NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

and

CAREMARKPCS HEALTH, L.L.C. d/b/a CVS CAREMARK

AGREEMENT NO. C000753

This Agreement ("Agreement" or "Contract") is entered into by and between New York State Department of Civil Service ("Department" or "DCS"), having its principal office at the Empire State Plaza, Albany, NY, 12239 and CaremarkPCS Health, L.L.C. d/b/a CVS Caremark ("Contractor"), a corporation authorized to do business in the State of New York with a principal place of business located at One CVS Drive, Woonsocket, RI 02895. The foregoing are collectively referred to as "the Parties".

WITNESSETH

WHEREAS, Civil Service Law Article XI authorizes and directs the President of the Civil Service Commission and New State Department of Civil Service ("President") to establish a health benefit plan for the benefit of State Employees, Retirees, and their Dependents, and for the benefit of Participating Employers' Employees, Retirees, and their Dependents; and

WHEREAS, New York State, through DCS, administers the New York State Health Insurance Program (NYSHIP) to provide essential pharmacy benefit services to eligible New York State (NYS) employees, retirees, and their Eligible Dependents enrolled in the Empire Plan, and Student Employee Health Plan; and

WHEREAS, Civil Service Law Article XI authorizes and directs the President to purchase a contract or contracts to provide the benefits under the plan of health benefits; and

WHEREAS, The Empire Plan Prescription Drug Program ("Program") provides those prescription drug benefits, purchased by the President, for the benefit of those stated above and shall be administered in accordance with New York State laws and regulations including the Civil Service Law, the State Finance Law Article XI, and their respective implementing regulations, including but not limited to the Regulations of the Department of Civil Service (President's Regulations); and

WHEREAS, the Department issued a Request for Proposal ("RFP") entitled "Pharmacy Benefit Services for The Empire Plan, Student Employee Health Plan, and NYS Insurance Fund Workers' Compensation Prescription Drug Programs" on May 1, 2024, which was amended on June 6, 2024, to secure the services of a qualified organization to administer The Empire Plan, and Student Employee Health Plan and the NYS Insurance Fund Workers' Compensation (NYSIF) Prescription Drug Programs as defined in the RFP; and

WHEREAS, the Contractor submitted a proposal in response to the RFP; and

WHEREAS, after thorough review and evaluation by NYS of proposals received in response to the RFP, the Contractor's Proposal was selected as representing the best value to the State by a responsive and responsible bidder; and

WHEREAS, the Department, in reliance upon the expertise of the Contractor, desires to engage the Contractor to deliver the Program Services, in the manner set forth in the RFP and the Contractor's Proposal, pursuant to the terms and conditions set forth in this Agreement; and

WHEREAS, pursuant to the terms of the RFP the selected Contractor is required to enter into separate contractual agreements with DCS and NYSIF as a result of the RFP; and

WHEREAS, after Agreements are separately executed with the Contractor and DCS and NYSIF, any change to the scope of an Agreement, including but not limited to the inclusion of any individual Network Pharmacy(ies), requested by one Agency shall have no impact on the other Agency's Agreement or cost thereunder, unless the other Agency likewise agrees to said change(s); and

WHEREAS, this Contract represents the agreement between DCS and the Contractor.

NOW THEREFORE, in consideration of the mutual covenants and provisions contained herein, the Parties agree as follows:

SECTION I: DEFINITION OF TERMS

The following terms when used in any part of the Contract shall have the meanings indicated below:

1.1 **Account Team** means a proactive, experienced Contractor account leader(s) 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.

1.2 **Advanced Flexible Formulary Preferred Drug List** (or "Advanced Flexible Formulary") means a Preferred Drug List (PDL) in which Brand Drugs may be assigned to different Copayment levels based on value to the Program and clinical judgment. In some cases, drugs may be excluded from coverage if a Therapeutic Equivalent or Over-the-Counter Drug is available.

1.3 **Affiliate** means a person or organization which, through stock ownership or any other affiliation, directly, indirectly, or constructively controls another person or organization, is controlled by another person or organization, or is, along with another person or organization, under the control of a common parent.

1.4 **Agreement or Contract** means the Agreement entered into between the Parties resultant from the RFP that was issued May 1, 2024, and amended on June 6, 2024.

1.5 **Ancillary Charge** means the amount in addition to the applicable Copayment an Enrollee/Dependent will pay when purchasing a Brand Drug if an A-rated or authorized generic equivalent is available in the market. The amount represents the difference to the Program between the Discounted Ingredient Cost of the dispensed Brand Drug and the Discounted Ingredient Cost of the available generic equivalent if it had been dispensed, not to exceed the actual cost of the drug. The Ancillary Charge does not apply if a Dispense as Written Exception Request is approved by the Plan; however, the enrollee must pay the applicable non-preferred copayment.

1.6 **AWP** means the Medi-Span per unit price for the eleven (11)-digit NDC of the drug dispensed as of the date the Prescription was filled unless the Parties mutually agree in writing to utilize a different source for AWP information.

1.7 **Brand Drug(s)** means a Prescription drug sold under a trade name other than its chemical name that is manufactured and marketed by a single manufacturer (or single group of manufacturers pursuant to agreement among the manufacturers) where the manufacturer holds or held a patent protecting the active ingredient from generic competition. For The Empire Plan and SEHP, the Contractor shall utilize the Department's approved process to replicate the results of the methodology used by the Program as of January 1, 2025, for determining the appropriate classification of drugs consistent with this definition.

1.8 **Brand For Generic** means an additional feature of the Flexible and Advanced Flexible Formularies that allows a Brand-Name drug to be placed on the lowest Copayment level and the new generic equivalent to be placed on the highest Copayment level, or excluded, when advantageous to the DCS Program.

1.9 **Breach** means acquiring of information by a person without valid authorization or through unauthorized acquisition.

1.10 **Business Associate** means the term as defined in the HIPAA implementing regulations at 45 CFR 160.103; the Contractor will be a Business Associate of the Department as a consequence of the Contractors provision of Project Services on behalf of the Department within the context of the Contractors performance under the Contract and that the Contractors provision of Project Services will involve the disclosure to the Contractor of individually identifiable health information from the Department or other service providers on behalf of the Department, as well as the Contractors disclosure to the Department of individually identifiable health information as a consequence of the Project Services performed under the Contract.

1.11 **Business Day(s)** means every Monday through Friday, except for Days designated as Business Holidays by the Contractor and approved as such by the Department prior to January 1st of each Calendar Year.

1.12 **Business Holiday(s)** means Days designated by the Contractor as Business Holidays and approved as such by the Department prior to January 1st of each Calendar Year.

1.13 **Business Hours** means 8:00am – 5:00pm ET on a Business Day(s).

1.14 **Calendar Year/Annual** means a period of 12 months beginning with January 1st and ending with December 31st.

1.15 **Call Center Hours** means 24 hours a Day, 365 Days a year.

1.16 **Chain Pharmacy** means any National Chain (National Chain is defined as any Pharmacy operating in eighteen or more States within CONUS), or Local and/or Regional Chain (Local or Regional Chain is defined as any Pharmacy operating in ten or more locations in New York State).

1.17 **Child(ren)** means children under 26 years of age, including natural children, legally adopted children, children in a waiting period prior to finalization of adoption, Enrollee stepchildren and children of the Enrollee's domestic partner. Other children who reside permanently with the Enrollee in the Enrollee's household and are chiefly dependent on the Enrollee are also eligible, subject to a Statement of Dependence and documentation.

1.18 **Claims Administration Fee** means the fee that the Contractor charges the DCS Program for all administration services provided by the Contractor. This includes the administration of the Empire Plan and SEHP, as may be modified from time to time. There are two (2) Claims Administration Fees that apply to this Agreement: DCS Program Primary Claims Administration Fee and Medicare Primary Claims Administration Fee.

1.19 **Commercial Coverage** means benefits and drug coverage available to the Empire Plan's active employees and/or non-Medicare-primary enrollees and dependents.

1.20 **Commissioner** means the Commissioner of the New York State Department of Civil Service.

1.21 **Compound Drug(s)** means a drug with two or more ingredients (solid, semi-solid or liquid), at least one of which is a Covered Drug with a valid NDC requiring a Prescription for dispensing, combined together in a method specified in a Prescription issued by a medical professional. The end result of this combination must be a Prescription medication for a specific patient that is not otherwise commercially available in that form or dose/strength from a single manufacturer. The Prescription must identify the multiple ingredients in the Compound, including active ingredient(s), diluents(s), ratios or amounts of product, therapeutic use, and directions for use. The act of compounding must be performed or supervised by a licensed Pharmacist. Any commercially available product with a unique assigned NDC requiring reconstitution or mixing according to the FDA-approved package insert prior to dispensing will not be considered a Compound Prescription by the Program.

1.22 **Confidential Information** is defined in Appendix B, Standard Clauses for All Department of Civil Service Contracts and includes Protected Health Information (PHI).

1.23 **Continental United States (CONUS)** means the 49 states and the District of Columbia, with the exception of Hawaii.

1.24 **Contract or Agreement** means the Agreement entered into between the Parties resultant from the RFP that was issued May 1, 2024, and amended on June 6, 2024.

1.25 **Contractor or Selected Offeror** means the Offeror selected as a result of the evaluation of Offerors' Proposals submitted in response to the RFP released May 1, 2024, amended on June 6, 2024, and who executes a separate Contract with the Department to provide Program Services.

1.26 **Controlled Drug** means drugs designated by Federal Law or New York State law as a Class I, II, III, IV, or V substance. A Controlled Drug includes, but is not limited to, some tranquilizers, stimulants, and pain medications.

1.27 **Cost Share or Copayment** means the amount the Enrollee/Dependent is required to pay for Covered Generic, Preferred and Non-Preferred Brand Drugs as specified by the

benefit design of the Program. The actual payment amount required from the Enrollee/ Dependent for a Prescription may not exceed the Ingredient Cost of the drug to the Plan after application of the Program's Lesser of Logic provision plus the applicable dispensing fee plus the prescribing fee, if applicable.

1.28 **Covered Drug(s)** means medically necessary Prescription drugs as defined in the *Certificate of Insurance*, subject to all limitations and exclusions set forth therein.

1.29 **Data** means any information, analytic derivatives, formula, algorithms, or other content that the Department or State may provide to the Contractor pursuant to this Contract. Data includes, but is not limited to, any of the foregoing that the Department and/or Contractor (i) uploads to a Cloud Service, and/or (ii) creates and/or modifies using a Cloud Service.

1.30 **Day(s)** means calendar Days unless otherwise noted.

1.31 **DCS Program(s)/Plan** means the New York State Health Insurance Program's Empire Plan Prescription Drug Program, Empire Plan Medicare Employer Group Waiver Prescription Drug Plan, and the Student Employee Health Program (SEHP) Prescription Drug Program.

1.32 **Dedicated Call Center** means a group of Customer Service Representatives trained and capable of responding to a wide range of questions, complaints, and inquiries specific to the Programs. The Customer Service Representatives are dedicated to the Programs and do not work on any other accounts.

1.33 **Department or DCS** means the New York State Department of Civil Service.

1.34 **Dependent** means the spouses, domestic partners, and children under twenty-six (26) years of age of an Enrollee. Dependent Children age twenty-six (26) or over are also eligible if they are incapable of supporting themselves due to mental or physical disability acquired before termination of their eligibility for coverage under the New York State Health Insurance Program.

1.35 **Dependent Survivor** means: a spouse who has not remarried; a Dependent Child(ren) who meets the eligibility requirements; or a domestic partner who has not married or acquired a new domestic partner; of an Enrollee who: died after having had at least ten (10) cumulative years of NYSHIP benefits-eligible service or after having retired with fewer than 10 years of service and receiving an accidental disability retirement benefit or a performance of duty disability pension; was covered as a Dependent of the Enrollee at the time of the Enrollee's death; and elects to continue coverage under NYSHIP following the three (3)-month extended benefit period.

1.36 **Designated Contact(s)** means the Department's authorized person(s) which all communications during the Restricted Period related to this Agreement, according to SFL 139-j and 139-k must be directed to.

1.37 **Designated Specialty Pharmacy** means all facilities owned, operated, subcontracted, or otherwise affiliated with the Contractor or any Key Subcontractor of the Contractor to provide certain Specialty Drugs. All facilities must meet all legal and contractual requirements as set forth in the Agreements.

1.38 **Designated Specialty Pharmacy Hard Edit** means a Network Pharmacy claims adjudication edit that will result in denial of the claim for a Specialty Drug under the Specialty Pharmacy Process after the Grace Period for Specialty Drugs has elapsed.

1.39 **Designated Specialty Pharmacy Passive Edit** means a Network Pharmacy claims adjudication edit that will prompt processing of the claim at the Designated Specialty Pharmacy but will permit continued processing and coverage for a Specialty Drug at the Network Pharmacy under the Specialty Pharmacy Process after the Grace Period for Specialty Drugs has elapsed.

1.40 **DFS** means the New York State Department of Financial Services.

1.41 **Disabled Lives Benefit** means the benefits provided to an Enrollee/Dependent who is Totally Disabled on the date coverage ends. The benefits are provided on the same basis as if coverage had continued with no change until the day the Enrollee/Dependent is no longer Totally Disabled or for ninety (90) days after the date the coverage ended, whichever is earlier.

1.42 **Discounted Ingredient Cost(s)** means the cost to the Plan for a specific drug or drugs dispensed to an Enrollee/Claimant after the Contractor has applied the appropriate discount exclusive of any associated dispensing fee(s), prescribing fee(s) (if applicable), sales tax or Copayments.

1.43 **Drug List** means a list of FDA-approved brand-name and generic prescription drugs developed by the Contractor for the Program. Unless otherwise specified, this definition applies to The Empire Plan Drug Lists including the: (1) Flexible Formulary Drug List; (2) Advanced Flexible Formulary Drug List; (3) Medicare Part D Drug List, with supplemental wrap coverage to meet or exceed The Empire Plan prescription drug benefit structure and (4) NYSIF PDL.

1.44 **Empire Plan Medicare Rx** means the Employer Group Waiver Program (EGWP) for Medicare-primary Empire Plan enrollees and Dependents that is a Medicare Part D Prescription Drug Plan (PDP) with supplemental wrap coverage and that provides benefits and drug coverage equivalent to, or in excess of, the benefits available to the Empire Plan's non-Medicare-primary enrollees and Dependents.

1.45 **Employee** means "Employee" as defined in 4 NYCRR Part 73, as amended, or as modified by collective bargaining agreement.

1.46 **Employer** means "Employer" as defined in 4 NYCRR Part 73, as amended.

1.47 **Employer Group Waiver Plan (EGWP)** means the Employer Group Waiver Program (EGWP) for Medicare-primary Empire Plan enrollees and Dependents that is a Medicare Part D Prescription Drug Plan (PDP) with supplemental wrap coverage that provides benefits and drug coverage equivalent to, or in excess of, the benefits available to the Empire Plan's non-Medicare-primary enrollees and Dependents.

1.48 **Enrollee** means an "Employee" or "Dependent" or "Member" enrolled in the Program with prescription drug benefits.

1.49 **Enrollee Submitted Claim(s) or Subscriber Claims** means a claim for benefits submitted by an Enrollee to the Contractor for direct reimbursement.

1.50 **Equal Employment Opportunity (EEO)** means the federal law designed to protect most U.S. employees from employment discrimination based upon that employee's (or applicant's) race, color, religion, sex, or national origin.

1.51 **ET** means prevailing Eastern Time.

1.52 **Excelsior Plan** means a lower cost version of the Empire Plan only offered to Participating Agencies, through calendar year 2024. Effective January 1, 2025, the Department will discontinue the Excelsior Plan, and the Contractor will not be responsible for administering this Plan.

1.53 **FDA** means the U.S. Food and Drug Administration.

1.54 **Final Paid Claim** means a claim processed and paid by the Contractor for a Prescription drug or covered medication, OTC product or non-drug device, provided to an Enrollee/Claimant, including but not limited to, claims for Prescriptions filled at a Retail Pharmacy or through the Mail Service Pharmacy Process or the Specialty Pharmacy Process. A claim that is denied prior to processing is not considered a Final Paid Claim. In addition, a claim that is processed and paid but is subsequently voided, reversed, or otherwise adjusted is not a Final Paid Claim. Zero balance claims are considered Final Paid Claims. Rebate- and non-rebate eligible claims are considered Final Paid Claims.

1.55 **Flexible Formulary Preferred Drug List** means a Preferred Drug List (PDL) in which Brand Drugs may be assigned to different Copayment levels based on value to the Program and clinical judgment. In some cases, drugs may be excluded from coverage if a Therapeutic Equivalent or Over-the-Counter Drug is available.

1.56 **Frozen Formulary Law** (Chapter 780 of the Laws of 2021, as amended by Chapter 99 of the Laws of 2022) limits an insurer from changing a formulary or imposing utilization management once a formulary is set at the start of the plan year. It also requires ninety-day notification of formulary changes. The law does not supersede the terms of collective bargaining agreements, or the rights of unions to collectively bargain formulary changes.

1.57 **Generic Drug(s)** means a prescription drug sold under its chemical name or drug sold under a name other than its chemical name by a manufacturer other than the manufacturer that held the original patent for the active ingredient in the drug. The term Generic Drug shall include “authorized generics” marketed by or in conjunction with the manufacturer that is the holder of the original patent for the active ingredient of the drug. Any drug approved through an FDA Generic Drug approval process, including any FDA approval process established for approving generic equivalents of biologic drugs shall be classified as a Generic Drug. For The Empire Plan and SEHP, the Contractor shall utilize the Department’s approved process to replicate the results of the methodology used by the Program as of January 1, 2025, for determining the appropriate classification of drugs.

1.58 **GPI** means Generic Product Identifier as defined by Medi-Span Master Drug Database by Wolters Kluwer Health.

1.59 **Grace Fill for Specialty Drugs** means an Enrollee's initial or very first dispensing of a Specialty Drug covered under the Empire Plan Specialty Pharmacy Program.

1.60 **Guaranteed Discount(s) off of AWP** means the Contractor's fixed, contracted, guaranteed Ingredient Cost discounts for Brand Drugs expressed as a percent off of AWP dispensed through the Mail Service Pharmacy Process.

1.61 **Guaranteed Dispensing Fee(s)** ("dispensing fee") represents the quoted dispensing fee(s) the Contractor guarantees is applicable to Generic, Brand and Compound Drugs dispensed through the Mail Service Pharmacy Process and separately are proposed under *Specialty Pharmacy Program Dispensing Fees* (Attachment 89), for Specialty Drugs dispensed through the Specialty Pharmacy Program.

1.62 **Guaranteed Maximum Dispensing Fee(s)** ("maximum dispensing fee") represents the quoted dispensing fee(s) the Contractor guarantees that the actual average dispensing fee assessed under Pass-through Pricing will not exceed. This Guaranteed Maximum Dispensing Fee(s) is applicable to the Program for Generic, Brand and Compound Drugs, calculated separately, for prescriptions dispensed by Retail Network Pharmacies.

1.63 **Guaranteed Maximum Prescribing Fee(s) ("prescribing fee(s)")** represents the prescribing fee(s) in Section 9.6.8 of the Contract the Contractor guarantees that the actual average prescribing fee assessed will not exceed. This fee is inclusive of fees for prescribing statutorily-authorized medication as well as fees for order statutorily-authorized tests. This Guaranteed Maximum Prescribing Fee(s) is applicable to the Program for Generic and Brand Drugs, calculated separately for certain medications (e.g., oral self-administered contraceptives) only where there is statutory authority for pharmacists, licensed pharmacy technicians, or those named in the law, to prescribe select medications and dispense them in the Retail Pharmacy Network.

1.64 **Guaranteed Minimum Discount(s) off of Aggregate AWP** means the guaranteed Ingredient Cost discount(s) as expressed as a percent off of Aggregate AWP and is applicable to Generic and Brand Drugs, separately, dispensed through the Retail Pharmacy Network, Specialty Drugs dispensed through the Specialty Pharmacy Process as well as Generic Drugs dispensed through the Mail Service Pharmacy Process. Specialty Drugs shall be charged at the lowest of: (a) the Guaranteed Minimum Discount off of Aggregate AWP for Specialty Drugs in Section 9.7 of the Contract plus Guaranteed Dispensing Fee as provided in Section 9.6.4 of the Contract; (b) MAC plus Guaranteed Dispensing Fee as provided in Section 9.6.4 of the Contract; or (c) WAC plus Guaranteed Dispensing Fee as provided in Section 9.6.4 of the Contract. The Contractor's Guaranteed Minimum Discount off of Aggregate AWP for all Specialty Drugs dispensed via specialty pharmacies or Mail Service Pharmacies shall be greater than the Contractor's Guaranteed Minimum Discount off of Aggregate AWP and Guaranteed Maximum Dispensing Fee.

1.65 **Hard Edit** means a Network Pharmacy claims adjudication edit that will result in denial of the claim.

1.66 **HIPAA** means Health Insurance Portability and Accountability Act of 1996, as amended.

1.67 **Implementation Date** means the first day of the month following a minimum implementation period of 90 Days subsequent to the Attorney General's Office and Office of State Comptroller's approval of this, but no sooner than January 1, 2025.

1.68 **Implementation Plan** means a plan to include the evaluation and assessment activities as well as the development of a project plan to achieve Contract requirements and deliver the Project Services.

1.69 **Implementation Period** means minimum of 90 Days prior to inception Project Services Start Date.

1.70 **Ingredient Cost(s)** means the cost to the Programs for a specific drug, or drugs dispensed to an Enrollee/Claimant exclusive of any associated dispensing fee(s), prescribing fee(s) (if applicable), other costs, or Copayments through application of the Programs' Lesser of Logic.

1.71 **Key Subcontractor(s)** means those vendors with whom the Contractor subcontracts to provide Program Services and incorporates as a part of the Contractor's Program Team. Key Subcontractors include all vendors who will provide $100,000 or more in Program Services over the term of the Agreement that results from this Agreement, as well as any vendor who will provide Program Services in an amount lower than the $100,000 threshold, and who is a part of the Contractor's Account Team.

1.72 **Lesser of Logic** means the methodology for charging the Program for Prescriptions as described below.

Retail Generic Prescriptions assigned a MAC price shall be charged to the Programs at:

- the lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee plus prescribing fee(s) (if applicable);
- the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is Usual and Customary);
- the Guaranteed Minimum Discount off of Aggregate AWP contracted with the Network Pharmacy plus dispensing fee plus prescribing fee(s) (if applicable);
- the Maximum Allowable Cost (MAC) plus dispensing fee plus prescribing fee(s) (if applicable); or,

Retail Brand Prescriptions, and Generic Prescriptions that are not assigned a MAC price, shall be charged to the Plan at:

- the lowest of the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is usual and customary);
- the Guaranteed Minimum Discount off of Aggregate AWP contracted with the Network Pharmacy plus dispensing fee plus prescribing fee(s) (if applicable);
- the Pharmacy-submitted Ingredient Cost plus dispensing fee plus prescribing fee(s) (if applicable), or,

Specialty Pharmacy Brand and Generic Prescriptions shall be charged to the Plan at:

- the lowest of the Guaranteed Minimum Discount off of Aggregate AWP plus Guaranteed Dispensing Fee; or
- MAC plus Guaranteed Dispensing Fee; or
- WAC plus Guaranteed Dispensing Fee; or,

Mail Service Pharmacy Generic Prescriptions shall be charged to the Plan at:

- the lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee plus prescribing fee(s) (if applicable);
- the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is Usual and Customary);
- the Guaranteed Minimum Discount off of the Aggregate AWP for prescriptions not assigned a MAC plus dispensing;
- the Maximum Allowable Cost (MAC) for Chain/Mail Pharmacy plus dispensing fee plus prescribing fee(s) (if applicable); or

Mail Service Pharmacy Brand Prescriptions shall be charged to the Plan at:

- the lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee plus prescribing fee(s) (if applicable);
- the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is usual and customary);
- the Guaranteed Discount off of AWP plus dispensing fee plus prescribing fee(s) (if applicable); or,

Once the Lesser of Logic has been applied, the pricing methodology resulting in the lowest claim cost to the Plan is determined, and to that amount any applicable sales tax is added and the applicable Copayment and any ancillary fee resulting from application of the Program's Mandatory Generic Substitution provisions are deducted.

1.73 **Limited Distribution Drug** means a Specialty Drug whose distribution is limited by the manufacturer to select Pharmacies and as a result of this restriction is not available to be dispensed from the Designated Specialty Pharmacy(ies) and/or Mail Service Pharmacy.

1.74 **Mail Service Pharmacy Process** means the method that the Contractor employs to accept, process, and dispense Prescriptions for Covered Drugs to Enrollees/Claimants through the mail or other home delivery service, excluding any drug eligible under the Specialty Pharmacy Process. For those Employee groups not participating in the Specialty Pharmacy Process, the Mail Service Pharmacy Process means the method that the Contractor employs to accept, process, and dispense Prescriptions for Covered Drugs to Enrollees/Claimants through the mail or other home delivery service including any drug that could be classified as a Specialty Drug, or that require special preparation or handling, using one or more Mail Service Pharmacy Process Facilities or other entities approved as distribution channels for dispensing Limited Distribution Drugs to Enrollees/Claimants through the Mail Service Pharmacy Process. Prescriptions are considered to be submitted through the Mail Service Pharmacy Process if they are submitted by phone, fax, internet, e-prescribing or mail to any Mail Service Pharmacy Process Facility. All Prescriptions filled through the Mail Service Pharmacy Process shall be processed in strict accordance with the provisions of the Agreement including all pricing provisions related to the Mail Service Pharmacy Process. Prescriptions dispensed through the Retail Pharmacy Network and delivered to the Enrollee/Claimant through the mail shall not be considered to have been filled through the Mail Service Pharmacy Process provided the Enrollee/Claimant or his/her Physician presented the Prescription directly to the dispensing Network Pharmacy. The Contractor or its Key Subcontractor will not refer an Enrollee/Claimant or his/her Physician to a retail Pharmacy without also making the Enrollee/Claimant aware of the Mail Service Pharmacy Process.

1.75 **Mail Service Pharmacy Process Facility(ies)** means all facilities owned, operated, subcontracted, or otherwise affiliated with the Contractor or any Key Subcontractor of the Contractor capable of being utilized by the Contractor in the Mail Service Pharmacy Process, including any mail service intake facility. For those employee groups participating in the Specialty Pharmacy Process, the Designated Specialty Pharmacy(ies) is not considered a Mail Service Pharmacy Process Facility. All facilities must meet all legal and contractual requirements.

1.76 **Maximum Allowable Cost** means the maximum price the Programs shall be charged and the dispensing retail Network Pharmacy shall be paid on a pass-through basis for the Ingredient Cost of a drug required to be included on the Program's MAC List managed by the Contractor.

1.77 **May** denotes the permissive in a contract clause or specification. Refers to items or information that the State has deemed are worthy of obtaining, but not required or obligatory. Also see "Should".

1.78 **Mandatory** denotes the imperative in a contract clause or specification. Means required - being determinative/mandatory, as well as imperative. Also see "Must" and "Shall".

1.79 **Medical Exception Program** means the DCS Program in which a physician can request a medical necessity review for non-formulary prescription drugs that are excluded from coverage when other covered therapeutic alternatives are ineffective or clinically inappropriate as documented by the prescribing Medical Professional.

1.80 **Medically Necessary Drug** means any drug that, as determined by the Contractor, is: (i) provided for the diagnosis or treatment of a medical condition; (ii) appropriate for the symptoms, diagnosis, or treatment of a medical condition; (iii) within the standards of generally accepted health care practice; and (iv) not used for cosmetic purposes.

1.81 **Medical Professional(s)** means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) licensed without limitation or restriction to practice medicine. For benefits provided in the Program, and for no other purpose, Physician also means a Doctor of Dental Surgery (D.D.S.), a Doctor of Dental Medicine (D.D.M.), a Podiatrist and any other health care professional licensed to prescribe medication, when he/she/they is acting within the scope of his or her license.

1.82 **Medicare Beneficiary Identifier** means Medicare's 11-character identifier assigned to Medicare enrollees for claim and identification purposes.

1.83 **Must** denotes the imperative in a contract clause or specification. Means required - being determinative/mandatory, as well as imperative. Also see "Shall" and "Mandatory."

1.84 **Narrow Therapeutic Index (NTI) Drugs** means a drug that small variances in blood levels can cause changes in the effectiveness or toxicity of that drug.

1.85 **NCPDP** *means* the *National Council for Prescription Drug Programs,* an American National Standards Institute (ANSI)-accredited, standards development organization providing healthcare solutions that improve patient safety and health outcomes, while also decreasing costs.

1.86 **NDC** means the National Drug Code number assigned to a pharmaceutical product obtained by the manufacturer of the product through a U.S. Food and Drug Administration administered process.

1.87 **Network Pharmacy** means a Pharmacy, other than those Pharmacies meeting the definition of Mail Service Pharmacy Process Facilities or a Designated Specialty Pharmacy, which has entered into an agreement with the Contractor, or any Affiliate or Key Subcontractor of the Contractor, to provide Covered Drugs to Enrollees/Claimants, including limited distribution or Specialty Drugs. The Contractor's records shall be conclusive as to whether a Pharmacy has a Network Pharmacy agreement in effect on the date a drug is dispensed.

1.88 **New York Benefits Eligibility and Accounting System (NYBEAS)** means the web-based enrollment system for the administration of employee benefits and the source of eligibility information for all Empire Plan, Excelsior Plan, and SEHP Members.

1.89 **Non-Network Pharmacy** means any Pharmacy, other than a Network Pharmacy, a Mail Service Pharmacy Process Facility or a Designated Specialty Pharmacy, which has not entered into an agreement with the Contractor, or any Affiliate or Key Subcontractor of the Contractor, to provide Covered Drugs to Enrollees/Claimants. The DCS Programs have no obligation to pay the Pharmacy; the Enrollee must file a claim form with the Contractor in order to receive reimbursement for Covered Drugs dispensed by a Non-Network Pharmacy.

1.90 **Non-Preferred Drug** means an FDA-approved prescription drug that is covered by the Program in accordance with the Program *Certificate of Insurance* but is not included on the Contractor's and/or its Key Subcontractor's Preferred Drug List and will result in a higher drug Copayment for Enrollees/Dependents.

1.91 **NYS or State** means the State of New York.

1.92 **NYSHIP** means the New York State Health Insurance Program.

1.93 **NYSIF or FUND** means the New York State Insurance Fund.

1.94 **Offeror** means any responsible and eligible entity submitting a responsive Proposal to the RFP. It shall be understood that references in the RFP to "Offeror" shall include said entity's proposed Key Subcontractor or Affiliates, if any.

1.95 **Option Transfer Period** means the period announced by the State to allow eligible Enrollees to join the plan, change coverage, or add eligible dependents.

1.96 **OSC** means the New York State Office of the State Comptroller.

1.97 **Over-the-Counter Drug (OTC)** means a drug approved by the FDA that has been determined to be safe and effective for use by the general public without a doctor's Prescription.

1.98 **Participating Agency (PA)** means any unit of local government such as school districts, special districts and district or municipal corporations which elects, with the approval of the

President of the Civil Service Commission, to participate in the New York State Health Insurance Program.

1.99 **Participating Employer (PE)** means a public authority, public benefit corporation, or other public agency, subdivision, or quasi-public organization of the State which elects, with the approval of the President of the Civil Service Commission, to participate in the New York State Health Insurance Program.

1.100 **Pass-through Pricing** means the Program is charged the same Ingredient Cost and/or dispensing fee and/or prescribing fee(s) (if applicable) paid to the dispensing Network Pharmacy or Mail Service Pharmacy Contractor does not own the Mail Service Pharmacy) for the Generic Drug, Brand Drug, Compound Drug, or vaccine dispensed.

1.101 **Pharmacist** means a person who is legally licensed to practice the profession of Pharmacy. He/she/they must regularly practice such profession within the scope of their license.

1.102 **Pharmacy or Pharmacies** means any establishment, which is registered as a Pharmacy with the appropriate State licensing agency or is a Veterans Affairs Hospital Pharmacy, and regularly dispenses medications that require a Prescription from a Physician.

1.103 **Pharmacy Benefit Services or Program Services** means all of the services to be provided by the Contractor as set forth in this Agreement.

1.104 **Pharmacy Submitted Ingredient Cost or Pharmacy Submitted Pricing or Submitted Cost** means the value entered by the Pharmacy in field 409, 'Ingredient Cost Submitted' of Telecommunication Standard Version 5.1 issued by the National Council for Prescription Drug Programs, Inc. For purposes of adjudication of Compound claims the value shall be no more than the total AWP of all ingredients in the Compound.

1.105 **Pharma Revenue** means any and all revenues generated from agreements between the pharmaceutical manufacturers and the Contractor and/or its Key Subcontractor or any Affiliate of the Contractor or its Key Subcontractor which relate to Program utilization and/or Pharmacy Benefit Management Services provided under the Agreements. Such revenues include, but are not limited to revenues described as: formulary rebates; market share rebates; administrative fees; AWP caps; inflation protection program; or by any other name including all other revenues collected by Contractor and/or its Key Subcontractor or Affiliate from pharmaceutical manufacturers and attributable to Program utilization. Contractor and/or its Key Subcontractor or Affiliate may not count Federal monies toward the Minimum Pharma Revenue Guarantee. Federal monies for purposes of this definition include the Manufacturer Discount Program, the CMS Direct Monthly Subsidy, the Catastrophic Reinsurance Subsidy, the Low-Income Cost Share Subsidy, and the IRA Subsidy.

1.106 **Physician** means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.). He/ she/they must be legally licensed without limitations or restrictions, to practice medicine. For benefits provided in the Program, and for no other purpose, Physician also means a Doctor of Dental Surgery (D.D.S.), a Doctor of Dental Medicine (D.D.M.), a Podiatrist and any other health care professional licensed to prescribe medication, when he/ she/they is acting within the scope of his or her license.

1.107 **Plan(s)/Program(s)** means The Empire Plan Prescription Drug Program, and Student Employee Health Plan (SEHP) Prescription Drug Program administered by the New York State Department of Civil Service, AND the Workers' Compensation Pharmacy Benefits Management Program administered by the New York State Insurance Fund.

1.108 **Plan Sponsor** means the Council on Employee Health Insurance, which is composed of the President of the Civil Service Commission, Director of the Office of Employee Relations, and the Director of the Division of Budget.

1.109 **Plan Year** means the period from January 1st to December 31st in each Plan Year, unless specified otherwise by the DCS.

1.110 **Preferred Brand Drug** means an FDA-approved brand-name prescription drug that is included on the Preferred Drug List developed by the Contractor for the Program.

1.111 **Prescription/Prescription Order** means the written or oral request for drugs issued by a Physician duly licensed to make such a request in the ordinary course of his or her professional practice. This order must be written in the name of the person for whom it is prescribed or be an authorized refill of that order.

1.112 **President** means the President of the Civil Service Commission and the Commissioner of the Department.

1.113 **Procuring Agencies** collectively means the DCS acting in its statutory authority as the administrator of NYSHIP's Empire Plan, and Student Employee Health Plan Prescription Drug Program, and the NYSIF acting in its statutory authority as the administrator of the NYS Workers' Compensation Pharmacy Benefits Management Program.

1.114 **Program MAC List** means the Program's specific Maximum Allowable Cost (MAC) List managed by the Contractor to set the maximum price the Programs shall be charged, and the dispensing retail Network Pharmacy shall be paid on a pass-through basis for the Ingredient Cost of a drug required to be included on the Program MAC List.

1.115 **Program Services or Pharmacy Benefit Services** means all of the services to be provided by the Contractor as set forth in this Agreement.

1.116 **Program Team** means the Contractor and those Key Subcontractors, if any, utilized by the Contractor who collectively undertake and perform the Program Services which are the subject of the Agreement.

1.117 **Program(s)/DCS Program/Plan(s)** means The Empire Plan Prescription Drug Program, and Student Employee Health Plan (SEHP) Prescription Drug Program administered by the New York State Department of Civil Service.

1.118 **Proposal or Submissions** means the Contractor's Administrative Proposal, Technical Proposal, and Financial Proposal, including all responses to supplemental requests for clarification, information, or documentation, submitted during the course of the Procurement.

1.119 **Protected Health Information (PHI)** means any information, including demographic information collected from an individual, that relates to the past, present, or future physical

or mental health or condition of an individual, to the provision of health care to an individual, or to the past, present, or future payment for the provision of health care to an individual, that identifies the individual, or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

1.120 **Reconciliation Due Date** means July 31 of each year of the Contract when the Contractor submits reporting to ensure that the claim amount charged to the Program is in accordance with the definition of Brand and Generic Drugs set forth in the RFP and the Contractor's Financial Proposal. The reconciliation will include claims paid during the Plan Year. If the Department's review of the Contractor's reconciliation indicates an adjustment is required, then the Department reserves the right to make an adjustment to the Contractor's submitted reconciliation.

1.121 **Regulations of the President of the New York State Civil Service Commission** means those regulations promulgated by the President of the Civil Service Commission under the authority of Civil Service Law, Article XI, as amended, and including, but not limited to those regulations to be promulgated as 4 New York Code of Rules and Regulations (NYCRR) Part 73.

1.122 **Retail Pharmacy Network** means the Contractor's credentialed network of participating independent, Chain Pharmacies, and specialty Pharmacies contracted to deliver services to Enrollees/Claimants.

1.123 **Retiree** means any person defined as a Retiree pursuant to the terms of 4 NYCRR Part 73, as amended.

1.124 **RFP or Procurement** means the Request for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Student Employee Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Programs."

1.125 **Selected Offeror or Contractor** means the Offeror selected as a result of the evaluation of Offeror's Proposals submitted in response to the RFP and who executes a separate Contract with the Department to provide Program Services.

1.126 **Shall** denotes the imperative in a contract clause or specification. Means required - being determinative/mandatory, as well as imperative. Also see "Must" and "Mandatory."

1.127 **Should** denotes the permissive in a contract clause or specification. Refers to items or information that the State has deemed are worthy of obtaining, but not required or obligatory. Also see "May."

1.128 **Specialty Drug(s)** means drugs that treat rare disease states; drugs requiring special handling, special administration, or intensive patient monitoring/testing; biotech drugs developed from human cell proteins and DNA, targeted to treat disease at the cellular level; or other drugs used to treat patients with chronic or life-threatening diseases identified as specialty medications through the mutual agreement of the Parties.

1.129 **Specialty Pharmacy Process** means the method that the Contractor employs to accept, process, and dispense Prescriptions for Covered Drugs to Enrollees/Claimants through the Designated Specialty Pharmacy(ies) or a Limited Distribution Drug Pharmacy, for those Employee groups participating in the specialty pharmacy benefit. Prescriptions are

considered to be submitted through the Specialty Pharmacy Process if they are a Limited Distribution Drug submitted directly to the Limited Distribution Drug Pharmacy, or if they are a Specialty Drug submitted directly to the Designated Specialty Pharmacy, by phone, fax, internet, e-prescribing or mail.

1.130 **State or NYS** means the State of New York.

1.131 **Student Employee Health Plan (SEHP)** means a health insurance plan for graduate student employees of the New York State University and the New York City University systems that provides benefits through the various Empire Plan Insurance Contracts. Like the Empire Plan, SEHP includes hospital, medical, managed mental health and substance use benefits, and prescription drug benefits, SEHP is administered by the New York State Department of Civil Service, Employee Benefits Division.

1.132 **Subcontractor** means any individual or legal entity (including but not limited to sole proprietor, partnership, limited liability company, firm or corporation) who has entered into a contract, express or implied, for the performance of a portion of the Contract with a Contractor.

1.133 **Supplemental Wrap Coverage** means standard Medicare Part D drug coverage that is coordinated with a Wrap plan to as closely as possible replicate benefits provided under the Empire Plan's Commercial Coverage.

1.134 **Supplier** means any entity that will provide supplies (i.e., inventory) as part of the Program Services under the Contract and could refer to a subcontractor depending on context.

1.135 **Therapeutic Equivalent Drug** means a drug that can be expected to produce essentially the same therapeutic outcome and toxicity.

1.136 **Transition Plan** means a written plan for transition, which outlines, at a minimum, the tasks, milestones, and deliverables associated with transitioning the Plan to a new Contractor.

1.137 **Use and Disclosure** means that the Contractor may create, receive, maintain, access, transmit, use and/or disclose the Department's Protected Health Information (PHI) solely in accordance with the terms of this Agreement.

1.138 **Usual and Customary (U&C)** means the retail price of a drug charged to the general public as submitted by the dispensing Pharmacy during claims processing.

1.139 **Vaccination Network** means the Contractor's credentialed network of participating independent and Chain Pharmacies contracted to deliver preventive vaccines to non-Medicare primary Enrollees.

1.140 **Vendor** means any entity that will provide Program Services under the Contract and could refer to the Contractor or their subcontractors depending on the context.

1.141 **Vestee** means a former Employee who is entitled to continue benefits under NYSHIP because he/she/they has met all the requirements for NYSHIP coverage as a Retiree, except for age eligibility for pension, at the time employment terminates.

SECTION II: TERM

The Contract will take effect and commence upon approval of the Contract by the New York State Office of the State Comptroller (OSC) (Effective Date). The term of the Contract shall include 5-years of Program Services commencing immediately upon OSC approval, on ~~January 1, 2025 (Project Services Start Date),~~ and ending on December 31, 2029, subject to the termination provisions contained herein.

DCS JP
CVS

In accordance with New York State policy and New York State Finance Law section 112(2), the Contract is deemed executory until it has been approved by the New York State Attorney General's Office (OAG) and approved and filed by the New York State Office of the State Comptroller (OSC).

The Agreement is subject to amendment(s) only upon mutual consent of the Parties, reduced to writing and if required, approved by the AG and the OSC.

SECTION III: INTEGRATION, MERGER AND ORDER OF PRECEDENCE

3.1 The Contract shall be composed solely of the following documents which, in the event of an inconsistency or conflicting terms, shall be given precedence in the order indicated:

DCS JP
CVS

3.1.1 **Appendix A (Standard Clauses for All New York State Contracts), dated June 2023, attached hereto, is hereby expressly made a part of this Contract as fully as if set forth at length herein;**

3.1.2 The body of the Contract (that portion preceding signatures);

3.1.3 Any Amendments to the body of the Contract;

~~Appendix A (Standard Clauses for All New York State Contracts), dated June 2023, attached hereto, is hereby expressly made a part of this Contract as fully as if set forth at length herein;~~

3.1.4 Appendix B (Standard Clauses for all Department Contracts), dated March 2024, attached hereto, is hereby expressly made a part of this Contract as if fully set forth herein;

3.1.5 Appendix C (New York State Department of Civil Service Information Security Requirements), dated March 2023, attached hereto, is hereby expressly made a part of this Contract as if fully set forth herein;

3.1.6 The following Attachments are incorporated by reference to the body of the Contract:

a. Attachment 1: Department' Official Responses to Contractors' Questions raised concerning the RFP, dated June 6, 2024;

b. Attachment 2: the Amended Request for Proposal, released on May 1, 2024, entitled, "Pharmacy Benefit Services for The Empire Plan, Student

Employee Health Plan, and NYS Insurance Fund Workers' Compensation Prescription Drug Programs", as amended on June 6, 2024, except for Appendix A (Standard Clauses for all New York State Contracts), which incorporates any appendices, attachments, exhibits, amendments, and updates to said RFP, including attachments thereto; and

c. Attachment 3, which consists of:

i. Contractor's Technical Proposal dated July 2, 2024;
ii. Contractor's Financial Proposal dated July 2, 2024; and
iii. Contractor's Written Response to the Technical Management Interview, dated July 31, 2024, including Contractor's submission of Additional Network Provider Report. In the event of an inconsistency or conflict, the Contractor's Written Response to the Technical Management Interview, dated July 31, 2024, shall be given precedence.

3.2 Only documents expressly enumerated above shall be deemed a part of the Contract, and references contained in those documents to additional Contractor documents not enumerated above shall be of no force and effect.

3.3 All prior agreements, representations, statements, negotiations, and undertakings are superseded. All statements made by the Department shall be deemed to be representations and not warranties.

3.4 The Department rejects all bid deviations or extraneous terms submitted by the Contractor not expressly accepted herein.

3.5 Nothing contained in this Contract, expressed, or implied, is intended to confer upon any person, corporation, or other entity, other than the Parties hereto and their successors in interest and assigns any rights or remedies under or by reason of the Agreement.

3.6 The terms, provisions, representations, and warranties contained in the Contract shall survive performance hereunder.

SECTION IV: MODIFICATIONS AND CLARIFICATIONS

4.1 For purposes of clarification, the reference to "independent contractors" in the first sentence to RFP Section 4.6.2(a), Specific Coverage and Limits, Commercial General Liability refers to vicarious liability for the negligence of the independent contractor.

4.2 Section 6.2 of the Contract, "Implementation Plan," has been modified from the original RFP requirements to remove the requirement for a formal Implementation Plan, in recognition that the Contractor is the incumbent vendor.

4.3 For purposes of clarification, Section 6.9.14 of the Contract, "Mail Service Pharmacy Process," applies to prescription orders over $100 as indicated in RFP Section 6.7.A.1.e.

4.4 For purposes of clarification, Appendix B Section 41, does not apply to unsuccessful

activity/attacks at the Business Associates firewall including pings and other broadcast attacks, port scans, unsuccessful log-on attempts, and denials of service.

SECTION V: LEGAL AUTHORITY TO PERFORM

5.1 The Contractor represents that it possesses the legal authority to perform Project Services in accordance with the terms and conditions of the Agreement.

5.2 The Contractor shall maintain appropriate corporate and/or legal authority, which shall include, but is not limited to, the maintenance of an administrative organization capable of delivering Project Services in accordance with the Agreement and the authority to do business in the State of New York or any other governmental jurisdiction in which the Project Services are to be delivered. The Contractor shall provide the Department with prompt notice in writing of the initiation of any legal action or suit which relates in any way to the Agreement, or which may affect performance of the Contractor's duties under the Agreement.

SECTION VI: PROJECT SERVICES

The Contractor will provide comprehensive administration of the DCS Program which includes the following services (Project Services) being procured under this Agreement:

6.1 Account Team

The Contractor must maintain, for the entire term of this Contract, an organization of sufficient size with staff that possesses the necessary skills and experience to administer, manage, and oversee all aspects of the DCS Drug Program during implementation, operation, and transition.

6.1.1 The Account Team(s) must be comprised of qualified and experienced individuals whose number and qualifications are acceptable to the Department and who are responsible for ensuring that the operational, clinical, and financial resources are in place to operate the DCS Program in an efficient manner. If there are separate Commercial and EGWP teams those teams must work together to provide joint support to the Department. The Account Team must include an Account Executive;

6.1.2 The Contractor 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 DCS Program requirements and to address any issues that may arise during the performance of each Contract.

6.1.3 The Contractor's dedicated Account Team must be experienced, accessible, and sufficiently staffed, as determined by the Department, 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 union representatives regarding member-specific claims issues for the duration of the separate Agreements to the satisfaction of the Department. The Department shall provide to the Contractor a written list of names of those individuals in its workforce (as defined in 45 CFR §160.103) that are authorized to receive or access Enrollee PHI on its behalf.

b. Provide urgent responses (within 3 Business Hours or less for requests submitted by 2 p.m. on a Business Day) to access to coverage concerns and inquiries posed by the Department, or other staff on behalf of the Council of Employee Health Insurance or union representatives regarding member-specific access to coverage issues for the duration of the respective Department's Contract to the satisfaction of the Department. The Department shall provide to the Contractor a written list of names of those individuals in its workforce (as defined in 45 CFR §160.103) that are authorized to receive or access Enrollee PHI on its behalf.

c. Immediately notify the Department in writing of actual or anticipated events impacting DCS Program costs and/or delivery of services to Members such as, but not limited to, legislation, litigation, drug recalls and withdrawals, class action settlements, and operational issues.

6.1.4 The proposed Account Team must guarantee that the Programs comply with all legislative and statutory requirements. In the event the Contractor is unable to comply with any legislative or statutory requirements, the Department must be notified in writing immediately. The Contractor is required to work with the Department to develop accurate NYSHIP General Information Book and Certificate of Insurance language, and any other forms of communication and/or Program material, subject to the Department's review and approval.

6.2 Implementation Plan

6.2.1 As this Contract is with the incumbent vendor, an Implementation Plan is not needed. However, the Department and the Contractor will, prior to the Project Services Start Date, discuss any implementation activities that need to be completed before the Project Services Start Date confirming all required services will be implemented. The removal of the need for a formal Implementation Plan does not relieve the Contractor from having all required services in place by the Project Services Start Date as stated in this Section.

6.3 Customer Service

The Contractor is responsible for all customer support and services including, but not limited to:

6.3.1 Providing Enrollees access to information on all Prescription drug benefits and services related to The Empire Plan, and SEHP through the Empire Plan consolidated toll-free number 24 hours a Day, 365 Days a year. The Empire Plan consolidated toll-free telephone service is provided through the AT&T

voice network services under a contract with The Empire Plan's Medical Program vendor and is available to callers 24-hours a Day, 365 Days a year. The Contractor is required to establish and maintain a transfer connection (currently an AT&T T-1 line), including a backup system that will transfer calls to the Contractor's line at their customer service site. The Contractor is required to work with The Empire Plan's Medical Program vendor (currently UnitedHealthcare) and AT&T to set up a connection. AT&T then bills the Contractor directly. In addition, the Contractor is also required to provide 24-hours a Day, 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability. The TTY number must provide the same level of access to customer service as required by Section 6.3 of this Contract.

6.3.2 Maintaining a call center located in the United States and staffed by fully trained customer service representatives and supervisors available 24-hours a Day, 365 Days a year. The Contractor must maintain a Dedicated Call Center for the DCS Program between the hours of 7:00 a.m. and 7:00 p.m. 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 center must also provide immediate access (either through warm transfers or call-back within four (4) hours) to Pharmacist(s) 24 hours a Day 365 Days a year. The Dedicated Call Center must be open and operational a minimum of 30 days prior to the DCS Programs implementation date, to assist Enrollees with questions concerning the Programs transition. The call centers must meet the Contractor's proposed customer service telephone guarantees set forth in Section 7 of this Contract. [Note: In accordance with New York State Labor Law section 773, the head of each State agency is required to use reasonable best efforts to ensure that all state-business-related contracts for call centers and customer service work be performed by contractors, agents, or subcontractors entirely within the State of New York.]

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

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

6.3.5 Maintaining a backup customer service staff located in the United States with Program-specific training to handle any overflow when the Dedicated Call Center is unable to meet the Contractor's proposed customer service performance guarantees. This backup system would also be utilized in the event the primary customer service center(s) become unavailable.

6.3.6 Maintaining and timely updating a secure online customized website

accessible by Enrollees which is available twenty-four (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, drug cost tools, comparative drug check functionality, Prescription drug history for both retail and mail claims and the Formularies (including alternatives for Non-Preferred Brand Name and excluded drugs). The website must be operational and available to Enrollees thirty (30) Days prior to the Implementation Date. The Department shall be notified of all regularly scheduled maintenance at least one (1) Business Day prior to such maintenance being performed. The Contractor must establish a dedicated link to the customized website for the DCS Program from the Department's website with content subject to the approval of the Department and limited to information that pertains to the DCS Program. Links bringing a viewer back to the Department website must be provided. No other links or non-Program related information is 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 solely by the Contractor. The Contractor shall fully cooperate with any Department initiatives to use new technologies, processes, and methods to improve the efficiencies of the customized website including development of an integrated Enrollee portal.

6.3.7 In accordance with federal and State law, the Contractor must provide access to a translation line or interpretation service to Members who do not read, speak, write or understand English as their primary language in order to remove potential barriers to accessing services.

6.4 Empire Plan Medicare Rx

The Contractor will be responsible for implementing and administering a Center for Medicare and Medicaid Services (CMS) approved and compliant Employer Group Waiver Plan (EGWP) for the Empire Plan's Medicare-eligible retirees beginning on the DCS Project Services Start Date. Empire Plan Medicare Rx is for Medicare- primary Empire Plan enrollees and Dependents. It is a Medicare Part D Prescription Drug Plan (PDP) with supplemental wrap coverage that provides benefits and drug coverage equivalent to, or in excess of, the benefits available to the Empire Plan's non-Medicare-primary enrollees and Dependents. Empire Plan Medicare Rx currently covers approximately 302,000 Medicare-primary enrollees and their Dependents. Required services for the EGWP shall include, but are not limited to, the following tasks. Such other tasks may be added in guidance and further regulation by CMS:

6.4.1 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" EGWP.

6.4.2 Fully supporting the Department with all operational aspects of a fully compliant 800-series EGWP including, but not limited to:

a. Medicare PDP EGWP premium development,

b. Enrollment, including providing temporary commercial plan coverage for Enrollees and/or Dependents who are pending enrollment by Medicare,

c. Enrollee Opt-Out process,

d. Eligibility Reconciliations on a cadence and format determined by the Department,

e. Medicare Beneficiary Identifier (MBI) administration,

f. Formulary management,

g. Issuing of Medicare PDP EGWP member identification cards,

h. Member Communications, including required explanation of benefits statements,

i. Claims Processing,

j. Administration of a Medicare Part D supplemental wrap with the goal of providing Medicare primary Enrollees with a prescription drug benefit that provides benefits and drug coverage that provides benefits and drug coverage equivalent to, or in excess of, the benefits available to the Empire Plan's non-Medicare-primary enrollees and Dependents in The Empire Plan,

k. Timely administration of catastrophic reinsurance claims,

l. Administration of Low-Income Subsidy requirements, including direct reimbursement of Low-Income Subsidies to eligible Enrollees of the Plan.

6.4.3 Submit an LIS report to the Department no later than fifteen (15) Business Days from the date the Contractor receives the subsidy payment from CMS. The report must include the following information regarding payments made by the Contractor to LIS Enrollees: NYSHIP Enrollee's name; NYSHIP Enrollee's SSN (if provided with the EGWP eligibility file); LIS eligible individual's name; LIS eligible individual's SSN (if provided with the EGWP eligibility file); LIS eligible individual's DOB; LIS eligibility start date, LIS eligibility end date; Monthly subsidy amount received from CMS for the LIS individual; Dual Eligibility indicator; Date LIS payment received from CMS (MM/DD/YYYY); LIS payment/adjustment start date; LIS payment/adjustment end date; LIS adjustment reason code/description; LIS eligible individual's MBI. Within forty-five (45) Business Days from the date the Contractor receives the Low-Income Subsidy (LIS) payment from CMS, the Contractor must send the LIS beneficiary the low-income premium subsidy payment.

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

6.4.5 Promptly credit the Department for all CMS premium subsidy payments (excluding LIS) and all pharmacy rebates received by the Contractor under the Medicare PDP EGWP plus Medicare D supplemental wrap.

6.4.6 The Department acknowledges and agrees that it shall be solely responsible for (1) for providing creditable coverage notices required with respect to the Empire Plan Medicare Rx Program; and (2) for determining whether enrolled individuals are Medicare Primary. The Contractor will work with the Department to obtain Medicare Beneficiary Identifiers (MBIs) for all eligible Medicare-primary members enrolled in the Empire Plan Medicare Rx Program.

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

6.4.8 The Contractor acknowledges that its provision of services pursuant to this Section 6 of this Contract is subject to audit and evaluation by the U.S. Department of Health and Human Services pursuant to 42 CFR Subpart R or other authority as may be cited by the federal government, as well as by the State of New York pursuant to Appendix A and Appendix B of this Contract. The Contractor shall comply with any record retention requirements required pursuant to 42 CFR Subpart R in this regard.

6.4.9 The Contractor is required to consult with the Department in analyzing its experience with the Empire Plan Medicare Rx, and recommending as well as implementing other permitted options under Medicare Part D that may be of advantage to the Department, agencies participating in NYSHIP and NYSHIP Enrollees.

6.4.10 Upon finalization of a subrogation process by CMS, the Contractor will be required to identify and recover claim payments made by the DCS Program from other plans that should have been the primary payer. The Contractor must apply appropriate procedures for the coordination of benefits based on the Department's records, including for members with multiple accounts and those moving between different Benefit Programs or lines of coverage. For Medicare primary members who are discovered to have both Commercial and EGWP accounts open concurrently in error, the Contractor will correct coverage to reflect EGWP for the accurate period and adjust Commercial as necessary. Accordingly, the Contractor will be required to move any claims erroneously paid under Commercial to EGWP for payment.

6.4.11 Utilizing the name of the Department's current EGWP, Empire Plan Medicare Rx, or a different name as directed by the Department, in all EGWP communication materials and identification cards.

6.5 Member Communication Support

6.5.1 All Member communications developed by the Contractor are subject to the Department's review and prior written approval, including but not limited to any regular standardized direct communication with Members or their Physicians in connection with Member drug utilization or the processing of Member claims, either through mail, e-mail, fax or telephone. The Department in its sole discretion reserves the right to require any change it deems necessary.

6.5.2 The Contractor 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 materials such as the materials presented in Attachment 29*, Various Empire Plan Publications* of the RFP, and any other form of communication, 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;

d. Developing timely and accurate Summary of Benefits and Coverage (SBC) documents that will be consolidated with coverage information from other Program vendors for The Empire Plan, and Student Employee Health Plan. Upon Enrollee request, the Contractor must direct Enrollees to the Department's website to view the SBC or distribute a copy of the SBC to the Enrollee within the federally required time period.

6.5.3 Upon request, subject to the discretion and approval of DCS, on an "as needed" basis, the Contractor agrees to provide staff to attend (in-person or virtually) Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States. The Contractor agrees that the costs associated with these services are included in the Contractor's Claims Administration Fee.

6.5.4 The Contractor must work with the Department to develop appropriate customized forms and letters for the DCS Program, including but not limited to mail order forms, Enrollee claim forms, prior authorization letters, specialty guideline management letters, Grace Fill letters, generic appeal letters, disruption letters, etc. All such communications must be customized as needed, sent on a timeline acceptable to the Department and the forms and letters must be approved by the Department. CMS-required communications are exempt from the customization requirement.

6.5.5 The fully functioning, customized Prescription Drug Program Benefits website, approved and accepted by the Department, must be available a minimum of 30 calendar days prior to commencement of the Project Services Start Date with a secure dedicated link from the Department's website with the ability to provide

Members with online access to the specific website requirements as set forth in Section 6.3.6 of this Contract. The website must conform to the New York State website style provided by the Department of Civil Service and meet all NYS Web Accessibility requirements.

6.5.6 The Contractor must include a web-based user interface compatible with:

a. Google Chrome current version for Windows;
b. Mozilla Firefox current version;
c. Safari current version; and
d. Microsoft Edge current version.

6.5.7 The websites must be mobile friendly, fully functional, and display correctly on devices such as:

a. Smartphones;
b. iPhones;
c. iPads;
d. Tablets; and
e. Laptops.

6.6 Enrollment Management

The Contractor must maintain accurate, complete, and up-to-date enrollment files, located in the United States, based on information provided by the Department. In the case of conflict, the Contractor must agree that the Department-provided enrollment system information governs. These enrollment files shall be used by the Contractor to process retail, mail order and specialty pharmacy claims, provide customer service, identify individuals in the enrollment file for whom Medicare is primary, and produce management reports and data files. The Contractor must provide enrollment management services including but not limited to:

6.6.1 Initial Testing

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

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

6.6.2 Providing an enrollment system capable of receiving, reading, interpreting, and storing secure enrollment transactions (Monday through Friday) and having all

transactions for Commercial plan members loaded to the claims processing system within twenty-four (24) hours of the release of a retrievable file by the Department. The Contractor shall, on a daily basis, manually review and load any transactions which did not process correctly from the daily ANSI x.12 834 standard 005010x220 file by reviewing the correct enrollment date maintained in the NYBEAS. The Contractor shall immediately notify the Department of each transaction that did not process correctly and any delay in loading enrollment transactions. In the event the Contractor experiences a delay due to the quality of the data supplied by the Department, the Contractor 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 Contractor in an electronic format daily (Monday through Friday). On occasion, the Department will release more than one enrollment file within a twenty-four-hour period. The Contractor must be capable of loading all enrollment files within the twenty-four-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 standard 005010x220 transaction set in the format specified by the Department. The Contractor must also have the capability to receive alternate identification numbers and any special update files from the Department containing eligibility additions and deletions, including emergency updates if required.

6.6.3 Acknowledge the Department's NYBEAS system is the controlling system for member enrollment and demographic information and, but not limited to:

a. Update enrollment and eligibility information solely based on the 834-transaction file for the Commercial NYSHIP population, and the EGWP eligibility file for the EGWP NYSHIP population;

b. Report the Empire Plan Alternate ID number (beginning with 890 or 891) in addition to the EGWP issued ID number when reporting information for EGWP members. Dependents enrolled in the EGWP must be linked back to the policy holder in the Department's system. Additionally, the Contractor is required to report back to the Department the Medicare Group Plan Number and the Medicare Prescription Drug Plan Number on all files for the membership;

c. Report data changes of name, date of birth, gender, or MBI from CMS to the Department, so that the Department can update its system as appropriate to report these changes on the 834 transaction and EGWP eligibility files;

d. Report address changes made to the Contractor to the Department via a file. The Department will update its system as appropriate and report these changes on the 834 transaction and EGWP eligibility files.

6.6.4 Coordinate enrollments, disenrollments, and cancellations of the EGWP using the EGWP eligibility file, including if a member has multiple alternate IDs (i.e., Dependent Survivors' coverage).

6.6.5 Accept and enroll members into the EGWP using the EGWP eligibility file and

submit the enrollment to CMS when a member is prospectively identified as Medicare primary:

a. The Contractor is responsible for providing temporary Commercial Coverage to those Medicare Rx Enrollees in the event automatic enrollment into Empire Plan Medicare Rx is unavailable.

6.6.6 Accept and enroll members into the EGWP using the EGWP eligibility file and submit the enrollment to CMS with the earliest EGWP enrollment date CMS allows, including but not limited to, when a member is retroactively identified as Medicare primary. The Contractor is required not only to submit the enrollment to CMS for the member, but also to extend Commercial Coverage until such point when the member is enrolled in the EGWP.

6.6.7 Process disenrollments for the EGWP using the EGWP eligibility file when a member is prospectively terminated from EGWP coverage (including ending Empire Plan coverage in its entirety or losing Medicare primacy). The Contractor will accept the disenrollment or cancellation on the EGWP eligibility file and use it to either disenroll or cancel an enrollment into the EGWP and submit the appropriate transaction to CMS.

6.6.8 Process disenrollments for the EGWP using the EGWP eligibility file when a member is retroactively terminated from EGWP coverage (including ending Empire Plan coverage in its entirety or Medicare primacy). The Contractor will accept the disenrollment or cancellation on the EGWP eligibility file and use it to either disenroll or cancel an enrollment into the EGWP plan with the earliest date CMS allows if the effective date of the termination cannot be processed and submit the appropriate transaction to CMS.

6.6.9 Accept EGWP eligible member enrollments with P.O. Box information as the Department attests to their eligibility and that they continue to reside in the EGWP service area.

6.6.10 Maintain eligibility files and generate a reconciliation eligibility file monthly for the Commercial Plan and quarterly for the EGWP. The file will contain data elements defined by the Department, but at a minimum will include, the member's Social Security Number, the policyholder alternate ID, NYSHIP assigned IDs (e.g., COBRA or Dependent Survivor), demographic information, enrollment date, and termination date. For the reconciliation of the EGWP eligibility information, the file must also include the MBI, Medicare Part D Plan information and PDP information.

6.6.11 Receive any other special update files from the Department containing eligibility additions and deletions, including emergency updates, which must be made within twenty-four (24) hours.

6.6.12 Providing the Department with all CMS Transaction Reason Codes (TRC) on an electronic Feedback file. Such responsibility must include, but not be limited to:

a. Transmitting all TRC codes, with the exception of the Low-Income Amount, received for a given member (enrollee or Dependent) with ordered

sequencing so all TRC codes may be processed in order;

b. Providing the Feedback file to the Department on a daily basis;

c. Submitting in a .txt file layout in accordance with Attachment 46, *NYBEAS EGWP Enrollment Record Layout – Header* of the RFP*,* as outlined in the RFP;

d. Initial testing to ensure the daily Feedback file loaded correctly and subsequent enrollment transactions are processed programmatically; and

e. Notifying the Department within twenty-four (24) hours if a Feedback file was unable to post.

6.6.13 Ensuring the security of all enrollment information as well as the security of a HIPAA-compliant computer system in order to protect the confidentiality of Enrollee/Dependent data contained in the enrollment file. Any transfers of enrollment data within the Contractor's system or to external parties must be completed via a secured process compliant with the information security requirements set forth in *Information Security Requirements* (Appendix C).

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

6.6.15 Cooperating fully with any Department, or third-party initiatives on behalf of the Department to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during this Contract.

6.6.16 Maintaining a read-only connection to the NYBEAS enrollment system for the purpose of providing the Contractor's authorized staff with access to current Program enrollment information. Contractor's authorized staff must be available to access enrollment information through NYBEAS, Monday through Friday, from 9:00 a.m. to 5:00 p.m., with the exception of NYS holidays as indicated on the Department's website.

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

6.6.18 Ability to manually load/correct an enrollment record and to contact the Pharmacy to allow the adjudication of a Prescription in an urgent or emergency situation.

6.6.19 Sharing data with entities to be determined by the State, including, but not limited to, health benefits administrators for New York State Agencies, Participating Employers and Participating Agencies.

6.6.20 Agreeing to the State defined eligibility periods as they relate to waiting periods and duration of coverage as a member (See General Information Books Referenced in Attachment 29, *Various Empire Plan Publications* of the RFP for additional information on State-defined eligibility periods).

6.6.21 Administering insurance coverage for any employee and their Eligible Dependents whom the Department determines is eligible for coverage.

6.6.22 Adhering to the Option Transfer Period which shall be the period announced by the State to allow eligible Enrollees to join the plan, change coverage, or add eligible Dependents.

6.6.23 Providing the State with online access to their enrollment information in real-time.

6.6.24 Maintaining a dedicated team to manually review enrollment and eligibility transactions that do not upload to the Contractor's system and report transactions that did not process in a format acceptable to the Department within one Business Day of discovery. A person will not be entitled to or deprived of benefits under the Agreement due to "clerical errors", such as those mistakes made in the recording or documentation process, due to human oversight or typos.

6.7 Reporting Services

The Contractor is responsible for accurate reporting services including, but not limited to:

6.7.1 Ensuring that all financial reports including claim reports are generated from amounts billed to the Programs, and tie to the amounts reported in quarterly and annual financial experience reports and Rebate reports.

6.7.2 Developing and delivering accurate and timely management, financial, and utilization reports as specified below and/or in Attachment 36, *Program Reporting* of the RFP. These reports will be delivered to the Department no later than their respective due dates and are required by the Department for its use in the review, management, monitoring, and analysis of the DCS Program. The exact format (paper and/or electronic Microsoft Access, Excel, Word), frequency, and due dates for such reports will be specified by the Department.

6.7.3 Providing direct, secure access to the Contractor's claims system and any online and web-based reporting tools to the Department's offices.

6.7.4 Providing ad hoc reports and other data analysis at no additional fee to the Department. The exact format, frequency, and due dates for such reports shall be specified by the Department. Any ad hoc report generated for the Department must be reflective of the Program's actual claims experience and Member population. Information required in the ad hoc reports may include, but is not limited to:

a. Forecasting and trend analysis data;
b. Data necessary to track drug pricing;
c. Utilization data on the Mail Order Pharmacy and the Specialty 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 including Department assigned Benefit Programs; (Attachment 28, *Benefit Programs),* of the RFP; and
h. Reports to monitor Contract compliance.

6.7.5 Reporting of all performance guarantees as specified within the Contract and for any occurrence when a performance guarantee is not met, when requested by the Department, Contractor will provide a root cause analysis and detail corrective action.

6.7.6 Assisting and supporting the Department with all aspects of the premium rate development including, but not limited to:

a. 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;

b. Developing projected aggregate claim, trend and Administrative Fee amounts for each DCS Plan 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, Employer Group Waiver Plan (EGWP) subsidies, changes in enrollment, changes in the Specialty Pharmacy Drug List as well as changes in all the formularies; and

c. Working with the Department and its contracted actuarial consultant through the annual premium 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 (DOB), Office of Employee Relations (OER) and the State's public employee unions.

6.7.7 Annual Reports

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

6.7.8 Quarterly Reports

a. Quarterly Performance Guarantee Report: The Contractor must submit quarterly the DCS Program's Performance Guarantee report that details the Contractor's compliance with all of the Contractor's proposed Performance Guarantees. The report should include the areas of: Implementation; system availability; customer service (telephone availability, response time, blockage rate, abandonment rate, website accuracy and website update timeliness); claims processing; management reports and claim files; enrollment; mail service turnaround; and Pharmacy composition and access. The Contractor should closely follow the current format specified by the Department in Attachment 41, *Quarterly Performance Guarantee Report* of the RFP. Documentation of compliance should be included with this report. The report is due thirty (30) Days after the end of the quarter;

b. Quarterly Network Access: The Contractor must submit a measurement of the Network access (using Attachment 20, *Contractor's Proposed Retail Pharmacy Network Access Prerequisite Worksheet* of the RFP) 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;

c. Quarterly Rebate and Other Pharma Revenue Report: The Contractor is required to submit a quarterly rebate and Other Pharma Revenue report detailing the amount of rebates and other Pharma Revenue received from the Contractor during the quarter. The report must include breakdowns by each manufacturer and drug with quarterly and year-to-date numbers, as well as any adjustments that are performed. The Contractor must follow the current format specified by the Department in Attachment 42, *Quarterly Rebate and Other Pharma Revenue Report* of the RFP. The Contractor's process for documenting rebates and other Pharma Revenue by manufacturer and issuing the payment of rebates and other Pharma Revenue to the DCS Program should not exceed sixty (60) 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 DCS Program.

6.7.9 Monthly Reports

a. Pharmacy Program Monthly Status Report: The Contractor is required to submit a monthly report that provides summarized information on: Production Statistics, Performance Guarantees, Customer Care Statistics, Mail Order Pharmacy Statistics, Prior Authorization Statistics, Appeals and Clinical Review Statistics, Top Therapeutic Classes by Commercial and EGWP, Top Drugs by Total Drug Cost and by Volume for Commercial and EGWP. The Contractor is required to submit this report in a format specified by the Department. The report is due thirty (30) Days after the end of the month.

b. Monthly Report of Program MAC List(s): Each month the Contractor is required to submit an updated Program MAC List that details all the drugs included on the Program MAC List and the corresponding prices used to charge the DCS Program. The following information shall be included: GPI,

NDC, drug name, form, strength, reference product, FDA rating, date the product was initially placed on the MAC List, initial MAC price, previous MAC price, current MAC price, effective date of current MAC price, the change in price from the previous Program MAC List and the Date the MAC Alert was sent to DCS. Drugs that are added or deleted from the Program MAC List shall be clearly marked or highlighted. The Contractor is required to submit this report in the current format specified by in Attachment 37, *Empire Plan Monthly MAC List* of the RFP, unless otherwise specified by the Departments. The report is due thirty (30) Days after the end of the month.

c. Drug Performance Reports: Each month the Contractor is required to submit a report with key monthly and year to date performance metrics, including utilization, cost, and discount statistics, for Brand and Generic drugs dispensed through the Retail Pharmacy Network and the Mail Service Pharmacy, and for Specialty Drugs dispensed through the Specialty Pharmacy Process. The Contractor is required to submit this report in the current format specified by DCS in Attachment 40, *Drug Performance Report* of the RFP, unless otherwise specified by the Department. The report is due thirty (30) days after the end of the month.

d. MAC Saving Reports: Each month the Contractor is required to submit year- to-date and annualized savings projections of the MAC price increases and decreases based on expected utilization. The following information shall be included: GPI, NDC, Drug Name, Strength, Initial MAC Price, Current Price, Quantity Filled, Actual Savings, Annual Savings and the Date the MAC Alert was sent to DCS. There must also be a Key for the FDA Rating, if needed, to ensure that all generic medications are AB-rated. The Contractor is required to submit this report specified by the Department in Attachment 39, *Monthly MAC Savings Report* of the RFP, unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month.

6.7.10 Bi-Weekly Reports

a. Detailed Claim File Data: The Contractor must transmit to the Department and/or its Decision Support System (DSS) Vendor a computerized file via secure transfer, containing detailed claim records in the format specified by the Department in Attachment 34, *NYS Detailed Claim File Layout (DCS)* of the RFP, unless otherwise specified by the Department, to support the bi-weekly invoice. The Department requires that all claims processed, reversed and adjusted be included in claims data. The file must facilitate reconciliation of claim payments to amounts charged to the DCS Program and include the current status of the claim (i.e., fields identifying claims as paid, adjusted, reversed). A rejected claim file is also required upon request by the Department. The Contractor is required to 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 (also within fifteen (15) Days after the end of each claims processing cycle) by claims processing cycle broken down by drug type (Generic/Brand) utilizing the

fields and the format specified by the Department in Attachment 35, *Cycle Claim Report* of the RFP. Based upon the analysis of the information contained in the report any important programmatic information, trends or abnormalities should be provided in a narrative; and

6.7.11 Reports Required at Other Frequencies

a. MAC Alert Notice: The Contractor is required to submit a report of the financial impact of enforcing mandatory generic substitution via a "MAC Alert Notice" utilizing the current format specified by the Department in Attachment 38, *MAC Alert Notice* of the RFP. This report must be submitted in accordance with the time frames specified in Section 6.15.1 of this Contract, under the subheading "Mandatory Generic Substitution at Retail and Mail."

6.8 Network Management

6.8.1 Retail Pharmacy Network

a. The Contractor must maintain a credentialed and contracted Retail Pharmacy Network that meets or exceeds the DCS Programs minimum access standards throughout the term of this Contract.

b. The DCS Programs require that the Contractor have available to Enrollees on the Project Services Start Date its proposed Retail Pharmacy Network in accordance with the requirements set forth in Section 7.1.0 of this Contract guaranteeing effective implementation of their proposed Retail Pharmacy Network.

c. The Contractor is required to substantially maintain the composition of independent Network Pharmacies. The Contractor must have contracts beginning on the Project Services Start Date, and throughout the term of this Contract, with independent pharmacies accounting for seventy-five percent (75%) or more of the DCS Program prescription drugs dispensed through independent pharmacies, based on the *Informational Claims File for 2023* (RFP Attachment 86). The layout specifications for these files are displayed in RFP Attachment 84 (*Layout Specification for DCS Program Informational Claims Data File*), provided such Pharmacies meet the requirements of Pharmacy Credentialing and Pharmacy Contracting of the RFP, and are willing to accept the proposed aggressive reimbursement rates.

d. The Contractor shall include in its Retail Pharmacy Network any Pharmacy(ies) upon the Department's request, where such inclusion is deemed necessary by the Department to meet the needs of Enrollees even if not otherwise necessary to meet the minimum access guarantees in Section 7.13.0. and Section 7.14.0 of this Contract.

e. The Contractor must effectively communicate the content (including any subsequent changes) and requirements of the DCS Program's Formularies to their Retail Pharmacy Network.

f. Prior to the Project Services Start Date, the Contractor must ensure that their Network Pharmacies have the correct claim identification information (i.e., RX BIN #, RXPCN, RXGRP, effective date, phone number for questions, etc.) to facilitate accurate claims submission and uninterrupted access for Enrollees.

g. The Contractor must establish a process to provide Enrollees with access to Limited Distribution Drugs through the Retail Pharmacy Network.

6.8.2 Pharmacy Credentialing

a. The Contractor must ensure its Retail Pharmacy Network is credentialed in accordance with all applicable federal and state laws, rules and regulations.

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

c. The Contractor must maintain credentialing records and make them available for review by the Department upon request.

d. The Contractor must have a procedure in place to notify impacted members in writing if a pharmacy they utilize is terminated from the Retail Pharmacy Network and such notification must provide the member with information on the nearest three Retail Pharmacy Network alternatives.

6.8.3 Pharmacy Contracting

The Contractor is responsible for providing Pharmacy contracting services including but not limited to:

a. Ensuring that all Network Pharmacies contractually agree to and comply with all of the DCS Program requirements and benefit design specifications. In addition, the Contractor shall, pursuant to the terms of this Agreement, provide any pharmacy network agreement requested for the DCS Programs to evaluate program requirements and benefit design specifications. If the Contractor identifies, in writing, the information requested as Contractor's Confidential or Proprietary information access to the information will be provided pursuant to Section 14.7 of this Contract, Contractor's Confidential Information.

b. Ensuring all Network Pharmacy contracts include a provision prohibiting the use of pharmacy manufacturer coupons that reduce or waive Enrollee Copayments. Manufacturer coupons are also prohibited for use in the Mail Service and Specialty Pharmacies.

c. Recruiting licensed Pharmacies affiliated with home care agencies that are participating providers under The Empire Plan's Home Care Advocacy Program (HCAP) administered by The Empire Plan's medical carrier.

These licensed pharmacies are provided in Attachment 32, *HCAP Providers for the NYS Empire Plan*, of the RFP.

d. Ensuring that Network Pharmacies accept as payment-in-full the Contractor's reimbursement for all claims processed based on the Program's Lesser of Logic as defined in Section I, "Definition of Terms," of this Contract.

e. Notifying the Department in writing of any plan to re-negotiate the financial terms of any Network Pharmacy contract utilized by the DCS 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.

f. Notifying the Department 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 Contractor, including but not limited to, those identified as participating in the Contractor's proposed network.

g. Upon the request of the Department, re-soliciting the entire Pharmacy Network to obtain more aggressive reimbursement rates that would pass-through to the DCS Program in exchange for a smaller, select network that meets proposed access guarantees, as modified.

h. Committing to administering Pharmacy contracts consistent with all representations made in the Contractor's financial proposal, including all representations regarding the administration of Generic Drug pricing and maintenance of MAC list(s).

6.8.4 Pharmacy & Program Audit

The Contractor must have a staffed and experienced, trained and highly credentialed audit unit employing a comprehensive Pharmacy and Program audit program that includes but is not limited to:

a. Providing ample audit resources including access to the Contractor's online claims processing system and historical claims data files to the Department and OSC at their respective offices through the date of the final financial settlement of the Agreement.

b. Providing the Department with access and monthly updates to the Prescription Drug industry reference material for drug classification and drug pricing that the Contractor will be utilizing for the Programs, including but not limited to Medi-span Master Drug Database and Drug Application File or equivalent if different reference materials are used.

c. Conducting routine and targeted onsite audits of Network Pharmacies, the Mail Service Pharmacy and the Specialty Pharmacy(ies). Audits must be conducted according to a plan agreed to by the Department. 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. Onsite audits must also be conducted upon request by the Department, or when information is received by the Contractor that indicates a pattern of conduct by a Pharmacy that is not consistent with the respective Programs design and objectives. Periodic, onsite audits must be conducted at least once during the course of the Contract for Pharmacies that fall into the top fifty (50) in terms of total dollar spend for the DCS Program or whose average prescription cost exceeds the program average prescription cost by 300%. Any modifications to the proposed Pharmacy audit programs must receive prior approval by the Department.

d. Providing reports to the Department detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Contractor. The Contractor must inform the Department in writing of any allegation or other indication of potential fraud and abuse identified within seven (7) Business Days of such allegations or identification. The Department must be fully informed of all fraud and abuse investigations impacting the Programs upon commencement, regardless of whether the individual fraud and abuse investigation has a material financial impact to the State.

e. The capability and contractual right to effectively audit the DCS Programs Retail Pharmacy Network, including the use of statistical sampling audit techniques, and the extrapolation of errors, unless the use of extrapolation of errors is prohibited by State law or regulation.

f. Agreement to fully cooperate with all Department and/or OSC audits consistent with the requirements of Appendices A, B, and C and as set forth in Section 14 "Additional Provisions" of this Contract, 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 Contractor must respond to all State (including OSC) audit requests for information and/or clarification within fifteen (15) Business Days. The Contractor must perform timely reviews and respond in a time period specified by the Department to preliminary findings submitted by the Department or the Comptroller's audit unit in accordance with the "Audit Authority" requirements of Section 14.5 of this Contract. 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 Contractor shall facilitate audits of network pharmacies, including onsite audits, as requested by the Department, and/or OSC;

g. Remitting 100% of pharmacy audit recoveries to the Department as applicable within thirty (30) Days upon final audit determination consistent with the process specified in Section VIII of this Contract, and Appendix B of this Contract.

h. Utilizing the auditing tools and performance measures proposed by the Contractor to identify fraud and abuse by Network Pharmacies and/or Enrollees.

i. Permitting the Department or a designated third party to audit pharmacy bills and drug company revenues.

6.9 Mail Service Pharmacy Process

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

6.9.1 Having a fully staffed and fully operational Mail Service Pharmacy Process throughout the term of this Contract, 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 or requires special preparation or handling for up to a 90-Day supply. The Contractor must establish a process to provide Enrollees with access to Limited Distribution Drugs placing no additional steps or burdens on the Enrollee. Prescriptions are considered to be "submitted through the Mail Service Process" if they are submitted by phone, fax, internet, e-prescribing or mail to any Mail Service Pharmacy Process Facility, regardless of how the Prescription is filled. All covered Prescriptions, except for Limited Distribution Drugs, submitted through the Mail Service Pharmacy Process or through a Mail Service Pharmacy Process Facility shall be charged to the DCS Program based on the Contractor's mail service pricing terms and dispensing fees (if any) applicable to Brand Name, Generic, and Compound Drug claims as set forth in Section IX, "DCS Program Claims Reimbursement," of the Contract, including Specialty Drugs for certain enrollees. Limited Distribution Drugs submitted through the Mail Service Pharmacy Process shall be charged to the Program based on the Contractor's Retail Network pricing terms and dispensing fees (if any) applicable to Brand Name, Generic and Compound Drug claims as set forth in Section IX, "DCS Program Claims Reimbursement," of the Contract. The Mail Service Pharmacy Process shall apply the same DCS Program benefit design features as the Network Pharmacies, including but not limited to Mandatory Generic Substitution, DUR, Prior Authorization and Flexible Formulary, and application of appropriate Copayments.

6.9.2 Ensuring that the Departments approved edits including, but not limited to, enforcing utilization edits (e.g., refill too soon, duplicate therapy) are built into the Prescription fulfillment system to protect an Enrollee's safety as well as to control DCS Program costs.

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

6.9.4 Providing a simple, user-friendly method(s) of ordering, reordering, or transferring Prescriptions from retail to mail. Maintaining a Dedicated Call Center located in the United States employing a staff of Pharmacists, and a staff of fully trained customer service representatives, and supervisors available 24 hours a Day 365 Days a year that must meet the Contractor's proposed Mail Service Pharmacy Process guarantees set forth in Section VII of this Contract.

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

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

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

6.9.6 Having efficient procedures in place to handle routine Prescriptions, "urgent" Prescriptions, and Prescriptions that require "special" handling (i.e., temperature control, limited shelf life, high cost, etc.)

6.9.7 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.

6.9.8 Having a system in place to track all Prescriptions (both intervention and nonintervention) received for processing through the Mail Service Pharmacy Process from the date the Prescription is received to the date the mailing agent picks up the package. The Contractor must also be able to track fill accuracy rates.

6.9.9 Maintaining a process to collect information necessary to ensure Enrollee safety. The process should collect such information as drug allergies, chronic medical conditions, and other medications taken on a regular basis.

6.9.10 Maintaining a system that notifies Enrollees about potential health and safety issues with their Prescriptions.

6.9.11 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, backup supplier contracts, etc.

6.9.12 Providing prompt notification to Enrollees regarding out-of-stock items, partial fill orders, and changes to Prescriptions (e.g., approved or required dispensing of Generic Drugs instead of Brand Drugs). In out-of- stock situations, the Contractor must have a system in place to ensure that Prescriptions are filled in the most efficient manner whether it be through an alternate facility(ies) or obtaining a re-stock from a supplier. If necessary, the Contractor shall contact the Enrollee first to obtain permission to contact their Physician to offer alternative medications, or to offer to return the prescription. This contact may be through a call, email or other secure means. If the Physician authorizes use of an alternative medication, a letter notifying the Enrollee of the change must be sent to the Enrollee before the medication is shipped or must accompany the Prescription.

6.9.13 Calling the prescribing Physician when a DAW-1 is indicated on the Prescription to confirm that the Physician understands the financial impact to the Enrollee and/or the DCS Program to determine if the Physician is willing to allow the generic version of the drug to be dispensed to the Enrollee. If the Physician was previously contacted regarding the same Prescription for a particular Brand Drug for the same Enrollee and required that the Brand Drug be dispensed, no call is required. If the Physician authorizes use of the generic version of the drug, a phone call shall be made to the Enrollee to advise of the approved change before the medication is shipped or the Contractor shall include a letter with the Prescription informing the Enrollee of their Physician's approval. If the Enrollee has indicated on the mail service order form that they do not wish their Physician to be contacted for such determinations, no call shall be made.

6.9.14 Informing the Enrollee prior to shipping if the total amount for a Prescription order submitted through the Mail Service Pharmacy Process exceeds $100 and Enrollee has payment information (e.g., credit card) on file or Enrollee's total balance is over $100 and Enrollee has no payment information (e.g., credit card) on file. The Mail Service Pharmacy Process Facility will not be required to inform Enrollees if there is a consistent history of the acceptance of shipments of the same medication that exceed the maximum amount specified. If the brand name drug is dispensed, the Contractor shall cause the dispensing facility to collect the applicable Brand Drug Copayment plus the calculated Ancillary Charge, if any. Under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the DCS Program.

6.9.15 The Contractor is expected to assist Enrollees, upon request, to establish a payment plan so that Prescriptions that are essential to an Enrollee's health will continue to ship when the outstanding amount exceeds the Contractor's proposed maximum limits.

6.9.16 Notifying the Department of nationwide out-of-stock issues, including information from the manufacturer or wholesaler regarding the anticipated date that the drug will resume shipment.

6.9.17 Utilizing best efforts to complete Physician clarification, verification, or other

interventions within the five (5) Business Day service level standard. Should this require more than eight (8) Business Days, the Contractor shall call the Enrollee and offer the Enrollee the option of returning the prescription or continuing the intervention attempt.

6.9.18 Ensuring that the consent of the Enrollee is obtained prior to calling the prescribing Physician with the exception of calls made for purposes of clarification, verification, settlement of other intervention claim issues or DAW-1 confirmations.

6.9.19 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.

6.9.20 Having a backup mail order facility(ies) to handle any overflow and/or situations where the primary mail order facility is unavailable.

6.9.21 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 Department. Any regular direct communication with Enrollees or their Physicians in connection with Enrollee drug utilization or the processing of Enrollee claims, either through mail, e-mail, fax or telephone must be submitted for the Departments approval. The cost of any approved promotion shall be borne by the Contractor, unless the Department specifically request a particular activity not required to be performed under the Agreement. The Department will not approve any mail order promotions that it determines will not result in a reduced net cost to the DCS Program.

6.9.22 The Contractor shall, at all times, act in the best interests of the DCS Program when dispensing Generic Drugs through the Mail Service Pharmacy Process by avoiding the dispensing of NDCs with higher AWPs unless market conditions exist making dispensing the more cost-effective NDC impractical or impossible.

6.10 Specialty Drugs

6.10.1 The Contractor must provide Enrollees with access to all Medically Necessary Specialty Drugs covered by the DCS Program through its proposed Retail Pharmacy Network and through the Mail Service Pharmacy Process in accordance with each Enrollee group benefit design. In the case of Limited Distribution Drugs, the Contractor shall provide Enrollees with access in accordance with the following:

a. *Retail Pharmacy Network Access:* The Contractor's Retail Pharmacy Discount Guarantees, dispensing fees and prescribing fee(s), if applicable, as stated in Section IX, "DCS Program Claims Reimbursement," of the Contract, shall apply for all Specialty Drug claims dispensed at retail pharmacies. Specialty Drug claims originating at Retail Pharmacies will be included with all claims in the respective Brand or Generic Guaranteed

Minimum Discount. The Enrollee shall be charged the applicable retail Copayment;

b. *Mail Service Pharmacy Process Access:* The Contractor must facilitate the Enrollee's receipt of the Limited Distribution Drug. The Contractor shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the DCS Program consistent with the Contractor's contracted discount off AWP for the Limited Distribution Drug, plus any dispensing fee. The Enrollee shall be charged the applicable mail order Copayment;

c. Individuals receiving home infusion services through the Home Care Advocacy Program (HCAP), a component of The Empire Plan's Medical/Surgical Program, have their home infusion drugs covered under the Prescription Drug Program. Currently the DCS Program has a network of licensed pharmacies affiliated with home care agencies participating in The Empire Plan's HCAP Program administered by The Empire Plan's medical carrier. The Contractor is expected to secure contracts with the licensed pharmacies provided in Attachment 32, *HCAP Providers for the NYS Empire Plan*, of the RFP to ensure continued utilization of a network Prescription drug benefit for those Enrollees utilizing the HCAP Program. The Contractor may propose to utilize entities owned by or affiliated with the Contractor to serve as an HCAP Provider. The Department at its sole discretion shall determine whether it is in the best interests of the DCS Program to allow the entity to participate in the HCAP Program. The Prescription drugs dispensed to Enrollees via the entities or pharmacies owned by or affiliated with the Contractor must be charged to the DCS Program based on the Contractor's mail service pricing terms and dispensing fees applicable to brand name, generic, and Compound Drug claims as stated in Section IX, "DCS Program Claims Reimbursement," of the Contract; and

d. Site of Care Program. Effective July 1, 2023, for ratified unions, a Site of Care Redirection Program was implemented for the infusion of Remicade and its biosimilars. Effective January 1, 2024, the Program expanded to include all infused drugs as determined by the Hospital Program, with the exception of drugs used to treat cancer and hemophilia. Upon implementation, the Department will inform the vendor of the ratified unions covered by the Site of Care Program. Prescription drug Copayments associated with infusions under the Program will be waived and there will be no additional Prior Authorizations required when the enrollee uses a non-hospital infusion site of care.

6.11 Specialty Pharmacy Program

The Contractor must provide all aspects of the Specialty Pharmacy Program. Such responsibility must include, but not be limited to:

6.11.1 Developing a listing of the Specialty Drugs proposed for inclusion in the Specialty Pharmacy Program.

6.11.2 Having a fully staffed and fully operational Specialty Pharmacy Program in which Specialty Drugs 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.

6.11.3 The Contractor must establish a process to provide Enrollees with access to Limited Distribution Drugs not available through the Designated Specialty Pharmacy(ies), which places no additional steps or burdens on the Enrollee. The Contractor shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the Programs consistent with the Contractor's contracted discount off AWP for the Limited Distribution Drug, plus any dispensing fee. The Enrollee shall be charged the applicable retail Copayment.

6.11.4 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 therapies. The Contractor must provide callers with access to customer service staff and Pharmacists through The Empire Plan consolidated line who are able to respond timely to questions, complaints and inquiries including but not limited to: DCS Program benefit inquiries, refills, order status, price estimates, billing, point-of-service issues, Specialty Pharmacy Process complaints, preferred drug status, and claim status. Callers must be able to reorder and check order status through both the customized website and the DCS Program telephone lines. Enrollees must also have real-time web access to their Prescription drug history file (retail, mail, and specialty) via a customized website.

6.11.5 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 manufacturers for certain drugs to ensure the benefits of a drug outweigh its risks.

6.11.6 Contracting a nationwide network of appropriately licensed clinicians and/or coordinating with appropriately trained HCAP clinicians to administer the Specialty Drugs to Enrollees in a home setting and providing Enrollees with education on proper treatment regimens and possible side effects.

6.11.7 Site of Care Program. Effective July 1, 2023, for ratified unions, a Site of Care Redirection Program will be implemented for the infusion of Remicade and its biosimilars. Effective January 1, 2024, the Program expanded to include all infused drugs as determined by the Hospital Program, with the exception of drugs used to treat cancer and hemophilia. Upon implementation, the Department will inform the vendor of the ratified unions covered by the Site of Care Program. Prescription drug Copayments associated with infusions under the Program will be waived and there will be no additional Prior Authorizations required when the enrollee uses a non-hospital infusion site of care.

6.11.8 Completing Physician consultation, coordination of care, patient care

management and other interventions on a clinically appropriate and timely basis.

6.11.9 Providing all necessary clinical and educational support to Enrollees, and/or their family/caregiver utilizing the Specialty Pharmacy Process, including but not limited to explaining the treatment plan and ancillary supplies, disease/drug education, side- effect management, compliance management and administration training.

6.11.10 Applying the same DCS Program benefit design features as the Mail Service Pharmacy Process, including but not limited to Mandatory Generic Substitution, DUR, Prior Authorization and application of appropriate Copayments. Specialty Drugs that are subject to the Designated Specialty Pharmacy Passive Edit and are dispensed at a Network Pharmacy must be subject to the Network Pharmacy Copayments.

6.11.11 Ensuring that all the Departments approved edits including, but not limited to, enforcing utilization edits (e.g., refill too soon, duplicate therapy) are built into the Prescription fulfillment process system to protect Enrollees' safety as well as to control DCS Program costs.

6.11.12 Ensuring that all Designated Specialty Pharmacies utilized in the Contractor's Specialty Pharmacy Program meet all Prescription drug packaging regulatory requirements. The Contractor must ensure that Specialty Drugs/ Medications are shipped to Enrollees in appropriate packing materials so that Specialty Drugs are safe and effective and delivered on time.

6.11.13 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 Contractor must send a Specialty Pharmacy Program letter to Enrollees, subject to review and approval by DCS, who have received a Grace Fill of a Specialty Drug 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 subject to the Designated Specialty Pharmacy Hard Edit and within thirty (30) Days of the Prescription being filled to Enrollees who have received a Specialty Drug subject to the Designated Specialty Pharmacy Passive Edit. Enrollees are allowed one Grace Fill for Specialty Drugs, except Specialty Drugs identified as being for short-term therapy for which a delay in starting therapy would not affect clinical outcome are not eligible for a Grace Fill.

6.11.14 Maintaining a comprehensive system for the Contractor's staff to utilize to track all Enrollee inquiries including, but not limited to: DCS Program benefits, refills, order and claim status, prices, billing, Flexible and Advanced Flexible Formulary inquiries and Specialty Pharmacy Process complaints. The system shall include call type, customer service actions, and resolutions.

6.11.15 Having a system in place to track all Prescriptions received for processing through the Specialty Pharmacy Process from the date the Prescription is received to the date the Prescription is shipped. The Contractor must also be able to track fill accuracy rates.

6.11.16 Maintaining a process to collect information from individuals necessary to ensure Enrollee safety. The process should collect such information as drug allergies, chronic medical conditions, and other medications taken on a regular basis.

6.11.17 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, backup supplier contracts, etc.

6.11.18 Providing notification to Enrollees as soon as possible for out-of-stock items, partial fill orders, and changes to Prescriptions (e.g., dosing or method of administration). In out-of-stock situations, the Contractor must have a system in place to ensure that Prescriptions are filled in the most efficient manner whether it be through an alternate facility(ies) or obtaining a re-stock from a supplier. The Contractor must contact the Enrollee's Physician, if necessary, to offer alternative medications or offer to return the Prescription. If the Physician authorizes use of an alternative medication, a letter notifying the Enrollee of the change must be sent to the Enrollee before the medication is shipped or must accompany the Prescription.

6.11.19 Informing the Enrollee prior to shipping if the total amount for a Prescription order submitted through the Specialty Pharmacy Process exceeds $100 and Enrollee has payment information (e.g., credit card) on file or Enrollee's total balance is over $100 and Enrollee has no payment information (e.g., credit card) on file. The Designated Specialty Pharmacy will not be required to inform an Enrollee if there is a consistent history of the acceptance of shipments of the same medication that exceed the $100 amount specified.

6.11.20 The Contractor is expected to assist Enrollees, upon request, to establish a payment plan so that Specialty Drug Prescriptions that are essential to an Enrollee's health will continue to ship when the outstanding amount exceeds the Contractor's proposed maximum limits.

6.11.21 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.

6.11.22 Having backup Designated Specialty Pharmacies to handle any overflow and/or situations where the primary Specialty Program facility is unavailable.

6.11.23 The mail order Copayment shall apply to all drugs dispensed through the Specialty Pharmacy Program as well as Limited Distribution Drugs facilitated through the Specialty Pharmacy Program.

6.11.24 Recommending newly launched Specialty Drugs for inclusion in the Specialty Pharmacy Program based on the established criteria/definition of Specialty Drug, in a format to be approved by the Department. If Contractor identifies in writing the information requested as Contractors' Confidential or Proprietary information access to the information will be provided pursuant to Section 14.7 of this Contract, Contractor's Confidential Information.

6.11.25 Prior to inclusion in the Programs, or if not accepted by the Department to be included in the Programs, the Contractor must bill the Programs for these Prescriptions consistent with Section IX, “DCS Program Claims Reimbursement,” of the Contract, based on where each Prescription was actually dispensed. Inclusion of new Specialty Drugs shall have a cost- neutral or positive financial impact on the DCS Program, and in no case shall the Ingredient Cost of a newly added Specialty Drug charged to the DCS Program exceeds the lowest of: (a) the Guaranteed Minimum Discount off of Aggregate AWP for Specialty Drugs stated in Section IX, “DCS Program Claims Reimbursement,” of the Contract, plus Guaranteed Dispensing Fee as stated in Section 9.6.4c of the Contract; (b) MAC plus Guaranteed Dispensing Fee as stated in Section 9.6.4c of the Contract; or (c) WAC plus Guaranteed Dispensing Fee as stated in Section 9.6.4c of the Contract. The Contractor’s Guaranteed Minimum Discount off of Aggregate AWP for all Specialty Drugs dispensed via specialty pharmacies or Mail Service Pharmacies shall be greater than the Contractor’s Guaranteed Minimum Discount off of Aggregate AWP of Brand Name Drugs dispensed through the Retail Pharmacy Network and Guaranteed Maximum Dispensing Fee.

6.12 Vaccination Network

The Contractor will arrange for provision of vaccine services permitted by applicable DCS Law, through the Contractor’s Vaccination Network, for non-Medicare primary enrollees to obtain seasonal and non-seasonal preventive vaccinations, including the COVID-19 vaccine and booster, when administered by a licensed pharmacist or, when authorized by applicable law or regulation, a pharmacy intern.

6.12.1 Seasonal Vaccines (influenza)

6.12.2 Non-Seasonal Vaccines (vaccines for viruses other than influenza) will be in effect until superseded or revoked by the Department through written notice to the Contractor during the term of this Contract.

6.12.3 COVID-19 Vaccines and Boosters (vaccines and boosters for COVID-19 are covered without Copayment).

6.13 Claims Processing

The Contractor must provide all aspects of claims processing. Such responsibility shall include, but not be limited to:

6.13.1 Verifying that the DCS Program benefit design has been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly.

6.13.2 Accurate and timely processing of all claims submitted under the DCS Program in accordance with the benefit design applicable to the Enrollee at the time the claim was incurred as specified to the Contractor by the Department.

6.13.3 Charging the Programs consistent with Sections VIII and IX of the Contract as well as the Contractor’s Financial Proposal of the RFP.

6.13.4 Developing and maintaining claim payment procedures, guidelines, and system

edits that guarantee accuracy of claim payments for covered expenses only, utilizing all edits as proposed and approved by the Department. The Contractor shall utilize Refill Too Soon edits and duplication of therapy edits for all claims unless exceptions are specifically approved in advance by the Department. The Contractor's system must ensure that refilling Prescriptions prior to use of the minimum prescribed Day's supply does not result in over-dispensing.

6.13.5 Managing Flexible Formulary, Advanced Flexible Formulary and Empire Plan Medicare Rx placement of drugs consistent with the DCS Program design and ensuring application of appropriate Copayments based on level assignment.

6.13.6 Maintaining claims histories for 24-months online and archiving older claim histories for 6-years and the balance of the calendar year in which they were made with procedures to easily retrieve and load claim records.

6.13.7 Maintaining the security of the claim files and ensuring HIPAA compliance.

6.13.8 Reversing all attributes of claim records, e.g., AWP, quantity, Days' supply, etc., processed in error 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 including but not limited to the Claims Administration Fee.

6.13.9 Agreeing that all claims data is the property of the State. Upon the request of the Department, the Contractor shall share appropriate claims data with other DCS Program carriers and consultants for various programs (e.g., Disease Management, Centers of Excellence) and the Department's DSS vendor. The Contractor cannot share, sell, release, or make the data available to third parties in any manner without the prior consent of the Department. The Department understand that the Selected Contractor will be required to share certain claims data with pharmaceutical manufacturers for purposes of obtaining for the Programs all Pharma Revenue due it under this Agreement. The Contractor shall inform the Department of the types of data being shared for these specific authorized purposes.

6.13.10 Maintaining a backup system and disaster recovery system for processing claims, which are compliant with the information security requirements set forth in *Information Security Requirements* (Appendix C) of this Contract, in the event that the primary claims payment system fails or is not accessible.

6.13.11 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.

6.13.12 Maintaining an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the DCS 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 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 DCS Program logic for the Pharmacy Submitted DAW codes is listed below:

Pharmacy Submitted DAW	**Enrollee Copay**	**Ancillary Charge**	**Pricing**
0*	Brand	No	Brand
1	Brand	Yes	Generic
2	Brand	Yes	Generic
3	Generic	No	Generic
4	Generic	No	Generic
5	Generic	No	Generic
6	Generic	No	Generic
7	Brand	No	Brand
8	Generic	No	Generic
9	Generic	No	Generic

*Logic applies unless the claim is rejected pursuant to this section.

6.13.13 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 IX "DCS Program Claims Reimbursement" of this Contract.

6.13.14 Maintaining a DCS Program MAC List(s) for Pharmacies.

6.13.15 Ensuring the claims processing system is capable of implementing and/or complying with the DCS Program "Lesser of Logic."

6.13.16 Processing Enrollee Submitted Claims in accordance with the following:

a. For Prescriptions filled with a Brand Drug with no generic equivalent, the Enrollee will be reimbursed using the Contractor's Guarantee Minimum Discount off of Aggregate AWP for the Retail Pharmacy Network plus dispensing fee and prescribing fee, if applicable, for Brand Drugs not to exceed the submitted charges, less the applicable Copayment;

b. 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;

c. 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;

d. 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

e. If the Enrollee has two Empire Plan coverages, the DCS Program will reimburse 100% of the copay. For specific methodology on how the DCS Program must be charged for Enrollee Submitted Claims, see Section IX "DCS Program Claims Reimbursement" of this Contract.

6.13.17 Processing claims for Employees enrolled in the SEHP who fill Prescriptions at SUNY pharmacies. These pharmacies are required to adhere to the retail network contract and prescriptions under this arrangement must be dispensed according to the Plan design for the SEHP, including required prior authorizations and Days' supply limits.

6.13.18 Processing all manually submitted claims including but not limited to Medicaid, VA, Skilled Nursing Facility claims, out-of-network claims, foreign claims, in-network manual claims, COB claims, and Medicare Part B primary claims in accordance with the Contractor's proposed Claims Adjudication Guarantee.

6.13.19 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 DCS Program shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses. The DCS Program will be charged a Claims Administration Fee only for Final Paid Claims. The Contractor shall credit the DCS Program the amount of any overpayment regardless of whether any overpayments are recovered from the Pharmacy and/or Enrollee in instances where a claim is paid in error due to Contractor error, or due to fraud or abuse, without additional administrative charge to the DCS Program. The Contractor shall report fraud and abuse to the appropriate authorities. In cases of overpayments resulting from errors only found to be the responsibility of the State, the Contractor shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the DCS Program upon receipt; however, the Contractor is not responsible to credit amounts that are not recovered.

6.13.20 Establishing a process where Pharmacies can verify eligibility of Enrollees and Dependents during Call Center Hours.

6.13.21 Requiring network pharmacies to submit to the Contractor for each drug dispensed the Pharmacy's Submitted Cost to ensure that the DCS Program is charged according to the Programs Lesser of Logic. Further, if an Ancillary Charge is applied, it will be deducted from the total claim cost.

6.13.22 Identifying Enrollees enrolled in Medicare Part D. The Contractor's claims processing system must decline claims at the point of service for Enrollees who are enrolled in a Medicare Part D Plan other than the DCS Program EGWP. Messaging to the Pharmacy must instruct the Pharmacist to submit the claim to the Enrollee's Medicare Part D Plan.

6.13.23 Establishing a process to support and respond to Federal Medicare Part D audits.

6.13.24 Having a process in place (fully staffed with ample telephone trunks) available 24 hours a Day, 7 Days a week where a Pharmacist can call to quickly resolve point-of-service issues.

6.13.25 In instances where a member is covered under two (2) separate Empire Plan policies (Dual Empire Plan Coverage), the Contractor must reimburse one hundred percent of the copay, regardless of the type of Empire Plan coverage (e.g., Medicare Part D versus Empire Plan Commercial Coverage).

6.14 Retrospective Coordination of Benefits

6.14.1 The Contractor is required to pursue collection of any money due the DCS Program from other payers or Enrollees who have primary Prescription drug coverage through another carrier and to credit the DCS Program's account one hundred percent (100%) of all recoveries within fifteen (15) Days after the end of the month.

6.14.2 The Contractor must maintain a system capable of receiving a historical COB data file from the current contractor and benefits information obtained from Enrollee surveys. The Contractor's system must be capable of tracking the date an initial letter is sent to the Enrollee or other carrier until the point money is recovered.

6.14.3 The Contractor must develop for Department review and approval COB correspondence including, but not limited to; an Enrollee questionnaire to confirm other Prescription drug coverage information, a letter(s) instructing Enrollees to file for reimbursement from the primary plan and advising that the Enrollee must reimburse the DCS Program for the cost of their claims and a collection letter(s) to other carriers who owe the DCS Program reimbursement.

6.14.4 The Contractor must have a system in place to facilitate collection, without Enrollee intervention, when the primary plan claims adjudicator is the same as the Contractor.

6.15 Utilization Management

6.15.1 Mandatory Generic Substitution at Retail and Mail

To ensure strict adherence to the DCS Program Mandatory Generic Substitution Requirement and to ensure that the DCS Program is provided to Enrollees and the Department at the lowest cost, the Contractor is required to:

a. Unless otherwise directed by the Department, apply mandatory generic substitution to all specific NDC's of Brand Drugs for which there is an FDA-approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc.) or an authorized Generic Drug as permissible by NYS law. Network Pharmacies shall comply with all state laws related to mandatory generic substitution. The DCS 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.

b. 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 DCS Programs MAC List price assigned when a Brand Drug for which an A-rated or authorized Generic Drug has been introduced in the market is dispensed to the Enrollee. In such cases, the Enrollee shall be responsible for paying the applicable Non- Preferred Brand Drug Copayment plus Ancillary Charge not to exceed the cost of the drug to the DCS Program. The Ancillary Charge shall be assessed even in the event a Physician has specifically directed a Pharmacist to dispense the Brand Drug rather than the A- rated or authorized Generic Drug through DAW notation.

c. Monitor the pharmaceutical industry on behalf of the Department to identify Generic Drugs expected to enter the market. Prior to the actual introduction of the Generic Drug to market, the Contractor shall inform the Department of anticipated shipping dates of the first Generic Drug introduced into the market for one or more strengths of a particular Brand Drug.

d. Following the first shipment of a first Generic Drug for one or more strengths of a particular Brand Drug, the Contractor is required to:

    i. Inform the Department as soon as practicable but in no event later than 14 Days during Business Hours, 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 6.7.11(a) of this Contract, under the subheading "Reports Required at Other Frequencies;"

    ii. For those drugs that will result in a lower net cost to the Program by enforcing mandatory generic substitution, the Contractor shall provide the "MAC Alert Notice" referenced in (i) above. The Contractor shall add the GPI to the DCS Program MAC List(s) 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 GPI is already subject to MAC pricing the Contractor is required to immediately apply the MAC price and mandatory generic substitution to any NDC added to the GPI following the first date of shipment;

iii. For those drugs that could potentially result in a higher net cost to the Programs by enforcing mandatory generic substitution, the Contractor shall provide the "MAC Alert Notice" referenced in (i) above. The Department, in its sole discretion, may determine that enforcement is contrary to the best financial interests of the DCS Program and shall inform the Contractor whether mandatory substitution shall be applied. If the Contractor does not receive a formal response to the information provided via the "MAC Alert Notice," enforcement shall commence, and the GPI shall be added to the DCS Program MAC List(s) effective on the 21st Day after shipment of the first A-rated generic equivalent drug or authorized Generic Drug provided that the majority of pharmacies are able to obtain the Generic Drug. In the event the Department decides to exercise its discretion not to enforce mandatory generic substitution, the Contractor shall apply MAC pricing to the Generic Drug;

iv. To assist the Department in determining when mandatory generic substitution should be enforced based on an adequate supply of Generic drugs being available in the market, the Contractor shall survey its Retail Pharmacy Network to identify the Pharmacies that are unable to obtain the new Generic Drug within 21 Days and weekly thereafter until the shortage resolves. The Contractor shall submit this information to the Department and provide any additional information as required by the Department to reach a determination. The Department, in its sole discretion, shall determine based on such evidence how the DCS Program's mandatory generic substitution provisions will be applied. The DCS Program will not consider, and the Contractor shall not act on availability information provided by third party sources, including but not limited to Medi-Span or wholesalers;

v. 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;

vi. 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;

vii. The Contractor shall require the dispensing Network Pharmacy to inform the Enrollee prior to dispensing the Brand Drug, that an Ancillary Charge will be applied in addition to the applicable Non-Preferred Brand Drug Copayment. If the prescribing Physician requires the Brand Drug be dispensed, the Contractor shall require the dispensing Network Pharmacy to collect the applicable Brand Drug Copayment plus the calculated Ancillary Charge. However, under no circumstances shall the Enrollee’s total cost exceed what the actual cost of the Brand Drug would have been to the DCS Program after application of the DCS Program Lesser of Logic provisions.

e. Charge the DCS Program based on the DCS Programs MAC List price assigned to the GPI of the dispensed Brand Drug subject to the DCS Program Lesser of Logic plus the applicable dispensing fee and prescribing fee(s), if applicable, as set forth within Section IX “DCS Program Claims Reimbursement" of this Contract, and as defined in Section I, “Definition of Terms,” of this Contract.

f. Promptly notify and receive the Department prior written approval for any and all exceptions to the DCS Program mandatory substitution provisions, other than those resulting the DCS Program Mandatory Substitution Appeal Process. Following commencement of mandatory generic substitution, the Contractor must receive the Department written approval prior to suspending enforcement of the DCS Program mandatory generic

substitution provisions.

g. Maintain an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the DCS Program mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the Generic Drug at the Network Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Network Pharmacy, the DCS Program mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized Generic Drug in stock, mandatory generic substitution provisions will not apply and the Enrollee shall receive the Brand Drug, be charged the applicable Generic Drug Copayment and the Programs charged based on Generic Drug pricing. The Contractor's claims processing system must reject, with appropriate messaging, claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW-0 code requiring resubmission of the claim (since a DAW-0 code provides no indication of Generic Drug availability in the Pharmacy). Similar rules can be applied to other DAW submission codes as necessary to ensure consistent, accurate application of the DCS Program mandatory generic substitution requirements.

h. Immediately notify the Department of changes (from brand to generic or generic to brand) in the NDC classification submitted by the Contractor, subject to the DCS Program definitions of Brand and Generic Drugs as defined in Sections 1.7 and 1.57 of this Contract; and

i. Manage the Narrow Therapeutic Index (NTI) list of multi-source Brand Drugs not subject to Ancillary Charges and make recommendations to the Department of suggested additions or deletions based on clinical evidence.

6.15.2 Mandatory Generic Substitution Appeal Process

The Contractor shall administer a Mandatory Generic Substitution Appeal, also known as a "Dispense as Written exception request" process. The Contractor is required to oversee and enforce the DCS Program's generic appeal process including:

a. 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.

b. 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 Section 6.7 of this Contract.

c. Following a successful generic appeal, charging the Enrollee for the Brand Drug at the Level 3 Copayment with no Ancillary Charge.

d. Loading into the Contractor's claims processing system one or more files from the incumbent contractor of the previously approved Generic Appeal requests by the DCS Project Services Start Date, once an acceptable file is received and a lag file seven (7) days after the implementation date to capture any Appeals that may have been in process but not yet concluded as reported in the initial file.

e. Responding to all External Appeals on behalf of the Department as requested by the New York State Department of Financial Services (DFS). The DFS External Appeals Process 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. The Contractor will be responsible for paying any fees charged by DFS for performance of the external reviews directly to DFS. All external appeals costs will be included in the Contractor's Claims Administration Fees and will not be charged separately to DCS.

6.16 Clinical Management/Drug Utilization Review (DUR)

6.16.1 Prior Authorization: To ensure that the resources available to the DCS Program are utilized for appropriate, Medically Necessary Drug therapy, the Contractor is required to administer prior authorization programs for the DCS Program which includes, at a minimum:

a. A Prior Authorization Program for high-cost Prescription drugs that are prescribed for very specific medical indications. Only medications that have been identified by the Contractor as appropriate for Prior Authorization and reviewed by the 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; Psychosis agents and, Pulmonary Arterial Hypertension agents. Only medications that have been identified as appropriate for the Prior Authorization Program by the Contractor and reviewed by the Department shall be included in the Prior Authorization Program;

b. Informing Medical Professionals who request, by phone, fax, or secure internet portal, a Prior Authorization for a Specialty Drug about the DCS Program's Specialty Pharmacy Program and providing the information necessary to utilize the Specialty Pharmacy Program to obtain the drug;

c. Monitoring market changes and recommending deletions or additions to the list of drugs requiring Prior Authorization on an ongoing basis which must be reviewed by the Department prior to implementation of any changes to the list of medications;

d. 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;

e. Promptly loading approved prior authorizations determined by the Contractor into the claims processing system;

f. 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 Patient Protection and Affordable Care Act (PPACA) compliant;

g. Responding to 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. The Contractor is responsible for fees associated with the External Appeal process;

h. Loading one or more files of Prior Authorization approved-through dates from the incumbent contractor, prior to the Project Services Start Date, once acceptable files are received, and a lag file seven (7) days after the implementation date to capture any Prior Authorizations that may have been in process but not yet concluded as reported in the initial file.

6.16.2 Concurrent Drug Utilization Review (DUR): To safeguard Enrollee health and ensure adherence with the DCS Programs benefit design, the Contractor must administer a concurrent DUR program which includes at a minimum:

a. 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.

b. A fully integrated point-of-service system capable of enforcing the DCS Programs benefit design features, where any program built into the Contractor's EGWP is implemented for the Commercial Plan.

6.16.3 Retrospective DUR Program: To safeguard the Enrollee's health the Contractor must administer a Retrospective DUR Program which:

a. Using the Contractor's standards, including any relevant program built into the Contractor's EGWP (segment-specific Retrospective DUR programs are allowed), evaluates the Enrollee's Prescription drug utilization against the Enrollee's profile using FDA and other evidence-based guidelines to identify potential safety related concerns. The Contractor shall alert the prescribing Physicians to drug specific, Enrollee-specific health, safety and utilization issues including potential overuse of opioids or other identified high-risk drugs.

b. Identifies potential drug therapy complications for Enrollees, develops Physician alerts (subject to Department review and approval) and sends the alerts to the prescribing Physician.

c. Reports the results of its Retrospective DUR Program initiatives, including outcomes, to the Department on a quarterly basis in a mutually agreed upon format.

6.16.4 Medical Exception Program

a. The Contractor is required to administer a Medical Exception Program that reviews clinical appropriateness of allowing an exception to the formulary for an excluded drug when other covered therapeutic alternatives are ineffective or clinically inappropriate as documented by the prescribing Medical Professional. Enrollees with Commercial coverage may not appeal a drug's placement on the second or third level of the Flexible or Advanced Flexible Formularies. An appropriate trial of formulary alternatives must be undertaken before a formulary exception can be approved.

6.16.5 Physician Education: Subject to review and approval by the Department, the Contractor must undertake a Physician education program involving communications with prescribing Physicians which includes at a minimum:

a. Analysis of Physicians' drug or condition specific prescribing patterns;

b. Educating Physicians about the clinical and economic aspects of their prescribing decisions. Any communication with Physicians prescribing medications for Enrollees shall make the Physician aware of the

distribution channel most cost effective to the DCS Program and the Enrollee;

c. Reporting the results of its Physician Education initiatives to the State on a quarterly basis in a mutually agreed upon format; and

d. The Physician Education Program may not be funded by pharmaceutical manufacturers.

6.16.6 Patient Education: Subject to State review and approval by the Department, the Contractor must develop and implement a patient education program consisting of communications to Enrollees which:

a. Analyzes drug utilization from a clinical standpoint to identify and facilitate communication with Enrollees that have chronic diseases to maximize health benefits of drug treatment;

b. Analyzes drug utilization to identify and facilitate communication with Enrollees not managing their drug utilization in the most cost- effective manner for the Enrollee;

c. Reports the results of its patient education initiatives to the Department on a quarterly basis in a mutually agreed upon format; and

d. The Patient Education Program may not be funded by Pharmacy manufacturers.

6.17 Drug List Development & Management

The Contractor must provide PDL development and management services for the DCS Program. Such responsibility shall include but not be limited to:

6.17.1 Developing and administering multi-level formularies, consistent with the DCS Program's benefit designs. The Advanced Flexible and Flexible Formularies are custom and are subject to the Department's approval. Drugs may be excluded from the Flexible and Advanced Flexible formularies 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 the other generic and brand name medications in the same therapeutic class. Drug considered to have no clinical advantage that may be excluded include any products that follow either the Flexible Formulary or the Advanced Flexible Formulary:

Flexible Formulary

a. Contain an active ingredient available in and therapeutically equivalent to another drug covered in the class;
b. Contain an active ingredient that is a modified version of and

therapeutically equivalent to another covered Prescription Drug Product; or

c. Are available in over-the-counter form or comprised of components that are available in over-the -counter form or equivalent.

Advanced Flexible Formulary

d. Contain an active ingredient available in or are therapeutically equivalent to another drug covered in the class;
e. Contain an active ingredient that is a modified version of or are therapeutically equivalent to another covered Prescription Drug Product; or
f. Are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent.

The Empire Plan Medicare Rx program must meet or exceed the prescription drug benefit for non-Medicare primary members as closely as possible. The Contractor's PDLs must be based on sound clinical criteria. In designating a drug as preferred or non-preferred for the Empire Plan's formularies, the Contractor must ensure that drugs recognized in documented medical evidence and studies as clinically superior to similar drugs in a therapeutic class be designated as preferred. In situations where there are multiple drugs in a therapeutic class of similar clinical characteristics, net costs shall be considered in determining a drug's status as preferred or non-preferred. The composition of the PDL for the formularies will be developed by the Contractor and reviewed annually (and revised quarterly, if allowed under the frozen formulary law) by the Department.

Any recommended mid-year changes to the Flexible Formularies must meet the requirements of the New York State Frozen Formulary Law and union agreements, where applicable, and shall be provided to the Department with a summary of the clinical and financial implications to the DCS Program. Such mid-year changes, which may be made no more than quarterly, include: Adding prior authorization requirements to certain drugs; or, Adding Specialty Guideline Management (SGM) to certain specialty drugs. The Department, at its sole discretion, may approve mid-year changes. In the instance when a change to the formularies is approved outside of the annual update, the Contractor must communicate the change to Members thirty (30) days in advance of the action.

6.17.2 Developing Preferred Drug Lists for each of the benefit designs, subject to the review and approval of the Department, for the purpose of distributing printed copies to Enrollees and medical providers. Additionally, electronic copies will be developed for posting on the Department's website and the Contractor's customized website for the DCS Program in order to inform Enrollees and providers of the placement of the most commonly prescribed medications on each Preferred Drug List. The Department shall be responsible for the distribution of the printed PDLs provided by the Contractor on an annual basis to Enrollees. The Contractor shall be responsible for producing and distributing all other copies of the printed PDLs, including but not limited to supplies sent to agencies, those sent with Contractor mailings to Enrollees and individual requests by Enrollees or providers. The Contractor is required to promptly mail the Preferred Drug List to

Enrollees who call requesting a copy.

6.17.3 Compiling and organizing the Drug Lists in several versions as listed below. The Contractor must work with the Department on the format of these PDLs. The Drug Lists that are 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 PDLs shall also list the name of the reference product in parenthesis next to the name of the Generic Drug (i.e., rosuvastatin (Crestor)) unless the Department otherwise directs. The PDLs shall indicate those drugs that require Prior Authorization and those that have quantity limits. The Contractor shall inform the Department of any rebate implications to the DCS Program as a result of including this information on the PDLs.

a. The most commonly prescribed medications (for posting and distribution), which includes an alphabetical listing of Preferred Drugs, a list of Non-Preferred Drugs, an Excluded Drug List and a listing of Preferred Drugs categorized by therapeutic category;

b. Comprehensive Formularies listing all covered prescription drugs on the formularies, including any tiering structure that it has adopted and any restrictions on the manner in which a prescription drug may be obtained, in a matter that is easily accessible. The Comprehensive formularies shall clearly identify the preventive prescription drugs that are available without copay;

c. Standalone Excluded Drug Lists;

d. Prior Authorization Drug Lists; and

e. Exclusive Specialty Drug Lists.

6.17.4 Developing the PDLs in a timely manner so that the Department approved, printed PDLs are available to be communicated to Enrollees and posted to the website at least forty-five (45) Days before the start of the Calendar Year, to coincide with the DCS Program’s option transfer period for Enrollees.

6.17.5 Developing and mailing a Department pre-approved disruption letter, via first class mail, to Enrollees who are affected by: a drug’s exclusion; a Preferred Brand Drug’s reclassification to a non-preferred status (unless the reclassification is the result of the introduction of an equivalent generic); or, if a Prior Authorization requirement or quantity limit is newly added to a drug for the formularies. Mailings must be sent 45-days prior to January 1 and 30-days prior for any allowable mid-year formulary change. 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 Day’s 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 PDL as of the effective date of the drug's exclusion or change from preferred to non-preferred status. In situations where Enrollees are affected by a Generic Drug's reclassification to a Brand Drug, the Contractor agrees to send a disruption letter to affected Enrollees.

6.17.6 Notifying the Department in writing when any drug recall or voluntary drug withdrawal occurs, including Plan utilization, by union. The Contractor must take proper action to help promote patient safety. The Contractor will notify Enrollees, Network Pharmacies and/or prescribing Physicians of the drug or device recalls or 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 Contractor must assist the Department in collecting monies from recalled products.

6.17.7 Using reasonable efforts to monitor the industry on behalf of the DCS Program and notifying the Department in writing of any class action lawsuits for which a class has been certified and of any proposed orders or settlements that the DCS Program may be entitled to participate in as a member of the class. Unless otherwise notified by the Department, the Contractor shall file claims on behalf of the Program and take all steps necessary to ensure the DCS Program's interests in the class action suit or proposed settlement are protected. Any recoveries collected by the Contractor on behalf of the DCS Program, net of the Contractor's actual costs in securing the DCS Program's participation in the recovery, due the DCS Program must be credited to the DCS Program within fifteen (15) Days upon the Contractor's receipt. The Contractor shall make reasonable efforts to maximize recoveries. Distribution of recoveries, net of the Contractor's actual costs incurred on behalf of the DCS Program, shall be made consistent with the terms of the final settlement order or court decision. The Contractor shall assist the State in its recovery efforts and provide the claims and rebate data required to file a claim on behalf of the DCS Program when requested by the Department.

6.17.8 Holding an annual meeting with the Department, DOB and OER, to review upcoming changes to the Advanced Flexible and Flexible Formularies as well as the Medicare Part D Drug List prior to the effective date of any changes. This meeting will include a review of the Contractor's Book of Business PDL strategy. Upon the Department's request, the Contractor shall provide a detailed explanation of the clinical and/or financial basis for the decision to change the classification of the drug(s) on the Flexible and Advanced Flexible Formularies as well as a detailed cost analysis of the impact of the changes to the Program. Changes are subject to Department, DOB and OER approval.

6.17.9 Assigning a new strength of a drug to the same PDL Level as the preexisting

strengths of the drug in the event a new strength of a drug already on the formularies is shipped from the manufacturer or wholesaler.

6.17.10 Working with the medical carrier and the mental health and substance use carriers to develop communications such as, but not limited to, provider newsletters to ensure that participating providers in those networks are fully apprised of the level/status of Covered Drugs.

6.17.11 The Contractor will be responsible for ensuring the formularies will be electronically available to Medical Professionals on Rx Hub and Level 1 and Level 2 drugs will be designated as Preferred.

6.17.12 The Contractor will be responsible for protecting the value of the DCS Program's pricing discounts by taking appropriate steps to control Prescription Drug AWP increases.

6.17.13 The Contractor will be responsible for developing, recommending, and implementing Brand for Generic strategies for the formularies 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.

6.18 Consolidated Appropriations Act

6.18.1 The Contractor must conduct and document a Non-Quantitative Treatment Limitation (NQTL) comparative analysis to verify that the DCS Program is compliant with the Mental Health Parity and Addiction Equity Act. This analysis must be included in the Administration Fee and not charged separately.

6.18.2 The Contractor must collect and report on prescription drug information (RxDC Reporting). This collection and reporting must be included in the Administration Fee and not charged separately.

6.18.3 The Contractor must ensure it is in compliance with all other provisions of the CAA

6.19 Consulting

The Contractor is responsible for providing advice and recommendations regarding the DCS Program including:

6.19.1 Informing the Department 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, formulary configuration, technological improvements, e-prescribing, Pharmacy innovations, and State/Federal legislation (i.e., Medicare, Prescription drug mandates, etc.) that may affect the DCS Program. The Contractor must provide information and recommendations to the

Department on Formulary placement of new generic and biological therapies prior to release into the marketplace to the extent such information is available in the public realm. The Contractor must also make available to the State one or more members of the clinical or account management team to discuss the implications of these new trends and developments. The Department is not under any obligation to act on such advice or recommendation.

6.19.2 Assisting the Department with recommendations and evaluation of proposed benefit design changes and implementing any changes necessary to accommodate DCS Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State. Recommendations must include a preliminary analysis of all associated costs, a clinical evaluation, and the anticipated impact of proposed DCS Program modifications and contemplated benefit design changes on Enrollees. In the event of a design change and the Contractor requests any change in compensation such change will be in accordance with Section 14.8 “Modification of Program Services” of this Contract. Additionally, the Contractor will be responsible for making collective bargaining changes using Department benefit codes.

SECTION VII: PERFORMANCE GUARANTEES

The Contractor acknowledges and agrees that failure to perform the Project Service features in such a manner which either meets or exceeds any and/or all of the Performance Guarantee(s), as set forth in Section VII of this Contract, shall result in a corresponding reduction(s) in fee to the Contractor for failure to meet each applicable guarantee.

Upon such determination of amounts due pursuant to this Section, the Department shall notify the Contractor, in writing, and the Contractor shall apply such amounts as a credit against the Monthly Administrative fee within 30-Calendar Days of receiving such notification by the Department.

Failure to meet any Performance Guarantee(s) does not relieve the Contractor of the performance of the activities, duties and obligations as otherwise set forth in the Contract.

7.1 Start-Up Guarantees & Credit Amounts

7.1.1 Performance Guarantee: The Contractor must complete all Implementation and Start-up activities by the Department’s Project Services Start Date. For the purpose of this guarantee, the Contractor must have in place and operational:

a. A contracted Retail Pharmacy Network in place, that meets or exceeds the required access standards set forth in Section 7.13.0 and Section 7.14.0 of this Contract. Additionally, in order to meet the Contractor’s implementation guarantee, the network implemented **must** include all chain pharmacies identified in the Attachment 18, *Contractor’s Proposed Retail Pharmacy Network File* of the RFP. Acceptable reasons for non-participation of any pharmacies identified in the Contractor’s Proposed Retail Pharmacy Network File contracting collectively include and are limited to: a

Pharmacy's violation of state and/or federal laws; a Pharmacy's failure to meet the Contractor's credentialing criteria; or a Pharmacy's failure to fulfill its contractual obligations and no remedy can be achieved. On the Project Services Start Date, the Retail Pharmacy Network must meet all requirements set forth in Section 6.8.0 of this Contract, 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 (for those Enrollees that do not participate in the Specialty Pharmacy Program);

b. A fully operational Mail Service Pharmacy Process utilizing facilities as necessary to ensure that Enrollees have access to all Covered Drugs, including Specialty Drugs (for those Enrollees that do not participate in the Specialty Pharmacy Program) as set forth in Section 6.9.0 of this Contract under the subheading "Mail Service Pharmacy Process." The Contractor must have a plan in place to facilitate the transfer of Prescription information, including open refills, prior authorizations and generic appeals from the previous Program administrators and outline the procedures that will be utilized to ensure a smooth mail service transition for Enrollees;

c. A fully operational Specialty Pharmacy Program utilizing facilities as necessary to ensure that Enrollees have access to all covered Specialty Drugs (for those Enrollees that participate in the Specialty Pharmacy Program) as set forth in Section 6.10.0 of this Contract, under the sub-heading "Specialty Drugs." The Contractor must have a plan in place to facilitate the transfer of specialty Prescription information, including open refills and prior authorizations, from the previous Program administrator and outline the procedures that will be utilized to assure a smooth Specialty Pharmacy Program transition for affected Enrollees;

d. A fully operational call center providing all aspects of customer support and services as set forth in Section 6.3.0 of this Contract. The call center must be open and operational a minimum of thirty (30) days prior to the Project Services Start Date to assist Enrollees with questions concerning Program transition;

e. An online claims processing system that applies the Department's approved edits and point-of-service edits, including drug utilization review edits, as set forth in Section 6.13.0 of this Contract.

f. An online claims processing system with real-time access to the most updated, accurate enrollment and eligibility data provided by the Department to correctly pay claims for eligible Enrollees/Dependents consistent with the DCS Programs benefit designs, including any benefit design changes implemented during the term of the contract, and contractual obligations;

g. A fully functioning customized Program website with a secure dedicated link from the Department's website able to provide Enrollees with online access to the specific website requirements as set forth in Section 6.3.6 of this Contract;

h. A fully functional integration plan to manage a group enrollment of all active NYSHIP participants from the incumbent Contractor to the Selected Contractor's Commercial Prescription Drug Plan and EGWP. The Contractor agrees to use the initial load text file to update its Commercial enrollment system and its EGWP enrollment system, and provide the following:

    i. An initial testing report identifying all participants who may be eligible to receive a Low-Income Subsidy;

    ii. A report identifying all participants who are covered under two (2) or more enrollment records; and

    iii. The Contractor agrees to use these reports, and with direction from the Department, to resolve discrepancies in the initial enrollment and eligibility file to minimize member disruption.

i. A fully functioning enrollment system capable of receiving and applying all enrollment updates as set forth in Section 6.6.0 of this Contract;

j. An integration plan capable of transitioning all DCS Program data, including but not limited to, a minimum of one (1) year of historical Enrollee claim data, detailed COB data, reporting formats, Mail Service Pharmacy, Specialty Pharmacy; and

k. An integration plan able to provide sufficient time to test loading of enrollment information that will provide at a minimum two (2) full initial load file tests to ensure members are enrolled in the Commercial Plan and EGWP appropriately. In instances where members are covered under two (2) or more enrollment records, benefits will coordinate in accordance with NYSHIP plan designs. The testing of the files will ensure seamless transition for participants who are covered under two (2) or more enrollment records.

7.1.2 Credit Amount: The Contractor's quoted percent to be credited for each day that all Start-up requirements are not met is [redacted] of the 2025 Claims Administration Fee (prorated on a daily basis).

7.2 Call Center Response Time Guarantee and Credit Amount

7.2.1 Performance Guarantee: The DCS Program's service level standard requires that at least [redacted] of the incoming calls to the Contractor's telephone line will be answered by a customer service representative within [redacted]. Response time is defined as the time it takes incoming calls to the Contractor's telephone line to be answered by a customer service representative. The call center telephone response time shall be reported monthly and calculated quarterly.

7.2.2 Credit Amount: For each [redacted] to [redacted] of incoming calls to the Contractor's telephone line below the standard of [redacted] that is not answered

by a customer service representative within [redacted], calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] per quarter.

7.3 Call Center Availability Guarantee and Credit Amount

7.3.1 Performance Guarantee: The DCS Program's service level standard requires that the Contractor's telephone line will be operational and available to Enrollees, Dependents, and pharmacies at least [redacted] of the Contractor's Call Center Hours. The call center availability shall be reported monthly and calculated quarterly.

7.3.2 Credit Amount: For each [redacted] to [redacted] below the standard of [redacted] that the Contractor's telephone line is not operational and available to Enrollees, Dependents, and Pharmacies during the Contractor's Call Center Hours calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] per quarter.

7.4 Telephone Abandonment Rate Guarantee and Credit Amount

7.4.1 Performance Guarantee: The DCS Program's service level standard requires that the percentage of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service representative will not exceed [redacted]. The telephone abandonment rate shall be reported monthly and calculated quarterly.

7.4.2 Credit Amount: For each [redacted] to [redacted] of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service representative in excess of [redacted] calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] per quarter.

7.5 Telephone Blockage Rate Guarantee and Credit Amount

7.5.1 Performance Guarantee: The DCS Program's service level standard requires that not more than [redacted] of incoming calls to the customer service telephone line will be blocked by a busy signal. The telephone blockage rate shall be reported monthly and calculated quarterly.

7.5.2 Credit Amount: For each [redacted] to [redacted] of incoming calls to the Contractor's telephone line that is blocked by a busy signal, in excess of [redacted], calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] per quarter.

7.6 Secure Online Customized Website Accuracy Guarantee and Credit Amount

7.6.1 Performance Guarantee: The DCS Program's service level standard requires that all inaccurate information, as reported by DCS, posted on the customized website is corrected within [redacted] Business Days. Website updates shall be reported monthly

for the duration of the Contract and calculated quarterly.

7.6.2 Credit Amount: For each Business Day in excess of the standard [redacted] Business Days in which the Contractor does not correct all the inaccurate information on the customized website as requested by the Department, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] per quarter.

7.7 Secure Online Customized Website Update Timeliness Guarantee and Credit Amount

7.7.1 Performance Guarantee: The DCS Program's service level standard requires that requested updates, such as posting quarterly Formularies or copayment information, are posted accurately to the customized website within [redacted] Business Days. Website updates shall be reported monthly for the duration of the Contract and calculated quarterly.

7.7.2 Credit Amount: For each Business Day in excess of the standard [redacted] Business Days in which the Contractor does not update the customized website with DCS requested updates, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] per quarter.

7.8 Member Communication Support Guarantee and Credit Amount

7.8.1 Performance Guarantee: The DCS Program's service level standard requires that the Contractor mails all forms or letters including, but not limited to; notifications of drug recalls or withdrawals and mid-year formulary changes, within [redacted] Calendar Days of the Department's requested effective date.

7.8.2 Credit Amount: For each Calendar Day in excess of the standard [redacted] Calendar Days in which the Contractor does not mail all forms or letter after the Department's requested effective date, is [redacted] per occurrence, calculated quarterly.

7.9 Formulary Coding Accuracy Guarantee and Credit Amount

7.9.1 Performance Guarantee: The Contractor must guarantee that all Department approved DCS Program Formulary(ies) and Drug List(s) decisions are coded and updated correctly for the start of the Plan Year, or as requested by the Department.

7.9.2 Credit Amount: For each instance of incorrect coding, such as coding not updated to reflect Department approved DCS Program Formulary(ies) and Drug List(s) decisions for the start of the Plan Year, or the Contractor applying Book of Business changes to the Plan without DCS approval, is [redacted] per occurrence, calculated quarterly.

7.10 Enrollment Management Guarantee and Credit Amount

7.10.1 Performance Guarantee: The Contractor must guarantee [redacted] of all DCS Program enrollment records that meet the quality standard for loading will be loaded into the Contractor's enrollment system within [redacted] hours of release

by the Department.

7.10.2 Credit Amount: The amount to be forfeited by the Contractor for each [redacted] period beyond [redacted] hours from release by the Department in which enrollment records that meet the quality standards for loading are not loaded in the Contractor's enrollment system is [redacted].

7.11 Reporting Services & Claim File Guarantee and Credit Amount

7.11.1 Performance Guarantee: The Contractor guarantees that all management reports and claim files listed in Section 6.7 of this Contract and/or Attachment 36, *Program Reporting*, of the RFP, including MAC Alert Notices, will be accurate and delivered to the Department no later than their respective due dates inclusive of the date of receipt.

7.11.2 Credit Amount: For each management report or claim file listed in Section 6.7 of this Contract and/or Attachment 36, *Program Reporting*, of the RFP, including MAC Alert Notices, that is not received by its respective due date, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] per report or claim file per 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.

7.12 Transition and Termination Guarantee and Credit Amount

7.12.1 Performance Guarantee: The Contractor guarantees that they will complete [redacted] of the Transition Plan requirements in the time frames stated in Section XI "Transition and Termination of Contract" of this Contract, to the satisfaction of the Department.

7.12.2 Credit Amount: The amount to be forfeited by the Contractor for each day, or part thereof, that the Transition Plan requirements are not met is [redacted].

7.13 Commercial Retail Pharmacy Network Access Guarantee and Credit Amount

7.13.1 Performance Guarantee: The Contractor guarantees that effective January 1, 2025 and throughout the term of the Agreement:

a. At least [redacted] of Enrollees in urban areas will have access to a Network Pharmacy. The minimum access guarantee for Enrollees in urban areas is at least one (1) Network Pharmacy, within [redacted] miles of an Enrollee's home;

b. At least [redacted] of Enrollees in suburban areas will have access to a Network Pharmacy. The minimum access guarantee for Enrollees in suburban areas is at least one (1) Network Pharmacy, within [redacted] miles of an Enrollee's home; and

c. At least [redacted] of Enrollees in rural areas will have access to a Network Pharmacy. The minimum access guarantee for Enrollees in rural areas is at least one (1) Network Pharmacy, within

[redacted] miles of an Enrollee's home.

7.13.2 Credit Amount:

a. The Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] for each [redacted] to [redacted] below the [redacted] minimum access guarantee for any quarter in which the Network Pharmacy Access for Urban Areas Guarantee is not met by the Contractor.

b. The Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] for each [redacted] to [redacted] below the [redacted] minimum access guarantee for any quarter in which the Network Pharmacy Access for Suburban Areas Guarantee is not met by the Contractor.

c. The Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] for each [redacted] to [redacted] below the [redacted] access guarantee for any quarter in which the Network Pharmacy Access for Rural Areas Guarantee is not met by the Contractor.

7.13.3 Measurement of compliance with each access guarantee in Section VII of this Contract will be based on a "snapshot" of the Retail Pharmacy Network taken on the last Day of each quarter within the current Plan Year. The results must be provided in the format specified by DCS in Attachment 20, *Offeror's Proposed Retail Pharmacy Network Access Prerequisite Worksheet* of the RFP, unless otherwise specified by DCS. The report is due thirty (30) Days after the end of the quarter.

7.14 Medicare Rx (EGWP) Retail Pharmacy Network Access Guarantee and Credit Amount

7.14.1 Performance Guarantee: The Contractor guarantees that effective January 1, 2025, and throughout the term of the Agreement:

a. At least [redacted] of EGWP Enrollees in urban areas will have access to a Network Pharmacy. The minimum access guarantee for Enrollees in urban areas is at least one (1) Network Pharmacy, within [redacted] miles of an Enrollee's home;

b. At least [redacted] of EGWP Enrollees in suburban areas will have access to a Network Pharmacy. The minimum access guarantee for Enrollees in suburban areas is at least one (1) Network Pharmacy, within [redacted] miles of an Enrollee's home; and

c. At least [redacted] of EGWP Enrollees in rural areas will have access to a Network Pharmacy. The minimum access guarantee for Enrollees in rural areas is at least one (1) Network Pharmacy, within [redacted] miles of an Enrollee's home.

7.14.2 Credit Amount:

a. The Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] for each [redacted] to [redacted] below the [redacted] minimum access guarantee for any quarter in which the Network Pharmacy Access for Urban Areas Guarantee is not met by the Contractor;

b. The Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] for each [redacted] to [redacted] below the [redacted] minimum access guarantee for any quarter in which the Network Pharmacy Access for Suburban Areas Guarantee is not met by the Contractor; and

c. The Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] for each [redacted] to [redacted] below the [redacted] access guarantee for any quarter in which the Network Pharmacy Access for Rural Areas Guarantee is not met by the Contractor.

7.14.3 Measurement of compliance with each access guarantee in Section VII of this Contract will be based on a "snapshot" of the Retail Pharmacy Network taken on the last Day of each quarter within the current Plan Year. The results must be provided in the format specified by DCS in Attachment 20, *Offeror's Proposed Retail Pharmacy Network Access Prerequisite Worksheet* of the RFP, unless otherwise specified by DCS. The report is due thirty (30) Days after the end of the quarter.

7.15 Turnaround Time for Nonintervention Mail Service Prescriptions Guarantee & Credit Amount

7.15.1 Performance Guarantee: The Contractor guarantees that at least [redacted] of all nonintervention mail service Prescriptions will be turned around in [redacted] 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.

7.15.2 Credit Amount: For each [redacted] to [redacted] below [redacted] percent of all nonintervention mail service Prescriptions not turned around within [redacted] Business Days, calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted].

7.16 Turnaround Time for Intervention Mail Service Prescriptions Guarantee & Credit Amount

7.16.1 Performance Guarantee: The Contractor guarantees that at least [redacted] of all intervention mail service Prescriptions shall be turned around in [redacted] 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.

7.16.2 Credit Amount: For each [redacted] to [redacted] below [redacted] of all intervention mail service Prescription not turned around within [redacted] Business Days, calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted].

7.17 Programs' Claims Processing System Availability Guarantee and Credit Amount

7.17.1 Performance Guarantee: The Contractor guarantees that the DCS Program's online claims processing system be available at least [redacted] of the time excluding periods of scheduled down time which shall be reported in advance to DCS and kept to a minimum, based on a 24-hours a Day, 7 Days a week availability.

7.17.2 Credit Amount: For each [redacted] to [redacted] below the standard of [redacted] that the Contractor's online claims processing system for the DCS Program, based on a 24-hours a Day, 7 Days a week availability, excluding periods of scheduled down time, which shall be reported in advance to DCS and kept to a minimum, is not available, as calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] per each quarter.

7.18 Programs' Claims Processing System Accuracy Guarantee and Credit Amount

7.18.1 Performance Guarantee: The Contractor guarantees that the DCS Program's online claims processing system accurately process claims at the point of service in accordance with the Program's benefits design at least [redacted] of the time excluding periods of scheduled down time which shall be reported in advance to DCS and kept to a minimum, based on a 24-hours a Day, 7 Days a week availability.

7.18.2 Credit Amount: For each [redacted] to [redacted] below the standard of [redacted] that the Contractor's online claims processing system for the DCS Program, based on a 24-hours a Day, 7 Days a week availability, excluding periods of scheduled down time, which shall be reported in advance to DCS and kept to a minimum, does not accurately process claims at the point of service in accordance with the DCS Program's benefits design, as calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] per each quarter.

7.19 Turnaround Time for Claims Adjudication Guarantee and Credit Amount

7.19.1 Performance Guarantee: The Contractor guarantees that at least [redacted] of Enrollee submitted claims that require no additional information in order to be properly adjudicated that are received by the Contractor shall be turned around within [redacted] Business Days. Turnaround time is measured from the date the Enrollee-submitted claim is received in the DCS Programs designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent.

7.19.2 Credit Amount: For each [redacted] to [redacted] of Enrollee-submitted claims that require

no additional information in order to be properly adjudicated that are received by the Contractor and not turned around within [redacted] Business Days from the date the claim is received in the Contractor's DCS Programs designated Post Office Box to the date the Explanation of Benefits is received by the mailing agent, below the standard of [redacted], as calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted].

7.20 Turnaround Time for Prior Authorizations Guarantee and Credit Amount

7.20.1 Performance Guarantee: The Contractor guarantees that at least [redacted] of Prior Authorization requests that are received by the Contractor will be turned around within [redacted] Business Days. Turnaround time is measured from the date all necessary supporting information from the prescriber for the Prior Authorization request is received by the Contractor in the Programs designated Post Office Box to the date the Contractor's response is received by the mailing agent.

7.20.2 Credit Amount: For each [redacted] to [redacted] below [redacted] of all Prior Authorizations received by the Contractor not turned around within [redacted] Business Days, calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted].

SECTION VIII: PAYMENT FOR SERVICES

8.1 The Contractor agrees to manage such financial transactions in accordance with the following:

8.1.1 The Plan will reimburse the Contractor for claim payments and associated Claims Administration Fees no sooner than two (2) Business Days and no later than five (5) Business Days after receipt of an accurate invoice, following each bi-weekly claims processing cycle. The Contractor is required to submit a detailed claim file within fifteen (15) Days after the end of each claims processing cycle to support the submitted invoices. The data file layout and file transmission protocol will be mutually agreed upon by the Contractor and the Department during implementation.

Note: On an annual basis coinciding with the end of the State's fiscal year, the Statewide Financial System (SFS) will be shut down for approximately one to two weeks during which no payment transactions will be processed. The shutdown typically occurs between the last week of March and first week of April. The SFS may also be shut down for short periods during other times of the year for maintenance or upgrades or other reasons that are outside the control of the Department. Payments delayed as a result of the SFS shut down will be processed on the first Business Day after the SFS returns to operation.

8.1.2 Any credit amounts due from the Contractor to the Department for failure of the Contractor to meet the performance guarantees set forth in this Contract shall be applied as a credit against the Claims Administration Fees charged separately to the DCS Programs in the first invoice(s) processed after the

performance guarantee has been calculated and agreed to by the Department.

8.1.3 Upon final audit determination by the Department, and consistent with the terms of Section X “100% Pharma Revenue Guarantee” of this Contract, any audit liability amount assessed by the Department shall be paid/credited to the DCS Program within thirty (30) Days of the date of final determination.

8.1.4 Coordination of Benefit recoveries collected by the Contractor shall be aggregated and paid/credited to the DCS Program within fifteen (15) Days after the end of each month.

8.1.5 Drug litigation recoveries and settlements shall be paid/credited to the DCS Program within fifteen (15) Days of receipt by the Contractor.

8.1.6 Sixty (60) Days after the end of the first quarter, the Contractor shall pay/credit the DCS Program the greater of (1) the actual Pharma Revenue received on behalf of the DCS Program or 2) the Minimum Pharma Revenue Guarantee Per Final Paid Claim, set forth in Section X “100% Pharma Revenue Guarantee” of this Contract, multiplied by the number of Final Paid Claims incurred for the first quarter.

a. For each subsequent quarter of the Program Year, the calculations shall be performed on a cumulative Program Year-to-Date basis. The Contractor shall pay the greater cumulative amount less the amount previously paid for the Program Year;

b. The Contractor shall perform a reconciliation of the prior DCS Program Year by May 31st of each year and the incremental Pharma Revenue amount shall be paid/credited to the Program within thirty (30) Days of May 31st; and

c. At the May 31st Pharma Revenue reconciliation, to the extent that any amount is owed by the Contractor, the Contractor shall pay/credit the DCS Program within thirty (30) Days after the Final Pharma Revenue reconciliation for the amount owed.

8.1.7 The Contractor must, within fifteen (15) business days from the date the Contractor receives the Low-Income Subsidy (LIS) payment from CMS, provide the Department with the detailed information set forth below. The Contractor must refund LIS beneficiaries the low-income premium subsidy payment within the required period of forty-five (45) days from the date the Contractor receives the monies from CMS. The information set forth below must be reported to the Department on a monthly basis and must contain information for each beneficiary, including the NYSHIP Enrollee’s identification number. The LIS Premium data report fields must include:

a. NYSHIP Enrollee’s name
b. NYSHIP Enrollee’s social security number (if provided with the EGWP eligibility file)
c. LIS eligible individual’s name
d. LIS eligible individual’s social security number (if provided with the

EGWP eligibility file)

e. LIS eligible individual's date of birth
f. LIS eligibility start date
g. Monthly subsidy amount received from CMS for the LIS individual
h. Dual Eligibility indicator
i. Date LIS payment received from CMS (MM/DD/YYYY)
j. LIS payment/adjustment start date
k. LIS payment/adjustment end date
l. LIS adjustment reason code/description

8.1.8 LIS eligible individual's Medicare identification number (HICN) and/or Medicare Beneficiary Identifier (MBI).

This Agreement is not subject to Article XI-A of NYS Finance Law. The Contractor agrees that DCS Program Services provided under this Contract shall continue in full force and effect for a minimum of at least thirty (30) days beyond the payment due date as set forth in Section VIII "Payment for Services" "of this Contract. If after the thirty-fifth (35th) calendar day after receipt of an accurate invoice and claims data file, as set forth in Section VIII "Payment for Services" of this Contract the Contractor has not yet received payment from the State for said invoice, the Contractor may proceed under the Dispute Resolution provision in Appendix B of this Contract and the Contract shall remain in full force and effect until such final decision is made, unless the Parties can come to a mutual agreement, in which case, the Contract shall also remain in full force and effect.

8.2 Claims Administration Fees

The Claims Administration Fee is the fee that the Contractor charges the DCS Program for all administration services provided by the Contractor. This includes the administration of the Empire Plan, and SEHP. There are two (2) Claims Administration Fees that apply to this Agreement: DCS Program Primary Claims Administration Fee and Medicare Primary Claims Administration Fee. The Contractor guarantees that the Claims Administration Fees shall be [redacted] per Final Paid Claim for DCS Program Primary and [redacted] per Final Paid Claim for Medicare-Primary Claim. The Contractor shall:

8.2.1 Be bound by its Claims Administration Fees for the entire term of the Agreement, unless agreed otherwise by both the State and the Contractor.

8.2.2 Implement any changes necessary to accommodate DCS Program modifications resulting from collective bargaining, legislation or within the statutory discretion of the State within 60-Days of notice, or as soon as practicable.

8.2.3 Agree not to request a higher Claims Administration Fee, and the Department will not consider any increases to the Claims Administration Fees, that is not based on a material change to the DCS Program requiring the Contractor to incur additional costs. The determination of what constitutes a material change is at the sole discretion of the Department. Implementation of an alternate formulary or multiple formularies shall not constitute a material change and the

Contractor agrees to implement, if required, all alternative formularies at the Claims Administration Fee set forth in this Section 8.2 of this Contract.

8.2.4 Manage all Program Enrollees based on the Contractor's associated Claims Administration Fees as proposed by the Contractor in its Proposal.

8.2.5 Submit detailed documentation of additional administrative/clinical costs, over and above existing administrative/clinical costs, with any request for an increase in the Claims Administration Fee(s) resulting from a material change in the benefit structure of the DCS Program. The Department reserves the right to request, and the Contractor agrees to provide any additional information and documentation the Department deems necessary to verify that the request for an increase to a Claims Administration Fee(s) is warranted. The Departments decision to modify the Claims Administration Fees to the extent necessary to compensate the Contractor for documented additional costs incurred shall be at the sole discretion of the Department, subject to the approval of a formal amendment to the Agreement by the New York State Attorney General and New York State Office of State Comptroller.

8.2.6 Implement all benefit designs as required by the Department with or without final resolution of any request for a Claims Administration Fee(s) adjustment. Refusal to implement changes will constitute a material breach of the Agreement and the Department will seek compensation for all damages resulting.

8.2.7 Agree that Claims Administration Fees shall be payable only for Final Paid Claims and that the DCS Program will not pay a Claims Administration Fee or other charge or fees for any claim that is denied prior to processing or any claim that is subsequently voided, reversed, or otherwise modified.

SECTION IX: DCS PROGRAM CLAIMS REIMBURSEMENT

The DCS Program shall be charged for dispensed drugs consistent with the provisions of this Section IX of this Contract. The Contractor may exclude from all applicable retail pricing and dispensing fee guarantees specified in this Section, but not from Pharma Revenue Guarantees specified in Section X: 100% Pharma Revenue Guarantee, any claims where the Contractor is required to comply with law or regulation which mandates that the claim is adjudicated according to a specific pricing methodology (e.g., National Average Drug Acquisition Cost) and/or with a specified dispensing fee, not agreed to under this Agreement.

9.1 Claim Ingredient Cost - General

9.1.1 All discounts and dispensing fees for Brand, Generic Drugs and Specialty Drugs/ Medications are guaranteed for the entire term of this Contract without qualification or condition. In addition, the Contractor's Compound Drug pricing methodology set forth in Section IX of this Contract, is guaranteed for the entire term of this Contract without qualification or condition.

9.1.2 All proposed discounts and dispensing fees for Specialty Drugs apply only to Enrollees who participate in and have drugs dispensed through the Specialty Pharmacy Program and must be guaranteed for the entire term of the Contract

without qualification or condition.

9.1.3 The Contractor shall utilize the Medi-Span field coded R028 entitled “AWP unit price” as the source of Average Wholesale Price (AWP) information for purposes of calculating Ingredient Cost.

9.1.4 During the term of the Contract, in the event the Medi-Span reporting service changes its methodology related to any of the information fields used in the Department’s classification of Brand and Generic Drugs, or its methodology for coding drugs in connection with these information fields, the Contractor is obligated to inform the Department in writing of such changes within thirty (30) Days of learning of such changes. Upon written notification, the Contractor and the Department will meet and agree in writing to any Brand and/or Generic Drug classification changes that may be necessary to enable the Parties to maintain the same economic position and obligations as are set forth in this Contract.

9.1.5 If, during the term of this Contract, industry events have caused the Contractor’s source of AWP to become obsolete or no longer available, the Department and the Contractor shall agree on revised pricing terms. In no event shall the DCS Programs actual costs for drugs increase as the result of new pricing terms. The Contractor shall notify the Department in writing as soon as any information indicating a problem with the future use of the Contractor’s AWP source is received. Within two weeks of the initial notification, and no less than 120 Days prior to the effective date of any revision, the Contractor shall submit a detailed written proposal to the Department for effectively revising pricing terms including but not limited to a file containing the Contractor’s pricing for all drugs dispensed during the prior six months utilizing the current AWP source and the Contractor’s revised pricing for such drugs using the proposed methodology. The Contractor’s Proposal should ensure continued alignment of the Contractor’s interests with those of the DCS Program. In no event can the Contractor’s Proposal deviate from the DCS Program’s Lesser of Logic.

9.1.6 To protect Enrollees from disruption due to reclassification of drugs during the term of the Agreement, drugs shall be classified for pricing purposes in accordance with current Program Brand/Generic Drug classifications and in accordance with the definitions in Sections 1.7 and 1.57 of this Contract.

9.1.7 The Contractor must use the DCS Programs current Brand/Generic classification methodology, which is primarily based on a particular set of Medi-Span indicators.

9.1.8 The following methodologies shall be used by the Contractor and will be used by the Department to determine the appropriate Brand/Generic Drug classification so as to comply with the contractual definitions set forth in Sections 1.7 and 1.57 of this Contract.

Classification Methodology - General

a. Drugs shall be classified for pricing purposes during the term of the Agreement in accordance with the DCS Program’s classification determinations based on the definitions contained in Section 1 “Definition

of Terms" of this Contract. No later than November 15th of each Plan Year, the Contractor shall submit for the DCS Program's written approval a file containing all NDCs dispensed through the DCS Program during the prior year and the classification of each NDC derived from application of the Contractor's electronic classification process. To the extent the Contractor's electronic process results in classifications inconsistent with the DCS Programs determinations, the Contractor commits to modify its classification methodology to replicate the results of the DCS Programs determination, including the steps set forth in Section 9.1.8(b) of this Contract. The Department's determination shall be final.

b. To the extent the electronic process fails to comprehensively replicate drug classifications consistent with the definitions of Brand and Generic Drugs set forth in Sections 1.7 and 1.57 of this Contract, the Contractor agrees to modify to the extent possible its electronic processing system before January 1, 2025, including setting appropriate Copayment levels as required, and to undertake all other necessary manual steps to ensure that the result of the prescription processing process from a cost basis to both Enrollee and Plan is in accordance with the DCS determination of classification.

c. The Contractor shall conduct a year end reconciliation each Plan Year to ensure that the claim amount charged to the Plan is in accordance with the definition of Brand and Generic Drugs set forth in Sections 1.7 and 1.57 of this Contract. The reconciliation will include claims paid during the Plan Year and is to be completed by February 15th of the following year. If DCS's review of the Contractor's reconciliation indicates an adjustment is required, then DCS reserves the right to make an adjustment to the Contractor's submitted reconciliation. The Contractor shall credit or debit the Plan as applicable no later than 30-Days following the date of reconciliation and reflect the result in the Annual Financial Statement.

Brand Drug Determination Methodology

d. A drug labeled with the identifier "M" or "O" in the Medi-Span Multi-Source code shall be processed as a Brand Drug unless the same drug is identified as "G" in the Medi-Span Brand- Name code.

e. In addition to drugs identified as "M" or "O" in the Medi-Span Multi-Source code, a drug that is identified as "N" in the Medi- Span Multi-Source code shall be designated a Brand Drug if the drug is identified as "T" in the Medi-Span Brand-Name code.

Generic Drug Determination Methodology

f. A drug identified as "Y" in the Medi-Span Multi-Source code shall be designated as a Generic Drug.

g. In addition to drugs identified as "Y" in the Medi-Span Multi-Source code, a drug identified as "N" in the Medi-Span Multi- Source Code shall be

designated as a Generic Drug if the corresponding Medi-Span Brand-Name code for such drug is “B” or “G.”

h. In addition, a drug identified as “G” in the Medi-Span Brand- Name Code shall be designated as a Generic Drug, regardless of the identifier designated in the Medi-Span Multi- Source code.

i. As stated in Section I, “Definition of Terms,” of this Contract, no drug approved through an FDA Generic Drug approval process, including any FDA approval process established for approving generic equivalents of biologic drugs, shall be processed as a Brand Drug regardless of the assigned Medi-Span indicators or the result of the Contractor’s proposed methodology for determining the appropriate classification of a drug. Furthermore, the DCS Program classifies a small list of drugs as Generic Drugs that are classified by Medi-Span as Brand Drugs (see Attachment 94, *DCS Brands Classified as Generic Drugs of the RFP*). The drugs listed in Attachment 94, *DCS Brands Classified as Generics,* of the RFP must be classified as Generic Drugs during the term of the agreement with the Department, unless a change to the list is requested by DCS in writing.

j. Attachment 76, *Current Brand-Generic Classification* of the RFP presents a listing of the NDC’s dispensed to DCS Program Enrollees in 2023 and the required brand name/generic drug classification assigned to each NDC.

Compound Drug Determination Methodology

k. A Compound Drug is a drug with two or more ingredients (solid, semi-solid or liquid), where the primary active ingredient is an FDA approved Covered Drug with a valid NDC requiring a Prescription for dispensing, combined together in a method specified in a Prescription issued by a medical professional. The end result of this combination must be a Prescription medication for a specific patient that is not otherwise commercially available in that form or dose/strength from a single manufacturer. The Prescription must identify the multiple ingredients in the Compound, including active ingredient(s), diluent(s), ratios or amounts of product, therapeutic use and directions for use. The act of compounding must be performed or supervised by a licensed Pharmacist. Any commercially available product with a unique assigned NDC requiring reconstitution or mixing according to the FDA approved package insert prior to dispensing will not be considered a Compound Prescription by the DCS Program.

9.1.9 The DCS Program’s Lesser of Logic, as defined in Section I, “Definition of Terms,” of this Contract, shall apply to <u>all</u> claims processed under the DCS Program.

9.2 Mandatory Generic Substitution at Retail and Mail

To ensure strict adherence to the DCS Program’s Mandatory Generic Substitution Requirement and protect the financial interests of the DCS Program, the Contractor shall

be required to:

9.2.1 Apply mandatory generic substitution to all specific NDC's (active or inactive) of Brand Drugs for which there is an FDA- approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc.) or an authorized Generic Drug as permissible by NYS law. Retail network pharmacies shall comply with all state laws related to mandatory generic substitution. The DCS 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.

9.2.2 Establish the Ancillary Charge by calculating the difference in the Discounted Ingredient Cost of the Brand Drug and the Discounted Ingredient Cost of the equivalent A-rated Generic Drug or authorized Generic Drug based on the DCS Programs MAC List price assigned when a Brand Drug for which an A-rated or authorized Generic Drug has been introduced in the market is dispensed to the Enrollee. In such cases, the Enrollee shall be responsible for paying the applicable Level 3 Drug Copayment plus Ancillary Charge not to exceed the cost of the drug to the DCS Program. The Ancillary Charge shall be assessed even in the event a doctor has specifically directed a Pharmacist to dispense the Brand Drug rather than the A- rated or authorized Generic Drug through DAW notation.

9.2.3 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 Contractor shall inform the Department of anticipated shipping dates of the first generic introduced into the market for one or more strengths of a particular Brand Drug.

9.2.4 Following the first shipment of a first NDC for a Generic Drug for one or more strengths of a particular Brand Drug (i.e., MAC Alerts are required for new NDCs of new GPIs and for new NDCs for GPIs already on the MAC List), the Contractor shall be required to:

a. Inform the Department as soon as practicable but in no event later than fourteen (14) Days during normal Business Hours 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 6.7.11(a) of this Contract.

b. For those drugs that will result in a lower net cost to the DCS Program by enforcing mandatory generic substitution, the Contractor shall provide the "MAC Alert Notice" as described in Section 9.2.4(a) of this Contract above. The Contractor shall add the GPI to the Programs' MAC List (if the GPI is not on the Programs' MAC List already) and begin enforcement as soon as practicable but in no event later than fourteen (14) Days during normal Business Hours after the first date of shipment provided that the participating retail network pharmacies are able to obtain the Generic Drug;

c. For those drugs that could potentially result in a higher net cost to the DCS Program by enforcing mandatory generic substitution, the Contractor shall provide the “MAC Alert Notice” as described in (a) above. The Contractor shall also notify the Department whether the drug should be included in the Brand for Generic strategy. The Department, in its sole discretion, may determine that enforcement is contrary to the best financial interests of the DCS Program and shall inform the Contractor whether Mandatory Substitution shall be applied. If the Contractor does not receive a formal response to the information provided via the “MAC Alert Notice,” enforcement shall commence, and the GPI shall be added to the DCS Programs MAC List (if the GPI is not on the DCS Program’s MAC List already) effective on the 21st Day after shipment of the first A-rated generic equivalent drug or authorized Generic Drug provided that the pharmacies are able to obtain the Generic Drug. In the event the Department decides to exercise its discretion not to enforce mandatory generic substitution, the Contractor shall apply MAC pricing to the Generic Drug when dispensed;

d. To assist the Department in determining whether or not mandatory generic substitution should be enforced within 21 Days, the Contractor shall survey its Retail Pharmacy Network to identify the pharmacies that are unable to obtain the new Generic Drug within 21 Days. The Contractor shall submit this information to the Department and provide any additional information as required by the Department to reach a determination. The DCS, in its sole discretion, shall determine based on such evidence how the DCS Programs mandatory generic substitution provisions will be applied. The DCS Program will not consider, and the Contractor shall not act on availability information provided by third party sources, including but not limited to Medi-Span;

e. For preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall be changed from preferred to Non-Preferred status concurrent with the commencement of the enforcement of mandatory generic substitution. Enrollees prescribed strengths of the Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the Level 1 Copayment. If the prescribing Physician requires that the Brand Drug be dispensed, the Enrollee will be charged the applicable Level 3 Drug Copayment and Ancillary Charge. Enrollees prescribed strengths of the preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Level 2 Copayment and mandatory generic substitution provisions shall not apply;

f. For Non-Preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall remain Non-Preferred for all strengths. Concurrent with enforcement of mandatory generic substitution, Enrollees prescribed strengths of the Non-Preferred Brand Drug for which an A-rated or authorized Generic

Drug has been introduced shall receive the Generic Drug and be charged the Level 1 Copayment. If the prescribing Physician requires that the Brand Drug be dispensed, the Enrollee will be charged the applicable Level 3 Drug Copayment and Ancillary Charge. Enrollees prescribed strengths of the Non-Preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Level 3 Drug Copayment and mandatory generic substitution provisions shall not apply; and

g. The Contractor shall cause the dispensing Network Pharmacy to inform the Enrollee prior to dispensing the Brand Drug, that an Ancillary Charge would be applied in addition to the applicable Level 3 Drug Copayment. If the prescribing Physician requires the Brand Drug be dispensed, the Contractor shall cause the dispensing Network Pharmacy to collect the applicable Level 3 Drug Copayment plus the calculated Ancillary Charge. However, under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the DCS Program after application of the Programs' Lesser of Logic provisions, as defined in Section I, "Definition of Terms," of this Contract.

9.2.5 Charge the DCS Program based on the DCS Program's MAC List price assigned to the GPI of the dispensed Brand Drug plus the applicable dispensing fee plus the prescribing fee(s), if applicable, as set forth in Section 9.6.4 of this Contract.

9.2.6 Receive written approval from the Department for any and all exceptions to the DCS Program's mandatory substitution provisions, beyond the approval of specific generic appeals or approval through the Medical Exception Program. Following commencement of mandatory generic substitution, the Contractor must receive the Department's written approval prior to suspending enforcement of the DCS Programs mandatory generic substitution provisions.

9.2.7 Maintain an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the DCS 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 DCS 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 and the Plan charged based on Generic Drug pricing. Currently, the DCS Program rejects, with appropriate messaging, claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW 0-code and require resubmission of the claim (since a DAW 0- code provides no indication of Generic Drug availability in the Network Pharmacy). Similar rules can be applied to other DAW submission codes as necessary to ensure consistent, accurate application of the DCS Program's mandatory generic substitution requirements. These rules are
specified in Section 6.13.12 of this Contract.

9.3 Retail Pharmacy Network Claims

9.3.1 Retail Pharmacy Network Claims – General

The following general provisions apply to all claims submitted by Retail Pharmacy Networks:

a. The Contractor shall ensure that the Network Pharmacy collects the appropriate Copayment (plus Ancillary Charge, if applicable) specified in Attachment 27 *DCS/NYSIF Prescription Drug Program Copayment Matrix* of the RFP*,* which are subject to collective bargaining negotiation*,* from the Enrollee and will charge the DCS Program the Discounted Ingredient Cost as determined through the application of the Lesser of Logic, as defined in Section I, "Definition of Terms," of this Contract, plus the Contractor's applicable pharmacy contracted dispensing fee, plus the prescribing fee(s), if applicable, minus the applicable Copayment for all drugs dispensed through a Network Pharmacy;

b. If the current Discounted Ingredient Cost plus the dispensing fee plus the prescribing fee(s), if applicable, or the submitted cost is less than the applicable Copayment, then the Contractor shall ensure that the Network Pharmacy charges the Enrollee the lesser amount; and

c. The Contractor shall implement a control process at point of service intended to protect the DCS Program from any inflated AWP costs associated with "repackaged" drugs charged to the DCS Program.

9.3.2 Retail Pharmacy Network Brand Name Drug Pricing

a. The Contractor shall charge the DCS Program utilizing Pass-through Pricing for all Brand Name Drugs and Limited Distribution Drugs dispensed to Enrollees through the Network Pharmacies. The Contractor's pharmacy contracted Guaranteed Minimum off of Aggregate AWP, pharmacy contracted dispensing fee(s) and prescribing fee(s), if applicable, for Brand Drugs shall be applicable to the aggregate AWP for all Brand Drugs dispensed to Enrollees from a Network Pharmacy;

b. The Contractor shall use the following Ingredient Cost, dispensing fee and prescribing fee, if applicable, minus Copayment and applicable Ancillary Charge, if any, to charge the DCS Program for each Prescription for a covered Brand Drug dispensed by a Network Pharmacy throughout the term of the Contract subject to application of the Lesser of Logic as defined in Section I, "Definition of Terms," of this Contract.

Ingredient Cost of Brand Drug Dispensed at Retail Pharmacy Network

Pass-through Pricing based on the terms of the Contractor's agreement with the dispensing Pharmacy related to Brand Drugs. (Pricing is subject to an overall annual minimum discount of [redacted] off the aggregate AWP, annual maximum average dispensing fee of [redacted] and annual

maximum average prescribing fee, if applicable, of [redacted] for all Brand Drugs dispensed through Network Pharmacies.);

c. The Contractor shall guarantee a minimum discount off of Aggregate AWP for all Brand Drugs dispensed at Retail Network Pharmacies as defined in the RFP. The Contractor shall guarantee the Department that its management of Brand Drug costs dispensed by pharmacies shall result in the DCS Program achieving the Contractor's Guaranteed Minimum Discounts of [redacted] during each Program Year.

   The discounts achieved off of the aggregate AWP for all Brand Drugs as a result of Pass-through Pricing will be calculated utilizing the following formula:1 minus (Sum of Ingredient Costs of dispensed Brand Drugs divided by sum of the AWP of dispensed Brand Drugs).

   The aggregate discount calculation will be based on Final Paid Claim Pharmacy Prescriptions filled with a Brand Drug including Empire Plan Medicare Rx claims. Claims submitted for secondary payer consideration, Compound Drug claims, powders, subrogation claims, long term care pharmacy claims, nursing home pharmacy claims, Veterans Affairs hospital pharmacy claims, and claims submitted by governmental entities must be excluded from the aggregate discount calculation. In addition, claims with a calculated AWP discount greater than 50% must be verified by the Contractor that the quantity and the validity of the calculated discount is correct, subject to the approval of the Department; and

d. If the aggregate discounts obtained, as calculated utilizing the formula set forth in the prior paragraph, are less than the Guaranteed Minimum Discounts of [redacted], the Contractor shall reimburse the DCS Program, the difference between the Ingredient Cost the DCS Program was charged utilizing Pass-through Pricing and the Ingredient Cost the DCS Program would have been charged if the Guaranteed Minimum Discount of [redacted] had been obtained. The DCS Program will be credited annually for this difference in Ingredient Cost. The DCS Program shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discounts off of Aggregate AWP for all Brand Drugs dispensed by pharmacies.

   This calculation shall be performed for each Program Year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Department on July 31st (Reconciliation Due Date). Contractor shall pay/credit the DCS Program within 30-Days. If the Department's review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Department reserves the right in their sole discretion to make an adjustment to the Contractor's calculations and adjust the amount due to the DCS Program or to the Contractor.

The DCS Program shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discount of [redacted] off of Aggregate AWP. Any shortfall in the Guaranteed Minimum Discount set forth in this Contract cannot be recovered by the Contractor in subsequent years.

9.3.3 Retail Pharmacy Network Generic Pricing

a. The Contractor shall charge the DCS Program utilizing Pass-through Pricing for all Generic Drugs dispensed to Enrollees through the Network Pharmacies;

b. The Contractor shall use the following Ingredient Cost and dispensing fee, minus applicable Copayment, to charge the DCS Program for each covered Generic Drug dispensed by retail Network Pharmacies throughout the term of the Agreement subject to the Lesser of Logic process, as defined in "Section I, Definition of Terms," of this Contract.

Ingredient Cost of Generic Drug dispensed at Retail Pharmacy Network:

Pass-through Pricing based on either the DCS Programs MAC List(s) or the Contractor's pharmacy contracted discount applied to the AWP of the dispensed Generic drug for Generic Drugs not assigned a MAC. (Pricing is subject to an overall annual minimum discount of [redacted] off of the aggregate AWP for all Generic Drugs dispensed through Network Pharmacies and Mail Service Pharmacy Process.)

c. To maximize savings for the DCS Program on Generic Drugs dispensed through a Network Pharmacy, the Contractor is required to:

i. Create and maintain a single, Program-specific Maximum Allowable Cost (MAC) List called the DCS Programs MAC List for Retail and Mail Service Pharmacies, setting the maximum price the DCS Program will be charged, and the amount the dispensing Network Pharmacy will be paid, for the Ingredient Cost for the drugs required to be included on the DCS Programs MAC List. The MAC price assigned shall not exceed the Discounted Ingredient Cost to the DCS Program achieved through Pharmacy submitted pricing or pricing achieved by using the Contractor's highest contracted Retail Pharmacy Brand Guaranteed Minimum Discount of [redacted] off of AWP applied to the AWP of the dispensed Generic Drug.

NOTE: The Department respectively, reserve its rights for the Contractor to create and maintain a second MAC List should industry or programmatic events necessitate the use of a second list. The use of a second MAC List will be at the sole discretion and approval of the Department, respectively. The Guaranteed Minimum Discount off of Aggregate AWP, the Guaranteed Maximum

Dispensing Fee and Prescribing Fee guarantees for generic drugs will be subject to negotiation if a second MAC List is utilized. As MAC Lists are set by GPI, not NDC, but MAC Alerts are done at the NDC level, DCS requires that the Contractor submit monthly adjudication reports and credit the applicable invoice for any NDC where the MAC price of the GPI is higher than the highest contracted Retail Pharmacy Brand Discount off of AWP of the Generic NDC.

ii. Assign a MAC price to all NDCs of drugs included within a GPI, including NDCs of all Brand Drugs, containing an A-rated or authorized Generic Drug form of the original Brand Drug in the GPI. The Contractor shall add the GPI to the Programs' MAC List and set a MAC price for the GPI in accordance with Section 6.15.0 of this Contract. The provisions of these paragraphs require that MAC pricing be applied in no event later than 21 Days after the first shipment of a first NDC for a Generic Drug from the manufacturer to a wholesaler or retailer. All A-rated or authorized Generic Drugs shall be placed on the MAC List in all instances including, but not limited to circumstances in which the Department in its sole discretion decides not to enforce mandatory generic substitution of the Brand Drug in that GPI. There shall be one MAC price applicable to all NDCs included in the GPI on the DCS Programs MAC List. However, depending on particular market factors, it may be in the best interests of the DCS Program, and therefore appropriate, for more than one MAC price to be assigned within a GPI. Such situations would require that the Contractor provide any information the Department deems necessary to support such action and obtain prior written approval from the Department;

iii. Assign a MAC price to the NDCs of B-rated or unrated Generic Drugs included within a GPI that does <u>not</u> include an A-rated or authorized Generic Drug. The Contractor shall add the GPI to the DCS Programs MAC List and set a MAC price for the Generic Drug NDCs included in the GPI as soon as practicable, but in no event later than 21 Days after the first shipment of a first NDC for a Generic Drug from the manufacturer to a wholesaler or retailer concurrent with transmission of the MAC Alert notice. The Contractor shall not apply the MAC price to the NDC(s) for Brand Drugs dispensed in the GPI and shall not enforce the DCS Programs mandatory generic substitution provisions for Brand Drugs dispensed in this GPI. There shall be one MAC price applicable to all Generic Drug NDCs included in the GPI on the DCS Programs MAC List. However, depending on particular market factors, it may be in the best interests of the DCS Program, and therefore appropriate, for more than one MAC price to be assigned within a GPI. Such situations would require that the Contractor

provide any information the Department deems necessary to support such action and obtain prior written approval from the Department;

iv. Charge the DCS Program for Generic Drugs not on the MAC list dispensed, utilizing Pass-through Pricing at the Contractor's pharmacy contracted discount applied to the AWP of the dispensed Generic Drug. The only Generic Drugs not on the MAC list will be Generic Drugs included in GPIs required to be on the DCS Programs' MAC List(s), but which have not yet been assigned a MAC price within the required time frame;

v. The Contractor shall inform the Department of any market-based condition which makes the strict compliance with paragraphs (i)-(iv) above contrary to the financial interests of the DCS Program. The Contractor shall agree that, in cases where the Department, at its sole discretion, determines that the above requirements are contrary to the best financial interests of the Programs, the Department may waive such requirements;

vi. Monitor the DCS Programs MAC List pricing to ensure that NDCs contained in GPIs subject to MAC pricing are paying at the MAC price after application of the DCS Program's Lesser of Logic provisions. The Contractor shall notify the Programs of any GPIs subject to MAC pricing in which the majority of claims are processing at a basis other than the MAC price;

vii. Agree that there shall be no increases to the DCS Program MAC List prices where such adjustment is intended to limit the discount achieved on behalf of the DCS Program to the Guaranteed Minimum Discounts off of Aggregate AWP for all Generic Drugs dispensed by Network Pharmacies during the Plan Year as set forth in Section 9.3.3 of this Contract;

viii. Provide to the Department full access to the DCS Program's MAC List used to price Generic Drugs dispensed by Network and Mail Service Pharmacies for the DCS Program.

Note: The Contractor must be prepared to provide valid documented market rationale to support the DCS Program's MAC pricing should the Department request this information. In order to protect the DCS Program's financial interests from the date of the award until the termination date of the Contract, the Contractor must agree that any increases to the proposed DCS Program's MAC pricing must be justified to the Department with valid documented market rationale. Prices for new GPIs added to the DCS Program's MAC List shall be equivalent to or below the Contractor's most aggressive MAC price

for that drug. To ensure compliance with these requirements, the Contractor shall notify the Department monthly of all changes, additions, and deletions made to the DCS Programs MAC List in the format specified in Section 6.7.9(b) of this Contract. Throughout the term of the Contract, the Contractor shall commit to use its best efforts to maintain the aggregate effectiveness of the DCS Program's MAC List. The Contractor must ensure that MAC pricing is reduced to an appropriate level based on any change in market conditions such as increased competition within a GPI;

ix. The Contractor shall strictly enforce all requirements of the DCS Programs mandatory generic substitution provision as detailed in Section 9.2.0 of this Contract entitled "Mandatory Generic Substitution at Retail and Mail;"

x. The Contractor must Guarantee a Minimum Discount off of Aggregate AWP for all Generic Drugs dispensed at Retail Pharmacies as defined in the RFP. The Contractor shall guarantee the DCS Program that its management of Generic Drug costs dispensed by pharmacies, including maintenance of the DCS Programs MAC List, and application of pricing provisions related to Generic Drugs that do not meet the requirements for inclusion on the DCS Programs MAC List, shall result in the DCS Program achieving the Contractor's overall Guaranteed Minimum Discount off of the aggregate AWP as set forth in subparagraph xii below, for all Generic Drugs dispensed by Network Pharmacies during the Plan Year. The discount achieved off of Aggregate AWP for all Generic Drugs as a result of the pricing set forth in subparagraph xii and Section 9.4.3c below will be calculated utilizing the following formula: 1 minus (Sum of Ingredient Costs of dispensed Generic Drugs at Retail Pharmacies divided by sum of the AWP of dispensed Generic Drugs).

xi. The aggregate discount calculation will be based on Final Paid Claim Pharmacy Prescriptions filled with a Generic Drug including Empire Plan Medicare Rx claims. Claims submitted for secondary payer consideration, Compound Drug claims, powders, subrogation, long term care pharmacy claims, nursing home pharmacy claims, Veterans Affairs hospital pharmacy claims, and claims submitted by governmental entities must be excluded from the aggregate discount calculation. In addition, claims with a calculated AWP discount greater than 90% and a total AWP greater than $500 must be verified by the Contractor that the quantity and validity of the calculated discount is correct, subject to the approval of the Department. The setting of a Guaranteed Minimum Discount off of Aggregate AWP for all Generic Drugs dispensed at Retail Network Pharmacies shall in no way modify the Contractor's contractual

obligation to maximize the DCS Programs aggregate discount above the Contractor's Guaranteed Minimum Discount of [redacted] off of Aggregate AWP; and

xii. If the overall aggregate discount obtained, as calculated utilizing the formula set forth in paragraph x above, is less than the Contractor's Guaranteed Minimum Discount set forth in Section 9.3.3b, the Contractor shall reimburse the DCS Program the difference between the Ingredient Cost the DCS Program were charged utilizing Pass-through Pricing and the Ingredient Cost the DCS Program would have been charged if the Guaranteed Minimum Discount off of Aggregate AWP had been obtained. The DCS Program will be credited annually for this difference in Ingredient Cost. The DCS Program shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discounts off the aggregate AWP for all Generic Drugs dispensed by Retail and Mail Service Pharmacies.

These calculations shall be performed for each Program Year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Department on or before July 31st (the "Reconciliation Due Date"). The Contractor shall pay/credit the DCS Program the applicable amount, if any, within 30 Days of the Reconciliation Due Date. If the Department's review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Department reserves the right in their sole discretion to make an adjustment to the Contractor's calculations and adjust the amount due to the DCS Program.

The Department shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discount of [redacted] off of aggregate AWP. Any shortfall in the Guaranteed Minimum Discount set forth in this Contract cannot be recovered by the Contractor in subsequent years. The Contractor is not allowed to apply any separate "offsets" to the cost savings that inure to the benefit of the Department in Section 9.3.0 of this Contract.

9.3.4 Retail Pharmacy Network Compound Drug Pricing

Compound Drugs must be classified consistent with the definition in Section 1.21 of this Contract. The Contractor is required to:

a. Utilize its pricing methodology for Compound Drugs utilizing Pass-through Pricing, as set forth in subparagraph e below, for the entire term of the Agreement. The proposed pricing methodology(ies) for Compound Drugs must be the same for Retail and Mail Service Pharmacy Process

claims;

b. Charge Enrollees the applicable Level 2 Drug Copayment for all Compound Drugs. If the current Discounted Ingredient Cost or the submitted cost is less than the applicable Level 2 Drug Copayment, then the Contractor shall ensure that the Enrollee is charged the lesser amount;

c. Process Compound Drug claims in a manner that verifies the validity of the claim as a Compound Drug according to the DCS Programs definition of a Compound Drug and provides appropriate claim Level control procedures to protect the financial interests of the DCS Program;

d. Conduct due diligence as well as audit Network Pharmacies to ensure that drugs are being properly classified as Compound Drugs consistent with the DCS Programs definition of a Compound Drug and to ensure that compound claims are priced in accordance with the Contractor's pricing methodology for Compound Drugs, as set forth in subparagraph e below;

e. The Department will be charged the Contractor's pricing methodology utilizing Pass-through Pricing for Compound Drugs dispensed by Network Pharmacies; its dispensing fees; and a level of effort fee based on the claims level of effort code below. The Contractor will notify the DCS, in writing, a minimum of 30 Days in advance of any changes to the Contractor's book of business Level of Effort fees, and such revised fees will be charged consistent with the pricing provisions of the Agreement.

	Level of Effort Code	Description	Fee
9.3.4e(1)	11	Single ingredient batched capsule; any combination of commercially available products; or	[redacted]
9.3.4e(2)	12	Two or three ingredient batched capsule; transdermal gel; or	[redacted]
9.3.4e(3)	13	Four or more ingredient batched capsule; three or less ingredient cream/ointment/gel; suppository; two or less ingredient capsule; noncomplex suspension; tablet triturate; or	[redacted]
9.3.4e(4)	14	Topical containing controlled ingredient; three or more ingredient troche; four or more ingredient capsule; complex suspensions (e.g., pediatric); custom capsule (includes rapid dissolution preparations); chemotherapy cream/ointment/gel; hormone therapy (capsules, troches, and suppositories); or	[redacted]
9.3.4e(5)	15	Sterile product	[redacted]

9.4 Mail Service Pharmacy Process – Claims

9.4.1 The Contractor Shall be required to:

a. Consistently enforce and administer all provisions of the DCS Program (including but not limited to mandatory generic substitution, drug utilization review, prior authorization, refill too-soon edits, etc.) to the claims dispensed through the Mail Service Pharmacy Process, consistent with the processing of claims through the Retail Pharmacy Network process;

b. Charge the DCS Program for those drugs dispensed to the Enrollee in original manufacturer packaging, based on the Contractor's source of AWP as proposed by the Contractor in its Proposal for the 11-digit NDC of the package size dispensed through the Mail Service Pharmacy Process, subject to MAC pricing for Generic drugs. If the drug is not dispensed to the Enrollee in original manufacturer packaging (i.e., dispensed from bulk), the DCS Program shall be charged based on the Contractor's source of AWP as proposed by the Contractor in its Proposal for the 11-digit NDC of the package size from which the drug was originally dispensed by the Mail Service Pharmacy Process Facility, subject to MAC pricing for Generic drugs. If the drug is dispensed from a bulk package size for which no AWP is reported in the Contractor's proposed AWP source as referenced in Section 9.1.3, the DCS Program will be charged based on the reported AWP for the NDC of the largest package size contained in the Contractor's AWP source as referenced in Section 9.1.3. The DCS Program shall not be charged based on an NDC assigned to repackaged drugs or based on package sizes prepared by special arrangement with the original manufacturer, unless such packaging offers a net savings to the DCS Program;

c. Charge the DCS Program based on the Contractor's pricing terms, dispensing fees (if any) and prescribing fee(s) (if applicable), applicable to Brand, Generic, and Compound Drug claims as set forth in Sections 9.4.2c, 9.4.3c and 9.4.4e for all prescriptions submitted through the Mail Service Pharmacy Process. The DCS Programs Lesser of Logic shall be applied at all times during the Contract term;

d. Ensure that the Mail Service Pharmacy Process Facilities collect the appropriate Copayment specified by DCS plus Ancillary Charge, if applicable, from the Enrollee and charge the DCS Program the balance of the Discounted Ingredient Cost as determined through the application of the Lesser of Logic, as defined in Section I, "Definition of Terms" of

this Contract, plus the Contractor's applicable proposed Guaranteed Dispensing Fee set forth in Section 9.6 minus the applicable Copayment for all drugs dispensed through the Mail Service Pharmacy Process;

e. Inform the Enrollee prior to shipping if the total amount for a Prescription order submitted through the Mail Service Pharmacy Process exceeds $100 and Enrollee has payment information (e.g., credit card) on file or Enrollee's total balance is over $100 and Enrollee has no payment information (e.g., credit card) on file. The Mail Service Pharmacy Process Facility will not be required to inform Enrollees if there is a consistent history of the acceptance of shipments that exceed the maximum amount specified for the same medications. If the Brand Drug is dispensed, the Contractor shall cause the dispensing facility to collect the applicable Level 3 Drug Copayment plus the calculated Ancillary Charge, if any. Under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the DCS Program; and

f. The Contractor is required to maximize savings to the DCS Program through aggressive pricing and discounts, consistent with the Lesser of Logic, as defined in Section I, "Definition of Terms," and Section IX, "DCS Program Claims Reimbursement," of this Contract. The Contractor agrees that all records supporting Lesser of Logic are subject to audit by DCS and its consultants or other State auditors with authority under Section IX and/or Appendices A & B of the Contract.

9.4.2 Mail Service Pharmacy Process – Brand Name Drug Pricing

The Contractor shall be required to:

a. Utilize the Guaranteed Discount off of AWP as specified in Section 9.4.2.c, below to determine the Ingredient Cost of the Prescription to charge the DCS Program. The Guaranteed Discount off of AWP shall be applicable to individual Brand Drug prescriptions dispensed to Enrollees through the Mail Service Pharmacy Process;

b. Ensure that the Mail Service Pharmacy Process dispensing facility collects the appropriate Brand Drug Copayment (plus Ancillary Charge if applicable) from the Enrollee and charges the DCS Program the balance of the Discounted Ingredient Cost plus the Guaranteed Dispensing Fee, if any, for Brand Drugs dispensed through the Mail Service Pharmacy Process, as specified in Section 9.4.2c, below. If the current Discounted Ingredient Cost plus the Guaranteed Dispensing Fee (if applicable) or the submitted cost is less than the applicable Level 2 or Level 3 Drug Copayment then the Contractor shall ensure that the Enrollee/Dependent is charged the lesser amount;

c. The Contractor shall use the following Ingredient Cost and dispensing fee, minus Copayment and applicable Ancillary Charge, if any, to charge the DCS Program for each Prescription for a covered Brand Drug dispensed through the Mail Service Pharmacy Process throughout the term of the Agreement.

Brand Drug: Ingredient Cost: [redacted] off AWP
Dispensing Fee: [redacted]

d. Guarantee a Discount off of AWP for Brand Drugs dispensed through the Mail Service Pharmacy as defined in the RFP. The Contractor shall guarantee the Department that the Plan will achieve the Contractor's Guaranteed Discounts off of AWP during the Plan Year, as specified in Section 9.4.2c, above;

e. The discount achieved off of AWP for Brand Drugs dispensed at Mail Service Pharmacies shall be billed to the Programs using Lesser of Logic, incorporating guaranteed contracted pricing;

f. If the Guaranteed Discount off of AWP for Brand Drugs is less than the Guaranteed Minimum Discount off of AWP as specified in Section 9.4.2c, above, the Contractor shall reimburse the DCS Program the difference between the Ingredient Cost the DCS Program were charged and the Ingredient Cost the DCS Program would have been charged if the Guaranteed Minimum Discount off of AWP had been obtained. The DCS Program will be credited annually for this difference in Ingredient Cost. The DCS Program shall retain the benefit of any cost savings, in excess of the Contractor's proposed Guaranteed Minimum Discounts off of AWP for Brand Drugs dispensed by the Mail Service Pharmacy;

g. This calculation shall be performed by the Contractor for each Program Year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The Contractor shall pay/credit the DCS Program the applicable amount, if any, within 30 Days of the Reconciliation Due Date. If the Departments review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Department reserves the right in their sole discretion to make an adjustment to the Contractor's calculations and adjust the amount due to the DCS Program or to the Contractor; and

h. In addition to performing this reconciliation, the Contractor shall provide reporting on the Actual Acquisition Cost of this Agreement for Brand drugs dispensed through the Mail Service Pharmacy to the Department on July 31st. If the Contractor identifies in writing the information requested as Contractor's Confidential or Proprietary information access

to the information will be provided pursuant to Section 14.7 of this Contract, Contractor's Confidential Information.

9.4.3 Mail Service Pharmacy Process – Generic Drug Pricing

The Contractor shall be required to:

a. Utilize the DCS Programs MAC list for Retail and Mail Service Pharmacies to determine the Ingredient Cost of each Prescription charged to the DCS Program. The Contractor's DCS Program MAC list for Retail and Mail Service Pharmacies shall be applicable to the aggregate AWP for all Generic Drugs dispensed to Enrollees through the Mail Service Pharmacy Process;

b. Ensure that the Mail Service Pharmacy Process dispensing facility collects the Level 1 Drug Copayment from the Enrollee and charges the DCS Program the balance of the Discounted Ingredient Cost plus the Contractor's Guaranteed Dispensing Fee for Generic Drugs dispensed through the Mail Service Pharmacy Process, if any, as specified in Section 9.4.3c, below. If the current Discounted Ingredient Cost plus the dispensing fee (if applicable) or the submitted cost is less than the applicable Level 1 Drug Copayment then the Contractor shall ensure that the Enrollee is charged the lesser amount;

c. The Contractor shall use the following Ingredient Cost and dispensing fee, minus Copayment, to charge the DCS Program for each Prescription for a covered Generic Drug dispensed through the Mail Service Pharmacy Process throughout the term of the Agreement subject to the Lesser of Logic process, as defined in Section I, "Definition of Terms," of this Contract.

   Ingredient Cost of Generic Drug dispensed at Mail Service Pharmacy: either the DCS Programs' MAC List(s) or the fixed, contracted Mail Service Pharmacy Process Guaranteed Discount off the equivalent Brand Drug as set forth in Section 9.4.2.c of this Agreement for the dispensing of Generic Drugs not assigned a MAC. (Pricing is subject to an overall annual minimum discount of [redacted] off of the aggregate AWP for all Generic Drugs dispensed through the Retail Pharmacy Network and Mail Service Pharmacy Process.)

   Dispensing Fee: [redacted]

d. The Contractor must Guarantee a Minimum Discount off of Aggregate AWP for all Generic Drugs dispensed through the Mail Service Pharmacy Process as set forth in Section 9.3.3.c.x and 9.3.3.c.xi of this Agreement. The Contractor shall guarantee the DCS Program that its management of Generic Drug costs dispensed by the Mail Service

Pharmacy, including maintenance of the DCS Programs MAC List for Retail and Mail Service Pharmacies, and application of pricing provisions related to Generic Drugs that do not meet the requirements for inclusion on the Programs' MAC List, shall result in the DCS Program achieving the Contractor's overall Guaranteed Minimum Discounts during the Program Year as proposed in the Contractor's Proposal.

e. The discount achieved off of Aggregate AWP for all Generic Drugs dispensed through the Mail Service Pharmacy Process as a result of Lesser of Logic will be calculated utilizing the following formula: 1 minus (Sum of Ingredient Costs of dispensed Generic Drugs at Mail Service Pharmacies divided by sum of the AWP of dispensed Generic Drugs). The aggregate discount calculation will be based on Final Paid Claim Pharmacy Prescriptions filled with a Generic Drug including Empire Plan Medicare Rx claims. Claims submitted for secondary payer consideration, Compound Drug claims, powders, subrogation, long term care pharmacy claims, nursing home pharmacy claims, Veterans Affairs hospital pharmacy claims, and claims submitted by governmental entities must be excluded from the aggregate discount calculation. In addition, claims with a calculated AWP discount greater than 90% and a total AWP greater than $500 must be verified by the Contractor that the quantity and validity of the calculated discount is correct, subject to the approval of the Department. The setting of a Guaranteed Minimum Discount off of Aggregate AWP for all Generic Drugs dispensed through the Mail Service Pharmacy Process shall in no way modify the Contractor's contractual obligation to maximize the Programs' aggregate discount above the Contractor's Guaranteed Minimum Discount off of Aggregate AWP;

f. If the overall aggregate discounts obtained, as calculated utilizing the formula set forth in the prior paragraph, are less than the Guaranteed Minimum Discount off of Aggregate AWP in Section 9.4.3.c of this Contract, the Contractor shall reimburse the DCS Program, the difference between the Ingredient Cost the DCS Program were charged utilizing Pass-through Pricing and the Ingredient Cost the DCS Program would have been charged if the Guaranteed Minimum Discount off of Aggregate AWP had been obtained. The DCS Program will be credited annually for this difference in Ingredient Cost. The DCS Program shall retain the benefit of any cost savings, in excess of the Contractor's proposed Guaranteed Minimum Discounts off of Aggregate AWP for all Generic Drugs dispensed by pharmacies; and

g. This calculation shall be performed by the Contractor for each Program Year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Department on July

31st. The Contractor shall pay/credit the DCS Program the applicable amount, if any, within 30 Days of the Reconciliation Due Date. If the Departments review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Department reserves the right in their sole discretion to make an adjustment to the Contractor's calculations and adjust the amount due to the DCS Program or to the Contractor.

9.4.4 Mail Service Pharmacy Process – Compound Drug Pricing

The Contractor shall be required to:

a. Utilize its pricing methodology for Compound Drugs utilizing Pass-through Pricing, as specified in Section 9.4.4e, below, for the entire term of the Agreement. The Contractor's pricing methodology(ies) for Compound Drugs, as proposed by the Contractor in its Proposal, must be the same for retail and Mail Service Pharmacy Process claims;

b. Charge Enrollees the applicable Level 2 Drug Copayment for all Compound Drugs. If the current Discounted Ingredient Cost or the submitted cost is less than the applicable Level 2 Drug Copayment then the Contractor shall ensure that the Enrollee is charged the lesser amount;

c. Process Compound Drug claims in a manner that verifies the validity of the claim as a Compound Drug according to the DCS Programs definition and provides appropriate claim control mechanisms to protect the financial interests of the DCS Program;

d. Conduct due diligence to ensure that drugs are being properly classified as Compound Drugs consistent with the DCS Programs definition of a Compound Drug and ensure that compound claims are priced in accordance with the Contractor's pricing methodology for Compound Drug, as specified in Section 9.4.4e, below, and

e. The Department will be charged the Contractor's pricing methodology utilizing Pass-through Pricing for Compound Drugs dispensed by Network Pharmacies; its dispensing fees; and a level of effort fee based on the claims level of effort code below. The Contractor will notify the DCS, in writing, a minimum of 30 Days in advance of any changes to the Contractor's book of business Level of Effort fees, and such revised fees will be charged consistent with the pricing provisions of the Agreement.

	Level of Effort Code	Description	Fee
9.4.4e(1)	11	Single ingredient batched capsule; any combination of commercially available products; or	[redacted]

9.4.4e(2)	12	Two or three ingredient batched capsule; transdermal gel; or	[redacted]
9.4.4e(3)	13	Four or more ingredient batched capsule; three or less ingredient cream/ointment/gel; suppository; two or less ingredient capsule; noncomplex suspension; tablet triturate; or	[redacted]
9.4.4e(4)	14	Topical containing controlled ingredient; three or more ingredient troche; four or more ingredient capsule; complex suspensions (e.g., pediatric); custom capsule (includes rapid dissolution preparations); chemotherapy cream/ointment/gel; hormone therapy (capsules, troches, and suppositories); or	[redacted]
9.4.4e(5)	15	Sterile product	[redacted]

9.5 Enrollee Submitted Claims

9.5.1 The cost to the DCS Program for Prescriptions for which Enrollees submit direct claims for reimbursement shall be charged to the DCS Program at the actual amounts reimbursed by the Contractor.

9.5.2 The Contractor shall utilize the following methodology to reimburse the Enrollee and charge the DCS Program:

a. Brand Drugs, including Specialty Drugs, must be charged to the DCS Program utilizing the Guaranteed Minimum Discount off of Aggregate AWP for Brand Drugs dispensed at the Retail Pharmacy Network set forth in Section 9.3.2.b plus Retail Brand Guaranteed Maximum Dispensing Fee for Brand Drugs set forth in Section 9.6.4.a, plus the Guaranteed Maximum Prescribing Fee (if applicable) set forth in Section 9.6.8.a, minus the applicable Copayment;

b. Generic Drugs, including Specialty Drugs, must be charged to the DCS Program utilizing the Contractor's assigned MAC price for the Retail and Mail Service Pharmacies, plus the applicable dispensing fee for Generic Drugs, plus the prescribing fee(s), if applicable, minus the applicable Copayment. Generic Drugs without a MAC price must be charged to the DCS Program using the Contractor's Guaranteed Minimum Discount off of Aggregate AWP for Brand Drugs, as specified in Section 9.3.2.b, off of AWP of the dispensed Generic Drug, plus the Guaranteed Maximum Dispensing Fee for Generic Drugs set forth in Section 9.6.4.a, minus the applicable Copayment;

c. Compound Drugs must be charged to the DCS Program by applying the

Contractor's pricing methodology for Compound Drugs as specified in Sections 9.3.4.e and 9.4.4.e, above, plus the Guaranteed Maximum Dispensing Fee for Compound Drugs set forth in Section 9.6.4.a minus the applicable Level 2 Drug Copayment; and

d. The DCS Program's Lesser of Logic must be applied to all Enrollee Submitted Claims.

9.6 Dispensing Fee and Prescribing Fee

9.6.1 The Guaranteed Maximum Dispensing Fees and Guaranteed Maximum Dispensing Fees set forth in 9.6.4 and 9.6.8 of this Section must be guaranteed for the term of this Agreement.

9.6.2 Dispensing fees at Retail Network Pharmacies shall be subject to Pass-through Pricing, up to a Guaranteed Maximum Dispensing Fee applied to aggregate claims. Prescribing fee(s), if applicable, at Retail Network Pharmacies shall be subject to Pass-through Pricing, up to a Guaranteed Maximum Prescribing Fee applied to aggregate claims.

9.6.3 No dispensing fee shall be charged to the DCS Program for any claim that is paid on the basis of the Pharmacy's Usual and Customary price.

9.6.4 The Contractor dispensing fee for Brand Drugs, Generic Drugs and Compound Drugs dispensed by Network Pharmacies shall be Pass-through Pricing, subject to an annual aggregate Guaranteed Maximum Dispensing fee set forth below. The Contractor's Guaranteed Dispensing fees for Brand Drugs, Generic Drugs and Compound Drugs dispensed by the Mail Service Pharmacy Process and the Designated Specialty Pharmacy are set forth below:

a. Retail Network Pharmacy Guaranteed Maximum Dispensing Fee:

[redacted] Per Brand Drug
[redacted] Per Generic Drug
[redacted] Per Compound Drug

b. Mail Service Pharmacy Process Guaranteed Dispensing Fee:

[redacted] Per Brand Drug
[redacted] Per Generic Drug
[redacted] Per Compound Drug

c. Designated Specialty Pharmacy Guaranteed Dispensing Fee:

[redacted] Per Brand Drug
[redacted] Per Generic Drug

9.6.5 The level of dispensing fees achieved as a result of Pass- through Pricing at Retail Pharmacies will be calculated utilizing the following formula:

Total Retail Network Dispensing Fees paid by the DCS Program on an annual basis divided by the number of Final Paid Claims at Retail Network Pharmacies for each of Generic, Brand, and Compound claims.

9.6.6 If the overall aggregate dispensing fees paid, as calculated utilizing the formula set forth in the prior paragraph, are more than the Guaranteed Maximum Dispensing Fee proposed for each of Brand, Generic, and Compound claims at Retail Network Pharmacies, the Contractor shall reimburse the DCS Program the difference between the Dispensing Fee the DCS Program was charged utilizing Pass-through Pricing and the Dispensing Fee the DCS Program would have been charged if the Guaranteed Maximum Dispensing Fee had been obtained.

9.6.7 This calculation shall be performed for each Program Year based on claims for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Department on July 31st. The Contractor shall pay/credit the DCS Program the applicable amount, if any, within 30 Days of the Reconciliation Due Date. If the Departments review of the Contractor's calculations indicates and adjustment to the calculation is required, then the Department reserve the right in its sole discretion to make an adjustment to the Contractor's calculations and adjust the amount due to the DCS Program or to the Contractor. The DCS Programs shall retain the benefit of any cost savings in excess of the Guaranteed Maximum Dispensing Fees set forth in Section 9.6. Any shortfall in the Guaranteed Maximum Dispensing Fees set forth in Section 9.6 cannot be recovered by the Contractor in subsequent years.

9.6.8 The Contractor prescribing fee for Brand Drugs and Generic Drugs dispensed by Network Pharmacies shall be Pass-through Pricing, subject to an annual aggregate Maximum Guaranteed Prescribing fee set forth below:

a. Retail Network Pharmacy Guaranteed Maximum Prescribing Fee:

[redacted] Per Brand Drug
[redacted] Per Generic Drug

9.6.9 The level of prescribing fee(s), if applicable, achieved as a result of Pass-through Pricing at Retail Pharmacies will be calculated utilizing the following formula:

Total Retail Network Prescribing Fees (if applicable) paid by the DCS Program on an annual basis divided by the number of Final Paid Claims at Retail

Network Pharmacies for each of Generic, and Brand claims.

9.6.10 If the overall aggregate prescribing fees, if applicable, paid, as calculated utilizing the formula set forth in the prior paragraph, are more than the Guaranteed Maximum Prescribing Fee proposed for each of Brand, and Generic claims at Retail Network Pharmacies, the Contractor shall reimburse the DCS Program the difference between the Prescribing Fee the DCS Program was charged utilizing Pass-through Pricing and the Prescribing Fee, if applicable, the DCS Program would have been charged if the Guaranteed Maximum Prescribing Fee had been obtained.

9.6.11 This calculation shall be performed for each Program Year based on claims for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to DCS on July 31st. The Contractor shall pay/credit the DCS Program the applicable amount, if any, within 30 Days of the Reconciliation Due Date. If the DCS review of the Contractor's calculations indicates and adjustment to the calculation is required, then the Department reserves the right in its sole discretion to make an adjustment to the Contractor's calculations and adjust the amount due to the DCS Program or to the Contractor. The Program shall retain the benefit of any cost savings in excess of the Guaranteed Maximum Prescribing Fees set forth in Section 9.6.8. Any shortfall in the Guaranteed Maximum Prescribing Fees set forth in Section 9.6.8 cannot be recovered by the Contractor in subsequent years.

9.7 Specialty Pharmacy Program Pricing

The Contractor shall:

9.7.1 Consistently enforce and administer all provisions of the DCS Program (including but not limited to mandatory generic substitution, drug utilization review, prior authorization, refill too-soon edits) to the claims dispensed through the Specialty Pharmacy Process, consistent with the processing of claims through the Retail and Mail Service Pharmacy Network processes.

9.7.2 Charge the DCS Program for those drugs dispensed to Enrollees in original manufacturer packaging, based on the Contractor's source of AWP for the 11-digit NDC of the package size dispensed through the Specialty Pharmacy Process. If the drug is not dispensed to the Enrollee in the original manufacturer packaging (i.e., dispensed in bulk), the DCS Program shall be charged based on the Contractor's source of AWP for the 11-digit NDC of the package size from which the drug was originally dispensed by the Designated Specialty Pharmacy. If the drug is dispensed from a bulk package size for which no AWP is reported in the Contractor's AWP source, the DCS Program shall be charged based on the reported AWP for the NDC of the largest package size contained in the Contractor's AWP source. The DCS Program shall not be charged based

on an NDC assigned to repackaged drugs or based on package sizes prepared by special arrangement with the original manufacturer unless such packaging offers a net savings to the DCS Program.

9.7.3 Charge the DCS Program based on the Contractor's pricing terms and dispensing fees (if any) applicable to Brand and Generic, Specialty Drug claims as set forth in Sections 9.7.5 through 7.7.9 of this Contract, for all prescriptions submitted through the Specialty Pharmacy Program.

9.7.4 Ensure that the Designated Specialty Pharmacy(ies) collects the appropriate Copayment specified by the Department (plus Ancillary Charge, if applicable) from the Enrollee and will charge the DCS Program the balance of the Discounted Ingredient Cost plus the Contractor's applicable guaranteed dispensing fee set forth in Section 9.6.4 of the Contract, minus the applicable Copayment for all drugs dispensed through the Specialty Pharmacy Process.

9.7.5 Classify Brand Drugs consistent with the definition in Section 1.7 of this Contract, as well as the methodology outlined within Section 9.1.8 of this Contract entitled "Brand Drug Determination Methodology."

9.7.6 Classify Generic Drugs consistent with the definition in Section 1.57 of this Contract, as well as the methodology outlined earlier within Section 9.1.8 of this Contract entitled "Generic Drug Determination Methodology."

9.7.7 Implement its fixed contracted Guaranteed Discount off of Average Wholesale Price (AWP) of [redacted] that will be utilized to determine the Ingredient Cost of the Prescription to charge the DCS Program. The Contractor's Guaranteed Discount shall be applicable to the aggregate AWP of all Prescriptions for Brand Drugs and Generic Drugs dispensed to Enrollees through the Specialty Pharmacy. The Contractor shall guarantee the Department that its management of drug costs dispensed through the Specialty Pharmacy Process shall result in the DCS Program achieving the Contractor's overall Guaranteed Minimum Discounts during each Program Year as set forth above. The discounts achieved off of the aggregate AWP for all Brand Drugs and Generic Drugs dispensed to Enrollees through the Specialty Pharmacy Process will be calculated utilizing the following formula:

1 minus (Sum of Ingredient Costs of Brand Drugs and Generic Drugs dispensed through the Specialty Pharmacy Process divided by sum of the AWP of Brand Drugs and Generic Drugs dispensed through the Specialty Pharmacy Process).

The aggregate discount calculation will be based on Final Paid Claim Pharmacy Prescriptions filled through the Specialty Drug Process. Claims submitted for secondary payer consideration, Compound Drug claims, powders, and subrogation claims must be excluded from the aggregate discount calculation. In addition, claims with a calculated AWP discount greater than 50% must be verified by the Contractor that the quantity and the validity of the calculated

discount is correct, subject to the approval of the Department.

9.7.8 If the overall aggregate discounts obtained, as calculated utilizing the formula set forth in the prior paragraph, are less than the Guaranteed Minimum Discount of [redacted] off Aggregate AWP, the Contractor shall reimburse the DCS Program, the difference between the Ingredient Cost the DCS Program were charged utilizing Lesser of Logic and the Ingredient Cost the DCS Program would have been charged if the Guaranteed Minimum Discount of [redacted] off Aggregate AWP had been obtained. The DCS Program will be credited annually for this difference in Ingredient Cost. The DCS Program shall retain the benefit of any cost savings, in excess of the Contractor's proposed Guaranteed Minimum Discounts of [redacted] off Aggregate AWP for all Brand Drugs and Generic Drugs dispensed to Enrollees through the Specialty Pharmacy.

9.7.9 This calculation shall be performed by the Contractor for each Program Year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Department on July 31st. The Contractor shall pay/credit the DCS Program the applicable amount, if any, within 30 Days of the Reconciliation Due Date. If the Departments review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Department reserves the right in its sole discretion to make an adjustment to the Contractor's calculations and adjust the amount due to the DCS Program or to the Contractor.

The Department shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discount of [redacted] off the aggregate AWP. Any shortfall in the Guaranteed Minimum Discount of [redacted] off the aggregate AWP cannot be recovered by the Contractor in subsequent years.

9.7.10 Act in the best financial interests of the DCS Program when dispensing Generic Drugs through the Specialty Pharmacy Process by avoiding the dispensing of NDC's with higher AWPs unless market conditions exist making dispensing the more cost effective NDC impractical or impossible.

9.7.11 The Contractor is required to maximize savings to the DCS Program through aggressive pricing and discounts, consistent with Lesser of Logic and the Contractor's Financial Proposal. The Contractor agrees that all records supporting Lesser of Logic are subject to audit by DCS and its consultants or other State auditors with authority under Section 14, Additional Provisions and/or Appendices A & B of this Contract.

9.8 Vaccination Network Pharmacy Pricing

The Contractor shall charge the DCS Program, on a pass-through basis, as follows:

9.8.1 Seasonal Vaccines shall be charged an Administration Fee to the DCS Program on a Pass-through basis, as proposed in Attachment 93, *Vaccination Administration Fees* of the RFP.

9.8.2 Non-Seasonal Vaccines shall be charged an Administration Fee to the DCS Program on a Pass-through basis, as proposed in Attachment 93, *Vaccination Administration Fees* of the RFP.

9.8.3 COVID-19 Vaccines and Boosters (vaccines and boosters for COVID- 19 are covered without Copayment) and, due to the changing nature of the vaccine coverage and financial information, are agreed to through an Enrollment Form, subject to approval by the Department.

9.8.4 The Contractor shall be bound by its Vaccination Administration Fee, as proposed in Attachment 93, *Vaccination Administration Fees* of the RFP for the entire term of the Contract.

9.8.5 Shall implement any changes necessary to accommodate DCS Program modifications resulting from collective bargaining, legislation or within the statutory discretion of the State within 60 Days of notice, or as soon as practicable.

SECTION X: 100% PHARMA REVENUE GUARANTEE

10.1 The Contractor agrees to and shall:

10.1.1 Negotiate Pharma Revenue agreements with manufacturers that maximize savings to the DCS Program, leveraging the significant enrollment of the DCS Program for each individual drug. The Contractor agrees that any Program specific Pharma Revenue agreement shall derive total Pharma Revenue that meets or exceeds the Pharma Revenue derived from any other Pharma Revenue agreements the Contractor uses to administer its Book of Business for each individual drug.

10.1.2 Pay the Programs quarterly within 60 Days of the end of each quarter, the greater of 100% Pharma Revenue received or the minimum guaranteed amount set forth in Section 10.1.9 of this Contract.

10.1.3 Calculate and distribute Pharma Revenue to the DCS Program in a fully transparent and verifiable process. The Contractor agrees that all direct and indirect revenue arrangements with manufacturers, suppliers, or other vendors shall be disclosed and the revenue generated related or attributable to the DCS Programs utilization shall be credited to the DCS Program. The Contractor acknowledges and agrees that the records, methods, and calculations utilized to total and distribute these amounts to the DCS Program are subject to audit by the State under the audit authority set forth in Section 14 Additional Provisions and Appendices A and B of this Contract thereto. In addition, the Contractor shall pursuant to the terms of the Contract provide all agreements as

necessary for the DCS Program to evaluate Drug List decisions including direct access to any manufacturer contracts in unredacted form, under which the DCS Program is entitled to derive Pharma Revenue pursuant to the terms of the Agreement. If Contractor identifies in writing the information requested as Contractors' Confidential or Proprietary information access to the information will be provided pursuant to Section 14.7 of the Contract, Contractor's Confidential Information.

10.1.4 Not enter into any agreement that has the effect of diverting, shortchanging, or trading off any form of Pharma Revenue that would otherwise be due the DCS Program for other consideration. There shall be no fees charged to the DCS Program or received from a manufacturer, separate from the Claims Administration Fees as described and authorized in Section 8.2, by the Contractor for rebate or other Pharma Revenue administration. The Contractor shall not divert, shortchange, or trade off Pharma Revenue that would otherwise inure to the Program's financial benefit for Enrollee drug utilization in return for reduced drug acquisition costs or other monetary or non-monetary consideration from manufacturers.

10.1.5 Throughout the term of the Agreement, the Contractor shall provide, upon the request of the State, all information and documentation related to Pharma Revenue agreements, including but not limited to, full direct access by the Department's staff or its agents to complete unredacted Pharma Revenue agreements pursuant to which the DCS Program derives Pharma Revenue. If Contractor identifies in writing the information requested as Contractors' Confidential or Proprietary information access to the information will be provided pursuant to Section 14.7 of the Contract, Contractor's Confidential Information.

10.1.6 Utilize manufacturer agreements for the DCS Program that meet or exceed the Contractor's best existing Pharma Revenue agreements for all individual drugs. If the Contractor's business model allows for more than one Pharma Revenue agreement with manufacturers, the Contractor agrees that in no instance will the DCS Program receive less Pharma Revenue in any therapeutic class than other clients of the Contractor with a comparable benefit design and consistent preferred drug designations in the class, provided the DCS Programs utilization of the drugs generating Pharma Revenue in the class is equal to or greater than those of other clients. The Contractor shall have a process satisfactory to the Department to confirm compliance with this provision and must implement and administer said satisfactory process under the Agreement. The DCS Program shall receive full pass-through of 100% of Pharma Revenue derived from any Pharma Revenue agreement with a pharmaceutical manufacturer. Where any Pharma Revenue contracts allow for higher Pharma Revenue for Mail Service Pharmacy or Specialty Pharmacy Program claims, the DCS Program will receive the full financial benefit of those higher rates receiving 100% of the Pharma Revenue derived from those agreements on mail order claims. If manufacturer agreements provide less Pharma Revenue for Mail Service Pharmacy or Specialty Pharmacy Program claims than retail claims for the same drug, the terms of the manufacturer agreement applicable to retail claims

shall be applied to Program Mail Service Pharmacy and Specialty Pharmacy Program claims for purposes of calculating the amount of Pharma Revenue due the DCS Program.

10.1.7 Ensure the Contractor's Minimum Pharma Revenue Guarantee Per Final Paid Claim set forth in Section 10.1.9 is not contingent upon the DCS Program's participation in any of the Contractor's formulary management or intervention programs, including, but not limited to, step therapy and Brand for Generic (B4G) strategies. The Contractor's Minimum Pharma Revenue Guarantee Per Final Paid Claim is also not contingent on the DCS Program's use of the Contractor's book of business or standard formulary offerings, or the timing of any patent expirations and/or introduction of generic equivalent drugs, including but not limited to early and/or at-risk Generic Drug launches. Any B4G strategy proposed must be financially advantageous to the State. The Program will review the guaranteed amount only in the event of legislative, regulatory, or judicial action excluding patent litigation not specific to the Contractor's business practices that serves to void existing Pharma Revenue agreements materially compromising the Contractor's ability to obtain contracted Pharma Revenue necessary to meet the Contractor's Minimum Pharma Revenue Guarantee Per Final Paid Claim. Further, any exclusions the Contractor is proposing as part of its Formulary must comply with the requirements of Section 6.17 of the Contract.

10.1.8 Calculate and perform an annual reconciliation of the Pharma Revenue credit to the Pharma Revenue earned. As part of this annual reconciliation the Contractor shall be required to:

a. Calculate the Pharma Revenue guarantee on all Final Paid Claims, incurred for the respective Program Year. The Pharma Revenue guarantee shall be on the aggregate level, not separated for each therapeutic class.

b. Credit the DCS Program an amount calculated based on the following formula: if in any Program Year, the Pharma Revenue realized and credited to the DCS Program by the Contractor is less than the amount due the DCS Program as determined utilizing the minimum Pharma Revenue credit set forth in 10.1.9, the amount of the credit shall be equal to the difference between the reported Pharma Revenue credited to the DCS Program and the Contractor's Minimum Pharma Revenue Guarantee Per Final Paid Claim.

c. Submit calculations and documentation supporting the amount of Pharma Revenue reported and credited to the DCS Program for the Department's review and written approval. The Contractor shall provide all information and documentation deemed necessary by the Department to verify the DCS Program were credited with all Pharma Revenue due it under the terms of the Agreement.

   If at the close of any Plan Year, the Pharma Revenue credited to the DCS Program is greater than the higher of the amount derived through

application of the Pharma Revenue guarantee formula or the actual Pharma Revenue realized by the DCS Program, upon notice and verification by the Department, the DCS Program shall pay the Contractor the difference between the amount previously credited to the DCS Program and the higher of the minimum Pharma Revenue guaranteed amount or actual Pharma Revenue realized during the Program Year.

d. If at the close of any Program Year, the Pharma Revenue credited to the DCS Program is less than the actual Pharma Revenue realized by the DCS Program, the Contractor shall credit the DCS Program the difference between what was previously credited and the full amount due to the DCS Program.

e. Include such reconciliation as part of the Contractor's annual financial summary report. The Department requires the Contractor's Minimum Pharma Revenue Guarantee Per Final Claim Paid be credited to the claims experience on the annual financial reports regardless of the amount of Pharma Revenue that has been received by the Contractor.

10.1.9 The Minimum Pharma Revenue amount due the DCS Program on an annual basis shall be calculated according to the formula: Contractor's Minimum Pharma Revenue Guarantee Per Final Paid Claim multiplied by the number of Final Paid Claims incurred for the respective Plan Year. The Contractor's Minimum Pharma Revenue Guarantee Per Final Paid Claim based on claims incurred for the respective Plan Year is:

a. [redacted] for the Plan Year 2025;
b. [redacted] for the Plan Year 2026;
c. [redacted] for the Plan Year 2027;
d. [redacted] for the Plan Year 2028;
e. [redacted] for the Plan Year 2029.

SECTION XI: TRANSITION & TERMINATION OF CONTRACT

11.1 The Contractor must commit to fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the DCS Program.

11.1.1 The Contractor must, within one hundred twenty (120) Days of the end of the Agreement, or within forty-five (45) Days of notification of termination, if the Agreement is terminated prior to the end of its term, provide the Department with a detailed written plan for transition, which 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 Department approve during implementation of the Programs in the format acceptable to the Department.

b. The transition of open refill prior authorization and generic appeal files should include but not be limited to the following:

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

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

iii. Providing a second production file to the new contractor by the close of business January 2nd (or 2 days after the Contract terminates) that contains all Enrollee Prescription refill availability as specified by the Department, working in conjunction with the selected successor contractor.

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 Contractor's Mail Service and Designated Specialty Pharmacy(ies) after the end of the year.

c. Transition of Enrollee information on all non-transferable compounds and controlled medications.

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

11.1.3 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.

11.1.4 The Contractor shall be responsible for transitioning the Programs in accordance with the approved Transition Plans.

11.1.5 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 to effectively manage the separate Agreement, the Contractor is required to provide the following Contractor-related obligations and deliverables to the DCS Program through the final financial settlement of the Agreement:

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 Agreement, including but not limited to paying network claims, Mail Service Pharmacy claims, Specialty Pharmacy claims, manual submit claims including but not limited to: Medicaid, VA, Skilled Nursing Facility claims, out-of-network claims, foreign claims, in-network claims, COB claims, Student Health Center Claims, and Medicare, reimbursing late filed claims if warranted, reimbursing customer credit balance accounts, resolution of Mail Service Pharmacy process and Specialty Pharmacy Process issues, repaying or recovering monies on behalf of the DCS Program for Medicare 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 DCS Program. In addition, the Contractor must continue to provide the Department access to any online claims processing data and history and online reporting systems through the final settlement dates, unless the Department notifies the Contractor that access may be ended at an earlier date;

b. Complete all required reports in the reporting Section 6.7 of this Contract and referenced in Attachment 36, *Program Reporting*, of the RFP;

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

d. Agree to fully cooperate with all the Department or Office of the State Comptroller (OSC) audits in accordance with the requirements outlined in the Contract;

e. Provide timely reviews and responses to audit findings submitted by the Department and the OSC's audit unit in accordance with the requirements in the RFP; and

f. Remit reimbursement due the Programs within fifteen (15) days upon final audit determination consistent with the process specified in Section 14.5, "Audit Authority" and Section 8 "Payment for Services" of this Contract and Appendix B.

11.1.6 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 Contractor's control.

11.1.7 The Contractor is required to receive and apply enrollment updates, keeping dedicated phone lines open with adequate available staffing to provide customer service at the same levels provided prior to termination of the Agreement, adjusting phone scripts, and transferring calls to the successor contractor's lines.

11.1.8 The Contractor is required to transmit point-of-service messaging to their Retail Pharmacy Network upon the termination date of the Agreement instructing Pharmacists to submit Enrollee claims to the appropriate RXBIN, RXPCN, RXGRP or other claim identification information as specified by the Department working in conjunction with the Contractor.

11.1.9 If the Contractor does not meet all of the Transition Plan requirements in the time frame stated above, the Contractor 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 Department. The amount shall be calculated by dividing the Claims Administrative Fees for each cycle that includes a day the requirements are not met, by the number of days in that cycle and multiplying the quotient of that calculation by the number of days in the cycle during which the requirement was not met.

SECTION XII: INSURANCE REQUIREMENTS

12.1 Amended RFP Section 4.6 sets forth the applicable insurance requirements that must be maintained by the Contractor during the Contract term and is hereby expressly made a part of this Contract as if fully set forth herein.

SECTION XIII: NOTICES

13.1 The Contractor shall immediately notify the Department upon learning of any situation that can reasonably be expected to adversely affect the delivery of Project Services.

13.2 All notices permitted or required hereunder shall be in writing and shall be transmitted via certified or registered United States mail, return receipt requested; by hand delivery; by expedited delivery service; or by e-mail. Such notification must be sent to:

State of New York Department of Civil Service

Name:	Dan Yanulavich
Title:	Director, Employee Benefits Division
Address:	Swan Street Building, Core 1, Albany, NY 12239
Telephone Number:	518-402-4709
E-Mail Address:	Daniel.Yanulavich@cs.ny.gov

With Additional Notice to:

Name:	Eugene Sarfoh
Title:	General Counsel, NYS Department of Civil Service
Address:	ESP, Agency Bldg. 1, Floor 20, Albany, NY 12242
Telephone Number:	518-473-1662
E-Mail Address:	eugene.sarfoh@cs.ny.gov

CaremarkPCS Health, L.L.C.

Name:	Attn: PBM Legal Notices

Title: Vice President, Senior Legal Counsel
Address: 2100 Lake Cook Road, 5th Floor, Buffalo Grove, IL 60089
Telephone Number: (401) 765-1500
E-Mail Address: RS4096@CVSHealth.com

With A Copy To:

Attn: Senior Vice President, Health Care Services
9501 E. Shea Blvd.
Scottsdale, AZ 85260
Fax Number: (480) 314-8231

13.3 Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of email, upon receipt.

13.4 The Parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this Agreement by giving fifteen (15) days written notice to the other party sent in accordance herewith. The Parties agree to mutually designate individuals as their respective representatives for the purposes of receiving notices under this Agreement. Additional individuals may be designated in writing by the Parties for purposes of implementation and administration/billing, resolving issues and problems and/or for dispute resolution.

SECTION XIV: ADDITIONAL PROVISIONS

In addition to the audit requirements specified in Appendices A, B, and C to this Contract, the Contractor must comply with the following requirements:

14.1 Work in The Continental United States of America

All work performed by Contractor personnel under this Contract must be performed within the Continental United States of America.

14.2 Information Classification

The Department has determined that the State information which the Contractor will either host, maintain, or have access to has an impact level of: Confidentiality = High, Integrity = High, and requires the Contractor to have appropriate security controls pursuant NIST SP 800-53B, Control Baselines for Information Systems and Organizations, implemented to uniformly protect the confidentiality, integrity, and availability of the information entrusted to the Contractor, unless the State indicates otherwise.

14.3 Continued Data Access

The period that the Contractor must provide the Department continued access to Data beyond the expiration or termination of the Agreement is no less than four years. All

Contract provisions related to the protection and security of the Data will survive termination of the Contract. This provision does not limit or lessen the time period or Contractor's obligations pursuant to Standard Clauses for New York State Contracts (Appendix A) to establish and maintain Records.

14.4 Use and Disclosure of Protected Health Information

14.4.1 The Contractor acknowledges that the Contractor is a "Business Associate" as that term is defined in the HIPAA implementing regulations at 45 CFR 160.103, of the Department as a consequence of the Contractor's provision of Project Services on behalf of the Department within the context of the Contractor's performance under the Contract and that the Contractor's provision of Project Services will involve the disclosure to the Contractor of individually identifiable health information from the Department or other service providers on behalf of the Department, as well as the Contractor's disclosure to the Department of individually identifiable health information as a consequence of the Project Services performed under the Contract. As such, the Contractor, as a Business Associate, will be required to comply with the provisions of this Section.

14.4.2 For purposes of this Section, the term "Protected Health Information" (PHI) means any information, including demographic information collected from an individual, that relates to the past, present, or future physical or mental health or condition of an individual, to the provision of health care to an individual, or to the past, present, or future payment for the provision of health care to an individual, that identifies the individual, or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. Within the context of the Contract, PHI may be received by the Contractor from the Department or may be created or received by the Contractor on behalf of the Department in the Contractor's capacity as a Business Associate. All PHI received or created by the Contractor in the Contractor's capacity as a Business Associate and as a consequence of its performance under the Contract is referred to herein collectively as "Department's PHI".

14.4.3 The Contractor acknowledges that the Department administers on behalf of New York State, several group health plans as that term is defined in HIPAA's implementing regulations at 45 CFR Parts 160 and 164, and that each of those group health plans consequently is a "covered entity" under HIPAA. These group health plans include NYSHIP, which encompasses the Empire Plan as well as participating health maintenance organizations; the Dental Plan, and the Vision Plan. In this capacity, the Department is responsible for the administration of these "covered entities" under HIPAA. The Contractor further acknowledges that the Department has designated NYSHIP and the Empire Plan as an Organized Health Care Arrangement (OHCA), respectively. The Contractor further acknowledges that:

a. The Contractor is a HIPAA "Business Associate" of the group health plans identified herein as "covered entities" as a consequence of the Contractor's provision of certain services to and/or on behalf of the Department as administrator of the "covered entities" within the context of the Contractor's performance under the Contract, and that the Contractor's provision of such services may involve the disclosure to the Contractor of individually

identifiable health information from the Department or from other parties on behalf of the Department, and also may involve the Contractor's disclosure to the Department of individually identifiable health information as a consequence of the services performed under the Contract; and

b. Contactor is a "covered entity" under HIPAA in connection with its provision of certain services under the Contract. To the extent Contractor acts as a HIPAA "Business Associate" of the group health plans identified as "covered entities", the Contractor shall adhere to the requirements as set forth herein. Contractor is responsible to obtain from Members and Enrollees all consents and/or authorizations, if any, required for Contractor to perform the services hereunder and for the use and disclosure of information, including the Department's PHI, as permitted under the Contract.

14.4.4 Permitted Uses and Disclosures of the Department's PHI: The Contractor may create, receive, maintain, access, transmit, use and/or disclose the Department's PHI solely in accordance with the terms of the Contract. In addition, the Contractor may use and/or disclose the Department's PHI to provide data aggregation services relating to the health care operations of the Department. Further, the Contractor may use and disclose the Department's PHI for the proper management and administration of the Contractor if such use is necessary for the Contractor's proper management and administration or to carry out the Contractor's legal responsibilities, or if such disclosure is required by law or the Contractor obtains reasonable assurances from the person to whom the information is disclosed that it shall be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Contractor of any instances of which it is aware in which the confidentiality of the information has been breached. Additionally, the Contractor may use and/or disclose the Department's PHI, as appropriate:

a. for treatment, payment and health care operations as described in 45 CFR Section 164.506(c)(2), (3) or (4); and

b. To de-identify the information or create a limited data set in accordance with 45 CFR §164.514, which de-identified information or limited data set may, consistent with this section, be used and disclosed by Contractor only as agreed to in writing by the Department and permitted by law.

14.4.5 Nondisclosure of the Department's PHI: The Contractor shall not create, receive, maintain, access, transmit, use, or further disclose the Department's PHI otherwise than as permitted or required by the Contract or as otherwise required by law. The Contractor shall limit its uses and disclosures of PHI when practicable to the information comprising a Limited Data Set, and in all other cases to the minimum necessary to accomplish the intended purpose of the PHI's access, use, or disclosure.

14.4.6 Safeguards: The Contractor shall use appropriate, documented safeguards to prevent the use or disclosure of the Department's PHI otherwise than as provided for in the Contract. The Contractor shall maintain a comprehensive written

information security program that includes administrative, technical, and physical safeguards that satisfy the standards set forth in the HIPPA Security Rule at 45 CFR §§ 164.308, 164.310, and 164.312, along with corresponding policies and procedures, as required by 45 CFR § 164.316, appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities, to reasonably and appropriately protect the confidentiality, integrity and availability of any electronic PHI that it creates, receives, maintains, accesses, or that it transmits on behalf of the Department pursuant to the Contract to the same extent that such electronic PHI would have to be safeguarded if created, received, maintained, accessed or transmitted by a group health plan identified herein.

14.4.7 Breach Notification: In addition to the Disclosure of Breach requirements specified in Standard Clauses for All Department Contracts (Appendix B), the following provisions shall apply:

a. Reporting: The Contractor shall report to the Department any breach of unsecured PHI, including any use or disclosure of the Department's PHI otherwise than as provided for by the Contract, of which the Contractor becomes aware. An acquisition, access, transmission, use or disclosure of the Department's PHI that is unsecured in a manner not permitted by HIPAA or the Contract is presumed to be a breach unless the Contractor demonstrates that there is a low probability that Department's PHI has been compromised based on the Contractor's risk assessment of at least the following factors:

    i. The nature and extent of Department's PHI involved, including the types of identifiers and the likelihood of re- identification;
    ii. The unauthorized person who used Department's PHI or to whom the disclosure was made;
    iii. Whether Department's PHI was actually acquired or viewed; and
    iv. The extent to which the risk to Department's PHI has been mitigated.

b. Required Information: In addition to the information required in Standard Clauses for All Department Contracts (Appendix B), paragraph 40, Disclosure of Breach,) the Contractor shall provide the following information to the Department within in the time period identified in Standard Clauses for All Department Contracts (Appendix B), Disclosure of Breach, except when, despite all reasonable efforts by the Contractor to obtain the information required, circumstances beyond the control of the Contractor necessitate additional time. Under such circumstances, the Contractor shall provide to the Department the following information as soon as possible and without unreasonable delay, but in no event later than thirty (30) Days from the date of discovery:

    i. the date of the breach incident;
    ii. the date of the discovery of the breach;
    iii. a brief description of what happened;
    iv. a description of the types of unsecured PHI that were involved;
    v. identification of each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or

disclosed during the breach;

vi. a brief description of what the Contractor is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches; and

vii. any other details necessary to complete an assessment of the risk of harm to the individual.

c. The Contractor will be responsible to provide notification to individuals whose unsecured PHI has been or is reasonably believed to have been accessed, acquired or disclosed as a result of a breach, as well as the Secretary of the United States Department of Health and Human Services and the media, as required by 45 CFR Part 164.

d. The Contractor shall maintain procedures to sufficiently investigate the breach, mitigate losses, and protect against any future breaches, and to provide a description of these procedures and the specific findings of the investigation to the Department upon request.

e. The Contractor shall mitigate, to the extent practicable, any harmful effects from any use or disclosure of PHI by the Contractor not permitted by the Contract.

14.4.8 Associate's Agents: The Contractor shall require all of its agents or Subcontractors to whom it provides the Department's PHI, whether received from the Department or created or received by the Contractor on behalf of the Department, to agree, by way of written contract or other written arrangement, to the same restrictions and conditions on the access, use, and disclosure of PHI that apply to the Contractor with respect to the Department's PHI under the Contract.

14.4.9 Availability of Information to the Department: The Contractor shall make available to the Department such information and documentation as the Department may require regarding any disclosures of PHI by the Contractor to fulfill the Department's obligations to provide access to, provide a copy of, and to account for disclosures of the Department's PHI in accordance with HIPAA and its implementing regulations. The Contractor shall provide such information and documentation within a reasonable amount of time of its receipt of the request from the Department. The Contractor must provide the Department with access to the Department's PHI in the form and format requested, if it is readily producible in such form and format; or if not, in a readable hard copy form or such other form and format as agreed to by the Parties, provided, however, that if the Department's PHI that is the subject of the request for access is maintained in one or more designated record sets electronically and if requested by the Department, the Contractor must provide the Department with access to the requested PHI in a readable electronic form and format.

14.4.10 Amendment of the Department's PHI: The Contractor shall make the Department's PHI available to the Department as the Department may require to fulfill the Department's obligations to amend individuals' PHI pursuant to HIPAA and its implementing regulations. The Contractor shall, as directed by the Department, incorporate any amendments to the Department PHI into copies of

such Department PHI maintained by the Contractor.

14.4.11 Internal Practices: The Contractor shall make its internal practices, policies and procedures, books, records, and agreements relating to the use and disclosure of the Department's PHI, whether received from the Department or created or received by the Contractor on behalf of the Department, available to Department and/or the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by the Department and/or the Secretary for purposes of determining the Department's compliance with HIPAA and its implementing regulations.

14.4.12 Termination: This Contract may be terminated by the Department at the Department's discretion if the Department determines that the Contractor, as a Business Associate, has violated a material term of this Section. Data return and destruction upon contract termination is governed by Information Security Requirements (Appendix C).

14.4.13 Indemnification: Notwithstanding the provisions in Standard Clauses for All Department Contracts (Appendix B), the Contractor agrees to indemnify, defend and hold harmless the State and the Department and its respective employees, officers, agents or other members of its workforce (each of the foregoing hereinafter referred to as "Indemnified Party") against all actual and direct losses suffered by the Indemnified Party and all liability to third parties arising from or in connection with any breach of this section, Use and Disclosure of Protected Health Information, or from any acts or omissions related to this section by the Contractor or its employees, officers, subcontractors, agents or other members of its workforce, without limitations. Accordingly, the Contractor shall reimburse any Indemnified Party for any and all actual and direct losses, liabilities, lost profits, fines, penalties, costs, or expenses (including reasonable attorneys' fees) which may for any reason be imposed upon any Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party which results from the Contractor's acts or omissions hereunder. The Contractor's obligation to indemnify any Indemnified Party shall survive the expiration or termination of this Contract. This section is not subject to the limitation of liability provisions of the Contract.

14.4.14 Miscellaneous:

a. Survival: The respective rights and obligations of Business Associate and the "covered entities" identified herein under HIPAA and as set forth in this Section, Use and Disclosure of Protected Health Information, shall survive termination of the Contract.

b. Regulatory References: Any reference herein to a federal regulatory section within the Code of Federal Regulations shall be a reference to such section as it may be subsequently updated, amended or modified, as of their respective compliance dates.

c. Interpretation: Any ambiguity in the Contract shall be resolved to permit covered entities to comply with HIPAA.

14.5 Audit Authority

In addition to the audit requirements specified in Appendices A, B, and C to this Contract, the Selected Contractor must comply with the following requirements:

14.5.1 The Contractor acknowledges that the Department has the authority to conduct financial and performance audits of the Contractor's delivery of Program services in accordance with the Contract and any applicable State and federal statutory and regulatory authorities;

14.5.2 Such audit activity may include, but not necessarily be limited to, the following activities:

a. Review of the Contractor's activities and records relating to the documentation of its performance under the resulting Agreement in areas such as determination of Enrollee or Dependent eligibility and application of various DCS program administrative features (e.g., dependent survivor benefits, reasonable adjudication of disabled dependent status);

b. Comparison of the information in the Contractor's enrollment file to that on the enrollment reports which will be issued to the Contractor by the DCS; and

c. Assessment of the Contractor's eligibility, financial and claim processing systems to verify accuracy of data on the reports provided to the Department in accordance with Section 6.7 "Reporting Services" of this Agreement and Attachment 36, "Program Reporting" of the RFP.

14.5.3 The Contractor must maintain and make available pursuant to the terms of the Contract, documentary evidence necessary to perform the reviews referenced herein. Documentation maintained and made available by the Contractor may include, but is not limited to, source documents, books of account, subsidiary records and supporting work papers, claim documentation, pertinent contracts, key subcontracts, provider agreements, and correspondence.

14.5.4 The Contractor must make available for audit all data in its computerized files that is relevant to and subject to the Agreement. Such data may, at DCS discretion, be submitted to the DCS in machine- readable format, or the data may be extracted by the DCS from information provided by the Contractor or by the Contractor under the direction of the DCS. The DCS acknowledges that it may not access processing environments or systems that contain actual PHI of other clients of Contractor; this shall not limit OSC audit authority under Appendices A & B of the Agreement.

14.5.5 The Contractor shall, at the DCS' request, and in a time period specified by the Department, search its files, retrieve information and records, and provide to the auditors such documentary evidence as they require. The Contractor shall make sufficient resources available for the efficient performance of audit procedures.

14.5.6 The Contractor may provide comments, if any, on the contents of any audit report prepared by the DCS and transmit such comments in writing to the DCS within 30

Days of receiving any audit report. The response will address the findings and each audit recommendation. If the Contractor agrees with the recommendation, the response will include a work plan and timetable to implement the recommendation. If the Contractor disagrees with an audit recommendation, the response will give all details and reasons for such disagreement. Resolution of any disagreement as to the resolution of an audit recommendation shall be subject to the dispute resolution procedures set forth in the Contract.

14.5.7 If the Contractor has an independent audit performed of the records relating to the Agreement, a certified copy of the audit report shall be provided to the DCS within ten (10) Days after receipt of such audit report by the Contractor.

14.5.8 The audit provisions contained herein shall in no way be construed to limit the audit authority or audit scope of the OSC as set forth in either Appendix A of this Contract, Standard Clauses for All New York State Contracts, or Appendix B, Standard Clauses for All DCS Contracts.

14.5.9 The Contractor shall provide ample audit resources including access to the Contractor's online claims processing system to the Department and the OSC at their respective offices for three years after the date of the final financial settlement of the Agreement.

14.5.10 The Contractor shall provide the Department with unlimited access and monthly updates to the Prescription Drug industry reference material for drug classification and drug pricing that the Contractor will be utilizing for the Programs, including but not limited to Medi-Span Master Drug Database and Drug Application File or equivalent if different reference materials are used.

14.5.11 The Contractor agrees to fully cooperate with all Department and/or OSC audits consistent with the requirements of the Contract including all Appendices as set forth in this Contract, including provision of access to Department Protected Health Information and all relevant other confidential information which may have an impact on this Agreement, when required for audit purposes as determined by the Department, and OSC as appropriate. The Contractor must respond to all State audit requests for information and/or clarification within fifteen (15) Days.

14.5.12 The Contractor must perform timely reviews and respond in a time period specified by the Department to preliminary findings submitted by the Department, and the Comptroller's audit unit in accordance with the requirements of this Section. Such audits may include but are not limited to: mail order claims; Enrollee submitted paper claims; and online Pharmacy claims. Use of statistical sampling of claims and extrapolation of findings resulting from such samples shall be acceptable techniques for identifying claims errors. The selected Contractor shall facilitate audits of network pharmacies as requested by the Department and/or OSC.

14.5.13 The Contractor shall permit the Department or a contracted third party designated by the Department to audit all pharmacy bills and drug company revenues to ensure accuracy by the Contractor in performing services under the Contracts and compliance with financial obligations, Performance Guarantees, business operations, and all other contractual obligations. Any designated third-

party must be subject to confidentiality terms and conditions that provide for the confidentiality of the requested data which is substantially equivalent to the confidentiality terms of the Contract (see Section 14.7, “Contractor’s Confidential Information”).

14.6 Ensuring Lowest Net Cost to the Program

14.6.1 The Contractor is required to maximize savings to the Program through negotiation of Pharma Revenue Agreements obtaining discounts or other consideration from manufacturers and passing through 100% of the value of the Pharma Revenue Agreements to the Program, including any consideration that would normally flow to the Contractor or Key Subcontractor(s) based on the Plan’s utilization pursuant to the terms of those Pharma Revenue Agreements. In addition, all Pharma Revenue Agreements with manufacturers and other entities applicable to the Program must meet or exceed the Contractor’s best existing Pharma Revenue Agreements for all individual drugs ensuring that in no instance will the Program receive less Pharma Revenue in any therapeutic class than other clients of the Contractor with a comparable benefit design and consistent preferred drug designations in the class provided the Program’s utilization of the drugs generating Pharma Revenue in the class is equal to or greater than those of other clients.

14.6.2 The Contractor is required to maximize savings to the Program through negotiation of customized Retail Pharmacy Network contracts that offer aggressive pricing and discounts, consistent with Section IX “DCS Program Claims Reimbursement” of this Contract. The Contractor agrees that all records supporting the pass-through pricing are subject to audit by DCS and its consultants or other State auditors with authority under Section 14.5 and/or Appendices A & B of this Contract. In addition, access to or hard copies of all Retail Pharmacy Network contracts must be made available, in Albany County, per Section 14.7, as deemed necessary for the Department or other State auditors with authority under Section 14.5 Audit Authority and/or Appendices A & B of this Agreement to evaluate whether the Contractor is meeting the requirements of the Agreement.

14.6.3 Maximize the discount achieved on behalf of the DCS Program for Generic and Brand Drugs dispensed by Network Pharmacies. The Contractor or its Key Subcontractor, if any, must manage the DCS Programs’ MAC List(s) consistent with, or better than, their most aggressive generic pricing list used to reimburse Pharmacies. The Contractor shall charge the Program utilizing Pass-through Pricing for all Generic and Brand Drugs dispensed to Enrollees through the Network Pharmacies.

14.6.4 The Contractor is required to maximize savings to the Programs through aggressive pricing and discounts in the Mail Service Pharmacy Process and the Specialty Pharmacy Process, consistent with Lesser of Logic and the Contractor’s Financial Proposal. The Contractor agrees that all records supporting Lesser of Logic are subject to audit by DCS and its consultants or other State auditors with authority under Section 14.5 Audit Authority and/or Appendices A & B of this Contract.

14.7 Contractor's Confidential Information

14.7.1 Throughout the term of the Contract the Contractor may be required upon the request of the DCS to provide the DCS or a third-party acting on behalf of the DCS with certain information Contractor deems confidential and/or proprietary in nature (hereinafter "Contractor's Confidential Information"). The sharing of that information with the DCS will be governed under the terms of this provision and no additional Non-disclosure or Confidentiality Agreement will be requested or required by the Contractor to provide such access.

14.7.2 **No Waiver, Modification or Limitation of Audit Authority**: Nothing in this Section and no exercise by DCS of its Review Authority under this Section shall waive, modify or limit the State's audit rights pursuant to Section 14.5 Audit Authority and Appendices A, B and C to this Contract to conduct audits.

14.7.3 Contractor's failure to comply with the terms of this provision will constitute a material breach of the Agreement and the DCS may seek compensation for all damages resulting from non-compliance.

14.7.4 Contractor's Confidential Information covered under this provision will include, but may not be limited to:

a. Any contracts between the Contractor (or its affiliates) and retail pharmacies in pharmacy networks established by the Contractor or its affiliates.

b. All manufacturer rebate agreements between the Contractor (or its affiliates) and pharmaceutical manufacturers.

c. Specialty Acquisition Cost, when Specialty Drugs are dispensed through the Specialty Pharmacy Program.

d. Actual Acquisition Cost, when Brand Name Drugs are dispensed through the Mail Service Pharmacy.

e. Prescription Drug pricing source materials (e.g., Medi-Span).

f. Third party and pharmacy audit findings and reports related to the Contract.

g. Any contracts between the Contractor (or its affiliates) and any public authority, public benefit corporation, school district, special district, district corporation, municipal corporation, agency, subdivision or quasi-public organization of the state for pharmacy benefit services upon written consent of the public authority, public benefit corporation, school district, special district, district corporation, municipal corporation, agency, subdivision or quasi-public organization.

14.7.5 **Exceptions**: "Contractor's Confidential Information" does not include information if and to the extent: (a) the information was already known by or available to the receiving party prior to the disclosure by the disclosing party on a non-confidential basis; (b) the information is subsequently disclosed to the receiving party by a

third-party who is not under any obligation of confidentiality to the disclosing party; (c) the information has already been or is hereafter independently acquired or developed by the receiving party without violating any confidentiality agreement or other similar obligation; or (d) the information is or becomes generally available or known to the public through no fault of the DCS.

14.7.6 **Disclosure due to judicial process, government investigation, legal proceeding, or other similar process**: If the DCS is required to disclose Contractor's Confidential Information pursuant to law or as part of a judicial process, government investigation, legal proceeding, or other similar process, such party, if it is reasonably possible to do so, shall give such prior written notice to the Contractor to allow the Contractor to seek an appropriate protective order or modification of any disclosure. Notwithstanding the above, the Contractor agrees and understands that the DCS is subject to certain disclosure laws and regulations including the NYS Freedom of Information Law including any applicable exemptions to disclosure.

14.7.7 **Review Authority**: The DCS is required to have access to Contractor's Confidential Information to ensure compliance with the terms and obligations of the Contract including:

a. To understand the discount terms of Network Pharmacies and how the Contractor will meet the Program requirements, including the Claim Reimbursement amounts specified in Section IX "DCS Program Claims Reimbursement" of this Contract.

b. To make informed decisions on formulary structure and how the Contractor will meet the Contract requirements, including the Pharma Revenue Guarantee.

c. To ensure the Contractor meets contractual requirements, including its responsibility to provide Lowest Net Cost to the Program as required under Section 14.6 of this Contract.

d. To make any other determinations and undertake any other actions the State in its discretion believes are necessary or appropriate for the administration of the Contract.

14.7.8 **Access to Contractor Confidential Information**: Contractor will provide access to Contractor's Confidential Information, as defined herein, within ten (10) Business Days of the DCS written request for the information. Contractor shall make available, at DCS's offices in Albany, New York, or as otherwise mutually agreed by the Parties, the Contractor's Confidential Information, in electronic or physical form, for DCS's exercise of its Review Authority by one or more DCS representatives that have a need to know (the "Designated DCS Staff"). The Parties agree that Designated DCS Staff may share the Confidential Information with other DCS employees or designated contractors in order to fulfill the requirements of the Contract, law or regulation. The Contractor shall make individuals with knowledge of the Contractor's Confidential Information available to the Designated DCS Staff to answer questions about provisions of the Contractor's Confidential Information as they relate to the services provided by

Contractor pursuant to the Contract. The Contractor may propose the methods they would use to meet the terms of access to the Contractor's Confidential Information, subject to the State's approval. Access will be provided for a reasonable amount of time for the State to conduct its review.

14.7.9 Designated DCS Staff may make copies (hard or digital) of any Contractor's Confidential Information, and/or take notes on such information, as necessary to fulfill the Contract requirements, law or regulations. In the alternative to providing copies to DCS, Contractor may provide secure access, in a format that is acceptable to DCS, to allow DCS or other authorized entities continued access to Contractor's Confidential Information, in Albany County throughout the term of the Contract.

14.7.10 **Protection of Contractor Confidential Information**: DCS agrees to maintain the confidentiality of the Contractor's Confidential Information and that it shall not:

a. transfer or disclose the Contractor's Confidential Information to any persons other than those individuals that have a need to know;

b. use the Contractor's Confidential Information for any purpose other than in connection with its exercise of its Review Authority, law or regulation;

c. make any record of the Confidential Information except as reasonably necessary in connection with its Review Authority, law or regulation; or

d. take any other action with respect to the Confidential Information inconsistent with the confidential and proprietary nature of such information. DCS shall use the same standard of care in protecting the Confidential Information as it uses to protect its own confidential and proprietary information.

14.7.11 **Remedies**. In addition to any other remedies which may be available at law, DCS and the Contractor shall be entitled to injunctive relief, specific performance or other equitable relief or any or all of the foregoing, for any breach or threatened breach of this provision without the necessity of proving damages and without waiving any other remedies otherwise available at law or in equity.

14.7.12 **Disclosure of Contractor's Confidential Information to Other Government Entities**. Nothing in this Section shall preclude DCS from providing, in accordance with the terms of this Section and without the prior written consent of Contractor, Contractor's Confidential Information to another New York State Agency or other appropriate government entity for the following purposes:

a. To a New York State Agency to assist DCS with the Review Authority cited above; or/and

b. To an appropriate government entity to facilitate the recoupment of State moneys that have been improperly expended or to provide information on potential violations of law, including, without limitation, the referral of any such matter to appropriate regulatory, investigative or prosecutorial authorities.

14.7.13 In the event that DCS determines it is necessary to provide Contractor Confidential Information to another New York State Agency to assist NYS DCS with the Review Authority cited above, DCS shall make reasonable efforts to ensure, to the extent practicable as determined by DCS, that the restrictions on disclosure of Confidential Information contained in the Contract continue to apply to all Confidential Information until such time as the assistance is no longer required of the other New York State Agency.

14.7.14 In the event that DCS determines it is necessary to provide Contractor Confidential Information to an appropriate government entity for the recoupment of State moneys from, or to investigate the potential violation of law by, a party other than the Contractor, DCS shall provide, unless restricted by law enforcement or court order or such notice would impede an investigation, Contractor with prompt notice of such determination and shall make reasonable efforts to ensure, to the extent practicable as determined by DCS, that the restrictions on disclosure of Confidential Information contained in the Contract continue to apply to all Confidential Information until such time as Contractor is made aware of the recoupment or investigational activities of the relevant government entity(ies). In addition, Contractor agrees not to disclose or otherwise make available to any third-party any information concerning or relating to DCS's disclosure of Confidential Information to another government entity pursuant to this sub-section (a) until such time as authorized by DCS and/or the other government entity.

14.7.15 Nothing in this Section shall preclude the State from exercising any appropriate remedy to obtain access to Contractor's Confidential Information pursuant to its contractual, constitutional or statutory authority.

14.8 Modification of Program Services

14.8.1 In the event that laws or regulations enacted by the Federal government and/or the State have an impact upon the conduct of the Agreement in such a manner that the DCS determines that any design elements or requirements of the Agreement must be revised, the DCS shall notify the Contractor of any such revisions and shall provide the Contractor with a reasonable time within which to implement such revisions.

14.8.2 In the event that the NYS and the unions representing State Employees enter into collective bargaining agreements, or the State otherwise requires changes in Plan design elements or requirements of the Agreement, the DCS shall notify the Contractor of such changes and shall provide the Contractor with reasonable notice to implement such changes. The Contractor will be responsible for making collective bargaining changes using Department benefit codes.

14.8.3 To the extent that any of the events as set forth in this Section shall take place and constitute a material and substantial change in the delivery of services that are contemplated in accordance with the terms of the DCS Program as of the DCS Program Services Start Date and which the Contractor is required to perform or deliver under the Agreement, the Contractor may submit a written request to the DCS to initiate review of the fee(s) received by the Contractor for services

provided and guarantees made by the Contractor under the terms of the Agreement, accompanied by appropriate documentation. The DCS reserves the right to request, and the Contractor shall agree to provide additional information and documentation the DCS deems necessary to verify that an increase in the fee(s), or modification of the guarantees is warranted. The DCS will agree to modify the fee(s) to the extent necessary to compensate the Contractor for documented additional costs determined by DCS to be reasonable and necessary. The DCS will agree to modify guarantees as determined by DCS to be necessary to reflect DCS Program modifications. Should the DCS approve the Contractor's request to modify the fee(s) and/or guarantees, such approval shall be subject to written amendment and approval by OSC and the AG. The Contractor shall implement changes as required by the DCS with or without final resolution of any fee proposal.

14.8.4 Any changes made by NYSIF to the scope of its contract with the Contractor for Prescription Drug Program Services after execution of this Agreement, including but not limited to the request to include any individual independent Network Pharmacy(ies), shall have no impact on the resulting DCS Contract or cost thereunder, unless the change is agreed to by DCS.

14.9 Control of Plan

14.9.1 Unless otherwise stated in the Contract, DCS retains the sole and absolute authority to design, amend, terminate or modify, in whole or in part, all or any portion of the DCS Plan, including the sole authority to control and administer the DCS Plan and any assets of the DCS Plan. DCS shall also have complete discretionary, binding and final authority to construe the terms of the DCS Plan, to interpret ambiguous DCS Plan language, to make factual determinations regarding the provision of benefits and the payment of drug claims, to review denied claims and to resolve complaints by Enrollee(s). Contractor agrees to be a fiduciary for the purpose of initial claim adjudication and all appeals relating to the coverage of prescription drug benefits under the Contract, including but not limited to all External Appeals, as set forth in Section 6.15.2(e) of this Contract.

14.10 Confidentiality and Non-Disclosure

14.10.1 In addition to the requirements specified in Appendix B, Standard Clauses for all Department Contracts, to this Agreement, Contractor agrees that all claims, enrollment, and other data (i.e., materials) provided to the Contractor by the Department or the Department's Data Providers is being provided to the Contractor solely for the purposes of allowing the Contractor to fulfill its duties and responsibilities under the Contract and said materials are the sole property of the State. Except as directed by a court of competent jurisdiction, or as necessary to comply with applicable New York State or federal law, the Contractor shall not share, sell, release, or make the materials available to third parties in any manner without the prior consent of the Department. This provision shall survive the expiration or termination of the Contract.

14.10.2 All claims, enrollment, and other data (i.e., materials) provided to the Contractor by the Department or the Department's Data Providers is deemed Confidential Information as defined in Appendix B, Section 28, and shall be used by the

Contractor solely for the purpose of carrying out its obligations under the Agreement, for measuring the performance of the Contractor in accordance with the performance guarantees set forth in Section VII of this Agreement, and for providing the DCS with material and information as may be specified elsewhere in this Agreement;

SECTION XV: ENTIRE AGREEMENT

15.1 The Contract, including all appendices and attachments, constitutes the entire agreement between the Parties hereto and no statement, promise, condition, understanding, inducement, or representation, oral or written, expressed or implied, which is not contained herein shall be binding or valid and the Contract shall not be changed, modified, or altered in any manner except by an instrument in writing executed by both Parties hereto, except as otherwise provided herein. The Contract is subject to amendment(s) only upon mutual consent of the Parties, reduced to writing and approved by the Office of the State Comptroller of the State of New York and subject to the termination provisions contained herein.

(Remainder of this page intentionally left blank)

IN WITNESS WHEREOF, the Parties hereto have hereunto signed this AGREEMENT on the day and year appearing opposite their respective signatures.

Agency Certification: "In addition to the acceptance of this Agreement, I also certify that original copies of this signature page will be attached to all exact copies of this Agreement."

Contractor Certification: By signing I certify my express authority to sign on behalf of myself, my company, or other entity and full knowledge and acceptance of this Agreement and all appendices. By signing, I affirm my understanding of and agreement to comply with the Department's procedures relative to the Procurement Lobbying Law as required by State Finance Law §139-j and §139-k.

NEW YORK STATE
DEPARTMENT OF CIVIL SERVICE

Name: Rebecca A. Corsi
Title: Executive Deputy Commissioner
By: Rebecca A Corsi
Date: 9/3/2024

CAREMARKPCS HEALTH, L.L.C

FEIN: 752882129
Name:
Title: VICE PRESIDENT, EMPLOYER SALES
By: CHERYL BYRON
Date: 29 August 2024

Approved as to form:

Letitia James
ATTORNEY GENERAL

By: _____
Date: _____

Approved:

Thomas P. DiNapoli
STATE COMPTROLLER

By: _____
Date: _____

APPROVED
DEPT. OF AUDIT & CONTROL
Jan 22 2025
James Iwaneczko
FOR THE STATE COMPTROLLER

CORPORATION ACKNOWLEDGMENT

STATE OF Illinois }

COUNTY OF Cook } **SS.:**

On the 29th day of August in the year 2024, before me personally appeared Cheryl anne Byron, known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that he/she/they maintains an office at Town of Chicago County of Cook, State of Illinois; and further that: he/she/they is (are) the VICE PRESIDENT of EMPLOYER SALES, the corporation described in and which executed the above instrument; that, by authority of the Board of Directors of said corporation, he/she/they is (are) authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, he/she/they executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

Notary Public: Christiana C Gonzalez

Christiana C Gonzalez

"OFFICIAL SEAL"
CHRISTIANA C GONZALEZ
NOTARY PUBLIC, STATE OF ILLINOIS
COMMISSION NO. 982347
MY COMMISSION EXPIRES 12/4/2027

"This is an original document"

State of Illinois - County of Cook
This instrument was acknowledged before me on August-29-2024 (Date)
By Cheryl anne Byron