Section 1. DCS and NYSIF Prescription Drug Program Services

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;

Name of Offeror
UnitedHealthcare Service, LLC.

Main Office Location
2950 Expressway South, Suite 240
Islandia, N.Y. 11749

Branch Office Location

900 Watervliet Shaker Road, Suite 105
Albany, N.Y. 12205

Michael Matteo, CEO and President of UnitedHealthcare Services, LLC, and Chief Growth Officer for OptumHealth, Inc., along with Dirk McMahon, CEO of OptumRx, Inc., will be the senior officers within UnitedHealth Group 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;

UnitedHealth Group is an interconnected company composed of business segments that each offer unique value. Its vast array of products and programs provide complementary care to help people in a wide array of health circumstances live healthier lives.

However large and diverse UnitedHealth Group is; it has one mission; to help people live healthier lives and to make health care work better for everyone.

In order to continue to provide superior service and innovation to the Empire Plan Programs and NYSIF throughout the contract period 2014-2018, UnitedHealthcare Service, LLC., and two of its affiliate organizations, OptumRx, Inc., and Medicare and Retirement Services (M&R, which provides services using the UnitedHealthcare Insurance Company of New York entity), will be responsible for service and support of the Programs' contract and service terms. For purposes of this response to RFP, we will collectively refer to the organizations that will be serving and supporting the Programs' duties and responsibilities as UnitedHealthcare.

Given the long-term relationship between UnitedHealthcare and the New York State Empire Plan, we have the unique advantage of understanding its objectives and approach to health benefit management.

UnitedHealthcare's pharmacy program is dedicated to making prescription medications more accessible and affordable for its customers and members. Our pharmacy program is responsible for the overall management, strategy and success of the pharmacy program. UnitedHealthcare has over 30 years of experience in managing complex pharmacy benefit plans similar to the Programs. Serving more than 20 million members today, including the

Programs' >1 million lives since 2008; we have the pharmacy management expertise and experience to understand and meet your needs.

We understand that the Programs require a pharmacy management program that is effective at managing its prescription drug costs and providing a quality pharmacy benefit to its Enrollees with service excellence. We understand your requirements as defined in the RFP and are uniquely able to assist you in accomplishing your objectives. The following represent the key areas where UnitedHealthcare's pharmacy program is uniquely positioned to meet your goals and objectives.

Value Statement: Integration-Leveraging the UnitedHealthcare value of Integration for the Programs

Having administered the Empire Plan's medical program over many years (Pharmacy Program since 2008 and MHSA Program since 2009), UnitedHealthcare is uniquely qualified to identify and implement synergies to optimize the administration of all three programs, without requiring the Programs to disrupt the "carve-out" self-insured structure of the DCS Programs. Each of the Programs' account teams (pharmacy, medical and MHSA) will collaborate together, consult and leverage opportunities among the companies to thoroughly benefit the Programs. Additionally, all teams are accountable to Steven Burdick, Senior Vice President of Specialty Solutions for UnitedHealthcare National Accounts.

Our total health care approach includes integrating medical, pharmacy, mental health and substance abuse programs for better, more effective outcomes. UnitedHealthcare ensures pharmacy decisions do not negatively impact overall medical management quality and cost. With access to one of the largest integrated databases, we are able to gain real-world insights into how consumers use health care. UnitedHealthcare links member diagnosis and lab data with pharmacy data to better identify gaps in care, potential therapy problems, and opportunities to promote best practices for more cost-effective care–and a simpler, more consistent experience for Enrollees.

With UnitedHealthcare, the Programs will have a pharmacy program that accesses and leverages the broad health and well-being capabilities of UnitedHealth Group. Our integrated approach allows us to communicate pharmacy messages more quickly and consistently through the Empire Plan network of physicians. Pharmacy messages are combined with medical

information, so physicians receive the information they need through the same consistent sources. In addition, the medical directors for the Empire Plan medical program, the Optum Disease Management Program and the Optum MHSA program are able to engage on pharmacy issues with the Empire Plan network physicians.

Value Statement: Aligned Interests

Our approach is based on a simple premise intrinsic to our business model. When the Programs are at risk for pharmacy costs; UnitedHealthcare is too. Being at risk for more than 20 million fully insured members motivates us to look for innovative and effective ways to manage costs and provide a quality pharmacy benefit. In addition, being at risk for total health care costs for our more than 20 million fully-insured lives we make pharmacy tier placement and clinical rules in the context of total health care costs. This allows us to be in complete alignment with the financial interests of the Program.

Value Statement: Experience

Over the past four years, UnitedHealthcare has been meeting and exceeding the requirements of the DCS Programs with expertise and a high level of service. Your dedicated and experienced Account Management team coupled with the vast resources within the UnitedHealthcare organization has proven how valuable experience is to the successful execution of the Programs contractual requirements.

Our Proposal presents a complete Program offering that not only meets the requirements but will exceed the Programs' expectations with regard to the following:

- An Account Management team with rooted experience and history in servicing the DCS Programs and its needs.
- Financial support and structure as demonstrated through our premium development experience, reporting capabilities and the financial strength of our organization.

- Consulting services that have provided assistance in trend mitigation through the development and implementation of the Empire Plan Flexible Formulary, the Empire Plan Designated Specialty Pharmacy, 2011 Collective Bargaining Process and the upcoming implementation of the Empire Plan Medicare Part D Plan for retirees eligible for coverage.
- Strong operational support through our award winning dedicated Customer Service unit specifically developed and trained to serve the Programs.
- Broad expertise and capabilities for identifying, interpreting and providing solutions for health care reform and legislation impacting the pharmacy care delivered under the Programs.

(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;

UnitedHealthcare is the current administrator of the Empire Plan and thereby has extensive experience managing large and complex pharmacy programs.

Across the UnitedHealth Group organization, we currently cover more than 20 million members and manage $10 billion dollars in drug spend. Our customer base is diverse, ranging from individuals to Fortune 500 organizations and includes many municipalities and state organizations.

Our affiliate pharmacy benefit manager, OptumRx, Inc. (OptumRx), which will provide a full suite of pharmacy benefit management (PBM) services for the Programs, is one of the largest PBM companies in the industry. Its claims system is completely scalable to meet the additional claim volume of the Programs, and its mail pharmacy operations and call center are designed to quickly adapt to new business. UnitedHealthcare has the stability, size and financial strength to continually make large investments in leading-edge technology to enhance its products and services.

OptumRx currently provides prescription drug benefit management services for 905 clients representing more than more than 20 million lives.

OptumRx serves a wide variety of clients in each of the major industry segments as stated above, including state agencies. With 23 years of experience as a forward-thinking PBM company, OptumRx can offer a distinctive synergy of technology, tools, and industry knowledge to its clients, who include Taft-Hartley funds, employer groups, health maintenance organizations, state and federal government-sponsored plans, and Medicare groups. Our exemplary performance is underscored by many awards and various industry recognitions. Some of these examples are provided below:

Transparency in Pharmaceuticals Purchasing Solutions Certification

OptumRx received the 2012 Transparency in Pharmaceuticals Purchasing Solutions certification from the HR Policy Association Pharmaceutical Coalition for the fourth consecutive year.

The Coalition bestows this certification to PBMs that agree to the Coalition's transparency standards. These standards provide employers with the most rigorous level of drug purchasing transparency available in the marketplace.

2011 Customer Service Awards

The Stevie Award for the Best Customer Service Department of the Year

OptumRx received the Stevie Award for Customer Service Department of the Year at the recent 9th Annual American Business Awards (ABA). In addition, OptumRx was also named a Stevie Finalist in two additional categories: the Training category for the video presentation, Blueprint: Onboarding New Clients and Customers, and the Pharmaceuticals category for the AdvoCassie Blog.

The 2011 ABA attracted more than 2,800 entries from organizations of all sizes and virtually every industry, judged by some 200 executives nationwide. UnitedHealthcare won for its Voice of the Customer and Customer Advocacy initiative.

Judges said they were impressed by the attention we pay to the Voice of the Customer, evaluating more than 500,000 after-call customer surveys each year

and using that feedback in conjunction with customer satisfaction mail surveys to continually evolve service programs to meet customer needs.

Multiple Contact Center World Gold and Silver Awards

Winning awards in every category entered, we picked up three Gold Awards at the Contact Center World Awards. The Gold Awards we won were for Best Contact Center–Large, Best Customer Service and Best Trainer. Silver Awards were bestowed for Best Technology Innovation–Internal Solution, and Best Community Spirit.

The awards are given by the Global Association for Contact Center Best Practices & Networking. Since 2006, the Contact Center World global awards have been dubbed 'the Olympics of the Contact Center World' as contact centers compete regionally, and then winners represent their nation at the World Finals.

(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.

The following table identifies which UnitedHealth Group organization will have day to day responsibility for the tasks as listed in each response for proposal (RFP) requirements and questions. As is done today, UnitedHealthcare National Accounts will manage the Programs and have oversight of all the contractual responsibilities committed to by UnitedHealthcare in its response to this RFP. Below is a chart detailing responsibility for the functions listed directly above:

	UnitedHealthcare National Accounts	OptumRx	Medicare and Retirement (M&R)
(a) Network Management	✓	✓	
(b) Specialty Pharmacy Program	✓	✓	
(c) Mail Service Pharmacy Process	✓	✓	
(d) Claims Processing	✓	✓	
(e) Retrospective Coordination of Benefits	✓	✓	

		UnitedHealthcare National Accounts	OptumRx	Medicare and Retirement (M&R)
(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	✓	✓	

		UnitedHealthcare National Accounts	OptumRx	Medicare and Retirement (M&R)
	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**	✓	✓	✓

2. General Qualifications of the Offeror

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?

UnitedHealthcare provides and will continue to provide a dynamic and highly effective proven partnership with the DCS Programs. Throughout its tenure as administrator for the Empire Plan Prescription Drug Program, UnitedHealthcare has demonstrated that it can offer you a unique business and clinical solution for the management of your pharmacy program. UnitedHealthcare's solution leverages innovative and market leading strategies. We are confident that we can continue to demonstrate the necessary financial and administrative wherewithal to deliver successful results to the DCS and NYSIF Programs as required by the RFP. Our Proposal presents a Program management offering that not only meets the requirements but will exceed the Programs' expectations with regard to the following:

- An Account Management team with rooted experience and history in servicing the DCS Programs and its needs.
- Financial Support and structure as demonstrated through our premium development experience, reporting capabilities and the financial strength of our organization.
- Consulting services that have provided assistance in trend mitigation through the development and implementation of the Empire Plan Flexible Formulary, the Empire Plan Designated Specialty Pharmacy, 2011 Collective Bargaining Process and the upcoming implementation of the Empire Plan Medicare Part D Plan for retirees eligible for coverage.
- Strong operational support through our award dedicated Customer Service unit specifically developed and trained to serve the Programs.

Additionally, UnitedHealthcare has been developing and managing pharmacy benefit programs for its customers for 30 years. Serving thousands of

customers and 20 million members nationwide, UnitedHealthcare has the experience, expertise, and proven success rate that the DCS and NYSIF are looking for in a pharmacy benefit management partner.

UnitedHealthcare manages pharmacy programs for large self-funded and public sector clients that have similar needs and requirements. We will work with you to ensure we are meeting the needs of your Enrollees.

UnitedHealthcare has a vested interest in pricing and affordability as more than half the pharmacy benefits it manages are fully insured by its own company. Our pharmacy management strategy has been extremely successful, outperforming the industry in trend management for the past several years.

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

Your dedicated Account Management team will continue to be locally based in Albany, New York. This talented team collectively has over 40 years' experience working with the Empire Plan in various capacities from operational duties in mail service pharmacy and call center, as well as account management experience. By coupling prior and current experience with the Program, they are extremely capable of handling the prescription drug plan (PDP)/employer group waiver plan (EGWP) and NYSIF components of the Program. Your Account Team will continue to have direct access to the Sr. Vice President of the Specialty Solutions division within UnitedHealthcare National Accounts, Steven Burdick. This reporting relationship allows for the corporate resources of UnitedHealthcare to be accessed whenever necessary. Additionally, Paula Gazeley-Daily will continue to lead the UnitedHealthcare team as strategic account executive and her team will have access to leadership at OptumRx and OptumHealth through the key co-executive sponsors of the Programs; Dirk McMahon, CEO of OptumRx and Mike Matteo, Chief Growth Officer for OptumHealth.

Your dedicated Account Management team will take ownership of the Programs' clinical and administrative activities, including but not limited to:

- Prescription Drug List management and administration
- Clinical Program oversight, including drug utilization review

- Enrollment management and escalated Enrollee issues
- Pipeline and Drug Industry monitoring
- Plan Design Consultation
- Financial Performance of the Programs
- Reporting requirements

Project Management Tools

The key to continued successful management of projects related to the Programs' contractual obligations is a Project Management list and weekly or bi-weekly project plan meetings. Throughout the last four years, UnitedHealthcare has conducted regular project list meetings with key members of the UnitedHealthcare, DCS and Governor's Office of Employee Relations (GOER) management in order to manage ongoing Program projects and issues and establish a pathway for resolution or completion. The project management process employed during the contract period will continue under the new contract term in order to support the Programs' desire to keep abreast of Program issues, drug industry trends and to provide for a consistent and concise mechanism for communication between the DCS, NYSIF and UnitedHealthcare.

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

The UnitedHealthcare Account team has established relationships with and access to regulatory and legal personnel, including government affairs within the organization. These experts are available to review and interpret state and federal legislation, Enrollee communication materials, and insure compliance with these regulations.

There is significant financial, legal and audit oversight and support of the DCS Program today and those resources will continue under the next contract term. As our own pharmacy benefits manager, OptumRx will be key in administering the Programs benefits and fulfilling the contractual requirements. UnitedHealthcare will leverage the existing oversight processes and programs that are in place for its fully insured lives moving to OptumRx

and will ensure that OptumRx and M&R are performing in a manner that is consistent with the Programs' requirements and contractual obligations. Your Account Management team at UnitedHealthcare will collaborate with a broader NYS UnitedHealthcare team that will span the M&R and OptumRx organizations, collectively administering and supporting the Programs' goals. Together, this cross-functional team will deliver key pharmacy results for your benefit program as well as assist with issue resolution and help to develop best practices and recommendations around future pharmacy solutions.

UnitedHealthcare's responses are provided throughout the Administrative Proposal, Technical Proposal, and Cost Proposal as related to the Pharmacy Benefit Management Services. Responses specific to the PDP/EGWP product offering are provided in the applicable EGWP sections of the RFP, including the:

- Mandatory Requirements
- Program References
- Financial Statements
- Performance Guarantees
- Contract Provisions
- EGWP section 5 of the Technical Proposal
- Implementation Timeline

UnitedHealthcare is able to adhere to the applicable provisions in the EGWP sections of the RFP, but there may be provisions or requirements related to PBM services that do not apply to the EGWP product and/or conflict with the laws and regulations applicable to the EGWP product.

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;

Confirmed.

(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.

Confirmed.

(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;

Confirmed.

(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).

Confirmed.

(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.

Confirmed.

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:

We have included an organizational chart as **Section 3., Exhibit A**, representing the Account Management team structure and key areas of the UnitedHealth Group interconnected companies that will service the Programs throughout the contract terms.

(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.

Strategic Client Executive

Paula Gazeley-Daily, R.Ph. will be your Strategic Account Executive for the proposed contract term. Paula will continue to be responsible for the leadership and direction of staff and all management associated with this Program. As she is today, Paula will be the key contact for the leadership of the DCS, GOER and Unions. Additionally, as she does today, she will facilitate resolution of significant business issues and manage the interface between multiple functional areas accountable for the Programs' administration.

Clinical Account Director

Dana Canning, R.Ph. will continue to be your Clinical Account Director for the proposed contract term. The clinical aspects of the Program include Formulary Management, Prior Authorization, Half Tablet Program, Drug Utilization Review and the High Utilization Narcotics Program. As she does today, Dana will have overall responsibility for the clinical management activities associated with the Empire Plan Prescription Drug Program and will coordinate with internal and external business partners involved in the clinical

management of the Programs. Additionally, she will continue to be responsible for providing information to the DCS regarding new strategies to manage costs, provide updates on current clinical programs, consult with DCS regarding new clinical developments, and explain the intricacies of the clinical aspects of the Programs.

Clinical Pharmacy Manager

Mary Beth Juron, R.Ph will continue to be your Clinical Pharmacy Manager for the proposed contract term. In this position, Mary Beth will continue to work in a consultative role with physicians and Enrollees responding to both telephonic and written inquiries regarding the level or exclusion of a medication on the Flexible Formulary. Inquires filed with the Department of Financial Services (DFS) may pertain to clinical aspects of the Program. Mary Beth will continue to research and discuss these inquiries with the DFS and explain the clinical rationale for the Program provision. She also will continue to respond to physician inquiries regarding the High Utilization Narcotics Program. Mary Beth also provides clinical guidance to the Account Team in resolving letters and escalated inquires of a clinical nature from Enrollees, the DCS, GOER, and Union representatives. Mary Beth will continue to be the primary Pharmacy Team Representative in the Empire Plan Synergy project. Synergy is a joint program sponsored by the UnitedHealthcare Medical, Pharmacy, Behavioral Health, and Disease Management teams with the goal of fostering sharing of information, coordination of care, and improvement in quality. Additionally, she will continue to assist the Clinical Director with ongoing oversight of the current clinical programs and the development of new clinical strategies.

Strategic Service Manager

Dawn Burton will continue to be your Strategic Service Manager for the proposed contact term. In this position, Dawn will have oversight of the activities involved in the daily management of the Program. This includes the operational services provided by the PBM such as customer service and mail and specialty pharmacy services. She will continue to have a consultative role in writing Enrollee notification letters, publications, and certificates. Dawn has and will continue to coordinate new strategies under the Programs. She played an active

role in the successful implementation of the Half Tablet and Specialty Programs and will continue to coordinate multi-functional teams to implement future additions to the Programs. Due to her vast experience on the DCS Programs, and her understanding of the intricacies of this Program, Dawn will continue to assist her team members from UnitedHealthcare and the PBM with suggestions and ideas on resolving complex inquires.

Clinical Account Manager

Katie Zareski will continue to be your Clinical Account Manager for the proposed contract term. In her unique role, Katie is responsible for supporting the clinical pharmacists, as well as resolving inquiries from the DCS, GOER, and Union representatives. She will continue to research the pipeline for new products, new generic equivalents, and recalls of medications. Katie also works with the subcontracted PBM and internal partners to implement and verify new benefits and plan design changes. Katie will continue to manage the Flexible Formulary development process and Enrollee communication plan. She also will continue to manage the custom MAC process for the Programs and records updates to the Specialty Drug list. Katie will continue to support the Account Management team with researching clinical questions.

Client Services Manager(s)

There will continue to be two people in this client facing role throughout the term of this contract period. Scott VanDerwerken and Jean Meher will continue to resolve and respond to day-to-day inquires received from the DCS and Enrollees. This role will continue to provide Program representation at Union events, educational seminars for retirees, HBA training sessions, and other events as requested by the Program. Working collaboratively with OptumRx, full access to the claim processing system will continue to enable Scott and Jean to facilitate timely resolution of escalated situations through an established dedicated client services team at the PBM level. Additionally, Scott and Jean monitor the eligibility process and work with internal partners on expedited updates as needed by the Programs.

(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;

Your incumbent dedicated Account Team, based in Albany, New York, has over 40 years of combined experience on this account, as well as direct access to the Senior Vice President of the Specialty Solutions division of UnitedHealthcare National Accounts, Steven Burdick. This reporting relationship allows for the corporate resources of UnitedHealthcare to be accessed whenever necessary. Additionally, Paula and her team will have access to leadership at OptumRx and OptumHealth through the key executive sponsors of the Programs: Dirk McMahon, Chief Executive Officer of OptumRx and Mike Matteo, Chief Growth Officer for OptumHealth.

(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?

Your incumbent Account team will continue to be based in Albany, New York and will have full access to the claim processing system and direct dedicated contacts at OptumRx to continue to provide timely responses. Due to the vast experience of this team, they have and will continue to provide direct access for Enrollees when necessary to meet the needs of the Programs.

(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.

UnitedHealthcare currently has protocols in place that have been successful in informing the DCS of events that may impact Program costs and/or service delivery. If awarded the business, these protocols will continue and will be extended to the Procuring Agencies.

During the current contract period, UnitedHealthcare has provided information to the Procuring Agencies regarding events that impacted Program Costs or delivery of services to Enrollees.

UnitedHealthcare continually reviews Federal and State legislation to determine whether this legislation will impact the Empire Plan. Your Strategic Client Executive keeps the DCS advised of legislative impacts to the Program not only on the monthly Project Plan call, but on an ongoing basis.

On a more specific level, UnitedHealthcare provided your Account Team with informational sessions regarding the Patient Protection and Affordable Care Act (PPACA). As a result of this information, we were able to provide consultative services to the DCS regarding the requirement to provide coverage to young adults up to age 26. UnitedHealthcare worked with the DCS on implementing this coverage and new eligibility data elements needed to successfully implement this requirement.

From a State legislative perspective, UnitedHealthcare provided both legal and regulatory guidance to the DCS on the New York State Oral Chemotherapy Bill. Our internal clinical partners identified the products impacted by this legislation, and system modifications were made to charge a zero copayment for these products.

UnitedHealthcare provides information to Enrollees and prescribers affected by a product recall or product withdrawal when there is a possibility of Enrollee safety being impacted.

On an Enrollee level, patients receive a letter advising them of the recall, the affected lot numbers, and what action they should take. In most instances, Enrollees are asked to consult with their physician or dispensing pharmacist. When an Enrollee receives their prescription from the Mail Service pharmacy, letters are sent only to patients who received the affected lot numbers, with next step actions to be taken by the Enrollee.

UnitedHealthcare also sends letters to physicians explaining the details of the recall and pertinent data to the recall such as the affected lot numbers.

On a client level, your local Clinical Account team, led by Dana Canning, R.Ph. provides the DCS with timely notification of drug recalls. This information includes the details of the recall and more specifically how the recall is being handled by UnitedHealthcare in concert with the contacted PBM.

(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.

The UnitedHealthcare Account team has established relationships with and access to regulatory and legal personnel across the organization, including government affairs. These experts are available to review and interpret State and Federal legislation, Enrollee communication materials, and insure compliance with these regulations.

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;

Confirmed.

(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

Confirmed.

(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.

Confirmed.

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.

Tom Butera – Vice President, Underwriting

Qualifications: With over 24 years of financial experience, 15 years focusing on the health care and risk management areas, Tom has a broad operational and financial healthcare background, including underwriting, financial planning, network operations and audit experience. Tom is also a Certified Public Accountant (CPA). He has an in-depth understanding of the Empire Plan's financial requirements and will be an expert resource to Tom Coy and other members of the Programs' Account team.

Tom Coy – Director of Underwriting and Financial Reporting UnitedHealthcare

Qualifications: Over 17 years of experience in the health insurance industry working for health insurance companies located within the State of New York and 9 years dedicated to the Empire Plan. Tom is familiar with the State's financial reporting requirements and the expectations of the State's financial management staff. Tom also has oversight responsibility for the annual renewal process and presentation to the Health Insurance Council and the Joint Labor Management Committee.

Myrene Santos FSA MAAA – Actuary, UnitedHealthcare National Accounts

Qualifications: Over 15 years of actuarial experience in the health insurance industry, dedicated actuary since 2008 for Empire Medical and Pharmacy and a key participant in the annual renewal process and presentation to the Health Insurance Council.

Greta Redmond FSA MAAA – Vice President of Group Retiree Services, UnitedHealthcare Medicare & Retirement

Qualifications: Over 20 years of actuarial experience in the health insurance industry; with 10 years of experience at UnitedHealthcare. Greta is the actuary

supporting the Medicare Part D portion of the 2013 premium development process for the Empire Plan.

Additional Underwriting, Reporting and Actuarial staff will support the individuals identified above.

Please see **Section 3., Exhibit A.,** the Account Management organizational structure, and please refer to **Section 2., Exhibit A** for our completed biographical sketch form.

(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.

Development of ghost premiums or premium equivalents for a program such as the Empire Plan is a complex process. UnitedHealthcare will follow a process similar to the current process, eliminating insured financial elements and including additional adjustments specific to the EGWP program.

For the first year of the new contract, the development of premium equivalents will begin with claims from 2012 and the first five months of 2013 repriced for the terms committed to in **Section V.A**. The repriced claims with then have the following adjustments applied:

- **Completion Factor** – to complete the latest available claim data.
- **Trend Factor** – trend assumptions will be based on a combination of historical Empire Plan specific and UnitedHealthcare Book of Business projections.
- **Annualizing/Seasonality Factor** – annualizing based on historical seasonality patterns as determined from the historical claim patterns.
- **Mail Order Utilization** – bottom line impact of any projected changes in utilization.

- **Clinical Programs** – to be applied only if there is a change in clinical programs offered by the State.
- **PDL** – inclusion of final 2014 PDL change projections as approved by GOER and DCS.
- **Plan or Benefit Design Change** – adjustments for any bargained, administratively extended or mandated though state of federal law.
- **Demographics** – changes in projected pharmacy costs due to changes in age/gender characteristics.
- **Mix/Severity** – change in the pharmacy cost due to intensity and normalization.
- **Workdays Adjustment** – change in pharmacy costs due to the number of workdays, holiday, leap impact, and etc.
- **Pipeline Adjustment** – change in pharmacy costs due to new drugs, drugs going off patent, and etc.
- **Leveraging** – an adjustment to account for unit cost changes that outpace member copays.
- **Rebates** – projection of 2014 rebates for the Empire Plan adjusted for 2014 PDL changes, price protection impact and patent expirations.
- **CMS Subsidy** – projection of 2014 subsidy resulting from the national bids and reflecting anticipated RAF scores.
- **50% Brand Discount** – projection of 2014 impact of the manufacturer brand discount in the donut hole.
- **80% Reinsurance** – projection of 2014 80% reinsurance for CMS. The preceding adjustments, applied to the re-priced claims base result in total net projected incurred claims for 2014.
- **Administrative Fee** – forecasted administrative fee based on the forecasted script volume for 2014 times the claim administrative fee included in **Exhibit V.F.**

- **Shared Communication Expense** – the amount DCS assigns to the Pharmacy Vendor for production and distribution of Summary Plan Description (SPD's) and other Empire Plan communication materials.

The sum total of net 2014 claims, projected administrative fee and shared communications expense will represent the premium equivalent for 2014. Separate monthly and biweekly premium equivalents will be presented for Empire Plan, Student Employee Health Plan (SEHP) and Excelsior Plan. In subsequent years we will follow a similar process eliminating any one-time adjustments.

UnitedHealthcare is committed to working with the DCS and its actuarial consultant to develop premium equivalent recommendations that support the expected performance of the upcoming plan year. UnitedHealthcare will be available to present annual renewal recommendations to the Health Insurance Counsel and the Joint Labor Management Committee as well as other meetings as required.

(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.

Confirmed.

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.

Confirmed.

(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);

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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

Confirmed.

(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.

Confirmed.

b. <u>Required Submission</u>

(1) Provide separate 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.

A successful implementation is important for the Programs, their Enrollees and Claimants and will result in minimal disruption for the Programs. UnitedHealthcare has demonstrated its ability to implement The Empire Plan Prescription Drug Program successfully in the past and will employ that strategy for the Programs during the implementation phase beginning in 2012. We are pleased to offer you our experience and proven processes to support effective implementation of the Programs.

The DCS Program is currently fully executed and running efficiently under the current contract terms with UnitedHealthcare. As the incumbent, the burden of implementation is minimized, however, still a necessary component of the contract award. As stated above, UnitedHealthcare has confirmed and has in place a customized network solution that will serve the DCS Programs, the Empire Plan EGWP and the NYSIF Program. This customized network solution embodies the proposed retail and mail service pharmacies, which includes chain and independent pharmacies as well as the designated Specialty

Pharmacies. As the incumbent, UnitedHealthcare also confirms and has in place an on-line processing system, customer support services and web site functionality as required above.

UnitedHealthcare has demonstrated an ability to implement large and complex pharmacy programs such as the Empire Plan Prescription Drug Program as it implemented this Program in the Fall of 2007 when awarded the contract for terms beginning January 1, 2008. Not only do we have the experience of implementing the Program in its entirety; throughout the term of our contract we successfully implemented the Empire Plan Flexible Formulary and Excelsior Plan effective January 2009 and the Empire Plan Specialty Pharmacy Program effective April 1, 2010.

UnitedHealthcare understands how to manage complex implementations. In particular, you will benefit from the knowledge and experience of the existing DCS Program Account team members such as Katie Zareski, Dawn Burton and Dana Canning, R.Ph. This expertise will be invaluable to the Programs' implementation effort.

Paula Gazeley-Daily, R.Ph. will lead the current Account Management team on this implementation effort. The Programs will benefit from her historical experience and in-depth understanding of the DCS Programs, while Enrollees will experience minimal disruption during the implementation of the new contract terms and Program requirements.

An Implementation Work Group (IWG) will be established whereby a team of specialists at UnitedHealthcare will be validating and confirming the DCS Programs' highly customized benefit designs that are already in place, in conjunction with any additional changes that will be effective with the new contract terms. The IWG work group will be responsible for managing the NYSIF Program implementation in a similar manner, with a focus on attention to detail.

By investing a significant amount of time in the pre-planning phase, we will maximize our understanding of the Programs' benefit program and set strategies for a successful implementation that will include:

- Hands-on support delivered by our experienced, knowledgeable client management and implementation specialists.

- Direct collaboration with the Programs to determine existing requirements and develop customized solutions.
- Extensive documentation of implementation project plans and action items to support strict attention to detail.
- Regular meetings with the Programs to communicate progress and address items for review.
- Effective testing protocols to provide accurate plan set-up and functionality.
- Efficient Enrollee transition and communications strategies to minimize disruption and support continuity of care.
- In-depth systems and procedure training for key Program personnel.

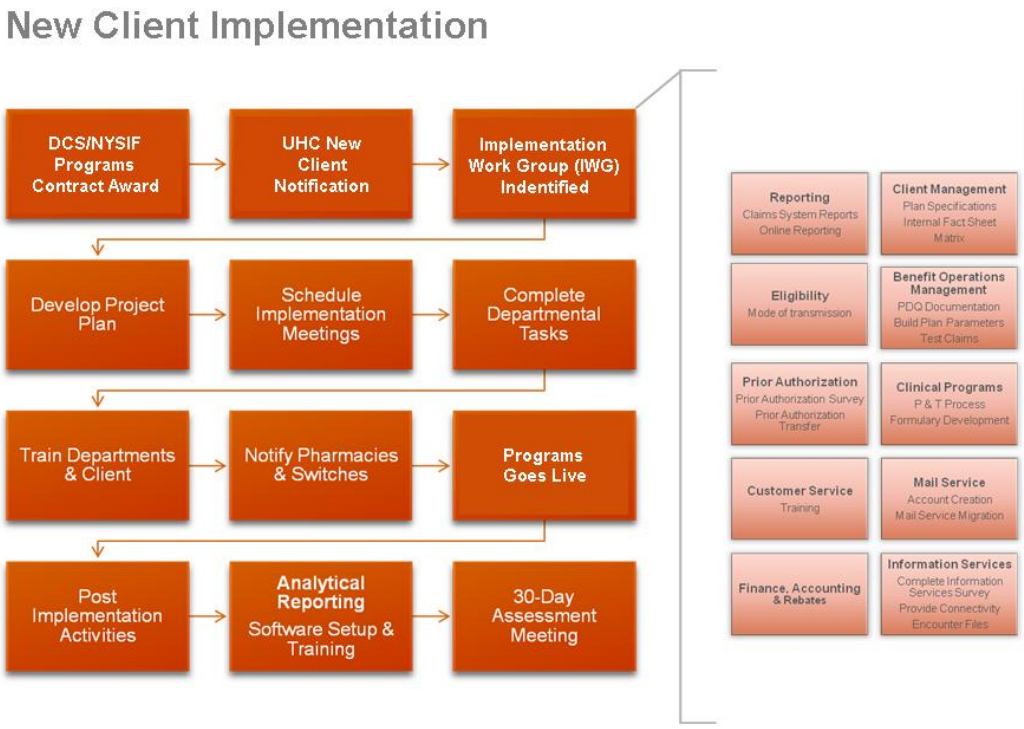
Below we have provided an overview of our implementation approach and key steps.

We have also included detailed implementation timelines for DCS and NYSIF in **Section 3., Exhibit B.**, of this proposal response which illustrates the tasks that will be completed by the Implementation Work Group (IWG) in preparation for January 1, 2014. We will revise the plans to reflect finalized agreements.

Implementation Overview

UnitedHealthcare will incorporate detailed project documentation, multiple checkpoints, progress updates and approval and input from the Programs' decision makers to ensure the smoothest implementation. Our approach allows maximum opportunity for the Programs to collaborate with us on key program elements and monitor our progress. And, although we will require active participation by the Programs at certain points during implementation, we will manage all project elements from start to finish, creating efficiencies and convenience for the DCS and NYSIF staff.

The following chart illustrates the general flow of key steps that will comprise the implementation plan for the DCS Programs, including the EGWP/Part D and the NYSIF Program.



Implementation Timetable

UnitedHealthcare recommends at minimum a 90-day implementation process for the core requirements of the Programs; however, we recognize that the EGWP will require implementation steps to begin in the Fall of 2012 in preparation for January 2014 go live. The following table includes a high-level timetable with target months and dates for completion of each key milestone. We will tailor this timetable, including specific events and target dates, upon contract award to meet the Programs' specific needs and requirements.

Event		Target Month/Date
Pre-Implementation	**Client Meetings**	Upon Contract Award-Fall 2012

Event		Target Month/Date
	Determine Implementation Work Group	Upon Contract Award-Fall 2012
	Pre-Implementation Internal Team Meeting	Upon Contract Award-Fall 2012
Implementation	**EGWP- Plan Filing**	December 2012
	EGWP –Network Filing	January 2013
	EGWP Formulary Filing	March 2013
	Pharmacy Networks	March – April 2013
	Information Systems /Eligibility	2nd Qtr. 2013
	Benefit Grid Development	2nd Qtr. 2013
	Customer Service Preparation	3rd Qtr. 2013
	Mail Service Pharmacy	3rd Qtr. 2013
	Customer Service Infusion Training	3rd Qtr. 2013
	Finance, Accounting & Rebates	3rd Qtr. 2013
	Communications Development	3rd Qtr. 2013
	Prior Authorization Transition	4th Qtr. 2013
	Specialty Program Transition	3rd - 4th Qtr. 2013

Pre-implementation Phase

Thorough, effective preplanning is essential to successful implementation. Consequently, we focus on every aspect of plan transition—from the big picture items down to the smallest details.

During the pre-implementation phase, your Implementation Work Group (IWG) will meet with the Programs to review the process that will take place during the months leading up to the transition date. During this meeting, the IWG and representatives from the Programs' management teams will review the implementation process and applicable documentation to assess the details necessary to successfully implement the Programs. We will use questionnaires

and surveys to gather pertinent information, including a Client Implementation Form, a Prior Authorization Survey and an Information Services (IS) Survey.

The Client Implementation Form reviews and assesses:

- Benefit design and set-up, including information regarding excluded and covered medications, medical supplies and products, dispensing limitations
- Eligibility transmission and record format
- Pharmacy network set-up, including the OptumRx Mail Service Pharmacy and the Designated Specialty Pharmacies
- Formulary design and clinical edits
- Manual claims payment, including direct member reimbursements

The Prior Authorization Survey reviews and assesses:

- The Programs' current policies and procedures
- Grandfathering, if applicable
- State and federal regulations
- Enrollee and physician communication requirements

The Information Services Survey reviews and assesses:

- Connectivity requirements, including information about operating systems, systems access, and data encryption
- Historical data, including transmission of data, format, and the Programs' reporting requirements
- Claims data exchange

Implementation Phase

After receiving all the necessary information and approvals, your IWG will kick-off the implementation phase. During this period, key contacts from various functional areas within UnitedHealthcare participate in regularly scheduled meetings internally and with the Programs to ensure a smooth

transition throughout our organization. The functional areas and their responsibilities include:

- **Benefit Operations Management.** Sets up the Programs' prescription benefit plan parameters, formulary and edits in the claims system.
- **Eligibility.** Defines the eligibility (EGWP, Enrollee and Benefit Program design) requirements and transmission requirements.
- **Pharmacy Network.** Develops a communication plan to the pharmacies regarding the change in PBM.
- **Clinical Services.** Defines the types of clinical programs and edits that the Programs require as well as supports implementation and development of the Programs' custom formularies and disruption.
- **Prior Authorization.** Defines the drugs that will require prior authorization, override criteria and transition of prior authorizations from the previous PBM.
- **Customer Service.** Trains the Programs' Dedicated Call Centers, Pharmacy Help Desk, Mail Service Customer Service and Prior Authorization team on the Programs' benefits.
- **Mail Service.** Defines requirements for transitioning existing prescriptions from the current mail service provider.
- **Claims Administration.** Develops manual claims process for direct member reimbursements (DMR), universal claims forms (UCF), and Medicaid payments.
- **Finance and Accounting.** Establishes the billing process, establishes bank account requirements and performs other billing/invoice/payment related activities.
- **Information Services.** Works directly with the Programs' Information Services Team to ensure that connectivity and data transfers occur seamlessly.

Post-implementation Phase

After the Programs "Go-Live" and we have launched our implementation strategies, your IWG will work closely with the Programs to monitor the

implementation and troubleshoot any problems. A number of statistical reports will be available to monitor the implementation including; call center statistics, mail service statistics, prior authorization statistics and a comprehensive issues log that will be used to manage the ongoing success of the implementation.

(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 50 percent (%) of the 2014 Claims Administration Fee (prorated on a daily basis) for the DCS Program and [redacted] percent (%) of the 2014 Claims Administration Fee (prorated on a daily basis) for NYSIF's Program.

UnitedHealthcare proposes that if all implementation and start-up requirements are not met, [redacted] of the 2014 Claims Administration Fees will be at risk for the DCS Program and if all implementation and start-up requirements are not met, [redacted] of the 2014 Claims Administration Fees will be at risk for the NYSIF programs.

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.

Confirmed.

(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;

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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;

Confirmed.

(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;

Confirmed. UnitedHealthcare will provide a customized website for the DCS Programs with the options available as stated above for Enrollees of the

DCS Programs. The website will meet CMS regulations as required for the Empire Plan EGWP Program.

(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;

Confirmed.

(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;

Confirmed.

(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

Confirmed.

(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.

Confirmed.

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.

Confirmed. OptumRx will provide 24 hours a day, 365 days a year access to the call centers. We are committed to providing exceptional service to the Programs. Our call centers are integrated through a virtual call center. This design connects all customer service representatives (CSRs), phone lines, and call center systems on the Internet. Thus, we can provide efficient, consolidated customer service support for the Programs.

(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.

Confirmed. OptumRx will coordinate with UnitedHealthcare to provide Enrollees with access to our dedicated call centers off the NYSHIP toll-free number. OptumRx has a Teletypewriter (TTY) line available for hearing impaired callers 24 hours a day, 365 days a year.

(3) Confirm that you will maintain separate Dedicated Ccall Ccenters 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.

Confirmed. We will provide a dedicated call center for the DCS and NYSIF Programs and a CMS approved and qualified designated call center for the PDP Program. Both dedicated call centers along with a staff of pharmacists and supervisors will be available 24 hours a day, 365 days a year.

The Programs' call centers will be in Overland Park, Kansas and the Empire Plan PDP Program will be serviced from our Tucson, Arizona location.

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

Customer service representatives (CSRs) are provided access to multiple applications designed to assist Enrollees and Claimants with obtaining their pharmacy benefits; including an on line reference knowledge base to resolve member concerns and questions.

The tools provided to our CSRs are:

- Claims details
  - Copay amounts
  - Drug price
  - Claims History

- Rejection codes
- Pharmacy detail
- Prescriber detail

- Order details
  - Order history
  - Order status
  - Order / Call documentation notes
- Benefit and plan coverage
  - Plan formulary
  - Pharmacy locator
- Resolution tools
  - Process rejection overrides
  - Expedite order delivery
  - Recall orders
  - Shipment tracking
  - Password resets
  - Intra department communication
  - Access to foreign language interpreters
  - Forms

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

Yes. UnitedHealthcare is proposing our Interactive Voice Response (IVR) system to meet the needs of callers. This tool provides intelligent, speech-enabled, self-service capabilities to our clients

for the Enrollee/Claimant and Provider Services, Mail Services and Prior Authorization inquiries. To better meet the needs of the caller, the IVR customizes the experience for the caller. Enrollees/Claimants may select from self-service options or opt to speak to a CSR at any time during the call. We use the Cisco Voice Portal.

Various IVR features for the Enrollee and Claimants include:

- Announcements
- Prescription refill
- Order status
- New prescriptions
- Prior authorization

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

Please refer to the **Section 3., Exhibit C.,** for our IVR script. We can customize any scripting, routing and verbiage/messaging on the IVR; however, transactional prompts are not customizable.

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

UnitedHealthcare documents and reports our call center performance on an aggregate basis. We provide quarterly management reports that show key customer service statistics, including:

- Number of calls received
- Number of calls handled
- Number of abandoned calls
- Service level

- Average speed of answer
- Average abandon delay
- Average handle time

In addition to call performance metrics, other custom reports available for a dedicated call center include:

- Customer satisfaction surveys
- Call reasons
- Customer escalation reasons

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

UnitedHealthcare tracks all Enrollee/Claimant and provider service inquiries and prior authorization inquiries, including calls, e-mail messages and direct mail communications, by annotating the Enrollee/Claimant's record in our on-line Customer Information Systems.

The Enrollee/Claimant record systematically logs the user id of the CSR each time an account transaction or inquiry is documented or submitted. This enables us to match inquiries or complaints to the representative as well as comply with HIPAA and ARRA privacy requirements.

We track multiple inquiry types and categories, including complaints and grievances on Enrollee/Claimant records using specific call tracking reason codes and source codes for each type.

Examples of Call Tracking Reason Codes:

- **Complaints** – includes specific type codes for Pharmacy, Benefit, Privacy, Customer Service, Formulary, Marketing, Pricing, and General complaints
- **Pharmacy Support** – Pharmacy Processing Assistance, and Transmission errors

- **Benefit Inquiries** – includes codes for Eligibility Inquiries and Updates, Co-Pay Inquiries, Plan Limits Exceeded, and Claim Reversals
- **Accounting issues**
- **Formulary** – includes codes for Inquiries and Alternatives
- **Mail Service** – How to Use Mail Service, Order inquiries, Refill requests or status checks, Price Checks, Pharmacist consultation requests
- **Prior authorization** – Process inquiry, Status check, Coverage Determination or Appeals process
- **Verification/update** of personal information – Privacy
- **Web site issue/comment**

Examples of Call Tracking Source Codes:

- Enrollee/Claimant
- Physician
- Pharmacy
- Internal
- Group/Client Broker

Enrollees/ Claimants may call or write us regarding any unresolved dispute or issue. Matters related to our business practices, including plan design, are routed to the assigned client relations manager for resolution.

All matters are documented and reviewed by the appropriate department(s) and all attempts are made to resolve the problem to the Enrollee/Claimant's satisfaction. If we are unable to resolve the matter, we refer the Enrollee/Claimant to the plan sponsor to file an appeal or grievance. This process may be customized to meet specific state laws or client requirements.

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

UnitedHealthcare offers a robust training program for our team of CSRs and Pharmacy Help Desk Technicians and Pharmacists. This program, supported by an award-winning Internal Learning Department, includes extensive initial and ongoing training that promotes quality, accuracy, and an enhanced customer experience.

New Hire Training

All new pharmacists receive intensive training for three months. They learn about injectable medication guidelines, market requirements, specific client benefits, case review policies and procedures. During the training phase, the new pharmacist will sit with senior pharmacists, listen to interactions with physicians, and learn how decisions are made. Senior pharmacists audit the new pharmacist by concurrently listening to telephone discussions regarding injectable therapy. After successfully completing all training activities, the new pharmacist will work independently alongside senior pharmacists. New pharmacy technicians receive similar training.

Fulfillment

New fulfillment pharmacists also receive intensive training for at least two months. The training curriculum for new pharmacists includes an introduction to:

- Specialty pharmacy data entry/distribution
- Pharmacist verification procedures
- Injectable inventory management
- Ordering procedures
- Fulfillment and shipping policy and procedures

During the training phase, the new pharmacist will work alongside senior pharmacists performing distribution functions. They learn how the pharmacists verify specific technician-fulfilled steps and how decisions are made.

Case Review

The training program for all new case review pharmacy technicians and patient care coordinators (PCCs)— involves [redacted] of classroom training. The training includes company and department expectations, systems, materials, and call handling procedures. Immediately following the classroom training, the new employees spend [redacted] in a controlled environment taking live calls under the supervision of the trainer. After passing a skills test, the new employee takes a desk on the floor to assist our members. PCCs must receive [redacted] per year of ongoing training.

All specialty pharmacy staff members receive Internal Fact Sheets. These standardized documents contain client-specific information, including formulary, case review, and copayment information. Additionally, the staff has real-time access to the claims system and online benefit reference tools. This includes all specific information related to claims and member history.

The Programs' dedicated call centers will receive extensive training on the Programs' specific plan designs and will be a knowledgeable resource for all Enrollees.

Below we provide details on our Learning Department and our initial and ongoing training activities.

Our Learning Department

The training experience for our CSRs and technicians is optimized by our award-winning Learning Department. Our commitment to training excellence has garnered us the prestigious BEST award from the American Society for Training and Development (ASTD) for our enterprise-wide training success with our Customer Advocacy initiative for customer service. We are the first PBM to be so honored.

Our in-house Learning Department, which supports initial CSR and technician instruction, includes experienced trainers who are professionally certified in various instructional skills, such as:

- Facilitation of adult learning
- Assessment of training needs
- Presentation and design
- Organization and planning of training programs

Our staff trainers complete a [redacted] professional development program offered by The Training Clinic, an internationally recognized trainer certification program.

Initial Training

During the initial training phase our CSRs and technicians receive approximately [redacted] of materials-based, instructor-led classroom training and [redacted] of on-the-job training in a controlled environment.

Classroom training begins with instruction on key company expectations, systems, materials, and basic call-handling procedures. Next, our trainers focus on capabilities training, which include detailed instruction on how to use our integrated claims and mail service systems.

Trainees receive detailed, hands-on training on specific member service tasks and view demonstrations on how to:

- Verify eligibility
- Check benefit design information
- Verify co-pay structure
- Check formulary
- Check benefit limits
- Check deductibles
- Track mail service prescriptions
- Verify coinsurance pricing
- Provide information on appeals and grievance processes
- Provide forms
- Check member drug history
- Escalate calls to a member service supervisor
- Route calls to a pharmacist

Finally, our trainers highlight skills that create an optimal member call experience. This segment of training focuses specifically on Customer Advocacy and includes such topics as:

- Connecting with the customer
- Advocate attitude
- Using tone of voice effectively
- Effective listening
- Understanding the customer
- Meeting customer needs
- Educating the customer
- Problem solving

After successfully completing classroom training, new advocates spend approximately [redacted] in a controlled environment taking live calls under the supervision of training and operations professionals. We then require agents to pass a rigorous skills test before we release them to a permanent role on our Customer Service team.

Ongoing Training

Following initial training, we continue to develop and reinforce the knowledge and skills the trainees have acquired through several post-training methods. This ensures consistent quality of service, overall transfer of knowledge, and effective use of reference tools. The methods we employ include:

- Regular coaching and development.
- Side-by-side quality monitoring by supervisors.
- Remote call observations, conducted by a staff of dedicated analysts, using Etalk's Qfiniti system. This technology enables recording and playing back calls while observing the online screens used by the agent.
- Skill Gaps, a proactive system for identifying and correcting operational deficiencies.

- Knowlagent, an eLearning system that makes training available to the desktop of every employee via our corporate network.
- Bulletins that alert advocates to the latest developments in our business.
- Message boards located throughout our call centers that provide instant information and performance feedback.
- Continuing education courses to fine-tune call flow and workflow skills, and provide new knowledge.

UnitedHealthcare also employs coaching techniques and refresher training sessions to retrain any call center staff members who do not meet our identified performance levels.

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

UnitedHealthcare's call quality program application that routinely records incoming and outgoing calls for our Customer Service center is Etalk's Qfiniti Call Center Monitoring system.

It captures both voice and screens and simultaneously monitors both call and desktop activity for a complete view of a CSR's performance. Our Quality Development Specialists perform independent assessments using synchronized voice and screen playback.

Our supervisors are able to monitor interactions for performance and examine processes for best practice. Supervisors also have the ability to immediately record interactions on demand or to monitor calls in a live setting.

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

The first call resolution rate for the proposed call centers will be [redacted] of telephone inquiries resolved during the initial call based on no return or repeat call request within 5 days.

UnitedHealthcare utilizes First Contact Resolution (FCR) to measure the effectiveness of our contact center. FCR enables us to constantly monitor and measure our success and provide optimum member satisfaction for our clients. One of the successful outcomes of our FCR program has been a reduction in the number of repeated calls.

Our sustained FCR performance efforts clearly indicate why our organization has received multiple awards for Customer Satisfaction. The following industry-recognized accomplishments reinforce our commitment to service:

- In 2011, we received The Stevie Award for Customer Service Department of the Year at the 9th Annual American Business Awards (ABA).
- Ranked in 2010 as ***the No. 1*** PBM in the industry in an analysis of Customer Service satisfaction among companies offering mail service pharmacy.
- Ranked as the seventh best call center among 800 cross-industry brands in a national study of call center satisfaction—positioning us as the only PBM in the top percentile of the study.
- Received the American Society for Training and Development's (ASTD) BEST Award—the first PBM so honored—for our enterprise-wide training success with our Customer Advocacy initiative for customer service.

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

UnitedHealthcare is extremely proud of its turnover rate for the call centers which was [redacted] for calendar year 2011. We believe in empowering our representatives to provide exemplary service to each caller. Additionally, UnitedHealthcare is committed to providing the tools and resources for our representatives to be successful in their jobs and in providing excellent service to each and every one of our callers.

All call centers are configured and connected into UnitedHealthcare's Virtual Call Center platform to provide uninterrupted 24 hours a day, 7 days a week, and 365 days a year service, call center redundancy,

multiple channel queuing and call routing, real-time dashboard, and workforce management tools.

Considerations for a dedicated call center location supporting DCS and NYSIF will include:

- Geographic diversity to support business recovery and 24 hours a day, 7 days a week, and 365 days a year service
- Human capital resource availability
- Office expansion capability
- Plan metro area preferences

Below is a list of the call center locations that will support the Programs:

Function	Address	Staff
Customer Service Call Centers	3515 Harbor Boulevard Costa Mesa, CA 92626	Approximately 1,200
	755 Research Parkway, Suite 160 Oklahoma City, OK 73104	
	11 Scott Street Wausau, WI 54403	
	6860 W. 115th Street, Suite 100 Overland Park, KS 66211	

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

Depending on the seasonality of workforce requirements, the department strives to maintain the following managerial and support ratios for CSRs, as this has proven to be the most effective and efficient resource structure:

[redacted]

[redacted]

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

We estimate approximately [redacted] and PA staff for the DCS and NYSIF call center teams. This will be a multi-disciplinary process starting with the number of lives to be supported and historical claims processing before applying industry standard Erlang traffic models to calculate the number of agents required. This calculation will take into account forecasted average handle time, average speed of answer and abandonment goals, plus contractual service levels during the hours of operation. Staffing levels are also determined by the performance guarantees agreed to for this contract term.

Leadership and support staff goals would be applied to the overall staffing levels supporting the dedicated sites. For example, training and development, quality assurance, prior authorization, workforce management, and business process staff.

(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.

UnitedHealthcare's Customer Service Centers are located in multiple locations across the country, functioning as a single virtual call center. The four call center locations we will use for the dedicated team support automatic call routing. These locations possess identical telecommunications systems, thus,

our approach provides the Programs with tried and true service to support most every situation. All dedicated call center staff will be thoroughly trained on the DCS and NYSIF Programs.

We have lost power, but due to our redundancy, we are able to recover those calls to one of our four locations.

We confirm that peak hour calls will be handled exclusively by the Program's dedicated team. The Program's team will use virtual call center technology that will act as a back-up and route calls to the next available representative on the team. Off-peak hour calls will be handled by our designated team.

(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.

Confirmed. UnitedHealthcare will provide a customized website for the DCS Programs with the options available as stated above for Enrollees of the DCS Programs. The website will meet CMS regulations as required for the Empire Plan EGWP Program.

We will provide Enrollees with a state-of-the-art Web portal where they can refill prescriptions, view their formulary, and access claims history for both retail and mail-service pharmacy claims, along with many other features.

Our award-winning Web site at www.optumrx.com provides Enrollees with a variety of online support services. In the following sections, we have provided an overview of how we can support DCS' Enrollees through our Web capabilities.

Personalized and Interactive Online Enrollee Content

Our highly interactive suite of Web services includes the following tools and features:

My Formulary Dashboard and Prescription Information

Our formulary look-up tool enables Enrollees to search, browse and sort drugs listed in their formulary by either drug name or drug class (when available).

- **Drug Information.** Enrollees can find up-to-date drug information about thousands of prescription drugs.
- **Drug Pricing Tool.** For Enrollees, we offer a search option that allows Enrollees to look up retail pricing by brand or generic drug name, dosage and quantity. Pricing information is based on list price available through our Mail Service facilities.
- **Pharmacy Locator powered by Google® Maps.** This tool gives Enrollees robust interactive map features, and helps them find the nearest local network pharmacy, even while on vacation.

My Prescriptions Dashboard

This personalized page makes it easy for Enrollees to refill prescriptions and renew expired prescriptions through our Mail Order pharmacy.

- **Prescription Refills.** Enrollees can conveniently refill their prescriptions with just a few clicks.
- **Transfer Prescriptions.** This feature evaluates the Enrollee's retail prescriptions to determine if they can be converted to our Mail Service pharmacy. If an Enrollee is eligible, the system produces easy-to-use, pre-populated "Transfer to Mail Service" forms that Enrollees can print and take to their physicians.
- **Renew Prescriptions.** This feature allows eligible members to create easy-to-use, pre-populated Prescription Renewal forms they can print and take to their physicians to renew those prescriptions.
- **Calendar Export.** Enrollees can add prescription refill reminders to a personal Outlook® calendar.

My Account Dashboard

The dashboard gives increased control to Enrollees so they can:

- Check on the status of a mail service order.
- Manage accounts and profile information.
- Review prescription history and benefit details.

Additional Content and Interactive Resources

- **Specialty Pharmacy and Disease Therapy Management (DTM) overview.**

  Enrollees can get details on how our Specialty Pharmacy works and get helpful information on using specialty medicines effectively. Specialty Pharmacy customers living with specific conditions or diseases can learn about the free-of-charge DTM program. This program features one-on-one interaction with our highly trained staff to help improve health and wellness.

- **Health Basics.**

  We offer up-to-date consumer health education through our health news partner, myoptumhealth.com. Links lead to these helpful tools:

  - Symptom Checker
  - Drug Guide
  - Diseases and Conditions List
  - Drug Interaction Calculator

- **Shop Over-the-Counter and Medical Supply Items**

  While ordering prescription medications, Enrollees can also purchase over-the-counter drugs.

- **Customer Service.**

Enrollees have multiple ways to contact customer service. Enrollees can browse a collection of help topics; access commonly used forms, and take a video tour of the Web site. With one click, Enrollees can request a call (at a time most convenient for them) from one of our CSRs.

Test Site

We encourage DCS to visit our Web site at www.prescriptionsolutions.com and after June 1, 2012, www.optumrx.com using this guest user name and password:

User Name: rxsguest
Password: welcom e08

Customization and Confidentiality

UnitedHealthcare also offers Web site customization for our clients, including co-branding and development of special member welcome messages. Specific co-branding functionality requirements will be specifically developed and addressed for the Programs during implementation.

Recently, we updated our Web site to include new mobile applications. Enrollees visiting our mobile site, m.optumrx.com, can access their personal prescription profiles, refill mail service medications, check order status, and other information. Our standard mobile Web site will be available to the DCS and its Enrollees.

In addition, we maintain the confidentiality of Enrollee data by requiring a secure logon with a unique user name and password. Enrollees may register and create user accounts that are verified through input of their member ID numbers and birth dates.

(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 [redacted] per quarter for DCS and [redacted] per quarter for NYSIF;

Confirmed. Additionally, UnitedHealthcare is willing to guarantee a standard of [redacted] UnitedHealthcare proposes that we place the following amounts at risk:

[redacted] per quarter for DCS
[redacted] 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, [redacted] per quarter for DCS and [redacted] per quarter for NYSIF;

Confirmed. Additionally, UnitedHealthcare will guarantee that [redacted] of all calls will be answered within [redacted] seconds.

UnitedHealthcare proposes that we place the following amounts at risk:

[redacted] per quarter for DCS
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 [redacted] per quarter for DCS and [redacted] per quarter for NYSIF; and

Confirmed. UnitedHealthcare proposes that we place the following amounts at risk:

[redacted] per quarter for DCS
[redacted] per quarter for NYSIF

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

The Standard Credit Amount for each .01 to 1.0% of incoming calls to theOfferor'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, [redacted] per quarter for DCS and [redacted] per quarter for NYSIF.

Confirmed. Additionally, UnitedHealthcare will guarantee that less than [redacted] of all calls will be blocked. UnitedHealthcare proposes that we place the following amounts at risk:

[redacted] per quarter for DCS
[redacted] 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;

Confirmed.

(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

Confirmed.

(b) Enrollment

Confirmed.

(c) Enrollee Opt-Out process

Confirmed.

(d) Health Insurance Claim Number (HICN) administration

Confirmed.

(e) Formulary management

Confirmed.

(f) Issuing of Medicare PDP EGWP member identification cards

Confirmed.

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

Confirmed.

(h) Claims Processing

Confirmed.

(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;

Confirmed.

(j) Timely administration of catastrophe re-insurance claims

Confirmed. UnitedHealthcare will administer catastrophic re-insurance of the Empire Plan EGWP claims.

(k) Administration of Low Income Subsidy requirements

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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.

Confirmed.

(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

Confirmed.

(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.

Confirmed. UnitedHealthcare will work closely with the Department and Office of the New York State Comptroller (OSC) to respond to audit requests for information. PHI will be shared only if allowed and in compliance with the HIPAA Security and Privacy Rules (45 CFR § 164, et seq.) and any other applicable privacy laws and regulations. Any and all audits must be in compliance with all federal and state privacy laws, including but not limited to HIPAA, as well all Medicare Regulations and Centers for Medicare & Medicaid Services (CMS) guidance. We are willing to work with the Department to review compliance with applicable laws and regulations, and define audit parameters that will meet mutual business needs.

We maintain a records schedule that describes record types generated and maintained by the organization and identifies the retention period. Retention assignments are established according to federal and state statutes, industry regulations, risk considerations and operational needs.

(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;

Confirmed.

(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.

Confirmed.

b. <u>Required Submission</u>

(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.

UnitedHealthcare has offered and successfully administered Medicare Part D EGWP plans since 2006. We have more than 30 years of experience serving Medicare populations and extensive knowledge of the laws and regulations governing CMS sanctioned benefits.

We are contracted by CMS as a sponsor of standalone Medicare Part D prescription drug plans (PDPs), which are available in all 34 regions (50 states) and all 5 U.S. territories.

UnitedHealthcare serves more than 600 employer groups and 395,000 retirees with our EGWP plans, and we currently provide EGWP Plus Wrap plans for 25 employer groups serving 340,000 retirees. We also provide coverage to over 6 million individual Medicare Part D total covered lives.

UnitedHealthcare has the ability to provide a full and complex range of administrative and clinical services for its clients. Although we do not track the number of payroll processing centers of our clients, we have experience in

providing benefits to clients with complex administrative needs. Some of the large employer clients who use our Medicare Part D services include:

- [redacted] – 130,000 members
- [redacted] – 79,000 members
- [redacted] – Over 9,300 members
- [redacted] – 6,700 members

UnitedHealthcare has extensive experience with employer groups and their post-65 retirees, including hundreds of Medicare Part D and EGWP implementations over the last nine years. We believe our proposed solution will meet the long-term needs and expectations of the Department and its post-65 retirees and will provide you confidence and comfort knowing your post-65 retirees will be well taken care of.

As part of our expertise in providing EGWP and Wrap services, we provide a full array of administrative services, including eligibility/enrollment, billing, claims, customer service, and our clinical Medication Therapy Management (MTM) program.

A hallmark of our EGWP plans, MTM program exceeds CMS requirements, and is provided with no additional costs or fees. Designed for our Medicare Part D member population, this program has been developed to achieve the following objectives:

- Manage medication use
- Reduce adverse events (for example, drug interactions)
- Improve overall management of Medicare Part D drug costs
- Improve adherence of maintenance medications in the elderly

Our MTM program promotes safe, appropriate and affordable medication use by providing education and consultation to targeted retirees, their caregivers and their prescribing physicians. Our MTMP offers a holistic approach to improving medication use by addressing all types of drug-related problems including overuse, underuse and misuse.

We review pharmacy claims data to determine program eligibility for members. Services include, but are not limited to:

- Providing patient and physician education.
- Detecting clinically significant drug interactions.
- Detecting medications that are considered inappropriate in older patients.
- Detecting patterns of over- and under-utilization of prescribed medications.
- Maximizing effectiveness of medication therapy.

Key components of our program include the following:

Safety:

- **Drug Interaction Alerts.**

  This provider-based program is designed to detect significant, patient-specific drug interactions to reduce the risk of adverse events.

- **Polypharmacy.**

  This provider-based intervention is designed to identify and address drug-disease interactions and duplicate therapy.

- **Geriatric RxMonitor.**

  This provider and member based intervention is designed to identify high-risk medication use and potentially harmful drug-disease interactions in the elderly.

- **Narcotic Drug Utilization.**

  This program is provider-based and designed to minimize the occurrence of diversion and inappropriate use of narcotic medications. The program targets providers of members on narcotic medications that may require evaluation.

Gaps in Care:

This provider based program works to identify and close potential gaps in medication therapy in five key disease categories. These include bone health, diabetes, coronary artery disease, heart failure and rheumatoid arthritis.

Comprehensive Medication Review:

This program includes individualized member counseling service by pharmacists to help address members' drug therapy concerns. Members who have certain multiple core chronic conditions and are taking multiple medications may be identified for the intervention using their pharmacy claims. Following the assessment, an individualized Medication Action Plan is sent to the member outlining medication-related issues identified and recommendations. Providers are also contacted for clinically significant issues such as dose or therapy adjustment as necessary. The review is intended to identify and address drug-related problems including:

- Adverse drug interactions
- Drug-disease interactions
- Duplicate therapy
- Medication adherence

Adherence:

A clinically oriented, comprehensive, provider based program to enhance medication adherence. The program alerts providers to their patients' medication non-adherence.

Enrollment and targeting:

Members meeting specific criteria are identified for the program. The targeted criteria are the following:

- Three of four chronic conditions:
  - Hypertension
  - Heart Failure
  - Diabetes
- Dyslipidemia

- Member takes eight or more chronic Medicare Part D medications
- Member incurs $3,000 or more in annual Medicare Part D covered drug costs

Reporting:

UnitedHealthcare internally measures the impact of its program by evaluating utilization and cost data, the interventions performed and resolution of the therapy issues identified.

Our consistent approach to plan administration supports retirees and their caregivers, uses technology to simplify and streamline administrative functions and leverages our Medicare experience and the full breadth of our unparalleled proprietary resources to provide continuity in an otherwise fragmented health care system.

(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

Confirmed. As described in detail below, UnitedHealthcare will work with the DCS to develop premiums for the Medicare PDP EGWP plus Medicare Part D supplemental wrap.

Development of ghost premiums or premium equivalents for a program such as the Empire Plan is a complex process. UnitedHealthcare will follow a process similar to the current process, eliminating insured financial elements and including additional adjustments specific to the EGWP program.

For the first year of the new contract, the development of premium equivalents will begin with claims from 2012 and the first five months of 2013, repriced for the terms committed to in Section V.A. The repriced claims will then have the following adjustments applied:

- **Completion Factor** – to complete the latest available claim data.
- **Trend Factor** – trend assumptions will be based on a combination of historical Empire Plan specific and UnitedHealthcare book of business projections.
- **Annualizing/Seasonality Factor** – annualizing based on historical seasonality patterns as determined from the historical claim patterns.
- **Mail Order Utilization** – bottom line impact of any projected changes in utilization.
- **Clinical Programs** – to be applied only if there is a change in clinical programs offered by the State.
- **PDL** – inclusion of final 2014 PDL change projections as approved by GOER and DCS.
- **Plan or Benefit Design Change** – adjustments for any bargained, administratively extended or mandated though state of federal law.
- **Demographics** – changes in projected pharmacy costs due to changes age/gender characteristics.
- **Mix/Severity** – change in the pharmacy cost due to intensity and normalization.
- **Workdays Adjustment** – change in pharmacy costs due to the number of workdays, holiday, leap impact, and etc.
- **Pipeline Adjustment** – change in pharmacy costs due to new drugs, drugs going off patent, and etc.
- **Leveraging** – an adjustment to account for unit cost changes that outpace member copays.
- **Rebates** – projection of 2014 rebates for the Empire Plan adjusted for 2014 PDL changes, price protection impact and patent expirations.

- **CMS Subsidy** – projection of 2014 subsidy resulting from the national bids and reflecting anticipated RAF scores.
- **50% Brand Discount** – projection of 2014 impact of the manufacturer brand discount in the donut hole.
- **80% Reinsurance** – projection of 2014 80% reinsurance for CMS.

The preceding adjustments, applied to the repriced claims base result in total net projected incurred claims for 2014.

- **Administrative Fee** – forecasted administrative fee based on the forecasted script volume for 2014 times the claim administrative fee included in our response to the cost proposal, in **Section 3., Exhibit F.**
- **Shared Communication Expense** – the amount DCS assigns to the Pharmacy Vendor for production and distribution of SPD's and other Empire Plan communication materials.

The sum total of net 2014 claims, projected administrative fee and shared communications expense will represent the premium equivalent for 2014.

(b) Enrollment

Confirmed. Our Group Medicare Part D plans can be group enrolled and processed electronically using an enrollment file supplied by DCS. No action is required of retirees if they agree to be enrolled into the employer plan. Retirees can change plans during each enrollment period by filling out a standard State of New York enrollment form. The form includes all of the offered plans and other personal information such as the Medicare health insurance claim number (HICN).

CMS allows us to accept enrollment requests into our employer/union-sponsored PDP using a group enrollment process that includes providing CMS with any information the Department has on other insurance coverage for the purposes of coordination of benefits, as well as creditable coverage history on each beneficiary group enrolled for

purposes of assessing the late enrollment penalty. It is UnitedHealthcare's responsibility to ensure the group enrollment process meets all applicable CMS PDP enrollment requirements.

Group enrollments are processed with an application date of the first day of the month prior to the effective date of the group enrollment. Following this process allows any subsequent retiree-generated enrollment request to supersede the group enrollment in CMS systems.

Specifically for the Empire Plan EGWP enrollment, UnitedHealthcare will continue to offer an integrated enrollment process to the DCS Programs by maintaining enrollment information for the prescription program, Medical and MHSA Programs. We provide the Program an accurate, complete, and up-to-date enrollment file based on information provided by the DCS. This enrollment file is used today and will continue to be used under the next contract to process retail and mail order claims, provide customer service, identify individuals in the enrollment file who have signed up for Medicare Part B and Part D, and produce management reports and data files. Our ability to accept and process enrollment with Medicare indicators assist the Program in important data compilation.

UnitedHealthcare has fine-tuned the current eligibility process employed for the DCS Programs since implementation of our current contract in 2008; therefore it will not be necessary to implement a new eligibility process for the DCS Programs. We are currently compliant with receiving an EDI Benefit Enrollment and Maintenance Transaction set 834(ANSI x.12 834 standards) as required by the DCS Programs. However; as part of the implementation plan, we will address and implement any necessary changes to the eligibility process as required by the DCS Programs, as well as testing as a result of those changes under the new terms of this contract.

UnitedHealthcare has a two stage process to identify enrollment records that cannot be loaded into its enrollment system. The first stage examines the 834 eligibility file after transmission by DCS for the require data segments before the file can be accepted by UnitedHealthcare. If the 834 file does not contain the required standard data segments, the file is then returned to DCS with an explanation of the data segments required. The required data segments

which will typically cause an 834 file to be rejected are missing demographic information, such as a missing Enrollee name or Enrollee address. After the first stage is completed, the file is accepted by UnitedHealthcare and the enrollment records are processed into our eligibility record system, CES, by our Electronic Eligibility Management System (EEMS). The records that cannot be loaded into the eligibility record system by EEMS generate an exception report in the morning which is worked by our eligibility specialists for correction. All the records on a typical exception report are then corrected within three to four hours by our eligibility specialists.

The typical exceptions which would cause an enrollment transaction not to load into our eligibility system requiring manual intervention are:

- Invalid postal codes
- Marital status missing (no indication if Enrollee is single or married)

Before eligibility is fully loaded into the claims processing system at the pharmacy benefit manager, all eligibility files are loaded to a pre-pass analysis, independent from the production setting. If test results do not exceed the agreed upon reject/term threshold we move forward and load the file into production.

Load/exception reports automatically generate after every production load. The reports are automatically distributed to designated recipients via e-mail or FTP. The reports detail the number of added, updated, rejected, or termed records on the file. If anything is rejected during the staging or loading process, the report shows which specific members or groups were rejected and the reason. For example, members may not load correctly with the following conditions:

- The Group ID is absent
- An invalid birth date is loaded
- There is no effective date on the file

All aspects of the stringent staged analysis/review phase occur in the pre-pass setting and do not involve production. If there are no

questionable rejections, the file runs through the same process in the production mode. After the information is loaded into production, the data is live and ready for claims processing and eligibility verification.

For the purposes of notification and other timeframe requirements, we use the date we receive the request. For example, if a valid group enrollment file is received on January 24 for enrollments effective February 1, the receipt date for the provision of required notices is January 24, and the application date submitted on the enrollment transactions is January 1. The Department must provide in the group enrollment file(s) all the information required for us to submit a complete enrollment request transaction to CMS.

The Kingston eligibility analyst has access to the NYBEAS system and also has direct contact with the DCS eligibility staff to resolve these transactions quickly. We will continue with this process under the terms of the new contract. Once the Kingston eligibility analyst has completed their work on the file, it is sent to the Medicare Eligibility team and loaded into GPS.

Generation Policy Administration System – Enrollment and Eligibility System

Generation Policy Administration System (GPS) is our strategic front-end platform for policy administration of Medicare Part D. The system provides a common platform to support enrollment/eligibility, premium billing and collections, fulfillment and letter generation. The application supports approximately 7 million Medicare retirees and has more than 6,000 users consisting primarily of call center and operations staff.

GPS allows us to present a seamless face to the customer. Having a single, comprehensive view of our members, for example, means that we can simultaneously track an application from start to finish through the enrollment process; see billing information, and know the order and delivery status of fulfillment material.

The overall benefits of GPS are substantial – improved service to CMS, reduced handle time for enrollment and greater standardization. The following examples illustrate several of the advanced features:

- Enrollment – only invalid applications (that is, applications with missing information or written comments) need to be viewed or touched by a processor.
- Eligibility – eligibility status can be efficiently tracked by storing detailed Enrollee information including eligibility segments, addresses, primary physicians and a record of CMS enrollment transactions.
- Fulfillment – advanced business rules allow for the creation of dynamic mailing scenarios; the majority of enrollment letters are triggered by the system rather than having to be manually generated.
- Billing – coupon books and multiple payment methods can be supported at a product level. For group retiree business, GPS provides the ability to send a bill to the employer group and also to the individual member.

Medicare Eligibility Verification

Upon receipt of eligibility files from Kingston, we work with CMS to verify the retiree's eligibility status. After receiving the group membership file, there are two primary steps in the eligibility verification process. Within the first 48 hours, clean and complete records are transmitted to CMS's pre-eligibility vendor, Info Crossing. This validation quickly confirms that the member meets basic Medicare eligibility requirements prior to submitting the transaction file to CMS. Once the record returns from this initial validation, if the validation is successful the member's record is then passed to CMS for final eligibility / enrollment processing. If the initial validation is unsuccessful, discrepancies are distributed to various work queues where processors review and resolve the errors. Teams will also work any records that may have fallen out from the original file load. The processors work closely with the client managers, employer or third party administrator; whoever is deemed the appropriate resource. Once issues are resolved, the process will continue and the application will result in either an approval or denial.

The standard processing timeframe from when Kingston sends the production file to when CMS provides an approval of the members' eligibility is from five to seven Business Days. For all transactions, eligibility is validated prior to enrollment transactions being sent to CMS.

CMS provides daily response files indicating if enrollments were accepted or denied. The list of successful enrollments is loaded into our system triggering distribution of various fulfillment items such as a member ID card and welcome kit.

Upon receipt of enrollment requests, members receive one of the following communications within 10 calendar days:

- Notice of acknowledgement stating that we have received the application data and have submitted the application to CMS for approval
- Request for additional Information should the application data be incomplete
- Notice of denial due to ineligibility

Some members may already be enrolled in an individual plan prior to switching to the employer's PDP plan. In these situations CMS compares the member's information with their records. CMS typically disenrolls the member from the individual plan and approves enrollment into the employer plan.

CMS also compares Medicare Part D enrollment transactions to information regarding the existence of employer or union coverage for which the beneficiary is also being claimed for the retiree drug subsidy (RDS). If there is a match indicating that the individual may have such other coverage, the enrollment is conditionally rejected by CMS. If an employer or union group is not replacing the existing RDS plan, we are required to contact the individual to inform him/her how enrolling into the new plan could affect current coverage. When an employer or union-group-sponsored PDP is replacing an existing retiree drug subsidy plan offered by that employer or union group, we may receive a conditional rejection. We are not required, though, to contact each

individual as described above. We simply resubmit the transactions to CMS with an indicator noting the replacement.

Retirees receive a denial letter if any of the following apply:

- They are not covered by Medicare Parts A or B.
- Their permanent residence is outside the plan service area.
- The PDP enrollment form is incomplete or missing information and is not received within 21days.
- They attempted to enroll outside an enrollment period (primarily only for members enrolling into an individual product and who have exhausted their special election period EGHP).
- They have drug coverage such as from another employer or union and they wish to remain on that plan.

(c) Enrollee Opt-Out process

Confirmed. The group enrollment process must include notification to retirees that:

- The Department intends to enroll the retiree in the PDP.
- The retiree's ability to affirmatively opt-out of such enrollment (notice must include instructions for opting out as well as a description of any consequences that opting out would have on retirees' benefits).

Retirees must be notified of the opt-out option at least 21 calendar days prior to the effective date of the retiree's enrollment in the group-sponsored PDP. We are able to provide guidance and the necessary documents (for example, summary of plan benefits, limitations and exclusions and opt-out form). The materials must also contain instructions for obtaining more information about the PDP as well as for contacting Medicare for information on other Medicare Part D options.

Retirees returning the opt-out form are excluded from the enrollment file and will not be processed; thereby excluding them from receiving prescription drug benefits under the PDP. We are not allowed to solicit retiree plan membership. Any members choosing to opt-out may not be contacted further by our staff as CMS may interpret this as an attempt to circumvent the required opt-out process.

(d) Health Insurance Claim Number (HICN) administration

Confirmed. CMS requires a HICN for each retiree in employer provided enrollment files. Enrollment applications missing the required HICN are considered incomplete by CMS and cannot be processed. Per Chapter 3 in the CMS Medicare Prescription Drug Benefit Manual, section 40.1.6 – Additional Enrollment Request Mechanisms for Employer/Union Sponsored Coverage regulations, "The employer or union must provide in the group enrollment file(s) all the information required for the PDP sponsor to submit a complete enrollment request transaction to CMS." This includes the HICN. Employer provided files that do not contain HICNs will not systematically load into our systems.

When a retiree enrolls using a paper application or over the phone and a HICN is missing or is identified as incorrect during the eligibility verification process, our enrollment processors will attempt to correct the data. If they are unable to resolve the situation, the processor will send a letter requesting the retiree provide the additional information by returning the letter or by calling our customer care professionals. Processors also make at least one outgoing call attempt to the retiree.

Once the HICN is received, the application processing continues, and the record is sent for approval. If the retiree does not respond within 21 days from the date the letter seeking additional information was sent, UnitedHealthcare is required to deny the application as lacking the required data, and a letter is sent to the retiree.

If a retiree is enrolling in an employer plan and the employer group wishes to assist in obtaining the retiree's additional information, we can provide the employer with a report called the Application Status

Report. Once the employer has provided UnitedHealthcare with the additional information, the application processing continues, and the record is sent to CMS for approval consideration.

CMS does not require we work with the employer in these situations; however, CMS does require that we attempt to gain the information directly from the retiree if we are unable to resolve the data discrepancy independently. Therefore, even if we provide the employer with this report, we are still required by CMS to send a letter to the retiree indicating we are in need of the information. If the retiree contacts us after the employer has resolved the situation, our customer care team accesses the retiree's record and is able to provide the retiree with this update and confirm the application status at that time.

(e) Formulary management

Confirmed. Creation of the 2013 Empire Plan EGWP Formulary required a comprehensive development and implementation process. [redacted], your Account Management team collaborated with experts within UnitedHealthcare's Medicare and Retirement division to create the 2013 Empire Plan PDP Formulary.

[redacted]

The formulary process UnitedHealthcare employed for the 2013 NYS EGWP will also be conducted for the 2014 EGWP formulary. This will ensure that the 2014 EGWP formulary process, which includes formulary execution and necessary updates, is overseen by clinical pharmacists across all UnitedHealthcare divisions and are in compliance with CMS requirements and regulations.

UnitedHealthcare currently administers the DCS Programs multiple formularies. UnitedHealthcare will continue to leverage the foundation of our fully insured Advantage PDL strategies to meet the Programs PDL requirements. The overall objective of the Empire Plan Flexible Formulary is to provide Enrollees and the Plan with the best value in prescription drug spending taking into consideration the clinical value of the drugs covered, while at the same time limiting disruption. This goal is accomplished by excluding coverage for a small number of drugs, lowering the copay on brand name drugs that provide the best value to the Plan and increasing the copay on other brand name drugs that do not provide a clinical advantage over existing generic and preferred brand name drug alternatives.

The purpose of the Empire Plan Flexible Formulary is to reduce unnecessary costs without impacting clinically appropriate medication options for Enrollees and their physicians. This is accomplished by:

- Excluding coverage for a small number of drugs.
- Placing brand-name drugs that provide the best overall healthcare value to the Plan on the Empire Plan Flexible Formulary Drug List.
- Applying the highest copayment to non-preferred brand-name drugs that provide no clinical advantage over generic or preferred brand-name drug alternatives.
- Providing for a dedicated Clinical Pharmacist to offer necessary Enrollee counseling specifically supporting the Flexible Formulary and its lower cost alternatives.

Certain drugs are excluded under the Empire Plan Prescription Drug Program so that the Plan can continue to provide the best value in prescription drug coverage to all Enrollees under the Plan. Whenever a prescription drug is excluded, therapeutic brand and/or generic alternatives will be covered. By excluding coverage for a small number of drugs, the Empire Plan Flexible Formulary discourages the use of expensive "me-too" or copycat medications that have been found to provide no significant healthcare advantage and yet are priced significantly higher than competing drugs. “Me-too” drugs are essentially the same as other drugs in their therapeutic category, with a

slight chemical modification that allows the manufacturer to have patent protection and continue to price the medication at a premium.

Our custom formulary process for the Programs has proven extremely successful and we look forward to working with the DCS to further develop and update these PDLs to meet program requirements.

The Clinical Services Department and National Pharmacy & Therapeutics (P&T) Committee are responsible for developing and maintaining formularies that meet CMS requirements.

(f) Issuing of Medicare PDP EGWP member identification cards

Confirmed. When your members' enrollment is approved by CMS, a random ID number is generated and assigned, and members will be sent their ID cards. Each family member receives his or her own ID card; the cards are mailed to members' home at no additional cost. Those with PDP plans have separate ID cards without any medical coverage information.

The Account Management team will establish an Implementation Work Group (IWG) whereby a team of specialists at UnitedHealthcare will be validating and confirming the DCS Programs' implementation tasks specific to the Empire Plan EGWP Program. As part of that implementation plan for the 2013 EGWP, member identification cards and any opportunity to co-brand and customize the cards while adhering to CMS regulations has been addressed. As part of the Programs' 2014 implementation, we will continue the strategies employed for member identification cards in 2013 for the contract period 2014 and beyond.

Upon receipt of enrollment requests, members receive one of the following communications within 10 calendar days:

- Notice of acknowledgement stating that we have received the application data and have submitted the application to CMS for approval.
- Request for additional Information should the application data be incomplete.

- Notice of denial due to ineligibility.

New members are sent an ID card when their enrollment is approved by CMS or upon request by the member.

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

Confirmed. The Account Management team will establish an Implementation Work Group (IWG) whereby a team of specialists at UnitedHealthcare will be validating and confirming the DCS Programs' implementation tasks specific to the Empire Plan EGWP Program. As part of that implementation plan for the 2013 EGWP, member communication materials and any opportunity to co-brand and customize member communications while adhering to CMS regulations has been addressed. As part of the Programs' 2014 implementation, we will continue the strategies employed for member communications in 2013 for the contract period 2014 and beyond.

Understanding Medicare Part D can be difficult and confusing for many Medicare members. We have designed a communication approach with two goals in mind:

To educate members so they can make informed decisions regarding their Medicare Part D benefits with materials that explain both Medicare in general and the availability of plans specifically.	To provide information about our products while walking prospective members through a needs analysis designed to help choose the plans that best meet their needs.

Pre-Enrollment Kit

When a retiree requests materials, we send an entire pre-enrollment kit, and the retiree receives the kit in four to seven days. If materials are ordered in bulk by the senior account executive, the average number of days for materials to arrive is 5 to 16 days. The pre-enrollment kit includes:

Pre-Enrollment Item
Outer Mailing Envelope
Cover Letter
PDP Plan Guide
Summary of Benefits
Rx Buy Up Addendum (if applicable)
Enrollment Application (includes sticker)
Business Reply Envelope
Statements of Understanding
Star Rating Sheet – Medicare Part D
Appeals and Grievance

Post-Enrollment Kit

Members are welcomed to their plan by the post-enrollment kit. This kit includes materials describing how to use their PDP benefits, and all regulatory required materials. Upon completion of eligibility processing, the materials sent to new members include:

Post-Enrollment Item
Outer Mailing Envelope
Cover Wrap*
Post Kit Cover Letter*
Summary of Benefits*
LIS/EOC Rider* (if applicable)
Medicare Part D Partner Letter*
Authorization Representative Form
Pharmacy Directory*
Your Plan. Getting Started*

Post-Enrollment Item
Evidence of Coverage
Abridged Formulary
Mail Order Form
** Items are printed as one document*

Annual Notice of Change

The Annual Notice of Change (ANOC) is sent to current members 15 days prior to the employer group's open enrollment period. The ANOC is sent 15 days prior to the renewal plan's effective date, if there is no open enrollment period. The ANOC includes key benefit information regarding changes in the new plan year. The ANOC kit includes:

Post-Enrollment Item
Outer Mailing Envelope
Cover Wrap*
Post Kit Cover Letter*
Summary of Benefits*
LIS/EOC Rider* (if applicable)
Medicare Part D Partner Letter*
Authorization Representative Form
Pharmacy Directory*
** Items are printed as one document*

Explanation of Benefits

Members receive monthly explanation of benefits (EOB) statements whenever they have claims in the prior month. The EOB is standard and approved by CMS. It informs members of their cumulative true out-of-pocket (TrOOP) limit and total drug spend as well as the status of their Medicare Part D benefits. It also includes details of claims

processed in the prior month, such as costs and amounts paid by the members, the plans and other payers.

An EOB is also used to announce any plan-initiated formulary changes within the CMS-required 60 day notice. EOBs are provided at no additional cost to employer groups or members.

Web-Based Educational Content

UnitedHealthcare will provide a customized website for the DCS Programs. The website will meet all the CMS regulations as required for the Empire Plan EGWP Program.

To avoid confusion for your retirees, we supplement this information with the following:

- Customized clinical education support telephonically
- Hard copy retiree enrollment materials as a component of our retiree-focused clinical programs
  - Drug utilization review
  - Medication therapy management
  - Prior authorization programs

(h) Claims Processing

Confirmed. In our response to the DCS Program requirements in the **Section 3. B. 12 Claims Processing**, we have detailed our claims processing capabilities offered to the Programs. In adhering to the requirements of the RFP and in processing claims adjudication under the Empire Plan EGWP, we will comply with all allowable and applicable CMS regulations. Please refer to our complete claims processing response in **Section 3. B. 12.** For purposes of the Empire Plan EGWP Program we have listed the following high level exceptions identified as of the date of this response to the Programs claims processing requirements.

- Mandatory Generic Substitution

- CMS Brand/Generic definitions
- Half Tablet Program
- New To You Program
- Drug Coverage Rules
- PDL Requirements

UnitedHealthcare uses SXC Health Solutions Corporation's RxCLAIM online transaction processing system to process all claims; retail, mail, and specialty claims, which comprises 99 percent of our claims electronically.

When UnitedHealthcare receives a claim, edits and checks are made to ensure that the claim is eligible for payment. Claim requests are checked for the following:

- Correct format
- Pharmacy network
- Enrollee eligibility
- Formulary status

Subsequent to a positive check, the request will be approved as a valid claim and then sent on for further processing. If the claim does not pass the initial checks, a rejection occurs.

Through our Real-Time Audit System, a copy of a prescription claim is immediately sent through filters, or edits, which flag claims that fall outside set algorithms. Customer service can then call the pharmacy to resolve the concern, often while the Enrollee is still at the pharmacy. This process helps prevent mistakes and reduces fraud in prescription claims submission.

Once a claim has been approved, we compare the reimbursement the pharmacy is requesting with the amount we have previously agreed upon based on Usual and Customary (U&C) cost, submitted, contracted dispensing rate, maximum allowable cost (MAC) list pricing, and Enrollee copayment.

UnitedHealthcare uses the latest in network and leased-line technology to receive electronically submitted claims from more than 64,000 pharmacies participating in our various networks. Submitted claims are immediately transferred to one of several claims processing engines that drive our system.

The adjudication process operating in each subsystem retrieves, matches, and validates the critical Enrollee information submitted by the pharmacy. The system selects the appropriate group and benefit level (based on the Enrollee number and date of service), and automatically applies edit parameters such as, validating drug products from the Programs' PDLs and benefit plan design.

Following formulary validation, drug and event-specific edits are applied. In addition, selected DUR edits based on the dosage, day's supply, and prior history, are applied. If at any point during the adjudication process the claim fails to pass an edit or validation, a detailed error message is immediately generated and returned online to the submitting pharmacy. If no errors are detected, the claim completes the stringent validation process and is priced for reimbursement and billing.

Various pricing formulas are used to determine the total allowable charge for the prescription. These pricing methodologies may involve comparisons to:

- AWP
- Submitted/ U&C charges
- MAC list price
- Other table-driven values

This charge is then proportioned between the covered Enrollee (copayment) and the Programs, based on the plan design.

Following adjudication, an approval message and paid claim response are returned to the submitting pharmacy. The paid response includes details on the:

- Pricing and cost values

- Amount to be collected from the Enrollee (if any)
- An amount that will be included in the next payment advice (amount due)

At the end of each claim submission time cycle, our robust system extracts all completed claims processed during the previous 24-hour period. The claims are then copied to pharmacy payment programs for normal pharmacy disbursement. The claims are also augmented with additional data from the various system databases. After the claims have been saved and updated, the information is then recorded in the system's claim history reporting libraries.

(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;

Confirmed. The Account Management and Clinical team will establish an IWG whereby a team of specialists at UnitedHealthcare will be validating and confirming the DCS Programs' implementation tasks specific to the Empire Plan EGWP Program. As part of that implementation plan for the 2013 EGWP, a thorough process was performed whereby an analysis of the commercial plan as compared to the Empire Plan EGWP documented plan design differences and identified solutions, both clinical and administrative in nature, to allow for parity of the commercial plan design to that of the Empire Plan EGWP. As part of the Programs' 2014 implementation, we will continue the strategies employed for plan design parity in 2013 for the contract period 2014 and beyond.

(j) Timely administration of catastrophe re-insurance claims

Confirmed. UnitedHealthcare will administer catastrophic re-insurance of the Empire Plan EGWP claims.

(k) Administration of Low Income Subsidy requirements

Confirmed. Eligibility for the Low Income Subsidy (LIS) is determined and verified by the Social Security Administration (SSA) for all Medicare Part D participants. Beneficiaries may fall into two potential LIS categories. Full subsidy eligible beneficiaries have income below 135 percent of the federal poverty level based on family size, and fit under an asset guideline. These beneficiaries automatically qualify and are enrolled in LIS. Partial subsidy eligible beneficiaries have an income below 150 percent of the federal poverty level based on family size, and also fit under an asset guideline. Partial subsidy eligible beneficiaries must apply to SSA or their state of residence to determine LIS qualification and entitlement level. All beneficiaries must continue to apply separately to us for their Medicare Part D coverage.

Some individuals automatically qualify for the low-income premium subsidy. Those individuals include:

- Full benefit dual eligibles
- Supplemental Security Income (SSI) recipients with Medicare
- Medicare Savings Programs participants

In addition, our customer care professionals have been trained to identify members who might require financial assistance. We refer these members to a special coordinator who facilitates the LIS application process. The coordinator walks the member through the application over the phone, submits the application to SSA, notifies the member of SSA's decision, and submits monthly eligibility information to CMS. Each member works with the same coordinator throughout the application process. Coordinators also provide ongoing support to help members retain the benefits for which they are eligible. This service is provided to all qualified UnitedHealthcare members at no additional charge.

As a condition of offering Employer/Union Sponsored Group Health Plans (EGHP), CMS requires that we meet the following requirements for the pass-through of low income premium subsidies:

- UnitedHealthcare will ensure the premium contributions of beneficiaries are reduced prior to monies being applied to any premium paid by the plan sponsor.
- Ensure Enrollee receive credits either through a check to the Enrollee, or by a credit to the State of New York within 45 days of receiving payment from CMS.
- We will obtain/retain evidence that the low income premium subsidy has been applied appropriately to the Enrollee within the guidelines above.

(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.

Confirmed. Please refer to **Section 3., Exhibit B.,** which represents the proposed Implementation timeline for the Empire Plan EGWP and includes all the necessary filing requirements of the Program.

(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.

We have included a table as **Section 3., Exhibit D.,** that represents potential CMS required drugs to be added to the Flexible Formulary and those drugs that are potentially to be excluded from coverage under the Empire Plan EGWP. We have also indicated areas where clinical edits may differ as a result of the CMS regulations. As the incumbent, UnitedHealthcare has already filed this adapted Flexible Formulary for 2013 and we will employ the practices utilized in 2013 for the 2014 formulary filing with CMS.

As the plan sponsor of the Empire Plan Program Part D plan, UnitedHealthcare will work closely with the DCS to replicate, to the extent possible, the plan design and flexible formulary of the DCS Program in accordance with all applicable federal laws, implementing regulations, together with guidance, instruction and other directives from CMS as well as generally accepted Medicare Part D pharmacy benefit practices.

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

We have included the requested sample communications as **Section 3., Exhibit E.**

(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.

For Empire Plan EGWP Program members aging into the EGWP from the commercial Empire Plan, UnitedHealthcare will develop and provide transition services to minimize member disruption. Although transition cannot be performed electronically due to the change in unique member id as a result of the EGWP, UnitedHealthcare is confident it can develop a customized solution to identify formulary and prior authorization disruption.

For Empire Plan EGWP Program members aging in from another plan, such as a NYSHIP approved HMO, a transition supply plan will be offered. Please see details below:

Transition Supply

During the first 90 days of plan membership, we cover transition supplies for new members using medications subject to utilization management restrictions (for example, prior authorization, quantity limits or step therapy) and medications that are not covered on the Formulary. For additional refills to be

covered by the plan, physicians, pharmacists or members initiate a coverage determination request by contacting the clinical help desk.

For members who reside in a long-term care (LTC) facility, we provide more than one transition fill during the first 90 days of plan enrollment. We also provide one time emergency fills for members who experience an unplanned transition, such as a change in care setting or level of care (for example, admittance or discharge to or from a LTC facility or hospital).

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

If a retiree chooses to disenroll directly with us and has passed the first day of his or her coverage, he or she may send a written request to be terminated from coverage. Requests are processed at the end of the month in which the request is received. If retirees request cancellation of their coverage prior to the effective date (for example, effective May 1 but called on April 25 to cancel), the request can be made by phone.

Termination dates are always the last day of the current month. For example, a retiree who is effective May 1 sends a termination request letter received on May 25. That retiree would be terminated as of May 31. Retroactive termination dates are not allowed for members enrolled in Medicare Part D.

If the Department wishes to make the termination request (for example, retiree chooses another plan, retiree opts out of coverage, or retiree loses his or her employer eligibility), we must receive notification at least 30 days prior to the termination date. The advance notice period allows us to provide members with adequate notification of the involuntary termination as required by CMS.

(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.

As we have developed for the 2013 implementation of the Empire Plan EGWP Program, the DCS Program's Account Management team will be extended to include a team of dedicated retiree health care professionals that will offer extensive consulting experience in Part D Plans. Many of the key team members that have worked on the 2013 implementation, such as actuary, Greta Redmond and operational expert, Ellen Sexton, will continue to support the DCS Program's operational and financial goals in implementing a Medicare Part D Plan in 2014.

As leaders in retiree health care, UnitedHealthcare starts by integrating program strategy, product development and employer decision support. We then leverage the many years of actuarial and business experience in the benefits consulting industry to monitor program effectiveness and look for improvements. Along with our experience, we use several quantitative and qualitative models to guide plan sponsors in developing the optimal program for their retirees which results in the maximum savings to the plan sponsor. The models consider each customer's specific culture, business needs, financial situation and program goals as well as their vision of their future state.

Using our benefit design modeling tool, UnitedHealthcare can estimate both the clinical and financial impact of plan design changes including modifications related to copayments, coinsurance, deductibles (family or individual), formulary coverage, out-of-pocket maximums, drug exclusions and more.

Our involvement with Medicare Part D began as soon as the Medicare Modernization Act was passed in late 2003 and continues to grow with each year and every new legislative change, such as the recent health care reform impacts. We are confident that we can partner with the State of New York to build the plan that offers the maximum savings to the State of New York.

(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.

Confirmed. Coordination of benefits (COB) for Medicare Part D plans is prescribed by CMS. UnitedHealthcare will provide Retrospective COB services to the DCS Programs and will assist in the identification, investigation and recovery of pharmacy claim overpayments where another insurance carrier or Medicare was primary.

6. Enrollee Communication Support

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. Duties and Responsibilities

(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.

Confirmed.

(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;

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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. <u>See sample ID card in Exhibit II.E.2d.</u>

Confirmed.

b. <u>Required Submission</u>

(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.

Currently your UnitedHealthcare Account Management team develops and reviews various Enrollee publications for the Program. When an Enrollee letter is needed to communicate changes to the Program, UnitedHealthcare composes the letter and works collaboratively with DCS to develop the final draft letter.

UnitedHealthcare provides customized Enrollee communications designed to help Enrollees understand their pharmacy benefit and fully maximize its value. The Corporate Review Process (CRP) works with your Account Team to support your communication needs. CRP is a formal review and approval process of new and revised Enrollee communication materials. Enrollee communication materials that go through the CRP process receive:

- **Legal Approval.** For legal implications; accuracy of facts and information; possible ambiguity; appropriate use of terms and language; footnotes, and etc.
- **Clinical Approval.** For accuracy of medication information, sometimes for plan information – if applicable; consistency of information; use of current pharmacy terms, and etc.

- **Marketing Approval.** For spelling, punctuation and grammar; branding; clarity of message; presentation and flow of ideas and information; consistency within the piece and with other communications; format; phone numbers and correct contact information, and etc.

The implementation of the Empire Plan Specialty Pharmacy Program in April 2010 provided a unique opportunity to work with the DCS on composing customized Program announcement letters, trigger letters, and various articles explaining the Program to be included in various DCS publications. Please see **Section 3., Exhibit F**., for samples of communication materials developed for the Specialty Drug Program.

Additionally, in order to have more control and oversight over the development and communication of PDL changes, in the fourth quarter of 2009, UnitedHealthcare contracted with a local printer experienced in servicing the Empire Plan to print and mail the Preferred Drug List, Flexible Formulary Drug List, and Enrollee disruption letters. This change made the process more streamlined and efficient as it provided an opportunity for direct oversight and control over the printing process. UnitedHealthcare plans to continue to employ the local printer throughout this contract award to insure efficiency and accuracy throughout the printing process.

The PDL disruption process is another example of how your UnitedHealthcare Account team works collaboratively with DCS to compose, edit and approve communication materials sent to Enrollees.

Your UnitedHealthcare Clinical team also works with DCS to develop new drug lists for the various employer groups. Most recently, the 2012 Flexible Formulary was redesigned to six pages to incorporate additional drugs and the Brand for Generic strategy all on one document. Please see **Section 3., Exhibit G.,** which is the disruption timeline for the 2012 PDL process and sample disruption letters.

(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.

Your current UnitedHealthcare Account team will remain in place to facilitate quick turnaround in developing and approving Enrollee communications. Their past experience in this area will enable them to compose Enrollee communication materials that are written in a similar style as DCS, and shorten the editing process for DCS. The UnitedHealthcare Account team has an established process that will continue through this contract award to prioritize DCS correspondence and can secure CRP approval in a matter of days.

(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.

Confirmed. Your current dedicated UnitedHealthcare Account team will be available to attend all conferences requested by the DCS. Collectively, this team of 4 individuals has over 40 years of collective experience working on the Empire Plan Prescription Drug Program in various capacities.

During the current contract award, this team has represented the Program at various Health Benefit Fairs, Union conventions, and retiree educational seminars. Being located in the Capital District makes this team easily accessible.

(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.

Confirmed. Your UnitedHealthcare Account team has developed customized forms for the current Program for paper claims submissions, health assessment questionnaire and mail service forms.

(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.

Confirmed. Please see **Section 3., Exhibit H.,** for samples of information packets developed and customized for other clients.

7. <u>Enrollment Management</u>

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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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.

UnitedHealthcare's enrollment system is capable of receiving secure enrollment transactions every day, including weekends and holidays and having all transactions fully loaded to the claims processing system within [redacted] of release of a retrievable file by NYSIF.

(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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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,

Confirmed.

(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.

Confirmed.

(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.

For the DCS Program and NYSIF, enrollment records that meet the quality standards for loading will be loaded into UnitedHealthcare's enrollment system within [redacted] of release by the Programs. However, EGWP enrollment records will be exempt from this performance guarantee as CMS application approval is required prior to loading eligibility for claims adjudication.

b. Required Submission

(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.

UnitedHealthcare will continue to offer the DCS Programs an integrated enrollment process by maintaining enrollment information for the Empire Plan Prescription Drug Program, Medical and MHSA Programs. We provide the Program an accurate, complete, and up-to-date enrollment file based on information provided by the DCS. This enrollment file is used today and will continue to be used under the next contract to process retail and mail order claims, provide customer service, identify individuals in the enrollment file who have signed up for Medicare Part B and Part D, and produce management reports and data files. Our ability to accept and process enrollment with Medicare indicators assists the Program in important data compilation.

Because UnitedHealthcare has fine-tuned the current eligibility process employed for the DCS Programs since implementation of its current contract in 2008, it will not be necessary to implement a new eligibility process for the DCS Programs and we are currently compliant with receiving an EDI Benefit Enrollment and Maintenance Transaction set 834(ANSI x.12 834 standards) as required by the DCS Programs. However, as part of the implementation plan, any necessary changes to the eligibility process as required by the DCS Programs as well as testing as a result of those changes under the new terms of this contract will be addressed and implemented.

For the Empire Plan EGWP Program, we will address the eligibility process in our response to **Section 3. B.5. Medicare Part D Employer Group Waiver Plan PDP**. However, EGWP eligibility will continue to follow the preliminary process described above before being sent on for the additional processing and approval through CMS.

Specifically, for the NYSIF Program, during the implementation process our expert eligibility analysts will work with the Program to test load eligibility prior to the "go-live" of the benefits on January 1, 2014.

DCS Programs and NYSIF Initial Production File for the PBM

Prior to the initial production load of the DCS Programs eligibility and NYSIF Program eligibility to our pharmacy benefit manager, OptumRx, testing will include a visual file analysis for proper content, placement and alignment of eligibility records. Files will then be loaded into to a pre-pass analysis, independent from the production setting. The initial file will not be loaded into the production environment without written confirmation from the Programs and the dedicated Account Management team.

DCS Programs and NYSIF Ongoing Eligibility Files

Ongoing eligibility files will be loaded into our pre-pass analysis, independent from the production setting. A separate IBM i server conducts the pre-pass or test loads prior to loading eligibility files onto our production system. To support data integrity, this process allows us to view the eligibility information prior to loading it into production.

The Programs can request the option to approve pre-pass/test results prior to loading a file into production. Alternatively, we can set up an automated threshold. If test results do not exceed the reject/term threshold [redacted] we move forward and load the file into production. Using thresholds reduces load delays that may occur when a client requests approval of test results prior to production load.

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

UnitedHealthcare defines a series of detailed, adjustable and systematic processing thresholds in the processing rules for each customer. These thresholds prevent the inadvertent application of an eligibility file that might produce an undesired result. For example, we may allow a maximum of [redacted] of incoming records to error during a file application. In the event that an eligibility file has more than [redacted] of its records in error, the file would fail to update our production system for exceeding the maximum allowed threshold.

UnitedHealthcare will work with the Programs during implementation to determine thresholds for eligibility error processing.

(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?

DCS

We have a two stage process to identify enrollment records that cannot be loaded into our enrollment system. We examine the 834 eligibility file after transmission by DCS for the require data segments before the file can be accepted by UnitedHealthcare. If the 834 file does not contain the required standard data segments, the file is then returned to DCS with an explanation of the data segments required. The required data segments which will typically cause an 834 file to be rejected is missing demographic information, such as missing Enrollee name or Enrollee address. After the first stage is completed, the file is accepted by UnitedHealthcare and the enrollment records are processed into our eligibility record system, CES, by our Electronic Eligibility Management System (EEMS). The record(s) that cannot be loaded into eligibility record system by EEMS generates an exception report in the morning which is worked by our eligibility specialists for correction. All the records on a typical exception report are then corrected within three to four hours by our eligibility specialists. The Kingston eligibility analyst has access to the NYBEAS system and also has direct contact with the DCS eligibility staff to resolve these transactions quickly. We will continue with this process under the terms of the new contract.

The typical exceptions which would cause an enrollment transaction not to load into our eligibility system requiring manual intervention are:

- Invalid postal codes

- Marital status missing (no indication if Enrollee is single or married)

DCS and NYSIF Eligibility Loading to the Pharmacy Benefit Manager

Before eligibility is fully loaded into the claims processing system at the pharmacy benefit manager, all eligibility files are loaded to a pre-pass analysis, independent from the production setting. If test results do not exceed the agreed upon reject/term threshold we move forward and load the file into production.

Load/exception reports automatically generate after every production load. The reports are automatically distributed to designated recipients by e-mail or FTP. The reports detail the number of added, updated, rejected, or termed records on the file. If anything is rejected during the staging or loading process, the report shows which specific members or groups were rejected and the reason. For example, members may not load correctly with the following conditions:

- The Group ID is absent
- An invalid birth date is loaded
- There is no effective date on the file

All aspects of the stringent staged analysis/review phase occur in the pre-pass setting and do not involve production. If there are no questionable rejections, the file runs through the same process in the production mode. After the information is loaded into production, the data is live and ready for claims processing and eligibility verification.

If we cannot process a file, the Account Management team will notify NYSIF immediately. If the problem is a non-system error related to either data content or format issues, the client sends a new file. The replacement file receives immediate attention and is loaded on a high-priority basis.

(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:

UnitedHealthcare currently receives enrollment update information from DCS Monday through Friday, processing the file and loading the information to the pharmacy claims processing system within [redacted]. The error reporting is managed by the dedicated eligibility staff in the UnitedHealthcare Kingston office. We currently cooperate fully with any DCS initiatives to use new technologies, processes and methods to improve the efficiencies of maintaining enrollment files.

NYSIF

We have the capability to receive and load NYSIF enrollment updates within [redacted].

Our eligibility team processes and monitors files from 8 a.m. to 5 p.m. Pacific Time, Monday through Friday. In addition, because our eligibility function is fully automated, files received after hours or on weekends will move through to production if the data meets the predetermined threshold specifications.

(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?

The UnitedHealthcare enrollment system maintains a history of enrollment transactions on both the file level and the member level. On the file level, an electronic log is maintained which includes the file received date, the file application date, the file name and other basic statistics. On the member level, a record of each transaction that impacts a member is maintained (this could be the result of an eligibility file, a manual transaction, or any other event that might change a record). The DCS Programs' history is currently being maintained indefinitely.

DCS and NYSIF Enrollment History at the Pharmacy Benefit Manager

Our claims system captures and stores information in the following data categories in our standard claims records:

- Member
- Pharmacy
- Prescriber
- Drug
- Financial
- Plan
- Group
- Prior authorization
- Accumulator values

Member profiles, eligibility history, and adjudicated claims are maintained within our active online claims processing system for up to 36 months. After removal, these records are archived and stored off-site for a minimum of seven years.

There is no 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;

UnitedHealthcare can receive and load retroactive, active, and future eligibility segments at any time and maintain the information in the system for as long as necessary.

Whenever an eligibility period changes on an Enrollee record, the previous active record remains with the eligibility history. Thus, we can verify when the eligibility period was changed in the system. We can also confirm whether the change was done by batch load or manual adjustment.

Eligibility files load from top to bottom. If the Programs wish to send historical eligibility periods on its full files, the current active segment must always be sent as the last eligibility record for a given member.

(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.

The UnitedHealthcare enrollment system currently captures Agency codes that are transmitted by DCS. The Agency codes are retained on an individual Enrollee's eligibility file. We will be able to match the Enrollee's eligibility file, including Agency code, with our claim files and report on claims and credits by Agency.

(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).

UnitedHealthcare's enrollment and claims processing system adjudicates claims under one primary identification number. We can store a social security number if provided by the Department or NYSIF. We also have the ability to capture a third identification number and identify and adjudicate claims against all three identification numbers when necessary or applicable. The UnitedHealthcare enrollment system will continue to link dependents to the Enrollee based on the Enrollee and dependent eligibility identification information provided in the 834 file provided by the DCS.

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

UnitedHealthcare's enrollment system, data transfers, and processes for handling enrollment data are HIPAA compliant. Our security measures conform to federal regulations (including HIPAA) and corporate policies that define the handling and privacy of protected health information.

Our preferred method for eligibility transmission and connectivity is FTP through a secure online external customer gateway. Clients receive logon identification and a password to use to transfer files to their designated and secure location.

We use one of the following encryption methods for transmitting PHI to third-party entities outside of our organization:

- Simple Mail Transfer Protocol (SMTP) e-mail using Cisco Registered Envelope Service. We prefer PGP encryption for e-mail submissions.
- Hypertext Transfer Protocol (HTTP) with secure socket layer (SSL) using VeriSign.
- Secure file transfer protocols.
- File transfer protocols using industry standard encryption tools, such as PGP.

(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;

DCS

In the event that enrollment information is unavailable at the point of service, eligibility can be easily confirmed by our Customer Service Center.

Eligibility is one example of Program management where the DCS Programs have benefited from the synergy of the Prescription Drug, Medical and MHSA Programs all being housed with one insurer. Our pharmacy benefit management experience coupled with a strong account management and technical expertise has provided for a virtually seamless eligibility process for Empire Plan Enrollees. We know how important access to medications is for

Empire Plan Enrollees. On a typical day, an Enrollee will call DCS, experiencing a rejected pharmacy claim, DCS will reach out to the UnitedHealthcare Account Management team who can resolve the eligibility issue for the Enrollee with a prompt response time.

NYSIF

If eligibility is denied at a retail pharmacy, our system prompts the pharmacist to call our Pharmacy Services Help Desk and the request is resolved as quickly as possible to prevent delays. A member of the help desk team reviews the eligibility denial, and, if the member is indeed eligible, we issue the pharmacist an override code. NYSIF, through the Account Management team, will directly be capable of entering an override through the online Internet Direct Access system. The Account Management team will work with NYSIF to resolve any eligibility issue.

(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.

UnitedHealthcare eligibility specialists currently maintain access to NYBEAS during the required hours and will continue to do so under the 2014 contract. In addition, the UnitedHealthcare Account Management team currently maintains access to the NYBEAS system during and after the required hours and during 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.

UnitedHealthcare's enrollment system has the capacity to store the information required by the National Medical Support Notices. Once we

receive the notice, we update the eligibility system with the required dependent coverage information including a different mailing address for the dependent for EOBs and checks if necessary. A copy of the notice is retained for documentation.

We store this information in our system and coordinate compliance with the Qualified Medical Support Order (QMCSO) by modifying the eligibility record in the UnitedHealthcare system and forwarding that modification onto the OptumRx system to be applied for claims processing and all correspondence.

(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.

UnitedHealthcare's eligibility system has the ability to both manually load completely new records or make corrections to an existing record. When these manual updates are made, our near instantaneous feed to the pharmacy benefit manager's claims processing system loads/corrects the enrollment record in the claims adjudication system.

Our eligibility specialists and UnitedHealthcare account managers maintain a read-only access to DCS' NYBEAS system. If an Enrollee is in urgent need of a Prescription, we can verify coverage using NYBEAS, activate and update coverage immediately, and then a UnitedHealthcare account manager will contact the pharmacy and have the prescription processed.

(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.

The UnitedHealthcare Account team will have direct access to the eligibility system to add enrollment in case of "Short Fill" situations. Information entered is real-time and immediately available to the processing pharmacy.

Additionally, personnel at NYSIF will have direct access to the eligibility system to add enrollment in case of the "Short Fill" situations.

This direct connection to our claims processing system facilitates important plan maintenance and management functions in real time that allow clients to:

- View all claims transactions online in real time
- View, update, and add eligibility
- View pharmacy information
- Enter overrides and prior authorizations
- Research drug information
- Verify client-specific plan designs

We offer this functionality at no additional charge for up to three NYSIF personnel users. This will allow NYSIF the option of activating an injured worker's pharmacy benefits immediately should NYSIF wish to do so.

(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 [redacted] for DCS and [redacted] or NYSIF.

UnitedHealthcare will guarantee that all clean eligibility is loaded [redacted].

UnitedHealthcare proposes for each business day beyond [redacted] from the release by the Department that one hundred percent (100%) of the Empire Plan Commercial Program enrollment records that meet the quality standard for loading is not loaded into the Offeror's eligibility system, the Offeror shall credit against the Program's administrative fees the amount of [redacted]

UnitedHealthcare proposes for each business day beyond [redacted] from the release by the NYSIF that one hundred percent (100%) of the Program enrollment records that meet the quality standard for loading is not loaded into the Offeror's eligibility system, the Offeror shall credit against the Program's administrative fees the amount of [redacted].

8. <u>Reporting</u>

<u>(Exclusive to DCS)</u>

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. <u>Duties and Responsibilities</u>

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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

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

Confirmed.

(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

Confirmed.

(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.

Confirmed.

(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:

Confirmed.

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;

Confirmed.

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;

Confirmed.

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;

Confirmed.

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;

Confirmed.

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.

Confirmed.

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.

Confirmed.

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.

Confirmed. As per the amendment provided by the State, UnitedHealthcare will match all of the billing records provided by the Offeror in the bi-weekly pharmacy billing files.

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.

Confirmed.

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;

Confirmed.

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;

Confirmed.

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;

Confirmed.

<u>Top 100 Specialty Drugs – Specialty Pharmacy Report</u>: 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;

Confirmed.

<u>Quarterly Reports</u>

<u>Quarterly Financial Summary Reports</u>: 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;

Confirmed.

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;

Confirmed.

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;

Confirmed.

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;

Confirmed.

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;

Confirmed.

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;

Confirmed.

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;

Confirmed.

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;

Confirmed.

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

Confirmed.

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.

Confirmed.

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;

Confirmed.

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;

Confirmed.

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;

Confirmed.

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.

Confirmed.

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

Confirmed.

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.

Confirmed.

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.

Confirmed.

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."

Confirmed.

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.

UnitedHealthcare will continue to provide the Program with a custom claims data file within 15 days after the end each billing cycle. This custom claims data extract will be the primary data source for reporting purposes for the Program allowing for final paid claims, net of reversals to be reflected in the cycle claim reports, quarterly financial experience and annual financial experience statements.

The claims processing system will show whether the claim has been reversed as a result of prescription returns or incorrect billings. A unique claim number and sequence number are assigned to each claim within the claims processing system. The sequence number continues to increment down by one for every new paid or rejected transaction. If a claim is reversed, the reversal transaction retains both the same claim number and sequence number, which allows for easy identification of a paid-reversal combination.

A claim within the reporting system can have one of the following statuses: Paid, Reversed In-Cycle, Reversed Out-Of-Cycle, and Rejected. Below are the definitions of each of the claim reporting statuses that are available:

- **Paid.** A fully adjudicated, complete and billable claim.
- **Reversed.** A fully adjudicated and complete paid claim that is negated. All aspects of the claim are reversed.
- **In-Cycle Reversal.** A paid claim that is reversed within the reporting period that "washes" and is not included in reporting.
- **Out-Of-Cycle.** A paid claim that is reversed outside of the reporting cycle and as such is included in reporting.
- **Rejected.** A claim that fails eligibility, benefit design or as a result of a DUR edit. Rejected claims can be reported on an ad hoc basis; however, they are not included in the Program's data provided today.

Within the adjudication system, an adjustment is displayed as a full reversal of a claim with a subsequent resubmission. The process described above outlines the processes of how both in-cycle and out-of-cycle reversals are reported.

Within the claims data, if a claim is reversed, the transaction retains the same claim number and sequence number, which allows for easy identification of a paid-reversal combination. If the claim is modified, the transaction retains the same claim number; however, the sequence number changes. As the same claim number and sequence number are retained for paid-reversed combinations, DCS will be able to easily identify final paid claims; this process applies to both in-cycle and out-of-cycle reversals.

(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.

Confirmed. UnitedHealthcare has included examples of the financial and utilization reports that are proposed for the Department to be able to analyze and manage the DCS Program as **Section 3., Exhibit I.**

Our Empire Plan Prescription Drug Program custom reporting package provided by UnitedHealthcare today for the Program sets us apart from our competition because they are customized to DCS' requirements and adaptable as needed for the changing pharmacy landscape. UnitedHealthcare has built a team of the "best of the best" from the organization to meet the DCS' reporting requirements. Our suite of reports incorporates our management philosophies with real proof points and opportunities. The reports bring forth current market trends and incorporate in-depth analytics to provide DCS with the data to make fact-based, pharmacy benefit design decisions.

The resources dedicated to the Programs that will have a continued focus on providing valuable information and insight we believe will help maximize the Programs' performance, assisting each Program's management staff to make decisions and determine strategy to improve the overall administration and value of the Programs to Enrollees and claimants, are significant reporting tools. The dedicated Program Reporting team, reporting to Tom Coy and Sonja Blanks has access to resources at OptumRx, UnitedHealthcare Pharmacy and the experts at Optum Insight for trend forecasting and additional reporting expertise.

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

Confirmed.

(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.

Confirmed. UnitedHealthcare has included a copy of the data sharing agreement proposed for Department staff to execute in order to obtain system access as **Section 3., Exhibit J.**

(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.

Confirmed. Please see **Section 3., Exhibit K.,** for samples of Ad Hoc reports that have been produced 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 [redacted] 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.

UnitedHealthcare proposes a penalty of [redacted] 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.

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. Duties and Responsibilities

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;

Confirmed.

(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;

Confirmed. UnitedHealthcare will provide this information for the GPI.

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

Confirmed.

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

Confirmed.

(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;
(d) Benefit design modeling analysis;
(e) Reports to meet clinical program review needs;
(f) Reports segregating claims experience for specific populations; and

(g) Reports to monitor Agreement compliance.

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

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.

Confirmed.

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.

Confirmed.

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.

Confirmed.

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;

Confirmed.

<u>Weekly Invoice</u>: 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;

As per the amendment by the State, UnitedHealthcare will provide billing twice a month, representing claims processed the 1st through the 15th of the month and the 16th through the end of the month and will work with NYSIF to provide weekly reporting of claims processed to evaluate expected costs on a weekly basis.

<u>Aging Bill Report File</u>: 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.

Confirmed.

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.

Confirmed.

b. Required Submission

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

Confirmed.

(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;

Confirmed. UnitedHealthcare can provide the information at the GPI and NDC code levels.

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

NYSIF;

Confirmed.

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

Confirmed.

(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.

Confirmed. Please see **Section 3., Exhibit K.,** for sample of ad hoc reports that have been produced for other clients.

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

UnitedHealthcare uses the latest in network and leased-line technology to receive electronically submitted claims from more than 64,000 pharmacies participating in our various networks. Submitted claims are immediately transferred to one of several claims processing engines that drive our system.

The adjudication process operating in each subsystem retrieves, matches, and validates the critical Enrollee information submitted by the pharmacy. The system selects the appropriate group and benefit level (based on the Claimants number and date of service), and automatically applies edit parameters, such as validating drug products from NYSIF's formulary and benefit plan design.

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

As part of the claim adjudication process the system selects the appropriate group and benefit level (based on the Claimants number and date of service)

and automatically applies edit parameters, such as validating drug products from NYSIF's formulary and benefit plan design.

Following formulary validation, drug and event-specific edits are applied. In addition, selected DUR edits based on the dosage, days' supply, and prior history, are applied.

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

If at any point during the adjudication process described above, the claim fails to pass an edit or validation, a detailed error message is generated and transmitted online to the submitting pharmacy. If no errors are detected, the claim completes the stringent validation process and is priced for reimbursement and billing.

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

If at any point during the online claim adjudication process described above the claim fails to pass an edit or validation, the pharmacy will receive a detailed error message using NCPDP reject codes and secondary instructional messaging if applicable.

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

The adjudication process operating in each subsystem retrieves, matches, and validates the critical Enrollee information submitted by the pharmacy. If the information submitted by the pharmacy is unable to be matched to the eligibility information provided by NYSIF, the network pharmacy will receive an NCPDP rejection message.

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

proprietary, etc;

The layout of UnitedHealthcare's pharmacy billing file is a customized, proprietary file format.

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

As a standard business practice, UnitedHealthcare uses SFTP (SSH File Transfer Protocol) as its required method of secure electronic file transmission for its pharmacy billing files.

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

As part of our disaster recovery plan, UnitedHealthcare conducts periodic disaster preparedness tests and evaluates our system failover and high availability capabilities several times a year as standard protocol. In addition, our maintenance contracts for all of our core systems stipulate rapid response times in the event of a disaster or system failure. UnitedHealthcare performs routine maintenance and testing on both the production and backup systems in the following ways:

- Any changes to the systems are thoroughly tested and documented prior to implementation.
- Monthly routine maintenance is scheduled for one day, on either a Saturday or Sunday. Maintenance involves a role swap in which the backup system is switched and assigned as the primary transaction system.
- An activity calendar is published at the beginning of each year with targeted dates for these events to take place.
- To support maintenance activities, we issue a service notice to all Programs at least ten days before scheduled maintenance or outage.

Scheduled downtime for routine maintenance is limited to less than 60 minutes; this allows execution of the role swap to the backup system. The primary system is completed and online within 48 hours.

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

In the rare event of system downtime not related to routine scheduled maintenance, NYSIF will be notified by its dedicated Account Management team.

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

Determinations will be made on whether a pharmacy claim is reported in the established claim or instant enrollment/short fill files based upon the claimant identification number and group number submitted by the pharmacy. Separate carrier and group numbers will be assigned for established claimants versus short fill claimants allowing for easy claim identification for reporting purposes.

(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;

Any pharmacy claims previously submitted in the Instant Enrollment/"Short Fill" file that cannot be matched to an established NYSIF claim after a time period to be determined by NYSIF will be placed in the Aging Bills file. Once the aged claim is able to be matched to an established NYSIF claim the Aging Bill will be removed from the Aging Bill file.

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

When a new member is added to our system, or a replacement ID card is ordered for an existing member, an ID Card Request is generated and sent on a

nightly feed, through a secure FTP, to the printer. Once the printer receives the ID Card Request, an ID card, ID Card Welcome Booklet, and Carrier Letter are printed and mailed to the member.

We have the ability to track the ID card information, through on an online interface with the printer, to see where it is in the production process. We can see when the printer receives the ID Card Request, when the completed ID Card Package is going to be mailed, and confirmation that the ID Card Package has mailed or shipped.

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

As a standard business practice, UnitedHealthcare uses SFTP (SSH File Transfer Protocol) as its required method of secure electronic file transmission.

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

Confirmed.

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

Paid claims data is aggregated by client and fed into a reporting system for therapeutic class compilation or "bucketing". [redacted] Rebates are billed to the specific manufacturer on a quarterly basis. Collections from the manufacturer are reconciled at UnitedHealthcare and then attributed and allocated based on the unique utilization of each client. Final client reporting is produced from that basis.

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

Once the paid claims data is aggregated by client and fed into the PRAS reporting system and the monies are collected from the manufacturer, rebate payments are allocated by client accordingly. Based on the contractual requirements, the client reporting rebate data will be compiled to support the quarterly 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 [redacted] 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.

Confirmed. UnitedHealthcare proposes a penalty amount of [redacted] 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

Confirmed.

(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.

Confirmed.

b. <u>Required Submission</u>

(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?

Currently, UnitedHealthcare proactively advises both the DCS and GOER of the latest developments in the prescription drug field as well as new legislation on a State and Federal level.

For the past four years of this contract term, UnitedHealthcare has held a weekly project plan meeting with the DCS, DOB, GOER, and our contracted PBM in order to manage ongoing Program projects and keep our partners at the State up-to-date on new clinical, legislative and programmatic topics.

From a clinical perspective, UnitedHealthcare will continue to provide updates regarding pipeline information, new generics, and new opportunities for prior authorization as the information is available. This information is provided to your Clinical Account Director by OptumRx clinicians who continually look for new advancements in the field of pharmacy. The Clinical News Summary is produced by OptumRx and sent to the Clinical Account Directors when new information may impact the Program.

Your dedicated Clinical Account Director, Dana Canning, R.Ph. will continue to oversee the clinical pharmacy aspects of the program. She leads the efforts in identifying cross-functional opportunities and solutions that improve outcomes for the DCS and your Enrollees. Additionally, she will continue to advise the DCS about emerging and immediate issues involving pharmaceutical industry events that impact or could impact the Empire Plan Prescription Drug Program.

During the current contract term, UnitedHealthcare has invited representatives from the DCS and GOER to observe the UnitedHealth Group National Pharmacy and Therapeutics (NP&T) Committee and the PDL Management Committee meetings. This is a unique opportunity to witness first hand UnitedHealthcare's PDL maintenance and review process. UnitedHealthcare considers clinical, pharmacoeconomic and financial factors when determining tier placement for medications.

On a yearly basis, UnitedHealthcare conducts an Annual Review meeting with the DCS and GOER where we review the prior year in terms of claim spend, PDL development, and operational performance. UnitedHealthcare also uses this forum to provide the DCS and GOER with new ideas in the fields of technology, plan design and pipeline information. During the current contract term, UnitedHealthcare presented guest speakers who are leaders in the field of prescription drug management.

In 2011, Lida Etemad, Pharm. D. and Vice President of PDL Development for UnitedHealthcare Pharmacy presented several strategies to manage prescription drug costs. During this meeting, the B4G strategy was discussed. This strategy was implemented for the DCS Programs in December 2011 upon the launch of a generic equivalent for Lipitor.

Also in 2011, Reed V. Tuckson, MD, FACP was our guest speaker. Dr. Tuckson is the most senior clinician at UnitedHealth Group and he presented many thought provoking strategies to attendees of this meeting. UnitedHealthcare plans to continue this venue to present top clinicians and their forward thinking strategies, to the Programs.

UnitedHealthcare also reviews pending legislation on both a State and Federal level and provides consultative services to the DCS and GOER regarding possible implications of new legislation to the Program. Your Strategic Client Executive, Paula Gazeley Daily, R.Ph. has attended Health Care Reform

lobbying sessions and follows new legislation which may impact the Program. The UnitedHealthcare Account team has established relationships with and access to regulatory and legal personnel, including government affairs within the organization. These experts are available to review and interpret state and federal legislation, Enrollee communication materials, and insure compliance with these regulations.

UnitedHealthcare has also provided legal and regulatory guidance to the DCS regarding certificate language and the implications of new legislation. UnitedHealthcare has legal counsel that is dedicated to the pharmacy portion of our business and is readily available to address your needs and questions.

By providing both face-to-face meetings and printed reference materials, UnitedHealthcare provides a comprehensive consulting package that meets and exceeds the State's expectations. UnitedHealthcare will continue to support the Program throughout this contract term by utilizing the strategies described above.

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.

Confirmed.

(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:

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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

Confirmed.

(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.

Confirmed.

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

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

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

Confirmed.

(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;

Confirmed.

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

Confirmed.

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

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

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.

UnitedHealthcare will fully cooperate with the successor vendor to ensure the timely, smooth transfer of information necessary to administer the Program. Additionally, we will be available to answer questions pertaining to the information and assist in facilitating a smooth transition for Enrollees.

The key elements of our transition plan would include the following:

- Confirming transition details, including timing and expectations.
- Partnering with the new vendor to establish agreements on needed data and information transfers, such as open refills, prior authorizations, and claims history.
- Determine member termination dates.
- Determine claim run-out periods.
- Determine customer care enrollment procedures.

Your Account Management team will be accountable for the transition to the new vendor and many of the tasks included within the implementation plan would be covered, in addition to the others listed above.

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

UnitedHealthcare will continue to provide a level of customer service which mirrors levels provided prior to termination of the contract. Our customer

service level commitments and resources will adjust as the demand declines over time. Customer Service will be available to support all claims incurred prior to the contract termination date.

Your Account Management team will be available after the contract termination through run out to provide reporting for incurred claims prior to the contract termination and to assist with other transition-related tasks.

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

(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.**

Confirmed.

(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.**

Confirmed.

(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.**

UnitedHealthcare will use its best efforts to substantially maintain the composition of independent Network Pharmacies included in the Programs' current Retail Pharmacy Network. UnitedHealthcare will solicit pharmacies at the request of the Programs; however, any claims adjudicated at these said pharmacies will be exempt from the minimum guaranteed discounts presented in the proposal.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

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

Confirmed. [redacted]

(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 <u>within two (2) miles</u>;

(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).

Confirmed.

b. <u>Required Submission</u>

(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
95%	Urban	[redacted]

% of Enrollees with Access to Retail Pharmacies	Enrollee Location	Access Guarantee - 1 Pharmacy at least within
95%	Suburban	[redacted]
95%	Rural	[redacted]

(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.

Confirmed. UnitedHealthcare has completed exhibit I.Y.1 as part of the Administrative proposal. Please refer to **Section 3., Exhibits K and L** of our Administrative proposal response.

(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.

Confirmed.

(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.

Confirmed.

(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.

UnitedHealthcare is confident the proposed contracted network for the Programs is of sufficient size to provide the deep discounts the Programs expect to achieve; however, if the proposed network needs more pharmacies at the request of the Programs, UnitedHealthcare will make every effort to contract with additional pharmacies and meet this standard.

Upon identification of additional pharmacies, UnitedHealthcare would first consider potential impact on the rates already accepted by the participating pharmacies. If inclusion of these pharmacies did not jeopardize the guaranteed rates already secured for the Programs, UnitedHealthcare would credential first and then secure the deepest reimbursement rate achievable through negotiations. For any pharmacies added at the request of the Programs, claims adjudicated at these pharmacies will be exempt from the minimum guaranteed discounts presented in the proposal.

(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.

Please see **Section 3., Exhibit L.**, for a listing of Limited and Sole source distributors for certain identified specialty medications. [redacted]

(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 [redacted] for DCS and [redacted] 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 [redacted] for DCS and [redacted] 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 [redacted] for DCS and [redacted] 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.

UnitedHealthcare proposes [redacted] at risk for DCS and [redacted] at risk for NYSIF for each of the following guarantees:

- [redacted] of members residing in an urban area will have access to 1 pharmacy within [redacted] miles.
- [redacted] of members residing in a suburban area will have access to 1 pharmacy within [redacted] miles.
- [redacted] of members residing in a rural area will have access to 1 pharmacy within [redacted] miles.

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.

Confirmed.

(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.

Confirmed.

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

Confirmed.

b. <u>Required Submission</u>

(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?

All contracted pharmacies must pass an initial credentialing process. UnitedHealthcare's network contracts are "evergreen" featuring an automatic, yearly renewal provision and are re-credentialed at least every three years, or as licenses expire, as new contract amendments are made, or as required by law. The following information is required for the credentialing process and the finalization of the contract:

- Copy of a valid license issued by a state pharmacy board
- Copy of a valid pharmacy permit issued by a state pharmacy board

- Information obtained from all national database queries
- Completed Provider Credentials form, which lists the following information:
  - State license information and verification
  - Federal tax identification
  - DEA license information
  - Insurance information with proof of liability certificate
  - Ownership and affiliation
  - Business name history
  - Most recent inspection date by the board of pharmacy
  - Signed attestation statement related to prior disciplinary actions, convictions, and restrictions

In addition to the above standard requirements, our network contracting strategy also calls for more rigorous criteria in credentialing pharmacies for network participation, including but not limited to stipulations that the pharmacy:

- Offers 100 percent point of service capability.
- Offers the ability to dispense durable medical equipment.
- Offers the ability to use electronic link.
- Demonstrates an acceptable disciplinary history.
- Maintains adequate hours of operation.
- Agrees to comply with all of our DUR and plan design parameters.
- Agree to maintain verifiable record of authorization for refills.
- Agrees not to charge a member more than amount determined by network.
- Agrees to allow on-site audits.

- Provides a current MediCal provider number (for California locations only).
- Presents proofs of pharmacy and pharmacist's licensure as required by all federal and state pharmacy laws.

Maintains professional liability insurance and general liability insurance in the minimum amounts of $1 million dollars each occurrence and $3 million dollars annual aggregate limit to cover the activities and errors and omissions of each of the company pharmacies, and their respective personnel. Universities and State owned pharmacies can be an exception and are reviewed on a case by case basis. The Federal Tort Claims Act (FTCA) is acceptable for Indian Health Services, as well as Federal Qualified Health Centers (FQHC) or 340B pharmacies.

(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?

UnitedHealthcare does not utilize an external credentialing verification organization. The pharmacy network credentialing process is managed in-house at UnitedHealthcare.

UnitedHealthcare takes several measures for its pharmacy network to be consistent, fully credentialed and compliant. Our coordination strategy requires that all contracted pharmacies are online with our claims adjudication system, that 100 percent of chain and independent pharmacies are compliant with our policies and practices, and that our pharmacy networks are willing and able to support our clinical initiatives such as formulary compliance and generic substitution.

Chief among these coordination measures is proactive and continuous communication directly with pharmacies and pharmacists. Through our fax broadcast system, we are able to provide all network pharmacies with current and updated policies and procedures.

UnitedHealthcare also offers a dedicated pharmacy help desk so network pharmacies can contact us directly at any time with questions or issues that may arise.

Coordination among our network pharmacies demands compliance with our stringent credentialing criteria. Our network contracts require that participating pharmacies have the ability to provide members with a number of point-of-service capabilities including parameters regarding access, compliance with plan design parameters, and adherence to agreed-upon policies. All pharmacies must agree to allow on-site audits and maintain verifiable records. Moreover, we emphasize throughout our networks the importance of formulary compliance, plan design compliance, and promotion of generic utilization, and we have developed pharmacy performance parameters to reinforce this operating principle.

UnitedHealthcare also uses its Real-Time Audit System to monitor pharmacy performance. We used pre-defined filters to screen all claims submitted from our network locations. Based on identification of outlier statistics or suspect claims activities, we conduct investigations and education activities to raise provider awareness of contractual obligations, correct procedures, and assess penalties for fraudulent or improper practices.

UnitedHealthcare re-credentials its contracted providers every three years, or as licenses expire, as new contract amendments are made, or as required by law. During this process, we re-evaluate all of the elements required for initial credentialing. If there are any material changes to qualifications, we may consider termination of the pharmacy from our network.

(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?

UnitedHealthcare checks the Office of Inspector General (OIG) Web site monthly for each of our contracted network pharmacies in accordance with CMS regulation as well as part of our credentialing and re-credentialing process. When a network pharmacy or pharmacist is discovered to be on the list, our Escalation Oversight Committee—which handles cases of potential or known fraud, waste, and abuse—takes action to determine if termination of a pharmacy is warranted based on the OIG exclusion.

Depending on the reason for OIG exclusion, the age of the issue, and the details of the particular situation, we may initiate any combination of the following actions:

- Send an inquiry letter to the pharmacy to determine how the issue in question was handled by the pharmacy, what steps were taken to rectify the issue, and if the pharmacy is due to be released from the OIG suspension.
- Send a cease and desist letter that allows the pharmacy 45 days to respond to or cure the issue.
- Send a termination notice with a 45-day review period during which the pharmacy may request an appeals hearing.
- Send an immediate termination letter if our findings warrant such action.

UnitedHealthcare attempts to rectify and correct issues that may have resulted in a pharmacy or pharmacist's inclusion on the OIG list. We do not immediately terminate listed entities as we attempt to identify a justification for termination prior to taking such an action.

We notify members of pharmacy termination via communications sent to members' homes by U.S. Postal Service.

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. <u>Duties and Responsibilities</u>

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;

Confirmed.

(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;

[redacted]

(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;

UnitedHealthcare will make every attempt to solicit participation in the Retail Pharmacy network all licensed pharmacies affiliated with the Empire Plan Home Care Advocacy Program at [redacted]

(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.

Confirmed. UnitedHealthcare's claim adjudication system will reject retail point of service claims if the pharmacy has not included a submitted or U&C price in the appropriate NCPDP field.

(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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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

Confirmed.

(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.

[redacted]

b. <u>Required Submission</u>

(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.

Confirmed. UnitedHealthcare has provided a copy of Programs' pharmacy network contract, rate sheet and the provider manual as **Section 3., Exhibit M.**

(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.

UnitedHealthcare will make every attempt to solicit participation in the Retail Pharmacy network all licensed pharmacies affiliated with the Empire Plan

Home Care Advocacy Program at [redacted]

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

Confirmed.

(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.

Confirmed.

(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.

[redacted]

[redacted]

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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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;

UnitedHealthcare will provide individually identifiable or protected health information regarding such allegations or investigations will only be disclosed to the Procuring Agencies to the extent allowed by state and/or federal privacy rules, including HIPAA.

(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;

Confirmed.

(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;**

UnitedHealthcare will work closely with the Department, NYSIF and OSC to respond to audit request for information [redacted] ndividually identifiable or protected health information will only be disclosed to the Procuring Agencies to the extent allowed by state and/or federal privacy rules, including HIPAA.

(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;**

UnitedHealthcare will return [redacted]

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

Confirmed.

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

Confirmed.

b. <u>Required Submission</u>

(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.

Confirmed.

(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.

Under UnitedHealthcare's proprietary license with Medispan we are not permitted to accommodate this request, however, we will provide weekly Medispan files to the Programs.

(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.

UnitedHealthcare is committed to addressing instances of potential fraud, waste and abuse. When appropriate, we report fraudulent and potentially fraudulent cases to law enforcement, other state and federal regulatory authorities.

In addition, we collaborate with the Empire Plan Medical and MHSA program as well as the Fraud and Abuse team of OptumRx. All these parties support collaboration to help identify and investigate cases that involve potential fraud, waste and abuse on both the medical and pharmacy side. Our processes include monitoring physician prescribing and Enrollee utilization patterns. Medical and hospital claims are reviewed and the Pharmacy program utilization records are reviewed to assist in identification of "Drug Seeking Behavior". When fraud, waste and abuse has been identified, notification of the appropriate law enforcement parties is conducted as appropriate. Below we have provided more detail on our procedures and controls for identifying fraud, waste and abuse at the pharmacy, Enrollee, and physician level.

Detecting Pharmacy Fraud and Abuse

UnitedHealthcare uses an advanced Real-Time Audit System to examine all claims on a continuous basis. All pharmacies in our network are audited electronically in real time using our Real-Time Audit System.

Through this type of audit, we run all claims through a set of pre-defined filters and algorithms that screen for appropriate utilization patterns, cost information, and other criteria. Any claims that do not pass this screening are flagged for potential review. Our skilled Audit team then investigates flagged

claims and contacts the associated Enrollee, pharmacy or prescriber as necessary to verify the claim's accuracy. When inaccurate claims transactions have been identified, the claims are reversed and properly resubmitted by the pharmacist. In some instances, an auditor will reverse and reprocess the claim if the adjudication window is closed.

The benefits of differentiating retrospective analysis of claims from real-time prospective review have been positive and substantial, with a potential for significant increases in the amount of money recovered on behalf of the Programs. An additional benefit is that a true sentinel effect comes into play because claims are acted upon immediately. Pharmacists learn that a higher percentage of claims are reviewed by our Real-Time Audit System and, therefore, take a more proactive approach in reducing erroneous and potentially fraudulent claims.

Auditing in real-time has the following advantages:

- A larger number of pharmacies are contacted per auditor in comparison to onsite or in-depth desktop audits.
- A greater sentinel effect is achieved as more pharmacies are contacted.
- Pharmacists are educated, which results in fewer errors, and also assists pharmacies with compliance to government regulations and health plan procedures.
- Questionable claims patterns are more easily identified, which allows for more timely development of additional audit screening criteria.
- The need for new edits is determined in a timely manner.
- Pharmacy claims are often corrected online prior to payment.

Beyond our Real-Time Audit System capabilities, we also apply a program of desktop and on-site audits that help us further investigate potential issues of fraud, waste and abuse in the retail setting.

Desktop Audits

These audits are conducted consistently throughout each day to investigate the integrity of individual claims submitted by pharmacies and paid by UnitedHealthcare on behalf of the Programs. Desktop audits include filtering and examining prior claims transactions for aberrant issues and in-depth

desktop audits where a larger number of source documents are requested from the pharmacy for review. In-depth desktop reviews are conducted when a more expanded review is appropriate and include the review of various source documents and proof of delivery.

On-site Audits

Pharmacies are audited on-site as deemed necessary, based on a number of factors, such as contractual agreement, analysis performed, internal and external referrals or complaints, random selection, or escalations from in-depth desk audits.

While on-site, auditors may review either a random sample of paid pharmacy claims, or a targeted subset, or both. Paid claims will be compared to on-site records such as:

- Hard-copy prescription files
- Computer printed daily transaction logs
- Purchase invoices where appropriate
- Other files and records
- Third party signature logs, etc.

UnitedHealthcare typically performs a facility review, pharmacy staff review, and other reviews for factors such as:

- Accuracy of data submission
- Compound/specialty medication review
- Review for potential fraudulent activity
- Return to stock policy adherence
- Regulatory compliance
- Contract compliance
- Monitoring of foot traffic and inventory handling

Detecting Enrollee Fraud and Abuse

An Enrollee must present a valid ID card to the pharmacy for initial set up within the contracted pharmacy's processing system. If the participant does not have an ID card, he or she may furnish suitable identification and ask the pharmacist to contact our Pharmacy Help Desk for verification of eligibility.

Because Enrollee profiles have become more sophisticated, pharmacies can process prescriptions without an ID card, although we recommend that pharmacies require suitable identification to protect against fraud. Additionally, many pharmacies will not fill a prescription under any circumstances without a participant ID card, for the protection of their clients. All contracted pharmacies are instructed to contact the provider when they believe that a prescription has been altered or submitted fraudulently.

Detecting Physician Fraud and Abuse

UnitedHealthcare's standard reporting package includes numerous reports that monitor individual physician prescribing patterns, such as the Sample Prescriber Detail report and Sample Top "N" Prescriber report.

The management staff of the Programs can also create their own ad hoc prescriber reports using the Online Reporting Tool to profile individual physicians. Physicians can be profiled by any number of variables, including:

- Count/percentage of
  - All prescriptions
  - Formulary drugs prescribed
  - Generics prescribed
  - Controlled substances prescribed
- Amount paid and ingredient cost of prescription
- DAW codes
- Drug types or class

UnitedHealthcare employs various strategies to reduce inappropriate prescribing patterns with physicians that are identified by these physician profiles. One such strategy involves physician specific mailings with Enrollee-specific reports and educational materials.

In addition, UnitedHealthcare coordinates with law enforcement authorities so that physicians are thoroughly investigated when fraud is committed against the Programs. Our process includes referral to the Empire Plan Special Investigation Unit and notification to appropriate governmental agencies, such as state medical boards, Medicare Drug Integrity Contractors (MEDICs) and law enforcement.

Fraud Investigative Process

After a determination has been made that a referral or tip should be investigated, and that a full investigation is warranted, a "case" is created and the investigator performs the following investigative steps.

Develop an Action Plan for Conducting the Investigation

Developing an action plan plots the course and describes the scope of the investigation and the approaches to be employed. The investigative work plan includes a checklist of sequential tasks to be performed during the investigation, but is also flexible and allows for modification as the situation demands. The investigative work plan includes a timeline for the accomplishment of specific tasks.

Investigators follow timeframes established by applicable state and/or federal law (including prompt payment laws as applicable) in investigating and resolving cases. Generally, any investigation will feature the following elements:

- Identifying potential sources of information on the matter in question.
- Gathering relevant information from those sources through medical records.
- Interviews or data collection.
- Recording the results of the investigation in writing.
- Evaluating investigative findings and potential resolution strategies in cooperation with the team, counsel or a Medical Director.
- Initiating a resolution strategy.

Collect Information and Evidence

In conducting investigations, our investigators collect information and evidence from a wide variety of sources. Investigators research both internal sources and external sources. Internal sources consist, in part, of the following:

- Past Abuse and Fraud cases or intelligence files
- Claim data history extracts via data analysis tools
- Internal experts: claim offices, medical directors, patient advocates, provider relations, and medical claim review

Evaluate Investigative Findings

In the final stage of the case, the investigator, in consultation with the investigative team, determines which action will be taken based on the investigator's evaluation of the investigative findings.

Initiate a Resolution Strategy

After the investigator has concluded the investigation and documented the case, the next step is to determine the appropriate resolution strategy. Investigative findings are communicated to appropriate business partners.

If fraud is detected, the case may be reported to the appropriate law enforcement and regulatory entities in the investigation and prosecution of violations of insurance fraud. Following are the resolution strategies most commonly pursued in resolving cases:

- **Closing the case.** Closing the case may be the best option when the evidence does not support findings of inappropriate benefit payments or the legal or medical merits of the case are ill defined.
- **Educating the pharmacy.** If investigation results indicate that the claims contained unintentional billing errors, it is necessary to contact the pharmacy and advise them of the errors and provide tips on appropriate billing techniques.
- **Implementing prospective controls.** When the results of an investigation do not indicate that all of the elements of fraud have been established, the investigator may flag a pharmacy or member in the system to monitor future activity to determine if a pattern of fraud or abuse is evident.

- **Pursuing an administrative remedy.** This may include discipline and/or network dismissal.
- **Pursuing mediation or arbitration.** This is generally less costly than filing a civil suit and is more expedient.
- **Litigating.** It may be appropriate for UnitedHealthcare to file a civil suit against a provider or member to recover defrauded funds. Our attorneys consider the merits of each case and proceed in a manner which they determine is legally sound.

(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?

In addition to the Audit department currently in place, UnitedHealthcare has an Escalation Oversight Committee that addresses all cases of potential or actual fraud, waste and abuse identified in our contracted pharmacy network. This Committee assesses all cases of fraud or abuse and determines one or more of the following courses of action:

- Termination of participation in network
- Probationary action including suspension of payments or claims adjudication services
- Cease and desist notification of any non-compliant activity (whether fraud, waste, or abuse, or contractual non-compliance)
- Continued observation of questionable activity

UnitedHealthcare will work together with relevant law enforcement authorities so pharmacies are thoroughly investigated for prosecution when fraud is committed against the Programs. We turn over information on pharmacies suspected of fraud to the proper authorities, such as the U.S. District Attorney's Office, the FBI, or the pharmacy's respective State Board of Pharmacy.

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

Below is a copy of our audit language, which is located in Section 9. Records and Audits section of our pharmacy network agreement:

9. Records and Audits.

9.1 **Records and Data.** Company shall keep and maintain in accordance with prudent business practices, accurate, complete and timely books, records and accounts of all transactions (including medical records and personal information), data, files (including prescription files), drug purchase invoices, signature logs and documentation (collectively, "Records") relating to the provision of Covered Prescription Services to Members, in accordance with applicable state and federal law, pharmacy board requirements, industry and Client standards, and this Agreement, including the Pharmacy Manual. Company shall retain such Records for a period of up to five (5) years after the date the Covered Prescription Service is dispensed or for the period required by applicable law or as required by an ongoing audit or investigation by Administrator, Client or Government Authority, whichever is longer. Company shall maintain reasonable safeguards against the destruction, loss, alteration, or unauthorized disclosure of data in possession, under the control of Company or its personnel or contractors, including, but not limited to Administrator's and Client's Proprietary Information and PHI.

9.2 **Access to Records and Audits.** During the term of the Agreement and for a period of five (5) years thereafter, Administrator or its designee shall have the right, upon reasonable notice and at reasonable times, to access, inspect, review, audit (including on-site and desktop audits) and make copies of the Records ("Administrator Audit"). In addition to the foregoing, Company shall honor and accommodate all audit requests by governmental authorities ("Governmental Audit"). Company shall pay all costs incurred by Company in connection with its provision of information for purposes of a Governmental Audit.

9.3 **Payment for Audit.** Administrator shall pay for prescription reproduction/copying and applicable travel costs associated with an Administrator Audit or Client or an external auditor who is conducting the audit on Administrator's or Client's behalf. Company shall pay all reasonable out-of-pocket costs associated with its providing information necessary for any Governmental Audit and Administrator Audit. In the event that an audit discovers any error by Company or its Pharmacies or discrepancy in the amount to be charged or paid to Administrator, Company shall reimburse Administrator the full amount of any amounts charged to Administrator in error.

At Administrator's option, Administrator may obtain reimbursement for such discovered amounts either by recouping against future payments due Company or by requiring reimbursement of such overpayments from Company, which Company will pay to Administrator within fifteen (15) days' notice thereof. Administrator shall reimburse Company the full amount of any amounts incurred and paid by Company to Administrator in error, as applicable. In the event that any error or discrepancy in the amount charged to Administrator is material, as determined by Administrator, in its sole and absolute discretion, Company shall pay Administrator all Confidential and Proprietary to UnitedHealthcare reasonable costs incurred in connection with the audit, including any out-of-pocket costs and expenses incurred by Administrator to uncover and correct the error or discrepancy. This Section 9 shall survive expiration or termination of the Agreement and if Company or its Pharmacies cease conducting business.

(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."

UnitedHealthcare will cooperate with all Department, NYSIF and Office of the NYS Comptroller (OSC) audits, as described in RFP Section 3.B.11.a.(6) and (7) of this RFP, under the subheading "Pharmacy Audit" with strict confidentiality and legally required NDAs. However, individually

identifiable or protected health information will be shared only as allowed under state and/or federal privacy rules, including HIPAA, [redacted]

(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.

UnitedHealthcare confirms it will return 100 percent of funds recovered through the audit process at both the network pharmacy level as well as through our Mail Service Pharmacy to the Programs, [redacted]

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

UnitedHealthcare offers a comprehensive auditing program that includes strategies for detecting fraud, waste, and abuse for both commercial and Medicare Part D plans. We will help protect the financial integrity of the services that we offer to NYSIF through:

- Advanced real-time auditing
- Traditional desktop, on-site, and in-depth pharmacy audits
- Prepayment and postpayment data mining and analysis
- Fraud, waste and abuse investigation and reporting

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

Confirmed, with strict confidentiality provisions and legally required NDAs.

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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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.

Confirmed.

(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;

Confirmed.

(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.

Confirmed.

(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.);

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(10) Maintaining a system that notifies Enrollees/Claimants about potential health and safety issues with their Prescriptions;

Confirmed.

(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.;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(20) Having a back-up mail order facility(ies) to handle any overflow and/or situations where the primary mail order facility is unavailable;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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

UnitedHealthcare will guarantee that at least [redacted] of all non- intervention mail service Prescription orders will be turned around in [redacted] (not including the date of Prescription order receipt).

(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.

UnitedHealthcare will guarantee that at least [redacted] of all intervention mail service Prescription orders will be turned around in [redacted] (not including the date of Prescription order receipt).

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;

Mail Service Prescriptions for the Empire Plan Prescription Drug Program will be filled primarily from UnitedHealthcare's affiliated Mail Service Pharmacy, OptumRx located at Overland Park, Kansas facility.

In addition to the Overland Park facility, OptumRx owns and operate five other licensed Mail Service facilities located in:

- Carlsbad, California
- Cypress, California
- Mission Valley (2), California
- Sugarland, Texas

In addition to filling regular mail service prescriptions, the Carlsbad facility houses our primary Specialty Pharmacy operations.

(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;

Mail Service Prescriptions for the Empire Plan Prescription Drug Program will be filled primarily from UnitedHealthcare's affiliated Mail Service Pharmacy, OptumRx located at Overland Park, Kansas facility.

In addition to the Overland Park facility, OptumRx owns and operate five other licensed mail service facilities located in:

- Carlsbad, California
- Cypress, California
- Mission Valley (2), California
- Sugarland, Texas

In addition to filling regular mail service prescriptions, the Carlsbad facility houses our primary Specialty Pharmacy operations.

(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;

Confirmed.

(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;

Our Carlsbad, California facility is 85,000 square feet and our Overland Park, Kansas facility is 300,000 square feet.

[redacted]

Following is our current mail service capacity:

2012 Mail Service Facility Capacity*					
Location	Daily	Weekly	Monthly	Quarterly	Annual
[redacted]					

2012 Mail Service Facility Capacity*					
Location	Daily	Weekly	Monthly	Quarterly	Annual
[redacted]					
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	

*

Please note that our capacity figures are based on two 8-hour shifts per day at both facilities, a 5-day work week, and 21.4 work days per month. We can increase our total capacity up to [redacted] by opening our facilities on weekends.

Our Mail Service Pharmacies dispensed approximately 21 million prescriptions in 2011 and we serviced over more than 1.5 million members. We are currently operating at 50 percent capacity across all our facilities. We do not anticipate that any technology or staffing changes would be necessary to accommodate the Programs' prescription volume.

(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

UnitedHealthcare makes every effort to ensure that Enrollees receive medication quickly and efficiently, but delays are sometimes unavoidable.

Out-of-stock situations typically result from a manufacturer's inability to meet supply demands for a variety of reasons including:

- Unexpected spikes in demand for a specific medication
- Manufacturing problems
- Raw material shortages

We maintain appropriate inventory levels at our Mail Service locations ensure the integrity of the supply chain. Stock levels are based on historical usage data and lead times required to replenish supplies.

UnitedHealthcare owns our Mail Service Pharmacies and we use workload balancing for virtual dispensing capabilities, we can nimbly adjust dispensing levels in unusual circumstances. In the case of the primary mail order process facility being unavailable, we can systematically route prescriptions to another facility for dispensing. For orders including medications that are backordered by the manufacturer, we may split orders between our facilities to facilitate drug delivery.

Our agreements with major wholesale distributors and more than 60 manufacturers help support quick reordering. An electronic data interchange (EDI) ordering system works with our claims and fulfillment system. This system reviews stock levels and compares them with the current fulfillment volume. Using an ordering algorithm, the system places an order with the appropriate vendor to help maintain inventory.

Our primary wholesale accounts are through two national distributors, McKesson and Cardinal. We also have direct purchase relationships with more than 60 drug manufacturers. Thus, medication remains readily available and in stock. We purchase both our generic and brand-name drug products through the same channels.

We require that our wholesalers maintain sufficient stock levels to immediately fill at least [redacted]

Communicating with Enrollees

If a delay occurs for any reason, we contact the Enrollee by phone within 48 hours to notify them of their order status. The mail service systems use a number of triggers to alert the intervention staff to any delays. If circumstances dictate, the order can be re-prioritized to expedite processing.

(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.

We prepare all non-sterile compounds that include creams, ointments and liquids at our Carlsbad, California facility. None of our facilities have commercial compounding licenses as we do not feel it necessary to meet the compounding needs of our members served.

(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.

Please see **Section 3., Exhibit N.**, for a chart describing the Mail Service Pharmacy Process proposed for the Programs.

System Edits

Upon receipt of a new or refill prescription order, we review the order for authenticity, clarity and alterations. If a prescription is unclear or appears altered, we contact the Enrollee or prescriber for clarification. After an order is verified, we scan the information into our system using imaging software. This image capture initiates our electronic documentation process. The prescription is assigned a barcode to further support accurate tracking throughout the order dispensing process. Once the order is logged into our system for tracking, a licensed pharmacy technician reviews the prescription for completeness. If the prescription is not complete or is not legible, the technician contacts the Enrollee and/or prescriber to obtain the necessary information.

Eligibility and Coverage Screening

Once we verify that the prescription information is complete, our mail service system screens and adjudicates the prescription according to Enrollee eligibility and the coverage status of the prescription. If the Enrollee is not eligible or the drug is not covered by the Enrollee's plan, the system denies the claim. We send written notification to the Enrollee if a prescription claim is denied.

Prior Authorization

If a drug utilization review (DUR) or prior authorization determination is required, a pharmacist contacts the prescriber to obtain the necessary clinical information. If the information submitted by the prescriber does not meet the criteria established by the plan sponsor (for example, the Enrollee does not meet medical necessity criteria for the prescription), the claim is denied and we send written notification to the Enrollee. If the information submitted meets the required criteria, we approve the claim and route the prescription for fulfillment.

Refill-Too-Soon

We employ system-based edits and criteria to screen for early refills. We recommend a "refill-too-soon" edit that identifies attempts to submit the same prescription number within a 75 percent timeframe from the shipping date of the prior prescription. This threshold can be customized for the Programs. For example, for a 90-day supply mail service prescription, an Enrollee must wait 67 days before refilling the prescription.

Depending on the Department's benefit design, early refill requests can result in a claim rejection or a DUR "hold". We can apply overrides for rejections based on client-specified exceptions (for example, clients may wish to allow exceptions for Enrollees with travel plans). For requests that result in a DUR hold, we can suspend the claim for a few days until our system indicates that the prescription is eligible for refill.

We can adjust this timeframe to accommodate the Programs' specific objectives. We will work with the Programs during the implementation process to identify customization requirements.

Duplicate Rx Edit

The Duplicate Rx edit will augment the Refill-Too-Soon edit described above.

The Duplicate Rx edit essentially differs from the Refill-Too-Soon edit in that this edit looks across pharmacy ID numbers, prescription numbers, or NDC numbers which share the same GPI number. This hard edit results in a rejection of the claim.

The Duplicate Rx edit helps curb over-utilization and the use of multiple providers. This edit alerts the pharmacy if the prescription being filled was filled recently at the same pharmacy or at another pharmacy, such as the OptumRx Mail Service Pharmacy. The Duplicate Rx edit is applied at the drug GPl level and identifies claims where the Enrollee is using multiple network pharmacies, including the OptumRx Mail Service Pharmacy, for the same prescription. The Refill-Too-Soon parameters apply to the Duplicate Rx edit.

The Duplicate Rx edit crosses both mail service and retail pharmacy supply channels to protect against over dispensing. During the Mail Service Pharmacy Process, the prescription is profiled and if fillable within 14 days the order is held and the system automatically releases the prescription for the Enrollee at the appropriate time. If the future fill date exceeds 14 days, the prescription is profiled and the Enrollee is notified to re-initiate their request for the prescription upon the date of allowable fill.

(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?

Enrollees will be assisted and offered an opportunity to set up their billing accounts prior to the transition on January 1, 2014 through a Mail Service Enrollment Welcome kit offered by UnitedHealthcare. Enrollees typically establish their billing accounts upon setting up their initial order when they mail in their first prescription.

Enrollees must submit a hard copy prescription to order a new prescription and may not fax or phone such an order. Physicians can initiate the fulfillment

process by sending new orders by phone, mail, fax, or e-prescribing technology.

Phone

Physicians can order new prescriptions over the phone by contacting a customer service representative (CSR) at our toll-free customer service number. The CSR can process payment with the Enrollee's credit card and provide detailed instructions for sending the original prescription to our order processing address. We can also contact the Enrollee's doctor and obtain the prescription directly from the prescriber.

Mail

Enrollees can submit new prescriptions by mail by sending a completed order form, the original prescription, and the appropriate payment to our mail service order processing address. A copy of our order form is included in our new Enrollee welcome mailing.

The form will also be available on the DCS custom website available January 2014. The online form can be completed electronically and then printed for mailing. Enrollees can also print the form and complete it by hand.

Fax

An order fax form is available on our Web site. The form includes an Enrollee section where Enrollees provide profile and payment information. It also includes a physician section where physicians provide profile and prescription information.

Enrollees or physicians can complete portions of this form online and then print and complete the form. We will only process faxed orders when we receive them directly from the physician's office.

E-Prescribing

Registered prescribers may securely transmit an electronic prescription to our Mail Service Pharmacy through SureScripts, an approved intermediary.

Reordering Prescriptions

Enrollees can order refills by phone, mail, fax, or through our Web site.

Phone

Our toll-free customer service phone line features an interactive voice response (IVR) system that allows Enrollees to order prescription refills. Our CSRs) are also available to initiate a refill order by calling the physician's office to approve a refill for a current or expired prescription. Our IVR system and CSRs are available 24 hours a day, 7 days a week.

Internet

Enrollees can order refills online by logging onto the DCS website or through the secure Enrollee portal of our Web site. We offer personalized pages, called "My Prescriptions," where Enrollees can manage all mail service prescriptions, including refills. Our Web site automatically displays prescriptions that are eligible for refill.

Mail

Enrollees receive a mail-in reorder form with each original prescription order. The reorder form lists the number of refills remaining, the date after which refills may be ordered, and the last date the order can be refilled.

Fax

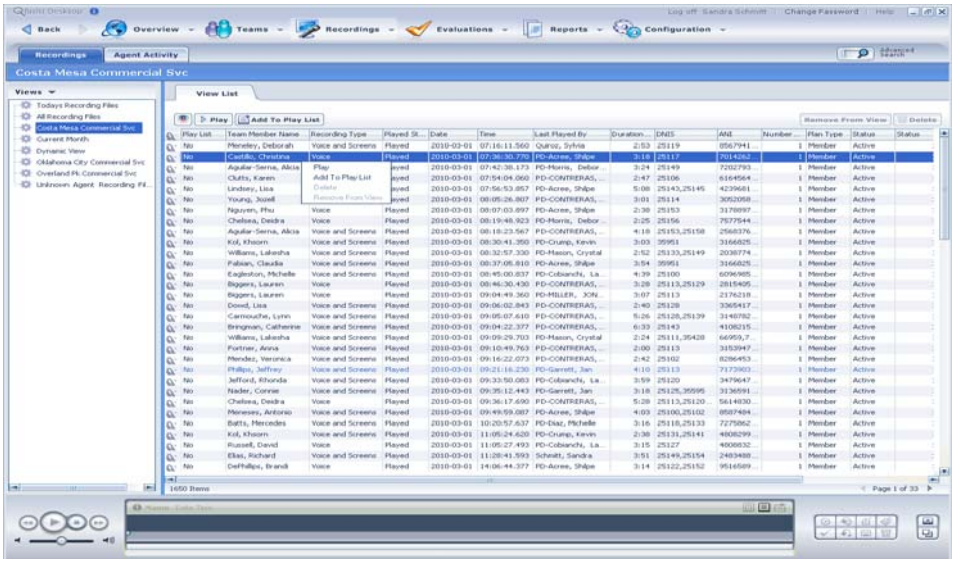
Enrollees have the option of faxing a refill request by using our reorder form.

(4) Describe the capabilities of the Mail Service Pharmacy call tracking system.

UnitedHealthcare routinely records all incoming calls to our Customer Service Center using Etalk's Qfiniti recording system. We notify all callers that conversations may be electronically recorded for training purposes.

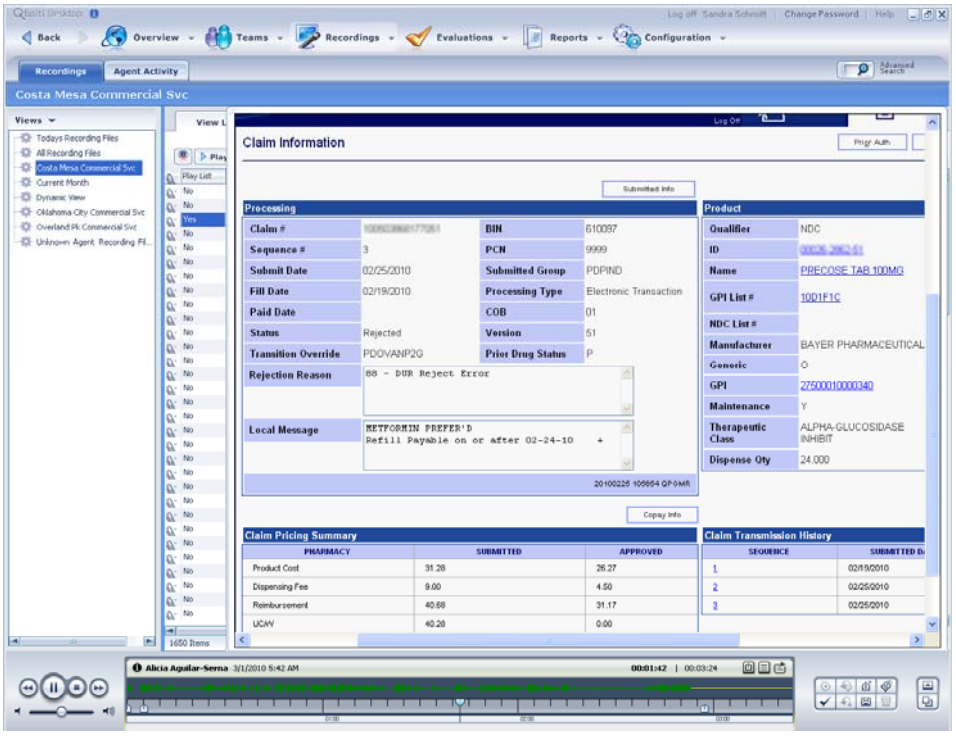
To maintain the highest level of Enrollee satisfaction, we focus on customer advocacy behaviors. We expect our CSRs to create a customer experience that goes beyond cordial efficiency. To support this experience, we utilize Quality Development Specialists to perform independent assessments with play back and evaluation of calls while observing the online screens and workflow documentation completed by our CSRs.

Below we show screenshots of our Etalk's Qfiniti recording system:



Our quality program technology supports quality assurance initiatives by providing the ability to use logged (recorded) calls for CSA monitoring and evaluation.

We capture both voice and screens with call recordings. We perform independent assessments using synchronized voice and screen play back with our Quality Development Specialists simultaneously monitoring both call and desktop activity for a complete view of CSR's performance. Our supervisors are able to monitor interactions for performance and examine processes for best practices, including the ability to immediately record interactions on demand, or to monitor calls in a live setting.



Supervisors and Quality Assurance Specialists may scroll vertically and horizontally through the screen record to view all of the resources on the CSAs desktop that are used to manage the customer interaction.

We record all calls, and calls are available for 90 days. We monitor approximately 1 percent of all calls. This percentage falls within the best practice range of the call center industry (from 0.5 percent to 1 percent).

We focus on call quality, formalized training programs, multimodal communications processes, and post-call surveys as key components to success. These quality assurance efforts have produced dramatic results as measured by substantial improvements in our customer satisfaction scores and call scoring quality metrics. [redacted]

(5) Confirm that you will supply sufficient quantities of mail order forms and

pre-paid envelopes to encourage mail service utilization.

Confirmed. UnitedHealthcare will supply sufficient quantities of mail order forms, which can also be downloaded on the custom DCS website, and we will provide pre-addressed postage paid envelopes to Enrollees in their initial mail service enrollment kit as well as with each mail service order.

(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?

Enrollee requested urgent prescriptions will be sent overnight delivery at the Enrollee's request for an additional charge to the Enrollee.

(b) Prescriptions that require "special" handling (i.e., temperature control, special preparation, controlled substances, limited shelf life, etc.);

Medications that require "special" handling such as refrigeration are packed with frozen gel-cold packs inside a Styrofoam cooler and are shipped to the Enrollee using an express next-day delivery carrier at no cost to the Enrollee. The outside of the package is clearly labeled, "refrigerate" for easy identification. Refrigerated orders are shipped Monday through Thursday and by Enrollee request for Saturday delivery if necessary.

During summer months, other medications such as suppositories or certain soft-gel capsules may also be shipped with cold packs.

(c) Narcotics for the original fill for an Enrollee; and

At the federal level, the Controlled Substances Act of 1970, enforced by the Drug Enforcement Administration (DEA), establishes standards concerning labeling, packaging and dispensing of "controlled"

substances by pharmacists. At the state level, each state has statutes that regulate pharmacies located within its borders. Our administrative and dispensing procedures comply with State and Federal regulatory requirements regarding controlled substances, including C-II medications.

C-II prescriptions must be written on state-issued serial blank. We employ secure procedures for ordering, receiving, and returning prescriptions. Each C-II prescription is routed directly to a controlled medication distribution station within the Mail Service Pharmacy and is processed and filled by a select group of pharmacists. Orders are identified and meticulously tracked throughout the entire dispensing process. A recipient's signature is required for orders containing controlled substances.

(d) Prescriptions requested to be mailed in easy open caps;

Confirmed. UnitedHealthcare uses dual-use caps that allow Enrollees to select twist-off or childproof functionality.

(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.

Prescriptions are tracked through the Mail Service Pharmacy Process beginning with the opening of the order (contains all prescriptions in the Enrollee's order), and a systematic identification number is assigned with a date stamp verification of the date the order is opened and entered into the system.

Upon receipt of a new or refill prescription order, we review the order for authenticity, clarity and alterations. If a prescription is unclear we contact the Enrollee or prescriber for clarification. After an order is verified, we scan the information into our system using imaging software. This image capture initiates our electronic documentation process. The prescription is assigned a

barcode to further support accurate tracking throughout the order dispensing process. Once the order is logged into our system for tracking, a licensed pharmacy technician reviews the prescription for completeness. If the prescription is not complete or is not legible, the technician contacts the Enrollee and/or prescriber to obtain the necessary information.

Fulfillment

After a prescription is approved, the claim system electronically records the approval, processes the Enrollee's check, money order, or credit card payment, and initiates the fulfillment phase. This phase includes a series of automated tasks through which the system identifies the type of medication, determines whether the medication is prepackaged or countable (for example, ointment versus tablets), flags the appropriate bottle size, if appropriate, and auto-dispenses the medication.

Our facilities employ an advanced pharmacy system (APS) for high volume fulfillment purposes. Our dispensing operation, including our automated systems and all manual and alternative methods, has a combined capacity that can dispense more than 9,000 prescriptions per hour. After an order is successfully imported, it is placed into the APS database to begin the filling process. All automated tasks are monitored and supported by a team of pharmacists and pharmacy technicians.

Pharmacist Verification

Following the fulfillment phase, a pharmacist performs a final verification of the prescription to ensure that the correct medication and quantity has been dispensed. This verification includes direct visual inspection of the medication dispensed. This verification phase is tracked by an electronic audit trail that time stamps the verification and notes the pharmacist performing the review. If an error is identified, the reviewing pharmacist flags the order for correction and re-dispensing. If the order is correct, it is flagged for shipping.

Shipping

In this final phase, our Mail Service staff packages approved and verified prescription orders in appropriate containers according to the medication type. For example, fragile items are packaged in sturdy cardboard containers and medications that require refrigeration are packaged in Styrofoam coolers with

gel cold packs. We also confirm that any necessary ancillary supplies, such as needles and Sharps containers, are included with the prescription order.

We ship most prescription orders through USPS First Class Mail. As required, we ship urgently needed medications and injectable drugs through overnight carrier or expedited delivery. We also require a signature for delivery of orders as appropriate, such as for controlled substances or high-cost medications. Medications which are valued at $2,000 or greater are considered high-cost medications. We can accommodate delivery to either an Enrollee's home or the physician's office.

After an order has been packaged and manifested through the APS system, a file is exported to the host system. The order is then delivered to the mailing agent. The file contains a complete history of the order's fulfillment process.

Our Interactive Voice Response (IVR) System will place an outbound call to Enrollees notifying them when an order has shipped.

(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?

UnitedHealthcare's Mail Service operations employ rigorous quality assurance processes to maintain accuracy and quality control. Our Mail Service Pharmacy routinely dispenses at a [redacted] We accomplish this level of performance by employing electronic and pharmacist verification checkpoints throughout our dispensing process.

We maintain quality oversight at each Mail Service facility by assigning a pharmacist-in-charge. The assigned pharmacist is responsible for correctly dispensing prescriptions at their respective location. The pharmacist-in-charge is assisted by our automated systems, which monitor and track each prescription during the process. All incoming prescriptions are physically inspected, and 75 percent of these are filled through the automated processes.

Quality checks at several points during the process are performed by pharmacists to confirm accurate fulfillment. Quality measures incorporate assembly-line automation, radio frequency identification, and barcode technologies to ensure dispensing accuracy. This stringent quality assurance process includes daily testing and audits of our automated dispensing equipment.

If a medication needs to be replaced due to an error, there is no additional charge to the Enrollee or the client. These situations receive a high priority in our systems and are addressed promptly to avoid Enrollee inconvenience or delay. We minimize the possibility of an error occurring by notifying and counseling anyone materially involved with the processing of a prescription dispensed from our facility.

Following an error, we conduct an investigation to identify the source of the error and to mitigate its effect. We evaluate the circumstances surrounding the error so that we can change and improve our processes. Our goal is to eliminate reoccurrences and improve the overall quality of our operations.

We document verification reviews in our online system to create audit trails that can be monitored and analyzed during retrospective quality review. We track errors and trace them back to the source. Furthermore, those analyzing the situation issue Accuracy Improvement Tips to the employee who made the error.

Our Medication Error Quality Assurance (MEQA) program applies quality control measures for identifying, reporting, and addressing pharmacy errors. In addition to our MEQA activities, we apply Six Sigma techniques to every aspect of our Mail Service Pharmacy. Through rigorous documentation of our performance, we can track, evaluate, and report our performance overall, as well as at the prescription level.

Accuracy

UnitedHealthcare consistently maintain an [redacted] The actual number or percentage of errors by category is proprietary.

The Programs will never be charged for incorrectly filled prescriptions or shipments that may need to be dispensed as a result of a pharmacy error.

Error Types

To confirm we are dispensing the appropriate medication and dosage, we use the following categorical identifiers. These categorical identifiers are used to define dispensing errors and level of severity.

MEQA
Fulfillment System Error
Inappropriate Dose/Sig
Inappropriate DUR Release
Enrollee Error
Prescriber Error
Shipping Errors
Wrong Diabetic Supply
Wrong Dosage Form
Wrong Drug
Wrong Drug Due To Filling Error
Wrong Formulation
Wrong Enrollee
Wrong Enrollee (Family Enrollee)
Wrong Enrollee , Same Name
Wrong Prescriber
Wrong Quantity
Wrong Sig
Wrong Strength
Wrong Substitution
Wrong Supply/Specialty

Error Type	Error Category
1	Right Drug, Wrong Dosage Form
2	Right Drug, Wrong Customer
3	Right Drug, Wrong Customer (Family Enrollee)
4	Right Drug, Wrong Strength
5	Right Drug, Wrong Signature
6	Right Drug, Wrong Substitution
7	Wrong Customer, Same Name
8	Wrong Prescriber
9	Inappropriate Dose
10	Inappropriate Dose, Age
11	Fulfillment System Error
12	Right Drug, Wrong Quantity
13	Inappropriate DUR release
14	Wrong Drug, Right Customer
15	Wrong Drug Due To Filling Error
16	Prescriber Error
17	Expired Drug
18	Shipping Error
19	Transcription Error
20	Customer Error

Level of Severity	Definition
0	No Ingestion

Level of Severity	Definition
1	Little/No potential for harm
2	Little/Moderate potential for harm
3	Moderate/Severe potential for harm

(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?

UnitedHealthcare defines intervention at Mail Service as a situation in which a prescription requires clarification or additional input from the Enrollee, his or her physician, or pharmacist prior to filling the prescription. Orders that require any kind of intervention that may extend turnaround time are defined as non-protocol to distinguish them from clean claims, which require no intervention.

Our systems monitor and track prescription status through multiple checkpoints, timers and reports during the dispensing process. When order timeliness exceeds specified parameters, a supervisor can reprioritize staff resources to expedite the order. Exception reports also enable the management team to focus on areas where intervention is warranted.

The following abbreviated list shows circumstances in which a prescription might require intervention:

- Clarification of an item (or missing item) by the prescribing physician.
- Drug-to-drug interactions that have a clinical impact on the Enrollee.
- Formulary or non-formulary agents requiring a prior authorization.

- Medication dose edits requiring a short-term or long-term override.
- Clarification or preference by the Enrollee regarding prescriptions (such as brand versus generic and monthly usage on diabetic supplies).
- Generic substitution in specific states which have unique regulatory requirements.
- Medications out-of-stock, back ordered, or discontinued by the manufacturer.
- Any credit issues that may arise (such as maximum benefit reached, non-formulary prescription as cash, and Enrollee questions to clarify unclear, or ambiguous orders).

On a per volume basis, approximately 15 percent of the total new prescriptions processed require one type of intervention or more. Changes to prescriptions can only occur with approval from the prescribing physician.

System Tracking

In general, we may hold a prescription requiring further information for up to five days. Each order that requires intervention is logged and reported as such. It also remains in the standard queue and is checked throughout the day. We maintain standard procedures for tracking and closing orders that require intervention.

Each interaction is tracked and thoroughly documented, and Enrollees and providers are contacted when necessary. "Further information required" can include, but is not limited to, missing or incomplete information on an order form, payment, eligibility discrepancies, or potential therapeutic conflicts (for example, drug-drug interaction).

(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.

[redacted]

When a prescription for a limited or sole source distribution drug is presented to the Mail Service Pharmacy Process, the prescription will be tracked and forwarded to the limited or sole source distribution provider for fulfillment. The process involving limited or sole source distributors is a seamless process for Enrollees to receive their medications as the Mail Service coordinates fulfillment for Enrollees every step of the way.

(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?

In today's world of polypharmacy, rising prescription drug costs and specialist prescribing patterns, patient counseling information and enhanced consumer engagement strategies are more important than ever. Communication is vital to the success of the Programs' Mail Service Pharmacy Process and Enrollees will have access to patient counseling tools through several mechanisms, including the following:

24/7 Access to Counseling Pharmacists

Clinical support is integrated with our customer service center. We support around-the-clock pharmacist availability. All callers have the option of consulting with a pharmacist to obtain information on medications, disease states, and other drug-related issues. Pharmacists have access to online claims information and can respond to inquiries about claims, including specialty, retail, and mail serviced claims.

Our Web site also offers a "click to call" function that Enrollees may use to receive a callback from a pharmacist.

During after-hours periods, pharmacists are available on an on-call basis to handle urgent clinical issues. When an Enrollee requires pharmacist assistance, we accommodate timely direct call-back by a licensed pharmacist who is trained to address clinical and medication issues.

- Educational material that accompanies new and refill prescriptions complies with OBRA90 regulations and is written in an easy-to-understand manner for the Enrollee. New prescriptions dispensed by the mail service pharmacies include a patient package insert (PPI). These leaflets include general information on the drug; the condition(s) for which it is prescribed; directions the member should follow before taking the medication, including whether to take the prescription with food, that it may cause drowsiness, to avoid driving, etc.; instructions on proper usage; and descriptions of possible side effects. Leaflets stress that the member should always contact his or her doctor should a potential side effect occur. PPIs are provided with refills for certain drugs, as required by the manufacturer.
- Easy to read prescription labeling with comprehensive patient counseling labels provide specific directions to the Enrollee on how to maximize the effectiveness of their medication.
- Prescription renewal and re-ordering that support adherence of medications and notify the Enrollee of timeliness and availability of refills.

(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.

UnitedHealthcare obtains pertinent health information such as drug allergies and diagnosed health conditions from the New Prescription Mail-In form which is submitted to the Mail Service pharmacy with an Enrollee's initial order. This form includes patient profile questions that support the dispensing of the medication and the ongoing safety of the Enrollee's prescription drug profile by capturing allergy information, disease information and any other pertinent information provided by the Enrollee.

Typically, patient profile information is provided as a hard copy with the Enrollee's first order, but the Enrollee can always provide additional medical and prescription drug information through the Customer Service department as well as the Web site.

(13) Describe your drug purchasing and inventory philosophy including:

UnitedHealthcare's drug purchasing and inventory philosophy is to apply rigorous inventory re-ordering protocols so the necessary medications are available to dispensing at the Mail Service Pharmacy Process. However, drug availability, particularly generic medications have seen large shortages in the market. Our drug purchasing and inventory philosophy is focused on maintaining appropriate inventory levels of safe, top quality drugs. We maintain appropriate inventory levels at our Mail Service locations to maintain the integrity of the supply chain. Stock levels are based on historical usage data and lead times required to replenish supplies.

Our agreements with major wholesale distributors and more than 60 manufacturers help support quick reordering. An electronic data interchange (EDI) ordering system works with our claims and fulfillment system to review stock levels and compare them with the current fulfillment volume. Using an ordering algorithm, the system places an order with the appropriate vendor to help maintain inventory.

Our primary wholesale accounts are through two national distributors, McKesson and Cardinal. We also have direct purchase relationships with over 60 drug manufacturers for medication to remain readily available and in stock. We purchase both our generic and brand-name drug products through the same channels. Where available, only AB rated generics are purchased.

Our Mail Service Pharmacy uses an ordering system that automatically reviews stock levels and compares them with current fulfillment volume. Using an ordering algorithm, the system places an order with the appropriate vendor to maintain consistent levels of inventory.

(a) What are the time frames as they relate to back orders or shipment from an alternate mail order facility;

Within 24 hours of identifying a drug as being out of stock, additional supplies will be pursued from our sister facilities.

(b) What are the time frames as they relate to backorders or shipments that are from your primary supplier;

Due to our size and scope, we have priority status with our wholesalers and manufacturers to deliver medications to our facilities as soon as available to the market, typically within one to two Business Days of availability.

(c) What is the percentage of Prescriptions that are filled when initially submitted to the primary mail service pharmacy facility you are proposing; and

Ninety-nine percent of prescriptions are filled when initially submitted to the Overland Park, Kansas Mail Service Pharmacy facility, not including national backorders.

(d) How are backorders and out of stock situations handled with members?

If a delay occurs for any reason, we contact the Enrollee by phone within 48 hours to notify them of their order status. The mail service systems use a number of triggers to alert the intervention staff to any delays. If circumstances dictate, the order can be re-prioritized to expedite processing.

If a shortage occurs, we contact and inform Enrollees of the anticipated duration of the situation. To minimize a delivery delay to an Enrollee, we will coordinate transfer of a portion of the prescription to a local retail pharmacy. In cases of long term unavailability of the medication, we may also coordinate a change to a therapeutic alternative if necessary and approved by the prescribing physician.

(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.

UnitedHealthcare makes every effort for Enrollees to receive medication quickly and efficiently, but delays are sometimes unavoidable. If a delay occurs for any reason, we contact the Enrollee by phone within 48 hours to notify them of their order status. The mail service systems use a number of triggers to alert the intervention staff to any delays. If circumstances dictate, the order can be re-prioritized to expedite processing.

Out-of-stock situations typically result from a manufacturer's inability to meet supply demands for a variety of reasons including:

- Unexpected spikes in demand for a specific medication
- Manufacturing problems
- Raw material shortages

Under such circumstances, we contact and inform Enrollees of the anticipated duration of the situation. If an Enrollee experiences delayed delivery of their mail service prescription, we will coordinate transfer of a portion of the prescription to a local retail pharmacy or we can coordinate a change to a therapeutic alternative. In cases of long term unavailability of the medication, we may also coordinate a change to a therapeutic alternative if necessary and approved by the prescribing physician.

Payment and Billing Issues

UnitedHealthcare contacts Enrollees directly if we encounter problems during the fulfillment process that can be quickly resolved with more information. For example, issues related to payment or address validation may result in direct contact with the Enrollee. If we cannot reach the Enrollee we leave HIPAA compliant voicemail requesting a return call. If the Enrollee does not comply, we will send a letter or a postcard requesting a return call.

If a delay requires the attention of a physician we make up to three attempts to call or fax the prescriber's office. If the prescriber does not respond to the first attempt, we make a second call and immediately contact the Enrollee within 48 hours if the question remains unresolved.

Potential problems that may prompt us to call an Enrollee or physician include:

- Clarification of missing Enrollee data or ambiguous orders
- Legibility of the written prescription

- Identification of drug-drug interactions that might have a clinical impact to the customer
- Quantity or dosage issues
- Orders for a non-covered drug or a drug that requires prior authorization
- Medication dose edits requiring a short or long term override
- Clarification or preference by the Enrollee regarding prescriptions
- Medication is out of stock, back ordered, or discontinued by the manufacturer
- Payment issues exist, such as maximum benefit has been reached or insufficient funds were included with the order
- If a claim is rejected at the point-of-sale in our mail-order pharmacy due to ineligibility we enlist our customer service center to assist in obtaining the Enrollee's correct eligibility. If necessary, we will reach out the Enrollee for additional information regarding their prescription drug benefit coverage.
- Lastly, every order includes an invoice in the order package mailed to the member that states the amount due if the correct payment was not submitted with the original prescription or if a credit card is not on file. UnitedHealthcare has not had the need to develop a payment plan process; however we will work with Enrollees on a case by case basis to secure payment for prescription orders.

(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?

UnitedHealthcare's affiliated Mail Service Pharmacy Process facilities will automatically substitute FDA approved A-rated generic drugs unless

prohibited by the prescribing physician. Our pharmacies do not stock B or un-rated generic drugs, nor will we substitute B or un-rated drugs for brand name medications. If a prescription is written for a generic drug, the Mail Service Pharmacy Process facility will dispense a generic drug.

(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?

There are no situations where a mail service prescription submitted for a Brand Drug is 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

UnitedHealthcare interprets the incoming mail service prescription as a maintenance or 90 days' supply prescription unless otherwise defined by the quantity and days' supply indicated by the prescriber. Customarily, the prescribing physician intended to prescribe a 90 day supply; therefore, we dispense a standard 90 day supply as described below.

The following table outlines the guidelines by which we determine days' supply on medications where the dosage can vary at each therapeutic occurrence, such as drops, lotions, and syrups.

Lotions and Ointments	▪ If Enrollee has a history of usage and requested a certain quantity, prescription is processed per history or request

	▪ If Enrollee has NOT identified quantity ▪ Process as three units = 90 days for solutions, shampoo's, lotions and foams. ▪ Process as approximately 90 grams = 90 days' supply for creams, gels and ointments OR ▪ If the prescriber has written for less than three units or less than 90 grams (including refills), the quantity is processed as 90 days ▪ If prescriber has written for more than three units or greater than 90 grams (not including refills) the quantity is processed as 90 days. ▪ If prescriber has written for only one package (no refills) and has not designated the package size, the largest package size available is provided (or closest to 90 grams) and process as 90 Days.
Eye/Ear Drops	▪ In general, we calculate 15 drops per ml for medications delivered via a dropper. There are specific medications for which we use a pre-determined calculation of drops per ml. We then determine the appropriate days' supply based on the directions on the prescription and dispense a quantity to sufficiently equal a 90 days' supply for the Enrollee.
Syrups	▪ In general, oral liquids are dispensed on the basis of the following equivalents: ▪ 1 fluid ounce is 30 ml and 1 teaspoon is 5 ml. We determine the appropriate days' supply based on the directions on the prescription and dispense a quantity sufficient for a 90 day

	supply.

(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?

For some of our clients who have benefit plan designs and pricing structures that warrant consideration of a Low-Cost 30 and 90 day programs similar to that of the Retail Pharmacy programs, UnitedHealthcare will work with these clients on implementing strategies such as described below. [redacted]

Low-Costs Generics at Mail

UnitedHealthcare competes with low-cost retail programs by offering our own low-cost generics program through our Mail Service. Our program provides 90-day supplies of low-cost generics for a copay of $10 in contrast to the $4, 30-day supply offered by many retailers. Because we provide more aggressive discounts for brand purchases at mail, certain clients can realize cost savings when their Enrollees use our Mail Service Pharmacy instead of retail for their high-cost generic and brand medications.

Our program provides these low-cost medications by establishing a maximum allowable cost (MAC) at $10. There are more than 500 drugs offered on our low-cost generics program, which surpasses most other retail programs for the number of medications offered. Following are examples of the benefits of this program for Enrollees:

- Enrollees are provided convenient access to low-cost generic medications at mail, even at a lower cost than at retail if 90 days at retail is not part of the benefit design.
- Enrollees who adopt mail services for their pharmacy purchases incur even further savings if the benefit design encourages mail through a copay reduction.

- Enrollees benefit from our commitment to promote affordable solutions by aligning the needs of Enrollees and their plan sponsor while mitigating drug trend and promoting the use of generics.

(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.**

UnitedHealthcare will guarantee that [redacted] of non-intervention (clean) prescription orders will have an [redacted].

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 [redacted] for DCS and [redacted] for NYSIF.

UnitedHealthcare proposes a [redacted] penalty for DCS and a [redacted] penalty 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.

UnitedHealthcare will guarantee that [redacted] of intervention prescription orders will have an [redacted]

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 $[redacted] for DCS and [redacted] for NYSIF.

UnitedHealthcare proposes a [redacted] penalty for DCS and a [redacted] penalty 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.**

Confirmed.

(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.**

Confirmed.

(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.

Confirmed.

b. <u>Required Submission</u>

(1) Explain how your proposed network provides access to all medically necessary covered Specialty Drugs/Medications.

Specialty Pharmacies in our network are held to high-quality standards. The Designated Specialty Pharmacies submit a quarterly data feed as well as analyses of clinical program metrics including quality-of-life assessments, depression screening, clinical outcomes and pharmacy utilization data. We

analyze the clinical and utilization data to ensure the outcomes are reported correctly for all of our Enrollees.

We also meet with each of our specialty providers on a quarterly basis to review clinical and service performance metrics, management reports and service needs and expectations. Currently, our benchmarking activity is focused on clinical program participation and adherence rates, dose optimization, hemophilia factor assay, clinical management program outcomes and market-share utilization of lower-tiered products when applicable.

In addition to quarterly reviews and reporting, our contracts and supporting Service and Operational Level Agreements outline required standards for service and quality. These contractual requirements include:

- Rigorous access and delivery standards.
- Around-the-clock access to pharmacists and other health care professionals.
- Staff certification and ongoing development plans.
- Training standards for specialty medications and disease states by all pharmacists and nurses with required submission of initial and ongoing training documentation.
- Well-defined policies and procedures with ongoing training programs.
- Continuous quality improvement program.
- Complaint tracking and corrective actions.
- Member satisfaction surveys evaluating overall experience at the pharmacy, delivery, ease of use, and Clinical Management Programs.
- Adherence programs with baseline expectations for rates or improvements.
- Establishment of clinical management programs for relevant categories with baseline expectations of education and oversight through clinician calls to Enrollees.
- Extensive reporting requirements with quarterly evaluations, yearly roll-ups, and longer term clinical outcome measurements.

(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).

[redacted]

When a prescription for a limited or sole source distribution drug is presented to the Mail Service Pharmacy Process, the prescription will be tracked and forwarded to the limited or sole source distribution provider for fulfillment. The process involving limited or sole source medications will be managed in a manner so Enrollees receive their medication easily.

(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.

UnitedHealthcare will make every attempt to solicit participation with all licensed pharmacies affiliated with the Empire Plan Home Care Advocacy Program [redacted]

(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?

In keeping with the current practice, HCAP will contact OptumRx, the Designated Specialty Pharmacy and the medication will be provided through 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.

Confirmed.

(6) Indicate the licensed pharmacies in Exhibit II.E.3 with whom you have a current contract.

Currently, UnitedHealthcare has a Network Pharmacy contract with the following pharmacies as depicted in **Exhibit II.E.3**:

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;

Confirmed.

(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.**

Confirmed.

(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.~~**

Confirmed.

(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).

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(7) Completing Physician consultation, coordination of care, patient care management and other interventions on a clinically appropriate and timely basis.

Confirmed.

(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.

Confirmed.

(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).

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(21) Having back-up Designated Specialty Pharmacies to handle any overflow and/or situations where the primary Specialty Program facility is unavailable.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

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.

While there is not an industry-standard definition for specialty drugs, UnitedHealthcare takes a strategic and broad approach to classifying drugs as specialty products.

Specialty medications are typically high-cost therapies, used to treat chronic illnesses or potentially life-threatening disease states. These drugs may also require special handling, patient education, adherence monitoring, or frequent pharmacist or physician intervention (for example, dose adjustments, drug interaction and laboratory monitoring, and side-effect support). UnitedHealthcare does not propose any additional criteria at this time. Please see **Section 3., Exhibit O**., for the proposed list of medications for the Empire Plan Designated Specialty Pharmacy Program.

The list of Specialty medications that we are proposing at this time is the list of medications that the Designated Specialty Pharmacies regularly dispense.

(2) Provide a detailed description of your proposed Specialty Pharmacy Program. Include the following:

UnitedHealthcare has been managing specialty pharmacy medications since 1996. As specialty medications began to move to the forefront of the pharmacy benefit management, UnitedHealthcare Pharmacy recognized the need to implement a robust specialty program in order to help our customers

manage escalating costs and to meet the unique needs of specialty patients. Over the past several years we have invested significant resources into developing our Specialty Pharmacy program.

In 2005, UnitedHealthcare Pharmacy launched our Designated Specialty Pharmacy program that included a network of specialty pharmacies. We limited the existing open network to benchmark provider performance in order to determine best practices in Clinical Management Programs and obtain overall market-rate competitiveness on high cost specialty medications. We continued to develop our specialty network and program offering, adding several therapeutic categories over the course of 2007, for a total of 11 contracted specialty providers and 13 therapeutic classes.

In July 2008, we further enhanced our Designated Specialty Pharmacy program offering with the addition of eight more therapeutic classes. At the same time, applying our experience and knowledge of industry best practices, we began a phased transition to a single provider approach to distribution and clinical management for specialty medications through our pharmacy benefit manager, OptumRx. This approach allows us to:

- Enhance our specialty clinical services.
- Leverage our aggressively contracted pricing.
- Simplify care, fulfillment, and education for Enrollees.
- Enhance our reporting and outcomes management.
- Reinforce and simplify our integrated, total health care approach.

In September 2009, we added the category of hemophilia to the program. Enrollees who are self-administering their medications will have their claims processed under the pharmacy benefit. These Enrollees will also participate in Clinical Management Programs available through the network of specialty pharmacies and hemophilia treatment centers.

The UnitedHealthcare Designated Specialty Pharmacy program will continue to offer targeted patient management programs, physician engagement and competitive discount levels. Our holistic specialty program not only aggressively manages costs and balances cost share, but also delivers improved outcomes for our Enrollees.

As specialty pharmaceuticals evolve, UnitedHealthcare Pharmacy will continue to develop new programs and strategies as well as enhance our existing offering to meet market demands.

(a) Customer service call center

Enrollees will continue to contact the primary Designated Specialty Pharmacy, Optum Rx, through the NYSHIP integrated toll free telephone number. As we do today, the Programs' dedicated call centers will transfer Enrollees to the Designated Specialty Pharmacy for assistance with questions regarding their specialty medication.

Our Designated Specialty Pharmacy provides customer service that effectively addresses Enrollee questions regarding their Specialty medication(s). Our Specialty Pharmacy provides 24 hours a day, 7 days a week access to a pharmacist or a nurse for Enrollee and physician calls regarding medication or administration.

(b) Administration of REMS

The FDA requires a Risk Evaluation and Mitigation Strategy (REMS) from manufacturers for particular medications (some of which are specialty medications) to ensure that the benefits of a drug or biological product outweigh its risks. Our Designated Specialty Pharmacies participate and comply in the REMS programs. These specialty pharmacies are required to adhere to all requirements of the REMS programs. Furthermore, UnitedHealthcare also requires the specialty pharmacies to provide incremental clinical programs, such as ongoing patient education and clinical management oversight, adherence programs and Clinical Management Programs. These programs provide the necessary and supplemental clinical monitoring of medications and deliver optimal clinical outcomes over time.

(c) (Exclusive to DCS) Whether Specialty Drugs/Medications administration will be through HCAP or a Specialty Pharmacy Program contracted network

In most cases, the Designated Specialty Pharmacies will provide required nursing for the administration of medications included in the Program. Approval for payment of the nursing charges under the Medical Program is obtained from HCAP. If Medicare is primary, HCAP does not approve the nursing care, however, the care must be provided by a Medicare approved nursing service. Additionally, if a specialty pharmacy needs assistance in locating a nursing provider that is in network with the Medical Program, HCAP will provide names of agencies in the geographic area where the nursing service is required.

(d) Clinical management, including demonstration of outcomes improvement

The Empire Plan Specialty Pharmacy Process will include numerous Clinical Management Programs for select disease states that require additional clinical education, support and ongoing monitoring to produce optimal outcomes. The structure of the program typically begins with monthly calls from a personalized pharmacist or nurse who evolves to quarterly calls unless more frequent contact is deemed necessary by the specialty clinician, based on Enrollee needs. These personalized phone consultations educate Enrollees on their disease state, self-management strategies, side effect management techniques, the importance of medication adherence, monitor specific laboratory and clinical response parameters, and identify potentially harmful drug-interactions. We provide up-to-date information on the latest research, clinical trials and financial assistance resources, as needed. These clinical management sessions include but are not limited to:

- Detailed member assessment on medication use, side effects, adherence, condition status, nutrition, exercise, case and care management needs.
- Disease specific laboratory values, therapy response parameter, status assessment or quality of life assessment performed for each therapeutic category to benchmark member therapy success and program outcomes.
- Depression screening performed at each consultation and, as needed, integration and referral to member's behavioral health services are offered.

- Utilization of medical services such as hospital, ER, and unscheduled physician visits are documented to provide feedback on member's condition and evaluated for additional interventions or services needed to meet the member's health needs.
- Extensive education on medication and disease state is provided directly to the Enrollees at each telephonic consultation and also specific topics are mailed at certain times during the member's therapy to strategically meet their educational needs.
- Intervention with the prescribing physician when significant issues are identified or recommendation for medication adjustment is appropriate.

Clinical Management Programs for the following disease states are available:

- Crohn's disease
- Hemophilia
- Hepatitis C
- HIV/AIDS
- Multiple sclerosis
- Oral oncology
- Transplant
- Psoriasis
- Pulmonary arterial hypertension
- Rheumatologic conditions such as rheumatoid arthritis, psoriatic arthritis, and ankylosing spondylitis

All Enrollees have around-the-clock access to a pharmacist trained in specialty medications and disease states to discuss any questions they have on their medications such as proper injection technique or how to manage a medication side effect. In addition to the phone consultations, we mail to each member personalized care plans, which

summarize the key topics that were discussed during the consultations to both Enrollees and provider. Relevant details of the care plan are also provided to the Enrollees physician to promote a collaborative practice relationship and advise of any patient medication issues or recommendations.

Case Study: Success of Clinical Management Programs

The impact of our unique clinical management programs is evident in the following case example of a 33-year-old male struggling to manage side effects from his multiple sclerosis medication and, therefore, missing scheduled doses. During calls with a clinician regarding his course of therapy, the following interventions and outcomes occurred:

- The experienced nurse assisted in developing a personalized plan for using techniques to manage pain and side effects that could be contributing to missed doses.
- Counseling was given regarding the importance of medication adherence (which has resulted in a 100 percent adherence rate since the session).
- The patient was educated on the use of a cooling vest to address heat intolerance and was assisted with an application from the Multiple Sclerosis Society for a free or subsidized device.
- A referral was made to OptumHealth Behavioral Solutions where the member received emotional and medication counseling support for anxiety and depression that was observed during the initial screening. The member now states he or she is in much better emotional health due to a more positive outlook.
- Education on diet and exercise along with Enrollee engagement and dedication to healthy lifestyle changes resulted in weight loss. This weight loss is anticipated to continue as he receives further support to adhere to his healthy choices.
- The patient has expressed gratitude for the personal support in making positive lifestyle changes and plans to continue working with his clinician.

Our specialty pharmacists and nurses go beyond simply refilling prescriptions. By delivering a holistic approach we engage Enrollees to achieve specific goals and empower them to make overall informed and healthier decisions.

(e) Fulfillment process, including cold-chain supply and shipping logistics

A registered pharmacist reviews the prescription for clinical appropriateness, potential drug interactions, and anticipated side effects and forwards the order to fulfillment if no issues are identified. If the pharmacist has any questions or concerns regarding the prescribed medication, the pharmacist will reach out to the prescribing physician for a clinical consultation. After the prescription is filled, a pharmacist checks the order against the prescription for accuracy. The order is then forwarded to the packing and shipping area, where any special handling and shipping requirements, such as temperature controlled packaging, are addressed. Patients are notified of these requirements during their initial assessments. Additionally, syringes, tubing, needles or Sharps containers are supplied to the member as needed and at no additional cost.

Maintaining the Cold Chain

We strictly adhere to manufacturer guidelines for product sensitivity and stability. We package each product to maintain product integrity and the cold chain during shipment. We use special cold packs, Styrofoam containers, and place in a cardboard box for additional stability when shipping all temperature-sensitive products. We also ship all specialty orders for stability by overnight carrier and track them online throughout the day. This supports product quality and timely delivery within appropriate timeframes.

We have validated our packages to maintain refrigerated medication at the required temperature during shipping through independent, certified third party lab.

(f) Transition process from First Fill at Retail or Mail

When the Empire Plan Specialty Pharmacy program was implemented in 2010, there were approximately 17,000 Enrollees taking a specialty medication who required a transition to the process. UnitedHealthcare developed, managed and implemented a sound transition plan for all Enrollees impacted by the implementation of the Program.

We propose implementing a transition plan of similar nature as described below:

- Letters will be sent to all Enrollees who are currently utilizing a specialty medication. Enrollees on a hard edit drug will receive a letter approximately 60 days prior to the implementation date of the new program. Please refer to **Section 4, Exhibit F**., which includes a sample announcement letter. The Designated Specialty Pharmacy will accept incoming calls from Enrollees and their physicians to assist in the transition. Enrollees on a soft edit drug will receive a letter advising them of the new Specialty Pharmacy program, however, they are not required to transition to the Specialty Pharmacy.
- HCAP authorizes nursing care and supplies under the medical component of the Empire Plan. The Designated Specialty Pharmacy calls HCAP for approval of nursing care to be provided for the administration of a Specialty Drug. HCAP will provide a list of all Enrollees who are receiving nursing care and a specialty drug to the Designated Specialty Pharmacy. The Designated Specialty Pharmacy will initiate a call to the patient to discuss their current care and explain that they will be providing their medication and nursing after January 1, 2014. Whenever possible, they will use the same nursing agency currently in place. The Designated Specialty Pharmacy will work with HCAP care coordination on difficult cases.

New medications added to the Empire Plan Specialty Pharmacy Process and Enrollees new to a specialty medication therapy are not immediately required to use one of the Designated Specialty Pharmacies. Enrollees will be allowed one grace fill of the specialty medication at a retail pharmacy. This grace fill facilitates the transition

to the Designated Specialty Pharmacy. During the grace period, a customized letter will be sent to the Enrollee within seven days of the first fill, explaining the Empire Plan Specialty Pharmacy program and how to transition to one of the Designated Specialty Pharmacies. When the grace fill is exhausted, subsequent claims are rejected with a message that refills are not covered.

Enrollees who start a specialty medication after implementation are also identified by claims analysis and a custom welcome letter is sent on a weekly basis.

(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.

Specialty pharmacies in our network are held to high-quality standards. The Designated Specialty Pharmacies submit a quarterly data feed as well as analyses of clinical program metrics including quality-of-life assessments, depression screening, clinical outcomes and pharmacy utilization data. We analyze the clinical and utilization data to ensure the outcomes are reported correctly for all of our Enrollees.

We also meet with each of our specialty providers on a quarterly basis to review clinical and service performance metrics, management reports and service needs and expectations. Currently, our benchmarking activity is focused on clinical program participation and adherence rates, dose optimization, hemophilia factor assay, clinical management program outcomes and market-share utilization of lower-tiered products when applicable.

In addition to quarterly reviews and reporting, our contracts and supporting Service and Operational Level Agreements outline required standards for service and quality. These contractual requirements include:

- Rigorous access and delivery standards.
- Around-the-clock access to pharmacists and other health care professionals.
- Staff certification and ongoing development plans.
- Training standards for specialty medications and disease states by all pharmacists and nurses with required submission of initial and ongoing training documentation.
- Well-defined policies and procedures with ongoing training programs.
- Continuous quality improvement program.
- Complaint tracking and corrective actions.
- Member satisfaction surveys evaluating overall experience at the pharmacy, delivery, ease of use, and Clinical Management Programs.
- Adherence programs with baseline expectations for rates or improvements.

- Establishment of Clinical Management Programs for relevant categories with baseline expectations of education and oversight through clinician calls to Enrollees.
- Extensive reporting requirements with quarterly evaluations, yearly roll-ups, and longer term clinical outcome measurements.

(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.

[redacted]

Although each of our Specialty Pharmacy providers maintains its own process flow, the processes are very similar with only minor variations. Clinical, educational and adherence support are heightened needs in Enrollees using specialty medications and given increased focus, as seen in the following description of the primary process flow through dispensing facilities.

- **Initial Order.** Customer service agents facilitate prescription transfers or renewals from the previous pharmacy or prescribing physician; confirm the prescription, diagnosis, patient demographics and insurance; and initiate any prior authorization, if required.
- **Patient Stratification.** Each member is assessed at the time of the initial order for potential adherence and side effect issues, injection training requirements, educational and clinical management needs, etc. For certain medications, the member is offered a clinical management and adherence program.
- **Fill Process.** A registered pharmacist reviews the prescription for clinical appropriateness, potential drug interactions, and anticipated side effects and forwards the order to fulfillment if no issues are identified. After the prescription is filled, a pharmacist checks the order against the prescription for accuracy. The order is then forwarded to the packing and shipping area, where any special handling and shipping requirements, such as temperature controlled packaging, are addressed. Patients are notified of these requirements during their initial assessments. Additionally, syringes, tubing, needles or Sharps containers are supplied to the member as needed and at no additional cost.
- **Delivery Process.** Each delivery is scheduled with patient approval for a convenient date prior to shipping. Educational materials and any ancillary supplies are included in one shipment to the member. Deliveries can be set for receipt confirmation or for drop-off to a specified location. Orders are appropriately packaged for temperature control and refrigerated items must be sent Next Day morning delivery. Packages include the pharmacy's P.O. Box return address and are discreet with no indication of contents or pharmacy details.

- **Refill Process/Adherence Program.** Starting approximately seven to ten days prior to the next scheduled medication fill, a patient care coordinator (PCC) contacts the patient via telephone to inquire about medication needs and to schedule the next shipment of medication. If the PCC is unable to contact the member, he or she leaves a message advising the member to call the pharmacy back. During these calls, the PCC also assesses medication adherence; if non-adherence or medication side effects are an issue, the member will be transferred to consult with a pharmacist or nurse for counseling and support.

If it is determined that the patient requires additional support, it is available at any time throughout the process. Examples of the types of patient support the specialty pharmacies provide include:

- Patient education
- Clinical Management Programs
- Adherence monitoring and intervention
- Side effects management
- Delivery management

Specifically for limited distribution drugs, our Designated Specialty Pharmacy program will provide access to all specialty drugs through our proposed program. For a very limited number of categories, exclusive arrangements are appropriate based on factors such as overall size of the category, limited general distribution networks and expertise of the contracted vendors. This arrangement meets our goals of appropriate access, patient management and cost containment while providing Enrollees with a seamless and united approach to specialty pharmacy management.

In the event the Enrollee requires specialized access to their specialty medication on an immediate need or the Designated Specialty Pharmacy is prohibited from shipping the specialty medication to the Enrollee's residence, an override of the "hard edit" will be granted and the Enrollee will have appropriate access to their medication.

(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?

When a specialty drug is dispensed that requires nursing care, the Designated Specialty Pharmacy will request an authorization from HCAP for coverage of nursing and supplies. The charges for nursing and infusion supplies are billed directly by OptumRx to the Medical portion of the Empire Plan.

If a participating provider with HCAP is providing nursing services but does not have an onsite pharmacy, HCAP will direct the patient or prescribing physician to a participating provider under the Empire Plan Prescription Drug Program. If the drug is a specialty drug, HCAP would direct the Enrollee or physician to the Designated Specialty Pharmacy to receive the medication.

(6) How does your system provide the ancillary supplies that accompany some of the Specialty Drugs/Medications?

The Designated Specialty Pharmacies provide ancillary supplies necessary to administer the medications as well as appropriate biohazard waste-disposal supplies (for example, Sharps containers). Tubing, needles, bandages and most ancillary supplies are included at no additional cost. The medication and supplies are sent at the same time to the Enrollee.

(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.

Our Specialty Drug Implementation Committee is a dedicated, cross-functional team that applies specific criteria to their review of all new specialty products released to the market for potential inclusion in our specialty program. This team, including leaders from our specialty pharmacy, network, medical and pharmacy business units, develops our over-arching specialty strategy and determines what medications are defined as specialty and included in the program.

While there is not an industry-standard definition for specialty drugs, we take a strategic and broad approach to classifying drugs as specialty products.

Specialty medications are typically high-cost therapies, used to treat chronic illnesses or potentially life-threatening disease states. These drugs may also require special handling, patient education, adherence monitoring, or frequent pharmacist or physician intervention (for example, dose adjustments, drug interaction and laboratory monitoring, and side-effect support).

Additionally, specialty drugs may be categorized as one or more of the following:

- Oral, injectable or inhaled medications including infusions in any outpatient setting (for example, physician office, infusion suite, home, hospital and outpatient) and biotechnology products that require additional clinical supports.
- Medications that require frequent management/monitoring such as:
  - Patient-specific dosing (for example, weight-based dosing)
  - Drug interaction and laboratory monitoring
  - Side-effect support
  - Narrow, targeted treatment focus
  - Treatments requiring focused in-depth patient education, adherence monitoring, side-effect management and injection technique education
- Orphan drugs used to treat rare diseases.

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;

Confirmed.

(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;

Confirmed.

(c) Charging the Programs consistent with the Offeror's proposed pricing quotes;

Confirmed.

(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;

Confirmed.

(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);

Confirmed.

(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;

Confirmed.

(g) Maintaining the security of the claim files and ensuring HIPAA compliance;

Confirmed.

(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

Confirmed.

(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.

Confirmed.

(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;

Confirmed.

(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.

Confirmed.

(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 Enrollee Ancillary			
Submitted DAW	**Copay**	**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);

Confirmed.

(n) Maintaining a Programs' MAC List for Pharmacies;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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

Confirmed.

(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."

Confirmed.

(p) (Exclusive to NYSIF) Processing Non-Network Pharmacy claims submitted to the Offeror in accordance with Chapter V of title 12 NYCRR.

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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.

[redacted]

[redacted]

(t) Establishing a process where Pharmacies can verify eligibility of Enrollees and Dependents during Call Center Hours;

Confirmed.

(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;

Confirmed.

(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.

Confirmed.

(w) (Exclusive to DCS) Establishing a process to support, and respond, to Federal Medicare Part D audits.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.**

Confirmed.

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.

UnitedHealthcare uses SXC Health Solutions Corporation's RxCLAIM online transaction processing system to process all claims; retail, mail, and specialty claims, which comprises 99 percent of our claims electronically. The remaining 1 percent account for manual or paper claims. SXC Health Solutions Corporation has proprietary ownership of the software; however,

UnitedHealthcare has purchased a license and regular upgrades from them to maintain the most current functionalities.

UnitedHealthcare has a contractual arrangement with SXC Health Solutions Corporation where we have rights to modify their standard RxCLAIM program with a variety of custom features that UnitedHealthcare uses exclusively. These custom features and the ongoing development of and familiarity with these custom features provide capabilities that are not offered by other RxCLAIM users. We provide our own support for the custom applications.

UnitedHealthcare has provided a flow chart of the step-by-step description of our 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 as **Section 3., Exhibit P.** When UnitedHealthcare receives a claim, edits and checks are made to ensure that the claim is eligible for payment. Claim requests are checked for the following:

- Correct format
- Pharmacy network
- Enrollee eligibility
- Formulary status

Subsequent to a positive check, the request will be approved as a valid claim and then sent on for further processing. If the claim does not pass the initial checks, a rejection occurs.

Through our Real-Time Audit System, a copy of a prescription claim is immediately sent through filters, or edits, which flag claims that fall outside set algorithms. Customer service can then call the pharmacy to resolve the concern, often while the Enrollee is still at the pharmacy. This process helps prevent mistakes and reduces fraud in prescription claims submission.

Once a claim has been approved, we compare the reimbursement the pharmacy is requesting with the amount we have previously agreed upon based on Usual and Customary (U&C) cost, submitted, contracted dispensing rate, Maximum Allowable Cost (MAC) list pricing, and Enrollee copayment.

We provide Direct Member Reimbursement (DMR) or paper claims processing for instances when the electronic point-of-service system is not used. This accounts for one percent (1%) of manual or paper claims, and these claims are adjudicated using the client's specific directions. There may be numerous reasons for processing a DMR claim such as:

Reason 1	Enrollee is traveling
Reason 2	Compound medication with limitations
Reason 3	Participating pharmacy POS system failure
Reason 4	State Medicaid subrogation, Indian Public Health Facilities
Reason 5	Foreign claims
Reason 6	Federal pharmacy claims (Military hospitals and VA hospitals)
Reason 7	Non-Participating pharmacy
Reason 8	COB (when the DCS Programs are secondary coverage)
Reason 9	Enrollee did not have their ID card to show the pharmacy

Network Pharmacy Process

UnitedHealthcare uses the latest in network and leased-line technology to receive electronically submitted claims from more than 64,000 pharmacies participating in our various networks. Submitted claims are immediately transferred to one of several claims processing engines that drive our system.

The adjudication process operating in each subsystem retrieves, matches, and validates the critical Enrollee information submitted by the pharmacy. The system selects the appropriate group and benefit level (based on the Enrollee number and date of service), and automatically applies edit parameters such as, validating drug products from the Programs' PDLs and benefit plan design.

Following formulary validation, drug and event-specific edits are applied. In addition, selected DUR edits based on the dosage, days' supply, and prior history, are applied. If at any point during the adjudication process the claim

fails to pass an edit or validation, a detailed error message is immediately generated and returned online to the submitting pharmacy. If no errors are detected, the claim completes the stringent validation process and is priced for reimbursement and billing.

Various pricing formulas are used to determine the total allowable charge for the prescription. These pricing methodologies may involve comparisons to:

- AWP
- Submitted / U&C charges
- MAC list price
- Other table-driven values

This charge is then proportioned between the covered Enrollee (copayment) and the Programs, based on the plan design.

Following adjudication, an approval message and paid claim response are returned to the submitting pharmacy. The paid response includes details on the:

- Pricing and cost values
- Amount to be collected from the Enrollee (if any)
- An amount that will be included in the next payment advice (amount due)

At the end of each claim submission time cycle, our robust system extracts all completed claims processed during the previous 24-hour period. The claims are then copied to pharmacy payment programs for normal pharmacy disbursement. The claims are also augmented with additional data from the various system databases. After the claims have been saved and updated, the information is then recorded in the system's claim history reporting libraries.

Non-Network Pharmacy

Non-network pharmacy claims are processed using the same adjudication process as all other electronically submitted claims. However, claims from non-network pharmacies will normally reject because of the nonparticipating status of the submitting non-network pharmacy. At this point, an Enrollee

whose prescription is rejected at a nonparticipating pharmacy can pay cash for the prescription and submit a paper claim.

Point of Service Edits

In the table below, we have listed a representative sample of the edits that our claims system performs at the point of service.

Category
Ineligible participant
Ineligible drug
Incorrect AWP or formula price
U&C input
Duplicate Rx
Refill-too-soon
Incorrect dosage
Drug interactions
Over utilization
Under utilization
COB Secondary Payer status
Benefit maximums for certain drug types
Drug inappropriate for the Enrollee due to age or gender

Refill-Too-Soon

We employ system-based edits and criteria to screen for early refills. We recommend a "refill-too-soon" edit that identifies attempts to submit the same prescription number within a 75 percent timeframe from the date of service (DOS) of the prior prescription. For example, for a 90-day supply mail service prescription, an Enrollee must wait 67 days before refilling the prescription.

We can adjust this timeframe to accommodate the Programs' objectives and will work with the Programs during the implementation process to identify timeframe customization requirements.

UnitedHealthcare confirms we will implement our proposed full RTS edit and Duplicate Rx edit on January 1, 2014 and the edits will be applied to claims with a date of service January 1, 2014 and forward.

In addition to the RTS edit described above, as part of the comprehensive DUR Program that will be available to the Programs, a Duplicate Rx edit will provide for cost effective dispensing of Drugs under the Programs. Please see below a description of how the Duplicate Rx edit will augment the RTS edit that will be in place for the Programs.

This edit performs two checks: the first is for a therapeutic duplication and the second is for ingredient duplication, as described below.

- **Duplicate Rx.** The Duplicate Rx edit differs from the Refill-Too-Soon edit in that DUR looks across pharmacy ID numbers or prescription numbers, or NDC numbers which share the same exact GPI number. This edit results in a rejection of the claim.

The Duplicate Rx edit helps to curb over-utilization and the use of multiple providers. This edit alerts the pharmacy if the prescription being filled was filled recently at the same pharmacy or at another pharmacy, such as the OptumRx Mail Service Pharmacy. The Duplicate Rx edit is applied at the drug GPl level and identifies claims where the Enrollee is using multiple network pharmacies, including the OptumRx Mail Service Pharmacy, for the same prescription. The Refill-Too-Soon parameters apply to the Duplicate Rx edit.

(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?

UnitedHealthcare processes claims on a single adjudication platform and also operates a second back-up adjudication and batch processing platform. We have a third high availability disaster recovery platform if necessary.

Through our disaster recovery plan, Enrollees will experience minimal, if any, disruption. Our claims processing system is available 99 percent of the time, however in the event that an Enrollee should require medication while the system is down, UnitedHealthcare will engage the assistance of the dispensing pharmacist to use their discretion and professional judgment in dispending an emergency temporary supply of medication for the Enrollee. The pharmacist will also have the opportunity to resubmit the claim as soon as the system is available.

Disaster Recovery

UnitedHealthcare conducts periodic disaster preparedness tests and evaluates our system failover and high availability capabilities several times a year as standard protocol. In addition, our maintenance contracts for all of our core systems stipulate rapid response times in the event of a disaster or system failure. UnitedHealthcare performs routine maintenance and testing on both the production and backup systems in the following ways:

- Any changes to the systems are thoroughly tested and documented prior to implementation.
- Monthly routine maintenance is scheduled for one day, on either a Saturday or Sunday. Maintenance involves a role swap in which the backup system is switched and assigned as the primary transaction system.
- An activity calendar is published at the beginning of each year with targeted dates for these events to take place.
- To support maintenance activities, we issue a service notice to all Programs at least ten days before scheduled maintenance or outage.

Scheduled downtime for routine maintenance is limited to less than 60 minutes; this allows execution of the role swap to the backup system. The primary system is completed and online within 48 hours.

Per UnitedHealth Group Policy, Business Continuity and Disaster Recovery Plans are tested on an annual basis, and adequate records are maintained, so the plans are up to date. Annual testing must be conducted to support the timely recovery of business processes, information technology systems, and related Information Assets in times of disasters and other emergencies.

(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;

UnitedHealthcare will use MediSpan indicators to assist with compliance of the Program's definition of a generic medication. UnitedHealthcare's online claims adjudication system is fully integrated for all retail, mail, and specialty claims, which enables UnitedHealthcare to maximize the rate of generic substitution for the Programs. (The mandatory generic substitution requirement will exclude the NYSIF and PDP Programs.) All claims adjudicated by UnitedHealthcare's system are verified against the Program's benefit plan design.

UnitedHealthcare will enforce the mandatory generic substitution provisions of the Program through the application of MAC pricing within the adjudication logic. We will apply mandatory generic substitution to all brand name drugs with an FDA-approved, A-rated generic drug (including but not limited to generic drugs rated AA, AB, AN, AD, AT, and etc.) or an authorized generic drug, as permissible by NYS law. When an Enrollee has a prescription filled for a Brand-Name drug where an A-rated or authorized generic exists on the MAC list, the Enrollee will be charged an ancillary fee, representative of the difference in cost between the discounted brand name AWP and the Empire Plan MAC Price, and the applicable copayment, not to exceed the full cost of the medication.

We will maintain a custom MAC list for the Programs that are managed by UnitedHealthcare and meet all the requirements of the Programs' proposal and subsequent contract.

The system is designed to provide the following POS adjudication results for multi-source Brand-Name drug claims:

- **DAW 0** - the claim rejects and messaging is sent back to the pharmacist to submit an appropriate DAW code. This reimbursement strategy ensures that when multi-source Brand-Name drug is adjudicated, the appropriate reason is captured.
- **DAW 1 and 2** - MAC reimbursement to the pharmacy and the Enrollee will pay the Non-Preferred Brand-Name copayment plus the ancillary charge that represents the difference in cost between the discounted Brand-Name AWP and the Programs' MAC price. This reimbursement strategy assures DCS will pay the MAC price regardless of the DAW 1 or 2 code.
- **DAW 3, 4 and 5** - MAC reimbursement to the pharmacy and the Enrollee will pay the applicable generic copayment.
- **DAW 6** – MAC reimbursement to the pharmacy and the Enrollee will pay the applicable generic copayment.
- **DAW 7** - The pharmacist is reimbursed for the Brand-Name medication and the Enrollee pays the Non-Preferred Brand-Name copayment with no ancillary charge applied.
- **DAW 8 -** MAC reimbursement to the pharmacy and the Enrollee will pay the applicable generic copayment.
- **DAW 9 -** MAC reimbursement to the pharmacy and the Enrollee will pay the applicable generic copayment.

UnitedHealthcare can administer the Program's generic substitution requirements based on the Programs' definition of a Generic Drug as set forth in **Section VIII**.

(b) A Prior Authorization Program for specific drugs that have an increased risk of inappropriate utilization;

UnitedHealthcare establishes coding requests for drugs approved for prior authorization. The data is coded into the system as edits, which are applied to claims adjudicated at retail, mail and specialty pharmacies.

For drugs that require prior authorization under the program guidelines, UnitedHealthcare sets up these agents on an NDC or GPI level to require prior authorization at the point of sale. When the Enrollee attempts to have their first prescription filled for an agent requiring prior authorization, the claim will reject and a message will be sent back to the dispensing pharmacist. The message indicates the drug requires prior authorization and the pharmacist will be provided the toll free telephone number for the Empire Plan Prescription Drug Program Prior Authorization Unit.

Once the prior authorization criterion has been met and approved, the pertinent information is loaded into the system, the prior authorization is approved for the Enrollee and the subsequent claims will pay without intervention.

(c) A concurrent DUR program identifying Enrollee drug therapy safety edits and Programs' benefit edits;

Concurrent DUR is a drug utilization review system designed to support the pharmacy networks' professional role in providing quality of care to the Programs' Enrollees. Concurrent DUR is the evaluation of drugs at the point of service for potential therapeutic complications such as drug-to-drug interactions or therapeutic duplications. This program also reviews for plan design parameters such as the frequency of prescription refills.

The Concurrent DUR program monitors drug prescribing and dispensing at the point of service, and alerts the dispensing pharmacist to possible drug concerns. The Concurrent DUR program performs online, real-time analysis at the point of service regardless of whether dispensing occurs at retail or at the mail service pharmacy. During this process, UnitedHealthcare's clinical database compares the incoming prescription to Enrollee demographics and checks for potential clinical conflicts that may result if the prescription is dispensed.

The concurrent DUR program screens for, but is not limited to, the following:

- Therapeutic duplication, duplicate prescription, and refills that occur too soon
- Age or gender related contraindications
- Over- or under-utilization, including minimum or maximum daily dose, minimum or maximum quantity per prescription, period or days' supply
- Drug-drug interaction
- Drug-allergy contraindications
- Drug-diagnosis caution screening
- Drug-inferred health state (pregnancy) screening

(d) Messaging capabilities to the Network Pharmacy;

UnitedHealthcare offers comprehensive capabilities for online, point-of-service messaging that helps promote appropriate claims processing and drug utilization. For example, we can apply Program specific messaging when a pharmacist enters a claim for a non-preferred medication. These messages can refer the pharmacist to appropriate alternative formulary medications. Custom messages can also alert pharmacists about other potential utilization or safety issues, such as maximum daily dosing, potential drug-to-drug interactions, and restrictions on selected drugs.

(e) Eligibility verification;

When a pharmacy submits a claim, our system automatically checks Enrollee eligibility and sends approval or denial messaging as appropriate. Claims for non-eligible Enrollees will not be paid.

(f) Customized edits for individual Enrollees;

UnitedHealthcare offers flexible benefit design options that accommodate the Programs' needs and facilitate customization of

utilization management criteria. Our options allow the Programs to set threshold values, rules for "hard" and "soft" edits, criteria for triggering point-of-service pharmacist alerts and messaging, and coverage limits at the drug or drug class level.

(g) Utilization of some medications intended to treat conditions limited to one sex;

Through our Concurrent DUR edits, we are able to screen for any gender-drug contradictions. If a potential drug therapy problem arises, an alert will appear on the pharmacist's computer display advising the appropriate steps to resolve the problem.

(h) Historic claims look up capability to reduce Enrollee disruption at the point of sale;

We maintain paid and reversed claims detail in our online claims system for up to a maximum of 24 months.

(i) (Exclusive to DCS) Multi-level cost sharing;

The UnitedHealthcare adjudication system has the ability to support various plan designs and Enrollee incentives that enable the Programs to devise benefits that optimize generic substitution consistent with their goals. We support multi-tiered cost sharing and a multi-tier formulary on a Program-specific basis.

(j) Identification and pricing of compounded Prescriptions consistent with the Programs' definitions and requirements set forth in this RFP; and

UnitedHealthcare supports NDC-based ingredient cost for determining the pricing of compound drug claims. In which case, we price compound prescription drugs using the standard pharmacy discount

rate. We take each individual ingredient (expensive or least expensive or in between) cost and calculate them based on quantity submitted. We then take this aggregate figure based on quantity submitted and apply it against the pharmacy contract rate. This calculated figure determines the final approved ingredient cost.

Compound Drug Payment and Processing

UnitedHealthcare uses a claim edit that defines how our claims system will handle payment requirements for a non-NDC defined compounded (local manufacturer multiple ingredient) medication. Pharmacies request payment for compounds by submitting the appropriate NCPDP claim format including the compound segment plus the negotiated dispensing fee. We require pharmacies to submit the AWP for the quantity used of each individual ingredient.
We can customize copayments and dispensing fees for compound drugs through the application of special edits in our claims processing system.

(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.

Our network pharmacy contracts include a provision stipulating that the lesser of retail price, MAC price, discounted price, or copayment is the amount the Enrollee pays. Our provider agreements require each pharmacy to submit its U&C charges for each claim.

Our plan designs are flexible and can support several variations of pharmacy payments based on different values, including the lesser of:

- U&C
- Copayment
- Submitted cost

(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.

The DAW 0 plan edit is used to validate and/or restrict the coverage of drugs based on both the DAW code submitted by the pharmacy and the FDA rating of the drug. Therefore, claims for brand name drugs that have both an A-rated generic available and are submitted with a DAW 0 will be coded to reject and a message returned to indicate invalid DAW code and that generic substitution is available.

(5) Describe how your adjudication system feeds the reporting and billing systems and any claim update data delays.

The day after the close of the cycle, the claims adjudication system feeds the financial reporting and billing systems with data as it existed on the last day of the cycle. Once a cycle closes, claims are frozen for billing and financial reporting purposes. Claims paid or reversed after the cycle closes will be included in the next cycle.

(6) Do you own the adjudication system, license the software or contract out this service?

UnitedHealthcare uses SXC Health Solutions Corporation's RxCLAIM online transaction processing system to process all claims; retail, mail, and specialty claims, which comprises altogether 99 percent of our claims electronically. The remaining 1 percent account for manual or paper claims. SXC Health Solutions Corporation has proprietary ownership of the software; however, UnitedHealthcare has purchased a license and regular upgrades from them to maintain the most current functionalities.

UnitedHealthcare has a contractual arrangement with SXC Health Solutions Corporation where we have rights to modify their standard RxCLAIM

program with a variety of custom features that UnitedHealthcare uses exclusively. These custom features and the ongoing development of and familiarity with these custom features provide capabilities that are not offered by other RxCLAIM users. We provide our own support for the custom applications.

(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?

UnitedHealthcare will comply with any new versions or capabilities of the standard NCPDP format for claims transmission on or before the required timeline as specified/mandated under HIPAA regulations.

(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.

We maintain a Pharmacy Services Help Desk that supports pharmacist overrides. This Help Desk can be reached through our main toll-free customer service phone line or through a separate toll-free direct line. Claims rejected as a result of Concurrent DUR or a standard NCPDP reject cannot be overridden by the pharmacist without the assistance of the pharmacy helpdesk unless the client requests. Overrides can be tracked and reported. Overrides do not override the Programs' plan design, unless the override is intended to do so. Overrides for circumstances such as vacation refills, college student refills, lost medications, or physician approved dosing are circumstances where UnitedHealthcare would approve quantities in excess of the benefit design

amounts. These decisions will be made jointly with the Programs upon award and implementation of the contracts.

To facilitate an override, pharmacies may call either number to request assistance with general inquiries, including benefit questions and overrides. The Help Desk is staffed by pharmacy technicians and customer service representatives (CSRs) who follow designated plan guidelines to determine if an override is necessary.

Our Pharmacy Services Help Desk is available 24 hours a day, 7 days a week.

The pharmacy's experience is customized by the IVR once their identity is authenticated by automatically providing error support for a recent claim transmission and offering eligibility verification or claim reversals. Pharmacies easily authenticate their identity by providing their National Provider Identification (NPI) which is matched with their caller ID.

(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?

We use our claims adjudication system, RxCLAIM online transaction processing system, to process claims for Network Pharmacy, Mail Service Pharmacy and Specialty Pharmacy.

We have fully integrated our Network Pharmacy, Mail Service Pharmacy and Specialty Pharmacy operations to achieve optimum efficiency and excellent customer service. Although claims from retail pharmacies and our mail service facilities enter our system through different channels, we process all claims using the current National Council for Prescription Drug Programs (NCPDP) telecommunications standard and one adjudication engine that includes all necessary eligibility and claims history information.

This level of integration supports:

- Application of DUR edits across all claims to assure consistency and avoid potential adverse events (exceptions may apply based on benefit design differences, such as days' supply limits).

- Comprehensive claims history profiles.
- Ability to generate combined or discrete data reporting by claim submission source.
- Consistent claims auditing processes to ensure high-quality service levels.

The adjudication process operating in each subsystem retrieves, matches, and validates the critical Enrollee information submitted by the pharmacy. The system selects the appropriate group and benefit level (based on the Enrollee number and date of service), and automatically applies edit parameters such as, validating drug products from the Programs' formulary or list of approved items.

Drug and event-specific edits are applied following formulary validation or acceptance of the primary drug product. In addition, selected DUR edits based on the dosage, days' supply, and prior history, are applied. If at any point during the adjudication process the claim fails to pass an editor validation, a detailed error message is immediately generated and returned online to the submitting pharmacy. If no errors are detected, the claim completes the stringent validation process and is priced.

Enrollee Profiles

Our claims processing system maintains a profile on each Enrollee for all retail and mail service prescriptions. Enrollee profiles are built through eligibility file feeds and by each online claims transmission, whether paid, rejected, or reversed.

In addition, we ask Enrollees who use our Mail Service to complete an Enrollee profile when placing an order. This profile includes known allergies, health conditions, and current medications. This information is stored on an internal host computer system and is not available to other external pharmacies.

A standard Enrollee profile includes:

Data Element	Information
Enrollee information	Name, date of birth, address, known allergies, sex. Can also include information related to

Data Element	Information
	the Enrollee's insurance coverage, medical clinic, or Medicare status.
Medication filled	Name of medication, strength, dosage form, quantity, days' supply, date filled prescription number.
Physician information	Name of prescribing physician, address, phone number, DEA number when required. Can also include information related to the Enrollees primary medical group.
Pharmacy information	Name of pharmacy, location, phone number.
Cost information	Pharmacy charges (U&C), total charges, what the Enrollee paid, what was paid by the Plan.
Prior authorization records	A listing of prior authorization requests entered for each individual Enrollee.
Enrollee notes	A series of text messages recorded that relate to the specific Enrollee or any claim records. May include notes on phone calls to customer support or from the Enrollee's pharmacy.
Health related information	May contain a list of diagnosis, or other health condition indicators like smoking, pregnancy, and alcohol.

(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.

UnitedHealthcare's benefit design process includes thorough planning and validation of the requested update or change and loading and testing strategies that help ensure accuracy and minimize errors.

Planning and Validation Steps

UnitedHealthcare takes a proactive approach to developing, testing, and executing benefit design initiation and changes, and we therefore invest a significant amount of time in planning and consulting with each client. Because much time is devoted to careful strategy, ultimately less time is spent on the implementation itself. Meticulous documentation and attention to detail early in the process are the reasons that errors are minimized.

UnitedHealthcare maintains a Benefit Operations Management (BOM) team that will participate in a number of meetings with the Programs' Account Management team, as well as other internal units, to determine an appropriate implementation strategy and plan. There is strict adherence to our established quality assurance process.

All implementation and benefit change requests are carefully reviewed and audited by a supervisor as well as a fellow technician to ensure accuracy. In addition, we incorporate quality assurance strategies that address resolution of performance issues. Some of our checks and balances include using standardized documentation and proactive query tools and reports to support accuracy on a proactive, rather than retrospective, basis.

The request review involves verification of the following components:

Completeness

We provide a standard form that helps track plan design and contract requirements, ensures details are not omitted, and allows for communication to all impacted departments before the change goes into effect. If a request is incomplete, the team follows up with the requesting member of the Account Management team.

Logic

The request will be verified for logic and compatibility with the Programs' benefit structure.

Impact Considerations

The request or change to plan design is analyzed for the impact it will have once it goes into effect. UnitedHealthcare will consider the impact on the Programs, Enrollees and/or claimants, pharmacies, physicians, and our internal support teams.

Loading and Testing Steps

Once the preliminary investigation and validation efforts are complete, project requests are prioritized and assigned to a Benefit Operations Management team technician by the team supervisor. Both the technician and the supervisor are required to document their action plan for the project.

The technician completes the project by carefully following the agreed upon action plan, documenting necessary changes in the related plan materials, such as the internal facts sheet and the plan design matrix. This step includes communicating with various internal departmental designees regarding the completion of the project and the final benefit details.

The technician audits all work for accuracy, employing an internal audit query tool. Finally, the auditor or team supervisor audits the technician's work for precision and accuracy. The audit function includes execution of several test cases to validate the benefit programming and identify any issues.

All testing is performed with true benefit codes in a test environment prior to migration to a production environment. We can provide the Programs with copies of test claims upon request.

As part of the testing phase, the Account Management team also works to validate plan design questionnaires, internal fact sheets, and other standard materials that document the Programs' benefit design criteria. These documents are provided to the Programs to help confirm technical accuracy and mutual understanding of program requirements and objectives.

Any changes to other client benefit designs will 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?

UnitedHealthcare strives to rectify all issues with processing a claim as quickly and efficiently as possible to prevent unnecessary delay or inconvenience for Enrollees/claimants. Our system allows for direct review and override when claim denials or other issues occur.

Pharmacists will have access to call our Pharmacy Help Desk, 24 hours a day, 7 days a week, to work with trained pharmacy technicians to resolve issues that occur at the point of service.

(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.

Confirmed. Based on eligibility information provided by the DCS Program, UnitedHealthcare can deny the claims at the point of service for Enrollees who are enrolled in a Medicare Part D and send an online message to the Pharmacist instructing him or her to submit the claims to an alternate carrier.

(13) Explain how your claims processing system collects overpayments from your Retail Pharmacy Network.

Recovered overpayment amounts are returned to the Programs through claim reversals and reprocessing in our claims system. After an error is identified, the discrepant claim is reversed and re-billed, where appropriate, with the accurate claim information. This allows us to maintain an accurate audit trail.

All reversed transactions are marked with a claims status code unique for reversed transactions.

A Claims Administration Fee will not be charged for reversed claims.

(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;

Recovered overpayment amounts are returned to the Programs through claim reversals and reprocessing in our claims system. After an error is identified, the discrepant claim is reversed and re-billed, where appropriate, with the accurate claim information. This allows us to maintain an accurate audit trail.

All reversed transactions are marked with a claims status code unique for reversed transactions.

A Claims Administration Fee will not be charged for reversed claims.

(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.**

Our Real-Time Audit System helps us identify overpayments by running claims through a set of pre-defined filters and algorithms that screen for appropriate utilization patterns, cost information, and other criteria. Any claims that do not pass this screening are flagged for potential review. Our Audit team then investigates claims immediately and contacts the associated

Enrollee/claimant, pharmacy or prescriber as necessary to verify the claim's accuracy. When inaccurate claims transactions have been identified, the claims are reversed and properly resubmitted by the pharmacist. In some instances, an auditor reverses and reprocesses the claim if the adjudication window is closed.

The Department will only be charged a Claims Administration Fee on the Final Paid Claims (which include claims that are resubmitted, as described above).

UnitedHealthcare is committed to addressing instances of potential fraud, waste and abuse. When appropriate, we report fraudulent and potentially fraudulent cases to law enforcement, other state and federal regulatory authorities.

In addition, we collaborate with the Empire Plan Medical and MHSA program as well as the Fraud and Abuse team of OptumRx. All these parties support collaboration to help identify and investigate cases that involve potential fraud, waste and abuse on both the medical and pharmacy side. Our processes include monitoring physician prescribing and Enrollee utilization patterns. Medical and hospital claims are reviewed and the Pharmacy program utilization records are reviewed to assist in identification of "Drug Seeking Behavior". When fraud, waste and abuse have been identified, notification of the appropriate law enforcement parties is conducted as appropriate.

Below we have provided more detail on our procedures and controls for identifying fraud, waste and abuse at the pharmacy, Enrollee, and physician level.

Detecting Pharmacy Fraud and Abuse

UnitedHealthcare uses an advanced Real-Time Audit System to examine all claims on a continuous basis. All pharmacies in our network are audited electronically in real time using our Real-Time Audit System.

Through this type of audit, we run all claims through a set of pre-defined filters and algorithms that screen for appropriate utilization patterns, cost information, and other criteria. Any claims that do not pass this screening are flagged for potential review. Our skilled Audit team then investigates flagged claims and contacts the associated Enrollee, pharmacy or prescriber as necessary to verify the claim's accuracy. When inaccurate claims transactions

have been identified, the claims are reversed and properly resubmitted by the pharmacist. In some instances, an auditor will reverse and reprocess the claim if the adjudication window is closed.

The benefits of differentiating retrospective analysis of claims from real-time prospective review have been positive and substantial, with a potential for significant increases in the amount of money recovered on behalf of the Programs. An additional benefit is that a true sentinel effect comes into play because claims are acted upon immediately. Pharmacists learn that a higher percentage of claims are reviewed by our Real-Time Audit System and, therefore, take a more proactive approach in reducing erroneous and potentially fraudulent claims.

Auditing in real-time has the following advantages:

- A larger number of pharmacies are contacted per auditor in comparison to onsite or in-depth desktop audits.
- A greater sentinel effect is achieved as more pharmacies are contacted.
- Pharmacists are educated, which results in fewer errors, and also assists pharmacies with compliance to government regulations and health plan procedures.
- Questionable claims patterns are more easily identified, which allows for more timely development of additional audit screening criteria.
- The need for new edits is determined in a timely manner.
- Pharmacy claims are often corrected online prior to payment.

Beyond our Real-Time Audit System capabilities, we also apply a program of desktop and on-site audits that help us further investigate potential issues of fraud, waste and abuse in the retail setting.

Desktop Audits

These audits are conducted consistently throughout each day to investigate the integrity of individual claims submitted by pharmacies and paid by UnitedHealthcare on behalf of the Programs. Desktop audits include filtering and examining prior claims transactions for aberrant issues and in-depth desktop audits where a larger number of source documents are requested from the pharmacy for review. In-depth desktop reviews are conducted when a

more expanded review is appropriate and include the review of various source documents and proof of delivery.

On-site Audits

Pharmacies are audited on-site as deemed necessary, based on a number of factors, such as contractual agreement, analysis performed, internal and external referrals or complaints, random selection, or escalations from in-depth desk audits.

While on-site, auditors may review either a random sample of paid pharmacy claims, or a targeted subset, or both. Paid claims will be compared to on-site records such as:

- Hard-copy prescription files
- Computer printed daily transaction logs
- Purchase invoices where appropriate
- Other files and records
- Third party signature logs, etc.

UnitedHealthcare typically performs a facility review, pharmacy staff review, and other reviews for factors such as:

- Accuracy of data submission
- Compound/specialty medication review
- Review for potential fraudulent activity
- Return to stock policy adherence
- Regulatory compliance
- Contract compliance
- Monitoring of foot traffic and inventory handling

Detecting Enrollee Fraud and Abuse

An Enrollee must present a valid ID card to the pharmacy for initial set up within the contracted pharmacy's processing system. If the participant does

not have an ID card, he or she may furnish suitable identification and ask the pharmacist to contact our Pharmacy Help Desk for verification of eligibility.

Because Enrollee profiles have become more sophisticated, pharmacies can process prescriptions without an ID card, although we recommend that pharmacies require suitable identification to protect against fraud. Additionally, many pharmacies will not fill a prescription under any circumstances without a participant ID card, for the protection of their clients. All contracted pharmacies are instructed to contact the provider when they believe that a prescription has been altered or submitted fraudulently.

Detecting Physician Fraud and Abuse

UnitedHealthcare's standard reporting package includes numerous reports that monitor individual physician prescribing patterns, such as the Sample Prescriber Detail report and Sample Top "N" Prescriber report.

The management staff of the Programs can also create their own ad hoc prescriber reports using the Online Reporting Tool to profile individual physicians. Physicians can be profiled by any number of variables, including:

- Count/percentage of
  - All prescriptions
  - Formulary drugs prescribed
  - Generics prescribed
  - Controlled substances prescribed
- Amount paid and ingredient cost of prescription
- DAW codes
- Drug types or class

UnitedHealthcare employs various strategies to reduce inappropriate prescribing patterns with physicians that are identified by these physician profiles. One such strategy involves physician specific mailings with Enrollee-specific reports and educational materials.

In addition, UnitedHealthcare coordinates with law enforcement authorities so that physicians are thoroughly investigated when fraud is committed against

the Programs. Our process includes referral to the Empire Plan Special Investigation Unit and notification to appropriate governmental agencies, such as state medical boards, Medicare Drug Integrity Contractors (MEDICs) and law enforcement.

(16) Can the adjudication system interact with a debit card program for flexible spending accounts?

Yes, the adjudication system can accommodate real-time Flexible Spending Account (FSA) adjustment through a mediatory debit card. In addition, we can accommodate deducting copayments, deductibles and coinsurance amounts from FSA by:

- Holding the payment and making a deduction in real time resulting in a zero copay.
- Charging a copay and posting to the Enrollee/claimant's savings account so the client can reimburse the Enrollee/claimant at a later date.
- Charging a zero copay, billing the Programs for the full drug cost, and reporting the portion that should be paid from the Enrollee/claimant's savings account.

During implementation, we will discuss the options available to the Programs to determine the most efficient method for updating FSA balances.

(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?

UnitedHealthcare supports NDC-based ingredient cost for determining pricing compound drug claims. In which case, we price compound prescription drugs using the standard pharmacy discount rate. We take each individual ingredient (expensive or least expensive or in between) cost and calculate them based on quantity submitted. We then take this aggregate figure based on quantity

submitted and apply it against the pharmacy contract rate. This calculated figure determines the final approved ingredient cost.

Compound Drug Payment and Processing

UnitedHealthcare uses a claim edit that defines how our claims system will handle payment requirements for a non-NDC defined compounded (local manufacturer multiple ingredient) medication. Pharmacies request payment for compounds by submitting the appropriate NCPDP claim format including the compound segment plus the negotiated dispensing fee. We require pharmacies to submit the AWP for the quantity used of each individual ingredient.

We can customize copayments and dispensing fees for compound drugs through application of special edits in our claims processing system.

	Compound Segment Segment Identification (111-AM) = "10"	Optional Segment Required for Compounds		Claim Billing/ Claim Rebill
Field #	***NCPDP Field Name***	**Value**	**Payor Usage**	**Payor Situation**
450-EF	Compound dosage form description code.	RW		Required when compound is being submitted.
451-EG	Compound dispensing unit form indicator.	RW		
447-EC	Compound ingredient component count.	Maximum 25 ingredients	RW	
488-RE	Compound product id qualifier.	RW		
489-TE	Compound product ID.		RW	
448-ED	Compound ingredient Quantity.	RW		

	Compound Segment Segment Identification (111-AM) = "10"	Optional Segment Required for Compounds		Claim Billing/ Claim Rebill
Field #	***NCPDP Field Name***	**Value**	**Payor Usage**	**Payor Situation**
449-EE	Compound ingredient drug cost.	RW		Required if needed for receiver claim determination when multiple products are billed.
490-UE	Compound ingredient basis of cost determination.	RW		*Imp Guide:* Required if needed for receiver claim determination when multiple products are billed.
362-2G	Compound ingredient modifier code.	Maximum count of 10.	O	*Imp Guide:* Required when Compound Ingredient Modifier Code (363-2H) is sent.
363-2H	Compound ingredient modifier code.	O		

(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.**

Confirmed.

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 [redacted] for DCS and [redacted] for NYSIF.

UnitedHealthcare proposes penalty amounts of [redacted] for DCS and [redacted] 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.**

Confirmed.

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 [redacted] for DCS.

UnitedHealthcare will guarantee that [redacted] of all Enrollee submitted claims that require no additional information will be turned around within [redacted]. UnitedHealthcare proposes a total of [redacted] at risk for failure to meet this guarantee.

(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.**

Confirmed.

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 [redacted] for NYSIF.

UnitedHealthcare will guarantee that [redacted] of all Enrollee submitted claims that require no additional information will be turned around within [redacted]. UnitedHealthcare proposes a total of [redacted] at risk for failure to meet this guarantee.

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.**

Confirmed.

(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.**

Confirmed.

(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.**

Confirmed.

(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.

Confirmed.

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. <u>Required Submission</u>

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.

UnitedHealthcare will fully comply with the duties and responsibilities outlined above and will provide the following services to the DCS Programs in the identification, investigation and recovery of pharmacy claim overpayments where another insurance carrier or Medicare was primary. Below we have provided additional details.

Services to be Provided	Explanation
Data File Management	Receive, load & accumulate monthly pharmacy claims and eligibility file information for data mining and case identification.
Case Identification	Perform data mining of eligibility and claims data to identify members with paid

Services to be Provided	Explanation
	pharmacy claims and other coverage indicators, or Medicare eligible drugs.
Case Creation and Administration	Create new investigations in the system to track status of cases and applicable pharmacy claim-level information.
Letter Generation & Response Processing (Member Letter)	Conduct mailings to members, as needed, to obtain new or additional COB coverage information or Medicare eligibility and entitlement information.
Customer Service (Member Inbound Calls)	Provide a toll-free number for all member responses or inquiries related to investigations. The analyst assigned to the audit case will assist members with questions, and update the case for relevant information gathered.
Investigation and Primacy Determination	Utilizing information gathered, investigate the other insurance through a series of validation procedures, including: ■ Contacting the other insurance carrier and/or pharmacy benefit manager to verify data and obtain required member, group, policy, and benefit information as well as specific RxBIN/PCN data required for pharmacy re-filing. ■ Contacting the prescribing physician or pharmacy, as needed, to verify specific diagnosis or related medical treatment information. ■ Determining primacy based on MSP and NAIC rules and the information obtained through investigation procedures.

Services to be Provided	Explanation
	■ Individually assess each prescription claim to confirm coverage through primary insurance carrier or Medicare.
Recovery of Paid Claims	Notify pharmacy or the other insurance carrier of the overpayment, providing all relevant patient and claim-level information for filing the claim correctly and recovery of mistaken payments. In addition, coordinate with member for recovery situations where member involvement in the claim submission or recovery process is required.
Investigation and Recovery Reporting	Provide monthly reporting of investigation and recovery activity. Reports to include: ■ Summary Report of Investigation Activities per Quarter. ■ Detail Recovery Report of all claims recovered at the patient and claim-level. ■ Report of all confirmed coordination of benefit information for recovered cases.

A flow chart and process description for our Retrospective COB program has been included as **Section 3., Exhibit Q.**

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

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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."

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

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.

UnitedHealthcare currently administers a mandatory generics program meeting all of the Programs' requirements in which Enrollees, in addition to a third-tier copayment, pay the difference between the brand and the generic drug when a chemically-equivalent generic is available. While members can continue to receive the brand drug, they will be financially responsible for this "ancillary charge".

The claims processing system that will administer the State's mandatory generic substitution provisions is highly flexible and can accommodate virtually any plan design. There are several ways that a mandatory generic program can be administered, including the provision outlined above by the Programs.

UnitedHealthcare currently administers more than 230 copayment options, many of which include the requirement that the Enrollees pay the difference between the cost of the brand drug and the generic drug plus the brand copayment when a brand drug is dispensed and a generic is available. These copayment options may be governed by the Dispense As Written (DAW) flag indicated on the inbound claim. The DAW flags that is transmitted on the

inbound claim will indicate that the Enrollee or physician has requested the brand drug over the generic and the difference in cost would be passed on to the Enrollee. The price differences are calculated based on the MAC price applied to the multisource brand drug. Consistent with the DCS requirements FDA non A-rated products submitted by the pharmacies with a DAW 7 can be excluded from an alternate non preferred brand copay and ancillary charge being applied. Furthermore no MAC price will be applied to the multi-source brand NDC's for FDA non A-rated products and the specific eight products listed as exceptions to the Mandatory Generic Substitution requirement. As such no ancillary charge will be applied to the Enrollee and there will be a reduction in reimbursement to the pharmacy for dispensing these multi-source brands.

Systematic programming of this requirement can be completed within 14-21 days.

(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?

Once new MAC pricing is determined, the MAC price is automatically a part of the adjudication process for each claim. This process ensures that continuous competitive unit cost discounts are made to our proprietary MAC pricing, while also promoting the rapid adoption of the generics for brands coming off patent. UnitedHealthcare, through the claim adjudication system, will cause the dispensing network pharmacy to inform the Enrollee prior to dispensing the brand name drug, that an ancillary charge would be applied in addition to the applicable non-preferred brand name drug copayment. If the prescribing physician requires that the brand name drug is dispensed, UnitedHealthcare will cause the dispensing pharmacy to collect the applicable brand name drug copayment plus the calculated ancillary charge. Pharmacies who do not submit the appropriate DAW code when submitting a multi-source brand name drug claim will receive reimbursement based on the Programs' custom MAC list and the Enrollee will pay the generic copayment, leaving the

pharmacy to bear the expense for the difference between the brand and the generic product.

(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.

UnitedHealthcare's sole source for determining a drug's classification status is Facts and Comparisons' Medi-Span Master Drug Data Base (MDDB) file. We obtain Medi-Span updates twice a week and enter relevant product changes in our claim system for our book of business. UnitedHealthcare maintains all original Medi-Span drug status indicators in our claims system. However, for the Programs we have the systematic flexibility to insure that the contract terms of the Programs' brand and generic definitions are adhered to and the policies for application of MAC pricing is employed as it is today.

(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.

UnitedHealthcare tracks the FDA Orange Book codes for all multi-source drugs with twice weekly feeds from Medispan and manual access to the FDA Approved Drug Products Orange Book and on-line access. This allows UnitedHealthcare to track at an NDC level if the product is A- rated or not. Our process for applying MAC pricing, but not enforcing generic substitution for non A-rated generic drugs, NTI drugs, or for A-rated generic drugs (that the DCS has required of the Offeror) is for these specific products to have the MAC price removed from the brand NDC numbers within the GPI only. This

will allow the MAC price to continue to be applied to the generic NDCs. Since the MAC is not being applied to the brand NDCs no penalties will be applied to the pharmacy or member for dispensing the brand drug.

(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.

UnitedHealthcare's sole source for determining a drug's classification status is Facts and Comparisons' Medi-Span MDDB file. We obtain Medi-Span updates twice a week and enter relevant product changes in our claim system for our book of business. We maintain all original Medi-Span drug status indicators in our claims system. However, for the Programs we have the flexibility to insure that the contract terms of the Programs' brand and generic definitions are adhered to and the policies for application of MAC pricing is employed as it is today.

[redacted]

[redacted]

Typically for our book of business, The MAC team monitors the generic landscape to ensure that appropriate pricing levels are in place for generics. We utilize market data to determine appropriateness of our pricing. As new generics launch our stated policy is to have them on the [redacted] We complete a monthly review to determine generic pricing on the MAC list outside of drug specific reviews which are usually prompted by network pharmacy pricing inquiries. Drug specific reviews happen in real time.

(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.

UnitedHealthcare does not maintain a list of NTI drugs. We consider AB-rated generic drugs to be therapeutically equivalent to their brand-name counterparts regardless of their status as an NTI drug.

There is no universally accepted definition, no formal designation by the Food and Drug Administration (FDA), and no official consensus list of NTI drugs.

No cases of therapeutic failure have been documented when an FDA-designated therapeutically-equivalent generic product was substituted for its reference product.

UnitedHealthcare will exclude the brand name medications on the DCS Program's NTI from mandatory generic substitution be exempting the brand name GPI from MAC pricing. Therefore the brand name medications will process at the non-preferred brand name copayment; however, no ancillary charge will be calculated or applied.

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

Confirmed.

(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.**

Confirmed.

(3) **Following a successful generic appeal, charging the Enrollee for the Brand Drug at the Level 3 Copayment with no Ancillary Charge.**

Confirmed.

(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.**

Confirmed.

(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.**

Confirmed.

b. <u>Required Submission</u>

(1) **Describe in detail how you would administer the required generic appeal processes for the DCS Program including:**

UnitedHealthcare will continue to administer The Mandatory Generic Appeal (GAP). This process will not apply to the PDP/EGWP, since EGWP plans do not allow for mandatory generic substitution provisions.

The Mandatory Generic Substitution Appeal process and corresponding program criteria will be administered by a dedicated and competent team of clinical pharmacists and technicians. The clinical pharmacists managing the GAP for the Program are supported by physician medical directors.

Enrollees are notified of generic appeal determinations in writing. The letter contains the determination of the request (for example, approval or denial). If a request is approved, an authorization is loaded and UnitedHealthcare will communicate, in writing, the approval determination to the Enrollee and their physician.

If the request is not approved, the Enrollee and their physician will be notified in writing of the decision. Information regarding the next steps available to the Enrollee is provided in the letter.

(a) The turnaround time;

As we do today, upon receipt of complete information from the prescribing physician, UnitedHealthcare will make a determination on the Mandatory Generic Substitution Appeal request within five Business Days, or less, as required.

(b) Qualifications of the staff that would conduct the review;

Mandatory Generic Substitution Appeal requests will be reviewed by a dedicated and competent team of clinical pharmacists and technicians. The clinical pharmacists managing the Generic Substitution Appeal Process for the Program are supported by physician medical directors.

(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?

The following criteria will continue to be used to administer the Mandatory Generic Substitution Appeal program. All approvals are loaded for an indefinite period of time. UnitedHealthcare does not utilize dollar thresholds as part of the program criteria.

[redacted]

(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:

The Mandatory Generic Substitution Appeal Program has been in place for the Program since inception of the contract with UnitedHealthcare beginning January 2008.

[redacted]

Approval rates for the following medications are listed below:

(i) Prilosec - [redacted]

(ii) Fosamax - [redacted]

(iii) Topamax - [redacted]

(iv) Keppra - [redacted]

(v) Cellcept - [redacted]

(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.

Confirmed. Once a Generic Appeal request has been approved, the Enrollee will receive a check reimbursement for any ancillary charges paid within 30 Days of the receipt of their completed appeal request.

(2) Confirm that you will load previously approved Generic Appeals data into your claims adjudication system.

Confirmed.

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. <u>Duties and Responsibilities</u>

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;

Confirmed.

(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.

Confirmed.

(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;

Confirmed.

(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;

Confirmed.

(5) Promptly loading approved prior authorizations determined by the Offeror or received from NYSIF for the NYSIF Program into the claims processing system;

Confirmed.

(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

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

b. <u>Required Submission</u>

(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;

UnitedHealthcare's prior authorization program manages the appropriate use of high-cost medications and/or highly-utilized therapeutic drug categories that have potential for inappropriate or unsafe use through the development and implementation of clinical evidence-based guidelines.

Drugs are selected for inclusion in the prior authorization program based on the potential for off-label (not in accordance with FDA-approved indications) use or use for excluded conditions (for example, cosmetic indications). If there is or could be significant off-label use of a drug

without evidence of safety and efficacy in the medical literature, the drug is a candidate for the prior authorization program. Factors such as the potential number of patients to be treated, total costs, and patterns of use are also taken into consideration.

Guideline Development and Prior Authorization Request Process

An expert team of clinical pharmacists defines our prior authorization guidelines with oversight from the physicians and pharmacists of our National Pharmacy & Therapeutics (NP&T) Committee. The guidelines are based on nationally recognized clinical practice guidelines, FDA labeling, published clinical literature, and input from practicing medical experts. The prior authorization process includes the following key steps:

1. A prior authorization request is received by telephone, fax, mail or our Web site.
2. A pharmacy technician performs the initial review of the request.
3. If the request falls outside the established guidelines, a clinical pharmacist reviews the request and contacts the prescriber if additional information is required.
4. After the request is approved or denied, the technician or pharmacist enters the information into our prior authorization system, which automatically generates written correspondences to both Enrollee and provider.

UnitedHealthcare complies with all state and federal regulations for prior authorization turnaround time.

Value of Our Prior Authorization Process

We consider our prior authorization strategy unique in the industry. Our development approach involves algorithms that assess drugs for efficacy and safety and balance these factors with various cost variables, such as drug cost, operational cost, and estimated averted costs. Using this formula, we can identify whether a prior authorization guideline might yield value from both clinical and savings perspectives.

(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?

UnitedHealthcare maintains a prior authorization department that handles coverage determination requests—either before a claim is submitted or after a claim denial has occurred.

We offer a vast library of existing guidelines that are derived from industry best practices and evidence-based studies that define criteria for utilization based on safety and clinical efficacy. We also support development of customized guidelines that meet client-specific criteria for coverage.

Our prior authorization staff includes licensed pharmacy technicians and clinical pharmacists who review medication requests for compliance with clinical guidelines. When necessary, these clinicians reach out to the prescriber for supporting clinical documentation and/or to our medical director for additional oversight on complex cases. Projected staffing for the prior authorization unit is estimated to be 17 employees.

We support timely review of prior authorization requests and meet all state and federal requirements related to claims denials, which we communicate to physicians by fax and to Enrollees by mail. Enrollee denial letters include details on how to request an appeal.

Appeals Management

UnitedHealthcare has an internal team of reviewers responsible for resolving appeal requests according to state and Federal guidelines. We deploy a two-tiered process: the first level of review is conducted by UnitedHealthcare's staff Clinical Pharmacist. In many cases, our Clinical Pharmacist is able to make a decision on the request based on new information received with the appeal request. In the event the employed Clinical Pharmacist is unable to overturn the denial based on new information or additional clinical insights, the case is forwarded to an external Independent Review Organization (IRO).

UnitedHealthcare contracts with MCMC, LLC for the administration and determination of Enrollee appeals of denials that our Clinical Pharmacist is unable to overturn. MCMC holds national accreditation from URAC and is an Enrollee of the National Association of Independent Review Organizations.

(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);

UnitedHealthcare's prior authorization program manages the appropriate use of high-cost medications and/or highly-utilized therapeutic drug categories that have potential for inappropriate or unsafe use through the development and implementation of clinical evidence-based guidelines.

The prior authorization program that UnitedHealthcare manages for the Empire Plan Prescription Drug Program targets drugs that may be subject to inappropriate clinical use. Please refer to **Section 3., Exhibit T.,** for a list of drugs subject to prior authorization for the Program.

The prior authorization program has been in place for the Program since inception of the contract with UnitedHealthcare beginning January 2008. Since contract inception, 32 new medications have been added to the program.

The table below provides an overview of prior authorization activity by year for the Program:

Empire Plan Prescription Drug Program Prior Authorization Statistics				
Year	**Reviews Requested**	**Denials**	**Approvals**	**Approval Rate Pct**
2008	[redacted]	[redacted]	[redacted]	[redacted]

Empire Plan Prescription Drug Program Prior Authorization Statistics				
Year	Reviews Requested	Denials	Approvals	Approval Rate Pct
2009	[redacted]	[redacted]	[redacted]	[redacted]
2010	[redacted]	[redacted]	[redacted]	[redacted]
2011	[redacted]	[redacted]	[redacted]	[redacted]

(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;

The prior authorization process includes the following key steps:

1. A prior authorization request is received via telephone, fax, mail or our Web site.
2. A pharmacy technician performs the initial review of the request.
3. If the request falls outside the established guidelines, a clinical pharmacist reviews the request and contacts the prescriber if additional information is required.
4. After the request is approved or denied, the technician or pharmacist enters the information into our prior authorization system, which automatically generates written correspondences to both Enrollee and provider.

For non-urgent prior authorization requests, the average turn-around time is three Business Days once all of the complete prior authorization information has been received from the prescribing physician. Urgent prior authorization requests are generally completed within one business day once all of the complete prior authorization information has been received from the prescribing physician.

(e) The methods you utilize to measure program effectiveness *(Do not include any reference to specific monetary savings).*

UnitedHealthcare Pharmacy analyzes trends for both drugs and drug categories. We look at specific claims reporting for targeted drugs, including percent of approvals and denials. We also review clinical literature to determine if criteria changes are needed.

As confirmed in the reporting section of this proposal, we will provide a Prior Authorization report that will provide information regarding the medications subject to PA under the Program and corresponding approval and denial data.

(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.

UnitedHealthcare's goal is to minimize disruption and support Enrollee continuity of care throughout the transition period.

We will facilitate the electronic transfer of existing prior authorizations to support optimal transition of the Program's benefit program to our platform. We have extensive experience with transitioning claims information—including current prior authorizations—to our systems. Through multiple client conversions, we have gained significant expertise managing multiple large and complex client conversions.

Furthermore, our familiarity with various claims processing systems allows us to write custom programs to convert prior authorization data to our system. This is crucial in the implementation process to continue key clinical and cost containment initiatives and minimize Enrollee dissatisfaction. Our thorough implementation process includes weekly teleconferences, project plans and resolution strategies. This process successfully transitions all facets of our client's benefit plans.

Our system is capable of grandfathering prior authorizations. We typically recommend the use of system-based contingency edits or overrides that allow "grandfathering" of certain benefit design parameters.

In 2008, UnitedHealthcare smoothly and successfully transitioned the Programs prior authorization data from a prior vendor. Moving forward, we will continue this success with transitioning claims information, including current prior authorizations, to our systems. Additionally, we will provide prior authorization specific training points to the OptumRx Call Center in order to assist the Enrollee during the transition process.

(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.

UnitedHealthcare will send letters to the Enrollee and/or Physician to advise of the outcome of the prior authorization review. For prior authorization approvals, a letter confirming approval of benefit coverage is sent. This letter also states the duration of the approval.

Please refer to **Section 3., Exhibit R.,** for a list of drugs subject to prior authorization for the Program along with general approval period timeframes.

(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.

Confirmed. UnitedHealthcare will send letters to the Enrollee and/or Physician to advise of the outcome of the prior authorization review and the Enrollee's appeals rights. Enrollee denial letters include details on how to request an appeal.

We support timely review of prior authorization requests and as we do today, UnitedHealthcare will work with the Programs and the New York State Department of Financial Services to meet all state and federal requirements related to claims denials, which we communicate to physicians by fax and to Enrollees by mail.

As the plan sponsor of the Empire Plan Program Part D plan, UnitedHealthcare will work closely with the DCS to replicate, to the extent possible, the plan design and flexible formulary of the DCS Program in accordance with all applicable federal laws, implementing regulations, together with guidance, instruction and other directives from CMS as well as generally accepted Medicare Part D pharmacy benefit practices.

Specifically, for the Empire Plan Medicare PDP EGWP, appeals and grievances will be administered according to the CMS requirements for turnaround time and appeal procedures.

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

Confirmed.

(2) A fully integrated point of service system capable of enforcing the

Programs' benefit design features.

Confirmed.

b. <u>Required Submission</u>

(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.

Concurrent DUR is a drug utilization review system designed to support the pharmacy networks' professional role in providing quality of care to the Programs' Enrollees. Concurrent DUR is the evaluation of drugs at the point of service for potential therapeutic complications such as drug-to-drug interactions or therapeutic duplications. This program also reviews for plan design parameters such as the frequency of prescription refills.

The Concurrent DUR program monitors drug prescribing and dispensing at the point of service, and alerts the dispensing pharmacist to possible drug concerns. The Concurrent DUR program performs online, real-time analysis at the point of service regardless of whether dispensing occurs at retail or at the mail service pharmacy. During this process, UnitedHealthcare's clinical database compares the incoming prescription to Enrollee demographics and checks for potential clinical conflicts that may result if the prescription is dispensed.

Please see the response to Question 3 below in this section for a complete listing of Concurrent DUR edits. Concurrent DUR screens for, but is not limited to, the following:

- Therapeutic duplication, duplicate prescription and refills that occur too soon.
- Age or gender related contraindications.
- Over- or under-utilization, including minimum or maximum daily dose, minimum or maximum quantity per prescription, period or days' supply.
- Drug-drug interaction.
- Drug-allergy contraindications.

- Drug-diagnosis caution screening.
- Drug-inferred health state (pregnancy) screening.

As the plan sponsor of the Empire Plan Program Part D plan, UnitedHealthcare will work closely with the DCS to replicate, to the extent possible, the plan design and flexible formulary of the DCS Program in accordance with all applicable federal laws, implementing regulations, together with guidance, instruction and other directives from CMS as well as generally accepted Medicare Part D pharmacy benefit practices.

Qualification of our Clinical Team

Our Clinical Services team is responsible for oversight of our Concurrent DUR program. UnitedHealthcare has an entire clinical management department that is responsible for the daily operation, development, and implementation of our Concurrent and Retrospective DUR programs. The Clinical Services department is led by Dr. Brian Solow, OptumRx Chief Medical Officer, who is board certified in Family Practice. Dr. Solow leads a team of pharmacists and program managers responsible for improving the medical appropriateness and cost-effectiveness of the prescribing physician and Enrollee drug utilization decisions.

Our Clinical Services department includes an array of experienced staff:

- Physicians
- Clinical pharmacists
- Pharmacy technicians
- Business analysts
- Project managers
- Biostatisticians
- Researchers

These professionals skillfully implement, manage and monitor utilization management, quality of care, and other clinical programs.

This team provides the clinical research and detailed Program analyses to support management of the Programs' benefit program.

Clinicians

The clinicians in our department are registered pharmacists who have completed residencies in areas such as general pharmacy, inpatient clinical pharmacy, and managed care. Before working with us, a pharmacist must have at least two years of previous pharmacy experience. As a group, our clinicians have extensive experience in drug topic research; they are also adept with the development of:

- Drug-related clinical data
- Quality improvement and disease related interventions
- Prescribing guidelines

Our pharmacists participate in an orientation program during which time we carefully monitor their work quality. The pharmacists attend specific training classes relating to newly employed programs.

Analysts

The business analysts on our team have extensive experience in database development and statistical analyses.

Our statisticians (health data analysts) hold doctoral and masters graduate degrees in statistics, public health and epidemiology. They have extensive analytic experience in health outcomes research, involving pharmacoeconomic retrospective database analysis, statistical modeling, and clinical program evaluation analysis. The analysts are proficient in several statistical and data analytic software packages including SAS version 9.1, SAS Enterprise Miner, Epilog, Microsoft Excel and Access.

The Clinical Services department taps into the latest industry research and information sources. The team works with our National Pharmacy & Therapeutics Committee and other external clinical consultants to deliver expert clinical guidance and support. The Clinical Services staff also works directly with the account management team and other company departments to ensure appropriate support of each client's benefit program. This collaboration includes joint analysis of the client's utilization data and development of recommendations for programs that optimize health outcomes and reduce overall plan costs.

(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.

UnitedHealthcare uses SXC Health Solutions Corporation's RxCLAIM online transaction processing software to interface with pharmacies and administer our concurrent DUR strategies. Through this system, we use Medi-Span's Cross-Check Drug-to-Drug Interaction database. This database contains thorough and comprehensive automated interaction and Enrollee consultation data for the indication of potential drug interactions. We have also enhanced our DUR detection abilities by adding internally developed criteria for identifying drug interactions or other clinical issues in real time.

SXC Health Solutions Corporation has proprietary ownership of the software; however, UnitedHealthcare has purchased a license and regular upgrades from them to maintain the most current functionalities.

(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;
(ix) drug-pregnancy interaction; and
(x) compliance with FDA approved drug utilization guidelines.

UnitedHealthcare's claims processing system includes Concurrent DUR capabilities. DUR messages received by the pharmacist at the point-of-service can be used to inform and work cooperatively with the prescribing physician to arrive at the optimal mode of therapy for the Enrollee.

The Concurrent DUR Program screens all retail and mail service pharmacy prescription claims at the point of service before the drug is dispensed. The Concurrent DUR system screens each prescription against the Enrollee's prescription drug history. The system checks for inappropriate drug prescribing and utilization, as well as potentially dangerous medical implications or drug interactions.

Our system's Concurrent DUR edits result in either informational messaging to the Pharmacist or a claim rejection as a result of a system hard or soft edit. A soft edit can often be overridden by the Pharmacist upon receiving the appropriate override code from the Pharmacy Help Desk. A hard edit cannot be overridden by the Pharmacist at the point of service without an authorization from the Pharmacy Help Desk based on the Programs' benefit plan design and criteria. Hard and soft edits alert the dispensing pharmacist of a potential severe adverse drug event and blocks the claim from adjudicating. The pharmacist must interface with the prescriber.

Enrollee or the Pharmacy Services Group before the claim can be adjudicated and the medication dispensed. Informational messages serve as warnings to the dispensing pharmacist, whereby the pharmacist views and evaluates after exercising professional judgment. Messaging edits are "information only" messages and will not block a claim from adjudicating.

The following standard Concurrent DUR edits can be performed by the claims processing system:

Minimum/Maximum Dosage

These edits identify prescriptions being filled for less than the

minimum recommended daily dose or greater than the maximum daily dose. An edit is sent to the pharmacist to warn that the prescribed dose may not effectively treat the Enrollee's medical condition. The Maximum daily does is administered as a hard edit at the point of sale.

Refill-Too-Soon

The Refill-Too-Soon edit screens for early refills. This hard edit monitors for same prescription number, same drug and same day supply to avoid billing of duplicate claims. This edit is read across the GPI and NDC level on prescriptions that are run on different dates of service.

UnitedHealthcare recommends a "refill-too-soon" edit that identifies attempts to submit the same prescription number within a 75 percent timeframe from the date of service of the prior prescription. For example, for a 90-day supply mail service prescription, an Enrollee must wait 67 days before refilling the prescription.

We can adjust this timeframe to accommodate the Programs' objectives and will work with the Programs during the implementation process to identify timeframe customization requirements.

Duplicate Rx

The Duplicate Rx edit will augment the Refill-Too-Soon edit described above.

The Duplicate Rx edit essentially differs from the Refill-Too-Soon edit in that this edit looks across pharmacy ID numbers, prescription numbers, or NDC numbers which share the same exact GPI number. This hard edit results in a rejection of the claim.

The Duplicate Rx edit helps to curb over-utilization and the use of multiple providers. This edit alerts the pharmacy if the prescription being filled was filled recently at the same pharmacy or at another pharmacy, such as the OptumRx Mail Service Pharmacy. The Duplicate Rx edit is applied at the drug GPl level

and identifies claims where the Enrollee is using multiple network pharmacies, including the OptumRx Mail Service Pharmacy, for the same prescription. The Refill-Too-Soon parameters apply to the Duplicate Rx edit.

We will implement our proposed full RTS edit and Duplicate Rx Edit on January 1, 2014 and the edits will be applied to claims with a date of service January 1, 2014 and forward.

Drug/Drug Interaction

These edits identify overlapping claims for potentially interacting drug therapy. Prescriptions are checked against medications active in the Enrollee's profile to determine if the addition of the new medication would result in a potential interaction. If a potential interaction is identified, an informational warning message is generated to alert the dispensing pharmacist. The message cites a potential interaction and indicates the applicable medication(s).

Drug/Allergy and Drug/Medical Condition Interaction

These edits identify drug therapies that may be contraindicated for use in Enrollees with specific allergies or medical conditions. These rules compare claims to Enrollee-specific tables indicating those medications contraindicated for use by the Enrollee due to an allergy or medical condition. The system will also infer a patient's medical condition based on the medications in the patient profile and will trigger an interaction message based on that information. Prescriptions submitted for contraindicated medications generate an informational warning message to the dispensing pharmacist alerting him or her of the reported allergy or medical condition. The pharmacist is then obliged to alert the prescriber to the drug-related contraindication and either obtain approval to dispense the medication, cancel the claim or modify the prescription according to the prescriber's direction.

Allergies and medical conditions are reported through Enrollee profile questionnaires or by the dispensing pharmacist through the NCPDP telecommunications standard, which allows allergy and medical condition information to be entered concurrently or independent of a prescription claim transaction.

Duplicate Therapy

The concomitant therapy rule identifies cases in which two or more medications in the same therapeutic class have been prescribed for the same individual. When concomitant therapeutic regimens are not clinically appropriate, the system generates an informational warning message to the dispensing pharmacist. For example, the concomitant use of NPH insulin and regular insulin does not generate a therapeutic duplication message. However, the concomitant use of two H2-receptor antagonists does generate an informational warning message because there is no known clinical justification for the concomitant use of these agents.

Drug-age Contraindication

These edits identify drugs contraindicated for use by children or older adults. For each prescription claim, the claims system compares the medication and the Enrollee's date of birth to drug-age contraindication tables. Prescriptions that trigger drug-age rules generate an informational warning message to the dispensing pharmacist. For example, a prescription for tetracycline, an antibiotic commonly used to treat acne, for a child less than eight years old results in an informational warning message. Using professional judgment, the dispensing pharmacist may contact the prescriber to discuss the drug-age contraindication and either obtain approval to dispense the medication, cancel the claim or modify the prescription, according to the prescriber's direction.

Drug-gender Conflict

These edits identify drugs contraindicated for Enrollees due to gender. For example, birth control pills should not be dispensed for male Enrollees. For each prescription, the claim system compares the medication and the Enrollee's gender with drug-gender contraindication tables. Prescriptions that trigger drug-gender rules generate an informational warning message. Dispensing pharmacists are obliged to alert the prescriber to the drug-gender contraindication and either obtain approval to dispense the medication, cancel the claim or modify the prescription according to the prescriber's direction.

Drug-pregnancy Contraindication

These edits identify drugs contraindicated for Enrollees who are pregnant, deemed as such either by self-report or by the presence of prenatal vitamins in their profiles. The claim system compares the prescribed medications to the drug-pregnancy contraindication tables. Prescriptions that trigger a drug-pregnancy rule generate an informational warning message. Dispensing pharmacists are obliged to alert the prescriber to the drug-pregnancy contraindication and either obtain approval to dispense the medication, cancel the claim or modify the prescription according to the prescriber's direction.

Compliance with FDA Approved Drug Utilization Guidelines

Compliance with FDA approved drug utilization guidelines does not always fall under Concurrent DUR as disease state information is not required on prescriptions. However, the Concurrent DUR program sends alerts based on drug utilization guidelines such as maximum daily dosages that are higher than recommended, drug-drug interactions and drug-implied disease contraindications.

In addition, messaging for medications subject to prior authorization in order to determine clinical appropriateness or quantity limits occurs at the point of service.

(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?

Please refer to **Section 3., Exhibit S.,** for a listing of the standard NCPDP reject codes. Additionally, as stated above please see a summary of the edits and messaging available from UnitedHealthcare's Concurrent DUR system:

- Drug-drug interaction – informational

- Duplicate therapy- informational
- Drug-allergy/drug medical condition-informational
- Drug-gender conflict-informational
- Drug-age contraindication- informational
- Drug-pregnancy contraindication-informational
- Maximum daily dosing-hard edit
- Refill-too-soon- hard edit
- Duplicate Rx- hard edit

(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.

Below is a description of the refill-too-soon, prior authorization and drug exclusion or limitation edits:

Refill-Too-Soon

The Refill-Too-Soon edit screens for early refills. This hard edit monitors for same prescription number, same drug and same day supply to avoid billing of duplicate claims. This edit is read across the GPI and NDC level on prescriptions that are run on different dates of service.

UnitedHealthcare recommends a "refill-too-soon" edit that identifies attempts to submit the same prescription number within a 75 percent timeframe from the date of service of the prior

prescription. For example, for a 90-day supply mail service prescription, an Enrollee must wait 67 days before refilling the prescription.

We can adjust this timeframe to accommodate the Programs' objectives and will work with the Programs during the implementation process to identify timeframe customization requirements.

Duplicate Rx

The Duplicate Rx edit will augment the Refill-Too-Soon edit described above.

The Duplicate Rx edit essentially differs from the Refill-Too-Soon edit in that this edit looks across pharmacy ID numbers, prescription numbers, or NDC numbers which share the same exact GPI number. This edit results in a rejection of the claim.

The Duplicate Rx edit helps to curb over-utilization and the use of multiple providers. This edit alerts the pharmacy if the prescription being filled was filled recently at the same pharmacy or at another pharmacy, such as the OptumRx Mail Service Pharmacy. The Duplicate Rx edit is applied at the drug GPl level and identifies claims where the Enrollee is using multiple network pharmacies, including the OptumRx Mail Service Pharmacy, for the same prescription. The Refill-Too-Soon parameters apply to the Duplicate Rx edit.

We will implement our proposed full RTS edit and Duplicate Rx Edit on January 1, 2014 and the edits will be applied to claims with a date of service January 1, 2014 and forward.

Prior Authorization

Claims for drugs that require prior authorization will also reject with a hard edit. Prior authorization is an important safeguard both for the plan and the Enrollee, protecting the Program from liability for inappropriate prescription costs and guarding the Enrollee against potentially dangerous drug therapy.

Once a prior authorization request for a medication is reviewed

and approved, an authorization is loaded into the system to allow the claim for the medication to process.

Drug Exclusions or Limitations

Drug exclusion or limitation edits are performed at the point of service through our claims system. The pharmacy is notified at point of service if a medication is excluded or has some other type of limitations, such as quantity limits. The medication will not process unless parameters are within the benefit design.

(5) Describe the methods you utilize to measure Program effectiveness (*Do not include any reference to specific monetary savings).*

We measure the effectiveness of our Concurrent DUR programs by reviewing pharmacy claims data and evaluating the number of drug alerts successfully intervened upon including avoidance of the identified drug therapy issue. System reports relating to performance and trends on our Concurrent DURs will be provided, upon request for monitoring and evaluation.

(6) Describe any other programs the Offeror proposes to provide to administer utilization management on behalf of the Programs.

Utilization management strategies, such as clinical edits, help to control escalating medication costs, decrease inappropriate medication utilization by patients of all ages, and promote appropriate prescribing by physicians. In addition, clinical quantity level limits are designed to assist pharmacy providers in appropriate utilization of medications.

UnitedHealthcare has the ability to implement a variety of quantity level limits on behalf of the Programs. The following is a sample listing of edits that are in place for the DCS Programs today and will be performed by our claims processing system under the new contract period:

- Migraine Medications
- Erectile Dysfunction
- Anti-Influenza Medications

- Narcotic Analgesics

Retrospective DUR Program (Exclusive to DCS)

The DCS Program's current Retrospective DUR Program reviews Enrollee prescription 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 Physicians to drug specific, Enrollee-specific health, safety and utilization issues including potential overuse of narcotics; and

Confirmed.

(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

Confirmed.

(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.

Confirmed.

b. Required Submission

Describe the Retrospective DUR Program that you propose to put in place for the DCS Program including:

Retrospective DUR involves a review of pharmacy or medical claims data to identify Enrollees who may benefit from our clinical interventions. The programs influence physician-prescribing patterns to improve quality of care and cost-savings. The interventions include the following objectives:

- Increase or optimize appropriate use of selected under-utilized medications.
- Reduce overutilization of inappropriately prescribed medications.

Depending on the intervention, program components may include the following:

- Provider letter introducing the specific intervention.
- Provider report of identified Enrollees.
- Provider education specific to the type of intervention.
- Enrollee letter introducing the specific intervention.
- Enrollee education specific to the type of intervention.

As the plan sponsor of the Empire Plan Program Part D plan, UnitedHealthcare will work closely with the DCS to replicate, to the extent possible, the plan design and flexible formulary of the DCS Program in accordance with all applicable federal laws, implementing regulations, together with guidance, instruction and other directives from CMS as well as generally accepted Medicare Part D pharmacy benefit practices.

Specifically, UnitedHealthcare will implement a Retrospective DUR Program for the Medicare Part D EGWP program as approved and in accordance with CMS requirements.

(1) The qualifications of the staff that would perform these reviews;

Our Clinical Services team is responsible for oversight of our Retrospective DUR program. UnitedHealthcare has an entire clinical management department that is responsible for the daily operation, development, and implementation of our concurrent and retrospective DUR programs. The Clinical Services department is led by Dr. Brian Solow, OptumRx Chief Medical Officer, who is board certified in Family Practice. Dr. Solow leads a

team of pharmacists and program managers responsible for improving the medical appropriateness and cost-effectiveness of the prescribing physician and Enrollee drug utilization decisions.

UnitedHealthcare's Clinical Services team is responsible for oversight of our Retrospective DUR program. Our Clinical Services department includes an array of experienced staff:

- Physicians
- Clinical pharmacists
- Pharmacy technicians
- Business analysts
- Project managers
- Biostatisticians
- Researchers

These professionals skillfully implement, manage and monitor utilization management, quality of care, and other clinical programs.

This team provides the clinical research and detailed Program analyses to support management of the Programs' benefit program.

Clinicians

The clinicians in our department are registered pharmacists who have completed residencies in areas such as general pharmacy, inpatient clinical pharmacy, and managed care. Before working with us, a pharmacist must have at least two years of previous pharmacy experience. As a group, our clinicians have extensive experience in drug topic research; they are also adept with the development of:

- Drug-related clinical data
- Quality improvement and disease related interventions
- Prescribing guidelines

Our pharmacists participate in an orientation program during which time we carefully monitor their work quality. The pharmacists attend specific training classes relating to newly employed programs.

Analysts

The business analysts on our team have extensive experience in database development and statistical analyses.

Our statisticians (health data analysts) hold doctoral and masters graduate degrees in statistics, public health and epidemiology. They have extensive analytic experience in health outcomes research, involving pharmacoeconomic retrospective database analysis, statistical modeling, and clinical program evaluation analysis. The analysts are proficient in several statistical and data analytic software packages including SAS version 9.1, SAS Enterprise Miner, Epilog, Microsoft Excel and Access.

The Clinical Services department taps into the latest industry research and information sources. The team works with our National Pharmacy & Therapeutics Committee and other external clinical consultants to deliver expert clinical guidance and support. The Clinical Services staff also works directly with the account management team and other company departments so each client's benefit program is appropriately supported. This collaboration includes joint analysis of the client's utilization data and development of recommendations for programs that optimize health outcomes and reduce overall plan costs.

(2) How you identify and select areas for retrospective review and the methods utilized to inform and educate Physicians;

UnitedHealthcare identifies Enrollees through retrospective analysis of prescription claims data or through a combination of prescription and medical claims data. Based on the examination of utilization and prescribing patterns, as well as medical data integration, we can identify specific Enrollee and provider groups that may benefit from interventions and educational materials via written communications.

Interventions we offer address various clinical issues including, but not limited to, excessive use of narcotics, over- or under-utilization of medications for

specific disease states, drug interactions, inappropriate duplicate therapy, and age-inappropriate therapy. We offer a comprehensive array of educational materials that focus on timely and relevant health topics, such as appropriate medication use, disease management, lifestyle issues, generic drug benefits, and general health tips and advice.

(3) A timeline for these reviews.

The frequencies and timelines of our interventions vary depending on the specific program, and may be conducted daily, monthly, quarterly, or biannually. The Enrollee's physician is typically provided a letter describing the program along with a report of the identified Enrollees. The physician may also receive education materials highlighting current evidence-based recommendations and treatment guidelines. Identified Enrollees typically receive a letter describing the program along with Enrollee-friendly education materials addressing the program intervention recommended. Communications may be provided by mail, fax, or web-posting on the UnitedHealthcare website.

(4) What type of follow-up you conduct after communicating the information to the Physician;

Resolution of drug issues will be monitored and determined from medical or pharmacy claims reviews and provider responses. Subsequent follow-up interventions may be conducted to monitor unresolved issues and new drug therapy problems that arise.

(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);*

UnitedHealthcare's Clinical Analytics team collects retrospective medical and pharmacy claims data as well as patient-reported data (for programs where this information is available) to evaluate patterns that measure the effectiveness of

our retrospective DUR programs. Data evaluation focuses on three components:

- **Clinical Outcomes.** These outcomes measure specific clinical markers (such as blood pressure, cholesterol or blood sugar) or pharmacy utilization patterns (such as medication adherence and persistence).
- **Economic Outcomes.** These outcomes measure both direct costs such as medication costs, and indirect costs, such as decreased productivity.
- **Humanistic Outcomes.** These outcomes evaluate issues like quality of life, the level of physical function a patient has or the perceived satisfaction of the care delivered.

Evaluation of these outcomes components is used throughout the clinical program development cycle to provide the following:

- A baseline measurement
- A post intervention measurement
- A complete post intervention analysis

Based upon this analysis, UnitedHealthcare provides program recommendations to clients. Our clinical programs are developed after careful analysis of current pharmacy and medical use patterns. We measure outcomes of each implemented program to assess the impact of the intervention and determine the need for program enhancements as appropriate. Our pharmaceutical and medical experts measure the impact on total health outcomes by improving the use of recommended medications and associated costs to determine how best to improve patient care.

With the programs we have listed in the table below, we perform an annual statistical analysis of program participants to determine program effectiveness.

Program Name	Analytical Objectives
Geriatric RxMonitor Program	■ Number of Enrollees and their providers identified for intervention. ■ Percentage of Enrollees who resolved their potentially inappropriate medication use.

Program Name	Analytical Objectives
	■ Mean cost-savings per Enrollee included in the intervention.
Polypharmacy Program	■ Number of Enrollees with duplicate therapy. ■ Number of providers identified for intervention. ■ Percentage of Enrollees who resolved any of their duplicate therapy issues following intervention.
Drug Interaction Alert Program (DIAP)	■ Number of Enrollees with potential drug interactions. ■ Number of providers identified for intervention. ■ How many Enrollees resolved their drug interaction issues.
High Utilization Narcotics Program	■ Number of Enrollees with potential inappropriate narcotics use. ■ Number of providers identified for intervention. ■ Percentage of Enrollees who resolved their potentially inappropriate narcotics use.

(6) Whether you currently administer a Retrospective DUR Program for other clients; and

Yes, we successfully administer Retrospective DUR Programs for the majority of our current clients.

(7) The reporting capability for your described program.

UnitedHealthcare offers expert ad hoc reporting solutions through our client management services. Our Geriatric RxMonitoring reporting capabilities provide the following information:

- Characteristics of Targeted Members Identified for the Use of High Risk Medications in the Elderly (sex, age).
- Characteristics of Targeted Members Identified for the Potentially Harmful Drug-Disease Interactions, History of Dementia Group (sex, age).
- Estimated pharmacy cost savings per member per month.

Our Misuse and Abuse program reporting capabilities provide the following information:

- Number of identified cases of potentially inappropriate medication use.
- Characteristics of Targeted Members (sex, age).
- Type potentially inappropriate drug use.

Our Polypharmacy/Duplicate therapy program reporting capabilities provide the following information:

- The number of providers targeted.
- Characteristics of Targeted Members (sex, age).
- Provide percent of cases for members included in the outcomes analysis that resolved any duplicate therapy incident during the measurement period.
- Mean costs for targeted duplicate therapy medications per case indeed in the outcomes analysis. Estimated pharmacy costs savings PMPM.

Our Drug Interaction Alert Program (DIAP) reporting capabilities include the following:

- Program Intervention Period.
- Identification Period (before intervention).
- Measurement Period (after intervention).
- Number of members identified for the intervention.
- Number of members who received the intervention.

- Number of providers targeted.
- Characteristics of Targeted Members (sex, age).
- Type of potentially inappropriate use.
- Number of members who received the intervention and were still enrolled with the plan at the end of the measurement period.
- Estimated pharmacy costs savings per member per month (PMPM).

In addition to the clinical reporting capabilities listed above, OptumRx offers our Standard Reporting Package which includes a wide selection of reports that measure drug utilization patterns. For example, this package—provided quarterly—includes detailed reports on:

- Generic and brand utilization
- Generic substitution rates
- Formulary compliance rates
- Specialty drug utilization rates
- Mail service utilization rates
- Member and provider profiling

In addition, our Online Reporting Tool will allow the Programs to dynamically select report parameters to generate reports at various levels on demand. Through this tool the Programs can track drug utilization by NDC, generic product indicator (GPI), drug class/category, or drug name. By drilling down to the Enrollee and/or physician level, clients can perform their own analyses of drug utilization patterns to identify potential abuse or addiction or other patterns of inappropriate or costly utilization.

UnitedHealthcare Client Management Services are also available to provide ad hoc reporting services. The business analyst and clinical pharmacist assigned to the Programs' account see to all reporting needs, including generation of DUR reports and development of customized utilization analyses. Furthermore, these teams are tasked with providing timely interpretation of results and strategic solutions for controlling utilization patterns and overall pharmacy and health care costs. Our Annual Summary Report provides

calendar year-over-year data analyses as well as recommendations such as benefit design changes, utilization management strategies and clinical programs to improve safety and promote quality of care for Enrollees as appropriate.

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;

Confirmed.

(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

Confirmed.

(3) Reporting the results of its Physician Education initiatives to the State on a quarterly basis in a mutually agreed upon format.

Confirmed.

(4) The Physician Education Program may not be funded by pharmaceutical manufacturers.

Confirmed.

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:

As outlined within the Retrospective DUR portion of this proposal, UnitedHealthcare has a suite of programs that involve a review of pharmacy and/or medical claims data to identify Enrollees who may benefit from our clinical interventions. The programs influence physician-prescribing patterns to improve quality of care and cost-savings.

The interventions include the following objectives:

- Increase or optimize appropriate use of selected under-utilized medications.
- Reduce overutilization of inappropriately prescribed medications.

Depending on the intervention, program components may include the following:

- Provider letter introducing the specific intervention.
- Provider report of identified Enrollees.
- Provider education specific to the type of intervention.
- Enrollee letter introducing the specific intervention.
- Enrollee education specific to the type of intervention.

As the plan sponsor of the Empire Plan Program Part D plan, UnitedHealthcare will work closely with the DCS to replicate, to the extent possible, the plan design and flexible formulary of the DCS Program in accordance with all applicable federal laws, implementing regulations, together with guidance, instruction and other directives from CMS as well as generally accepted Medicare Part D pharmacy benefit practices.

Specifically, UnitedHealthcare will implement a Physician Education Program for the Medicare Part D EGWP program as approved and in accordance with CMS requirements.

(1) Whether you currently administer a Physician profiling and education program for other clients similar to the Programs;

All of our programs influence physician-prescribing patterns to improve quality of care and cost-savings. UnitedHealthcare successfully administers these programs for the majority of our current clients.

Specifically targeting physician prescribing patterns and included in this suite of programs is a High Utilization Narcotics Program. The High Utilization Narcotics Program identifies Enrollees who may be over-utilizing narcotic analgesics or are potentially seeking narcotic medications inappropriately. The physicians/prescribers of these Enrollees are notified in order for appropriate therapy review.

The High Utilization Narcotics Program is currently in place for the DCS Programs and will continue throughout the new contract term.

(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;

The goal of the High Utilization Narcotics Program is to identify Enrollees with pharmacy claim history that may suggest narcotic abuse. Often, these Enrollees receive narcotic prescriptions from several different physicians without any coordination of care or physician knowledge that another physician or prescriber is also writing these types of prescriptions. In addition, they often obtain prescriptions from several different pharmacies. The physicians/prescribers of these Enrollees are notified in order for appropriate therapy review.

The criteria utilized for identifying Enrollees for this program include:

- Nine or more narcotic prescriptions filled during the quarter.
- Written by three or more physicians/prescribers.
- Filled at three or more pharmacies.

Once an Enrollee is identified, each physician/prescriber that wrote a narcotic prescription during the defined time period is provided with a letter and Enrollee-specific prescription history information to assist in the review of pharmacy utilization. The program also has the capability of limiting an

Enrollee to a single retail pharmacy if the Enrollee is identified in three consecutive quarters.

The letter that is sent to physicians is custom for the Empire Plan and also contains an Empire Plan dedicated toll-free phone number and fax number for physicians to call with any questions regarding the program. All calls received are reviewed and responded to by an Empire Plan dedicated pharmacist.

An example of an Empire Plan specific High Utilization Program Letter is provided as **Section 3., Exhibit V.**

(3) The frequency of your educational efforts;

The High Utilization Narcotics Program is performed quarterly.

(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;

The High Utilization Narcotics Program was implemented for the Empire Plan Prescription Drug Program during the fourth quarter of 2008. Since program implementation, over 4,800 High Utilization Narcotic Program letters have been mailed to physicians. As mentioned above, all calls are responded to by an Empire Plan dedicated pharmacist. Overall program feedback has been positive. Physicians have responded that they appreciate the clinical information provided and find it useful in their practice. The program also provides added value by assisting physicians with identifying Enrollees with drug-seeking behaviors, Enrollees who have altered prescriptions and Enrollees who are seeing multiple physicians and would therefore benefit from coordination of care.

(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

UnitedHealthcare provides an Empire Plan specific High Utilization Narcotics Program Activity and Call Summary report which includes physician feedback from past quarters.

In addition, an Empire Plan specific High Utilization Narcotics Program effectiveness summary is also provided which illustrates changes in utilization that were identified when comparing pre-mailing periods to post-mailing periods.

The overall goal of the High Utilization Narcotics Program is to provide clinical/safety benefits and encourage appropriate use and changes in utilization as necessary.

(6) Whether you will adapt your Physician Education Program standards to meet the Program's needs as specified by the Department.

UnitedHealthcare will continue to adapt the High Utilization Narcotics Program to meet the Program's needs.

Since implementation of program, UnitedHealthcare has provided the DCS with the following program enhancements:

- Custom Empire Plan specific physician letter, including a dedicated toll-free number for physicians to call with questions.
- Empire Plan specific call summary activity and effectiveness reports.

(7) Confirm that the Physician Education program will not be funded by pharmaceutical manufacturers.

Confirmed. UnitedHealthcare does not receive funding from pharmaceutical manufacturers for any of the clinical programs offered to the Programs in our proposal.

<u>Patient Education</u> (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.

UnitedHealthcare will continue to administer the Half Tablet Program for the DCS Programs, however, covered Enrollees in the Medicare Part D EGWP Program will not be eligible for the Half Tablet Program and as part of the implementation of the contract terms for 2014, and UnitedHealthcare will identify and notify EGWP Enrollees of the discontinuation of the Program.

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

(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;

Confirmed.

(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;

Confirmed.

(c) Reports the results of its patient education initiatives to the Department on a quarterly basis in a mutually agreed upon format; and

Confirmed.

(d) The Patient Education Program may not be funded by Pharmacy manufacturers.

Confirmed

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(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;

Confirmed.

(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;

Confirmed.

(c) Provide each Enrollee newly participating in the Half Tablet Program with one tablet splitter, at no charge to the Enrollee; and

Confirmed.

(d) Load a file to transfer current Enrollees with qualifying Prescriptions into the Half Tablet Program as of January 1, 2014.

Confirmed.

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;

UnitedHealthcare successfully administers these programs for the majority of our current clients.

As the plan sponsor of the Empire Plan Program Part D plan, UnitedHealthcare will work closely with the DCS to replicate, to the extent possible, the plan design and flexible formulary of the DCS Program in accordance with all applicable federal laws, implementing regulations, together with guidance, instruction and other directives from CMS as well as generally accepted Medicare Part D pharmacy benefit practices.

Specifically, UnitedHealthcare will implement a Patient Education Program for the Medicare Part D EGWP program as approved and in accordance with CMS requirements.

(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;

All claims are reviewed to identify the need for clinical interventions.

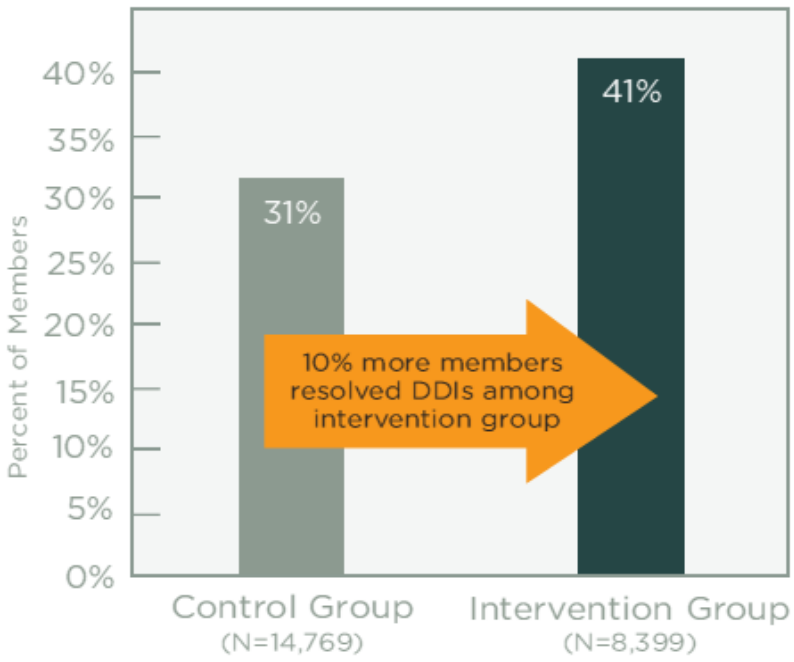
Based on the examination of utilization and prescribing patterns, as well as medical data integration, we can identify specific Enrollee and provider groups that may benefit from interventions and educational materials for the clinical intervention programs we offer.

Interventions we offer address various clinical issues including, but not limited to, excessive use of narcotics, over- or under-utilization of medications for specific disease states, drug interactions, inappropriate

duplicate therapy, and age-inappropriate therapy. We offer a comprehensive array of educational materials that focus on timely and relevant health topics, such as appropriate medication use, disease management, lifestyle issues, generic drug benefits, and general health tips and advice.

(c) The number of educational interventions and the expected Enrollee response rate;

UnitedHealthcare monitors the impact of program communications. For example, UnitedHealthcare tracked the Drug Interaction Alert Program (DIAP) outcomes in more than [redacted] members who received intervention. [redacted]



[redacted]

(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**

UnitedHealthcare's Clinical Analytics team collects retrospective medical and pharmacy claims data as well as patient-reported data (for programs where this information is available) to evaluate patterns that measure the effectiveness of our Retrospective DUR programs. Data evaluation focuses on three components:

- **Clinical Outcomes.** These outcomes measure specific clinical markers (such as blood pressure, cholesterol or blood sugar) or pharmacy utilization patterns (such as medication adherence and persistence).
- **Economic Outcomes.** These outcomes measure both direct costs such as medication costs, and indirect costs, such as decreased productivity.
- **Humanistic Outcomes.** These outcomes evaluate issues like quality of life, the level of physical function a patient has or the perceived satisfaction of the care delivered.

Evaluation of these outcomes components is used throughout the clinical program development cycle to provide the following:

- A baseline measurement
- A post intervention measurement
- A complete post intervention analysis

Based upon this analysis, UnitedHealthcare provides program recommendations to clients. Our clinical programs are developed after careful analysis of current pharmacy and medical use patterns. We measure outcomes of each implemented program to assess the impact of the intervention and determine the need for program enhancements as appropriate. Our pharmaceutical and medical experts measure the

impact on total health outcomes by improving the use of recommended medications and associated costs to determine how best to improve patient care.

(e) Confirm that the Patient Education Program will not be funded by Pharmacy manufacturers.

Confirmed. UnitedHealthcare does not receive funding from pharmaceutical manufacturers for any of the clinical programs offered to the Programs in its proposal.

(2) If proposed, describe the Half Tablet Program for the DCS Program, including:

UnitedHealthcare successfully implemented the Half Tablet Program in September 2008. In collaboration with the DCS, we developed a customized announcement letter with a customized question and answer document. Initially, the announcement letter was sent to all Enrollees who were currently utilizing a medication and strength that was part of the Half Tablet Program. Additionally, on a monthly basis we continued to review claims data and send additional letters to new users of a drug and strength that was part of the Program.

UnitedHealthcare will continue to administer the Half Tablet Program for the DCS Programs, however, covered Enrollees in the Medicare Part D EGWP Program will not be eligible for the Half Tablet Program and as part of the implementation of the contract terms for 2014, and UnitedHealthcare will identify and notify EGWP Enrollees of the discontinuation of the Program.

(a) Confirm which drugs listed in Exhibit II.M will be included in the Half Tablet Program.

Confirmed. UnitedHealthcare has reviewed **Exhibit II.M** and confirm that all drugs listed 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.

The UnitedHealth Group National Pharmacy &Therapeutic Committee has developed the following clinical criteria to determine if a medication should be included in the Half Tablet Program.

(c) Describe in detail the process to identify newly eligible Enrollees for the Half Tablet Program, including timeframes.

On a monthly basis, claim files will be reviewed to identify Enrollees who have filled a prescription for a drug and dosage that is included in the Half Tablet Program. When an Enrollee is identified, UnitedHealthcare will send the Enrollee a customized welcome letter explaining the voluntary Half Tablet Program and a Q&A document that will assist them in understanding how to participate. The customized letter will be subject to review and approval by the DCS.

(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.

Confirmed. A free tablet splitter will be included in the Program. The process to request a free tablet splitter will be included in the Enrollee welcome letter.

Enrollment in the Half Tablet Program is not necessary, and the Program is completely voluntary and should only be done under medical supervision or guidance. The physician or healthcare provider should clearly explain the pill splitting process to the Enrollee and adequately address any questions or concerns that he or she may have.

For drugs that are eligible for the program, the physician can prescribe a dose at twice the desired strength and instruct the Enrollee to take half the tablet. Only drugs in tablet form that can be split are included in the program. When a prescription for a drug included in the Half Tablet Program is submitted for adjudication by either a participating retail pharmacy or the mail service pharmacy and the dose is one-half tablet per day, the copayment will be automatically reduced by 50 percent.

(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.

Confirmed. When a prescription for a drug included in the Half Tablet Program is submitted for adjudication by either a participating retail pharmacy or the mail service pharmacy and the dose is one-half tablet per day, the copayment will be automatically reduced by 50 percent.

NOTE: THE COST OF ALL THE PROGRAMS LISTED ABOVE ARE REQUIRED TO BE IN THE CLAIMS ADMINISTRATION FEE.

<u>Other Safety Related Programs</u>

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. <u>Duties and Responsibilities</u>

Not applicable.

b. <u>Required Submission</u>

(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.

We have offered a valuable and comprehensive suite of programs represented above in our clinical offering. These programs include Prior Authorization, Concurrent DUR, Retrospective DUR, Patient Education and Physician Education.

We will continue to offer the Programs integrated solutions for clinical management and superior clinical care across all the Empire Plan components managed by UnitedHealthcare. The Programs will benefit from the value of integration UnitedHealthcare brings without having to alter the design of the self-insured pharmacy carve-out contract. The following describes how

UnitedHealthcare's total health care approach provides added benefits for the Empire Plan:

Having administered the Empire Plan's medical program over many years, UnitedHealthcare is uniquely qualified to identify and implement synergies to optimize the administration of both the medical and prescription drug programs. While the programs' Account teams will be separate, they will both be accountable to Steven Burdick, the Senior Vice President of Specialty Solutions. This organizational structure will assure that both teams consult and leverage opportunities to benefit both programs.

Our total health care approach includes integrating medical and pharmacy management for better, more effective outcomes, so our pharmacy decisions support overall medical management quality and cost-management. With access to one of the largest integrated databases, we are able to gain real-world insights into how consumers use health care. We link member diagnosis and lab data with pharmacy data to better identify gaps in care, potential therapy problems, and opportunities to promote best practices for more cost-effective care – and a simpler, more consistent experience for Enrollees.

With UnitedHealthcare, the Programs will have a pharmacy benefit program that accesses and leverages the broad health and well-being capabilities of UnitedHealth Group. Our integrated approach allows us to communicate pharmacy messages more quickly and consistently through the Empire Plan network of physicians. Pharmacy messages are combined with medical information, so physicians receive the information they need through the same consistent sources. In addition, the medical directors for the Empire Plan Medical Program and the Optum Disease Management Program are able to engage on pharmacy issues with the Empire Plan network physicians.

Enhancing the Coordination of Care across Program Lines

The Empire Plan Account Management team at UnitedHealthcare participates in a synergy initiative we share with the Empire Plan Behavioral Health and Medical teams. The objective of the initiative is to improve the coordination of care of our Empire Plan Enrollees within each program. We hold a monthly multi-disciplinary meeting to facilitate and enhance education, synergy and management of complex cases with medical, pharmacy and behavioral health attributes. Each team brings expertise to a select group of cases monthly in an effort to improve care and support medication compliance and adherence.

Ideas and suggestions are shared on how to improve the management of the Enrollee's disease state, drug regimen and overall quality of life. Clinical care advocates are then able to take the expert information and suggestions gained during the meetings back with them as they continue to manage the case. The information your Programs' pharmacists provide offers added value to future discussions between the care advocate and the Enrollee and can assist in opening up new avenues of discussion between them which often leads to better compliance and re-enforcement of the importance of taking their medications properly.

The Programs' clinical pharmacists also work in tandem with the disease management team on a program to identify cases of over or under-medication of depression and bi-polar disorders. It is a high-touch program, reaching approximately twenty members per month. The Programs' clinical pharmacists personally reviews the prescription claims history for each selected case and identifies duplicate therapy, non-compliance, and excessive or under treatment of the disease state. The pharmacist then prepare a synopsis of utilization for each Enrollee, shares it with the OptumHealth Behavioral Solutions team and highlights areas for potential discussion between the care advocates and the Enrollees. They look for Enrollees who may benefit from a telephonic outreach or engagement in a program. The care advocates also have the benefit of knowing what medications the Enrollee may need assistance with or encouragement to get back on track taking properly. They also use the information provided by the Pharmacist to encourage Enrollees to reach out to their providers with questions and support.

(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.

The funding source of the clinical programs UnitedHealthcare is proposing above for the Programs is included in our 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 1. 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 percent 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;

Confirmed.

(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;

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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;

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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;

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

(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.

Confirmed.

b. <u>Required Submission</u>

<u>Preferred Drug List Management – General</u>

(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.

Yes. UnitedHealthcare currently maintains and administers plans with three-tier benefit designs utilizing preferred drug lists.

UnitedHealthcare currently administers the DCS Programs multiple formularies.

UnitedHealthcare will continue to leverage the foundation of our fully insured Advantage PDL strategies to meet the Programs PDL requirements. The overall objective of the Empire Plan Flexible Formulary is to provide Enrollees and the Plan with the best value in prescription drug spending taking into consideration the clinical value of the drugs covered, while at the same time limiting disruption. This goal is accomplished by excluding coverage for a small number of drugs, lowering the copay on brand name drugs that provide the best value to the Plan and increasing the copay on other brand name drugs that do not provide a clinical advantage over existing generic and preferred brand name drug alternatives.

The purpose of the Empire Plan Flexible Formulary is to reduce unnecessary costs without impacting clinically appropriate medication options for Enrollees and their physicians. This is accomplished by:

- Excluding coverage for a small number of drugs.
- Placing brand-name drugs that provide the best overall healthcare value to the Plan on the Empire Plan Flexible Formulary Drug List.
- Applying the highest copayment to non-preferred brand-name drugs that provide no clinical advantage over generic or preferred brand-name drug alternatives.
- Providing for a dedicated Clinical Pharmacist to offer necessary Enrollee counseling specifically supporting the Flexible Formulary and its lower cost alternatives.

Certain drugs are excluded under the Empire Plan Prescription Drug Program so that the Plan can continue to provide the best value in prescription drug coverage to all Enrollees under the Plan. Whenever a prescription drug is excluded, therapeutic brand and/or generic alternatives will be covered. By excluding coverage for a small number of drugs, the Empire Plan Flexible

Formulary discourages the use of expensive "me-too" or copycat medications that have been found to provide no significant healthcare advantage and yet are priced significantly higher than competing drugs. Me-too drugs are essentially the same as other drugs in their therapeutic category, with a slight chemical modification that allows the manufacturer to have patent protection and continue to price the medication at a premium.

Our custom formulary process for the Programs has proven extremely successful and we look forward to working with the DCS to further develop and update these PDLs to meet program requirements.

As the plan sponsor of the Empire Plan Program Part D plan, UnitedHealthcare will work closely with the DCS to replicate, to the extent possible, the plan design and flexible formulary of the DCS Program in accordance with all applicable federal laws, implementing regulations, together with guidance, instruction and other directives from CMS as well as generally accepted Medicare Part D pharmacy benefit practices.

(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?

Yes, UnitedHealthcare has a standard three copay level preferred drug list we use for our fully insured book of business.

UnitedHealthcare has been managing pharmacy benefits since 1976. We developed one of the first formularies in the industry, which has evolved into our current Prescription Drug List (PDL) strategy, in place since 2002. Our PDL strategy is unique in the industry, with the highest-value drugs in the lowest tier, regardless of brand or generic status. We assign prescription medications a copayment tier based on an evaluation of clinical, economic/financial and pharmacoeconomic evidence. This strategy engages the consumer by aligning Enrollee cost share with the total health care value of the drug.

We have an Advantage PDL and a Traditional PDL. UnitedHealthcare makes changes to the Advantage PDL two times a year with the ability to make other changes as the market conditions warrant. Tier

placement is determined based on the overall value of each medication. Unlike other formulary approaches, we place the highest-value medications in the lowest tier regardless of brand or generic status.

With the Traditional PDL, brand-name drugs can be placed in any tier, and drugs may be moved to lower tiers at any time, based on new evidence. Generic drugs are typically placed on tier one and brand drugs may only be moved to a higher tier one time per year, unless a generic is released.

(b) Do you maintain multiple standard and custom preferred drug lists? Provide a description of the differences.

UnitedHealthcare has two standard PDLs, the Advantage PDL and the Traditional PDL. However, benefit requirements can create differences in the PDL for a specific customer depending on factors such as coverage requirements, exclusions, etc.

At the core of our standard pharmacy management approach is the UnitedHealthcare Advantage PDL. Our unique ability to drive affordability and access for prescription medications, regardless of their brand or generic status, has become the cornerstone of our Advantage PDL.

The Advantage PDL's capabilities and negotiating leverage with pharmaceutical manufacturers also benefits clients using our Traditional PDL. Many times, we will be able to improve the pricing on drugs without changing the tier based on our PDL capabilities.

Advantage Prescription Drug List

The Advantage PDL uniquely promotes medications with the greatest overall health care value, regardless of brand or generic status. This aligns the copayment level with the overall health care value of the medication and makes the highest value medications more affordable. To determine total health care value, our PDL Management Committee, comprised of members in the highest level of clinical, medical and business leadership within UnitedHealth Group, examines the clinical value, medication cost and health care cost. This analysis supports alignment of our PDL decisions and will not positively

impact pharmacy costs at the expense of total health care costs. To quickly respond to market trends, price changes and new clinical information, we make changes to the Advantage PDL twice a year, on January 1 and July 1.

Traditional Prescription Drug List

While our Advantage PDL offers proven value and far greater cost savings, we do offer a Traditional PDL to meet the diverse requirements of our customers. With the Traditional PDL, like the Advantage PDL, brand-name drugs can be placed in any tier and drugs may be moved to lower tiers at any time, based on new evidence. Generic drugs are typically placed on tier one and drugs may only be moved to a higher tier one time per year (on January 1), unless a generic is released.

We also maintain custom PDLs for our customers. UnitedHealthcare currently administers the Program's three different formulary benefit DCS Program designs that are custom for the Program.

UnitedHealthcare currently administers the Program's custom Traditional Empire Plan PDL, Flexible Formularies and Excelsior Plan PDL. We have provided a copy of the alpha and therapeutic versions of these formularies as **Section 3, Exhibit U** of the proposal response. Our custom formulary process has proven extremely successful and we look forward to working with the DCS to further develop and update these PDLs to meet program requirements.

(c) What is the goal of these alternative preferred drug lists?

UnitedHealthcare maintains alternative preferred drug lists to meet the needs of our various lines of business and to meet our contractual client obligations for PDL composition and plan design.

(d) What role do clients play in the development of your preferred drug lists?

Specific to the Programs' custom Flexible formulary and Traditional PDL, UnitedHealthcare reviews potential formulary changes with the DCS on an annual basis.

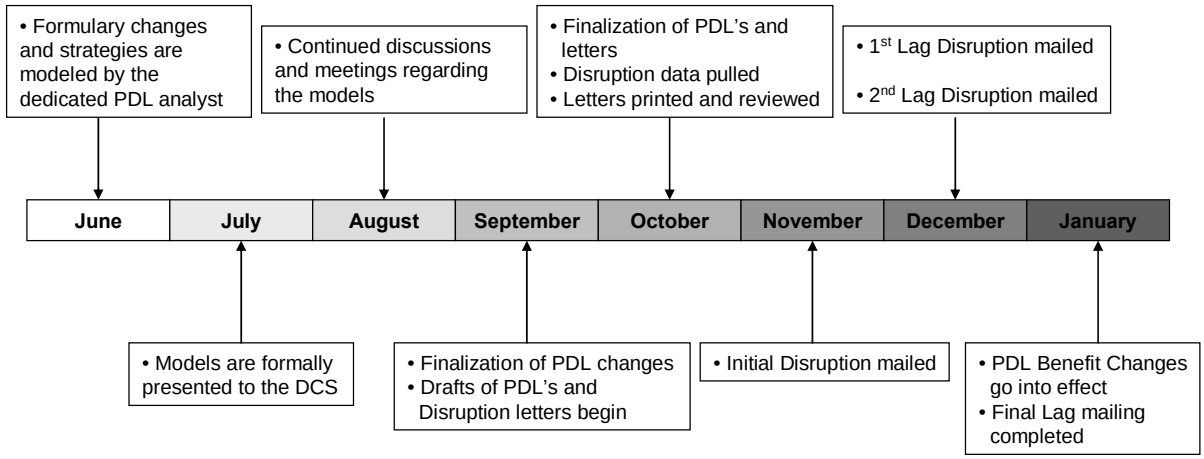
[redacted]

[redacted]

[redacted] nication materials are provided to the DCS for review and approval.

[redacted]

Empire Plan PDL Development Timeline



For UnitedHealthcare's standard PDLs, clients do not directly participate in the development of our PDL; however their benefit designs and other [redacted]

(e) How often are changes made for both additions and deletions?

For the Traditional Empire Plan PDL and the Flexible Formularies, changes are made once a year. Other changes may be made during the year as a result of drugs recalls, the introduction of new drugs, drugs going off patent, and Enrollee safety issues. We use the website as a

mechanism to update and notify Enrollees of changes that are made to the Programs PDLs outside of the annual disruption.

The Excelsior PDL follows the UnitedHealthcare Advantage PDL, whereby PDL changes are made twice a year, on January 1 and July 1. For the UnitedHealthcare Traditional PDL, changes are made once a year on January 1. Other changes may be made during the year as a result of drugs recalls, the introduction of new drugs, drugs going off patent, and Enrollee safety issues.

(f) Are there special considerations for biological and specialty Pharmacy products in your preferred drug list and/or process?

The UnitedHealth Group National Pharmacy & Therapeutics Committee, Pharmacoeconomic Work Group and PDL Management Committee use the same method for evaluating specialty drugs commonly covered under the pharmacy benefit as for other medications considered for our PDL.

(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?

UnitedHealthcare currently administers the Program's Traditional Empire Plan PDL, Flexible Formulary and Excelsior Plan PDL. We have provided a copy of these formularies as **Section 3, Exhibit U** of the proposal response. Our custom formulary process has proven extremely successful and we look forward to working with the DCS to further develop and update these PDLs to meet program requirements. UnitedHealthcare will continue to leverage the foundation of our fully insured Advantage PDL strategies to meet the Programs PDL requirements.

The overall objective of the Empire Plan Flexible Formulary is to provide Enrollees and the Plan with the best value in prescription drug options taking into consideration the clinical value of the drugs covered, while at the same time limiting disruption. This goal is accomplished by excluding coverage for a small number of drugs, lowering the copay on brand name drugs that provide the best value to the Plan and increasing the copay on other brand name drugs that do not provide a clinical advantage over existing generic and preferred brand name drug alternatives.

The purpose of the Empire Plan Flexible Formulary is to reduce unnecessary costs without impacting clinically appropriate medication options for Enrollees and their physicians. This is accomplished by:

- Excluding coverage for a small number of drugs.
- Placing brand-name drugs that provide the best overall healthcare value to the Plan on the Empire Plan Flexible Formulary Drug List.
- Applying the highest copayment to non-preferred brand-name drugs that provide no clinical advantage over generic or preferred brand-name drug alternatives.
- Providing for a dedicated Clinical Pharmacist to offer necessary Enrollee counseling specifically supporting the Flexible Formulary and its lower cost alternatives.

Certain drugs are excluded under the Empire Plan Prescription Drug Program so that the Plan can continue to provide the best value in prescription drug coverage to all Enrollees under the Plan. Whenever a prescription drug is excluded, therapeutic brand and/or generic alternatives will be covered. By excluding coverage for a small number of drugs, the Empire Plan Flexible Formulary discourages the use of expensive "me-too" or copycat medications that have been found to provide no significant healthcare advantage and yet are priced significantly higher than competing drugs. Me-too drugs are essentially the same as other drugs in their therapeutic category, with a slight chemical modification that allows the manufacturer to have patent protection and continue to price the medication at a premium.

Our custom formulary process for the Programs has proven extremely successful and we look forward to working with the DCS to further develop and update these PDLs to meet program requirements.

There are no therapeutic classes that are composed of only non-preferred drugs due to documented evidence of inferior clinical attributes or safety concerns. UnitedHealthcare does not determine the safety of prescription drugs. All drugs on our PDLs must be approved by the FDA. Tier placement decisions are based on clinical evidence and how drugs relate to other products in their therapeutic categories. Clinical safety is part of the overall value calculation.

(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.

Your dedicated UnitedHealthcare Account Team will continue to provide information about the Prescription Drug Program to our internal partners who administer the Medical and Behavioral Health Programs. We have created a unique synergy between the programs that allows us to resolve Enrollee questions about each other's programs through our internal communication program. When an Enrollee calls into one of the other programs and has a question about the Prescription Drug Program, your UnitedHealthcare Account team is contacted either via e mail or our internal communication program for information. If it is a simple question about a copayment, those questions are resolved immediately. If it is a more in depth inquiry, it is sent to your UnitedHealthcare Account team via e mail for research.

[redacted]

[redacted]

(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.

Confirmed. Level 1 and level 2 drugs will be designated as Preferred drugs on both the Flexible Formulary and the Preferred Drug List. When physicians ePrescribe through RX Hub, there is a color coded display that encourages physicians to prescribe the lowest cost alternative; for example, Level 1 drugs are displayed in green, Level 2 drugs are in yellow and most Level 3 drugs are in red. Depending on the level of software purchased by the physician, the copayment may be displayed as well.

The Network Account Managers who visit UnitedHealthcare's participating provider network, also can explain the different levels of prescription drugs, and have direct access to the dedicated UnitedHealthcare Account team for more specific questions. Through this partnership, when necessary, a member

of the UnitedHealthcare Account team will continue to call a participating physician to answer questions about the Program.

(6) Describe the strategy which would be implemented to control Prescription Drug AWP increases.

Price inflation on pharmaceuticals has become a large and unpredictable risk as manufacturers raise prices multiple times a year to make up for lost patents, missed sales targets, and other industry setbacks.

UnitedHealthcare employs a manufacturer contracting strategy for our pharmaceutical manufacturer contracts to include "price protection" terms when applicable. Price Protection allows the manufacturers the ability to take reasonable price increases each year, but caps the net of rebate increase to provide predictability in product pricing.

The ability to obtain price protection on products is related to the ability to manage the category and our associated leverage with the manufacturer to impact market share. For non-contracted products, standard PDL management programs such a supply limits, step therapy and product tiering/exclusion are applied to drive utilization to lower cost/higher value medication options.

[redacted]

(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.

Brand or generic designation does not always determine value of product in market place, yet most PDLs/Formularies are set up to place products in tiers by this status.

UnitedHealthcare monitors the generic drug pipeline to assess Brand for Generic (B4G) opportunities based on the drug category and product utilization. Patent factors such as exclusivity are also assessed as this provides insight into the B4G window of opportunity.

At product launch, competition remains limited during a specified time period where exclusivity has been granted versus "floodgate" expirations in which numerous competitors are expected, thereby limiting the potential opportunity. Essentially, UnitedHealthcare looks for specific opportunities where we expect a generic to be at a premium to the contracted brand due to authorized generics, exclusivity, settlements, and etc. This allows us to support the use of the lowest net cost product. Post the exclusivity period, more manufacturers will begin to manufacturer the generic product, competition increases, and the cost of the generic will drop considerably.

The B4G strategy provides an opportunity to place a Brand product on a lower level than its generic equivalent. This strategy would be in place upon the release of a new generic product, as in most cases, the cost of the new generic product is very close to the cost of the Brand product. In addition, when a generic equivalent is first launched, the manufacturer of the Brand product will lose market share and eventually lose profit on the Brand product. Because of this, UnitedHealthcare is able to negotiate continued rebates on the Brand product and encourage continued prescribing of the Brand product, by placing the Brand on a lower level than the generic equivalent and implementing point of service messaging on the higher tier generic. This financial arrangement is a win-win strategy. It results in a net lower cost of the Multisource Brand product for our clients and Enrollees saves because their copayment is reduced. From a prescribing perspective this is beneficial to Enrollees, as they can continue taking the Brand product at a lower copayment for a defined period of time.

Specifically for the Empire Plan, UnitedHealthcare implemented a B4G strategy for Lipitor in December 2011. Through collaboration with the DCS, customized letters were sent announcing the Program, and in early May 2012, an additional custom letter will be sent to all Enrollees currently taking Lipitor to advise them that their dispensing pharmacist will begin substituting atorvastatin (generic Lipitor) beginning June 1, 2012. The B4G strategy implemented for the DCS Programs was very beneficial in controlling costs, even for a short period of time when the new generic product for Lipitor was launched.

UnitedHealthcare has experience in successfully implementing this strategy on several drugs across its book of business. This strategy was successfully implemented for the following products:

Adderall XR	Protonix
Astelin Select	Oral Contraceptives
Effexor XR	Skelaxin
Lipitor Zegerid	

Our implementation strategy combines negotiations with the Brand manufacturer, notification letters to Enrollees, and most importantly a strategic point of service messaging at the pharmacy to require the pharmacist to enter an override code when dispensing the generic product.

(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.

[redacted]

[redacted]

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;

We assign prescription medications a copayment tier based on an evaluation of clinical, economic/financial and pharmacoeconomic evidence. This strategy engages the consumer by aligning member cost share with the total health care value of the drug.

UnitedHealthcare considers all clinical, pharmacoeconomic and financial factors of prescription medications to determine tier placement for medications. Our PDL maintenance and review process is performed by the following committees:

UnitedHealth Group National Pharmacy and Therapeutics Committee

Our UnitedHealth Group National Pharmacy and Therapeutics (NP&T) Committee reviews and evaluates all clinical and therapeutic factors that affect prescription medications. The NP&T Committee's evaluation includes, but is not limited to, a prescription medication's place in therapy, its relative safety and efficacy, and any programs or limitations that should be applied to its utilization.

The NP&T Committee meets at least quarterly to review new medications for the PDL and to evaluate new clinical evidence for existing products. Additionally, it reviews and approves all of our clinical programs and policies to ensure they are consistent with

published evidence. It forwards the analyses to our PDL Management Committee, which uses the information to determine tier placement for each medication, as well as clinical programs to be applied to coverage.

Pharmacoeconomic Work Group

The Pharmacoeconomic Work Group evaluates available medical and outcomes literature, as well as cost-consequence and budget impact models where available. For example, the Pharacoeconomic Work Group analyzes each medication's potential cost offsets, such as decrease in hospital stays or emergency room visits, or added costs associated with the medication, such as lab tests or other subsequent medical utilization due to side effects. A summary of findings and recommendations is presented to the PDL Management Committee for use in determining PDL tier placement of a medication.

Economic Review

Our clinical and financial experts evaluate evidence related to a medication's acquisition cost (pricing), rebates and market factors (for example, market share penetration). Included in the analysis is a review of cost factors relative to equivalent or similar medications to treat a specific condition.

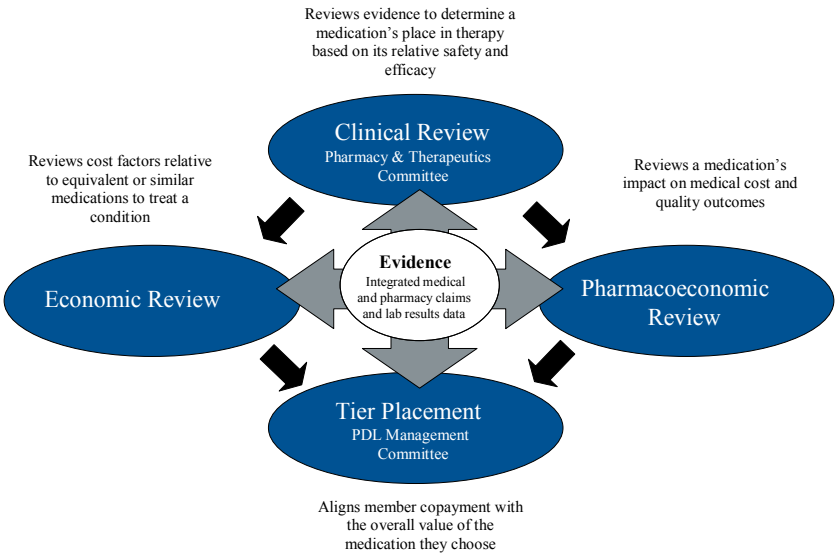
PDL Management Committee

The PDL Management Committee consists of eight voting members, who are high-level medical and business executives across UnitedHealth Group. The PDL Management Committee meets at least five times annually to evaluate the following:

- Clinical recommendations of the NP&T Committee
- Evidence provided by the PE Work Group
- The medication's net cost
- Supporting financial analyses
- Market dynamics

Based on this evaluation, they determine the total health care value of each medication, and, in turn, the tier placement of new and existing medications on our PDL.

The following graphic illustrates our PDL development process:



Participation of UnitedHealth Group senior medical leadership in our PDL decisions means that our pharmacy decisions are made with an understanding of their effect on medical costs and outcomes. It is our goal that our pharmacy decisions do not negatively impact overall medical management strategies and cost. Additionally, our medical

leadership considers the impact of our PDL decisions on the physician community and leverages our relationships with the network physicians to encourage compliance. Through our review process, we also contact medical specialty societies to gain insight and perspective on our strategies. Finally, our medical leaders promote our pharmacy decisions to their respective areas within UnitedHealth Group for consistency across all areas of health care.

(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;

The UnitedHealth Group NP&T Committee shall have 15 to 20 members, a majority of whom are external members. Members shall have clinical expertise that spans a broad range of clinical specialties and sub-specialties.

Our P&T Committee members represent specialties including by not limited to: Pediatric Hematology/Oncology, Geriatrics, Psychiatry, Infectious Disease, and Gastroenterology.

The Chief Medical Officer for OptumRx chairs the UnitedHealth Group NP&T Committee and shall appoint voting and non-voting advisory members to the committee. The chair has the authority to designate a co-chair from among the remaining members.

External committee members are selected based on specialty, expertise and geographic and demographic penetration. Recommended candidates for external membership are first submitted to a Membership Subcommittee by the chairperson, another committee member, or a member of our staff. These recommendations are made in consultation with recognized external experts as necessary. The Membership Subcommittee reviews all recommendations and submits candidates to the full committee for a final vote.

Each committee member serves a one-year term that that may be automatically renewed for successive one-year terms upon mutual agreement between the member and the NP&T Committee

chairperson. There are no term limits and members may serve on the committee for an indefinite number of terms.

External members may not be employed by UnitedHealth Group or any of their affiliates. Representatives of pharmaceutical, biologic or device manufacturers and other product sponsors are excluded from membership and from attending committee meetings.

All NP&T Committee members must sign a consultant agreement, updated annually, addressing confidentiality, non-coercion and conflict of interest. Our conflict of interest requirements include the following:

- Member shall abide by, attest to and make all required disclosures under our Conflict of Interest Policy.
- Member may not have a material conflict of interest relationship (as defined in our Conflict of Interest Policy).
- Member may not use or disclose information relating to our business for personal profit or advantage, or divulge confidential information in advance of official authorization of its release.
- Any member who violates any of the above conflict of interest requirements may be asked to resign from service on the NP&T Committee.

A conflict of interest is defined as any business or personal involvement by a member that may in any way conflict with or appear to conflict with such member's responsibilities to the NP&T Committee or which might otherwise compromise his/her independence. Examples of potential conflicts of interest that could disqualify a member from serving on the NP&T Committee include, but are not limited to:

- The holding, directly or indirectly, of a material financial interest by a member or his/her close family member, in any outside entity or concern that is related in any manner to a product currently under evaluation, or that could be under evaluation, by the NP&T Committee.

- Compensation paid to the member or his/her close family member from a pharmaceutical, biologic or device manufacturer for activities or relationships where such compensation constitutes a significant source of the member's or his/her close family member's annual income.
- Member or his or her close family member providing directive, managerial or consultative services to any outside concern that is related to any product under evaluation by the NP&T Committee

The PDL Management Committee consists of eight voting members, who are high-level medical and business executives across UnitedHealth Group. Five of the members are MDs and all of the members have significant experience in managed care.

(c) The role of net cost in this determination;

Evaluation of financial considerations and net cost are one aspect of the process in determining tier placement of drugs on our PDL. Clinical and pharmacoeconomic (medical cost offset) evidence is also considered in making all decisions. Each of these evidence domains is given due consideration and appropriately impacts any and all financial decisions.

(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;

Our review process is governed by established policy and procedure Charters for the NP&T Committee and PDL Management Committee.

(e) Whether the process is governed by formal procedures to ensure sound clinical examination resulting in quality pharmaceutical care;

Our PDL decision making process is governed by charters as well as formal policies and procedures for all tiering/benefit program decisions. Clinical evaluation for all programs is provided by our NP&T Committee. Clinical information reviewed during the process includes, but is not limited to, FDA approved product labeling, clinical trial information, peer-reviewed articles, national treatment guidelines, manufacturer's information, consultation with leading experts in the field, and quality of life studies when appropriate.

(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;

Minutes are kept and recorded for meetings of our NP&T and PDL Management Committees. While the meeting minutes themselves are privileged and confidential, we will provide a summary of decisions made by the PDL Management Committee upon request.

(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;

The NP&T Committee meets at least quarterly to review new medications for the PDL and to evaluate new clinical evidence for existing products. Additionally, it reviews and approves all of our clinical programs and policies to ensure they are consistent with published evidence. It forwards the analyses to our PDL Management Committee, which uses the information to determine tier placement for each medication, as well as clinical programs to be applied to coverage.

Complete class reviews are conducted as needed. New drugs are evaluated against other drugs in the class or as new clinical,

pharmacoeconomic and/or economic information become available. For example, upon the release of a new medication or when a brand loses its patent and generics are introduced to the market, we typically review the entire therapeutic class for potential PDL tier changes or opportunities to negotiate better discounts with manufacturers.

The Committees will also meet outside of scheduled meetings in order to quickly react to new clinical, financial or pharmacoeconomic information and changing market conditions.

The Empire Plan's Traditional Empire Plan PDL and Flexible Formularies will be updated annually, in accordance with the Programs' requirements.

(h) Whether the process is different for innovative new therapies than for therapies that already have a competitive alternative; and

Our NP&T and PDL Management Committees evaluate new and innovative therapies in a manner consistent with any other medication administered on an outpatient basis. Review is based on clinical, financial and pharmacoeconomic evidence, which in turn determines tier placement on our PDL.

(i) The conditions that would cause a drug's preferred, non-preferred, or excluded status to change and several recent examples.

Our NP&T and PDL Management Committees review all appropriate and available evidence in determining a drug's place in therapy and subsequent tier placement. Conditions that might prompt an evaluation of a drug's tier status include such things as price adjustments, availability of new brand or generic alternatives, new clinical or pharmacoeconomic information or new indications; for example:

- Lipitor was down tiered to Tier 1 beginning in the fall of 2011 as part of the brand for Generic (B4G) strategy adopted by the DCS Programs.
- Tricor was excluded as competing products such as Antara and Lipofen offered additional value upon the exclusion.
- Asmanex, Alvesco and QVAR are brands that were down tiered to tier one.

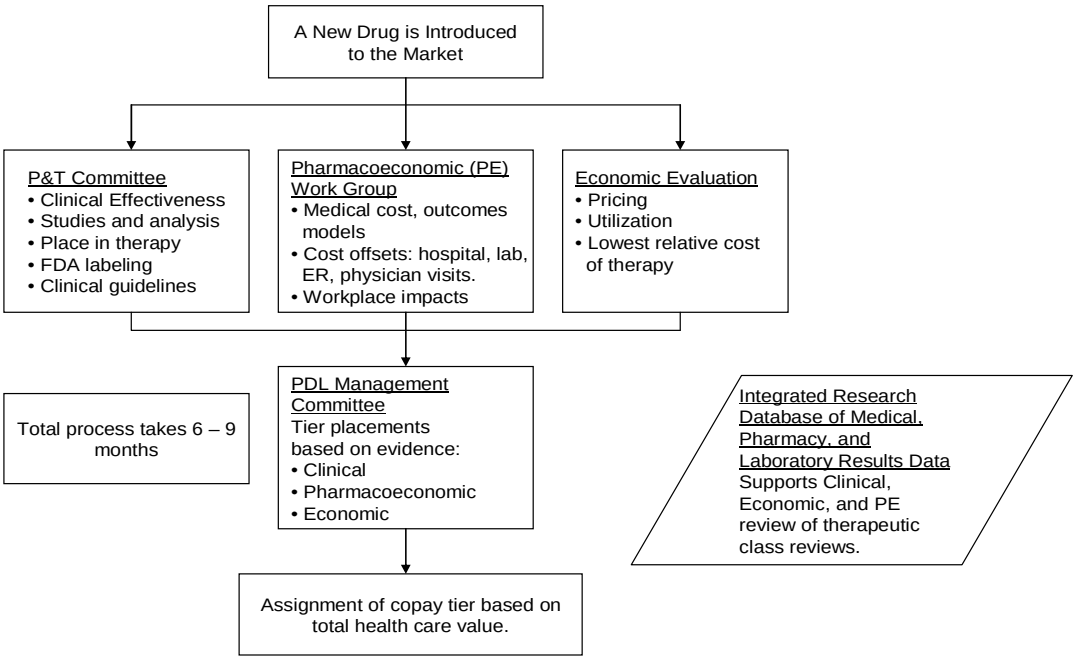
(2) Describe the type of analysis you would perform when a Preferred Brand Drug is being considered for movement to a Non-Preferred Brand Drug list and vice versa.

UnitedHealthcare reviews medications based on clinical, economic and pharmacoeconomic evidence, which in turn determines tier placement on our PDL.

An overview of what is reviewed within these components is listed below:

- Clinical: Review of FDA label, current guidelines, clinical studies/analysis and expert opinion. Assess options within the category and the medication's fit within the product category/categories. Assessment of available clinical programs to ensure appropriate use if applicable.
- Economic: Market dynamics within the category, current market share, utilization, pricing, etc. Assessment of available management capabilities and the ability to drive share to lowest cost brand or generic options in the category. Assess current and future contracting implications and pricing dynamics.
- Pharmacoeconomic Evaluation of medical cost and outcomes modeling, cost offsets, and Enrollee level utilization patterns.

(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?

UnitedHealthcare places drugs in copayment tiers based on an evaluation of clinical, economic and outcomes evidence.

For the Empire Plan's Traditional PDL, generics are placed on Level 1, representing the lowest copayment option. For the Empire Plan's Flexible Formularies, generics are placed on Level 1, representing the lowest copayment option, unless the Brand name counterpart is excluded. In such case, the generic equivalent may also be excluded.

When a new generic drug becomes available, it will be placed on Level 1 on the Empire Plan's Traditional PDL. For the Flexible Formularies, when a new

generic drug becomes available, it will be placed on Level 1, unless the Brand name counterpart is excluded. In such case the generic equivalent may also be excluded.

For the Enhanced Flexible Formulary, a brand-name drug may be placed on Level 1 or excluded and the generic equivalent placed on Level 3 or excluded. The placement may then be revised mid-year when such changes are advantageous to the Empire Plan.

(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.

Unlike our competitors' traditional formulary approach, our Advantage Prescription Drug list (PDL) strategy assigns tier status based on the overall health care value of the medication. That means that certain brand-name medications may be placed in Tier 1, offering member's affordable and effective treatment options, while some generic medications may be placed in Tier 2 or Tier 3 reflecting their relative therapeutic and economic value to our customers and members. Copayment tiers are assigned to medications based on an evaluation of clinical, economic and pharmacoeconomic evidence. We encourage the use of the highest-value medications by placing them in the lowest tier regardless of brand or generic status. When generics are placed in Tier 2 or Tier 3 we continually monitor the price of those generics over time and will move them to a lower tier when the price of the generic justifies lower-tier placement.

[redacted]

[redacted]

[redacted]

(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.

DCS Program

Certain drugs on the UnitedHealthcare PDL may be excluded from coverage in accordance with the applicable benefit design. For example, many standard benefit plans exclude coverage for certain medications for which there are medications with therapeutically-equivalent over-the-counter (OTC) alternatives or medications with same active ingredient or modified active ingredient to other covered prescription medications.

UnitedHealthcare does not make the decision to exclude medications from benefit coverage lightly. While we understand that exclusions can be disruptive, they can be necessary, especially in situation where medications offer no additional health care value over other options in the class. By excluding certain prescription drugs, we are often able to negotiate more aggressive discounts or higher rebates for drugs intended to treat the same condition. This approach results in a lower overall net cost for the medication class while maintaining affordable options for Enrollee.

The ability to exclude a medication from coverage provides an incentive for manufacturers with an excludable product to contract aggressively or risk fully losing their position in the market to their competitors. Additionally, exclusion allows UnitedHealthcare to leverage other aggressive terms (price protection, supply limits, and etc.) to establish long-term security if we choose to accept contracting rather than implementing exclusion. Further, exclusion of a competitor product provides incentive to remaining products within the

category to contract aggressively to provide further incentive to exclude one of their competitors.

The Empire Plan's Flexible Formulary and the Excelsior PDL both contain drugs excluded from the benefit plan design. Drugs may be excluded in situations in which there are medications with therapeutically-equivalent OTC alternatives or medications with same active ingredient or modified active ingredient to and therapeutically equivalent to other covered prescription medications. Medications that are currently excluded for the Flexible Formulary are provided on **Section 3, Exhibits U** and medications that are currently excluded for the Excelsior PDL are provided on **Section 3, Exhibit U**.

(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.).

UnitedHealthcare's NP&T and PDL Management Committees evaluate all prescription medications administered on an outpatient basis following the same process. This includes drugs classified as "biotech," "specialty," "me too," and so-called "lifestyle" products. Review is based on clinical, financial and pharmacoeconomic evidence, which in turn determines tier placement on our PDL.

We define a "me too" drug as a new drug that has been slightly modified from its original version by the manufacturer and offers little or no additional clinical value—for example, making the medication an "extended release" version, offering a different dosage form or combining two medications to make a new one. Our NP&T Committee, Pharmacoeconomic Work Group, and PDL Management Committee follow the same process to evaluate all prescription medications. Their review is based on clinical value, medication cost and health care cost to determine overall health care value and ultimately, tier placement of a medication.

"Me too" drugs provide us the opportunity to negotiate with manufacturers to lower the overall net costs for the therapeutic class.

UnitedHealthcare's strategy and process for evaluating and determining the appropriate PDL designation for PPI's and Statins are described below:

- PPI medications are used to treat ulcers, heartburn and reflux. It is a crowded therapeutic class with multiple options including brand, generic and OTC medications. Due to the market dynamics of this widely utilized category of medications, UnitedHealthcare implemented cost effective clinically appropriate PDL strategies to manage this class of medications.

(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.

To continue providing affordable access to prescription drugs, UnitedHealthcare has developed an Exclude at Launch Program. This program delays PDL coverage for new medications that may offer little or no additional health care value until a full evaluation can be completed.

The PDL Management Committee includes a medication in our Exclude at Launch Program if it:

- Includes the same active ingredient, is a modified version or is a derivative of an existing medication.

- The new prescription medication belongs to a class in which other prescription medications have been excluded from benefit coverage based on therapeutic equivalence to an over-the-counter medication.

[redacted]

(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.

UnitedHealthcare's line extension policy is the first step to managing follow-on and combination products. When a new product is launched it is reviewed to determine the following:

- If the patent differs from its parent product.
- Is the cost per day the same as its parent product.

If the new product meets those criteria it will roll into coverage as a line extension. However, if the product does not meet those criteria it rolls into

Exclude at Launch and subsequently UnitedHealthcare's PDL review process. Combination drugs basically are evaluated in the same manner when considered for placement on the PDL. Two specific examples of combination products that were evaluated and then excluded from coverage under the benefit plan design as a result of our PDL process are:

- Caduet is a combination of amlodipine (generic Norvasc) and atorvastatin (Lipitor). Amlodipine and Lipitor were both preferred on the 2009 Flexible Formulary and the combination product was excluded.
- Treximet is a combination of prescription naproxen and sumatriptan (generic Imitrex). Naproxen and sumatriptan were both preferred on the 2009 Flexible Formulary and the combination product was excluded.

(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.

UnitedHealthcare's business model is founded on clinical efficacy and overall healthcare value eliminating conflict with the clinical and financial interests of the Programs. Pharmacoeconomic and cost-effectiveness data are integral to the Prescription Drug List (PDL) decision-making process, which is based on the evaluation of a medication's total health care value.

Our Pharmacoeconomic Work Group evaluates available medical and outcomes literature, as well as cost-consequence and budget impact models. For example, the Pharmacoeconomic Work Group analyzes each medication's potential cost offsets such as a decrease in hospital stays or emergency room visits, or added costs associated with the medication, such as lab tests or other subsequent medical utilization due to side effects of taking the medication. Along with a financial analysis of each medication relative to equivalent or similar medications, a summary of findings and recommendations is forwarded to the PDL Management Committee for use in determining PDL tier placement of a medication.

Examples of therapeutic classes where pharmacoeconomic data impacts decisions include:

- Statin medications for lipid lowering
- Acute migraine pain therapies
- Migraine episode prophylactic therapies
- Asthma controller medications
- Rheumatoid arthritis therapies
- Psoriasis therapies

Further, it is our goal that our pharmacy decisions do not negatively impact overall medical management strategies and cost. The participation of UnitedHealth Group senior medical leadership in our PDL decisions means that our pharmacy decisions are made with an understanding of their impact on the medical plan.

Our alternative to a traditional formulary focuses on engaging and supporting consumers, lowering total net costs, and addressing total health care value—all while preserving access, quality and choice for consumers.

Although the DCS Programs are being administered on a self-insured basis for the contract period beginning 2014-2018, upon continued contracting with UnitedHealthcare for the DCS Programs prescription drug benefit management philosophy, the DCS Programs will benefit from UnitedHealthcare's "fully insured" view when managing prescription drug benefits. Additionally, the DCS Programs will continue to be supported by the experienced PDL Management groups that have evaluated and shepherd the Program through the implementation of the Flexible Formulary.

(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.

Specifically for the Programs' PDLs; Avapro and Diovan are non-preferred currently and expected to go generic in 2012. Lexapro was a non-preferred

brand name product before the release of its generic competition just within the last month. Additionally, these products are on the third tier for UnitedHealthcare's Advantage PDL as well.

UnitedHealthcare monitors the generic pipeline as we do product/category reviews in the context of the current PDL status. If a generic is expected to be released, its impact on the category and its potential opportunity for the B4G strategy will be assessed. Placement of competing generics does not impact the rebates on existing contracted brands, however as generics enter the market it can prompt a category review of all products depending on the expected impact.

If a brand product is determined to offer limited value thus warranting current Tier 3 or Exclusion status, its impending generic does not necessarily mean additional value exists. At the time of launch the generic will be assessed to determine if it offers sufficient value relative the rest of the category before its tier placement is determined. If the generic is in its exclusivity period it will likely offer no more value than its existing parent product relative its competitors in the category which will commonly be reflected in tie placement on the Advantage PDL.

Additionally, brand AWP inflation prior to the launch of the generic is another reason that managing specifically toward a patent date can be problematic as manufacturers often aggressively increase prices as the life cycle of a product nears its end. While at some point in the future the cost of the generic may be very inexpensive and warrant lower tier placement, the last 18 months of brand life as well as the first 6 months of an exclusive generic bring significant cost risk.

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;

Confirmed.

(2) Providing NYSIF with a list of therapeutic categories routinely excluded from coverage;

Confirmed.

(3) Agreeing that the Offeror does not and will not accept payments from drug companies to promote specific products;

Confirmed.

(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;

Confirmed.

(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,

Confirmed.

(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.

Confirmed.

b. <u>Required Submission</u>

(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;

[redacted]

[redacted]

UnitedHealthcare will work with NYSIF regarding medications subject to prior authorization and the necessary Enrollee communication process.

(2) Provide in electronic format, preferably Excel, a list of therapeutic categories you routinely exclude from coverage;

[redacted]

(3) Confirm that you do not and will not accept payments from drug companies to promote specific products;

UnitedHealthcare will accept rebate revenue from drug manufacturers on behalf of the NYSIF Program claims utilization and pass any pharmaceutical manufacturer revenue to the Program under the terms of the contract with NYSIF. Rebates will be available to the NYSIF Program under UnitedHealthcare's core formulary and the requirement that the accepted NYSIF PDL is posted and available on the NYSIF website.

(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;

Confirmed.

(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,

Confirmed.

(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.

Confirmed. UnitedHealthcare will provide NYSIF with an electronic file of all formulary drugs including dosages, NDC numbers and GPI numbers. We will work with NYSIF to determine the frequency of this report.

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?

UnitedHealthcare closely monitors FDA and drug manufacturer actions including drug withdrawals, market withdrawals, product discontinuation and significant prescribing information changes. The procedures we follow for drug withdrawals are clearly defined and focused on protecting Enrollees from continued use of potentially harmful drugs. We can easily and quickly identify Enrollees and physicians affected by a product withdrawal, because pharmacy claims are included in our reporting database.

The mail service pharmacy immediately discontinues dispensing the affected drug. Additionally, for Class I withdrawals as well as select Class II, Class III and voluntary recalls or withdrawals, we may send letters regarding the withdrawal to physicians who prescribed the impacted medication as well as

Enrollees who have recently filled a prescription for the withdrawn medication.

Recall from the Market

To maintain member safety when drug recalls occur, we review recalls and voluntary withdrawals immediately to determine appropriate action.

We provide communication and outreach to Enrollees and physicians affected by Class I drug recalls within 15 calendar days of the FDA notification. For Class II, III drug recalls and voluntary drug withdrawals, communication and outreach to affected members and physicians occurs within 30 calendar days of the FDA notification.

In addition, we identify and mail letters to Enrollees who filled a prescription and to physicians whose patients filled a prescription within:

- 90 days for a maintenance drug.
- 30 days for a short-term use drug.

The above are minimum look-back periods. Adjustments will be considered based on the specific drug being recalled or withdrawn.

EXAMPLE:Darvocet Products

UnitedHealthcare took a multi-faceted approach to managing the market withdrawal of propoxyphene and its combination products, which included the following:

- We tracked the FDA information that ultimately led to product withdrawal.
- We communicated the withdrawals to impacted Enrollees and their physicians.
- We provided information to our field staff and our customers.

If there is a refund or reimbursement available from the manufacturer as a result of a withdrawal or recall of a drug from the market, UnitedHealthcare will make this reimbursement is available to the Program.

(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.

OptumInsight, a division of UnitedHealth Group, will make the National Recovery Program (NRP) available to the State of New York. The NRP provides access to identify pharmaceutical overpayment cases that may be based on allegations such as patent infringement or anti-trust theories of recovery. Services will be performed based upon Optum's proprietary and confidential Procedures, Standards and Practices.

[redacted]

In cases involving national providers or when the total recovery potential is in excess of $50,000, and it appears that the State of New York would have exposure in the case, OptumInsight will notify the State of New York, through the dedicated UnitedHealthcare strategic account executive, of matters with

recovery potential. Potential recoveries may involve State of New York-specific overpayments or participation by the State of New York in a group recovery action in which OptumInsight presents the health care provider or supplier with total paid claim figures from multiple payers. OptumInsight agrees to comply with all HIPAA privacy regulations with respect to client claim information.

If the State of New York is among a group of OptumInsight clients, and agrees to participate in the recovery case, the State agrees to cooperate with the interest of the group. OptumInsight's obligation is to ensure an opportunity to participate in recoveries on the terms agreeable to the largest number of Customers, which the State of New York may decline to accept. UnitedHealthcare will credit the Program within [redacted] of receipt of the refund by OptumInsight.

OptumInsight will notify the State of New York, through the NYS dedicated Account Management team, of matters with recovery potential.

[redacted]

UnitedHealthcare will credit the Program within thirty (30) days of receipt of the refund by OptumInsight.

Section 2. Required Exhibits

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Sonja D. Blanks

Title: Associate Director, Reporting – Empire Plan Prescription Drug Program

Relationship to Project: As the Associate Director of Reporting, Sonja is dedicated to the Empire Plan Prescription Drug Program and is responsible for all internal and external financial, ad hoc and contractual data reporting and analysis. Additionally, Sonja manages prospective and retrospective audit activities between the Insurer, Pharmacy Benefit Manager and the Department of Civil Service and Office of State Comptroller.

EDUCATION

Institution & Location	Year Conferred	Discipline
SUNY Empire State College	2001-2003	Completed coursework in Healthcare Management
Columbia-Greene Community College	1991-1992	Completed Coursework in Individual Studies

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2008-Present	UnitedHealthcare	Associate Director, Reporting
2005-2008	Empire BlueCross BlueShield	Account Executive, Empire Plan Prescription Drug Program
2002-2005	Express Scripts	Senior Account Manager, Empire Plan Prescription Drug Program
2001-2002	Express Scripts	QA/Client Relations Coach, Empire Plan Prescription Drug Program
1999-2001	Express Scripts	Customer Service Assoc, Empire Plan Prescription Drug Program
1994-2000	St. Peter's Hospital	Pharmacy Technician
1990-1994	CVS/Pharmacy	Pharmacy Technician

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Sonja has over 21 years experience within the pharmacy field, including 4 years in the retail pharmacy setting, 5 years in the hospital pharmacy setting and 12 years in pharmacy benefits management and reporting on both the Insurer and Pharmacy Benefit Manager sides of the business. Sonja has worked with the Empire Plan Prescription Drug Program in a number of roles of increasing responsibility for more than 11 years with expertise in the areas of plan design administration, claims processing and pricing, enrollment management, reporting and pharmacy claims audits.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Scott VanDerWerken

Title: Client Service Manager

Relationship to Project: As the Client Service Manager for UnitedHealthcare, Scott will serve as a liaison between DCS and the PBM. Scott will reseach and respond to questions and will provide guidance on answering inquires from DCS, unions, and Enrollees. In addition, Scott will offer suggestions to the team on managing the PBM to achieve desired results, while making sure that the PBM is meeting the contractual obligations set forth in the RFP, and contracts between UnitedHealthcare and the PBM.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
State University of New York at Albany Albany, NY	BA	2000	Psychology

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2007 – Present	UnitedHealthcare National Accounts Empire Plan Prescription Drug Program	Client Service Manager
2006 – 2007	Empire Blue Cross Blue Shield Empire Plan Prescription Drug Program	Reporting Analyst
2000 – 2006	Express Scripts Empire Plan Prescription Drug Program	Corporate Reporter

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Scott has over 12 years of experience working on the Empire Plan Prescription Drug Program in a variety of roles. Scott started his relationship with the Program in 1999 in the mail order prescription fulfillment department at Express Scripts, later transitioning to customer service where he assisted enrollees with their questions regarding the Program. Scott then transitioned to the role of Corporate Reporter at Expreess Scripts where he was responsible claims data analysis, quality assurance, and performance guarantee reporting. Currently Scott is Client Service Manager for the Empire Plan Prescription Drug Program at UnitedHealthcare. In addition to his regular duties as a Client Service Manager, Scott is responsible for oversight of all aspects of eligibility, the New York State project plan management, and representing the Program at New York State employee union, particpating agency/employer, and retiree meetings.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Paula Gazeley Daily, R.Ph.

Title: Strategic Client Executive

Relationship to Project: As the Strategic Client Executive (SCE) for UnitedHealthcare, Paula is responsible for the leadership and direction of staff and management activities associated with the Empire Plan Prescription Drug Program. Paula serves as the point of contact for all internal and external business partners involved in the administration of the Empire Plan Prescription Drug Program. This includes leaders from NYS management and leaders from the functional areas of UnitedHealthcare and OptumRx, all of whom involved in reaching solutions for the Empire Plan Prescription Drug Program, the New York State Health Insurance Program (NYSHIP) and NYSIF.

Paula is responsible for managing the Pharmacy Benefit Management services provided by OptumRx. She is also is responsible for insuring that all contractual obligations are performed and meet the standards of the contract between UnitedHealthcare and the DCS.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Albany College of Pharmacy, Albany, NY	B.S. Pharmacy	1989	Pharmacy

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2007 – Present	UnitedHealthcare National Accounts	Strategic Client Executive, Empire Plan Prescription Drug Program
2005 – 2007	Empire Blue Cross Blue Shield	Assistant Vice President,

		Empire Plan Prescription Drug Program
2000 – 2005	Express Scripts	Sr. Account Director, Empire Plan Prescription Drug Program
1996 – 2000	Express Scripts	Director, Clinical and Mail Service Operations Empire Plan Prescription Drug Program
1995 – 1996	Express Scripts	Clinical Operations Pharmacist, Empire Plan Prescription Drug Program
1994-1995	Express Scripts	Mail Service Pharmacist, Empire Plan Prescription Drug Program

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Paula has more than 23 years of pharmacy expertise which includes both retail and managed care pharmacy experience. Paula has worked with the Empire Plan Prescription Drug Program for more than 18 years beginning as a mail service pharmacist in 1994. Paula is dedicated to the Empire Plan Prescription Drug Program and is responsible for the leadership and direction of all management activities associated with the Program. Paula has direct access to all Senior Management at UnitedHealthcare and OptumRx to assist with the overall operation of the Program. Paula reports directly to Steven Burdick, Senior Vice President of Specialty Client Group at UnitedHealthcare. Paula is also responsible for the direct oversight of the Empire Plan Prescription Drug Program services provided by OptumRx and works in concert with UnitedHealthcare's PBM to insure the contract is executed and adhered to in accordance with contract terms.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Nick Gunderson

Title: Senior Financial analyst

Relationship to Project: Dedicated analyst to the State of New York account, Nick is responsible for modeling initiatives, as well as creating rebate and drug utilization reports. Nick will work with the accounting teams to validate reports and ensure what goes into the ledger supports the contract. This position works with the PDL Manager, in creating formulary savings models. Nick will also show actual savings, after the changes have been implemented.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
St. John's University, Collegeville MN	Bachelor of Arts	2009	Accounting

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2011-present	UnitedHealthcare Pharmacy	Senior Financial Analyst
2009-2011	UnitedHealthcare Pharmacy	Financial Analyst

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Nick has three years of Pharmacy experience working specifically at UnitedHealthcare Pharmacy. During this time, Nick has supported the State of New York account as well as the State of Georgia account. He has also worked on several other initiatives throughout UnitedHealthcare Pharmacy. Nick will model benefit changes for other populations, assist in RFP requests, and lead meetings to further understand pharmacy data. Nick reports to Abigail Yueh, Manager of Pharmacy Analytics.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Myrene Santos

Title: Actuary, UnitedHealthcare National Accounts

Relationship to Project: Provides actuarial analyses, support and oversight of the Empire Medical and Prescription Drug programs.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Connecticut	MS	1995	Actuarial Science
University of the Philippines	BS	1991	Mathematics

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2007 – Present	United Healthcare National Accounts	Actuary, Nat'l Accounts
1995 – 2007	Guardian Life Insurance Company of America	Associate Actuary
1991-1993	University of the Philippines	Instructor

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Myrene has over 17 years of actuarial experience, 15 of which have been in the health insurance industry. In the 6 years with UnitedHealthcare, Myrene has been providing actuarial and plan design consulting work for UnitedHealthcare's National Accounts clients including pricing, valuation, risk analysis, plan design analysis and projections, and product development responsibilities. Since 2008, Myrene has been the actuary for Empire's medical and prescription drug programs. Her responsibilities for both products include claim projections, reserve analysis, trend analysis and projections, benefit pricing, and risk analysis. She had similar actuarial, financial and product development responsibilities at the Guardian Life Insurance Company of America, with focus on small group medical insurance including prescription drugs. Myrene is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Michael Matteo

Title: Chief Growth Officer, Optum Health and Executive Sponsor to the NYS Prescription Drug Program RFP

Relationship to Project: Responsible for overall sales strategies with a particular focus on large complex clients.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
The College of Holy Cross Worcester, MA	BA	1989	Economics
Columbia University New York, NY			Executive Management Program

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
Present	Optum Health	Chief Growth Officer
1997 – 2012	UnitedHealthcare	Sr. Vice President, CEO
1994 – 1997	Physician's Health	Senior Underwriter
1989 – 1994	Travelers Insurance	Account Manager

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Previously, Michael led all business development efforts for UnitedHealthcare focusing on large, multi-site employers and delivering tailored health benefit solutions. Michael joined UnitedHealth Group in 1997 as a strategic account executive and has personally worked with customers such as General Electric and Accenture. He was able to focus on his passion for modernizing the health care system when he transitioned to a product development role and helped design and launch our innovative consumer-driven products.

Prior to joining to UnitedHealthcare, Michael began his career at Traveler's Insurance Companies serving in a variety of positions including claims manager, underwriter, client service manager, financial analyst and sales. From 1993 to 1997, Michael was employed at Physicians Health Services, serving as an underwriting director and senior account executive.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Mary Beth Juron, RPh

Title: Clinical Pharmacy Manager, Empire Plan Rx Program

Relationship to Project: As the Clinical Pharmacy Manager for the Program at UnitedHealthcare, Mary Beth is dedicated to the Empire Plan Prescription Drug Program and is responsible for all Flexible Formulary and Traditional PDL related enrollee and physician correspondence and consultation. Mary Beth is also responsible for the Specialty Pharmacy Program, the Narcotics Utilization program, and acts as a clinical resource for the Program's account management team at UnitedHealthcare and DCS.

The Clinical Pharmacy Manager also assists Dana Canning, RPh, with her duties as Clinical Account Director for the Empire Plan Prescription Drug Program.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Albany College of Pharmacy	BS	1989	Pharmacy

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
Sept 2011- present	UnitedHealthcare	Clinical Pharmacy Manager Empire Plan Rx Program
Jul 1999- May 2011	Express Scripts	Staff Pharmacist/Clinical
Apr 1991- Jun1999	Merck-Medco Rx Services	Staff Pharmacist/All Depts.
Jul 1989- Apr 1991	Hannaford Bros. Co.	Staff Pharmacist/Pt Counseling Task Team

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Mary Beth has been a pharmacist for over 20 years with significant experience in clinical pharmacy as well as retail. At her last two jobs, her responsibilities have centered on clinical programs such as prior authorization, managed care intervention, step therapy and Drug Utilization Review. She has experience in PBM criteria development and contributed to the launch of Merck-Medco's managed care intervention program in 1995. More recently with Express Scripts, she worked as a physician and patient counselor.

As Clinical Pharmacy Manager for the Empire Plan Prescription Drug Program, Mary Beth will be able to draw upon much industry expertise to develop clinical and plan design enhancements that will provide additional savings and the clinical oversight that does not require collective bargaining for NYS. These may include drugs considered for Prior Authorization, criteria updates, PDL strategies, quantity level limits and specialty drug knowledge.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Susan V. Maddux, Pharm.D., BCPS

Title: Chief Pharmacy Officer

Relationship to Project: As Chief Pharmacy Officer for UnitedHealthcare, Susan is responsible for clinical content of the programs impacting the pharmacy benefit and oversees patient safety and quality related programs for UnitedHealthcare Pharmacy.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Illinois College of Pharmacy	PharmD	1987	Pharmacy
University of Illinois College of Pharmacy	BS Pharm	1981	Pharmacy

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
October 2009 – current	UnitedHealthcare	Chief Pharmacy Officer
April 2007 – Sept 2009	UnitedHealthcare	National Director of Pharmacy
Aug 2000 – March 2007	UnitedHealthcare	Director of Pharmacy
January 1999 – August 2000	Health Partners of the Midwest	Director of Clinical Services/ Pharmacy
October 1996 – December 1998	Group Health Plan	Director of Pharmaceutical Serv.
May 1991 – September 1996	Group Health Plan	Clinical Pharmacy Coordinator
June 1987 – April 1991	Univ of Illinois	Clinical Supervisor of Pharmacy
August 1983 – June 1987	Univ of Illinois	Clinical Pharmacist, Transplant
June 1981 – August 1983	Univ of Illinois	Staff Pharmacist

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Susan has been involved in the development of Prescription Drug Lists/formularies and clinical programs impacting pharmacy benefits for the last 21 years. She has chaired, co-chaired or been a member of Pharmacy and Therapeutics Committees during this entire time. Susan has extensive experience working with physicians, other health care professionals and patients in delivering the right pharmaceutical care. She also works directly with our clients and develops custom initiatives to manage their pharmacy utilization. Susan spent 10 years in an academic hospital-based clinical practice setting delivering clinical pharmacy services to patients. She reports directly to the Chief Executive Officer of the UnitedHealthcare Pharmacy division but works closely with physicians and medical directors across UnitedHealthcare. Susan is a Board Certified Pharmacotherapy Specialist.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Lida R. Etemad, Pharm.D., M.S.

Title: Vice President, Pharmacy Management Strategies, UnitedHealthcare Pharmacy

Relationship to Project: UnitedHealthcare Pharmacy strategist

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Southern California Los Angeles, CA	M.S.	2002	Pharmaceutical Economics and Policy
North Dakota State University, Fargo, ND	Pharm D.	2000	Pharmaceutical Sciences
North Dakota State University, Fargo, ND	B.S.	1998	Pharmaceutical Sciences

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
01/12 – present	UnitedHealth Group	V.P., Pharmacy Management Strategies
01/11 – 12/11	UnitedHealth Group	V.P., PDL and Clinical Program & Outcomes Strategy Development - Pharmacy
03/10 – 01/11	UnitedHealth Group	V.P., PDL and Clinical Program Development Pharmaceutical Solutions
06/07 – 03/10	UnitedHealth Group	Sr. Director, PDL Development Pharmaceutical Solutions
11/05 – 06/07	Ingenix Inc.	Director, PDL Development and Support
01/05 – 11/05	Ingenix Inc.	Manager, Pharmacy Analytic Services
09/02 – 12/04	Ingenix Inc.	Researcher, Economic and Health Outcomes

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Dr. Etemad has been with UnitedHealth Group since 2002, where she initially conducted pharmacoeconomic research in the Economics and Outcomes Research group of Ingenix, later joining the Pharmacy Analytic Strategies department that provides analytic support for UnitedHealthcare Pharmacy. In 2007, Dr. Etemad moved to UnitedHealthcare Pharmacy in a

strategic development role. Since that time, Dr. Etemad has had increasing responsibilities and is currently responsible for the strategic direction of the Prescription Drug List, Clinical Programs, Health Outcomes Programs, and Pharmacy Network Programs. She has had significant experience with claims data analysis and as well as managing relationships with the pharmaceutical industry – including rebate contracting.

Dr. Etemad received her PharmD from North Dakota State University. Subsequently, she completed a fellowship at the University of Southern California in conjunction with then Pharmacia Corporation and Wellpoint Pharmacy Management. She holds a Masters of Science degree in Pharmaceutical Economics and Policy from USC.

Lida has served as an officer of the American Pharmacists Association, a grant reviewer for the APhA Foundation, an abstract reviewer for APhA and ISPOR, and as an Associate Editor for the Journal of Managed Care Pharmacy. She has been a speaker for AMCP, FMCP, and Institute for International Research educational programs as well as a guest lecturer for the University of Southern California.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Katie Zareski

Title: Client Service Manager

Relationship to Project: As the Client Service Manager for UnitedHealthcare, Katie will serve as a liaison between the DCS and the PBM. Katie will research and respond to questions and provide guidance on answering inquires from DCS, unions, and Enrollees. In addition, Katie will offer suggestions to the team on managing the PBM to achieve desired results, while making sure that the PBM is meeting the contractual obligations set forth in the RFP, and contracts between UnitedHealth care and the PBM.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
The Catholic University of America Washington, DC			Social Work

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2008 – Present	UnitedHealthcare National Accounts Empire Plan Prescription Drug Program	Client Service Manager
2005 – 2008	Empire BlueCross BlueShield Empire Plan Prescription Drug Program	Account Manager
1998 – 2005	NMHCRx	Purchasing Associate

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)
Katie has worked on the Empire Plan Prescription Drug Program since October 2005. Her experience with the Program began in the dedicated Prior Authorization department and has since developed into a client facing position as a Client Service Manager. Katie not only responds to enrollee inquires, but also attends meeting with HBA's and the client. In 2006, while working on the Program, Katie received her certification as a Pharmacy Technician.

As a Client Service Manager, Katie has been involved in all parts of the Program, with her main focus being on PDL development and maintenance, as well as the customized MAC process. With the complexity of the yearly disruptions, Katie employed the services of a local printer to ensure the contract guidelines were upheld. She was also involved in the implementation of the Specialty Pharmacy Program and is instrumental in maintaining the design of the Excelsior Plan.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Jean Meher

Title: Client Service Manager

Relationship to Project: As the Client Sevice Manager for UnitedHealthcare, Jean serves as a liaison between the DCS and the PBM. Jean is responsible for researching and responding to all enrollee and physician correspondence as well as inquires from DCS and unions. She also assist with MAC alerts, disruption mailings and reviewing Enrollee communication materials. Jean attends benefit fairs for the unions as well as coordinates materials for meetings with the DCS.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Schenectady County Community College	AAS	1999	Business Administration

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2009-Present	United Healthcare National Accounts	Client Service Manager Empire Plan Prescription Drug Program
2000-2009	Express Scripts	Data Entry/Eligibility Specialist

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Jean began working with the Program in January 2000. While at Express Scripts, she held operational roles including; date entry, eligibility and paper claims processing. Beginning in April

2009, she assumed a full time role in Account Management at UHC. As a Client Service Manager, Jean responds to Enrollee and physician correspondence, takes calls from HBAs and DCS and also attends benefit fairs and meetings for the Program.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

Name: Greta Redmond, FSA, MAAA

Title: Vice President, Group Retiree Services, Actuarial & Underwriting

Relationship to Project: As lead Underwriter and Actuary for the Group Retiree products of Medicare and Retirement branch of UnitedHealthcare, Greta and her team will support the pricing and renewal work for the Part D Empire Plan in partnership with the extended Empire financial team.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Society of Actuaries	FSA	2000	Healthcare
American Academy of Actuaries	MAAA	1995	Healthcare
St. Olaf College, Northfield, MN	B.A.	1989	Mathematics

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2010 to Present	UnitedHealth Group	VP Group Retiree Services
2002 – 2010	UnitedHealth Group	Principal with R&A/ Ingenix Consulting
2000-2002	Allianz Life Insurance Company	Pricing Actuary - Self Insured Book
1989-2000	Fortis Benefits Insurance Company	Actuary

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Greta is a healthcare actuary with 20+ years of experience working as a pricing, reserving, trend analytics, and product development activities, working exclusively in the Medicare arena with Employer Group Coverage since 2010. Greta works with large groups retiree coverages for their Part D and Medicare Advantage products to customize plans and help creatively solve business needs while making sure CMS compliance remains paramount. Our Medicare and Retirement Part D team leverages Healthcare reform's new opportunities for cost effective management of drug coverage. Before joining the Medicare and Retirement team, Greta worked to consult with Commercial and Medicare health plans to forecast and manage both medical & pharmacy trends. Greta also served on the Actuarial Review Board for the Ingenix Health Technology Pipeline that forecasts the new drug and medical technologies impacts on cost and utilization trends.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Dirk McMahon

Title: Chief Executive Officer, OptumRx

Relationship to Project: Responsible for overseeing UnitedHealth Group pharmacy benefit management (PBM) programs, including pharmacy network, mail service, specialty pharmacy and Diabetes ActiveCareSM services.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Notre Dame South Bend, Indiana	M.B.A.	1985	Finance
Marist College Poughkeepsie, New York	B.S.	1982	Finance

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
12/11 – Present	OptumRx	Chief Executive Officer
12/06 – 11/11	UnitedHealthcare Benefit Operations	President and CEO
9/85 – 4/03	Northwest Airlines	Head of Airport Operations

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Dirk joined UnitedHealthcare in 2003, holding various management positions in Information Technology, Operations and Finance. Prior to his current position, he served as president and CEO of UnitedHealthcare Benefit Operations. Before joining UnitedHealthcare, Dirk was head of airport operations worldwide for Northwest Airlines for 19 years.

Dirk received a Bachelor of Science degree in Finance from Marist College and a Masters in Business Administration (M.B.A.) in Finance from the University of Notre Dame. He serves on the board of directors for Bridging, a non-profit organization in Minneapolis that provides families and individuals transitioning out of homelessness and poverty with furniture and household goods to improve their lives.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Dana Canning, R.Ph.

Title: Clinical Account Director, Empire Plan Prescription Drug Program

Relationship to Project: As the Clinical Account Director for the Program at UnitedHealthcare, Dana is responsible for managing and coordinating all clinical Account Management activities associated with the New York State Empire Plan Prescription Drug Program. Clinical activities include providing clinical program initiatives, communications and formulary oversight. This role also includes serving as a daily clinical information resource for the NYS Department of Civil Service and the Governor's Office of Employee Relations.

The Clinical Account Director also works closely with OptumRx in order to provide the NYS Empire Plan Prescription Drug Program with clinical opportunities, pharmaceutical information, and to ensure that contractual obligations pertaining to clinical functions are met.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Albany College of Pharmacy, Albany, NY	B.S.	1995	Pharmacy

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2007 – Present	UnitedHealthcare National Accounts	Clinical Account Director, Empire Plan Prescription Drug Program
2005 – 2007	Empire BlueCross BlueShield	Clinical Client Relations Director, Empire Plan Prescription Drug Program
2002 – 2005	Express Scripts	Senior Clinical Program Manager, Empire Plan Prescription Drug Program
1998 – 2002	Express Scripts	Clinical Program Manager, Empire Plan Prescription Drug Program

1997 – 1998	Express Scripts	Clinical Operations Pharmacist, Empire Plan Prescription Drug Program
1995 – 1997	Hannaford Food and Drug	Supervising Pharmacist

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Dana has 17 years of pharmacy expertise which includes both retail and managed care pharmacy experience. She has worked with the Empire Plan Prescription Drug Program in various capacities since 1997. Her experience with the Program includes overall clinical program management, formulary oversight and serving as a clinical information resource for the NYS Department of Civil Service and the Governor's Office of Employee Relations.

Dana works closely with the Empire Plan Account Management Team and the Clinical Team at OptumRx to provide clinical opportunities and to ensure that the administrative and operational aspects of clinical programs are met. Dana reports directly to Paula Gazeley Daily, R.Ph. Strategic Client Executive, Empire Plan Prescription Drug Program.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Thomas K. Coy

Title: Underwriting Director, National Accounts - Empire Plan

Relationship to Project : As Director of National Accounts Underwriting for UnitedHealthcare, Tom is dedicated to the Empire Plan and is responsible for all internal and external financial, customer reporting and underwriting functions supporting the Empire Plan Prescription Drug Program.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Russell Sage Graduate School	MBA	1997	Finance
Siena College	BBA	1989	Accounting

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
08/17/2003 – Present	UnitedHealthcare National Accounts	Underwriting Director Empire Plan Prescription Drug Program
05/24/2001 – 08/14/2003	Group Health Inc	Director Gov't Programs
01/01/2000 – 05/21/2001	CDPHP	Mgr Market Research
08/28/1995 – 12/31/1999	CHP/Kaiser Permanente	Underwriting Manager
07/17/1989 – 04/30/1995	Amsterdam Memorial Hospital	Accountant

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Tom has 24 years of healthcare finance experience with over 17 years of health insurance underwriting, pricing and reporting experience. The most recent 9 years at UnitedHealthcare in National Accounts dedicated to the Empire Plan including the Prescription Drug Program since 2008. Responsibilities include all internal and external financial and reporting activities specific to Empire as well as coordinating actuarial activities related to the Empire Plan. Prior to United Healthcare, he worked on a consultative basis with customers including fortune 500 companies, developing plan designs and offering scenarios for their self-funded health insurance programs. Plan designs included development of pharmacy offerings and cost impact of changes made to the pharmacy component. He had oversight responsibility during GHI's PBM conversion and implementation as it related to participation in New York State's Family Health Plus and Child

Health Plus Programs. Actively licensed by the State of New York Insurance Department as a Life, Accident and Health Insurance Agent.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Colleen Gilchrist

Title: Sr. Reporting Analyst

Relationship to Project: As the Senior Reporting Analyst for UnitedHealthcare, Colleen focuses on claims analysis to ensure claims are processing correctly in accordance with the benefit plan design and identifies potential audit issues. When a possible processing error is identified internally through proactive review, Colleen facilitates the global review and adjustment process with the Department of Civil Service and the Pharmacy Benefit Manager. Colleen also works with the Department of Civil Service and the Office of State Comptroller in cases where a processing issue is identified and a claim audit file or report is issued.

Colleen is involved in the production of the quarterly and annual financial statements of experience which detail the financial aspects of the plan and the plans performance. She is also supports the Underwriting team with ensuring accuracy and timely delivery of all contractual client reporting.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Siena College, Loudonville NY	BS	2004	Finance
Hudson Valley Community College Troy, NY	AS	2001	Business Administration

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2008 - Current	UnitedHealthcare National Accounts	Senior Reporting Analyst Empire Plan Prescription Drug Program
2005 - 2008	Empire Blue Cross Blue Shield	Account Manager Empire Plan Prescription Drug Program
2001 - 2005	Express Scripts	Associate Support Specialist Empire Plan Prescription Drug Program

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)
Colleen has over 10 years experience with the Empire Plan Prescription Drug Program working in a variety of roles focusing on different aspects of the Program. Experience includes working in the areas of customer service, claims processing, prior authorization, account management, claim and program audits, and contractual reporting. Colleen is currently licensed by the State of New York Insurance Department as a Life, Accident and Health Insurance Agent.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: A. Andrew Casano, MD

Title: Senior Medical Director Empire Plan Medical Program

Relationship to Project: Clinical Consultant

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Albany Medical College, Albany, NY	M.D.	1968	
Board Certified Internal Medicine and Nephrology			
Villanova University, Villanova, PA	B.S.	1963	

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
1997 – Present	UnitedHealthcare	Senior Medical Director, The Empire Plan
1997 – Corporate Medical Director and Chief Medical Officer United Correctional Managed Care		
1994 – 1996 Corporate Medical Director, Better Health Plan		
1984 – 1996 Senior Vice President for Managed Care and Network Development, Albany Medical Center		
1975 – 1984 Private practice Nephrology		

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Previous experience as clinical leader of pharmacy management for statewide Health Plan.
Experience with physician data sharing and utilization management.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Tom Butera, CPA, MS, MBA

Title: Vice President, National Accounts Underwriting

Relationship to Project: The Vice President of National Accounts Underwriting is responsible for overall oversight of the financial, customer reporting and underwriting functions that support the Empire Plan Prescription Drug Program.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Hartford Hartford, CT	MBA	2000	Management
Georgia State University Atlanta, GA	MS	1994	Accounting
University of Connecticut Storrs, CT	BS	1988	Finance
Certified Public Accountant – State of CT			

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2005 – Present	UnitedHealthcare National Accounts	VP Underwriting
2004 – 2005	Magellan Health Services	VP Finance
2003 – 2004	Konover Properties Corporation	CFO
1997 – 2003	CIGNA	AVP Finance
1994 – 1997	PriceWaterhouse	Senior Auditor
1988 – 1994	GE	Senior Financial Analyst

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Tom has 24 years of financial experience with over 15 years of healthcare and financial risk management experience. Tom has worked on the Empire Plan Prescription Drug Program since 2008. Tom also leads the West Underwriting Region for National Accounts and is responsible for developing underwriting solutions for large National Account Clients in that region. Previously, he held senior roles in National Provider Contracting, Financial Planning and Analysis and Internal Audit.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Dawn Burton

Title: Strategic Service Manager

Relationship to Project: As the Strategic Service Manager at UnitedHealthcare, Dawn will be responsible for all aspects of Account Management relating to the Program. This includes providing consultative services to the Client, composing Enrollee communication materials and Certificate revisions, oversight of the operational units provided by OptumRx and resolving escalated Enrollee inquiries received from the Client.

Currently, Dawn is responsible for the oversight of all current aspects of the Program in accordance with the terms of the contract. This includes oversight of the call center, network management, mail service pharmacy, and specialty pharmacy services.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
SUNY at Oswego	BA	1979	Psychology and Business

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2007 - Present	UnitedHealthcare National Accounts Empire Plan Prescription Drug Program	Strategic Service Manager
2005 – 2007	Empire BlueCross BlueShield Empire Plan Prescription Drug Program	Operations Manager
1993 – 2005	Express Scripts	Call Center Manager Empire Plan Prescription Drug Program
1980 – 1993	Travelers Insurance	Claims Manager

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Dawn has 18 years of experience working on the Empire Plan Prescription Drug Program. Her operational responsibilities included day to day management of the call center, paper claims processing and prior authorization.

Currently, Dawn is responsible for managing and coordinating all Account Management activities in a manner which satisfies the DCS' expectations. Dawn coordinated all aspects of the implementation of the current Program as well as the Specialty Drug Program implementation to insure a smooth Enrollee transition to the Program's Designated Specialty Pharmacy. She also works closely with the contracted PBM and internal partners to insure that the Program is executed in accordance with contract terms.

Empire Plan Prescription Drug Program

BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual.

Name: Steven Burdick

Title: Sr. Vice President, Specialty Client Group

Relationship to Project: Lead UnitedHealthcare Manager accountable for the Empire Plan Pharmacy Account Team

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Hamilton College	BA	1982	Political Science
Fordham University		1988	Graduate Business Courses

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2005 – Present	UnitedHealth Group	Sr. Vice President, Specialty Client Group
1982 – 2005	CIGNA	Vice President, Business Development

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Steve is the senior vice president of the Specialty Client Group for National Accounts, the business segment that provides customized health care benefit and administrative solutions for two of UnitedHealth Group's largest customers -- The State of New York and the Railroad Account. Steve has overall responsibility for business strategy, administration and account management for these two major clients.

Prior to joining UnitedHealth Group in March 2005, Steve spent 22 years at CIGNA HealthCare, where he served in senior level positions in Sales, Marketing and Operations. His most recent position was vice president of Business Development, where he was responsible for the strategy, management and performance of CIGNA's national consultant and broker distribution channel. Steve also served in sales leadership roles for CIGNA in North Carolina, Arizona and New York.

Section 3. Supplemental Attachments

Effective
January 1, 2012

THE EMPIRE PLAN

2012 EMPIRE PLAN PREFERRED DRUG LIST

Administered by UnitedHealthcare

The following is a list of the most commonly prescribed generic and brand-name drugs included on the 2012 Empire Plan Preferred Drug List. **This is not a complete list of all prescription drugs on the preferred drug list or covered under the Empire Plan.** This list is subject to change due to FDA approval of new brand and generic drugs and product availability. For specific questions about your prescriptions, coverage and copayments, please call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select The Empire Plan Prescription Drug Program or visit the website at https://www.cs.ny.gov. Click on Benefit Programs, then NYSHIP Online. Provide your group and plan information if prompted. On the resulting NYSHIP Online page, select Using Your Benefits and scroll to the 2012 Empire Plan Preferred Drug List link.

For the enrollee: ***Enrollees are encouraged to ask their doctors to prescribe generic versions of brand-name drugs whenever appropriate, as this will result in a lower copayment. Generic medications contain the same active ingredients as their corresponding brand-name medications, although they may look different in color or shape. They have been FDA-approved under strict standards.***

For the physician: ***Please prescribe Level 1 or generic and Level 2 or preferred products when medically appropriate for your patients.***

CARDIOVASCULAR

Antiarrhythmics
amiodarone
disopyramide
mexiletine
quinidine gluconate
quinidine sulfate
sotalol
Multaq

Blood Modifiers
fondaparinux (generic Arixtra)
ticlopidine
warfarin
Lovenox**(g)***
Plavix*

Blood Pressure Lowering
amlodipine (generic Norvasc)
amlodipine and benazepril (generic Lotrel)
atenolol
atenolol with chlorthalidone
benazepril
benazepril with hydrochlorothiazide
bisoprolol with hydrochlorothiazide
captopril
captopril with hydrochlorothiazide
clonidine
clonidine patch (generic Catapres-TTS)
diltiazem (all formulations)
enalapril
enalapril with hydrochlorothiazide
felodipine (generic Plendil)
fosinopril
fosinopril with hydrochlorothiazide
furosemide
guanfacine
hydrochlorothiazide
indapamide
isradipine
labetalol
lisinopril
lisinopril with hydrochlorothiazide
losartan (generic Cozaar) **½T**
losartan with hydrochlorothiazide (generic Hyzaar)
metoprolol
metoprolol succinate sustained release (generic Toprol XL)
moexipril **½T**
nadolol
nadolol with bendroflumethiazide
nifedipine (all formulations)
nisoldipine (generic Sular)
perindopril (generic Aceon) **½T**
prazosin
propranolol sustained action capsule
propranolol tablet
quinapril
quinapril with hydrochlorothiazide
ramipril
spironolactone
spironolactone with hydrochlorothiazide
torsemide
trandolapril **½T**
triamterene with hydrochlorothiazide
verapamil
verapamil sustained release
Atacand***½T**
Atacand HCT*
Benicar **½T**
Benicar HCT
Bystolic
Cardizem LA **(g)***
Innopran XL
Micardis
Micardis HCT

Cholesterol Lowering
cholestyramine
colestipol
fenofibrate
gemfibrozil
lovastatin
pravastatin (generic Pravachol) **½T**
simvastatin (generic Zocor) **½T**
Advicor
Altoprev
Antara
Crestor **½T**
Fenoglide
Lipitor*
Lipofen
Lofibra Tablet
Niaspan
Triglide
Vytorin
Welchol

Heart Failure
carvedilol (generic Coreg)
digoxin
BiDil

Nitrates/Other Angina
isosorbide
Nitrostat
Ranexa

Pulmonary Artery Hypertension Agents
Adcirca **(PA)**
Letairis **(PA)**
Revatio***(PA)**
Tracleer **(PA)**
Tyvaso **(PA)**
Ventavis **(PA)**

CENTRAL NERVOUS SYSTEM

Alzheimer's Disease
donepezil 5mg, 10mg (generic Aricept)
galantamine (generic Razadyne)
galantamine extended release (generic Razadyne ER)
Namenda

Multiple Sclerosis
Ampyra **(PA)**
Avonex **(PA)**
Copaxone **(PA)**
Rebif **(PA)**

Nausea/Vomiting
granisetron (generic Kytril)
ondansetron (generic Zofran)
prochlorperazine
promethazine
Emend

Parkinson's Disease
amantadine
benztropine
carbidopa/levodopa
pramipexole (generic Mirapex)
ropinirole (generic Requip)
Apokyn

KEY

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Seizure Disorder
carbamazepine
clonazepam
divalproex sodium (generic Depakote)
divalproex sodium extended release (generic Depakote ER)
gabapentin
lamotrigine
levetiracetam (generic Keppra)
oxcarbazepine
phenobarbital
phenytoin
primidone
topiramate (generic Topamax) **½T**
Dilantin **(g)**
Felbatol
Gabitril*
Lyrica
Tegretol XR **(g)***

DERMATOLOGY/ SKIN DISORDER

adapalene (generic Differin) **(PA)**
benzoyl peroxide/erythromycin
betamethasone dipropionate
clindamycin (all formulations)
clobetasol
erythromycin topical
fluocinonide
hydrocortisone topical
imiquimod (generic Aldara)
isotretinoin
metronidazole topical
mometasone furoate topical
mupirocin ointment
podofilox topical
sulfacetamide/sulfur
tretinoin **(PA)**
triamcinolone topical
Condylox **(g)***
Dovonex **(g)***
Duac
Protopic
Soriatane
Stelara **(PA)**

DIABETES

acarbose (generic Precose)
glimepiride
glipizide
glipizide extended release
glipizide with metformin
glyburide
glyburide with metformin
glyburide, micronized
metformin
metformin extended release
nateglinide (generic Starlix)
Actoplus Met*
Actos***½T**
Byetta
Duetact
Humalog
Humulin
Janumet
Januvia
Lantus
Levemir
Novolin
Novolog
Onglyza
Prandin
Symlin
Victoza

GASTROINTESTINAL

GERD/Peptic Ulcer
lansoprazole capsule (generic Prevacid capsule)
metoclopramide
misoprostol
nizatidine oral solution
omeprazole (generic Prilosec)
omeprazole/sodium bicarbonate capsule (generic Zegerid capsule)
pantoprazole (generic Protonix)
ranitidine
sucralfate
Helidac
Prevpac
Pylera

Gastrointestinal-Other
chlordiazepoxide/clidinium
dicyclomine
hyoscyamine

Pancreatic Enzymes
Creon
Zenpep

Ulcerative Colitis
balsalazide disodium (generic Colazal)
budesonide (generic Entocort EC)
mesalamine enema
sulfasalazine
Apriso
Asacol
Lialda

GROWTH HORMONES

Nutropin/Nutropin AQ **(PA)**
Saizen **(PA)**
Serostim **(PA)**
Tev-Tropin **(PA)**
Zorbtive **(PA)**

INFECTION

Antibiotics-Oral
amoxicillin
amoxicillin with potassium clavulanate (generic Augmentin)
ampicillin
azithromycin (generic Zithromax)
cefaclor
cefadroxil
cefdinir (generic Omnicef)
cefprozil
cefuroxime
cephalexin
ciprofloxacin
clarithromycin (generic Biaxin)
clarithromycin extended release (generic Biaxin XL)
clindamycin capsule
doxycycline
erythromycin
levofloxacin (generic Levaquin)
metronidazole
minocycline
penicillin V potassium
sulfamethoxazole with trimethoprim
tetracycline

Antifungal Drugs-Oral
fluconazole
itraconazole **(PA)**
ketoconazole
nystatin
terbinafine (generic Lamisil) **(PA)**
Noxafil
Vfend

Antifungal Drugs-Topical
ciclopirox solution, non-oral
clotrimazole with betamethasone
nystatin
nystatin with triamcinolone
Naftin

Antiviral Drugs
acyclovir
amantadine
famciclovir
rimantadine
valacyclovir (generic Valtrex) **½T**
Tamiflu
Zovirax Ointment, Cream

Hepatitis
ribavirin **(PA)**
Baraclude
Hepsera
Infergen **(PA)**
Intron-A **(PA)**
Pegasys **(PA)**
Peg-Intron **(PA)**
Tyzeka

MIGRAINE HEADACHE

butalbital/acetaminophen/caffeine
butalbital/aspirin/caffeine
butorphanol nasal spray
ergotamine/caffeine
propranolol tablet
sumatriptan (generic Imitrex)
Frova
Maxalt*
Relpax
Zomig

MUSCLE RELAXANTS

carisoprodol 350mg
cyclobenzaprine (generic Flexeril)
diazepam
metaxalone (generic Skelaxin)
methocarbamol
orphenadrine/orphenadrine compound

OPHTHALMIC (EYE)

Glaucoma
betaxolol
brimonidine
dorzolamide (generic Trusopt)
latanoprost (generic Xalatan)
pilocarpine
timolol maleate
Azopt
Betimol
Combigan
Lumigan
Travatan/Travatan Z

Other Eye Medications
azelastine (generic Optivar)
ciprofloxacin drops
cromolyn sodium drops
cyclopentolate
diclofenac sodium drops (generic Voltaren Ophthalmic)
epinastine drops (generic Elestat)
flurbiprofen drops
ketorolac tromethamine drops
ofloxacin drops
prednisolone drops
tobramycin drops
tobramycin/dexamethasone drops (generic Tobradex)
Flarex
FML Forte/FML SOP
Pred Mild
Restasis
Vexol

OTIC (EAR)

ofloxacin (generic Floxin)
Ciprodex

PAIN/ARTHRITIS

acetaminophen with codeine
acetaminophen with hydrocodone
diclofenac

KEY

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etodolac
fentanyl citrate lollipop **(PA)**
fentanyl transdermal system
flurbiprofen
ibuprofen
ibuprofen with hydrocodone
indomethacin
ketoprofen
leflunomide
meloxicam (generic Mobic)
methotrexate
nabumetone
naproxen
oxaprozin
oxycodone with acetaminophen
oxycodone with aspirin
oxymorphone (generic Opana)
piroxicam
sulindac
tolmetin
tramadol
tramadol extended release
tramadol with acetaminophen
Celebrex
Cimzia **(PA)**
Enbrel **(PA)**
Opana ER
Oxycontin
Simponi **(PA)**
Voltaren Gel

PSYCHOTHERAPEUTIC AGENTS

Anxiety, Insomnia and Sedative Agents
alprazolam/alprazolam extended release
buspirone
diazepam
flurazepam
lorazepam
temazepam
triazolam
zaleplon (generic Sonata)
zolpidem (generic Ambien)

Attention Deficit Hyperactivity Disorder (ADHD)
amphetamine with dextroamphetamine salt combination
amphetamine with dextroamphetamine salt combination extended release (generic Adderall XR)
dextroamphetamine sustained release
methylphenidate
methylphenidate extended release
Intuniv
Vyvanse

Depression
amitriptyline
bupropion hcl
bupropion hcl extended release
bupropion hcl sustained release
citalopram (generic Celexa)
desipramine
doxepin
fluoxetine (generic Prozac)
imipramine
mirtazapine
mirtazapine dispersible tablet
nortriptyline
paroxetine (generic Paxil)
paroxetine sustained release 24 hour (generic Paxil CR)
phenelzine (generic Nardil)
sertraline (generic Zoloft) **½T**
tranylcypromine
trazodone
venlafaxine (generic Effexor)
venlafaxine extended release capsule (generic Effexor XR**)**

Psychosis
clozapine
haloperidol
olanzapine (generic Zyprexa)
risperidone (generic Risperdal)
Geodon*
Moban
Seroquel (except for XR)***½T**
Symbyax*

RESPIRATORY

Allergy-Antihistamines
hydroxyzine
levocetirizine (generic Xyzal)

Allergy-Nasal Antihistamines
azelastine nasal spray (generic Astelin**)**

Allergy-Nasal Corticosteroids
flunisolide nasal spray
fluticasone (generic Flonase)
Nasonex

Allergy-Other
epinephrine pen
EpiPen

Asthma-Inhaled Drugs
albuterol inhalation solution
albuterol/ipratropium solution
cromolyn
ipratropium inhalation solution
Advair
Alvesco
Asmanex
Combivent
Foradil
Pulmicort Respules **(g)***
QVAR
Spiriva
Symbicort
Ventolin HFA

Asthma-Oral Drugs
albuterol
prednisolone
prednisone
terbutaline
theophylline
Singulair*

THYROID REPLACEMENT

levothyroxine (generic Synthroid)
liothyronine (generic Cytomel)
Tirosint

URINARY TRACT

Benign Prostatic Hyperplasia (BPH)
doxazosin
finasteride (generic Proscar)
tamsulosin (generic Flomax)
terazosin

Erectile Dysfunction
Viagra

Miscellaneous Anticholinergics/ Antispasmodics-Other
desmopressin
oxybutynin/oxybutynin extended release
trospium (generic Sanctura)
Enablex
Gelnique
Oxytrol
Sanctura XR
Vesicare

VITAMIN DEFICIENCY

cyanocobalamin injection
Nascobal

WEIGHT LOSS

phentermine **(PA)**

WOMEN'S HEALTH

Contraceptives
aviane
gianvi (generic Yaz)
kariva
levonorgestrel-ethinyl estradiol tablet, dosepack, 3 month (generic Seasonale)
medroxyprogesterone 150mg/ml
microgestin fe
ocella (generic Yasmin)
tri-sprintec
trinessa
NuvaRing

Hormone Therapy-Oral
estradiol/norethindrone (generic Activella)
estropipate
medroxyprogesterone tablet
methyltestosterone with esterified estrogens
Cenestin
Enjuvia
Prefest
Prometrium

Hormone Therapy-Patches
estradiol patch
Combipatch
Estraderm
Vivelle/Vivelle-Dot

Hormone Therapy-Miscellaneous
Estrace Cream
Estring
Vagifem

Infertility
clomiphene
leuprolide
Cetrotide
Follistim AQ
Gonal-F
Luveris
Ovidrel

Osteoporosis
alendronate sodium tablet (generic Fosamax)
etidronate disodium
Actonel
Boniva
Evista
Forteo **(PA)**

Other Agents
clindamycin vaginal cream
metronidazole vaginal gel
prenatal vitamins (generic)
tamoxifen
terconazole
Clindesse
Lysteda

KEY

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Examples of Level 3 or Non-Preferred Brand-Name Drugs with 2012 Empire Plan Preferred Drug List Alternatives

Level 3 or Non-Preferred Drugs	Empire Plan Preferred Drug List Alternatives
Abilify ½**T**	olanzapine (generic Zyprexa), risperidone (generic Risperdal), Geodon*, Seroquel (except for XR)*½**T**
Aciphex	lansoprazole capsule (generic Prevacid capsule), omeprazole (generic Prilosec), omeprazole/sodium bicarbonate capsule (generic Zegerid capsule), pantoprazole (generic Protonix)
Androgel	Testim
Aricept 23mg	donepezil 5mg, 10mg (generic Aricept)
Avalide*	losartan with hydrochlorothiazide (generic Hyzaar), Atacand HCT*, Benicar HCT, Micardis HCT
Avapro*½**T**	losartan (generic Cozaar) ½**T**, Atacand*½**T**, Benicar ½**T**, Micardis
Avelox	ciprofloxacin, levofloxacin (generic Levaquin), ofloxacin
Avodart	doxazosin, finasteride (generic Proscar), tamsulosin (generic Flomax), terazosin
Azor	amlodipine (generic Norvasc) plus Benicar ½**T**
Betaseron **(PA)**	Avonex **(PA)**, Copaxone **(PA)**, Rebif **(PA)**
Caduet*	amlodipine (generic Norvasc) plus Lipitor*
Cialis	Viagra
Clobex Shampoo	clobetasol
Cymbalta	venlafaxine (generic Effexor), venlafaxine extended release capsule (generic Effexor XR)
Dexilant (formerly Kapidex)	lansoprazole capsule (generic Prevacid capsule), omeprazole (generic Prilosec), omeprazole/sodium bicarbonate capsule (generic Zegerid capsule), pantoprazole (generic Protonix)
Diovan*½**T**	losartan (generic Cozaar) ½**T**, Atacand*½**T**, Benicar ½**T**, Micardis
Diovan HCT*	losartan with hydrochlorothiazide (generic Hyzaar), Atacand HCT*, Benicar HCT, Micardis HCT
Flovent	Alvesco, Asmanex, QVAR
Humatrope **(PA)**	Nutropin **(PA)**, Nutropin AQ **(PA)**, Saizen **(PA)**, Tev-Tropin **(PA)**
Humira **(PA)**	Cimzia **(PA)**, Enbrel **(PA)**, Simponi **(PA)**, Stelara **(PA)**
Levitra	Viagra
Lexapro*½**T**	citalopram (generic Celexa), fluoxetine (generic Prozac), paroxetine (generic Paxil), paroxetine sustained release 24 hour (generic Paxil CR), sertraline (generic Zoloft) ½**T**, venlafaxine (generic Effexor), venlafaxine extended release capsule (generic Effexor XR)
Lunesta	zaleplon (generic Sonata), zolpidem (generic Ambien)
Nexium	lansoprazole capsule (generic Prevacid capsule), omeprazole (generic Prilosec), omeprazole/sodium bicarbonate capsule (generic Zegerid capsule), pantoprazole (generic Protonix)
Norditropin **(PA)**	Nutropin **(PA)**, Nutropin AQ **(PA)**, Saizen **(PA)**, Tev-Tropin **(PA)**
Ortho Tri-Cyclen Lo	tri-sprintec, trinessa
Premarin Cream	Estrace Cream
Premarin Tablet	estradiol, estropipate, Cenestin, Enjuvia
Premphase	estradiol/norethindrone (generic Activella), Prefest
Prempro	estradiol/norethindrone (generic Activella), Prefest
Proventil HFA	Ventolin HFA
Provigil***(PA)**	amphetamine with dextroamphetamine salt combination, amphetamine with dextroamphetamine salt combination extended release (generic Adderall XR), dextroamphetamine, methylphenidate
Pulmicort Flexhaler	Alvesco, Asmanex, QVAR
Retin-A Micro **(PA)**	tretinoin **(PA)**
Serevent	Foradil
Simcor	simvastatin (generic Zocor) ½**T** plus Niaspan
Strattera	amphetamine with dextroamphetamine salt combination extended release (generic Adderall XR), methylphenidate, Intuniv, Vyvanse
Tazorac***(PA)**	adapalene (generic Differin) **(PA)**, tretinoin **(PA)**
Tricor	fenofibrate, Antara, Fenoglide, Lipofen, Triglide
Twinject	epinephrine pen, EpiPen
Veramyst	flunisolide, fluticasone (generic Flonase), Nasonex
Xopenex HFA	Ventolin HFA
Xopenex Inhalation Solution **(g)***	albuterol inhalation solution
Zetia	lovastatin, pravastatin (generic Pravachol) ½**T**, simvastatin (generic Zocor) ½**T**, Crestor ½**T**, Lipitor*, Vytorin, Welchol

KEY

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Effective
January 1, 2012

THE EMPIRE PLAN

2012 EMPIRE PLAN FLEXIBLE FORMULARY

Administered by UnitedHealthcare

The following is a list of the most commonly prescribed generic and brand-name drugs included on the 2012 Empire Plan Flexible Formulary. **This is not a complete list of all prescription drugs on the flexible formulary or covered under The Empire Plan. This list and excluded medications are subject to change. New prescription drugs may be subject to exclusion when they become available in the market.** For specific questions about your prescriptions, coverage and copayments, please call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select The Empire Plan Prescription Drug Program or visit the website at https://www.cs.ny.gov. Click on Benefit Programs, then NYSHIP Online. Provide your group and plan information if prompted. On the resulting NYSHIP Online page, select Using Your Benefits and scroll to the 2012 Empire Plan Flexible Formulary links.

***For the enrollee:* Enrollees are encouraged to ask their doctors to prescribe covered generic versions of brand-name drugs whenever appropriate, as this will result in a lower copayment, unless the brand-name drug has been placed on Level 1. Brand products on Level 1 will be less expensive than the generic equivalent. Generic medications contain the same active ingredients as their corresponding brand-name medications, although they may look different in color or shape. They have been FDA-approved under strict standards.**

***For the physician:* Please prescribe covered Level 1 and Level 2 or preferred products when medically appropriate for your patients.**

CARDIOVASCULAR

Antiarrhythmics
amiodarone
disopyramide
mexiletine
quinidine gluconate
quinidine sulfate
sotalol
Multaq

Blood Modifiers
fondaparinux (generic Arixtra)
ticlopidine
warfarin
Lovenox **(g)***
Plavix*

Blood Pressure Lowering
amlodipine (generic Norvasc)
amlodipine and benazepril (generic Lotrel)
atenolol
atenolol with chlorthalidone
benazepril
benazepril with hydrochlorothiazide
bisoprolol with hydrochlorothiazide
captopril
captopril with hydrochlorothiazide
clonidine
clonidine patch (generic Catapres-TTS)
diltiazem (all formulations)
enalapril
enalapril with hydrochlorothiazide
felodipine (generic Plendil)
fosinopril
fosinopril with hydrochlorothiazide
furosemide
guanfacine
hydrochlorothiazide
indapamide
isradipine
labetalol
lisinopril
lisinopril with hydrochlorothiazide
losartan (generic Cozaar) **½T**
losartan with hydrochlorothiazide (generic Hyzaar)
metoprolol
metoprolol succinate sustained release (generic Toprol XL)
moexipril **½T**
nadolol
nadolol with bendroflumethiazide
nifedipine (all formulations)
nisoldipine (generic Sular)
perindopril (generic Aceon) **½T**
prazosin
propranolol sustained action capsule
propranolol tablet
quinapril
quinapril with hydrochlorothiazide
ramipril
spironolactone
spironolactone with hydrochlorothiazide
torsemide
trandolapril **½T**
triamterene with hydrochlorothiazide
verapamil
verapamil sustained release
Atacand***½T**
Atacand HCT*
Benicar **½T**
Benicar HCT
Bystolic
Cardizem LA **(g)***
Innopran XL
Micardis
Micardis HCT

Cholesterol Lowering
cholestyramine
colestipol
fenofibrate
gemfibrozil
lovastatin
pravastatin (generic Pravachol) **½T**
simvastatin (generic Zocor) **½T**
Advicor
Altoprev
Antara
Crestor **½T**
Fenoglide
Lipitor*
Lipofen
Lofibra Tablet
Niaspan
Triglide
Vytorin
Welchol

Heart Failure
carvedilol (generic Coreg)
digoxin
BiDil

KEY

Generic Drugs are listed in lower case letters. Brand-name drugs are listed with the first letter of the name capitalized.

The symbol * next to a brand-name drug signifies that this drug may be available as a generic in 2011 or 2012. When a generic version is available, mandatory generic substitution will apply, unless the brand-name drug has been placed on Level 1. Use of a covered Level 3 or non-preferred brand-name prescription drug when the generic is available will result in the enrollee paying the applicable Level 3 or non-preferred copayment plus the difference in cost between the brand-name drug and the generic, not to exceed the full retail cost of the drug, unless the brand-name drug has been placed on Level 1 of the Flexible Formulary. **The symbol (g)** next to a brand-name drug indicates that a generic is currently available for at least one or more strengths of the brand medication. When a generic is available for a particular strength of the brand-name drug, that strength of the brand-name drug, if covered, may be Level 3 or non-preferred. **The symbol (PA)** next to a drug name indicates that prior authorization is required. **The symbol ♦** next to a drug indicates a brand-name medication with a Level 1 copayment. **The symbol ½T** next to a drug indicates that certain strengths may be eligible for the Half Tablet Program.

Nitrates/Other Angina
isosorbide
Nitrostat
Ranexa

Pulmonary Artery Hypertension Agents
Adcirca **(PA)**
Letairis **(PA)**
Revatio***(PA)**
Tracleer **(PA)**
Tyvaso **(PA)**
Ventavis **(PA)**

CENTRAL NERVOUS SYSTEM

Alzheimer's Disease
donepezil 5mg, 10mg (generic Aricept)
galantamine (generic Razadyne)
galantamine extended release (generic Razadyne ER)
Namenda

Multiple Sclerosis
Ampyra **(PA)**
Avonex **(PA)**
Copaxone **(PA)**
Rebif **(PA)**

Nausea/Vomiting
granisetron (generic Kytril)
ondansetron (generic Zofran)
prochlorperazine
promethazine
Emend

Parkinson's Disease
amantadine
benztropine
carbidopa/levodopa
pramipexole (generic Mirapex)
ropinirole (generic Requip)
Apokyn

Seizure Disorder
carbamazepine
clonazepam
divalproex sodium (generic Depakote)
divalproex sodium extended release (generic Depakote ER)
gabapentin
lamotrigine
levetiracetam (generic Keppra)
oxcarbazepine
phenobarbital
phenytoin
primidone
topiramate (generic Topamax) **½T**
Dilantin **(g)**
Felbatol
Gabitril*
Lyrica
Tegretol XR **(g)***

DERMATOLOGY/ SKIN DISORDER

adapalene (generic Differin) **(PA)**
benzoyl peroxide/erythromycin
betamethasone dipropionate
clindamycin (all formulations)
clobetasol
erythromycin topical
fluocinonide
hydrocortisone topical
imiquimod (generic Aldara)
isotretinoin
metronidazole topical
mometasone furoate topical
mupirocin ointment
podofilox topical
sulfacetamide/sulfur
tretinoin **(PA)**
triamcinolone topical
Condylox **(g)***
Dovonex **(g)***
Duac
Protopic
Soriatane
Stelara **(PA)**

DIABETES

acarbose (generic Precose)
glimepiride
glipizide
glipizide extended release
glipizide with metformin
glyburide
glyburide with metformin
glyburide, micronized
metformin
metformin extended release
nateglinide (generic Starlix)
Actoplus Met*
Actos***½T**
Byetta
Duetact
Humalog
Humulin
Janumet
Januvia
Lantus
Levemir
Novolin
Novolog
Onglyza
Prandin
Symlin
Victoza

GASTROINTESTINAL

GERD/Peptic Ulcer
metoclopramide
misoprostol
nizatidine oral solution
omeprazole (generic Prilosec)
pantoprazole (generic Protonix)
ranitidine
sucralfate
Helidac
Prevpac
Pylera

Gastrointestinal-Other
chlordiazepoxide/clidinium
dicyclomine
hyoscyamine

Pancreatic Enzymes
Creon
Zenpep

Ulcerative Colitis
balsalazide disodium (generic Colazal)
budesonide (generic Entocort EC)
mesalamine enema
sulfasalazine
Apriso
Asacol
Lialda

GROWTH HORMONES

Nutropin/Nutropin AQ **(PA)**
Saizen **(PA)**
Serostim **(PA)**
Tev-Tropin **(PA)**
Zorbtive **(PA)**

INFECTION

Antibiotics-Oral
amoxicillin
amoxicillin with potassium clavulanate (generic Augmentin)
ampicillin
azithromycin (generic Zithromax)
cefaclor
cefadroxil
cefdinir (generic Omnicef)
cefprozil
cefuroxime
cephalexin
ciprofloxacin
clarithromycin (generic Biaxin)
clarithromycin extended release (generic Biaxin XL)
clindamycin capsule
doxycycline
erythromycin
levofloxacin (generic Levaquin)
metronidazole
minocycline
penicillin V potassium
sulfamethoxazole with trimethoprim
tetracycline

Antifungal Drugs-Oral
fluconazole
itraconazole **(PA)**
ketoconazole
nystatin
terbinafine (generic Lamisil) **(PA)**
Noxafil
Vfend

Antifungal Drugs-Topical
ciclopirox solution, non-oral
clotrimazole with betamethasone
nystatin
nystatin with triamcinolone
Naftin

Antiviral Drugs
acyclovir
amantadine
famciclovir
rimantadine
valacyclovir (generic Valtrex) **½T**
Tamiflu
Zovirax Ointment, Cream

Hepatitis
ribavirin **(PA)**
Baraclude
Hepsera
Infergen **(PA)**
Intron-A **(PA)**
Pegasys **(PA)**
Peg-Intron **(PA)**
Tyzeka

MIGRAINE HEADACHE

butalbital/acetaminophen/caffeine
butalbital/aspirin/caffeine
butorphanol nasal spray
ergotamine/caffeine
propranolol tablet
sumatriptan (generic Imitrex)
Frova
Maxalt*
Relpax
Zomig

MUSCLE RELAXANTS

carisoprodol 350mg
cyclobenzaprine (generic Flexeril)
diazepam
metaxalone (generic Skelaxin)
methocarbamol
orphenadrine/orphenadrine compound

OPHTHALMIC (EYE)

Glaucoma
betaxolol
brimonidine
dorzolamide (generic Trusopt)
latanoprost (generic Xalatan)
pilocarpine
timolol maleate
Azopt
Betimol
Combigan
Lumigan
Travatan/Travatan Z

Other Eye Medications
azelastine (generic Optivar)
ciprofloxacin drops
cromolyn sodium drops
cyclopentolate
diclofenac sodium drops (generic Voltaren Ophthalmic)
epinastine drops (generic Elestat)
flurbiprofen drops
ketorolac tromethamine drops
ofloxacin drops
prednisolone drops
tobramycin drops

tobramycin/dexamethasone drops (generic Tobradex)
Flarex
FML Forte/FML SOP
Pred Mild
Restasis
Vexol

OTIC (EAR)

ofloxacin (generic Floxin)
Ciprodex

PAIN/ARTHRITIS

acetaminophen with codeine
acetaminophen with hydrocodone
diclofenac
etodolac
fentanyl citrate lollipop **(PA)**
fentanyl transdermal system
flurbiprofen
ibuprofen
ibuprofen with hydrocodone
indomethacin
ketoprofen
leflunomide
meloxicam (generic Mobic)
methotrexate
nabumetone
naproxen
oxaprozin
oxycodone with acetaminophen
oxycodone with aspirin
oxymorphone (generic Opana)
piroxicam
sulindac
tolmetin
tramadol
tramadol extended release
tramadol with acetaminophen
Celebrex
Cimzia **(PA)**
Enbrel **(PA)**
Opana ER
Oxycontin
Simponi **(PA)**
Voltaren Gel

PSYCHOTHERAPEUTIC AGENTS

Anxiety, Insomnia and Sedative Agents
alprazolam/alprazolam extended release
buspirone
diazepam
flurazepam
lorazepam
temazepam
triazolam
zaleplon (generic Sonata)
zolpidem (generic Ambien)

Attention Deficit Hyperactivity Disorder (ADHD)
amphetamine with dextroamphetamine salt combination
amphetamine with dextroamphetamine salt combination extended release (generic Adderall XR)
dextroamphetamine sustained release
methylphenidate
methylphenidate extended release
Intuniv
Vyvanse

Depression
amitriptyline
bupropion hcl
bupropion hcl extended release
bupropion hcl sustained release
citalopram (generic Celexa)
desipramine
doxepin
fluoxetine (generic Prozac)
imipramine
mirtazapine
mirtazapine dispersible tablet
nortriptyline
paroxetine (generic Paxil)
paroxetine sustained release 24 hour (generic Paxil CR)
phenelzine (generic Nardil)
sertraline (generic Zoloft) **½T**
tranylcypromine
trazodone
venlafaxine (generic Effexor)
venlafaxine extended release capsule (generic Effexor XR**)**

Psychosis
clozapine
haloperidol
olanzapine (generic Zyprexa)
risperidone (generic Risperdal)
Geodon*
Moban
Seroquel (except for XR)***½T**
Symbyax*

RESPIRATORY

Allergy-Antihistamines
hydroxyzine
levocetirizine (generic Xyzal)

Allergy-Nasal Antihistamines
azelastine nasal spray (generic Astelin)

Allergy-Nasal Corticosteroids
flunisolide nasal spray
fluticasone (generic Flonase)
Nasonex

Allergy-Other
epinephrine pen
EpiPen

Asthma-Inhaled Drugs
albuterol inhalation solution
albuterol/ipratropium solution
cromolyn
ipratropium inhalation solution
Advair
Alvesco♦
Asmanex♦
Combivent
Foradil
Pulmicort Respules **(g)***
QVAR♦
Spiriva
Symbicort
Ventolin HFA♦

Asthma-Oral Drugs
albuterol
prednisolone
prednisone
terbutaline
theophylline
Singulair*

THYROID REPLACEMENT

levothyroxine (generic Synthroid)
liothyronine (generic Cytomel)
Tirosint

URINARY TRACT

Benign Prostatic Hyperplasia (BPH)
doxazosin
finasteride (generic Proscar)
tamsulosin (generic Flomax)
terazosin

Erectile Dysfunction
Viagra

Miscellaneous Anticholinergics/ Antispasmodics-Other
desmopressin
oxybutynin/oxybutynin extended release
trospium (generic Sanctura)
Enablex
Gelnique
Oxytrol
Sanctura XR
Vesicare

VITAMIN DEFICIENCY

cyanocobalamin injection
Nascobal

WEIGHT LOSS

phentermine **(PA)**

WOMEN'S HEALTH

Contraceptives
aviane
gianvi (generic Yaz)
kariva
levonorgestrel-ethinyl estradiol tablet, dosepack, 3 month (generic Seasonale)
medroxyprogesterone 150mg/ml
microgestin fe
ocella (generic Yasmin)
tri-sprintec
trinessa
NuvaRing

Hormone Therapy-Oral
estradiol/norethindrone (generic Activella)
estropipate
medroxyprogesterone tablet
methyltestosterone with esterified estrogens
Cenestin
Enjuvia
Prefest
Prometrium

Hormone Therapy-Patches
estradiol patch
Combipatch
Estraderm
Vivelle/Vivelle-Dot

Hormone Therapy-Miscellaneous
Estrace Cream
Estring
Vagifem

Infertility
clomiphene
leuprolide
Cetrotide
Follistim AQ
Gonal-F
Luveris
Ovidrel

Osteoporosis
alendronate sodium tablet (generic Fosamax)
etidronate disodium
Actonel
Boniva
Evista
Forteo **(PA)**

Other Agents
clindamycin vaginal cream
metronidazole vaginal gel
prenatal vitamins (generic)
tamoxifen
terconazole
Clindesse
Lysteda

Examples of Level 3 or Non-Preferred Drugs with 2012 Empire Plan Flexible Formulary Alternatives

Level 3 or Non-Preferred Drugs	Empire Plan Flexible Formulary Alternatives
Abilify ½**T**	olanzapine (generic Zyprexa), risperidone (generic Risperdal), Geodon*, Seroquel (except for XR)*½**T**
Aciphex	omeprazole (generic Prilosec), pantoprazole (generic Protonix)
Avalide*	losartan with hydrochlorothiazide (generic Hyzaar), Atacand HCT*, Benicar HCT, Micardis HCT
Avapro*½**T**	losartan (generic Cozaar) ½**T**, Atacand*½**T**, Benicar ½**T**, Micardis
Avelox	ciprofloxacin, levofloxacin (generic Levaquin), ofloxacin
Avodart	doxazosin, finasteride (generic Proscar), tamsulosin (generic Flomax), terazosin
Azor	amlodipine (generic Norvasc) plus Benicar ½**T**
Betaseron **(PA)**	Avonex **(PA)**, Copaxone **(PA)**, Rebif **(PA)**
Cialis	Viagra
Cymbalta	venlafaxine (generic Effexor), venlafaxine extended release capsule (generic Effexor XR)
Diovan*½**T**	losartan (generic Cozaar) ½**T**, Atacand*½**T**, Benicar ½**T**, Micardis
Diovan HCT*	losartan with hydrochlorothiazide (generic Hyzaar), Atacand HCT*, Benicar HCT, Micardis HCT
Flovent	Alvesco♦, Asmanex♦, QVAR♦
Humira **(PA)**	Cimzia **(PA)**, Enbrel **(PA)**, Simponi **(PA)**, Stelara **(PA)**
Lexapro*½**T**	citalopram (generic Celexa), fluoxetine (generic Prozac), paroxetine (generic Paxil), paroxetine sustained release 24 hour (generic Paxil CR), sertraline (generic Zoloft) ½**T**, venlafaxine (generic Effexor), venlafaxine extended release capsule (generic Effexor XR)
Lunesta	zaleplon (generic Sonata), zolpidem (generic Ambien)
Proventil HFA	Ventolin HFA♦
Pulmicort Flexhaler	Alvesco♦, Asmanex♦, QVAR♦
Retin-A Micro **(PA)**	tretinoin **(PA)**
Serevent	Foradil
Simcor	simvastatin (generic Zocor) ½**T** plus Niaspan
Twinject	epinephrine pen, EpiPen
Zegerid Powder for Oral Suspension	omeprazole (generic Prilosec), pantoprazole (generic Protonix)
Zetia	lovastatin, pravastatin (generic Pravachol) ½**T**, simvastatin (generic Zocor) ½**T**, Crestor ½**T**, Lipitor*, Vytorin, Welchol

For enrollee groups eligible for the Enhanced Flexible Formulary, you have an additional feature called Brand for Generic (B4G) which saves you money on certain Brand-Name drugs that have a new generic available. When advantageous to the Plan, this feature allows a Brand-Name drug to be placed on Level 1, the lowest copayment level, and the new generic equivalent to be placed on Level 3, the highest copayment level or excluded. These placements are for a limited time, typically six months, and may be revised mid-year when such changes are advantageous to The Empire Plan.

UnitedHealthcare will notify you when B4G savings are available.
We will also notify your pharmacist so that the lowest cost option will always be dispensed.
Please refer to the DCS website at https://www.cs.ny.gov
for the most current information regarding the B4G feature.

KEY

Generic Drugs are listed in lower case letters. Brand-name drugs are listed with the first letter of the name capitalized.

The symbol * next to a brand-name drug signifies that this drug may be available as a generic in 2011 or 2012. When a generic version is available, mandatory generic substitution will apply, unless the brand-name drug has been placed on Level 1. Use of a covered Level 3 or non-preferred brand-name prescription drug when the generic is available will result in the enrollee paying the applicable Level 3 or non-preferred copayment plus the difference in cost between the brand-name drug and the generic, not to exceed the full retail cost of the drug, unless the brand-name drug has been placed on Level 1 of the Flexible Formulary. **The symbol (g)** next to a brand-name drug indicates that a generic is currently available for at least one or more strengths of the brand medication. When a generic is available for a particular strength of the brand-name drug, that strength of the brand-name drug, if covered, may be Level 3 or non-preferred. **The symbol (PA)** next to a drug name indicates that prior authorization is required. **The symbol ♦** next to a drug indicates a brand-name medication with a Level 1 copayment. **The symbol ½T** next to a drug indicates that certain strengths may be eligible for the Half Tablet Program.

Excluded drugs with 2012 Empire Plan Flexible Formulary Alternatives

Excluded Drugs†	Empire Plan Flexible Formulary Alternatives
Acuvail	diclofenac sodium drops (generic Voltaren Ophthalmic), ketorolac tromethamine drops
Adoxa	doxycycline
Amrix	cyclobenzaprine (generic Flexeril)
Analpram Advanced Kit	hydrocortisone/pramoxine cream
Androgel	Testim
Aplenzin	bupropion hcl extended release, bupropion hcl sustained release
Aricept 23mg	donepezil 5mg, 10mg (generic Aricept)
Asacol HD	Apriso, Asacol, Lialda
BenzEFoam	benzoyl peroxide
Caduet	amlodipine (generic Norvasc) plus Lipitor*
Cambia	diclofenac
carisoprodol 250mg (generic Soma 250mg)	carisoprodol 350mg
Centany AT	mupirocin ointment
Clindacin PAC	clindamycin topical
Clobex Shampoo	clobetasol
Coreg CR	carvedilol (generic Coreg)
cyclobenzaprine extended release capsule (generic Amrix)	cyclobenzaprine (generic Flexeril)
Detrol LA	oxybutynin, oxybutynin extended release, trospium (generic Sanctura), Enablex, Sanctura XR, Vesicare
Dexilant (formerly Kapidex)	omeprazole (generic Prilosec), pantoprazole (generic Protonix)
Doryx	doxycycline
doxycycline hyclate extended release tablet (generic Doryx)	doxycycline
doxycycline monohydrate 150mg capsule (generic Adoxa 150mg capsule)	doxycycline
Edluar	zaleplon (generic Sonata), zolpidem (generic Ambien)
Epiduo	adapalene (generic Differin) **(PA)** plus benzoyl peroxide
Extavia	Avonex **(PA)**, Copaxone **(PA)**, Rebif **(PA)**
Flector	Voltaren Gel
Genotropin **(PA)°**	Nutropin **(PA)**, Nutropin AQ **(PA)**, Saizen **(PA)**, Tev-Tropin **(PA)**
Humatrope **(PA)°°**	Nutropin **(PA)**, Nutropin AQ **(PA)**, Saizen **(PA)**, Tev-Tropin **(PA)**
Jalyn	finasteride (generic Proscar) plus tamsulosin (generic Flomax)
lansoprazole capsule	omeprazole (generic Prilosec), pantoprazole (generic Protonix)
Metozolv ODT	metoclopramide
Momexin Kit	mometasone furoate topical plus ammonium lactate
Morgidox Kit	doxycycline
Naprelan	diclofenac, ibuprofen, naproxen
Neobenz Micro	benzoyl peroxide
Nexium	omeprazole (generic Prilosec), pantoprazole (generic Protonix)
Norditropin **(PA)°°°**	Nutropin **(PA)**, Nutropin AQ **(PA)**, Saizen **(PA)**, Tev-Tropin **(PA)**
Olux/Olux-E Complete Pack	clobetasol
omeprazole/sodium bicarbonate capsule (generic Zegerid)	omeprazole (generic Prilosec), pantoprazole (generic Protonix)
Omnitrope **(PA)**°	Nutropin **(PA)**, Nutropin AQ **(PA)**, Saizen **(PA)**, Tev-Tropin **(PA)**
Orbivan	butalbital/acetaminophen/caffeine

° Excluded, except for the treatment of growth failure due to Prader-Willi syndrome or Small for Gestational Age.
°° Excluded, except for the treatment of growth failure due to SHOX deficiency or Small for Gestational Age.
°°° Excluded, except for the treatment of short stature associated with Noonan syndrome or Small for Gestational Age.
† Coverage for prescription drugs excluded under the benefit plan design are not subject to exception. This includes prescription medications excluded from coverage under The Empire Plan Flexible Formulary. **New prescription drugs may be subject to exclusion when they become available in the market. Please refer to the DCS website at https://www.cs.ny.gov or call The Empire Plan Prescription Drug Program toll free at 1-877-7-NYSHIP (1-877-769-7447) for current information regarding exclusions of newly launched prescription drugs.**

Excluded Drugs†	Empire Plan Flexible Formulary Alternatives
Pacnex HP/Pacnex LP/Pacnex MX	benzoyl peroxide
Pennsaid	Voltaren Gel
Prevacid Capsule	omeprazole (generic Prilosec), pantoprazole (generic Protonix)
Requip XL	ropinirole (generic Requip)
Rybix ODT	tramadol, tramadol extended release
Ryzolt	tramadol, tramadol extended release
Silenor	doxepin
Soma 250	carisoprodol 350mg
Sumaxin TS	sodium sulfacetamide/sulfur
Terbinex	terbinafine (generic Lamisil) **(PA)**
Tobradex ST	tobramycin/dexamethasone drops (generic Tobradex)
Treximet	naproxen sodium plus sumatriptan (generic Imitrex)
Triaz	benzoyl peroxide
Tribenzor	amlodipine (generic Norvasc) plus hydrochlorothiazide plus Benicar **½T** or amlodipine (generic Norvasc) plus Benicar HCT
Tricor	fenofibrate, Antara, Fenoglide, Lipofen, Triglide
Trilipix	fenofibrate, Antara, Fenoglide, Lipofen, Triglide
Twynsta	amlodipine (generic Norvasc) plus Micardis
Uramaxin GT	urea
Veltin	tretinoin **(PA)** plus clindamycin topical
Veramyst	flunisolide, fluticasone (generic Flonase), Nasonex
Vimovo	naproxen plus omeprazole (generic Prilosec)
Xerese	Zovirax Ointment, Cream
Xopenex Inhalation Solution	albuterol inhalation solution
Zegerid Capsule	omeprazole (generic Prilosec), pantoprazole (generic Protonix)
Ziana	tretinoin **(PA)** plus clindamycin topical
Zipsor	diclofenac, ibuprofen, naproxen
Zuplenz	ondansetron (generic Zofran)
Zyclara	imiquimod (generic Aldara)

° Excluded, except for the treatment of growth failure due to Prader-Willi syndrome or Small for Gestational Age.
°° Excluded, except for the treatment of growth failure due to SHOX deficiency or Small for Gestational Age.
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THE EMPIRE PLAN

Effective
January 1, 2012

2012 EMPIRE PLAN FLEXIBLE FORMULARY

Administered by UnitedHealthcare

The following is a list of the most commonly prescribed generic and brand-name drugs included on the 2012 Empire Plan Flexible Formulary. **This is not a complete list of all prescription drugs on the flexible formulary or covered under The Empire Plan. This list and excluded medications are subject to change. New prescription drugs may be subject to exclusion when they become available in the market.** For specific questions about your prescriptions, coverage and copayments, please call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select The Empire Plan Prescription Drug Program or visit the website at https://www.cs.ny.gov. Click on Benefit Programs, then NYSHIP Online. Provide your group and plan information if prompted. On the resulting NYSHIP Online page, select Using Your Benefits and scroll to the 2012 Empire Plan Flexible Formulary links.

***For the enrollee:* Enrollees are encouraged to ask their doctors to prescribe covered generic versions of brand-name drugs whenever appropriate, as this will result in a lower copayment, unless the brand-name drug has been placed on Level 1. Brand products on Level 1 will be less expensive than the generic equivalent. Generic medications contain the same active ingredients as their corresponding brand-name medications, although they may look different in color or shape. They have been FDA-approved under strict standards.**

***For the physician:* Please prescribe covered Level 1 and Level 2 or preferred products when medically appropriate for your patients.**

A

acarbose (generic Precose)
acetaminophen with codeine
acetaminophen with hydrocodone
Actonel
Actoplus Met*
Actos*½T
acyclovir
adapalene (generic Differin) **(PA)**
Adcirca **(PA)**
Advair
Advicor
albuterol
albuterol inhalation solution
albuterol/ipratropium solution
alendronate sodium tablet (generic Fosamax)
alprazolam/alprazolam extended release
Altoprev
Alvesco♦
amantadine
amiodarone
amitriptyline
amlodipine (generic Norvasc)
amlodipine and benazepril (generic Lotrel)
amoxicillin
amoxicillin with potassium clavulanate (generic Augmentin)
amphetamine with dextroamphetamine salt combination
amphetamine with dextroamphetamine salt combination extended release (generic Adderall XR)
ampicillin
Ampyra **(PA)**
Antara
Apokyn
Apriso
Asacol
Asmanex♦
Atacand*½T
Atacand HCT*
atenolol
atenolol with chlorthalidone
aviane
Avonex **(PA)**
azelastine (generic Optivar)
azelastine nasal spray (generic Astelin)
azithromycin (generic Zithromax)
Azopt

B

balsalazide disodium (generic Colazal)
Baraclude
benazepril
benazepril with hydrochlorothiazide
Benicar ½T
Benicar HCT
benzoyl peroxide/erythromycin
benztropine
betamethasone dipropionate
betaxolol
Betimol
BiDil
bisoprolol with hydrochlorothiazide
Boniva
brimonidine
budesonide (generic Entocort EC)
bupropion hcl
bupropion hcl extended release
bupropion hcl sustained release
buspirone
butalbital/acetaminophen/caffeine
butalbital/aspirin/caffeine
butorphanol nasal spray
Byetta
Bystolic

C

captopril
captopril with hydrochlorothiazide
carbamazepine
carbidopa/levodopa
Cardizem LA **(g)***
carisoprodol 350mg
carvedilol (generic Coreg)
cefaclor
cefadroxil
cefdinir (generic Omnicef)
cefprozil
cefuroxime
Celebrex
Cenestin

KEY

Generic Drugs are listed in lower case letters. Brand-name drugs are listed with the first letter of the name capitalized.

The symbol * next to a brand-name drug signifies that this drug may be available as a generic in 2011 or 2012. When a generic version is available, mandatory generic substitution will apply, unless the brand-name drug has been placed on Level 1. Use of a covered Level 3 or non-preferred brand-name prescription drug when the generic is available will result in the enrollee paying the applicable Level 3 or non-preferred copayment plus the difference in cost between the brand-name drug and the generic, not to exceed the full retail cost of the drug, unless the brand-name drug has been placed on Level 1 of the Flexible Formulary. **The symbol (g)** next to a brand-name drug indicates that a generic is currently available for at least one or more strengths of the brand medication. When a generic is available for a particular strength of the brand-name drug, that strength of the brand-name drug, if covered, may be Level 3 or non-preferred. **The symbol (PA)** next to a drug name indicates that prior authorization is required. **The symbol ♦** next to a drug indicates a brand-name medication with a Level 1 copayment. **The symbol ½T** next to a drug indicates that certain strengths may be eligible for the Half Tablet Program.

cephalexin
Cetrotide
chlordiazepoxide/clidinium
cholestyramine
ciclopirox solution, non-oral
Cimzia **(PA)**
Ciprodex
ciprofloxacin
ciprofloxacin drops
citalopram (generic Celexa)
clarithromycin (generic Biaxin)
clarithromycin extended release (generic Biaxin XL)
clindamycin (all formulations)
Clindesse
clobetasol
clomiphene
clonazepam
clonidine
clonidine patch (generic Catapres-TTS)
clotrimazole with betamethasone
clozapine
colestipol
Combigan
Combipatch
Combivent
Condylox **(g)***
Copaxone **(PA)**
Creon
Crestor **½T**
cromolyn
cromolyn sodium drops
cyanocobalamin injection
cyclobenzaprine (generic Flexeril)
cyclopentolate

D

desipramine
desmopressin
dextroamphetamine sustained release
diazepam
diclofenac
diclofenac sodium drops (generic Voltaren Ophthalmic)
dicyclomine
digoxin
Dilantin **(g)**
diltiazem (all formulations)
disopyramide
divalproex sodium (generic Depakote)
divalproex sodium extended release (generic Depakote ER)
donepezil 5mg, 10mg (generic Aricept)
dorzolamide (generic Trusopt)
Dovonex **(g)***
doxazosin
doxepin
doxycycline
Duac
Duetact

E

Emend
Enablex
enalapril
enalapril with hydrochlorothiazide
Enbrel **(PA)**
Enjuvia
epinastine drops (generic Elestat)
epinephrine pen
EpiPen
ergotamine/caffeine
erythromycin
erythromycin topical
Estrace Cream
Estraderm
estradiol/norethindrone (generic Activella)
estradiol patch
Estring
estropipate
etidronate disodium
etodolac
Evista

F

famciclovir
Felbatol
felodipine (generic Plendil)
fenofibrate
Fenoglide
fentanyl citrate lollipop **(PA)**
fentanyl transdermal system
finasteride (generic Proscar)
Flarex
fluconazole
flunisolide nasal spray
fluocinonide
fluoxetine (generic Prozac)
flurazepam
flurbiprofen
flurbiprofen drops
fluticasone (generic Flonase)
FML Forte/FML SOP
Follistim AQ
fondaparinux (generic Arixtra)
Foradil
Forteo **(PA)**
fosinopril
fosinopril with hydrochlorothiazide
Frova
furosemide

G

gabapentin
Gabitril*
galantamine (generic Razadyne)
galantamine extended release (generic Razadyne ER)
Gelnique
gemfibrozil
Geodon*
gianvi (generic Yaz)
glimepiride
glipizide
glipizide extended release
glipizide with metformin
glyburide
glyburide micronized
glyburide with metformin
Gonal-F
granisetron (generic Kytril)
guanfacine

H

haloperidol
Helidac
Hepsera
Humalog
Humulin
hydrochlorothiazide
hydrocortisone
hydrocortisone topical
hydroxyzine
hyoscyamine

I

ibuprofen
ibuprofen with hydrocodone
imipramine
imiquimod (generic Aldara)
indapamide
indomethacin
Infergen **(PA)**
Innopran XL
Intron-A **(PA)**
Intuniv
ipratropium inhalation solution
isosorbide
isotretinoin
isradipine
itraconazole **(PA)**

J

Janumet
Januvia

K

kariva
ketoconazole
ketoprofen
ketorolac tromethamine drops

L

labetalol
lamotrigine
Lantus
latanoprost (generic Xalatan)
leflunomide
Letairis **(PA)**
leuprolide
Levemir
levetiracetam (generic Keppra)
levocetirizine (generic Xyzal)
levofloxacin (generic Levaquin)
levonorgestrel-ethinyl estradiol tablet, dosepack, 3 month (generic Seasonale)
levothyroxine (generic Synthroid)
Lialda
liothyronine (generic Cytomel)
Lipitor*
Lipofen
lisinopril
lisinopril with hydrochlorothiazide
Lofibra Tablet
lorazepam
losartan (generic Cozaar) **½T**
losartan with hydrochlorothiazide (generic Hyzaar)
lovastatin
Lovenox **(g)***
Lumigan
Luveris
Lyrica
Lysteda

M

Maxalt*
medroxyprogesterone 150mg/ml
medroxyprogesterone tablet
meloxicam (generic Mobic)
mesalamine enema
metaxalone (generic Skelaxin)
metformin
metformin extended release
methocarbamol
methotrexate
methylphenidate
methylphenidate extended release
methyltestosterone with esterified estrogens
metoclopramide
metoprolol
metoprolol succinate sustained release (generic Toprol XL)
metronidazole
metronidazole topical
metronidazole vaginal gel
mexiletine
Micardis
Micardis HCT
microgestin fe
minocycline
mirtazapine
mirtazapine dispersible tablet
misoprostol
Moban
moexipril **½T**
mometasone furoate topical
Multaq
mupirocin ointment

N

nabumetone
nadolol
nadolol/bendroflumethiazide
Naftin
Namenda
naproxen
Nascobal
Nasonex
nateglinide (generic Starlix)
Niaspan
nifedipine (all formulations)
nisoldipine (generic Sular)
Nitrostat
nizatidine oral solution
nortriptyline
Novolin
Novolog
Noxafil
Nutropin/Nutropin AQ **(PA)**
Nuvaring
nystatin
nystatin with triamcinolone

O

ocella (generic Yasmin)
ofloxacin (generic Floxin)
ofloxacin drops
olanzapine (generic Zyprexa)
omeprazole (generic Prilosec)
ondansetron (generic Zofran)
Onglyza
Opana ER
orphenadrine/orphenadrine compound
Ovidrel
oxaprozin
oxcarbazepine
oxybutynin/oxybutynin extended release
oxycodone with acetaminophen
oxycodone with aspirin
Oxycontin
oxymorphone (generic Opana)
Oxytrol

P

pantoprazole (generic Protonix)
paroxetine (generic Paxil)
paroxetine sustained release 24 hour (generic Paxil CR)
Peg-Intron **(PA)**
Pegasys **(PA)**
penicillin V potassium
perindopril (generic Aceon) **½T**
phenelzine (generic Nardil)
phenobarbital
phentermine **(PA)**
phenytoin
pilocarpine
piroxicam
Plavix*
podofilox topical
pramipexole (generic Mirapex)
Prandin
pravastatin (generic Pravachol) **½T**
prazosin
Pred Mild
prednisolone
prednisolone drops
prednisone
Prefest
prenatal vitamins (generic)
Prevpac
primidone
prochlorperazine
promethazine
Prometrium
propranolol sustained action capsule
propranolol tablet
Protopic
Pulmicort Respules **(g)***
Pylera

Q

quinapril
quinapril with hydrochlorothiazide
quinidine gluconate
quinidine sulfate
QVAR♦

R

ramipril
Ranexa
ranitidine
Rebif **(PA)**
Relpax
Restasis
Revatio***(PA)**
ribavirin **(PA)**
rimantadine
risperidone (generic Risperdal)
ropinirole (generic Requip)

S

Sanctura XR
Saizen **(PA)**
Seroquel (except for XR)***½T**
Serostim **(PA)**
sertraline (generic Zoloft) **½T**
Simponi **(PA)**
simvastatin (generic Zocor) **½T**
Singulair*
Soriatane
sotalol
Spiriva
spironolactone
spironolactone with hydrochlorothiazide
Stelara **(PA)**
sucralfate
sulfacetamide/sulfur
sulfamethoxazole with trimethoprim
sulfasalazine
sulindac
sumatriptan (generic Imitrex)
Symbicort
Symbyax*
Symlin

T

Tamiflu
tamoxifen
tamsulosin (generic Flomax)
Tegretol XR **(g)***
temazepam
terazosin
terbinafine (generic Lamisil) **(PA)**
terbutaline
terconazole
tetracycline
Tev-Tropin **(PA)**
theophylline
ticlopidine
timolol maleate
Tirosint
tobramycin drops
tobramycin/dexamethasone drops (generic Tobradex)
tolmetin
topiramate (generic Topamax) **½T**
torsemide
Tracleer **(PA)**
tramadol
tramadol extended release
tramadol with acetaminophen
trandolapril **½T**
tranylcypromine
Travatan/Travatan Z
trazodone
tretinoin **(PA)**
tri-sprintec
triamcinolone topical
triamterene with hydrochlorothiazide
triazolam
Triglide
trinessa
trospium (generic Sanctura)
Tyvaso **(PA)**
Tyzeka

U

V

Vagifem
valacyclovir (generic Valtrex) **½T**
venlafaxine (generic Effexor)
venlafaxine extended release capsule (generic Effexor XR)
Ventavis **(PA)**
Ventolin HFA♦
verapamil sustained release
Vesicare
Vexol
Vfend
Viagra
Victoza
Vivelle/Vivelle Dot
Voltaren Gel
Vytorin
Vyvanse

W

warfarin
Welchol

X

Y

Z

zaleplon (generic Sonata)
Zenpep
zolpidem (generic Ambien)
Zomig
Zorbtive **(PA)**
Zovirax Ointment, Cream

Examples of Level 3 or Non-Preferred Drugs with 2012 Empire Plan Flexible Formulary Alternatives

Level 3 or Non-Preferred Drugs	Empire Plan Flexible Formulary Alternatives
Abilify ½**T**	olanzapine (generic Zyprexa), risperidone (generic Risperdal), Geodon*, Seroquel (except for XR)*½**T**
Aciphex	omeprazole (generic Prilosec), pantoprazole (generic Protonix)
Avalide*	losartan with hydrochlorothiazide (generic Hyzaar), Atacand HCT*, Benicar HCT, Micardis HCT
Avapro*½**T**	losartan (generic Cozaar) ½**T**, Atacand*½**T**, Benicar ½**T**, Micardis
Avelox	ciprofloxacin, levofloxacin (generic Levaquin), ofloxacin
Avodart	doxazosin, finasteride (generic Proscar), tamsulosin (generic Flomax), terazosin
Azor	amlodipine (generic Norvasc) plus Benicar ½**T**
Betaseron **(PA)**	Avonex **(PA)**, Copaxone **(PA)**, Rebif **(PA)**
Cialis	Viagra
Cymbalta	venlafaxine (generic Effexor), venlafaxine extended release capsule (generic Effexor XR)
Diovan*½**T**	losartan (generic Cozaar) ½**T**, Atacand*½**T**, Benicar ½**T**, Micardis
Diovan HCT*	losartan with hydrochlorothiazide (generic Hyzaar), Atacand HCT*, Benicar HCT, Micardis HCT
Flovent	Alvesco♦, Asmanex♦, QVAR♦
Humira **(PA)**	Cimzia **(PA)**, Enbrel **(PA)**, Simponi **(PA)**, Stelara **(PA)**
Lexapro*½**T**	citalopram (generic Celexa), fluoxetine (generic Prozac), paroxetine (generic Paxil), paroxetine sustained release 24 hour (generic Paxil CR), sertraline (generic Zoloft) ½**T**, venlafaxine (generic Effexor), venlafaxine extended release capsule (generic Effexor XR)
Lunesta	zaleplon (generic Sonata), zolpidem (generic Ambien)
Proventil HFA	Ventolin HFA♦
Pulmicort Flexhaler	Alvesco♦, Asmanex♦, QVAR♦
Retin-A Micro **(PA)**	tretinoin **(PA)**
Serevent	Foradil
Simcor	simvastatin (generic Zocor) ½**T** plus Niaspan
Twinject	epinephrine pen, EpiPen
Zegerid Powder for Oral Suspension	omeprazole (generic Prilosec), pantoprazole (generic Protonix)
Zetia	lovastatin, pravastatin (generic Pravachol) ½**T**, simvastatin (generic Zocor) ½**T**, Crestor ½**T**, Lipitor*, Vytorin, Welchol

For enrollee groups eligible for the Enhanced Flexible Formulary, you have an additional feature called Brand for Generic (B4G) which saves you money on certain Brand-Name drugs that have a new generic available. When advantageous to the Plan, this feature allows a Brand-Name drug to be placed on Level 1, the lowest copayment level, and the new generic equivalent to be placed on Level 3, the highest copayment level or excluded. These placements are for a limited time, typically six months, and may be revised mid-year when such changes are advantageous to The Empire Plan.

UnitedHealthcare will notify you when B4G savings are available.
We will also notify your pharmacist so that the lowest cost option will always be dispensed.
Please refer to the DCS website at https://www.cs.ny.gov
for the most current information regarding the B4G feature.

KEY

Generic Drugs are listed in lower case letters. Brand-name drugs are listed with the first letter of the name capitalized.

The symbol * next to a brand-name drug signifies that this drug may be available as a generic in 2011 or 2012. When a generic version is available, mandatory generic substitution will apply, unless the brand-name drug has been placed on Level 1. Use of a covered Level 3 or non-preferred brand-name prescription drug when the generic is available will result in the enrollee paying the applicable Level 3 or non-preferred copayment plus the difference in cost between the brand-name drug and the generic, not to exceed the full retail cost of the drug, unless the brand-name drug has been placed on Level 1 of the Flexible Formulary. **The symbol (g)** next to a brand-name drug indicates that a generic is currently available for at least one or more strengths of the brand medication. When a generic is available for a particular strength of the brand-name drug, that strength of the brand-name drug, if covered, may be Level 3 or non-preferred. **The symbol (PA)** next to a drug name indicates that prior authorization is required. **The symbol ♦** next to a drug indicates a brand-name medication with a Level 1 copayment. **The symbol ½T** next to a drug indicates that certain strengths may be eligible for the Half Tablet Program.

Excluded drugs with 2012 Empire Plan Flexible Formulary Alternatives

Excluded Drugs†	Empire Plan Flexible Formulary Alternatives
Acuvail	diclofenac sodium drops (generic Voltaren Ophthalmic), ketorolac tromethamine drops
Adoxa	doxycycline
Amrix	cyclobenzaprine (generic Flexeril)
Analpram Advanced Kit	hydrocortisone/pramoxine cream
Androgel	Testim
Aplenzin	bupropion hcl extended release, bupropion hcl sustained release
Aricept 23mg	donepezil 5mg, 10mg (generic Aricept)
Asacol HD	Apriso, Asacol, Lialda
BenzEFoam	benzoyl peroxide
Caduet	amlodipine (generic Norvasc) plus Lipitor*
Cambia	diclofenac
carisoprodol 250mg (generic Soma 250mg)	carisoprodol 350mg
Centany AT	mupirocin ointment
Clindacin PAC	clindamycin topical
Clobex Shampoo	clobetasol
Coreg CR	carvedilol (generic Coreg)
cyclobenzaprine extended release capsule (generic Amrix)	cyclobenzaprine (generic Flexeril)
Detrol LA	oxybutynin, oxybutynin extended release, trospium (generic Sanctura), Enablex, Sanctura XR, Vesicare
Dexilant (formerly Kapidex)	omeprazole (generic Prilosec), pantoprazole (generic Protonix)
Doryx	doxycycline
doxycycline hyclate extended release tablet (generic Doryx)	doxycycline
doxycycline monohydrate 150mg capsule (generic Adoxa 150mg capsule)	doxycycline
Edluar	zaleplon (generic Sonata), zolpidem (generic Ambien)
Epiduo	adapalene (generic Differin) **(PA)** plus benzoyl peroxide
Extavia	Avonex **(PA)**, Copaxone **(PA)**, Rebif **(PA)**
Flector	Voltaren Gel
Genotropin **(PA)°**	Nutropin **(PA)**, Nutropin AQ **(PA)**, Saizen **(PA)**, Tev-Tropin **(PA)**
Humatrope **(PA)°°**	Nutropin **(PA)**, Nutropin AQ **(PA)**, Saizen **(PA)**, Tev-Tropin **(PA)**
Jalyn	finasteride (generic Proscar) plus tamsulosin (generic Flomax)
lansoprazole capsule	omeprazole (generic Prilosec), pantoprazole (generic Protonix)
Metozolv ODT	metoclopramide
Momexin Kit	mometasone furoate topical plus ammonium lactate
Morgidox Kit	doxycycline
Naprelan	diclofenac, ibuprofen, naproxen
Neobenz Micro	benzoyl peroxide
Nexium	omeprazole (generic Prilosec), pantoprazole (generic Protonix)
Norditropin **(PA)°°°**	Nutropin **(PA)**, Nutropin AQ **(PA)**, Saizen **(PA)**, Tev-Tropin **(PA)**
Olux/Olux-E Complete Pack	clobetasol
omeprazole/sodium bicarbonate capsule (generic Zegerid)	omeprazole (generic Prilosec), pantoprazole (generic Protonix)
Omnitrope **(PA)**°	Nutropin **(PA)**, Nutropin AQ **(PA)**, Saizen **(PA)**, Tev-Tropin **(PA)**
Orbivan	butalbital/acetaminophen/caffeine

° Excluded, except for the treatment of growth failure due to Prader-Willi syndrome or Small for Gestational Age.
°° Excluded, except for the treatment of growth failure due to SHOX deficiency or Small for Gestational Age.
°°° Excluded, except for the treatment of short stature associated with Noonan syndrome or Small for Gestational Age.
† Coverage for prescription drugs excluded under the benefit plan design are not subject to exception. This includes prescription medications excluded from coverage under The Empire Plan Flexible Formulary. **New prescription drugs may be subject to exclusion when they become available in the market. Please refer to the DCS website at https://www.cs.ny.gov or call The Empire Plan Prescription Drug Program toll free at 1-877-7-NYSHIP (1-877-769-7447) for current information regarding exclusions of newly launched prescription drugs.**

Excluded Drugs†	Empire Plan Flexible Formulary Alternatives
Pacnex HP/Pacnex LP/Pacnex MX	benzoyl peroxide
Pennsaid	Voltaren Gel
Prevacid Capsule	omeprazole (generic Prilosec), pantoprazole (generic Protonix)
Requip XL	ropinirole (generic Requip)
Rybix ODT	tramadol, tramadol extended release
Ryzolt	tramadol, tramadol extended release
Silenor	doxepin
Soma 250	carisoprodol 350mg
Sumaxin TS	sodium sulfacetamide/sulfur
Terbinex	terbinafine (generic Lamisil) **(PA)**
Tobradex ST	tobramycin/dexamethasone drops (generic Tobradex)
Treximet	naproxen sodium plus sumatriptan (generic Imitrex)
Triaz	benzoyl peroxide
Tribenzor	amlodipine (generic Norvasc) plus hydrochlorothiazide plus Benicar **½T** or amlodipine (generic Norvasc) plus Benicar HCT
Tricor	fenofibrate, Antara, Fenoglide, Lipofen, Triglide
Trilipix	fenofibrate, Antara, Fenoglide, Lipofen, Triglide
Twynsta	amlodipine (generic Norvasc) plus Micardis
Uramaxin GT	urea
Veltin	tretinoin **(PA)** plus clindamycin topical
Veramyst	flunisolide, fluticasone (generic Flonase), Nasonex
Vimovo	naproxen plus omeprazole (generic Prilosec)
Xerese	Zovirax Ointment, Cream
Xopenex Inhalation Solution	albuterol inhalation solution
Zegerid Capsule	omeprazole (generic Prilosec), pantoprazole (generic Protonix)
Ziana	tretinoin **(PA)** plus clindamycin topical
Zipsor	diclofenac, ibuprofen, naproxen
Zuplenz	ondansetron (generic Zofran)
Zyclara	imiquimod (generic Aldara)

° Excluded, except for the treatment of growth failure due to Prader-Willi syndrome or Small for Gestational Age.
°° Excluded, except for the treatment of growth failure due to SHOX deficiency or Small for Gestational Age.
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THE EMPIRE PLAN

Effective
January 1, 2012

2012 EMPIRE PLAN PREFERRED DRUG LIST

Administered by UnitedHealthcare

The following is a list of the most commonly prescribed generic and brand-name drugs included on the 2012 Empire Plan Preferred Drug List. **This is not a complete list of all prescription drugs on the preferred drug list or covered under the Empire Plan.** This list is subject to change due to FDA approval of new brand and generic drugs and product availability. For specific questions about your prescriptions, coverage and copayments, please call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select The Empire Plan Prescription Drug Program or visit the website at https://www.cs.ny.gov. Click on Benefit Programs, then NYSHIP Online. Provide your group and plan information if prompted. On the resulting NYSHIP Online page, select Using Your Benefits and scroll to the 2012 Empire Plan Preferred Drug List link.

For the enrollee: ***Enrollees are encouraged to ask their doctors to prescribe generic versions of brand-name drugs whenever appropriate, as this will result in a lower copayment. Generic medications contain the same active ingredients as their corresponding brand-name medications, although they may look different in color or shape. They have been FDA-approved under strict standards.***

For the physician: ***Please prescribe Level 1 or generic and Level 2 or preferred products when medically appropriate for your patients.***

A

acarbose (generic Precose)
acetaminophen with codeine
acetaminophen with hydrocodone
Actonel
Actoplus Met*
Actos*½T
acyclovir
adapalene (generic Differin) **(PA)**
Adcirca **(PA)**
Advair
Advicor
albuterol
albuterol inhalation solution
albuterol/ipratropium solution
alendronate sodium tablet (generic Fosamax)
alprazolam/alprazolam extended release
Altoprev
Alvesco
amantadine
amiodarone
amitriptyline
amlodipine (generic Norvasc)
amlodipine and benazepril (generic Lotrel)
amoxicillin
amoxicillin with potassium clavulanate (generic Augmentin)
amphetamine with dextroamphetamine salt combination
amphetamine with dextroamphetamine salt combination extended release (generic Adderall XR)
ampicillin
Ampyra **(PA)**
Antara
Apokyn
Apriso
Asacol
Asmanex
Atacand*½T
Atacand HCT*
atenolol
atenolol with chlorthalidone
aviane
Avonex **(PA)**
azelastine (generic Optivar)
azelastine nasal spray (generic Astelin)
azithromycin (generic Zithromax)
Azopt

B

balsalazide disodium (generic Colazal)
Baraclude
benazepril
benazepril with hydrochlorothiazide
Benicar ½T
Benicar HCT
benzoyl peroxide/erythromycin
benztropine
betamethasone dipropionate
betaxolol
Betimol
BiDil
bisoprolol with hydrochlorothiazide
Boniva
brimonidine
budesonide (generic Entocort EC)
bupropion hcl
bupropion hcl extended release
bupropion hcl sustained release
buspirone
butalbital/acetaminophen/caffeine
butalbital/aspirin/caffeine
butorphanol nasal spray
Byetta
Bystolic

C

captopril
captopril with hydrochlorothiazide
carbamazepine
carbidopa/levodopa
Cardizem LA **(g)***
carisoprodol 350mg
carvedilol (generic Coreg)
cefaclor
cefadroxil
cefdinir (generic Omnicef)
cefprozil
cefuroxime
Celebrex
Cenestin
cephalexin
Cetrotide
chlordiazepoxide/clidinium
cholestyramine
ciclopirox solution, non-oral
Cimzia **(PA)**
Ciprodex
ciprofloxacin
ciprofloxacin drops
citalopram (generic Celexa)
clarithromycin (generic Biaxin)
clarithromycin extended release (generic Biaxin XL)
clindamycin (all formulations)
Clindesse
clobetasol
clomiphene
clonazepam
clonidine
clonidine patch (generic Catapres-TTS)
clotrimazole with betamethasone
clozapine
colestipol
Combigan
Combipatch
Combivent
Condylox **(g)***
Copaxone **(PA)**
Creon
Crestor ½T
cromolyn
cromolyn sodium drops
cyanocobalamin injection
cyclobenzaprine (generic Flexeril)
cyclopentolate

KEY

Generic Drugs are listed in lower case letters. Brand-name drugs are listed with the first letter of the name capitalized.

The symbol * next to a brand-name drug signifies that this drug may be available as a generic in 2011 or 2012. When a generic version is available, mandatory generic substitution will apply. Use of a Level 3 or non-preferred brand-name prescription drug when the generic is available will result in the enrollee paying the applicable Level 3 or non-preferred copayment plus the difference in cost between the brand-name drug and the generic, not to exceed the full retail cost of the drug. **The symbol (g)** next to a brand-name drug indicates that a generic is currently available for at least one or more strengths of the brand medication. When a generic is available for a particular strength of the brand-name drug, that strength of the brand-name drug is Level 3 or non-preferred. **The symbol (PA)** next to a drug name indicates that prior authorization is required. **The symbol ½T** next to a drug indicates that certain strengths may be eligible for the Half Tablet Program.

D

desipramine
desmopressin
dextroamphetamine sustained release
diazepam
diclofenac
diclofenac sodium drops (generic Voltaren Ophthalmic)
dicyclomine
digoxin
Dilantin **(g)**
diltiazem (all formulations)
disopyramide
divalproex sodium (generic Depakote)
divalproex sodium extended release (generic Depakote ER)
donepezil 5mg, 10mg (generic Aricept)
dorzolamide (generic Trusopt)
Dovonex **(g)***
doxazosin
doxepin
doxycycline
Duac
Duetact

E

Emend
Enablex
enalapril
enalapril with hydrochlorothiazide
Enbrel **(PA)**
Enjuvia
epinastine drops (generic Elestat)
epinephrine pen
EpiPen
ergotamine/caffeine
erythromycin
erythromycin topical
Estrace Cream
Estraderm
estradiol/norethindrone (generic Activella)
estradiol patch
Estring
estropipate
etidronate disodium
etodolac
Evista

F

famciclovir
Felbatol
felodipine (generic Plendil)
fenofibrate
Fenoglide
fentanyl citrate lollipop **(PA)**
fentanyl transdermal system
finasteride (generic Proscar)
Flarex
fluconazole
flunisolide nasal spray
fluocinonide
fluoxetine (generic Prozac)
flurazepam
flurbiprofen
flurbiprofen drops
fluticasone (generic Flonase)
FML Forte/FML SOP
Follistim AQ
fondaparinux (generic Arixtra)
Foradil
Forteo **(PA)**
fosinopril
fosinopril with hydrochlorothiazide
Frova
furosemide

G

gabapentin
Gabitril*
galantamine (generic Razadyne)
galantamine extended release (generic Razadyne ER)
Gelnique
gemfibrozil
Geodon*
gianvi (generic Yaz)
glimepiride
glipizide
glipizide extended release
glipizide with metformin
glyburide
glyburide micronized
glyburide with metformin
Gonal-F
granisetron (generic Kytril)
guanfacine

H

haloperidol
Helidac
Hepsera
Humalog
Humulin
hydrochlorothiazide
hydrocortisone
hydrocortisone topical
hydroxyzine
hyoscyamine

I

ibuprofen
ibuprofen with hydrocodone
imipramine
imiquimod (generic Aldara)
indapamide
indomethacin
Infergen **(PA)**
Innopran XL
Intron-A **(PA)**
Intuniv
ipratropium inhalation solution
isosorbide
isotretinoin
isradipine
itraconazole **(PA)**

J

Janumet
Januvia

K

kariva
ketoconazole
ketoprofen
ketorolac tromethamine drops

L

labetalol
lamotrigine
lansoprazole capsule (generic Prevacid capsule)
Lantus
latanoprost (generic Xalatan)
leflunomide
Letairis **(PA)**
leuprolide
Levemir
levetiracetam (generic Keppra)
levocetirizine (generic Xyzal)
levofloxacin (generic Levaquin)
levonorgestrel-ethinyl estradiol tablet, dosepack, 3 month (generic Seasonale)
levothyroxine (generic Synthroid)
Lialda
liothyronine (generic Cytomel)
Lipitor*
Lipofen
lisinopril
lisinopril with hydrochlorothiazide
Lofibra Tablet
lorazepam
losartan (generic Cozaar) **½T**
losartan with hydrochlorothiazide (generic Hyzaar)
lovastatin
Lovenox **(g)***
Lumigan
Luveris
Lyrica
Lysteda

M

Maxalt*
medroxyprogesterone 150mg/ml
medroxyprogesterone tablet
meloxicam (generic Mobic)
mesalamine enema
metaxalone (generic Skelaxin)
metformin
metformin extended release
methocarbamol
methotrexate
methylphenidate
methylphenidate extended release
methyltestosterone with esterified estrogens
metoclopramide
metoprolol
metoprolol succinate sustained release (generic Toprol XL)
metronidazole
metronidazole topical
metronidazole vaginal gel
mexiletine
Micardis
Micardis HCT
microgestin fe
minocycline
mirtazapine
mirtazapine dispersible tablet
misoprostol
Moban
moexipril **½T**
mometasone furoate topical
Multaq
mupirocin ointment

KEY

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N

nabumetone
nadolol
nadolol/bendroflumethiazide
Naftin
Namenda
naproxen
Nascobal
Nasonex
nateglinide (generic Starlix)
Niaspan
nifedipine (all formulations)
nisoldipine (generic Sular)
Nitrostat
nizatidine oral solution
nortriptyline
Novolin
Novolog
Noxafil
Nutropin/Nutropin AQ **(PA)**
Nuvaring
nystatin
nystatin with triamcinolone

O

ocella (generic Yasmin)
ofloxacin (generic Floxin)
ofloxacin drops
olanzapine (generic Zyprexa)
omeprazole (generic Prilosec)
omeprazole/sodium bicarbonate capsule (generic Zegerid capsule)
ondansetron (generic Zofran)
Onglyza
Opana ER
orphenadrine/orphenadrine compound
Ovidrel
oxaprozin
oxcarbazepine
oxybutynin/oxybutynin extended release
oxycodone with acetaminophen
oxycodone with aspirin
Oxycontin
oxymorphone (generic Opana)
Oxytrol

P

pantoprazole (generic Protonix)
paroxetine (generic Paxil)
paroxetine sustained release 24 hour (generic Paxil CR)
Peg-Intron **(PA)**
Pegasys **(PA)**
penicillin V potassium
perindopril (generic Aceon) **½T**
phenelzine (generic Nardil)
phenobarbital
phentermine **(PA)**
phenytoin
pilocarpine
piroxicam
Plavix*
podofilox topical
pramipexole (generic Mirapex)
Prandin
pravastatin (generic Pravachol) **½T**
prazosin
Pred Mild
prednisolone
prednisolone drops
prednisone
Prefest
prenatal vitamins (generic)
Prevpac
primidone
prochlorperazine
promethazine
Prometrium
propranolol sustained action capsule
propranolol tablet
Protopic
Pulmicort Respules **(g)***
Pylera

Q

quinapril
quinapril with hydrochlorothiazide
quinidine gluconate
quinidine sulfate
QVAR

R

ramipril
Ranexa
ranitidine
Rebif **(PA)**
Relpax
Restasis
Revatio***(PA)**
ribavirin **(PA)**
rimantadine
risperidone (generic Risperdal)
ropinrole (generic Requip)

S

Saizen **(PA)**
Sanctura XR
Seroquel (except for XR)***½T**
Serostim **(PA)**
sertraline (generic Zoloft) **½T**
Simponi **(PA)**
simvastatin (generic Zocor) **½T**
Singulair*
Soriatane
sotalol
Spiriva
spironolactone
spironolactone with hydrochlorothiazide
Stelara **(PA)**
sucralfate
sulfacetamide/sulfur
sulfamethoxazole with trimethoprim
sulfasalazine
sulindac
sumatriptan (generic Imitrex)
Symbicort
Symbyax*
Symlin

T

Tamiflu
tamoxifen
tamsulosin (generic Flomax)
Tegretol XR **(g)***
temazepam
terazosin
terbinafine (generic Lamisil) **(PA)**
terbutaline
terconazole
tetracycline
Tev-Tropin **(PA)**
theophylline
ticlopidine
timolol maleate
Tirosint
tobramycin drops
tobramycin/dexamethasone drops (generic Tobradex)
tolmetin
topiramate (generic Topamax) **½T**
torsemide
Tracleer **(PA)**
tramadol
tramadol extended release
tramadol with acetaminophen
trandolapril **½T**
tranylcypromine
Travatan/Travatan Z
trazodone
tretinoin **(PA)**
tri-sprintec
triamcinolone topical
triamterene with hydrochlorothiazide
triazolam
Triglide
trinessa
trospium (generic Sanctura)
Tyvaso **(PA)**
Tyzeka

U

V

Vagifem
valacyclovir (generic Valtrex) **½T**
venlafaxine (generic Effexor)
venlafaxine extended release capsule (generic Effexor XR)
Ventavis **(PA)**
Ventolin HFA
verapamil
verapamil sustained release
Vesicare
Vexol
Vfend
Viagra
Victoza
Voltaren Gel
Vivelle/Vivelle Dot
Vytorin
Vyvanse

W

warfarin
Welchol

X

Y

Z

zaleplon (generic Sonata)
Zenpep
zolpidem (generic Ambien)
Zomig
Zorbtive **(PA)**
Zovirax Ointment, Cream

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Examples of Level 3 or Non-Preferred Brand-Name Drugs with 2012 Empire Plan Preferred Drug List Alternatives

Level 3 or Non-Preferred Drugs	Empire Plan Preferred Drug List Alternatives
Abilify **½T**	olanzapine (generic Zyprexa), risperidone (generic Risperdal), Geodon*, Seroquel (except for XR)***½T**
Aciphex	lansoprazole capsule (generic Prevacid capsule), omeprazole (generic Prilosec), omeprazole/sodium bicarbonate capsule (generic Zegerid capsule), pantoprazole (generic Protonix)
Androgel	Testim
Aricept 23mg	donepezil 5mg, 10mg (generic Aricept)
Avalide*	losartan with hydrochlorothiazide (generic Hyzaar), Atacand HCT*, Benicar HCT, Micardis HCT
Avapro***½T**	losartan (generic Cozaar) **½T**, Atacand***½T**, Benicar **½T**, Micardis
Avelox	ciprofloxacin, levofloxacin (generic Levaquin), ofloxacin
Avodart	doxazosin, finasteride (generic Proscar), tamsulosin (generic Flomax), terazosin
Azor	amlodipine (generic Norvasc) plus Benicar **½T**
Betaseron **(PA)**	Avonex **(PA)**, Copaxone **(PA)**, Rebif **(PA)**
Caduet*	amlodipine (generic Norvasc) plus Lipitor*
Cialis	Viagra
Clobex Shampoo	clobetasol
Cymbalta	venlafaxine (generic Effexor), venlafaxine extended release capsule (generic Effexor XR)
Dexilant (formerly Kapidex)	lansoprazole capsule (generic Prevacid capsule), omeprazole (generic Prilosec), omeprazole/sodium bicarbonate capsule (generic Zegerid capsule), pantoprazole (generic Protonix)
Diovan***½T**	losartan (generic Cozaar) **½T**, Atacand***½T**, Benicar **½T**, Micardis
Diovan HCT*	losartan with hydrochlorothiazide (generic Hyzaar), Atacand HCT*, Benicar HCT, Micardis HCT
Flovent	Alvesco, Asmanex, QVAR
Humatrope **(PA)**	Nutropin **(PA)**, Nutropin AQ **(PA)**, Saizen **(PA)**, Tev-Tropin **(PA)**
Humira **(PA)**	Cimzia **(PA)**, Enbrel **(PA)**, Simponi **(PA)**, Stelara **(PA)**
Levitra	Viagra
Lexapro***½T**	citalopram (generic Celexa), fluoxetine (generic Prozac), paroxetine (generic Paxil), paroxetine sustained release 24 hour (generic Paxil CR), sertraline (generic Zoloft) **½T**, venlafaxine (generic Effexor), venlafaxine extended release capsule (generic Effexor XR)
Lunesta	zaleplon (generic Sonata), zolpidem (generic Ambien)
Nexium	lansoprazole capsule (generic Prevacid capsule), omeprazole (generic Prilosec), omeprazole/sodium bicarbonate capsule (generic Zegerid capsule), pantoprazole (generic Protonix)
Norditropin **(PA)**	Nutropin **(PA)**, Nutropin AQ **(PA)**, Saizen **(PA)**, Tev-Tropin **(PA)**
Ortho Tri-Cyclen Lo	tri-sprintec, trinessa
Premarin Cream	Estrace Cream
Premarin Tablet	estradiol, estropipate, Cenestin, Enjuvia
Premphase	estradiol/norethindrone (generic Activella), Prefest
Prempro	estradiol/norethindrone (generic Activella), Prefest
Proventil HFA	Ventolin HFA
Provigil***(PA)**	amphetamine with dextroamphetamine salt combination, amphetamine with dextroamphetamine salt combination extended release (generic Adderall XR), dextroamphetamine, methylphenidate
Pulmicort Flexhaler	Alvesco, Asmanex, QVAR
Retin-A Micro **(PA)**	tretinoin **(PA)**
Serevent	Foradil
Simcor	simvastatin (generic Zocor) **½T** plus Niaspan
Strattera	amphetamine with dextroamphetamine salt combination extended release (generic Adderall XR), methylphenidate, Intuniv, Vyvanse
Tazorac***(PA)**	adapalene (generic Differin) **(PA)**, tretinoin **(PA)**
Tricor	fenofibrate, Antara, Fenoglide, Lipofen, Triglide
Twinject	epinephrine pen, EpiPen
Veramyst	flunisolide, fluticasone (generic Flonase), Nasonex
Xopenex HFA	Ventolin HFA
Xopenex Inhalation Solution **(g)***	albuterol inhalation solution
Zetia	lovastatin, pravastatin (generic Pravachol) **½T**, simvastatin (generic Zocor) **½T**, Crestor **½T**, Lipitor*, Vytorin, Welchol

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Prior Authorization Drug List for the Empire Plan Prescription Drug Program

The following brand drugs and their generics require prior authorization. Certain medications that may require prior authorization based on age or quantity limitations specifications are not listed here.

Drugs (and their generics) that require Prior Authorization

- Abstral
- Lamisil
- Actemra
- Lazanda
- Actiq
- Letairis
- Adcirca
- Makena
- Amevive
- Myobloc
- Ampyra
- Nuvigil
- Aranesp
- Onsolis
- Avonex
- Orencia
- Betaseron
- Pegasys
- Botox
- Peg-Intron
- Cayston
- Procrit
- Cimzia
- Provigil
- Copaxone
- Rebif
- Dysport
- Remicade
- Egrifta
- Remodulin
- Enbrel
- Revatio
- Epogen
- Ribavirin
- Extavia
- Simponi
- Fentanyl powder
- Sporanox
- Fentora
- Stelara
- Flolan
- Synagis
- Forteo
- Terbinex
- Gilenya
- Tracleer
- Growth Hormone
- Tysabri
- Humira
- Tyvaso
- Immune Globulin
- Veletri
- Incivek
- Ventavis

- Increlex
- Victrelis
- Infergen
- Weight Loss drugs
- Intron-A
- Xeomin
- Kalydeco
- Xolair
- Kineret
- Xyrem
- Kuvan

Point-of-Sale Reject Codes and Descriptions
01 M/I BIN
02 M/I Version Number
03 M/I Transaction Code
04 M/I Processor Control Nbr
05 M/I Pharmacy Number
06 M/I Group Number
07 M/I Cardholder ID Number
08 M/I Person Code
09 M/I Birthdate
10 M/I Patient Gender Code
11 M/I Relationship Code
12 M/I Patient Location
13 M/I Other Coverage Code
14 M/I Eligibility Clarification Code
15 M/I Date of Service
16 M/I Prescription / Service Ref Number
17 M/I Fill Number
18 M/I Metric Quantity
19 M/I Days Supply
20 M/I Compound Code
21 M/I Product/Service ID
22 M/I M/I Dispense As Written (DAW)/Product Selection Code
23 M/I Ingredient Cost Submitted
24 M/I Sales Tax
25 M/I Prescriber ID
26 M/I Unit of Measure
27 M/I Amount Due
28 M/I Date Rx Written
29 M/I # Refills Authorized
30 M/I P.A./M.C. Code & Nbr
32 M/I Level of Service
33 M/I Rx Origin Code
34 M/I Submitted Clarification Code
35 M/I Primary Care Provider Id
36 M/I Clinic Identification
38 M/I Basis of Cost Determination

39	M/I Diagnosis Code
40	Pharmacy Not Contracted on Plan with Date of Service
41	Submit bill to Other Processor or Primary Payer
50	Non-Matched Pharmacy Number
51	Non-Matched Group ID
52	Non-Matched Cardholder ID
53	Non-Matched Person Code
54	Non-Matched Prod/Srv ID Number
55	Non-Matched Product Package Size
56	Non-Matched Prescriber ID
57	Non-Matched P.A./M.C. Nbr
58	Non-Matched Primary Prescriber
59	Non-Matched Clinic ID
60	Product / Service Not Covered for Patient Age
61	Product / Service Not Covered for Patient Gender
62	Patient / Cardholder ID NameMismtch
63	Institutionalized Patient/Product Service ID Not Covered
64	Claim Submitted Does Not Match Prior Authorization
65	Patient is Not Covered
66	Patient Age Exceeds Maximum Age
67	Filled Before Coverage Effective
68	Filled After Coverage Expired
69	Filled After Coverage Terminated
70	Prod/Service Not Covered
71	Prescriber is Not Covered
72	Primary Prscrbr Not Covrd
73	Refills Are Not Covered
74	Other Carrier Payment Meets or Exceeds Payable
75	Prior Authorization Required
76	Plan Limitations Exceeded
77	Discontinued Prod/Service ID Number
78	Cost Exceeds Maximum
79	Refill Too Soon
80	Drug-Diagnosis Mismatch
81	Claim Too Old
82	Claim Is Post-Dated
83	Duplicate Paid/Capt Claim

84 Claim Not Paid/Captured
85 Claim Not Processed
86 Submit Manual Reversal
87 Reversal Not Processed
88 DUR Reject Error
89 Rejected Claim Fees Paid
90 Host Hung Up
91 Host Response Error
92 System/Host Unavailable
93 Planned Unavailable
94 Invald Msg-Undecipherable
95 Time Out
96 Scheduled Downtime
97 Payer Unavailable
98 Connection to Payor Down
99 Host Processing Error
234 M/I Patient E-Mail Address
235 M/I Patient Residence
252 M/I CMS Part D Defined Qualified Facility
253 M/I Medicaid ID Number
254 M/I Medicaid Agency Number
267 M/I Submission Clarification Code Count
286 M/I Delay Reason Code
287 M/I Transaction Reference Number
288 M/I Patient Assignment Indicator (Direct Member Reimbursement Indicator)
289 M/I Route of Administration
290 M/I Compound Type
291 M/I Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN)
292 M/I Pharmacy Service Type
310 M/I Prescriber First Name
311 M/I Prescriber Street Address
312 M/I Prescriber City Address
313 M/I Prescriber State/Province Address
314 M/I Prescriber Zip/Postal Zone
328 M/I Other Payer-Patient Responsibility Amount Qualifier
329 M/I Other Payer-Patient Responsibility Amount

330 M/I Benefit Stage Count
331 M/I Benefit Stage Qualifier
332 M/I Benefit Stage Amount
342 M/I Billing Entity Type Indicator
343 M/I Pay To Qualifier
344 M/I Pay To ID
345 M/I Pay To Name
346 M/I Pay To Street Address
347 M/I Pay To City Address
348 M/I Pay to State/Province Address
349 M/I Pay To Zip/Postal Zone
350 M/I Generic Equivalent Product ID Qualifier
374 M/I Medicaid Paid Amount
378 M/I Compound Ingredient Modifier Code Count
379 M/I Compound Ingredient Modifier Code
572 M/I Medigap ID
569 CMS Appeal Rights Notice (SR 27841)
597 LTC DspType NotSupp PkgTyp (SR 28167)

1C M/I Smk/Non-Smkr Code
1E M/I Prescriber Location Code
1R Version/Release Not Supported
1S Transaction Code/Type Not Supported
1T PCN Must Contain Processor/Payer Assigned Value
1U Transaction Count Does Not Match Number of Transactions
1V Multiple Transactions Not Supported
1W Multi-Ingredient Compound Must Be A Single Transaction
1X Vendor Not Certified For Processor/Payer
1Y Claim Segment Required For Adjudication
1Z Clinical Segment Required For Adjudication
2B M/I Medicaid Indicator
2C M/I Pregnancy Indicator
2D M/I Provider Accept Assignment Indicator
2E M/I Primary Care Provider ID Qualifier
2Q M/I Additional Documentation Type ID
2R M/I Length of Need
2S M/I Length of Need Qualifier

2T M/I Prescriber/Supplier Date Signed
2U M/I Request Status
2V M/I Request Period Begin Date
2W M/I Request Period Recert/Revised Date
2X M/I Supporting Documentation
2Z M/I Question Number/Letter Count
3A M/I Request Type
3B M/I Request Prd Dte-Begin
3C M/I Request Prd Dte-End
3D M/I Basis of Request
3E M/I Authorized Representative First Name
3F M/I Authorized Representative Last Name
3G M/I Auth Rep Street Address
3H M/I Auth Rep City Address
3J M/I Auth Rep State
3K M/I Auth Rep Zip
3M M/I Prescriber Phone Number
3N M/I Prior Auth Nbr-Assign
3P M/I Authorization Number
3Q M/I Facility Name
3R Prior Auth Not Required
3S M/I Prior Auth Supp Doc
3T Active Prior Auth Exists
3U M/I Facility Street Address
3V M/I Facility State/Province Address
3W Prior Auth In Process
3X Authorization# Not Found
3Y Prior Auth Denied
4B M/I Question Number/Letter
4C M/I COB/Other Payment Cnt
4D M/I Question Percent Response
4E M/I Prm Care Prv Last Nme
4G M/I Question Date Response
4H M/I Question Dollar Amount Response
4J M/I Question Numeric Response
4K M/I Question Alphanumeric Response
4M Compound Ingredient Modifier Code Count Does Not Match Number of

Repetitions
4N Question Number/Letter Count Does Not Match Number of Repetitions
4P Question Number/Letter Not Valid for Identified Document
4Q Question Response Not Appropriate for Question Number/Letter
4R Required Question Number/Letter Response for Indicated Document Missing
4S Compound Product ID Requires a Modifier Code
4T M/I Additional Documentation Segment
4W Fill thru Specialty
4X M/I Patient Residence
4Y Patient Residence Not Supported by Plan
4Z Place of Service Not Support By Plan
5C M/I Oth Pay Coverage Type
5E M/I Other Payer Rej Count
5J M/I Facility City Address
6C M/I Other Payer ID Qual
6D M/I Facility Zip/Postal Zone
6E M/I Other Payer Rej Code
6G Coordination Of Benefits/Other Payments Segment Required For Adjudication
6H Coupon Segment Required For Adjudication
6J Insurance Segment Required For Adjudication
6K Patient Segment Required For Adjudication
6M Pharmacy Provider Segment Required For Adjudication
6N Prescriber Segment Required For Adjudication
6P Pricing Segment Required For Adjudication
6Q Prior Authorization Segment Required For Adjudication
6R Worker's Compensation Segment Required For Adjudication
6S Transaction Segment Required For Adjudication
6T Compound Segment Required For Adjudication
6U Compound Segment Incorrectly Formatted
6V Multi-ingredient Compounds Not Supported
6W DUR/PPS Segment Required For Adjudication
6X DUR/PPS Segment Incorrectly Formatted
6Y Not Authorized To Submit Electronically
6Z Provider Not Eligible To Perform Service/Dispense Product
7A Provider Does Not Match Authorization On File
7B Service Provider ID Qualifier Value Not Supported For Processor/Payer

7C M/I Other Payer ID
7D Non-Matched DOB
7E M/I DUR/PPS Code Counter
7F Future date not allowed for Date of Birth
7G Future Date Not Allowed For DOB
7H Non-Matched Gender Code
7J Patient Relationship Code Not Supported
7K Discrepancy Between Other Coverage Code And Other Payer Amt.
7M Discrepancy Between Other Coverage Code And Other Coverage Information On File
7N Patient ID Qualifier Submitted Not Supported
7P Coordination Of Benefits/Other Payments Count Exceeds Number of Supported Payers
7Q Other Payer ID Qualifier Not Supported
7R Other Payer Amount Paid Count Exceeds Number of Supported Groupings
7S Other Payer Amount Paid Qualifier Not Supported
7T Quantity Intended To Be Dispensed Required For Partial Fill Transaction
7U Days Supply Intended To Be Dispensed Required For Partial Fill Transaction
7V Duplicate Refills
7W Refills Exceed allowable Refills
7X Days Supply Exceeds Plan Limitation
7Y Compounds Not Covered
7Z Compound Requires Two Or More Ingredients
8A Compound Requires At Least One Covered Ingredient
8B Compound Segment Missing On A Compound Claim
8C M/I Facility ID
8D Compound Segment Present On A Non-Compound Claim
8E M/I DUR/PPS Lvl of Effort
8G Prod ID must be a single zero for compounds
8H Product/Service Only Covered On Compound Claim
8J Incorrect Product/Service ID For Processor/Payer
8K DAW Code Not Supported
8M Sum Of Compound Ingredient Costs Does Not Equal Ingredient Cost Submitted
8N Future Date Prescription Written Not Allowed
8P Date Written Different On Previous Filling

8Q Excessive Refills Authorized
8R Submission Clarification Code Not Supported
8S Basis Of Cost Not Supported
8T U&C Must Be Greater Than Zero
8U GAD Must Be Greater Than Zero
8V Negative Dollar Amount Is Not Supported In The Other Payer Amount Paid Field
8W Discrepancy Between Other Coverage Code and Other Payer Amount Paid
8X Collection From Cardholder Not Allowed
8Y Excessive Amount Collected
8Z Product/Service ID Qualifier Value Not Supported
9B Reason For Service Code Value Not Supported
9C Professional Service Code Value Not Supported
9D Result Of Service Code Value Not Supported
9E Quantity Does Not Match Dispensing Unit
9G Quantity Dispensed Exceeds Maximum Allowed
9H Quantity Not Valid For Product/Service ID Submitted
9J Future Other Payer Date Not Allowed
9K Compound Ingredient Component Count Exceeds Number Of Ingredients Supported
9M Minimum Of Two Ingredients Required
9N Compound Ingredient Quantity Exceeds Maximum Allowed
9P Compound Ingredient Drug Cost Must Be Greater Than Zero
9Q Route Of Administration Submitted Not Covered
9R Prescription/Service Reference Number Qualifier Submitted Not Covered
9S Future Associated Prescription/Service Date Not Allowed
9T Prior Authorization Type Code Submitted Not Covered
9U Provider ID Qualifier Submitted Not Covered
9V Prescriber ID Qualifier Submitted Not Covered
9W DUR/PPS Code Counter Exceeds Number Of Occurrences Supported
9X Coupon Type Submitted Not Covered
9Y Compound Product ID Qualifier Submitted Not Covered
9Z Duplicate Product ID In Compound
A1 ID Submitted is associated to a Sanctioned Prescriber
A2 ID Submitted is associated to a Deceased Prescriber
A5 Not Covered Under Part D Law

A6 This Medication May Be Covered Under Part B
A7 M/I Internal Control Number
A9 M/I Transaction Count
AA Patient Spenddown Not Met
AB Dte Wrtn after Dte Filled
AC Prd Not Cov Non-Part Mftr
AD ProvNotElig to BillClmTyp
AE QMB-Bill Medicare
AF Patient enrolled under Managed Care
AG Product Days Supply Limit
AH Unit Dose Packaging Only Payable for Nursing Home Recipients
AJ Generic Drug Required
AK M/I Software Vendor/Certification ID
AM M/I Segment Identification
AQ M/I Facility Segment
B2 M/I Service Prov ID Qualifier
BA Compound Basis of Cost Determination Submitted Not Covered
BB Diagnosis Code Qualifier Submitted Not Covered
BC Future Measurement Date Not Allowed
BD Sender Not Authorized To Submit File Type
BE M/I Prof Service Fee Sbm
BF M/I File Type
BG Sender ID Not Certified For Processor/Payer
BH M/I Sender ID
BJ Transmission Type Submitted Not Supported
BK M/I Transmission Type
BM M/I Narrative Message
CA M/I Patient's First Name
CB M/I Patient's Last Name
CC M/I Cardholder's Frst Nme
CD M/I Cardholder's Last Nme
CE M/I Home Plan
CF M/I Employer Name
CG M/I Employer Address
CH M/I Employer City
CI M/I Employer State
CJ M/I Employer Zip Code

CK M/I Employer Phone Number
CL M/I Employer Contact Name
CM M/I Patient Address
CN M/I Patient City
CO M/I Patient State
CP M/I Patient Zip Code
CQ M/I Patient Phone Number
CR M/I Carrier ID
CT Patient Social Security #
CW M/I Alternate ID
CX M/I Patient ID Qualifier
CY M/I Patient ID
CZ M/I Employer ID
DC M/I Dispensing Fee Sbmtd
DN M/I Basis Cost Determntn
DP M/I Drug Type Override
DQ M/I Usual & Customary
DR M/I Doctor's Last Name
DS M/I Postage Amt Claimed
DT M/I Unit Dose Indicator
DU M/I Gross Amount Due
DV M/I Other Payer Amt Paid
DW M/I Basis/Days Supply Det
DX M/I Patient Paid Amount
DY M/I Date of Injury
DZ M/I Claim Reference ID
E1 M/I Prod/Srv ID Qualifier
E3 M/I Incentive Amount Sbm
E4 M/I Reason for Service
E5 M/I Professional Service
E6 M/I Result of Service
E7 M/I Quantity Dispensed
E8 M/I Other Payer Date
E9 M/I Provider ID
EA M/I OrigPrscrbd Prod Code
EB M/I OrigPrscrbd Qty
EC M/I Cmpnd Ingredient Cnt

ED M/I Cmpnd Ingredient Qty
EE M/I Cmpnd Ingredient Cost
EF M/I Cmpnd Dosage FormDesc
EG M/I Cmpnd DispUnitFormInd
EH M/I Cmpnd Route of Admin
EJ M/I OrigPrscrbd Prod Type
EK M/I Scheduled Rx ID Nbr
EM M/I Rx/Srv Nbr Qualifier
EN M/I Assoc Rx/Srv Ref Nbr
EP M/I Assoc Rx/Service Date
ER M/I Procedure Modifier Cd
ET M/I Quantity Prescribed
EU M/I P.A. Type Code
EV M/I P.A. Number Submitted
EW M/I Intermed Auth Type ID
EX M/I Intermed Auth ID
EY M/I Provider ID Qualifier
EZ M/I Prescriber ID Qual
FO M/I Plan ID
G4 Physician must contact plan
G5 Pharmacist must contact plan
G6 Pharmacy Not Contracted in Specialty Network
G7 Pharmacy Not Contracted in Home Infusion Network
G8 Pharmacy Not Contracted in Long Term Care Network
G9 Pharmacy Not Contracted in 90 Day Retail Network
G9c (this message would be used when the pharmacy is not contracted to provide a 90 days supply of drugs)
GE M/I % Sls Tax Amt Sbm
H1 M/I Measurement Time
H2 M/I Measurement Dimension
H3 M/I Measurement Unit
H4 M/I Measurement Value
H5 M/I PrmCareProv Loc Code
H6 M/I DUR Co-Agent ID
H7 M/I Oth Amt Clm Sbm Cnt
H8 M/I Oth Amt Clm Sbm Qual
H9 M/I Oth Amt Clm Sbm

HA M/I Flat Sls Tax Amt Sbm
HB M/I Oth Pay Amt Paid Cnt
HC M/I Oth Pay Amt Paid Qual
HD M/I Dispensing Status
HE M/I Percentage Sales Tax Rate Submitted
HF M/I Quantity Intended To Be Dispensed
HG M/I Days Supply Intended To Be Dispensed
J9 M/I DUR Co-Agent ID Qualifier
JE M/I Percentage Sales Tax Basis Submitted
KE M/I Coupon Type
M1 Patient Not Cvrd-Aid Catg
M2 Recipient Locked In
M3 Host PA/MC Error
M4 Prescription / Service Reference Number Time/Limit Exceeded
M5 Requires Manual Claim
M6 Host Eligibility Error
M7 Host Drug File Error
M8 Host Provider File Error
ME M/I Coupon Number
MG M/I Other Payer BIN Number
MH M/I Other Payer Processor Control Number
MJ M/I Other Payer Group ID
MK Non-Matched Other Payer BIN Number
MM Non-Matched Other Payer Processor Control Number
MN Non-Matched Other Payer Group ID
MP Non-Matched Other Payer Cardholder ID
MR Drug Not on Formulary
MS Multiple members matched - More than 1 Cardholder found - Narrow Search Criteria
MX Benefit Stage Count Does Not Match Number Of Repetitions
MY M/I Address Count
MZ Error Overflow
N1 No patient match found
N7 Use Prior Authorization Code Provided During Transition Period
N8 Use Prior Authorization Code Provided For Emergency Fill
N9 Use Prior Authorization Code Provided For Level of Care Change
NA M/I Address Qualifier

NB M/I Client Name
NC M/I Discontinue Date Qualifier
ND M/I Discontinue Date
NE M/I Coupon Value Amount
NF M/I Easy Open Cap Indicator
NG M/I Effective Date
NH M/I Expiration Date
NJ M/I File Structure Type
NK M/I Inactive Prescription Indicator
NM M/I Label Directions
NN Transaction Rejected at Switch or Intermediary
NR M/I Other Payer-Patient Responsibility Amount Count
NU M/I Other Payer Cardholder ID
NW M/I Most Recent Date Filled
NY M/I Number Of Fills To-Date
P0 Non-zero Value Required for Vaccine Administration
P1 Associated Prescription/Service Reference Number Not Found
P2 Clinical Information Count Out of Sequence
P3 Compound Ingredient Component Count Does Not Match Number of Repetitions
P4 COB / Other Payments Count Does Not Match Number of Repetitions
P5 Coupon Expired
P6 Date of Service Prior to Date of Birth
P7 Diagnosis Code Count Does Not Match Number of Repetitions
P8 DUR/PPS Code Counter Out of Sequence
P9 Field is Non-Repeatable
PA P.A. Exhausted/Not Renewable
PB Invalid Transaction Count for Transaction Code
PC M/I Request Claim Segment
PD M/I Request Clinical Segment
PE M/I Request Coordination of Benefits/Other Payment Segment
PF M/I Request Compound Segment
PG M/I Request Coupon Segment
PH M/I Request DUR/PPS Segment
PJ M/I Request Insurance Segment
PK M/I Request Patient Segment
PM M/I Request Pharmacy Provider Segment

PN M/I Request Prescriber Segment
PP M/I Request Pricing Segment
PQ M/I Narrative Segment
PR M/I Request Prior Auth Segment
PS M/I Transaction Header Segment
PT M/I Worker's Compensation Segment
PU M/I Number Of Fills Remaining
PV Non-Matched Associated Prescription / Service Date
PW Non-Matched Employer ID
PX Non-Matched Other Payer ID
PY Non-Matched Unit Form / Route of Administration
PZ Non-Matched Unit of Measure to Product/Service ID
R0 Professional Service Code Required For Vaccine Incentive Fee
R1 Other Amount Claimed Submitted Count Does Not Match Number of Repetitions
R2 Other Payer Reject Count Does Not Match Number of Repetitions
R3 Procedure Modifier Code Count Does Not Match Number Of Repetitions
R4 Procedure Modifier Code Invalid For Product/Service ID
R5 Product/Service ID Must Be Zero When Product/Service ID Qualifier Equals 06
R6 Product / Service Not Appropriate for this Location
R7 Repeating Segment Not Allowed in Same Transaction
R8 Syntax Error
R9 Value in Gross Amount Due Does Not Follow Pricing Formula
RA PA Reversal Out of Order
RB Multiple Partials Not Allowed
RC Different Drug Entity Between Partial & Completion
RD Mismatch Cardholder / Group ID Partial to Completion
RE M/I Compound Product ID Qualifier
RF Improper Order of Dispensing Status Code on Partial Fill Transaction
RG M/I Assoc Prescription / Service Reference Number on Completion Transaction
RH M/I Associated Prescription/Service Date On Completion Transaction
RJ Associated Partial Fill Transaction Not On File
RK Partial Fill Transaction Not Supported
RL Transitional Benefit/Resubmit Claim
RM Completion Transaction Not Permitted with same Date of Service as Partial Transaction

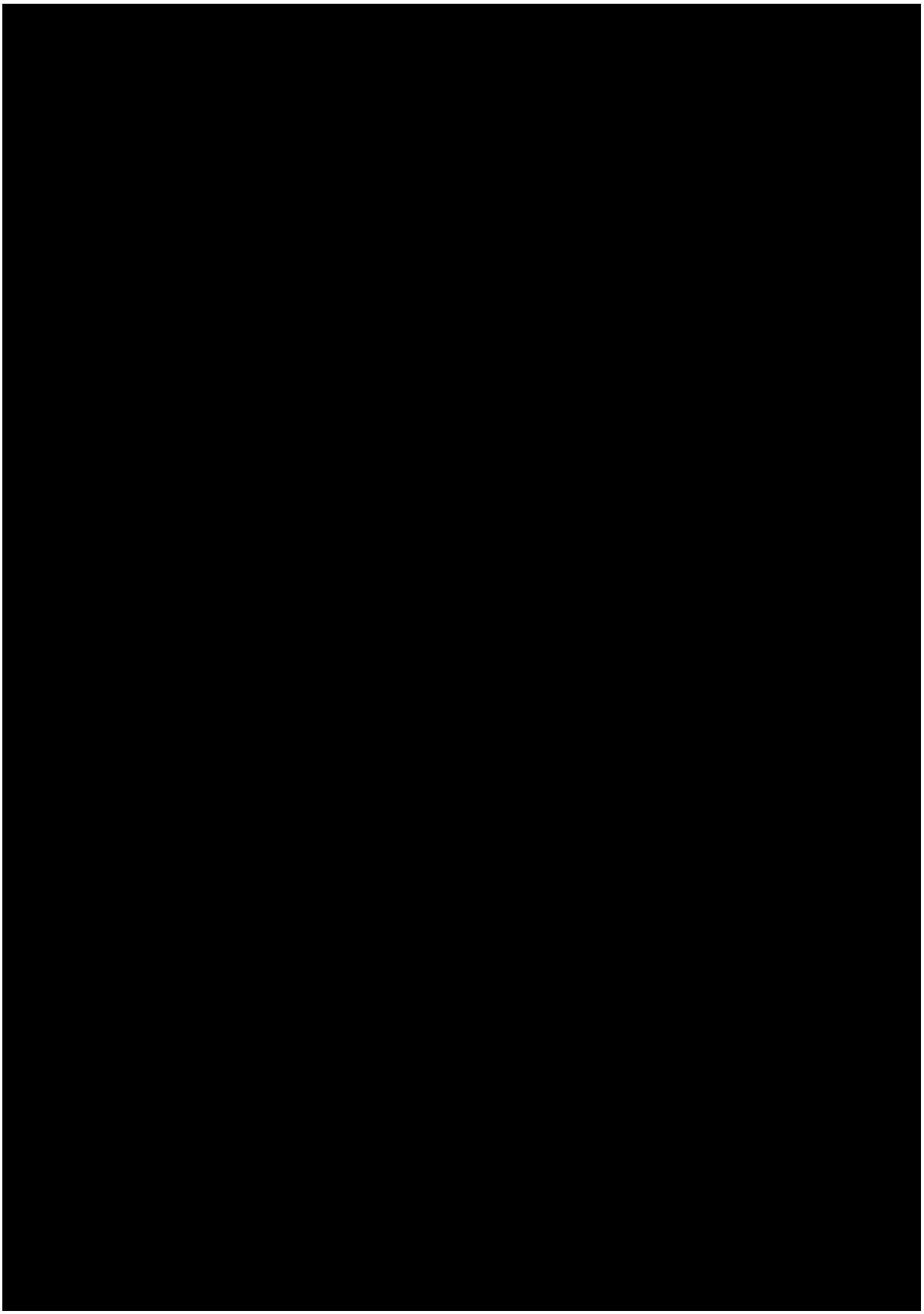
RN Plan Limits Exceeded On Intended Partial Fill Field Limitations
RP Out of Sequence 'P' Reversal on Partial Fill Transaction
RQ M/I Original Dispensed Date
RR M/I Patient ID Qualifier Count
RS M/I Associated Prescription / Service Date on Partial Transaction
RT M/I Associated Prescription / Service Reference Number on Partial Txn
RU Mandatory Data Elements Must Occur Before Optional Data Elements in a Segment
RV Multiple Reversals Per Transmission Not Supported
RW M/I Prescribed Drug Description
RX M/I Prescriber ID Count
RY M/I Prescriber Specialty
RZ M/I Prescriber Specialty Count
S0 Accum Month Count Does Not Match Number of Repetitions
S1 M/I Accumulator Year
S2 M/I Transaction Identifier
S3 M/I Accumulated Patient True Out of Pocket Amount
S4 M/I Accumulated Gross Covered Drug Cost Amount
S5 M/I DateTime
S6 M/I Accum Month
S7 M/I Accum Month Count
S8 Non-Matched Transaction Identifier
S9 M/I Financial Information Reporting Transaction Header Segment
SA M/I Quantity Dispensed To Date
SB M/I Record Delimiter
SC M/I Remaining Quantity
SD M/I Sender Name
SE M/I Procedure Modifier Code Count
SF Other Payer Amount Paid Count Does Not Match Number Of Repetitions
SG Submission Clarification Code Count Does Not Match Number of Repetitions
SH Other Payer-Patient Responsibility Amount Count Does Not Match Number of Repetitions
SJ M/I Total Number Of Sending And Receiving Pharmacy Records
SK M/I Transfer Flag
SM M/I Transfer Type
SN M/I Package Acquisition Cost
SP M/I Unique Record Identifier

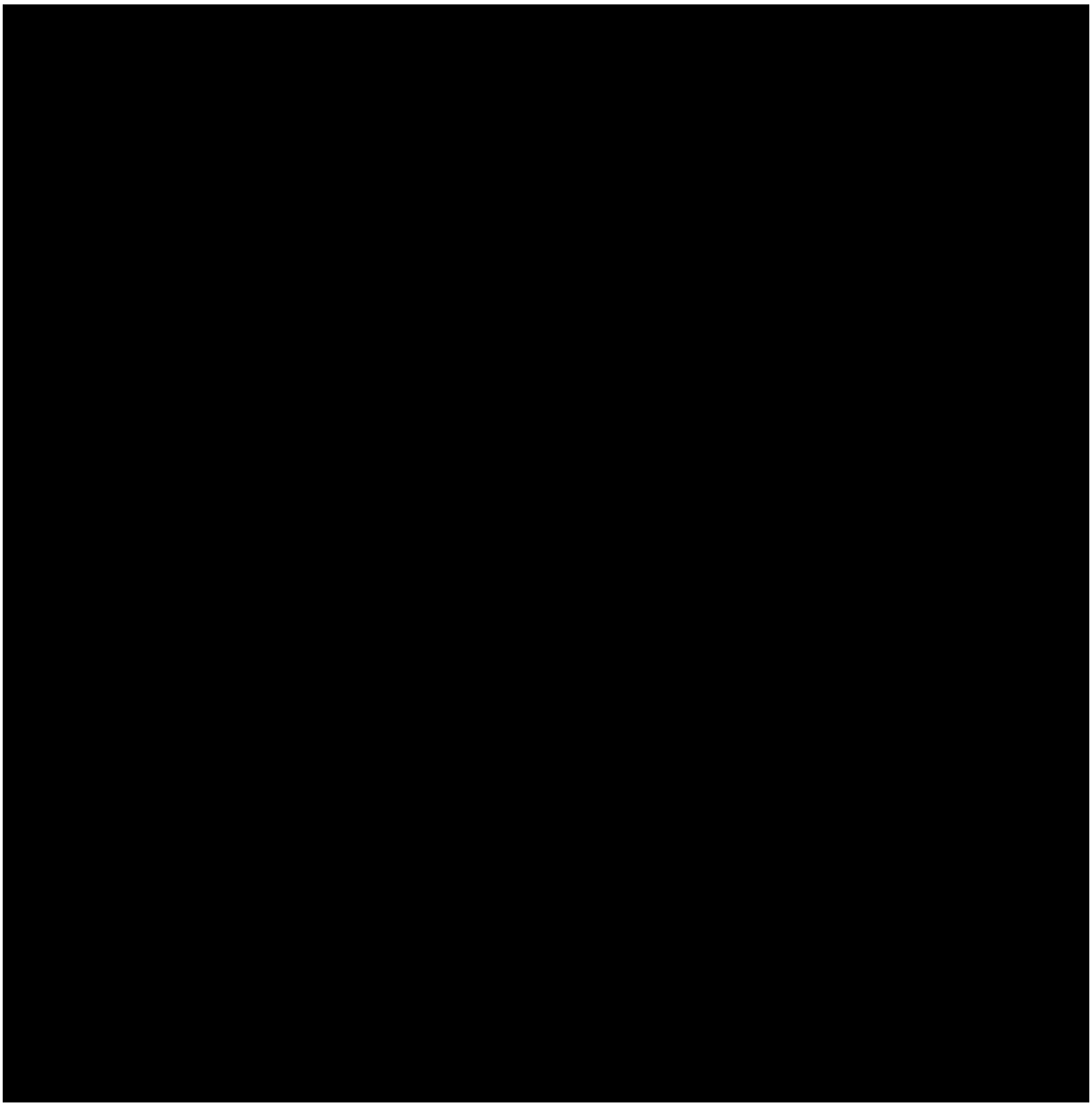
SQ M/I Unique Record Identifier Qualifier
SW Accumulated True Out of Pocket Amount msut be greater than or equal to 0
T0 Accum Month Count Exceeds Number of Occurrences Supported
T1 Request Financial Segment Required for Financial Information Reporting
T2 M/I Request Reference Segment
T3 Out of Order DateTime
T4 Duplicate DateTime
TD M/I Pharmacist Initials
TE M/I Compound Product ID
TF M/I Technician Initials
TG Address Count Does Not Match Number Of Repetitions
TH Patient ID Qualifier Count Does Not Match Number Of Repetitions
TJ Prescriber ID Count Does Not Match Number Of Repetitions
TK Prescriber Specialty Count Does Not Match Number Of Repetitions
TM Telephone Number Count Does Not Match Number Of Repetitions
TN Emergency Fill/Resubmit Claim
TP Level of Care Change/Resubmit Claim
TQ Dosage Exceeds Product Labeling Limit
U0 M/I Sending Pharmacy ID
UA M/I Generic Equivalent Product ID
UE M/I Cmpnd Ingredient Basis Cost of Determination
UU DAW 0 cannot be submitted on a multisource drug with available generics
UZ Other Payer Coverage Type (338-5C) required on reversals to downstream payers. Resubmit reversal with this field.
V0 M/I Telephone Number Count
VA Pay To Qualifier Submitted Not Supported
VB Generic Equivalent Product ID Qualifier Submitted Not Supported
VC Pharmacy Service Type Submitted Not Supported
VD Eligibility Search Time Frame Exceeded
VE M/I Diagnosis Code Count
W0 M/I Telephone Number Qualifier
W5 M/I Bed
W6 M/I Facility Unit
W7 M/I Hours of Administration
W8 M/I Room
W9 Accumulated Gross Drug Cost Amount Must Be Greater Than or Equal

to 0
WE M/I Diagnosis Code Qualifier
X0 M/I Associated Prescription/Service Fill Number
X1 Accumulated Patient True Out of Pocket exceeds maximum
X2 Accumulated Gross Covered Drug Amount exceeds maximum
X3 Out of Order Accumulator Months
X4 Accum Year not current or prior
X5 M/I Financial Information Reporting Request Insurance Segment
X6 M/I Request Financial Segment
X7 FIR Request Insurance Segment Required for Financial Reporting
X8 Procedure Modifier Code Count Exceeds Number Of Occurrences Supported
X9 Diagnosis Code Count Exceeds Number Of Occurrences Supported
XE M/I Clinical Information Counter
XZ M/I Associated Prescription/Service Reference Number Qualifier
Y0 M/I Purchaser Last Name
Y1 M/I Purchaser Street Address
Y2 M/I Purchaser City Address
Y3 M/I Purchaser State/Province Code
Y4 M/I Purchaser Zip/Postal Code
Y5 M/I Purchaser Country Code
Y6 M/I Time of Service
Y7 M/I Associated Prescription/Service Provider ID Qualifier
Y8 M/I Associated Prescription/Service Provider ID
Y9 M/I Seller ID
YA Compound Ingredient Modifier Code Count Exceeds Number Of Occurrences Supported
YB Other Amount Claimed Submitted Count Exceeds Number Of Occurrences Supported
YC Other Payer Reject Count Exceeds Number Of Occurrences Supported
YD Other Payer-Patient Responsibility Amount Count Exceeds Number Of Occurrences Supported
YE Submission Clarification Code Count Exceeds Number of Occurrences Supported
YF Question Number/Letter Count Exceeds Number Of Occurrences Supported
YG Benefit Stage Count Exceeds Number Of Occurrences Supported
YH Clinical Information Counter Exceeds Number of Occurrences Supported
YJ Non-Matched Medicaid Agency Number

YK M/I Service Provider Name
YM M/I Service Provider Street Address
YN M/I Service Provider City Address
YP M/I Service Provider State/Province Code Address
YQ M/I Service Provider Zip/Postal Code
YR M/I Patient ID Associated State/Province Address
YS M/I Purchaser Relationship Code
YT M/I Seller Initials
YU M/I Purchaser ID Qualifier
YV M/I Purchaser ID
YW M/I Purchaser ID Associated State/Province Code
YX M/I Purchaser Date of Birth
YY M/I Purchaser Gender Code
YZ M/I Purchaser First Name
Z0 Purchaser Country Code Not Supported For Processor/Payer
Z1 Prescriber Alternate ID Qualifier Not Supported
Z2 M/I Purchaser Segment
Z3 Purchaser Segment Present On A Non-Controlled Substance Reporting Transaction
Z4 Purchaser Segment Required On A Controlled Substance Reporting Transaction
Z5 M/I Service Provider Segment
Z6 Service Provider Segment Present On A non-Controlled Substance Reporting Transaction
Z7 Service Provider Segment Required On A Controlled Substance Reporting Transaction
Z8 Purchaser Relationship Code Not Supported
Z9 Prescriber Alternate ID Not Covered
ZA The Coordination of Benefits/Other Payments Segment is mandatory to a downstream payer.
ZB M/I Seller ID Qualifier
ZC Associated Prescription/Service Provider ID Qualifier Value Not Supported For Processor/Payer
ZD Associated Prescription/Service Reference Number Qualifier Submitted Not Covered
ZE M/I Measurement Date
ZF M/I Sales Transaction ID
ZK M/I Prescriber ID Associated State/Province Address
ZM M/I Prescriber Alternate ID Qualifier

ZN Purchaser ID Qualifier Value Not Supported For Processor/Payer
ZP M/I Prescriber Alternate ID
ZQ M/I Prescriber Alternate ID Associated State/Province Address
ZX M/I Contract Number (SR 27133)
ZY M/I PBP Number (SR 27133)
ZZ Cardholder ID submitted is inactive. New Cardholder ID on file.





Note: Certain medications that may require prior authorization based on age or quantity limitations specifications are not listed here.

*** Approval period may vary depending on clinical factors such as diagnosis, clinical condition and/or previous use of medication.**

UnitedHealthcare®

Section 3. Supplemental Exhibits

Exhibit Q. Retrospective COB Program Flowchart

Section 3. Supplemental Exhibits

Exhibit P. Claims Processing Process Flow

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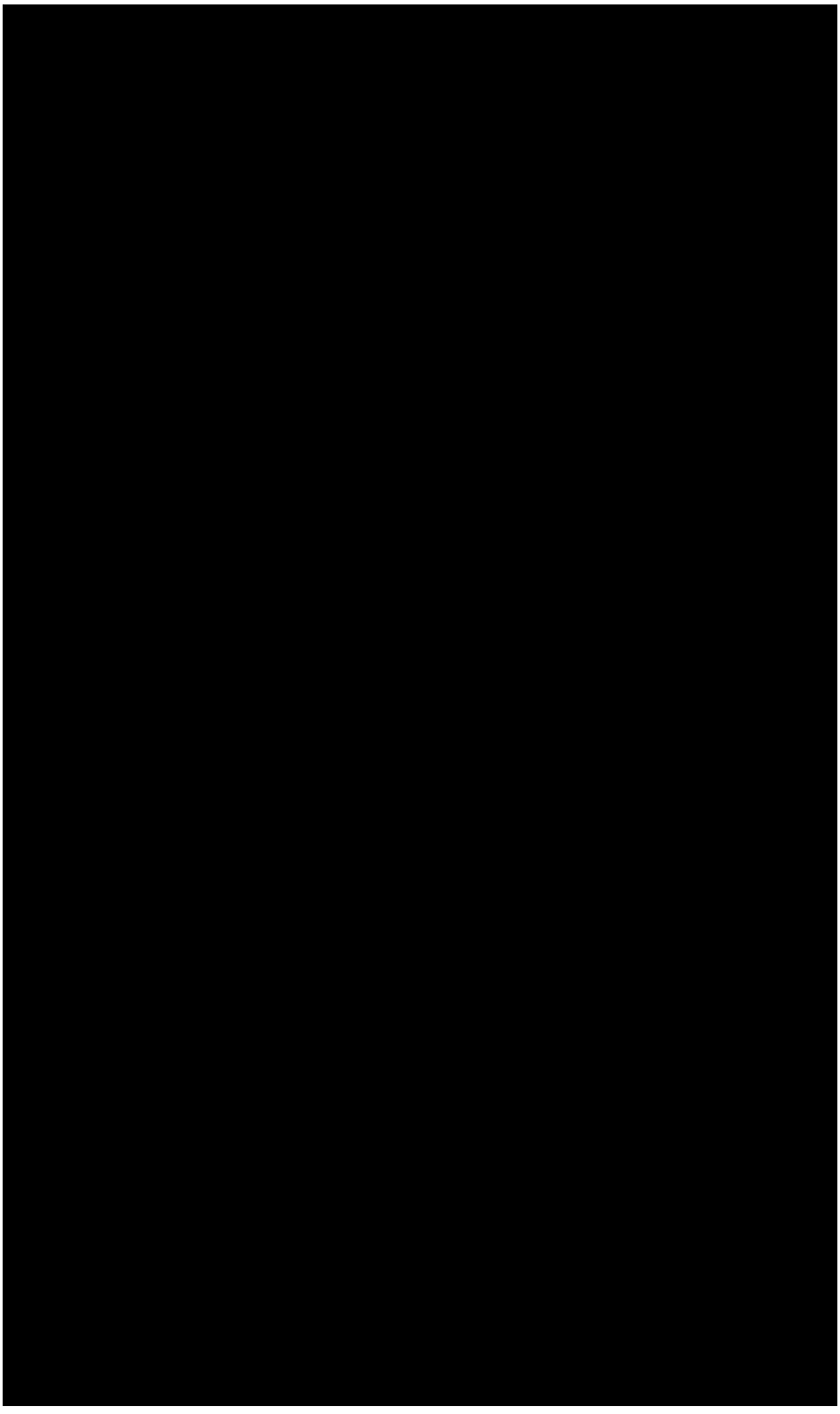

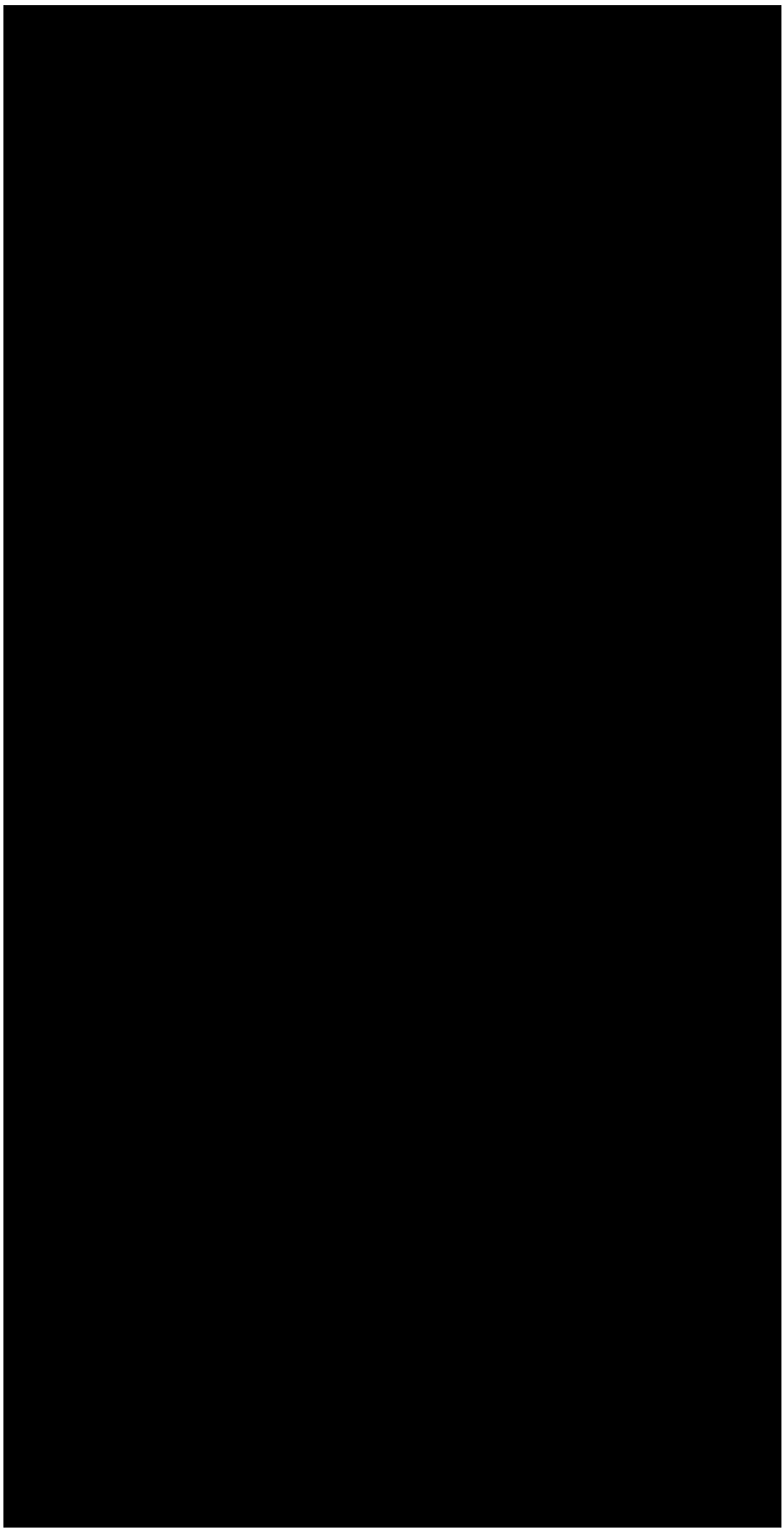

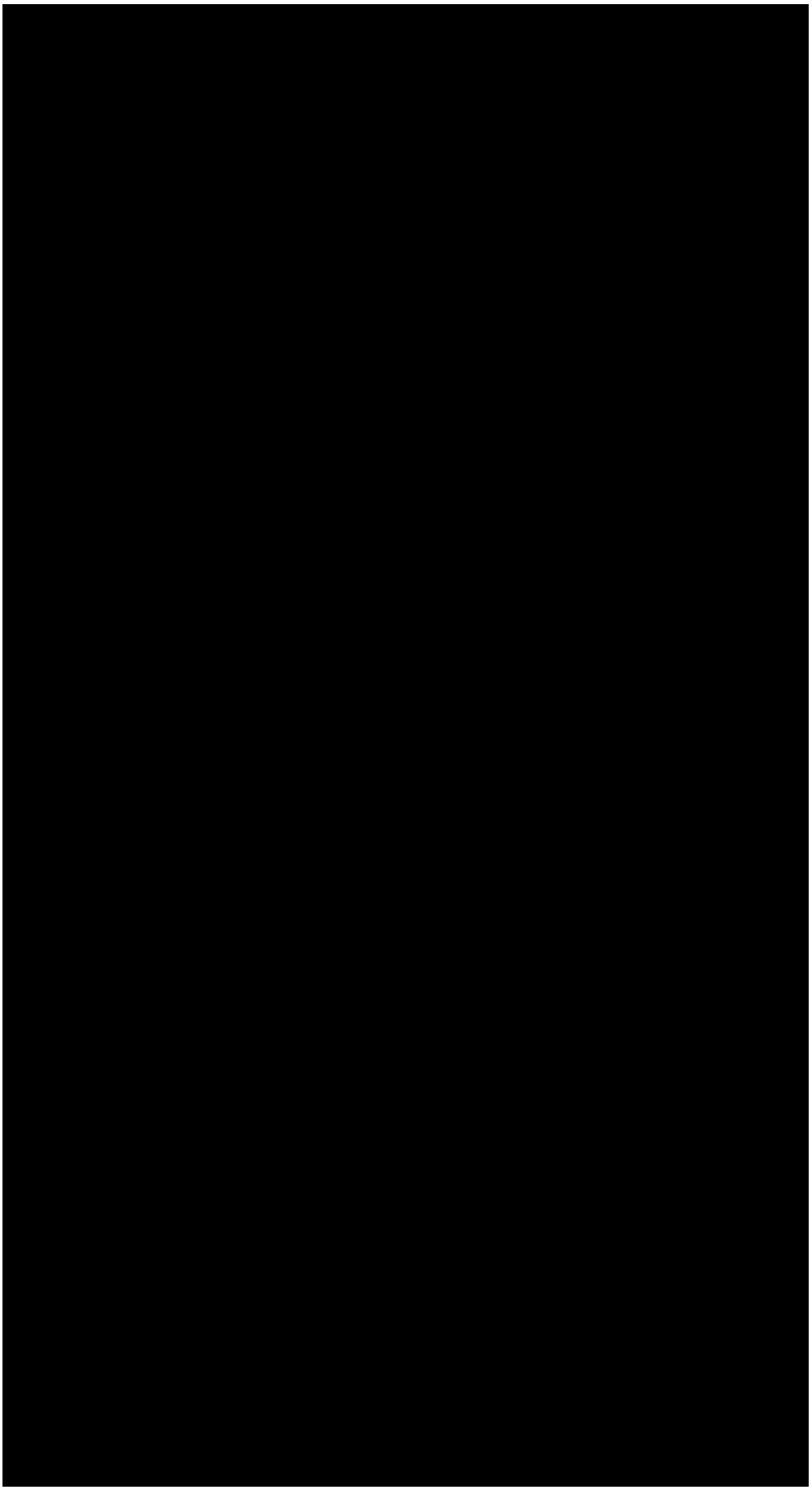

Section 3. Supplemental Exhibits

Exhibit N. Mail Service Pharmacy Process Flow

Section 3. Supplemental Exhibits

Exhibit M.1. 2011 Pharmacy Network Agreement

Exhibit M.2. Network Pharmacy Manual

Our 2011 Pharmacy Network Agreement and Manual are protected under FOIL.

Limited/ Sole Distribution Specialty Drugs *

Medication Name	Distributing Pharmacies
[redacted]	

Medication Name	Distributing Pharmacies
[redacted]	

Medication Name	Distributing Pharmacies
[redacted]	

* Recorded by UnitedHealthcare as of April 15, 2012

Monthly Utilization Report

The client implemented a new formulary on 1/1/2012, and wanted to see the financial impact of their move. A Monthly Summary report was requested with certain metrics to show the impact. This report was delivered electronically in Excel format.

OPTUMRx™ DATA ANALYTICS AND REPORTING

The information contained in this report is confidential and must be restricted to authorized personnel only and only for the purposes authorized under the Pharmacy Services Agreement between Prescription Solutions and the Client.

Client:	XYZ
Report Name:	Monthly Utilization Report
Report Filter:	({Submitted Month} = MARCH-2012, FEBRUARY-2012, JANUARY-2012, DECEMBER-2011, NOVEMBER-2011, OCTOBER-2011) And (Carrier = ZYX)

Carrier	Account	Submitted Month	OCTOBER-2011	NOVEMBER-2011	DECEMBER-2011	JANUARY-2012	FEBRUARY-2012	MARCH-2012	Total
Total		Amount Paid Member Months Utilizing Member Count Rx Count Days Supply Rx Count - % Generic Rx Count - Mail Rx Count - Retail Pharmacy							
PSIXYZ	ACTIVE	Amount Paid							
PSIXYZ	ACTIVE	Member Months							
PSIXYZ	ACTIVE	Utilizing Member Count							
PSIXYZ	ACTIVE	Rx Count							
PSIXYZ	ACTIVE	Days Supply							
PSIXYZ	ACTIVE	Rx Count - % Generic							
PSIXYZ	ACTIVE	Rx Count - Mail							
PSIXYZ	ACTIVE	Rx Count - Retail Pharmacy							
PSIXYZ	RETIREE	Amount Paid							
PSIXYZ	RETIREE	Member Months							
PSIXYZ	RETIREE	Utilizing Member Count							
PSIXYZ	RETIREE	Rx Count							
PSIXYZ	RETIREE	Days Supply							
PSIXYZ	RETIREE	Rx Count - % Generic							
PSIXYZ	RETIREE	Rx Count - Mail							
PSIXYZ	RETIREE	Rx Count - Retail Pharmacy							

Drug Utilization

Client requested utilizers of inhalers in order to do a member communication to implement a new program. This report was delivered electronically in Excel format.

OPTUMRx

DATA ANALYTICS AND REPORTING

The information contained in this report is confidential and must be restricted to authorized personnel only and only for the purposes authorized under the Pharmacy Services Agreement between Prescription Solutions and the Client.

Client:	XYZ
Report Name:	Inhalers Report
Report Filter:	{(Submitted Year) = 2011, 2010) And (Carrier = XYZ) And ({NDC Drug Name} = PROAIR HFA , PROVENTIL , XOPENEX HFA)

Carrier		Member ID	Member Name			NDC Drug Name	NDC Number (11 Digit)	GPI Number (14 Digit)	Filled Date	Submitted Date	Rx Count	Copay	Amount Paid	Drug Quantity	Days Supply
Totals															
PSIXYZ	Client XYZ	000000000	JANE	D	DOE	PROAIR HFA	59310057920	44201010103410	10/04/2010	10/04/2010	1	$38.49	$0.00	9	15

DATA SHARING AND SYSTEM ACCESS AGREEMENT

This Agreement is entered into by and between ("United") and New York DCS Department of Civil Service ("DCS") and is effective on [Effective Date] ("Effective Date"), with respect to the DCS' electronic access to United information and/or United Information Systems as required in the contract for services ("Services Agreement") entered into between the parties dated [Effective Date].

Whereas, United agrees to provide DCS with nonexclusive, nontransferable right to access and use the functionalities contained within United Information Systems under the terms specified below;

Whereas, DCS agrees that all rights, title and interest in United Information Systems and all rights in patents, copyrights, trademarks, and trade secrets encompassed in United Information Systems will remain United's;

Whereas, DCS acknowledges that DCS will obtain, and be responsible for maintaining the hardware, software, and Internet browser requirements necessary to access United Information Systems;

Whereas, DCS will be responsible for obtaining an Internet Services Provider or other access to the Internet, the parties hereby agree to the following:

1. Definitions. The following terms shall have the meanings as set forth below:

1.1 "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of United Information or interference with the operations of any of the DCS Processing Resources. Security Incidents are classified as follows:

(a) "High Severity" or severity 1 (severe impact) means external loss or exposure of United Information, causing significant impact to mission critical information technology systems including large-scale outages. Incidents or exposures classified at this level affect critical United Information Systems and will affect United' customers.

(b) "Medium Severity" or severity 2 (major impact) means internal loss or exposure of United Information, causing significant business interruption. Incidents or exposures classified at this level affect non-critical United Information Systems and may affect United' customers.

(c) "Low Severity" or severity 3 (moderate impact) means loss or exposure of United public information, causing a limited or confined business interruption. Incidents or exposures classified at this level affect United Information Systems or assets, but do not affect United' customers.

1.2 "United Information" includes Private and Confidential Information of United as such is defined in the Agreement, Personal Non-Public Information, as defined under the Gramm-Leach-Bliley Act and implementing regulations ("GLB"), as well as Protected Health Information and Electronic Protected Health Information, as such terms are defined in 45 C.F.R. Parts 160 and 164 (or successor regulations).

1.3 "United Information Systems" means information systems resources supplied or operated by United or its contractors, including without limitation, network infrastructure, computer systems, workstations, laptops, hardware, software, databases, storage media, proprietary applications, printers, and internet connectivity which are owned, controlled or administered by or on behalf of United.

1.4 "DCS Processing" means any information collection, storage or processing performed by DCS or its contractors (i) which directly or indirectly supports the services or functions now or hereafter furnished by United under the Services Agreement, (ii) using any United Information, or (iii) in respect of any other information pertaining to United's business, operations or services.

1.5 "DCS Processing Resources" means information processing resources supplied or operated by DCS, including without limitation, network infrastructure, computer systems, workstations, laptops, hardware, software,

databases, storage media, printers, proprietary applications, Internet connectivity, printers and hard copies which are used, either directly or indirectly, in support of DCS Processing.

2. Security Management

2.1 DCS Security Contact. DCS shall provide a security representative as the single point of contact for United on all security issues who shall be responsible for overseeing compliance with this Agreement.

2.2 Policies and Procedures. DCS shall maintain written security management policies and procedures to prevent, detect, contain, and correct violations of measures taken to protect the confidentiality, integrity, availability, or security of DCS Processing Resources and/or United Information. Such policies and procedures shall (i) assign specific data security responsibilities and accountabilities to specific individual(s); (ii) include a formal risk management program which includes periodic risk assessments; and (iii) provide an adequate framework of controls that safeguard United Information Systems and United Information.

2.3 Infrastructure Protection. DCS shall maintain industry standard procedures to protect DCS Processing Resources, including, at a minimum:

(a) Formal security programs (policies, standards, processes, etc.);
(b) Processes for becoming aware of, and maintaining, security patches and fixes;
(c) Router filters, firewalls, and other mechanisms to restrict access to the DCS Processing Resources, including without limitation, all local site networks which may be accessed via the Internet (whether or not such sites transmit information);
(d) Resources used for mobile access to United Information Systems shall be protected against attack and penetration through the use of firewalls; and
(e) Processes to prevent, detect, and eradicate malicious code (e.g., viruses, etc.) and to notify United of instances of malicious code detected on DCS Processing Resources or affecting United Information.

3. Risk Management

3.1 General Requirements. DCS shall maintain appropriate safeguards and controls and exercise due diligence to protect United Information and DCS Processing Resources against unauthorized access, use, and/or disclosure, considering all of the below factors. In the event of any conflict or inconsistency, DCS shall protect the United Information and DCS Processing Resources in accordance with the highest applicable requirement:

(a) Federal, DCS, legal and regulatory requirements;
(b) Information technology and healthcare industry best practices;
(c) Sensitivity of the data;
(d) Relative level and severity of risk of harm should the integrity, confidentiality, availability or security of the data be compromised, as determined by DCS as part of an overall risk management program;
(e) United' data security requirements, as set forth in this Agreement, the due diligence process and/or in the Agreement; and
(f) Any further information security requirements which are included in a statement of work or equivalent document which is attached to or relates to the Service Agreement.

3.2 Security Evaluations. DCS shall periodically (no less than annually) evaluate its processes and systems to ensure continued compliance with obligations imposed by law, regulation or contract with respect to the confidentiality, integrity, availability, and security of United Information and DCS Processing Resources. DCS shall document the results of these evaluations and any remediation activities taken in response to such evaluations, and provide to United a copy.

3.3 Internal Records. DCS shall maintain mechanisms to capture, record, and examine information relevant to Security Incidents and other security-related events. In response to such events, DCS shall take appropriate action to address and remediate identified vulnerabilities to United Information and DCS Processing Resources.

3.4 United Audits. DCS agrees to permit United or its auditors, or any governmental authority, upon reasonable advance notice, to inspect and examine DCS Processing Resources, the facilities used to perform DCS Processing, as well as policies, procedures, and other records and documentation as reasonably necessary for United to verify DCS' compliance with this Agreement. United reserves the right to require DCS to install appropriate systems management and security software to ensure appropriate protection is in place. United shall not disclose any information learned by United in the course of performing any such inspection or examination except as may be reasonably necessary for United to comply with obligations relating to the protection of United Information or as may otherwise be required by law.

3.5 Remediation. DCS will remedy any High Severity security exposure or finding discovered by United within twenty-four (24) hours from the time the finding is identified and notice is provided to DCS. DCS will remedy any Medium to Low Severity security exposure or finding discovered by United within two (2) to five (5) business days, from the time the finding is identified and notice is provided to DCS. If DCS does not address the exposure or finding within the applicable time obligation, United shall have the right to immediately terminate access to United Information Systems and United Information without penalty to the services related to the access.

3.6 Audit Practices. DCS shall provide to United, at least annually, information on its audit processes, procedures and controls, including a report on any findings and remediation efforts. DCS shall also provide to United an independent attestation of DCS' security practices and process controls that provide sufficient evidence of such practices and controls (e.g., Statements on Auditing Standards 70 Type II equivalent, etc.).

3.7 DCS Locations. Unless previously authorized by United in writing, all work performed by DCS related to the Service Agreement shall be performed from the DCS location(s) designated in Exhibit A of this Agreement.

4. Personnel Security

4.1 Access to United Information. DCS shall require its employees, contractors and agents who have, or may be expected to have, access to United Information or United Information Systems to comply with the provisions of the Service Agreement, this Agreement, including but not limited to any confidentiality provisions binding upon DCS. DCS will remain responsible for any breach of this Agreement by its employees, contractors, and agents.

4.2 Security Awareness. DCS shall ensure that its employees and contractors remain aware of industry standard security practices, and their responsibilities for protecting the United Information. This shall include, but not be limited to:

(a) Protection against malicious software (such as viruses);
(b) Appropriate password protection and password management practices; and
(c) Appropriate use of workstations and computer system accounts.

4.3 Sanction Policy. DCS shall maintain a sanction policy to address violations of DCS' internal security requirements or security requirements which are imposed on DCS by law, regulation, or contract.

4.4 Supervision of Workforce. DCS shall maintain processes for authorizing and supervising its employees, temporary employees, and independent contractors and for monitoring access to United Information, United Information Systems and/or DCS Processing Resources.

4.5 Background Checks. DCS shall maintain processes to determine whether a prospective member of DCS' workforce is sufficiently trustworthy to work in an environment which contains DCS Processing Resources and United Information. At a minimum, such processes shall meet the requirements set forth in the Background Investigations Exhibit to the Agreement.

5. Physical Security. DCS shall maintain appropriate physical security controls (including facility and environmental controls) to prevent unauthorized physical access to DCS Processing Resources and areas in which

United Information is stored or processed. Where practicable, this obligation shall include controls to physically protect hardware (e.g., lockdown devices). DCS shall adopt and implement a written facility security Customer which documents such controls and the policies and procedures through which such controls will be maintained. DCS shall maintain appropriate records of maintenance performed on DCS Processing Resources and on the physical control mechanisms used to secure DCS Processing Resources. DCS shall obtain United' prior written approval prior to moving storage or processing of United Information, or personnel which have access to United Information or United Information Systems, to a location outside the U.S.

6. Software

6.1 Software Licensing. Any access provided to DCS under this Agreement is limited to United Information and United Information Systems and United is not granting DCS a license to use the software programs contained within United Information Systems. Any license to the software programs contained within the United Information Systems shall be pursuant to a separate agreement between the parties.

6.2 Software Usage. DCS shall not attempt to reverse engineer or otherwise obtain copies of the software programs contained in United Information Systems. This Agreement does not transfer DCS title of any ownership rights or rights in patents, copyrights, trademarks and trade secrets included in United Information Systems.

7. Security Monitoring and Response

7.1 Incident Response. DCS shall maintain formal processes to detect, identify, report, respond to, and resolve Security Incidents in a timely manner.

7.2 Incident Notification. DCS shall notify United in writing and provide a resolution Customer within two (2) hours of any Security Incident(s) which result in, or which DCS reasonably believes may result in, unauthorized access to, modification of, or disclosure of United Information, United Information Systems or other United applications.

7.3 Incident Resolution. After obtaining a written notification and resolution from DCS, United will determine the severity of the Security Incident and advise DCS of such severity. If United considers the risk to be a High Severity exposure, DCS must resolve or mitigate the High Severity within twenty-four (24) hours of providing such notice. If United considers the exposure a Medium or Low Severity exposure, then DCS must resolve or mitigate the risk within two (2) to five (5) business days of providing such notice. If DCS does not resolve the Security Incident within the applicable time obligation, United shall have the right to immediately terminate access to United information and United Information Systems without penalty.

7.4 Site Outage. DCS shall promptly report to United any DCS site outages where such outage may impact United or DCS' ability to fulfill its obligations to United.

8. Communication Security

8.1 Exchange of Confidential Information. The parties agree to utilize a secure method of transmission when exchanging Confidential Information electronically.

8.2 Encryption. DCS shall maintain encryption, in accordance with standards mutually agreed upon between the parties, for all transmission of United Information via public networks (e.g., the Internet). Such transmissions include, but are not limited to:

(a) Sessions between web browsers and web servers;
(b) Email containing United Information (including passwords); and
(c) Transfer of files via the Internet (e.g., FTP).

8.3 Protection of Storage Media. DCS shall ensure that storage media containing United Information is properly sanitized of all United Information or is destroyed prior to disposal or re-use for non-DCS Processing. All media on which United Information is stored shall be protected against unauthorized access or modification. DCS

shall maintain reasonable and appropriate processes and mechanisms to maintain accountability and tracking of the receipt, removal and transfer of storage media used for DCS Processing or on which United Information has been stored.

8.4 Data Integrity. DCS shall maintain processes to prevent unauthorized or inappropriate modification of United Information, for both data in transit and data at rest.

9. Access Control

9.1 Identification and Authentication. All access to any United Information or any DCS Processing Resources shall be Identified and Authenticated as defined in this Section. "Identification" refers to processes which establish the identity of the person or entity requesting access to United Information and/or DCS Processing Resources. "Authentication" refers to processes which validate the purported identity of the requestor. For access to United Information or DCS Processing Resources, DCS shall require Authentication by the use of an individual, unique user ID and an individual password or other appropriate Authentication technique approved by United in writing. DCS shall obtain written approval from United prior to using digital certificates as part of DCS' Identification or Authorization processes. DCS shall maintain procedures to ensure the protection, integrity, and soundness of all passwords created by DCS and/or used by DCS in connection with the Service Agreement.

9.2 Account Administration. DCS shall maintain appropriate processes for requesting, approving, and administering accounts and access privileges for DCS Processing Resources and United Information. These processes shall be required for both United-related accounts and DCS' internal accounts for DCS Processing Resources, and shall include procedures for granting and revoking emergency access to DCS Processing Resources and United Information. All access by DCS' employees or contractors to United Information Systems shall be subject to advance approval by United and shall follow United standard policies and procedures.

9.3 Access Control. DCS shall maintain appropriate access control mechanisms to prevent all access to United Information and/or DCS Processing Resources, except by (i) specified users expressly authorized by United and (ii) DCS personnel who have a "need to access" to perform a particular function in support of DCS Processing. The access and privileges granted shall be limited to the minimum necessary to perform the assigned functions. DCS shall maintain processes to ensure that employee or contractor access to Electronic Protected Health Information is revoked no later than 2 business days upon termination. DCS shall maintain appropriate mechanisms and processes for detecting, recording, analyzing, and resolving unauthorized attempts to access United Information or DCS Processing Resources.

10. Network Security

10.1 Authorized Access. DCS shall only have access to United Information Systems authorized by United and shall use such access solely related to the Services Agreement. DCS shall not attempt to access any applications, systems or data which United has not authorized DCS to access or which DCS does not need to access. DCS further agrees to access such applications, data and systems solely to the extent minimally necessary to provide services to United. DCS' attempt to access any applications, data or systems in violation of the terms in this Section 10.1 shall be a material breach of the Agreement.

10.2 Remote Access Requirements. In the event United authorizes DCS to remotely access United Information Systems, DCS shall only do so only from locations approved by United in writing. These locations may include, but are not limited to, DCS primary locations, co-locations, employee home offices, and required business travel destinations. DCS remote access shall be subject to United security and audit controls as referenced below in sections 10.3 and 10.4.

10.3 Remote Access Security Controls. In the event United authorizes DCS to remotely access United Information Systems, unless authorized by United in writing, only United-owned and maintained mobile/PC devices (i.e., laptops, electronic notebooks, desktop PCs, etc) may be used for remote access into United Information Systems. In the event that United approves DCS-owned mobile/PC devices for remote access connections, DCS agrees to the following security controls:

(a) DCS shall procure mobile/PC devices and related operational hardware, manage the facilities used for remote or at home use, and provision access to United systems.
(b) DCS shall establish mutually agreed upon policies, procedures and protocols that are to address the facilities requirements for remote or at home access.
(c) Mobile/PC devices shall be registered with the United security guard or the United manager, as required.
(d) DCS shall restrict administrative rights to mobile/PC device and will provide United field support the rights necessary to verify configuration on periodic basis.
(e) DCS shall configure the mobile/PC device according to United' connectivity requirements, including approved VPN software.
(f) DCS will maintain mobile/PC device password and screen saver safeguards.
(g) DCS shall disable all wireless capability from the mobile/PC device when not in use.
(h) DCS shall only use current, commercially supported operating systems on the mobile/PC device.
(i) DCS shall only use current and up to date patches, hot fixes, and service. United reserves the right to require installation of appropriate systems management and security software to ensure adequate protection.
(j) DCS shall not simultaneously connect to the United network and a non-secure network (third party network or other non-standard connections).
(k) DCS may only connect to United Information Systems through a United approved network.
(l) DCS remote access users shall adhere to United standard authentication protocols including, but not limited to, network and application login accounts, and/or two factor authentication tokens.
(m) DCS shall remotely connect to United systems using only the following United-provided solutions:
    (i) External Corporate Connection through a dedicated private network connection and/or via Virtual Private Network Business To Business Internet Connection ("VPN B2B"), with appropriate firewall rules to restrict connectivity to only required resources, or
    (ii) External Corporate Connection Virtual Private Network Client solution to a specified user group to restrict connectivity to only required resources, or
    (iii) External Corporate Connection with a CITRIX presentation model, restricting connectivity and access to only required resources.

10.4 Remote Access Audit Controls. Unless authorized by United in writing, all contracted work by DCS shall be conducted from the designated DCS locations as referenced in the Service Agreement and/or relevant statement of Work(s). If United authorizes DCS personnel to provide services to United remotely (from a site not identified in the designated DCS list), the following audit controls shall apply:

(a) DCS shall monitor remote or at home users on a periodic basis, which shall include both quarterly onsite audits and a summary report on findings and remediation efforts. DCS shall provide such reports to United.
(b) DCS shall follow the additional confidentiality obligations:
    (i) DCS will not remove any United Information from DCS location(s), and will not print or download any including information resulting from connectivity or access to a United system(s), without prior approval of United.
    (ii) DCS shall inventory any United Information obtained by DCS and shall return or destroy United Information as required by United. If requested by United, DCS shall provide a certificate of secure destruction.
    (iii) DCS will comply with all United policies and procedures regarding the safekeeping of United Information. Policies and procedures must include limitations regarding the storage of information on mobile/PC devices.
    (iv) DCS will keep any United Information, in a locked file cabinet, when such information is not in use.
    (v) DCS will maintain written security management policies and procedures regarding secure possession of United Information when traveling and utilizing United Information in public environments.

11. Business Continuity Management. DCS will, at its sole expense, establish and maintain (i) written business continuity plans for the Services and supporting facilities and (ii) written disaster recovery plans for critical technology and systems infrastructure and (iii) proper risk controls (collectively, the "Contingency Plans") to enable continued performance under this Agreement in the event of a disaster or other unexpected break in Services. DCS will update and test the operability of any applicable Contingency Plan at least annually, and will maintain each such plan upon the occurrence of a disaster event. As used herein, a disaster is defined as an unanticipated incident or event, including, without limitation, force majeure events, technological accidents, or human-caused events, that may causes a material service or critical application to be unavailable without any reasonable prediction for resumption, or that causes data loss, property damage or other business interruption without any reasonable prediction for recovery, within a commercially reasonable time period.

12. System Access Termination. United reserve the right to terminate DCS' System access (i) on the date DCS fails to accept the hardware, software and browser requirements provided by United, including any amendments thereto or (ii) immediately on the date United reasonably determine that DCS has (i) breached, or allowed a breach of, any applicable provision of this Agreement or (ii) materially breached or allowed a material breach of, any other applicable provision of this Agreement. DCS' system access will also terminate upon termination of the Service Agreement, provided however that if run-out is provided in accordance with the Service Agreement, DCS may continue to access applicable functionalities with in the systems during the run-out period. Upon any of the termination events described in this Agreement, DCS agrees to cease all use of United Information Systems, and United will deactivate DCS' identification numbers, passwords, and access to such systems.

13. Compliance with Laws. DCS shall comply with all federal, state, and local laws, regulations, ordinances and requirements relating to the confidentiality, integrity, availability, or security of United Information applicable to DCS' obligations under the Services Agreement. In relation to and in conjunction with DCS' obligations under this Agreement, DCS shall maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of United as required by 45 CFR, Part 164, Subpart C.

14. Third Parties. DCS shall ensure that any agent, including a subcontractor, to whom DCS provides Electronic Protected Health Information agrees to maintain reasonable and appropriate safeguards to protect such Electronic Protected Health Information.

15. Agreements. This Agreement may be modified by a written agreement executed by DCS and United. Notwithstanding the foregoing or anything else, United may amend this Agreement by providing thirty (30) days advance written notice of such amendment if United reasonably determines that such amendment is necessary for United to comply with the Standards for Privacy of Individually Identifiable Health Information or the Security Standards for the Protection of Electronic Protected Health Information (both of which are set forth at 45 CFR Parts 160 and 164) or any other federal, DCS or local law, regulation, ordinance, or requirement relating to the confidentiality, integrity, availability, or security of individually identifiable medical or personal information.

This Agreement may be executed in counterparts, each of which will constitute an original and all of which will be one and the same document.

Acknowledged and agreed:

UNITED HEALTHCARE SERVICE, LLC	**NEW YORK DEPARTMENT OF CIVIL SERVICE**
By: _____	By: _____
Print Name: _____	Print Name: _____
Print Title: _____	Print Title: _____
Date: _____	Date: _____

EXHIBIT A

Locations from which DCS will access United Information Systems:

State of New York - Empire Plan

Prescription Drug Program

Final Financial Statement

3/15/20XX

Statement of Experience

Claim Exhibits

Administrative Exhibits

Section IA

Current Year Experience Projections for the Year Ending 12/31/20XX

COMBINED	(1) Projected at Time of Premium Establishment	(2) 1st Quarter Report	(3) 2nd Quarter Report	(3) 3rd Quarter Report	(3) 4th Quarter Report	(4) Final Report
1. Premium Equivalents	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
2a. Paid Claims	$0	$0	$0	$0	$0	$0
2b. Projected Liability for Outstanding Claims at End of Reporting Period	$0	$0	$0	$0	$0	$0
2c. Projected Liability for Outstanding Claims at Beginning of Reporting Period	$0	$0	$0	$0	$0	$0
2d. Incurred Claims (2a + 2b - 2c)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
3a. Rebate Revenue Receipts	$0	$0	$0	$0	$0	$0
3b. CMS Funding for EGWP Receipts	$0	$0	$0	$0	$0	$0
3c. Coordination of Benefits Receipts	$0	$0	$0	$0	$0	$0
3d. Incurred Claim Adjustments (3a + 3b+3c)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
4. Total Incurred Claims (2d - 3c)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
5a. Claim Administrative Fees	$0	$0	$0	$0	$0	$0
5b. Shared Communication Expense	$0	$0	$0	$0	$0	$0
5c. Audit/Performance Adjustment	$0	$0	$0	$0	$0	$0
5d. Total Retention (5a through 5c)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
6. Projected Premium Equivalents Surplus / (Deficit) (1 - 4 - 5d)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Please note that totals may differ due to rounding

Section IB

Determination of Open & Unreported Claims as of 12/31/20XX

I.	20XX Gross Claims Incurred	$0.00	
	Less: 20XX Gross Claims Incurred Paid Through 12/31/20XX	$0.00	
	20XX Runout due to 20XX Incurrals		$0.00
	Runout Prior to 20XX		$0.00
	Total Runout		$0.00
II.	Administrative Runout Expense		$0.00
III.	20XX Unreported CMS funding for EGWP		$0.00
IV.	20XX Unreported Rebate Revenue		$0.00
V.	Total Projected Open and Unreported		$0.00

Please note that totals may differ due to rounding

Section II

Components of Projected Surplus / Deficit for the 20XX Contract Year
(In Millions)

Components of Projected Surplus /Deficit:	1st Quarter Report	2nd Quarter Report	Renewal Report	3rd Quarter Report	4th Quarter Report	Final Report
Change in Projected 20XX Premium Equivalents	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Change in 20XX Projected Claim Base	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Change in Expected 20XX Trend/Plan Changes	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Change in Expected Rebate Revenue	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Change in Expected 20XX Administration	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Total	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Projected Surplus / Deficit:						
Ghost Premium based on Premium Equivalents	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Projected Surplus / Deficit	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Projected Surplus / Deficit as a % of Ghost Premium	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Please note that totals may differ due to rounding

Section III

20XX Projected Annual Experience - Renewal Year

COMBINED	(1) Total	(2) Empire Plan	(3) SEHP
1. Premium Equivalents	**$0**	**$0**	**$0**
2a. Paid Claims	$0	$0	$0
2b. Projected Liability for Outstanding Claims at End of Reporting Period	$0	$0	$0
2c. Projected Liability for Outstanding Claims at Beginning of Reporting Period	$0	$0	$0
2d. Incurred Claims (2a + 2b - 2c)	**$0**	**$0**	**$0**
3a. Rebate Revenue Receipts	$0	$0	$0
3b. CMS Funding for EGWP Receipts	$0	$0	$0
3c. Coordination of Benefits Receipts	$0	$0	$0
3d. Incurred Claim Adjustments (3a + 3b+3c)	**$0**	**$0**	**$0**
. Total Incurred Claims (2d - 3c)	**$0**	**$0**	**$0**
5a. Claim Administrative Fees	$0	$0	$0
5b. Shared Communication Expense	$0	$0	$0
5c. Audit/Performance Adjustment	$0	$0	$0
5d. Total Retention (5a through 5c)	**$0**	**$0**	**$0**
6. Projected Premium Equivalents Surplus / (Deficit) (1 - 4 - 5d)	**$0**	**$0**	**$0**

Please note that totals may differ due to rounding

State of New York - Empire Plan
Exhibit 1
Projected Incurred Claims 01/01/XX - 12/31/XX

	Incurred & Paid as of 12/31/20XX	Projected Unpaid Incurrals	Total Projected Incurrals
Number of Prescriptions			
Direct	0	0	0
Mail	0	0	0
Pharmacy	0	0	0
Total	0	0	0
Claims Spend			
Direct	$0.00	$0.00	$0.00
Mail	$0.00	$0.00	$0.00
Pharmacy	$0.00	$0.00	$0.00
Total	$0.00	$0.00	$0.00
Average Contracts	00000		
Cost per Prescription			
Direct	$0.00	$0.00	$0.00
Mail	$0.00	$0.00	$0.00
Pharmacy	$0.00	$0.00	$0.00
Composite	$0.00	$0.00	$0.00
Prescriptions per Contract			
Direct	0	0	0
Mail	0	0	0
Pharmacy	0	0	0
Composite	0	0	0
Claims Spend per Contract			
Direct	$0.00	$0.00	$0.00
Mail	$0.00	$0.00	$0.00
Pharmacy	$0.00	$0.00	$0.00
Composite	$0.00	$0.00	$0.00

Please note that totals may differ due to rounding

State of New York - Empire Plan

Exhibit 2

20XX Incurred Claims based on
Claim cycles through XXX, 20XX

Cycle Date	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
20XX	$0												$0
20XX	$0												$0
20XX	$0	$0											$0
20XX	$0	$0											$0
20XX	$0	$0	$0										$0
20XX	$0	$0	$0										$0
20XX	$0	$0	$0	$0									$0
20XX	$0	$0	$0	$0									$0
20XX	$0	$0	$0	$0	$0								$0
20XX	$0	$0	$0	$0	$0								$0
20XX	$0	$0	$0	$0	$0								$0
20XX	$0	$0	$0	$0	$0	$0							$0
20XX	$0	$0	$0	$0	$0	$0							$0
20XX	$0	$0	$0	$0	$0	$0	$0						$0
20XX	$0	$0	$0	$0	$0	$0	$0						$0
20XX	$0	$0	$0	$0	$0	$0	$0	$0					$0
20XX	$0	$0	$0	$0	$0	$0	$0	$0					$0
20XX	$0	$0	$0	$0	$0	$0	$0	$0	$0				$0
20XX	$0	$0	$0	$0	$0	$0	$0	$0	$0				$0
20XX	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0			$0
20XX	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0			$0
20XX	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0		$0
20XX	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0		$0
Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Completion	-	-	-	-	-	-	-	-	-	-	-	-	-
Incurred	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Please note that totals may differ due to rounding

Exhibit 3
20XX Claims Activity by Cycle

Cycle Date	Total Scripts		Total Claims	Cycle Number
Month Day, 20XX	000,000		$00,000,000	1
Month Day, 20XX	000,000		$00,000,000	2
Month Day, 20XX	000,000		$00,000,000	3
Month Day, 20XX	000,000		$00,000,000	4
Month Day, 20XX	000,000		$00,000,000	5
Month Day, 20XX	000,000		$00,000,000	6
Month Day, 20XX	000,000		$00,000,000	7
Month Day, 20XX	000,000		$00,000,000	8
Month Day, 20XX	000,000		$00,000,000	9
Month Day, 20XX	000,000		$00,000,000	10
Month Day, 20XX	000,000		$00,000,000	11
Month Day, 20XX	000,000		$00,000,000	12
Month Day, 20XX	000,000		$00,000,000	13
Month Day, 20XX	000,000		$00,000,000	14
Month Day, 20XX	000,000		$00,000,000	15
Month Day, 20XX	000,000		$00,000,000	16
Month Day, 20XX	000,000		$00,000,000	17
Month Day, 20XX	000,000		$00,000,000	18
Month Day, 20XX	000,000		$00,000,000	19
Month Day, 20XX	000,000		$00,000,000	20
Month Day, 20XX	000,000		$00,000,000	21
Month Day, 20XX	000,000		$00,000,000	22
Month Day, 20XX	000,000		$00,000,000	23
Month Day, 20XX	000,000		$00,000,000	24
20XX Totals	00,000,000		$0,000,000,000	

Please note that totals may differ due to rounding

Exhibit 4
Claims Administrative Fees - 20XX

	[A] Number of Claims	[B] Admin. Fee per Claim	[A] * [B] = [C] Claim Administrative Fees	
Jan	0	$0.00	$0	
Feb	0	$0.00	$0	
Mar	0	$0.00	$0	
	0	$0.00	$0	1st Quarter Total
Apr	0	$0.00	$0	
May	0	$0.00	$0	
Jun	0	$0.00	$0	
	0	$0.00	$0	2nd Quarter Total
Jul	0	$0.00	$0	
Aug	0	$0.00	$0	
Sep	0	$0.00	$0	
	0	$0.00	$0	3rd Quarter Total
Oct	0	$0.00	$0	
Nov	0	$0.00	$0	
Dec	0	$0.00	$0	
	0	$0.00	$0	4th Quarter Total
2010 Total	0	$0.00	$0	

Please note that totals may differ due to rounding

Exhibit 5
Contracts

	Original Contracts		
	Employees	Single	Family
Empire Rx	0	0	0
SEHP	0	0	0
Excelsior Plan	0	0	0
Total	0	0	0

Original Contracts
Contracts for Empire Rx and Excelsior Plan represent actual as of XX

Contracts for SEHP represent average enrollment through XX

OPTUMRx™

Your OptumRx ID Card

Welcome to OptumRx

OptumRx is a leading provider of comprehensive prescription benefit services throughout the United States. We're pleased to welcome you to our pharmacy benefit program.

Please fill in your identification number on the front of each card and keep this ID card with you. Present the card along with your prescription to any participating pharmacy to receive your medication. To find a pharmacy near you, visit our website at **www.PrescriptionSolutions.com** and use our Locate A Pharmacy tool. Presentation does not guarantee eligibility for the holder of this card.

If you have any questions regarding your pharmacy benefit, please call OptumRx Customer Service at
1-800-797-9791
24 hours, 7 days a week.

Please present this card at a participating pharmacy to access your prescription benefits.

OPTUMRx™

Rx BIN: 610494
Rx PCN: 9999
Rx GRP:
Issuer (80840): 9151014609
Rx ID:
Name:

This card is for Pharmacy Benefits
Administered by OptumRx

OPTUMRx™

Rx BIN: 610494
Rx PCN: 9999
Rx GRP:
Issuer (80840): 9151014609
Rx ID:
Name:

This card is for Pharmacy Benefits
Administered by OptumRx

OPTUM™ **www.optumrx.com**

2300 Main Street, Irvine, CA 92614

OptumRx specializes in the delivery, clinical management and affordability of prescription medications and consumer health products. We are an Optum™ company — a leading provider of integrated health services. Learn more at **www.optum.com**.

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This card does not guarantee coverage. Present your ID card along with your prescription when ordering your medication. If you have any questions regarding your pharmacy benefit program, please call Customer Service 7 days a week/24 hrs a day or visit our website.

For Members: www.prescriptionsolutions.com 1-800-797-9791

Pharmacists: www.prescriptionsolutions.com 1-800-797-9791
Claims: PO Box 29044, Hot Springs, AR 71903

This card does not guarantee coverage. Present your ID card along with your prescription when ordering your medication. If you have any questions regarding your pharmacy benefit program, please call Customer Service 7 days a week/24 hrs a day or visit our website.

For Members: www.prescriptionsolutions.com 1-800-797-9791

Pharmacists: www.prescriptionsolutions.com 1-800-797-9791
Claims: PO Box 29044, Hot Springs, AR 71903

OPTUMRx™

Welcome to OptumRx
Your Prescription Benefit Program


OptumRx offers you more ways to improve
your health, while keeping medications
more affordable and accessible.

Welcome to OptumRx

OptumRx manages your pharmacy benefits on behalf of your plan sponsor. Your pharmacy benefit plan helps you and your eligible family members get the prescription drugs you need at affordable costs. We look forward to helping you make informed decisions about your medicine.

We understand that it is important to get the right prescription drug at the right time. Your plan's pharmacy network can help.

Retail Pharmacies

Your plan's retail pharmacy network includes many national chains and most independent pharmacies. For a complete list of participating pharmacies, use the Locate a Pharmacy Tool at **www.PrescriptionSolutions.com** or call one of our helpful Customer Service Advocates at **1-800-797-9791 (TTY 711)**.

Mail Service Pharmacy

Obtaining maintenance drugs — those you take on an ongoing or regular basis — through OptumRx™ Mail Service Pharmacy is safe, easy and affordable. You can get up to a 90-day supply of most maintenance drugs delivered right to your mailbox, often for less than they cost at a retail pharmacy. If you take one or more drugs on an ongoing basis, we encourage you to try the Mail Service Pharmacy. Our website, **www.PrescriptionSolutions.com**, makes it easy to manage your prescriptions. If you have not already done so, we encourage you to register at our website as soon as your pharmacy coverage begins.

Making Health Care Work Better for Everyone

OptumRx (formerly Prescription Solutions) is part of Optum, a leading provider of integrated health services. Our goal is to help make the health care system work better for everyone.

From all of us at OptumRx, we look forward to serving you and helping you make informed prescription drug choices.

Our Website

Our website, **www.PrescriptionSolutions.com**, is easy to use and offers a fast, safe and secure way to refill mail service prescriptions, manage your account, get drug pricing, find helpful information and more.

You can register to use the website on the day your pharmacy benefits begin with OptumRx. Registration is free and takes only minutes. Visit **www.PrescriptionSolutions.com** and:

- Click Register Now
- Enter the required information
- Click Submit

Once you register, you can use your online account to:

- Refill mail service prescriptions
- Shop for medical supplies and over-the-counter products
- Learn how much a drug may cost you
- Get detailed information on thousands of prescription drugs
- Learn about managing your health in the Consumer Health Education section

---

You can also use these helpful tools to manage your drugs:

Medication reminders — sign up for text messages that remind you to refill or take your medicine

My Medicine Cabinet — use this virtual medicine cabinet to see the status of your active mail and retail prescriptions. You can also refill, renew and transfer your prescriptions from retail to mail service, or add over-the-counter medicines you take

Claims history — view past prescription claims

Your Mail Service Pharmacy

The OptumRx Mail Service Pharmacy delivers up to a three-month supply of most maintenance drugs right to your door. These are drugs you take on a long term or ongoing basis. When you use mail service instead of a retail pharmacy, you often pay less for the same drug. Plus, there is no charge for standard shipping to U.S. addresses.

You'll save money and be able to:

- Talk with a licensed pharmacist 24 hours a day, 7 days a week
- Get the same brand-name and generic drugs you get from your retail pharmacy

Here's How it Works

1. Your prescription order enters our processing system.

2. A pharmacist reviews your dosage and checks for drug interactions and allergies.

3. For added safety, another pharmacist double checks your order for accuracy after it is dispensed.

4. For security, we mail your drugs in a plain, tamper-evident package.

Get Started with Mail Service

OptumRx makes getting your medications convenient.

Mail service is an easy way to receive your maintenance drugs. And you may save money. To get started, talk to your doctor about using OptumRx Mail Service Pharmacy. Be sure to ask for a new prescription for up to a 90-day supply with three refills. Then choose one of these easy ways to place your order:

Option 1
Call OptumRx at **1-800-797-9791 (TTY 711)**. We will contact your doctor and help you get you started with mail service.

Option 2
Remove the order form inside this booklet and complete it. Then mail it with your prescriptions in the enclosed envelope.

Timely Reminders

Sign up to get text messages and email reminders. They will help you remember to take your drugs, and when to refill them. Plus, our online calendar gives you, your family and caregivers helpful tips and alerts.

To get started, go to **www.PrescriptionSolutions.com**. Then create or log in to your account. Next, click on Manage My Account, followed by Manage My Medication Reminders. You can also use our mobile site at **m.PrescriptionSolutions.com**.

Retail Pharmacy Network

Your plan's large network of retail pharmacies lets you go to many chain and independent retail pharmacies. Finding one close to you is easy. Just visit **www.PrescriptionSolutions.com**. Then use the Locate A Pharmacy tool. If you still need help, call Customer Service at the number on the back of your ID card.

Using your Member ID Card

Show your ID card each time you fill a prescription at a network pharmacy. They will enter your card information and collect your share of the payment.

If you do not show the pharmacy your ID card, or you fill a prescription at a non-network pharmacy, you must pay 100% of the pharmacy's price for the drug. If the drug is covered by your plan, you can be reimbursed. Just send OptumRx a Direct Member Reimbursement Form with the pharmacy receipt. For a copy of the form, go to **www.PrescriptionSolutions.com**, or call the Customer Service number on the back of your ID card.

Please note: Your plan may not cover prescriptions filled by pharmacies outside the network. If your prescription is eligible for coverage, the reimbursement amount is based on the network pharmacy's cost for the drug, minus your copayment or coinsurance.

All claims are subject to your pharmacy benefit plan's rules and limits. Please see your benefit plan documents for specific coverage information.

Generic Drugs

A generic drug (also know as a generic equivalent), is comparable to a brand-name drug. Generic drugs work the same way in the body, and have the same ingredients, strength, dosage and form as their brand-name counterparts. Generic drugs are safe and effective. Like all prescription drugs, generics are fully tested and FDA approved. Nearly three out of four drugs prescribed in the United States are generics.*

Can generic drugs save me money?
Yes. Generic drugs often cost 80 to 85% less than brand-name drugs. Because of this, you often pay your lowest copayment or coinsurance for generics. Your plan also pays less for generics. By using generics, you help your plan keep your coverage more affordable.

Can I get my prescription drugs in generic form?
Generics are available for many, but not for all brand-name drugs. When generic drugs exist, many plans require you to use them. You and/or your doctor can ask for the brand-name drug, but you may pay more — up to the entire cost of the drug, depending on your plan.

What if my brand-name drug doesn't have a generic?
Ask your doctor or pharmacist if there is a generic alternative for your brand-name drug. A **generic alternative** may not have the same ingredients as the brand-name drug, but it treats the same illness.

How can I lower my costs with generics?
Start by talking with your doctor or pharmacist. To prepare:

- Make a list of your current drugs. Then go over it with your doctor or pharmacist to see if any generic drugs may be right for you.
- When you are prescribed a new drug, ask if a generic is right for you.
- Tell your pharmacist you prefer generic drugs whenever possible.

* Expanding the Use of Generic Drugs. December 2010. http://www.aspe.hhs.gov/sp/reports/2010/GenericDrugs/ib.shtml. Accessed January 23, 2012.

Taking Your Prescription Drugs As Directed

Taking drugs exactly as prescribed by your doctor or pharmacist can improve your health. Missing doses or stopping drugs early can also lead to serious problems. Follow these tips to get the most from your prescription drugs:

- Read the label carefully before taking any drug.
- Ask your doctor or pharmacist what to do if you miss a dose.
- Take each drug as directed, including the correct amount, the correct number of times a day, week, or month, and at the right time of day or night.
- Talk to your doctor or pharmacist before you stop taking a drug, even if you feel better.
- Do not crush or split tablets without talking to your doctor or pharmacist first.
- Keep a list of your current drugs, vitamins and supplements for your records. Include the names, when you take them and why. You may record them using the chart on the next page.
- Write down any problems you have with your drugs. Then discuss them with your doctor or pharmacist.
- Throw away outdated drugs properly. To learn how, call Customer Service, visit **www.PrescriptionSolutions.com** or review the FDA guidelines by searching for "medication disposal" at **www.fda.gov**.
- Keep drugs away from heat, light and moisture. Never store them in the bathroom.
- Make taking your drugs part of your regular schedule.

My Medications

Write down the names of all your prescriptions and other drugs in the chart below. Include why you take them, the prescribed dosage and directions for taking them. Use this list when you see your doctor or pharmacist.

Or go online to see a virtual record of your drugs. You can also keep track of your prescriptions and other drugs online. First, create your online account at **www.PrescriptionSolutions.com**. Then, go to My Prescriptions, then My Medicine Cabinet.

Medication/Dosage:
Reasons for Taking: Directions:

Medication/Dosage:
Reasons for Taking: Directions:

Medication/Dosage:
Reasons for Taking: Directions:

Medication/Dosage:
Reasons for Taking: Directions:

Medication/Dosage:
Reasons for Taking: Directions:

Utilization Management Programs

The cost of prescription drugs is on the rise, for both you and your plan sponsor. To help control costs and make sure you get the proper medicine, your plan includes the programs described below.

Prior Authorization

Prior authorization means that specific criteria must be met before your plan will cover certain drugs. Every prior authorization review is based on clinical guidelines, to make sure you and your family get the most appropriate drugs. Prior authorization may apply to a drug that is:

- Approved to treat only a certain condition
- More costly than other drugs used to treat the same condition or illness
- Not yet proven to be safe and effective in treating your condition

Prior authorization may also apply to make sure that the right steps are being taken before you begin using a drug.

Quantity Limits

Some drugs can only be dispensed in a limited quantity or for a defined period of time. For example, your plan may allow up to 30 tablets of a drug in a 30-day period. Quantity limits help lower the risk of over-use and misuse.

Step Therapy

Step therapy requires you to try one or more specific drugs before the requested drug will be covered by your plan. For example, if Drug A and Drug B both treat your medical condition, your plan may require you to try Drug A first. If Drug A does not work well or is not right for you, then your plan may cover Drug B.

To learn more, visit our website at **www.PrescriptionSolutions.com** or call the Customer Service number on the back of your ID card.

Contact Us

When you have questions, issues or just want to learn more about your plan, there are many ways to contact us. We're here to help.

Website

www.PrescriptionSolutions.com

Customer Service and Mail Service Pharmacy

For general benefit information, as well as mail service refills, order information, or to talk with a pharmacist: **1-800-797-9791 (TTY 711)**

Refill Emergencies

If you need help getting your drugs due to an emergency or natural disaster, call Customer Service. When allowed by your plan, we can help you get an immediate refill from a local pharmacy.

If you are having a medical crisis, call 911 or contact your local emergency assistance service immediately.

For Your Doctor

Prior Authorization

Call **1-800-711-4555**, Option 1

Fax 1-800-527-0531
(5 a.m.-7 p.m., PT, Monday – Friday,
6 a.m.-3 p.m., PT, Saturday)

Specialty Pharmacy

Call **1-866-218-5445**

Fax 1-800-853-3844

My Notes

My Notes

Helping you make the most
of your pharmacy benefits.

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Prescription Solutions

by OPTUMRx™

New Prescription Mail-In Form

1 Please use black or blue ink and mail this completed order form with your new prescription(s). DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.

Primary Member ID Number: Plan Name:		(Additional coverage, if applicable) Secondary Member ID Number: Plan Name:	
Last Name		First Name	MI
Delivery Address			Apt. #
City	State	ZIP	Phone Number ( )
Date of Birth (mm/dd/yyyy) / /	Gender ☐ M ☐ F	Email	
Physician's Name			Physician's Phone Number ( )

2 Health history

If you are a new customer or your allergies or health conditions have changed, please indicate below. The information you provide will allow a more complete review of your current medication request.

Notes to Pharmacy:

Please complete order information on back side.

PRESCRIPTION SOLUTIONS BY OPTUMRX
PO BOX 2975
MISSION KS 66201-1375

RETURN ADDRESS

Post Office will not deliver without proper postage.

3 Generic substitution

FDA-approved generic equivalents will be dispensed for brand-name medications whenever possible, unless you or your physician indicate otherwise. If you require brand-name medications, please list those medications with a "brand-name only" notation below. Note: brand-name medications may be subject to a higher cost.

Notes to Pharmacy:

4 "Keep on file". Do not ship.

All prescriptions will be shipped unless otherwise indicated. If you are including any prescriptions that you want to keep on file for shipment at a later date, please list them below.

Do not ship the following medications:

5 Payment and shipping information — do not send cash.

Standard delivery is at no charge. Most orders arrive about 7 days from the date your completed order is received. If clarification of your order is required, delivery may take longer. If you would like overnight shipping, please indicate below. Please note that expedited shipping only affects shipping time, not the processing time of your order.

You may log on to **www.PrescriptionSolutions.com** to see if drug pricing information is available before enclosing payment. Once shipped, medications may not be returned for a refund or adjustment.

- ☐ **Ship overnight.** Add $12.50 to order amount (subject to change).
- ☐ **Check enclosed.** All checks must be signed and made payable to Prescription Solutions by OptumRx.
- ☐ **Charge to my credit card on file.**
- ☐ **Charge to my NEW credit card.** Visa, MasterCard, AMEX and Discover are accepted.

New Credit Card Number

Expiration Date (Month/Year)

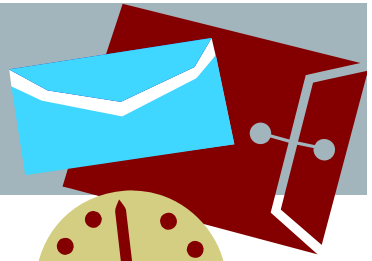
		/				

Signature:

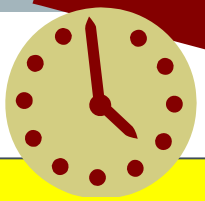
Date:

This credit card will be billed for applicable medications, overnight shipping and outstanding balances. **I authorize Prescription Solutions by OptumRx to maintain my credit card on file as payment method for any future charges or outstanding balances.** To modify payment selection, please contact Customer Service.

Timeline for Deliverables for 2012 PDL Disruption



Section IV. Technical Proposal
Exhibit G – PDL Disruption Timeline Line
May 4, 2012
4-1



- [redacted]

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Timeline for Deliverables for 2012 PDL Disruption Continued

Section IV. Technical Proposal
Exhibit G – PDL Disruption Timeline Line
May 4, 2012
4-2

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

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<DATE>

<MAIL_FULL_NAME>
<MAIL_LN1>
<MAIL_LN2>
<MAIL_CITY>, <MAIL_ST> <MAIL_ZIP>
<MAIL_CNTRY>

Effective Date: <INS_PLN_EFF_DT>

Here are your UnitedHealthcare® MedicareRx for Groups (PDP) member ID cards.

Dear <FULL_NAME>,

We are pleased to have you as a member in the UnitedHealthcare MedicareRx for Groups (PDP) plan for your Medicare Part D prescription drug coverage. Your member ID card is the key to getting your plan's benefits.

You may begin using your member ID card as of the effective date at the top of this letter. If this date has already passed, you can begin using your card now. Please detach both member ID cards right away, and:

- Check your member ID card to make sure that all information is correct. If your card has wrong information, please call Customer Service.
- Keep your member ID card with you at all times so you can easily access your benefits.
- Give the other member ID card to someone who may pick up prescriptions for you, or put it in a safe place in case your first card is lost.

(Over, please)

Fold cards along the perforated lines below and detach by starting with a corner.

UnitedHealthcare®

UnitedHealthcare MedicareRx for Groups (PDP)

RxBin **<RX_BIN>**
RxPCN **<RX_PCN>**
RxGrp **<RX_GRP>**
Issuer **<80840>**
ID **<MEM_NUM>**
Name **<FULL_NAME>**

MedicareRx Prescription Drug Coverage

Plan member since: <PLAN_MEM_SNC>

<CMS_CNTRCT_NUM> <PBP_NUM>

UnitedHealthcare®

UnitedHealthcare MedicareRx for Groups (PDP)

RxBin **<RX_BIN>**
RxPCN **<RX_PCN>**
RxGrp **<RX_GRP>**
Issuer **<80840>**
ID **<MEM_NUM>**
Name **<FULL_NAME>**

MedicareRx Prescription Drug Coverage

Plan member since: <PLAN_MEM_SNC>

<CMS_CNTRCT_NUM> <PBP_NUM>

MCXUHEN000_PD3321475
Y0066_PDP3235058_000 CMS Approved 07082010

Y – M – M

Client Alts	Internal & External Team	Project Details	Color	Color Proofs	Dimensions	Notes
2F YMM	Date: 7.12.11 Creative/Prod. Mgr.: Missy Teff Creative: YMM/Yuliya, Stephanie Job Number: 13696	DMS Number: PDP3321475_000 Depot Number: SPRJ2617 Name: United Replacement ID Carrier UHC MRx_Replace Stage: FINAL Reading Level: 6.9 File Name: PDP3321475_000_071211.indd	K | PMS 072 + 7544 K 072 7544	Required? Pulled? Client Approved?	Flat: 8.5" x 11" Software: InDesign CS4	

Always present your member ID card.

Use your member ID card every time you purchase your prescriptions at one of our 60,000 network pharmacies. Using your member ID card will ensure you pay the plan's discounted prices and that the money you spend on your drugs is correctly tracked. This is especially important as you reach the coverage gap (if applicable), or move out of the coverage gap into catastrophic coverage.

Go to www.UHCMedicareRxforGroups.com to find network pharmacies, request refills or access plan materials.

We're here to answer your questions.

If you have any questions about your coverage or need a replacement member ID card in the future, simply call Customer Service:

Call <TOLL_FREE_NUM>, TTY 711

8 a.m. to 8 p.m. local time, 7 days a week.

www.UHCMedicareRxforGroups.com

Sincerely,

[redacted]

Thomas S. Paul
Chief Executive Officer, UnitedHealthcare Medicare Solutions

This Medicare Prescription Drug Plan (PDP) is insured by UnitedHealthcare Insurance Company or UnitedHealthcare Insurance Company of New York for New York residents (together called "UnitedHealthcare"). UnitedHealthcare contracts with the Federal government as a Medicare-approved Part D sponsor.

Fold cards along the perforated lines below and detach by starting with a corner.

UnitedHealthcare MedicareRx for Groups (PDP)
Customer Care: <TOLL_FREE_NUM>
TTY **711**
Visit www.UHCMedicareRxforGroups.com
Providers submit claims to (pharmacy use only):
UnitedHealthcare MedicareRx for Groups (PDP)
P.O. Box 29046
Hot Springs, AR 71903
Provider Line (pharmacy use only):
1-877-889-6481
Medicare: 1-800-MEDICARE (1-800-633-4227)
TTY/TDD 1-877-486-2048
Issued: 2012

UnitedHealthcare MedicareRx for Groups (PDP)
Customer Care: <TOLL_FREE_NUM>
TTY **711**
Visit www.UHCMedicareRxforGroups.com
Providers submit claims to (pharmacy use only):
UnitedHealthcare MedicareRx for Groups (PDP)
P.O. Box 29046
Hot Springs, AR 71903
Provider Line (pharmacy use only):
1-877-889-6481
Medicare: 1-800-MEDICARE (1-800-633-4227)
TTY/TDD 1-877-486-2048
Issued: 2012

Empire Plan EGWP Program PDL Anticipated Exceptions*

Drug Name/Drug Category	Current NYS Empire Plan Flexible Formulary Coverage	2013 NYS EGWP Formulary Coverage	Comments
PDL Placement Exceptions			
[redacted]			
Quantity Level Limit Exceptions			

[redacted]

*** To date (4/17/12), these are the differences identified between the Empire Plan Flexible Formulary and the 2013 Empire Plan EGWP Program PDL. CMS reviews submitted PDL's in a five stage process in which UnitedHealthcare is currently at Stage 1. As we work through the 2013 implementation, we do not expect drug coverage and exclusions to change. However, clinical criteria and edits may need to be adapted to meet CMS requirements.**

NY State Dept. of Civil Service *Caller Experience*

Caller Dials Dedicated 800 No.

Thank you for calling Prescription Solutions by OptumRx Pharmacy Help Desk. (Spanish prompt.)

So tell me why you're calling:

If you are a pharmacy, press 1.

Member, press 2.

Provider, press 3.

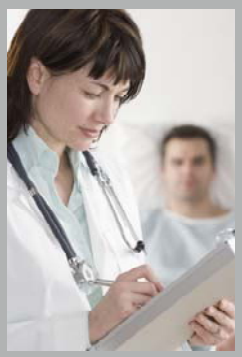
Condor or Input Codes, press 4.

Caller Selects "Pharmacy"

Caller Selects "Member"

Caller Selects "Provider"

Caller Selects "Condor"



Condor Menu and List Announcement

NY State Dept. of Civil Service Member Experience

Member calls customer service dedicated 800# for mail service prescription refill

IVR Server

Claims Database

IVR

Are you a new member? Yes or No?

Ms. Jane Doe
(555) 555-5555

Caller enters Date of Birth and Zip Code to complete authentication

IVR Server

Claims Database

IVR

"Would you like to refill Lexapro?"

YES

IVR

Would you like to use your VISA card on file ending in 5555? Would you like your order mailed to 1234 Main St.?"

TRANSACTION PROCESSED

NY State Dept. of Civil Service Pharmacy Experience

Pharmacist calls the pharmacy help desk number due to a transmission error

IVR

Pharmacy #ABCDE Identified

"Are you calling regarding prescription #123456?"

IVR Server

Claims Database

YES

IVR

"You submitted prescription #123456 with the incorrect gender code, please correct and resubmit"

Pharmacist hangs up and resubmits the claim

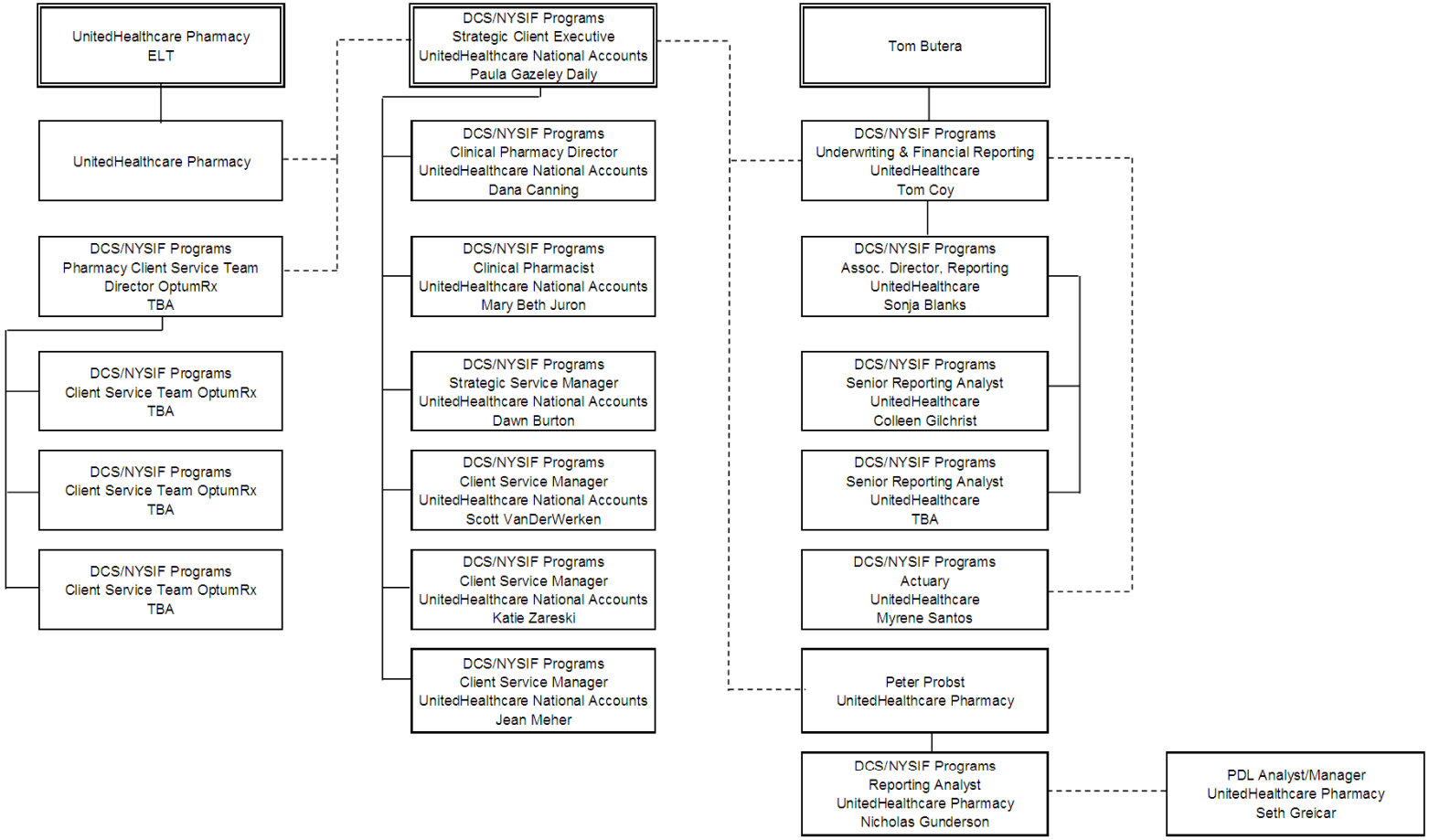
Post-65 Retiree Pharmacy Program Implementation Project Plan						
Status	**Section / Key Task Name**	**Primary Work stream**	**Deadline Date**	**Projected Target Completion**	**Actual Completion**	**Dependencies & Notes**
	1a. Implementation Kick-off	Admin / Set-up Requirements				
	Face-to-Face Kick-Off MTG: Introductions, confirmation of implementation team members/roles, review of overall implementation process and tools	Admin / Set-up Requirements		October 2012		entire core implementation team required to participate - provide employer with draft of implementation guide and project plan
	Review and sign-off on updated project plan including critical dates	Admin / Set-up Requirements		October 2012		
	Initial review of implementation guide - implementation sequence, major work streams, nature of data requirements and responsible parties	Admin / Set-up Requirements		October 2012		
	1b. Decision to implement Part D EGWP plan by State of New York	Admin / Set-up Requirements				
	Benefit plan design decisions finalized/confirmed	Admin / Set-up Requirements		January 2013		
	Review PDL	Admin / Set-up Requirements		Jan. - April 2013		
	File PDL	Admin / Set-up Requirements		April 2013		
	1c. Document Current Retiree Pharmacy Plan Designs	Admin / Set-up Requirements				
	Document current plan designs for plan comparison charts	Admin / Set-up Requirements		April - June 2013		
	Review and sign off on documented information	Admin / Set-up Requirements		May 2013		
	1d. Finalize New Program Eligibility / Event Administration Rules	Admin / Set-up Requirements				
	Review and document eligibility rules	Admin / Set-up Requirements		June 2013		
	State of New York sign-off on eligibility rules	Admin / Set-up Requirements		June 2013		
	1e. Finalize Administration of Employer Subsidy Approach	Subsidy Approach				
	Confirm subsidy approach	Subsidy Approach		June 2013		
	Review and sign off on documented information	Admin / Set-up Requirements		June 2013		
	1f. Eligibility File Development/Transmission Process	Admin / Set-up Requirements				
	Face-to-Face MTG 2: Review and documentation of all data transfer processes, required file formats, etc and and related business rules	Admin / Set-up Requirements		July 2013		entire core implementation team required to participate - provide implementation guide and /or alternative document that captures required data
	Review the file format(s), provide file specifications document(s)	Admin / Set-up Requirements		July 2013		
	Confirm file transfer process, owners and frequency	Admin / Set-up Requirements		July 2013		
	Set-up FTP sites	Admin / Set-up Requirements		Septemberr 2013		
	Provide 1st eligibility test file	Admin / Set-up Requirements		Septemberr 2013		NOTE: needs to be received at a minimum 1 month prior to mail date
	Test file and provide results/error reports	Admin / Set-up Requirements		Septemberr 2013		typically require 5 business days to test
	Provide 2nd eligibility test file	Admin / Set-up Requirements		October 2013		NOTE: needs to be received at a minimum 1 month prior to mail date
	Test file and provide results/error reports	Admin / Set-up Requirements		October 2013		typically require 5 business days to test
	Provide live eligibility file	Admin / Set-up Requirements		October 2013		
	Load final eligibility into UHC eligibility systems	Admin / Set-up Requirements		October 2013		
	Provide reporting to State of New York on status of eligibility	Admin / Set-up Requirements		October 2013		
	Receive and process LEP Attestation File from State of New York	Admin / Set-up Requirements		October 2013		
	Reconcile any retirees who are not accepted per CMS	Admin / Set-up Requirements		October 2013		
	Provide access to weekly reporting via Data Warehouse	Admin / Set-up Requirements		October 2013		
	2a. Finalize UHC Retiree Engagement Approach & Communications Development (review prior to mailing)	Communications				
	Face-to-Face Working MTG 2: Review of UHC Template Approach and Overall Communications strategy planning	Communications		July 2013		
	Confirm communications objectives and success measures	Communications		July 2013		
	Finalize sequence of communication events and deliverables	Communications		July 2013		
	Discuss key messages for each communication event	Communications		July 2013		
	Confirm roles (Draft/Review/Distribute) for each communication piece	Communications		July 2013		
	Align with active health care strategy communications	Communications		July 2013		
	Align with pre-65 health care strategy communications	Communications		July 2013		

EGWP Sample Client Implementation Plan

Status	Section / Key Task Name	Primary Work stream	Deadline Date	Projected Target Completion	Actual Completion	Dependencies & Notes
	Detailed review and update of UHC template communications and identify needed customization	Communications		July 2013		
	Document proposed communications strategy - obtain employer sign-off to move into draft production	Communications		July 2013		
	Announcement Letter					
	Draft of announcement letter by State of New York					
	Detailed review of employer-specific communications / corporate announcement	Communications		August 2013		
	Provide final version of announcement letter to UHC	Communications		September 2013		
	Produce and print: Announcement letter	Communications		September 2013		
	Mail: Announcement letter	Communications		September 2013		
	UHC communications/Opt out					
	Provide first draft of opt out letter and retiree education materials to State of New York for employer review and signoff	Communications		August 2013		
	Incorporate State of New York revisions to retiree education materials			August 2013		
	UHC provide legal review of retiree education materials	Communications		September 2013		
	State of New York signoff on final version of retiree education materials	Communications		September 2013		
	Provide final version of retiree education materials to State of New York	Communications		October 2013		
	Produce and print: State of New York opt out letter and retiree education materials	Communications		October 2013		
	Mail: State of New York opt out letter and retiree education materials	Communications		October 2013		
	3a. Case Installation/Group Set Up Finalization	Admin / Set-up Requirements				
	Employer information entered into all Enrollment systems	Admin / Set-up Requirements		August 2013		all internal case set-up forms must be submitted by this date ("Final UAF")
	Quality Review Group Setup and System Testing	Admin / Set-up Requirements		August 2013		
	3b. Call Center Set-up	Call center				
	Provide 1-800 # for General Member Education	Call center		September 2013		TFN: TBD
	UHC Develop talking points for call centers	Call center		September 2013		
	State of New York review/edits of talking points for call center provide to UHC	Call center		September 2013		
	Training of UHC Benefit Specialists and Job Aid Updates (Train the Trainer Session)	Call center		September 2013		to include overview of employer-specific program changes, recent retiree communications and review of call center job aid
	State of New York receive final talking points for call center	Call center		September 2013		
	State of New York Call Center Training (if needed)	Call center		September 2013		
	UHC Benefit Specialist Call Center "Live" date	Call center		September 2013		
	3c. Data Warehouse	Reporting				
	Provide access to weekly reporting via Data Warehouse	Reporting		October 2013		
	Member acknowledgement letter released to retirees	Reporting		December 2013		
	Member approval letters released to retirees	Reporting		December 2013		
	UHC Medical Welcome Kits/ID cards mailed	Reporting		December 2013		
	Coverage Effective for those Enrolling During Enrollment Period	Reporting		January 2014		
	4a. Implementation closeout	Implementation closeout				
	Implementation debrief meeting	Implementation closeout		May 2014		
	Transition of primary client relationship to UHC client manager	Implementation closeout		May 2014		

UnitedHealthcare

Key Personnel Organizational Chart for the New York State Department of Civil Services



2012 Three-Level Preferred Drug List Reference Guide

Effective January 1, 2012

THE EXCELSIOR PLAN℠
AN EMPIRE PLAN OPTION

Anti-Infectives **Antibiotics** (Oral, inhaled and ear antibiotics are listed)

Level 1	Level 2	Level 3
Amoxicillin	Augmentin	Adoxa **E**
Amoxicillin/Potassium Clavulanate	Cefdinir	Amoxicillin-Clavulanate ER **E**
Ampicillin	Cipro Suspension	Augmentin XR **E**
Azithromycin	Ciprodex Otic	Avelox
Cefadroxil	Clarithromycin	Cipro HC
Cefprozil	Cleocin HCl 75 mg	Ciprofloxacin Tablet, Sustained-Release 24 Hour
Cephalexin Monohydrate	Dapsone	Doryx **E**
Ciprofloxacin Tablet	Ery-Tab 500 mg	Doxycycline Hyclate Enteric-Coated Tablet **E**
Clarithromycin Tablet	Macrodantin 25 mg	Doxycycline Monohydrate Capsule 150 mg **E**
Clindamycin HCl	Tobi	Oracea
Dicloxacillin Sodium	Vancocin HCl **SL**	Solodyn
Doxycycline Monohydrate	Zyvox **SL**	Suprax
Erythromycin		
Levofloxacin		
Metronidazole		
Minocycline HCl		
Neomycin/Polymyxin/HC Otic		
Nitrofurantoin Macrocrystal		
Ofloxacin Otic		
Penicillin V Potassium		
Sulfamethoxazole/Trimethoprim		
Tetracycline HCl		

Anti-Infectives **Antifungals** (Oral and topical antifungals are listed)

Level 1	Level 2	Level 3
Clotrimazole	Clindesse Vaginal	Extina
Fluconazole	Metronidazole Vaginal	Gynazole-1 Vaginal
Itraconazole Capsule **SL**	Mycostatin	Lamisil Granules **SL**
Ketoconazole	Noxafil	
Nystatin	Sporanox Solution, Oral	
Terbinafine HCl Tablet **SL**		
Terconazole Vaginal		

Anti-Infectives **Antivirals**

Level 1	Level 2	Level 3
Acyclovir	Baraclude	Relenza **SL**
Amantadine HCl	Epivir HBV	Tamiflu **SL**
Ribavirin **N**	Famciclovir **SL**	Valtrex **SL**
	Hepsera	
	Rebetol Solution **N**	
	Valacyclovir **SL**	
	Valcyte **SL**	

Cardiovascular/Heart Disease **High Blood Pressure**

Level 1	Level 2	Level 3
Amlodipine	Aldactazide 50-50 mg	Aceon **½T**
Atenolol	Benicar **½T, SL**	Amlodipine/Benazepril **SL**
Benazepril	BiDil	Amturnide **E**
Bisoprolol	Bystolic	Atacand **SL**
Bumetanide	Cardizem	Avalide **SL**
Captopril	Dibenzyline	Azor **SL**
Carvedilol	Eplerenone	Cardizem LA
Chlorthalidone	Metoprolol Succinate Tablet, Sustained-Release 24 Hour 50, 100, 200 mg	Catapres-TTS **SL**
Clonidine HCl	Micardis **SL**	Clonidine Patch **SL**
Diltiazem	Micardis HCT **SL**	Coreg CR **E**
Doxazosin	Nisoldipine 20, 30, 40 mg	Diovan **½T, SL**
Enalapril	Perindopril Erbumine **½T**	Diovan HCT **SL**
Felodipine	Quinapril HCl/Hydrochlorothiazide	Exforge **SL**
Fosinopril	Thalitone	Exforge HCT **SL**
Furosemide		Propranolol HCl Sustained-Action Capsule
Guanfacine HCl		Tarka
Hydralazine		Tekamlo **E**
Hydrochlorothiazide		Tekturna **SL**
Indapamide		Tekturna HCT **SL**
Labetalol HCl		Teveten **SL**

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2012 Three-Level Preferred Drug List Reference Guide

Cardiovascular/Heart Disease High Blood Pressure (cont. from page 1)

Level 1
Lisinopril
Lostartan **½T**
Methyldopa
Metolazone
Metoprolol Succinate Tablet, Sustained-Release 24 Hour 25 mg
Metoprolol Tartrate
Moexipril **½T**
Nadolol
Nifedipine
Propranalol
Quinapril
Ramipril
Spironolactone
Terazosin HCl
Timolol Maleate
Torsemide
Trandolapril **½T**
Triamterene/Hydrochlorothiazide
Verapamil HCl

Level 2

Level 3
Tribenzor **E**
Twynsta **E**
Valturna **E**
Verapamil HCl Capsule, 24 Hour Sustained-Release Pellets

Cardiovascular/Heart Disease High Cholesterol

Level 1
Cholestyramine
Colestipol HCl
Fenofibrate
Gemfibrozil
Lovastatin
Pravastatin Sodium **½T**
Simvastatin **½T**

Level 2
Altoprev **SL**
Antara
Crestor **½T, SL**
Lipitor **SL**
Lipofen
Welchol

Level 3
Advicor **SL**
Atorvastatin **SL**
Caduet **E**
Fenoglide
Lescol XL **SL**
Lovaza **N**
Niaspan
Simcor **SL**
Tricor **E**
Triglide
Trilipix **E**
Vytorin **SL**
Zetia **SL**

Cardiovascular/Heart Disease Other

Level 1
Amiodarone
Digoxin
Mexiletine
Sotalol

Level 2
Lanoxin
Multaq
Nitrostat
Ranexa

Level 3
Nitroglycerin Spray **E**
Nitrolingual **E**
Nistromist **SL**
Propafenone Sustained-Release 12 Hour Capsule

Central Nervous System Attention Deficit Disorder

Level 1
Amphetamine Salt Combo
Dextroamphetamine Sulfate
Methamphetamine HCl Tablet
Methylphenidate

Level 2
Adderall XR **SL**
Intuniv **SL**
Vyvanse **SL**

Level 3
Amphetamine Aspartate/Amphetamine Sulfate/Dextroamphetamine Capsule, Sustained-Release 24 Hour **SL**
Concerta **SL**
Daytrana **SL**
Focalin XR **SL**
Ritalin LA **SL**
Strattera **SL**

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2012 Three-Level Preferred Drug List Reference Guide

Central Nervous System **Depression**

Level 1	Level 2	Level 3
Amitriptyline		Aplenzin **E**
Bupropion HCl		Cymbalta **RS, SL**
Citalopram Hydrobromide		Lexapro **½T, SL**
Doxepin HCl		Luvox CR **SL**
Fluoxetine Capsule **SL**		Paroxetine HCl Sustained-Release, 24 Hour **SL**
Fluvoxamine Maleate		Pexeva **½T, SL**
Imipramine		Pristiq **RS, SL**
Mirtazapine		Venlafaxine Extended-Release **E**
Nortriptyline HCl		
Paroxetine HCl Tablet		
Sertraline HCl **½T**		
Trazodone HCl		
Venlafaxine HCl		

Central Nervous System **Migraine**

Level 1	Level 2	Level 3
Acetaminophen/Caffeine/Butalbital	Cafergot	Alsuma **E**
Aspirin/Caffeine/Butalbital **SL**	Ergomar	Axert **SL**
Relpax **SL**	Sumatriptan Succinate Nasal Spray **SL**	Cambia **E**
Sumatriptan Succinate Injection, Tablet **SL**		Frova **SL**
		Maxalt **SL**
		Migranal
		Treximet **E**
		Zomig **SL**

Central Nervous System **Multiple Sclerosis**

Level 1	Level 2	Level 3
	Ampyra **N, SL**	Betaseron **N, SL**
	Avonex **N, SL**	Extavia **E**
	Copaxone **N, SL**	Gilenya **N**
	Rebif **N, SL**	

Central Nervous System **Sedatives/Hypnotics**

Level 1	Level 2	Level 3
Temazepam		Ambien **SL**
Triazolam		Edluar **E**
Zaleplon **SL**		Lunesta **SL**
Zolpidem Tartrate **SL**		Rozerem **SL**
		Sonata **SL**

Central Nervous System **Seizure Disorders**

Level 1	Level 2	Level 3
Carbamazepine	Carbamazepine Tablet, Sustained-Release 12 Hour	Depakote ER
Clonazepam	Dilantin	Keppra
Divalproex Sodium Tablet	Divalproex Sodium Sprinkle	Keppra XR
Divalproex Sodium Tablet, Sustained-Release	Felbatol	Lamictal Dose Pack **SL**
Lamotrigine	Gabitril	Lamictal ODT
Levetiracetam	Mysoline	Lamictal XR
Oxcarbazepine	Sabril	Lyrica **SL**
Phenobarbital	Tegretol	Stavzor
Phenytoin Sodium		Topamax
Topiramate		
Zonisamide		

Central Nervous System **Other**

Level 1	Level 2	Level 3
Alprazolam	Apokyn	Abilify **SL**
Benztropine Mesylate	Comtan	Aricept 23 mg **E**
Buspirone HCl	FazaClo	Invega **SL**
Carbidopa/Levodopa	Geodon **SL**	Mirapex ER **E**
Clozapine	Seroquel **SL**	Namenda
Diazepam	Symbyax **SL**	Nuvigil **N, SL**
Donepezil 5 mg, 10 mg	Tasmar	Provigil **E**
Lithium Carbonate	Xyrem **N, SL**	Requip XL **E**
Lorazepam	Zyprexa **SL**	Seroquel XR **SL**
Risperidone **SL**		Zyprexa Zydis **SL**
Ropinirole HCl		

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2012 Three-Level Preferred Drug List Reference Guide

Dermatology

Level 1

Alclometasone Dipropionate
Betamethasone
Ciclopirox
Clindamycin Phosphate
Clobetasol Propionate
Clotrimazole/Betamethasone
Desonide
Econazole Nitrate
Erythromycin
Fluocinonide
Fluticasone Propionate
Halobetasol Propionate
Hydrocortisone
Ketoconazole
Lidocaine HCl
Metronidazole
Mometasone Furoate
Mupirocin
Nystatin
Silver Sulfadiazine
Sulfacetamide Sodium/Sulfur
Tretinoin **N**
Triamcinolone Acetonide
Urea

Level 2

Azelex **SL**
Benzaclin 25 gm
Benzamycin
Ciclopirox Shampoo 1% **MC**
Clindamycin Phosphate/Benzoyl Peroxide Gel 1%-5% **SL**
Condylox Gel
Differin Cream, Gel 0.1% **N, SL**
Isotretinoin
Oxsoralen-Ultra
Protopic **N, SL**
Regranex **N**
Retin-A Micro **N, SL**
Stelara **N, SL**

Level 3

Adapalene **N, SL**
Aldara
Altabax **SL**
Atralin **MC, N, SL**
Bactroban **SL**
Benzaclin 50 gm **E**
Brevoxyl **E**
Clindamycin Phosphate Foam 1% **SL**
Clobex **SL**
Clobex Shampoo **E**
Cutivate Lotion **MC**
Denavir
Desonate **SL**
Differin Gel 0.3% **N, SL**
Duac-CS **SL**
Elidel **N, SL**
Epiduo **E**
Evoclin **SL**
Finacea
Locoid Lipocream **SL**
Loprox Shampoo **MC**
Metrogel 1% **MC**
Momexin Kit **E**
Naftin
NeoBenz Micro **E**
NeoBenz Micro SD **E**
Olux-E **SL**
Olux-Olux-E **E**
Taclonex **SL**
Tazorac **N, SL**
Triaz **E**
Xerese **E**
Ziana **E**
Zyclara **E**

Endocrine/Diabetes **Growth Hormone**

Level 1

Level 2

Nutropin, AQ, NuSpin **N, SL**
Saizen **N, SL**
Serostim **N, SL**
Tev-Tropin **N, SL**

Level 3

Genotropin **E**
Humatrope **E**
Norditropin **E**
Omnitrope **E**
Zorbtive **N, SL**

Endocrine/Diabetes **Insulin**

Level 1

Humalog Vials
Humulin Vials

Level 2

Humalog Pens/Cartridges
Humulin Pens
Lantus Vials
Levemir Vials

Level 3

Apidra
Lantus Solostar Pens/Cartridges
Novolin 70/30 Vials
Novolin L Vials
Novolin N Vials
Novolin R Vials
NovoLog FlexPen
NovoLog Mix 70/30 Vials
NovoLog Vials

Endocrine/Diabetes **Non-Insulin**

Level 1

Acarbose
Glimepiride
Glipizide
Glyburide
Glyburide/Metformin HCl
Metformin HCl

Level 2

Actoplus Met **SL**
Actos **½T, SL**
Byetta **SL**
Duetact **SL**
Glipizide/Metformin HCl
Glyset
Janumet **SL**
Januvia **SL**
Prandin **SL**

Level 3

Fortamet
Glumetza
Onglyza **SL**
Starlix **SL**
Symlin
Victoza **SL**

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Eye Conditions **Anti-Allergy**

Level 1	Level 2	Level 3
Ketorolac Tromethamine	Optivar **SL**	Azelastine HCl **SL**
		Bepreve **SL**
		Elestat **E**
		Emadine **E**
		Epinastine **E**
		Pataday **E**
		Patanol **E**

Eye Conditions **Antibiotics**

Level 1	Level 2	Level 3
Ciprofloxacin HCl	Blephamide S.O.P.	Azasite **SL**
Erythromycin	Tobramycin/Dexamethasone	Tobradex ST **E**
Gentamicin Sulfate		Vigamox
Neomycin/Polymyxin B Sulfate/Dexamethasone		Zylet
Ofloxacin		Zymar
Polymyxin B Sulfate/Trimethoprim		Zymaxid **SL**
Sulfacetamide Sodium		
Tobramycin Sulfate Drops		

Eye Conditions **Glaucoma**

Level 1	Level 2	Level 3
Acetazolamide	Alphagan P 0.1% **SL**	Iopidine 1%
Apraclonidine	Azopt **SL**	
Brimonidine Tartrate	Betimol **SL**	
Dorzolamide HCl	Brimonidine Tartrate 0.15%	
Latanoprost **SL**	Combigan **SL**	
Timolol Maleate	Dorzolamide HCl/Timolol Maleate	
	Lumigan **SL**	
	Phospholine Iodide	
	Pilopine HS	
	Travatan Z **SL**	

Gastrointestinal **Acid Suppression**

Level 1	Level 2	Level 3
Cimetidine	Helidac	Aciphex **SL**
Misoprostol	Nizatidine Oral Solution	Carafate Oral Suspension
Omeprazole	Prevpac **SL**	Dexilant **SL**
Pantoprazole	Pylera	Lansoprazole **E**
Ranitidine HCl Syrup		Nexium **E**
Sucralfate Tablet		Omeprazole/Sodium Bicarbonate Capsule **E**
		Prevacid Capsule **E**
		Prevacid Solutab **E**
		Prilosec Rx **E**
		Protonix **SL**
		Zegerid **SL**

Gastrointestinal **Other**

Level 1	Level 2	Level 3
Chlordiazepoxide/Clidinium	Apriso	Amitiza **N, SL**
Diphenoxylate/Atropine	Canasa	Asacol
Lactulose	Creon	Asacol HD **E**
Mesalamine	GoLYTELY Packet	Dipentum
Metoclopramide HCl	Lialda	Entocort EC
Polyethylene Glycol	Lotronex **SL**	Metozolv ODT **E**
Sulfasalazine	Relistor	Moviprep
Ursodiol	Zenpep	Pancreaze
		Pentasa

Men's Health **Prostate**

Level 1	Level 2	Level 3
Doxazosin Mesylate		Alfuzosin
Finasteride		Avodart **N**
Tamsulosin		Jalyn **E**
Terazosin HCl		Rapaflo
		Uroxatral

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Miscellaneous

Level 1	Level 2	Level 3
Azathioprine	Cellcept Suspension	Acuvail **E**
Benzonatate	Epinepherine Pen Injector **SL**	Aromasin
Chlorhexidine Gluconate	Epipen **SL**	Bravelle
Megestrol Acetate	Lidoderm **SL**	Infergen **N, SL**
Mycophenolate Mofetil Capsule, Tablet	Myfortic	Intron A **N, SL**
Phenazopyridine	Neoral	Restasis **N, SL**
Tacrolimus Anhydrous	Rapamune	Tussionex **SL**
Tamoxifen	Sandimmune	Twinject **SL**

Miscellaneous Overactive Bladder

Level 1	Level 2	Level 3
Dicyclomine Tablet	Enablex	Detrol
Hyoscyamine Sulfate	Gelnique	Detrol LA **E**
Oxybutynin	Oxytrol	Toviaz
Trospium	Sanctura XR	
	Vesicare	

Musculoskeletal Osteoporosis

Level 1	Level 2	Level 3
Alendronate Sodium **SL**	Actonel **SL**	Fosamax Plus D **SL**
	Boniva Tablet **SL**	
	Calcitonin Salmon Nasal Spray	
	Evista	
	Forteo **N**	
	Fortical	

Musculoskeletal Pain Relief

Level 1	Level 2	Level 3
Diclofenac	Codeine Phosphate	Arthrotec
Duragesic **SL**	Fentanyl Citrate Lollipop **N, SL**	Avinza **SL**
Etodolac	MSIR Capsule	Celebrex **SL**
Hydromorphone HCl	Opana ER **SL**	Fentanyl Transdermal **SL**
Ibuprofen	OxyContin **SL**	Fentora **N, SL**
Indomethacin	Voltaren Gel	Flector **E**
Ketorolac Tromethamine		Kadian **E**
Meloxicam		Mefenamic Acid
Meperidine HCl		Naprelan **E**
Methadone HCl		Onsolis **N, SL**
Morphine		Opana **SL**
Naproxen		Pennsaid **E**
Oxaprozin		Rybix ODT **E**
Oxycodone		Ryzolt **E**
Piroxicam		Vimovo **E**
Sulindac		Zipsor **E**
Tramadol HCl		
Tramadol HCl/Acetaminophen **SL**		

Musculoskeletal Rheumatoid Arthritis

Level 1	Level 2	Level 3
Azathioprine	Cimzia **N, SL**	Humira **N, SL**
Hydroxychloroquine Sulfate	Enbrel **N, SL**	Kineret **N, SL**
Leflunomide	Simponi **N, SL**	
Methotrexate Sodium	Trexall	
Sulfasalazine		

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2012 Three-Level Preferred Drug List Reference Guide

Musculoskeletal Other

Level 1	Level 2	Level 3
Allopurinol	Colcrys	Amrix **E**
Baclofen	Orphenadrine	Carisoprodol 250 mg **E**
Carisoprodol 350 mg	Skelaxin	Cyclobenzaprine Extended-Release 24 Hour Capsule **E**
Cyclobenzaprine		Metaxalone
Methocarbamol		Savella **SL**
Tizanidine		Soma 250 mg **E**

Respiratory Asthma/COPD

Level 1	Level 2	Level 3
Albuterol Sulfate	Budesonide Inhalation Suspension 0.25 mg/2 ml, 0.5 mg/2 ml **SL**	Advair **RS, SL**
Alvesco **SL**	Foradil **SL**	Atrovent **SL**
Asmanex **SL**	Pulmicort Respules 1 mg/2 ml **SL**	Combivent **SL**
Ipratropium Bromide	Singulair **SL**	Dulera **RS, SL**
QVAR **SL**	Spiriva **SL**	Flovent **SL**
Theophylline		Maxair Autohaler **SL**
Ventolin HFA **SL**		Proair HFA **SL**
		Proventil HFA **SL**
		Pulmicort Flexhaler **SL**
		Serevent Diskus **SL**
		Symbicort **SL**
		Xopenex HFA **SL**
		Xopenex Vial, Nebulizer **E**

Respiratory Nasal Allergy

Level 1	Level 2	Level 3
Flunisolide	Astelin **SL**	Azelastine HCl **SL**
Fluticasone Propionate **SL**	Nasonex **SL**	Beconase AQ **SL**
		Nasacort AQ **SL**
		Patanase
		Rhinocort Aqua **SL**
		Triamcinolone Acetonide **SL**
		Veramyst **E**

Respiratory Oral Allergy

Level 1	Level 2	Level 3
Hydroxyzine		Clarinex **E**
Promethazine HCl		Levocetirizine **SL**

Women's Health Contraceptives

Level 1	Level 2	Level 3
Apri	Depo-SubQ Provera **MC**	Beyaz **E**
Aviane	Jolessa **MC**	Camrese **MC**
Azurette	NuvaRing	Errin
Enpresse	Ovrette	Femcon Fe
Junel	Quasense **MC**	Loestrin 24 Fe
Junel Fe	Yasmin	LoSeasonique **MC**
Kariva	Yaz	Mononessa
Levora		Necon 7/7/7
Low-Ogestrel		Nora-Be
Lutera		Norethindrone
Medroxyprogesterone Acet 150 mg/ml **MC**		Nortrel 7/7/7
Microgestin		Ocella
Ortho Micronor		Ortho Evra
Ortho Tri-Cyclen		Ortho Tri-Cyclen Lo
Ortho-Cyclen		Safyral **E**
Ortho-Novum 7/7/7		Seasonique **MC**
Tri-Lo-Sprintec		Sprintec
Zenchent		Tri-Legest Fe
Zovia		Tri-Previfem
		Tri-Sprintec
		Trinessa

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Women's Health Estrogen/Progesterone

Level 1
Estradiol
Estradiol Patch, Transdermal Weekly **SL**
Estropipate
Medroxyprogesterone Acet
Norethindrone Acetate

Level 2
Cenestin
Climara **SL**
Crinone **N**
Enjuvia
Estrace Cream with Applicator
Estraderm **SL**
Estradiol/Norethindrone Acetate
Estratest
Estring **SL**
Evamist
Prefest
Vagifem
Vivelle **SL**
Vivelle-Dot **SL**

Level 3
Activella
Combipatch **SL**
Estrogel **SL**
Femhrt
Femring **SL**
First Progesterone **N**
Menostar Patch, Transdermal Weekly **SL**
Premarin
Premphase
Prempro
Prochieve **N**

Additional Level 3 Drugs with a generic equivalent in Level 1

Accupril (Quinapril)
Acular, Acular LS **SL** (Ketorolac Tromethamine **SL**)
Adderall (Amphetamine with Dextroamphetamine Salt Combination)
Aldactone (Spironolactone)
Altace (Ramipril)
Amaryl (Glimepiride)
Ambien **SL** (Zolpidem **SL**)
Aricept (Donepezil)
Ativan (Lorazepam)
Augmentin ES (Amoxicillin with Potassium Clavulanate)
Biaxin Tablet (Clarithromycin Tablet)
Buspar (Buspirone)
Calan, Calan SR (Verapamil)
Capoten (Captopril)
Cardizem CD except for 360 mg strength (Diltiazem Sustained-Release 24 Hour Capsule)
Cardura (Doxazosin)
Ceftin (Cefuroxime)
Cefzil (Cefprozil)
Celexa (Citalopram)
Ciloxan Eye Drops (Ciprofloxacin)
Cipro (Ciprofloxacin)
Cleocin T (Clindamycin Gel, Lotion, Solution, Swabs)
Clozaril (Clozapine)
Colazal (Balsalazide)
Colestid (Colestipol)
Coreg (Carvedilol)
DDAVP (Desmopressin)
Depo-Provera **MC** (Medroxyprogesterone Acetate 150 mg/ml **MC**)
DiaBeta, Micronase, Glynase (Glyburide)
Didronel (Etidronate Disodium)
Diflucan (Fluconazole)
Ditropan XL (Oxybutynin Chloride Tablet, Sustained-Release)
Flomax (Tamulosin)
Flonase **SL** (Fluticasone Nasal Spray **SL**)
Floxin Otic (Ofloxacin Otic Drops)
Fosamax **SL** (Alendronate **SL**)
Glucophage, XR (Metformin)
Hytrin (Terazosin)
Imitrex **SL** (Sumatriptan Succinate **SL**)
Inderal (Propranolol)
Keflex (Cephalexin)
Keppra (Levetiracetam)
Lamictal (Lamotrigine)
Lamisil Tablet **SL** (Terbinafine Tablet **SL**)
Lasix (Furosemide)
Levaquin (Levofloxacin)
Lopid (Gemfibrozil)
Lopressor (Metoprolol)
Mavik **½T** (Trandolapril **½T**)
Mobic (Meloxicam)
Monopril (Fosinopril)
Motrin (Ibuprofen) - Prescription strengths only
Naprosyn (Naproxen) - Prescription strengths only
Norvasc (Amlodipine Besylate)
Ocuflox Eye Drops (Ofloxacin)
Paxil (Paroxetine)
Penlac (Ciclopirox Solution, Non-Oral)
Plan B (Levonorgestrel)
Pletal (Cilostazol)
Pravachol **½T** (Pravastatin **½T**)
Precose (Acarbose)
Prilosec (Omeprazole)
Prinivil, Zestril (Lisinopril)
Procardia XL (Nifedipine Extended-Release)
Proscar (Finasteride)
Provera (Medroxyprogesterone)
Prozac (Fluoxetine Capsule)
Remeron (Mirtazapine)
Requip (Ropinirole)
Restoril (Temazepam)
Risperdal (Risperidone)
Ritalin (Methylphenidate)
Sonata **SL** (Zaleplon **SL**)
Tenormin (Atenolol)
Tiazac (Diltiazem)
Topamax (Topiramate)
Toprol XL 25 mg (Metoprolol Succinate Sustained-Release)
Trusopt **SL** (Dorzolamide Eye Drops **SL**)
Ultracet **SL** (Tramadol with Acetaminophen **SL**)
Ultram (Tramadol)
Valium (Diazepam)
Vicodin **SL**, Vicodin ES **SL** (Acetaminophen with Hydrocodone **SL**)
Vicoprofen (Ibuprofen with Hydrocodone)
Voltaren Tablet (Diclofenac)
Wellbutrin (Bupropion)
Xanax, Xanax XR (Alprazolam)
Zantac Syrup (Ranitidine Syrup)
Ziac (Bisoprolol with Hydrochlorothiazide)
Zithromax (Azithromycin)
Zocor **½T** (Simvastatin **½T**)
Zofran (Ondansetron)
Zoloft **½T** (Sertraline **½T**)
Zonegran (Zonisamide)
Zovirax Capsule, Tablet, Suspension (Acyclovir)