharmacy Submitted Cost equaling the Total AWP of all ingredients in the Compound as submitted by the Pharmacy. (eg, AWP of NDC 1 plus AWP of NDC 2 plus AWP of NDC 3); OR

11.9.6e(3) The Pharmacy's Usual and Customary price as submitted by the Pharmacy less the dispensing fee plus sales tax when applicable.

The NYSIF Program shall be charged the lowest Ingredient Cost derived through application of the above "Lesser of Logic" process plus the guaranteed dispensing fee (when applicable).

Dispensing Fee: $(TBD)

11.10.0 <u>Enrollee Submitted Claims</u>

11.10.1 The cost to the NYSIF Program for Prescriptions for which non-network pharmacies submit direct claims for reimbursement shall be charged to the NYSIF Program. State

Workers' Compensation Board laws and regulations, specifically, Section 440 of Chapter V, of Title 12 NYCRR (New York Codes Rules and Regulations).

11.10.2 The Contractor shall utilize the following methodology to charge the NYSIF Program:

11.10.2a Brand Drugs, including Specialty Drugs/Medications, must be charged to the NYSIF Program at the New York State Workers' Compensation Board rates, currently a twelve percent (12%) discount off of AWP, plus a $4 Dispensing Fee.

11.10.2b Generic Drugs, including Specialty Drugs/Medications, must be charged to the NYSIF Program at the New York State Workers' Compensation Board rates, currently a twenty percent (20%) discount off of AWP, plus a $5 Dispensing Fee.

11.11.0 <u>Dispensing Fee</u>

11.11.1 The Guaranteed Dispensing Fees and Maximum Guaranteed Dispensing Fees set forth in 11.11.3 of this Section must be guaranteed for the term of this Agreement.

11.11.2 No dispensing fee shall be charged to the NYSIF Program for any claim that is paid on the basis of the Pharmacy's Usual and Customary price.

11.11.3 The Contractor dispensing fee for Brand Drugs, Generic Drugs and Compound Drugs dispensed by Network Pharmacies shall be Pass-through Pricing, subject to an annual aggregate Maximum Guaranteed Dispensing fee set forth below. The Contractor's Guaranteed Dispensing fees for Brand Drugs, Generic Drugs and Compound Drugs dispensed by the Mail Service Pharmacy Process and the Designated Specialty Pharmacy are set forth below:

11.11.3a Network Retail Pharmacy Guaranteed Maximum Dispensing Fee:

$(TBD) Per Brand Drug
$(TBD) Per Generic Drug
$(TBD) Per Compound Drug

11.11.3b Mail Service Pharmacy Process Guaranteed Dispensing Fee:

$(TBD) Per Brand Drug

$(TBD) Per Generic Drug

$(TBD) Per Compound Drug

11.11.3c Designated Specialty Pharmacy dispensing fees may vary based on the specific NDC of the drug dispensed. Specialty Pharmacy Program dispensing fees are set forth in Exhibit V.D.

11.11.4 The Level of dispensing fees achieved as a result of Pass-through Pricing will be calculated utilizing the following formula:

Total Retail Network dispensing fees paid by the NYSIF Program on an annual basis divided by the number of Final Paid Claims at Retail Network Pharmacies for each of Generic, Brand and Compound claims.

11.11.5 If the overall aggregate dispensing fees paid, as calculated utilizing the formula set forth in Section 11.11.4 of this Agreement are more than the Guaranteed Maximum Dispensing Fee proposed for each of Brand, Generic and Compound claims at Retail Network Pharmacies, the Contractor shall reimburse the NYSIF Program the difference between the Dispensing fee the NYSIF Program was charged utilizing Pass-through Pricing and the Dispensing Fee the NYSIF Program would have been charged if the Guaranteed Maximum Dispensing Fee had been obtained. The Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the FUND on July 31st. If the FUND's review of the Contractor's calculations indicates an adjustment to the calculation is required, then the FUND reserves the right in their sole discretion to make an adjustment to the Contractor's calculations. Upon approval by the FUND, the Contractor shall pay/credit the Program the applicable amount, if any, within 30 (thirty) Days. ~~The NYSIF Program will be credited annually for this difference by February 15th.~~ The NYSIF Program shall retain the benefit of any cost savings in excess of the Guaranteed Maximum Dispensing Fees set forth in Section 11.11.3. Any shortfall in the Guaranteed Maximum Dispensing Fees set forth in Section 11.11.3 cannot be recovered by the Contractor in subsequent years.

11.12.0 Specialty Pharmacy Program Pricing

The Contractor shall:

11.12.1 Consistently enforce and administer all provisions of the NYSIF Program (including but not limited to mandatory generic substitution, drug utilization review, prior authorization, refill too-soon edits, etc.) to the claims dispensed through the Specialty Pharmacy Program, consistent with the processing of claims through the Retail and Mail Service Pharmacy Network processes.

11.12.2 Charge the Program for those drugs dispensed to the Claimant in original manufacturer packaging, based on the Contractor's source of AWP for the 11 digit NDC of the package size dispensed through the Specialty Pharmacy Program. If the drug is not dispensed to the Claimant in original manufacturer packaging (i.e., dispensed from bulk), the NYSIF Program shall be charged based on the Contractor's source of AWP for the 11 digit NDC of the package size from which the drug was originally dispensed by the Designated Specialty Pharmacy. If the drug is dispensed from a bulk package size for which no AWP is reported in the Contractor's AWP source, the NYSIF Program shall be charged based on the reported AWP for the NDC of the largest package size contained in the Contractor's AWP source. The NYSIF Program shall not be charged based on an NDC assigned to repackaged drugs or based on package sizes prepared by special arrangement with the original manufacturer unless such packaging offers a net savings to the NYSIF Program.

11.12.3 Charge the NYSIF Program based on the Contractor's pricing terms and dispensing fees applicable to brand and generic, Specialty Drug/Medication claims as set forth in Sections 11.12.4 through 11.12.7 for all Prescriptions submitted through the Specialty Pharmacy Program.

11.12.4 Classify Brand Drugs consistent with the definition in Section 1.3.0 of this Agreement as well as the methodology outlined in Section 11.3.0 of this Agreement.

11.12.5 Classify Generic Drugs consistent with the definition in Section 1.29.0 of this Agreement.

11.12.6 Subject to the terms of Section 11.2.2 as amended, implement its fixed contracted Guaranteed Discount off of Average Wholesale Price (AWP) of (TBD_% to determine the Ingredient Cost of the Prescription to charge the NYSIF Program. The Contractor's Guaranteed Discount shall be applicable to all individual Prescriptions for Brand Drugs and Generic Drugs dispensed to Claimants through the Specialty Pharmacy Program.

11.12.7 Act in the interests of the NYSIF Program when dispensing Generic Drugs through the Specialty Pharmacy Program by avoiding the dispensing of NDC's with higher AWPs unless market conditions exist making dispensing the more cost effective NDC impractical or impossible.

ARTICLE XII: 100% PHARMA REVENUE GUARANTEE

The Contractor is required to maximize savings to the NYSIF Program through negotiation of Pharma Revenue Agreements obtaining discounts or other consideration from manufacturers and passing through 100% of the value of the Pharma Revenue agreements to the NYSIF Program, including any consideration that would normally flow to the Contractor or Key Subcontractor(s) based on the NYSIF Program's utilization pursuant to the terms of those Pharma Revenue Agreements. In addition, all Pharma Revenue agreements with manufacturers and other entities applicable to the NYSIF Program must meet or exceed the Contractor's best existing Pharma Revenue agreements for all individual drugs ensuring that in no instance will the NYSIF Program receive less Pharma Revenue in any therapeutic class than other clients of the Contractor with a comparable benefit design and consistent preferred drug designations in the class provided the NYSIF Program's utilization of the drugs generating Pharma Revenue in the class is equal to or greater than those of other clients.

12.1.0 Negotiate Pharma Revenue agreements with manufacturers that maximize savings to the NYSIF Program, leveraging the significant enrollment of the NYSIF Program for each individual drug. The Contractor agrees that any Plan specific Pharma Revenue agreement shall derive total Pharma Revenue that meets or exceeds the Pharma Revenue derived from any other agreements the Contractor uses to administer its book of business for each individual drug.

12.2.0 Include the value of the guaranteed Pharma Revenue set forth in Section 12.9.7 as a credit in the development of Claims Administration Fees throughout the term of this Agreement.

12.3.0 Credit the NYSIF Program quarterly within 150 Days of the end of each quarter, the greater of 100% of the Pharma Revenue received or the minimum guaranteed amount set forth in Section 12.9.7.

12.4.0 Calculate and distribute Pharma Revenue to the NYSIF Program in a fully transparent and verifiable process. The Contractor agrees that all direct and indirect revenue arrangements with manufacturers, suppliers, or other vendors shall be disclosed and the revenue generated related or attributable to the NYSIF Program's utilization be credited to the NYSIF Program. The Contractor must agree that the records, methods and calculations utilized to total and distribute these amounts to the NYSIF Program are subject to audit by the FUND or other State auditors with authority under Article XVII and/or Appendices A & B of this Agreement. In addition, all agreements must be provided as necessary for the NYSIF Program to evaluate Preferred Drug List decisions including direct access to any manufacturer contracts in unredacted form, under which the NYSIF Program is entitled to derive Pharma Revenue pursuant to the terms of this Agreement.

12.5.0 Not enter into any agreement that has the effect of diverting, shortchanging, or trading off any form of Pharma Revenue that would otherwise be due the NYSIF Program for other consideration. There shall be no fees charged to the NYSIF Program or received from a manufacturer, separate from the Claims Administration Fee as described and authorized in this Agreement, by the Contractor for rebate or other Pharma Revenue administration. The Contractor agrees that it will not divert, shortchange, or trade off Pharma Revenue that would otherwise inure to the NYSIF Program's financial benefit for Claimant drug utilization in return for reduced drug acquisition costs or other monetary or non-monetary consideration from manufacturers.

12.6.0 Upon selection and as a condition of contract award and throughout the term of the Agreement, the contractor shall provide at the request of the State all information and documentation related to Pharma Revenue agreements, including but not limited to, full direct access by FUND staff or its agents to complete unredacted Pharma Revenue agreements pursuant to which the NYSIF Program derives Pharma Revenue**.**

12.7.0 Utilize manufacturer agreements for the NYSIF Program that meet or exceed the Contractor's best existing Pharma Revenue agreements for all individual drugs. If the Contractor's business model allows for more than one Pharma Revenue agreement with manufacturers, the Contractor agrees

that in no instance will the NYSIF Program receive less Pharma Revenue in any therapeutic class than other clients of the Contractor with a comparable benefit design and consistent preferred drug designations in the class provided the NYSIF Program's utilization of the drugs generating Pharma Revenue in the class is equal to or greater than those of other clients. The Contractor shall have a process satisfactory to the State to confirm compliance with this provision. The NYSIF Program shall receive a full pass-through of 100% of Pharma Revenue derived from any agreement with a pharmaceutical manufacturer. Where any Pharma Revenue contracts allow for higher Pharma Revenue for mail order claims, the Program will receive the full financial benefit of those higher rates receiving 100% of the Pharma Revenue derived from those agreements on mail order claims. If manufacturer agreements provide less Pharma Revenue for Mail Service Pharmacy or Specialty Pharmacy claims than retail claims for the same drug, the terms of the manufacturer agreement applicable to retail claims shall be applied to Program Mail Service Pharmacy and Specialty Pharmacy claims for purposes of calculating the amount of Pharma Revenue due the NYSIF Program.

12.8.0 Ensure the Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee, set forth in Section 12.9.7 is not contingent upon the NYSIF Program's participation in any of the Contractor's formulary management or intervention programs. Nor shall the Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee be contingent or dependent on the timing of any patent expirations and/or introduction of generic equivalent drugs, including but not limited to early and/or at risk Generic Drug launches. The NYSIF Program will review the guaranteed amount only in the event of legislative, regulatory, or judicial action excluding patent litigation not specific to the Contractor's business practices that serves to void existing Pharma Revenue agreements materially compromising the Contractor's ability to obtain contracted Pharma Revenue necessary to meet the Minimum Per Final Paid Claim Pharma Revenue Guarantee.

12.9.0 Calculate and perform an annual reconciliation of the Pharma Revenue credit to the Pharma Revenue earned. As part of this annual reconciliation the Contractor is required to:

12.9.1 Calculate the Pharma Revenue guarantee on all Final Paid Claims, incurred for the respective NYSIF Program Year. The Pharma Revenue guarantee shall be on the aggregate level, not separated for each therapeutic class.

12.9.2 Credit the NYSIF Program an amount calculated based on the following formula: if in any NYSIF Program Year, the Pharma Revenue realized and credited to the Program by the Contractor is less than the amount due the NYSIF Program as determined utilizing the minimum Pharma Revenue credit set forth in Section 12.9.7, the amount of the credit shall be equal to the difference between the reported Pharma Revenue credited to the NYSIF Program and the Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee set forth in Section 12.9.7.

12.9.3 Submit calculations and documentation supporting the amount of Pharma Revenue reported and credited to the NYSIF Program for FUND review and approval. The Contractor shall provide all information and documentation deemed necessary by the FUND to verify the NYSIF Program was credited with all Pharma Revenue due it under the terms of this Agreement.

12.9.4 If at the close of any NYSIF Program Year, the Pharma Revenue credited to the NYSIF Program is greater than the higher of the amount derived through application of the Pharma Revenue guarantee formula or the actual Pharma Revenue realized by the NYSIF Program, upon notice and verification by the FUND, the FUND shall pay the Contractor the difference between the amount previously credited and the higher of the minimum Pharma Revenue guaranteed amount, set forth in Section 12.9.7, or actual Pharma Revenue realized during the NYSIF Program Year.

12.9.5 If at the close of any NYSIF Program Year, the Pharma Revenue credited to the NYSIF Program is less than the actual Pharma Revenue realized by the NYSIF Program, the Contractor shall pay the NYSIF Program the difference between what was previously paid and the full amount due to the NYSIF Program in accordance with Article XIV, Payment/(Credits) to/from the Contractor, of this Agreement.

12.9.6 Include such reconciliations as part of the annual rebate report. The FUND requires the Contractor's minimum Pharma Revenue guarantee, set forth in Section 12.9.7, be credited to the claims on the annual financial settlement regardless of the amount of Pharma Revenue that has been received by the Contractor.

12.9.7 The Minimum Pharma Revenue amount due the NYSIF Program on an annual basis shall be calculated according to the formula: Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee multiplied by the number of Final Paid Claims incurred for the respective Plan Year. The Contractor's Minimum Per Final Paid Claim Pharma Revenue Guarantee based on claims incurred for the respective Plan Year is:

12.9.7a $(TBD) for the Plan Year 2014.

12.9.7b $(TBD) for the Plan Year 2015.

12.9.7c $(TBD) for the Plan Year 2016.

12.9.7d $(TBD) for the Plan Year 2017.

12.9.7e $(TBD) for the Plan Year 2018.

ARTICLE XIII: CLAIMS ADMINISTRATION FEE

13.1.0 The Claims Administration Fee is the fee that the Contractor charges the NYSIF Program for all administrative services provided by the Contractor. This includes the administration of the FUND's Prescription Drug Program, as may be modified from time to time. The Contractor guarantees that the Claims Administration Fee shall be $(TBD) per Final Paid Claim. The Contractor shall:

13.1.1 Agree that its Claims Administration Fee is binding for the entire term of this Agreement, unless agreed otherwise by both the State and the Contractor.

13.1.2 Implement any changes necessary to accommodate NYSIF Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State within sixty (60) Days of notice, or as soon as practicable.

13.1.3 Agree not to request a higher Claims Administration Fee, and the FUND will not consider any modification to the Claims Administration Fee, that is not based on a material change to the NYSIF Program requiring the Contractor to incur additional costs. The determination of what constitutes a material change is at the sole discretion of the FUND. Implementation of an alternate formulary or multiple formularies shall not constitute a material change and the Contractor agrees to implement, if required, all alternative formularies at the Claims Administration Fee set forth in Section 13.1.0.

13.1.4 Submit detailed documentation of additional costs, over and above existing management costs, with any request for an increase in the Claims Administration Fee resulting from a material change in the benefit structure of the NYSIF Program. The FUND reserves the right to request and the Contractor must agree to provide any additional information and documentation the FUND deems necessary to verify that the request for an additional Claims Administration Fee is warranted. The FUND's decision to modify the Claims Administration Fee to the extent necessary to compensate the Contractor for documented additional costs incurred shall be at the sole discretion of the State.

13.1.5 Implement all benefit designs as required by the FUND with or without final resolution of any request for a Claims Administration Fee adjustment. Refusal to implement changes will constitute a material breach of this Agreement and the FUND will seek compensation for all damages resulting.

13.1.6 Agree the Claims Administration Fee shall be payable only for Final Paid Claims and that the NYSIF Program will not pay an additional Fee(s) or other charge for any claim that is denied prior to processing or any claim that is subsequently voided, reversed, or otherwise modified.

ARTICLE XIV: Payments/(Credits) to/(from) the Contractor

14.1.0 The Contractor agrees to manage such financial transactions in accordance with the following:

14.1.1 The NYSIF Program will reimburse the Contractor for claim payments and associated Claims Administration Fees no sooner than two (2) Business Days and no later than five (5) Business Days after receipt of an accurate invoice, following each weekly claims processing cycle. The data file layout and file transmission protocol will be mutually agreed upon by the selected Contractor and the FUND during the implementation period.

(Amended April 4, 2012)

14.1.2 Any credit amounts due from the Contractor to the FUND for failure of the Contractor to meet the performance guarantees set forth in this Agreement shall be applied as a credit against the Claims Administration Fees charged separately to the NYSIF Program in the ~~next~~ first invoice(s) processed after the performance guarantee has been calculated and agreed to by the FUND.

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14.2.0 Upon final audit determination by the FUND, any audit liability amount assessed by the FUND shall be paid/credited to the NYSIF Program within thirty (30) Days of the date of final determination.

14.3.0 Drug litigation recoveries and settlements shall be paid to the NYSIF Program within fifteen (15) Days from the Contractor's receipt of such recoveries and settlements.

14.4.0 One hundred and fifty (150) Days after the end of the first quarter, the Contractor shall pay/credit the NYSIF Program the greater of (1) the actual Pharma Revenue received on behalf of the NYSIF Program or 2) the minimum Per Final Paid Claim Pharma Revenue Guarantee, set forth in Section 12.9.7, multiplied by the number of Final Paid Claims incurred for the first quarter.

14.4.1 For each subsequent quarter of the Plan Year the calculations must be performed on a cumulative NYSIF Program Year-to-Date basis utilizing the calculations stipulated in Section 12.9.7. The Contractor shall pay/credit the NYSIF Program the greater cumulative amount less the amount previously credited for the NYSIF Program Year.

14.4.2 The Contractor shall perform a reconciliation by May 31st of each year and the incremental Pharma Revenue amount shall be paid/credit to the Plan within thirty (30) Days of May 31st.

14.4.3 At the May 31st Pharma Revenue reconciliation, to the extent that any amount is owed by the Contractor, the Contractor shall pay/credit the Plan within thirty (30) Days after the Final Pharma Revenue reconciliation for the amount owed.

14.5.0 The FUND will pay the Claims Administration Fee on a monthly basis thirty (30) Days after receipt of an accurate invoice. Any credit amounts due from the Contractor to the FUND for failure to meet the performance guarantees set forth in the Agreement shall be applied as a credit against the Claims Administration Fee charged to the NYSIF Program.

14.6.0 This Agreement is not subject to Article XI-A of NYS Finance Law. The Contractor agrees that Program Services provided under the Agreement shall continue in full force and effect for a minimum of at least thirty (30) days beyond the payment due date as set forth in this Article

XIV. If after the thirty-fifth (35) calendar day after receipt of an accurate invoice and claims data file, as set forth in this Article XIV, the Contractor has not yet received payment from the State for said invoice, the Contractor may proceed under the Dispute Resolution provision in Appendix B and the Agreement shall remain in full force and effect until such final decision is made, unless the Parties can come to a mutual agreement, in which case, the Agreement shall also remain in full force and effect.

ARTICLE XV: REPORTS AND CLAIM FILES

15.1.0 Annual Reports

15.1.1 ***Rebate True-up File:*** The Contractor is required to transmit a computerized file via secure transfer containing a yearly true-up of rebate records in a format specified by NYSIF. The true-up rebate file must match all of the billing records provided by the Contractor in the weekly pharmacy billing files. The report is due one hundred fifty (150) Days after the end of the Calendar Year. Issue resolution timeframe: within 1 week of the original submission.

15.2.0 Quarterly Reports

15.2.1 ***Rebate File:*** The Contractor is required to transmit a computerized file via secure transfer containing prescription rebate information for all earned rebates in a format specified by NYSIF. The pharmacy rebate records in the Rebate File must match all prescriptions billed to NYSIF by the Contractor. The report is due one hundred fifty (150) Days after the end of the quarter. Issue resolution timeframe: within 1 week of the original submission.

15.3.0 Monthly Reports

15.3.1 ***Card Issuance File:*** The Contractor is required to submit a computerized file via secure transfer with the names of all NYSIF Claimants who have been issued a permanent ID card that is used when filing their injury-related prescriptions. The Contractor is required to submit this report in the current format specified by NYSIF in Exhibit B, the Requests for Proposals entitled “Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and New York State Insurance Fund Workers’

Compensation Prescription Drug Programs," of this Agreement unless otherwise specified by NYSIF. The report is due no later than fifteen (15) calendar Days after the end of the month being reported. Issue resolution timeframe: within 1 week of the original submission.

15.4.0 Weekly Reports

15.4.1 ***Established Claim Billing File:*** The Contractor must transmit a computerized file via secure transfer, as specified by the FUND, containing only those pharmacy bills that are in accordance with the defined FUND business rules for pharmacy bill submission and contains only those pharmacy bills that have been successfully matched to an established FUND claim. The report is due on the Monday following the week reported. Issue resolution timeframe: prior to the next scheduled submission;

15.4.2 ***Weekly Invoice:*** The Contractor must submit a weekly Vendor Invoice as follows:

15.4.2a Hard copy of the Vendor Invoice submitted to the FUND via USPS.

15.4.2b Electronic submission of the Vendor Invoice Details file supporting the charges on the Vendor Invoice.

15.4.2b(1) The Contractor must submit the Vendor Invoice Detail file in the form an ASCII text file. The purpose of the detailed invoice file is to provide the FUND with the information needed in order to programmatically reconcile the Vendor Invoice. The report is due on the Monday following the week reported. Issue resolution timeframe: within 1 week of the original submission;

15.4.3 ***Aging Bill Report File:*** The Contractor is required to submit a computerized pharmacy billing file via secure transfer with bills previously submitted in the Instant Enrollment/ "Short Fill" file that remain unmatched to an established NYSIF claim. In the event there are not records meeting the above criteria, an empty file should be transmitted. The report is due each Monday? Issue resolution timeframe: prior to the next scheduled submission.

15.5.0 Daily Reports

15.5.1 ***Short File Report File:*** The Contractor is required to submit a computerized file via secure transfer with pharmacy bills for those injured workers of NYSIF policy holders where the bill cannot be matched to an established NYSIF claim. The report is due within twenty four (24) hours following the Day reported. Issue resolution timeframe: prior to the next scheduled submission.

ARTICLE XVI: TRANSITION AND TERMINATION OF CONTRACT

16.1.0 The Contractor must commit to fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the NYSIF Program.

16.1.1 The Contractor must, within one hundred twenty (120) Days of the end of the Agreement, or within forty-five (45) Days of notification of termination, if the Agreement is terminated prior to the end of its term, provide the FUND with a detailed written plan for transition, which outlines, at a minimum, the tasks, milestones and deliverables associated with:

16.1.1a Transition of NYSIF Program data, including but not limited to a minimum of one year of historical Claimant data, detailed COB data, report formats, Mail Service Pharmacy, Specialty Pharmacy and retail scripts with available refills, prior authorization approved through dates, generic exceptions that have been entered into the adjudication system on behalf of the Claimant, as well as other data the successor organization may request and the FUND approves during implementation of the NYSIF Program in the format acceptable to the FUND. The transition of open refill prior authorization files should include but not be limited to the following:

16.1.1a(1) Providing a test file to the successor organization in advance of the implementation date to allow the new Contractor to address any potential formatting issues;

16.1.1a(2) Providing one or more pre-production files at least four (4) weeks prior to implementation that contains Claimant Prescription refill availability, one year of claims history and prior authorization and appeal approved through dates as specified by the FUND working in conjunction with the successor organization;

16.1.1a(3) Providing a second production file to the new contractor by the close of business January 2nd (or 2 days after this Agreement terminates) that contains all Claimant Prescription refill availability as specified by the FUND, working in conjunction with the selected successor contractor; and

16.1.1a(4) Providing a lag file seven (7) Days after the implementation date to capture any refills that may have been in process but not yet shipped at the Contractor's Mail Service and Designated Specialty Pharmacy(ies) after the end of the year.

16.1.2 Transition of Claimant information on all non-transferable compounds and controlled medications.

16.1.3 Within fifteen (15) Business Days from receipt of the Transition Plan, the FUND shall either approve the Transition Plan or notify the Contractor, in writing, of the changes required to the Transition Plan so as to make it acceptable to the FUND.

16.1.4 Within fifteen (15) Business Days from the Contractor's receipt of the required changes, the Contractor shall incorporate said changes into the Transition Plan and submit such revised Transition Plan to the FUND.

16.1.5 The Contractor shall be responsible for transitioning the NYSIF Program in accordance with the approved Transition Plan.

16.1.6 To ensure that the transition to a successor organization provides Claimant's with uninterrupted access to their Prescription drug benefits and associated customer services, and to enable the FUND to effectively manage the Agreement, the Contractor is required to provide the following Contractor related obligations and deliverables to the NYSIF Program through the final financial settlement of the Agreement:

16.1.6a Provide all Contractor provided services associated with claims incurred on or before the scheduled termination date of the Agreement, including but not limited to paying network claims, Mail Service Pharmacy claims, Specialty

Pharmacy claims, manual submit claims including but not limited to: Medicaid, VA , Skilled Nursing Facility claims, out of network claims, foreign claims, in-network claims, COB claims, Student Health Center Claims, and Medicare, reimbursing late filed claims if warranted, reimbursing customer credit balance accounts, resolution of Mail Service Pharmacy process and Specialty Pharmacy Process issues, continuing to provide updates on pending litigation and settlements and claims/rebate data for class action litigation that the Contractor or the AG has/may file on behalf of the NYSIF Program. In addition, the Contractor must continue to provide the FUND access to any online claims processing data and history and online reporting systems through the final settlement dates, unless the FUND notifies the Contractor that access may be ended at an earlier date;

16.1.6b Complete all required reports in Article XV "Reports and Claim Files";

16.1.6c Provide the NYSIF Program with sufficient staffing in order to address State audit requests and reports in a timely manner;

16.1.6d Agree to fully cooperate with all the FUND or OSC audits consistent with the requirements of Appendices A and B;

16.1.6e Perform timely reviews and responses to audit findings submitted by the FUND and the Comptroller's audit unit in accordance with the requirements set forth in Article XVII "Audit Authority";

16.1.6f Remit reimbursement due the NYSIF Program within fifteen (15) Days upon final audit determination consistent with the process specified in Article XVII "Audit Authority," Article XIV "Payments/(credits) to/(from) the Contactor" and Appendix B; and

16.1.7 The Contractor is required to receive and apply enrollment updates, keeping dedicated phone lines open with adequate available staffing to provide customer service at the same levels provided prior to termination of this contract, adjusting phone scripts, and transferring calls to a new vendor's lines.

16.1.8 The Contractor is required to transmit point of service messaging to their Retail Pharmacy Network upon the termination date of the Agreement instructing Pharmacists to submit NYSIF Program Claimant claims to the appropriate RXBIN, RXPCN, RXGRP or other claim identification information as specified by the FUND working in conjunction with the Contractor.

16.1.9 If the Contractor does not meet all of the Transition Plan requirements found in this Article, the Contractor **will permanently forfeit 100%** of all Claims Administrative Fees (prorated on a daily basis) from the due date of the Transition Plan requirements to the date the Transition Plan requirements are completed to the satisfaction of the FUND.

ARTICLE XVII: AUDIT AUTHORITY

In addition to the Audit Authority requirements specified in Appendices A and B to this Agreement, the following provisions shall apply:

17.1.0 The Contractor acknowledges that the FUND has the authority to conduct financial and performance audits of the Contractor's delivery of NYSIF Program services in accordance with the Agreement and any applicable State and federal statutory and regulatory authorities;

17.2.0 Such audit activity may include, but not necessarily be limited to, the following activities:

17.2.1 Review of the Contractor's activities and records relating to the documentation of its performance under this Agreement in areas such as determination of Claimant eligibility and application of various FUND program administrative features,

17.2.2 Comparison of the information in the Contractor's enrollment file to that on the enrollment reports issued to the Contractor by the FUND.

17.2.3 Assessment of the Contractor's information, utilization and demographic systems to the extent necessary to verify accuracy of data on the reports provided to the FUND in accordance with Article XV "Reports and Claim Files," of this Agreement.

17.3.0 The Contractor shall maintain and make available documentary evidence necessary to perform such reviews. Documentation maintained and made available by the Contractor may include, but

is not limited to, source documents, books of account, subsidiary records and supporting work papers, claim documentation, pertinent contracts, Key Subcontracts, provider agreements, and correspondence;

17.4.0 The Contractor shall make available for audit all data in its computerized files that is relevant to and subject to the Agreement. Such data may, at the FUND's discretion, be submitted to the FUND in machine-readable format, or the data may be extracted by the FUND, or by the Contractor under the direction of the FUND;

17.5.0 The Contractor shall, at the FUND's request, and in a time period specified by the FUND, search its files, retrieve information and records, and provide to the auditors such documentary evidence as they require. The Contractor shall make sufficient resources available for the efficient performance of audit procedures;

17.6.0 The Contractor shall comment on the contents of any audit report prepared by the FUND and transmit such comments in writing to the FUND within 30 days of receiving any audit report. The response will specifically address each audit recommendation. If the Contractor agrees with the recommendation, the response will include a work plan and timetable to implement the recommendation. If the Contractor disagrees with an audit recommendation, the response will give all details and reasons for such disagreement. Resolution of any disagreement as to the resolution of an audit recommendation shall be subject to the dispute resolution procedures set forth in Appendix B of this Agreement.

17.7.0 If the Contractor has an independent audit performed of the records relating to this Agreement, a certified copy of the audit report shall be provided to the FUND within ten (10) Days after receipt of such audit report by the Contractor.

17.8.0 The audit provisions contained herein shall in no way be construed to limit the audit authority or audit scope of the OSC as set forth in either Appendix A of this Agreement, Standard Clauses for All New York State Contracts, or Appendix B, Standard Clauses for All FUND Contracts.

ARTICLE XVIII: CONFIDENTIALITY

In addition to the Confidentiality requirements specified in Appendices A and B to this Agreement, the following provisions shall apply:

18.1.0 All claims and enrollment records relating to the Agreement are confidential and shall be used by the Contractor solely for the purpose of carrying out its obligations under the Agreement, for measuring the performance of the Contractor in accordance with the performance guarantees set forth in Article VII of this Agreement, and for providing the FUND with material and information as may be specified elsewhere in this Agreement;

18.2.0 Except as directed by a court of competent jurisdiction, or as necessary to comply with applicable New York State or Federal law, or with the written consent of the Claimant, no records may be otherwise used or released to any party other than the FUND by the Contractor, its officers, Employees, agents, consultants or Key Subcontractors either during the term of the Agreement or in perpetuity thereafter. Deliberate or repeated accidental breach of this provision may, at the sole discretion of the FUND, be grounds for termination of the Agreement;

18.3.0 The Contractor, its officers, Employees, agents, consultants and/or any Key Subcontractors agree to comply, during the performance of the Agreement, with all applicable Federal and State privacy, security and confidentiality statutes, including but not limited to the Personal Privacy Protection Law (New York Public Officer's Law Article 6-A, as amended), and its implementing regulations, policies and requirements, for all material and information obtained by the Contractor through its performance under the Agreement, with particular emphasis on such information relating to Claimants;

18.4.0 The Contractor shall be responsible for assuring that any Agreement between the Contractor and any of its officers, Employees, agents, consultants and/or Key Subcontractors contains a provision that strictly conforms to the various confidentiality provisions of this Agreement; and

18.5.0 The Contractor shall promptly advise the FUND of all requests made to the Contractor for information regarding the performance of services under this Agreement, including, but not limited to, requests for any material and information provided by the FUND except as required by Key Subcontractors or agents solely for the purpose of fulfilling the Contractor's obligations under this Agreement or as required by law.

ARTICLE XIX: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

19.1.0 For purposes of this Article, the term "Protected Health Information" ("PHI") means any information, including demographic information collected from an individual, that relates to the past, present, or future physical or mental health or condition of an individual, to the provision of health care to an individual, or to the past, present, or future payment for the provision of health care to an individual, that identifies the individual, or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. Within the context of this Agreement, PHI may be received by the Contractor from the FUND or may be created or received by the Contractor on behalf of the FUND. All PHI received or created by the Contractor as a consequence of its performance under this Agreement is referred to herein collectively as "FUND's PHI."

19.2.0 The Contractor acknowledges that the FUND administers a Workers' Compensation Prescription Drug Program that term is defined in HIPAA's implementing regulations at 45 CFR Parts 160 and 164, and that each of those group health plans consequently is a "covered entity" under HIPAA. These group health plans include NYSHIP, which encompasses The Empire Plan as well as participating health maintenance organizations; the Dental Plan, and the Vision Plan. In this capacity, the Department is responsible for the administration of these "covered entities" under HIPAA. The Contractor further acknowledges that the Department has designated NYSHIP and The Empire Plan as an Organized Health Care Arrangement (OHCA), respectively. The Contractor further acknowledges that the Contractor is a HIPAA "business associate" of the Department as a consequence of the Contractor's provision of services to and/or on behalf of the Department within the context of the Contractor's performance under this Agreement, and that the Contractor's provision of such services may involve the disclosure to the Contractor of individually identifiable health information from the Department or from other parties on behalf of the Department, and also may involve the Contractor's disclosure to the Department of individually identifiable health information as a consequence of the services performed under this Agreement.

19.3.0 ***Permitted Uses and Disclosures of the Department's PHI*:** The Contractor may use and/or disclose the FUND's PHI solely in accordance with the terms of this Agreement. In addition, the Contractor may use the FUND's PHI to provide data aggregation services relating to the health care operations of the FUND. Further, the Contractor may use and disclose the FUND's PHI for the proper management and administration of the Contractor if such use is necessary for the

Contractor's proper management and administration or to carry out the Contractor's legal responsibilities, or if such disclosure is required by law or the Contractor obtains reasonable assurances from the person to whom the information is disclosed that it shall be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Contractor of any instances of which it is aware in which the confidentiality of the information has been breached.

19.4.0 ***Nondisclosure of the Department's PHI*:** The Contractor shall not use or further disclose the FUND's PHI otherwise than as permitted or required by this Agreement or as otherwise required by law. The Contractor shall limit its uses and disclosures of PHI when practical to the information comprising a Limited Data Set, and in all other cases to the minimum necessary to accomplish the intended purpose of the PHI's access, use, or disclosure.

19.5.0 ***Safeguards:*** The Contractor shall use appropriate, documented safeguards to prevent the use or disclosure of the Department's PHI otherwise than as provided for by this Agreement. The Contractor shall maintain a comprehensive written information security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities, to reasonably and appropriately protect the confidentiality, integrity and availability of any electronic PHI that it creates, receives, maintains, or that it transmits on behalf of the FUND pursuant to this Agreement.

19.6.0 ***Breach Notification:***

19.6.1 ***Reporting:*** The Contractor shall report to the FUND any breach of unsecured PHI, including any use or disclosure of the FUND's PHI otherwise than as provided for by this Agreement, of which the Contractor becomes aware. Further, the Contractor shall report to the FUND any security incident of which it becomes aware. "Security incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations in an information system. The Contractor shall notify the FUND within five (5) business days of the date the Contractor becomes aware of the event.

19.6.2 ***Required Information:*** The Contractor shall provide the following information to the FUND within ten (10) business days of discovery except when, despite all reasonable efforts by the Contractor to obtain the information required, circumstances beyond the control of

the Contractor necessitate additional time. Under such circumstances, the Contractor shall provide to the FUND with the following information as soon as possible and without unreasonable delay, but in no event later than thirty (30) Days from the date of discovery:

19.6.2a the date of the breach incident;

19.6.2b the date of the discovery of the breach;

19.6.2c a brief description of what happened;

19.6.2d a description of the types of unsecured PHI that were involved;

19.6.2e identification of each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed during the breach;

19.6.2f a brief description of what the Contractor is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches; and

19.6.2g any other details necessary to complete an assessment of the risk of harm to the individual.

19.6.3 The FUND will be responsible to provide notification to individuals whose unsecured PHI has been or is reasonably believed to have been accessed, acquired or disclosed as a result of a breach, as well as the Secretary and the media, as required by 45 CFR Part 164.

19.6.4 The Contractor shall maintain procedures to sufficiently investigate the breach, mitigate losses, and protect against any future breaches, and to provide a description of these procedures and the specific findings of the investigation to the FUND upon request.

19.6.5 For purposes of this Agreement, "Unsuccessful Security Incidents" include activity such as pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above, so long as no such incident results in unauthorized access, use, or disclosure of electronic PHI.

19.6.6 The Contractor shall mitigate, to the extent practicable, any harmful effects from any use or disclosure of PHI by the Contractor not permitted by this Agreement.

19.7.0 ***Associate's Agents:*** The Contractor shall require all of its agents or Key Subcontractors to whom it provides the FUND's PHI, whether received from the FUND or created or received by the

Contractor on behalf of the FUND, agree to the same restrictions and conditions on the access, use, and disclosure of PHI that apply to the Contractor with respect to the FUND's PHI under this Agreement.

19.8.0 ***Availability of Information to the Department:*** The Contractor shall make available to the FUND such information and documentation as the FUND may require regarding any disclosures of PHI by the Contractor to fulfill the FUND's obligations to provide access to, to provide a copy of, and to account for disclosures of the FUNDS's PHI in accordance with HIPAA and its implementing regulations. The Contractor shall provide such information and documentation within a reasonable amount of time of its receipt of the request from the FUND.

19.9.0 ***Amendment of the Department's PHI:*** The Contractor shall make the FUND's PHI available to the FUND as the FUND may require to fulfill the FUNDS's obligations to amend individuals' PHI pursuant to HIPAA and its implementing regulations. The Contractor shall, as directed by the FUND, incorporate any amendments to the FUNDS's PHI into copies of the FUND's PHI as maintained by the Contractor.

19.10.0 ***Internal Practices*****:** The Contractor shall make its internal practices, policies and procedures, books, records, and agreements relating to the use and disclosure of the FUNDS's PHI, whether received from the FUND or created or received by the Contractor on behalf of the FUND, available to the FUND and/or the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by the FUND and/or the Secretary for purposes of determining the FUND's compliance with HIPAA and its implementing regulations.

19.11.0 ***Termination:***

19.11.1 This Agreement may be terminated by the FUND at the FUNDS's discretion if the FUND determines that the Contractor, as a business associate, has violated a material term of this Article or of the Agreement with respect to the Contractor's obligations under this Article.

19.11.2 ***Disposition of the Department's PHI:*** At the time this Agreement is terminated, the Contractor shall, if feasible, return or destroy all of the FUND's PHI, whether received from the FUND or created or received by the Contractor on behalf of the FUND, that the Contractor still maintains in any form and retain no copies of such information.

Alternatively, if such return or destruction is not feasible, the Contractor shall extend indefinitely the protections of this Agreement to the information and shall limit further uses and disclosures to those purposes that make the return or destruction of the FUND's PHI infeasible.

19.12.0 ***Indemnification:*** The Contractor agrees to indemnify, defend and hold harmless the State and the FUND and its respective employees, officers, agents or other members of its workforce (each of the foregoing hereinafter referred to as "Indemnified Party") against all actual and direct losses suffered by the Indemnified Party and all liability to third parties arising from or in connection with any breach of this Agreement or from any acts or omissions related to this Agreement by the Contractor or its employees, officers, Key Subcontractors, agents or other members of its workforce. Accordingly, the Contractor shall reimburse any Indemnified Party for any and all actual and direct losses, liabilities, lost profits, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be imposed upon any Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party which results from the Contractor's acts or omissions hereunder. The Contractor's obligation to indemnify any Indemnified Party shall survive the expiration or termination of this Agreement.

19.13.0 ***Miscellaneous:***

19.13.1 ***Amendments*****:** This Agreement may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed by authorized representatives of the Parties. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary to achieve and maintain compliance with the requirements of the Regulations.

19.13.2 ***Survival*****:** The respective rights and obligations of Business Associate and Covered Entity under HIPAA as set forth in this Business Associate Agreement shall survive termination of this Agreement.

19.13.3 ***Regulatory References*****:** Any reference herein to a federal regulatory section within the Code of Federal Regulations shall be a reference to such section as it may be subsequently updated, amended or modified.

19.13.4 ***Interpretation*:** Any ambiguity in this Agreement shall be resolved to permit covered entities to comply with HIPAA.

ARTICLE XX: NOTICES

20.1.0 All notices permitted or required hereunder shall be in writing and shall be transmitted either:

20.1.1 via certified or registered United States mail, return receipt requested;

20.1.2 by facsimile transmission;

20.1.3 by personal delivery;

20.1.4 by expedited delivery service; or

20.1.5 by e-mail.

Such notices shall be addressed as follows or to such different addresses as the parties may from time-to-time designate:

State of New York [Agency Name]

Name:
Title:
Address:
Telephone Number:
Facsimile Number:
E-Mail Address:

[Contractor Name]

Name:
Title:
Address:
Telephone Number:
Facsimile Number:
E-Mail Address:

20.2.0 Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or email, upon receipt.

20.3.0 The parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this Agreement by giving fifteen (15) days written notice to the other party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representatives for the purposes of receiving notices

under this Agreement. Additional individuals may be designated in writing by the parties for purposes of implementation and administration/billing, resolving issues and problems and/or for dispute resolution.

Contractor: _____

Contract Number: _____

Agency Certification: "In addition to the acceptance of this contract, I also certify that original copies of this signature page shall be attached to all other exact copies of this contract."

NEW YORK STATE INSURANCE FUND

Date: _____ By: _____

Name: XXXXXXXXXXXX

Title: _____

SELECTED CONTRACTOR

Date: _____ By: _____

Name: _____

Title: _____

STATE OF)
) ss:
COUNTY OF)

On the _____ day of _____, _____, before me personally came _____, to me known, and known to me to be the person who executed the above instrument, who, being duly sworn by me, did for her/himself depose and say that (s)he is the _____ of _____ the corporation or organization described in and which executed the above instrument; and that (s)he signed his/her name thereto.

My commission expires: _____ _____

NOTARY PUBLIC

Approved as to Form:

ERIC SCHNEIDERMAN
ATTORNEY GENERAL

By: _____

Date: _____

Approved:

THOMAS P. DINAPOLI
COMPTROLLER

By: _____

Date: _____

SECTION VIII: GLOSSARY OF TERMS

Affiliate means a person or organization which, through stock ownership or any other affiliation, directly, indirectly, or constructively controls another person or organization, is controlled by another person or organization, or is, along with another person or organization, under the control of a common parent.

Ancillary Charge means the amount in addition to the applicable Copayment an Enrollee/Dependent will pay when purchasing a Brand Drug if an A-rated or authorized generic equivalent is available in the market. The amount represents the difference to the Program between the Discounted Ingredient Cost of the dispensed Brand Drug and the Discounted Ingredient Cost of the available generic equivalent if it had been dispensed, not to exceed the actual cost of the drug.

AWP means the [source identified in Offeror's Proposal] AWP Price for the eleven (11) digit NDC of the drug dispensed as of the date the Prescription was filled, unless the Parties mutually agree in writing to utilize a different source for AWP information.

Brand Drug means a Prescription drug sold under a trade name other than its chemical name that is manufactured and marketed by a single manufacturer (or single group of manufacturers pursuant to agreement among the manufacturers) where the manufacturer holds or held a patent protecting the active ingredient from generic competition. For The Empire Plan, SEHP, and the NYSIF's Pharmacy Benefits Management Program, the Contractor shall utilize the Procuring Agencies approved process to replicate the results of the methodology used by the Program as of January 1, 2012 for determining the appropriate classification of drugs consistent with this definition. The Excelsior Plan will utilize the Contractor's book of business PDL classification and tier placement for generic and brand name medications.

Brand For Generic means an additional feature of the Enhanced Flexible Formulary which allows a Brand-Name drug to be placed on the lowest copayment level and the new generic equivalent to be placed on the highest copayment level, or excluded, when advantageous to the DCS Program.

Business Day(s) means every Monday through Friday, except for days designated as Business Holidays.

Business Holiday(s) means days designated by the Contractor as business holidays and approved as such by the State prior to January 1 of each Calendar Year.

Calendar Year/Annual means a period of 12 months beginning with January 1 and ending with December 31.

Call Center Hours means 24 hours a Day, 365 days a year.

Child(ren) means children under 26 years of age, including natural children, legally adopted children, children in a waiting period prior to finalization of adoption, Enrollee stepchildren and children of the Enrollee's domestic partner. Other children who reside permanently with the Enrollee in the Enrollee's household and are chiefly dependent on the Enrollee are also eligible, subject to a Statement of Dependence and documentation.

Claimant means an injured employee who sustains an at-injury accident (loss) while in the employ of individuals or companies that have workers' compensation insurance policies with NYSIF.

Compound Drug(s)/Medication(s) or Compounded Drug(s)/Medication(s) means a drug with two or more ingredients (solid, semi-solid or liquid), at least one of which is a Covered Drug with a valid NDC requiring a Prescription for dispensing, combined together in a method specified in a Prescription issued by a medical professional. The end result of this combination must be a Prescription medication for a specific patient that is not otherwise commercially available in that form or dose/strength from a single manufacturer. The Prescription must identify the multiple ingredients in the Compound, including active ingredient(s), diluents(s), ratios or amounts of product, therapeutic use, and directions for use. The act of compounding must be performed or supervised by a licensed Pharmacist. Any commercially available product with a unique assigned NDC requiring reconstitution or mixing according to the FDA approved package insert prior to dispensing will not be considered a Compound Prescription by the Program.

Contractor means the successful Offeror selected as a result of the evaluation of Offerors' Proposals submitted in response to this RFP and who executes an Agreement with the Department to provide Program Services.

Controlled Drug means drugs designated by Federal Law or New York State law as a Class I, II, III, IV, or V substance. A Controlled Drug includes but is not limited to: some tranquilizers, stimulants, and pain medications.

Copayment (DCS only) means the amount the Enrollee/Dependent is required to pay for Covered Generic, Preferred and Non-Preferred Brand Drugs as specified by the benefit design of the Program. The actual payment amount required from the Enrollee/Dependent for a Prescription may not exceed the Ingredient Cost of the drug to the Plan after application of the Program's Lesser of Logic provision plus the applicable dispensing fee.

Covered Drug(s) DCS Program: means medically necessary Prescription drugs as defined in the Summary Plan Description, subject to all limitations and exclusions set forth therein. NYSIF Program: means medically necessary and appropriate drugs that are causally related to the loss.

Day(s) means calendar days unless otherwise noted.

DCS or Department means the New York State Department of Civil Service.

DCS Program(s)/Plan means the New York State Health Insurance Program's Empire Plan Prescription Drug Program, the Excelsior Plan Prescription Drug Program and Student Employee Health Program (SEHP) Prescription Drug Program.

Dedicated Call Center means a group of Customer Service Representatives trained and capable of responding to a wide range of questions, complaints, and inquiries specific to the Programs. The Customer Service Representatives are dedicated to the Programs and do not work on any other accounts.

Dependent means the spouses, domestic partners, and children under twenty-six (26) years of age of an Enrollee. Young adult dependent children age twenty-six (26) or over are also eligible if they are incapable of supporting themselves due to mental or physical disability acquired before termination of their eligibility for coverage under the DCS Program.

Dependent Survivor means the unremarried spouse, dependent child, or domestic partner who has not acquired another domestic partner, of an Enrollee who died after having had at least ten (10) years of service, who were covered as dependents of the deceased Enrollee at the time of the Enrollee's death and who elect to continue coverage under NYSHIP following the three (3) month extended benefits period.

Designated Specialty Pharmacy means all facilities owned, operated, subcontracted or otherwise affiliated with the Contractor or any Key Subcontractor of the Contractor to provide certain Specialty Drugs/Medications. All facilities must meet all legal and contractual requirements as set forth in the Agreements.

Designated Specialty Pharmacy Hard Edit means a Network Pharmacy claims adjudication edit that will result in denial of the claim for a Specialty Drug/Medication under the Specialty Pharmacy Process after the Grace Period for Specialty Drugs has elapsed.

Designated Specialty Pharmacy Passive Edit means a Network Pharmacy claims adjudication edit that will prompt processing of the claim at the Designated Specialty Pharmacy but will permit continued processing and coverage for a Specialty Drug/Medication at the Network Pharmacy under the Specialty Pharmacy Process after the Grace Period for Specialty Drugs has elapsed.

Disabled Lives Benefit means the benefits provided to an Enrollee/Dependent who is Totally Disabled on the date coverage ends. The benefits are provided on the same basis as if coverage had continued with no change until the day the Enrollee/Dependent is no longer Totally Disabled or for ninety (90) days after the date the coverage ended, whichever is earlier.

Discounted Ingredient Cost(s) means the cost to the Plan for a specific drug or drugs dispensed to an Enrollee/Claimant after the Contractor has applied the appropriate discount exclusive of any associated dispensing fee(s), sales tax, or Copayments.

Employee means “Employee” as defined in 4 NYCRR Part 73, as amended, or as modified by collective bargaining agreement.

Employer means “Employer” as defined in 4 NYCRR Part 73, as amended.

Employer Group Waiver Plan (EGWP) means a Medicare Part D program in which the Contractor contracts with the Center for Medicare and Medicaid Services directly to provide prescription drug benefits, replicating the current Empire Plan prescription drug benefit structure, for Medicare primary Enrollee/Dependents.

Enhanced Flexible Formulary means a Flexible Formulary Drug List which includes the ability to place drugs on the appropriate Copayment level based on their economic and therapeutic value, including placement of Brand Drugs on the lowest Copayment level and to exclude Generic Drugs or place them on a higher Copayment level.

Enrollee/Claimant means an "Employee" or "Dependent" enrolled in the Program with prescription drug benefits, or an injured employee who sustains an at-injury accident (loss) while in the employ of individuals or companies that have workers' compensation insurance policies with NYSIF.

Enrollee Submitted Claim(s) or Subscriber Claims means a claim for benefits submitted by an Enrollee to the Contractor for direct reimbursement.

ET means prevailing Eastern Time.

Final Paid Claim means a claim processed and paid by the Contractor for a Prescription drug provided to an Enrollee/Claimant, including but not limited to, claims for Prescriptions filled at a Retail Pharmacy or through the Mail Service Pharmacy Process or the Specialty Pharmacy Process. A claim that is denied prior to processing is not considered a Final Paid Claim. In addition, a claim that is processed and paid but is subsequently voided, reversed, or otherwise adjusted is not a Final Paid Claim. Zero balance claims are considered Final Paid Claims.

First Fill means an Enrollee/Claimant's initial or very first dispensing of a Specialty Drug/Medication covered under the Program's Specialty Pharmacy Program.

Flexible Formulary Drug List means a Preferred Drug List in which Brand Drugs may be assigned to different copayment levels based on value to the Program and clinical judgment. In some cases, drugs may be excluded from coverage if a Therapeutic Equivalent or Over-The-Counter Drug is available.

GCN means Generic Code Number as assigned by First Data Bank.

Generic Drug means a prescription drug sold under its chemical name or drug sold under a name other than its chemical name by a manufacturer other than the manufacturer that held the original patent for the active ingredient in the drug. The term Generic Drug shall include "authorized generics" marketed by or in conjunction with the manufacturer that is the holder of the original patent for the active ingredient of the drug. Any drug approved through an FDA Generic Drug approval process, including any FDA approval process established for approving generic equivalents of biologic drugs shall be classified as a Generic Drug. For The Empire Plan, SEHP, and NYSIF's Pharmacy Benefits Management Program, the Contractor shall utilize a Procuring Agencies approved process to replicate the results of the methodology used by the Program as of January 1, 2012, for determining the appropriate classification of drugs. The Excelsior Plan will utilize the Contractor's book of business PDL classification and tier placement for generic and brand name medications.

Grace Period means a period of time, representing 30 Days.

Grace Period for Specialty Drugs means the period of time during which Enrollees/Claimants may receive one fill of a Specialty Drug/Medication at a Pharmacy other than the Designated Specialty Pharmacy.

Guaranteed Discount(s) means the Contractor's fixed, contracted, guaranteed Ingredient Cost discounts for Brand Drugs expressed as a percent off of AWP dispensed through the Mail Service Pharmacy Process. For Specialty Drug/Medications dispensed through the Specialty Pharmacy Process, Guaranteed Discounts means the Contractor's fixed, contracted, guaranteed Ingredient Cost discounts for Brand and Generic Drugs expressed as a percent off of AWP.

Guaranteed Maximum Dispensing Fee(s) represents the quoted dispensing fee(s) the Contractor guarantees that the actual average dispensing fee assessed under Pass Thru Pricing will not exceed. This Guaranteed Maximum Dispensing Fee(s) is applicable to the Program for Generic, Brand and Compound Drugs, calculated separately, for prescriptions dispensed by Retail Network Pharmacies.

Guaranteed Minimum Discount(s) means the guaranteed Ingredient Cost discount(s) as expressed as a percent off of the aggregate AWP and is applicable to Generic and Brand Drugs separately, dispensed through the Retail Pharmacy Network as well as Generic Drugs dispensed through the Mail Service Pharmacy Process.

Hard Edit means a Network Pharmacy claims adjudication edit that will result in denial of the claim.

Ingredient Cost(s) means the cost to the Programs for a specific drug, or drugs dispensed to an Enrollee/Claimant exclusive of any associated dispensing fee(s), other costs, or Copayments through application of the Programs' Lesser of Logic.

Instant Enrollment/Short Fill Service means allowing Claimants covered by NYSIF immediate acceptance by any pharmacy in the Contractor's network in order to provide a limited number of cost-effective medications.

Key Subcontractor means those vendors with whom the Contractor subcontracts to provide Program Services and incorporates as a part of the Contractor's Project Team.

Lesser of Logic means the methodology for charging the Program for Prescriptions. Retail Generic Prescriptions assigned a MAC price shall be charged to the Programs at the following Lesser of Logic: the lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee; the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is Usual and Customary); the AWP Discounted Ingredient Cost contracted with the Network Pharmacy plus dispensing fee; the Maximum Allowable Cost plus dispensing fee; or the WCB Fee Schedule (NYSIF Program only). Retail Brand Prescriptions and Generic Prescriptions that are not assigned a MAC price shall be charged to the Plan at the following Lesser of Logic: the lowest of the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is usual and customary); the AWP Discounted Ingredient Cost contracted with the Network Pharmacy plus dispensing fee; the Pharmacy-submitted Ingredient Cost plus dispensing fee, or the WCB Fee Schedule (NYSIF Program only). Mail Service Pharmacy Generic Prescriptions shall be charged to the Plan at the following Lesser of Logic: the lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee; the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is Usual and Customary; the Minimum Guaranteed Discounted Ingredient Cost off of AWP pertaining Mail Service Pharmacy Brand prescriptions for those Mail Service Generic prescription not assigned a MAC plus dispensing; the Maximum Allowable Cost for Chain/Mail Pharmacy plus dispensing fee; or the WCB Fee Schedule (NYSIF Program only). Mail Service Pharmacy Brand and Specialty Pharmacy Brand and Generic Prescriptions shall be charged to the Plan at the following Lesser of Logic: the lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee; the Pharmacy's Usual and Customary

Price (no dispensing fee is to be paid on claims when the pricing basis is usual and customary); the Guaranteed Discounted Ingredient Cost off of AWP plus dispensing fee; or the WCB Fee Schedule (NYSIF Program only). Once the Lesser of Logic has been applied, the pricing methodology resulting in the lowest claim cost to the Plan is determined, and to that amount any applicable sales tax is added and the applicable Copayment and any ancillary fee resulting from application of the Program's Mandatory Generic Substitution provisions are deducted.

(Amended April 4, 2012)

Limited Distribution Drug means a Specialty Drug/Medication whose distribution is limited by the manufacturer to select Pharmacies and as a result of this restriction is not available to be dispensed from the Designated Specialty Pharmacy and/or Mail Service Pharmacy.

Mail Service Pharmacy Process means the method that the Contractor employs to accept, process, and dispense Prescriptions for Covered Drugs to Enrollees/Claimants through the mail or other home delivery service, excluding any drug eligible under the Specialty Pharmacy Process. For those employee groups not participating in the Specialty Pharmacy Process, the Mail Service Pharmacy Process means the method that the Contractor employs to accept, process, and dispense Prescriptions for Covered Drugs to Enrollees/Claimants through the mail or other home delivery service including any drug that could be classified as a Specialty Drug/Medication, or that require special preparation or handling, using one or more Mail Service Pharmacy Process Facilities or other entities approved as distribution channels for dispensing Limited Distribution Drugs to Enrollees/Claimants through the Mail Service Pharmacy Process. Prescriptions are considered to be submitted through the Mail Service Pharmacy Process if they are submitted by phone, fax, internet, e-prescribing or mail to any Mail Service Pharmacy Process Facility. All Prescriptions filled through the Mail Service Pharmacy Process shall be processed in strict accordance with the provisions of the Agreement including all pricing provisions related to the Mail Service Pharmacy Process. Prescriptions dispensed through the Retail Pharmacy Network and delivered to the Enrollee/Claimant through the mail shall not be considered to have been filled through the Mail Service Pharmacy Process provided the Enrollee/Claimant or his/her Physician presented the Prescription directly to the dispensing Network Pharmacy. The Contractor or its Key Subcontractor will not refer an Enrollee/Claimant or his/her Physician to a retail Pharmacy without also making the Enrollee/Claimant aware of the Mail Service Pharmacy Process.

Mail Service Pharmacy Process Facility(ies) means all facilities owned, operated, subcontracted or otherwise affiliated with the Contractor or any Key Subcontractor of the Contractor capable of being utilized by the Contractor in the Mail Service Pharmacy Process, including any mail service intake facility. For those employee groups participating in the Specialty Pharmacy Process, the Designated Specialty Pharmacy is not considered a Mail Service Pharmacy Process Facility. All facilities must meet all legal and contractual requirements.

Maximum Allowable Cost means the maximum price the Programs shall be charged and the dispensing retail Network Pharmacy shall be paid on a pass through basis for the Ingredient Cost of a drug required to be included on the Program's MAC List managed by the Contractor.

Medically Necessary Drug means any drug which, as determined by the Contractor, is: (i) provided for the diagnosis or treatment of a medical condition; (ii) appropriate for the symptoms, diagnosis or treatment of a medical condition; (iii) within the standards of generally accepted health care practice; and (iv) not used for cosmetic purposes.

Medical Professional(s) means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) licensed without limitation or restriction to practice medicine. For benefits provided in the Program, and for no other purpose, Physician also means a Doctor of Dental Surgery (D.D.S.), a Doctor of Dental Medicine (D.D.M), a Podiatrist and any other health care professional licensed to prescribe medication, when he or she is acting within the scope of his or her license.

Narrow Therapeutic Index (NTI) Drugs means a drug that small variances in blood levels can cause changes in the effectiveness or toxicity of that drug.

NDC means the National Drug Code number assigned to a pharmaceutical product obtained by the manufacturer of the product through a U.S. Food and Drug Administration administered process.

Network Pharmacy means a Pharmacy, other than those Pharmacies meeting the definition of Mail Service Pharmacy Process Facilities or a Designated Specialty Pharmacy, which has entered into an agreement with the Contractor, or any Affiliate of the Contractor or Key Subcontractor or any Key Subcontractor of the Contractor, to provide Covered Drugs to Enrollees/Claimants, including limited distribution or Specialty Drugs. The Contractor's records shall be conclusive as to whether a Pharmacy has a Network Pharmacy agreement in effect on the date a drug is dispensed.

Non-Network Pharmacy means any Pharmacy, other than a Network Pharmacy, a Mail Service Pharmacy Process Facility or a Designated Specialty Pharmacy, which has not entered into an agreement with the Contractor, or any Affiliate of the Contractor or a Key Subcontractor or any Key Subcontractor of the Contractor, to provide Covered Drugs to Enrollees/Claimants. The DCS Programs have no obligation to pay the Pharmacy; the Enrollee must file a claim form with the Contractor in order to receive reimbursement for Covered Drugs dispensed by a Non-Network Pharmacy.

Non-Preferred Drug means an FDA approved prescription drug that is covered by the Program in accordance with the Program Summary Plan Description, but is not included on the Contractor's and/or its Key Subcontractor's Preferred Drug List and will result in a higher drug Copayment for Enrollees/Dependents.

NYS means New York State.

NYSHIP means the New York State Health Insurance Program.

NYSIF or Fund means the New York State Insurance Fund.

Offeror means a person or entity that submits a Proposal in response to this RFP.

Over-The-Counter Drug (OTC) means a drug approved by the FDA, which has been determined to be safe and effective for use by the general public without a Doctor's Prescription.

Participating Agency (PA) means any unit of local government such as school districts, special districts and district or municipal corporations which elects, with the approval of the President of the Civil Service Commission, to participate in the New York State Health Insurance Program.

Participating Employer (PE) means a public authority, public benefit corporation, or other public agency, subdivision, or quasi-public organization of the State which elects, with the approval of the President of the Civil Service Commission, to participate in the New York State Health Insurance Program.

Pass-through Pricing means the Program is charged the same Ingredient Cost and/or dispensing fee paid to the dispensing Network Pharmacy or Mail Service Pharmacy for the Generic, Brand or Compound Drug dispensed.

Pharmacist means a person who is legally licensed to practice the profession of Pharmacy. He or she must regularly practice such profession within the scope of their license.

Pharmacy or Pharmacies means any establishment, which is registered as a Pharmacy with the appropriate State licensing agency or is a Veterans Affairs Hospital Pharmacy, and regularly dispenses medications that require a Prescription from a Physician.

Program Services or Pharmacy Benefit Services means all of the services to be provided by the Contractor as set forth in this RFP.

Pharmacy Submitted Ingredient Cost or Pharmacy Submitted Pricing or Submitted Cost means the value entered by the Pharmacy in field 409, 'Ingredient Cost Submitted' of Telecommunication Standard Version 5.1 issued by the National Council for Prescription Drug Programs, Inc. For purposes of adjudication of Compound claims the value shall be no more than the total AWP of all ingredients in the Compound.

Pharma Revenue means any and all revenues generated from agreements between pharmaceutical manufacturers and the Contractor, or any Affiliate of the Contractor or any Key Subcontractor or any Key Subcontractor of the Contractor, which relate to Program utilization and/or Pharmacy Benefit Services provided under the Agreements. Such revenues include revenue described by any name, but not limited to, revenues described as: formulary rebates, market share rebates, administrative fees, AWP caps or by any other name.

Physician means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.). He or she must be legally licensed without limitations or restrictions, to practice medicine. For benefits provided in the Program, and for no other purpose, Physician also means a Doctor of Dental Surgery (D.D.S.), a Doctor of Dental Medicine (D.D.M), a Podiatrist and any other health care professional licensed to prescribe medication, when he or she is acting within the scope of his or her license.

Plan/Program means The Empire Plan Prescription Drug Program, the Excelsior Plan Prescription Drug Program, and Student Employee Health Plan (SEHP) Prescription Drug Program administered by the New York State Department of Civil Service, AND the Workers' Compensation Pharmacy Benefits Management program administered by the New York State Insurance Fund.

Plan Sponsor means the Council on Employee Health Insurance, which is composed of the President of the Civil Service Commission, Director of the Governor's Office of Employee Relations, and the Director of the Division of Budget.

Plan Year means the period from January 1st to December 31st in each Plan Year, unless specified otherwise by the DCS.

Preferred Brand Drug means a FDA approved brand name prescription drug that is included on the Preferred Drug List developed by the Contractor for the Program.

Preferred Drug List or PDL means a list of FDA approved brand name and generic prescription drugs developed by the Contractor for the Programs. Unless otherwise specified, this definition applies to all five of the Program's PDLs including: (1) the Traditional Empire Plan PDL (which applies to employee groups who have not agreed to implementation of a Flexible Formulary Drug List); (2) Flexible Formulary Drug List; (3) Enhanced Flexible Formulary; (4) Contractor's book of business PDL which applies to Enrollees/Dependents with Excelsior Plan benefits (Excelsior Plan PDL); and the (5) NYSIF PDL.

Prescription/Prescription Order means the written or oral request for drugs issued by a Physician duly licensed to make such a request in the ordinary course of his or her professional practice. This order must be written in the name of the person for whom it is prescribed or be an authorized refill of that order.

President means the President of the Civil Service Commission and the Commissioner of the DCS.

Procuring Agencies means the DCS acting in its statutory authority as the administrator of NYSHIP's Empire Plan, Excelsior Plan, and Student Employee Health Plan Prescription Drug Program, and the NYSIF acting in its statutory authority as the administrator of the NYS Workers' Compensation Pharmacy Benefits Management Program.

Program MAC List means the Program's specific Maximum Allowable Cost (MAC) List managed by the Contractor to set the maximum price the Program shall be charged and the dispensing retail Network Pharmacy shall be paid on a pass through basis for the Ingredient Cost of a drug required to be included on the Program MAC List.

Program Services or Pharmacy Benefit Services means all of the services to be provided by the Contractor as set forth in this RFP.

Program Team means the Contractor and those Key Subcontractors, if any, utilized by the Contractor who collectively undertake and perform the Program Services which are the subject of the Agreement.

Proposal means the Contractor's Administrative Proposal, Technical Proposal, and Cost Proposal, including all responses to supplemental requests for clarification, information, or documentation, submitted during the course of the Procurement.

Regulations of the President of the New York State Civil Service Commission means those regulations promulgated by the President of the Civil Service Commission under the authority of Civil Service Law, Article XI, as amended, and including, but not limited to those regulations to be promulgated as 4 New York Code of Rules and Regulations (NYCRR) Part 73.

Renewal Date means January 1, 2015, and annually thereafter up to and including January 1, 2018.

Retail Pharmacy Network means the Contractor's credentialed network of participating independent, chain Pharmacies, and specialty Pharmacies contracted to deliver services to Enrollees/Claimants.

Retiree means any person defined as a Retiree pursuant to the terms of 4 NYCRR Part 73, as amended.

RFP or Procurement means the Request for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Programs."

Specialty Drugs/Medications means drugs that treat rare disease states; drugs requiring special handling, special administration, or intensive patient monitoring/testing; biotech drugs developed from human cell proteins and DNA, targeted to treat disease at the cellular level; or, other drugs used to treat patients with chronic or life threatening diseases identified as specialty medications through the mutual agreement of the Parties.

Specialty Pharmacy Process means the method that the Contractor employs to accept, process, and dispense Prescriptions for Covered Drugs to Enrollees/Claimants through the Designated Specialty Pharmacy or a Limited Distribution Drug Pharmacy, for those employee groups participating in the

specialty pharmacy benefit. Prescriptions are considered to be submitted through the Specialty Pharmacy Process if they are a Limited Distribution Drug submitted directly to the Limited Distribution Drug Pharmacy, or if they are a Specialty Drug/Medication submitted directly to the Designated Specialty Pharmacy, by phone, fax, internet, e-prescribing or mail.

State means New York State as a whole.

Summary Plan Description(s) (SPD) means the document(s) issued pursuant to and attached by reference to the Agreement. The SPD is issued to Enrollees/Dependents and describes Program benefits. The SPD includes the initial SPD and amendments, if any.

Therapeutically Equivalent means drugs that can be expected to produce essentially the same therapeutic outcome and toxicity.

Traditional Preferred Drug List means a list of FDA approved brand name and generic prescription drugs developed by the Contractor for the employee groups who have not agreed to implementation of the Flexible Formulary Drug List.

Usual and Customary (U&C) means the retail price of a drug charged to the general public as submitted by the dispensing Pharmacy during claims processing.

Vestee means a former Employee who is entitled to continue benefits under NYSHIP because he/she has met all the requirements for NYSHIP coverage as a Retiree, except for age eligibility for pension, at the time employment terminates.

WCB means the New York State Workers' Compensation Board.

APPENDIX A

STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

December, 2011

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STANDARD CLAUSES FOR NYS CONTRACTS

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licenser, licensee, lessor, lessee or any other party):

1. EXECUTORY CLAUSE. In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.

2. NON-ASSIGNMENT CLAUSE. In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of without the State's previous written consent, and attempts to do so are null and void. Notwithstanding the foregoing, such prior written consent of an assignment of a contract let pursuant to Article XI of the State Finance Law may be waived at the discretion of the contracting agency and with the concurrence of the State Comptroller where the original contract was subject to the State Comptroller's approval, where the assignment is due to a reorganization, merger or consolidation of the Contractor's business entity or enterprise. The State retains its right to approve an assignment and to require that any Contractor demonstrate its responsibility to do business with the State. The Contractor may, however, assign its right to receive payments without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

3. COMPTROLLER'S APPROVAL. In accordance with Section 112 of the State Finance Law (or, if this contract is with the State University or City University of New York, Section 355 or Section 6218 of the Education Law), if this contract exceeds $50,000 (or the minimum thresholds agreed to by the Office of the State Comptroller for certain S.U.N.Y. and C.U.N.Y. contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds $10,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office. Comptroller's approval of contracts let by the Office of General Services is required when such contracts exceed $85,000 (State Finance Law Section 163.6.a).

4. WORKERS' COMPENSATION BENEFITS. In accordance with Section 142 of the State Finance Law, this contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

5. NON-DISCRIMINATION REQUIREMENTS. To the extent required by Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, sex, national origin, sexual orientation, age, disability, genetic predisposition or carrier status, or marital status. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. Contractor is subject to fines of $50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

6. WAGE AND HOURS PROVISIONS. If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law. Additionally, effective April 28, 2008, if this is a public work contract covered by Article 8 of the Labor Law, the Contractor understands and agrees that the filing of payrolls in a manner consistent with Subdivision 3-a of Section 220 of the Labor Law shall be a condition precedent to payment by the State of any State approved sums due and owing for work done upon the project.

7. NON-COLLUSIVE BIDDING CERTIFICATION. In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor affirms, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further affirms that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

8. INTERNATIONAL BOYCOTT PROHIBITION. In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds $5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2NYCRR 105.4).

9. SET-OFF RIGHTS. The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

10. RECORDS. The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this contract (hereinafter, collectively, "the Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this contract, shall have access to the Records during normal business hours at an office of the Contractor within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation.

11. IDENTIFYING INFORMATION AND PRIVACY NOTIFICATION. (a) Identification Number(s). Every invoice or New York State Claim for Payment submitted to a New York State agency by a payee, for payment for the sale of goods or services or for transactions (e.g., leases, easements, licenses, etc.) related to real or personal property must include the payee's identification number. The number is any or all of the following: (i) the payee's Federal employer identification number, (ii) the payee's Federal social security number, and/or (iii) the payee's Vendor Identification Number assigned by the Statewide Financial System. Failure to include such number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or Claim for Payment, must give the reason or reasons why the payee does not have such number or numbers.

(b) Privacy Notification. (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law. (2) The personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease the real or personal property covered by this contract or lease. The information is maintained in the Statewide Financial System by the Vendor Management Unit within the Bureau of State Expenditures, Office of the State Comptroller, 110 State Street, Albany, New York 12236.

12. EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN. In accordance with Section 312 of the Executive Law and 5 NYCRR 143, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of $25,000.00, whereby a contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to

be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of $100,000.00 whereby a contracting agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of $100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then the following shall apply and by signing this agreement the Contractor certifies and affirms that it is Contractor's equal employment opportunity policy that:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status, shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on State contracts and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment, promotion, upgradings, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

Contractor will include the provisions of "a", "b", and "c" above, in every subcontract over $25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment opportunity which effectuates the purpose of this section. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Department of Economic Development's Division of Minority and Women's Business Development pertaining hereto.

13. CONFLICTING TERMS. In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix A, the terms of this Appendix A shall control.

14. GOVERNING LAW. This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

15. LATE PAYMENT. Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article 11-A of the State Finance Law to the extent required by law.

16. NO ARBITRATION. Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

17. SERVICE OF PROCESS. In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

18. PROHIBITION ON PURCHASE OF TROPICAL HARDWOODS. The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of Section 165 of the State Finance Law, (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State.

In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the

subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in §165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES. In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

20. OMNIBUS PROCUREMENT ACT OF 1992. It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts.

Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development
Division for Small Business
30 South Pearl St -- 7th Floor
Albany, New York 12245
Telephone: 518-292-5220
Fax: 518-292-5884
http://www.empire.state.ny.us

A directory of certified minority and women-owned business enterprises is available from:

NYS Department of Economic Development
Division of Minority and Women's Business Development
30 South Pearl St -- 2nd Floor
Albany, New York 12245
Telephone: 518-292-5250
Fax: 518-292-5803
http://www.empire.state.ny.us

The Omnibus Procurement Act of 1992 requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than $1 million:

(a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;

(b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

(c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and

(d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

21. RECIPROCITY AND SANCTIONS PROVISIONS. Bidders are hereby notified that if their principal place of business is located in a country, nation, province, state or political subdivision that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively) require that they be denied contracts which they would otherwise obtain. NOTE: As of May 15, 2002, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii. Contact NYS Department of Economic Development for a current list of jurisdictions subject to this provision.

22. COMPLIANCE WITH NEW YORK STATE INFORMATION SECURITY BREACH AND NOTIFICATION ACT. Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208).

23. COMPLIANCE WITH CONSULTANT DISCLOSURE LAW. If this is a contract for consulting services, defined for purposes of this requirement to include analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health, and mental health services, accounting, auditing, paralegal, legal or similar services, then, in accordance with Section 163 (4-g) of the State Finance Law (as amended by Chapter 10 of the Laws of 2006), the Contractor shall timely, accurately and properly comply with the requirement to submit an annual employment report for the contract to the agency that awarded the contract, the Department of Civil Service and the State Comptroller.

24. PROCUREMENT LOBBYING. To the extent this agreement is a "procurement contract" as defined by State Finance Law Sections 139-j and 139-k, by signing this agreement the contractor certifies and affirms that all disclosures made in accordance with State Finance Law Sections 139-j and 139-k are complete, true and accurate. In the event such certification is found to be intentionally false or intentionally incomplete, the State may terminate the agreement by providing written notification to the Contractor in accordance with the terms of the agreement.

25. CERTIFICATION OF REGISTRATION TO COLLECT SALES AND COMPENSATING USE TAX BY CERTAIN STATE CONTRACTORS, AFFILIATES AND SUBCONTRACTORS.

To the extent this agreement is a contract as defined by Tax Law Section 5-a, if the contractor fails to make the certification required by Tax Law Section 5-a or if during the term of the contract, the Department of Taxation and Finance or the covered agency, as defined by Tax Law 5-a, discovers that the certification, made under penalty of perjury, is false, then such failure to file or false certification shall be a material breach of this contract and this contract may be terminated, by providing written notification to the Contractor in accordance with the terms of the agreement, if the covered agency determines that such action is in the best interest of the State.

APPENDIX B

STANDARD CLAUSES FOR ALL DEPARTMENT CONTRACTS

TABLE OF CONTENTS

1. INTEGRATION

The contract executed between the Department and the Contractor (or Purchase Order issued by the Department) is hereinafter referred to as the Agreement. The Agreement, including all Exhibits and Appendices, including this Appendix B, copies of which are attached thereto, and incorporated therein by reference, constitutes the entire agreement between the Parties for the purpose of the fulfillment of Program Services or Project Services. All prior agreements, representations, statements, negotiations and undertakings are superseded hereby.

All statements made by the Department shall be deemed to be representations and not warranties.

2. EXECUTORY PROVISION

Section 112 of the State Finance Law requires that any contract made by a State department which exceeds fifty thousand dollars ($50,000) in amount be first approved by the Comptroller of the State of New York before becoming effective. The Parties recognize that, if the Agreement is for fifty thousand dollars or more, it is wholly executory until and unless approved by the Comptroller of the State of New York.

3. CHOICE OF LAW

The Parties agree that the Agreement shall be interpreted according to the laws of the State of New York, except where the federal supremacy clause requires otherwise. The Contractor shall be required to bring any legal proceeding against the Department arising from the Agreement in New York State courts located in Albany County.

4. DISPUTE RESOLUTION

Except as otherwise provided in the Agreement, any dispute raised by the Contractor concerning any question of fact or law arising under the Agreement which is not disposed of by mutual agreement of the Parties shall be decided initially by the designee of the President of the Civil Service Commission (President). A copy of the written decision shall be furnished to the Contractor. The Parties shall proceed diligently with the performance of the Agreement and shall comply with the provisions of such decision and continue to comply pending further resolution of any such dispute as provided herein. The decision of the designee of the President shall be final and conclusive unless, within ten (10) Days from the receipt of such decision, the Contractor furnishes the President a written appeal. In the event of an appeal, the President shall promptly review the initial decision, and confirm, annul, or modify it. The decision of the President shall be final and conclusive unless, as determined by a court of competent jurisdiction, it violates one of the provisions of section 7803 of the Civil Practice Law and Rules. Pending final decision of any Article 78 proceeding hereunder, both Parties shall proceed diligently with the performance of the Agreement in accordance with the President's decision.

5. WAIVER OF BREACH

No term or provision of the Agreement shall be deemed waived and no breach excused, unless such waiver or consent shall be in writing and signed by the Party claimed to have waived or consented. No consent by a Party to, or waiver of, a breach under the Agreement shall constitute a consent to, a waiver of, or excuse for any other, different or subsequent breach.

6. NEW YORK STATE REQUIREMENTS

The Contractor acknowledges that it is bound by the terms of Appendix A, Standard Clauses For All New York State Contracts, which is attached and incorporated by reference to the Agreement.

7. OUTSIDE OF SCOPE

The Contractor agrees that any and all work performed outside the scope of the Agreement shall be deemed to be gratuitous and not subject to any charge, cost or payment of any kind.

8. NON-ASSIGNABILITY

Neither the rights nor the obligations of the Contractor under the Agreement may be conveyed, assigned, delegated, or otherwise transferred in any manner whatsoever by the Contractor, either in whole or in part, without the prior written approval of the Department.

9. NOTIFICATION

All notices permitted or required by the Agreement to be given by one Party to the other shall be in writing and shall be transmitted either (1) via certified or registered mail, return receipt requested; (2) by facsimile transmission; (3) by personal delivery; (4) by expedited delivery service; or (5) by e-mail.

10. INDEMNIFICATION

The Contractor agrees to indemnify, defend and save harmless the Department, the State, its officers, agents and employees, for any claims or losses the Department, the State or any individuals may suffer when such claims or losses result from the claims of any person or organization for any and all injuries or damages caused by the negligent acts or omissions of the Contractor, its officers, employees, agents, consultants and/or sub-contractors in performance of the Agreement. Furthermore, the Contractor agrees to indemnify, defend and save harmless the Department and the State, its officers, agents, and employees from any and all claims or losses caused by the acts or omissions of any and all contractors, sub-contractors, consultants and any other persons, firms, or corporations furnishing or supplying work, services, materials, or supplies in connection with the performance of the Agreement and from all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Contractor in the performance of the Agreement, and against any loss, damages or actions, including, but not limited to, costs and expenses, for violation of proprietary rights, copyrights, patents, or rights of privacy, arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any material, information or data furnished under the Agreement, or based on any libelous or otherwise unlawful matter contained in such material, information or data, except as otherwise provided in the Article entitled "Patent Copyright or Proprietary Rights Infringement" of this Appendix B.

The Contractor also shall provide indemnification against all losses, and/or cost expenses (including reasonable counsel fees) that may be incurred by reason of the Contractor's breach of any term, provision, covenant, warranty, or representation contained herein and/or in connection with the enforcement of the Agreement or any provision hereof.

The Department does not agree to any indemnification provisions in any documents attached hereto that require the Department or the State of New York to indemnify or save harmless the Contractor or third parties.

Notwithstanding anything to the contrary in the Agreement, neither the Department nor the Contractor shall be liable to the other for any special, consequential, or punitive damages, or loss of profits or revenues, whether such damages are alleged as a result of tort (including strict liability), contract, warranty, or otherwise, arising out of or relating to either Party's acts or omissions under the Agreement.

11. PATENT, COPYRIGHT OR PROPRIETARY RIGHTS INFRINGEMENT

The Contractor, solely at its expense, shall defend any claim or suit which may be brought against the Department or the State for the infringement of United States patents, copyrights or proprietary rights arising from the Contractor's or the Department's use of any software, equipment, data, materials and/or information of any kind prepared, developed or furnished by the Contractor in connection with performance of the Agreement and, in any such suit, shall satisfy any final judgment for such infringement. The Department shall give the Contractor written notice for such claim or suit and full right and opportunity to conduct the defense thereof, together with full information and all reasonable cooperation.

If principles of governmental or public law are involved, the State of New York may participate in the defense of any action identified under this Article, but no costs or expenses shall be incurred upon the account of the Contractor without the Contractor's written consent.

If, in the Contractor's opinion, any software, equipment, data, materials and/or information prepared, developed or furnished by the Contractor is likely to or does become the subject of a claim of infringement of a United States patent, copyright or proprietary right, then, without diminishing the Contractor's obligation to satisfy any final award, the Contractor may, with the Department's prior written approval, substitute other equally suitable software, equipment, materials, data and/or information. In the event that an action at law or in equity is commenced against the Department arising out of a claim that the Department's use of any software, equipment, materials and/or information under the Agreement infringes on any patent, copyright, or proprietary right, such action shall be forwarded by the Department to the Contractor for defense and indemnification under this Article and to the Office of the Attorney General of the State of New York together with a copy of the Agreement. If upon receipt of such request for defense, or at any time thereafter, the Contractor is of the opinion that the allegations in such action, in whole or in part, are not covered by the defense and indemnification set forth herein, the Contractor shall immediately notify the Department and the Office of the Attorney General of the State of New York, in writing, and shall specify to what extent the Contractor believes it is and is not obligated to defend and indemnify under the terms and conditions of the Agreement. The Contractor shall in such event protect the interests of the State of New York and shall take the steps necessary to secure a continuance to permit the State of New York to appear and defend its interest in cooperation with the Contractor, as is appropriate, including any jurisdictional defenses which the State shall have.

12. DATE/TIME WARRANTY

The Contractor warrants that products furnished pursuant to the Agreement shall be able to accurately process, date/time data (including, but not limited to, calculating, comparing, and sequencing) transitions, including leap year calculations. Where a Contractor proposes or an acquisition requires that specific products and/or services must perform as a package or system, this warranty shall apply to the products and/or services as a system.

Where the Contractor is providing ongoing services, including but not limited to: i) consulting, integration, code or data conversion, ii) maintenance or support services, iii) data entry or processing, or iv) contract administration services (e.g. billing, invoicing, claim processing), the Contractor warrants that services shall be provided in an accurate and timely manner without interruption, failure, or error due to the inaccuracy of the Contractor's business operations in processing date/time data (including, but not limited to, calculating, comparing, and sequencing) various date/time transitions, including leap year calculations. The Contractor shall be responsible for damages resulting from any delays, errors, or untimely performance resulting there from, including but not limited to the failure or untimely performance of such services.

This Date/Time Warranty shall survive beyond termination or expiration of the Agreement through a) ninety (90) days or b) the Contractor's or product manufacturer/developer's stated date/time warranty term, whichever is longer. Nothing in this warranty statement shall be construed to limit any rights or remedies otherwise available under the Agreement for breach of warranty.

13. VIRUS WARRANTY

Product contains no viruses, either known to the Contractor or which reasonably should have been known to the Contractor exercising due diligence. The Contractor is not responsible for viruses introduced at the Department's site.

14. TITLE AND OWNERSHIP WARRANTY

The Contractor warrants, represents and conveys (i) full ownership, clear title free of all liens, or (ii) the right to transfer or deliver perpetual license rights to any Product(s) transferred to the Department under the Agreement. The Contractor shall be solely liable for any costs of acquisition associated therewith. The Department may require the Contractor to furnish appropriate written documentation establishing the above rights and interests as a condition of payment. The Department's request or failure to request such documentation shall not relieve the Contractor of liability under this warranty.

15. USE RESTRICTIONS AND INTELLECTUAL PROPERTY

The Parties agree that all work by the Contractor for the Department is intended as work for hire. The Parties agree that the Contractor's work is specifically ordered and commissioned for use as contributions to a collective work, or is other such work as specified by section 101(2) of the U.S. Copyright Act [17 U.S.C. 101(2)], and is intended to be a work for hire that is made for the use and ownership of the State of New York and the Department. Furthermore, the Department and the Contractor agree that the State of New York and the Department are the owners of all copyrights regarding the work. The Contractor warrants to the State of New York and the Department that the Contractor, and all of its subcontractors and their employees, who have been, or may be used in regard to the Agreement, forfeits all past or future claims of title or ownership to the work produced.

Materials such as forms and publications used by the Contractor in the course of its performance under the Agreement which have been agreed upon by the Parties as generic materials are specifically excluded from this provision.

16. OWNERSHIP/TITLE TO PRODUCT DELIVERABLES

For purposes of this Article, the term "Department" is understood to mean the Department acting on behalf of the State.

(A) Definitions

1. Product(s):
   A deliverable furnished under the Agreement by or through the Contractor, including existing and custom Product(s), including, but not limited to: a) components of the hardware environment; b) printed materials (including but not limited to training manuals, system and user documentation, reports, drawings); c) third party software; d) modifications, customizations, custom programs, program listings, programming tools, data, modules, components; and e) any properties embodied therein, whether in tangible or intangible form (including but not limited to utilities, interfaces, templates, subroutines, algorithms, formulas, source code, object code).

2. Existing Product(s):

Tangible Product(s) and intangible licensed Product(s) which exist prior to the commencement of work under the Agreement. The Contractor retains the burden of proving that a particular product existed before commencement of the Agreement.

3. Custom Product(s):
   Product(s), preliminary, final or otherwise, which are created or developed by the Contractor, or its subcontractors, partners, employees, or agents under the Agreement for the benefit of the Department.

(B) Title to Project Deliverables

The Contractor acknowledges that it is commissioned by the Department to perform services detailed in the Agreement. Unless otherwise specified in writing in the Agreement, the Department shall have ownership and/or license rights as follows:

1. Existing Product(s):
   a) Hardware - Title and ownership of Existing Hardware Product shall pass to Department upon acceptance.

   b) Software - Title and ownership to Existing Software Product(s) delivered by the Contractor under the Agreement which is normally commercially distributed on a license basis by the Contractor or other independent software vendor/proprietary owner ("Existing Licensed Product"), whether or not embedded in, delivered or operating in conjunction with hardware or Custom Products, shall remain with the Contractor or other independent software vendor/proprietary owner ("ISV"). Effective upon acceptance, such Product shall be licensed to the Department in accordance with the Contractor or ISV owner's standard license agreement, provided, however, that such standard license, must, at a minimum: (a) grant the Department a non-exclusive, perpetual license to use, execute, reproduce, display, perform, adapt (unless the Contractor advises the Department as part of the Contractor's bid proposal that adaptation will violate existing agreements or statutes and the Contractor demonstrates such to the Department's satisfaction) and distribute Existing Licensed Product to the Department up to the license capacity stated in the work order with all license rights necessary to fully effect the general business purpose(s) stated in the Agreement and (b) recognize the State of New York as the licensee. Where these rights are not otherwise covered by the ISV's standard license agreement, the Contractor shall be responsible for obtaining these rights at its sole cost and expense. The Department shall reproduce all copyright notices and any other legend of ownership on any copies authorized under this paragraph.

2. Custom Product(s):
   Effective upon creation of Custom Product(s), the Contractor hereby conveys, assigns and transfers to State the sole and exclusive rights, title and interest in Custom Product(s), whether preliminary, final or otherwise, including all trademark and copyrights. The Contractor hereby agrees to take all necessary and appropriate steps to ensure that the Custom Product(s) are protected against unauthorized copying, reproduction and marketing by or through the Contractor, its agents, employees, or subcontractors. Nothing herein shall preclude the Contractor from otherwise using the related or underlying general knowledge, skills, ideas, concepts, techniques and experience developed under the Agreement in the course of the Contractor's business.

   Where payment for Custom Product does not involve Certificates of Participation (COPS) pursuant to Article 5-A of the State Finance Law or other third party

financing, the Department may, by providing written notice thereof to the Contractor, elect in the alternative to take a non-exclusive perpetual license to Custom Products in lieu of State taking exclusive ownership and title to such Products. In such case, the Department shall be granted a non-exclusive perpetual license to use, execute, reproduce, display, perform, adapt and distribute Custom Product as necessary to fully effect the general business purpose(s) as stated herein.

In the event that the Contractor wishes to obtain ownership rights to Custom Product(s), the sale or other transfer shall be at fair market value as determined by the Parties at the time of such sale or other transfer, and must be pursuant to a separate written agreement in a form acceptable to the State which complies with the terms of this paragraph.

3. Documentation, Data & Reports
The Department shall own title to all documentation, drawings, (e.g., engineering drawings, system diagrams, logic/schematics, plans, reports, training, maintenance or operating manuals), including network design, equipment configurations and other documentation prepared or developed pursuant to the Agreement, whether preliminary, final or otherwise. The Contractor shall deliver to the possession of the Department all work-in-progress documentation as it becomes available, but in no case longer than thirty (30) days after creation.

(Amended 4/4/12)

17. FORCE MAJEURE

Neither Party to the Agreement shall be liable or deemed to be in default for any delay or failure in performance under the Agreement resulting directly or indirectly from acts of God, civil or military authority, acts of public enemy, wars, riots, civil disturbances, insurrections, accident, fire, explosions, earthquakes, floods, the elements, acts or omissions of public utilities or strikes, work stoppages, slowdowns or other labor interruptions due to labor/management disputes involving entities other than the Parties to the Agreement, or any other causes not reasonably foreseeable or beyond the control of a Party. **In accordance with Article 6.14.10 of the Agreement, cases of fraud and/or abuse shall not qualify as a cause which is not reasonably foreseeable or beyond the control of a Party.** The Parties are required to use best efforts to eliminate or minimize the effect of such events during performance of the Agreement and to resume performance of the Agreement upon termination or cessation of such events.

18. TIME OF THE ESSENCE

The Department and the Contractor acknowledge and agree that time is of the essence for the Contractor's performance under the Agreement.

19. RIGHTS AND REMEDIES

The rights, duties and remedies set forth in the Agreement shall be in addition to, and not in limitation of, rights and obligations otherwise available at law.

20. FEDERAL AND STATE COMPLIANCE

The Contractor shall ensure that its employment practices comply with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended.

The Contractor shall ensure compliance with the Americans With Disabilities Act (42 USC §2101 et. seq.) such that programs and services provided during the course of performance

of the Agreement shall be accessible under Title II of the Americans With Disabilities Act and as otherwise applicable under the Americans With Disabilities Act.

21. TAXES

It shall be understood that the Department, as an agency of the State of New York, is not liable for the payment of any sales, use, excise, or other form of tax however designated, levied or imposed, and shall agree to reimburse the Contractor for same only if taxes would have been incurred through the Department's normal business operations.

22. INDEPENDENT CONTRACTOR

The Parties agree that the Contractor is an independent contractor, and the Contractor, its officers, employees, agents, consultants and/or sub-contractors in the performance of the Agreement shall act in an independent capacity and not as agents, officers or employees of the State or the Department. Neither the Contractor nor any sub-contractor shall thereby be deemed an agent, officer, or employee of the State. The Contractor agrees, during the term of the Agreement, to maintain at the Contractor's expense those benefits to which its employees would otherwise be entitled by law, including health benefits, and all necessary insurance for its employees, including worker's compensation, disability and unemployment insurance, and to provide the Department with certification of such insurance upon request. The Contractor remains responsible for all applicable federal, State, and local taxes, and all FICA contributions.

23. NO THIRD PARTY BENEFICIARIES

Nothing contained in the Agreement, expressed or implied, is intended to confer upon any person, corporation, other than the Parties hereto and their successors in interest and assigns, any rights or remedies under or by reason of the Agreement.

24. HEADINGS OR CAPTIONS

The headings or captions contained within the Agreement are intended solely for convenience and reference purposes and shall in no way be deemed to define, limit or describe the scope or intent of the Agreement or any provisions thereof.

25. PARTIAL INVALIDITY

Each Party agrees that it shall perform its obligations under the Agreement in accordance with all applicable federal and State laws, rules, and regulations, policies and/or guidelines now or hereafter in effect. If any term or provision of the Agreement shall be found to be illegal or unenforceable, then, notwithstanding such term or provision, the Agreement shall remain in full force and effect, and such term or provision shall be deemed stricken.

26. CONFLICT OF INTEREST

The Contractor shall ensure that its officers, employees, agents, consultants and/or sub-contractors comply with the requirements of the New York State Public Officers Law ("POL"), as amended, including but not limited to sections 73 and 74, as amended, with regard to ethical standards applicable to State employees, and particularly POL sections 73(8)(a)(i) and (ii) regarding post-employment restrictions affecting former State employees. Additionally, the Contractor shall ensure that no violation of these provisions will occur by reason of the Contractor's proposal for or negotiation and execution of the Agreement or in its delivery of services pursuant to the Agreement. If, during the term of the Agreement, the Contractor becomes aware of a relationship, actual or potential, which may be considered a violation of the POL or which may otherwise be considered a conflict of interest, the Contractor shall notify the Department in writing immediately. Should the Department thereafter determine that such employment is inconsistent with State law; the Department shall so advise the Contractor in writing, specifying its basis for so determining, and may require that the contractual or employment relationship be canceled. Failure to

comply with these provisions may result in suspension or cancellation of the Agreement and criminal proceedings as may be required by law.

The Contractor is required to make full disclosure of any circumstances that could affect its ability to perform in complete compliance with the POL. Any questions as to the applicability of these provisions should be addressed by the Contractor to the New York State Ethics Commission, 540 Broadway, Albany, NY 12207 (518) 408-3976.

27. AUDIT AUTHORITY

The Contractor acknowledges that the Department and the Office of the State Comptroller have the authority to conduct financial and performance audits of the Contractor's delivery of Program Services (or Project Services) in accordance with the Agreement and any applicable State and federal statutory and regulatory authorities. Such audit activity may include, but not necessarily be limited to, the review of documentary evidence to determine the accuracy and fairness of all items on the Contractor's submission of claims for payment under the Agreement, and the review of any and all activities relating to the Contractor's performance and administration of the Agreement.

The Contractor shall make available documentary evidence necessary to perform such reviews. Documentation made available by the Contractor may include, but is not limited to, source documents, books of account, subsidiary records and supporting work papers, claim documentation and pertinent contracts and correspondence.

The audit provisions contained herein shall in no way be construed to limit the audit authority or audit scope of the Office of the State Comptroller as set forth in Appendix A of the Agreement - Standards Clauses for All New York State Contracts.

28. CONFIDENTIALITY

All records maintained by the Contractor and relating to the Agreement are confidential and shall be used by the Contractor and its officers, employees, and subcontractors or agents solely for the purpose of carrying out its obligations under the Agreement. Except as directed by a court of competent jurisdiction or as may be permitted or required by applicable New York State or federal law or regulations, no such records may be otherwise used or released to any person by the Contractor, its employees, subcontractors or agents, either during the term of the Agreement or in perpetuity thereafter. Deliberate or repeated accidental breach of this provision may, at the sole discretion of the Department, be grounds for termination of the Agreement.

The Contractor shall promptly advise the Department of all requests made to the Contractor for information regarding the performance of services under the Agreement, including any information provided by the Department, except as required by subcontractors or agents solely for the purpose of carrying out obligations under the Agreement or as required by law.

The Contractor shall be responsible for assuring that any agreement between the Contractor and any of its officers, agents and employees or applicable subcontractors contains a provision that conforms strictly to the provisions of this Article.

29. INFORMATION SECURITY REQUIREMENTS

In accordance with the Information Security Breach and Notification Act (ISBNA) (General Business Law §889-aa, State Technology Law §208), Contractor shall be responsible for complying with provisions of the ISBNA and the following terms contained herein with respect to any private information (as defined in ISBNA) received by Contractor under the

Agreement (Private Information) that is within the control of the Contractor either on the Department's information security systems or the Contractor's information security system (System). In the event of a breach of the security of the System (as defined by ISBNA), Contractor shall immediately commence an investigation, in cooperation with the Department, to determine the scope of the breach and restore security of the System to prevent any further breaches. Contractor shall also notify the Department of any breach of the security of the System immediately following discovery of such breach.

Except as otherwise instructed by the Department, Contractor shall, to the fullest extent possible, first consult with and receive authorization from the Department prior to notifying any individuals, the State Office of Cyber Security and Critical Infrastructure Coordination (CSCIC), the State Consumer Protection Board and the Office of the Attorney General (OAG) or any consumer reporting agencies of a breach of the security of the System or concerning any determination to delay notification due to law enforcement investigations. Contractor shall be responsible for providing the notice to all such required recipients and for all the costs associated with providing such notice. Contractor shall be liable for any other costs associated with noncompliance of ISBNA if caused by the Contractor or Contractor's agents, officers, employees, or subcontractors. Nothing herein shall in any way impair the authority of the OAG to bring an action against the Contractor to enforce the provisions of ISBNA or limit Contractor's liability for any violation of the ISBNA. Additional information relative to the law and the notification process is available at:
http://www.cscic.state.ny.us/security/securitybreach

Contemporaneous with the execution of the Agreement, the Contractor and its designees shall execute the Department's Third Party Connection and Data Exchange Agreement and any other protocol required by the Department, and shall ensure its employees, agents and designees complete the related Third Party Acceptable Use Policy and Agreement if applicable, to ensure the security of data transmissions and other information related to the administration of the Agreement. This request may be waived by the Department in its sole discretion.

30. NONDISCLOSURE OF CONFIDENTIAL INFORMATION

Except as may be required by applicable law or a court of competent jurisdiction, the Contractor, its officers, agents, employees, and subcontractors shall maintain strict confidence with respect to any Confidential Information to which the Contractor, its officers, agents, employees, and subcontractors have access in the course of the Contractor's performance under the Agreement. For purposes of the Agreement, all State information of which the Contractor, its officers, agents, employees and subcontractors becomes aware during the course of performing services for the Department shall be deemed to be Confidential Information (oral, visual or written). Notwithstanding the foregoing, information that falls into any of the following categories shall not be considered Confidential Information:

(a) information that is previously rightfully known to the receiving party without restriction on disclosure;
(b) information that becomes, from no act or failure to act on the part of the receiving party, generally known in the relevant industry or is in the public domain; and
(c) information that is independently developed by the Contractor without use of confidential information of the State.

The Contractor shall hold the State and the Department harmless from any loss or damage to the State or the Department resulting from the disclosure by the Contractor, its officers, agents, employees, and subcontractors of such Confidential Information.

The Contractor shall provide for its officers, agents, employees, and subcontractors to acknowledge and execute a nondisclosure agreement containing substantially the terms described in this Article, if requested to do so by the Department or the State.

This representation shall survive termination of the Agreement.

31. FREEDOM OF INFORMATION LAW

Disclosure of information and material provided to the Department by the Contractor in the course of the Contractor's performance under the Agreement shall be permitted consistent with the laws of the State of New York, and specifically the Freedom of Information Law (FOIL), Article 6 of the Public Officers Law. The Department shall take reasonable steps to protect from public disclosure any of the records relating to the Contractor's performance under the Agreement that otherwise are exempt from disclosure under FOIL.

If the Contractor believes that any information or material provided to the Department constitutes trade secret information that should be exempted from FOIL disclosure, the Contractor must, at the time of the materials' submission, request the exemption in writing, specifically identifying the material by page number, line, or other appropriate designation, and provide a particularized explanation as to why the material constitutes trade secret information and how the disclosure of the identified information would cause substantial injury to the Contractor's competitive position. The material sought to be protected from disclosure must be clearly marked in yellow highlighter, on a duplicate copy of the submission and may be provided in hardcopy or on a CD. Generically marking all material as "Confidential" will not be considered adequate for the purpose of this Article.

The Department's receipt of the Contractor's submission of material and the Contractor's request for protection of the material from FOIL disclosure does not constitute a determination that the information is exempt from disclosure under FOIL. In the event any information or material is requested pursuant to FOIL, the Department will address each party's interests fully in accordance with the procedures required by Article 6 of the Public Officers Law.

32. TERMINATION OF AGREEMENT

In addition to any termination provisions specified elsewhere in the Agreement, the following provisions also shall apply:

The Agreement may be terminated by mutual written agreement of the Parties.

The Agreement may be terminated by the Department for cause upon the failure of the Contractor to comply with the terms and conditions of the Agreement, including any exhibits incorporated herein, provided that the Department shall give the Contractor written notice via registered or certified mail, return receipt requested, or hand delivery, such written notice to specify the Contractor's failure and the termination of the Agreement. Termination shall be effective ten (10) Business Days after receipt of such notice unless the Contractor, in the opinion of the Department, has cured such failure. The Contractor agrees to incur no new obligations nor to claim for any expenses made after receipt of the notification of termination. Upon termination for cause, the Department shall have the right to award a new contract to another contractor. Termination for cause shall create a liability upon the Contractor for actual damages incurred and for all reasonable additional costs incurred in reassigning the Agreement.

The Agreement may be terminated if the Department deems that termination would be in the best interest of the State provided that the Department shall give written notice to the Contractor not less than thirty (30) Days prior to the date upon which termination shall become effective, such notice to be made via registered or certified mail, return receipt

requested or hand delivered. The date of such notice shall be deemed to be the date of postmark in the case of mail or the date of hand delivery.

The Agreement may be terminated immediately in the event the Department determines that funds are unavailable. The Department agrees to provide notice to the Contractor as soon as it becomes aware that funds are unavailable in the event of termination under this paragraph. If the initial notice is via oral notification, the Department shall provide written notice immediately thereafter. The Department shall be obligated to pay the Contractor only for the expenditures made and obligations incurred by the Contractor until such time as notice of termination or received either orally or in writing by the Contractor from the Department.

In the event of termination for any reason, the Contractor shall not incur new obligations for the terminated portion. The Contractor agrees, after consultation with the Department, to cancel such outstanding obligations as the Contractor deems appropriate in the exercise of sound business judgment.

Upon termination of the Agreement each Party shall, if applicable, return to the other all papers, materials, and other properties of the other Party held by each for purposes of performance under the Agreement. In addition, each Party shall assist the other Party in orderly termination of the Agreement and the transfer of all aspects hereof, tangible, and intangible, as may be necessary to ensure the orderly administration of the State program.

33. CONTRACTOR PERSONNEL

The Contractor shall designate an Account Executive, who shall be the contact person for all matters arising under the Agreement.

The Contractor agrees to be solely responsible for the recruitment, hiring, provision of employment benefits, payment of salaries, and management of its personnel. These functions shall be carried out by the Contractor in accordance with the provisions of the Agreement and with all applicable federal and State laws and regulations.

The Contractor is required to commit key personnel for the administration of all aspects of the Agreement. In the event that any of the key personnel will be or are unavailable for the performance of their duties, the Contractor will designate and propose to the Department an equally qualified alternate with full authority to act for the unavailable key person.

The Contractor shall notify the Department in writing of any changes in the key personnel designated for performance of the Agreement. This shall include any changes in the personnel designated to bind the Contractor.

The Department reserves the right to demand the reassignment or cancellation of assignment to duties under the Agreement of any Contractor personnel so assigned. The Department shall not exercise the authority unreasonably. The Contractor agrees to replace any employees so reassigned or canceled with an employee of equal or better qualifications. If the Department exercises its right under this provision, it agrees to provide written notice to the Contractor setting forth its reasons with specificity.

34. OPERATIONAL CONTACTS

The Contractor shall maintain appropriate corporate and/or legal authority, which shall include, but not be limited to, the maintenance of an organization capable of delivering Program Services in accordance with the Agreement and the authority to do business in the State of New York or any other governmental jurisdiction in which Program Services are to be delivered pursuant to the Agreement. The Contractor also shall maintain operations, financial and legal staff that shall be directly available to the Department's operations,

financial and legal staff, respectively. For purposes of the Agreement, maintenance of such staff and staff availability by the Contractor shall in no way create any agency relationship between the Department and the Contractor.

The Contractor acknowledges and agrees that no aspect of the Contractor's performance under the Agreement is contingent upon Department personnel or the availability of Department resources, with the exception of all proposed actions of the Contractor specifically identified in the Agreement as requiring the Department approval. With respect to such approval, the Department shall act promptly and in good faith.

The Contractor must cooperate fully with any other contractors who may be engaged by the Department relative to the the Agreement.

The Contractor must ensure that all contacts by the Contractor personnel with other New York State agencies, external organizations (Federal Agencies, Unions, etc.) which result in any charge, cost or payment of any kind, must receive prior written authorization from the Department's Contract Manager.

35. SUBCONTRACTING

If allowed in the solicitation instrument (e.g., Request for Proposal, Invitation for Bids, etc.) that results in the Agreement, the Contractor may arrange for specified portion(s) of its responsibilities under the Agreement to be subcontracted to a Key Subcontractor(s). A “Key Subcontractor” means that vendor(s) with whom the Contractor subcontracts to provide any portion of Program Services. If the Contractor determines to subcontract a portion(s) of Program Services, the Key Subcontractors must be clearly identified and the nature and extent of its involvement in and/or proposed performance under the Agreement must be fully explained by the Contractor to the Department. The Contractor retains ultimate responsibility for all Program Services performed under the Agreement.

All subcontracts shall be in writing and shall contain provisions, which are functionally identical to, and consistent with, the provisions of the Agreement including, but not be limited to, the body of the Agreement, Appendix A - Standard Clauses For All New York State Contracts, Appendix B - Standard Clauses for All Department Contracts and if applicable as determined by the Department, Appendix C - Third Party Connection and Data Exchange Agreement. Unless waived in writing by the Department, all subcontracts between the Contractor and a Key Subcontractor shall expressly name the State of New York, through the Department, as the sole intended third party beneficiary of such subcontract. The Department reserves the right to review and approve or reject any subcontract with a Key Subcontractor, as well as any amendments to said subcontract(s), and this right shall not make the Department or the State of New York a party to any subcontract or create any right, claim, or interest in the Key Subcontractor or proposed Key Subcontractor against the Department.

The Department reserves the right, at any time during the term of the Agreement, to verify that the written subcontract between the Contractor and Key Subcontractor(s) is in compliance with all of the provision of this Article and any subcontract provisions contained in the Agreement. In addition to other remedies allowed by law, the Department reserves the right to terminate the Agreement for cause if an executed subcontract does not contain all of the provisions/statements stipulated above. If during the term of the Agreement, any executed subcontract between the Contractor and a Key Subcontractor is amended, the Contractor shall, within 30 calendar days of such amendment, provide a copy to the Department.

The Contractor shall give the Department immediate notice in writing of the initiation of any legal action or suit which relates in any way to a subcontract with a Key Subcontractor or

which may affect the performance of the Contractor's duties under the Agreement. Any subcontract shall not relieve the Contractor in any way of any responsibility, duty and/or obligation of the Agreement.

36. PUBLICITY AND COMMUNICATIONS

The Contractor shall ensure that all requests for the Contractor's participation in events where the Contractor will be participating on behalf of the Department receive prior written authorization from the Department.

No public discussion or news releases relating to the Agreement shall be made or authorized by the Contractor or the Contractor's agent without the prior written approval of the Department, which written approval shall not be unreasonably withheld or delayed provided, however, that Contractor shall be authorized to provide copies of the Agreement and answer any questions relating thereto to any State or federal regulators or, in connection with its financial activities, to financial institutions for any private or public offering.

37. CONSULTANT DISCLOSURE REQUIREMENTS

Unless directed otherwise by the Department, the Contractor shall demonstrate its compliance with Chapter 10 of the Laws of 2006 throughout the term of the Agreement by submitting to the Department and to the Office of the State Comptroller a "State Consultant Services - Contractor's Annual Employment Report" for each State Fiscal Year. Such report shall be due no later than May 15th of each year following the end of the State Fiscal Year being reported. Such report shall be required of any contract that includes services for analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health and mental health services, accounting, auditing, paralegal, legal, or similar services. Such report shall conform with Bulletin No. G-226 – Form B as issued by the Office of the State Comptroller. The report must be submitted to the Office of the State Comptroller, Bureau of Contracts, 110 State Street, 11th floor, Albany, NY 12236, ATTN: Consultant Reporting; and to the Department's Contract Manager.

38. PROCUREMENT LOBBYING RESTRICTIONS UNDER STATE FINANCE LAW SECTIONS 139-j AND 139-k

The Contractor certifies that all information that it has provided or will provide to the Department pursuant to State Finance Law sections 139-j and 139-k is complete, true, and accurate, including but not limited to information regarding prior determinations of non-responsibility within the past four years based upon (i) impermissible contacts of other violations of SFL section 139-j, or (ii) the intentional provision of false or incomplete information to a governmental entity.

The Department reserves the right to terminate the Agreement in the event it is found that the Contractor's certification of its compliance with SFL sections 139-j or 139-k was intentionally false or intentionally incomplete. Upon such finding, the Department may exercise its right to terminate the Agreement by providing written notification to the Contractor in accordance with Article 9 of this Appendix B.

39. VENDOR RESPONSIBILITY

The Contractor is required to provide the Department with an updated Vendor Responsibility Questionnaire when requested to do so by the Department throughout the term of the Agreement. Regardless, the Contractor is required to report to the Department any material changes in the information reported in its initial Vendor Responsibility Questionnaire.

40. TAX LAW SECTION 5-A - CERTIFICATION REGARDING SALES AND COMPENSATING USE TAXES

In the event the value of the Agreement exceeds $100,000, the Contractor must file a properly completed Form ST-220-CA with the Department and a properly completed Form ST-220-TD with the Department of Taxation & Finance before the Agreement may take effect.

In addition, after the Agreement has taken effect, the Contractor must file a properly completed Form ST-220-CA with the Department if the Agreement's term is renewed; further, a new Form ST-220-TD must be filed with the Department of Taxation & Finance if no ST-220-TD has been filed by the Contractor or if a previously filed Form ST-220-TD is no longer correct and complete.

41. CONTRACT PAYMENT

Contractor shall provide complete and accurate billing invoices to the Department in order to receive payment. Billing invoices submitted to the Department must contain all information and supporting documentation required by the Agreement, the Department and the State Comptroller. Payment for invoices submitted by the Contractor shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The Contractor shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by e-mail at epunit@osc.state.ny.us, or by telephone at 518-474-4032. Contractor acknowledges that it will not receive payment on any invoices submitted under the Agreement if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

May 2011

APPENDIX B

STANDARD CLAUSES FOR ALL NYSIF CONTRACTS

TABLE OF CONTENTS

1. INTEGRATION

The contract executed between New York State Insurance Fund (NYSIF) and the Contractor (or Purchase Order issued by NYSIF) is hereinafter referred to as the Agreement. The Agreement, including all Exhibits and Appendices, including this Appendix B, copies of which are attached thereto, and incorporated therein by reference, constitutes the entire agreement between the Parties for the purpose of the fulfillment of Program Services or Project Services. All prior agreements, representations, statements, negotiations and undertakings are superseded hereby.

All statements made by NYSIF shall be deemed to be representations and not warranties.

2. EXECUTORY PROVISION

Section 112 of the State Finance Law requires that any contract made by a State department which exceeds fifty thousand dollars ($50,000) in amount be first approved by the Comptroller of the State of New York before becoming effective. The Parties recognize that, if the Agreement is for fifty thousand dollars or more, it is wholly executory until and unless approved by the Comptroller of the State of New York.

3. CHOICE OF LAW

The Parties agree that the Agreement shall be interpreted according to the laws of the State of New York, except where the federal supremacy clause requires otherwise. The Contractor shall be required to bring any legal proceeding against NYSIF arising from the Agreement in New York State courts located in Albany County.

4. DISPUTE RESOLUTION

Except as otherwise provided in the Agreement, any dispute raised by the Contractor concerning any question of fact or law arising under the Agreement which is not disposed of by mutual agreement of the Parties shall be decided initially by the designee of the Executive Director of NYSIF (Executive Director). A copy of the written decision shall be furnished to the Contractor. The Parties shall proceed diligently with the performance of the Agreement and shall comply with the provisions of such decision and continue to comply pending further resolution of any such dispute as provided herein. The decision of the designee of the Executive Director shall be final and conclusive unless, within ten (10) Days from the receipt of such decision, the Contractor furnishes the Executive Director a written appeal. In the event of an appeal, the Executive Director shall promptly review the initial decision, and confirm, annul, or modify it. The decision of the Executive Director shall be final and conclusive unless, as determined by a court of competent jurisdiction, it violates one of the provisions of section 7803 of the Civil Practice Law and Rules. Pending final decision of any Article 78 proceeding hereunder, both Parties shall proceed diligently with the performance of the Agreement in accordance with the Executive Director's decision.

5. WAIVER OF BREACH

No term or provision of the Agreement shall be deemed waived and no breach excused, unless such waiver or consent shall be in writing and signed by the Party claimed to have waived or consented. No consent by a Party to, or waiver of, a breach under the Agreement shall constitute a consent to, a waiver of, or excuse for any other, different or subsequent breach.

6. NEW YORK STATE REQUIREMENTS

The Contractor acknowledges that it is bound by the terms of Appendix A, Standard Clauses For All New York State Contracts, which is attached and incorporated by reference to the Agreement.

7. OUTSIDE OF SCOPE

The Contractor agrees that any and all work performed outside the scope of the Agreement shall be deemed to be gratuitous and not subject to any charge, cost or payment of any kind.

8. NON-ASSIGNABILITY

Neither the rights nor the obligations of the Contractor under the Agreement may be conveyed, assigned, delegated, or otherwise transferred in any manner whatsoever by the Contractor, either in whole or in part, without the prior written approval of NYSIF.

9. NOTIFICATION

All notices permitted or required by the Agreement to be given by one Party to the other shall be in writing and shall be transmitted either (1) via certified or registered mail, return receipt requested; (2) by facsimile transmission; (3) by personal delivery; (4) by expedited delivery service; or (5) by e-mail.

10. INDEMNIFICATION

The Contractor agrees to indemnify, defend and save harmless NYSIF, the State, its officers, agents and employees, for any claims or losses NYSIF, the State or any individuals may suffer when such claims or losses result from the claims of any person or organization for any and all injuries or damages caused by the negligent acts or omissions of the Contractor, its officers, employees, agents, consultants and/or sub-contractors in performance of the Agreement. Furthermore, the Contractor agrees to indemnify, defend and save harmless NYSIF and the State, its officers, agents, and employees from any and all claims or losses caused by the acts or omissions of any and all contractors, sub-contractors, consultants and any other persons, firms, or corporations furnishing or supplying work, services, materials, or supplies in connection with the performance of the Agreement and from all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Contractor in the performance of the Agreement, and against any loss, damages or actions, including, but not limited to, costs and expenses, for violation of proprietary rights, copyrights, patents, or rights of privacy, arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any material, information or data furnished under the Agreement, or based on any libelous or otherwise unlawful matter contained in such material, information or data, except as otherwise provided in the Article entitled "Patent Copyright or Proprietary Rights Infringement" of this Appendix B.

The Contractor also shall provide indemnification against all losses, and/or cost expenses (including reasonable counsel fees) that may be incurred by reason of the Contractor's breach of any term, provision, covenant, warranty, or representation contained herein and/or in connection with the enforcement of the Agreement or any provision hereof.

NYSIF does not agree to any indemnification provisions in any documents attached hereto that require NYSIF or the State of New York to indemnify or save harmless the Contractor or third parties.

Notwithstanding anything to the contrary in the Agreement, neither NYSIF nor the Contractor shall be liable to the other for any special, consequential, or punitive damages, or loss of profits or revenues, whether such damages are alleged as a result of tort (including strict liability), contract, warranty, or otherwise, arising out of or relating to either Party's acts or omissions under the Agreement.

11. PATENT, COPYRIGHT OR PROPRIETARY RIGHTS INFRINGEMENT

The Contractor, solely at its expense, shall defend any claim or suit which may be brought against NYSIF or the State for the infringement of United States patents, copyrights or proprietary rights arising from the Contractor's or NYSIF's use of any software, equipment, data, materials and/or information of any kind prepared, developed or furnished by the Contractor in connection with performance of the Agreement and, in any such suit, shall satisfy any final judgment for such infringement. NYSIF shall give the Contractor written notice for such claim or suit and full right and opportunity to conduct the defense thereof, together with full information and all reasonable cooperation.

If principles of governmental or public law are involved, the State of New York may participate in the defense of any action identified under this Article, but no costs or expenses shall be incurred upon the account of the Contractor without the Contractor's written consent.

If, in the Contractor's opinion, any software, equipment, data, materials and/or information prepared, developed or furnished by the Contractor is likely to or does become the subject of a claim of infringement of a United States patent, copyright or proprietary right, then, without diminishing the Contractor's obligation to satisfy any final award, the Contractor may, with NYSIF's prior written approval, substitute other equally suitable software, equipment, materials, data and/or information. In the event that an action at law or in equity is commenced against NYSIF arising out of a claim that NYSIF's use of any software, equipment, materials and/or information under the Agreement infringes on any patent, copyright, or proprietary right, such action shall be forwarded by NYSIF to the Contractor for defense and indemnification under this Article and to the Office of the Attorney General of the State of New York together with a copy of the Agreement. If upon receipt of such request for defense, or at any time thereafter, the Contractor is of the opinion that the allegations in such action, in whole or in part, are not covered by the defense and indemnification set forth herein, the Contractor shall immediately notify NYSIF and the Office of the Attorney General of the State of New York, in writing, and shall specify to what extent the Contractor believes it is and is not obligated to defend and indemnify under the terms and conditions of the Agreement. The Contractor shall in such event protect the interests of the State of New York and shall take the steps necessary to secure a continuance to permit the State of New York to appear and defend its interest in cooperation with the Contractor, as is appropriate, including any jurisdictional defenses which the State shall have.

12. DATE/TIME WARRANTY

The Contractor warrants that products furnished pursuant to the Agreement shall be able to accurately process, date/time data (including, but not limited to, calculating, comparing, and sequencing) transitions, including leap year calculations. Where a Contractor proposes or an acquisition requires that specific products and/or services must perform as a package or system, this warranty shall apply to the products and/or services as a system.

Where the Contractor is providing ongoing services, including but not limited to: i) consulting, integration, code or data conversion, ii) maintenance or support services, iii) data entry or processing, or iv) contract administration services (e.g. billing, invoicing, claim processing), the Contractor warrants that services shall be provided in an accurate and timely manner without interruption, failure, or error due to the inaccuracy of the Contractor's business operations in processing date/time data (including, but not limited to, calculating, comparing, and sequencing) various date/time transitions, including leap year calculations. The Contractor shall be responsible for damages resulting from any delays, errors, or untimely performance resulting there from, including but not limited to the failure or untimely performance of such services.

This Date/Time Warranty shall survive beyond termination or expiration of the Agreement through a) ninety (90) days or b) the Contractor's or product manufacturer/developer's stated date/time warranty term, whichever is longer. Nothing in this warranty statement shall be construed to limit any rights or remedies otherwise available under the Agreement for breach of warranty.

13. VIRUS WARRANTY

Product contains no viruses, either known to the Contractor or which reasonably should have been known to the Contractor exercising due diligence. The Contractor is not responsible for viruses introduced at NYSIF's site.

14. TITLE AND OWNERSHIP WARRANTY

The Contractor warrants, represents and conveys (i) full ownership, clear title free of all liens, or (ii) the right to transfer or deliver perpetual license rights to any Product(s) transferred to NYSIF under the Agreement. The Contractor shall be solely liable for any costs of acquisition associated therewith. NYSIF may require the Contractor to furnish appropriate written documentation establishing the above rights and interests as a condition of payment. NYSIF's request or failure to request such documentation shall not relieve the Contractor of liability under this warranty.

15. USE RESTRICTIONS AND INTELLECTUAL PROPERTY

The Parties agree that all work by the Contractor for NYSIF is intended as work for hire. The Parties agree that the Contractor's work is specifically ordered and commissioned for use as contributions to a collective work, or is other such work as specified by section 101(2) of the U.S. Copyright Act [17 U.S.C. 101(2)], and is intended to be a work for hire that is made for the use and ownership of the State of New York and NYSIF. Furthermore, NYSIF and the Contractor agree that the State of New York and NYSIF are the owners of all copyrights regarding the work. The Contractor warrants to the State of New York and NYSIF that the Contractor, and all of its subcontractors and their employees, who have been, or may be used in regard to the Agreement, forfeits all past or future claims of title or ownership to the work produced.

Materials such as forms and publications used by the Contractor in the course of its performance under the Agreement which have been agreed upon by the Parties as generic materials are specifically excluded from this provision.

16. OWNERSHIP/TITLE TO PRODUCT DELIVERABLES

For purposes of this Article, the term "Department" is understood to mean NYSIF acting on behalf of the State.

(A) Definitions

1. Product(s):
   A deliverable furnished under the Agreement by or through the Contractor, including existing and custom Product(s), including, but not limited to: a) components of the hardware environment; b) printed materials (including but not limited to training manuals, system and user documentation, reports, drawings); c) third party software; d) modifications, customizations, custom programs, program listings, programming tools, data, modules, components; and e) any properties embodied therein, whether in tangible or intangible form (including but not limited to utilities, interfaces, templates, subroutines, algorithms, formulas, source code, object code).

2. Existing Product(s):

Tangible Product(s) and intangible licensed Product(s) which exist prior to the commencement of work under the Agreement. The Contractor retains the burden of proving that a particular product existed before commencement of the Agreement.

3. Custom Product(s):
   Product(s), preliminary, final or otherwise, which are created or developed by the Contractor, or its subcontractors, partners, employees, or agents under the Agreement for the benefit of NYSIF.

(B) Title to Project Deliverables

The Contractor acknowledges that it is commissioned by NYSIF to perform services detailed in the Agreement. Unless otherwise specified in writing in the Agreement, NYSIF shall have ownership and/or license rights as follows:

1. Existing Product(s):
   a) Hardware - Title and ownership of Existing Hardware Product shall pass to Department upon acceptance.

   b) Software - Title and ownership to Existing Software Product(s) delivered by the Contractor under the Agreement which is normally commercially distributed on a license basis by the Contractor or other independent software vendor/proprietary owner ("Existing Licensed Product"), whether or not embedded in, delivered or operating in conjunction with hardware or Custom Products, shall remain with the Contractor or other independent software vendor/proprietary owner ("ISV"). Effective upon acceptance, such Product shall be licensed to NYSIF in accordance with the Contractor or ISV owner's standard license agreement, provided, however, that such standard license, must, at a minimum: (a) grant NYSIF a non-exclusive, perpetual license to use, execute, reproduce, display, perform, adapt (unless the Contractor advises NYSIF as part of the Contractor's bid proposal that adaptation will violate existing agreements or statutes and the Contractor demonstrates such to NYSIF's satisfaction) and distribute Existing Licensed Product to NYSIF up to the license capacity stated in the work order with all license rights necessary to fully effect the general business purpose(s) stated in the Agreement and (b) recognize the State of New York as the licensee. Where these rights are not otherwise covered by the ISV's standard license agreement, the Contractor shall be responsible for obtaining these rights at its sole cost and expense. NYSIF shall reproduce all copyright notices and any other legend of ownership on any copies authorized under this paragraph.

2. Custom Product(s):
   Effective upon creation of Custom Product(s), the Contractor hereby conveys, assigns and transfers to State the sole and exclusive rights, title and interest in Custom Product(s), whether preliminary, final or otherwise, including all trademark and copyrights. The Contractor hereby agrees to take all necessary and appropriate steps to ensure that the Custom Product(s) are protected against unauthorized copying, reproduction and marketing by or through the Contractor, its agents, employees, or subcontractors. Nothing herein shall preclude the Contractor from otherwise using the related or underlying general knowledge, skills, ideas, concepts, techniques and experience developed under the Agreement in the course of the Contractor's business.

   Where payment for Custom Product does not involve Certificates of Participation (COPS) pursuant to Article 5-A of the State Finance Law or other third party financing, NYSIF may, by providing written notice thereof to the Contractor, elect

in the alternative to take a non-exclusive perpetual license to Custom Products in lieu of State taking exclusive ownership and title to such Products. In such case, NYSIF shall be granted a non-exclusive perpetual license to use, execute, reproduce, display, perform, adapt and distribute Custom Product as necessary to fully effect the general business purpose(s) as stated herein.

In the event that the Contractor wishes to obtain ownership rights to Custom Product(s), the sale or other transfer shall be at fair market value as determined by the Parties at the time of such sale or other transfer, and must be pursuant to a separate written agreement in a form acceptable to the State which complies with the terms of this paragraph.

3. Documentation, Data & Reports
NYSIF shall own title to all documentation, drawings, (e.g., engineering drawings, system diagrams, logic/schematics, plans, reports, training, maintenance or operating manuals), including network design, equipment configurations and other documentation prepared or developed pursuant to the Agreement, whether preliminary, final or otherwise. The Contractor shall deliver to the possession of NYSIF all work-in-progress documentation as it becomes available, but in no case longer than thirty (30) days after creation.

17. FORCE MAJEURE

Neither Party to the Agreement shall be liable or deemed to be in default for any delay or failure in performance under the Agreement resulting directly or indirectly from acts of God, civil or military authority, acts of public enemy, wars, riots, civil disturbances, insurrections, accident, fire, explosions, earthquakes, floods, the elements, acts or omissions of public utilities or strikes, work stoppages, slowdowns or other labor interruptions due to labor/management disputes involving entities other than the Parties to the Agreement, or any other causes not reasonably foreseeable or beyond the control of a Party. The Parties are required to use best efforts to eliminate or minimize the effect of such events during performance of the Agreement and to resume performance of the Agreement upon termination or cessation of such events.

18. TIME OF THE ESSENCE

NYSIF and the Contractor acknowledge and agree that time is of the essence for the Contractor's performance under the Agreement.

19. RIGHTS AND REMEDIES

The rights, duties and remedies set forth in the Agreement shall be in addition to, and not in limitation of, rights and obligations otherwise available at law.

20. FEDERAL AND STATE COMPLIANCE

The Contractor shall ensure that its employment practices comply with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended.

The Contractor shall ensure compliance with the Americans With Disabilities Act (42 USC §2101 et. seq.) such that programs and services provided during the course of performance of the Agreement shall be accessible under Title II of the Americans With Disabilities Act and as otherwise applicable under the Americans With Disabilities Act.

21. TAXES

It shall be understood that NYSIF, as an agency of the State of New York, is not liable for the payment of any sales, use, excise, or other form of tax however designated, levied or

imposed, and shall agree to reimburse the Contractor for same only if taxes would have been incurred through NYSIF's normal business operations.

22. INDEPENDENT CONTRACTOR

The Parties agree that the Contractor is an independent contractor, and the Contractor, its officers, employees, agents, consultants and/or sub-contractors in the performance of the Agreement shall act in an independent capacity and not as agents, officers or employees of the State or NYSIF. Neither the Contractor nor any sub-contractor shall thereby be deemed an agent, officer, or employee of the State. The Contractor agrees, during the term of the Agreement, to maintain at the Contractor's expense those benefits to which its employees would otherwise be entitled by law, including health benefits, and all necessary insurance for its employees, including worker's compensation, disability and unemployment insurance, and to provide NYSIF with certification of such insurance upon request. The Contractor remains responsible for all applicable federal, State, and local taxes, and all FICA contributions.

23. NO THIRD PARTY BENEFICIARIES

Nothing contained in the Agreement, expressed or implied, is intended to confer upon any person, corporation, other than the Parties hereto and their successors in interest and assigns, any rights or remedies under or by reason of the Agreement.

24. HEADINGS OR CAPTIONS

The headings or captions contained within the Agreement are intended solely for convenience and reference purposes and shall in no way be deemed to define, limit or describe the scope or intent of the Agreement or any provisions thereof.

25. PARTIAL INVALIDITY

Each Party agrees that it shall perform its obligations under the Agreement in accordance with all applicable federal and State laws, rules, and regulations, policies and/or guidelines now or hereafter in effect. If any term or provision of the Agreement shall be found to be illegal or unenforceable, then, notwithstanding such term or provision, the Agreement shall remain in full force and effect, and such term or provision shall be deemed stricken.

26. CONFLICT OF INTEREST

The Contractor shall ensure that its officers, employees, agents, consultants and/or sub-contractors comply with the requirements of the New York State Public Officers Law ("POL"), as amended, including but not limited to sections 73 and 74, as amended, with regard to ethical standards applicable to State employees, and particularly POL sections 73(8)(a)(i) and (ii) regarding post-employment restrictions affecting former State employees. Additionally, the Contractor shall ensure that no violation of these provisions will occur by reason of the Contractor's proposal for or negotiation and execution of the Agreement or in its delivery of services pursuant to the Agreement. If, during the term of the Agreement, the Contractor becomes aware of a relationship, actual or potential, which may be considered a violation of the POL or which may otherwise be considered a conflict of interest, the Contractor shall notify NYSIF in writing immediately. Should NYSIF thereafter determine that such employment is inconsistent with State law; NYSIF shall so advise the Contractor in writing, specifying its basis for so determining, and may require that the contractual or employment relationship be canceled. Failure to comply with these provisions may result in suspension or cancellation of the Agreement and criminal proceedings as may be required by law.

The Contractor is required to make full disclosure of any circumstances that could affect its ability to perform in complete compliance with the POL. Any questions as to the

applicability of these provisions should be addressed by the Contractor to the New York State Ethics Commission, 540 Broadway, Albany, NY 12207 (518) 408-3976.

27. AUDIT AUTHORITY

The Contractor acknowledges that NYSIF and the Office of the State Comptroller have the authority to conduct financial and performance audits of the Contractor's delivery of Program Services (or Project Services) in accordance with the Agreement and any applicable State and federal statutory and regulatory authorities. Such audit activity may include, but not necessarily be limited to, the review of documentary evidence to determine the accuracy and fairness of all items on the Contractor's submission of claims for payment under the Agreement, and the review of any and all activities relating to the Contractor's performance and administration of the Agreement.

The Contractor shall make available documentary evidence necessary to perform such reviews. Documentation made available by the Contractor may include, but is not limited to, source documents, books of account, subsidiary records and supporting work papers, claim documentation and pertinent contracts and correspondence.

The audit provisions contained herein shall in no way be construed to limit the audit authority or audit scope of the Office of the State Comptroller as set forth in Appendix A of the Agreement - Standards Clauses for All New York State Contracts.

28. CONFIDENTIALITY

All records maintained by the Contractor and relating to the Agreement are confidential and shall be used by the Contractor and its officers, employees, and subcontractors or agents solely for the purpose of carrying out its obligations under the Agreement. Except as directed by a court of competent jurisdiction or as may be permitted or required by applicable New York State or federal law or regulations, no such records may be otherwise used or released to any person by the Contractor, its employees, subcontractors or agents, either during the term of the Agreement or in perpetuity thereafter. Deliberate or repeated accidental breach of this provision may, at the sole discretion of NYSIF, be grounds for termination of the Agreement.

The Contractor shall promptly advise NYSIF of all requests made to the Contractor for information regarding the performance of services under the Agreement, including any information provided by NYSIF, except as required by subcontractors or agents solely for the purpose of carrying out obligations under the Agreement or as required by law.

The Contractor shall be responsible for assuring that any agreement between the Contractor and any of its officers, agents and employees or applicable subcontractors contains a provision that conforms strictly to the provisions of this Article.

29. INFORMATION SECURITY REQUIREMENTS

In accordance with the Information Security Breach and Notification Act (ISBNA) (General Business Law §889-aa, State Technology Law §208), Contractor shall be responsible for complying with provisions of the ISBNA and the following terms contained herein with respect to any private information (as defined in ISBNA) received by Contractor under the Agreement (Private Information) that is within the control of the Contractor either on NYSIF's information security systems or the Contractor's information security system (System). In the event of a breach of the security of the System (as defined by ISBNA), Contractor shall immediately commence an investigation, in cooperation with NYSIF, to determine the scope of the breach and restore security of the System to prevent any further

breaches. Contractor shall also notify NYSIF of any breach of the security of the System immediately following discovery of such breach.

Except as otherwise instructed by NYSIF, Contractor shall, to the fullest extent possible, first consult with and receive authorization from NYSIF prior to notifying any individuals, the State Office of Cyber Security and Critical Infrastructure Coordination (CSCIC), the State Consumer Protection Board and the Office of the Attorney General (OAG) or any consumer reporting agencies of a breach of the security of the System or concerning any determination to delay notification due to law enforcement investigations. Contractor shall be responsible for providing the notice to all such required recipients and for all the costs associated with providing such notice. Contractor shall be liable for any other costs associated with noncompliance of ISBNA if caused by the Contractor or Contractor's agents, officers, employees, or subcontractors. Nothing herein shall in any way impair the authority of the OAG to bring an action against the Contractor to enforce the provisions of ISBNA or limit Contractor's liability for any violation of the ISBNA. Additional information relative to the law and the notification process is available at:
http://www.cscic.state.ny.us/security/securitybreach

Contemporaneous with the execution of the Agreement, the Contractor and its designees shall execute NYSIF's Third Party Connection and Data Exchange Agreement and any other protocol required by NYSIF, and shall ensure its employees, agents and designees complete the related Third Party Acceptable Use Policy and Agreement if applicable, to ensure the security of data transmissions and other information related to the administration of the Agreement. This request may be waived by NYSIF in its sole discretion.

30. NONDISCLOSURE OF CONFIDENTIAL INFORMATION

Except as may be required by applicable law or a court of competent jurisdiction, the Contractor, its officers, agents, employees, and subcontractors shall maintain strict confidence with respect to any Confidential Information to which the Contractor, its officers, agents, employees, and subcontractors have access in the course of the Contractor's performance under the Agreement. For purposes of the Agreement, all State information of which the Contractor, its officers, agents, employees and subcontractors becomes aware during the course of performing services for NYSIF shall be deemed to be Confidential Information (oral, visual or written). Notwithstanding the foregoing, information that falls into any of the following categories shall not be considered Confidential Information:

(a) information that is previously rightfully known to the receiving party without restriction on disclosure;
(b) information that becomes, from no act or failure to act on the part of the receiving party, generally known in the relevant industry or is in the public domain; and
(c) information that is independently developed by the Contractor without use of confidential information of the State.

The Contractor shall hold the State and NYSIF harmless from any loss or damage to the State or NYSIF resulting from the disclosure by the Contractor, its officers, agents, employees, and subcontractors of such Confidential Information.

The Contractor shall provide for its officers, agents, employees, and subcontractors to acknowledge and execute a nondisclosure agreement containing substantially the terms described in this Article, if requested to do so by NYSIF or the State.

This representation shall survive termination of the Agreement.

31. FREEDOM OF INFORMATION LAW

Disclosure of information and material provided to NYSIF by the Contractor in the course of the Contractor's performance under the Agreement shall be permitted consistent with the laws of the State of New York, and specifically the Freedom of Information Law (FOIL), Article 6 of the Public Officers Law. NYSIF shall take reasonable steps to protect from public disclosure any of the records relating to the Contractor's performance under the Agreement that otherwise are exempt from disclosure under FOIL.

If the Contractor believes that any information or material provided to NYSIF constitutes trade secret information that should be exempted from FOIL disclosure, the Contractor must, at the time of the materials' submission, request the exemption in writing, specifically identifying the material by page number, line, or other appropriate designation, and provide a particularized explanation as to why the material constitutes trade secret information and how the disclosure of the identified information would cause substantial injury to the Contractor's competitive position. The material sought to be protected from disclosure must be clearly marked in yellow highlighter, on a duplicate copy of the submission and may be provided in hardcopy or on a CD. Generically marking all material as "Confidential" will not be considered adequate for the purpose of this Article.

NYSIF's receipt of the Contractor's submission of material and the Contractor's request for protection of the material from FOIL disclosure does not constitute a determination that the information is exempt from disclosure under FOIL. In the event any information or material is requested pursuant to FOIL, NYSIF will address each party's interests fully in accordance with the procedures required by Article 6 of the Public Officers Law.

32. TERMINATION OF AGREEMENT

In addition to any termination provisions specified elsewhere in the Agreement, the following provisions also shall apply:

The Agreement may be terminated by mutual written agreement of the Parties.

The Agreement may be terminated by NYSIF for cause upon the failure of the Contractor to comply with the terms and conditions of the Agreement, including any exhibits incorporated herein, provided that NYSIF shall give the Contractor written notice via registered or certified mail, return receipt requested, or hand delivery, such written notice to specify the Contractor's failure and the termination of the Agreement. Termination shall be effective ten (10) Business Days after receipt of such notice unless the Contractor, in the opinion of NYSIF, has cured such failure. The Contractor agrees to incur no new obligations nor to claim for any expenses made after receipt of the notification of termination. Upon termination for cause, NYSIF shall have the right to award a new contract to another contractor. Termination for cause shall create a liability upon the Contractor for actual damages incurred and for all reasonable additional costs incurred in reassigning the Agreement.

The Agreement may be terminated if NYSIF deems that termination would be in the best interest of the State provided that NYSIF shall give written notice to the Contractor not less than thirty (30) Days prior to the date upon which termination shall become effective, such notice to be made via registered or certified mail, return receipt requested or hand delivered. The date of such notice shall be deemed to be the date of postmark in the case of mail or the date of hand delivery.

The Agreement may be terminated immediately in the event NYSIF determines that funds are unavailable. NYSIF agrees to provide notice to the Contractor as soon as it becomes aware that funds are unavailable in the event of termination under this paragraph. If the initial notice is via oral notification, NYSIF shall provide written notice immediately

thereafter. NYSIF shall be obligated to pay the Contractor only for the expenditures made and obligations incurred by the Contractor until such time as notice of termination or received either orally or in writing by the Contractor from NYSIF.

In the event of termination for any reason, the Contractor shall not incur new obligations for the terminated portion. The Contractor agrees, after consultation with NYSIF, to cancel such outstanding obligations as the Contractor deems appropriate in the exercise of sound business judgment.

Upon termination of the Agreement each Party shall, if applicable, return to the other all papers, materials, and other properties of the other Party held by each for purposes of performance under the Agreement. In addition, each Party shall assist the other Party in orderly termination of the Agreement and the transfer of all aspects hereof, tangible, and intangible, as may be necessary to ensure the orderly administration of the State program.

33. CONTRACTOR PERSONNEL

The Contractor shall designate an Account Executive, who shall be the contact person for all matters arising under the Agreement.

The Contractor agrees to be solely responsible for the recruitment, hiring, provision of employment benefits, payment of salaries, and management of its personnel. These functions shall be carried out by the Contractor in accordance with the provisions of the Agreement and with all applicable federal and State laws and regulations.

The Contractor is required to commit key personnel for the administration of all aspects of the Agreement. In the event that any of the key personnel will be or are unavailable for the performance of their duties, the Contractor will designate and propose to NYSIF an equally qualified alternate with full authority to act for the unavailable key person.

The Contractor shall notify NYSIF in writing of any changes in the key personnel designated for performance of the Agreement. This shall include any changes in the personnel designated to bind the Contractor.

NYSIF reserves the right to demand the reassignment or cancellation of assignment to duties under the Agreement of any Contractor personnel so assigned. NYSIF shall not exercise the authority unreasonably. The Contractor agrees to replace any employees so reassigned or canceled with an employee of equal or better qualifications. If NYSIF exercises its right under this provision, it agrees to provide written notice to the Contractor setting forth its reasons with specificity.

34. OPERATIONAL CONTACTS

The Contractor shall maintain appropriate corporate and/or legal authority, which shall include, but not be limited to, the maintenance of an organization capable of delivering Program Services in accordance with the Agreement and the authority to do business in the State of New York or any other governmental jurisdiction in which Program Services are to be delivered pursuant to the Agreement. The Contractor also shall maintain operations, financial and legal staff that shall be directly available to NYSIF's operations, financial and legal staff, respectively. For purposes of the Agreement, maintenance of such staff and staff availability by the Contractor shall in no way create any agency relationship between NYSIF and the Contractor.

The Contractor acknowledges and agrees that no aspect of the Contractor's performance under the Agreement is contingent upon NYSIF personnel or the availability of NYSIF resources, with the exception of all proposed actions of the Contractor specifically identified

in the Agreement as requiring NYSIF approval. With respect to such approval, NYSIF shall act promptly and in good faith.

The Contractor must cooperate fully with any other contractors who may be engaged by NYSIF relative to the the Agreement.

The Contractor must ensure that all contacts by the Contractor personnel with other New York State agencies, external organizations (Federal Agencies, Unions, etc.) which result in any charge, cost or payment of any kind, must receive prior written authorization from NYSIF's Contract Manager.

35. SUBCONTRACTING

If allowed in the solicitation instrument (e.g., Request for Proposal, Invitation for Bids, etc.) that results in the Agreement, the Contractor may arrange for specified portion(s) of its responsibilities under the Agreement to be subcontracted to a Key Subcontractor(s). A "Key Subcontractor" means that vendor(s) with whom the Contractor subcontracts to provide any portion of Program Services. If the Contractor determines to subcontract a portion(s) of Program Services, the Key Subcontractors must be clearly identified and the nature and extent of its involvement in and/or proposed performance under the Agreement must be fully explained by the Contractor to NYSIF. The Contractor retains ultimate responsibility for all Program Services performed under the Agreement.

All subcontracts shall be in writing and shall contain provisions, which are functionally identical to, and consistent with, the provisions of the Agreement including, but not be limited to, the body of the Agreement, Appendix A - Standard Clauses For All New York State Contracts, Appendix B - Standard Clauses for All NYSIF Contracts and if applicable as determined by NYSIF, Appendix C - Third Party Connection and Data Exchange Agreement. Unless waived in writing by NYSIF, all subcontracts between the Contractor and a Key Subcontractor shall expressly name the State of New York, through NYSIF, as the sole intended third party beneficiary of such subcontract. NYSIF reserves the right to review and approve or reject any subcontract with a Key Subcontractor, as well as any amendments to said subcontract(s), and this right shall not make NYSIF or the State of New York a party to any subcontract or create any right, claim, or interest in the Key Subcontractor or proposed Key Subcontractor against NYSIF.

NYSIF reserves the right, at any time during the term of the Agreement, to verify that the written subcontract between the Contractor and Key Subcontractor(s) is in compliance with all of the provision of this Article and any subcontract provisions contained in the Agreement. In addition to other remedies allowed by law, NYSIF reserves the right to terminate the Agreement for cause if an executed subcontract does not contain all of the provisions/statements stipulated above. If during the term of the Agreement, any executed subcontract between the Contractor and a Key Subcontractor is amended, the Contractor shall, within 30 calendar days of such amendment, provide a copy to NYSIF.

The Contractor shall give NYSIF immediate notice in writing of the initiation of any legal action or suit which relates in any way to a subcontract with a Key Subcontractor or which may affect the performance of the Contractor's duties under the Agreement. Any subcontract shall not relieve the Contractor in any way of any responsibility, duty and/or obligation of the Agreement.

36. PUBLICITY AND COMMUNICATIONS

The Contractor shall ensure that all requests for the Contractor's participation in events where the Contractor will be participating on behalf of NYSIF receive prior written authorization from NYSIF.

No public discussion or news releases relating to the Agreement shall be made or authorized by the Contractor or the Contractor's agent without the prior written approval of NYSIF, which written approval shall not be unreasonably withheld or delayed provided, however, that Contractor shall be authorized to provide copies of the Agreement and answer any questions relating thereto to any State or federal regulators or, in connection with its financial activities, to financial institutions for any private or public offering.

37. CONSULTANT DISCLOSURE REQUIREMENTS

Unless directed otherwise by NYSIF, the Contractor shall demonstrate its compliance with Chapter 10 of the Laws of 2006 throughout the term of the Agreement by submitting to NYSIF and to the Office of the State Comptroller a "State Consultant Services - Contractor's Annual Employment Report" for each State Fiscal Year. Such report shall be due no later than May 15th of each year following the end of the State Fiscal Year being reported. Such report shall be required of any contract that includes services for analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health and mental health services, accounting, auditing, paralegal, legal, or similar services. Such report shall conform with Bulletin No. G-226 – Form B as issued by the Office of the State Comptroller. The report must be submitted to the Office of the State Comptroller, Bureau of Contracts, 110 State Street, 11th floor, Albany, NY 12236, ATTN: Consultant Reporting; and to NYSIF's Contract Manager.

38. PROCUREMENT LOBBYING RESTRICTIONS UNDER STATE FINANCE LAW SECTIONS 139-j AND 139-k

The Contractor certifies that all information that it has provided or will provide to NYSIF pursuant to State Finance Law sections 139-j and 139-k is complete, true, and accurate, including but not limited to information regarding prior determinations of non-responsibility within the past four years based upon (i) impermissible contacts of other violations of SFL section 139-j, or (ii) the intentional provision of false or incomplete information to a governmental entity.

NYSIF reserves the right to terminate the Agreement in the event it is found that the Contractor's certification of its compliance with SFL sections 139-j or 139-k was intentionally false or intentionally incomplete. Upon such finding, NYSIF may exercise its right to terminate the Agreement by providing written notification to the Contractor in accordance with Article 9 of this Appendix B.

39. VENDOR RESPONSIBILITY

The Contractor is required to provide NYSIF with an updated Vendor Responsibility Questionnaire when requested to do so by NYSIF throughout the term of the Agreement. Regardless, the Contractor is required to report to NYSIF any material changes in the information reported in its initial Vendor Responsibility Questionnaire.

40. TAX LAW SECTION 5-A - CERTIFICATION REGARDING SALES AND COMPENSATING USE TAXES

In the event the value of the Agreement exceeds $100,000, the Contractor must file a properly completed Form ST-220-CA with NYSIF and a properly completed Form ST-220-TD with NYSIF of Taxation & Finance before the Agreement may take effect.

In addition, after the Agreement has taken effect, the Contractor must file a properly completed Form ST-220-CA with NYSIF if the Agreement's term is renewed; further, a new Form ST-220-TD must be filed with NYSIF of Taxation & Finance if no ST-220-TD has been filed by the Contractor or if a previously filed Form ST-220-TD is no longer correct and complete.

41. CONTRACT PAYMENT

Contractor shall provide complete and accurate billing invoices to NYSIF in order to receive payment. Billing invoices submitted to NYSIF must contain all information and supporting documentation required by the Agreement, NYSIF and the State Comptroller. Payment for invoices submitted by the Contractor shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The Contractor shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by e-mail at epunit@osc.state.ny.us, or by telephone at 518-474-4032. Contractor acknowledges that it will not receive payment on any invoices submitted under the Agreement if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

May 2011

THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

THIS AGREEMENT (the "Agreement") by and between the NYS Department of Civil Service ("DCS"), with principal offices in Albany, NY 12239, and

with principal offices at

(hereinafter "Third Party"), is entered into as of the date last written below ("the Effective Date").

This Agreement consists of this signature page and the following attachments incorporated by reference:

1. Attachment 1: Third Party Connection and Data Exchange Agreement Terms and Conditions
2. Attachment 2: Third Party Connection and Data Exchange Request Requirements Document
3. Attachment 3: Third Party Acceptable Use Policy and Agreement
4. Attachment 4: DCS Equipment Loan Agreement (Applicable: ☐Yes ☐No)

This Agreement may only be modified by a written document executed by the parties hereto. Any disputes arising out of or in connection with this Agreement shall be governed by New York State law without regard to choice of law provisions.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed. Each party warrants and represents that its respective signatories whose signatures appear below have been and are on the date of signature duly authorized to execute this Agreement.

Third Party Name:	*NYS Department of Civil Service (DCS)*
Authorized Signature	Authorized Signature
Name *(Print)*	Name *(Print)*
Date	Date

THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

ATTACHMENT 1 – SECURITY REQUIREMENTS

1. ***Right to Use Connection***

Third Party may only use the connection and the information obtained from DCS for business purposes as outlined by the Third Party Connection and Data Exchange Request Requirements Document (Attachment 2*)*.

2. ***Data Exchange***

2.1 Third Party may only use the data obtained for purposes outlined by the Third Party Connection and Data Exchange Request Requirements Document (Attachment 2) and the contract or Memoranda of Understanding, if any, that exists between DCS and Third Party for the provision of goods or services or governing conduct between DCS and Third Party with respect to the access to and use of DCS data.

2.2 Data exchange may be conducted only by methods and/or services outlined by the Third Party Connection and Data Exchange Request Requirements Document (Attachment 2). Third Party should expect that access to information and services may be limited, as determined or required by DCS.

3. ***Network Security***

3.1 Third Party will allow only its own employees approved in advance by DCS ("Third Party Users") to access the Network Connection or any DCS-owned equipment. Third Party shall be solely responsible for ensuring that Third Party Users are not security risks, and upon DCS' request, Third Party will provide DCS with any information reasonably necessary for DCS to evaluate security issues relating to any Third Party User.

3.2 Third Party will promptly notify DCS whenever any Third Party User leaves Third Party's employ or no longer requires access to the connection or DCS-owned Equipment.

3.3 Each Party will be solely responsible for the selection, implementation, and maintenance of security procedures and policies that are sufficient to ensure that (a) such party's use of the connection (and Third Party's use of DCS-owned Equipment) is secure and is used only for authorized purposes, and (b) such Party's business records and data are protected against improper access, use, loss alteration or destruction.

3.4 The preferred connectivity method is via the Internet to a DCS-approved or DCS-provided Virtual Private Network (VPN) device. If the device is DCS-provided, DCS will loan the Third Party, in accordance with the DCS Equipment Loan Agreement, the required client software for establishing VPN connections with DCS. Normal DCS perimeter security measures will control access to the internal network.

3.5 Extranet – Designated routers are used in combination with firewall rules to allow access to be managed. A second authentication may be required.

3.6 Remote Access - Using the DCS-provided remote access software, Third Party will connect via an Internet browser. The account may be disabled until usage is required and controls are placed and managed by DCS. Third Party will be required to follow procedures to enable the account for each use.

3.7 Third Party Connections will be audited. All remote access user accounts for Third Parties will be given an expiration time. Renewals must be requested by Third Party and approved by the Department Sponsor. Obsolete Third Party connections will be terminated.

3.8 Software versions on all Third Party computers that connect to the DCS network must be versions that are currently supported by the software manufacturer, and all available security updates and hot fixes for that software must be applied in a timely fashion. Software and firmware for all Third Party networking equipment that is part of the connection to the DCS network must be kept up to date, especially with patches that fix security vulnerabilities.

3.9 Anti-virus software and firewalls must be installed and enabled at all times on DCS-owned computers and on Third Party computers that connect to the DCS network. Additionally, virus definition files must be kept up to date.

3.10 In no case may a Third Party Connection to DCS be used as an Internet Connection for Third Party or for a Third Party User.

4. *Notifications*

4.1 Third Party shall notify DCS in writing promptly of any change in its Users for the work performed over the Network Connection or whenever Third Party believes a change in the connection and/or functional requirements of the connection is necessary.

4.2 Any notices required by this Agreement shall be given in hand, sent by first class mail, or via facsimile to the applicable address set forth below.

Third Party Name:	NYS Department of Civil Service Albany, New York 12239
Address:	
Attention:	Attention:

5. ***Citizen Notifications***

If Third Party maintains "identifying personal information" on behalf of the Department and such information is compromised, Third Party shall notify the Department immediately that the information has been compromised, the circumstances under which the information was compromised, and the measures undertaken by Third Party to address those circumstances and to otherwise mitigate the effects of the compromise. If encrypted data is compromised along with the corresponding encryption key and encryption software, the data shall be considered unencrypted and the information will be considered compromised through unauthorized access. If the Department requests Third Party to do so, Third Party shall notify the persons whose identifying information was compromised. Such notification shall be communicated via postal service or email, as directed by the Department, and shall otherwise be executed in accordance with the Department's direction. Notification shall be delayed if a law enforcement agency determines that such notification may impede a criminal investigation. For the purpose of this section, "identifying personal information" shall be any information concerning an individual which, because of name, number, symbol, mark or other identifier in combination with any of the following, is unencrypted: (1) Social Security Number; or (2) driver's license number; or (3) financial account number, credit or debit card number, in combination with any required security code, access code, or password which would permit access to an individual's financial account; or (4) password which would permit access to the individual's account.

6. ***Payment of Costs***

Each Party will be responsible for all costs incurred by that Party under this Agreement, including, without limitation, costs for phone charges, telecommunications equipment and personnel for maintaining the connection.

7. ***Confidentiality***

7.1 Information exchanged for the business purposes outlined in Attachment 2 will be held confidential by the Parties to the maximum extent permitted by law. Each Party may internally use the information received from the other Party hereunder in connection with and as specifically necessary to accomplish the Business Purpose set forth in Attachment 2 and for no other purposes. Each Party may otherwise share such information with other third parties (e.g. consultants, subcontractors, control agencies) as required or permitted by law in order to effect the business purposes outlined in Attachment 2 and for no other purposes, provided that such third parties agree to the confidentiality restrictions set forth herein and as may be required otherwise by State and federal law.

7.2 Third Party must implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the sensitive information that it creates, receives, maintains, or transmits on behalf of DCS.

7.3 Unencrypted DCS information must not be transmitted over email.

7.4 Third Party must ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it and report to the DCS Help Desk any security incident of which it becomes aware.

8. ***Third Party Users***

8.1 Third Party must require that each Third Party User executes a Third Party Acceptable Use Policy and Agreement (Attachment 3). Third Party must ensure that DCS is notified by fax or mail when the user base changes, following the specifications in the Third Party Connection & Data Exchange Agreement.

8.2 All aspects of Third Party connections within DCS control may be monitored by the appropriate DCS support group and/or the DCS Information Security Officer. Any unauthorized use or change to devices will be investigated immediately.

8.3 All Third Party Connections will be reviewed on a regular basis and information regarding specific Third Party connection will be updated as necessary. Obsolete Third Party connections will be terminated.

9. ***DCS-owned Equipment***

9.1 DCS may, in DCS' sole discretion, loan to Third Party certain equipment and/or software for use on Third Party premises (the DCS-owned Equipment) under the terms of the DCS Equipment Loan Agreement set forth in Attachment 4. DCS-owned equipment will only be configured for TCP/IP, and will be used solely by Third Party on Third Party's premises or other locations authorized by DCS for the purposes set forth in this Agreement. DCS is responsible for ensuring that it has the right under applicable software licenses to permit third party use.

9.2 Third Party may modify the configuration of the DCS-owned equipment only after notification and approval in writing by authorized DCS personnel.

9.3 Third Party will not change or delete any passwords set on DCS-owned equipment without prior approval by authorized DCS personnel. Promptly upon any such change, Third Party shall provide DCS with such changed password.

10. ***Term, Termination and Survival***

10.1 This Agreement will remain in effect until terminated by either Party, but in no event prior to the termination or expiration of any contract or agreement between the Parties for the purchase of goods or services that provides the business purpose for the exchange of data between the Parties, unless both Parties mutually agree to so terminate this Agreement.

10.2 Upon termination, Third Party shall return all tangible DCS data to DCS within a timeframe specified by DCS for that purpose, and further shall certify in writing to DCS that all other DCS data in whatever form has been destroyed. Additionally, any DCS-owned equipment and/or software shall be promptly returned to DCS at Third Party's expense.

10.3 Notwithstanding the above, the Parties' obligations to safeguard the confidentiality of the data subject to this Agreement shall survive the termination of this Agreement, and shall bind the Parties' employees, subcontractors, agents, heirs, successors and assigns.

11. Severability

If for any reason a court of competent jurisdiction finds any provision or portion of this Agreement to be unenforceable, that provision of the Agreement will be enforced to the maximum extent permissible so as to affect the intent of the Parties, and the remainder of this Agreement will continue in full force and effect.

12. Waiver

The failure of any Party to enforce any of the provisions of this Agreement will not be construed to be a waiver of the right of such Party thereafter to enforce such provisions.

13. Assignment

Third Party may not assign this Agreement, in whole or in part, without the prior written consent from DCS. Any attempt to assign this Agreement, without such consent, will be null and of no effect. Subject to the foregoing, this Agreement is for the benefit of and will be binding upon the parties' respective successors and permitted assigns.

14. *Force Majeure*

Neither Party will be liable for any failure to perform its obligations if such failure results from any act of God or other cause beyond such Party's reasonable control (including, without limitation, any mechanical, electronic or communications failure) which prevents such party from transmitting or receiving any data.

15. *Partial Invalidity*

If this Agreement is entered into as a consequence of Third Party's provision of goods or services to DCS pursuant to a contract or other written agreement, that Agreement supersedes this Agreement to the extent the agreements' provisions may be inconsistent.

THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

ATTACHMENT 2 – REQUEST REQUIREMENTS

In accordance with the DCS *Third Party Connection and Data Exchange Policy*, all requests for Third Party connections and data exchanges must be accompanied by this completed requirements document. This document should be completed by the DCS person or group requesting the Third Party connection and/or data exchange. The DCS Department Sponsor must be the Director of the Division whose business requires the Third Party connection and/or data exchange. DCS Divisions are encouraged to work with their IRM Liaison to complete the information in this document.

Part 1 – Business Justification

A. DCS Sponsor *(Division Director)*

Name: Division:

Office Location: Phone Number:

Email Address:

Back-up Point of Contact: (Data Custodian)

Name: Division:

Office Location: Phone Number:

Email Address:

B. Business Reason for Connection *(To be completed by Sponsor)*

State the purpose of establishing the connection and the purpose of the data transmission. Specify the business needs of the proposed connection. Use additional sheets of paper if needed.

C. Specify the details of the work to be accomplished via the connection. What applications will be used? What information will be used? What transactions will be accomplished?

D. Specify the Third Party Controls to be Implemented for Safeguarding DCS Data:
Access Controls:

Audit Controls:

Working procedures or practices for handling printed material and verbal exchanges:

Method of Disposal of media and paper:

User Account Management, including review of accounts:

Physical Security:

Other:

E. Estimated number of hours of use each week?

☐ 1 – 20 ☐ 21 – 40 ☐ More than 40 hours per week

F. Anticipated normal hours of use?

☐ M – F, 8:00 – 5:00 pm Eastern time ☐ Other (specify):

G. What is the requested installation date? *(Minimum lead-time is 30 days)*

H. Approximately how long will the connection be needed?

☐ Up to 6 months ☐ 6 – 12 months ☐ More than 12 months
☐ Specific time period:

Note: If a connection is needed for more than a year, the Connection Agreement must be renewed annually.

I. Other useful information

J. Third Party Information

Name of Third Party: Main Phone Number:

Main Office Address:

Management Contact

Name: Department:

Address: Email Address:

Phone Number: Manager's Name:

Manager's Phone:

Backup Contact

Name: Department:

Address: Email Address:

Phone Number: Manager's Name:

Manager's Phone:

Technical Contact

Name: Department:

Address: Email Address:

Phone Number:

Manager's Name: Manager's Phone:

Technical Support Hours:

Escalation List:

Domain name(s): Host name(s):

User Names and Contact Information. *(List all employees of the Third Party who will use this access.)*

User 1 *(name, phone, email):*

User 2 *(name, phone, email):*

User 3 *(name, phone, email):*

User 4 *(name, phone, email):*

User 5 *(name, phone, email):*

User 6 *(name, phone, email):*

User 7 *(name, phone, email):*

User 8 *(name, phone, email):*

User 9 *(name, phone, email):*

User 10 *(name, phone, email*):

K. Other information

THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

ATTACHMENT 3 – THIRD PARTY ACCEPTABLE USE POLICY AND AGREEMENT

This Policy and Agreement applies to all forms of computer and networking use, including local access at the Department of Civil Service (DCS) premises, remote access via public or private networks, access using DCS equipment, access using individual or group accounts, and access via other methods.

A signed paper copy of this form must be submitted by any individual (1) for whom authorization of a new user account is requested, (2) who will use a shared third party account, and/or (3) who is requesting reauthorization of an existing use. Modifications to the terms and conditions of this agreement will not be accepted by DCS management.

Indicate here if this is a notification that the User named below no longer requires access: ☐

User's Name *(print)*:			
Organization:			
Telephone Number:	Area code	Number	Extension
Office Address:			

The undersigned acknowledges that he or she has read, understands, and agrees to comply with this Third Party Acceptable Use Policy and Agreement governing the use of DCS computing resources.	
User Signature:	Date:

You must sign this signature page and send it to DCS. Retain a copy of the signature page and the attached Policy for your records. This form must be delivered either by fax or mail to:

MAIL: **NYS Department of Civil Service, Albany, NY 12239**
Attention: Help Desk
FAX: **518-485-5588**

THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

ATTACHMENT 3 – THIRD PARTY ACCEPTABLE USE POLICY AND AGREEMENT

I. *Protection of DCS Information*

All records and information maintained in DCS systems accessed by the User are confidential and shall be used by the User solely for the purpose of carrying out the User's official duties. Users may not use any such records and information for any other purpose. No such records or information may otherwise be used or released to any person by the User or by the User's employer or agent, except as may be required by applicable State or federal law or by a court of competent jurisdiction. All accounts and connections will be regularly reviewed.

II. *DCS Log-on Banner*

All users will follow the guidelines of the DCS Log-on Banner as stated below.

NOTICE * The contents of this banner have been recommended to all State agencies by the Office for Technology in the NYS Preferred Standards and Procedures for Information Security. * This electronic system, which includes hardware, software and network components and all data contained therein (the "system"), is the property of the New York State Department of Civil Service (DCS). * Unauthorized use or attempted unauthorized use of this system is not permitted and may constitute a federal or state crime. Such use may subject you to appropriate disciplinary and/or criminal action. Use of this system is only permitted to the extent authorized by DCS. * Use is limited to conducting official business of DCS. Under the Electronic Communications Privacy Act of 1986 (18 U.S.C. 2510, et seq.), notice is hereby given that there are NO facilities provided by this system for sending or receiving private confidential electronic communication. Any use, whether authorized or not, may be monitored, intercepted, recorded, read, copied, accessed or captured in any manner, and used or disclosed in any manner, by authorized DCS personnel without additional prior notice to users. In this regard, users have no legitimate expectation of privacy during any use of this system or in any data on this system. * Use, whether authorized or unauthorized, constitutes expressed consent for DCS to monitor, intercept, record, read, copy, access or capture and use or disclose such information. * DCS policy regarding this matter can be reviewed on the DCS internal website. Copies can also be obtained from the Office of Human Resources Management. Such policies are subject to revision. This notice is consistent with the Acceptable Use Policy issued to DCS employees regarding acceptable use, June 15, 2005. I have read and understand this notification and department policy.

III. *Passwords*

The User is not permitted to share his/her password with anyone. Passwords must never be written down. The User must not use the same password for multiple applications. The User must use passwords that are not easily guessed and must not use their email address as their password.

IV. ***Shared Accounts***

All use of shared accounts must be authorized by DCS. Users of shared accounts must be identified to DCS via the completion and signing of this policy/agreement. Third Parties are responsible for notification to DCS when the user base changes. Passwords for shared accounts must not be provided to individuals who have not been identified by Third Party to DCS and who have not completed and signed this policy/agreement.

V. ***Virus Protection***

Anti-virus software must be installed and enabled at all times on DCS-owned computers and on third party computers used to conduct DCS business. Virus definition files must be kept up to date. DCS Information Resource Management (IRM) provides anti-virus software and maintains the configuration of that software for all DCS-owned computers.

VI. ***Acceptable Use***

DCS computers, computing systems and their associated communication systems are provided to support the official business of DCS. All uses inconsistent with DCS' business activities and administrative objectives are considered to be inappropriate use.

Examples of unacceptable behavior include, but are not limited to the following.

- Any illegal activities that could result in legal actions against and/or financial damage to DCS.
- Computer usage that reasonably harasses or offends other employees, users, or outsiders, or results in public embarrassment to DCS.
- Computer usage that is not specifically approved and which consumes significant amounts of computer resources not commensurate with its benefit to DCS' mission or which interferes with the performance of a worker's assigned job responsibilities.
- Use in connection with compensated outside work or unauthorized not-for-profit business activities.
- Use of sniffers, spyware, ad-ware or other related technology.

VII. ***Software Protection***

The User is responsible for complying with copyright, licensing, trademark protection, and fair use restrictions.

VIII. ***Reporting Incidents***

Users are required to report incidents of system errors, data discrepancies, application performance problems, to the DCS Help Desk, at 518-457-5406 phone; 518-485-5588 fax.

IX. *DCS Rights*

Pursuant to the Electronic Communications Privacy Act of 1986 (18 USC 2510 et seq.), notice is hereby given that there are no facilities provided by this system for sending or receiving private or confidential electronic communications. DCS has access to all access attempts, messages created and received, and information created or stored using DCS resources, and will monitor use as necessary to assure efficient performance and appropriate use. Information relating to or in support of illegal activities will be reported to the appropriate authorities.

DCS reserves the right to log and monitor use. DCS reserves the right to remove a user account from the network. DCS assumes no responsibility or liability for files or information deleted.

The DCS will not be responsible for any damages. This includes the loss of data resulting from delays, non-deliveries, or service interruptions caused by negligence, errors or omissions, or caused by the way the user chooses to use DCS computing facilities.

DCS reserves the right to change its policies and rules at any time.

X. *Penalties*

The User shall hold the State and DCS harmless from any loss or damage to the State and/or DCS resulting from the User's inappropriate disclosure of information covered by this User Agreement. Further, the User's non-compliance with this Agreement may result in the revocation of system privileges, termination of employment or contract with DCS, and/or criminal and/or civil penalties.

Name And Address Of Borrower	DCS Business Unit (Loaning Organization)	
	Point Of Contact	
	Work Location	Telephone
Shipping Address (*If different from borrower's)*	Manager's Name	
	Date To Be Loaned	
	Date To Be Returned	

Equipment To Be Loaned

Quantity	Description	Value

Purpose Of Loan

CONDITIONS OF LOAN

1. The Borrower of the above equipment agrees to return same in like condition as received from DCS, normal wear and tear excepted, on or before the above return date, unless the loan period is formally extended.
2. Upon termination of this Agreement, Borrower shall uninstall all DCS software included in this Agreement from Borrower's computer and/or network equipment.
3. The Borrower shall not make **any** copies of DCS software included in this Agreement.
4. In case of loss or damage beyond repair, DCS shall be reimbursed by Borrower at the current price of replacement.
5. The equipment shall not be loaned or transferred to a third party without the written consent of DCS.
6. The right is reserved to cancel the loan or recall the equipment upon _____ days notice.
7. The Borrower shall assume all shipping and/or transportation costs involved.
8. Other conditions:

Agreed (Borrower)	**Approved** (DCS)
Borrowing Organization	Loaning Organization
Signature Of Authorized Official	Signature Of Authorized Official
Title	Title
Date	Date

RECEIPT OF EQUPMENT

Borrower *(Upon initial receipt)*	**DCS Lender** *(Upon termination of Agreement)*
Borrowing Organization	Loaning Organization
Signature Of Authorized Official	Signature Of Authorized Official
Title	Title
Date	Date

THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

THIS AGREEMENT (the "Agreement") by and between the NYS Insurance Fund ("NYSIF"), with principal offices in New York, NY 10007, and

with principal offices at

(hereinafter "Third Party"), is entered into as of the date last written below ("the Effective Date").

This Agreement consists of this signature page and the following attachments incorporated by reference:

1. Attachment 1: Third Party Connection and Data Exchange Agreement Terms and Conditions
2. Attachment 2: Third Party Connection and Data Exchange Request Requirements Document
3. Attachment 3: Third Party Acceptable Use Policy and Agreement
4. Attachment 4: NYSIF Equipment Loan Agreement (Applicable: ☐Yes ☐No)

This Agreement may only be modified by a written document executed by the parties hereto. Any disputes arising out of or in connection with this Agreement shall be governed by New York State law without regard to choice of law provisions.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed. Each party warrants and represents that its respective signatories whose signatures appear below have been and are on the date of signature duly authorized to execute this Agreement.

Third Party Name:	*NYS Insurance Fund (NYSIF)*
Authorized Signature	Authorized Signature
Name *(Print)*	Name *(Print)*
Date	Date

THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

ATTACHMENT 1 – SECURITY REQUIREMENTS

1. ***Right to Use Connection***

Third Party may only use the connection and the information obtained from NYSIF for business purposes as outlined by the Third Party Connection and Data Exchange Request Requirements Document (Attachment 2).

2. ***Data Exchange***

2.1 Third Party may only use the data obtained for purposes outlined by the Third Party Connection and Data Exchange Request Requirements Document (Attachment 2) and the contract or Memoranda of Understanding, if any, that exists between NYSIF and Third Party for the provision of goods or services or governing conduct between NYSIF and Third Party with respect to the access to and use of NYSIF data.

2.2 Data exchange may be conducted only by methods and/or services outlined by the Third Party Connection and Data Exchange Request Requirements Document (Attachment 2). Third Party should expect that access to information and services may be limited, as determined or required by NYSIF.

3. ***Network Security***

3.1 Third Party will allow only its own employees approved in advance by NYSIF ("Third Party Users") to access the Network Connection or any NYSIF -owned equipment. Third Party shall be solely responsible for ensuring that Third Party Users are not security risks, and upon NYSIF' request, Third Party will provide NYSIF with any information reasonably necessary for NYSIF to evaluate security issues relating to any Third Party User.

3.2 Third Party will promptly notify NYSIF whenever any Third Party User leaves Third Party's employ or no longer requires access to the connection or NYSIF-owned Equipment.

3.3 Each Party will be solely responsible for the selection, implementation, and maintenance of security procedures and policies that are sufficient to ensure that (a) such party's use of the connection (and Third Party's use of NYSIF-owned Equipment) is secure and is used only for authorized purposes, and (b) such Party's business records and data are protected against improper access, use, loss alteration or destruction.

3.4 The preferred connectivity method is via the Internet to a NYSIF-approved or NYSIF-provided Virtual Private Network (VPN) device. If the device is NYSIF-provided, NYSIF will loan the Third Party, in accordance with the NYSIF Equipment Loan Agreement, the required client software for establishing VPN connections with NYSIF. Normal NYSIF perimeter security measures will control access to the internal network.

3.5 Extranet – Designated routers are used in combination with firewall rules to allow access to be managed. A second authentication may be required.

3.6 Remote Access - Using the NYSIF-provided remote access software, Third Party will connect via an Internet browser. The account may be disabled until usage is required and controls are placed and managed by NYSIF. Third Party will be required to follow procedures to enable the account for each use.

3.7 Third Party Connections will be audited. All remote access user accounts for Third Parties will be given an expiration time. Renewals must be requested by Third Party and approved by the NYSIF Sponsor. Obsolete Third Party connections will be terminated.

3.8 Software versions on all Third Party computers that connect to the NYSIF network must be versions that are currently supported by the software manufacturer, and all available security updates and hot fixes for that software must be applied in a timely fashion. Software and firmware for all Third Party networking equipment that is part of the connection to the NYSIF network must be kept up to date, especially with patches that fix security vulnerabilities.

3.9 Anti-virus software and firewalls must be installed and enabled at all times on NYSIF-owned computers and on Third Party computers that connect to the NYSIF network. Additionally, virus definition files must be kept up to date.

3.10 In no case may a Third Party Connection to NYSIF be used as an Internet Connection for Third Party or for a Third Party User.

4. *Notifications*

4.1 Third Party shall notify NYSIF in writing promptly of any change in its Users for the work performed over the Network Connection or whenever Third Party believes a change in the connection and/or functional requirements of the connection is necessary.

4.2 Any notices required by this Agreement shall be given in hand, sent by first class mail, or via facsimile to the applicable address set forth below.

Third Party Name:	NYS Insurance Fund New York, New York 10007
Address:	
Attention:	Attention:

5. ***Citizen Notifications***

If Third Party maintains "identifying personal information" on behalf of NYSIF and such information is compromised, Third Party shall notify NYSIF immediately that the information has been compromised, the circumstances under which the information was compromised, and the measures undertaken by Third Party to address those circumstances and to otherwise mitigate the effects of the compromise. If encrypted data is compromised along with the corresponding encryption key and encryption software, the data shall be considered unencrypted and the information will be considered compromised through unauthorized access. If NYSIF requests Third Party to do so, Third Party shall notify the persons whose identifying information was compromised. Such notification shall be communicated via postal service or email, as directed by NYSIF, and shall otherwise be executed in accordance with NYSIF's direction. Notification shall be delayed if a law enforcement agency determines that such notification may impede a criminal investigation. For the purpose of this section, "identifying personal information" shall be any information concerning an individual which, because of name, number, symbol, mark or other identifier in combination with any of the following, is unencrypted: (1) Social Security Number; or (2) driver's license number; or (3) financial account number, credit or debit card number, in combination with any required security code, access code, or password which would permit access to an individual's financial account; or (4) password which would permit access to the individual's account.

6. ***Payment of Costs***

Each Party will be responsible for all costs incurred by that Party under this Agreement, including, without limitation, costs for phone charges, telecommunications equipment and personnel for maintaining the connection.

7. ***Confidentiality***

7.1 Information exchanged for the business purposes outlined in Attachment 2 will be held confidential by the Parties to the maximum extent permitted by law. Each Party may internally use the information received from the other Party hereunder in connection with and as specifically necessary to accomplish the Business Purpose set forth in Attachment 2 and for no other purposes. Each Party may otherwise share such information with other third parties (e.g. consultants, subcontractors, control agencies) as required or permitted by law in order to effect the business purposes outlined in Attachment 2 and for no other purposes, provided that such third parties agree to the confidentiality restrictions set forth herein and as may be required otherwise by State and federal law.

7.2 Third Party must implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the sensitive information that it creates, receives, maintains, or transmits on behalf of NYSIF.

7.3 Unencrypted NYSIF information must not be transmitted over email.

7.4 Third Party must ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it and report to the NYSIF Help Desk any security incident of which it becomes aware.

8. ***Third Party Users***

8.1 Third Party must require that each Third Party User executes a Third Party Acceptable Use Policy and Agreement (Attachment 3). Third Party must ensure that NYSIF is notified by fax or mail when the user base changes, following the specifications in the Third Party Connection & Data Exchange Agreement.

8.2 All aspects of Third Party connections within NYSIF control may be monitored by the appropriate NYSIF support group and/or the NYSIF Information Security Officer. Any unauthorized use or change to devices will be investigated immediately.

8.3 All Third Party Connections will be reviewed on a regular basis and information regarding specific Third Party connection will be updated as necessary. Obsolete Third Party connections will be terminated.

9. ***NYSIF-owned Equipment***

9.1 NYSIF may, in NYSIF' sole discretion, loan to Third Party certain equipment and/or software for use on Third Party premises (the NYSIF-owned Equipment) under the terms of the NYSIF Equipment Loan Agreement set forth in Attachment 4. NYSIF-owned equipment will only be configured for TCP/IP, and will be used solely by Third Party on Third Party's premises or other locations authorized by NYSIF for the purposes set forth in this Agreement. NYSIF is responsible for ensuring that it has the right under applicable software licenses to permit third party use.

9.2 Third Party may modify the configuration of the NYSIF-owned equipment only after notification and approval in writing by authorized NYSIF personnel.

9.3 Third Party will not change or delete any passwords set on NYSIF-owned equipment without prior approval by authorized NYSIF personnel. Promptly upon any such change, Third Party shall provide NYSIF with such changed password.

10. ***Term, Termination and Survival***

10.1 This Agreement will remain in effect until terminated by either Party, but in no event prior to the termination or expiration of any contract or agreement between the Parties for the purchase of goods or services that provides the business purpose for the exchange of data between the Parties, unless both Parties mutually agree to so terminate this Agreement.

10.2 Upon termination, Third Party shall return all tangible NYSIF data to NYSIF within a timeframe specified by NYSIF for that purpose, and further shall certify in writing to NYSIF that all other NYSIF data in whatever form has been destroyed. Additionally, any NYSIF-owned equipment and/or software shall be promptly returned to NYSIF at Third Party's expense.

10.3 Notwithstanding the above, the Parties' obligations to safeguard the confidentiality of the data subject to this Agreement shall survive the termination of this Agreement, and shall bind the Parties' employees, subcontractors, agents, heirs, successors and assigns.

11. Severability

If for any reason a court of competent jurisdiction finds any provision or portion of this Agreement to be unenforceable, that provision of the Agreement will be enforced to the maximum extent permissible so as to affect the intent of the Parties, and the remainder of this Agreement will continue in full force and effect.

12. Waiver

The failure of any Party to enforce any of the provisions of this Agreement will not be construed to be a waiver of the right of such Party thereafter to enforce such provisions.

13. Assignment

Third Party may not assign this Agreement, in whole or in part, without the prior written consent from NYSIF. Any attempt to assign this Agreement, without such consent, will be null and of no effect. Subject to the foregoing, this Agreement is for the benefit of and will be binding upon the parties' respective successors and permitted assigns.

14. *Force Majeure*

Neither Party will be liable for any failure to perform its obligations if such failure results from any act of God or other cause beyond such Party's reasonable control (including, without limitation, any mechanical, electronic or communications failure) which prevents such party from transmitting or receiving any data.

15. *Partial Invalidity*

If this Agreement is entered into as a consequence of Third Party's provision of goods or services to NYSIF pursuant to a contract or other written agreement, that Agreement supersedes this Agreement to the extent the agreements' provisions may be inconsistent.

THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

ATTACHMENT 2 – REQUEST REQUIREMENTS

In accordance with the NYSIF *Third Party Connection and Data Exchange Policy*, all requests for Third Party connections and data exchanges must be accompanied by this completed requirements document. This document should be completed by the NYSIF person or group requesting the Third Party connection and/or data exchange. The NYSIF Sponsor must be the Director of the Division whose business requires the Third Party connection and/or data exchange. NYSIF Divisions are encouraged to work with their technical liaison to complete the information in this document.

Part 1 – Business Justification

A. NYSIF Sponsor *(Division Director)*

Name: Division:

Office Location: Phone Number:

Email Address:

Back-up Point of Contact: (Data Custodian)

Name: Division:

Office Location: Phone Number:

Email Address:

B. Business Reason for Connection *(To be completed by Sponsor)*

State the purpose of establishing the connection and the purpose of the data transmission. Specify the business needs of the proposed connection. Use additional sheets of paper if needed.

C. Specify the details of the work to be accomplished via the connection. What applications will be used? What information will be used? What transactions will be accomplished?

D. Specify the Third Party Controls to be Implemented for Safeguarding NYSIF Data:
Access Controls:

Audit Controls:

Working procedures or practices for handling printed material and verbal exchanges:

Method of Disposal of media and paper:

User Account Management, including review of accounts:

Physical Security:

Other:

E. Estimated number of hours of use each week?

☐ 1 – 20 ☐ 21 – 40 ☐ More than 40 hours per week

F. Anticipated normal hours of use?

☐ M – F, 8:00 – 5:00 pm Eastern time ☐ Other (specify):

G. What is the requested installation date? *(Minimum lead-time is 30 days)*

H. Approximately how long will the connection be needed?

☐ Up to 6 months ☐ 6 – 12 months ☐ More than 12 months
☐ Specific time period:

Note: If a connection is needed for more than a year, the Connection Agreement must be renewed annually.

I. Other useful information

J. Third Party Information

Name of Third Party: Main Phone Number:

Main Office Address:

Management Contact

Name: Department:

Address: Email Address:

Phone Number: Manager's Name:

Manager's Phone:

Backup Contact

Name: Department:

Address: Email Address:

Phone Number: Manager's Name:

Manager's Phone:

Technical Contact

Name: Department:

Address: Email Address:

Phone Number:

Manager's Name: Manager's Phone:

Technical Support Hours:

Escalation List:

Domain name(s): Host name(s):

User Names and Contact Information. *(List all employees of the Third Party who will use this access.)*

User 1 *(name, phone, email):*

User 2 *(name, phone, email):*

User 3 *(name, phone, email):*

User 4 *(name, phone, email):*

User 5 *(name, phone, email):*

User 6 *(name, phone, email):*

User 7 *(name, phone, email):*

User 8 *(name, phone, email):*

User 9 *(name, phone, email):*

User 10 *(name, phone, email*):

K. Other information

THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

ATTACHMENT 3 – THIRD PARTY ACCEPTABLE USE POLICY AND AGREEMENT

This Policy and Agreement applies to all forms of computer and networking use, including local access at the NYSIF premises, remote access via public or private networks, access using NYSIF equipment, access using individual or group accounts, and access via other methods.

A signed paper copy of this form must be submitted by any individual (1) for whom authorization of a new user account is requested, (2) who will use a shared third party account, and/or (3) who is requesting reauthorization of an existing use. Modifications to the terms and conditions of this agreement will not be accepted by NYSIF management.

Indicate here if this is a notification that the User named below no longer requires access: ☐

User's Name *(print)*:			
Organization:			
Telephone Number:	Area code	Number	Extension
Office Address:			

The undersigned acknowledges that he or she has read, understands, and agrees to comply with this Third Party Acceptable Use Policy and Agreement governing the use of NYSIF computing resources.	
User Signature:	Date:

You must sign this signature page and send it to NYSIF. Retain a copy of the signature page and the attached Policy for your records. This form must be delivered either by fax or mail to:

MAIL: **NYS Insurance Fund, New York, NY 10007**
Attention: Help Desk
FAX: **xxx-xxx-xxxx**

THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

ATTACHMENT 3 – THIRD PARTY ACCEPTABLE USE POLICY AND AGREEMENT

I. *Protection of NYSIF Information*

All records and information maintained in NYSIF systems accessed by the User are confidential and shall be used by the User solely for the purpose of carrying out the User's official duties. Users may not use any such records and information for any other purpose. No such records or information may otherwise be used or released to any person by the User or by the User's employer or agent, except as may be required by applicable State or federal law or by a court of competent jurisdiction. All accounts and connections will be regularly reviewed.

II. *NYSIF Log-on Banner*

All users will follow the guidelines of the NYSIF Log-on Banner as stated below.

NOTICE * The contents of this banner have been recommended to all State agencies by the Office for Technology in the NYS Preferred Standards and Procedures for Information Security. * This electronic system, which includes hardware, software and network components and all data contained therein (the "system"), is the property of the NYSIF. * Unauthorized use or attempted unauthorized use of this system is not permitted and may constitute a federal or state crime. Such use may subject you to appropriate disciplinary and/or criminal action. Use of this system is only permitted to the extent authorized by NYSIF. * Use is limited to conducting official business of NYSIF. Under the Electronic Communications Privacy Act of 1986 (18 U.S.C. 2510, et seq.), notice is hereby given that there are NO facilities provided by this system for sending or receiving private confidential electronic communication. Any use, whether authorized or not, may be monitored, intercepted, recorded, read, copied, accessed or captured in any manner, and used or disclosed in any manner, by authorized NYSIF personnel without additional prior notice to users. In this regard, users have no legitimate expectation of privacy during any use of this system or in any data on this system. * Use, whether authorized or unauthorized, constitutes expressed consent for NYSIF to monitor, intercept, record, read, copy, access or capture and use or disclose such information. * NYSIF policy regarding this matter can be reviewed on the NYSIF internal website. Copies can also be obtained from the Office of Human Resources Management. Such policies are subject to revision. This notice is consistent with the Acceptable Use Policy issued to NYSIF employees regarding acceptable use, xxxx xx, xxxx. I have read and understand this notification and NYSIF policy.

III. *Passwords*

The User is not permitted to share his/her password with anyone. Passwords must never be written down. The User must not use the same password for multiple applications. The User must use passwords that are not easily guessed and must not use their email address as their password.

IV. ***Shared Accounts***

All use of shared accounts must be authorized by NYSIF. Users of shared accounts must be identified to NYSIF via the completion and signing of this policy/agreement. Third Parties are responsible for notification to NYSIF when the user base changes. Passwords for shared accounts must not be provided to individuals who have not been identified by Third Party to NYSIF and who have not completed and signed this policy/agreement.

V. ***Virus Protection***

Anti-virus software must be installed and enabled at all times on NYSIF-owned computers and on third party computers used to conduct NYSIF business. Virus definition files must be kept up to date. NYSIF provides anti-virus software and maintains the configuration of that software for all NYSIF-owned computers.

VI. ***Acceptable Use***

NYSIF computers, computing systems and their associated communication systems are provided to support the official business of NYSIF. All uses inconsistent with NYSIF' business activities and administrative objectives are considered to be inappropriate use.

Examples of unacceptable behavior include, but are not limited to the following.

- Any illegal activities that could result in legal actions against and/or financial damage to NYSIF.
- Computer usage that reasonably harasses or offends other employees, users, or outsiders, or results in public embarrassment to NYSIF.
- Computer usage that is not specifically approved and which consumes significant amounts of computer resources not commensurate with its benefit to NYSIF' mission or which interferes with the performance of a worker's assigned job responsibilities.
- Use in connection with compensated outside work or unauthorized not-for-profit business activities.
- Use of sniffers, spyware, ad-ware or other related technology.

VII. ***Software Protection***

The User is responsible for complying with copyright, licensing, trademark protection, and fair use restrictions.

VIII. ***Reporting Incidents***

Users are required to report incidents of system errors, data discrepancies, application performance problems, to the NYSIF Help Desk, at xxx-xxx-xxxx phone; xxx-xxx-xxxx fax.

IX. *NYSIF Rights*

Pursuant to the Electronic Communications Privacy Act of 1986 (18 USC 2510 et seq.), notice is hereby given that there are no facilities provided by this system for sending or receiving private or confidential electronic communications. NYSIF has access to all access attempts, messages created and received, and information created or stored using NYSIF resources, and will monitor use as necessary to assure efficient performance and appropriate use. Information relating to or in support of illegal activities will be reported to the appropriate authorities.

NYSIF reserves the right to log and monitor use. NYSIF reserves the right to remove a user account from the network. NYSIF assumes no responsibility or liability for files or information deleted.

The NYSIF will not be responsible for any damages. This includes the loss of data resulting from delays, non-deliveries, or service interruptions caused by negligence, errors or omissions, or caused by the way the user chooses to use NYSIF computing facilities.

NYSIF reserves the right to change its policies and rules at any time.

X. *Penalties*

The User shall hold the State and NYSIF harmless from any loss or damage to the State and/or NYSIF resulting from the User's inappropriate disclosure of information covered by this User Agreement. Further, the User's non-compliance with this Agreement may result in the revocation of system privileges, termination of employment or contract with NYSIF, and/or criminal and/or civil penalties.

Name And Address Of Borrower	NYSIF Business Unit (Loaning Organization)	
	Point Of Contact	
	Work Location	Telephone
Shipping Address (*If different from borrower's)*	Manager's Name	
	Date To Be Loaned	
	Date To Be Returned	

Equipment To Be Loaned

Quantity	Description	Value

Purpose Of Loan

CONDITIONS OF LOAN

1. The Borrower of the above equipment agrees to return same in like condition as received from NYSIF, normal wear and tear excepted, on or before the above return date, unless the loan period is formally extended.
2. Upon termination of this Agreement, Borrower shall uninstall all NYSIF software included in this Agreement from Borrower's computer and/or network equipment.
3. The Borrower shall not make **any** copies of NYSIF software included in this Agreement.
4. In case of loss or damage beyond repair, NYSIF shall be reimbursed by Borrower at the current price of replacement.
5. The equipment shall not be loaned or transferred to a third party without the written consent of NYSIF.
6. The right is reserved to cancel the loan or recall the equipment upon _____ days notice.
7. The Borrower shall assume all shipping and/or transportation costs involved.
8. Other conditions:

Agreed (Borrower)	**Approved** (NYSIF)
Borrowing Organization	Loaning Organization
Signature Of Authorized Official	Signature Of Authorized Official
Title	Title
Date	Date

RECEIPT OF EQUPMENT

Borrower *(Upon initial receipt)*	**NYSIF Lender** *(Upon termination of Agreement)*
Borrowing Organization	Loaning Organization
Signature Of Authorized Official	Signature Of Authorized Official
Title	Title
Date	Date

APPENDIX D - Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures

CONTRACTOR REQUIREMENTS AND OBLIGATIONS UNDER NEW YORK STATE EXECUTIVE LAW, ARTICLE 15-A (PARTICIPATION BY MINORITY GROUP MEMBERS AND WOMEN WITH RESPECT TO STATE CONTRACTS)

I. General Provisions

A. The Department is required to implement the provisions of New York State Executive Law Article 15-A and 5 NYCRR Parts 142-144 ("MWBE Regulations") for all "State contracts" as defined therein, with a value (1) in excess of $25,000 for labor, services, equipment, materials, or any combination of the foregoing or (2) in excess of $100,000 for real property renovations and construction.

B. Contractor agrees, in addition to any other nondiscrimination provision of the Contract and at no additional cost to the New York State Department (the "Department"), to fully comply and cooperate with the Department in the implementation of New York State Executive Law Article 15-A. These requirements include equal employment opportunities for minority group members and women ("EEO") and contracting opportunities for certified minority and women-owned business enterprises ("MWBEs"). Contractor's demonstration of "good faith efforts" pursuant to 5 NYCRR §142.8 shall be a part of these requirements. These provisions shall be deemed supplementary to, and not in lieu of, the nondiscrimination provisions required by New York State Executive Law Article 15 (the "Human Rights Law") or other applicable federal, state or local laws.

C. Failure to comply with all of the requirements herein may result in a finding of non-responsiveness, non-responsibility and/or a breach of contract, leading to the withholding of funds or such other actions, liquidated damages pursuant to section VII of this Appendix or enforcement proceedings as allowed by the Contract.

II. Contract Goals

A. For purposes of the Contract, the Department established an overall goal of 20% for Minority and Women-Owned Business Enterprises ("MWBE") participation as subcontractors and suppliers, as relates only to the administrative cost component of the overall cost of the Contract.

B. For purposes of providing meaningful participation by MWBEs on the Contract and achieving the Contract Goals established in section II-A above, Contractor should reference the directory of New York State Certified MBWEs found at the following internet address:
http://www.nylovesmwbe.ny.gov/cf/search.cfm

Additionally, Contractor is encouraged to contact the Division of Minority and Woman Business Development ((518) 292-5250; (212) 803-2414; or (716) 846-8200) to discuss additional methods of maximizing participation by MWBEs on this Contract.

C. Where MWBE goals have been established herein, pursuant to 5 NYCRR §142.8, Contractor must document "good faith efforts" to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract. In accordance with section 316-a of Article 15-A and 5 NYCRR §142.13, the Contractor acknowledges that if Contractor is found to have willfully and intentionally failed to comply with the MWBE participation goals set forth in the Contract, such a finding constitutes a breach of contract and the Contractor shall be liable to the Department for liquidated or other appropriate damages, as set forth herein.

III. Equal Employment Opportunity (EEO)

A. Contractor agrees to be bound by the provisions of Article 15-A and the MWBE Regulations promulgated by the Division of Minority and Women's Business Development of the Department of Economic Development (the "Division"). If any of these terms or provisions conflict with applicable law or regulations, such laws and regulations shall supersede these requirements.

B. Contractor shall comply with the following provisions of Article 15-A:
   1. Contractor and subcontractors shall undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status. For these purposes, EEO shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation.
   2. The Contractor shall submit an EEO policy statement to the Department within seventy two (72) hours after the date of the notice by Department of proposed award of the Contract to the Contractor.
   3. If Contractor or subcontractor does not have an existing EEO policy statement, the Department may provide the Contractor or subcontractor a model statement (see Form EEO-102 entitled "Minority and Women-Owned Business Enterprises M/WBE - Equal Employment Opportunity (EEO) Policy Statement.
   4. The Contractor's EEO policy statement shall include the following language:
      a. The Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, age, disability or marital status, will undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination, and shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force.
      b. The Contractor shall state in all solicitations or advertisements for employees that, in the performance of the contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.
      c. The Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union, or representative will not discriminate on the basis of race, creed, color, national origin, sex age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein.
      d. The Contractor will include the provisions of sections (a) through (c) of this subsection 4 and paragraph "E" of this section III, which provides for relevant provisions of the Human Rights Law, in every subcontract in such a manner that the requirements of the subdivisions will be binding upon each subcontractor as to work in connection with the Contract.

C. Form EEO-100 – EEO Staffing Plan
   To ensure compliance with this section III, the Contractor shall submit an EEO Staffing Plan to document the composition of the proposed workforce to be utilized in the performance of the Contract by the specified categories listed, including ethnic background, gender, and Federal occupational categories. The Contractor shall complete the EEO Staffing Plan form and submit it as part of its Proposal or within a reasonable time, but no later than the time of proposed award of the Contract.

D. Form EEO-101 - Workforce Utilization/Compliance Report ("Workforce Report")

1. Once proposed contract award has been made and during the term of Contract, Contractor is responsible for updating and providing notice to the Department of any changes to the previously submitted EEO Staffing Plan. This information is to be submitted on a quarterly basis during the term of the Contract to report the actual workforce utilized in the performance of the Contract by the specified categories listed including ethnic background, gender, and Federal occupational categories. The Workforce Report must be submitted to report this information.
2. Separate forms shall be completed by Contractor and any subcontractor performing work on the Contract.
3. In limited instances, Contractor may not be able to separate out the workforce utilized in the performance of the Contract from Contractor's and/or subcontractor's total workforce. When a separation can be made, Contractor shall submit the Workforce Report and indicate that the information provided related to the actual workforce utilized on the Contract. When the workforce to be utilized on the Contract cannot be separated out from Contractor's and/or subcontractor's total workforce, Contractor shall submit the Workforce Report and indicate that the information provided is Contractor's total workforce during the subject time frame, not limited to work specifically under the Contract.

E. Contractor shall comply with the provisions of the Human Rights Law, all other State and Federal statutory and constitutional non-discrimination provisions. Contractor and subcontractors shall not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

IV. MWBE Utilization Plan Form (MWBE-100) and Certification of Good Faith Efforts (Form MWBE-104)

A. The Contractor represents and warrants that Contractor has submitted an MWBE Utilization Plan (form MWBE-100) either prior to, or at the time of, the execution of the Contract for Department consideration and acceptance. The Contractor shall ensure that enterprises have been identified within the MWBE Utilization Plan, and the Contractor shall attempt, in good faith, to utilize such enterprise(s) at least to the extent indicated in the Contractor's MWBE Utilization Plan as accepted by the Department. The Contractor must document "good faith efforts" to provide meaningful participation by New York State Certified MWBE subcontractors or suppliers in the performance of the Contract. In support of such efforts, the Contractor will include with its MWBE Utilization Plan submission a Certification of Good Faith Efforts statement (Form MWBE-104).

B. Contractor agrees to use such MWBE Utilization Plan, as accepted by the Department, for the performance of MWBEs on the Contract pursuant to the prescribed MWBE goals set forth in section III-A of this Appendix D.

C. Contractor further agrees that a failure to submit and/or use such MWBE Utilization Plan shall constitute a material breach of the terms of the Contract. Upon the occurrence of such a material breach, Department shall be entitled to any remedy provided herein, including but not limited to, a finding of Contractor non-responsiveness.

V. Waiver Requests (MWBE-101)

A. For Waiver Requests Contractor should use Form MWBE-101 – Request for Waiver Form.

B. If the Contractor, after making good faith efforts, is unable to comply with MWBE goals, the Contractor may submit a Request for Waiver Form documenting good faith efforts by the Contractor to meet such goals. If the documentation included with the Waiver Request is complete, the Department shall evaluate the request and issue a written notice of acceptance or denial within twenty (20) days of receipt.

C. If the Department, upon review of the MWBE Utilization Plan and updated Quarterly M/WBE Contractor Compliance Reports determines that Contractor is failing or refusing to comply with the Contract goals and no waiver has been issued in regards to such non-compliance, the Department may issue a notice of deficiency to the Contractor. The Contractor must respond to the notice of deficiency within seven (7) business days of receipt. Such response may include a request for partial or total waiver of MWBE Contract Goals.

VI. Quarterly M/WBE Contractor Compliance Report (Form MWBE-103)

Contractor is required to submit a Quarterly M/WBE Contractor Compliance Report (Form MWBE-103) to the Department by the 10th day following each end of quarter over the term of the Contract documenting the progress made towards achievement of the MWBE goals of the Contract.

VII. Liquidated Damages - MWBE Participation

A. Where Department determines that Contractor is not in compliance with the requirements of the Contract and Contractor refuses to comply with such requirements, or if Contractor is found to have willfully and intentionally failed to comply with the MWBE participation goals, Contractor shall be obligated to pay to the Department liquidated damages.

B. Such liquidated damages shall be calculated as an amount equaling the difference between:
   1. All sums identified for payment to MWBEs had the Contractor achieved the contractual MWBE goals; and
   2. All sums actually paid to MWBEs for work performed or materials supplied under the Contract.

C. In the event a determination has been made which requires the payment of liquidated damages and such identified sums have not been withheld by the Department, Contractor shall pay such liquidated damages to the Department within sixty (60) days after they are assessed by the Department unless prior to the expiration of such sixtieth day, the Contractor has filed a complaint with the Director of the Division of Minority and Woman Business Development pursuant to subdivision 8 of section 313 of the Executive Law in which event the liquidated damages shall be payable if Director renders a decision in favor of the Department.

VII. Further Information:

General questions concerning New York's MWBE program should be directed to:

New York State Department of Economic Development
633 Third Avenue
New York, NY 10017
Telephone: (212) 803-2414

New York State Department of Economic Development
Division of Minority and Women's Business Development
30 South Pearl Street
Albany, NY 12245

Telephone: (518) 292-5150

All of the EEO and M/WBE forms referenced herein this Appendix D are available for download at the Department's website at: http://www.cs.ny.gov/pio/mwbe-eeo-forms.cfm). These forms are to be submitted without change to the goals specified by Department in the Contract.