NEW YORK STATE OF OPPORTUNITY. | Department of Civil Service

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE
EMPLOYEE BENEFITS DIVISION

PHARMACY BENEFIT SERVICES

AGREEMENT #C000724

between

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

and

CAREMARKPCS HEALTH, L.L.C.

January 1, 2019 – December 31, 2019

AGREEMENT NO. #C000724

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

and

CAREMARKPCS HEALTH, L.L.C.

THIS Agreement is entered into by and between New York State Department of Civil Service ("Department" or "DCS"), having its principal office at Empire State Plaza, Agency Building #1, Albany, NY 12239 and CaremarkPCS Health, L.L.C.("Contractor"), a limited liability company authorized to do business in the State of New York with a principal place of business located at One CVS Drive, Woonsocket, Rhode Island 02895, and collectively referred to as "the Parties."

WITNESSETH

WHEREAS, Civil Service Law Article XI authorizes and directs the President of the State Civil Service Commission and New York 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, 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, on May 29, 2018 the Department of Civil Service issued a Request for Proposal (RFP) entitled, "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," to secure the services of a qualified organization to provide Program Services as defined in the RFP; and

WHEREAS, a conditional award of the Program was made to Contractor on August 21, 2018, but the resulting contract, #C000718, has not received all necessary approvals.

WHEREAS, the Contractor is the current provider of Program services under C000615, which expires on December 31, 2018;

WHEREAS, in order to ensure the continuous availability of pharmacy benefit management services to over one million insured lives, the Department entered into this single source contract (C000724) substantially based upon the terms and conditions of C000718 with Contractor; 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 May 29, 2018 RFP and the Contractor's Proposal, pursuant to the terms and conditions set forth in this Agreement;

NOW, THEREFORE, in consideration of the premises and the mutual promises set forth below, the Parties agree as follows:

ARTICLE I: DEFINITION OF TERMS

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

1.2.0 **Agreement or Contract** means this single source Contract (C000724) entered into between the Parties.

1.3.0 **Ancillary Charge** means the amount in addition to the applicable Copayment an Enrollee/ Dependent will pay when purchasing a Brand Drug if an A-rated or authorized generic equivalent is available in the market. The amount represents the difference to the Program between the Discounted Ingredient Cost of the dispensed Brand Drug and the Discounted Ingredient Cost of the available generic equivalent if it had been dispensed, not to exceed the actual cost of the drug.

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

1.5.0 **Brand Drug** means a Prescription drug sold under a trade name other than its chemical name that is manufactured and marketed by a single manufacturer (or single group of manufacturers pursuant to agreement among the manufacturers) where the manufacturer holds or held a

patent protecting the active ingredient from generic competition. For The Empire Plan and SEHP, the Contractor shall utilize the Department's approved process to replicate the results of the methodology used by the DCS Program as of December 31, 2018, for determining the appropriate classification of drugs consistent with this definition. The Excelsior Plan will utilize the Contractor's Book of Business PDL classification and tier placement for generic and brand-name medications.

1.6.0 **Brand for Generic** means an additional feature of the Flexible Formulary Drug List(s) 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.

1.7.0 **Business Day(s)** means every Monday through Friday, except for days designated as Business Holidays by the State.

1.8.0 **Business Holiday(s)** means days designated by the State as Business Holidays prior to January 1st of each Calendar Year.

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

1.10.0 **Call Center Hours** means 24 hours a Day, 365 days a year.

1.11.0 **Certificate** means the document(s) attached by reference as Exhibit D: *The Empire Plan Certificate of Insurance*. The Certificate is issued to Enrollees to describe DCS Program benefits and includes the initial Certificate and amendments, if any.

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

1.13.0 **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, SEHP, and the Excelsior Plan, 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.

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

1.15.0 Commissioner means the Commissioner of the New York State Department of Civil Service.

1.16.0 Compound Drug(s)/Medication(s) or Compounded Drug(s)/Medication(s) means a drug with two or more ingredients (solid, semi-solid, or liquid), at least one of which is a Covered Drug with a valid NDC requiring a Prescription for dispensing, combined 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.

1.17.0 Contract or Agreement means this single source Contract (C000724).

1.18.0 Contractor means CaremarkPCS Health, L.L.C., the Contractor who executes a Contract with the Department to provide Program Services.

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

1.20.0 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 DCS Program. The actual payment amount required from the Enrollee for a Prescription may not exceed the Ingredient Cost of the drug to the Plan after application of the Program's Lesser of Logic provision plus the applicable dispensing fee.

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

1.22.0 Day(s) means calendar Days unless otherwise noted.

1.23.0 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, the Excelsior Plan Prescription Drug Program, and the Student Employee Health Program (SEHP) Prescription Drug Program administered by the New York State Department of Civil Service.

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

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

1.26.0 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.

1.27.0 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; 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.

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

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

1.30.0 Designated Specialty Pharmacy Passive Edit means a Network Pharmacy claims adjudication edit that will prompt processing of the claim at the Designated Specialty Pharmacy but will permit continued processing and coverage for a Specialty Drug/Medication at the

Network Pharmacy under the Specialty Pharmacy Process after the Grace Period for Specialty Drugs has elapsed.

1.31.0 DFS means the New York State Department of Financial Services.

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

1.33.0 Discounted Ingredient Cost(s) means the cost to the Plan for a specific drug or drugs dispensed to an Enrollee after the Contractor has applied the appropriate discount exclusive of any associated dispensing fee(s), other costs or Copayments.

1.34.0 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(s); (2) Contractor's Book of Business PDL that applies to Enrollees/Dependents with Excelsior Plan benefits (Excelsior Plan Drug List); (3) Medicare Part D Drug List, and the Medicare Part D Supplemental Wrap Drug List to replicate the Empire Plan prescription drug benefit structure; and (4) NYSIF PDL.

1.35.0 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, to the extent possible, mirrors the benefits and drug coverage available to the Empire Plan's non-Medicare-primary enrollees and dependents.

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

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

1.38.0 Employer Group Waiver Plan (EGWP) means the Employer Group Waiver Plan (EGWP) for Medicare-primary Empire Plan enrollees and dependents that is a Medicare Part D Prescription Drug Plan (PDP), in conjunction with a self-funded supplemental wrap coverage benefit and that, to the extent possible, mirrors the benefits and drug coverage available to the Empire Plan's non-Medicare-primary enrollees and dependents. While the EGWP services under this Agreement are provided by Contractor's Affiliate and Subcontractor,

SilverScript Insurance Company ("SilverScript"), a Medicare Part D Plan sponsor contracted with the Centers for Medicare and Medicaid Services (CMS), the Contractor remains responsible for providing EGWP services as specified under this Agreement.

1.39.0 Enrollee means an "Employee" or "Dependent" enrolled in the DCS Programs with prescription drug benefits.

1.40.0 Excelsior Plan Drug List means the Contractor's proposed standard Book of Business Preferred Drug List (PDL) classification and tier placement for generic and brand name medications.

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

1.42.0 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.

1.43.0 ET means prevailing Eastern Time.

1.44.0 Final Paid Claim means all paid claims processed and paid by the Contractor for Prescription drugs, Over-the Counter Drugs, and non-drug devices covered under the Program and provided to an Enrollee, including but not limited to, claims filled at a retail Pharmacy or through the Mail Service Pharmacy Process or the Specialty Pharmacy Process. A claim that is denied prior to processing is not considered a Final Paid Claim. In addition, a claim that is processed and paid but is subsequently voided, reversed, or otherwise adjusted is not a Final Paid Claim. Zero balance claims are considered Final Paid Claims.

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

1.46.0 Generic Drug means a prescription drug sold under its chemical name or drug sold under a name other than its chemical name by a manufacturer other than the manufacturer that held the original patent for the active ingredient in the drug. The term Generic Drug shall include "authorized generics" marketed by or in conjunction with the manufacturer that is the holder of the original patent for the active ingredient of the drug. Any drug approved through an FDA

Generic Drug approval process, including any FDA approval process established for approving generic equivalents of brand name biologic drugs, shall be classified as a Generic Drug. For The Empire Plan and SEHP, the contractor shall utilize the Department's approved process to replicate the results of the methodology used by the DCS Program as of December 31, 2018, for determining the appropriate classification of drugs. The Excelsior Plan will utilize the Contractor's Book of Business PDL classification and tier placement for generic and brand-name medications.

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

1.48.0 **Grace Fill** means an Enrollee's initial or very first dispensing of a Specialty Drug/Medication covered under The Empire Plan Specialty Pharmacy Process.

1.49.0 **Grace Period for Specialty Drugs** means the period of time during which Enrollees may receive one fill of a Specialty Drug/Medication at a Pharmacy other than the Designated Specialty Pharmacy(ies).

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

1.51.0 **Guaranteed Maximum Dispensing Fee(s)** means 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 DCS Program for Generic, Brand, and Compound Drugs, calculated separately, for prescriptions dispensed by retail Network Pharmacies.

1.52.0 **Guaranteed Minimum Discount(s)** means the guaranteed Ingredient Cost discount(s) as expressed as a percent off of the aggregate AWP and is applicable to Generic and Brand Drugs, separately, dispensed through the Retail Pharmacy Network; Generic and Brand Drugs dispensed through the Specialty Pharmacy Process; as well as Generic Drugs dispensed through the Mail Service Pharmacy Process.

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

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

1.55.0 **Implementation Date** means January 1, 2019, but no sooner than approval by the Attorney General's Office and the Office of State Comptroller.

1.56.0 **Ingredient Cost(s)** means the cost to the Plan for a specific drug, or drugs dispensed to an Enrollee exclusive of any associated dispensing fee(s), other costs, or Copayments through application of the Program's Lesser of Logic.

1.57.0 **Key Subcontractor(s)** means those vendors with whom the Contractor subcontracts to provide DCS 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 the May 29, 2018 RFP, 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.

1.58.0 **Lesser of Logic** means the methodology for charging the Program for Prescriptions. Retail Generic Prescriptions assigned a MAC price shall be charged to the DCS Program at the following Lesser of Logic: the lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee; the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is Usual and Customary); the AWP Discounted Ingredient Cost contracted with the Network Pharmacy plus dispensing fee; the Maximum Allowable Cost plus dispensing fee. Retail Brand Prescriptions and Generic Prescriptions that are not assigned a MAC price shall be charged to the Plan at the following Lesser of Logic: the lowest of the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is usual and customary); the AWP Discounted Ingredient Cost contracted with the Network Pharmacy plus dispensing fee; the Pharmacy-submitted Ingredient Cost plus dispensing fee. Mail Service Pharmacy Process Generic Prescriptions shall be charged to the Plan at the following Lesser of Logic: the lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee; the Guaranteed Minimum Discounted Ingredient Cost off of AWP pertaining Mail Service Pharmacy Process Brand prescriptions for those Mail Service Pharmacy Process Generic prescription not assigned a MAC plus dispensing; the Maximum Allowable Cost for Chain/Mail Pharmacy plus dispensing fee. Mail Service Pharmacy Process Brand and Specialty Pharmacy Process Brand and Generic Prescriptions shall be charged to the Plan at the following Lesser of Logic: the lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee; the Guaranteed Minimum Discounted Ingredient Cost off of AWP plus dispensing fee. Once the Lesser of Logic has been applied, the pricing methodology resulting in the lowest claim cost to the Plan is determined, and to that amount any applicable sales tax is added and the applicable Copayment and any ancillary fee

resulting from application of the Program's Mandatory Generic Substitution provisions are deducted.

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

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

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

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

1.63.0 Medical Exception Program means the 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.

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

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

1.66.0 Minimum Pharma Revenue Guaranteed Per Final Paid Claim means the guarantee referenced in Section 13.8.6 of this Agreement.

1.67.0 MWBE means Minority and Women Owned Business Enterprises.

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

1.69.0 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.

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

1.71.0 Network Pharmacy means a Pharmacy, other than those Pharmacies meeting the definition of Mail Service Pharmacy Process Facilities or a Designated Specialty Pharmacy, which has

entered into an agreement with the Contractor, or any Affiliate or Key Subcontractor of the Contractor, to provide Covered Drugs to Enrollees, including limited distribution or Specialty Drugs. The Contractor's records shall be conclusive as to whether a Pharmacy has a Network Pharmacy agreement in effect on the date a drug is dispensed.

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

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

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

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

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

1.77.0 Intentionally Omitted.

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

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

1.80.0 **Participating Agency (PA)** means any unit of local government such as school districts, special districts and district or municipal corporations which elects, with the approval of the President of the Civil Service Commission, to participate in the New York State Health Insurance Program.

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

1.82.0 Pass-through Pricing means the DCS Program is charged the same Ingredient Cost and/or dispensing fee paid to the dispensing retail Network Pharmacy for the Generic Drug, Brand Drug, Compound Drug or vaccine dispensed.

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

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

1.85.0 Pharmacy Benefit Services or Program Services means all of the services to be provided by the Contractor as set forth in the May 29, 2018 RFP.

1.86.0 Pharmacy Submitted Ingredient Cost or Pharmacy Submitted Pricing or Submitted Cost means the value entered by the Pharmacy in field 409, 'Ingredient Cost Submitted' of Telecommunication D.0 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.

1.87.0 Pharma Revenue means any and all revenues generated from agreements between pharmaceutical manufacturers and the Contractor, or any Affiliate or Key Subcontractor of the Contractor, which relate to DCS Program utilization and/or Pharmacy benefit management services provided under this Agreement. Such revenues include revenue described by any name, but not limited to, revenues described as formulary rebates, market share rebates, administration fees, AWP caps or by any other name.

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

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

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

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

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

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

1.94.0 President means the President of the Civil Service Commission and the Commissioner or Acting Commissioner of the Department.

1.95.0 Procuring Agencies means the New York State Department of Civil Service (DCS) and the New York State Insurance Fund (NYSIF).

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

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

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

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

1.100.0 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.

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

1.102.0 Retail Pharmacy Network means the Contractor's credentialed network of participating independent, chain Pharmacies, and specialty Pharmacies contracted to deliver services to Enrollees.

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

1.104.0 RFP or Procurement means the Request for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs," dated May 29, 2018.

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

1.106.0 Specialty Pharmacy Process means the method that the Contractor employs to accept, process, and dispense Prescriptions for Covered Drugs to Enrollees through the Designated Specialty Pharmacy(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/Medication submitted directly to the Designated Specialty Pharmacy, by phone, fax, internet, e-prescribing or mail. All Prescriptions filled through the Specialty Pharmacy Process shall be processed in strict

accordance with the provisions of the Contract to be agreed upon by the Department and the Contractor.

1.107.0 State or NYS means the State of New York.

1.108.0 Supplemental Wrap Coverage means a self-funded Plan enhancement that is coordinated with the Medicare Part D EGWP drug coverage to, as closely as possible, replicate benefits provided under the Empire Plan's Commercial coverage.

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

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

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

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

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

1.114.0 WCB means the New York State Workers' Compensation Board.

ARTICLE II: AGREEMENT DURATION AND AMENDMENTS

2.1.0 This Agreement shall be subject to and effective upon the approval of the New York State Attorney General's Office ("AG") and the NYS Office of the State Comptroller ("OSC"). The term of this single source Agreement shall be one (1) year of Program Services or until Contract #C000718 receives all necessary approvals under State Finance Law section 112, whichever occurs earlier. It is the Department's intent that all contractual responsibilities, will begin on January 1, 2019, through and including December 31, 2019 or until Contract #C000718 receives all necessary approvals under State Finance Law section 112, whichever occurs earlier and subject to the termination provisions contained herein.

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

2.3.0 Upon termination of this Agreement the DCS shall have the right to award a new contract.

ARTICLE III: INTEGRATION

3.1.0 This Agreement, including all Exhibits, copies of which are attached hereto and incorporated by reference, constitutes the entire Agreement between the Parties. All prior Agreements, representations, statements, negotiations, and undertakings are superseded hereby.

3.2.0 All statements made by the DCS shall be deemed to be representations and not warranties.

ARTICLE IV: DOCUMENT INCORPORATION AND ORDER OF PRECEDENCE

4.1.0 The Agreement consists of:

4.1.1 The body of the Agreement (that portion preceding the signatures of the Parties in execution), and any amendments thereto;

4.1.2 Appendix A – Standard Clauses for All New York State Contracts;

4.1.3 Appendix B – Standard Clauses for All DCS Contracts;

4.1.4 Appendix C – Third Party Connection and Data Sharing Agreement; and Appendix C-1 – ITS-AGS Information Security;

4.1.5 Appendix D – Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures; Appendix D-1 – Minority and Women-Owned Business Enterprises-Equal Employment Opportunity Policy Statement; and Appendix D-2 – MWBE Utilization Reporting Responsibilities under Article 15-A;

4.1.6 The following Exhibits attached and incorporated by reference to the body of the Agreement:

4.1.6a Exhibit A: which includes: the MacBride and Non-Collusive Bidding Certification;

4.1.6b Exhibit B: the Request for Proposals entitled “Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Workers’ Compensation Prescription Drug Programs,” dated May 29, 2018, and Exhibit B-1, the official Procuring Agencies response to questions raised concerning the RFP;

4.1.6c Exhibit C: the Contractor's Proposal and Exhibit C-1 the Contractor's written responses to the Technical Management Interview

4.1.6d Exhibit D: *The Empire Plan Certificate of Insurance*;

4.1.6e Exhibit E: Specialty Pharmacy Process Dispensing Fees;

4.1.6f Exhibit F: Financial Guarantee; and

4.1.6g Exhibit G: Vaccination Administration Fees.

4.1.7 In the event of any inconsistency in, or conflict among, the document elements of the Agreement identified above, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

4.1.7a First, Appendix A – Standard Clauses for All New York State Contracts;

4.1.7b Second, Appendix B – Standard Clauses for All Department of Civil Service Contracts;

4.1.7c Third, Appendix C – Third Party Data Connection and Data Exchange Agreement; and Appendix C-1 ITS-AGS: Information Security;

4.1.7d Fourth, Appendix D – Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures; Appendix D-1 Minority and Women-Owned Business Enterprises-Equal Employment Opportunity Policy Statement; and Appendix D-2: MWBE Utilization Reporting Responsibilities under Article 15-A;

4.1.7e Fifth, any Amendments to the body of the Agreement;

4.1.7f Sixth, the body of the Agreement;

4.1.7g Seventh, Exhibit A, the MacBride and Non-Collusive Bidding Certification;

4.1.7h Eighth, Exhibit B, the Request for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," dated May 29, 2018, and Exhibit B-1, the official Procuring Agencies response to questions raised concerning the RFP;

4.1.7i Ninth, Exhibit C: the Contractor's Proposal; and Exhibit C-1 the Contractor's written responses to the Technical Management Interview

4.1.7j Tenth, Exhibit D, *The Empire Plan Prescription Drug Program Certificate of Insurance*;

4.1.7k Eleventh**,** Exhibit E, Specialty Pharmacy Process Dispensing Fees;

4.1.7l Twelfth, Exhibit F, Financial Guarantee; and

4.1.7m Thirteenth, Exhibit G, Vaccination Administration Fees.

4.2.0 The terms, provisions, representations and warranties contained in the Agreement shall survive performance hereunder.

ARTICLE V: LEGAL AUTHORITY TO PERFORM

5.1.0 Contractor agrees that it shall perform its obligations under this Agreement in accordance with all applicable federal and NYS laws, rules and regulations, policies and/or guidelines now or hereafter in effect, including but not limited to the requirements set forth in Chapter 56 of the Laws of 2010.

5.2.0 The Contractor shall maintain appropriate corporate and/or legal authority, which shall include but is not limited to the maintenance of an administrative organization capable of delivering the Program Services in accordance with the Agreement and the authority to do business in the State of New York or any other governmental jurisdiction in which the Program Services are to be delivered.

5.3.0 The Contractor shall provide the Department with written notice within two (2) Business Days of the Contractor becoming aware of, or obtaining, notice in writing of the initiation of any legal action or suit (whichever occurs first) which relates in any way to the Agreement, or which may affect the performance of Contractor's duties under the Agreement, or Contractor becomes aware that a pending matter has such relation or impact.

ARTICLE VI: PROGRAM SERVICES

6.1.0 The Contractor shall provide all of the Program Services as set forth herein this Article VI of the Agreement for the entire term of the Agreement pursuant to the *Certificate of Insurance* incorporated into this Agreement as Exhibit D. All Program Services shall be provided in accordance with the New York State Civil Service Law and its implementing regulations, and other NYS and Federal Law as may be applicable. In addition, the Contractor shall deliver the Program Services in such a manner so as to comply with all provisions of this Agreement. The Contractor may provide certain services through Key Subcontracts with the prior review and

approval of DCS. Each subcontract entered into with a corporate entity separate from the Contractor for the purpose of delivering Program Services must be maintained throughout the term of the Agreement unless such change is approved in writing by DCS. All Key Subcontracts shall expressly name the State of New York, through the Department, as the sole intended beneficiary of any such Key Subcontract. The Contractor must maintain significant financial, legal, and audit oversight of any of its Key Subcontractors. The Contractor remains fully responsible for all services and actions performed under this Agreement. The Contractor shall submit all Key Subcontracts to DCS for its approval. The Contractor shall submit all such Key Subcontracts with no redactions to the Department before execution for its review and approval. **(Note: Costs/Fees for all services required under this Agreement shall be included in the Contractor's Claims Administration Fee).**

6.1.1 Control of Plan. Unless otherwise stated in this Agreement, the 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. The 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. 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 this Agreement, including but not limited to all External Appeals, as set forth in Section 6.17.2e.

6.2.0 Intentionally omitted.

6.3.0 Account Team

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

6.3.1a The account team(s) must be comprised of qualified and experienced individuals who are acceptable to the Department and who are responsible for ensuring that the operational, clinical, and financial resources are in place to operate the DCS Program in an efficient manner;

6.3.1b The Contractor must ensure that there is a process in place for the account team to gain immediate access to appropriate corporate resources and senior management necessary to meet all DCS Program requirements and to address any issues that may arise during the performance of the Agreement.

6.3.2 The Contractor's dedicated account team must be experienced, accessible and sufficiently staffed to:

6.3.2a Provide timely responses (within 1 to 2 Business Days) to administrative and clinical concerns and inquiries posed by the Department or other staff on behalf of the Council of Employee Health Insurance, or union representatives regarding member-specific claims issues for the duration of the Agreement to the satisfaction of the Department. The Department shall provide to 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; and

6.3.2b Immediately notify the Department in writing of actual or anticipated events impacting DCS Program costs and/or delivery of services to DCS Program Enrollees such as, but not limited to, legislation, litigation, drug recalls and withdrawals, class action settlements, and operational issues.

6.3.3 The Contractor's dedicated account team(s) must ensure that the DCS Program is in compliance with all applicable statutory and regulatory requirements. If the Contractor is unable to comply with any such statutory or regulatory requirements, the Department must be notified in writing immediately. The Contractor is required to work with the Department to develop accurate *Certificate of Insurance* and/or DCS Program Material.

6.4.0 **Premium Development Services:** The Contractor is responsible for assisting and supporting the Department with all aspects of premium rate development, including, but not limited to:

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

6.4.2 Development of claim, trend and administration fee projections for each DCS Program Year. Analysis of all DCS Program components impacting the DCS Program cost shall be performed including, but not limited to claims, trend factors, administration fees,

projected Pharma Revenue, changes in enrollment, changes in the Specialty Pharmacy Process Drug List, as well as changes in the formularies including The Empire Plan's Specialty Drug List, Flexible Formulary Drug List(s), the Medicare Part D and Medicare Part D supplemental drug lists; Contractors' Book of Business PDL; and

6.4.3 Working with the Department and its contracted actuarial consultant through the annual rate renewal process to further document and explain a premium rate recommendation. This process includes presenting the premium rate recommendation to staff of the Department, Division of the Budget (DOB), and GOER.

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

6.5.1 Providing Enrollees access to information on all Prescription drug benefits and services related to The Empire Plan, Excelsior Plan, and SEHP through the Empire Plan consolidated toll-free number 24 hours a Day, 365 Days a year. The Empire Plan consolidated toll-free telephone service is provided through the AT&T voice network services under a contract with The Empire Plan's medical carrier/third party administrator 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 which will transfer calls to the contractor's line at their customer service site. The Contractor is required to sign a shared service agreement with The Empire Plan's Medical carrier/third party administrator (currently United Healthcare) and AT&T. In addition, the Contractor is also required to provide 24 hours a Day, 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability. The TTY number must provide the same level of access to customer service as required by Section 6.5.0 of this Agreement;

6.5.2 Maintaining a call center located in the United States staffed by fully trained customer service representatives and supervisors available 24 hours a Day, 365 Days a year. The Contractor must maintain a Dedicated Call Center for the Program between the hours of 7:00 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 call center must meet the Contractor's proposed customer service telephone guarantees set forth in Section 7.8.0 of this Agreement.

6.5.3 The call center must be open 8:00 a.m. to 5:00 p.m. Monday through Friday and operational a minimum of thirty (30) days prior to the Program Implementation Date and through and including four (4) months after termination of the Contract to assist Enrollees with questions concerning the Program transition, per Article XVII;

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

6.5.5 Customer service representatives must be trained and capable of responding to a wide range of questions, complaints and inquiries including but not limited to: DCS 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, and Flexible Formularies alternatives;

6.5.6 Maintaining a backup call center staff located in the United States with DCS Program-specific training to handle any overflow when the Dedicated Call Center is unable to meet the Contractor's performance guarantees as set forth in Section 7.8.0, Program Call Center Telephone Guarantees and Credit Amounts, of this Agreement. This backup system would also be utilized in the event the primary call center becomes unavailable; and

6.5.7 Maintaining and timely updating a secure online customized website accessible by Enrollees, a minimum of thirty (30) Days prior to the Implementation Date, 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, comparative price check functionality, Prescription drug history for both retail and mail claims, and the Flexible Formularies (including alternatives for Non-Preferred Brand Name and excluded drugs). The website shall not contain any links to the Contractor's standard website for other customers. 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 by the Contractor. Also, the Contractor shall fully cooperate with any Department initiatives to use new technologies, processes, and methods to improve the efficiencies of the customized website including development of an integrated Enrollee portal.

6.6.0 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) and Medicare D supplemental wrap around (wrap) Prescription Drug Plan (PDP) for the Empire Plan's Medicare-eligible retirees beginning on January 1, 2019. DCS hereby delegates to Contractor the authority to enter into a written agreement with SilverScript to provide the EGWP services to eligible Enrollees as described in this Agreement and the written contract between Contractor and SilverScript. DCS authorizes Contractor to provide to SilverScript any information available through this Agreement which is required in connection with the provision of EGWP services, in each case, in accordance with applicable law, and notwithstanding such delegation and authorization, DCS maintains the right to control and direct its plans, and all contracts, amendments and services shall be reviewed and approved by DCS prior to implementation by Contractor through its written agreement with SilverScript. Such services shall include at least the following tasks and such other tasks as may be added in guidance and further regulation by CMS:

6.6.1 Disclosing to CMS, on a timely basis and on behalf of the DCS Program, any filings, applications, reports, formularies, and other DCS Program material necessary for the Department to comply with the requirements of an "800-series" Medicare PDP Employer Group Waiver Plan (EGWP), plus, as applicable, Medicare Part D Supplemental Wrap Coverage;

6.6.2 Fully supporting the Program with all operational aspects of a fully compliant Medicare PDP EGWP plus Medicare Part D Supplemental Wrap Coverage, including but not limited to:

6.6.2a Medicare PDP EGWP Premium Development;

6.6.1b Enrollment (in accordance with the terms of Section 6.8.0 of the Agreement, subject to CMS enrollment processes);

6.6.1c Enrollee Opt Out Process;

6.6.1d Health Insurance Claim Number (HICN) and/or Medicare Beneficiary Identifier (MBI) administration;

6.6.1e Formulary management;

6.6.1f Issuing of Medicare PDP EGWP member identification cards;

6.6.1g Member Communications, including required explanation of benefits statements;

6.6.1h Claims Processing;

6.6.1i Administration of a Medicare Part D Supplemental Wrap Coverage with the goal of providing Medicare primary Enrollees with a prescription drug benefit replicating as closely as possible the prescription drug benefit design for non-Medicare- primary retirees in the Empire Plan;

6.6.1j Timely administration of catastrophe reinsurance claims;

6.6.1i Administering a Low Income Subsidy (LIS) procedure to reimburse eligible Enrollees for LIS premiums and apply appropriate copayments in a timely manner and in accordance with CMS rules and regulations.

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

6.6.4 Promptly credit the Department for all CMS premium subsidy payments and all pharmacy rebates received by the Contractor under the Medicare PDP EGWP, plus Medicare Part D Supplemental Wrap Coverage;

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

6.6.6 The Contractor acknowledges and agrees that it shall use the Department's 834 enrollment and/or EGWP eligibility file and NYBEAS to confirm if a member has creditable coverage prior to his or her enrollment in the Medicare PDP EGWP, as all NYSHIP plans have provided creditable coverage since January 1, 2006 when CMS required creditable prescription drug coverage be offered by employer group plans. The Contractor is required to provide such services to ensure the seamless transition of creditable coverage including:

6.6.6a Using NYBEAS to validate periods of creditable coverage that may be in question by CMS;

6.6.6b Agreeing to use NYBEAS to research and validate creditable coverage for members whom CMS has assessed a potential LEP. The Contractor will report this information to the Department, and the Department will attest to the vendor of creditable coverage for members as appropriate;

6.6.6c Accepting a group attestation for its membership. The Contractor must accept Department attestations of creditable coverage and transmit this information to CMS on the Department's behalf;

6.6.6d Accepting from the Department during a group enrollment a report that attests to which members are not subject to LEP due to continuous creditable coverage. The Contractor must transmit this information to CMS and mitigate LEP issues; and

6.6.6e Providing temporary Commercial coverage to those Medicare Rx Enrollees in the event automatic enrollment into Empire Plan Medicare Rx is unavailable.

6.6.7 The Contractor acknowledges that the information furnished in connection with the administration of the Medicare PDP EGWP is being provided to obtain federal funds. The Contractor shall require all subcontractors, 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;

6.6.8 The Contractor acknowledges that its provision of services pursuant to this Section of this Agreement is subject to audit and evaluation by the U.S. Department of Health and

Human Services pursuant to 42 CFR Subpart R or other authority as may be cited by the federal government, as well as by the State of New York pursuant to Appendix A and Appendix B of this Agreement. The Contractor shall comply with any record retention requirements required pursuant to 42 CFR SubPart R in this regard;

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

6.6.10 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 payor;

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

6.6.12 The Contractor is required to develop enrollee communications in strict accordance with CMS guidelines and agrees to, at the Department's direction, to remove language that is not applicable under the Plan design.

6.7.0 Enrollee Communication Support

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

6.7.2 The Contractor will be responsible for providing Enrollee communication support and services to the Department including, but not limited to:

6.7.2a Developing language describing the DCS Program for inclusion in the NYSHIP *General Information Book* and Empire *At A Glance*, subject to the Department's review and approval;

6.7.2b Developing articles for inclusion in Empire Plan Reports and other publications on an "as needed" basis, detailing DCS Program benefit features and/or highlighting trends in drug utilization;

6.7.2c Timely reviewing and commenting on proposed Empire Plan communication material developed by the Department; and

6.7.2d Developing timely and accurate Summaries of Benefits Coverage (SBC), which will be consolidated with coverage information from other Program carriers/third party administrators for The Empire Plan, Student Employee Health Plan and Excelsior Plan. The Department will post the SBCs on NYSHIP Online. Upon Enrollee request, the Contractor must direct Enrollees to the NYSHIP Online website to view the SBC or distribute a copy of the SBC to the Enrollee within the federally required time period.

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

6.7.4 The Contractor must work with the Department to develop appropriate customized forms and letters for the DCS Program, including but not limited to mail order forms, Enrollee claim forms, prior authorization letters, generic appeal letters, Flexible Formularies, disruption letters, etc. All such communications must be approved by the Department.

6.8.0 **Enrollment Management:** The Contractor is responsible for the maintenance of an accurate, complete, and up-to-date enrollment files based on information provided by the Department. These enrollment files shall be used by the Contractor to process retail, mail order and specialty pharmacy claims, and produce management reports and data files. The 834-transaction file identifies individuals in the Commercial NYSHIP population. The EGWP eligibility file identifies individuals who are enrolled in the EGWP or another Medicare Part D plan The Contractor is required to provide enrollment management services including, but not limited to:

6.8.1 **Initial testing**

6.8.1a Performing an initial enrollment load to commence upon receipt from the Department during DCS Program implementation. The file will be a text file with layout to be determined by the Department; and

6.8.1b Testing to determine if the enrollment files and daily enrollment transactions loaded correctly and that the enrollment system interfaces with the claims processing system to accurately adjudicate claims. The Contractor must submit enrollment test files to the Department for auditing, provide the Department with secure, online access required to ensure accurate loading of DCS Program enrollment data, and promptly correct any identified issues to the satisfaction of the Department.

6.8.2 Providing an enrollment system capable of receiving secure enrollment transactions (Monday through Friday) and having all transactions for Commercial Plan enrollees fully loaded to the claims processing system within twenty-four (24) hours of release of a retrievable file by the Department. The Contractor must immediately notify the Department of any delay in loading enrollment transactions. In the event the Contractor experiences a delay due to the quality of the data supplied by the Department, the Contractor must immediately load all records received (that meet the quality standards for loading) within twenty-four (24) hours of their release, as required. The Department will release enrollment changes to the Contractor in an electronic format daily (Monday through Friday). On occasion, the Department will release more than one Commercial Plan enrollment file within a 24-hour period and will promptly notify Contractor in such instances to enable Contractor to meet its loading timeliness obligations. The Contractor must be capable of loading both Commercial Plan files within the twenty-four (24) hour performance standard. The format of these transactions will be in an EDI Benefit Enrollment and Maintenance transaction set, utilizing an ANSI x.12 834 transaction set in a format specified by the Department. The Contractor is required to:

6.8.2a Acknowledge the Department's NYBEAS system is the controlling system for member demographic information and, but not limited to:

6.8.2a(1) 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;

6.8.2.a(2) Report the Empire Plan Alternate ID number (beginning with 890) in addition to the EGWP issued ID number when reporting information

for EGWP plan members. Dependents enrolled in the EGWP plan must be linked back to the policy holder in the Departments 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;

6.8.2a(3) Report data changes of name, date of birth, gender, or HICN and/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; and

6.8.2a(4) 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.

6.8.2b Coordinate enrollments, disenrollments, and cancellations of the EGWP plan using the EGWP eligibility file, including if a member has multiple alternate IDs, (i.e., Dependent Survivors' coverage);

6.8.2c Accept and enroll members into the EGWP plan using the EGWP eligibility file and submit the enrollment to CMS when a member is prospectively identified as Medicare primary;

6.8.2c(1) 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.

6.8.2d Accept and enroll members into the EGWP plan 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 plan;

6.8.2e Process disenrollments for the EGWP plan 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 plan and submit the appropriate transaction to CMS;

6.8.2f Process disenrollments for the EGWP plan 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;

6.8.2g Accept EGWP plan 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;

6.8.2h Maintain eligibility files and generate a reconciliation eligibility file upon request for both the Commercial plan and EGWP plan. The file will contain data elements defined by the Department, but at a minimum will include, the member's Social Security Number, the policy holder alternate ID, NYSHIP assigned IDs, demographic information, enrollment date, and termination date. For the reconciliation of the EGWP plan eligibility information, the file must also include the Medicare Part D Plan information and PDP information;

6.8.2i Receive any other special update files from the Department containing eligibility additions and deletions, including emergency updates;

6.8.2j Providing the Department with all CMS Transaction Reason Codes (TRC) on an electronic Feedback file. Such responsibility must include, but not be limited to:

6.8.2k(1) Transmitting all TRC codes received for a given member (enrollee or dependent) with ordered sequencing so all TRC codes may be processed in order;

6.8.2k(2) Providing the Feedback file to the Department on a daily basis

6.8.2k(3) Submitting in a .txt file layout in accordance with Exhibit II.G.5 as outlined in the Request for Proposals entitled "Pharmacy Benefit

Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Programs;" dated May 29, 2018;

6.8.2k(4) Initial testing to ensure the daily Feedback file loaded correctly and subsequent enrollment transactions are processed programmatically; and

6.8.2k(5) Notifying the Department twenty-four (24) hours if a Feedback file was unable to post.

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

6.8.4 Providing a 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;

6.8.5 Cooperating fully with any State or Department initiatives to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of this Agreement;

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

6.8.7 Meeting the administrative requirements for National Medical Support Notices. A child covered by a Qualified Medical Child Support Order (QMCSO), or the child's custodial parent, legal guardian, or the provider of services to the child, or a NYS agency to the extent assigned the child's rights, may file claims and the Contractor must make payment for covered benefits or reimbursement directly to such party. A Contractor will be required to store this information in their system so that any claim payments or any other plan

communication distributed by the Contractor, including access to information on the Contractor's website would go to the person designated in the QMCSO; and

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

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

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

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

6.9.3 Supplying reports in paper format and/or in an electronic format (Microsoft Access, Excel, Word) as determined by the Department. This includes, but is not limited to, reports and data files listed in Article XVI of this Agreement;

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

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

6.9.5a Forecasting and trend analysis data;
6.9.5b Data necessary to track drug pricing;
6.9.5c Utilization data on the Mail Service Pharmacy Process and the Special Pharmacy Process Program;
6.9.5d Utilization review savings;
6.9.5e Benefit design modeling analysis;
6.9.5f Reports to meet clinical program review needs;
6.9.5g Reports segregating claims experience for specific populations; and
6.9.5h Reports to monitor Agreement compliance.

6.10.0 Consulting: The Contractor is responsible for providing advice and recommendations regarding the DCS Program. Such responsibility shall include, but not be limited to:

6.10.1 Informing the 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, Flexible Formulary Drug List(s) configuration, technological improvements, e-prescribing, Pharmacy innovations, and State/Federal legislation (i.e., Medicare, Prescription drug mandates, etc.) that may affect the DCS Program. The Contractor must provide information and recommendations to the Department on Flexible Formulary Drug List(s) placement of new generic and biological therapies prior to release into the marketplace to the extent such information is available in the public realm. The Contractor must also make available to the State one or more members of the clinical or account management team to discuss the implications of these new trends and developments. The Department is not under any obligation to act on such advice or recommendation; and

6.10.2 Assisting the 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 Article VIII of this Agreement. Additionally, the Contractor will be responsible for making collective bargaining changes using Department benefit codes.

6.11.0 Network Management

6.11.1 Retail Pharmacy Network

6.11.1a The Contractor must maintain a credentialed and contracted Retail Pharmacy Network that meets or exceeds the DCS Program's minimum access standards throughout the term of the Agreement.

6.11.1b The DCS Programs require the Contractor have available to Enrollees on January 1, 2019, a Retail Pharmacy Network, in accordance with the requirements set forth

in Section 7.4.0 and Section 7.5.0 of this Agreement, guaranteeing effective implementation of their Retail Pharmacy Network.

6.11.1c The Contractor is required to substantially maintain the composition of independent Network Pharmacies in its Retail Pharmacy Network. Substantially maintain the composition means that, in developing its Retail Pharmacy Network, the Contractor is expected to have contracts through the term of the Contract with independent pharmacies accounting for seventy-five percent (75%) or more of the Program's prescription drugs dispensed through independent pharmacies, provided such Pharmacies meet the requirements of Sections 6.11.2 and 6.11.3 of this Agreement, and are willing to accept the proposed aggressive reimbursement rates.

6.11.1d The Contractor shall include in its Retail Pharmacy Network any Pharmacy(ies) upon the Department's request, where such inclusion is deemed necessary by the Department to meet the needs of Enrollees even if not otherwise necessary to meet the minimum access guarantees in Section 7.4.0 and Section 7.5.0 of this Agreement, provided such Pharmacies meet the requirements of Sections 6.11.2 and 6.11.3 of this Agreement, and are willing to accept the proposed aggressive reimbursement rates.

6.11.1e Any changes made by NYSIF to the scope of its Agreement with the Contractor for Prescription Drug Program Services after execution of this Agreement, including but not limited to the request to include any individual independent Network Pharmacy(ies), shall have no impact on this Agreement or cost thereunder, unless the change is agreed to by the Department.

6.11.1f The Contractor must effectively communicate the content (including any subsequent changes) and requirements of the Program's Flexible Formularies to their Retail Pharmacy Network.

6.11.1g Prior to January 1, 2019, the Contractor must ensure that their Network Pharmacies have the correct claim identification information (i.e. RX BIN #, RXPCN, RXGRP, effective date, phone number for questions, etc.) to facilitate accurate claims submission and uninterrupted access for DCS Program Enrollees.

6.11.1h The Contractor must establish a process to provide Enrollees with access to Limited Distribution Drugs through the Retail Pharmacy Network.

6.11.2 Pharmacy Credentialing

6.11.2a The Contractor must ensure its Retail Pharmacy Network is credentialed in accordance with all applicable federal and state laws, rules and regulations.

6.11.2b The Contractor must credential Pharmacies in a timely manner and shall have an effective process by which to confirm Network Pharmacies continuing compliance with credentialing standards.

6.11.2c The Contractor must maintain credentialing records and make them available for review by the Department upon request.

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

6.11.3a Ensuring that all Network Pharmacies contractually agree to and comply with all of the DCS Program's requirements and benefit design specifications;

6.11.3b Ensuring all Network Pharmacy contracts include a provision for prohibiting the use of pharmacy manufacturer coupons that reduce or waive Enrollee Copayments;

6.11.3c Recruiting licensed Pharmacies affiliated with home care agencies that are participating providers under the Empire Plan's Home Care Advocacy Program administered by the Empire Plan's medical carrier, as may be updated throughout the term of the Agreement;

6.11.3d Ensuring that Network Pharmacies accept as payment-in-full, the Contractor's reimbursement for all claims processed based on the DCS Program's Lesser of Logic, as set forth in Section 12.6.0 of this Agreement;

6.11.3e Notifying the Department in writing of any plan to renegotiate the financial terms of any Network Pharmacy contract utilized by the DCS Program for any Pharmacy that is located in the State of New York, or for any such Pharmacy located outside NYS that accounts for more than 0.25% of total DCS Program final paid claim Ingredient Costs;

6.11.3f Notifying the Department in writing within one (1) Business day of any changes, negotiated pursuant to Section 6.11.3e, above, to contracts with Retail Pharmacy Network chain Pharmacies or independent Pharmacies negotiating collectively with the Contractor, including but not limited to, those identified as participating in the Contractor's network;

6.11.3g Upon the request of the Department, resoliciting the entire Pharmacy Network to obtain more aggressive reimbursement rates that would pass-through to the DCS Program in exchange for a smaller, select network that meets proposed access guarantees, as modified; and

6.11.3h Committing to administering Pharmacy contracts consistent with all representations made in the Contractor's cost proposal, including all representations regarding the administration of generic pricing and maintenance of MAC List(s).

6.11.3i In the event that any Pharmacy participating in the Retail Pharmacy Network proposed by Contractor in Exhibit C, Contractor's Proposal, of this Agreement, declines to participate in the Retail Pharmacy Network for the one-year term of this Agreement (as opposed to the five-year term contemplated in the RFP), in order to facilitate an orderly transition of Plan member prescriptions to a Pharmacy that continues to participate in the Retail Pharmacy Network, Contractor shall: (A) ensure such Pharmacy continues to participate in the Retail Pharmacy Network until at least January 31, 2019; (B) provide the Department with at least thirty (30) days' prior written notification of any such Pharmacy's election not to participate in the Retail Pharmacy Network under this Agreement; and (C) provide outbound communications to all impacted Plan members, subject to the Department's prior review and approval, in order to assist such Plan members with the transition of their prescriptions to a Pharmacy that continues to participate in the Retail Pharmacy Network.

6.11.4 **Pharmacy and Program Audit:** The Contractor must have a staffed audit unit employing a comprehensive Pharmacy audit program that includes, but is not limited to:

6.11.4a Providing ample audit resources including access to the Contractor's online claims processing system to the Department and the Office of the State Comptroller (OSC)

at their respective offices through the date of the final financial settlement of the Agreement;

6.11.4b Providing Department with access and monthly updates to the Prescription Drug industry pricing source material (e.g. Medi-Span) that the Contractor will be utilizing for the Program;

6.11.4c Conducting routine and targeted on-site audits of Network Pharmacies, the Mail Service Pharmacy Process and the Specialty Pharmacy Process. Pharmacies that deviate significantly from patterns of dispensing in terms of cost, drug selection, overrides, Days supply or utilization are to be identified and targeted for on-site and desk audits in accordance with established selection and screening criteria. On-site audits must also be conducted upon request by the Department, or when information is received by the Contractor that indicates a pattern of conduct by a Pharmacy that is not consistent with the DCS Program's design and objectives. Periodic, on-site audits must be conducted at least once during the course of the one (1) year resultant Agreement for at least twenty percent (20%) of the Pharmacies that fall into the top fifty (50) in terms of total dollar spend for the DCS Program. Any modifications to the proposed Pharmacy audit programs must receive prior approval by the Department;

6.11.4d Providing reports to the Department detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Contractor. The Contractor must inform the Department in writing of any allegation or other indication of potential fraud and abuse identified within seven (7) Business Days of such allegations or identification. The Department must be fully informed of all fraud and abuse investigations impacting the DCS Program upon commencement regardless of whether the individual fraud and abuse investigation has a material financial impact to the State;

6.11.4e The Contractor must maintain the capability and contractual right to effectively audit the DCS Program's Retail Pharmacy Network, including the use of statistical sampling audit techniques and the extrapolation of errors;

6.11.4f Agreement to fully cooperate with all Department and/or OSC audits consistent with the requirements of Appendices A and B as set forth in this Agreement,

including provision of access to protected health information and all other confidential information when required for audit purposes as determined by the Department and OSC as appropriate. The Contractor must respond to all State audit requests for information and/or clarification within fifteen (15) Business Days. The Contractor must perform timely reviews and respond in a time period specified by the Department to preliminary findings submitted by the Department and the Comptroller's audit unit in accordance with the requirements of Article XVIII, "Audit Authority." 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;

6.11.4g Remitting 100% of pharmacy audit recoveries to the DCS Program within thirty (30) Days upon final audit determination consistent with the process specified in Article XV "Payments/(Credits) to/from the Contractor" and Appendix B of this Agreement;

6.11.4h Utilizing the auditing tools and performance measures proposed by the Contractor to identify fraud and abuse by Network Pharmacies and/or Enrollees; and,

6.11.4i Permitting the Department or a designated third party to audit pharmacy bills and drug company revenues.

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

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

fax, internet, e-prescribing or mail to any Mail Service Pharmacy Process Facility, regardless of how the Prescription is filled. All covered Prescriptions, except for Limited Distribution Drugs, submitted through the Mail Service Pharmacy Process or through a Mail Service Pharmacy Process Facility shall be charged to the DCS Program based on the Contractor's mail service pricing terms and dispensing fees (if any) applicable to Brand name, Generic, and Compound Drug claims as set forth in Article XII, "DCS Program Claims Reimbursement" of this Agreement, including Specialty Drugs/Medications for certain enrollees. Limited Distribution Drugs submitted through the Mail Service Pharmacy Process shall be charged to the DCS Program based on the Contractor's Retail Pharmacy Network pricing terms and dispensing fees (if any) applicable to Brand Name, Generic and Compound Drug claims as set forth in Article XII, "DCS Program Claims Reimbursement" of this Agreement. The Mail Service Pharmacy Process shall apply the same DCS Program benefit design features as the Network Pharmacies, including but not limited to Mandatory Generic Substitution, DUR, Prior Authorization, Flexible Formularies, and application of appropriate Copayments;

6.12.2 Ensuring that all the Department approved edits including, but not limited to, enforcing utilization edits (i.e. refill to soon, duplicate therapy, etc.) are built into the Prescription fulfillment system to protect an enrollee's safety as well as to control DCS Program costs;

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

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

6.12.4a The Contractor must have an integrated system for customer service staff to utilize to respond to, log and track all Enrollee inquiries. The system must create

a record of the Enrollee contacting the call center, the call type and all customer service actions and resolutions.

6.12.4b Customer service representatives must be trained and capable of responding to a wide range of questions, complaints and inquiries including but not limited to: DCS Program benefit levels, refills, order status, prices and billing, point of service issues, prior authorization, eligibility, generic appeals, Mail Service Pharmacy Process, Specialty Pharmacy Process services and complaints, and Flexible Formularies alternatives. Callers must be able to reorder and check order status through both the customized website and the consolidated telephone line. Enrollees must also have access to their Prescription drug history file (both retail and mail) via the customized website.

6.12.5 Providing pre-addressed, postage-paid mail service envelopes to Enrollees, health benefit administrators for inclusion in Empire Plan publications, at the request of the Department;

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

6.12.7 Providing standard mail service delivery using packaging that is appropriate for the drug dispensed and the address it is shipped to at no additional cost to the Plan or the Enrollee. Easy open caps also must be provided to Enrollees upon request at no additional cost;

6.12.8 Having a system in place to track all Prescriptions (both intervention and 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;

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

6.12.10 Maintaining a system that notifies Enrollees about potential health and safety issues with their Prescriptions;

6.12.11 Maintaining efficient procedures regarding inventory management of the Mail Service Pharmacy Process Facility(ies) including, but not limited to, backorders, inventories of high demand drugs, supplies of difficult to obtain drugs, backup supplier contracts, etc.;

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

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

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

cost exceed what the actual cost of the Brand Drug would have been to the DCS Program;

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

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

6.12.17 Utilizing best efforts to complete Physician clarification, verification, or other interventions within the five (5) Business Day service level standard. Should this require more than eight (8) Business Days, the Contractor shall call the Enrollee (or contact Enrollee through Enrollee's preferred alternate method) and offer the Enrollee the option of returning the prescription or continuing the intervention attempt;

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

6.12.19 Providing all necessary clinical and educational support to DCS Program Enrollees, and/or their family/caregiver utilizing the Mail Service Pharmacy Process, including Enrollees taking injectable, infusion or other drugs requiring special handling or special administration;

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

6.12.21 Promoting the utilization of the Mail Service Pharmacy Process through targeted mailings, Physician communications, etc. if the Department determines that such promotions are in the best financial interests of the Plan. All such activities, including mailings, are subject to change and require the prior written approval of the Department. Any regular direct communication with Enrollees or their Physicians in connection with Enrollee drug utilization or the processing of Enrollee claims, either through mail, e-mail, fax or telephone must be submitted for the Department's approval. The cost of any approved promotion shall be borne by the Contractor, unless the Department specifically requests a particular activity not required to be performed under the Agreement. The Department will

not approve any mail order promotions that it determines will not result in a reduced net cost to the DCS Program; and,

6.12.22 The Contractor shall act in the best interests of the DCS Program when dispensing Generic Drugs through the Mail Service Pharmacy Process by avoiding the dispensing of NDC's with higher AWPs unless market conditions exist making dispensing the more cost effective NDC impractical or impossible.

6.13.0 Specialty Drugs/Medications

6.13.1 The Contractor must provide Enrollees with access to all Medically Necessary Specialty Drugs/Medications covered by the DCS Program through its Retail Pharmacy Network, Mail Service Pharmacy Process and Specialty Pharmacy 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:

6.13.1a *Retail Pharmacy Network Access*

The Contractor shall secure the participation of the authorized distributor in its Retail Pharmacy Network and bill the DCS Program consistent with the Contractor's contracted discount off of AWP for the Limited Distribution Drug, plus any dispensing fee. The Enrollee shall be charged the applicable retail Copayment.

6.13.1b *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.

6.13.2 Individuals receiving home infusion services through the Home Care Advocacy Program (HCAP), a component of the Empire Plan's Medical/Surgical Program, have their home infusion drugs covered under the Prescription Drug Program. Currently the DCS Program has a network of licensed pharmacies affiliated with home care agencies participating in the Empire Plan's HCAP Program administered by the Empire Plan's medical carrier. The Contractor is expected to secure contracts with the licensed

pharmacies provided in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," of this Agreement, to ensure continued utilization of a network Prescription drug benefit for those Enrollees utilizing the HCAP Program. The Contractor may propose to utilize entities owned by or affiliated with the Contractor to serve as an HCAP Provider. The Department at its sole discretion shall determine whether it is in the best interests of the DCS Program to allow the entity to participate in the HCAP Program. The Prescription drugs dispensed to Enrollees via the entities or pharmacies owned by or affiliated with the Contractor must be charged to the DCS Program based on the Contractor's mail service pricing terms and dispensing fees applicable to brand name, generic, and Compound Drug claims set forth in Article XII of this Agreement.

6.13.3 <u>Specialty Pharmacy Process</u>

6.13.3a The Contractor must provide Enrollees with access to all Medically Necessary Specialty Drugs/Medications covered by the DCS Program through its proposed Specialty Pharmacy Process in accordance with each Enrollee group benefit design. Such responsibility must include, but not be limited to:

6.13.3a(1) Developing a listing of the Specialty Drugs/Medications proposed for inclusion in the Specialty Pharmacy Process;

6.13.3a(2) Having a fully staffed and fully operational Specialty Pharmacy Process in which Specialty Drugs/Medications are provided by one or more Designated Specialty Pharmacies. All Designated Specialty Pharmacies must meet all New York State legal requirements. Any facility located outside New York State that will provide service for the DCS Program must be registered with the NYS Department of Education and meet all requirements of Section 6808-b of NYS Education Law. The Specialty Pharmacy Process must recognize the full prescribing authority of Medical Professionals granted by NYS where allowed by state law;

6.13.3a(3) The Contractor must establish a process to provide Enrollees with access to Limited Distribution Drugs not available through the Designated Specialty Pharmacy(ies), which places no additional steps or burdens on the Enrollee. The 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 retail Copayment;

6.13.3a(4) Providing a fully staffed and fully operational customer support call center available to Enrollees 24 hours a day, 365 Days a year including Pharmacists, clinicians, and registered nurses trained in an Enrollee's specific Specialty Drug/Medication therapies. The Contractor must provide callers with access to customer service staff and Pharmacists through the Empire Plan consolidated line who are able to respond timely to questions, complaints and inquiries including but not limited to: DCS Program benefit inquiries, refills, order status, price estimates, billing, point of service issues, Specialty Pharmacy Process complaints, preferred drug status, and claim status. Callers must be able to reorder and check order status through both the customized website and the consolidated telephone line. Enrollees must also have web access to their Prescription drug history file (retail, mail, and specialty) via a customized website;

6.13.3a(5) Administering a safety monitoring system that complies with the Food and Drug Administration (FDA) Amendments Act of 2007 which requires a Risk Evaluation and Mitigation Strategy (REMS) from the Specialty Drugs/Medications manufacturers to ensure the benefits of a drug outweigh its risks;

6.13.3a(6) Contracting a nationwide network of appropriately licensed clinicians and/or coordinating with appropriately trained HCAP clinicians to administer the Specialty Drugs/Medications to Enrollees in a home setting and providing Enrollees with education on proper treatment regimens and possible side effects;

6.13.3a(7) Completing Physician consultation, coordination of care, patient care management and other interventions on a clinically appropriate and timely basis;

6.13.3a(8) Providing all necessary clinical and educational support to Enrollees, and/or their family/caregiver utilizing the Specialty Pharmacy Process, including but not limited to explaining the treatment plan and ancillary supplies, disease/drug education, side-effect management, compliance management and administration training;

6.13.3a(9) Applying the same DCS Program benefit design features as the Mail Service Pharmacy Process, including but not limited to Mandatory Generic Substitution, DUR, Prior Authorization and Flexible Formularies, and application of appropriate Copayments. Specialty Drugs/Medications that are subject to the Designated Specialty Pharmacy Passive Edit and are dispensed at a Network Pharmacy must be subject to the Network Pharmacy Copayments;

6.13.3a(10) Ensuring that all the Department's approved edits including, but not limited to, enforcing utilization edits (e.g. refill to soon, duplicate therapy, etc.) are built into the Prescription fulfillment process system to protect an Enrollee's safety as well as to control DCS Program costs;

6.13.3a(11) Ensuring that all Designated Specialty Pharmacies utilized in the Contractor's Specialty Pharmacy Process meet all Prescription drug packaging regulatory requirements. The Contractor must ensure that Specialty Drugs/Medications are shipped to Enrollees in appropriate packing materials so that Specialty Drugs/Medications are safe and effective and delivered on time;

6.13.3a(12) Providing a simple, user friendly method(s) of ordering, reordering, and transferring Prescriptions from retail and mail to the Designated Specialty Pharmacy(ies) including pre-addressed postage paid Specialty Pharmacy Process envelopes. The Contractor must send a Specialty Pharmacy Process letter to Enrollees who have received a Grace Fill of a Specialty Drug/Medication through a Network Pharmacy. The letters must be sent within seven (7) Days of the Prescription being filled to Enrollees who have received a Specialty

Drug/Medication subject to the Designated Specialty Pharmacy Hard Edit and within thirty (30) Days of the Prescription being filled to Enrollees who have received a Specialty Drug/Medication subject to the Designated Specialty Pharmacy Passive Edit. Enrollees are allowed one Grace Period for Specialty Drugs/Medications, 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;

6.13.3a(13) Maintaining a comprehensive system for the Contractor's staff to utilize to track all Enrollee inquiries including, but not limited to: DCS Program benefits, refills, order and claim status, prices, billing, Flexible Formulary inquiries and Specialty Pharmacy Process complaints. The system shall include call type, customer service actions and resolutions;

6.13.3a(14) Having a system in place to track all Prescriptions received for processing through the Specialty Pharmacy Process from the date the Prescription is received to the date the Prescription is shipped. The Contractor must also be able to track fill accuracy rates;

6.13.3a(15) Maintaining a process to collect information from individuals necessary to ensure Enrollee safety. The process should collect such information as drug allergies, chronic medical conditions, and other medications taken on a regular basis;

6.13.3a(16) Ensuring that the Designated Specialty Pharmacy(ies) have efficient procedures regarding inventory management including, but not limited to, backorders, inventories of high demand drugs, supplies of difficult to obtain drugs, backup supplier contracts, etc.;

6.13.3a(17) Providing notification to Enrollees as soon as possible for out of stock items, partial fill orders, and changes to Prescriptions (e.g., dosing or method of administration). In out of stock situations, the Contractor must have a system in place to ensure that Prescriptions are filled in the most efficient manner whether it be through an alternate facility(ies) or obtaining a re-stock from a supplier. The Contractor must contact

the Enrollee's Physician, if necessary, to offer alternative medications or offer to return the Prescription. If the Physician authorizes use of an alternative medication, a letter notifying the Enrollee of the change must be sent to the Enrollee before the medication is shipped or must accompany the Prescription;

6.13.3a(18) Informing the Enrollee prior to shipping if the total amount for a new Prescription order submitted through the Specialty Pharmacy Process exceeds $100 and Enrollee has payment information (e.g. credit card) on file or Enrollee's total balance is over $100 and Enrollee has no payment information (e.g. credit card) on file. The Designated Specialty Pharmacy will not be required to inform an Enrollee if there is a consistent history of the acceptance of shipments of the same medication that exceed the $100 amount specified;

6.13.3a(19) The Contractor is expected to assist Enrollees, upon request, to establish a payment plan so that Specialty Drug/Medication Prescriptions that are essential to an Enrollee's health will continue to ship when the outstanding amount exceeds the Contractor's proposed maximum limits;

6.13.3a(20) Promptly notifying the Department of nationwide out of stock issues, including information from the manufacturer or wholesaler regarding the anticipated date that the drug will resume shipment;

6.13.3a(21) Having backup Designated Specialty Pharmacies to handle any overflow and/or situations where the primary Specialty Program facility is unavailable;

6.13.3a(22) The mail order Copayment shall apply to all drugs dispensed through the Specialty Pharmacy Process as well as Limited Distribution Drugs facilitated through the Special Pharmacy Program; and,

6.13.3a(23) Recommending newly launched Specialty Drugs/Medications for inclusion in the Specialty Pharmacy Process based on the established criteria/definition of Specialty Drug/Medications, in a format to be approved by the Department. Prior to inclusion in the Specialty

Pharmacy Process, or if not accepted by the Department to be included in the Specialty Pharmacy Process, the Contractor must bill the DCS Program for these Prescriptions consistent with the Contractor's contracted discount off of AWP at the dispensing Network Pharmacies or the Guaranteed Minimum Discount at the Mail Service Pharmacy Process, based on where each Prescription was actually dispensed. Inclusion of new Specialty Drugs/Medications shall have a cost-neutral or positive financial impact on the DCS Program, and in no case shall the Ingredient Cost of a newly added Specialty Drug/Medication charged to the DCS Program exceed the Guaranteed Minimum Discount on Specialty Pharmacy Drugs.

6.14.0 Claims Processing

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

6.14.1a Verifying that the DCS Program's benefit designs have been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly;

6.14.1b Accurate and timely processing of all claims submitted under the DCS Program in accordance with the benefit design applicable to the Enrollee at the time the claim was incurred as specified to the Contractor by the Department;

6.14.1c Charging the DCS Program consistent with the Contractor's proposed pricing quotes;

6.14.1d Developing and maintaining claim payment procedures, guidelines, and system edits that guarantee accuracy of claim payments for covered expenses only, utilizing all edits as proposed and approved by the Department. The Contractor shall utilize refill too soon edits and duplication of therapy edits for all claims unless exceptions are specifically approved in advance by the Department. The Contractor's system must ensure that refilling Prescriptions prior to use of the minimum prescribed Days supply does not result in over dispensing;

6.14.1e Managing Flexible Formularies and Empire Plan Medicare Rx placement of drugs consistent with Program design and ensuring application of appropriate Copayments based on level assignment;

6.14.1f Maintaining claims histories for 24 months online and archiving older claim histories for 6 years and the balance of the calendar year in which they were made with procedures to easily retrieve and load claim records;

6.14.1g Maintaining the security of the claim files and ensuring HIPAA compliance;

6.14.1h Reversing all attributes of claim records, e.g. AWP, quantity, Days supply, etc., processed in error including the reversal of any Claim Administration Fee associated with the original claim and crediting the DCS Program for all costs associated with the claim processed in error including but not limited to the Claim Administration Fee; and

6.14.1i Agreeing that all claims data is the property of the State. Upon the request of the Department, the Contractor shall share appropriate claims data with other DCS Program carriers and consultants for various programs (e.g., Disease Management, Centers of Excellence) and the Department's Decision Support System (DSS) contractor, however, Contractor may require the recipient to execute a nondisclosure agreement prior to such data sharing. The Contractor agrees not to unreasonably deny access to such data. The Contractor cannot share, sell, release, or make the data available to third parties in any manner without the prior consent of the Department. The Department understands that the selected Contractor will be required to share certain claims data with pharmaceutical manufacturers for purposes of obtaining for the Program all Pharma Revenue due it under this Agreement. The Contractor shall inform the Department of the types of data being shared for these specific authorized purposes.

6.14.2 Maintaining a backup system and disaster recovery system for processing claims in the event that the primary claims payment system fails or is not accessible;

6.14.3 Maintaining a claims processing system capable of integrating and enforcing the various utilization review components of the DCS Program, including, but not limited to: Mandatory Generic Substitution, Prior Authorization, messaging capability in the current NCPDP format and a concurrent DUR program to aid the Pharmacist at the point of sale;

6.14.4 Maintaining an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the DCS Program's mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the generic at the Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Retail Pharmacy Network, the DCS Program's mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized generic in stock, mandatory generic substitution provisions will not apply and the Enrollee shall receive the Brand Drug, be charged the applicable Level 1 Copayment and the DCS Program charged based on generic pricing. The DCS Program shall reject claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW-0 code with appropriate messaging and requires resubmission of the claim since a DAW-0 code provides no indication of Generic Drug availability in the Pharmacy. The DCS Program logic for the Pharmacy Submitted DAW codes is listed below:

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

*Logic applies unless the claim is rejected pursuant to 6.14.4.

6.14.5 Maintaining a claims processing system capable of ensuring that claims are consistently processed with the appropriate brand name/generic/compound classification in accordance with the requirements set forth in Article XII: "DCS Program Claims Reimbursement" of this Agreement;

6.14.6 Maintaining a DCS Programs' MAC List(s) for Pharmacies;

6.14.7 Processing Enrollee Submitted Claims in accordance with the following:

6.14.7a For Prescriptions filled with a Brand Drug with no generic equivalent, the Enrollee will be reimbursed using the Contractor's Minimum overall Guaranteed Minimum Discounted Ingredient Cost for the Retail Pharmacy Network and dispensing fee for Brand Drugs not to exceed the submitted charges, less the applicable Copayment;

6.14.7b For Prescriptions filled with a Brand Drug that has a generic equivalent, the Enrollee will be reimbursed up to the amount the DCS Program would reimburse the Retail Pharmacy Network for filling the Prescription with that drug's generic equivalent; not to exceed the submitted charges, less the applicable Copayment;

6.14.7c For Prescriptions filled with a Generic Drug the Enrollee will be reimbursed up to the amount the DCS Program would reimburse the Retail Pharmacy Network for that Prescription, not to exceed the submitted charges, less the applicable Copayment;

6.14.7d For Prescriptions filled with a Compound Drug the Enrollee will be reimbursed up to the amount the DCS Program would reimburse the Retail Pharmacy Network for that Prescription, not to exceed the submitted charges, less the applicable Copayment; and

6.14.7e If the Enrollee has two Empire Plan coverage's, the Plan will reimburse 100% of the copay upon submission of a paper claim form prepared by the Enrollee. For specific methodology on how the DCS Program must be charged for Enrollee Submitted Claims, see Section 13.9.0, "Enrollee Submitted Claims."

6.14.8 Processing claims for Employees enrolled in the SEHP who fill Prescriptions at the SUNY Stony Brook Student Health Service Pharmacy, and other SUNY pharmacies as may be requested by the Department during the term of the Agreement. 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, where applicable, Day's supply limits;

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

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

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

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

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

6.14.14 Establishing a process to support, and respond to Federal Medicare Part D audits;

6.14.15 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; and

6.14.16 Processing claims pursuant to Enrollees covered under the Disabled Lives Benefit. DCS agrees to reimburse the Contractor for claims processed under the Disabled Lives Benefit in accordance with Article XV "Payments/(Credits) to/(from) the Contractor.

6.15.0 Dual Empire Plan Coverage: In instances where a member is covered under two (2) separate Empire Plan policies, 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) and must:

6.15.1 Coordinate benefits in accordance with COB rules, whereby the secondary Empire Plan policy reimburses copays paid for in-network benefits;

6.15.2 Agree to manage the same benefit design regarding copay reimbursement regardless if the coverage is two Commercial, two Medicare or any combination of Commercial and Medicare;

6.15.3 Agree that a policy termination will not affect another policy, and will not disrupt coverage. This includes two Commercial, two Medicare or any combination of Commercial and Medicare; and;

6.15.4 Continue coordination of benefits consistent with CMS COB rules following employment status changes that result in COB changes. The member shall experience no disruption during this transition, including, but not limited to, Contractor system generated notifications. Any communications sent automatically during this transition must be reviewed and approved by the Department.

6.16.0 Retrospective Coordination of Benefits

6.16.1 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.

6.16.2 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.

6.16.3 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.

6.16.4 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.

6.17.0 Utilization Management

6.17.1 Mandatory Generic Substitution at Retail and Mail

To ensure strict adherence to the DCS Program's Mandatory Generic Substitution Requirement and protect the financial interests of the DCS Program, the Contractor is required to:

6.17.1a Unless otherwise directed by the Department, apply mandatory generic substitution to all specific NDC's of Brand Drugs for which there is an FDA approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc.) or an authorized Generic Drug as permissible by NYS law. Network Pharmacies shall comply with all state laws related to mandatory generic substitution. The DCS Program's mandatory generic substitution provisions shall apply to any claim where the A-rated or authorized Generic Drug is required or permitted to be substituted under state law. Mandatory generic substitution provisions will not apply to B-rated or unrated Generic Drugs or in the unlikely event that state law prohibits dispensing of the A-rated or authorized Generic Drug.

6.17.1b Establish the Ancillary Charge by calculating the difference in the Discounted Ingredient Cost of the Brand Drug and the Ingredient Cost of the equivalent A-rated Generic Drug or authorized Generic Drug based on the DCS Programs' MAC List(s) 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 Copayment plus Ancillary Charge not to exceed the cost of the drug to the DCS Program. The Ancillary Charge shall be assessed even in the event a Physician has specifically directed a Pharmacist to dispense the Brand Drug rather than the A-rated or authorized Generic Drug through DAW notation.

6.17.1c Monitor the pharmaceutical industry on behalf of the Department to identify Generic Drugs expected to enter the market. Prior to the actual introduction of the Generic Drug to market, the Contractor shall inform the Department of anticipated shipping dates of the first Generic Drug introduced into the market for one or more strengths of a particular Brand Drug.

6.17.1d Following the first shipment of a first Generic Drug for one or more strengths of a particular Brand Drug, the Contractor is required to:

6.16.1d(1) Inform the Department as soon as practicable but in no event later than fourteen (14) Days after the first date of shipment, (from manufacturer to wholesaler or retailer) of the financial impact of enforcing mandatory generic substitution via the "MAC Alert Notice" detailed in Section 16.6.1 of this Agreement.

6.17.1d(2) For those drugs that will result in a lower net cost to the DCS Program by enforcing mandatory generic substitution, the Contractor shall provide the "MAC Alert Notice" as described in (1) above. The Contractor shall add the GPI to the DCS Programs' MAC List(s) and begin enforcement as soon as practicable but in no event later than fourteen (14) Days after the first date of shipment provided that the majority of retail Network Pharmacies are able to obtain the Generic Drug. In the case where a 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.

6.17.1d(3) For those drugs that could potentially result in a higher net cost to the DCS Program by enforcing mandatory generic substitution, the Contractor shall provide the "MAC Alert Notice" as described in (1) above. The Department, in its sole discretion, may determine that enforcement is contrary to the best financial interests of the DCS Program and shall inform the Contractor whether mandatory substitution shall be applied. If the Contractor does not receive a formal response to the information provided via the "MAC Alert Notice," enforcement shall commence and the GPI shall be added to

the DCS Programs' 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.

6.17.1d(4) To assist the Department in determining when mandatory generic substitution should be enforced based on an adequate supply of Generic drug being available in the market, the Contractor shall survey its Retail Pharmacy Network to identify the Pharmacies that are unable to obtain the new Generic Drug within 21 Days and weekly thereafter until the shortage resolves. The Contractor shall submit this information to the Department and provide any additional information as required by the Department to reach a determination. The Department, in its sole discretion, shall determine based on such evidence how the DCS Program's mandatory generic substitution provisions will be applied. The DCS Program will not consider and the Contractor shall not act on availability information provided by third party sources, including but not limited to Medi-Span or wholesalers.

6.17.1d(5) For Preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall be changed from preferred to non-preferred status concurrent with the commencement of the enforcement of mandatory generic substitution. Enrollees who are prescribed strengths of the Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the Level 1 Copayment unless the prescribing Physician requires that the Brand Drug be dispensed. In that case, the Enrollee shall be charged the applicable Level 3 Copayment and Ancillary Charge. Enrollees 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 Level 2 Copayment;

6.17.1d(6) For Non-Preferred Brand Name drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall remain Non-Preferred for all strengths. Concurrent with enforcement of mandatory generic substitution, Enrollees who are prescribed strengths of the Non-Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the Level 1 Copayment unless the prescribing Physician requires that the Brand Drug be dispensed. In that case, the Enrollee shall be charged the applicable Level 3 Copayment and Ancillary Charge. Enrollees 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 Level 3 Copayment;

6.17.1d(7) The Contractor shall require the dispensing Network Pharmacy to inform the Enrollee prior to dispensing the Brand Drug, that an Ancillary Charge will be applied in addition to the applicable Level 3 Copayment. If the prescribing Physician requires the Brand Drug be dispensed, the Contractor shall require the dispensing Network Pharmacy to collect the applicable 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 Programs' Lesser of Logic provisions.

6.17.1e Charge the DCS Program based on the DCS Programs MAC List(s) price assigned to the GPI of the dispensed Brand Drug subject to the DCS Programs' Lesser of Logic plus the applicable dispensing fee as set forth within Article XII, "DCS Program Claims Reimbursement" of this Agreement.

6.17.1f Receive Department prior written approval for any and all exceptions to the DCS Program's mandatory substitution provisions, other than those resulting the Program's Mandatory Substitution Appeal Process. Following commencement

of mandatory generic substitution, the Contractor must receive Department written approval prior to suspending enforcement of the DCS Program's mandatory generic substitution provisions.

6.17.1g Maintain an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the DCS Program's mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the Generic Drug at the Network Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Network Pharmacy, the DCS Program's mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized Generic Drug in stock, mandatory generic substitution provisions will not apply and the Enrollee shall receive the Brand Drug, be charged the applicable Level 1 Copayment and the DCS Program charged based on Generic Drug pricing. The Contractor's claims processing system must reject, with appropriate messaging, claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW-0 code requiring resubmission of the claim (since a DAW-0 code provides no indication of Generic Drug availability in the Pharmacy). Similar rules can be applied to other DAW submission codes as necessary to ensure consistent, accurate application of the DCS Program's mandatory generic substitution requirements.

6.17.1h Immediately notify the Department of changes (from brand to generic or generic to brand) in the NDC classification submitted by the Contractor, subject to the DCS Program's definitions of Brand and Generic Drugs contained in Article I of this Agreement.

6.17.1i Manage the Narrow Therapeutic Index (NTI) list of multi-source Brand Drugs not subject to Ancillary Charges, and make recommendations to the Department of suggested additions or deletions based on clinical evidence.

6.17.2 Mandatory Generic Substitution Appeal Process

The Contractor shall administer a Mandatory Generic Substitution Appeal process. The selected Contractor is required to oversee and enforce the DCS Program's generic appeal process including:

6.17.2a Administering a clinically sound generic appeal process at no additional cost to the DCS Program or to the Enrollee. The process must include developing an appeal form and criteria for establishing medical necessity, reviewing appeals for medical necessity, preparing communications to notify Enrollees (subject to Department review and approval) of the outcome of appeals within five (5) Business Days, and integrating the decisions into the claims processing systems including reimbursing the Enrollee for any Ancillary charge paid up to 30 Days prior to receipt of the approved generic appeal;

6.17.2b Reporting the results of the generic appeal process for the DCS Program to the Department on a drug by drug basis in the format and frequency required in the Article XVI of this Agreement;

6.17.2c Following a successful generic appeal, charging the Enrollee for the Brand Drug at the Level 3 Copayment with no Ancillary Charge;

6.17.2d Loading into Contractor's claims processing system one or more files from the incumbent contractor of the previously approved Generic Appeal requests by January 1, 2019, 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; and

6.17.2e Responding to all External Appeals on behalf of the Department as requested by the New York State Department of Financial Services. 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 associated with the External Appeal process directly to DFS. All External Appeal fees shall be included in the Contractors Claims Administration Fees and will not be charged separately to DCS.

6.18.0 Clinical Management/Drug Utilization Review (DUR)

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

6.18.1a A Prior Authorization Program for high cost Prescription drugs that are prescribed for very specific medical indications. Only medications that have been identified by the Contractor as appropriate for Prior Authorization and reviewed by the Department shall be included in the Prior Authorization Program. The Prior Authorization Program also subjects specific drugs in certain categories to clinical criteria before benefits are authorized for payment including but not limited to: anti-obesity agents; topical tretinoin; antifungal agents; Hepatitis C agents; Hepatitis B agents for interferon use; select Osteoporosis agents; Respiratory Syncytial Virus (RSV) Therapy agents, select stimulant agent; Multiple Sclerosis agents; Low Molecular Weight Heparin agents; Growth Hormones; Cancer; Pain/Arthritis; 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;

6.18.1b Informing Medical Professionals who request, by phone, fax, secure internet portal, a Prior Authorization for a Specialty Drug/Medication about the DCS Program's Specialty Pharmacy Process and providing the information necessary to utilize the Specialty Pharmacy Process to obtain the drug;

6.18.1c Monitoring market changes and recommending deletions or additions to the list of drugs requiring Prior Authorization on an ongoing basis which must be reviewed by the Department prior to implementation of any changes to the list of medications;

6.18.1d Preparing and sending communications (reviewed and approved by the Department) to notify Enrollees and/or their Physicians of the outcome of their prior authorization request and notifying them of date the Prior Authorization is approved through;

6.18.1e Promptly loading approved prior authorization determined by the contractor into the claims processing system;

6.18.1f Administering an expeditious, HIPAA compliant, internal appeals process which allows Physicians and/or Enrollees and Dependents to appeal denied coverage on the basis that a Prescription drug is not medically necessary or is an experimental or investigational drug. For the Prior Authorization Program, there

must be at least one level of appeal, and it must be expeditious and Patient Protection and Affordable Care Act ("PPACA") compliant;

6.18.1g 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;

6.18.1h Administer a Medical Exception Program for excluded drugs 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. An appropriate trial of formulary alternatives must be undertaken before a formulary exception can be approved; and

6.18.1i Acknowledge that the Plan benefit design does not include the inclusion of Step Therapy as an alternative treatment program.

6.18.2 Concurrent Drug Utilization Review (DUR)

To safeguard Enrollee health and ensure adherance with the DCS Program's benefit design, the Contractor must administer a concurrent DUR program which includes at a minimum:

6.18.2a A point of service system at all Retail Pharmacy Network locations, Mail Service Pharmacy Process Facilities and Designated Specialty Pharmacies which is continually updated with the latest patient safety edits with the capacity to "message" Pharmacists related to safety issues prior to the dispensing of the Prescription drug; and

6.18.2b A fully integrated point of service system capable of enforcing the DCS Program's benefit design features.

6.18.3 Retrospective DUR Program

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

6.18.3a Using the Contractor's standards, evaluates the Enrollee's Prescription drug utilization against the Enrollee's profile using FDA and other evidence based guidelines to identify potential safety related concerns. The Contractor shall alert the prescribing Phyicians to drug specific, Enrollee-specific health, safety and utilization issues including potential overuse of narcotics acetaminophen or other identified high risk drugs;

6.18.3b Identifies potential drug therapy complications for Enrollees, develops Physician alerts (subject to Department review and approval) and sends the alerts to the prescribing Physician; and

6.18.3c Reports the results of its Retrospective DUR Program initiatives including outcomes to the Department on a quarterly basis in a mutually agreed upon format.

6.18.4 Physician Education

6.18.4a Subject to Department review and approval, the Contractor must undertake a Physician education program involving communications with prescribing Physicians which includes at a minimum:

6.18.4a(1) Analysis of Physician's drug or condition specific prescribing patterns;

6.18.4a(2) Educating Physicians about the clinical and economic aspects of their prescribing decisions. Any communication with Physicians prescribing medications for Enrollees shall make the Physician aware of the distribution channel most cost effective to the DCS Program and the Enrollee;

6.18.4a(3) Reporting the results of its Physician Education initiatives to the Department on a quarterly basis in a mutually agreed upon format; and

6.18.4a(4) The Physician Education Program may not be funded by pharmaceutical manufacturers.

6.18.5 Patient Education

6.18.5a Subject to Department review and approval, the Contractor must develop and implement a Patient Education program consisting of communications to Enrollees which:

6.18.5a(1) Analyzes drug utilization from a clinical standpoint to identify and facilitate communication with Enrollees that have chronic diseases to maximize health benefits of drug treatment;

6.18.5a(2) Analyzes drug utilization to identify and facilitate communication with Enrollees not managing their drug utilization in the most cost effective manner for the Enrollee;

6.18.5a(3) Reports the results of its patient education initiatives to the Department on a quarterly basis in a mutually agreed upon format; and

6.18.5a(4) The Physician Education Program may not be funded by pharmaceutical manufacturers.

6.18.5b The Patient Education Program may not be funded by pharmaceutical manufacturers.

6.19.0 Drug List Development and Management

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

6.19.1 Developing and administering multi-level formularies, consistent with the DCS Program's benefit designs (The Empire Plan Medicare Rx must replicate the prescription drug benefit for non-Medicare primary retirees as closely as possible) as follows:

6.19.1a *Flexible Formularies*: Under the Flexible Formularies, Generics may be on Level 1 or excluded. Brand Drugs may be on Level 1, 2, or 3 or excluded. A proposed Drug List that includes Generics on Level 2 or Level 3 does not meet the Program requirements for the Flexible Formulary Drug List(s) and would not be acceptable.

Drugs may be excluded from the Flexible Formularies based on sound clinical and financial criteria, as follows:

Access to one or more drugs in select therapeutic categories may be restricted (not covered) if the drug(s) has no clinical advantage over other generic and brand name medications in the same therapeutic class. Drugs considered to have no clinical advantage that may be excluded include any products that follow either **List 1** or **List 2**:

List 1

a. Contain an active ingredient available in and therapeutically equivalent to another drug covered in the class;

b. Contain an active ingredient which is a modified version of and therapeutically equivalent to another covered Prescription Drug Product, or;

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

List 2

a. Contain an active ingredient available in or are therapeutically equivalent to another drug covered in the class;

b. Contain an active ingredient which is a modified version of or are 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.

In addition, the current benefit design does not allow an Enrollees with Commercial coverage to appeal a drug's placement on the second or third level of the Drug List(s). Enrollees are able to appeal a drug exclusion through the Medical Exception Program, in the event other therapeutic alternatives are ineffective or clinically inappropriate as documented by the prescribing Medical Professional. The Flexible Formularies is updated once a year on January 1st. Mid-year changes to the Drug List are generally not acceptable. However, mid-year changes resulting from drug recalls, the introduction of new clinically superior drugs, drugs off patent, or patient safety issues are allowed.

The Flexible Formularies includes a “Brand for Generic” feature. With this feature, a brand-name drug may be placed on Level 1, or excluded, and the generic equivalent placed on Level 3, or excluded. With State approval, these placements may be revised mid-year when such changes are advantageous to the Plan.

6.19.1b *Excelsior Plan Drug List*: Under the Excelsior Plan Drug List, both Brand and Generic Drugs may be placed on Level 1, 2 or 3 or excluded. A proposed Excelsior Plan Drug List that includes Generics on Level 2 or Level 3 and/or has Brand Drugs on Level 1 meets Program requirements and would be acceptable for the Excelsior Plan. Drugs may be excluded from the Excelsior Plan Drug List based on sound clinical and financial criteria. In addition, the current benefit design does not allow an Enrollee to appeal a drug’s placement on the second or third level of the Excelsior Plan Drug List. The Excelsior Plan Drug List may be updated throughout the year. It is currently updated on January 1 and July 1 each year. The goal of the Excelsior Plan Drug List is to offer a therapeutically sound formulary that results in a Plan design that costs a minimum of 15% less than the Empire Plan Flexible Formulary.

6.19.2 The Contractor’s Drug Lists must be based on sound clinical and financial criteria. The Contractor’s Book of Business PDL for the Excelsior Plan Drug Lists must include non-self-administered, intravenous and intramuscular injectable drugs covered under the Excelsior benefit plan design. In designating a drug as preferred or non-preferred for the Flexible Formulary Drug List(s), 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 Drug List for the Flexible Formularies will be developed by the Contractor and reviewed annually by the Department.

6.19.3 The Contractor may recommend and the Department may, at its sole discretion, approve a mid-year change in a drug’s status from non-preferred to preferred for the Flexible Formularies. Any recommended mid-year changes to the Drug List shall be provided to the Department with a summary of the clinical and financial implications to the DCS Program. In the instance when a change to a Drug List is approved outside of the annual

update, the Contractor's communication responsibilities are the same as the annual Drug List update. For the Excelsior Plan, the timing of up-tiers and exclusion shall be consistent with the Contractor's Book of Business PDL.

6.19.4 Developing 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 to inform Enrollees and providers of the placement of the most commonly prescribed medications on each Drug List. The Department shall be responsible for the distribution of the printed Drug list 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 Drug List, 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 Drug List to Enrollees who call requesting a copy.

6.19.5 Compiling and organizing the Drug Lists in two versions, limited to the most commonly prescribed medications for posting and distribution: an alphabetical listing of Preferred Drugs and a listing of Preferred Drugs categorized by therapeutic category. A full listing of the Drug List must be available for posting on the website. The Contractor must work with the Department on the format of the Drug List. The Drug List that is developed for distribution to Enrollees, and providers and posted on the websites 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 Drug List shall also list the name of the reference product in parenthesis next to the name of the Generic Drug (i.e., simvastatin (Zocor)) unless the Department otherwise directs. The Drug List 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 Drug List.

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

6.19.7 Developing and mailing a Department preapproved 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 Flexible Formulary Drug List. Disruption mailings for the Enrollees in the Excelsior Plan will follow the disruption mailing plan employed for the Contractor's Book of Business PDL. Such letters must be sent to Enrollees who have utilized a medication at least once within the latest four-month time period, regardless of the Days supply or whether the medication is categorized as maintenance or acute. An additional mailing must be sent to Enrollees who are new users of a medication between the date claims records were selected for the initial disruption mailing and the date that the Drug List 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 Drug List as of the effective date of the drug's exclusion or change from preferred to non-preferred status. In situations where Enrollees are affected by a Generic Drug's reclassification to a Brand Drug, the Contractor agrees to send a disruption letter to affected Enrollees.

6.19.8 Notifying the Department in writing when a Class I drug recall or voluntary drug withdrawal occurs. The Contractor must take proper action to help promote patient safety. The Contractor will review with the Department the need to communicate and at the Department's discretion will notify Enrollees, Network Pharmacies and/or prescribing Physicians of the Federal Food and Drug Administration drug or device recalls and manufacturer drug or device withdrawals at no additional cost to the DCS Program, provided, however, that the Contractor will contact Enrollees regarding any patient-level recalls of drugs dispensed to Enrollees by a Contractor Mail Service Pharmacy Process Facility or Specialty Pharmacy Process facility. Such notification must be timely and all written materials subject to Department review and prior written approval. The Contractor must to assist the Department in collecting money for recalled products.

6.19.9 Using reasonable efforts to monitor the industry on behalf of the DCS Program and notifying the Department in writing of any class action lawsuits for which a class has been certified and of any proposed orders or settlements that the DCS Program may be entitled to participate in as a member of the class. Unless otherwise notified by the Department, the Contractor shall file claims on behalf of the DCS Program and take all steps necessary to ensure the DCS Program's interests in the class action suit or

proposed settlement are protected. Any recoveries collected by the Contractor on behalf of the DCS Program, net of the Contractor's actual costs in securing the DCS Program's participation in the recovery, due the DCS Program must be paid to the DCS Program as set forth in Article XV Payments/(Credits) to/(from) the Contractor of this Agreement. The Contractor shall make reasonable efforts to maximize recoveries. Distribution of recoveries, net of the Contractor's actual costs incurred on behalf of the DCS Program, shall be made consistent with the terms of the final settlement order or court decision. The Contractor shall assist the State in its recovery efforts and provide the claims and rebate data required to file a claim on behalf of the DCS Program when requested by the Department.

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

6.19.11 Assigning a new strength of a drug to the same Drug List Level as the preexisting strengths of the drug in the event a new strength of a drug already on the Flexible Formulary Drug List(s) is shipped from the manufacturer or wholesaler.

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

6.19.13 The Contractor will be responsible for ensuring the Empire Plan Flexible Formularies will be electronically available to Medical Professionals on Rx Hub and Level 1 and Level 2 drugs will be designated as Preferred.

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

6.19.15 The Contractor will be responsible for developing, recommending and implementing Brand for Generic Strategies for the Flexible Formularies that financially beneficial to the

State. All Brand for Generic placements are subject to Department approval. These placements may be revised mid-year, with Department approval, when such changes are advantageous to the Plan.

6.19.16 The Contractor must ensure any proposed Formulary and Program benefit designs comply with all applicable federal and NYS laws, rules, and regulations including, but not limited to, the Affordable Care Act of 2010 requirements, to cover certain preventive care services with no cost-sharing to Enrollees and that complies with the non-discrimination provisions of the Affordable Care Act of 2010.

6.20.0 Vaccination Network

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

6.20.1 Seasonal Vaccines. Seasonal vaccines (vaccines for influenza) are subject to annual enrollment, as vaccine availability, pricing terms and dates of service may change from year to year.

6.20.2 Non-Seasonal Vaccines. 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.

6.20.3 Contractor's Vaccination Network is a subset of the Network Pharmacies, which have elected to administer vaccinations consistent with the terms of this Section 6.20.0. Contractor shall provide the Department with a listing of Network Pharmacies participating in the Vaccination Network upon request. Generally, in-pharmacy health care clinics do not participate in the Vaccination Network. Not all Network Pharmacies participating in the Vaccination Network regularly stock all the vaccines that may be administered pursuant to this Section 6.20.0. Participating Network Pharmacies may decline to provide vaccinations to minors based on state law or clinical considerations.

ARTICLE VII: PERFORMANCE GUARANTEES

The Parties agree that the following guarantees and the corresponding credit amounts for failure to meet the Contractor Performance Guarantees shall be implemented effective January 1, 2019. The

Contractor acknowledges and agrees that failure to perform the Program Services features in such a manner which either meets or exceeds any, and/or all of the Contractor Performance Guarantee(s) as set forth in this Article VII, and/or fails to make any payment(s) of any such credit amounts for such failure to meet any Performance Guarantee(s) does not relieve the Contractor of the performance of the activities, duties, and obligations as otherwise set forth in the Agreement. Credit amounts are cumulative. Amounts due from the Contractor to DCS for failure to perform and audit credit amounts, as determined pursuant to Article XV of this Agreement, shall be made in such amounts as determined by DCS to be final. Upon such determination, DCS shall notify the Contractor, in writing, and the Contractor shall apply such amounts as a credit against the monthly Claims Administration Fee in accordance with Article XV of this Agreement within thirty (30) Days of receiving such notification by the DCS. These amounts must also be applied as a credit against the Claim Administration Fee reported in the Annual Financial Report.

7.1.0 Start-up Guarantees and Credit Amount

7.1.1 ***Guarantee:*** The Contractor guarantees that effective January 1, 2019, the Contractor will continue full operational responsibility for the DCS Program. For the purpose of this guarantee, the Contractor must, on January 1, 2019, have in place and operational:

7.1.1a A contracted Retail Pharmacy Network that meets the access standards set forth in Sections 7.4.0 and 7.5.0 of this Agreement. Additionally, in order to meet the Contractor's Start-up Guarantee, the Retail Pharmacy Network implemented on January 1, 2019, must meet all requirements set forth in Section 6.11.1 of this Agreement and be available to fill Enrollee Prescriptions for all Covered Drugs including Specialty Drugs/Medications (for those Enrollees that do not participate in the Specialty Pharmacy Process);

7.1.1b A fully operational Mail Service Pharmacy Process utilizing facilities as necessary to ensure that Enrollees have access to all Covered Drugs, including Specialty Drugs/ Medications (for those Enrollees that do not participate in the Specialty Pharmacy Process) as set forth in Section 6.12.0 of this Agreement;

7.1.1c A fully operational Specialty Pharmacy Process utilizing facilities as necessary to ensure that Enrollees have access to all covered Specialty Drugs/Medications (for those Enrollees that participate in the Specialty Pharmacy Process) as set forth in Section 6.13.3 of this Agreement;

7.1.1d A fully operational call center providing all aspects of customer support and services as set forth in Section 6.5.0 of this Agreement;

7.1.1e An online claims processing system that applies DCS approved edits and point of service edits, including drug utilization review edits, as set forth in Section 6.14.0 of this Agreement;

7.1.1f An online claims processing system with real time access to the most updated, accurate enrollment and eligibility data provided by DCS to correctly pay claims for eligible Enrollees/Dependents consistent with Program benefit design, including any benefit design changes implemented during the term of the Contract, and contractual obligations;

7.1.1g A fully functioning customized Program website with a secure dedicated link from DCS's website able to provide Enrollees with online access to the specific website requirements as set forth in Section 6.5.7 of this Agreement; and

7.1.1h A fully functioning enrollment system capable of receiving and applying all enrollment updates as set forth in Section 6.8.0 of this Agreement.

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 2019 Claims Administration Fee (prorated on a daily basis).

7.2.0 <u>Enrollment Management Guarantee and Credit Amount</u>

7.2.1 ***Guarantee:*** The Contractor guarantees that one hundred percent (100%) of all DCS Commercial Program enrollment records that meet the quality standards for loading will be loaded into the Contractor's enrollment system within [redacted] of release by DCS.

***7.2.2 Credit Amount*:** For each 24-hour period beyond [redacted] from the release by DCS that one hundred percent (100%) of the DCS Commercial Program enrollment records that meet the quality standards for loading is not loaded into the Contractor's enrollment system, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted].

7.3.0 <u>Management Reports and Claim Files Guarantee and Credit Amount</u>

7.3.1 ***Guarantee:*** For each management report or claim file listed in Article XVI of this Agreement, the Contractor guarantees that accurate management reports and claims files shall be delivered to the DCS no later than their respective due dates inclusive of the date of receipt.

7.3.2 ***Credit Amount*****:** For each management report or claim file listed in Article XVI of this Agreement that is not received by its respective due date, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] per report per each Business Day between the due date and the date the management report or claims file is received by the DCS inclusive of the date of receipt.

7.4.0 **Commercial Retail Pharmacy Network Access Guarantee and Credit Amount**

7.4.1 ***Guarantee:*** The Contractor guarantees that effective January 1, 2019, and throughout the term of the Agreement:

7.4.1a 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 two (2) miles of an Enrollee's home;

7.4.1b 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 five (5) miles of an Enrollee's home; and

7.4.1c 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 fifteen (15) miles of an Enrollee's home.

7.4.2 ***Credit Amount:***

7.4.2a The Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] for each .01 to 1.0% 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.

7.4.2b The Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] for each .01 to 1.0% 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.

7.4.2c The Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] for each .01 to 1.0% below the [redacted] access guarantee for any quarter in which the Network Pharmacy Access for Rural Areas Guarantee is not met by the Contractor.

7.4.3 Measurement of compliance with each access guarantee in Section 7.4.0 of this Agreement will be based on a "snapshot" of the Retail Pharmacy Network taken on the last Day of each quarter within the current Plan Year. The results must be provided in the format specified by DCS in Exhibit B, the Request for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," unless otherwise specified by DCS. The report is due thirty (30) Days after the end of the quarter.

7.5.0 <u>Medicare Rx (EGWP) Retail Pharmacy Network Access Guarantee and Credit Amount</u>

7.5.1 ***Guarantee:*** The Contractor guarantees that effective January 1, 2019, and throughout the term of the Agreement:

7.5.1a 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 two (2) miles of an Enrollee's home;

7.5.1b 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 five (5) miles of an Enrollee's home; and

7.5.1c 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 fifteen (15) miles of an Enrollee's home.

7.5.2 ***Credit Amount:***

7.5.2a The Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] for each .01 to 1.0% 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;

7.5.2b The Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] for each .01 to 1.0% 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

7.5.2c The Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted] for each .01 to 1.0% below the [redacted] access guarantee for any quarter in which the Network Pharmacy Access for Rural Areas Guarantee is not met by the Contractor.

7.5.3 Measurement of compliance with each access guarantee in Section 7.5.0 of this Agreement will be based on a "snapshot" of the Retail Pharmacy Network taken on the last Day of each quarter within the current Plan Year. The results must be provided in the format specified by DCS in Exhibit B, the Request for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," unless otherwise specified by DCS. The report is due thirty (30) Days after the end of the quarter.

7.6.0 Turnaround Time for Claims Adjudication Guarantee and Credit Amount

7.6.1 ***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 ten (10) 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.

7.6.2 ***Credit Amount:*** For each .01 to .25% of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Contractor and not turned around within ten (10) Business Days from the date the claim is received in the Contractor's DCS designated Post Office Box to the date the

Explanation of Benefits is received by the mailing agent, below the standard of [redacted] percent [redacted] as calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted]

7.7.0 Turnaround Time for Mail Service Pharmacy Process Prescriptions Guarantee and Credit Amount

7.7.1 ***Guarantee:*** The Contractor guarantees that at least [redacted] percent [redacted] of all nonintervention mail service Prescriptions, excluding Prescriptions for Limited Distribution Drugs, will be turned around within two (2) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the day after the Prescription is received by the Mail Service Pharmacy Process Facility to the date the Prescription is metered for shipment. For example, a Prescription order received on Monday, January 7, 2019, by the Mail Service Pharmacy Process Facility, must be metered for shipment no later than Thursday, January 10, 2019.

7.7.2 ***Credit Amount:*** For each .01 to 1.0% below [redacted] percent [redacted] percent of all nonintervention mail service Prescriptions not turned around within two (2) Business Days, calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted]

7.7.3 ***Guarantee*****:** The Contractor guarantees that at least [redacted] percent [redacted] of all intervention mail service Prescriptions, excluding Prescriptions for Limited Distribution Drugs, shall be turned around within five (5) Business Days (not including the date of Prescription receipt). Turnaround time is measured from the date the Prescription is received by the Mail Service Pharmacy Process Facility to the date the Prescription is metered for shipment. For example, a Prescription order received on Monday, January 7, 2019, by the Mail Service Pharmacy Process Facility must be metered for shipment no later than Monday, January 14, 2019.

7.7.4 ***Credit Amount:*** For each .01 to 1.0% below [redacted] percent [redacted] of all intervention mail service Prescription not turned around within five (5) Business Days, calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of [redacted]

7.8.0 Program Call Center Telephone Guarantees and Credit Amounts

7.8.1 ***Guarantees:***

7.8.1a ***Call Center Availability*****:** The DCS Program's service level standard requires that the Contractor's telephone line will be operational and available to Enrollees, Dependents, and pharmacies at least [redacted] percent [redacted] of the Contractor's Call Center Hours. The call center availability shall be reported monthly and calculated quarterly;

7.8.1b ***Call Center Telephone Response Time:*** 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 forty-five (45) seconds. Response time is defined as the time it takes incoming calls to the Contractor's telephone line to be answered by a customer service representative. The call center telephone response time shall be reported monthly and calculated quarterly;

7.8.1c ***Telephone Abandonment Rate*****:** The DCS Program's service level standard requires that the percentage of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service representative will not exceed [redacted] The telephone abandonment rate shall be reported monthly and calculated quarterly; and

7.8.1d ***Telephone Blockage Rate*****:** 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.

7.8.2 ***Credit Amounts:***

7.8.2a ***Call Center Availability*****:** For each .01 to .25% 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;

7.8.2b ***Call Center Telephone Response Time*****:** For each .01 to 1.0% of incoming calls to the Contractor's telephone line below the standard of [redacted]

[redacted] that is not answered by a customer service representative within forty-five (45) seconds, calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of $[redacted] per quarter;

7.8.2c ***Telephone Abandonment Rate*****:** For each .01 to 1.0% of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service representative in excess of [redacted] calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of $[redacted] per quarter; and

7.8.2d ***Telephone Blockage Rate*****:** For each .01 to 1.0% of incoming calls to the contractor's telephone line that is blocked by a busy signal, in excess of [redacted], calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of $[redacted] per quarter.

7.9.0 Program Claims Processing System Guarantees and Credit Amounts

7.9.1 *Guarantees:*

7.9.1a ***Processing System Availability:*** 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.

7.9.1b ***Processing System Accuracy:*** 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.

7.9.2 *Credit Amounts:*

7.9.2a ***Processing System Availability:*** For each .01 to .25% 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; and

7.9.2b ***Processing System Accuracy:*** For each .01 to .25% 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 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.

7.10.0 Turnaround Time for Prior Authorizations Guarantee and Credit Amount

7.10.1 ***Guarantee:*** The Contractor guarantees that at least [redacted] of Prior Authorization requests that are received by the Contractor will be turned around within two (2) 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 DCS Programs' designated Post Office Box to the date the Contractors response is received by the mailing agent.

7.10.2 ***Credit Amount:*** For each .01 to .25% below [redacted] of all Prior Authorizations received by the Contractor not turned around within two (2) Business Days, calculated on a quarterly basis, the Contractor shall credit against the DCS Program's Claims Administration Fee the amount of $[redacted]

ARTICLE VIII: MODIFICATION OF PROGRAM SERVICES

8.1.0 In the event that laws or regulations enacted by the Federal government and/or the State have an impact upon the conduct of this Agreement in such a manner that the DCS determines that any design elements or requirements of the Agreement must be revised, the DCS shall notify the Contractor of any such revisions and shall provide the Contractor with a reasonable time within which to implement such revisions.

8.2.0 In the event that the NYS and the unions representing State Employees enter into collective bargaining agreements, or the State otherwise requires changes in Plan design elements or requirements of the Agreement, the DCS shall notify the Contractor of such changes and shall provide the Contractor with reasonable notice to implement such changes. The Contractor will be responsible for making collective bargaining changes using Department benefit codes.

8.3.0 To the extent that any of the events as set forth in this Article shall take place and constitute a material and substantial change in the delivery of services that are contemplated in accordance with the terms of the DCS Program as of the Effective Date and which the Contractor is required to perform or deliver under the Agreement, the Contractor may submit a written request to the DCS to initiate review of the fee(s) received by the Contractor for services provided and guarantees made by the Contractor under the terms of the Agreement, accompanied by appropriate documentation. The DCS reserves the right to request, and the Contractor shall agree to provide additional information and documentation the DCS deems necessary to verify that an increase in the fee(s), or modification of the guarantees is warranted. The DCS will agree to modify the fee(s) to the extent necessary to compensate the Contractor for documented additional costs determined by DCS to be reasonable and necessary. The DCS will agree to modify guarantees as determined by DCS to be necessary to reflect DCS Program modifications. Should the DCS approve the Contractor's request to modify the fee(s) and/or guarantees, such approval shall be subject to written amendment and approval by OSC and the AG. The Contractor shall implement changes as required by the DCS with or without final resolution of any fee proposal.

8.4.0 Any changes made by NYSIF to the scope of its contract with the Contractor for Prescription Drug Program Services after execution of this Agreement, including but not limited to the request to include any individual independent Network Pharmacy(ies), shall have no impact on this Agreement or cost thereunder, unless the change is agreed to by DCS.

ARTICLE IX: DEVELOPMENT OF CERTIFICATE OF INSURANCE

9.1.0 The Contractor shall present to the DCS its recommendations for the development of the necessary *Certificate of Insurance* for the Empire Plan, Excelsior Plan and SEHP Prescription Drug Programs. The DCS shall review the Contractor's recommendations and shall make the final determination regarding the manner in which the *Certificates* shall be developed and issued by the Contractor.

ARTICLE X: ENROLLMENT INFORMATION AND RECORDS

10.1.0 The Contractor shall maintain records from which may be determined at all times the names of all Enrollees receiving benefits hereunder, and their Dependents, and the benefits in force for each such Enrollee/Dependent, together with the date when any coverage became effective and the effective date of any change in benefits.

10.2.0 The DCS shall transmit enrollment information provided by the Enrollee to the Contractor for the DCS Program in an electronic format through the New York State Benefit Eligibility and Accounting System consistent with Section 6.8.2 of this Agreement. The eligibility rules and the enrollment reports generated as a result of these eligibility rules shall be the sole means of determining valid enrollment for benefits under the DCS Program.

10.3.0 The DCS and the Enrollees/Dependents shall furnish to the Contractor all information that the Contractor may reasonably require with regard to any matters pertaining to the enrollment of Enrollees/Dependents under this Agreement. A person will not be entitled to or deprived of benefits under the Agreement due to clerical errors.

10.4.0 The DCS agrees to provide the Contractor with reasonable access to records of the DCS which may have a bearing on the benefits provided by the Contractor or calculation of the Contractor's Claims Administration Fee as set forth under Article XIV of this Agreement.

ARTICLE XI: DATA SHARING AND OWNERSHIP

11.1.0 All claims and other data related to the DCS Program is the property of the State. Upon the request of the DCS, the Contractor shall share appropriate claims data with other NYSHIP carriers, DCS consultants and the Department's DSS contractor. Except as directed by a court of competent jurisdiction in New York State, or as necessary to comply with applicable New York State or Federal law, or with the written consent of the Enrollee/Dependent, the Contractor shall not share, sell, release, or make the data available to third parties in any manner without the prior written consent of the DCS. The DCS understands that the Contractor is required to share certain claims data with pharmaceutical manufacturers for purposes of obtaining for the DCS Program all Pharma Revenue due it under the Agreement. The Contractor shall inform the DCS of the types of data being shared for these specific authorized purposes.

ARTICLE XII: DCS PROGRAM CLAIMS REIMBURSEMENT

The DCS Program shall be charged for dispensed drugs consistent with the provisions of this Article XII.

12.1.0 General Provisions

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

12.2.0 Average Wholesale Price (AWP) Source and Brand, Generic Drug and Compound Drug Classification

The pricing formulas set forth in this Article are based on the classification of drugs as either Brand Drugs, Generic Drugs, or Compounded Drugs.

12.2.1 Throughout the term of the Agreement, the Contractor shall utilize Medi-Span) as the source of Average Wholesale Price (AWP) information for purposes of calculating Ingredient Cost unless the Parties mutually agree in writing to use a different source for AWP information. The AWP used for pricing purposes during claim adjudication should be the AWP in effect on the date the drug was filled.

12.2.2 In the event the 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 Parties will meet and agree in writing to any Brand and/or Generic Drug classification changes that may be necessary to enable the Parties to maintain the same economic position and obligations as are set forth in the Agreement.

12.2.3 Notwithstanding any other provision of the Agreement to the contrary, when during the term of this Agreement industry events have caused the Contractor's source of AWP to become obsolete or no longer available, the parties shall agree on revised pricing terms. In no event shall the DCS Program's actual costs for drugs increase as the result of new pricing terms. The Contractor shall notify the DCS in writing as soon as any information indicating a problem with the future use of the Contractor's AWP source is received. Within two weeks of the initial notification, the Contractor agrees to submit a detailed written proposal to DCS, if sufficient information is available to prepare such proposal,

and in any event no less than 120 days prior to the effective date of any revision, for effectively revising pricing terms including but not limited to a file containing the Contractor's pricing for all drugs dispensed during the prior six months utilizing the current AWP source and the Contractor's revised pricing for such drugs using the proposed methodology. The Contractor's proposal shall ensure continued alignment of the Contractor's interests with those of the DCS Program.

12.2.4 ***Classification Methodology General***

12.2.4a Drugs shall be classified for pricing purposes under this Agreement in accordance with DCS classification determinations based on the definitions contained in Article I Definition of Terms of this Agreement. No later than November 15th of each Plan Year, the Contractor shall submit for DCS written approval a file containing all NDCs dispensed through the Program during the prior year and the classification of each NDC derived from application of the Contractor's electronic classification process. To the extent the Contractor's electronic process results in classifications inconsistent with DCS determinations, the Contractor commits to modify its classification methodology to replicate the results of the DCS determination, including the steps set forth in Section 12.2.4b below. The DCS determination shall be final.

12.2.4b To the extent the electronic process fails to comprehensively replicate drug classifications specified by the DCS Program in this Article XII DCS Program Claims Reimbursement of this Agreement consistent with the definitions of Brand and Generic Drugs as set forth in Sections 1.5.0 and 1.46.0 of this Agreement, the Contractor agrees to modify to the extent possible its electronic processing system before January 1, 2019, including setting appropriate Copayment levels as required, and to undertake all other necessary manual steps to ensure that the result of the prescription processing process from a cost basis to both Enrollee and Plan is in accordance with the DCS determination of classification.

12.2.4c The Contractor shall conduct a year end reconciliation each Plan Year to ensure that the claim amount charged to the Plan is in accordance with the definition of Brand and Generic Drugs set forth in Sections 1.5.0 and 1.46.0 of this Agreement. The reconciliation will include claims paid during the Plan Year and is to be completed by February 15th of the following year. If DCS's review of the Contractor's reconciliation indicates an adjustment is required, then DCS reserves

the right to make an adjustment to the Contractor's submitted reconciliation. The Contractor shall credit or debit the Plan as applicable no later than thirty (30) Days following the date of reconciliation and reflect the result in the Annual Financial Statement.

12.3.0 Brand Drug Determination Methodology

12.3.1 The classification of a drug as a Brand Drug for the purpose of applying the appropriate pricing formula and Copayment level shall be based on the definition of the Brand Drug set forth in Section 1.5.0. The Contractor shall utilize an electronic process for claims processing using Medi-Span indicators to determine classification with the results subject to the review and approval of DCS for consistency with Section 1.5.0 prior to commencement of all contractual responsibilities on January 1, 2019. The Contractor agrees that the DCS determination shall be final.

12.3.2 A drug labeled with the identifier "M" or "O" in the Medi-Span Multi-Source code shall be processed as a Brand Drug unless the same drug is identified as "G" in the Medi-Span Brand-Name code. In addition to drugs identified as "M" or "O" in the Medi-Span Multi-Source code, a drug that is identified as "N" in the Medi-Span Multi-Source code shall be designated a Brand Drug if the drug is identified as "T" in the Medi-Span Brand- Name code. To the extent the electronic process fails to comprehensively replicate drug classifications proposed by the Program in this Section 12.3.2 of this Agreement consistent with the definition of Brand Drug set forth in Section 1.5.0 of this Agreement, the Contractor agrees to modify its electronic processing system before January 1, 2019, including setting appropriate Copayment levels as required, and to undertake all other necessary manual steps to ensure that the result of the prescription processing process to both Enrollee and Plan is in accordance with the correct classification.

12.3.3 To the extent the Contractor cannot process claims consistent with DCS Brand Drug determinations, the reconciliation process set forth above will be performed.

12.4.0 Generic Drug Determination Methodology

12.4.1 The classification of a drug as a Generic Drug for the purpose of applying the appropriate pricing formula shall be based on the definition of Generic Drug set forth in Section 1.46.0 of this Agreement. The Contractor shall utilize an electronic process using Medi-Span indicators to establish classification with the results subject to the review and approval of

DCS prior to commencement of all contractual responsibilities on January 1, 2019. The Contractor agrees that the DCS determination shall be final.

12.4.2 A drug identified as "Y" in the Medi-Span Multi-Source code shall be designated as a Generic Drug. In addition to drugs identified as "Y" in the Medi-Span Multi-Source code, a drug identified as "N" in the Medi-Span Multi-Source Code shall be designated as a Generic Drug if the corresponding Medi-Span Brand-Name code for such drug is "B" or "G." In addition, a drug identified as "G" in the Medi-Span Brand-Name Code shall be designated as a Generic Drug, regardless of the identifier designated in the Medi-Span Multi-Source code. To the extent the electronic process fails to comprehensively replicate the drug classification proposed by the Program in this Section 12.4.2 of this Agreement consistent with the definition set forth in 1.46.0 of this Agreement, the Contractor agrees to modify its electronic processing system before January 1, 2019, including setting appropriate Copayment levels as required, and to undertake all other necessary manual steps to ensure that the result of the prescription processing process to both Enrollee and Plan is in accordance with the correct classification.

12.4.3 To the extent the Contractor cannot process claims consistent with DCS Generic Drug determinations, the reconciliation process set forth above will be performed.

12.5.0 Compound Drug Determination Methodology

The Contractor shall implement a process to review Compound Drug claim submissions for compliance with the contracted definition. The classification of a drug as a Compound Drug for the purpose of applying the appropriate pricing formula shall be based on the definition of Compound Drug set forth in Section 1.16.0 of this Agreement.

12.6.0 Program's Lesser of Logic

The Program's Lesser of Logic applies to all claims processed under the DCS Program. Retail Generic Prescriptions assigned a MAC price shall be charged to the Plan at the following Lesser of Logic: the lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee; the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is Usual and Customary); the AWP discount contracted with the Network Pharmacy plus dispensing fee; or the Maximum Allowable Cost plus dispensing fee. Retail Brand Prescriptions and Generic Prescriptions that are not assigned a MAC price shall be charged to the Plan at the following Lesser of Logic: the lowest of the Pharmacy's Usual and Customary Price (no dispensing fee is to be paid on claims when the pricing basis is usual and

customary); the Discounted Ingredient Cost contracted with Network Pharmacy plus dispensing fee; or the Pharmacy-submitted Ingredient Cost plus dispensing fee. Mail Service Pharmacy Process Generic Prescriptions shall be charged to the Plan at the following Lesser of Logic: The lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee; the Guaranteed Minimum Discounted Ingredient Cost off of AWP plus dispensing fee or the Maximum Allowable Cost plus dispensing fee. Mail Service Pharmacy Process Brand and Specialty Pharmacy Process Brand and Generic Prescriptions shall be charged to the Plan at the following Lesser of Logic: the lowest of the Pharmacy-Submitted Ingredient Cost plus dispensing fee; or the Guaranteed Minimum Discounted Ingredient Cost off of AWP plus dispensing fee. Once the Lesser of Logic has been applied, the pricing methodology resulting in the lowest claim cost to the Plan is determined, and to that amount any applicable sales tax is added and the applicable Copayment and any ancillary fee resulting from application of the Program's Mandatory Generic Substitution provisions are deducted.

12.7.0 Mandatory Generic Substitution at Retail and Mail

The Contractor shall:

12.7.1 Apply mandatory generic substitution to all specific NDC's of Brand Drugs for which there is an FDA approved A-rated Generic Drug (including but not limited to, Generic Drugs rated AA, AB, AN, AO, AT, etc.) or an authorized Generic Drug as permissible by NYS law. Network Pharmacies shall comply with all state laws related to mandatory generic substitution. The Contractor shall apply mandatory generic substitution to all specific NDC's (inactive or active) of Brand Drugs. The DCS Program's mandatory generic substitution provisions shall apply to any claim where the A-rated or authorized Generic Drug is required or permitted to be substituted under state law. Mandatory generic substitution provisions will not apply to B-rated or unrated Generic Drugs or in the unlikely event that state law prohibits dispensing of the A-rated or authorized Generic Drug.

12.7.2 Establish the Ancillary Charge by calculating the difference in the Discounted Ingredient Cost of the Brand Drug and the Discounted Ingredient Cost of the equivalent A-rated Generic Drug or authorized Generic Drug based on the DCS Programs' MAC List(s) 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 Copayment plus Ancillary Charge not to exceed the cost of the drug to the DCS Program. The Ancillary Charge shall be assessed even in the event a doctor has specifically directed a Pharmacist to dispense

the Brand Drug rather than the A-rated or authorized Generic Drug through DAW notation.

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

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

12.7.4a Inform the DCS as soon as practicable but in no event later than fourteen (14) Days after the first date of shipment, (from manufacturer to wholesaler or retailer) of the financial impact of enforcing mandatory generic substitution via the "MAC Alert Notice" detailed in Section 16.6.1 of this Agreement.

12.7.4b For those drugs that will result in a lower net cost to the DCS Program by enforcing mandatory generic substitution, the Contractor shall provide the "MAC Alert Notice" as described in Section 12.7.4a above. The Contractor shall add the GPI to the DCS Programs' MAC List(s) and begin enforcement as soon as practicable but in no event later than fourteen (14) Days after the first date of shipment provided that the retail Network Pharmacies are able to obtain the Generic Drug. In the case where a 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.

12.7.4c For those drugs that could potentially result in a higher net cost to the DCS Program by enforcing mandatory generic substitution, the Contractor shall provide the "MAC Alert Notice" as described in Section 12.7.4a above. DCS, in its sole discretion, may determine that enforcement is contrary to the best financial interests of the DCS Program and shall inform the Contractor whether Mandatory Generic Substitution shall be applied. If the Contractor does not receive a formal response to the information provided via the "MAC Alert Notice," enforcement shall commence and the GPI shall be added to the DCS Programs' MAC List(s) effective on the 21st Day after shipment (from manufacturer to wholesaler or retailer) of the first A-rated generic equivalent

drug or authorized Generic Drug provided that the Pharmacies are able to obtain the Generic Drug. In the event the DCS decides to exercise its discretion not to enforce mandatory generic substitution, the Contractor shall apply MAC pricing to the Generic Drug.

12.7.4d To assist the DCS in determining whether or not mandatory generic substitution should be enforced within 21 Days, the Contractor shall survey its Retail Pharmacy Network to identify the Pharmacies that are unable to obtain the new generic within 21 Days. The Contractor shall submit this information to the DCS and provide any additional information as required by DCS to reach a determination. The DCS, in its sole discretion, shall determine based on such evidence how the DCS Program's mandatory generic substitution provisions shall be applied. The DCS Program will not consider and the Contractor shall not act on availability information provided by third-party sources, including but not limited to Medi-Span, or wholesalers.

12.7.4e For Preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall be changed from preferred to non-preferred status concurrent with the commencement of the enforcement of mandatory generic substitution. Enrollees prescribed strengths of the Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the Level 1 Copayment unless the prescribing Physician requires that the Brand Drug be dispensed. In that case, the Enrollee shall be charged the applicable Level 3 Copayment and Ancillary Charge. Enrollees prescribed strengths of the Preferred Brand Drug for which no A-rated or authorized Generic Drug has been introduced shall continue to receive the prescribed drug at the applicable Level 2 Copayment and mandatory generic substitution provisions shall not apply.

12.7.4f For Non-Preferred Brand Drugs for which an A-rated or authorized Generic Drug has been introduced into the market for one or more strengths of a Brand Drug, the status of the Brand Drug shall remain non-preferred for all strengths. Concurrent with enforcement of mandatory generic substitution, Enrollees prescribed strengths of the Non-Preferred Brand Drug for which an A-rated or authorized Generic Drug has been introduced shall receive the Generic Drug and be charged the Level 1 Copayment unless the prescribing Physician

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

12.7.4g The Contractor shall require the dispensing Network Pharmacy to inform the Enrollee prior to dispensing the Brand Drug, that an Ancillary Charge would be applied in addition to the applicable Level 3 Copayment. If the prescribing Physician requires the Brand Drug be dispensed, the Contractor shall require the dispensing Network Pharmacy to collect the applicable Level 3 Copayment plus the calculated Ancillary Charge. However, under no circumstances shall the Enrollee's total cost exceed what the actual cost of the Brand Drug would have been to the Program after application of the DCS Program's Lesser of Logic provisions.

12.7.4h Charge the DCS Program based on the DCS Programs' MAC List(s) price assigned to the GPI of the dispensed Brand Drug subject to the Program's Lesser of Logic set forth in Section 12.6.0 of this Agreement, plus the applicable dispensing fee as set forth in Section 12.11.3 of this Agreement.

12.7.4i Receive DCS written approval for any and all exceptions to the DCS Program's mandatory generic substitution provisions, beyond the approval of specific generic appeals or approval through the Medical Exception Program. Following commencement of mandatory generic substitution, the Contractor must receive DCS approval prior to suspending enforcement of the DCS Program's mandatory generic substitution provisions.

12.7.4j Maintain an electronic claims processing system capable of obtaining information from Network Pharmacies to ensure consistent enforcement of the DCS Program's mandatory generic substitution provisions. In particular, the claims processing system must be capable of capturing information concerning the availability of the Generic Drug at the Network Pharmacy submitting the electronic claim. If a Generic Drug is available to be dispensed by the Network Pharmacy, the DCS Program's mandatory generic substitution rules shall be applied. If the Network Pharmacy does not have the A-rated or authorized Generic Drug in

stock, mandatory generic substitution provisions will not apply and the Enrollee shall receive the Brand Drug, be charged the applicable Level 1 Copayment and the DCS Program charged based on Generic Drug pricing. The Contractor's claims processing system must reject, with appropriate messaging, claims for Brand Drugs subject to mandatory generic substitution that are submitted with a DAW-0 code requiring resubmission of the claim (since a DAW-0 code provides no indication of Generic Drug availability in the Pharmacy). Similar rules shall be applied to other DAW submission codes as necessary to ensure consistent, accurate application of the DCS Program's mandatory generic substitution requirements. These rules are specified in Section 6.14.4 of this Agreement.

12.7.5 Immediately notify DCS in writing of changes (from brand to generic or generic to brand) in the NDC classification submitted by the Contractor.

12.8.0 <u>Retail Pharmacy Network Claims</u>

12.8.1 The cost of all Covered Drugs dispensed at Network Pharmacies shall be charged to the DCS Program consistent with the requirements set forth in this Section, including but not limited to application of the Lesser of Logic set forth in Section 12.6.0 of this Agreement. Under no circumstances may the Enrollee be charged costs not specifically provided for under the Plan benefit design.

12.8.1a The Contractor shall ensure that the Network Pharmacy collects the appropriate Copayment specified by DCS plus Ancillary Charge, if applicable, from the Enrollee and will charge the Program the Discounted Ingredient Cost as determined through the application of the Lesser of Logic detailed in Section 12.6.0 of this Agreement plus the Contractor's applicable pharmacy contracted dispensing fee minus the applicable Copayment for all drugs dispensed through a Network Pharmacy;

12.8.1b If the cost derived through application of the DCS Program's Lesser of Logic provision as set forth in 12.6.0 of this Agreement, plus the applicable dispensing fee and any applicable tax, is lower than the Enrollee's applicable Copayment, then the Contractor shall ensure that the Enrollee is not charged more than that cost of the drug;

12.8.1c The Contractor shall administer a control process at point of service to protect the DCS Program from any inflated AWP costs associated with "repackaged" drugs charged to the DCS Program; and

12.8.1d 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 this Agreement and the Contractor's proposal in Exhibit C. 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 Article VIII and/or Appendices A & B of this Agreement. In addition, access to or hard copies of all Retail Pharmacy Network contracts must be made available, in Albany County as deemed necessary for the Department or other State auditors with authority under Article XVIII and/or Appendices A & B of this Agreement to evaluate whether the Contractor is meeting the requirements of the Agreement.

12.8.2 <u>Retail Pharmacy Network Brand Drug Pricing</u>

12.8.2a The Contractor shall charge the DCS Program utilizing Pass-through Pricing for all Brand Drugs and Limited Distribution Drugs dispensed to Enrollees through the Network Pharmacies.

12.8.2b The Contractor shall use the following Ingredient Cost and dispensing fee, minus Copayment and applicable Ancillary Charge, if any, to charge the DCS Program for each Prescription for a covered Brand Drug dispensed by a Network Pharmacy throughout the term of the Agreement subject to application of the Lesser of Logic as set forth in Section 12.6.0 of this Agreement.

12.8.2b(1) ***Ingredient Cost of Brand Drug Dispensed at Retail Pharmacy 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 and annual maximum average dispensing fee of [redacted] for all Brand Drugs dispensed through Network Pharmacies.)

12.8.2c The Contractor shall guarantee an overall minimum discount off of the aggregate AWP for all Brand Drugs dispensed at retail Network Pharmacies as defined in the RFP. The Contractor guarantees the DCS Program that its management of Brand Drug costs dispensed by pharmacies shall result in the Plan achieving the Contractor's proposed overall Guaranteed Minimum Discounts of [redacted] percent during the Plan Year. The discounts achieved off of the aggregate AWP for all Brand Drugs as a result of Pass-through Pricing will be calculated utilizing the following formula: 1 minus (Sum of Ingredient Costs of dispensed Brand Drugs divided by sum of AWP of dispensed Brand Drugs). The aggregate discount calculation will be based on Pharmacy Prescriptions filled with a Brand Drug where the Plan was the primary payer (including Enrollee submitted claims). Claims submitted for secondary payer consideration, Compound Drug claims, vaccines, 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

12.8.2d If the overall aggregate discounts obtained, as calculated utilizing the formula set forth in the prior paragraph, are less than the Guaranteed Minimum Discounts of [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] off of the aggregate AWP had been obtained. The DCS Program will be credited annually for this difference in Ingredient Cost. The DCS Program shall retain the benefit of any cost savings, in excess of the Contractor's proposed Guaranteed Minimum Discounts off the aggregate AWP for all Brand Drugs dispensed by pharmacies.

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

on July 31st. If the Department Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Department reserves the right in their sole discretion to make an adjustment to the Contractor's calculations. Upon approval by the Department, the Contractor shall pay/credit the Plan the applicable amount, if any, within 30 Days. The Contractor shall also reflect the adjustment, if any, in the Contractor's Annual Financial Summary Report. The DCS Program shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discount of [redacted] off the aggregate AWP. Any shortfall in the Guaranteed Minimum Discount of this Agreement cannot be recovered by the Contractor in subsequent years.

12.8.3 Retail Pharmacy Network Generic Pricing

The Contractor shall:

12.8.3a Maximize the discount achieved on behalf of the DCS Program for Generic Drugs dispensed by Network Pharmacies. The Contractor or its Key Subcontractor, if any, must manage the 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 Drugs dispensed to Enrollees through the Network Pharmacies.

12.8.3b Create and maintain a single Program-Specific Maximum Allowable Cost (MAC) List called the Program MAC List(s) setting the Ingredient Cost the DCS Program shall be charged, and the amount the dispensing Network Pharmacy shall be paid, for the Ingredient Cost for the drugs required to be included on the Program MAC List(s). Under no circumstances shall the MAC price assigned exceed the Discounted Ingredient Cost to the DCS Program achieved by using the Contractor's highest contracted Retail Pharmacy Network Brand Guaranteed Minimum Discount of [redacted] off of AWP applied to the AWP of the dispensed Generic Drug.

NOTE: The Department reserves its right for the Contractor to create and maintain a second MAC List(s) should industry or programmatic events necessitate the use of a second list. The use of a second MAC List(s) will be at the sole discretion and approval of the Department. The Guaranteed Minimum Discounts and the overall maximum dispensing fee guarantees for

generic drugs will be subject to negotiation if a second MAC List(s) is utilized.

12.8.3c 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 DCS Programs' MAC List(s) and set a MAC price for the GPI in accordance with Section 6.17.1 of this Agreement. The provisions of this Section require that MAC pricing be applied in no event later than 21 Days after the first shipment of the first Generic Drug from the manufacturer to a wholesaler or retailer. For those Generic Drugs with an established GPI that are already subject to MAC pricing the Contractor is required to immediately apply MAC pricing to any generic NDC added to the GPI. All A-rated or authorized Generic Drugs shall be placed on the MAC List(s) in all instances including, but not limited to circumstances in which the DCS in its sole discretion decides not to enforce mandatory generic substitution of the Brand Drug in that GPI. There shall be one MAC price applicable to all NDCs included in the GPI on the DCS Programs' MAC List(s). The MAC price shall be consistent with the process in Section 12.8.3b. However, depending on particular market factors, it may be in the best interests of the DCS Program, and therefore appropriate, for more than one MAC price to be assigned within a GPI. Such situations would require that the Contractor provide any information DCS deems necessary to support such action and obtain prior written approval from DCS. MAC prices may, for example, be appropriately set at the NDC level for specific dosage forms (e.g. creams, ointments, suspensions, etc.) or for "branded generics", particularly for NTI drugs.

12.8.3d Assign a MAC price to all NDCs of B-rated or unrated Generic Drugs included within a GPI that does not include an A-rated or authorized Generic Drug. The Contractor shall add the GPI to the DCS Programs' MAC List(s) 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 the first Generic Drug from the manufacturer to a wholesaler or retailer concurrent with transmission of the MAC alert notice. The Contractor shall not apply the MAC price to the NDC(s) for Brand Drugs dispensed in the GPI and shall not enforce the DCS Program's 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. 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 DCS deems necessary to support such action and obtain prior written approval from DCS. MAC prices may, for example, be appropriately set at the NDC level for specific dosage forms (e.g. creams, ointments, suspensions, etc.) or for "branded generics", particularly for NTI drugs.

12.8.3e Charge the DCS Program for Generic Drugs not on the MAC List(s) dispensed, utilizing pass-through pricing of the Contractor's pharmacy contracted discount applied to the AWP of the dispensed Generic Drug. The only Generic Drugs not on the MAC List(s) shall 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.

12.8.3f The Contractor shall inform the DCS of any market based condition which makes the strict compliance with Section 12.8.3b–12.8.3e of this Agreement contrary to the financial interests of the DCS Program. The DCS in its sole discretion may waive such requirements.

12.8.3g Monitor the DCS Programs' MAC List(s) 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 DCS Program of any GPIs subject to MAC pricing in which the majority of claims are processing at a basis other than the MAC price.

12.8.3h Agree that there shall be no increases to DCS Programs' MAC List(s) prices where such adjustment is intended to limit the discount achieved on behalf of the DCS Program to the Guaranteed Minimum Discount off of the aggregate AWP as set forth in Section 12.8.3m below, for all Generic Drugs dispensed by Network Pharmacies during the Plan Year.

12.8.3i Provide to the DCS full access to the DCS Programs' MAC List(s) used to price Generic Drugs dispensed by Retail Pharmacy Network and Mail Service Pharmacy Process for the DCS Program. The Contractor must be prepared to

provide valid documented market rationale to support their DCS Programs' MAC pricing should DCS request this information. In order to protect the DCS Program's financial interests from the date of the award until the termination date of the Agreement, the Contractor must agree that any increases to the DCS Programs' MAC pricing must be justified to DCS with valid documented market rationale. Following selection, the Contractor shall manage the content of the DCS Programs' MAC List(s) consistent with the requirements of this Agreement. Prices assigned to required new additions to the DCS Programs' MAC List(s) shall be equivalent to the Contractor's most aggressive MAC price for that drug. To ensure compliance with these requirements, the Contractor shall notify the DCS on a monthly basis of all changes, additions, and deletions made to the DCS Programs' MAC List(s) in the format specified by DCS in Section 16.4.3 of this Agreement. Throughout the term of the Agreement, the Contractor commits to use its best efforts to maintain the aggregate effectiveness of its DCS Programs' MAC List(s). 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.

12.8.3j The Contractor shall strictly enforce all requirements of the DCS Program's mandatory generic substitution provision as detailed in Section 12.7.0 of this Agreement.

12.8.3k The Contractor guarantees that its management of Generic Drug costs dispensed by Network Pharmacies, including maintenance of the DCS Programs' specific MAC List(s), and application of pricing provisions related to Generic Drugs that do not meet the requirements for inclusion on the DCS Programs' specific MAC List(s), shall result in the DCS Program achieving the Contractor's overall Guaranteed Minimum Discount off of the aggregate AWP as set forth in Section 12.8.3m below, for all Generic Drugs dispensed by Network Pharmacies during the Plan Year. The discount achieved off of the aggregate AWP for all Generic Drugs as a result of the pricing set forth in Sections 12.8.3m and 12.9.6c, below, shall be calculated utilizing the following formula: 1 minus (Sum of Ingredient Costs of dispensed Generic Drugs at Retail Pharmacy Network and Mail Service Pharmacy Process divided by sum of the AWP of dispensed Generic Drugs). The aggregate discount calculation shall be based on Final Paid Claim Network Pharmacy Prescriptions filled with a Generic Drug

including Empire Plan Medicare Rx claims. Claims submitted for secondary payer consideration, Compound Drug claims, vaccines, powders, subrogation, long term care pharmacy claims, nursing home pharmacy claims, Veterans Affairs hospital pharmacy claims, and claims submitted by governmental entities are excluded from the aggregate discount calculation. In addition, claims with a calculated AWP discount greater than 90% and a total AWP greater than $500 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 an overall minimum discount off of the aggregate AWP for all Generic Drugs dispensed at Retail Pharmacy Network and Mail Service Pharmacy Process shall in no way modify the Contractor's contractual obligation to maximize the DCS Program's aggregate discount above the Contractor's overall Guaranteed Minimum Discount of [redacted] off of the aggregate AWP.

12.8.3l If the overall aggregate discount obtained, as calculated utilizing the formula set forth in Section 12.8.3k, above, is less than the Guaranteed Minimum Discount set forth in Section 12.8.3m, the Contractor shall reimburse the DCS Program the difference between the Ingredient Cost the DCS Program was charged utilizing Pass-through Pricing and the Ingredient Cost the DCS Program would have been charged if the Guaranteed Minimum Discount off of the aggregate AWP set forth in Section 12.8.3m for all Generic Drugs was obtained.

This calculation shall be performed for each Plan Year based on claims paid for each incurred year. Specifically, the Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the Department on July 31st. The Contractor shall pay/credit the DCS Program the applicable amount, if any, within 30 Days of the reconciliation due date. If the Department Agencies' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the Department reserves the right in their sole discretion to make an adjustment to the Contractor's calculations and adjust the amount paid to or from the Contractor. The DCS Program shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discount off the aggregate AWP set forth in Section 12.8.3m for all Generic Drugs dispensed by Retail Pharmacy Network and Mail Service

Pharmacy Process. Any shortfall in the Guaranteed Minimum Discount set forth in Section 12.8.3m cannot be recovered by the Contractor in subsequent years.

12.8.3m The Contractor shall use the following Ingredient Cost and dispensing fee, minus applicable Copayment, to charge the DCS Program for each covered Generic Drug dispensed by retail Network Pharmacies throughout the term of the Agreement subject to the Lesser of Logic process set forth in Section 12.6.0 of this Agreement.

12.8.3m(1) ***Ingredient Cost of Generic Drug dispensed at Retail Pharmacy 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.)

12.8.4 <u>Retail Pharmacy Network Compound Drug Pricing</u>

Compound Drugs must be classified consistent with the definition in Section 1.16.0 of this Agreement.

The Contractor shall:

12.8.4a Implement the pricing methodology for Compound Drugs as set forth in Section 12.8.4e and 12.8.4f below. The Program's "Lesser of Logic" will apply;

12.8.4b Charge Enrollees the applicable Level 2 Drug Copayment for all Compound Medications. If the current Discounted Ingredient Cost, plus dispensing fee, or the submitted cost is less than the applicable Level 2 Copayment then the Contractor shall ensure that the Enrollee is charged the lesser amount;

12.8.4c Process Compound Drug claims in a manner that verifies the validity of the claim as a Compound Medication according to the DCS Program's definition of a Compound Drug and provides appropriate claim level control procedures to protect the financial interests of the DCS Program;

12.8.4d Conduct due diligence as well as audit Network Pharmacies to ensure that drugs are being properly classified as Compound Drugs consistent with the DCS Program's definition of a Compound Drug and to ensure that claims are priced in accordance with the methodology for Compound Medications as set forth in Section 12.8.4e below;

12.8.4e The 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 in Section 12.8.4f below.

12.8.4e(1) 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.

12.8.4f

12.8.4f (1)	11	Single ingredient batched capsule; any combinatio of commercially available products; or
12.8.4f (2)	12	Two or three ingredient batched capsule; transdermal gel; or
12.8.4f (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
12.8.4f (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
12.8.4f (5)	15	Sterile product

[redacted]

12.9.0 Mail Service Pharmacy Process Pricing – Brand Drugs, Generic Drugs, and Compound Drugs

The Contractor shall:

12.9.1 Consistently enforce and administer all provisions of the DCS Program (including but not limited to mandatory generic substitution, drug utilization review, prior authorization, refill too-soon edits, etc.) to the claims dispensed through the Mail Service Pharmacy

Process, consistent with the processing of claims through the Retail Pharmacy Network process.

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

12.9.3 Charge the DCS Program based on the Contractor's pricing terms and dispensing fees applicable to brand, generic, and Compound Drug claims as set forth in Sections 12.9.5, 12.9.6 and 12.9.7 for all Prescriptions submitted through the Mail Service Pharmacy Process. The DCS Program's Lesser of Logic shall be applied.

12.9.4 Ensure that the Mail Service Pharmacy Process Facilities collect the appropriate Copayment specified by DCS plus Ancillary Charge, if applicable, from the Enrollee and will charge the DCS Program the balance of the Discounted Ingredient Cost as determined through the application of the Lesser of Logic detailed in Section 12.6.0 of this Agreement plus the Contractor's applicable guaranteed dispensing fee set forth in Section 12.11.3, of this Agreement, minus the applicable Copayment for all drugs dispensed through the Mail Service Pharmacy Process.

12.9.5 <u>Mail Service Pharmacy Process - Brand Drug Pricing</u>

The Contractor shall:

12.9.5a Classify Brand Drugs consistent with the definition in Section 1.5.0 of this Agreement as well as the methodology outlined in Section 12.3.0 of this Agreement.

12.9.5b Implement its fixed contracted Guaranteed Discount off of Average Wholesale Price (AWP) as set forth below in Section 12.9.5d, that shall be utilized to determine the Ingredient Cost of the Prescription to charge the DCS Program. The Contractor's Guaranteed Discount shall be applicable to all individual Prescriptions for Brand Drugs dispensed to Enrollees through the Mail Service Pharmacy Process.

12.9.5c Ensure that the dispensing Mail Service Pharmacy Process Facility collects the appropriate Brand Drug Copayment plus Ancillary Charge, if applicable, from the Enrollee. If the Ingredient Cost derived through application of the DCS Program's Lesser of Logic provision as set forth in 12.6.0 of this Agreement, plus any applicable tax, is lower than the Enrollee's applicable Copayment, then the Contractor shall ensure that the Enrollee is not charged more than the cost of that drug.

12.9.5d The Contractor shall use the following Ingredient Cost and dispensing fee, minus Copayment and applicable Ancillary Charge, if any, to charge the DCS Program for each Prescription for a covered Brand Drug dispensed through the Mail Service Pharmacy Process throughout the term of the Agreement.

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

12.9.6 <u>Mail Service Pharmacy Process - Generic Drug Pricing</u>

The Contractor shall:

12.9.6a Classify Generic Drugs consistent with the definition in Section 1.46.0 of this Agreement.

12.9.6b Ensure that the Mail Service Pharmacy Process dispensing facility collects the Level 1 Copayment from the Enrollee. If the Ingredient Cost derived through application of the DCS Program's Lesser of Logic provision as set forth in Section 12.6.0 of this Agreement, plus any applicable tax, is lower than the Enrollee's applicable Copayment, then the Contractor shall ensure that the Enrollee is not charged more than the cost of that drug.

12.9.6c The Contractor shall use the following Ingredient Cost and dispensing fee, minus Copayment, to charge the DCS Program for each Prescription for a covered Generic Drug dispensed through the Mail Service Pharmacy Process

throughout the term of the Agreement subject to the Lesser of Logic process set forth in Section 12.6.0 of this Agreement:

Ingredient Cost of Generic Drug dispensed at Mail Service Pharmacy: 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 12.9.5d 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]

12.9.6d The contractor must guarantee an overall minimum discount off the aggregate AWP for all Generic Drugs dispensed through the Mail Service Pharmacy Process, as set forth in Sections 12.8.3k and 12.8.3l of this Agreement.

12.9.7 <u>Mail Service Pharmacy Process - Compound Drug Pricing</u>

The Contractor shall:

12.9.7a Classify Compound Drugs consistent with the definition in Section 1.16.0 of this Agreement;

12.9.7b Implement its pricing methodology for Compound Drugs as set forth below in Section 12.9.7g. The DCS Program's Lesser of Logic will apply;

12.9.7c Charge Enrollees the applicable Level 2 Copayment for all Compound Medications. If the current Discounted Ingredient Cost or the submitted cost is less than the applicable Level 2 Copayment then the Contractor shall ensure that the Enrollee is charged the lesser amount;

12.9.7d Process Compound Drug claims in a manner that verifies the validity of the claim as a Compound Medication according to the DCS Program's definition and provides appropriate claim level control procedures to protect the financial interests of the DCS Program;

12.9.7e Conduct due diligence to ensure that drugs are being properly classified as Compound Drugs consistent with the Program's definition of a Compound Drug

and to ensure that claims are priced in accordance with the methodology for Compound Medications as set forth below in Section 12.9.7g below; and

12.9.7f 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 in Section 12.9.7g.

12.9.7f(1) 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.

12.9.7g

12.9.7e (1)	11	Single ingredient batched capsule; any combination of commercially available products or
12.9.7e (2)	12	Two or three ingredient batched capsule; transdermal gel; or
12.9.7e (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
12.9.7e (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
12.9.7e (5)	15	Sterile product

[redacted]

12.10.0 <u>Enrollee Submitted Claims</u>

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

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

12.10.2a Brand Drugs, including Specialty Drugs/Medications, must be charged to the DCS Program utilizing the Guaranteed Minimum Discount off of AWP for Brand

Drugs dispensed at the Retail Pharmacy Network set forth in Section 12.8.2b(1) and retail brand Guaranteed Maximum Dispensing Fee set forth in Section 12.11.3a for Brand Drugs minus the applicable Copayment;

12.10.2b Generic Drugs, including Specialty Drugs/Medications, must be charged to the DCS Program utilizing the Contractor's assigned MAC price for the retail Network Pharmacies and Mail Service Pharmacy Process Facilities plus the Guaranteed Maximum Dispensing Fee, for Generic Drugs set forth in Section 12.11.3 of this Agreement minus the applicable Copayment. Generic Drugs without a MAC price must be charged to the DCS Program using the Contractor's Guaranteed Minimum Discount set forth in Section 12.8.3b applied to the AWP of the dispensed Generic Drug, plus the Guaranteed Maximum generic dispensing fee, set forth in Section 12.11.3 of this Agreement, minus the applicable Copayment;

12.10.2c Compound Drugs must be charged to the DCS Program by applying the methodology for pricing Compound Drugs dispensed through the retail Network Pharmacy set forth in Section 12.8.4f of this Agreement plus the Guaranteed Maximum dispensing fee set forth in Section 12.11.3a for Compound Drugs minus the applicable Level 2 Copayment; and

12.10.2d The DCS Program's "Lesser of Logic" must be applied to all Enrollee Submitted Claims.

12.11.0 Dispensing Fee

12.11.1 The Guaranteed Dispensing Fees and Maximum Guaranteed Dispensing Fees set forth in 12.11.3 of this Section must be guaranteed for the term of this Agreement.

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

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

12.11.3a Retail Network Pharmacy Guaranteed Maximum Dispensing Fee:

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

12.11.3b Mail Service Pharmacy Process Guaranteed Dispensing Fee:

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

12.11.3c Designated Specialty Pharmacy Guaranteed Dispensing Fee:

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

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

Total Retail Network dispensing fees paid by the Plan on an annual basis divided by the number of Final Paid Claims at retail Network Pharmacies for each of Generic, Brand and Compound claims.

12.11.5 If the overall aggregate dispensing fees paid, as calculated utilizing the formula set forth in Section 12.11.4 of this Agreement are more than the Guaranteed Maximum Dispensing Fee set forth in Section 12.11.3a of the Agreement, for each of Brand, Generic and Compound claims at retail Network Pharmacies, the Contractor shall reimburse the DCS Program the difference between the Dispensing fee the DCS Program was charged utilizing Pass-through Pricing and the Dispensing Fee the DCS Program would have been charged if the Guaranteed Maximum Dispensing Fee had been obtained. The Contractor shall perform a reconciliation to include claims incurred in each Program Year and paid through June of the following Program Year. The reconciliation shall be submitted to the DCS on July 31st. If the DCS' review of the Contractor's calculations indicates an adjustment to the calculation is required, then the DCS reserves the right in their sole discretion to make an adjustment to the Contractor's calculations. Upon approval by the DCS, the Contractor shall pay/credit the Program the applicable amount, if any, within 30 (thirty) Days. The DCS Program shall retain the benefit of any cost savings in excess of the Guaranteed Maximum

Dispensing Fees set forth in Section 12.11.3. Any shortfall in the Guaranteed Maximum Dispensing Fees set forth in Section 12.11.3 cannot be recovered by the Contractor in subsequent years.

12.12.0 <u>Specialty Pharmacy Process Pricing</u>

The Contractor shall:

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

12.12.2 Charge the DCS Program for those drugs dispensed to the Enrollee in original manufacturer packaging, based on the Contractor's source of AWP for the 11-digit NDC of the package size dispensed through the Specialty Pharmacy Process. If the drug is not dispensed to the Enrollee in original manufacturer packaging (i.e., dispensed from bulk), the Program shall be charged based on the Contractor's source of AWP for the 11-digit NDC of the package size from which the drug was originally dispensed by the Designated Specialty Pharmacy. If the drug is dispensed from a bulk package size for which no AWP is reported in the Contractor's AWP source, the DCS Program shall be charged based on the reported AWP for the NDC of the largest package size contained in the Contractor's AWP source. The DCS Program shall not be charged based on an NDC assigned to repackaged drugs or based on package sizes prepared by special arrangement with the original manufacturer unless such packaging offers a net savings to the DCS Program.

12.12.3 Charge the DCS Program based on the Contractor's pricing terms and dispensing fees applicable to brand and generic, Specialty Drug/Medication claims as set forth in Sections 12.12.5 through 12.12.8 for all Prescriptions submitted through the Specialty Pharmacy Process.

12.12.4 Ensure that the Designated Specialty Pharmacies collect the appropriate Copayment specified by DCS plus Ancillary Charge, if applicable from the Enrollee and will charge the DCS Program the balance of the Discounted Ingredient Cost plus the Contractor's applicable guaranteed dispensing fee set forth in Exhibit E of this

Agreement, minus the applicable Copayment for all drugs dispensed through the Specialty Pharmacy Process.

12.12.5 Classify Brand Drugs consistent with the definition in Section 1.5.0 of this Agreement as well as the methodology outlined in Section 12.3.0 of this Agreement.

12.12.6 Classify Generic Drugs consistent with the definition in Section 1.46.0 of this Agreement.

12.12.7 Subject to the terms of Section 12.2.2, implement its fixed contracted Guaranteed Minimum Discount off of Average Wholesale Price (AWP) of [redacted] to determine the Ingredient Cost of the Prescription to charge the DCS Program. The Contractor's Guaranteed Minimum Discount shall be applicable to the aggregate AWP of all Prescriptions for Brand Drugs and Generic Drugs dispensed to Enrollees through the Specialty Pharmacy Process. The Contractor shall guarantee the DCS Program 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 Procuring Agencies.

12.12.8 If the overall aggregate discounts obtained, as calculated utilizing the formula set forth in the prior paragraph, are less than the Guaranteed Minimum Discounts of [redacted] the Contractor shall reimburse the DCS Program the difference between the Ingredient Cost the Program was charged and the Ingredient Cost the Program would have been charged if the Guaranteed Minimum Discount of [redacted] off of the aggregate AWP had been obtained. The Program will be credited annually for this difference in Ingredient Cost.

The Program shall retain the benefit of any cost savings, in excess of the Contractor's Guaranteed Minimum Discounts of [redacted] off the aggregate AWP for all Brand Drugs and Generic Drugs dispensed to enrollees through the Specialty Pharmacy Process.

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. The Contractor shall pay/credit the Department 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 its sole discretion to make an adjustment to the Contractor's calculations and adjust the amount due to the Department 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.

12.12.9 Act in the 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.

12.13.0 Vaccination Network Participating Pharmacy Pricing

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

12.13.1 Seasonal and Non-Seasonal Vaccines shall be charged to the Program on a pass-through basis, per the methodology set forth in Exhibit G of this Agreement;

12.13.2 The Contractor is bound by its Vaccination Network Pricing, as specified in Exhibit G – Vaccine Administration Fees set forth herein, for the entire term of the Agreement; and

12.13.3 The Contractor shall implement any changes necessary to accommodate 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.

ARTICLE XIII: 100% PHARMA REVENUE GUARANTEE

The Contractor is required to maximize savings to the Program through negotiation of Pharma Revenue Agreements obtaining discounts or other consideration from manufacturers and passing through 100% of the value of the Pharma Revenue agreements to the Program, including any consideration that would normally flow to the Contractor or Key Subcontractor(s) based on the Plan's utilization pursuant to the terms of those Pharma Revenue Agreements. In addition, all Pharma Revenue agreements with manufacturers and other entities applicable to the Program must meet or exceed the Contractor's best existing Pharma Revenue agreements for all individual drugs ensuring that in no instance will the Program receive less Pharma Revenue in any therapeutic class than other clients of the Contractor with a comparable benefit design and consistent preferred drug designations in the class provided the Program's utilization of the drugs generating Pharma Revenue in the class is equal to or greater than those of other clients.

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

13.2.0 Credit the DCS Program quarterly within 60 Days of the end of each quarter, the greater of 100% of the Pharma Revenue received or the minimum guaranteed amount set forth in Section 13.8.6.

13.3.0 Calculate and distribute Pharma Revenue to the DCS Program in a fully transparent and verifiable process. The Contractor agrees that all direct and indirect revenue arrangements with manufacturers, suppliers, or other vendors shall be disclosed and the revenue generated related or attributable to the DCS Program's utilization be credited to the DCS Program. The Contractor must agree that the records, methods and calculations utilized to total and distribute these amounts to the DCS Program are subject to audit by DCS or other State auditors with authority under Article XVIII and/or Appendices A & B of this Agreement. In addition, all agreements must be provided 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 this Agreement.

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

13.5.0 Throughout the term of the Agreement, the contractor shall provide upon the request of the State all information and documentation related to Pharma Revenue agreements, including but not limited to, full direct access by DCS staff or its agents to complete unredacted Pharma Revenue agreements pursuant to which the DCS Program derives Pharma Revenue**.** Agents of the DCS shall execute a mutually agreeable nondisclosure agreement with Contractor prior to reviewing any Pharma Revenue agreements or other confidential information, provided however that this does not affect the Office of State Comptroller's audit authority under Appendices A & B of the Agreement.

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

13.7.0 Ensure the Contractor's Minimum Pharma Revenue Guarantee Per Final Paid Claim, set forth in Section 13.8.6 is not contingent upon the DCS Program's participation in any of the Contractor's formulary management or intervention programs, including step therapy. Nor shall the Contractor's Minimum Pharma Revenue Guarantee Per Final Paid Claim be contingent or dependent on the 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. The DCS Program will review the guaranteed amount only in the event of legislative, regulatory, or judicial action excluding patent litigation not specific to the Contractor's business practices that serves to void existing Pharma Revenue agreements materially compromising the Contractor's ability to obtain contracted Pharma Revenue necessary to meet the Minimum 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 6.19.1a.

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

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

13.8.2 Credit the DCS Program an amount calculated based on the following formula: if in any Plan Year, the Pharma Revenue realized and credited to the DCS Program by the Contractor is less than the amount due the DCS Program as determined utilizing the minimum Pharma Revenue credit set forth in Section 13.8.6, 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 set forth in Section 13.8.6.

13.8.3 Submit calculations and documentation supporting the amount of Pharma Revenue reported and credited to the DCS Program for DCS review and approval. The Contractor shall provide all information and documentation deemed necessary by DCS to verify the DCS Program was credited with all Pharma Revenue due it under the terms of this Agreement.

13.8.4 If at the close of any Plan Year, the Pharma Revenue credited to the Program is greater than the higher of the amount derived through application of the Pharma Revenue guarantee formula or the actual Pharma Revenue realized by the Program, upon notice and verification by DCS, the DCS shall pay the Contractor the difference between the amount previously credited and the higher of the minimum Pharma Revenue guaranteed amount, set forth in Section 13.8.6, or actual Pharma Revenue realized during the Plan Year.

13.8.5 If at the close of any Plan Year, the Pharma Revenue credited to the Program is less than the actual Pharma Revenue realized by the Program, the Contractor shall pay the Program the difference between what was previously paid and the full amount due to the Program in accordance with Article XV, Payments/(Credits) to/(from) the Contractor, of this Agreement.

13.8.6 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:

13.8.6a $[redacted] for the Plan Year 2019.

13.9.0 <u>Enrollee Submitted Claims</u>

The Contractor shall be required to utilize the following methodology to charge the DCS Programs:

13.9.1 Brand Drugs, including Specialty Drugs/Medications, must be charged to the Program utilizing the Guaranteed Minimum Discount off of AWP for Brand Drugs dispensed at the Retail Pharmacy Network and retail brand Guaranteed Maximum Dispensing Fee for Brand Drugs, minus the applicable Copayment;

13.9.2 Generic Drugs, including Specialty Drugs/Medications, must be charged to the Program utilizing the Contractor's assigned MAC price for the Retail Pharmacy Network and Mail Service Pharmacy Process, plus the Guaranteed Maximum Dispensing Fee for Generic Drugs, minus the applicable Copayment. Generic Drugs without a MAC price must be charged to the DCS Program using the Contractor's Guaranteed Minimum

Discount for Brand Drugs, as proposed by the Contractor in its Proposal, off of AWP of the dispensed Generic Drug, plus the Guaranteed Maximum Dispensing Fee for Generic Drugs, minus the applicable Copayment;

13.9.3 Compound Drugs must be charged to the DCS Program by applying the Contractor's pricing methodology for Compound Drugs as defined in Sections 12.8.4f and 12.9.7g, above, plus the Guaranteed Maximum Dispensing Fee for Compound Drugs minus the applicable Level 2 Drug Copayment; and

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

ARTICLE XIV: CLAIMS ADMINISTRATION FEE

14.1.0 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, SEHP, and the Excelsior Plan, 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. 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:

14.1.1 Agree that its Claims Administration Fees are binding for the entire term of this Agreement, unless agreed otherwise by both the State and the Contractor.

14.1.2 Implement any changes necessary to accommodate DCS Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State within sixty (60) days of notice, or as soon as practicable.

14.1.3 Agree not to request a higher Claims Administration Fee, and the DCS will not consider any modification to the Claims Administration Fees, that is not based on a material change to the DCS Program requiring the Contractor to incur additional costs. The determination of what constitutes a material change is at the sole discretion of the DCS. Implementation of an alternate formulary or multiple formularies shall not constitute a material change and the Contractor agrees to implement, if required, all alternative formularies at the Claims Administration Fee set forth in Section 14.1.0.

14.1.4 Submit detailed documentation of additional costs, over and above existing management costs, with any request for an increase in the Claims Administration Fee resulting from a material change in the benefit structure of the DCS Program. The DCS reserves the right to request and the Contractor must agree to provide any additional information and documentation the DCS deems necessary to verify that the request for an additional Claims Administration Fee is warranted. DCS's decision to modify the Claims Administration Fee to the extent necessary to compensate the Contractor for documented additional costs incurred shall be at the sole discretion of the State.

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

14.1.6 Agree the Claims Administration Fee shall be payable only for Final Paid Claims and that the DCS Program will not pay an additional Fee(s) or other charge for any claim that is denied prior to processing or any claim that is subsequently voided, reversed, or otherwise modified.

14.2.0 The Contractor will charge the DCS Program for administration of the Medical Exception Program, pursuant to Section 6.18.1i, and subsequent appeals submitted as a result of the Contractor's denial, on the basis of a medical necessity review, of an Enrollee's request for a medical exception for a drug excluded from the Flexible Formulary Drug List(s) and/or Excelsior Plan Drug List. The Contractor's Administration Fees shall be inclusive of the costs for the Medical Exception Program.

ARTICLE XV: Payments/(Credits) to/from the Contractor

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

15.1.1 The Plan will reimburse the Contractor for claim payments and associated Claims Administration Fees no sooner than two (2) Business Days and no later than five (5) Business Days after receipt of an accurate invoice, following each twice-monthly 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.

15.1.2 Any credit amounts due from the Contractor to the DCS for failure of the Contractor to meet the performance guarantees set forth in this Agreement shall be applied as a credit against the Claims Administration Fees charged separately to the DCS Programs in the first invoice(s) processed after the performance guarantee has been calculated and agreed to by the Department.

15.2.0 Upon final audit determination by DCS and consistent with the terms of Article XIII 100% Pharma Revenue Guarantee of this Agreement, any audit liability amount assessed by the DCS shall be paid/credited to the Plan within thirty (30) Days of the date of final determination. For Pharmacy audits conducted by the Contractor, any Pharmacy audit recoveries shall be paid/credited to the Plan no later than thirty (30) Days after the final audit determination.

15.3.0 Coordination of Benefit recoveries collected by the Contractor shall be aggregated and paid to the Plan within fifteen (15) Days after the end of each month.

15.4.0 Drug litigation recoveries and settlements shall be paid to the Plan within fifteen (15) Days from the Contractor's receipt of such recoveries and settlements.

15.5.0 Sixty (60) Days after the end of the first quarter, the Contractor shall pay/credit the Plan the greater of (1) the actual Pharma Revenue received on behalf of the DCS Program or 2) the Minimum Pharma Revenue Guarantee Per Final Paid Claim, set forth in Section 13.8.6, multiplied by the number of Final Paid Claims incurred for the first quarter.

15.5.1 For each subsequent quarter of the Plan Year, the Contractor shall pay/credit the Plan the greater of: (1) the cumulative Pharma Revenue received on behalf of the DCS Program for the Plan Year, or (2) the Minimum Pharma Revenue Guarantee Per Final Paid Claim set forth in Section 13.8.6 multiplied by the number of Final Paid Claims processed from the beginning of the Plan Year through the end of the respective quarter, less the cumulative amount of Pharma Revenue previously paid/credited to the DCS Program for the Plan Year.

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

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

15.6.0 The Plan will pay the Claims Administration Fee on a monthly basis thirty (30) Days after receipt of an accurate invoice. Any credit amounts due from the Contractor to the DCS for failure to meet the performance guarantees set forth in the Agreement shall be applied as a credit against the Claims Administration Fee charged to the DCS Program.

15.7.0 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:

15.7.1 NYSHIP Enrollee's name
15.7.2 NYSHIP Enrollee's social security number
15.7.3 LIS eligible individual's name
15.7.4 LIS eligible individual's social security number
15.7.5 LIS eligible individual's date of birth
15.7.6 LIS eligibility start date
15.7.7 LIS eligibility end date
15.7.8 Monthly subsidy amount received from CMS for the LIS individual
15.7.9 Dual Eligibility indicator
15.7.10 Date LIS payment received from CMS (MM/DD/YYYY)
15.7.11 LIS payment/adjustment start date
15.7.12 LIS payment/adjustment end date
15.7.13 LIS adjustment reason code/description
15.7.14 LIS eligible individual's Medicare identification number (HICN) and/or Medicare Beneficiary Identifier (MBI).

The total amount reported in the monthly LIS Premium data report must equal the LIS Payments.

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

ARTICLE XVI: REPORTS AND CLAIM FILES

16.1.0 Annual Reports

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

16.1.2 ***Annual Rate Renewal Report*****:** The Contractor must submit an Annual Premium Renewal no later than September 1st of each Calendar Year. This renewal package must detail all assumptions utilized to backup the rate renewal request, including, but not limited to: paid claim amounts, administration fees, projected Pharma Revenue, COB recoveries, changes in enrollment, changes in the Specialty Pharmacy Process Drug List as well as changes in the Flexible Formularies.

16.1.3 ***Annual Mail Service Pharmacy Process Satisfaction Survey Summary Report:*** The Contractor must submit a report which details, in summary form, the results of Enrollee satisfaction surveys designed to evaluate the level of DCS Program Enrollee satisfaction with the Mail Service Pharmacy Process. The surveys should cover areas of order processing, quality of services, and timeliness. The format of the survey instrument and reports is subject to NYS input and approval. The report is due annually, on May 1st of the year following the Calendar Year being surveyed. The report must include Enrollee comments and an accounting and resolution of any Enrollee issues.

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

16.1.5 ***Annual Report of Claims and Credits Paid by Agency*****:** The Contractor must submit a report that details claims and credits paid by agency. The Contractor is required to submit this report in the current format specified by the Department in Exhibit B, the Requests for Proposals, entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the Calendar Year. The report must accurately reflect only Final Paid Claims.

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

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

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

16.2.0 Semi-Annual Reports

16.2.1 ***Top 100 Brand and Generic Drugs – Retail Pharmacy Report:*** The Contractor is required to submit a semi-annual report that details the top 100 brand name and top 100 Generic Drugs dispensed to Enrollees of the DCS Program through the Contractor's Retail Pharmacy Network sorted by drug spend and script count. The report should include fields such as: drug name, indication of use (i.e., cholesterol, diabetes, etc.), preferred drug indicator, number of Rx's, number of Enrollees utilizing the drug, Rx cost, average cost per script, average Copayment, and average Days supply. The Contractor should closely follow the current format specified by the Department in Exhibit B, the Requests for Proposals entitled Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement. The numbers should be submitted on a year-to-year comparison basis. Any trends or abnormalities should be submitted in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter.

16.2.2 ***Top 20 Therapeutic Categories Report:*** The Contractor is required to submit a semi-annual report that details the top 20 therapeutic categories by drug spend on the Contractor's Flexible Formulary Drug List(s) (broken down by drug) utilized by Enrollees of the DCS Program (combined retail, mail service and specialty Network Pharmacy). The report should include fields such as: drug name, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Days supply. The Contractor should closely follow the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement. The numbers should be submitted on a year-to-year comparison basis. Any trends or abnormalities should be submitted in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter.

16.2.3 ***Top 100 Brand Name and Generic Drugs – Mail Service Pharmacy Report*****:** The Contractor is required to submit a semi-annual report that details the top 100 brand name and top 100 Generic Drugs dispensed to Enrollees of the DCS Program through the Contractor's Mail Service Pharmacy Process sorted by drug spend and script count. The report should include fields such as: drug name, indication of use (i.e., cholesterol,

diabetes, etc.), preferred drug indicator, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Days supply. The Contractor should closely follow the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement. The numbers should be provided on a year-to-year comparison basis. Any trends or abnormalities should be provided in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter.

16.2.4 ***Top 100 Specialty Drugs – Specialty Pharmacy Report*****:** The Contractor is required to submit a semi-annual report that details the top 100 Specialty Drugs dispensed to Enrollees of the Program through the Contractor's Designated Specialty Pharmacy sorted by drug spend and script count. The report should include fields such as: drug name, indication of use (i.e., cholesterol, diabetes, etc.), preferred drug indicator, number of Rx's, number of members utilizing the drug, Rx cost, average cost per script, preferred drug indicator, average Copayment, and average Days supply. The Contractor should closely follow the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement. The numbers should be provided on a year-to-year comparison basis. Any trends or abnormalities should be provided in a narrative. The report is due sixty (60) Days after the end of the second and fourth quarter.

16.3.0 <u>Quarterly Reports</u>

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

- annual financial performance;
- assessment of DCS Program costs;
- incurred claim triangles;
- Pharma Revenue;

- coordination of benefit recoveries;
- audit recoveries;
- drug settlement and litigation recoveries
- administration expenses;
- premium projection for subsequent plan year; trend statistics; and
- such other information as the Department deems necessary.

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

16.3.2 ***Quarterly Performance Guarantee Report:*** The Contractor must submit quarterly the DCS Program's Performance Guarantee report that details the Contractor's compliance with all of the Contractor's proposed Performance Guarantees. The report should include the areas of: Start-up; system availability; customer service (telephone availability, response time, blockage rate, abandonment rate); claims processing; management reports and claim files; enrollment; mail service turnaround; and Pharmacy composition and access. The Contractor should closely follow the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement. Documentation of compliance should be included with this report. The report is due thirty (30) Days after the end of the quarter.

16.3.3 ***Quarterly Network Access:*** The Contractor must submit a measurement of the Network access as proposed in Exhibit C, the Contractor's Proposal of this Agreement is based on a "snapshot" of the network taken on the last day of each quarter. The report is due thirty (30) Days after the end of the quarter.

16.3.4 ***Quarterly Audit Report:*** The Contractor must submit a quarterly audit report detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Contractor. The report should include fields such as Pharmacy name, NABP number, recovery amounts, audit method or type, and basis for and method of recovery. The Contractor should closely follow the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and New York State Insurance Fund Workers' Compensation

Prescription Drug Programs," of this Agreement. The report is due thirty (30) Days after the end of the quarter.

16.3.5 ***Quarterly Coordination of Benefit Report:*** The Contractor must submit a report that details the amount of recoveries received as a result of coordinating benefits with other Plans including Medicare. The Contractor's report should identify the COB source, the Enrollee, the original claim amounts, and the amount received from the other insurance carriers or Medicare. The Contractor is required to work out the final format of this report with the Department. The report is due thirty (30) Days after the end of the quarter.

16.3.6 ***Quarterly Rebate and Other Pharma Revenue Report*****:** The Contractor is required to submit a quarterly rebate and other Pharma Revenue report detailing the amount of rebates and other Pharma Revenue received from the Contractor during the quarter. The report must include breakdowns by each manufacturer and drug with quarterly and year-to-date numbers, as well as any adjustments that are performed. The Contractor should closely follow the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for the Empire Plan, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Program," of this Agreement. The Contractor's process for documenting rebates and other Pharma Revenue by manufacturer and issuing the payment of rebates and other Pharma Revenue to the Program should not exceed 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 Program.

16.3.7 ***Quarterly Participating Agency Claims:*** The Contractor is required to submit a quarterly report that details claims by Participating Agency. The Contractor is required to submit this report in the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for the Empire Plan, Excelsior Plan, Student Employee Health Plan, and New York State Insurance Fund Workers' Compensation Prescription Drug Program," of this Agreement unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the quarter.

16.3.8 ***Quarterly Generic Appeals and Prior Authorization and Medical Exception Report:*** The Contractor is required to submit a quarterly report that provides the number of generic appeals, prior authorization requests, and medical exception by individual drug.

The report must include numerical breakdowns on the number of generic appeals, prior authorization and medical exception requests made by the individual drug as well as the success/declination rate of these requests. The Contractor should closely follow the current format specified by the Department in Exhibit B, the Requests for Proposals entitled Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement. The report is due thirty (30) Days after the end of the quarter.

16.3.9 ***Quarterly Rebate File:*** Each quarter the Contractor is required to transmit a computerized file via secure transfer containing prescription rebate information for all earned rebates in a format specified by the Department. The pharmacy rebate records in the Rebate File must match all prescriptions billed to the Department by the Contractor. The report is due one hundred fifty (150) Days after the end of the quarter.

16.3.10 ***Quarterly Website Analytics Report:*** The Contractor is required to submit a quarterly report that provides comprehensive performance information for the Contractor's customized DCS Program website as set forth in Section 6.5.7 of this Agreement. The report must include summarized and detailed website performance information and statistics, as well as proposed modifications to the layout and design of the website to improve communications with Enrollees. The report is due thirty (30) Days after the end of the quarter.

16.3.11 ***Quarterly EEO Workforce Utilization Compliance Report***: The Contractor is required to submit a quarterly report identifying the work force utilized on the Contract in accordance with State and Federal statutory and constitutional non-discrimination provisions. The Contractor is required to submit this report in the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," of this Agreement unless otherwise specified by the Department. Form EEO-101 Workforce Utilization Compliance Report is due ten (10) Days after the end of the quarter.

16.3.12 ***Quarterly MWBE Compliance Report:*** The Contractor is required to submit a quarterly report documenting the progress made toward achievement of the MWBE goals of the Contract pursuant to New York State Executive Law Article 15-A and 5

NYCRR 104-145 as well as Executive Order 162. The Contractor is required to submit this report in the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," of this Agreement unless otherwise specified by the Department. Form MWBE-103 Quarterly M/WBE Contractor Compliance Report is due ten (10) Days after the end of the quarter.

16.4.0 Monthly Reports

16.4.1 ***Monthly Report of Paid Claims by Month of Incurral*****:** The Contractor is required to submit a monthly report that provides summarized paid claims by month of incurral. The Contractor is required to submit this report in the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," of this Agreement unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month.

16.4.2 ***Monthly Report of Paid Claims by Pharmacy and Rx Type:*** The Contractor is required to submit a monthly report that provides summarized paid claims by Pharmacy type by Rx type. This report must distinguish reversals and allow the Department to verify Guaranteed Discounts and Guaranteed Minimum Discounts. The Contractor is required to submit this report in the current format as specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," of this Agreement unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month.

16.4.3 ***Monthly Report of Empire Plan MAC List(s)*****:** Each month the Contractor is required to submit an updated Program MAC List(s) that details all the drugs included on the Program MAC List(s) and the corresponding prices used to charge the DCS Program. The following information shall be included: GPI, drug name, form, strength, reference product, FDA rating, date the product was initially placed on the MAC List(s), initial MAC price, previous MAC price, current MAC price, effective date of current MAC price and the change in price from previous Program MAC List(s). Drugs that are added or

deleted from the Program MAC List(s) shall be clearly marked or highlighted. The Contractor is required to submit this report in the current format specified by DCS in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month.

16.4.4 ***Monthly Report of Generic and Brand Effective Rate, Specialty and Mail Service Drug Performance*****:** Each month the Contractor is required to submit a summary by month of performance of the Generic and Brand Effective Rates, Specialty Drugs, and Mail Service Pharmacy Process Brand Drug claims. The following information should be included for the Generic and Effective Rates – number of claims, Ingredient Cost, Dispensing Fee, Total AWP, Actual Discount, Target Rate, Performance Penalty, Average Dispensing Fee, Target Dispensing Fee, Dispensing Fee Penalty. Specialty – Number of Claims, Ingredient Cost, Dispensing Fee, Total AWP, Actual Discount, Target Rate, Performance Penalty. Mail Service Pharmacy Process Brands – Number of Claims, Ingredient Cost, Dispensing Fee, Total WAP, Actual Discount, Target Rate, Performance Penalty. The Contractor is required to submit this report in the current format specified by DCS in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP, unless otherwise specified by the Department. The report is due thirty (30) days after the end of the month.

16.4.5 ***MAC Savings Report*****:** Each month the Contractor is required to submit a year-to-date and annualized savings projection of the MAC price increases and decreases, based on expected utilization. The following information shall be included: GPI, Drug Name, Strength, Initial MAC Price, Current Price, Quantity Filled, Actual Savings, Annual Savings. The Contractor is required to submit this report specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," of this Agreement unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month.

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

16.4.7 ***Low Income Subsidy (LIS):*** Each month the Contractor is required to submit a 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: 1) NYSHIP Enrollee's name; 2) NYSHIP Enrollee's social security number; 3) LIS eligible individual's name; 4) LIS eligible individual's social security number; 5) LIS eligible individual's date of birth; 6) LIS eligibility start date; 7) LIS eligibility end date; 8) Monthly subsidy amount received from CMS for the LIS individual; 9) Dual Eligibility indicator; 10) Date LIS payment received from CMS (MM/DD/YYYY); 11) LIS payment/adjustment start date; 12) LIS payment adjustment end date; 13) LIS adjustment reason code/description; and, 14) LIS eligible individual's Medicare identification number (HICN) and/or Medicare Beneficiary Identifier (MBI).

16.5.0 <u>Bi-Weekly Reports</u>

16.5.1 ***Detailed Claim File Data Custom State Feed & Cycle Summary*****:** The Contractor must transmit to the Department and/or its Decision Support System (DSS) vendor a computerized file via secure transfer, as specified by the Department, containing detailed claim records in the format specified by the Department in Exhibit B, the Requests for Proposals entitled Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement unless otherwise specified by the Department, to support the bi-weekly invoice. The Department requires that all claims processed, reversed and adjusted be included in claims data. The file must facilitate reconciliation of claim payments to amounts charged to the DCS Program and include the current status of the claim (i.e., fields identifying

claims as paid, adjusted, reversed). A rejected claim file is also required upon request by the Department. The Contractor is required to:

16.5.1a Securely forward the required claims data on a claims processing cycle basis to the Department and/or its DSS vendor within fifteen (15) Days after the end of each claims processing cycle; and

16.5.1b Submit a summarized report by claims processing cycle broken down by drug type (generic/brand) utilizing the fields and the format specified by the Department in Exhibit B, the Requests for Proposals entitled Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and the New York State Insurance Fund Workers' Compensation Prescription Drug Programs RFP," of this Agreement. Based upon the analysis of the information contained in the report any important programmatic information, trends or abnormalities should be provided in a narrative.

16.6.0 Reports Required at Other Frequencies

16.6.1 ***MAC Alert Notice:*** The Contractor is required to submit a report of the financial impact of enforcing mandatory generic substitution via a "MAC Alert Notice" utilizing the current format specified by the Department in Exhibit B, the Requests for Proposals entitled "Pharmacy Benefit Services for The Empire Plan, Excelsior Plan, Student Employee Health Plan and New York State Insurance Fund Workers' Compensation Prescription Drug Programs," of this Agreement. This report must be submitted in accordance with the time frames specified in Section 12.7.4 of this Agreement.

ARTICLE XVII: TRANSITION AND TERMINATION OF CONTRACT

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

17.1.1 The Contractor must, within one hundred twenty (120) Days of the end of the Agreement, or within forty-five (45) Days of notification of termination, if the Agreement is terminated prior to the end of its term, provide the Department with a detailed written plan for transition, which outlines, at a minimum, the tasks, milestones and deliverables associated with:

17.1.1a Transition of DCS Program data, including but not limited to a minimum of one year of historical Enrollee claim data, detailed COB data, report formats, Mail Service Pharmacy Process, Specialty Pharmacy Process and retail scripts with available refills, prior authorization approved through dates, generic appeal approved through dates and exceptions that have been entered into the adjudication system on behalf of the Enrollee, as well as other data the successor contractor may request and the Department approves during implementation of the DCS Program in the format acceptable to the Department. The transition of open refill prior authorization and generic appeal files should include but not be limited to the following:

17.1.1a(1) Providing a test file to the successor contractor in advance of the implementation date to allow the successor contractor to address any potential formatting issues;

17.1.1a(2) Providing one or more pre-production files at least four (4) weeks prior to implementation that contains Enrollee Prescription refill availability, one year of claims history and prior authorization and appeal approved-through dates as specified by the Department working in conjunction with the successor contractor;

17.1.1a(3) Providing a second production file to the new contractor by the close of business January 2nd (or 2 days after this Agreement terminates) that contains all Enrollee Prescription refill availability as specified by the Department, working in conjunction with the selected successor contractor; and

17.1.1a(4) Providing a lag file seven (7) Days after the implementation date to capture any refills that may have been in process but not yet shipped at the Contractor's Mail Service Pharmacy Process Facilities and Designated Specialty Pharmacy(ies) after the end of the year.

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

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

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

17.1.5 The Contractor shall be responsible for transitioning the DCS Program in accordance with the approved Transition Plan.

17.1.6 To ensure that the transition to a successor contractor provides Enrollee's with uninterrupted access to their Prescription drug benefits and associated customer services, and to enable the Department to effectively manage the DCS Program, the Contractor is required to provide the following Contractor-related obligations and deliverables to the DCS Program through the final financial settlement of the Agreement:

17.1.6a Provide all Contractor-provided services associated with claims incurred on or before the scheduled termination date of the Agreement, including but not limited to paying network claims, Mail Service Pharmacy Process claims, Specialty Pharmacy Process claims, manual submit claims including but not limited to: Medicaid, VA , Skilled Nursing Facility claims, out of network claims, foreign claims, in-network claims, COB claims, Student Health Center Claims, and Medicare, reimbursing late filed claims if warranted, reimbursing customer credit balance accounts, resolution of Mail Service Pharmacy Process and Specialty Pharmacy Process issues, repaying or recovering monies on behalf of the DCS Program for Medicare Part D claims, retaining NYBEAS access, continuing to provide updates on pending litigation and settlements and claims/rebate data for class action litigation that the Contractor or the AG has/may file on behalf of the DCS Program. In addition, the Contractor must continue to provide the Department access to any online claims processing data and history and online reporting systems through the final settlement dates, unless the Department notifies the Contractor that access may be ended at an earlier date;

17.1.6b Complete all required reports in Article XVI "Reports and Claim Files";

17.1.6c Provide the Program with sufficient staffing in order to address State audit requests and reports in a timely manner;

17.1.6d Agree to fully cooperate with all the Department or OSC audits consistent with the requirements of Article XVIII "Audit Authority" and Appendices A and B;

17.1.6e Perform timely reviews and responses to audit findings submitted by the Department and the Comptroller's audit unit in accordance with the requirements set forth in Article XVIII "Audit Authority";

17.1.6f Remit reimbursement due the DCS Program within fifteen (15) Days upon final audit determination consistent with the process specified in Article XVIII "Audit Authority," Article XV "Payments/(Credits) to/from the Contractor" and Appendix B; and

17.1.6g Assist the Department in all activities necessary to ensure the correct and adequate interface between NYSHIP and the Centers for Medicare and Medicaid Services (CMS) with respect to the administration of the Medicare EGWP in accordance with Subpart R of 42 CFR §423 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.

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

17.1.8 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.

17.1.9 If the Contractor does not meet all of the Transition Plan requirements found in this Article, the Contractor **will permanently forfeit 100%** of all Claims Administration Fees (prorated on a daily basis) from the due date of the Transition Plan requirements to the date the Transition Plan requirements are completed to the

satisfaction of the Department. The amount shall be calculated by dividing the Claims Administration 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.

ARTICLE XVIII: AUDIT AUTHORITY

In addition to the Audit Authority requirements specified in Appendices A and B to this Agreement, the following provisions shall apply:

18.1.0 The Contractor acknowledges that the DCS has the authority to conduct financial and performance audits of the Contractor's delivery of DCS Program services in accordance with the Agreement and any applicable State and federal statutory and regulatory authorities;

18.2.0 Such audit activity may include, but not necessarily be limited to, the following activities:

18.2.1 Review of the Contractor's activities and records relating to the documentation of its performance under this Agreement in areas such as determination of Enrollee or Dependent eligibility and application of various DCS program administrative features (e.g., dependent survivor benefits, reasonable adjudication of disabled dependent status).

18.2.2 Comparison of the information in the Contractor's enrollment file to that on the enrollment reports issued to the Contractor by the DCS.

18.2.3 Assessment of the Contractor's eligibility, financial and claim processing systems to the extent necessary to verify accuracy of data on the reports provided to the DCS in accordance with Article XVI "Reports and Claim Files" of this Agreement.

18.3.0 The Contractor shall maintain and make available documentary evidence necessary to perform the reviews referenced herein this Article XVIII. 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;

18.4.0 The Contractor shall make available for audit all data in its computerized files that is relevant to and subject to the Agreement. Such data may, at DCS discretion, be submitted to the DCS in machine-readable format, or the data may be extracted by the DCS from information provided

by 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 this Agreement;

18.5.0 The Contractor shall, at the DCS' request, and in a time period specified by the Department, search its files, retrieve information and records, and provide to the auditors such documentary evidence as they require. The Contractor shall make sufficient resources available for the efficient performance of audit procedures;

18.6.0 The Contractor shall comment on the contents of any audit report prepared by the DCS and transmit such comments in writing to the DCS within 30 days of receiving any audit report. The response will specifically address each audit recommendation. If the Contractor agrees with the recommendation, the response will include a work plan and timetable to implement the recommendation. If the Contractor disagrees with an audit recommendation, the response will give all details and reasons for such disagreement. Resolution of any disagreement as to the resolution of an audit recommendation shall be subject to the dispute resolution procedures set forth in Appendix B of this Agreement;

18.7.0 If the Contractor has an independent audit performed of the records relating to this Agreement, a certified copy of the audit report shall be provided to the DCS within ten (10) Days after receipt of such audit report by the Contractor;

18.8.0 The audit provisions contained herein shall in no way be construed to limit the audit authority or audit scope of the OSC as set forth in either Appendix A of this Agreement, Standard Clauses for All New York State Contracts, or Appendix B, Standard Clauses for All DCS Contracts;

18.9.0 The Contractor shall provide ample audit resources including access to the Contractor's on-line claims processing system to the Department and the Office of the State Comptroller (OSC) at their respective offices through the date of the final financial settlement of the Agreement;

18.10.0 The Contractor shall provide the Department with access and monthly updates to the Medi-Span Prescription Drug industry reference material for drug classification and drug pricing that the Contractor will be utilizing for the Program;

18.11.0 The Contractor agrees to fully cooperate with all Department and/or OSC audits consistent with the requirements of Appendices A and B as set forth in this Agreement, including provision of access to 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) Business Days. The Contractor must perform timely reviews and respond in a time period specified by the Department to preliminary findings submitted by the Department and the Comptroller's audit unit in accordance with the requirements of this Article. Such audits may include, but are not limited to: mail order claims; Enrollee submitted paper claims; and on-line Pharmacy claims. Use of statistical sampling of claims and extrapolation of findings resulting from such samples shall be acceptable techniques for identifying claims errors. The selected Contractor shall facilitate audits of network pharmacies as requested by the Department and/or OSC; and

18.12.0 The Contractor shall permit the Department or a designated third party to audit all pharmacy bills and drug company revenues to ensure accuracy by Contractor in performing services under this Agreement and compliance with financial obligations, performance guarantees, business operations, and all other contractual obligations. Any designated third party must execute a confidentiality agreement reasonably acceptable to the Department and Contractor. This shall not limit OSC audit authority under Appendices A & B of this Agreement.

ARTICLE XIX: CONFIDENTIALITY

In addition to the Confidentiality requirements specified in Appendices A and B to this Agreement, the following provisions shall apply:

19.1.0 All claims and enrollment records relating to the Agreement are confidential and shall be used by the Contractor solely for the purpose of carrying out its obligations under the Agreement, for measuring the performance of the Contractor in accordance with the performance guarantees set forth in Section VII of this Agreement, and for providing the DCS with material and information as may be specified elsewhere in this Agreement;

19.2.0 Except as directed by a court of competent jurisdiction in New York State, or as necessary to comply with applicable New York State or Federal law, or with the written consent of the Enrollee/Dependent, no records may be otherwise used or released to any party other than the DCS or its agent by the Contractor, its officers, employees, agents, consultants or Subcontractors either during the term of the Agreement or in perpetuity thereafter. Deliberate or

repeated accidental breach of this provision may, at the sole discretion of the DCS, be grounds for termination of the Agreement;

19.3.0 The Contractor, its officers, employees, agents, consultants and/or any Key Subcontractors agree to comply, during the performance of the Agreement, with all applicable Federal and State privacy, security and confidentiality statutes, including but not limited to the Personal Privacy Protection Law (New York Public Officer's Law Article 6-A, as amended), and its implementing regulations, policies and requirements, for all material and information obtained by the Contractor through its performance under the Agreement, with particular emphasis on such information relating to Enrollees and Dependents;

19.4.0 The Contractor shall be responsible for assuring that any agreement between the Contractor and any of its officers, employees, agents, consultants and/or Key Subcontractors contains a provision that strictly conforms to the various confidentiality provisions of this Agreement;

19.5.0 The Contractor shall promptly advise the DCS of all requests made to the Contractor for information specifically regarding the performance of services under this Agreement, including, but not limited to, requests for any material and information provided by the DCS, except as required by Key Subcontractors solely for the purpose of fulfilling the Contractor's obligations under this Agreement or as required by law, but excluding requests made by Enrollees or their authorized representatives pursuant to HIPAA for their own PHI; and

19.6.0 In the event any material of Contractor's is requested pursuant to FOIL, DCS will address the Contractor's interests fully in accordance with the procedures required by Article 6 of the Public Officer's Law and Appendix B of this Agreement.

ARTICLE XX: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

20.1.0 For purposes of this Article, the term "Protected Health Information" ("PHI") means any information, including demographic information collected from an individual, that relates to the past, present, or future physical or mental health or condition of an individual, to the provision of health care to an individual, or to the past, present, or future payment for the provision of health care to an individual, that identifies the individual, or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. Within the context of this Agreement, PHI may be received by the Contractor from the Department or may be created or received by the Contractor on behalf of the Department 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 this Agreement is referred to herein collectively as "Department's PHI."

20.2.0 The Contractor acknowledges that the Department administers on behalf of New York State several group health plans as that term is defined in HIPAA's implementing regulations at 45 CFR Parts 160 and 164, and that each of those group health plans consequently is a "covered entity" under HIPAA. These group health plans include NYSHIP, which encompasses the Empire Plan as well as participating health maintenance organizations; the Dental Plan, and the Vision Plan. In this capacity, the Department is responsible for the administration of these "covered entities" under HIPAA. The Contractor further acknowledges that the Department has designated NYSHIP and the Empire Plan as an Organized Health Care Arrangement (OHCA), respectively. The Contractor further acknowledges that (i) 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 this Agreement, and that the Contractor's provision of such services may involve the disclosure to the Contractor of individually identifiable health information from the Department or from other parties on behalf of the Department, and also may involve the Contractor's disclosure to the Department of individually identifiable health information as a consequence of the services performed under this Agreement; and (ii) Contactor is a "covered entity" under HIPAA in connection with its provision of certain services under this Agreement. To the extent Contractor acts as a HIPAA "business associate" of the group health plans identified as "covered entities" in this Article XX, the Contractor shall adhere to the requirements as set forth in this Article XX of this Agreement. 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 this Agreement have been obtained from Enrollees.

20.3.0 ***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 this Agreement. 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 for 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, (i) for treatment, payment and health care operations as described in 45 CFR Section 164.506(c)(2), (3) or (4); and (ii) 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 Section 20.4.0, below, be used and disclosed by Contractor only as agreed to in writing by the Department and permitted by law.

20.4.0 ***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 this Agreement 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.

20.5.0 ***Safeguards:*** The Contractor shall use appropriate, documented safeguards to prevent the use or disclosure of the Department's PHI otherwise than as provided for by this Agreement. The Contractor shall maintain a comprehensive written information security program that includes administrative, technical, and physical safeguards that satisfy the standards set forth in the HIPPA Security Rule at 45 C.F.R §§164.308, 164.310, and 164.312, along with corresponding policies and procedures, as required by 45 C.F.R. § 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 this Agreement 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.

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20.6.0 ***Breach Notification:***

20.6.1 ***Reporting:*** The Contractor shall report to the Department any breach of unsecured PHI, including any use or disclosure of the Department's PHI otherwise than as provided for by this Agreement, of which the Contractor becomes aware. An acquisition, access, transmission, use or disclosure of the Department's PHI that is unsecured in a manner not permitted by HIPAA or this Agreement 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. Further, the Contractor shall report to the Department any security incident of which it becomes aware, subject to the terms of Section 20.6.5, below. "Security incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations in an information system. The Contractor shall notify the Department within five (5) Business days of the date the Contractor becomes aware of the event for which reporting is required pursuant to this Section 20.6.1.

20.6.2 ***Required Information:*** The Contractor shall provide the following information to the Department within ten (10) Business days of discovery except when, despite all reasonable efforts by the Contractor to obtain the information required, circumstances beyond the control of the Contractor necessitate additional time. Under such circumstances, the Contractor shall provide to the Department the following information as soon as possible and without unreasonable delay, but in no event later than thirty (30) Days from the date of discovery:

20.6.2a the date of the breach incident;

20.6.2b the date of the discovery of the breach;

20.6.2c a brief description of what happened;

20.6.2d a description of the types of unsecured PHI that were involved;

20.6.2e identification of each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed during the breach;

20.6.2f a brief description of what the Contractor is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches; and

20.6.2g any other details necessary to complete an assessment of the risk of harm to the individual.

20.6.3 The Department will be responsible to provide notification to individuals whose unsecured PHI has been or is reasonably believed to have been accessed, acquired or disclosed as a

result of a breach, as well as the Secretary of the U.S. Department of Health and Human Services, and the media, as required by 45 CFR Part 164;

20.6.4 The Contractor shall maintain procedures to sufficiently investigate the breach, mitigate losses, and protect against any future breaches, and to provide a description of these procedures and the specific findings of the investigation to the Department upon request;

20.6.5 For purposes of this Agreement, "Unsuccessful Security Incidents" include activity such as pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above, so long as no such incident results in unauthorized access, use, or disclosure of electronic PHI, for which no additional reporting shall be required; and

20.6.6 The Contractor shall mitigate, to the extent practicable, any harmful effects from any use or disclosure of PHI by the Contractor not permitted by this Agreement.

20.7.0 ***Associate's Agents:*** The Contractor shall require all of its agents or Key Subcontractors to whom it provides the Department's PHI, whether received from the Department or created or received by the Contractor on behalf of the Department, 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 this Agreement.

20.8.0 ***Availability of Information to the Department:*** The Contractor shall make available to the Department such information and documentation as the Department may require regarding any disclosures of PHI by the Contractor to fulfill the Department's obligations to provide access to, 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.

20.9.0 ***Amendment of the Department's PHI:*** The Contractor shall make the Department's PHI available to the Department as the Department may require to fulfill the Department's obligations to amend individuals' PHI pursuant to HIPAA and its implementing regulations. The Contractor shall, as directed by the Department, incorporate any amendments to the Department PHI into copies of such Department PHI maintained by the Contractor.

20.10.0 ***Internal Practices*****:** The Contractor shall make its internal practices, policies and procedures, books, records, and agreements relating to the use and disclosure of the Department's PHI, whether received from the Department or created or received by the Contractor on behalf of the Department, available to Department and/or the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by the Department and/or the Secretary for purposes of determining the Department's compliance with HIPAA and its implementing regulations.

20.11.0 ***Termination:***

20.11.1 This Agreement may be terminated by the Department at the Department's discretion if the Department determines that the Contractor, as a business associate, has violated a material term of this Article XX or of the Agreement with respect to the Contractor's obligations under this Article XX.

20.11.2 ***Disposition of the Department's PHI:*** At the time this Agreement is terminated, the Contractor shall, if feasible, return or destroy all of the Department's PHI, whether received from the Department or created or received by the Contractor on behalf of the Department, that the Contractor still maintains in any form and retain no copies of such information. Alternatively, if such return or destruction is not feasible, the Contractor shall extend indefinitely the protections of this Agreement to the information and shall limit further uses and disclosures to those purposes that make the return or destruction of the Department's PHI infeasible.

20.12.0 ***Indemnification:*** The Contractor agrees to indemnify, defend and hold harmless the State and the Department and its respective employees, officers, agents or other members of its workforce (each of the foregoing hereinafter referred to as "Indemnified Party") against all actual and direct losses suffered by the Indemnified Party and all liability to third parties arising from or in connection with any breach of this Agreement or from any acts or omissions related to this Agreement by the Contractor or its employees, officers, 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 Agreement.

20.13.0 ***Miscellaneous:***

20.13.1 ***Amendments*****:** This Agreement may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed by authorized representatives of the Parties and approved by the NYS AG and NYS OSC. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary to achieve and maintain compliance with the requirements of HIPAA and its implementing regulations.

20.13.2 ***Survival*****:** The respective rights and obligations of business associate and the "covered entities" identified herein under HIPAA and as set forth in this Article XX shall survive termination of this Agreement.

20.13.3 ***Regulatory References*****:** Any reference herein to a federal regulatory section within the Code of Federal Regulations shall be a reference to such section as it may be subsequently updated, amended or modified, as of their respective compliance dates.

20.13.4 ***Interpretation*****:** Any ambiguity in this Agreement shall be resolved to permit covered entities to comply with HIPAA.

ARTICLE XXI: NOTICES

21.1.0 All notices permitted or required hereunder shall be in writing and shall be transmitted either:

21.1.1 via certified or registered United States mail, return receipt requested;

21.1.2 by facsimile transmission;

21.1.3 by personal delivery;

21.1.4 by expedited delivery service; or

21.1.5 by e-mail.

Such notices shall be addressed as follows or to such different addresses as the parties may from time-to-time designate:

State of New York [Department of Civil Service]

Name: James DeWan
Title: Director, Employee Benefits Division
Address: Employee Benefits Division, Room 1106, Albany, NY 12239
Telephone Number: 518-473-1977
Facsimile Number: 518-473-3292
E-Mail Address: James.DeWan@cs.ny.gov

CaremarkPCS Health, L.L.C. [Contractor]

Name: CaremarkPCS Health, L.L.C.
Title: Vice President and Senior Legal Counsel, Healthcare Services
Address: 2211 Sanders Road, 10th Floor, Northbrook, IL 60062
Facsimile Number: 847-559-4879

With a copy to:

Name: CaremarkPCS Health, L.L.C.
Title: Senior Vice President, Healthcare Services
Address: 9501 E. Shea Blvd.
Scottsdale, AZ 85260
Facsimile Number: 480-391-4704

21.2.0 Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or email, upon receipt.

21.3.0 The Parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this Agreement by giving fifteen (15) days written notice to the other Party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representatives for the purposes of receiving notices under this Agreement. Additional individuals may be designated in writing by the Parties for purposes of implementation and administration/billing, resolving issues and problems and/or for dispute resolution.

ARTICLE XXII: IRAN DIVESTMENT ACT

22.1.0 As a result of the Iran Divestment Act of 2012 (for purposes of this Section only hereinafter referred to as “Act”), Chapter 1 of the 2012 Laws of New York, a new provision was added to the State Finance Law (“SFL”), §165-a, effective April 12, 2012. Under the Act, the Commissioner of the Office of General Services (“OGS”) was charged with the responsibility to develop a list (“prohibited entities list”) of “persons” who are engaged in “investment activities

in Iran" (both are defined terms in the law). Pursuant to SFL § 165-a(3)(b), the initial list was posted on the OGS website on August 10, 2012.

22.2.0 By entering into the Agreement, Contractor certifies that it is not on the "Entities Determined To Be Non-Responsive Bidders/Offerors Pursuant to The New York State Iran Divestment Act of 2012" list ("Prohibited Entities List") posted on the OGS website at http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf and further certifies that it will not utilize on the Agreement any subcontractor that is identified on the Prohibited Entities List. Contractor agrees that should it seek to renew or extend the Agreement, it must provide the same certification at the time the Agreement is renewed or extended. Contractor also agrees that any proposed Assignee of the Agreement will be required to certify that it is not on the Prohibited Entities List before the Department may approve a request for Assignment of the Agreement.

22.3.0 During the term of the Contract, should the Department receive information that a person (as defined in State Finance Law 165-a) is in violation of the above-referenced certification, the Department will review such information and offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment which is in violation of the Act within ninety (90) days after the determination of such violation, then the Department shall take such action as may be appropriate and provided for by law, rule or contract, including, but not limited to, seeking compliance, recovering damages, or declaring the Contractor in default.

22.4.0 The Department reserves the right to reject any request for renewal, extension, or assignment for an entity that appears on the Prohibited Entities List prior to the renewal, extension or assignment of the Agreement, and pursue a responsibility review with Contractor should it appear on the Prohibited Entities List hereafter.

ARTICLE XXIII: VENDOR RESPONSIBILITY

23.1.0 The Contractor is required to provide the Department with an updated Vendor Responsibility Questionnaire when requested to do so by the Department throughout the term of the Agreement. Regardless, the Contractor is required to report to the Department any material changes in the information reported in its initial Vendor Responsibility Questionnaire.

23.2.0 The Contractor shall at all times during the Agreement term remain responsible. The Contractor agrees, if requested by the Commissioner or his or her designee, to present

evidence of its continuing legal authority to do business in New York State, integrity, experience, ability, prior performance, and organizational and financial capacity.

23.3.0 Suspension of Work (for Non-Responsibility): The Commissioner or his or her designee, in his or her sole discretion, reserves the right to suspend any or all activities under this Agreement, at any time, when he or she discovers information that call into question the responsibility of the Contractor. In the event of such suspension, the Contractor must comply with the terms of the suspension order. Agreement activity may resume at such time as the Commissioner or his or her designee issues a written notice authorizing a resumption of performance under the Agreement.

23.4.0 Termination (for Non-Responsibility): Upon written notice to the Contractor, a reasonable opportunity to be heard with the appropriate Department officials or staff, the Contract may be terminated by the Commissioner or his or her designee at the Contractor's expense where the Contractor is determined by the Commissioner of the Department or his or her designee to be non-responsible. In such an event, the Commissioner or his or her designee may complete the requirements of the Agreement in any manner he or she may deem advisable and pursue legal or equitable remedies for breach.

ARTICLE XXIV: MERGERS/ACQUISITIONS

24.1.0 The Contractor's obligations to perform under the Agreement shall not be affected or impaired by any reorganization, consolidation or merger to which the Contractor is, or may become, a party. In any such event, the Contractor shall continue to be bound by, and shall perform under, all terms and conditions set forth herein.

ARTICLE XXV: ALL LEGAL PROVISIONS DEEMED INCLUDED

25.1.0 It is the intent and understanding of the Parties to the Agreement that each and every provision of law required to be inserted in the Agreement shall be and is inserted herein. Furthermore, it is hereby stipulated that every such provision is to be deemed to be inserted herein, and if, through mistake or otherwise, any such provision is not inserted, or is not inserted in correct form, then the Agreement shall forthwith upon the application of either Party be amended by such insertion so as to comply strictly with the law without prejudice to the rights of either Party hereunder.

ARTICLE XXVI: ENTIRE AGREEMENT

26.1.0 The Agreement and the appendices, exhibits and attachments hereto constitute 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. The Agreement shall not be changed, modified, or altered in any manner except by an instrument in writing executed by the Parties hereto.

(Remainder of Page Left Intentionally Blank)

Contractor: CaremarkPCS Health, L.L.C.

Contract Number: #C000724

Agency Certification: "In addition to the acceptance of this contract, I also certify that original copies of this signature page shall be attached to all other exact copies of this contract."

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

Date: 12/20/18

By: DCS REDACTION

Name: DCS REDACTION

Title: Acting Commissioner

CAREMARKPCS HEALTH, L.L.C.

Date: 12-18-18

By: DCS REDACTION

Name: Diane Galo

Title: Vice President – Group Head

LEGAL REVIEW

STATE OF ILLINOIS

) ss:

COUNTY OF COOK

On the 18th day of December, 2018, before me personally came Diane Galo, to me known, and known to me to be the person who executed the above instrument, who, being duly sworn by me, did for her/himself depose and say that (s)he is the Vice President – Group Head of CaremarkPCS Health, L.L.C. the corporation or organization described in and which executed the above instrument; and that (s)he signed his/her name thereto.

My commission expires: 3/25/22

DCS REDACTION

NOTARY PUBLIC

OFFICIAL SEAL
KAREN CEBULA
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:03/25/22

Approved as to Form:

BARBARA UNDERWOOD
ATTORNEY GENERAL

By: DCS REDACTION

Date:

APPROVED AS TO FORM
NYS ATTORNEY GENERAL
DEC 21 2018
DCS REDACTION
LORRAINE I. REMO
SECTION CHIEF

Approved:

THOMAS P. DINAPOLI
COMPTROLLER

By:

Date:

APPROVED
DEPT. OF AUDIT & CONTROL
DEC 24 2018
DCS REDACTION
FOR THE STATE COMPTROLLER

Exhibit G, Vaccination Administration Fees

Administration Fees for seasonal and non-seasonal vaccines dispensed through the Vaccination Network shall be billed to the DCS Program on a Pass-through basis. Offeror's should enter their contracted Administration Fees as of May 1, 2018, for each listed vaccine.

Seasonal* Vaccines	Administration Fee
Influenza (Injectable Trivalent)	[redacted]
Influenza (Injectable Quadrivalent)	
Influenza (Intradermal/Injectable Short Needle)	
Influenza (Intranasal Flu Mist - Quadrivalent)	
Influenza (Injectable High Dose - Trivalent)	
Influenza (Injectable High Dose - Quadrivalent)	

Non-Seasonal Vaccines	Administration Fee
Zostavax	[redacted]
Shingrix	
Pneumococcal	
Meningococcal	

* Seasonal means August through April