STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION

REQUEST FOR PROPOSALS
FOR
PHARMACY BENEFITS MANAGEMENT

RFP #31786-00174
Release #4

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1. INTRODUCTION

The State of Tennessee, the State, Local Education, and Local Government Insurance Committees, hereinafter referred to as "the State," issues this Request for Proposals (RFP) to define minimum contract requirements; solicit responses; detail response requirements; and outline the State's process for evaluating responses and selecting a contractor to provide the needed goods or services.

Through this RFP, the State seeks to procure necessary goods or services at the most favorable, competitive prices and to give ALL qualified respondents, including those that are owned by minorities, women, service-disabled veterans, persons with disabilities and small business enterprises, an opportunity to do business with the state as contractors, subcontractors or suppliers.

1.1. Statement of Procurement Purpose

The State intends to secure a contract with a single Pharmacy Benefits Manager (PBM) for pharmacy benefit account management, network and Formulary management, utilization management, custom clinical programs as required, and an online Point-of-Sale (POS) pharmacy claims processing system. The PBM shall establish and maintain its broadest available national pharmacy provider network, a Mail Order network, and a statewide any willing pharmacy provider network of Retail-30 Pharmacies, 90-Day-At-Retail Pharmacies, Specialty Pharmacies, and vaccine network administering pharmacies. The POS system shall include prospective/concurrent Drug Utilization Review (DUR), retrospective Drug Utilization Review (Retro-DUR), reporting capabilities, adjudication capabilities, and full pharmacy benefit Member services for retail-30, 90-day-at-retail, Mail Order, Specialty, and vaccine Pharmacy benefits for Members of the Plans (Plan). The Contractor shall perform all services described in the Scope of the pro forma contract (RFP Attachment 6.6). The State is seeking a PBM partner who can help appropriately manage the State Group Insurance Program's (SGIP) pharmacy spend, which continues to be a cost driver, by ensuring Members receive the most clinically appropriate treatment in the right setting at the lowest cost for both the Member and the State.

1.1.1 Background and Context

Benefits Administration (BA) provides prescription drug benefits through a contract with CaremarkPCS Health, LLC that runs until December 31, 2024. Benefits for the contract under this RFP will go-live on January 1, 2025, and run through December 31, 2027, constituting a three (3) year PBM proposal requirement. Prescription drug benefits for the Plan requested under this RFP, and as defined in the pro forma contract, (RFP Attachment 6.6), will be provided to approximately 293,000 members in three separate plans with coordinated governing bodies charged with the responsibilities of providing benefits to the Plan. The State Insurance Committee, aka the State Plan, provides benefits to state and higher education employees, retirees and Consolidated Omnibus Budget Reconciliation Act (COBRA) participants and their dependents. The Local Education Insurance Committee, aka the Local Education Plan, provides benefits to 126 local education agencies (public school systems) and educational co-ops. The Local Government Insurance Committee, aka the Local Government Plan, provides benefits to 392 local government and quasi-governmental entities in Tennessee. See the *2021 Annual Program and Financial Report*, State Group Insurance Program, for a description of program and plan information. The report can be accessed at https://www.tn.gov/finance/fabenefits.html. Hover on the *Publications* tab, then click on *Reports*.

The State Plan currently provides self-funded medical coverage to approximately 141,658 total lives (132,413 State and higher education employees, 9,245 pre-65 retirees and their eligible dependents) through three health plan options: a Standard PPO, Premier PPO and a Consumer Driven Health Plan (CDHP) paired with a Health Savings Account (HSA). As the employer, the State contributes monthly to premiums for enrollment in all plan options. Approximately $397.2 million in pharmacy claims (net plan costs) were paid under these plan options during calendar year 2022.
As a supplement to the medical plan, which includes pharmacy, the State offers a carved-out employee assistance program (EAP) and behavioral health benefit. An employee population health program is also available to all plan Members. Voluntary benefits include vision, dental, life insurance, and short- and long-term disability.

The Local Education Plan is a financially separate, self-funded program, which offers similar health benefits (Standard PPO, Premier PPO, Limited PPO, and Local CDHP/HSA) as the State Plan, to 126 Local Education Agency employees and eligible pre-65 retirees. Enrollment, as of May 2023, was approximately 119,275 employees and 5,261 retirees and their dependents for a total of 124,536 covered lives. Most employees in this plan are teachers; the balance is comprised of administrators, cafeteria workers, maintenance and other support personnel. Approximately $282.5 million in pharmacy claims (net plan costs) were paid under these plan options during calendar year 2022. In addition to benefits coverage consisting of medical, pharmacy, behavioral health, and EAP, Local Education Agencies may offer the same vision and dental plans to Members.

The Local Government Plan is also a financially separate, self-funded program, available to employees of 392 local governments or quasi-governmental entities in Tennessee who elect health insurance coverage through this plan. The health benefits (Standard PPO, Premier PPO, Limited PPO and Local CDHP/HSA) and their administrators are identical to those under the Local Education Plan. In May 2023 there were approximately 26,572 employees, 361 pre-65 retirees, and their dependents enrolled in the plan options for a total of approximately 26,933 covered lives. Approximately $70.3 million in pharmacy claims (net plan costs) were paid under these plan options during calendar year 2022. In addition to benefits coverage consisting of medical, pharmacy, behavioral health, and EAP, Local Government Agencies may offer the same vision and dental plans to Members.

The State has an open formulary with no drug exclusions beyond those identified in our Plan Documents. The State is open to the acceptance of utilization management edits, but such edits must be prior approved by the State. Refer to the RFP Appendices 7.17 and 7.18 to review current utilization edits, and Appendix 7.23 for current exclusions. The pharmacy benefits include a value-based benefit design for diabetic drugs (oral, insulin, and other non-insulin injectables) and supplies (needles, test strips, continuous glucose monitors, and lancets only), statins, anti-hypertensives, as well as medications used to treat depression, coronary artery disease (CAD), congestive heart failure (CHF), osteoporosis, asthma, and chronic obstructive pulmonary disease (COPD). A 90-day supply of these medications and supplies is available for a lower Copayment (or Coinsurance, if enrolled in the CHPA/HSA or Local CDHP/HSA options) if obtained from an in-network Retail 90 pharmacy or through Mail Order. In addition, these medications bypass the deductible for those enrolled in a CDHP. More information about the medical options provided to Members is shown in Appendix 7.1. Summaries of insurance coverage by plan and plan group are shown in Appendices 7.4 and 7.5.

Plan pharmacy claims data (de-identified, basic cost and use data only) for January 2018 – July 2023 is included as Appendix 7.8. See Appendix 7.1 for a grid showing the benefits and Copayments for the State & Higher Education plans and the Local Education/Local Government plans for plan year 2023. A full year of claims data representing 7/1/2022 through 6/30/2023 by individual claim line item is provided in Appendices 7.13. through 7.16. Appendix 7.12 provides background information on data sets and how potential respondents may merge them to respond to this RFP.

1.1.2. The maximum liability for the resulting contract will be determined through the best evaluated cost proposal and estimated cost associated with this service. The maximum liability will exceed one dollar ($1.00).

1.2. **Scope of Service, Contract Period, & Required Terms and Conditions**

The RFP Attachment 6.6., *Pro Forma* Contract details the State's requirements:

- Scope of Services and Deliverables (Section A);
- Contract Period (Section B);
- Payment Terms (Section C);
- Standard Terms and Conditions (Section D); and,
- Special Terms and Conditions (Section E).

The *pro forma* contract substantially represents the contract document that the successful Respondent must sign.

1.3. Nondiscrimination

No person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of a Contract pursuant to this RFP or in the employment practices of the Contractor on the grounds of handicap or disability, age, race, creed, color, religion, sex, national origin, or any other classification protected by federal, Tennessee state constitutional, or statutory law. The Contractor pursuant to this RFP shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

1.4. RFP Communications

1.4.1. The State has assigned the following RFP identification number that must be referenced in all communications regarding this RFP:

RFP # 31786-00174

1.4.2. **Unauthorized contact about this RFP with employees or officials of the State of Tennessee except as detailed below may result in disqualification from consideration under this procurement process.**

1.4.2.1. Prospective Respondents must direct communications concerning this RFP to the following person designated as the Solicitation Coordinator:

Heather Pease, Director of Procurements & Contracts
Tennessee Department of Finance & Administration
Division of Benefits Administration
William R. Snodgrass Tennessee Tower
312 Rosa L. Parks Avenue, Suite 1900
Nashville, TN 37243
heather.pease@tn.gov
Telephone: 615.253.1652
Fax: 615.253.8556

1.4.2.2. Notwithstanding the foregoing, Prospective Respondents may alternatively contact:

a. staff of the Governor's Office of Diversity Business Enterprise for assistance available to minority-owned, woman-owned, service-disabled veteran-owned, businesses owned by persons with disabilities, and small businesses as well as general, public information relating to this RFP (visit https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/governor-s-office-of-diversity-business-enterprise--godbe--/godbe-general-contacts.html for contact information); and

b. the following individual designated by the State to coordinate compliance with the nondiscrimination requirements of the State of Tennessee, Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, and associated federal regulations:

Lucian Geise, General Counsel
Tennessee Department of Finance & Administration
312 Rosa L. Parks Avenue, Suite 2000 Nashville, Tennessee 37243
Phone Number: 615-532-9617
Fax:615-532-8532
FA.CivilRights@tn.gov

1.4.3. Only the State's official, written responses and communications with Respondents are binding with regard to this RFP. Oral communications between a State official and one or more Respondents are unofficial and non-binding.

1.4.4. Potential Respondents must ensure that the State receives all written questions and comments, including questions and requests for clarification, no later than the Written Questions & Comments Deadline detailed in the RFP Section 2, Schedule of Events.

1.4.5. Respondents must assume the risk of the method of dispatching any communication or response to the State. The State assumes no responsibility for delays or delivery failures resulting from the Respondent's method of dispatch. Actual or digital "postmarking" of a communication or response to the State by a specified deadline is not a substitute for the State's actual receipt of a communication or response. It is encouraged for Respondents to submit bids digitally.

1.4.6. The State will convey all official responses and communications related to this RFP to the prospective Respondents from whom the State has received a Notice of Intent to Respond (refer to RFP Section 1.8).

1.4.7. The State reserves the right to determine, at its sole discretion, the method of conveying official, written responses and communications related to this RFP. Such written communications may be transmitted by mail, hand-delivery, facsimile, electronic mail, Internet posting, or any other means deemed reasonable by the State. For internet posting, please refer to the following website: https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/supplier-information/request-for-proposals--rfp--opportunities1.html.

1.4.8. The State reserves the right to determine, at its sole discretion, the appropriateness and adequacy of responses to written comments, questions, and requests related to this RFP. The State's official, written responses will constitute an amendment of this RFP.

1.4.9. Any data or factual information provided by the State (in this RFP, an RFP amendment or any other communication relating to this RFP) is for informational purposes only. The State will make reasonable efforts to ensure the accuracy of such data or information, however it is the Respondent's obligation to independently verify any data or information provided by the State. The State expressly disclaims the accuracy or adequacy of any information or data that it provides to prospective Respondents.

All statistical or fiscal data or information provided by the State in conjunction with this RFP, whether by way of exhibits, amendments or modifications to this RFP, are provided by the State "as is." The State expressly disclaims any warranty as to the accuracy or the adequacy of any statistical or fiscal data that it provides to Respondents. A Respondent's reliance upon the accuracy or adequacy of such data shall not be the basis of relief from contract performance or recovery of actual, consequential or punitive damages from the State.

1.5. Assistance to Respondents With a Handicap or Disability

Prospective Respondents with a handicap or disability may receive accommodation relating to the communication of this RFP and participating in the RFP process. Prospective Respondents may contact the Solicitation Coordinator to request such reasonable accommodation no later than the Disability Accommodation Request Deadline detailed in the RFP Section 2, Schedule of Events.

1.6. Respondent Required Review & Waiver of Objections

1.6.1. Each prospective Respondent must carefully review this RFP, including but not limited to, attachments, the RFP Attachment 6.6., *Pro Forma* Contract, and any amendments, for questions, comments, defects, objections, or any other matter requiring clarification or correction (collectively called "questions and comments").

1.6.2. Any prospective Respondent having questions and comments concerning this RFP must provide them in writing to the State no later than the Written Questions & Comments Deadline detailed in the RFP Section 2, Schedule of Events.

1.6.3. Protests based on any objection to the RFP shall be considered waived and invalid if the objection has not been brought to the attention of the State, in writing, by the Written Questions & Comments Deadline.

1.7. Pre-Response Conference

A Pre-response Conference will be held at the time and date detailed in the RFP Section 2, Schedule of Events. Pre-response Conference attendance is not mandatory, and prospective Respondents may be limited to a maximum number of attendees depending upon overall attendance and space limitations.

The conference will be held at:

WebEx information:
https://tn.webex.com/tn/j.php?MTID=m8bdffde617fdf8f42622842d34a47797
Meeting number (access code): 2300 698 6227
Meeting password: DsvNbM6iq56

The purpose of the conference is to discuss the RFP scope of goods or services. The State will entertain questions, however prospective Respondents must understand that the State's oral response to any question at the Pre-response Conference shall be unofficial and non-binding. Prospective Respondents must submit all questions, comments, or other concerns regarding the RFP in writing prior to the Written Questions & Comments Deadline date detailed in the RFP Section 2, Schedule of Events. The State will send the official response to these questions and comments to prospective Respondents from whom the State has received a Notice of Intent to respond as indicated in RFP Section 1.8 and on the date detailed in the RFP Section 2, Schedule of Events.

1.8. Notice of Intent to Respond

Before the Notice of Intent to Respond Deadline detailed in the RFP Section 2, Schedule of Events, prospective Respondents should submit to the Solicitation Coordinator a Notice of Intent to Respond (in the form of a simple e-mail or other written communication). Such notice should include the following information:

- the business or individual's name (as appropriate);
- a contact person's name and title; and
- the contact person's mailing address, telephone number, facsimile number, and e-mail address.

A Notice of Intent to Respond creates no obligation and is not a prerequisite for submitting a response, however, it is necessary to ensure receipt of any RFP amendments or other notices and communications relating to this RFP.

1.9. Response Deadline

A Respondent must ensure that the State receives a response no later than the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events. The State will not accept late responses, and a Respondent's failure to submit a response before the deadline will result in disqualification of the response. It is the responsibility of the Respondent to ascertain any additional security requirements with respect to packaging and delivery to the State of Tennessee. Respondents should be mindful of any potential delays due to security screening procedures, weather, or other filing delays whether foreseeable or unforeseeable.

2. RFP SCHEDULE OF EVENTS

2.1. The following RFP Schedule of Events represents the State's best estimate for this RFP.

EVENT	TIME (central time zone)	DATE
1. RFP Issued		September 28, 2023
2. Disability Accommodation Request Deadline	2:00 p.m.	October 3, 2023
3. Pre-response Conference	1:00 p.m.	October 4, 2023
4. Notice of Intent to Respond Deadline	2:00 p.m.	October 5, 2023
5. Written "Questions & Comments" Round 1 Deadline	2:00 p.m.	October 16, 2023
6. State Response to Written "Questions & Comments" Round 1		November 7, 2023
7. Written "Questions & Comments" Round 2 Deadline	2:00 p.m.	November 14, 2023
8. State Response to Written "Questions & Comments" Round 2 ***NOTE: Vendors may submit no more than ten (10) questions to the State in the 2nd round of Written Questions and Comments.**		December 1, 2023
9. Response Deadline	2:00 p.m.	December 14, 2023
10. State Opening of Cost Proposals		December 21, 2023
11. Cost Proposal Analysis		December 21, 2023 – February 5, 2024
12. State Completion of Technical Response Evaluations		January 26, 2024
13. State Notice of Intent to Award Released and RFP Files Opened for Public Inspection	1:00 p.m.	February 22, 2024
14. End of Open File Period		February 29, 2024
15. State sends contract to Contractor for signature		March 1, 2024
16. Contractor Signature Deadline	2:00 p.m.	March 8, 2024

2.2. **The State reserves the right, at its sole discretion, to adjust the RFP Schedule of Events as it deems necessary.** Any adjustment of the Schedule of Events shall constitute an RFP amendment, and the State will communicate such to prospective Respondents from whom the State has received a Notice of Intent to Respond (refer to section 1.8).

3. RESPONSE REQUIREMENTS

3.1. Response Form

A response to this RFP must consist of two parts, a Technical Response and a Cost Proposal.

3.1.1. **Technical Response**. RFP Attachment 6.2., Technical Response & Evaluation Guide provides the specific requirements for submitting a response. This guide includes mandatory requirement items, general qualifications and experience items, and technical qualifications, experience, and approach items all of which must be addressed with a written response and, in some instances, additional documentation.

NOTICE: A technical response must not include any pricing or cost information. If any pricing or cost information amounts of any type (even pricing relating to other projects) is included in any part of the technical response, the state may deem the response to be non-responsive and reject it.

3.1.1.1. A Respondent should duplicate and use the RFP Attachment 6.2., Technical Response & Evaluation Guide to organize, reference, and draft the Technical Response by duplicating the attachment, adding appropriate page numbers as required, and using the guide as a table of contents covering the Technical Response.

3.1.1.2. A response should be economically prepared, with emphasis on completeness and clarity. A response, as well as any reference material presented, must be written in English and must be written on standard 8 ½" x 11" pages (although oversize exhibits are permissible) and use a 12 point font for text. All response pages must be numbered.

3.1.1.3. All information and documentation included in a Technical Response should correspond to or address a specific requirement detailed in the RFP Attachment 6.2., Technical Response & Evaluation Guide. All information must be incorporated into a response to a specific requirement and clearly referenced. Any information not meeting these criteria will be deemed extraneous and will not contribute to evaluations.

3.1.1.4. The State may determine a response to be non-responsive and reject it if:

a. the Respondent fails to organize and properly reference the Technical Response as required by this RFP and the RFP Attachment 6.2., Technical Response & Evaluation Guide; or

b. the Technical Response document does not appropriately respond to, address, or meet all of the requirements and response items detailed in the RFP Attachment 6.2., Technical Response & Evaluation Guide.

3.1.2. **Cost Proposal**. A Cost Proposal must be recorded on an exact duplicate of the RFP Attachment 6.3., Cost Proposal & Scoring Guide.

NOTICE: If a Respondent fails to submit a cost proposal exactly as required, the State may deem the response to be non-responsive and reject it.

3.1.2.1. A Respondent must only record the proposed cost exactly as required by the RFP Attachment 6.3., Cost Proposal & Scoring Guide and must NOT record any other rates, amounts, or information.

3.1.2.2. The proposed cost shall incorporate ALL costs for services under the contract for the total contract period, including any renewals or extensions.

3.1.2.3. A Respondent must sign and date the Cost Proposal.

3.1.2.4. A Respondent must submit the Cost Proposal to the State on a separate e-mail, digital online submission, or USB flash drive from the Technical Response (as detailed in RFP Sections 3.2.3., et. seq).

3.2. Response Delivery

3.2.1. A Respondent must ensure that both the Technical Response and Cost Proposal files meet all form and content requirements, including all required signatures, as detailed within this RFP.

3.2.2. A Respondent must submit their response as specified in one of the two formats below.

3.2.2.1. Digital Media Submission

3.2.2.1.1. Technical Response

The Technical Response document should be in the form of one (1) digital document in "PDF" format properly recorded on its own otherwise blank USB flash drive or uploaded to our digital submission platform and should be clearly identified as the:

"RFP #3186-00174 TECHNICAL RESPONSE ORIGINAL"

and one (1) digital copy of the Technical Response each in the form of one (1) digital document with **separate individual corresponding appendices or exhibits** in "PDF" format properly recorded on its own otherwise blank USB flash drive clearly labeled:

"RFP #3186-00174 TECHNICAL RESPONSE COPY"

The customer references should be delivered by each reference in accordance with RFP Attachment 6.4. Reference Questionnaire.

3.2.2.1.2. Cost Proposal:

The Cost Proposal should be in the form of one (1) digital document in "PDF" or "XLS" format properly recorded on a separate, otherwise blank USB flash drive clearly labeled:

"RFP #3186-00174 COST PROPOSAL"

An electronic or facsimile signature, as applicable, on the Cost Proposal is acceptable.

3.2.2.2. E-mail Submission

3.2.2.2.1. Technical Response

The Technical Response document should be in the form of one (1) digital document in "PDF" format or other easily accessible digital format attached to an e-mail to the Solicitation Coordinator. Both the subject and file name should be clearly identified as follows:

"RFP #3186-00174 TECHNICAL RESPONSE"

The customer references should be delivered by each reference in accordance with RFP Attachment 6.4. Reference Questionnaire.

3.2.2.2.2. Cost Proposal:

The Cost Proposal should be in the form of one (1) digital document in "PDF" or "XLS" format or other easily accessible digital format attached to an e-mail to the Solicitation Coordinator. Both the subject and file name should be clearly identified as follows:

"RFP #3186-00174 COST PROPOSAL"

An electronic or facsimile signature, as applicable, on the Cost Proposal is acceptable.

3.2.3. For e-mail submissions, the Technical Response and Cost Proposal documents must be dispatched to the Solicitation Coordinator in **separate** e-mail messages. For digital media submissions, a Respondent must separate, seal, package, and label the documents and copies for delivery as follows:

3.2.3.1. The Technical Response and copies must be placed in a sealed package that is clearly labeled:

"DO NOT OPEN… RFP #3186-00174 TECHNICAL RESPONSE FROM [RESPONDENT LEGAL ENTITY NAME]"

3.2.3.2. The Cost Proposal must be placed in a separate, sealed package that is clearly labeled:

"DO NOT OPEN… RFP #3186-00174 COST PROPOSAL FROM [RESPONDENT LEGAL ENTITY NAME]"

3.2.3.3.The separately, sealed Technical Response and Cost Proposal components may be enclosed in a larger package for mailing or delivery, provided that the outermost package is clearly labeled:

"RFP #3186-00174 SEALED TECHNICAL RESPONSE & SEALED COST PROPOSAL FROM [RESPONDENT LEGAL ENTITY NAME]"

3.2.3.4. Any Respondent wishing to submit a Response in a format other than digital may do so by contacting the Solicitation Coordinator.

3.2.4. A Respondent must ensure that the State receives a response no later than the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events at the following address:

Heather Pease, Director of Procurements & Contracts
Department of Finance and Administration, Division of Benefits Administration

312 Rosa L. Parks Avenue, Suite 1900
heather.pease@tn.gov
Telephone: 615.253-1652
Fax: 615.253.8556

3.3. **Response & Respondent Prohibitions**

3.3.1. A response must not include alternate contract terms and conditions. If a response contains such terms and conditions, the State, at its sole discretion, may determine the response to be a non-responsive counteroffer and reject it.

3.3.2. A response must not restrict the rights of the State or otherwise qualify either the offer to deliver goods or provide services as required by this RFP or the Cost Proposal. If a response restricts the rights of the State or otherwise qualifies either the offer to deliver goods or provide services as required by this RFP or the Cost Proposal, the State, at its sole discretion, may determine the response to be a non-responsive counteroffer and reject it.

3.3.3. A response must not propose alternative goods or services (*i.e*., offer services different from those requested and required by this RFP) unless expressly requested in this RFP. The State may consider a response of alternative goods or services to be non-responsive and reject it.

3.3.4. A Cost Proposal must be prepared and arrived at independently and must not involve any collusion between Respondents. The State will reject any Cost Proposal that involves collusion, consultation, communication, or agreement between Respondents. Regardless of the time of detection, the State will consider any such actions to be grounds for response rejection or contract termination.

3.3.5. A Respondent must not provide, for consideration in this RFP process or subsequent contract negotiations, any information that the Respondent knew or should have known was materially incorrect. If the State determines that a Respondent has provided such incorrect information, the State will deem the Response non-responsive and reject it.

3.3.6. A Respondent must not submit more than one Technical Response and one Cost Proposal in response to this RFP, except as expressly requested by the State in this RFP. If a Respondent submits more than one Technical Response or more than one Cost Proposal, the State will deem all of the responses non-responsive and reject them.

3.3.7. A Respondent must not submit a response as a prime contractor while also permitting one or more other Respondents to offer the Respondent as a subcontractor in their own responses. Such may result in the disqualification of all Respondents knowingly involved. This restriction does not, however, prohibit different Respondents from offering the same subcontractor as a part of their responses (provided that the subcontractor does not also submit a response as a prime contractor).

3.3.8. The State shall not consider a response from an individual who is, or within the past six (6) months has been, a State employee. For purposes of this RFP:

3.3.8.1. An individual shall be deemed a State employee until such time as all compensation for salary, termination pay, and annual leave has been paid;

3.3.8.2. A contract with or a response from a company, corporation, or any other contracting entity in which a controlling interest is held by any State employee shall be considered to be a contract with or proposal from the employee; and

3.3.8.3. A contract with or a response from a company, corporation, or any other contracting entity that employs an individual who is, or within the past six (6) months has been, a State employee shall not be considered a contract with or a proposal from the employee and shall not constitute a prohibited conflict of interest.

3.3.9. This RFP is also subject to Tenn. Code Ann. § 12-4-101—105.

3.4. Response Errors & Revisions

A Respondent is responsible for any and all response errors or omissions. A Respondent will not be allowed to alter or revise response documents after the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events unless such is formally requested, in writing, by the State.

3.5. Response Withdrawal

A Respondent may withdraw a submitted response at any time before the Response Deadline time and date detailed in the RFP Section 2, Schedule of Events by submitting a written request signed by an authorized Respondent representative. After withdrawing a response, a Respondent may submit another response at any time before the Response Deadline. After the Response Deadline, a Respondent may only withdraw all or a portion of a response where the enforcement of the response would impose an unconscionable hardship on the Respondent.

3.6. Additional Services

If a response offers goods or services in addition to those required by and described in this RFP, the State, at its sole discretion, may add such services to the contract awarded as a result of this RFP. Notwithstanding the foregoing, a Respondent must not propose any additional cost amounts or rates for additional goods or services. Regardless of any additional services offered in a response, the Respondent's Cost Proposal must only record the proposed cost as required in this RFP and must not record any other rates, amounts, or information.

NOTICE: If a Respondent fails to submit a Cost Proposal exactly as required, the State may deem the response non-responsive and reject it.

3.7. Response Preparation Costs

The State will not pay any costs associated with the preparation, submittal, or presentation of any response.

4. GENERAL CONTRACTING INFORMATION & REQUIREMENTS

4.1. RFP Amendment

The State at its sole discretion may amend this RFP, in writing, at any time prior to contract award. However, prior to any such amendment, the State will consider whether it would negatively impact the ability of potential Respondents to meet the response deadline and revise the RFP Schedule of Events if deemed appropriate. If an RFP amendment is issued, the State will convey it to potential Respondents who submitted a Notice of Intent to Respond (refer to RFP Section 1.8). A response must address the final RFP (including its attachments) as amended.

4.2. RFP Cancellation

The State reserves the right, at its sole discretion, to cancel the RFP or to cancel and reissue this RFP in accordance with applicable laws and regulations.

4.3. State Right of Rejection

4.3.1. Subject to applicable laws and regulations, the State reserves the right to reject, at its sole discretion, any and all responses.

4.3.2. The State may deem as non-responsive and reject any response that does not comply with all terms, conditions, and performance requirements of this RFP. Notwithstanding the foregoing, the State reserves the right to waive, at its sole discretion, minor variances from full compliance with this RFP. If the State waives variances in a response, such waiver shall not modify the RFP requirements or excuse the Respondent from full compliance, and the State may hold any resulting Contractor to strict compliance with this RFP.

4.4. Assignment & Subcontracting

4.4.1. The Contractor may not subcontract, transfer, or assign any portion of the Contract awarded as a result of this RFP without prior approval of the State. The State reserves the right to refuse approval, at its sole discretion, of any subcontract, transfer, or assignment.

4.4.2. If a Respondent intends to use subcontractors, the response to this RFP must specifically identify the scope and portions of the work each subcontractor will perform (refer to RFP Attachment 6.2., Section B, General Qualifications & Experience Item B.12.).

4.4.3. Subcontractors identified within a response to this RFP will be deemed as approved by the State unless the State expressly disapproves one or more of the proposed subcontractors prior to signing the Contract.

4.4.4. After contract award, a Contractor may only substitute an approved subcontractor at the discretion of the State and with the State's prior, written approval.

4.4.5. Notwithstanding any State approval relating to subcontracts, the Respondent who is awarded a contract pursuant to this RFP will be the prime contractor and will be responsible for all work under the Contract.

4.5. Right to Refuse Personnel or Subcontractors

The State reserves the right to refuse, at its sole discretion and notwithstanding any prior approval, any personnel of the prime contractor or a subcontractor providing goods or services in the performance of a contract resulting from this RFP. The State will document in writing the reason(s) for any rejection of personnel.

4.6. **Insurance**

The State will require the awarded Contractor to provide a Certificate of Insurance issued by an insurance company licensed or authorized to provide insurance in the State of Tennessee. Each Certificate of Insurance shall indicate current insurance coverages meeting minimum requirements as may be specified by this RFP. A failure to provide a current, Certificate of Insurance will be considered a material breach and grounds for contract termination.

4.7. **Professional Licensure and Department of Revenue Registration**

4.7.1. All persons, agencies, firms, or other entities that provide legal or financial opinions, which a Respondent provides for consideration and evaluation by the State as a part of a response to this RFP, shall be properly licensed to render such opinions.

4.7.2. Before the Contract resulting from this RFP is signed, the apparent successful Respondent (and Respondent employees and subcontractors, as applicable) must hold all necessary or appropriate business or professional licenses to provide the goods or services as required by the contract. The State may require any Respondent to submit evidence of proper licensure.

4.7.3. Before the Contract resulting from this RFP is signed, the apparent successful Respondent must be registered with the Tennessee Department of Revenue for the collection of Tennessee sales and use tax. The State shall not award a contract unless the Respondent provides proof of such registration or provides documentation from the Department of Revenue that the Contractor is exempt from this registration requirement. The foregoing is a mandatory requirement of an award of a contract pursuant to this solicitation. To register, please visit the Department of Revenue's Tennessee Taxpayer Access Point (TNTAP) website for Online Registration and the Vendor Contract Questionnaire. These resources are available at the following: https://tntap.tn.gov/eservices/_/#1

4.8. **Disclosure of Response Contents**

4.8.1. All materials submitted to the State in response to this RFP shall become the property of the State of Tennessee. Selection or rejection of a response does not affect this right. By submitting a response, a Respondent acknowledges and accepts that the full response contents and associated documents will become open to public inspection in accordance with the laws of the State of Tennessee.

4.8.2. The State will hold all response information, including both technical and cost information, in confidence during the evaluation process.

4.8.3. Upon completion of response evaluations, indicated by public release of a Notice of Intent to Award, the responses and associated materials will be open for review by the public in accordance with Tenn. Code Ann. § 10-7-504(a)(7).

4.9. **Contract Approval and Contract Payments**

4.9.1. After contract award, the Contractor who is awarded the contract must submit appropriate documentation with the Department of Finance and Administration, Division of Accounts.

4.9.2. This RFP and its contractor selection processes do not obligate the State and do not create rights, interests, or claims of entitlement in either the Respondent with the apparent best-evaluated response or any other Respondent. State obligations pursuant to a contract award shall commence only after the Contract is signed by the State agency head and the Contractor and after the Contract is approved by all other state officials as required by applicable laws and regulations.

4.9.3. No payment will be obligated or made until the relevant Contract is approved as required by applicable statutes and rules of the State of Tennessee.

4.9.3.1. The State shall not be liable for payment of any type associated with the Contract resulting from this RFP (or any amendment thereof) or responsible for any goods delivered or services rendered by the Contractor, even goods delivered or services rendered in good faith and even if the Contractor is orally directed to proceed with the delivery of goods or the rendering of services, if it occurs before the Contract Effective Date or after the Contract Term.

4.9.3.2. All payments relating to this procurement will be made in accordance with the Payment Terms and Conditions of the Contract resulting from this RFP (refer to RFP Attachment 6.6., *Pro Forma* Contract, Section C).

4.9.3.3. If any provision of the Contract provides direct funding or reimbursement for the competitive purchase of goods or services as a component of contract performance or otherwise provides for the reimbursement of specified, actual costs, the State will employ all reasonable means and will require all such documentation that it deems necessary to ensure that such purchases were competitive and costs were reasonable, necessary, and actual. The Contractor shall provide reasonable assistance and access related to such review. Further, the State shall not remit, as funding or reimbursement pursuant to such provisions, any amounts that it determines do not represent reasonable, necessary, and actual costs.

4.10. Contractor Performance

The Contractor who is awarded a contract will be responsible for the delivery of all acceptable goods or the satisfactory completion of all services set out in this RFP (including attachments) as may be amended. All goods or services are subject to inspection and evaluation by the State. The State will employ all reasonable means to ensure that goods delivered or services rendered are in compliance with the Contract, and the Contractor must cooperate with such efforts.

4.11. Contract Amendment

After Contract award, the State may request the Contractor to deliver additional goods or perform additional services within the general scope of the Contract and this RFP, but beyond the specified Scope, and for which the Contractor may be compensated. In such instances, the State will provide the Contractor a written description of the additional goods or services. The Contractor must respond to the State with a time schedule for delivering the additional goods or accomplishing the additional services based on the compensable units included in the Contractor's response to this RFP. If the State and the Contractor reach an agreement regarding the goods or services and associated compensation, such agreement must be effected by means of a contract amendment. Further, any such amendment requiring additional goods or services must be signed by both the State agency head and the Contractor and must be approved by other state officials as required by applicable statutes, rules, policies and procedures of the State of Tennessee. The Contractor must not provide additional goods or render additional services until the State has issued a written contract amendment with all required approvals.

4.12. Severability

If any provision of this RFP is declared by a court to be illegal or in conflict with any law, said decision will not affect the validity of the remaining RFP terms and provisions, and the rights and obligations of the State and Respondents will be construed and enforced as if the RFP did not contain the particular provision held to be invalid.

4.13. Next Ranked Respondent

The State reserves the right to initiate negotiations with the next ranked Respondent should the State cease doing business with any Respondent selected via this RFP process.

5. EVALUATION & CONTRACT AWARD

5.1. Evaluation Categories & Maximum Points

The State will consider qualifications, experience, technical approach, and cost in the evaluation of responses and award points in each of the categories detailed below (up to the maximum evaluation points indicated) to each response deemed by the State to be responsive.

EVALUATION CATEGORY	MAXIMUM POINTS POSSIBLE
General Qualifications & Experience (refer to RFP Attachment 6.2., Section B)	**10**
Technical Qualifications, Experience & Approach (refer to RFP Attachment 6.2., Section C)	**40**
Cost Proposal (refer to RFP Attachment 6.3.)	**50**

5.2. Evaluation Process

The evaluation process is designed to award the contract resulting from this RFP not necessarily to the Respondent offering the lowest cost, but rather to the Respondent deemed by the State to be responsive and responsible who offers the best combination of attributes based upon the evaluation criteria. ("Responsive Respondent" is defined as a Respondent that has submitted a response that conforms in all material respects to the RFP. "Responsible Respondent" is defined as a Respondent that has the capacity in all respects to perform fully the contract requirements, and the integrity and reliability which will assure good faith performance.)

5.2.1. **Technical Response Evaluation.** The Solicitation Coordinator and the Proposal Evaluation Team (consisting of three (3) or more State employees) will use the RFP Attachment 6.2., Technical Response & Evaluation Guide to manage the Technical Response Evaluation and maintain evaluation records.

5.2.1.1. The State reserves the right, at its sole discretion, to request Respondent clarification of a Technical Response or to conduct clarification discussions with any or all Respondents. Any such clarification or discussion will be limited to specific sections of the response identified by the State. The subject Respondent must put any resulting clarification in writing as may be required and in accordance with any deadline imposed by the State.

5.2.1.2. The Solicitation Coordinator will review each Technical Response to determine compliance with RFP Attachment 6.2., Technical Response & Evaluation Guide, Section A— Mandatory Requirements. If the Solicitation Coordinator determines that a response failed to meet one or more of the mandatory requirements, the Proposal Evaluation Team will review the response and document the team's determination of whether:

a. the response adequately meets RFP requirements for further evaluation;

b. the State will request clarifications or corrections for consideration prior to further evaluation; or,

c. the State will determine the response to be non-responsive to the RFP and reject it.

5.2.1.3. Proposal Evaluation Team members will independently evaluate each Technical Response (that is responsive to the RFP) against the evaluation criteria in this RFP and

will score each in accordance with the RFP Attachment 6.2., Technical Response & Evaluation Guide.

5.2.1.4. For each response evaluated, the Solicitation Coordinator will calculate the average of the Proposal Evaluation Team member scores for RFP Attachment 6.2., Technical Response & Evaluation Guide, and record each average as the response score for the respective Technical Response section.

5.2.1.5. The Proposal Evaluation Team will review the Technical Response Evaluation record and any other available information pertinent to whether or not each Respondent is responsive and responsible. If the Proposal Evaluation Team identifies any Respondent that does not meet the responsive and responsible thresholds such that the team would not recommend the Respondent for Cost Proposal Evaluation and potential contract award, the team members will fully document the determination.

5.2.2. **Cost Proposal Evaluation.** The Solicitation Coordinator will open for evaluation the Cost Proposal of each Respondent deemed by the State to be responsive and responsible. for an initial check for completion of the Cost Proposals in accordance with the RFP Attachment 6.3., Cost Proposal & Scoring Guide.

This information for each responsible Respondent will be forwarded to an independent consulting firm under contract with the Department of Finance & Administration, Division of Benefits Administration based on the RFP Schedule of Events. Any review or analysis of the cost proposal will be done by an independent consulting firm and Benefits Administration staff not associated with the evaluation team. The Solicitation Coordinator is the only person during the evaluation that will have access to both the Technical Response and the Cost Proposal information. At no time will Cost Proposal information be provided to individual evaluation team members.

The consulting firm will also check for the completion of the cost proposals according to the directions contained in RFP Attachment 6.3. Cost Proposal & Scoring Guide. If any questions surface regarding the completion of the forms, the firm is instructed to contact the Solicitation Coordinator with the concern and the Solicitation Coordinator will take appropriate steps to determine the Proposal's responsiveness. The results from the analysis will be provided to the Solicitation Coordinator. The Solicitation Coordinator will calculate and record each Cost Proposal score in accordance with the RFP Attachment 6.3. Cost Proposal & Scoring Guide.

Please note: Tenn. Code Ann. § 10-7-504(n)(1)(A) provides that the following documents submitted to the state in response to a request for proposal or other procurement method shall remain confidential after completion of the evaluation period:

A. Discount, Rebate, pricing or other financial arrangements at the individual drug level between pharmaceutical manufacturers, pharmaceutical wholesalers/distributors, and pharmacy benefits managers, as defined in Tenn. Code Ann. § 56-7-3102 that a proposer:

i. Submits to the state in response to a request for proposals or other procurement methods for pharmacy-related benefits or services;
ii. Includes in its cost or price proposal, or provides to the state after the notice of intended award of the contract is issued, where the Respondent is the apparent contract awardee; and
iii. Explicitly marks as confidential and proprietary; and

B. Discount, Rebate, pricing or other financial arrangements at the individual provider level between health care providers and health insurance entities, as defined in Tenn. Code Ann.56-7-109, insurers, insurance arrangements and third party administrators that a Respondent:

i. Submits to the state in response to a request for proposals or other procurement method after the notice of intended award of the contract is issued,

where the Respondent is the apparent contact awardee, in response to a request by the state for additional information, and
ii. Explicitly marks as confidential and proprietary

As such, the State commits to maintain strict confidentiality and oversight over any proprietary data, to the extent permitted by the statute.

5.3. **Contract Award Process**

5.3.1 The Solicitation Coordinator will submit the Proposal Evaluation Team determinations and scores to the head of the procuring agency for consideration along with any other relevant information that might be available and pertinent to contract award.

5.3.2. Benefits Administration's executive director will determine the apparent best-evaluated Response. To effect a contract award to a Respondent other than the one receiving the highest evaluation process score, the head of the procuring agency must provide written justification and obtain the written approval of the Chief Procurement Officer and the Comptroller of the Treasury.

5.3.3. Benefits Administration will present the apparent best-evaluated Response recommendation before the State, Local Education, and Local Government Insurance Committees, as applicable, for approval to enter into a contract with the best-evaluated Respondent.

5.3.4. The State will issue a Notice of Intent to Award identifying the apparent best-evaluated response and make the RFP files available for public inspection at the time and date specified in the RFP Section 2, Schedule of Events.

NOTICE: The Notice of Intent to Award shall not create rights, interests, or claims of entitlement in either the apparent best-evaluated Respondent or any other Respondent.

5.3.5. The Respondent identified as offering the apparent best-evaluated response must sign a contract drawn by the State pursuant to this RFP. The Contract shall be substantially the same as the RFP Attachment 6.6., *Pro Forma* Contract. The Respondent must sign the contract by the Contractor Signature Deadline detailed in the RFP Section 2, Schedule of Events. If the Respondent fails to provide the signed Contract by this deadline, the State may determine that the Respondent is non-responsive to this RFP and reject the response.

5.3.6. Notwithstanding the foregoing, the State may, at its sole discretion, entertain limited terms and conditions or pricing negotiations prior to Contract signing and, as a result, revise the *pro forma* contract terms and conditions or performance requirements in the State's best interests, PROVIDED THAT such revision of terms and conditions or performance requirements shall NOT materially affect the basis of response evaluations or negatively impact the competitive nature of the RFP and contractor selection process.

5.3.7. If the State determines that a response is non-responsive and rejects it after opening Cost Proposals, the Solicitation Coordinator will re-calculate scores for each remaining responsive Cost Proposal to determine (or re-determine) the apparent best-evaluated response.

RFP ATTACHMENT 6.1.

RFP # 31786-00174 STATEMENT OF CERTIFICATIONS AND ASSURANCES

The Respondent must sign and complete the Statement of Certifications and Assurances below as required, and it must be included in the Technical Response (as required by RFP Attachment 6.2., Technical Response & Evaluation Guide, Section A, Item A.1.).

The Respondent does, hereby, expressly affirm, declare, confirm, certify, and assure ALL of the following:

1. The Respondent will comply with all of the provisions and requirements of the RFP.
2. The Respondent will provide all services as defined in the Scope of the RFP Attachment 6.6., *Pro Forma* Contract for the total Contract Term.
3. The Respondent, except as otherwise provided in this RFP, accepts and agrees to all terms and conditions set out in the RFP Attachment 6.6., *Pro Forma* Contract.
4. The Respondent acknowledges and agrees that a contract resulting from the RFP shall incorporate, by reference, all proposal responses as a part of the Contract.
5. The Respondent will comply with:
   (a) the laws of the State of Tennessee;
   (b) Title VI of the federal Civil Rights Act of 1964;
   (c) Title IX of the federal Education Amendments Act of 1972;
   (d) the Equal Employment Opportunity Act and the regulations issued there under by the federal government; and,
   (e) the Americans with Disabilities Act of 1990 and the regulations issued there under by the federal government.
6. To the knowledge of the undersigned, the information detailed within the response submitted to this RFP is accurate.
7. The response submitted to this RFP was independently prepared, without collusion, under penalty of perjury.
8. No amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Respondent in connection with this RFP or any resulting contract.
9. Both the Technical Response and the Cost Proposal submitted in response to this RFP shall remain valid for at least 120 days subsequent to the date of the Cost Proposal opening and thereafter in accordance with any contract pursuant to the RFP.
10. The Respondent affirms the following statement, as required by the Iran Divestment Act Tenn. Code Ann. § 12-12-111: "By submission of this bid, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of its knowledge and belief that each bidder is not on the list created pursuant to §12-12-106." For reference purposes, the list is currently available online at: https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/library-/public-information-library.html.

By signing this Statement of Certifications and Assurances, below, the signatory also certifies legal authority to bind the proposing entity to the provisions of this RFP and any contract awarded pursuant to it. If the signatory is not the Respondent (if an individual) or the Respondent's company *President* or *Chief Executive Officer*, this document must attach evidence showing the individual's authority to bind the Respondent.

DO NOT SIGN THIS DOCUMENT IF YOU ARE NOT LEGALLY AUTHORIZED TO BIND THE RESPONDENT

SIGNATURE: _____

PRINTED NAME & TITLE: _____

DATE: _____

RESPONDENT LEGAL ENTITY NAME: _____

TECHNICAL RESPONSE & EVALUATION GUIDE

SECTION A: MANDATORY REQUIREMENTS. The Respondent must address all items detailed below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the response page number for each item in the appropriate space below.

The Solicitation Coordinator will review the response to determine if the Mandatory Requirement Items are addressed as required and mark each with pass or fail. For each item that is not addressed as required, the Proposal Evaluation Team must review the response and attach a written determination. In addition to the Mandatory Requirement Items, the Solicitation Coordinator will review each response for compliance with all RFP requirements.

RESPONDENT LEGAL ENTITY NAME:	

Response Page # (Respondent completes)	Item Ref.	Section A— Mandatory Requirement Items	Pass/Fail
		The Response must be delivered to the State no later than the Response Deadline specified in the RFP Section 2, Schedule of Events.	
		The Technical Response and the Cost Proposal documentation must be packaged separately as required (refer to RFP Section 3.2., *et. seq.*).	
		The Technical Response must NOT contain cost or pricing information of any type.	
		The Technical Response must NOT contain any restrictions of the rights of the State or other qualification of the response.	
		A Respondent must NOT submit alternate responses (refer to RFP Section 3.3.).	
		A Respondent must NOT submit multiple responses in different forms (as a prime and a subcontractor) (refer to RFP Section 3.3.).	
	A.1.	Provide the Statement of Certifications and Assurances (RFP Attachment 6.1.) completed and signed by an individual empowered to bind the Respondent to the provisions of this RFP and any resulting contract. The document must be signed without exception or qualification.	
	A.2.	Provide a statement, based upon reasonable inquiry, of whether the Respondent or any individual who shall cause to deliver goods or perform services under the contract has a possible conflict of interest (*e.g.*, employment by the State of Tennessee) and, if so, the nature of that conflict. NOTE: Any questions of conflict of interest shall be solely within the discretion of the State, and the State reserves the right to cancel any award.	
	A.3.	Provide a current bank reference indicating that the Respondent maintains a satisfactory business relationship with the financial institution. Such reference must be written in the form of a standard business letter, signed, and dated within the past three (3) months.	
	A.4.	Provide two current positive credit references from vendors with which the Respondent has done business written in the form of standard business letters, signed, and dated within the past three (3) months.	

RESPONDENT LEGAL ENTITY NAME:			
Response Page # (Respondent completes)	**Item Ref.**	**Section A— Mandatory Requirement Items**	**Pass/Fail**
	A.5.	Provide at least one of the following financial documents dated within the last three (3) months: (1) an official document or letter from an accredited credit bureau, indicating a satisfactory credit score for the Respondent (NOTE: A credit bureau report number without the full report is insufficient and will not be considered responsive.); (2) income statement, indicating the Respondent's financial operations; or (3) balance sheet, showing the Respondent's flow of funds. Any documentation disclosing the amount of cash flows from operating activities should be for the Respondent's most current operating period and must indicate whether the cash flows are positive or negative. If the cash flows are negative for the most recent operating period, the documentation must include a detailed explanation of the factors contributing to the negative cash flows. NOTICE: All persons, agencies, firms, or other entities that provide opinions regarding the Respondent's financial status must be properly licensed to render such opinions. The State may require the Respondent to submit proof of such licensure detailing the state of licensure and licensure number for each person or entity that renders the opinions.	
	A.6.	Provide a current credit rating from Moody's, Standard & Poor's, Dun & Bradstreet, A.M. Best or Fitch Ratings, verified and dated within the last three (3) months and indicating a positive credit rating for the Respondent. OR, in lieu of the aforementioned credit rating, provide an official document or letter from an accredited credit bureau, dated within the last three (3) months and indicating a satisfactory credit score for the Respondent (NOTE: A credit bureau report number without the full report is insufficient and will not be considered responsive.)	
	A.7.	Provide the Respondent's most recent independent audited financial statements. Said independent audited financial statements must: (1) reflect an audit period for a fiscal year ended within the last 36 months; (2) be prepared with all monetary amounts detailed in United States currency; (3) be prepared under United States Generally Accepted Accounting Principles (US GAAP); (4) include the auditor's opinion letter; financial statements; and the notes to the financial statements; and (5) be deemed, in the sole discretion of the State to reflect sufficient financial stability to undertake the subject contract with the State if awarded pursuant to this RFP. **OR**, in lieu of the aforementioned independent audited financial statements, provide a financial institution's letter of commitment for a general Line of Credit in the amount of **WRITTEN AMOUNT ≥ ONE MILLION DOLLARS** (**$NUMBER AMOUNT**), U.S. currency, available to the Respondent. Said letter must specify the Respondent's name, be signed and dated within the past three (3) months by an authorized agent of the financial institution, and indicate that the Line of Credit shall be available for at least PERIOD **≥ 6 MONTHS**.	

RESPONDENT LEGAL ENTITY NAME:			
Response Page # (Respondent completes)	**Item Ref.**	**Section A— Mandatory Requirement Items**	**Pass/Fail**
		NOTES: ▪ Reviewed or Compiled Financial Statements will not be deemed responsive to this requirement and will not be accepted. All persons, agencies, firms, or other entities that provide opinions regarding the Respondent's financial status must be properly licensed to render such opinions. The State may require the Respondent to submit proof that the person or entity who renders an opinion regarding the Respondent's financial status is licensed, including the license number and state in which the person or entity is licensed.	
	A.8.	Provide a written attestation that if awarded the contract the Respondent shall not use information gained through this Contract, including but not limited to utilization and pricing information, in marketing or expanding non-State business relationships or for any pecuniary gain.	
	A.9.	Confirm that all networks that will be available to Plan Members will comply, as applicable, with all state laws, including but not limited to, Tenn. Code Ann. § 56-7-2359, Tennessee Public Acts Chapter 1070 as passed during the 112th General Assembly, Tennessee Public Acts Chapter 405 as passed during the 112th General Assembly, and Tennessee Public Acts Chapter 569 as passed during the 112th General Assembly.	
	A.10.	Provide a copy of the Respondent's URAC (formerly known as Accreditation Review Commission) Pharmacy Benefit Management accreditation certificate or other proof that URAC Pharmacy Benefit Management accreditation will occur on or before the pharmacy contract effective date. The successful Respondent will be required to maintain URAC Pharmacy Benefit Management accreditation during the entire term of this contract, including runout.	
	A.11	Provide written confirmation that the Respondent has been operating as a Pharmacy Benefit Manager for a minimum of three (3) years.	
	A.12	Confirm that the Respondent has at least one (1) client with 100,000 or more lives currently receiving PBM services, as well as two (2) clients with at least 50,000 lives each.	
	A.13	Submit a statement that the Respondent understands and agrees to the following: Regardless of the baseline measure used to adjudicate claims, the Contractor shall reconcile claims, as required in Contract Section C.3.s.-u to a minimum Discount Guarantee by channel using the Medi-span post-settlement Average Wholesale Price (AWP) methodology. The Contractor understands and agrees that this contract is deemed a '100% fully pass-through, transparent contract'. The minimum Discount Guarantees will be subject to all Payment Terms and Conditions in the Pro Forma Contract. The Contractor shall use the Medi-Span post-settlement Average Wholesale Price (AWP) methodology to provide Guarantees.	
State Use – Solicitation Coordinator Signature, Printed Name & Date:			

TECHNICAL RESPONSE & EVALUATION GUIDE

SECTION B: GENERAL QUALIFICATIONS & EXPERIENCE. The Respondent must address all items detailed below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the response page number for each item in the appropriate space below. Proposal Evaluation Team members will independently evaluate and assign one score for all responses to Section B— General Qualifications & Experience Items.

RESPONDENT LEGAL ENTITY NAME:	

Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
	B.1.	Detail the name, e-mail address, mailing address, telephone number, and facsimile number, if applicable, of the person the State should contact regarding the response.
	B.2.	Describe the Respondent's form of business (*i.e*., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and business location (physical location or domicile).
	B.3.	Detail the number of years the Respondent has been in business.
	B.4.	Briefly describe how long the Respondent has been providing the goods or services required by this RFP.
	B.5.	Describe the Respondent's number of employees, client base, and location of offices.
	B.6.	Provide a statement of whether there have been any mergers, acquisitions, or change of control of the Respondent within the last ten (10) years. If so, include an explanation providing relevant details.
	B.7.	Provide a statement of whether the Respondent or, to the Respondent's knowledge, any of the Respondent's employees, agents, independent contractors, or subcontractors, involved in the delivery of goods or performance of services on a contract pursuant to this RFP, have been convicted of, pled guilty to, or pled *nolo contendere* to any felony. If so, include an explanation providing relevant details.
	B.8.	Provide a statement of whether, in the last ten (10) years, the Respondent has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, include an explanation providing relevant details.
	B.9.	Provide a statement of whether there is any material, pending litigation against the Respondent that the Respondent should reasonably believe could adversely affect its ability to meet contract requirements pursuant to this RFP or is likely to have a material adverse effect on the Respondent's financial condition. If such exists, list each separately, explain the relevant details, and attach the opinion of counsel addressing whether and to what extent it would impair the Respondent's performance in a contract pursuant to this RFP. NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Respondent must be properly licensed to render such opinions. The State may require the Respondent to submit proof of license for each person or entity that renders such opinions.
	B.10.	Provide a statement of whether there are any pending or in progress Securities Exchange Commission investigations involving the Respondent. If such exists, list each separately, explain the relevant details, and attach the opinion of counsel addressing whether and to what extent it will impair the Respondent's performance in a contract pursuant to this RFP.

RFP ATTACHMENT 6.2. — SECTION B (continued)

RESPONDENT LEGAL ENTITY NAME:		
Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
		NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Respondent must be properly licensed to render such opinions. The State may require the Respondent to submit proof of license for each person or entity that renders such opinions.
	B.11.	Provide a brief, descriptive statement detailing evidence of the Respondent's ability to deliver the goods or services sought under this RFP (*e.g.*, prior experience, training, certifications, resources, program and quality management systems, *etc.*).
	B.12.	Provide a statement of whether the Respondent intends to use subcontractors to meet the Respondent's requirements of any contract awarded pursuant to this RFP, and if so, detail: (a) the names of the subcontractors along with the contact person, mailing address, telephone number, and e-mail address for each; (b) a description of the scope and portions of the goods each subcontractor involved in the delivery of goods or performance of the services each subcontractor will perform; and (c) a statement specifying that each proposed subcontractor has expressly assented to being proposed as a subcontractor in the Respondent's response to this RFP.
	B.13.	Provide documentation of the Respondent's commitment to diversity as represented by the following: (a) Business Strategy. Provide a description of the Respondent's existing programs and procedures designed to encourage and foster commerce with business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises. Please also include a list of the Respondent's certifications as a diversity business, if applicable. (b) Business Relationships. Provide a listing of the Respondent's current contracts with business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises. Please include the following information: (i) contract description; (ii) contractor name and ownership characteristics (*i.e.*, ethnicity, gender, service-disabled veteran-owned or persons with disabilities); (iii) contractor contact name and telephone number. (c) Estimated Participation. Provide an estimated level of participation by business enterprises owned by minorities, women, service-disabled veterans, persons with disabilities and small business enterprises if a contract is awarded to the Respondent pursuant to this RFP. Please include the following information: (i) a percentage (%) indicating the participation estimate. (Express the estimated participation number as a percentage of the total estimated contract value that will be dedicated to business with subcontractors and supply contractors having such ownership characteristics only and **DO NOT INCLUDE DOLLAR AMOUNTS**). (ii) anticipated goods or services contract descriptions; (iii) names and ownership characteristics (i.e., ethnicity, gender, service-disabled veterans, or disability) of anticipated subcontractors and supply contractors. NOTE: In order to claim status as a Diversity Business Enterprise under this contract, businesses must be certified by the Governor's Office of Diversity Business Enterprise (Go-DBE). Please visit the Go-DBE website at https://tn.diversitysoftware.com/FrontEnd/StartCertification.asp?TN=tn&XID=9810 for more information. (d) Workforce. Provide the percentage of the Respondent's total current employees by ethnicity and gender.

RFP ATTACHMENT 6.2. — SECTION B (continued)

RESPONDENT LEGAL ENTITY NAME:		
Response Page # (Respondent completes)	**Item Ref.**	**Section B— General Qualifications & Experience Items**
		NOTE: Respondents that demonstrate a commitment to diversity will advance State efforts to expand opportunity to do business with the State as contractors and subcontractors. Response evaluations will recognize the positive qualifications and experience of a Respondent that does business with enterprises owned by minorities, women, service-disabled veterans, persons with disabilities, and small business enterprises and who offer a diverse workforce.
	B.14.	Provide a statement of whether or not the Respondent has any current contracts with the State of Tennessee or has completed any contracts with the State of Tennessee within the previous five (5) year period. If so, provide the following information for all of the current and completed contracts: (a) the name, title, telephone number and e-mail address of the State contact knowledgeable about the contract. (b) the procuring State agency name. (c) a brief description of the contract's scope of services. (d) the contract period; and (e) the contract numbers.
	B.15.	Provide a statement and any relevant details addressing whether the Respondent is any of the following: (a) is presently debarred, suspended, proposed for debarment, or voluntarily excluded from covered transactions by any federal or state department or agency; (b) has within the past three (3) years, been convicted of, or had a civil judgment rendered against the contracting party from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (c) is presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed above; and (d) has within a three (3) year period preceding the contract had one or more public transactions (federal, state, or local) terminated for cause or default.
	B.16.	Provide up to five (5) customer references from individuals who are not current or former State employees for projects similar to the goods or services sought under this RFP and which represent: ▪ two (2) accounts Respondent currently services with at least one of them covering 100,000 lives and the other covering at least 50,000 lives; **and** ▪ three (3) completed projects. References from at least three (3) different individuals are required to satisfy the requirements above, e.g., an individual may provide a reference about a completed project and another reference about a currently serviced account. The standard reference questionnaire, which must be used and completed, is provided at RFP Attachment 6.4. References that are not completed as required may be deemed non-responsive and may not be considered. The Respondent will be solely responsible for obtaining fully completed reference questionnaires and ensuring they are e-mailed to the solicitation coordinator. NOTES: • The State will not accept late references or references submitted by any means other than the two which is described above, and each reference questionnaire submitted must be completed as required. • The State will not review more than the number of required references indicated above.

RFP ATTACHMENT 6.2. — SECTION B (continued)

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		• While the State will base its reference check on the contents of the reference e-mails, the State reserves the right to confirm and clarify information detailed in the completed reference questionnaires and may consider clarification responses in the evaluation of references. The State is under no obligation to clarify any reference information.
	B.17.	Other than the mandatory URAC accreditation, provide information on any accreditations related to the services required under this contract for which your organization has been certified.
		SCORE *(for all Section B—Qualifications & Experience Items above)*: *(maximum possible score = 10)*
State Use – Evaluator Identification:		

RFP ATTACHMENT 6.2. — SECTION C

TECHNICAL RESPONSE & EVALUATION GUIDE

SECTION C: TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH. The Respondent must address all items (below) and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Respondent must also detail the response page number for each item in the appropriate space below.

A Proposal Evaluation Team, made up of three or more State employees, will independently evaluate and score the response to each item. Each evaluator will use the following whole number, raw point scale for scoring each item:

0 = little value ***1 = poor*** ***2 = fair*** ***3 = satisfactory*** ***4 = good*** ***5 = excellent***

The Solicitation Coordinator will multiply the Item Score by the associated Evaluation Factor (indicating the relative emphasis of the item in the overall evaluation). The resulting product will be the item's Raw Weighted Score for purposes of calculating the section score as indicated.

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
	C.1.	**Scope** (a) Describe your experience as the PBM for large self-funded employer groups. Also describe any experience with public sector clients. (b) Succinctly describe how your company helps your clients, and will help the State, address the following concerns: 1. Rising cost of medications, especially specialty medications 2. State and federal policy requirements or mandates 3. Utilization of low value or ineffective medications (c) How engaged is your organization at the national level with advocating for the needs of self-funded employers and weighing in on policy development?		**6**	
	C.2.	**Plan Implementation** (a) Describe your experience with large-scale PBM implementations by completing the following table for your three largest implementations completed within the last 2 years: (b) Generally, what are the top three (3) implementation tasks you deem to be the most important? Describe your ability to successfully manage these tasks. (c) What do you consider to be the single biggest implementation risk of this program? How will you mitigate this risk? (d) Provide a project implementation plan that includes: 1. A brief description of the role of each employee on the Respondent's implementation team including the Implementation Project Lead. 2. The relevant experience of, and any certifications held by, the Implementation Project Lead that will be assigned to the state account.https://tennessee-		**7**	

	Number of Covered Lives	Industry	Length of Implementation	Implemented on time – Yes or No
Client 1				
Client 2				
Client 3				

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		my.sharepoint.com/personal/ag04is3_tn_gov/_layouts/15/Doc.aspx?sourcedoc={E2A37983-D98D-4ADB-B35D-73D50EBEA79D}&file=Change over time - pain ED migraine sleep PPIs_020323.xlsx&action=default&mobileredirect=true			
	C.3.	**Benefit Setup** (a) Describe how you will ensure the accuracy of the benefits setup for all the state-sponsored insurance plans, including the Formulary and Claims accuracy testing processes. Explain the documentation confirming accurate setup that will be provided to state staff prior to the go-live date, after any benefit change, and prior to January 1st of each plan year. (b) Briefly describe your plan to ensure that the transition is seamless for Members. (c) Describe your experience with the following setup activities and confirm that your data conversion plan will include these tasks: 1. The loading of historical claims and open Prior Authorizations (PA) issued under the incumbent PBM. How long will these PAs last? 2. The conversion of existing Mail Order Service program(s) to your Mail Order Service program (refill history, access, requirement of new prescriptions, etc.). 3. The transition and implementation of utilization management programs discussed and approved by the State during implementation.		**6**	
	C.4.	**Staffing** (a) For the proposed account team provide: 1. A list of members of the ongoing account team and what roles they will play (e.g., Account Manager, Clinical Pharmacist, Account Executive) during the term of this contract. 2. An organizational chart identifying the key people who will be assigned to deliver the goods or services required by this RFP. 3. The estimated number of hours that each team member will devote to this contract. 4. A resume for each of the people listed. The resumes must detail the individual's title, education, current position with the Respondent, and employment history (b) Confirm the account team's access to appropriate executive sponsors to escalate and resolve issues of importance to the State, who these executive sponsors are and what their role is with your organization. (c) Describe any compensation received by account team members to promote or sell additional services offered by your organization (Specialty Pharmacy, disease-state management, point solution management programs, etc.). (d) Describe the Respondent's experience working with states on legislative bill analysis and the development of fiscal notes outlining any fiscal impact to the Plan. Which team members are utilized? How will you ensure tight deadlines are met and the requested information is provided?		**6**	

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	C.5.	**Claims Adjudication** Regarding the Respondent's claims adjudication system and processes: (a) Confirm the usage of a POS system that meets national security standards and includes data protection capabilities and can meet, or exceed, all contractual claims processing/adjudication requirements. (b) Is the POS system flexible and can the Respondent customize the system based upon client needs (e.g., copays for some plans and coinsurance for others, along with different deductibles and MOOPs that vary by level of member coverage (I.e., employee only, employee+spouse, employee+children, or employee+spouse+children)? (c) Confirm the Respondent's ability to implement a coordination of benefits model, including possible reimbursement, for Members who have other prescription drug coverage; include how it would work from the Member's perspective. (d) Confirm initial and ongoing testing and auditing of the system for accuracy, timeliness, and quality of the Contractor's services; include frequency of ongoing testing.		**7**	
	C.6.	**Claims Payment and Reconciliation** Regarding the Respondent's claims payment processes confirm the following: (a) The Respondent's agreement to offer Pass-Through Transparent Pricing as defined in Contract Section A.2. **NOTE: DO NOT include any pricing in this response.** (b) The ability of system edits to prevent payment of incomplete or denied claims or claims for Members whose eligibility is not current. (c) Describe in detail your process for correcting pharmacy claims when an error has been detected in the benefits setup or other incorrect processing. How do you reimburse members when the incorrect adjudication is the result of a benefits setup error caused by your organization? How will you work to reverse and reprocess incorrect pharmacy claims and adjust member deductibles and maximum out of pocket amounts and trade this data with other vendors, such as the State's medical TPAs? (d) Describe any relationships you have with external prescription discount programs or any similar internal program you have that will allow you to comply with contract requirement A.7.i.		**7**	
	C.7.	**Compliance** (a) Discuss how your organization will ensure compliance with Public Chapter 1070 and Tenn. Code Ann. § 56-7-2359 as it relates to the state group insurance program. (b) Describe your approach to coverage of all Affordable Care Act (ACA) required pharmacy benefits and all USPSTF "A" and "B" rated pharmacy benefits/vaccinations and ensuring plan compliance with all associated requirements under Section 2713 of the ACA. (c) Describe how your organization will ensure the State's compliance with all requirements (Rx Data Collection reporting, Gag Clauses, etc.) of		**8**	

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		the 2021 Consolidated Appropriations Act and Transparency in Coverage rules, including required federal reporting. (d) As it relates to transparency, list: 1. All sources and amounts of revenue your organization and/or your PBM Affiliates will receive while managing this account. 2. Any commissions, TPA fees, or broker fees that will be paid by you as the PBM and to whom they will be paid.			
	C.8.	**Retail-30 Network** Provide a Quest mapping report for your proposed national/statewide any willing provider Retail-30 network. Use the Member ZIP code file enclosed in Appendix 7.2, to demonstrate that your proposed network meets the criteria described in Contract Section A.8.e. Quest Analytics instructions and sample report are shown in Appendices 7.6 and 7.7. **NOTE: Respondents MUST use Appendix 7.2 for ZIP Code Classifications and the classifications listed (urban, suburban, rural). The ZIP code list and classifications must match in the Respondent's report. The Respondent must use Quest Analytics. Please see Appendices 7.6 and 7.7 for Instructions and Sample Report.**		**10**	
	C.9.	**Networks** (a) Complete the table below for the networks that you are proposing to utilize for this contract. (b) In Appendix 7.20 Proposed Networks - populate each of the four tabs with the contracted pharmacies in your networks that will be utilized for this contract. The total number of pharmacies listed should match the total number of pharmacies nationally in RFP question C.9.(a). List the following for each individual pharmacy that you list on each tab of Appendix 7.20 Proposed Networks: 1. Pharmacy NCPDP identifier 2. Pharmacy name 3. Pharmacy street address 4. Pharmacy City 5. Pharmacy State (abbreviation)		**10**	

Network	**# of Pharmacies Nationally**	**# of Pharmacies in TN**
Retail-30		
Retail-90		
Mail		
Specialty		
Vaccination		
Total		

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		6. Pharmacy Zip (c) Populate Appendix 7.21 Network Disruption with the requested information. (d) Explain the ongoing frequency of pharmacy network efforts including contract renegotiation and renewal with pharmacies. (e) List any major chain pharmacies that do **not** participate in your Retail-30, 90-day- at-retail or vaccination networks and specifically which network/s (e.g., 30-day. 90 days, or vaccine network) they are not in.			
	C.10.	**Mail Order** List the Mail Order Service facility that would be used for this contract including the length of time the facility has been in operation and then describe or provide the following information: (a) The ability to obtain, and load, open refill files from the State's current Mail Order Service pharmacy/PBM, if available. (b) The average turnaround time in the most recent quarter for prescriptions that: 1. Required intervention (in days) 2. Did not require intervention (in days) and 3. Were marked as rush orders.		**2**	
	C.11	**Specialty Pharmacy Network** (a) Describe your specialty pharmacy program. Is it managed by your organization as the PBM or by an outside vendor? (b) If you have your own specialty pharmacy describe: (1) the shipping and handling policy for specialty products including how the first fill of Specialty Drugs is handled when Members require immediate access (I.e., do you allow a first fill at a retail pharmacy to get the member started, if needed and urgent, then work to transition them to a pharmacy in your specialty network?) and (2) your organization's willingness to ship to the Member's choice of location (e.g., physician's office, infusion center, etc.). (c) Confirm that the specialty pharmacies in your specialty network do not auto ship and will contact the plan Member before filling to ensure the medication is still needed and the Member is using the medication (in order to reduce plan cost and waste). (d) If you operate your own specialty pharmacy that you intend for SGIP members to use, explain how your organization will avoid any unintended incentives to fill specialty prescriptions when a non-specialty drug may be a better clinical alternative for the member.		**7**	
	C.12.	**Formulary Management** (a) List your Pharmacy & Therapeutics Committee member qualifications (credentials and affiliations). Describe the various disciplines represented. Are any of the voting members also employees of your organization or any parent organization?		**7**	

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		(b) Describe the number of times per year (how often, or which months) that your Preferred Drug List (PDL) is updated and the process and timing for adding products new to the market to the Formulary. (c) Explain how Formulary products are selected and what place price has in the placement of drugs on the Formulary. Are ICER reports used in determining the formulary? If so, how? (d) Where on your formulary are current biosimilar medications positioned? What steps, if any, are you taking to increase their utilization? (e) Describe your organization's efforts to remove hyperinflated, wasteful, or otherwise low-value medications and products from your formulary. How can your organization assist the state group insurance program to reduce spend on products with less clinical value or for which there are other less costly OTC products or medications available?			
	C.13	**<u>Formulary Disruption</u>** The State currently has an open formulary (see Appendix 7.24) with a few exclusions specifically listed in Appendix 7.23. Regarding the Respondent's Formulary management policies, procedures, and processes describe or provide: (a) A copy of the Formulary and the name of the Formulary you intend the State to use for its current benefit plans if selected as the best evaluated Respondent. This **MUST** be an open formulary with exclusions (only as listed in Appendix 7.23) and utilization management such as Step Therapy, quantity limits and/or PA requirements that aligns with the current plan design in Appendices 7.17 and 7.18. See RFP Appendices 7.17, 7.18, 7.23. and 7.24 for a summary of the State's current Formulary management edits and exclusions. (b) A disruption analysis related to a switch from the current Formulary to the new Formulary. Complete the tables in RFP Appendix 7.3. for this analysis.		**8**	
	C.14	**<u>Specialty Drugs</u> (See definition in Contract Section A.2.)** (a) Describe your organization's approach to managing specialty drugs and keeping costs down while ensuring the most clinically effective care for Members. Include how biosimilars factor into this approach. (b) List the criteria and frequency of review used to make additions to the Respondent's Specialty Drug list. (c) List any recommended clinical management/utilization (Prior Authorization, Step Therapy, Quantity Limits etc.) programs to assess the appropriateness of therapy prior to dispensing specialty products. (d) Describe any clinical support available to members taking specialty medications through your own specialty pharmacy, if you have one. Examples include access to nurses or pharmacists for consultation and education, any efforts commonly used to improve adherence rates for Specialty Drugs, and any case management programs including outreach and any coordination of care activities. When is this clinical support available to plan members (days and hours)?		**8**	
	C.15.	**<u>Benefit Coverage/Plan Design</u>** (a) What is your organization's strategy around managing the use of copay cards and preventing members from being financially incentivized to utilize a high-cost drug when other less costly, clinically effective options are available?		**6**	

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		(b) Describe your organization's experience with and/or ability to implement value-based payments on medications where provider payments are differentiated based on quality, efficacy, and/or patient outcomes (or any combination of these). (c) Describe your organization's ability to offer point solution management programs for conditions such as weight management, insomnia, anxiety, depression or other clinical conditions. If the state were to decide to ever exercise the option to utilize one of these programs, would our existing contract with you suffice or would we be required to sign other documents? Would you be providing these services or would a subcontractor, and if so, who? Are these typically buy-up programs (do not include any costs here)?			
	C.16.	**<u>Clinical Programs</u>** (a) Does the Respondent have a therapeutic substitution and Generic Drug dispensing program available for the State to implement at its own discretion? Describe the typical or average savings potential for this program for a plan of our size. (b) Provide a description of available Step Therapy programs the State may choose to implement that target Brand Drugs for drug classes such as: Proton Pump Inhibitors (PPIs), Migraine medications, Atopic dermatitis, Anti-asthmatics, Pain (Rheumatoid Arthritis/Osteoarthritis), Compound medications in excess of $300, and Narcolepsy/excessive daytime drowsiness. (c) Provide a description of your recommended PA programs that the State may choose to implement. Include the timing for authorization requirements, the plan to communicate the findings, and how the Respondent plans to manage this process. Describe the typical or average savings potential for these programs. (d) What other cost containment programs does your organization offer that you would recommend the State adopt? (e) What clinical programs support the formulary in achieving best patient outcomes?		**8**	
	C.17.	**<u>Prospective/Concurrent DUR</u>** Describe or provide the following information regarding the Respondent's Drug Utilization Review (DUR) program: (a) The capabilities of the DUR systems and the processes to support them. (b) A full list of the edits used to identify issues such as overutilization, incorrect drug dosages, contraindications, incorrect drug treatments and potential abuse and/or misuse at the POS, prior to the medication being dispensed.		**2**	
	C.18.	**<u>Retro-DUR</u>** Describe or provide the following information regarding the Respondent's Retro-DUR program: (a) An overview of the Retro-DUR program including how required interventions are identified, timeframes for intervention, who is notified		**2**	

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		and in what manner, and how outcomes of interventions are documented. (b) Criteria and trends used to identify: 1. Providers who practice outside of their peer's norm. 2. Members with excessive use of controlled substances. (c) Standard pharmacy lock-in guidelines when Member fraud or abuse is identified. Describe the supporting documentation to be provided to the State (e.g., amount of time claims were reviewed, quantity of filled prescriptions, name of drug and drug class that was filled and at which pharmacies, prescriber name, etc.) so that the State can decide regarding whether to lock a member into a single pharmacy.			
	C.19.	**Financials** Describe the following regarding financials: (a) The Respondent's Maximum Allowable Cost (MAC) pricing program. Include: 1. How it is developed, updated, pricing methodology, criteria for inclusion/removal, pharmacy types where it applies (retail, mail, and specialty) and how frequently updated. 2. The percentage of Generic Drug National Drug Codes (NDC or NDC-11) included on the MAC List and the percentage of your Generic Drug claims that hit the MAC List for your total Book of Business; and 3. The number of MAC pricing lists you manage. Describe the differences between each list (content, pricing, etc.). Please confirm that you will use the most aggressive MAC list for the State. Will you share your MAC list(s) with the State at any time upon State request? (b) In instances where a brand prescription drug has considerable market share, provide how quickly the Respondent sets a MAC price for competing Generic Drugs coming to market. (c) Confirm that the Respondent will adhere to the definition of Pass-Through Transparent Pricing in the **Contract Section A.2.**		**9**	
	C.20.	**Pharmacy Manufacturer Payments** Describe the following regarding Manufacturer Payments: (a) How will the State be notified of Rebate/Manufacturer Payment contract changes that may have a material impact? Please include detail on financial impact and disruption reporting provided, how many days in advance of a decision this will be provided to the state, and any additional pertinent detail regarding the notification process. (b) Confirm the ability to substantiate any Rebate/Manufacturer Payment guarantee adjustments, if needed. (c) Confirm the ability to provide a breakout with (or before) each Rebate payment made to the State which shows the total amount of the payment by drug at the NDC-11 level, which previous **quarters** and which **groups** (e.g., State actives, State retirees, Local Education actives, Local Education retirees, Local Government actives, Local		**9**	

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		Government retirees) make up each portion of the rebate check, in Excel format. If the Respondent is not able to provide NDC-11 level Rebate reporting, please provide information on the highest level of detail that the Respondent can provide with each Rebate payment to the State, respectively. (d) If the State decides mid-year to exclude coverage of a particular class of drugs altogether, or to exclude a few different drugs themselves (e.g., combination drugs made of up several Generic Drugs), describe how long it would take your organization to analyze the impact on contractual guarantees as required in the contract and effectuate the change. (e) Describe your organization's strategy and thinking around: 1. Providing immediate POS Rebates for all brand and Specialty Drugs filled at <u>any network pharmacy</u>. Can you implement POS rebates for a subset of health plans, such as just the CDHP plans, but keep pharmacy rebates for non-CDHP plans via checks that accrue to Benefits Administration? Explain how it would work. 2. Forgoing rebates and providing the lowest net cost at the point of sale. 3. Does your organization prefer one of these approaches over the other? (f) Confirm the Contractor's understanding of the contract requirement to pay the State each quarter at least the minimum Manufacturer Payment guarantees for that quarter out of the Contractor's own funds, then any additional Rebates and Manufacturer Payments as they are paid over time.			
	C.21	**<u>State Technical Requirements & Data & Information Technology</u>** (a) Confirm ability to interface with the State's Edison ERP system to ensure the accurate and timely processing of daily enrollment files including eligibility additions, changes, and deletions based on the full population 834 file that will be supplied daily by the State. See Appendix 7.10. (b) Confirm your organization's understanding and ability to make changes to the enrollment file on a manual basis if requested by the State on an as-needed basis. The State will not re-issue another file with the changes included. (c) Confirm your organization's understanding that when the State sends a termination date on the 834 for a Member(s), the "actual" date that coverage ceases is one day prior. For example, if the term date shows as 7/1/2025, the Member pharmacy benefits should cease on 6/30/2025. (d) Confirm your organization's ability to contact the State eligibility team anytime there are 300 or more terms or drop-offs before the daily enrollment file is loaded. Describe how enrollment errors will be communicated to the State eligibility team. (e) Confirm capabilities to transmit pharmacy data and provide daily, weekly or monthly data feeds to any third parties as requested by the State at no additional cost to the State. (f) Confirm your ability to provide to and receive from the State's TPAs Member out of pocket costs for deductibles and maximum out of pocket amounts (at both the individual and family levels) for all health plan types offered by the state (currently PPOs and CDHPs) so that Members' deductibles and MOOPs can be correctly tracked in real time. How do you accomplish this and ensure its accuracy on a regular basis? Describe how frequently this can occur.		**8**	

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	C.22.	**Privacy & Confidentiality** (a) Describe the safeguards to protect the privacy and confidentiality of Members and to prevent unauthorized use or disclosure of Protected Health Information (PHI) that you create, receive, transmit, or maintain related to the Plan pharmacy benefit. (b) Complete Appendix 7.19. regarding HIPAA Business Associate Assessment and submit it with your technical response as a separate appendix/exhibit file.		**3**	
	C.23.	**Appeals** (a) Provide a written statement attesting that the Respondent will provide all Members with a three (3) level appeals process (two levels within your organization), including the right to an independent review organization (IRO), as required by the PPACA, and as described in Contract Section A.21. Contractor shall also confirm that they are responsible for the cost of appeals at all three (3) levels. (b) What is your most common turnaround time for pre-service appeals and post-service appeals?		**2**	
	C.24	**Customer Services- General** Describe or provide the following information regarding customer services: (a) The number of, and services related to, all toll-free lines that will be maintained to meet the various call center requirements outlined in Contract Section A.22. Explain if different numbers, or a single number, will be used for Members, pharmacists, and systems inquiries. (b) A description of the operations of your call center(s). Include the location (city and state) of call center(s), hours of operation, staffing projections, and plans for rerouting of calls and in what circumstances that may happen. (c) The flexibility of your call center to handle fluctuations in call volume resulting from program, benefit or enrollment changes. (d) Describe your problem escalation and resolution process. (e) Are your Specialty, Retail and Mail systems fully integrated so that a complete patient profile is always accessible to your customer service staff? Yes, or no? If no, why?		**6**	
	C.25	**Customer Services – Staffing and Training** Describe or provide the following regarding your customer service call staff: (a) The annual turnover rate for calendar years 2020, 2021, and 2022 of your customer service representatives and customer service management staff. (b) The duration and scope of training for new customer service representatives and how they will be trained on the State account and its benefits prior to program implementation and as new CSRs are added to the State call center staff during the term of this contract. (c) A sample of the quarterly customer service/call center statistics that will be provided to the State.		**3**	
	C.26.	**Member Communication/Materials**		**4**	

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		Describe or provide the following information: (a) Sample copies of any standard Member materials to be provided to Members such as network lists, formulary documents (such as tailored member letters notifying them of a formulary change to their medication), I.D. cards, pharmacy benefit descriptive booklets, and welcome packets. Name the file: [Your Organization's Name] Sample Employee Communication Materials. (b) Describe your methods of outreach to plan members to educate and inform them of pharmacy benefits and drive effective utilization of benefits. (c) What data can you provide to demonstrate performance and impact of communication activities? (d) How do you inform Members and prescribers of the reasons for clinical decisions? Provide examples of written notification of denied PAs that would be mailed to members and their prescribers. (e) In the past, Benefits Administration has sent a quarterly email to Members who have pharmacy benefits, utilizing information supplied by our existing PBM. Past topics include: CDHP/HSA Preventive Drug List, Medication Adherence, Retail-90 Campaign and Tobacco Cessation Benefit. Would you be able to develop and email directly, with State approval, quarterly emails to Members with pharmacy benefits if we supply email addresses for them? (f) As they are sometimes the health care decision makers in a household, do you create/provide messaging for covered spouses and/or dependents?			
	C.27	**Member ID Cards** (a) Explain your organization's approach to listing Member deductibles and MOOPs on Member pharmacy ID cards (physical and electronic). Specifically, please address Code section 9816(e), ERISA section 716(e), and PHS Act section 2799A–1(e), as added by section 107 of division BB of the CAA. Do you interpret this to mean that you will need to list this information on physical and electronic member ID cards? (b) Provide a written statement attesting that the State's Edison ID number will be the sole number used on your Member ID cards and, in your systems, to identify the State's Members. (The Edison ID is an eight-digit number including two leading zeroes).		**4**	
	C.28.	**Splash Page, Website and Mobile App** Describe or provide the following information: (a) All web-based pharmacy services that you currently offer. Include the intended audience for these services (Members, providers, clients, etc.) (b) Your ability to create and maintain a Splash Page (a.k.a. microsite) that is specific to the State and that the State can review for clarity and content by the date specified in Contract Section A.33. For example, refer to the current Pharmacy Benefit Manager's splash page at this site: http://info.caremark.com/stateoftn or the BCBS and Cigna pages at this quick links site: https://www.tn.gov/partnersforhealth/quicklinks.html		**7**	

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		(c) Describe how Members would be able to go on the website to view their claims history and easily navigate your cost calculator and other tools to determine prescription costs and any medication alternatives. (d) Do you have a mobile app in place for Members today? If so, describe some of the current capabilities, features, and member benefits that are included on the app. If not, do you have plans to develop a mobile app? (e) Your organization's drug pricing features that would be placed on our Splash Page to allow members to look up their specific drug cost and any utilization management rules (prior auth, step therapy, quantity limits) that may apply. (f) Can your organization provide on the Splash Page a video on pharmacy benefits to illustrate to plan members how they can use your website to compare costs of drugs at various pharmacies? Can you provide a video specific to Members with our pharmacy benefits each year prior to the Annual Enrollment period beginning (Sept. 1 deadline)?			
	C.29.	**<u>Reporting & Systems Access</u>** Describe or provide the following information regarding your reporting capabilities: (a) An overview of your reporting system that the State staff will have access to pull cost and utilization data and how many years of claims history will be available for State staff to view claims. Does your system allow for pulling claims data reports through the previous day? (b) Ad-hoc reporting capabilities and the access the State will have to an ad-hoc reporting liaison to assist in our development of ad-hoc reporting requests and the general use of your system. (c) Capabilities of the Respondent to perform modeling and projections based upon historical utilization. (d) As specified in Contract Section A.28(b) describe how State staff will be provided with various access capabilities to either view, update, or manage eligibility in your online system including how State staff will be able to manually add new Members and how soon after the addition, claims can be adjudicated for the Member Describe your process for training all relevant state BA staff on the use of your system, to include reviewing claims history and pulling at least a one-year historical list of member claims (including pharmacy name, date of service, member paid amount, and plan paid amount) for our Service Center staff. Describe who will conduct these trainings, length of time, location (online or in BA's Nashville offices) (e) Does your system allow the end user to create an ad-hoc claims history report to query on the number of utilizers, plan cost, and member cost by drug name, NDC, and GPI levels 2 through 14? (f) Describe the ability of your online reporting and eligibility system to: 1. Allow the end user to query the system for data by unique member ID or IDs and by group (e.g., state actives, state retirees, local education actives, local education retirees, local government actives and local government retirees) 2. Allow staff in the Benefits Administration service center to update in real time member eligibility so that a member who may not be eligible for pharmacy benefits can immediately be updated and fill a prescription.		**9**	
	C.30.	**<u>Audits (Internal) and Fraud</u>**		**5**	

RESPONDENT LEGAL ENTITY NAME:					
Response Page # (Respondent completes)	**Item Ref.**	**Section C— Technical Qualifications, Experience & Approach Items**	**Item Score**	**Evaluation Factor**	**Raw Weighted Score**
		Describe or provide the following information regarding your audit and fraud processes and capabilities: (a) How often you audit the accuracy of plan program pricing and overall adjudication accuracy. (b) Audit capabilities including a description of your audit team, their experience, capabilities and the audit related activities they routinely perform with regard to your retail network of pharmacies. (c) Confirm the ability of auditors to follow claims through the system so that appropriate pricing and crediting of Rebates can be confirmed. (d) The Respondent's agreement to comply with Tenn. Code Ann. § 4-3-1021 and to cooperate with BA, the State, and any auditors during the process. Note: Tenn. Code Ann. § 4-3-1021 requires the BA to compile a report by each July 1 using data from various audit reports completed for BA during the year. These audit reports are developed by BA's benefits consulting firm. BA requires the participation and timely assistance of the Contractor to work with the actuaries and benefits analysts both in and outside the State to ensure that each report is completed timely. (e) Please describe your process for auditing your benefits setup to ensure that your systems adjudicate to the correct copayment or coinsurance to match your client's intent and that the correct tiers are set up in your adjudication platform. How many times and how often does this occur?			
	C.31.	**<u>Pharmacy Audits</u>** Describe or provide the following information regarding your pharmacy audit processes: (a) Frequency that your pharmacy networks (retail, mail, and specialty) are audited and the percentage for each that is audited annually. (b) How many pharmacies you audit annually that are in Tennessee. (c) How pharmacies with consistent or repeat findings are handled and if they are removed from the network. (d) How you recoup funds from onsite pharmacy audits and your agreement that 100% of those recoveries will be distributed to the State in accordance with Contract Section A.32.b. (e) Your processes to detect and prevent errors, fraud or abusive pharmacy utilization by Members, pharmacies or prescribers.		**4**	

The Solicitation Coordinator will use this sum and the formula below to calculate the section score. All calculations will use and result in numbers rounded to two (2) places to the right of the decimal point.		**Total Raw Weighted Score:** *(sum of Raw Weighted Scores above)*	
Total Raw Weighted Score	**X 40** *(maximum possible score)*	**= SCORE:**	
Maximum Possible Raw Weighted Score *(i.e., 5 x the sum of item weights above)*			

State Use – Evaluator Identification:

State Use – Solicitation Coordinator Signature, Printed Name & Date:

RFP ATTACHMENT 6.3.

COST PROPOSAL & SCORING GUIDE

The Respondent shall complete and submit its Cost Proposal in accordance with the instructions given in RFP Section 3.2.2.2.2 The Respondent shall use an XLS spreadsheet to prepare the Cost Proposal. This spreadsheet is found at the following website address, under the section labeled RFP # 31786-00174:

https://www.tn.gov/generalservices/procurement/central-procurement-office--cpo-/supplier-information/request-for-proposals--rfp--opportunities1.html

Further instructions specific to the content of the Cost Proposal are found in the above referenced spreadsheet.

The spreadsheet will calculate the Total Evaluation Cost Amount. This Amount will be used in the formula in the cost proposal to derive the Proposer's Cost Proposal score.

REFERENCE QUESTIONNAIRE

The standard reference questionnaire provided on the following pages of this attachment should be completed by all individuals offering a reference for the Respondent.

The Respondent will be solely responsible for obtaining completed reference questionnaires as detailed below. Provide references from individuals who are not current State employees of the procuring State Agency for projects similar to the goods or services sought under this RFP and which represent:

- two (2) contracts Respondent currently services that are similar in size and scope to the services required by this RFP; **and**
- three (3) completed contracts that are similar in size and scope to the services required by this RFP.

References from at least three (3) different individuals are required to satisfy the requirements above, e.g., an individual may provide a reference about a completed project and another reference about a currently serviced account. The individual contact reference provided for each contract or project shall not be a current State employee of the procuring State agency. Procuring State agencies that accept references from another State agency shall document, in writing, a plan to ensure that no contact is made between the procuring State agency and a referring State agency. The standard reference questionnaire, should be used and completed, and is provided on the next page of this RFP Attachment 6.4. In order to obtain and submit the completed reference questionnaires following process below.

Email:

(a) Add the Respondent's name to the standard reference questionnaire at RFP Attachment 6.4. and make a copy for each reference.

(b) E-mail a reference questionnaire to each reference.

(c) Instruct the reference to:

  (i) complete the reference questionnaire;

  (ii) sign and date the completed reference questionnaire;

  (iii) E-mail the reference directly to the Solicitation Coordinator by the RFP Technical Response Deadline with the Subject line of the e-mail as "[Respondent's Name] Reference for RFP # **31786-00174**".

NOTES:

- The State will not accept late references or references submitted by any means other than the two which are described above, and each reference questionnaire submitted must be completed as required.
- The State will not review more than the number of required references indicated above.
- While the State will base its reference check on the contents of the reference e-mails included in the Technical Response package, the State reserves the right to confirm and clarify information detailed in the completed reference questionnaires, and may consider clarification responses in the evaluation of references.
- The State is under no obligation to clarify any reference information.

RFP # 31786-00174 REFERENCE QUESTIONNAIRE

REFERENCE SUBJECT: RESPONDENT NAME (completed by Respondent before reference is requested)

The "reference subject" specified above, intends to submit a response to the State of Tennessee in response to the Request for Proposals (RFP) indicated. As a part of such response, the reference subject must include a number of completed reference questionnaires (using this form).

Each individual responding to this reference questionnaire is asked to follow these instructions:

- complete this questionnaire (either using the form provided or an exact duplicate of this document);
- sign and date the completed questionnaire and follow the process outlined below;

E-Mail:

- e-mail the completed questionnaire to: Heather Pease, heather.pease@tn.gov

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a. What is the name of the individual, company, organization, or entity responding to this reference questionnaire?

b. Please provide the following information about the individual completing this reference questionnaire on behalf of the above-named individual, company, organization, or entity.

NAME:	
TITLE:	
TELEPHONE #	
E-MAIL ADDRESS:	

c. What goods or services does/did the reference subject provide to your company or organization?

d. If the goods or services that the reference subject provided to your company or organization are completed, were the goods or services provided in compliance with the terms of the contract, on time, and within budget? If not, please explain.

e. If the reference subject is still providing goods or services to your company or organization, are these goods or services being provided in compliance with the terms of the contract, on time, and within budget? If not, please explain.

f. How satisfied are you with the reference subject's ability to perform based on your expectations and according to the contractual arrangements?

REFERENCE SIGNATURE:
(by the individual completing this request for reference information)

DATE:

RFP ATTACHMENT 6.5.

SCORE SUMMARY MATRIX

	RESPONDENT NAME		*RESPONDENT NAME*		*RESPONDENT NAME*	
GENERAL QUALIFICATIONS & EXPERIENCE (maximum: 10						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE:		**AVERAGE:**		**AVERAGE:**	
TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH (maximum: 40)						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE:		**AVERAGE:**		**AVERAGE:**	
COST PROPOSAL (maximum: 50)	**SCORE:**		**SCORE:**		**SCORE:**	
TOTAL RESPONSE EVALUATION SCORE: (maximum: 100)						

Solicitation Coordinator Signature, Printed Name & Date:

RFP # 31786-00174 *PRO FORMA* CONTRACT

The *Pro Forma* Contract detailed in following pages of this exhibit contains some "blanks" (signified by descriptions in capital letters) that will be completed with appropriate information in the final contract resulting from the RFP.

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
Department of Finance & Administration, Division of Benefits Administration, State Insurance Committee, Local Education Insurance Committee, Local Government Insurance Committee
AND
CONTRACTOR NAME

This Contract, by and between State of Tennessee, Department of Finance & Administration, Division of Benefits Administration, State Insurance Committee, Local Education Insurance Committee, Local Government Insurance Committee ("State") and Contractor Legal Entity Name ("Contractor"), is for the provision of Scope of Goods or Services Caption, as further defined in the "SCOPE." State and Contractor may be referred to individually as a "Party" or collectively as the "Parties" to this Contract.

The Contractor is a/an Individual, For-Profit Corporation, Non-Profit Corporation, Special Purpose Corporation Or Association, Partnership, Joint Venture, Or Limited Liability Company.
Contractor Place of Incorporation or Organization: Location
Contractor Edison Registration ID # Number

A. SCOPE:

A.1. The Contractor shall provide all goods or services and deliverables as required, described, and detailed below and shall meet all service and delivery timelines as specified by this Contract.

a. The Contractor shall provide Pharmacy benefit management services, which shall include custom clinical programs as required, specialty care management, Formulary management, network management, Member services, an online POS Pharmacy Claims processing system, and all other services described within this Contract. This POS system shall include a state-wide and nationwide Retail Pharmacy network, prospective/concurrent DUR, Retro-DUR, utilization management, reporting capabilities, adjudication capabilities, and full Pharmacy benefit Member services for retail, Mail order and Specialty Pharmacy benefits for Members.

b. The time period January 1, 2028, through June 30, 2028, shall be considered a Claims runout period during which the Contractor shall adjudicate Claims incurred during the Term prior to January 1, 2028. The Contractor shall process all Member calls into the Contractor's call center from Members related to Claims that were incurred during the benefits Term throughout the Claims runout period. If a Member files a Paper Claim for a product or service that was incurred during the Term, and the Paper Claim is received during the Claims runout period, the Contractor shall process such Claims, minus the Member's applicable Copayment or Coinsurance and bill the State for the contracted Ingredient Cost and Dispensing Fees paid to the Pharmacy.

A.2. **Definitions.** For purposes of this Contract, definitions shall be as follows and as set forth in the Contract:

a. **340B Claim(s) -** a Claim that receives 340B program pricing and is dispensed from a 340B program covered entity. 340B Claims are identified by (i) the submission of "20" in the 'Submission Clarification Code' field (420-DK) AND includes a covered entity owned

pharmacies 340B status coded as “37" or "38” in the NCPDP DataQ database and (ii) Claims that include a covered entity owned pharmacies 340B status coded as “39” in the NCPDP DataQ database.

b. **Actual Cost** – The amount a Pharmacy paid as evidenced by documentation that includes, but is not limited to, the invoice price minus Discounts, price concessions, Rebates, or other reductions. Discounts, price concessions, Rebates, or other reductions do not include a cash Discount.

c. **Administrative Fee –** The fee for Pharmacy benefit management services paid by the State to the Contractor. It is the only compensation due the Contractor under the contract, unless the Contractor also bid a Clinical Fee. The Contractor’s monthly compensation is a function of the contractor’s Administrative Fee multiplied by the number of participating Members per month (“PMPM”). Clinical Fees are not included in the Administrative Fee. The Administrative Fee shall constitute all payments due to the Contractor not included in the Clinical Fee and shall include, but not be limited to, all costs incurred by the Contractor to comply with all state and federal laws including, but not limited to, appeals by pharmacies to the Tennessee Department of Commerce & Insurance associated with PBM claim reimbursement related to Tennessee Public Chapter 1070.

d. **Agency Benefits Coordinator (“ABC”) -** The individual within each agency or department who is the officially designated liaison between BA and employees.

e. **At-Risk Performance Payment -** Contractor’s payment based on KPI performance listed on the SLA Scorecard set forth in Contract Attachment C. The payment is calculated based on the SLA Scorecard score and percentage of the Administrative Fees at risk.

f. **Authorized Generic** - a drug that is marketed, sold or distributed in the United States as a Generic Drug version of a Brand Drug where the authority for such marketing, sale and or distribution is based upon a Manufacturer’s New Drug Application (NDA) or Biologic License Application (BLA) for the associated Brand Drug.

   Also, the Authorized Generic is marketed, sold or distributed under a different labeler code, product code, trade name, trademark, or packaging (other than repacking the listed drug for use in institutions) than the Brand Drug. Authorized Generics will be identified using Medi-Span Multisource Code of “M” (co-branded product) with a Brand Drug Code of “B” (Branded Generic Name).

g. **Average Speed of Answer (“ASA”) -** The average waiting time for a caller before he/she is answered by a call center service representative. For this definition, the term “answer” shall mean to begin an uninterrupted dialogue with the caller. If a call center representative asks the caller to hold during the first 60 seconds of the dialogue, the Contractor shall not consider the call to be “answered” for purposes of this definition until the call center representative returns to the caller and begins an uninterrupted dialogue.

h. **AWP -** Average Wholesale Price is a reference price for prescription drug products. Pharmacy reimbursement can be calculated based on AWP minus a percentage. The AWP is the average wholesale price per unit for a product's NDC-11 on the date the Claim is adjudicated as set forth from the most current pricing information from Medi-Span.

i. **Benefits -** The services available to Members and the corresponding amounts that Members and the Program will pay for covered services under this contract.

j. **Benefits Administration (“BA”) -** The division of the Tennessee Department of Finance & Administration that administers the State Group Insurance Program.

k. **Biosimilar Drug -** a biological product that is highly similar to a US-licensed reference biological product notwithstanding minor differences in clinically inactive components, and for which there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product as defined in the Biologics Price Competition and Innovation Act of 2009 at 42 U.S.C. §262(i)(2) and approved under Section 351(k) of the Public Health Services Act and as identified in the Purple Book.

l. **Brand Drug –** an FDA approved drug, or a drug that is designated by FDA a DESI (Drug Efficacy Study Implementation) drug, or product, which is manufactured and distributed by an innovator drug company, or its licensee, set forth in Medi-Span's National Drug Data File (MS) as a Brand Drug identified by all of the products meeting at least one of the following criteria:

(1) Brand Name code of "T" and Multisource Code "M"
(2) Brand Name code of "B" or "T" and Multisource Code of "N"
(3) Brand Name code of "B" or "T" and Multisource Code "O" and a DAW code of 0, 1, 2, 7, 8, or 9

For the avoidance of doubt, Brand Drugs shall also include brand name vaccines, supplies, medical devices, kits, diabetic supplies, OTC products, and test strips.

m. **Business Days -** Traditional workdays, including Monday, Tuesday, Wednesday, Thursday, and Friday. State Government Holidays are excluded.

n. **Claim -** Any electronic or paper request for payment or reimbursement processed through PBM's on-line Claims adjudication system or otherwise transmitted or processed in accordance with the terms of an agreement in connection with the State's Plan, including Claims in which the Member pays the full cost and the State has no cost liability, but does not include requests for payment or reimbursement that rejected due to system edits designed to enforce the State's Pharmacy benefit programs or were reversed or cancelled from the Claim payment system. At the State's request this may include any product or service utilized by a member via a point solution offered by the Contractor for which the state elects to participate.

o. **Claims Payment Accuracy -** The measurement of Claims processed with an accurate payment of Benefits divided by the total number of Claims with payments in the audited population.

p. **Claims Processing Accuracy -** The measurement of Claims processed without any type of error divided by the total number of Claims in the audited population.

q. **Clinical Fee** – The fee, if applicable, paid to the Contractor for their management of clinical programs which at a minimum shall include Prior Authorization, appeals, dose optimization, Step Therapy, quantity limits (specialty and non-specialty), closing gaps in care, retrospective safety, Medication Therapy Management, safety & monitoring programs (including identifying members with suspected abuse and locking them into a single Pharmacy with approval from the State), and all Specialty Drug management programs (Step Therapy, recalls, Member adherence education, PA, and first fill counseling). The Clinical Fee shall also include all nursing services or charges.

r. **Coinsurance -** The percentage amount of allowable charges paid by the Member to a Provider for a product or service provided to the Member.

s. **Compound Prescription –** a mixture of two (2) or more ingredients when at least one of the ingredients in the preparation is an FDA approved federal legend drug, and the mixture of which is not otherwise generally available in an equivalent commercial form or strength in response to a physician's prescription to create a medication tailored to the specialized medically required need for an individual patient. A Compound Drug is identified by the

compound indicator on the Claim feed. It excludes the addition of any flavoring to any prescription or medication requiring reconstitution (e.g., powdered oral antibiotics, topical acne preparations, etc.).

t. **Continuity of Therapy Utilization** – continued coverage of a medication, that is not on PBM's formulary, by a Member who was receiving the drug on, or before the effective date of the agreement between the PBM and the State.

u. **Coordination of Benefits** or **COB Claim(s)** – a Claim where more than one health insurance program, policy, or other form of coverage, including governmental or non-governmental coverage, and State acts as the secondary or tertiary payor for the Claim.

v. **Copayment -** That portion of the charge (flat dollar amount) for pharmaceutical product or service provided to the Member that is the responsibility of the Member.

w. **Covered Drug** or **Covered Product** – a drug, device or supplies that is covered under the Formulary adopted by the State and requires a prescription for dispensing and/or coverage as a plan benefit.

x. **Data Fees** – fees received by PBM or PBM Affiliates for the sale of aggregate blinded data to a limited group of third parties including nationally recognized data integration firms.

y. **Days' Supply** – the number of days the Brand Drug, Generic Drug or Specialty Drug is to be taken as prescribed and submitted to PBM by the dispensing Pharmacy.

z. **DEA Number -** A Drug Enforcement Agency Number is a series of numbers assigned to a health care Provider allowing them to write prescriptions for controlled substances. The DEA Number is often used as a prescriber identifier.

aa. **Denied Claim –** A Claim that is not paid for reasons such as eligibility, coverage rules etc.

bb. **DESI Drug -** A drug that has been designated as experimental or ineffective by the Food and Drug Administration (FDA).

cc. **Discount(s)** – The percentage difference between the applicable AWP for a covered service and (i) the MAC, where applicable, or (ii) the Contractor's negotiated reimbursement amount with a participating Pharmacy for prescription drugs, OTCs and other services provided by such Pharmacy to Members. The Discount excludes the Dispensing Fee, Copayment and sales tax, if any. For Discount purposes and other related contract calculations, Single-Source Generics should be considered as Multi-source generics and must not be considered Brands for the purpose of pricing or guarantee reconciliation.

dd. **Dispensing Fee** – the fee paid to the dispensing Pharmacy for the professional service of filling a Claim and is equal to the Total Claim Cost less the Ingredient Cost and less the applicable sales tax. U&C Claims will always have a zero-dollar Dispensing Fee.

ee. **Decision Support System ("DSS") -** A database and query tool containing health care information and Claims data which allows for analytics and executive decision making.

ff. **Dependent -** The child or spouse of an employee or retiree.

gg. **Drug Utilization Review ("DUR") -** A POS Claim edit to facilitate Drug Utilization Review (DUR) objectives.

hh. **Edison -** The State's enterprise resource planning system, which supports human resources, payroll, insurance, contracting, procurement and other agency functions.

ii. **Formulary or Formularies** – the list of FDA-approved prescription drugs and supplies developed by PBM's Pharmacy and Therapeutics Committee ("P&T Committee"). The Formulary consists of (i) a ranking of Covered Products into preferred and non-preferred tiers, (ii) a listing of Non-Covered Products, and (iii) associated utilization review programs pursuant to PBM's standard clinical criteria, which may include, but not limited to, Prior Authorizations, Step Therapy and/or quantity limits for one or more Covered Products.

jj. **First Call Resolution** - A Member or employee's question(s) is answered during their first call eliminating the need for the Contractor or Member to call back.

kk. **Generic Code Number ("GCN") -** A standard number assigned by First DataBank (a drug pricing service) to each strength, formulation, and route of administration of a drug entity.

ll. **Generic Drug** – an FDA approved drug, or a drug that is designated by FDA a DESI (Drug Efficacy Study Implementation) drug, or product, that is therapeutically equivalent to other pharmaceutically equivalent products, as set forth in Medi-Span's National Drug Data File (MS) as a generic drug identified by all products meeting at least one of the following criteria:

(1) Brand Name code of "G" for all Multisource Codes (M, N, O, and Y)
(2) Multisource Code of "Y"
(3) Multisource Code of "M" with a Brand Drug Code of "B" (Authorized Generic)
(4) "O" with a DAW code of 3, 4, or 6
(5) Multisource Codes (M, N, O, and Y) with a DAW code of 5 (House Generic).

For the avoidance of doubt, Generic Drugs shall also include generic vaccines, supplies, medical devices, kits, diabetic supplies, OTCs, and test strips.

mm. **Generic Product Identifier ("GPI") –** A fourteen (14)-digit code, as defined by Medi-Span, which includes all drugs sharing the same chemical composition, in the same strength, in the same form and that are administered via the same route.

nn. **Group Purchasing Organizati**on or **GPO** - an entity that aggregates the purchasing power of a group of businesses to obtain Discounts or Rebates from Pharmaceutical Manufacturers. These services may include contracting with manufacturers for Manufacturer Payments or any similar service conducted on behalf of the PBM. Any entity who provides the same or similar services as the PBM on behalf of the PBM under this Agreement shall also be considered a GPO. For purposes of this Agreement, rebate aggregators or any similar/competing entity shall also be a GPO.

PBM represents and warrants that PBM's agreements with a Group Purchasing Organization shall contain (and will continue to contain through the term of this Agreement) provisions or obligations that are substantially similar to any provision or obligation contained in this Agreement which directly or indirectly relates to any service under this Agreement that is or may be performed by a GPO as defined herein.

oo. **Guaranteed Minimum Manufacturer Payment** or **Rebate Guarantee** - the minimum Rebate per Rx by dispensing channel. The performance will be calculated for the annual period using the following formula for each dispensing Channel independently, then summed: 'The calculation of the Annual Rebate Guarantee Amount will be [Rebate Guarantee] multiplied by [total Rx count minus the exclusions as identified by the Stat**e** in Contract Section A.16].

pp. **Holidays -** Days on which official holidays and commemorations as defined in Tenn. Code Ann. § 15-1-101 *et seq*., are observed.

qq. **Home Infusion Pharmacy** or **HIF** - a Retail Pharmacy-based, decentralized patient care organization with expertise in USP 797-compliant sterile drug compounding that provides care to patients with acute or chronic conditions generally pertaining to parenteral administration of drugs, biologics and nutritional formulae administered through catheters and/or needles in home and alternate sites. These Pharmacies are identified by a National Council for Prescription Drug Program's (NCPDP's) dispenser type code of 6.

rr. **House Generics** - a Brand Drug submitted with a Dispense As Written (DAW) 5 code in place of the generic equivalent and where the Pharmacy is reimbursed at a Generic Drug rate, including MAC, as applicable. For reconciliation of the Generic Drug Discount guarantees, the AWP of House Generic drugs shall be the per unit AWP of the generic equivalent and not the AWP of the Brand Drug. House Generics will be identified using Medi-Span Multisource Code M, N, O, or Y and a Dispense as Written (DAW) code of 5.

ss. **Indian Health Services, Tribal or Urban Indian Health** or **I/T/U** - a Retail Pharmacy operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization as defined in Section 4 of the Indian Health Care Improvement Act, 25 U.S.C. 1603. These Pharmacies are identified by a National Council for Prescription Drug Program's (NCPDP's) dispenser type code of 8.

tt. **Inflation Protection Payments** - payments received by your firm (if any; and whether separately made or in the form of increased Rebates) or PBM Affiliates from a pharmaceutical manufacturer for the purpose of adjusting for year over year price inflation of the manufacturer's price to your firm for prescriptions on which Rebates are paid; in accordance with and pursuant to applicable pharmaceutical manufacturer agreements.

uu. **Ingredient Cost** – Will be defined for the Contract according to the criteria below:

(1) For retail, Ingredient Cost means the lowest of

- U&C Price
- MAC, where applicable; or
- Mutually agreed upon baseline pricing measure value (i.e., AWP, NADAC, WAC, or other) less all applicable Discounts or other applicable reimbursement amounts negotiated with the participating Retail Pharmacy which adheres to Discount Guarantees, as applicable, and as set forth in this Contract.

(2) For brands dispensed via the Contractor's Mail order and Specialty Pharmacies, Ingredient Cost means the Discounted price using the guaranteed Discount percentage set forth in the price schedule(s) of this Contract, based on the baseline pricing measure value (i.e., AWP, NADAC, WAC, or other) as mutually agreed upon by the parties.

(3) For generics dispensed via the Contractor's Mail Order and Specialty Pharmacies, Ingredient Cost means the lower of the MAC, where applicable, or the Discounted price using the default Discount percentage set forth in the Price Schedule(s), based on the baseline pricing measure value (i.e., AWP, NADAC, WAC, or other) as mutually agreed upon by the parties.

(4) Ingredient Cost does not include the Dispensing Fee, the Copayment, Coinsurance, deductibles or sales tax, if any.

vv. **Identical, Related or Similar ("IRS") -** Drugs that are identical, related or similar to drugs identified as LTE (Less Than Effective) by the FDA.

ww. **In Writing -** Written communication between the Parties, which may be in the form of an official memo, or documents sent via postal mail, fax, or email communications.

xx. **Key Performance Indicators ("KPI") -** Performance indicators which are the metrics used to measure and evaluate Contractor's performance against the desired outcomes. These

indicators are used to determine Contractor's At-Risk Performance Payment as set forth in Contract Attachment D.

yy. **Less Than Effective ("LTE") -** Drugs considered by the FDA to have a lack of substantial evidence of effectiveness for all labeled indications and for which there is no compelling justification for their medical need.

zz. **Limited Distribution Specialty Drug -** those Specialty Drugs only available through select Pharmacy Providers as determined by the drug manufacturer.

aaa. **Lock In -** A restrictive logic that limits Claims at Point Of Sale to selected prescribers or pharmacies. Members under this restriction are said to be "locked-in".

bbb. **Long Term Care Pharmacy** or **LTC** - a Retail Pharmacy that dispenses medicinal preparations delivered to patients residing within an intermediate or skilled nursing facility, including intermediate care facilities for mentally disabled, hospice, assisted living facilities, group homes, and other forms of congregate living arrangements. These Pharmacies are identified by a National Council for Prescription Drug Program's (NCPDP's) dispenser type code of '04'.

ccc. **Low Volume Pharmacy** – A network Pharmacy who has provided certification to the Contractor that their annual prescription volume is at a level that, if the Pharmacy were a TennCare-participating ambulatory Pharmacy, would qualify the Pharmacy for the enhanced amount of professional Dispensing Fee for a Low Volume Pharmacy under the operative version of the Division of TennCare Pharmacy Provider Manual, or a successor manual.

ddd. **Mail Order Pharmacy or Mail Order** - an automated Pharmacy that processes prescriptions at one or more central locations and delivers them through the mail or other third-party delivery service to the locations of customers and does not have a physical customer-facing storefront. If such an automated Pharmacy dispenses Specialty Drugs and non- Specialty Drugs, such Mail Order Pharmacy shall constitute a Mail Order Pharmacy solely with respect to the dispensing of non-Specialty Drugs and shall constitute a Specialty Pharmacy with respect to the dispensing of Specialty Drugs. These Pharmacies are identified by a National Council for Prescription Drug Program's (NCPDP's) dispenser type code of '05'.

eee. **Manufacturer Administrative Fee(s) (MAF)**- fees for services rendered to Pharmaceutical Manufacturers in relation to administrative duties in connection with aggregation, allocating, collecting, and invoicing for Rebates. Manufacturer Administrative Fees are considered inclusive of "rebate Administrative Fee(s)," "formulary administrative fees," "GPO fees" or any other fee paid to Contractor or a GPO in relation to administrative duties in connection with the collection of Manufacturer Payments, excluding fees retained by the GPO for Contractor's participation in the GPO.

fff. **Manufacturer** or **Pharmaceutical Manufacture**r – a pharmaceutical, biotech, medical equipment or device manufacturer and any other entity that directly or indirectly performs sales, distribution and/or marketing functions (including wholesalers and distributors) with respect to any such manufacturer's products.

ggg. **Manufacturer Payments** - any and all compensation, financial benefits and remuneration PBM, PBM Affiliates, or a GPO, receives from a Pharmaceutical Manufacturer, that is in any way attributable to the State's Claims and/or utilization, including but not limited to, Discounts; credits; Rebates, regardless of how categorized; market share incentives, chargebacks, commissions, Inflation Protection adjustments or payments, access fees, MAF, and administrative and management fees. Manufacturer Payments also include any fees received for sales of utilization data to a Pharmaceutical Manufacturer. For avoidance of doubt, Manufacturer Payments excludes Other Pharmaceutical Manufacturer Revenue that is not in any way attributable to the State's Claims and/or utilization.

hhh. **Material Change** - one or more of the following circumstances:

(1) A change in the Pricing Source's method of calculation, including if the Pricing Source ceases to be published or otherwise becomes unavailable or if the Contractor becomes required to change the Pricing Source to an alternate option, if such change has or upon becoming effective will have a material adverse impact on the benefits, costs or economics for Contractor or the State that arise from or relate to this Contract.

(2) Unexpected industry changes, limited to: Unexpected Generic Drug introductions, unexpected OTC introductions, unexpected FDA recalls or market withdrawals, and unexpected launches of Biosimilars.

(3) A change in law as pertains to payment of Rebates by Pharmaceutical Manufacturers.

(4) A change in any federal or state laws or regulations that causes any aspect of the services to become unnecessary or necessary at a lower level of effort on the part of the Contractor and the State determines to eliminate or reduce the Contractor's obligations under this Contract with respect to such services to address such change in law, if the elimination or a reduction in scope of such aspect of the services would result in a material reduction in the Contractor's cost of performance under this Contract.

(5) Client-initiated change to benefit design or formulary (including utilization management) that impacts Rebates negatively by more than five hundred thousand dollars ($500,000) per year. Such a change initiated by the State is limited to changes to the Pharmacy benefit program, plan design, or formulary alignment. In the event a modification to financial guarantees is necessary, the parties will mutually agree on an appropriate adjustment which shall be economically neutral to the impact of the change, such agreement not to be unreasonably withheld.

(6) Change in the scope of services to be performed by the Contractor, but not limited to: Retail networks, Mail Order service, formulary management or Rebate administration, customer care services, or Specialty Pharmacy services.

For the avoidance of doubt, changes in Pricing Source inflation rates, as applicable, differences between underwriting projections and actual performance (other than covered in above items), drug mix shifts due to any dynamics other than those listed above, and Pharmaceutical Manufacturer merger and acquisition activity shall not constitute a Material Change.

In the event that Manufacturer Rebates are substantially replaced in the marketplace by an alternate strategy, prior to the Effective Date of this Contract or during the Contract term, the Contractor will work with the State in a collaborative manner to establish appropriate alternate contract provisions to reflect such alternate strategy.

iii. **Maximum Allowable Cost ("MAC")** – the price that has been established by PBM for a Brand Drug or Generic Drug included on its MAC drug list, which may be amended from time to time by PBM. A copy of such MAC drug list shall be provided to the State, prior to execution and upon the State's reasonable request, and shall be updated by PBM in its sole discretion. The same MAC list will be used for a Retail Pharmacy, a Mail Order Pharmacy, and a Specialty Pharmacy (i.e., same number of drugs, same drugs). The Mail Order Pharmacy and Specialty Pharmacy MAC list price points for individual drugs/generic class numbers shall be equal to or less (i.e., more deeply Discounted) than the Retail Pharmacy MAC price points for the same drugs/generic class numbers.

jjj. **Maximum Allowable Cost (MAC) List** – A list of Multi-source drugs that are reimbursed at an upper limit per unit price. The list is developed and maintained by the Contractor and is usually reviewed quarterly but individual drug prices may be adjusted more frequently. MAC Lists vary among PBMs. Considerations for inclusion on the MAC list include: availability of the Generic Drug from multiple Manufacturers; clinical implications of generic substitution; national availability of generic versions; price differences between the Brand and Generic; therapeutic equivalence; and volume of Claims.

kkk. **Medication Therapy Management ("MTM")** – a pharmacist provided service that includes: (1) complete review of all medications, including herbals and over-the-counter products; (2.) personal medication record (e.g., drugs, instructions, prescribers, allergies, problems); (3.) medication action plan for the patient; (4.) intervention and/or referral to other healthcare Providers; and (5.) documentation.

lll. **Member(s) -** Employees and their Dependents, retirees and their Dependents and/or survivors, and individuals qualified under The Federal Consolidated Omnibus Budget Reconciliation Act ("COBRA") and their Dependents who are enrolled in the Program sponsored by the State, Local Education, and Local Government Insurance Committees.

mmm. **Member Cost Share** - the amount which a Member is required to pay for a Claim in accordance with the State's benefit design, which may be a deductible, a percentage of the Claim price, a fixed amount and/or other charge or penalty.

nnn. **Member-Submitted Claim(s)** or **Paper Claim(s)** - a Claim for which the Member paid the full amount of the Claim and was then submitted to PBM by a Member for reimbursement. These Claims are identified by the Claim type code of '3' (Pharmacy submitted paper Claim) or '4' (Member submitted Paper Claim)

ooo. **Military Pharmacy** - a Retail Pharmacy whose primary function is to store, prepare and dispense pharmaceuticals and other associated items to uniformed services beneficiaries. These pharmacies may be associated with Department of Defense or U.S. Coast Guard clinic, Department of Defense hospital or freestanding. Usually associated with outpatient services. Associated with taxonomy code "332000000X". These Pharmacies are identified by a National Council for Prescription Drug Program's (NCPDP's) dispenser type code of 17.

ppp. **Multi-source ("MS")** - Brands and Generic Drugs available from more than one source.

qqq. **NADAC** - The National Average Drug Acquisition Cost. NADAC represents a national pricing benchmark, published by CMS, that is reflective of actual invoice costs that pharmacies pay to acquire prescription and over-the-counter drugs. It is based upon invoice cost data collected from retail community pharmacies and reflects actual drug purchases.

rrr. **National Council of Prescription Drug Programs ("NCPDP") -** A not-for-profit American National Standards Institute ("ANSI") Accredited Standards Development Organization.

sss. **National Drug Code ("NDC" or "NDC-11")** – A universal product identifier. The National Drug Code (NDC) Number is a unique, eleven-digit, three-segment number that identifies the labeler/vendor, product, and trade package size.

ttt. **National Provider Identification Number ("NPI") -** A 10-position, intelligence-free numeric identifier (10-digit number). The numbers do not carry other information about healthcare Providers, such as the state in which they live or their medical specialty.

uuu. **Non-Covered Products** or **Formulary Exclusions** - drugs or other related products that are not Covered Products. All designations of products as Non-Covered Products shall be approved by PBM's P&T Committee.

vvv. **Off-Invoice Wholesaler Remuneration** - various off-invoice reconciliation payments made by wholesalers to PBM that are not booked to an individual NDC and therefore not attributable to an individual client. Examples of these payments include but are not limited to: true-ups, distribution fees, operational excellence fees, and price-protection credits.

www. **Open Formulary** – a preferred drug list where all FDA-approved medications are covered by the plan and are subject to tiering based on the Pharmacy Benefit Manager's own preferred drug list (for example, Tier 1 = generic medications, Tier 2 = preferred brand medications,

Tier 3 = non-preferred brand medications, and Tier 4 = Specialty) with the exception of those expressly excluded from coverage by the State of Tennessee's governing Plan Document(s) or if otherwise requested by or approved by the State.

xxx. **Other Pharmaceutical Manufacturer Revenue** - any revenue that PBM or PBM Affiliates receive from Pharmaceutical Manufacturers. This may include but is not limited to: Off-Invoice Wholesaler Remuneration, Pharmacy Purchase Discounts (i.e., Mail Order Volume Discounts), Transmission Fees, and Specialty Service Fees.

yyy. **Over-the-Counter Claim(s)** or **OTC Claim(s)** - a prescription Claim for products that do not necessarily require a prescription for a Member to purchase and that the State has chosen to or has been required to include as Covered Products under the prescription drug benefit. OTC Claims are defined as having an 'O' or 'P' indication in Medi-Span's Rx-OTC Indicator Code.

zzz. **Out-of-Network Pharmacy** – A Pharmacy that does not have an agreement with the Contractor to provide covered services to Members and submits Claims for reimbursement.

aaaa. **Paid Claim -** A Claim that meets all coverage criteria of the Program and is paid by the Contractor and submitted to the plan for reimbursement.

bbbb. **Pass-Through Transparent Pricing** – a pricing structure comprised of fixed guaranteed Discounts at PBM's Mail Order Pharmacy and Specialty Pharmacy and a full pass through (100%) of PBM's contracted rates with Participating Pharmacies and Pharmaceutical Manufacturers. In this arrangement, PBM retains the difference between Mail Order and Specialty Pharmacy acquisition costs and the amounts guaranteed to the State. PBM passes through (1) its contracted rates with Participating Pharmacies and (2) all Manufacturer Payments it receives from Pharmaceutical Manufacturers in excess of the State's guaranteed Manufacturer Payments. The amount billed to the State at Retail Pharmacies will be equal to the amount paid by PBM to the Retail Pharmacies. The PBM's only profits are the Administrative Fee, Other Pharmaceutical Manufacturer Revenue not directly attributable to the State's Claims and/or utilization, and any clinical program fees. The PBM is also allowed to retain the difference between Mail Order and Specialty Pharmacy acquisition costs and the amounts guaranteed to the State, as described in this Contract. All financial negotiated Retail Pharmacy contracts and Rebate contracts are fully disclosed to and auditable by the State or its authorized agent. The State is protected in this model by requiring guaranteed Discounts, fees, and Manufacturer Payments from the PBM and any PBM Affiliates. Discounts and Manufacturer Payments achieved on the State's behalf that exceed the financial guarantees are payable to the State. Dispensing Fees that are paid lower than the guaranteed are also passed through to the State. Hence, the financial guarantees are the minimum Discounts and Manufacturer Payments the State will achieve and the maximum Dispensing Fees and Administrative Fees the State will pay

cccc. **PBM Affiliates** - an entity:

(1) which is directly or indirectly, through one or more intermediaries, controlling such party;
(2) which is under the same direct or indirect ownership or control as such party; or
(3) which is directly or indirectly, through one or more intermediaries, owned or controlled by such party.

For purposes of this definition and the Agreement, "control" (including the terms controlling, controlled by or under common control with) means (a) the possession, direct or indirect, (b) the power to direct or cause the direction of the management or policies of an entity, or (c) the ability to direct an entity's affairs or to control the composition of its board of directors or equivalent body, whether through (i) 50% of more of voting securities, (ii) partnership or membership interests, (iii) by contract or (iii) any other means. Further, a Group Purchasing

Organization shall also be considered a PBM Affiliate to the extent the GPO meets the above definition.

dddd. **Pharmacy or Participating Pharmacy** - a Retail Pharmacy, Mail Order Pharmacy, Specialty Pharmacy, non-traditional Pharmacy (such as I/T/U, LTC, HIF, Military, TER or VA) or other Pharmacy that participates in the PBM's network of Participating Pharmacies pursuant to an agreement between the Participating Pharmacy and PBM for such Pharmacy's dispensing of Covered Drugs to Members.

eeee. **Pharmacy Benefit Manager (PBM)** or **Contractor** - the combination of (i) a business or other entity that, pursuant to a contract with the State, either directly or through an intermediary, manages the prescription drug benefit provided by the State including, but not limited to, the processing and payment of Claims for prescription drugs, the performance of Drug Utilization Review, the processing of drug Prior Authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs; and (ii) all entities that have a majority ownership interest in, or majority control over, the business or other entity that is in contract with the State referenced in (i).

ffff. **Pharmacy Discount Card(s)** - a prescription drug saving program that negotiate Discounts at retail pharmacies by partnering with Pharmacy Benefit Managers, in order to provide underinsured, terminated employees, and part-time employees with access to lower medication prices. Pharmacy Discount Card programs are marketed and distributed for free to patients who access the program by using the free card or mobile app provided by the savings program.

gggg. **Pharmacy Purchase Discount(s)** or **Volume Discount(s)** - discounts, paid at time of purchase, or retrospectively, received by PBM or its Affiliates from Pharmaceutical Manufacturers, which are attributable to or based on products purchased by PBM affiliated dispensing pharmacies.

hhhh. **Pharmacy and Therapeutics ("P&T") Committee** - an independent body of health care professionals and academicians recognized as national experts and leaders in their fields of specialty who periodically review new drugs introduced to the market, re-evaluate selected therapeutic drug classes and drugs in the pharmaceutical development pipeline, and evaluate any current, relevant drug safety issues.

iiii. **Plan Year -** January 1 through December 31 of the same calendar year.

jjjj. **Post-Service Appeals -** an appeal from a covered plan Member or prescribing clinician after the plan Member or prescribing physician's initial request for initial PA is denied and the next level of appeal is then initiated.

kkkk. **Pre-Service Appeals -** an appeal from a covered plan Member or prescribing clinician before the plan Member initiates actual filling of a prescription.

llll. **Pricing Source** - Medi-Span Prescription Guide including supplements.

mmmm. **Prior Authorization ("PA") -** A Program requirement where certain therapies must gain approval before payment can be authorized.

nnnn. **Program -** The Pharmacy benefit management services provided under the provisions of this Contract.

oooo. **Provider** – An entity or individual that has an agreement with the Contractor to provide covered pharmaceutical, medical, or other health care services to plan Members according to contracted terms and rates.

pppp. **Protected Health Information ("PHI") -** Individually identifiable health information, held or maintained by a covered entity or its business associates acting for the covered entity, that is transmitted or maintained in any form or medium

qqqq. **Public Key Infrastructure ("PKI") -** The framework and services that provide for the generation, production, distribution, control, accounting, and destruction of public key certificates. Components include the personnel, policies, processes, server platforms, software, and workstations used for the purpose of administering certificates and public-private key pairs, including the ability to issue, maintain, recover, and revoke public key certificates.

rrrr. **Quantity Dispensed**– the number of units (e.g., tablets, capsules, mL) of a product that is dispensed for a Claim as submitted to PBM by the dispensing Pharmacy.

ssss. **Rebates -** All revenue received by the PBM and PBM Affiliates (including rebate aggregators or any similar contracted entities) from outside sources related to the Plan's utilization or enrollment in programs also known as Total Manufacturer Value. Also, the amounts paid to the PBM, PBM Affiliates, or a GPO, (i) pursuant to the terms of an agreement with a pharmaceutical manufacturer pursuant to the terms of a rebate contract, negotiated directly or indirectly with a pharmaceutical company by PBM, PBM Affiliates, or a GPO, (ii) in consideration for the inclusion of such manufacturer's drug(s) on the Formulary, and (iii) which are directly or indirectly related and attributable to, and calculated based upon, the specific and identifiable utilization of certain prescriptions by Members. This includes but is not limited to: access fees, market share fees, Rebates, Specialty Drug Rebates, onsite Pharmacy Claims, low day supply Claims, Generic Drug Claims, Biosimilar Drugs, Formulary access fees, service fees, Manufacturer Administrative Fees and marketing grants from Pharmaceutical Manufacturers, wholesalers and data warehouse contractors, Discounts, credits, Inflation Protection, charge backs, commissions, and any fees received for sales of utilization data to a pharmaceutical manufacturer. Rebates do not include purchase Discounts (e.g., prompt pay Discounts) from mail and specialty products, the value of drug manufacturer coupons, or the value from any other patient assistance programs.

tttt. **Retail Pharmacy** – Any type of Pharmacy other than a Mail Order Pharmacy or Specialty Pharmacy, and includes any independent pharmacies, supermarket pharmacies, chain pharmacies or mass merchandiser pharmacies having a state license to dispense medications to the general public.

uuuu. **Retail-30** – A network Retail Pharmacy that offers up to a 30-day supply of medications.

vvvv. **Retail-90 or 90-Day-At-Retail** – A network Retail Pharmacy that offers a 90-day ('mail at retail') supply of medications.

wwww. **Retrospective DUR ("Retro-DUR") -** A post payment Claims analysis to facilitate Drug Utilization Review (DUR) objectives.

xxxx. **Section 508 -** Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d) and implementing regulations at 36 CFR 1194 Parts A-D which requires accessibility among persons with a disability.

yyyy. **Service Level Agreement ("SLA") Scorecard -** Performance management scorecard that contains Contractor's KPIs and desired outcomes in Contract Attachment D. The At-Risk Performance Payments will be based on the Contractor's ability to meet the listed KPIs.

zzzz. **Single-Source Generic(s)** or **SSG(s)** - Generic Drugs that are manufactured by one generic drug manufacturing company.

aaaaa. **Specialty Drugs** – certain pharmaceuticals, biotech or biological drugs, that are used in the management of complex or genetic disease that meet at least one of the first two criteria (1 and 2) and all the last three criteria (3-5) in order to be placed on your Specialty Drug list:

(1) Produced through DNA technology or biological processes
(2) Targets a complex disease caused by a combination of genetic, environmental and lifestyle factors
(3) Unique handling, distribution, and/or administration requirements such that the drug cannot be safely dispensed from a Mail Order Pharmacy
(4) Requires a customized medication management program that includes medication use review, patient training, coordination of care and adherence management for successful use such that more frequent monitoring and training is required
(5) Are not a device, supply, medical food, or durable medical equipment.

Lastly, only newly FDA-approved and launched drugs, and drugs not on the market as of January 1, 2025, may be considered for addition to the Specialty Pharmacy drug price list after this date, unless the Specialty Pharmacy gains access to a previously unavailable Limited Distribution Specialty Drug.

bbbbb. **Specialty Pharmacy** – (a) an automated Pharmacy that processes prescriptions at one or more central locations and delivers them through the mail or other third-party delivery service to the locations of Members, and does not have a physical Member-facing storefront, (b) the PBM Specialty Pharmacies, (c) a Pharmacy that dispenses a Limited Distribution Specialty Drug, and (d) any other Pharmacy that the parties agree in writing is a Specialty Pharmacy for purposes of this definition. If such a Pharmacy dispenses Specialty Drugs and non-Specialty Drugs, such Specialty Pharmacy shall constitute a Specialty Pharmacy only with respect to the dispensing of Specialty Drugs and shall constitute a Mail Pharmacy (in the case of clause (a) of the preceding sentence) or a Retail Pharmacy (in the case of clause (b) and (d) of the preceding sentence) with respect to the dispensing of non-Specialty Drugs.

ccccc. **Specialty Service Fees** – fees collected by a PBM or PBM Affiliates from pharmaceutical companies for certain costs or services associated with stocking, handling and dispensing certain Specialty Drugs, such as distribution data reporting, inventory tracking and management, FDA Risk Evaluation and Mitigation Strategy (REMS) support and enhanced adverse even reporting and coordination.

ddddd. **Splash Page -** Dedicated and customized webpage for this Contract, which does not require individuals to log in, containing information specific to the Program.

eeeee. **Spread** - A term applicable to Traditional Pricing wherein the PBM retains the differential between negotiated contracts and financial terms offered to the client. For example, the PBM may have a higher Discount with pharmacies than it offers to its clients and retain the difference or "Spread" as profit. With the traditional model, the "Spread" represents the PBMs profit, but the actual amount of this profit may not be fully disclosed to the client.

fffff. **State Group Insurance Program ("Plan") -** Refers to all benefit options sponsored by the State, Local Government, and Local Education Insurance Committees (e.g., health plan options, disability insurance, life insurance, other voluntary benefits).

ggggg. **State, Local Government, and Local Education Insurance Committees -** Policy making bodies for the State, Local Government, and Local Education agencies established under Tenn. Code Ann. § 8-27-101, 8-27-207, and 8-27-301 respectively.

hhhhh. **Step Therapy -** The practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug and stepping up through a sequence of alternative drug therapies as preceding treatment option fails. Step Therapy programs apply coverage rules at the point of service when a Claim is adjudicated. If a Claim is submitted for a second-line

drug and the Step Therapy rule was not met, the Claim is rejected, and a message is transmitted to the Pharmacy indicating that the patient should be treated with the first-line drug before coverage of the second-line drug can be authorized.

iiiii. **Subrogation Claim** - a Claim submitted by any state or a person or entity acting on behalf of a state under Medicaid or similar United States or state government health care programs, for which the State is deemed to be the primary payor by operation of applicable federal or state laws.

jjjjj. **Territory Pharmacy** or **TER** - a Retail Pharmacy located in one of the United States territories, i.e. American Samoa, Guam, Northern Mariana Islands, Puerto Rico, United States Virgin Islands. These Pharmacies are identified by an ISO 3166 code (state code) of AS, GU, MP, PR, and VI.

kkkkk. **Third Party Administrator ("TPA") -** The State's contracted medical contractor(s) responsible for processing medical Claims and providing other administrative support for the contract.

lllll. **Total Claim Cost** - equal to the Ingredient Cost plus the applicable Dispensing Fee plus the applicable sales tax.

mmmmm. **Traditional Pricing** - a financial structure comprised of fixed guaranteed Discounts and fees. In this arrangement, PBM retains the difference between (1) Mail Order Pharmacy and Specialty Pharmacy acquisition costs and the amounts guaranteed to the State and (2) contracted rates with Retail Pharmacies and the amounts guaranteed to the State. PBM passes through all Manufacturer Payments it receives in excess of the State's guaranteed Manufacturer Payments. Retail Pharmacy rates may vary and the amount paid by PBM to the Retail Pharmacy may not be equal to the amount billed to the State and PBM shall retain any difference.

nnnnn. **Transmission Fees** - fees paid by Participating Pharmacies that directly or indirectly arise from Claims or Covered Drugs dispensed to Members. These fees shall not constitute Pharmacy Rebates if (a) such fees do not in aggregate exceed $0.15/Claim (b) such fees constitute a fair and reasonable compensation for services actually performed by PBM for a Participating Pharmacy and (c) the receipt and retention of such fees by PBM are in compliance with all applicable laws.

ooooo. **Usual and Customary ("U&C") –** the cash price available to the general public as submitted by the Retail Pharmacy for a Claim on the date such Claim is dispensed. A U&C Claim is one in which the Claim is adjudicated at the Usual and Customary Price and always has a Dispensing Fee of $0.00.

ppppp. **URAC** – an independent, nonprofit organization that promotes health care quality through its accreditation and certification programs. Originally, URAC was incorporated under the name Utilization Review Accreditation Commission. However, that name was shortened to the acronym URAC in 1996 when URAC began accrediting other types of organizations such as health plans and preferred provider organizations.

qqqqq. **Vaccine Administration Fee** - a professional service fee associated with a Member receiving a Vaccine Claim from a Participating Pharmacy. This charge is directly tied to the bona-fide service of vaccine administration vaccine to a Member.

rrrrr. **Vaccine Claim(s)** - a Claim in which the dispensed product is a preparation used as a preventative inoculation to confer immunity against a specific disease, usually employing an innocuous form, fragment, toxin, or DNA of the disease agent to stimulate antibody production, and for which the purchase price includes the Ingredient Cost, the Dispensing Fee, the vaccine fee and the cost to administer the vaccine. These Claims are identified with

a Medi-Span Generic Product ID (GPI-2) of '17' or '18' or has an AHFS Extended Therapeutic Class Code of 80120000 or 80080000.

sssss. **Veteran Affairs Pharmacy** or **VA** - a Retail Pharmacy under veteran affairs jurisdiction where drugs are dispensed and pharmaceutical care is provided to enrolled veterans, by licensed pharmacists. These Pharmacies are identified by a National Council for Prescription Drug Program's (NCPDP's) dispenser type code of 9.

ttttt. **Zero Balance Due or ZBD** – any Claim where the Member pays the total amount of the Claim, including any applicable sales tax, and the plan pays zero. ZBD Claims are calculated at the original Discounted Ingredient Cost prior to the application of the Member copay and are not artificially inflated to a 100% Discount or zero-dollar amount.

A.3. Pharmacy Benefit and Policies

a. The State will determine all Pharmacy benefits and related policies. If the Contractor has a question on policy determinations, benefits, or operating guidelines required for proper performance of the Contractor's responsibilities, the Contractor shall request In Writing a determination by the State. The State will respond In Writing with a final determination and the Contractor shall then act to comply with such policy determinations and/or operating guidelines.

b. The State will have the sole responsibility for and authority to clarify and/or revise the plan documents which govern the structure of the Pharmacy benefits available to Members. The Program cannot and does not cover all benefit situations. In a case where the benefits are not referenced or are not clear, the Contractor shall clarify In Writing the State's intent with the State. The State shall have the exclusive and final authority to interpret the plan documents.

c. Unless otherwise directed by the State In Writing, the Contractor shall not attempt to interpret statutes, regulations, plan documents, or policy materials. Rather, the Contractor shall refer, In Writing, all questions regarding a policy interpretation to the contact designated by the State within one (1) Business Day of discovery of the issue in question.

d. The Contractor shall possess and maintain full Pharmacy Benefit Management accreditation status with URAC during the entire term of this contract.

A.4. Plan Implementation

a. The Pharmacy benefit for the Plan will take effect and be fully operational on the go-live date specified in Contract Section A.33.

b. The Contractor shall implement the systems required to process all Plan Pharmacy Claims and all other services described herein. The Contractor shall work with the State to ensure that the Program satisfies the functional and informational requirements as outlined by this Scope and in the plan document.

c. The Contractor shall provide a dedicated full-time implementation team. All the Contractor's implementation team Members shall have participated, as team Members, in the implementation of Pharmacy benefit services for at least one other large employer (employers with Pharmacy plans covering at least 100,000 lives). The Contractor's implementation team shall include: a project management specialist to lead the implementation, a full-time licensed pharmacist designated to this Contract, and a full-time

account manager designated to this Contract, who will be the main contact with the State for all day-to-day matters relating to the implementation and ongoing operations of the Contract. Also, the Contractor shall assign an information systems project coordinator to coordinate activities among the Contractor and the State's existing contractors and any affected state agencies other than Benefits Administration (including Edison, Strategic Technology Solutions, Department of Human Resources) and other state contractors (including the current PBM, TPAs, DSS contractor, etc.).

d. All key Contractor project staff shall attend a project kick-off meeting at the State of Tennessee offices in Nashville, TN within the first thirty (30) days after the Effective Date, as requested by the State. State project staff shall provide access and orientation to the Plan and system documentation, as requested by the Contractor. Contractor staff may attend virtually, as approved by the State.

e. The Contractor shall provide a written project implementation plan within thirty (30) days of the contract effective date. The plan shall be electronically maintained and accessible to the State. The plan shall detail all aspects of implementation, which includes all tasks with deliverable dates necessary to satisfactorily install the Program no later than the go-live date specified in Contract Section A.33. and a description of the Members on the transition team and their roles. The plan shall include a detailed timeline description of all work to be performed both by the Contractor and the State. This plan shall require approval In Writing by the State. At a minimum, the implementation plan shall provide specific details on the following:

   (1) Identification and timing of significant responsibilities and tasks
   (2) Names and titles of key implementation staff
   (3) Identification and timing of the State's responsibilities
   (4) Data requirements (indicate type and format of data required)
   (5) Data conversion plan including procedures for testing the conversion data
   (6) Identification and timing for the testing, acceptance and certification of receipt of State's eligibility through Edison
   (7) Identification and timing for testing and certification of Claims payment and reconciliation process
   (8) Timing and testing of benefit design setup
   (9) Drug Formulary development consistent with the State Pharmacy benefit
   (10) Plan Member communications
   (11) Communications with network pharmacies regarding the Plan's participation
   (12) Schedule of in-person meeting and conference calls
   (13) Transition requirements with the incumbent PBM; and
   (14) Staff assigned to attend and present (if required) at annual enrollment/ educational sessions.

f. The Contractor shall provide a comprehensive operational readiness review to the State at least sixty (60) days prior to the go-live date, as long as the State and the Contractor have met all implementation milestones necessary for the audit. The Contractor shall pay for the comprehensive readiness review to ensure the plan design, eligibility and financial contract terms have been set up correctly.

Such review by the State may include, but not be limited to, an on-site review of the Contractor's operational readiness for all services required in this contract. The review may also include desk reviews of documentation that includes but is not limited to:

(1) Policy and procedures manual

(2) Information systems

(3) All deliverables and reports

(4) System testing for all Plan options (PPOs, CDHPs, etc.) for correct Member Cost Share (deductible, Copayments and/or Coinsurance) for Generic Drugs, preferred Brand Drugs, non-preferred Brand Drugs at both Mail Order and Retail Pharmacies, for 30-day and 90-day supplies, and for maintenance tier medications provided at lower cost share for those filled in a 90-day supply; and

(5) Copies of Contractor's proposed Member handbooks or welcome letters/kits and the front and back of the Contractors' proposed Pharmacy benefits ID card for plan Members.

g. At its discretion, the State may conduct an additional, pre-implementation review of the Contractor's progress towards fulfilling the IT and telecommunication technology requirements.

h. At the State's request, the Contractor shall host one or more officials of the State onsite at its call center no later than one (1) month prior to the go-live date and during the month after the go-live date to ensure that all customer service representatives have been adequately trained on all aspects of the State's unique Plans (to ensure that accurate benefits and information will be provided to our Members after go-live). A tour of the facility and a review of the Plans will be reviewed as well. These State officials will help to coordinate activities with BA staff and the Contractor's call center.

i. The Contractor shall conduct status meetings concerning project development, project implementation, and Contractor performance at least weekly during implementation and daily for the first month following the go-live date, unless otherwise approved or requested by the State. Thereafter, all ongoing operational meetings shall be conducted on a State specified schedule but shall occur no less than once a month. Such meetings shall be either by phone, virtual, or on-site at the offices of the State, as determined by the State and shall include the Contractor's account manager, pharmacist and appropriate systems staff. Any costs incurred by the Contractor as a result of a meeting with the State shall be the responsibility of the Contractor. In lieu of monthly meetings, the State may choose to hold such meetings virtually with Contractor staff on an as-needed basis, subject to State staff needs.

j. No later than forty-five (45) days post-go-live, the State shall perform an implementation performance assessment survey of the Contractor's performance to determine the State's satisfaction with the implementation process and Contractor. Results shall be shared with the Contractor including the identification of any deficiencies. The Contractor shall respond within fifteen (15) days of receiving the results with a corrective action plan as necessary to remedy any identified deficiencies. In response to the corrective action plan the Contractor shall comply with all recommendations/requirements within the timeframes agreed upon by the State.

A.5. Staffing

a. The Contractor shall provide an ongoing designated, full-time account team that can provide daily operational support as well as strategic planning and analysis. All Members of the account team shall have previous experience administering Pharmacy benefits for large employers.

b. The account team shall be available for consultation with the State during the hours of 8:00 a.m. to 4:30 p.m. Central Time, Monday through Friday.

c. The Contractor shall designate a full time licensed chief pharmacist as a Member of the ongoing account team. This individual shall have over five (5) years' experience working at the executive level for a PBM and shall have the responsibility for providing the State with clinical pharmacological advice in the review and development of a specific Formulary for the Plan, Pharmacy benefit design and utilization review activities to include PA, Step Therapy, and other approaches to managing the prescription drug benefits for the Plan. The clinical pharmacist shall have experience working as a clinical pharmacist on an account team with at least one employer group or client with a minimum of 100,000 covered lives. In addition, the Contractor shall, at the State's request, have said pharmacist available to participate with the State's population health contractor and/or case managers at the State's TPAs in regular (or as needed) calls to discuss complex Member cases, Member issues, poly Pharmacy issues, and other similar issues. These discussions will typically take place virtually on an as-needed basis as determined by the case managers and/or the medical director at the State's population health contractor.

d. The Contractor shall designate a full-time account manager as a Member of the ongoing account team. The account manager shall be a Member of the implementation team in order to ensure a seamless transition from implementation to ongoing operations.

e. The account manager shall have the responsibility and authority to manage the entire range of services and shall respond immediately to changes in benefit plan design, changes in Claims processing procedures, or general administrative problems identified by the State. Further, this account manager shall be readily available via telephone and email throughout the Business Day to answer calls and emails by the director of Pharmacy services at the State and by other State staff to research Member issues.

f. The account manager shall participate in all ongoing operational meetings as required in A.4.i. and shall meet in person with the State at least annually and more often if requested by the State. At its discretion, the State may allow the Contractor to participate in such meetings virtually.

g. The Contractor shall designate a strategic account executive with overall responsibility for the Contract and ensuring that all contract requirements are met, that reports and other deliverables are provided, that the benefits are executed properly, as well as providing long term vision and feedback of Plan benefits and working on fiscal notes with State staff.

h. The State shall perform an account team satisfaction survey of the Contractor's performance annually during the contract period to determine the State's satisfaction with the ongoing account team and Contractor. Results shall be shared with the Contractor including the identification of any deficiencies. The Contractor shall respond within fifteen (15) days of receiving the results with a corrective action plan as necessary to remedy any identified deficiencies.

i. The Contractor shall train all Contractor staff and subcontractors regarding all applicable aspects of the Plan's Pharmacy Program. The State shall approve the Contractor's subcontractors, or its staff, as defined in this Contract Section.

j. At the State's request, In Writing, the Contractor must replace staff Members or subcontractors providing core services. Core services are defined as those that touch or affect the Member, specifically Member customer services, Member call center, mail and Specialty Pharmacy services, Claims processing and adjudication, appeals processing at all levels. Also included are such services that affect the plan administrator such as the Contractor's account team that routinely interacts with the State, and clinical advisors or pharmacists on the account team. The decision of the State on these matters shall not be subject to appeal.

k. The Contractor shall notify the State at least fifteen (15) Business Days in advance, or as soon as the information is available, of proposed changes to key personnel commitments (implementation manager, ongoing account manager, strategic account executive, and chief pharmacist) made in the Contractor's proposal. If any key positions become vacant, Contractor shall provide a replacement with commensurate experience and required professional credentials within sixty (60) days of the vacancy unless the State grants an exception to this requirement In Writing. The Contractor shall submit justification (including proposed substitutions) in sufficient detail regarding education and experience equal to previous staff to the State to evaluate the impact of the new key personnel assigned to the State's account. The State reserves the right to require personnel changes. The decision of the State on these matters shall not be subject to appeal.

l. For matters designated as urgent by the State, the Contractor shall provide a response to the State within four (4) hours. Staff Members, from the respective business unit, with final decision-making authority shall provide responses.

m. Contractor shall employ no employees or contract with subcontractors that are on the U.S. Department of Health and Human Services' Office of Inspector General (OIG) exclusions list unless the Contractor receives prior approval In Writing from the State.

n. Contractor shall assist Benefits Administration staff throughout the year on legislative inquiries and potential bills proposed by the Tennessee General Assembly. This will require a thorough review of any bill shared with the Contractor, including a section-by-section written analysis and a cost estimate of the impact of each section. This may be further requested at the State, Local Education and/or Local Government level and may be required to be returned within 48 hours.

A.6. Point Of Sale Claims Adjudication (for Retail, Mail Order, and Specialty Pharmacy)

a. The Contractor shall provide an integrated, electronic retail, Mail Order and Specialty POS Claims processing system that can meet the needs of the State and the Plan.

b. The Contractor shall provide system design, modification, development, implementation and operation for the Plan POS system, which uses the specified, current NCPDP format. The Contractor's POS system shall allow it to interface with the existing Pharmacy switch networks that connect Pharmacy Providers with the Contractor's system.

c. The POS system shall automate the entire Pharmacy Claims processing system and shall price and adjudicate Claims online and in real time. The POS system shall adjudicate and

process all Retail, Specialty and Mail Order electronic POS and Paper Claims incurred during the Term in strict accordance with the State's Pharmacy benefits as contained in the Plan Document, which is located on the State's website. (https://www.tn.gov/partnersforhealth/publications/publications.html) in the publications section (three (3) Plan Documents for the Plan).

d. The Contractor shall process ninety-nine point five percent (99.5%) of POS Claims on a daily basis within five (5) seconds excluding scheduled maintenance downtime. For this calculation the number of Claims processed within five (5) seconds during each twenty-four (24) hour period shall be the numerator and the number of Claims processed during each twenty-four (24) hour period shall be the denominator. To measure compliance with this standard, the Contractor shall measure for each Claim the time from when the Claim is received by the Contractor's processor to the time the results are transmitted from the Contractor's processor. The Contractor's measure shall reflect the time required for all procedures required to complete Claim adjudication.

e. The Contractor shall notify the State's Pharmacy director, via e-mail and phone, immediately upon knowledge of unscheduled or unapproved downtime involving more than ten percent (10%) of production for fifteen (15) minutes or longer. The Contractor shall also provide the State updates at regular intervals during a sustained downtime. The State will be presented with recovery options as appropriate.

f. Participating Pharmacies shall be responsible for submitting Member Claims through POS telecommunications devices. However, the Contractor shall also process Paper Claims within thirty (30) days of receipt when submitted by Members or by a prescriber on behalf of a Member.

g. The Contractor shall ensure that retail network Claims submitted by Participating Pharmacies will be paperless for the Members. The Contractor's agreement with network Pharmacy Providers shall obligate the network Pharmacy Providers to submit Claims directly to the Contractor.

h. The Contractor's system must provide Members a POS explanation of Pharmacy benefits for Claims processed through its Retail, Mail Order, and Specialty Pharmacies, and concurrently provide online Claims records for prescriptions dispensed through all channels, which lists the individual Member's pharmaceutical out-of-pocket expenses, the Plan's costs, and concurrently provides online any cost savings opportunities for the Member.

i. The Contractor shall work as needed and as requested with the State's TPAs in their work related to Subrogation Claims. The Contractor shall share data or support the TPAs as needed.

j. The POS Claims system shall fully integrate the PA, quantity limits, and Step Therapy programs, as described in Contract Sections A.12.g and A.12.h, and have edits to verify eligibility, the current Formulary, and Claim completeness as Claims are submitted.

k. On a quarterly basis, the Contractor shall accurately process greater than or equal to 99.9% of Claims at Retail, greater than or equal to 99.99% of Claims at Mail Order, and greater than or equal to 99.99% of Claims at Specialty, either filed directly by Members and/or their prescriber(s), to comply with Contract Attachment D. Claims Processing Accuracy shall be measured by dividing the weighted number of Claims processed without any type of error by the total number of Claims in the population. The Contractor shall calculate this and include

it on the SLA scorecard and shall also include with each submission of the SLA scorecard a second document which shows how the Contractor calculated this (I.e., “show your work.”)

l. The Contractor shall track Member utilization across all Participating Pharmacies and shall report Member utilization to the State at the State’s request.

m. The POS system shall generate a Claim pay status of pay or deny. The system shall allow a Pharmacy to initiate a reversal (void) of a submitted Claim. The telecommunications system supporting the POS function shall be available for Claims submissions by pharmacies twenty-four (24) hours-a-day, seven (7) days-a-week (except for regularly scheduled and separately approved downtimes). The Contractor shall not charge participating Pharmacy Providers any POS fees for services, including but not limited to Transmission Fees, rendered under this contract. Network Pharmacy Providers are responsible for purchasing POS hardware, software and all telecommunications linkages. The Contractor shall require all participating network Pharmacy Providers to have the POS function. POS system used by contracted pharmacies to process Pharmacy Claims shall be accessible and operational 99.90% of the time exclusing scheduled maintenance.

n. The Contractor shall apply a unique identification number to each Claim and any supporting documentation. The Contractor shall use said identification number to recognize the Claim for research or audit purposes. The Contractor shall ensure that all Claims have been processed to completion (e.g., approved or denied). The Contractor shall ensure that safeguards are in place to protect the confidentiality of Member information.

o. At the POS, the Contractor shall identify and deny Claims that contain invalid Provider numbers. Pharmacy Providers shall submit Claims and be identified by their individual and specific NPI. Prescribers shall be identified on all Pharmacy Claims by their specific NPI or DEA Numbers, or any other identifying number as required by the State, federal law, or HIPAA.

p. The Contractor shall identify and deny Claims (unless specifically instructed differently by the State) that contain NDC or NDC-11 numbers that contain non-covered drug codes, LTE drug codes based on the Drug Efficacy Study Implementation (“DESI”), drug codes which are IRS to DESI Drugs classified as LTE and any terminated or obsolete drug codes. Such Claims shall reject with situation specific messaging and error codes.

q. The Contractor’s POS adjudication system must have the ability to reject Claims when the Member’s Plan coverage is secondary to another plan and notify Members and the Retail Pharmacy why the Claim rejected. The Contractor must process secondary coverage Claims for possible reimbursement as appropriate.

r. Upon conclusion of this Contract, or in the event of its termination or cancellation for any reason, the Contractor shall be responsible for the processing of all Claims incurred for Members rendered during the period of this contract with no additional administrative cost to the State and according to the pharmaceutical price quoted for the year in which the Pharmacy expense was incurred. The Contractor shall also be responsible for the payment of Rebates on all Claims incurred prior to termination or cancellation. The Claims run out period shall commence for a period of six (6) calendar months after December 31, 2027, unless otherwise directed by the State.

s. The Contractor shall maintain a dedicated toll-free number to support system operations (Help Desk). The Help Desk shall be available twenty-four (24) hours a day, seven (7) days

a week to respond to questions and problems from Pharmacy Providers regarding system operations and Claims inquiries. The Contractor shall supply all the required information systems, telecommunications, and personnel to perform these operations. The Contractor's Help Desk and representatives/operators shall be located in the contiguous United States.

t. The Contractor shall process all the State's Claims on the same platform and shall not transition the State from the Claims adjudication platform that they are implemented onto during the Term without prior approval In Writing by the State.

u. Payment card information processed on behalf of the State or for systems that support services provided by the State or on behalf of the State by the Contractor or approved sub-contractor shall be compliant with the current version of PCI DSS.

v. POS system messages shall in no way steer or encourage Members or Providers to utilize a particular Pharmacy.

A.7. Claims Payment and Reconciliation

a. The Contractor shall adjudicate Claims as payable only if said Claims are (i) for Members (ii) for approved services (iii) delivered by in-network Pharmacies or Providers (or Out-of-Network Pharmacies, payable up to Ingredient Cost minus any Member Cost Share) and (iv) comply with the payment rules and other policies of the State. The State will only pay for approved and correctly Paid Claims, not for rejected or reversed Claims. Out-of-network Claims shall be paid via direct Member reimbursement for (i) Members (ii) for approved services (iii) and comply with the payment rules and other policies of the State.

b. The Contractor shall pay the Claim or advise the Provider that a submitted Claim is: (1) a Denied Claim (specifying all reasons for denial); or (2) remains as a transaction that cannot be denied or allowed due to insufficient information and/or documentation (specifying all information and/or documentation that is needed from the Provider in order to allow or deny the Claim). An incomplete transaction may be resubmitted with the information necessary to complete the Claim.

c. The Contractor, GPO, and any PBM Affiliates shall pass through the full value of any and all contracted rates negotiated with Participating Pharmacies (including, but not limited to, Discounts, Dispensing Fees, and any other contracted terms) and Pharmaceutical Manufacturers (Rebates, MAF, Manufacturer Payments) directly to the Plan. Thus, the Contractor shall not receive any differential, or Spread, between the Pharmacy or manufacturer contracted rate and the Plan contracted rate. The Contractor shall provide a quarterly report to demonstrate the level of Pass-Through Transparent Pricing. The Contractor understands and agrees to the statement in contract section C.3.y and acknowledges that this will be audited on an annual basis by the State's benefits and actuarial consultants, in order to comply with Tenn. Code Ann. § 4-3-1021.

d. The Contractor shall be responsible for ensuring that any payments funded by or to the State are accurate and in compliance with the terms of this contract; agreements between the Contractor and Providers; and State and federal laws and regulations.

e. The Contractor shall ensure that every Paid Claim is attributed to one of the State's funding accounts. Any later adjustments of Claims requested or initiated by either the State or by the Contractor shall be debited or credited to one of the State's funds and not to the funds that are paid to the Contractor in the way of Administrative Fees. Any adjustments or later Claims processed that results in the State being owed money or the State owing money for a

Claim processed should be debited or credited against one of the State's funds and NOT against any Administrative Fees payments. Claims payment accuracy shall be ninety-nine-point nine percent (99.9%) or higher for retail, mail order, and specialty. Based on vendor's internal quality review. Calculated as all Claims audited and found to be without adjudication error of any kind (i.e., any Claim processing inaccuracy that results in an incorrect charge to the State or its plan Members), divided by all Claims audited.

f. The Contractor shall notify the State within thirty (30) calendar days of a retroactive termination of all Claims paid on behalf of the affected Member during the period covering the retroactivity. The State will require the Contractor to assist the State in the recovery of Claims.

g. The Contractor shall reimburse pharmacies for claims from their own funds and accounts. For the payment of all Claims under this contract, the Contractor shall issue payments in the form of checks and/or Automated Clearing House ("ACH") electronic funds transfer against the Contractor's own bank account. The Contractor shall maintain security and quality controls over the design, printing, and mailing of checks, as well as any fraud prevention features of checks. Additional requirements related to payments are listed in Contract Section C.3. These Claims paid by the Contractor will be reimbursed by the State's Office of Business and Finance (OBF) upon receiving sufficient documentation and reports from the Contractor to validate/justify the accuracy of the requested reimbursement for Paid Claims. The State will only reimburse the Contractor for Paid Claims. Claims that have been processed and adjudicated but not yet paid by the Contractor to pharmacies will not be reimbursed by the State.

h. Contractor's Pharmacy payment process shall comply with any state prompt pay laws. In the absence of any prompt pay laws in Tennessee for PBMs, BA has chosen to use the following language regarding prompt payment of pharmacies: the lesser of thirty (30) calendar days or the contracted turnaround time with the Pharmacy. Payment reports provided to the State must assist the State in reconciling payment detail and recording accounting entries.

i. The Contractor shall, at the State's request and with prior approval, perform drug price comparisons with one or more prescription Discount programs at the point of sale thereby allowing Members to pay lower prices, when available, on certain medications while having the amount paid by the Member seamlessly applied to their deductible and/or out-of-pocket maximum.

A.8. Pharmacy Network

a. The Contractor shall establish and maintain its broadest available national Pharmacy/statewide any willing Provider Retail-30, Retail-90, Specialty, and vaccine administering Provider networks and a Mail Order network. These networks shall be adequate to provide covered Pharmacy services and Pharmacy location sites available and accessible to comply with this contract and in support of all Tennessee state laws. The Contractor shall process different Member Cost Share (e.g., Copayments, Coinsurance, deductibles, and maximum out of pocket) amounts depending on the Pharmacy and network utilized by the Member. The Contractor shall offer:

(1) a statewide any willing Provider/national network of pharmacies for the thirty (30) day network wherein Members may fill a prescription for their applicable thirty (30) day cost share (Copayment or Coinsurance).

(2) a Mail Order Pharmacy for ninety (90) day prescription fills.

(3) a statewide any willing Provider/national Retail-90 Pharmacy network of pharmacies wherein Members can fill their ninety (90) day prescriptions for the same cost share as Mail Order and the Plan would pay the same reimbursement rates for the medication as the Mail Order reimbursement rates.

(4) a statewide any willing Provider/national network of Specialty pharmacies from which Members must choose a Pharmacy to fill any Specialty Medication; and

(5) a statewide any willing Provider/national network of pharmacies that include the ability to have a broad array of vaccines administered at the State-determined cost sharing.

b. The Contractor shall execute network participation agreements with any willing Pharmacy Providers for Retail, Specialty, and Vaccine pharmacies that maintain all federal, state and local licenses, certifications, and permits, without restriction, required to provide pharmaceutical services and shall comply fully with all applicable laws and regulations. Contractor shall also offer Mail Order to Members filling an extended supply of non-specialty medications for the applicable Member Cost Share.

c. The Contractor shall provide a list of the individual pharmacies (including at a minimum: name, NCPDP number, NPI, address, city, state, zip code, and telephone number) participating in the Retail-30, Retail-90, Mail Order, Specialty, and vaccine networks on the Contractor maintained Splash Page at least one (1) month prior to the State's annual enrollment period each year. The Contractor shall update these lists at least quarterly, and these lists shall appear in a prominent place on the Splash Page specific for the State's Members. Such list shall be easy to locate and utilize for all Members and all network lists shall be in alphabetical order by state, then city within state. The Contractor shall also include on the Splash Page a list of all drugs that have Quantity Limits, PA requirements, and Step Therapy requirements. Those with quantity limits or morphine milligram equivalents (MME) per day limits should be listed by drug name and the day limit for each. Those with Step Therapy limits should list the drug that must be utilized prior.

d. The Contractor shall not require the State to mandate the use of Mail Order pharmacies or require Members to utilize one single Pharmacy or a single chain of pharmacies.

e. Retail-30 Network:

The Contractor shall maintain a network of Pharmacy Providers to provide the covered services such that in urban areas, at least ninety-seven percent (97%) of Members, on average, live within one and one half (1.5) miles of a Retail Pharmacy participating in the Contractor's network; in suburban areas, at least ninety-seven percent (97%) of Members, on average, live within three (3) miles of a Retail Pharmacy participating in the Contractor's network; and in rural areas, at least ninety-seven percent (97%) of Members, on average, live within ten (10) miles of a Retail Pharmacy participating in the Contractor's network. The Contractor shall justify and document all exceptions, which are subject to prior approval In Writing by the State. Contractor shall ensure that any Pharmacy providing services will process and charge Members either their Plan Copayment or Coinsurance or the lesser-of (if the actual cost of the drug is less than the Member's adjudicated cost share). In no instance shall the Contractor restrict a

pharmacist from advising a Member of a less-costly drug or from collecting the less-of cost if it is lower than the Member's adjudicated cost share.

f. Retail 90 Network:

To comply with Tenn. Code Ann. § 56-7-2359, the Contractor shall allow any willing network retail pharmacies that agree with the Contractor's terms and conditions for Mail Order Pharmacy to participate in a Retail-90 network. The Contractor must create the Retail-90 network for the Plan; Contractor must not under any circumstances attempt to direct Members to any Pharmacy. Neither the State nor the PBM may engage in any sort of influence as to which Pharmacy a Member uses to fill a prescription, except for Specialty Drugs referenced in Contract Section A.8.h. (which the State requires be filled at a Specialty Network Pharmacy).

g. Mail Order Network:

(1) The Mail Order Pharmacy shall possess sufficient staff and facilities capable of meeting the following requirements:

i. Turnaround time specific to clean Claims not requiring intervention (non-protocol or clean cleans) - 96% shipped within two (2) Business Days (not an average). This guarantee is measured in Business Days from the date the prescription drug Claim is received by the vendor (either via paper, phone, fax or Internet) to the date it is shipped

ii. Turnaround time specific to Claims that require additional intervention - 96% of prescriptions requiring administrative/clinical intervention will be shipped within four (4) Business Days (not an average). This guarantee is measured in Business Days from the date the prescription drug Claim is received by the vendor (either via paper, phone, fax or Internet) to the date it is shipped

iii. Mail Order dispensing accuracy – 99.95% accuracy. Dispensing Accuracy Rate means (i) the number of all Mail Order prescriptions dispensed in a contract quarter less the number of those prescriptions dispensed in such contract quarter which are reported and verified as having been dispensed with the incorrect drug, strength, dosage form, patient name, directions, packing non-conformance, or address causing medication to be delivered incorrectly divided by (ii) the number of all Mail Order prescriptions dispensed in such contract quarter.

The Mail Order Pharmacy shall possess a current license to dispense controlled drugs (Schedule 2, 3, 4 and 5 substances).

(2) The Contractor's Mail Order Pharmacy will not be required to dispense prescriptions for greater than a ninety (90) day supply of Covered Drugs, per prescription or refill, subject to the professional judgment of the dispensing pharmacist, limitations imposed on controlled substances (see Tennessee Code Annotated 63-1-164), and manufacturer's recommendations. Exceptions to the ninety (90) day limit include medications that may be packaged by the drug manufacturer in quantities of just over ninety (90) days and that do not lend themselves to being split by the pharmacist (e.g., insulins); in those instances, the Mail Order Pharmacy may fill using the packaging as is and charge ninety (90) day cost sharing to the Member. Prescriptions may be refilled providing the prescription states that refills remain. All prescriptions filled must comply with Tennessee laws and regulations.

(3) The Contractor shall guarantee that MAC pricing will apply at mail for Generic Drugs, as applicable. Contractor shall guarantee that a Generic Drug will never cost more at mail than at a Retail Pharmacy.

(4) The Contractor shall guarantee that the mutually agreed upon baseline measure value (i.e., AWP, NADAC, WAC, or other) applied to Mail Order Claims must be based on the actual NDC or NDC-11 of the package size dispensed.

(5) The PBM Mail Order Pharmacy shall inform the Member, the prescriber, and the State if it substitutes products that will result in Member or plan cost that is greater than the cost that would have been incurred had the prescription been dispensed as written. The Contractor shall only engage in such substitutions when there are widespread marketplace drug availability issues with the more cost-effective product, if there is a Member safety issue or if there is a drug interaction or efficacy issue – and only with prescriber approval, if applicable.

(6) The Mail Order Pharmacy shall communicate to the Member, by phone, e-mail or text, any delays, beyond three (3) Business Days, in delivery of prescriptions. Members shall be notified of such delays within twenty-four (24) hours of the discovery of the delay.

(7) The Mail Order Pharmacy shall provide Members refunds for monies owed back to them instead of maintaining credits at the mail facility.

(8) The State will not pay any outstanding balances owed by Members to the Contractor or its network Pharmacy Providers.

(9) The Contractor shall obtain open refill files from the State's current Mail Order contractor. At the term of this contract the Contractor shall ensure their Mail Order contractor provides open refill files to the State's new PBM contractor.

(10) The Contractor shall maintain a secure website supporting the Mail Order function, which allows Members to access their Pharmacy Claims and request and pay for refills online. Said website shall be operational no later than thirty (30) days prior to the go-live date.

h. Specialty Network:

(1) The Specialty Pharmacy network shall be the preferred Pharmacy Provider of certain drugs. The Specialty Pharmacy network shall guarantee more favorable reimbursement rates than the Retail, Mail Order, and 90-day At Retail networks on the designated products, in the aggregate, and possess unique clinical monitoring, Member assistance, and distribution capabilities.

(2) The Contractor, or other third-party Specialty Pharmacy that has contracted with the Contractor, may provide Specialty Drugs. The Contractor shall add new Specialty products and the pricing for these products to the list of Specialty Drugs.

(3) Unless otherwise directed by the State, all drugs placed on the Contractor's Specialty Drug list shall meet the definition of Specialty Drugs in Contract Section A.2. The Contractor cannot reclassify an existing Specialty Drug as non-specialty or non-specialty drug as Specialty without mutual agreement with justification.

(4) Unless otherwise directed by the State, the Contractor shall limit Specialty Drugs to no more than a thirty (30) day supply, which it shall provide exclusively via Specialty network pharmacies. The Contractor must solicit pharmacies inside the State of Tennessee to join their Specialty Pharmacy network, to comply with Tenn. Code Ann § 56-7-2359, even if the Contractor operates its own Specialty Pharmacy. Neither the Contractor nor the Contractor's staff shall attempt to steer Members to utilize any particular Pharmacy within the Specialty Pharmacy Network, so long as Members do utilize a Pharmacy in said network for their Specialty medications.

(5) Contractor understands that the sole Administrative Fee (PMPM) and any Clinical Fee (if applicable) paid to the Contractor monthly constitutes all services payable under this Contract, including Specialty Drug management (Step Therapy, first fill counseling, recalls, Member adherence education, PA, and similar industry standard PBM activities that relate to Specialty Drug management including but not limited to nursing services or charges.)

(6) The Contractor shall guarantee that the mutually agreed upon baseline measure value (i.e., AWP, NADAC, WAC, or other) applied to Specialty Claims will be based on the actual NDC or NDC-11 of the package size dispensed.

(7) In addition to the Contractor's own requirements for Pharmacy participation in the Specialty Pharmacy Network, the State imposes the following requirements:

i. State Specialty Network Participation Criteria

a) Storage, Shipping & Handling: Pharmacy must have the ability to properly store, handle and ship (if offered) medications per the product labeling.

b) Registration and Licensure: Pharmacy must be registered/licensed and in good standing with the Board of Pharmacy in the state in which it is located and in Tennessee, if located out of state.

c) Member Counseling & Clinical Monitoring: Pharmacy must have a licensed pharmacist on staff to assist with, and counsel, Members on issues common to Specialty Medications. Such issues include identification and management of potential side effects, appropriate use of the medication and the importance of medication adherence.

d) Member Notification of Recalls: In the event of any product recalls, the Pharmacy will identify and notify affected Members.

(8) The Contractor shall notify affected Members by letter within thirty (30) calendar days after any Specialty Pharmacy drops out or leaves the Specialty Pharmacy network. Upon notification that any Specialty Pharmacy is leaving the Specialty Pharmacy Network, the Contractor shall determine if any Members have utilized said Pharmacy within the previous ninety (90) calendar days and mail these Members a notification letter that the Pharmacy is leaving the network on a specific date and also include with the letter a printed list of remaining contracted Specialty Network Pharmacies. The State has the right to review any such letter and make appropriate edits prior to approval and mailing. In addition, the Contractor must notify the State's Director of Pharmacy Services In Writing within ten (10) Business Days any time a Specialty Pharmacy leaves the Specialty Pharmacy network.

i. The Contractor shall Lock In Members who meet the Contractor's Lock In guidelines into just one Participating Pharmacy and one prescriber. The Contractor's Lock In guidelines shall be provided to the State for approval during plan implementation. At least quarterly, Contractor shall use automated systems and human review of prescription drug Claims to detect Members with possible abuse of pain medications or other heavily abused narcotics, or for possible Pharmacy and/or doctor shopping. Contactor shall send evidence of such cases via secure email to Benefits Administration on occurrence and ask for a review and determination as to whether to lock into a single Pharmacy. If the appropriate BA staff determine that the Member shall be locked into a single Pharmacy, BA will communicate this to the Contractor as well as note the Pharmacy name, address, NABP number, and date that the Lock In is to start. BA will notify the Member prior to the Lock In effective date to explain the reason(s) why, etc.

j. The Contractor shall routinely monitor Member prescription drug fill habits for potential Pharmacy shopping of narcotics and other addictive type medications as well as prescribing habits of physicians to review for possible doctor shopping by Members for these type medications. When the Contractor deems that prescribing or fill habits by Members or physicians are outside the norm, the Contractor shall initiate contact with physician and/or all other prescribers in the Member's profile history to determine the diagnosis and/or need to such medications. When the Contractor's clinical pharmacist deems it is appropriate for a Member to be Locked Into a single Pharmacy in order to restrict fill habits, he or she should initiate contact with State to initiate such a Lock In.

k. The Contractor shall annually provide the State with a Quest or comparable report showing service and geographic access for the Retail-30 network and the Retail-90 network broken down for each network by urban, suburban, and rural Members to ensure that Members have the desired access as noted in this Contract. The State will review the Pharmacy network structure and shall inform the Contractor In Writing of any deficiencies. The Contractor shall develop a plan of action, approved by the State, to correct said deficiencies within sixty (60) calendar days from the date the Contractor was first notified of the problem.

l. The Contractor shall generate and deliver to the State, within five (5) Business Days of the end of each quarter, a Quarterly Network Changes Report for the Retail-30 network, the Retail-90 network and the State's Specialty Pharmacy network. This report shall include all additions to the network and all pharmacies no longer participating in the applicable networks.

m. The Contractor shall develop a nationwide vaccine network of Pharmacies where Members may receive covered plan vaccinations.

n. If one of the top five network Pharmacy chains leaves any of the Contractor's networks or notifies Contractor of plans to leave any of its networks, the Contractor shall immediately notify the State as well as draft Member notification letters for mailing to affected Members at the Contractor's cost. Letters should be mailed at least thirty (30) calendar days before the effective date the Pharmacy intends to leave the network and should list the three (3) pharmacies closet to the Member that remain in the applicable network. State must approve notification letters before they are mailed.

o. Should the number of Retail Pharmacies in your network be reduced by more than 3% of all pharmacies in the network (add, drop certain chains, etc.) and/or one of the top 5 Pharmacy chains by store count before the effective date and or any point during the contract term, you will provide the State with an improved pricing offer for the proposed reduced Retail network

at least ninety (90) calendar days prior to the effective date of such change. If the revised pricing that results from a change in the Pharmacy network is not acceptable to the State, the State reserves the right to renegotiate pricing.

A.9. Formulary Management

a. The Contractor shall design, develop, and implement a Formulary, or Formularies, to comply with coverage defined in the Plan Documents. The Formulary/Formularies shall include FDA-approved drugs that have been evaluated for inclusion by the Contractor's P&T Committee. The Contractor shall be the exclusive Formulary administrator of all Formularies for the prescription drug benefit. The initial Formulary, or Formularies, that will impact Members on the date of go-live shall be in place and ready for state review no later than 60 days prior to go-live.

b. By the go-live date the Contractor shall assume responsibility for administering and maintaining the Formulary/Formularies, including the PA criteria and clinical programs. The Contractor shall also assume responsibility for administering and maintaining additional Formularies during the term of this contract at the State's request.

c. The Contractor shall allow the addition of a new and/or different Formulary if requested by the State and shall be able to manage different Formularies for different plan designs. The Contractor will work with the State to add or adjust contractual discount guarantees as needed, based on the adoption of new and/or different Formularies. The Contractor shall also allow Formulary customizations at the State's request at no additional cost to the State, including the ability to remove or add any products, including over the counter ("OTC") products. The Contractor shall implement customized formularies within an acceptable timeframe proposed by the Contractor and approved by the State In Writing.

d. The Contractor shall monitor Formulary compliance and, if requested by the State, report compliance information to the State quarterly. If requested by the State, Contractor shall provide suggestions for improving Formulary compliance.

e. The Contractor shall implement changes to the Formulary, Step Therapy, PA, and other clinical edit requirements within forty-five (45) Business Days of the State's approval or request. Additional time, beyond thirty (30) Business Days, may be granted with the State's prior approval In Writing. Changes shall include modifications to the POS system and all supporting systems and documents. The Contractor shall notify Pharmacy Providers and affected Members In Writing at least forty-five (45) days prior to the implementation, unless the State requests a shorter notification time. The State must provide prior approval In Writing for all Pharmacy Provider and Member notifications.

f. The Contractor shall not implement or administer any program that results in the therapeutic switching of Members from lower net cost products to higher net cost products. The only exceptions are for Member safety or efficacy issues or, upon notification to the State and with prescriber approval, in response to widespread marketplace drug availability issues with the more cost-effective product.

g. Final decisions for inclusion or exclusion from the Formulary shall be at the sole discretion of the State. For the purposes of this contract, the Contractor shall offer and manage an Open Formulary where all FDA approved medications are to be covered, or have a pathway to coverage, except for those expressly excluded from coverage by the State of Tennessee's

governing Plan Document(s) or if otherwise requested by or approved by the State. No utilization management tools (such as Step Therapy, PA, and quantity limits) will apply unless the state grants approval to such utilization management tools during contract implementation or during the term of the contract.

h. The Contractor shall regularly review the State's three (3) Plan Documents for the State, Local Education, and Local Government Plans to ensure compliance with providing medications and supplies as noted or excluded in these documents. The Contractor must ensure compliance with this and other similar language in the Plan Documents throughout the Term.

i. Upon request by the State, the Contractor will work with State staff to reduce the use of coupons or drug cards utilized at retail pharmacies to keep these from artificially contributing to a Member's maximum out of pocket costs or deductibles.

j. Formulary Design and Development:

(1) Based on the recommendations by the Contractor's P&T Committee, the Contractor shall design the Formulary to (i) maximize the prescribing and dispensing of safe and clinically effective drugs within each therapeutic class that are the most clinically effective as well as the most cost-effective for the State; (ii) ensure that the more costly drugs, which do not have any significant clinical or therapeutic advantage over others in their class, are used only when medically necessary; have a higher Formulary tier; (in certain instances, these drugs may be excluded from the Formulary); and (iii) ensure that ninety-five percent (95%) or more of Mail Order prescriptions and ninety percent (90%) or more of retail prescriptions for Multi-source drugs shall be dispensed with a Generic Drug product.

(2) The Contractor's P&T Formulary review process shall be an evidence-based review of clinical guidelines and medical literature to identify which agents and classes of drugs shall be included on the Formulary. Within the classes of drugs determined to be included on the Formulary, the Contractor shall determine which drugs within each class are safe, clinically effective, cost rational and provide equivalent clinical outcomes. The Committee's recommendations for inclusion on the Formulary shall be based on a thorough review of clinical effectiveness, safety, and health outcomes, followed by an analysis of the relative costs of the drugs in each class under consideration. The Contractor shall, at the State's request, provide the State documentation describing the Formulary review process, and the logic and methodology utilized by the Contractor's P&T Committee.

(3) The Contractor shall identify therapeutic alternatives and opportunities for savings and report these opportunities quarterly to the State. The Contractor shall also present recommendations at the annual review meeting concerning therapeutic categories that should be avoided with regard to inclusion on the Formulary, if applicable.

(4) The Contractor may modify drugs included on the Formulary as a result of factors including, but not limited to, medical appropriateness, manufacturer Rebate arrangements, and patent expirations. The Contractor shall notify the State of modifications to the Formulary, which will include a statement as to the reason for the modification. If one of the top twenty (20) drugs (by prescription volume) utilized by eligible Members is being modified, the Contractor shall provide a more detailed analysis justifying the proposed modification including financial analysis,

(5) Upon review and approval by the State, the Contractor shall implement Formulary management programs, which may include cost containment initiatives, such as therapeutic interchange programs; communications with eligible Members, participating pharmacies and/or physicians (including communications regarding Generic Drug substitution programs); and financial incentives to participating pharmacies for their participation.

(6) The Contractor shall design, develop, implement, administer and maintain a listing of quantity limits for certain preferred and non-preferred drugs. The Contractor shall base this list on therapeutic best practices (current clinical guidelines) or opportunities to reduce the cost of the most appropriate dosage form. The Contractor shall include drugs and quantities on the quantity limits listing in the Formulary documents and shall code these limits and Pharmacy messaging into the POS system.

(7) The Contractor shall ensure the Formulary is readily available on the Internet for both prescribers and Members and that prescribers and Members can easily identify utilization restrictions, or Formulary alternatives for non-Formulary or high-cost products.

(8) The Contractor shall coordinate its Formulary development process and criteria with the Contractor's clinical program requirements (PA, Step Therapy, etc.) to ensure consistent processes and minimize Member or prescriber impact.

(9) The Contractor shall ensure that the Pharmacy Program and POS system include provisions for the dispensing of an emergency supply (early refill, Member lost prescription, vacation supply, dose increase, etc.), as described and determined by the Plan Document.

(10) The Contractor shall work with the state to implement utilization edits on medications deemed by the State or Contractor to be wasteful or of low value. Affected Members should be lettered by the Contractor at least 60 days prior to the change, and as new drugs are added to the wasteful, low-value program and current utilizers are identified.

(11) The Contractor shall have a program in place to reduce the utilization of drugs with hyperinflated costs that provide no meaningful clinical value. The State's intent is to reduce the utilization of such drugs and redirect Members to other medications of less cost that provide better clinical value. Affected Members should be lettered by the Contractor at least 60 days prior to the change, and as new drugs are added to the Program and current utilizers are identified.

k. The Contractor shall not require participation in any Formulary management programs or alter pricing and Rebate Guarantees based on the state's decision not to participate in any Formulary management program. The State will make all final determinations regarding participation in Formulary management programs.

l. The Contractor shall allow Members impacted by a State-approved Formulary management program change a period of no less than sixty (60) days, unless otherwise agreed to by the State, to comply with the change and shall allow Member exemptions/Continuity of Therapy Utilization at the State's request.

m. The Contractor shall send Member and prescriber notification letters at least 45 days in advance of formulary updates to advise Members and their prescribers of any change that negatively impacts the Member once the formulary changes. The Member and prescriber letters shall indicate the formulary change date, the Member's currently used medication(s)

and the soon-to-be formulary alternatives. The State shall not be billed for these letters, and they shall be included in the monthly PMPM Administrative Fee paid to the Contractor.

A.10. Benefit Coverage/Plan Design

a. The Contractor shall support and administer the Pharmacy benefit structure developed by the State, which may include the following:

(1) Any updated benefit Plan design.

(2) Copayments/Coinsurance at retail, 90-Day-At-Retail, Mail Order and Specialty.

(3) Mixed Copayments at retail and Mail Order (fixed dollar + %)

(4) Minimum/Maximum amounts with Coinsurance

(5) Annual Out-Of-Pocket maximums per person and per family

(6) Out-Of-Pocket maximum per Rx

(7) Deductibles on brand name drugs only

(8) Deductibles based on network

(9) Different formularies for different plans

(10) Therapeutic Class "Maximum Allowable Charges"

(11) Therapeutic Copayments/Coinsurance for specific drug classes such as asthma and diabetes

(12) Copayments/Coinsurance based on previous drug trials (e.g., higher co-pay if Claims history does not include trial of first line/preferred drug/drug class);

(13) Copayments/Coinsurance based on place of service (e.g., incentives to use preferred retail pharmacies, Specialty pharmacies, etc.)

(14) Copayments/Coinsurance dependent on Member's behavior (e.g., enrollment or stratification level in a disease management program)

(15) Copayments/Coinsurance on the days supplied (e.g., a mail Claim processed for a thirty (30) day supply)

(16) Administration of a preventative drug list allowing first dollar coverage to products on the list for Members enrolled in a CDHP

(17) As required by Section 2713 of the ACA, provide coverage for the range of recommended preventive services with no cost sharing (such as copayments, deductibles, or Coinsurance) on plan Members receiving these services.

b. At the State’s request, the Contactor shall implement value-based payments on medications where Provider payments are differentiated based on quality, efficacy, and/or patient outcomes (or any combination of these). The Contractor shall not implement such value-oriented payments to pharmacies or manufacturers without prior approval In Writing from the State. Upon implementation of any value-based payments, the Contractor shall report descriptive information and data about its value-oriented payments in sufficient detail to enable the State to adequately monitor the Contractor’s payments. The information that may be requested may include the following:

- The drug name(s), NDC, and full GPI
- Drug manufacturer name
- The total number of prescriptions filled

- The total number of Members filling a prescription for each drug
- The projected financial impact and savings to the plan as a result of the Program.

c. Each fall, no later than November 1, the Contractor shall provide to the State various test results documents of the following Plan Year's benefits set-up in the Contractor's Claims adjudication platform broken down by Generics, preferred brands, non-preferred brands, Specialty Drugs and by 30 (thirty) and 90 (ninety) day supplies. Such test results documents shall also provide State staff with the applicable deductibles and maximum out of pocket amounts by coverage level offered by the State. This exercise is to ensure proper benefit design set up for all Plan options. Additionally, if any benefits are changed by the state mid-year, Contractor staff shall – prior to the benefits going into production in the Contractor's system – provide screenshots and meet with State staff to walk through the benefit change to ensure Contractor's correct setup and understanding of the change(s).

d. The Contractor shall maintain the thirty (30) day and ninety (90) day supply limits for Members as appropriate; however, in certain circumstances where Members are vacationing or traveling for longer periods of time the State – at its sole discretion – may grant a courtesy override depending on the individual circumstances. The Contractor in any such instance shall contact the State to inquire if an extended supply or courtesy vacation override may be approved. In these instances, the Contractor shall make special provision for the Member to pay the applicable cost sharing for the extended vacation override (e.g., multiple Copayments or Coinsurance). Further, the Contractor shall keep detailed records related to such in its POS and financial systems in the event of an audit.

e. The State may request, and the Contractor shall support, an industry and innovation review and planning meeting to occur annually during the Term of this contract. Said meeting(s) shall occur at either the State offices or at the Contractor's offices, with an opportunity for virtual participation as needed, and shall include Contractor executives and key leadership individuals with direct knowledge and influence of the Contractor's corporate vision and direction. Meeting date, agenda, and attendees shall be mutually developed, at a minimum, by the Program director and account executive.

f. The Contractor shall work with the State to implement any State requested point solution offerings the Contractor has available. This could include, but is not limited to, programs for clinical conditions such as insomnia, anxiety, depression or other conditions that may be prevalent in the State's population.

A.11. Compliance

a. The Contractor will be responsible for ensuring that all pharmaceutical benefits and programs offered by the State and administered by the Contractor meet all current and future requirements of the PPACA and shall advise the State on all such benefits and programs, including benefit design, Formulary design and management, Copayment and/or Coinsurance structure, and appeals of all levels. The Administrative Fees in Contract Section C.3 are to include all possible work to ensure that the State and its PBM contractor are compliant with the PPACA.

b. The Contractor shall assist the State in complying with all requirements of the Consolidated Appropriations Act of 2021, and Transparency in Coverage rules including Prescription Drug

Data Collection (RxDC) reporting requirements at no additional cost to the State. The Contractor must provide, at no additional cost to the State, copies of all data that the Contractor provides to CMS each year to meet their portion of the RxDC reporting requirements (e.g., files D3-D8 and the prescription drug portion of the narrative response).

c. The Contractor shall provide the State with a Gag Clause Prohibition Compliance Attestation annually by the federal deadline with the Centers for Medicare and Medicaid Services (CMS) to comply with the Consolidated Appropriations Act of 2021.

d. The Contractor shall ensure that the Plan benefits are delivered in compliance with all state and federal rules and regulations including, but not limited to, Tennessee Public Acts Chapter 1070 as passed during the 112th General Assembly, Tennessee Public Acts Chapter 405 as passed during the 112th General Assembly, and Tennessee Public Acts Chapter 569 as passed during the 112th General Assembly. The Contractor will be responsible for all related costs for complying with these laws including, but not limited to, appeals by pharmacies to the Tennessee Department of Commerce & Insurance associated with PBM claim reimbursement related to Tennessee Public Chapter 1070.

e. Any fines for non-compliance related to services provided by the Contractor under this Contract will be the Contractor's sole responsibility.

f. At the State's request, the Contractor shall prepare and provide a comparative analysis with respect to non-quantitative treatment limitations (and provide any supporting documentation) as required under and consistent with any relevant legislation, in each case, as soon as administratively practicable following the State's request but no later than 14 days thereafter.

A.12. Clinical Programs

a. The Contractor shall employ prescription drug Claims data to enhance:
   (1) DUR
   (2) Clinical management initiatives
   (3) Therapeutic management initiatives; and
   (4) Gaps in care analysis

b. The Contractor's clinical program offering shall at a minimum include the following at no additional cost:
   (1) An evidenced-based approach
   (2) Compliance (adherence) improvement
   (3) Utilization management programs
   (4) Information available via the web
   (5) Outcomes data (savings and Member impact); and
   (6) Custom programs based on the State's specific utilization

c. The Contractor shall provide clinical, utilization management programs specific for Specialty Drugs/self-administered injectable medications. A clinician shall be available, through the Specialty Pharmacy network, to patients taking Specialty Medications twenty-four (24) hours a day, seven (7) days a week.

d. The Contractor shall provide a therapeutic substitution and Generic Drug dispensing program with provisions for written, phone, virtual, and/or face-to-face contact with prescribing

physicians and Members in order to advise them of the potential savings resulting from substituting a costlier drug with a lower cost medically appropriate alternative drug. The Contractor shall report results of the Program to the State on an annual basis, and more frequently as requested by the State. The Contractor shall receive prior approval In Writing from the State prior to implementing Member-targeted activities.

e. The Contractor shall maintain a Generic Drug dispensing rate ("GDR") of 85.0% or higher, including all vaccines.

f. The Contractor shall only communicate with Members about pharmacotherapy alternatives or alternative places of service when a change will save both the Member and State monies (net of Copayments/Coinsurance).

g. Step Therapy:

(1) The Contractor shall administer and maintain a Step Therapy program that promotes the use of the most cost-effective drug therapy for a specific indication, regardless of drug class.

(2) At the State's request, the Contractor shall implement a Step Therapy program targeting specific drugs and/or drug classes at any time during the contract and the Program shall be implemented by the Contractor at no cost to the State.

(3) As each Formulary is re-evaluated and/or expanded, the Contractor shall develop proposed Step Therapy criteria for non-preferred drugs and certain preferred drugs and present those criteria to the State for review and input. The Contractor shall base these recommendations on therapeutic best practices and drive utilization to the most cost-effective agents or classes.

(4) The Contractor shall describe the drugs and the criteria included in the Step Therapy program on all Formulary documents. The Contractor shall code these criteria into the POS system such that the system shall have an edit on all drugs in the target classes that Pharmacy Providers submit for dispensing. Before the new drug may gain approval through a PA, the Contractor shall review the Claims history of prior use of a more cost-effective drug and approve the PA only if such evidence is present.

h. Prior Authorization (PA):

(1) The Contractor shall disclose and share, In Writing, all PA criteria and procedures and decision trees applicable to the State during plan implementation and within two (2) Business Days of written request from the State at any time during the Term of the Contract at no additional charge.

(2) The Contractor's POS system shall determine whether a prescribed drug requires PA and if so, ensure that the Member received the necessary approval prior to authorizing the transaction and permitting reimbursement. All PA services shall be provided at no additional cost to the State.

(3) By the go-live date the Contractor shall offer to prescribing physicians an online PA portal whereby the physician can go online to initiate a PA request via secure medium. Providing this information strictly via telephone or customer service record ("CSR") does not exempt the Contractor from this requirement.

(4) The Contractor shall ensure that PA staff evaluates ninety-nine percent (99%) of PA requests and notifies the prescribing physician and issues a determination within twenty-four (24) hours, In Writing. The Contractor shall implement an agreed upon set of edits and PA criteria on the go-live date. Additional PA edits may be implemented at the State's direction at any point without additional cost to the State.

(5) The Contractor shall submit a quarterly PA performance report, as requested by the State, which includes PA statistics including, but not limited to, the number of PAs submitted, by drug (at the NDC-11 level), the number approved and denied by drug, the number of PAs denied that went to appeal by drug, the cost of alternative medications filled by drug, the number of Members who abandoned therapy after denial and who did not fill any alternative medications (i.e., walkways) by drug, and the net savings of each program by drug (provided in both dollars and as a PMPM).

(6) The State, or its qualified auditor selected in the sole opinion of the State, shall have the ability at any time to do clinical auditing of Specialty Claims approved by the Contractor for filling and payment. The State, or its qualified auditor, will be auditing to verify that the Contractor is following the specific criteria of each PA program, such that documentation such as medical records or chart notes are provided and align with PA decisions, as required in each PA program, respectively. Evidence based PA criteria are needed and must be adhered to when approving Specialty Drug Claims for filling and payment.

(7) The Contractor shall not provide a PA override which, in effect, freezes a Member into a set, specific Copayment or Coinsurance amount in perpetuity. All drugs are always subject to the then-in-effect Copayment or Coinsurance for a particular Plan Year.

i. Prior to implementing any program or service for which the Contractor receives external funding, the Contractor shall disclose the details of such program and such sources of external funding to the State. The State shall have the authority to opt-out of any such program that the State determines is not in the best interest of its Members.

j. At the State's request, the Contractor shall support the State's efforts to develop a MTM program. Such assistance shall include providing requested Member Pharmacy data, communicating with and educating participating network pharmacies, and assisting in the identification of Members who should receive MTM services.

k. At the State's request, the Contractor shall implement an opioid management program that is no less strict than the current CDC-recommendations https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf (with PA requests that may allow a higher MME per day, as approved by the State, if appropriately documented by a Provider). Any program targeting opioids or opioid management must comport with Tennessee law at all times during the Term.

l. The Contractor shall provide case management services to plan participants who fill Specialty Medications through the Contractor's own Specialty Pharmacy. This shall include identifying and outreaching to Members with conditions such as cancer, rheumatoid arthritis, Hepatitis C, Multiple Sclerosis, and Hemophilia (conditions listed here are examples only and not an all-inclusive list). Registered pharmacists shall work with the Member, health care Providers, primary caregivers and the state's contracted medical vendors to coordinate the most appropriate, cost-effective site of care and place-of-fill for Specialty Medications.

m. At the State's request, the Contractor shall implement a program for poly-chronic patients taking multiple medications and will contact these Members to assist them with their medication use and enroll them in programs or engage them in other methods that may encourage use of different medications or strengths of existing medications in order to lower Member and plan cost and improve Member medication utilization.

n. The Contractor will, upon request, provide a complete list of all currently available clinical programs to the State and the Contractor will maintain an inventory of the clinical programs the State has both selected and not selected. When there is a change (addition, deletion, or other Program change) to the list of the Contractor's available clinical programs, the Contractor will present the opportunity or change to the State within ten (10) Business Days of availability and will provide the State with an updated clinical program list and the State's selection inventory at the same time. The State may "opt-out" of any clinical program and will make all final determinations regarding participation in any clinical programs.

o. The Contractor will proactively provide the complete clinical program list and the State's selection inventory to the State at least once every six (6) months and within two (2) Business Days of receipt of written request from the State.

p. The Contractor agrees that the State, at the State's sole discretion, may utilize third party services for Prior Authorization and utilization management for Specialty Drugs and/or non-Specialty Drugs without objection, charge, or penalty if the State chooses to exercise this right. The Contractor will also, at no charge and as directed by the State, provide support needed by such third party or parties to perform its services including, but not limited to, exchanging needed claims, accumulator, and eligibility data; redirecting prescriber, member, drug manufacturer, and/or pharmacy inquiries related to such services to the applicable entity; and providing needed access to PBM Claims and/or Prior Authorization override systems allowing such third party or parties to enter Prior Authorization and other claims reject overrides and quantity limits, run test claims, confirm member eligibility in real-time, look up claims history in real-time, and look up state-specific drug coverage status in real-time.

A.13. Prospective/Concurrent DUR

a. The Contractor shall furnish a fully automated prospective/concurrent DUR system that meets all applicable state and federal requirements. The DUR function shall meet minimum federal DUR regulations as well as the additional specifications in this section and Contract Section A.12. as well as being flexible enough to accommodate any future changes required by the State. The Contractor shall recommend to the State, annually at review meetings, new DUR edits that improve quality and reduce Pharmacy Program costs.

b. Prior to authorizing Claims and permitting reimbursement, the Contractor's system shall provide DUR services that apply State-approved edits to all Claims. The edits shall provide clinically appropriate information described in Contract Section A.13.c. to the dispensing pharmacist.

c. The Contractor's POS system shall apply the results of DUR processing in the Claim adjudication process. Claims that reject as a result of DUR processing shall include situation specific messaging and error codes that enable the Pharmacy Provider to take appropriate actions. The Contractor may use an existing DUR package which meets all applicable state and federal requirements. The Contractor's system shall include the following minimum DUR features at installation:

(1) Potential Drug Problems Identification - The Contractor's system shall perform automated DUR functions. The system shall automatically identify and report issues to the Pharmacy Provider including, but not limited to:

i. Problems that involve potential drug overutilization
ii. Problems that involve therapeutic duplication of drugs when the submitted Claim is associated with other drugs or historical Claims identified for a given Member
iii. Problems that involve drug use contraindicated by age, gender and presumed diagnosis codes on historical Claims for a given Member
iv. Problems that involve drug use contraindicated by other drugs on current or historical Claims for a given Member (drug-to-drug interactions)
v. The level of severity of drug-to-drug interactions
vi. Potentially incorrect drug dosages or a change to the quantity per prescription to ensure the most cost-effective strength is dispensed
vii. Potentially incorrect drug treatments
viii. Insufficient or excessive drug usage
ix. Potential drug abuse and/or misuse based on a given Member's prior use of the same or related drugs; and
x. Early refill conditions and provide, at the drug code level, the ability to deny these Claims. The Contractor shall customize refill-too-soon edits.

(2) POS Pharmacy Provider Cancel or Override Response to DUR Messages – Prior to the final submission of POS Pharmacy Claims, the Contractor's system shall automatically generate DUR messages in a manner that shall enable a Pharmacy Provider to cancel submission of the Claim or to submit it if it is a message that can be overridden by the Pharmacy. Providers are individually responsible for acting or not acting upon information generated and transmitted through the DUR Services, and for performing services in each jurisdiction consistent with the scope of their licenses. The DUR services are necessarily limited by the amount, type and accuracy of Member information made available to the Contractor.

(3) Flexible Parameters for Generation of DUR Messages - The Contractor's system shall have the ability to transmit new or revised DUR messages and to define the DUR criteria that activate these messages.

(4) DUR Member Profile Records - The Contractor's system shall provide and maintain Member profiles for DUR processing of submitted Claims. The Contractor shall base Member profiles on presumed diagnoses from Pharmacy Claims and other data available.

(5) Disease/Drug Therapy Issues Screening - The DUR system shall have the capability to screen for drug therapy concerns by specific drugs relative to high-risk diseases including, but not limited to, cardiovascular disease; diabetes; psychiatric disease; and respiratory disease.

(6) Patient Counseling Support - The Contractor's system shall present DUR results to Pharmacy providers in a format that supports the ability to advise and counsel Members appropriately.

A.14. Retrospective DUR (Retro-DUR)

a. The Contractor shall provide a Retro-DUR program supported by licensed clinical pharmacists. The Contractor shall develop, maintain and update a set of evidence-based clinical criteria, which the Contractor shall use to detect potential problems such as polypharmacy and related over-utilization, underutilization, drug-to-drug interactions,

therapeutic duplications, incorrect drug dosage and duration of treatment, possible fraud and abuse issues, and other instances of inappropriate drug therapy as may also be related to a Member's age or disease state. The Contractor's Retro-DUR system shall:

(1) Provide Provider practice analyses that includes identification of key performance indicators such as Generic Drug dispensing rate, controlled substance prescribing rates, Formulary compliance, etc.

(2) Trend Providers' prescribing habits and identify those who practice outside of their peers' norm

(3) Identify patients who may be abusing resources through poly-pharmacy utilization patterns or visiting multiple Providers

(4) Identify patients with excessive use of controlled substances or other highly abused medications

(5) Produce reports that detail patient and prescriber trends and that identify potential quality of care problems and/or potential fraud and abuse; and

(6) Have in place an intervention process and a system for tracking prescriber response to the interventions.

b. The Contractor shall utilize evidence-based clinical criteria to conduct quarterly prescriber and Member profile reviews. The Contractor shall set the number of Member and prescriber profile reviews, with approval In Writing by the State, to be conducted quarterly. The Contractor will notify the State In Writing of the focus of, and methodology to be used in, the profile reviews at least thirty (30) calendar days prior to the initial review start date.

c. The Contractor shall complete quarterly prescriber and Member profile reviews and distribute results/interventions, as recommended by the clinical pharmacist, to prescribers within ninety (90) calendar days of the end of the quarter. The Contractor shall implement interventions designed to address problems identified during profile reviews. These interventions may include mailings, phone calls, virtual interactions, or face-to-face visits. Other interactions may occur after receiving approval from the State. Communications shall consist of an intervention letter to the prescriber and/or Pharmacy Provider detailing the reason for the letter, the purpose of the intervention and providing educational information. Member profile(s) illustrating the potential problem and suggesting corrective action may also be included. The State will approve any summaries, correspondence or other documents produced as a result of the review process prior to their distribution.

d. The Contractor shall maintain a system capable of tracking all interventions and determining cost savings related to the specific interventions.

e. DUR and Retro-DUR Reporting

(1) The Contractor shall have a qualified DUR clinical pharmacist, designated to the Plan, prepare presentations and attend meetings with the State to present DUR and Retro-DUR data, findings, utilization, and recommendations for improvement. Such presentations shall occur up to four (4) times annually, as requested by the State. The Contractor shall present, at a minimum, the following reports/information for each of the State sponsored plans, which shall convey rolling twelve (12) month trends:

i. Utilizing-Members data

ii. Utilization by age demographics

iii. Utilization by top twenty (20) therapeutic classes determined both by number of Claims and by payment amount

iv. Top twenty (20) drugs as ranked by Claim count and by total payment

v. DUR data including totals of DUR messages sent and savings associated with the top twenty (20) drugs associated with each DUR edit

vi. Retro-DUR reviews, summary of the interventions and estimated cost savings information as associated with both Member and Provider profile review and interventions

vii. Distribution of Clinical Alerts as prepared monthly by the Contractor's Clinical Management staff; and

viii. Any additional reports included in the Contractor's standard DUR reporting package.

(2) The Contractor shall, upon request of the State, report quarterly the outcomes of the Retro-DUR initiatives. The Contractor's system shall track the impact of DUR initiatives by comparing specified data elements pre- and post-intervention. At the State's request, the data elements tracked will vary according to the focus of study and/or type of intervention employed and may include, but shall not be limited to:

i. Drug change within a sixty (60) or ninety (90) day period of the intervention, or within another time period as otherwise directed by the State

ii. Total number of drugs pre- and post-intervention

iii. Change in dose/dosing frequency of medication within a sixty (60) or ninety (90) day period of intervention or within another time period as otherwise directed by the State

iv. Daily dose of drug in question pre and post intervention

v. Assessment of various interactions (as relevant to the activity) pre- and post-intervention which may include drug-to-drug interactions (e.g., number of drugs identified and severity index), pregnancy interactions, disease state interactions, therapeutic duplications, allergy interactions, and age-related medication problems

vi. Compliance with national guidelines (e.g., percentage of patients with CHF on beta-blocker, diuretic, etc.) depending on the disease state targeted by the Retro-DUR initiative

vii. Generic Drug medication utilization

viii. Emergency supply frequency

ix. Formulary compliance; and

x. Patient adherence as defined by medication possession ratio.

A.15. Financials

a. Other than those addressed in this Contract, the Contractor shall not collect any additional fees, premiums, or revenue from the State of Tennessee.

b. Baseline Pricing Measure:

(1) The Contractor shall guarantee the mutually agreed upon baseline pricing measure (i.e., AWP, NADAC, WAC, or other) used to price Claims will be the one associated with the actual NDC or NDC-11 for the product on the date dispensed and the actual package size from which the product was dispensed at a participating Pharmacy, Mail Order Service Pharmacy, and Specialty Pharmacy. The Contractor shall communicate any exceptions to this rule (e.g., Compound Prescriptions, etc.) to the State In Writing and such exceptions are subject to approval by the State.

(2) If using various sources to price Claims, the Contractor shall use the version of the baseline pricing measure (per the terms of this Section) that provides the lowest price available.

(3) If the Contractor supports an AWP-based pricing strategy:

i. For Claims processed at Participating Pharmacies that do not qualify as a Low Volume Pharmacy: The Contractor shall use the post-settlement AWP for this Contract's pricing terms.

ii. For Claims processed at Participating Pharmacies that do qualify as a Low Volume Pharmacy: The Contractor shall use NADAC for this Contract's pricing terms.
   a) In the event that Covered Drugs lack a reported NADAC value as of the date the Claims for such Covered Drugs are adjudicated, such Claims will adjudicate with an Ingredient Cost consistent with the network applicable to Participating Pharmacies not qualifying as a Low Volume Pharmacy

(4) If the Contractor does not support an AWP-based pricing strategy:
   i. The Contractor shall use NADAC as the basis for this Contract's pricing terms for all Claims.
      a) In the event that Covered Drugs lack a reported NADAC value as of the date the Claims for such Covered Drugs are adjudicated, such Claims will default to the PBM's standard adjudication logic.

(5) The Contractor shall guarantee that in the event there are changes in the marketplace to the baseline measure used for the Ingredient Costs of drugs (i.e., post-settlement AWP, NADAC, WAC, or other) the Contractor shall adjust accordingly to provide an equivalent price. The Contractor shall provide notice to the State and the conversion shall be agreed upon In Writing before any changes are made.

In the event of substantial changes in the marketplace that are outside of the Contractor's control which impact the pricing components of this agreement, the Contractor may request approval from the State to make adjustments to their pricing and guarantees. Such adjustments must be prior approved In Writing by the State and must result in cost neutrality or cost savings to the State, as compared to the terms that were in place prior to the adjustments going into effect. The Contractor must provide the State and/or its consulting actuary NDC-11 level information to analyze the request and its impact prior to its implementation and to ensure that the result is cost neutral or provides cost savings to the State. The State may deny any such requests and all decisions of the State are final.

For avoidance of doubt, known launches of biosimilars and Authorized Generics for brand-name reference products that occur before and throughout the term of the Contract (and beyond), known market events in the respiratory category, and insulin price reductions and related insulin market changes are expected to occur before or during the term of the Contract, including but not limited to price reductions and maximum price caps (AMP cap). The Contractor agrees these known market events will not constitute "Unexpected industry changes, limited to: Unexpected Generic Drug introductions, unexpected OTC introductions, unexpected FDA recalls or market withdrawals or unexpected launches of Biosimilars," i.e., will not constitute a Material Change. If the State either directs or approves a change in Biosimilar strategy, respiratory strategy, or insulin strategy during the Contract term, the Contractor agrees

that any adjustments made to Rebate Guarantees shall be either economically neutral or favorable to the State. A change in Biosimilar strategy will not result in adjustment to Rebate Guarantees in any other distribution channel besides Specialty. A change in insulin strategy will not result in an adjustment to Rebate Guarantees in any other distribution channels besides Retail-30 and Retail-90, and Mail. Furthermore, the Contractor shall provide the State with NDC-11 level information to ensure economically neutral or favorable adjustments are made to the Rebate Guarantee.

Except as explicitly set forth in the definition of Material Change, pricing and financial guarantees will only change with the explicit written approval of the State. Should there be an event of Material Change, the Contractor shall provide the request to the State along with the reason for the change, a State-specific analysis of the financial impact and any Member impact. The State will have forty-five (45) calendar days to review and determine if the change is reasonably acceptable. If the State, in good faith, determines that the change is not reasonably acceptable, except as required by law, it will not occur during the term of the Agreement. For the avoidance of doubt, changes in AWP inflation rates, differences between underwriting projections and actual performance (other than covered in above items), drug mix shifts due to any dynamics other than those listed above, and pharmaceutical manufacturer merger and acquisition activity shall not constitute a Material Change.

(6) The Contractor shall apply a MAC List at Mail Order pharmacies and at Retail-90 network pharmacies for Generic Drug medications. The list will have prices equivalent to or lower than the MAC List prices applied to retail Claims and effective MAC Discounts are required to be more aggressive than effective non-MAC AWP Discounts. The Contractor shall use the same MAC List for network Pharmacies (Retail-30, Retail-90, Specialty and Mail Order) and shall, upon the State's request, provide the most current MAC List to the State on a quarterly basis and as requested by the State in a spreadsheet format. The Contractor will employ your most aggressive (i.e., highest discount) MAC list prices which must include a minimum of 95% of all Generic Drugs. In addition, the MAC List pricing schedule at Mail Order and Retail-90 (including Specialty Drugs) will include the same or more favorable pricing (lower per unit prices) than at Retail-30 for every MAC drug. The Contractor's MAC pricing schedule at Mail Order and Retail-90 will include a comparable list of low-cost Generic Drugs included in retail Generic Drug fixed price programs at competitive pricing. In all cases when a Member moves from the retail channel to the mail channel, the Member will NOT be charged more unless there has been a manufacturer price increase or the Retail Pharmacy's Usual & Customary charge was the Member's previous charge. Products will be added to the MAC list no later than twenty-one (21) days after the products become available.

(7) The Contractor shall utilize a brand/Generic Drug indicator based on data elements available from only one nationally recognized source such as Medi-Span, etc. unless a change in the indicator will lower the price for the State or the State agrees that the change is acceptable.

(8) The Contractor shall apply 'lowest-of-pricing' logic at retail, Mail Order, 90-Day-At-Retail, and Specialty Pharmacies, which means that the plan and plan Members will pay the lesser of (i) Copayment/Coinsurance, (ii) Ingredient Cost as defined in this section or MAC, plus Dispensing Fee or (iii) U & C. In no event will the Member or plan cost share be greater than the contracted cost. The State will not be billed for any Zero Balance Due Claims.

(9) The Contractor shall not charge a minimum Copayment/Coinsurance for any Mail Order, Retail-30, 90-Day-At-Retail, or Specialty Pharmacy Claims.

c. Prescriptions dispensed from Mail Order must be priced according to the baseline pricing measure, per the terms of Section A.15, and receive Mail Order Rebate Guarantees, regardless of the day-supply dispensed.

d. The Contractor shall adhere to the discount guarantees, Dispensing Fee guarantees, and any associated requirements for each listed in contract Section C.3.

e. All brand specialty Claims, regardless of where filled, shall be included in the same specialty Manufacturer Payment Guarantees and specialty network discount guarantees listed in Contract Section C.3.b.

A.16. Pharmacy Manufacturer Payments

a. The Contractor shall adhere to the additional requirements related to Pharmacy Manufacturer Payments listed in Contract Section C.3.

b. The Contractor, or any other entity that negotiates and collects Manufacturer Payments allocable to the State shall pass the full value of all Rebates properly allocated to the State via check. All payments shall also be accompanied by a spreadsheet allocating the amount by each of the six (6) state funds: Fund 55000 (State Actives), Fund 56000 (Local Education Actives), Fund 58000 (Local Government Actives), Fund 51010 (State Retirees), Fund 52000 (Local Education Retirees) or Fund 53000 (Local Government Retirees). For Rebate payments, the amount must be further broken down by the calendar quarter(s) for which the check amount(s) are attributable. The Contractor shall not enter into any agreement with a Pharmaceutical Manufacturer for Rebates with the impact to reduce or otherwise circumvent monies received from Pharmaceutical Manufacturers as being considered Rebates. Further, the Contractor will not require the State to enroll in programs, other than standard formulary participation without any exclusions (beyond those exclusions identified in the State's plan documents or as otherwise as agreed to In Writing by the State), to receive Manufacturer Payments.

c. The Contractor, or any third party that negotiates and collects Manufacturer Payment allocable to the State, shall provide, with each Pharmacy Manufacturer Payment remitted to the State, an Excel spreadsheet showing the amount of the payment broken down by the groups (State Actives, State Retirees, Local Education Actives, Local Education Retirees, Local Government Actives, and Local Government Retirees) that comprise the total payment amount, as well as the calendar quarter that the various Manufacturer Payment amounts are attributable to, at the NDC-11 level.

d. The State shall have the ability at any time to exclude or block from coverage one or more drugs for any reason. If such changes result in a material impact to the Contractor's ability to meet the applicable Rebate Guarantee, Contractor shall notify the State within thirty (30) calendar days of the State's requested change. Any changes the State then decides to pursue may result in a Contract amendment.

e. Contractor shall pay the State no less than the minimum Rebate Guarantees. The Contractor shall also pay to the State any additional Rebate yield, above the guarantees, thereby resulting in 100% of Manufacturer Payments being passed to the State.

f. Contractor shall only exclude the following Claims from the calculation of Manufacturer Payment Guarantee; however, if Contractor does in fact receive Manufacturer Payments on any of these products or Claims, they will be passed back to Participating Groups in their entirety: Subrogation Claims; COVID Vaccine and Vaccine Administration Fee Claims, authorized and approved COVID treatment Claims and other COVID testing-related Claims; 340B Claims; COB Claims; Vaccine Claims; Paper Claims; and Compounds.

g. For Specialty Drugs, Rebates and Manufacturer Payments shall be based on 30 day supply adjusted Claim count. Manufacturer Payment guarantees shall take into consideration anticipated movement of Brand Drugs to Generic Drugs throughout the term of the Contract.

h. If the State chooses to implement POS Rebates for any or all plan options, the Contractor will administer Rebates at the POS at the NDC-11 level within sixty (60) calendar days' notice by the State.

i. The value of Pharmaceutical Manufacturer coupons or the value of any and all other patient assistance programs cannot be considered manufacturer revenue or Manufacturer Payments and shall neither count toward the calculation nor reconciliation of Manufacturer Payments and Manufacturer Payment Guarantees.

j. Contractor shall invoice Pharmaceutical Manufacturers for all Manufacturer Payments attributable to State Member utilization that the State is qualified to earn pursuant to the State's benefit design and the Contractor's contracts with Pharmaceutical Manufacturers, collect the associated Manufacturer Payment funds, and remit them to the State. If a bona fide dispute exists as to the eligibility of a Claim to earn a Manufacturer Payment, the Contractor is authorized to negotiate a commercially reasonable settlement with a manufacturer to resolve the dispute, provided that the Contractor negotiates such settlement in good faith, with recognition of the State's interest in maximizing Manufacturer Payment collection.

A.17. Market Check Provision

a. The Contractor shall provide most favored nation ("MFN") terms wherein it shall not provide any similar account more favorable pricing terms than that provided to the State. If there are changes to any of the MFN measurement components or methodology and those changes are reasonably designed to achieve greater comparability under this provision, the State will approve In Writing before those changes are implemented. The Contractor must agree to an annual market check, if requested by the State, to compare the aggregate value of financial terms of the Contract (including but not limited to discount guarantees, Rebates, Administrative Fees, Dispensing Fees). There shall not be a minimum threshold of savings as a result of the market check in order for the Contractor to offer better pricing to the State. If the market check indicates that at least one comparator group has more favorable pricing terms than the State in aggregate, the parties shall negotiate to reach mutual agreement on revised pricing terms and other applicable pricing provisions. The Contractor shall implement mutually agreed upon improved pricing for the State by, at a minimum, the identified difference in value no later than January 1 of the next Plan Year. If the market check indicates no pricing adjustments are needed, the contract pricing will continue until a new market check warrants a change. The market check will focus on comparable arrangements in the marketplace, including but not limited to aggregate value of the Discounts, minimum Rebates, Dispensing Fees, and Administration Fee pricing terms, for the purpose of recommending adjustments necessary to restore and maintain competitive advantage. The State's benefits consultant and actuarial consulting firm will determine similar employer

groups for size and benefit structure to serve as comparison(s). The State's contracted benefits and actuarial consulting firm shall complete the market check with the full cooperation of the PBM Contractor. There shall not be a minimum threshold of savings as a result of the market check in order for the Contractor to offer better pricing to the State.

A.18. State Technical Requirements

a. To maintain the privacy of PHI, the Contractor shall enable Transport Layer Security (TLS) on the mail server used for daily communications (i.e., email) between the State and the Contractor. TLS shall be enabled no later than one month after the Contract Effective Date and shall remain in effect throughout the Term.

b. The Contractor shall establish and maintain an electronic data interface with the State's Edison System for the purpose of retrieving and processing Member enrollment information. The Contractor shall be responsible for providing and installing the hardware and software necessary for the interface. When the Contractor requires the exchange of PHI with the State, the State requires the use of second level authentication. Second level authentication is accomplished using the State's standard software product, which supports Public Key Infrastructure. The Contractor shall design a solution and submit to the State In Writing how their design meets the requirements of this Contract using industry standard software that can transmit files in a secure fashion. The initial implementation phase of this solution and the final production solution will differ in the method of authentication. The requirement for this solution is that all files that are transmitted will be encrypted, and the method of transmission will also be encrypted. Decryption of the files that are downloaded from this solution will not be decrypted until they are securely stored within the Contractor's environment. Additionally, federal standards require encryption of all electronic protected health data at rest as well as during transmission. The State uses public key encryption with Advanced Encryption Standard to encrypt PHI. If the State plans to adopt a different or additional encryption standard or tool in the future, the State will notify the Contractor and the Contractor shall comply. The Contractor shall establish and maintain the security of all confidential state data according to all applicable state and federal standards within thirty (30) days of the State's use of the new or additional encryption standard or tool. Refer also to Attachment B, Liquidated Damages.

c. Notwithstanding the requirement to maintain enrollment data, the Contractor shall not perform changes to enrollment data without the State's approval In Writing. This prohibition shall include, but not necessarily be limited to initiation, termination, and/or changes of coverage. Contractor shall make changes to the enrollment file on a manual basis if requested by the State on an as-needed basis. Contractor shall not ask State to re-issue another file with the changes included.

d. At least two (2) months prior to Go-Live, the Contractor shall load, test, and verify the test enrollment file from the State.

e. At least one (1) month prior to Go-Live, the Contractor shall load, verify and make available online the State's production enrollment file for use (refer also to Contract Attachment B, Liquidated Damages). The Contractor shall certify, In Writing, to the State that the Contractor understands and can fully accept and utilize the enrollment files as provided by the State, in the format provided by the State, with no modifications.

f. Contractor will receive enrollment files daily from the State and shall provide Pharmacy services only to Members. The Contractor shall confirm eligibility of each Member based on

enrollment information provided by the State, which applies to the period during which the charges were incurred.

A.19 Data and Information Technology

a. The Contractor shall maintain, in its computer system, in-force enrollment records of all Members. Specifically, the Contractor shall perform the following tasks:

(1) Daily Enrollment Update: To ensure that Members' enrollment records remain accurate and complete, the Contractor shall retrieve, via secure medium, (see Contract Section A.18.f), daily enrollment data electronic transfer files from the State, in the State's Edison 834 file format which may be revised. Files will include full population records for all Members and will be in the format of ANSI ASC X12N, Benefit Enrollment and Maintenance 834 (5010), version 005010X220A1, with several fields customized by the State. Change files will not be sent. Files will include full population records for all Members. Contractor understands and agrees that daily enrollment files will be provided to the Contractor by the State, and the Contractor shall make manual changes to the enrollment file (e.g., a request may come across from the State if a data element is preventing the file from loading in the Contractor's system.) Contractor shall make all manual changes requested by the State, and the State will not reissue another enrollment file. The Contractor shall contact the State eligibility team anytime there are three hundred (300) or more terms or drop-offs before the daily enrollment file is loaded.

(2) The Contractor and/or its subcontractors, as applicable, shall post ninety-eight percent (98%) of electronically transmitted enrollment updates within one (1) Business Day of receipt of the daily file and one hundred percent (100%) shall be posted within two (2) Business Days of receipt of the daily file.

(3) The Contractor shall submit to the State a daily enrollment file error report, in a format agreed upon by the State, within two (2) Business Days of receipt of the daily file, which shall contain (a) only errors that require correction and (b) an indication of the correction required to resolve the error (also refer to Contract Attachment C).

(4) The Contractor and/or its subcontractors, as applicable, shall resolve all discrepancies identified by the processing of the enrollment file within two (2) Business Days of identification.

b. The Contractor shall add new groups to all systems within three (3) Business Days of receipt of necessary documents. The Contractor and/or its subcontractors, with collaboration from the State, shall resolve associated system errors, as identified through enrollment discrepancy resolution, in a timeframe required by the State.

c. State Enrollment System Data Verification: Upon request by the State, not to exceed two (2) times annually, the Contractor shall submit to the State, in a secure manner, its full file of State Members, by which the State may conduct a data verification against the State's Edison database. The purpose of this data verification will be to determine the extent to which the Contractor is maintaining its database of State Members. The State will communicate results of this verification to the Contractor, including any Contractor requirements, and associated timeframes, for resolving the discrepancies identified.

d. Decision Support System

(1) Contractor shall provide the State's DSS contractor with all the State's Claim data, data layouts, and data dictionaries in a timely manner and in the formats, layouts and specifications, including GPI and GCN for all prescription drug Claims, as specified by the DSS contractor and approved by the State. Unless otherwise directed by the State, all Claims data provided to the DSS contractor shall include the individual social security number along with all other agreed upon data.

(2) Contractor shall submit complete and accurate data to the State's DSS contractor by the tenth (10^{th}) day after the end of each month. Complete and accurate data is defined to be data that:

i. Contains records for all activity (e.g., Pharmacy Claims data, Program participation) within the specified time periods

ii. Has the same format and content as the agreed-upon record layout and data dictionary

iii. Does not have unreported changes in either format or content; and

iv. Is submitted in a single record format.

(3) Contractor shall provide the data files at no charge to the State or the State's DSS contractor.

(4) If Contractor's Contract with the State is terminated, Contractor shall continue to provide run-out Pharmacy Claims data to the State's DSS contractor until the end of the agreed-upon run-out period.

(5) Contractor shall provide the data without any restrictions on its use.

(6) Contractor shall ensure that production data matches the test data in format, layout, and content.

(7) Contractor shall update valid values and maps in a timely manner and notify the State's DSS contractor of any such updates at least ten (10) Business Days before the scheduled data submission date.

(8) For each quarter, Claims data shall meet the quality standards measured and reported by the State's DSS contractor on either a monthly or quarterly basis. The Contractor's data submission to the DSS contractor shall meet the following measures:

i. Date of birth: Data missing for ≤ 3% of Claims

ii. Pharmacy Provider ID missing: Data missing for ≤ 1.5% of Claims; and

iii. NDC or NDC 11 missing: Data missing for ≤ 1.5% of Claims

(9) All Claims data shared with the DSS contractor shall include all payment sources and amounts such that the total Claim nets out to zero after the Member Cost Share and plan cost share. This shall include any third-party payments, and any adjustments to the Contractor's file to include all relevant fields shall be at the Contractor's expense.

e. The Contractor shall provide transmittal of Pharmacy data via secure medium to any of BA's contractors including the TPAs, health management contractor(s), Behavioral Health/EAP contractor(s) or any other contractor or State fiduciary as identified by the State. Unless otherwise directed by the State, the Contractor shall provide, at no additional charge, data feeds of Pharmacy accumulator data to the third parties during the Term and following the Term until all Claims incurred during the Term have been paid. Transmission of accumulator data feeds shall be in a manner, format, and frequency specified by the State, preferably in near real time and by individual. The Contractor shall be required to receive accumulator data files from the State's TPAs to accurately maintain in near real time medical and Pharmacy individual and family deductibles and maximum out of pocket costs. Contractor shall be expected to receive and send data and work with the State and its other contractors on a regular basis to this end. If at any time a deficiency or miscalculation exists either between the Contractor and one or more of the state's TPAs, the Pharmacy Contractor must work with the TPAs to make the corrections necessary to the transmitted files in order to correct all deficiencies within ten (10) Business Days, unless otherwise approved by the State. In these instances, the State does not revise its enrollment file. If directed by the State, Contractor shall provide out-of-network accumulator Pharmacy data in a manner, frequency, and format specified by the State via secure email to one or more of the State's TPAs. See Contract Attachment C for specific report requirements.

f. The Contractor shall load all current PAs and overrides (Mail Order, specialty and retail) that exist for current Members from all existing PBMs no later than thirty (30) calendar days prior to the go-live date. Open refills shall be loaded 12 calendar days prior to the go-live date.

g. At the State's request, the Contractor shall accept at least one (1) year of historical data from the State's previous PBM contractor. This includes, but is not limited to, Pharmacy Claims history, Provider data, recipient data, preferred drug list, PAs, refills, lock-in and reference data. If requested, the data will be used to transfer prescriptions to the Contractor's Mail Order and Specialty Pharmacy. The Contractor shall also share at least one (1) year of historical data with the State's new PBM at the Term of this contract.

f. The Contractor shall store Claims data online for a minimum of twenty-four (24) months after the Claim has been adjudicated.

g. The Contractor shall agree to transfer to the State, within sixty (60) days of notice of Contract termination, all required data and records necessary to administer the plan(s)/Program(s), subject to state and federal confidentiality considerations. The transfer may be made electronically via secure medium, in a file format as specified by the State.

A.20. Provider Education

a. At the State's request, the Contractor shall develop and implement educational programs and notification processes for the Plan prescriber and Pharmacy Provider community. The Contractor shall design these programs and processes with the goal of improving awareness of Plan Pharmacy program policies and procedures and increasing Formulary compliance rates. Educational initiatives shall include, but not be limited to Pharmacy Provider and prescriber letters, Formulary distribution, POS messaging, training sessions, website postings of the Formulary and other educational materials. The Contractor shall implement agreed upon communication strategies through direct involvement with prescribers and Pharmacy Providers via a combination of site visits, telephone support, Internet-based application, and direct mail.

b. Educational topics may include PA criteria and processes; how to access and use the Formulary; POS edits; Step Therapy criteria and processes; quantity level limits; and Specialty Medication processes.

c. The Contractor shall ensure that all prescribers and Pharmacy Providers have timely and complete information about all drugs on the Plan Formulary. The Contractor shall make such information available through written materials, Internet sites, and electronic personal data assistants ("PDA").

d. The Contractor shall develop and produce letters and other Program materials to be shared with prescribers and Pharmacy Providers. Such materials shall contain information related to the operation of the Plan Pharmacy Program. The Contractor shall prepare and maintain a document suitable for printing or posting to the Contractor-managed Splash Page. The Contractor shall obtain prior approval In Writing from the State for all materials.

e. The Contractor shall distribute all PA call center toll-free telephone numbers, facsimile numbers, web addresses and e-mail addresses, as well as the appropriate mailing address for PA requests, at all prescriber and Pharmacy Provider training sessions and education programs.

f. If requested by the State, the Contractor shall offer recommendations to the State regarding Provider education at the beginning of the calendar year.

A.21. Appeals

a. The Contractor shall maintain a formal three (3) level grievance procedure, by which Members and Providers may appeal decisions and disputes regarding Pharmacy administration and Pharmacy benefit coverage. This process must include at the third level an independent review organization ("IRO") as required by the PPACA. The Contractor shall comply with the appeals provisions set forth in the State's Plan Document. Certain Pharmacy issues are not appealable including, but not limited to, Copayment/Coinsurance amounts, Formulary decisions, and network coverage.

b. At least thirty (30) days prior to the go-live date, the Contractor shall provide to the State information describing in detail the Contractor's grievance procedures. The State reserves the right to review the procedure and make recommendations, where appropriate.

c. The Contractor shall decide Pre-Service Appeals within fifteen (15) calendar days and Post-Service Appeals within thirty (30) calendar days. Ninety-nine percent (99%) of Pre-Service Appeals shall be decided within fifteen (15) calendar days and ninety-nine percent (99%) of Post-Service Appeals within thirty (30) calendar days from receipt of appeal. The Contractor shall offer an expedited appeals process. If a denial of coverage or authorization can reasonably be expected to prevent a covered individual from obtaining urgently needed medications, then a request for an expedited consideration may be submitted by the Member, their duly authorized representative or treating physician. The Contractor shall respond to ninety-eight percent (98%) of expedited (urgent) appeals within seventy-two (72) hours. An appeal may come in the form of a PA request from the prescriber in which case the Contractor will render an approval and PA number and length of time the authorization is approved or a denial on the PA request. All costs and charges associated with appeals at all levels shall be included in the monthly Administrative Fees that the State will self-bill and pay to the Contractor each month. The State shall not be invoiced for any appeals-related charges.

d. The Contractor shall include notification of a Member's right to appeal in any Member communications regarding Pharmacy benefit coverage decisions.

e. The Contractor shall respond to all inquiries In Writing from the State within one (1) week after receipt of said inquiry. In cases where additional information to answer the State's inquiry is required, the Contractor shall notify the State immediately as to when the response can be furnished to the State.

A.22. Customer Services

a. The Contractor shall operate and maintain a dedicated toll-free customer service phone line manned by qualified benefits specialists for Members and Pharmacy Provider inquiries twenty-four (24) hours a day, seven (7) days a week. Contractor personnel shall be trained to answer questions regarding all aspects of the State's Pharmacy benefit including Plan design, participating pharmacies, clinical programs, clinical management programs, Mail Order Pharmacy, and the Specialty network. The Contractor's toll-free customer service line shall be open and staffed with trained staff at least two (2) weeks prior to the go-live date.

b. All Member calls regarding Pharmacy benefits including Copayments, Coinsurance, deductibles, out of pocket maximums, network Pharmacies, drug coverage, and Coordination Of Benefits shall be directed to the Contractor's customer service center. The State's BA Service Center representatives only serve to answer questions about eligibility and the Contractor's customer service center representatives should only refer eligibility-related issues back to Benefits Administration.

c. The Contractor's call center and all call center representatives/operators with whom our Members interact will be physically located within the contiguous United States.

d. The call center shall have call management systems and communications infrastructure that can manage the potential call volume and achieve the required performance.

e. The Contractor's call management systems shall be scalable and flexible so they can be adapted as needed, within negotiated timeframes where applicable, in response to Program, benefit or enrollment changes.

f. The Contractor's call center shall be equipped to support and communicate with persons with a hearing or speech impairment via Telecommunications Relay Services (TRS) to comply with the federal Americans with Disabilities Act.

g. The Contractor's call center shall have at least one Member services representative who is bilingual in English and Spanish and available twenty-four (24) hours a day, seven (7) days a week.

h. The toll-free telephone number assigned to the State for Members to call for assistance with their Pharmacy benefits questions will be exclusive to the State, will not be shared with any other client of the PBM, will not be changed during the Term without the approval of the State In Writing, and will be customized to include a greeting approved by the State.

i. The Contractor's call center shall maintain a First Call Resolution rate of ninety-five percent (95%) or greater.

j. All inbound calls to the Contractor's call center and/or toll-free customer service lines shall be answered within an average time of twenty (20) seconds or less, including calls routed to an IVR.

k. Inbound calls to the Contractor's call center and/or toll-free customer service lines shall be answered with an abandonment rate of 2% or less. Measurement includes calls routed to an IVR and excludes calls abandoned by the Member within the first twenty (20) seconds.

l. The Contractor shall resolve at least ninety-five percent (95%) of issues at the first point of contact. The Contractor shall close one hundred percent (100%) of open call issues within five (5) Business Days.

m. The Contractor shall provide customer service/call center statistics for Members to the State on a quarterly basis.

n. The Contractor's call management systems shall provide greeting messaging when necessary. The Contractor may play canned music for the callers while they are on hold; the Contractor may also play messages about clinical programs that the State has adopted, and other subjects as approved by the State. The Contractor shall not play advertising or informational messages for callers while they are on hold unless approved in advance and In Writing by the State (or the State directs the Contractor to play certain messages). Additionally, the Contractor's systems shall provide a message that notifies callers that calls may be monitored by the Contractor and the State for quality control purposes.

o. The Contractor's call management system shall record and index all calls such that the Contractor can easily retrieve recordings of individual calls based on the phone number of the caller, the caller's name, the date/time of the call, or the call center representative who handled the call. The Contractor shall provide a full recording of each call upon the State's request, using only the Member's name or identifier to locate the call(s).

p. The Contractor shall have the ability to allow the State to monitor and provide feedback on pre-recorded calls from a remote location.

q. The call management system shall transfer calls to other telephone lines as necessary and appropriate, including transfers to BA service center and other external call centers, as designated by the State.

r. The Contractor may use an automated interactive voice response ("IVR") system for managing inbound calls, provided that the caller can always leave the IVR system and wait in queue in order to speak directly with a live-voice representative rather than continue through additional prompts. The Contractor shall not have more than one (1) level of menu choice unless approved in advance and In Writing by the State. The Contractor's call decision tree and menu are subject to State review and approval.

s. The Contractor shall inform callers of their likely wait times as they enter the queue. Additionally, the Contractor shall have voice-mail capabilities such that callers can record messages when all Call center representatives/operators are occupied tending to other callers. The Contractor shall also provide a dial back option that allows callers to receive a call back from the next available call center representative.

t. The Contractor shall have the ability to make outbound calls without interrupting the ability of callers to continue to access the call center.

u. The call management system shall enable the logging of all calls, including:
   (1) The caller's identifying information (e.g., employee ID)
   (2) The call date and time
   (3) The reason for the call)
   (4) The call center representative/operator that handled the call
   (5) The length of call; and
   (6) The resolution of the call (and if unresolved, the action taken and follow up steps required).

v. The call management systems shall maintain a history of correspondence and call transactions for performance management, quality management and audit purposes. This history will contain the actual information, a date/time stamp that corresponds to when the transaction took place, the origin of the transaction (the State and/or the State's designee, the Customer, etc.) and the Contractor representative/operator that processed the transaction.

w. The Contractor shall provide Members and Pharmacy Providers with an option on the toll-free telephone number to immediately consult with a licensed pharmacist between the hours of 7am – 7pm Central Standard Time Monday through Friday. Outside of the hours of 7am – 7pm Central Standard Time Monday through Friday, Members and Pharmacy Providers will have an option to receive a call back from a pharmacist within one (1) hour. This help desk shall be available twenty-four (24) hours a day, seven days a week to respond to questions and problems from Pharmacy Providers and Members. The Contractor shall supply all the required information systems, telecommunications, and personnel to perform these operations.

x. The Contractor's customer service representatives shall have access to an application, which allows them to review alternative drug therapies (Formulary status, Generic Drug alternatives available, etc.) and run test Claims for Members who may request this information.

y. The Contractor shall maintain a full-service staff to respond to inquiries, correspondence, complaints, and problems. The Contractor shall answer, In Writing, ninety-five percent (95%) of written (mail and e-mail) inquiries from Members concerning requested information, including the status of Claims submitted and benefits available through the Pharmacy Program within five (5) business and one hundred percent (100%) within ten (10) days.

z. The Contractor shall make available a geo-access and customized Pharmacy Provider locator service via customer service.

aa. The Contractor shall notify the State of any customer service disruptions lasting more than an hour. Customer service disruptions include, but are not limited to, unexpected technical issues, scheduled maintenance, or known unknown risks (e.g., weather-related).

A.23. General Communications

a. The Contractor shall develop a written marketing and communications plan by the date specified in Contract Section A.33. In addition, the Contractor shall update this plan on an annual basis or as needed by the State to reflect any changes in marketing strategy and updated methods, tools or technology and/or address emerging needs to engage with Members. Contractor's marketing plan will reflect a thoughtful, proactive approach to drive

engagement and utilization of applicable services and programs. Contractor is encouraged to relay what resources they have that will support marketing and communications. All plan updates shall be approved In Writing by the State.

(1) Contractor shall collaborate with other contractors to generally promote Program initiatives, if appliable.

(2) Contractor will provide a quarterly analytics report of marketing and communications efforts and results that should include direct mail, email, website and/or other communications statistics. Contractor shall use the State's template or the Contractor's template with prior approval In Writing by the State. Analytics should include metrics on both activities conducted and results achieved to drive engagement and utilization of applicable ParTNers for Health services and programs for heads of contracts, and enrolled spouses and dependents if applicable and data is available.

(3) Contractor agrees that all materials distributed and prepared or produced by the Contractor shall be accurate in all material respects.

b. Unless otherwise specified, the Contractor shall be responsible for all costs related to the design, development, printing, distribution, mailing (if applicable) and revision of all materials that are required to be produced under this Contract.

c. The Contractor shall assist the State, if requested, in the education of Members and dissemination of information regarding the Program. This assistance may include but not be limited to:

(1) Written information;

(2) Audio/video and webinar presentations;

(3) Member and Agency Outreach: With notification In Writing to the State, attendance at virtual and in-person meetings, workshops, Benefits fairs, marketing events and conferences.

i. Educating State staff, Agency Benefits Coordinators, Members and other persons on Contractor's administrative and Benefits procedures. Specifically, when a new agency joins the Plan, Contractor may be asked to attend onsite enrollment and Benefits educational events and provide educational materials.
ii. Educating Members and Agency Benefits Coordinators could include targeted agency outreach and partnering with other state departments on outreach efforts across the state on benefit implementation, engagement and education.
iii. Any on-site visits to agencies, marketing or other state department co-marketing efforts covered shall require prior notification In Writing by the State. The Contractor shall attend specific events at the request of the State.

d. On an annual basis, at least two (2) months prior to the State's annual enrollment period, the Contractor shall provide to the State, in electronic format, any enrollment material requested by the State that may be helpful to potential Members. Items may include, but not be limited to, a toll-free Member services number, website address, website logon information, a

confidentiality statement, procedures for accessing services, informational fliers, and other pertinent updates, changes and/or materials.

e. At any time and at the State's request, the Contractor shall notify Members, In Writing, of any benefit, Plan or Program changes no less than thirty (30) Business Days prior to the implementation of the change.

f. The Contractor shall update web-based versions of all materials as Plan changes are made and to correct errors. The Contractor shall update web-based versions at the request of the State, within five (5) Business Days. New Plan Year information must be added no later than one (1) month prior to annual enrollment.

g. Unless prior approved In Writing by the State, and in compliance with state and federal law, the Contractor shall not use information gained through this Contract, including utilization and pricing information, in marketing or expanding non-State business relationships or for any pecuniary gain.

h. Unless approved in advance and In Writing by the State, the Contractor shall not distribute any promotional materials or gifts to employees or Members, even if such gifts are of a de minimis value (e.g., magnets, pens, etc.).

i. Contractor shall comply with the Federal Register Nondiscrimination in Health Programs and Activities (81 FR 31375, 45 CFR 92).

A.24. Member Communication/Materials

a. The Contractor shall, in consultation with the State, develop and disseminate Member information and communication materials. All material must have approval In Writing by the State prior to distribution. Contractor shall ensure that all Member materials and other communications meet any state or federal regulatory compliance, if applicable. The Contractor shall develop all materials in conformance with the style, formatting and other related standards developed by the State and its communications and marketing staff. All marketing and communications materials, including contact information for any Members, shall become property of the State.

(1) Materials could include, but are not limited to, Member handbooks, Provider directories, identification (ID) cards, welcome packet, administrative forms, letters, emails, manuals, brochures, fliers, webinars, text messages, website copy, website images, mobile app and app content, social media content, PowerPoints, training materials, marketing materials specific to Plan or agency and videos.

(2) Marketing/segmenting: Contractor may offer or suggest marketing and communications based on segmentation of population (e.g., demographics, geography, etc.). Contractor may provide data to address paths and barriers to engagement.

(3) Personalization of Member materials and digital communications (e.g., email salutation) may be an option upon request by the State.

(4) Contractor shall provide marketing and communications samples of how they introduce Plan options to Members and continually drive engagement and utilization of preferred services.

(5) The Contractor shall use graphics to communicate key messages to populations with limited literacy, limited health plan literacy or limited English proficiency. The Contractor shall also prominently display the call center's telephone number in large, bolded typeface and hours of operation on all materials.

(6) The Contractor shall provide text and graphics, if applicable, for the State's communication to Members.

(7) As part of its submission to the State, the Contractor, with consultation with the State, shall specify how the materials will be sent i.e., email, text, regular mail, other.

b. The Contractor shall provide the State with draft versions of all communications materials and letters at least fourteen (14) Business Days prior to planned printing, assembly, and/or distribution (including web posting). The Contractor shall not distribute any materials until the State issues approval In Writing to the Contractor for the respective materials.

c. The State has and retains the ability to edit and customize all communication pieces distributed by the Contractor, including the right to require that the State branding "ParTNers for Health" logo be included on any Member letters, correspondence or other materials. The Contractor shall ensure communications are specific to the Plan design and not simply a rebranding/repackaging of standard book-of-business materials or communications unless it is to remain in compliance with other regulatory requirements.

d. The Contractor shall work in conjunction with the State's staff to ensure continuity of branding across all Program materials, mailings, emails, website, apps, social media and any other communications information, tools, communication methods and resources. This branding shall include, but is not limited to, use of the ParTNers for Health logo, color scheme and applicable taglines. All uses of these branding elements shall be subject to prior approval In Writing by the State. All marketing and communications materials, including contact information for any Members, shall become property of the State.

e. The Contractor shall have the exclusive responsibility to write, edit and arrange for clearance of materials (such as securing full time use of a stock photograph for perpetuity) for any and all marketing and communication materials.

f. The Contractor shall distribute materials that are culturally sensitive and professional in content, appearance and design with prior approval In Writing by the State.

g. The Contractor shall provide electronic templates of all finalized materials in a format that the State can easily alter, edit, revise and update.

h. Unless otherwise prior approved In Writing by the State, the Contractor shall design all marketing and communication materials at a sixth (6.0) grade reading level or lower using the Flesch-Kincaid Index, or a comparable product. The Contractor shall evaluate materials using the entire text of the materials (except return addresses). When submitting draft materials to the State for approval, the Contractor shall provide a certification of the reading level of each piece of material.

i. The Contractor shall ensure that up-to-date versions of all printed Member marketing and communication materials can be downloaded from the Splash Page (see Contract Section

A.27) or accessible via a mobile device or other method. The Contractor shall provide the State an electronic copy of all marketing and communication materials, including Provider directories, at the State's request for posting on the State's website.

A.25. Communications Mailing

a. Postage and production costs incurred by the Contractor, which are the direct result of communications requested by the State for benefit Plan changes or other communications outside of annual enrollment, shall be treated as pass-through costs. Such costs shall be billed to the State and shall include substantiating documentation, including a line-item description of the postage and production costs incurred by the Contractor with all charges being allocated to the number of Member letters by fund (state actives, state retirees, local education actives, local education retirees, local government actives, local government retirees). The Contractor shall not pass on postage or mailing fees for your Mail Order Pharmacy and your preferred Specialty Pharmacy to the State during the term of the Contract. The State shall pay the postage, printing and production costs of such mailings to comply with Contract Section C.3. However, if a mistake is the result of the Contractor's error and is not corrected prior to printing or distribution, the Contractor shall pay the postage, printing and production costs for these communications. The Contractor shall produce and distribute corrected versions of individual materials at the State's discretion within ten (10) Business Days.

b. The Contractor shall use First Class Mail for all mailings, unless otherwise directed or unless otherwise approved by the State In Writing. With prior approval, the State may approve, marketing, bulk or alternative rates.

c. Unless otherwise directed by the State, the Contractor shall print and distribute any mass mailings developed by the State within fourteen (14) Business Days of receiving the language/copy from the State.

A.26. Member Identification (ID) Cards and Welcome Packets

a. The Contractor shall provide eligible Members with ID cards and shall establish a process that allows Members to request replacement or duplicate cards by phone, online and mobile app (if applicable) and/or other possible future methods or technology upon request. Members shall also have access to a digital ID card.

b. The ID card shall include the State's "ParTNers for Health" color logo, on the top front of the card, as directed by the State and the Contractor's logo may appear on the front in a corner.

(1) The words "Administered by CONTRACTOR NAME: may appear beneath this in a smaller font size.
(2) The front of the card shall also include the following information: Member name, Member ID number (which shall NOT be the Member's Social Security Number), RxBIN, RxPCN, RxGRP, and Issuer code.
(3) The back of the card shall include the following information: the Contractor's Pharmacy Help Desk phone number for Pharmacists, the Contractor's Member services phone number, the address for Paper Claims submission by Members and any additional information required by state of federal law to be included. The State has final approval of the ID card appearance and language/copy, including Contractor name and logo presentation.

c. Initial Member ID cards, and welcome packets if requested by the state, must be mailed to all Members no later than fourteen (14) Business Days prior to go-live.

d. Ninety-eight percent (98%) of ongoing welcome packets and ID cards shall be produced and mailed within four (4) business days of receipt of complete and accurate enrollment information.

e. ID cards shall contain unique identifiers for each Member, which shall be the employee's unique Edison ID provided on the enrollment file. Such identifier shall NOT be the Member's federal Social Security number (SSN). Contractor may add additional identifiers if prior approved by the State In Writing.

f. As directed by the State, the Contractor shall re-issue ID cards to reflect approved Plan design changes, including but not limited to changes in cost sharing, within thirty (30) calendar days.

A.27. Splash Page, Contractor Website, and Mobile Application

a. The Contractor shall maintain a Splash Page dedicated to and customized to the State containing Program information specific to the Plan membership, which does not require a Member to log in. The design of the Splash Page, inclusive of the site map, page layout, color/font scheme and branding, static content and any documents which can be accessed via, or downloaded from, the Splash Page must be prior approved In Writing by the State. The Contractor shall obtain prior approval In Writing from the State for any links from the site to an external website/portal or webpage.

b. The Contractor shall link the Splash Page to the Benefits Administration website, other State-contracted vendor websites, microsites, content or other web or mobile device enabled video/multimedia tools apps, methods or technology as determined by the State that are useful or applicable for Members (State-approved tools from other approved vendors).

c. The Splash Page shall have the capability to host streamed content (both audio and video) from other vendors including video/multimedia tools as determined by the State if useful and applicable to Members.

d. Splash Page shall include but not be limited to the following: a home page with information and links to additional information including, but not limited to, Benefits, access to temporary ID cards, and Member tools.

e. Contractor shall include on the Splash Page a Pharmacy search function that will allow Members to search for a Pharmacy type of their choice (including but not limited to Retail-30 Pharmacy, Retail-90 Pharmacy, Specialty Pharmacy, and Vaccine Pharmacy).

f. The Splash Page shall at a minimum contain the following information or a link to the information:
    (1) Contractor customer service phone number and hours
    (2) Plan Benefits
    (3) Current listing of the most recent Formulary or preferred drug list (with a prominent effective date shown on page 1 of the PDL)

(4) A list of all pharmacies in the national network whereby Members can fill a thirty (30) day prescription
(5) A list of all pharmacies participating in the special 90-Day-At-Retail network
(6) A list of all Specialty Pharmacies (especially those in Tennessee). These listings shall include Pharmacy name, address, city, state, zip code, and phone number;
(7) A list of all pharmacies participating in the vaccine network
(8) A separate list of drugs that are considered Specialty Drugs that the Member may only obtain in thirty (30) day supply increments, a list of drugs that require PA, and a list of drugs that have quantity limits or Step Therapy requirements
(9) Links to other State contractors' websites; and
(10) Other information as requested by the State.

g. The Contractor shall grant the State access to the customized developed Splash Page for review and approval no later than the date specified in Contract Section A.33.

h. The Contractor shall provide all information pertinent to each new Plan Year on the Splash Page and website by the date specified in Contract Section A.33.

i. Unless otherwise approved by the State, the Contractor shall update content and/or documents posted to the Splash Page or website/portal within five (5) Business Days of the State's prior approval of changes to said content and/or documents.

j. The Contractor shall host the Splash Page on a non-governmental server, which shall be located within the United States. The contractor shall have adequate server capacity and infrastructure to support the likely volume of traffic from Members without disruption or delay with the ability to sustain ninety-nine-point nine percent (99.9 %) continuous uptime.

k. The Contractor shall obtain and cover the cost of the domain name for the Contractor's Splash Page. The Splash Page URL must be prior approved by the State In Writing.

l. To ensure accessibility among persons with a disability, the Contractor's Splash Page and Contractor's own log-in portal and website shall comply with Section 508. If the Contractor posts any video content it shall include closed captioning option and/or include text scripting to comply with Section 508 for these products.

m. The Splash Page and Contractor website shall be fully operational (go-live) except for Member data and PHI on or before the date specified in Contract Section A.33. The Contractor shall submit the text and screenshots of the Splash Page and provide log-in credentials to Contractor website to the State for review and approval at least one (1) month prior to the Splash Page and website go-live date specified in Contract Section A.33. Contractor shall obtain prior approval In Writing from the State for any links from the site to a non-governmental website or webpage.

n. Contractor shall have a Contractor website with a Member log-in portal on the Splash Page so Members can view Member-specific documents, including but not limited to Claims information, Plan documents and other material pertaining to Benefits. Contractor must maintain this website which shall be available twenty-four (24) hours a day, three hundred sixty-five (365) days a year except for maintenance windows.

o. The Contractor's website shall be enabled for mobile devices, mobile app or by other methods that may apply. The website shall at a minimum contain:
    (1) Member specific Benefits;
    (2) Member Claims history;
    (3) An intuitive user interface, including other resources such as online secure messaging or chat capabilities to answer questions from Members;
    (4) Access to temporary and digital Member ID cards;
    (5) Access to check Benefits status (deductibles met, etc.)
    (6) Any applicable Member forms (e.g., Claim forms, appeal forms, direct Member reimbursement, etc.);
    (7) Mail Order refill/order tracking
    (8) Pharmacy locator
    (9) Formulary support
    (10) Drug pricing tool
    (11) Requests for explanation of Benefits
    (12) Links to other State contractors' websites; and
    (13) Up-to-date information on a Member's out-of-pocket costs.

p. The Contractor's website shall also contain consumer cost transparency and quality tools which allow Members to research the price and quality of health care services. At a minimum the tools must:
    (1) Alert Members about opportunities for savings;
    (2) Provide Members with their Member Cost Share amount for medications as well as that of other alternative medications in the same class and with the same efficacy that would be less expensive to the Member. Also provide other savings opportunities and the cost associated with those, such as switching to a 90-day supply or utilizing a cash pay program. This function should allow Members to search on any drug but should also offer savings opportunities once the Member logs into the Contractor's site and views a list of their own medications that have been filled historically.
    (3) Allow for a Member shared savings payment, as directed by the State;
    (4) Provide medication alternative information;
    (5) Provide access to a Prescriber Page, which includes, but is not limited to:
        i. An interactive Formulary, complete with hot-links from drugs to the PA criteria established for those drugs and also linked to drug specific PA forms and drug specific web-based PA application;
        ii. A search function, which allows Providers to enter a drug name and be routed to the drug in the interactive Formulary;
        iii. Procedures for obtaining PAs, call center hours of operation and contact numbers;
        iv. Printable education material specific to prescribers.
    (6) Provide access to a Pharmacist Page, which includes, but is not limited to:
        i. An interactive inquiry system using Pharmacy Providers' identifying number (NCPDP, NPI, etc.) to verify the status of pending payments, and other supported function(s) as deemed necessary by the State;
        ii. An online listing of the Contractor's MAC drug list; and
        iii. Printable online Pharmacy handbook and Provider education material specific to pharmacists.

q. The Contractor's website shall contain Member-accessible secure messaging capabilities.

r. The internet-based, searchable Provider directory shall include Pharmacy name, address and phone number and shall accurately reflect pharmacies that have joined or ceased participation in the network in the past quarter. The Contractor shall provide the internet-based Pharmacy directory on its Contractor website and a link on the Splash Page on or before the date specified in Contract Section A.33.

s. The Contractor shall include a mobile application for use by Members with prior approval In Writing by the State. The Contractor must agree to and adhere to all security measures as it relates to Member data. The Contractor must provide a one hundred percent (100%) secure web-based application that requires only a web-browser and an Internet connection.

t. At the State's request, the Contractor's mobile application(s) shall be linked with other web applications to allow for seamless data linkage (this may include, but is not limited to, single sign-on) of Member information including the ability for Members to, as applicable, access Claims information, view and order ID cards, upload information (through a mobile device), or link to other technology or information that is helpful to the Member. The Contractor must work with any and all State vendors on data updates and shall send and/or receive files as needed.

u. Contractor agrees that the State shall have the authority to request any revisions to the Contractor's online terms and conditions, any terms and conditions Members must consent to, or any online service agreement before the Contract effective date. Contractor cannot change any online terms and conditions, Members terms and conditions, or online service agreement during the Contract period without prior approval by the State.

A.28. Reporting & Systems Access

a. The Contractor shall, upon State request, submit monthly operational/performance reports by which the State can assess the Plan's activity and performance. The Contractor shall submit reports electronically, and shall include information such as enrollment, utilization, prescription sources and types, Plan expenses, Member demographic information and other information as requested by the State. If the Contractor's ad-hoc reporting system that is made available to the State allows the State Vendor Services staff who oversee this contract to pull data in various forms and full ad-hoc capability, then the State may, in its sole authority, waive the requirement to provide this information.

b. The Contractor shall provide access to an online reporting system (e.g., eligibility system and Claims history system) to BA staff no later than one (1) month prior to the system go-live date. Additional users must be added at any time at the State's request, with no limit to the number of users, and at no additional cost. The State will provide the Contractor with a list of the names, telephone numbers, and email addresses and specify to the Contractor what kind of access the State requires for each employee: read only, update eligibility, view historical Claims history etc. and to which system (eligibility, Claims history and detail, or both). The Contractor shall train BA staff with access to the Contractor's system on all Contractor systems and tools no later than one (1) month prior to the go-live date. This training must be conducted either virtually or on-site at the BA office unless otherwise approved by the State. The State will provide laptop computers and Internet access, but the training materials, system, and trainer/teacher/coach must be provided by the Contractor and the teacher must be fully trained himself or herself on all the various system-generated reports, ad-hoc reports, and is able to fully explain and walk State staff through them in a

clear, articulate manner. At the State's request, the Contractor shall provide system access to the State's Benefits consultants/actuaries at no additional cost.

c. To maintain the privacy of PHI, the Contractor shall provide to the State a method of securing e-mail for daily communications between the State and the Contractor. The Contractor shall set up Transport Layer Security (TLS) with the State.

d. At the State's request, the Contractor shall provide reporting specific to the activity and outcomes associated with all the utilization management tools and programs provided by the Contractor. The Contractor shall deliver such reports to the State within five (5) Business Days of the State's request.

e. The Contractor shall provide the State access to an ad-hoc reporting liaison to assist in the development of our own ad-hoc reports that cannot be generated using the Contractor's standard reporting package. The Contractor shall deliver such reports to the State within five (5) Business Days of the State's request. If requested by the State, the Contractor shall deliver up to ten (10) reports annually deemed as "urgent" by the State within twenty-four (24) hours at no additional cost to the State.

f. The Contractor, as requested by the State, shall generate a file of Members on a monthly basis with a first fill during the previous month for any antidepressant or anti-anxiety medication. Contractor shall share via secure server or email this list of Members and Edison I.D. numbers with the State's EAP/BHO contractor so that said contractor may communicate with the identified Members on the State's behalf by notifying them of the EAP/BHO program and its associated Benefits.

g. The Contractor shall provide the State a compliance report (also known as a report card), no later than sixty (60) days following the end of each quarter, which captures performance related to the requirements. See item #11 in Contract Attachment C.

h. The Contractor shall provide the State reports illustrating the Contractor's compliance with financial terms in Contract Section C.3. Reports shall be submitted no later than ninety (90) days following the end of each quarter and an annual reconciliation shall be submitted during the first calendar quarter of the following calendar year. See item #9 in Contract Attachment C.

i. The Contractor shall provide the State a report, no later than sixty (60) days following the end of each quarter, illustrating the Rebate payments due to the State summarized at the NDC or NDC-11 level. The Contractor shall also provide an annual reconciliation report demonstrating true-up to one hundred percent (100%) no later than one hundred fifty (150) days after the end of each calendar year. See item #12 in Contract Attachment C.

j. Contractor shall ensure that its reporting system available to state staff allows for pulling Claims data by, at a minimum, various dates, groups, plan types, Member ID (Edison ID) and can be broken down by product name, Pharmacy name, address, city and state, the NDC of the product, and GPIs 2 through 14 (code and description) that applies to the product, as well as provide the Pharmacy-submitted drug cost, net plan paid amount, and any Member Cost Share (Copayment/Coinsurance).

k. The Contractor, if requested by the State, shall provide the State a monthly report describing open service issues at the plan level.

A.29. Member Satisfaction Survey

a. The Contractor shall perform, following review and approval by the State, an annual Member satisfaction survey specific to the State's Plan. The Contractor shall conduct the survey once annually during each calendar year at a time approved by the State and shall involve a statistically valid random sample of Members. The survey question or questions should be specific to the services and touchpoints the Contractor has with our Members, rather than the Benefits or Benefits structure itself (i.e., Members should be rating the satisfaction they have with the Contractor and the services provided by the Contractor rather than their Copayments or Coinsurance which are not controlled by the Contractor.) Based upon the results of the survey, the Contractor and the State will jointly develop an action plan approved In Writing by the State, to correct problems or deficiencies identified through this activity. The level of overall customer satisfaction shall be equal to or greater than eighty-five percent (85%) in the first year of the Contract, and ninety percent (90%) in all subsequent year(s).

A.30. SLA Scorecard and Performance

a. The SLA scorecard measures the Contractor's performance against the desired outcomes listed in Contract Attachment D.

b. The Contractor shall be responsible for meeting or exceeding the KPIs throughout the Contract Term. The Contractor and State shall review quarterly and annually the Contractor's success in achieving its performance objectives for the prior quarter and prior year in which services were delivered. Such performance shall be measured to comply with the KPIs, and desired outcomes outlined in the SLA Scorecard (Contract Attachment D). The quarterly SLA Scorecard for the previous calendar quarter shall be provided to the State in Excel format within 60 days of the end of each calendar quarter. The annual SLA Scorecard for the previous calendar year shall be provided to the State in Excel format within 90 days of the end of the calendar year. The Per Incident SLA Scorecard shall be provided to the State in Excel format within 30 days of either KPI occurring.

A.31. Audit Authority

a. Upon thirty (30) calendar days' notice In Writing and the establishment of applicable third-party confidentiality agreement(s), if any, reasonably required by the Contractor, the State and/or its representative shall have the right to examine and audit the Contractor services and pricing to ensure compliance with all applicable requirements. For the purpose of this requirement, the term, "Contractor," shall include its parent organization, PBM Affiliates, subsidiaries, and subcontractors.

b. The State has sole authority to determine who to choose for any kind of audit related to the services contained in the contract. This includes, but does not limit to, the selection of state employees, state employees from the Comptroller's audit staff, and BA's consulting firm.

c. If the State contracts with a private entity (non-state employees) to conduct an audit of the Contractor, the State will require the auditing entity to negotiate a reasonable confidentiality agreement with the Contractor. The Contractor shall not attempt to limit the State's audit rights in any way or timeframe; the State in its sole authority and with execution of any confidentiality document shall be allowed to audit the Contractor on any contracted service including, but not limited to, discount guarantees, Manufacturer Payment Guarantees, Pass-through Transparent Pricing provisions, Pharmacy pricing comparison, Claims processing, customer service, or any other provision of this contract by whomever the State in its sole authority deems appropriate.

d. In no instance shall the Contractor advise the State that one set of auditors is appropriate while another set is not. In addition, the State may audit or re-audit any time period in order to comply with the timeframe for audits listed in Contract Section D.11. Previous audits of a set of Claims, Providers, time periods, or any other sort of audit does not negate the State's right to re-audit the same information again later. There shall be no audit blackout periods at any point during a year nor any charges or fees in any form for any audits that the State chooses to exercise.

e. The Contractor shall provide access within thirty (30) days' notice from the State, at any time during the term of this Contract and for five (5) years after final contract payment (longer if required by law), to the State and/or its representative to examine and audit Contractor services, payments, and pricing pursuant to this Contract. The State reserves the right to request that documentation be provided for review virtually, at the representative's location, the State's location, or at the Contractor's corporate site.

f. The Contractor shall, at its own cost, provide the State and/or its representative with prompt and complete access to any data, data extracts, documents, a Contractor's representative to view the system or system screenshots as requested, and other information necessary to ensure Contractor compliance with all requirements of this Contract.

g. The Contractor shall provide reasonable cooperation with requests for information, which includes, but is not limited to, the timing of the audit, deliverables, data/information requests and the Contractor's response time to the State's questions during and after the process. The Contractor shall provide written responses to all 'findings' received during the audit process to assist in clarification and suggested resolutions. The Contractor shall also provide a formal audit response within thirty (30) calendar days of the audit conclusion, or at a later date, if mutually determined with the State to be more reasonable based on the number and type of findings.

h. At the State's discretion, the Contractor shall fund the following audits which shall be conducted by a qualified organization or representative chosen by the State and the scope of the audit shall be defined by the State:
    (1) A pre-and/or a post implementation benefit review audit to ensure that the Pharmacy Benefits are set up and functioning as intended by the State and adjudicating correctly (e.g., correct Copayments or Coinsurance are pulling for various drugs at various pharmacies and Days' Supply. correct Copayments/Coinsurance, deductibles, maximum out of pocket amounts, accumulators for TPAs, drug lists, etc.)
    (2) An operational audit focusing on, at a minimum, staffing, customer service capabilities, TPA audit programs, and Claims administration; and
    (3) Any follow-up audits if significant deficiencies, as determined by the State, are noted.

i. The State shall not be responsible for time, or any costs incurred by the Contractor in association with an audit including, but not limited to, the costs associated with providing data, reports, documentation, systems access, or space.

j. If the outcome of the audit results in an amount due to the State, the Contractor shall pay the full amount due within (30) thirty calendar days of final audit report notification from the State. Any amount due the State which is not paid within (30) thirty calendar days of the final audit report will be deducted from the total amount due from the fees due to the Contractor pursuant to C.3 until the full amount due is paid. If the Contractor disagrees with a finding resulting in a payment to the State, the State will review the Contractor's comments, but if the State retains the original audit findings the Contractor will be responsible for any payment to the State.

k. Any Claims extract that may be provided to the State Comptroller's audit staff for their audit purposes must include, among other standard fields, the adjudicated date (date the Pharmacy was paid by the PBM) for each individual Claim.

l. The Contractor shall comply with Tenn. Code Ann § 4-3-1021. This requires BA to compile a report each July 1 using data from various audit reports completed during the year and publish the results in a report every July 1st to the Tennessee Speakers of the House and Senate, the Comptroller of the Treasury, and Members of the Tennessee General Assembly. BA requires the participation and timely assistance of the Contractor to work with the actuaries and Benefits analysts both in and outside the State to ensure that each report is completed timely. Compliance with this state law requires that the Contractor be audited by the State's contracted Benefits consultants each year through a series of four audits: a financial/Claims audit, a rebate audit (drug Manufacturers selected by the State), a pass-through pricing analysis, and a Pharmacy pricing comparison report. Reconciliation of the PBM's payments to pharmacies with the State's reimbursement to the PBM is required to comply with Tenn. Code Ann § 4-3-1021(c) (5).

    (1) The State, or its contracted Benefits consultants, will have access to any data necessary to ensure the Contractor is complying which includes, but is not limited to, one hundred percent (100%) of Claims data, which includes at least all NCPDP fields from the most current version and release, Retail Pharmacy contracts, pharmaceutical manufacturer contracts, GPO, Mail Order and Specialty Pharmacy contracts to the extent they exist with other contractor(s), utilization management reviews, clinical program outcomes, appeals, and any additional information needed to complete the audits.

m. Pharmacy Rebate audits can include, but are not limited to, review and examination of manufacturer Rebate contracts, Rebate payments, special Discounts, fee reductions, incentive programs or the like with Pharmacy Manufacturers, and Program financial records as necessary to perform an accurate and complete audit of Rebates received by the State. To the extent that the Contractor contracts with a separate group purchasing organization (GPO) in connection with Rebates or Manufacturer Payments for the State, the State may (a) directly confirm the existence of contract(s) between the Contractor and such third-party GPO (I.e., view the contract introduction, recitals, and signature block) and (b) audit all aspects of such contract with the establishment of applicable third-party confidentiality agreement(s), if any, as reasonably required by the GPO**.** Upon request by the State, or its designated authorized independent auditor, the Contractor shall provide full disclosure of Rebates and Manufacturer Payments received by the Contractor, its Affiliates, subsidiaries, or subcontractors on behalf of the State. This disclosure shall include line-item detail by NDC or NDC-11 and line-item detail by pharmaceutical manufacturer showing Actual Cost remitted and other related Claim and financial information as needed to satisfy the scope of the audit. One hundred percent (100%) of all drugs dispensed and paid for from the go-live date on January 1, 2025 until the termination of Benefits shall be included in any kind of Pharmacy audit, regardless of tier level (Generic Drug, preferred brand, or non-preferred brand or absence of a tier assignment), and without regard to enrollment plan type, number of Members enrolled in said Plan, Copayment/Coinsurance assigned by the State (or lack thereof), Spread or differential between drug tier Copayments/Coinsurance, or any kind of utilization.

n. The Contractor and any PBM Affiliates and GPOs shall disclose to the State's authorized representative any and all Manufacturer Payments including but not limited to Manufacturer Administrative Fees or other reimbursements received in connection with any Rebates, Discounts, fee reductions, incentive programs, or the like received by Contractor as a result of the drug Manufacturer Payments, which include volume of pharmaceutical use by, or on behalf of, the State. In addition, the Contractor shall, upon request by the State, disclose any and all fees or other reimbursements received in connection with any grants, educational programs or other incentive programs received by the Contractor on behalf of the State.

o. The Contractor must assist the State in identifying fraud and perform fraud investigations of Members and Providers, in consultation with the State, for the purpose of recovery of overpayments due to fraud. Reviews shall include all possible actions necessary to locate and investigate cases of potential, suspected, or known fraud and abuse. In the event the Contractor discovers evidence that an unusual transaction has occurred that merits further investigation, the Contractor shall simultaneously inform the State and the Division of State Audit, in the Office of the Comptroller of the Treasury. The State will review the information and inform the Contractor whether it wishes the Contractor to:

(1) Discontinue further investigation if there is insufficient justification; or

(2) Continue the investigation and report back to the State and the Division of State Audit; or

(3) Continue the investigation with the assistance of the Division of State Audit; or

(4) Discontinue the investigation and turn the Contractor's findings over to the Division of State Audit for its investigation.

p. The Division of State Audit may request full Claims extract for their audit purposes at any time. Contractor shall work with State Audit to supply them a full Claims extract including (but not limited to) such variables as date filled, Pharmacy name, address, and phone number, drug name and NDC or NDC-11, quantity dispensed, gross cost, plan cost, Member cost, prescriber name and NPI, adjudicated (paid date; the date that the actual Pharmacy was paid) – all for each Claim processed under this contract and provided in any Claims extract to the Division of State Audit.

q. The Contractor shall refer all media and legislative inquiries of any type to BA, which will have the sole and exclusive responsibility to respond to all such queries. However, the Contractor shall respond directly to audit requests from the Comptroller to audit requests from divisions within the Department of Finance & Administration, and to subpoenas related to this Contract; in all such instances, the Contractor shall copy BA on all correspondence.

A.32. Pharmacy Audits

a. The Contractor shall audit at least five percent (5%) of network Pharmacies in Tennessee annually. The same audits performed on the Contractor's Retail Pharmacy network will be conducted on the Mail Order and Specialty pharmacies.

b. The Contractor shall establish and maintain a process to detect and prevent errors, fraud or abusive Pharmacy utilization by Members, pharmacies or prescribers. The Contractor shall contact pharmacies with aberrant Claims or trends to gain an acceptable explanation for the finding or to submit a corrected Claim. The Contractor shall develop a trend or log of aberrancies that shall be shared with the State – upon the State's request. Each quarter or upon the State's request, the Contractor shall summarize findings from the reports and share

with the State to address Program revisions and remit payment to the State for any Claims recovered from pharmacies that were paid in error. Each payment shall be made by check and the contractor shall provide substantiating documentation in Excel format at the fund level (State Actives, State Retirees, Local Education Actives, Local Education Retirees, Local Government Actives, and Local Government Retirees).

c. The State may request that the Contractor initiate a field audit when desk audits consistently identify aberrations that cannot be explained by other means or upon requests from legal authorities or regulatory agencies. The objective of the field audit shall include financial recovery, and elimination of the aberrant practice. The Contractor shall have the qualified staff available to conduct field audits or have an agreement with a contractor acceptable to the State within ninety (90) days of the date the Contractor assumes full responsibility for the Pharmacy Benefits Program.

d. The State, or its contracted Benefits consultant and actuarial consulting firm, will audit the Manufacturer Payments that are accrued and paid to the State. These Payments shall be one hundred percent (100%) auditable to the NDC or NDC-11 level.

A.33. Due Dates for Project Deliverables

Unless otherwise specified In Writing by the State, the Contractor shall adhere to the following schedule for the deliverables and milestones for which it is responsible under this Contract:

	Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates:
Plan Implementation			
1.	Pharmacy benefit go-live	A.4.a	January 1, 2025
2.	Kick-off meeting for all key Contractor staff	A.4.d	Within thirty (30) days after Contract effective date
3.	Implementation plan and timetable	A.4.e	Within thirty (30) days after Contract effective Date
4.	State readiness review	A.4.f	November 1, 2024 (On or before)
5.	Call center onsite visit	A.4.h	November 1-30, 2024, and again after go live date, January 1-30, 2025
Staffing			
6.	Account Team Satisfaction	A.5.h	Within fifteen (15) days of receiving the State's satisfaction survey results with a corrective action plan as necessary to remedy any identified deficiencies.
POS Claims Adjudication			
7.	Business continuity/Disaster Recovery results	E.7.d	December 1, 2024, and annually thereafter.
Pharmacy Network			
8.	Network lists available on splash page	A.8.c	September 1, 2024 and September 1 of each successive year
9.	Updated network lists	A.8.c	Quarterly after go-live date

	Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates:
10.	Mail Order website operational	A.8.g.(10)	December 1, 2024
11.	Network Access report	A.8.k	Annually
12.	Quarterly network changes report	A.8.l	Within five (5) Business Days of the end of each quarter following go-live date
Formulary Management			
13.	Initial Formulary development	A.9.a	November 1, 2024
14.	Formulary compliance report	A.9.d	Quarterly after go-live date if requested by the State
Benefit Coverage/Plan Design			
15.	Benefits set-up test results	A.10.c	Annually, no later than November 1
Clinical Programs			
16.	Therapeutic substitution and Generic Drug dispensing program reporting	A.12.d	Annually if requested by the State
17.	Disclosure of PA criteria and procedures	A.12.h.(1)	December 1, 2024 (On or before) if requested by the State
18.	PA Reporting	A.12.h.(5)	Quarterly after go-live date as requested by the State
19.	Complete clinical program list and the State's selection inventory	A.12.o	Every 6 months and within two (2) Business Days of receipt of written request from the State
Retro-DUR			
20.	Profile review focus and methodology	A.14.b	Thirty (30) days prior to initial review start date
21.	DUR and Retro-DUR presentations	A.14.e.(1)	Up to four (4) times annually, as requested by the State
22.	Retro-DUR Outcomes	A.14.e.(2)	Quarterly after go-live date as requested by the State
State Technical Requirements			
23.	Enrollment file acceptance	A.18.d	November 1, 2024
Data and Information Technology			
24.	Daily enrollment update	A.19.a.(1)	Daily after go-live date
25.	State enrollment data match	A.19.c	Up to four (4) times annually, as requested by the State
26.	Claims data transmission to DSS contractor	A.19.d.(2)	Ten (10) days following the end of each calendar month
27.	Claims data transmission to third parties	A.19.e	Daily, unless otherwise directed by the State
28.	Load PAs, overrides, and open refills	A.19.f	December 1, 2024
29.	Claims data transmission to State	A.19.i	Within sixty (60) days of notice of Contract termination

	Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates:
Provider Education			
30.	Provider education recommendations	A.20.f	Annually in January if requested by the State
Appeals			
31.	Contractor grievance procedures	A.21.b	December 1, 2024
Customer Services			
32.	Toll-free customer service line	A.22.a	Two (2) weeks prior to the go-live date
33.	Customer service/call center statistics	A.22.m	Quarterly after go-live date
Member Communication/Materials			
34.	Written marketing and communications plan	A.23.a	Within ninety (90) days after Contract effective date
35.	Annual Enrollment information	A.23.d	Two (2) months prior to annual enrollment
36.	Website updates	A.27.i	Updates within five (5) Business Days / New Plan Year information one (1) month prior to annual enrollment
Member ID Cards and Welcome Packets			
37.	Initial ID cards and welcome packets	A.26.c	Fourteen (14) Business Days prior to go-live
38.	Ongoing ID cards and welcome packets	A.26.d	Within four (4) Business Days of receipt of the enrollment file.
Splash Page, Contractor Website, and Mobile Application			
39.	Splash Page and Website go-live	A.27.h	September 1, 2024, and September 1 of each year thereafter
40.	Submit Splash Page text and screenshots and website login credentials	A.27.m	August 15, 2024
41.	Access to Splash Page	A.27.m	August 15, 2024
42.	Splash Page and website updates	A.27.i	Within five (5) Business Days of State's Approval
43.	Splash Page and website Plan Year updates	A.27.h	September 1 of each year
44.	Internet Based Provider Directory	A.27.r	September 1, 2024
Reporting and Systems Access			
45.	Reporting and eligibility system access	A.28.b	December 1, 2024
46.	State staff systems training	A.28.b	December 1, 2024
47.	Compliance report	A.28.g	Sixty (60) days following the end of each quarter after go-live
48.	Financial terms compliance report	A.28.h	Ninety (90) days following the end of each quarter after go-live and

	Deliverables/Milestones:	Contract Reference(s):	Deliverable Due Dates & Milestone Target Dates:
			annually during the first calendar quarter for the previous year
49.	Rebate payments report and annual reconciliation	A.28.i	Sixty (60) days following the end of each quarter after go-live and annually no later than one hundred fifty (150) days after the end of each calendar year
50.	Open service issues	A.28.k	Monthly after go-live if requested by the State
51.	SOC2 Type II report	E.7.e	Within thirty (30) days of the contract effective date and annually thereafter (in addition to periodic requests for bridge reports from State Audit)
Member Satisfaction Survey			
52.	Member satisfaction survey	A.29.a	Annually
Pharmacy Audits			
53.	Network Pharmacy audits	A.32.a	Annually
54.	Aberrancy findings	A.32.b	As requested by the State
55.	Field audit staff	A.32.c	Within ninety (90) days of go-live
Payment Methodology			
56.	Measure guaranteed Discounts and fees	C.3.s	Within ninety (90) days following the end of each quarter and annually during the first quarter of the following calendar year
57.	Measure Manufacturer Payment Guarantees	C.3.u	Quarterly and one hundred fifty (150) days after the end of each calendar year

A.34. Warranty. Contractor represents and warrants that the term of the warranty ("Warranty Period") shall be the greater of the Term of this Contract or any other warranty generally offered by Contractor, its suppliers, or Manufacturers to customers of its goods or services. The goods or services provided under this Contract shall conform to the terms and conditions of this Contract throughout the Warranty Period. Any nonconformance of the goods or services to the terms and conditions of this Contract shall constitute a "Defect" and shall be considered "Defective." If Contractor receives notice of a Defect during the Warranty Period, then Contractor shall correct the Defect, at no additional charge.

Contractor represents and warrants that the State is authorized to possess and use all equipment, materials, software, and deliverables provided under this Contract.

Contractor represents and warrants that all goods or services provided under this Contract shall be provided in a timely and professional manner, by qualified and skilled individuals, and in conformity with standards generally accepted in Contractor's industry.

If Contractor fails to provide the goods or services as warranted, then Contractor will re-provide the goods or services at no additional charge. If Contractor is unable or unwilling to re-provide the goods or services as warranted, then the State shall be entitled to recover the fees paid to

Contractor for the Defective goods or services. Any exercise of the State's rights under this Section shall not prejudice the State's rights to seek any other remedies available under this Contract or applicable law.

A.35. Inspection and Acceptance. The State shall have the right to inspect all goods or services provided by Contractor under this Contract. If, upon inspection, the State determines that the goods or services are Defective, the State shall notify Contractor, and Contractor shall re-deliver the goods or provide the services at no additional cost to the State. If after a period of thirty (30) days following delivery of goods or performance of services the State does not provide a notice of any Defects, the goods or services shall be deemed to have been accepted by the State.

B. TERM OF CONTRACT:

This Contract shall be effective on April 1, 2024 ("Effective Date") and extend for a period of fifty-one (51) months after the Effective Date ("Term"). The first nine months (April 2024-December 2024) are for implementation activities. January 2025 through December 2027 are the service delivery dates. January 2028 through June 2028 is the Claims runout period. The State shall have no obligation for goods or services provided by the Contractor prior to the Effective Date.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Written Dollar Amount ($Number) ("Maximum Liability"). This Contract does not grant the Contractor any exclusive rights. The State does not guarantee that it will buy any minimum quantity of goods or services under this Contract. Subject to the terms and conditions of this Contract, the Contractor will only be paid for goods or services provided under this Contract after a purchase order is issued to Contractor by the State or as otherwise specified by this Contract.

C.2. Compensation Firm. The payment methodology in Section C.3. of this Contract shall constitute the entire compensation due the Contractor for all goods or services provided under this Contract regardless of the difficulty, materials or equipment required. The payment methodology includes all applicable taxes, fees, overhead, and all other direct and indirect costs incurred or to be incurred by the Contractor.

C.3. Payment Methodology. The Contractor shall be compensated based on the payment methodology for goods or services authorized by the State in a total amount as set forth in Section C.1.

a. The Contractor's compensation shall be contingent upon the satisfactory provision of goods or services as set forth in Section A.

b. The Contractor shall be compensated based upon the following payment methodology:

PLACEHOLDER FOR COST PROPOSAL TABLE(S)

c. The State reserves the right to review files prior to issuing payment and to hold or adjust any payment that is not satisfactory to the State. If the Contractor submits a Claims payment request and the State overpays the Claim, then the State may withhold the overpaid monies.

d. The State authorizes the Contractor to retain monies received through subrogation, on a per patient basis, of no more than five percent (5%) of the gross recoveries received. The Contractor may retain an additional twenty percent (20%) of the gross recoveries, when

such recoveries are made by subrogation subcontractor(s). The Contractor's subrogation processes shall include the recovery of Claims paid as a result of work-related illnesses or injuries relative to worker's compensation Claims.

e. The State will fund the Contractor for the total issue amount of the payments, net of cancellations, voids or other payment credit adjustments, at least weekly provided the Contractor's payment process includes timely settlement of ACH transactions. Unless otherwise provided In Writing and approved by the State, the Contractor shall notify the State of the week's funding requirement amount. The State requires the Contractor to ACH debit the appropriate funds from a designated State bank account. The Contractor acknowledges and agrees that since the State intends to fund payments at the time of issuance, the State will not maintain a separate bank account or an escrow account with the Contractor or to otherwise pre-fund an account.

f. The State will fund the Contractor monthly for the Administrative Fee and Clinical Fee based on the State's record of enrolled Members as of the first day of the month. The State will fund the Contractor monthly for the poly-chronic Member management fee based on the roster of engaged members supplied by the Contractor. The Contractor shall provide the State a roster of engaged polychronic members for the current month no later than the last Business Day of the month. Specifically, the Contractor shall provide the State with an invoice showing the counts of the polychronic members by fund (state actives, state retirees, local education actives, local education retirees, local government actives and local government retirees) along with a supporting Excel spreadsheet containing, at a minimum, member name, date of birth, and Edison ID (employee ID) for the billing.

g. The State shall reimburse the Contractor for the following, selected Actual Costs in the performance of this Contract:

(1) Postage. The State shall reimburse the Contractor for the Actual Cost of postage for mailing materials produced at the specific request of the State. Postage for materials and mailings referenced in the contract (ID cards, welcome packets, welcome fliers etc.) are the sole responsibility of the Contractor.

(2) Printing / Production (refer to Contract Section A.25.a). Subject to compliance with Section E.6., the State shall reimburse the Contractor an amount equal to the Actual Cost of document printing/production as required and authorized by the State.

Notwithstanding the foregoing, the State retains the option to authorize the Contractor to deliver a product to be printed, approve and accept the product but not use the Contractor to print the material. In those situations, the State shall have the discretion to use other printing and production services at its disposal.

h. The Contractor shall reimburse, when necessary and appropriate, monies to plan Members when an overpayment has occurred by the Member.

i. Payments from the State to the Contractor are allowed, if the State implements any Contractor value-based payment arrangements, as referenced in Contract Section A.10.b.

j. The Contractor shall guarantee that the Dispensing Fee per Paid Claim is based on Paid Claims only, not Claims that are reversed or rejected.

k. The Contractor shall guarantee that U&C priced Claims will not be assessed a Dispensing Fee.

l. The Contractor shall guarantee that the average Dispensing Fee per Paid Claim shall not exceed the guaranteed maximum average per Paid Claim. Retail Claims priced using the U&C price (or submitted price, etc.) will NOT be included in the guaranteed maximum average Dispensing Fee per Paid Claim.

m. The financial guarantees are NOT contingent upon the State maintaining a minimum number of Members.

n. The Contractor shall guarantee that the financial terms presented are State-specific, not book-of-business averages or Discount guarantees.

o. The Contractor shall NOT require the State to make any Plan design changes or implement any programs in order to receive or maintain Discount, Dispensing Fee, Rebate, or Manufacturer Payment Guarantees, including but not limited to Pharmacy Discount Card programs.

p. The Contractor's specialty network Discount guarantees for Brand Specialty Drugs will include new drugs added to the list of Specialty Drugs each year and Limited Distribution Specialty Drugs that the Contractor's Specialty Pharmacy has access to. For purposes of annual financial reconciliation, specialty network Discount reconciliation will be on Brand Drugs only. Generic Specialty Drugs will be calculated as Retail-30 generics.

q. The contractor shall guarantee that the guaranteed Discount off AWP shall only exclude the following types of claims: Compounds, bulk chemicals, powders, COB claims, Subrogation claims, Prescriptions filled at VA Hospitals, Claims processed at 340B pricing, and Out of Network Paper claims.

r. The Contractor will calculate the achieved Discounts with the following formula: [1 minus (total Discounted Ingredient Cost, excluding Dispensing Fees and penalties due to DAW Claims and prior to application of Copayments, of applicable prescription drug Claims for the measurement period) divided by total AWP for the measurement guarantee period]. Both the Discounted Ingredient Cost and the AWP will be calculated as of the date of adjudication. Discounted Ingredient Cost will always be the lowest of the post settlement, reconciled AWP Discount, MAC or U&C adjudication methodology

s. The Contractor shall individually measure the brand Discount guarantees, generic Discount guarantees, and Dispensing Fee guarantees for the Retail-30 network, Mail Order Pharmacy program, specialty network, and Retail-90 Pharmacy network. Specialty reconciliation will be on Brand only. All Brand drugs that are on the Contractor's specialty drug list, will be included in the Specialty Network Discount Guarantees. Brand drugs not on the Contractor's specialty drug list will be included in the non-specialty Discounts, and the channel of distribution dictates the Discount Guarantees for any Brand drug not included on the Contractor's specialty drug list. Generic specialty will be calculated with Retail-30 generics. Over performance in one contract area will not offset under performance in other contract areas. The Contractor shall measure guaranteed Discounts and Dispensing Fees within ninety (90) days following the end of each quarter and reconcile with the State annually during the first quarter of the following calendar year. The Contractor shall reimburse the State the difference between actual Discounts and fees and the contracted overall effective Discounts (i.e., Discount guarantees and Dispensing Fee guarantees) by cash or check only. Credits to the Plan are not acceptable unless otherwise approved by the State In Writing. The Contractor will pay one hundred percent (100%) of any guarantee shortfalls to the State within forty-five (45) days of the close of each annual reconciliation period with the State retaining one hundred percent (100%) of any savings above the

guarantees. Further, should the Contractor miss the annual retail Generic Drug Discount guarantee by at least two (2) percentage points, the State will receive one hundred percent (100%) of the shortfall plus an additional payment of ten (10) percent of the shortfall amount (under-performance payment). The Contractor will not be able to offset or recoup any under-performance payment in any reconciliation.

t. The Contractor agrees that any and all amounts owed to the State including Rebates, Manufacturer Payments, guarantee shortfalls, and recoveries identified during Claims audits will be paid by the appropriate due date. Any amounts unpaid after the stated due date will bear interest at nine percent (9%) per year accruing after the due date until payment is received for all payments due to the State.

u. The Contractor shall measure the guaranteed minimum Manufacturer Payments each quarter, with an annual true-up. The Contractor shall pay the State no less than the guaranteed minimum Manufacturer Payments plus any additional Rebate and Manufacturer Payment yield, above the guarantee, thereby resulting in 100% of Manufacturer Payments being passed to the State. Payment shall occur via check sixty (60) calendar days after the end of each calendar quarter. True-up to one hundred percent (100%) will occur one hundred fifty (150) calendar days after the end of each calendar year. Specialty reconciliation will be on Brand Drugs only. All Brand drugs that are on the Contractor's specialty drug list will be included in the Specialty Guaranteed Minimum Manufacturer Payment Per Paid Claim. Brand drugs not on the Contractor's specialty drug list will be included in the non-specialty Guaranteed Minimum Manufacturer Payment Per Paid Claim, and the channel of distribution dictates the Guaranteed Minimum Manufacturer Payment Per Paid Claim for any Brand drug not included on the Contractor's specialty drug list. Generic specialty will be calculated as Retail-30 Generic.

v. The Contractor shall pay out to the State all Manufacturer Payments earned by the State regardless of termination of this contract with final reconciliation and payment made to the State 180 calendar days post termination.

w. Any Rebates and Manufacturer Payments received from Manufacturers after the reconciliation will be applied to the next reconciliation and will be clearly noted in the next reconciliation.

x. For Discount purposes and other related contract calculations, Single-Source Generics should be considered as Multi-Source generics and must not be included in the Brand Drugs bucket for the purpose of pricing or guarantee reconciliation.

y. The Contractor understands and agrees that this contract is deemed a '100% fully pass-through, transparent contract' and agrees that the same costs charged to the Plan and Members, combined, are the same costs paid to network pharmacies.

z. Transmission fees paid by Participating Pharmacies that directly or indirectly arise from Claims or Covered Drugs dispensed to Members shall not constitute Pharmacy Rebates if (a) such fees do not in aggregate exceed $0.15/Claim (b) such fees constitute a fair and reasonable compensation for services actually performed by PBM for a Participating Pharmacy and (c) the receipt and retention of such fees by PBM are in compliance with all applicable laws.

C.4. Travel Compensation. The Contractor shall not be compensated or reimbursed for travel time, travel expenses, meals, or lodging.

C.5. SLA Scorecard.

a. The Parties shall conduct an assessment (Contract Attachment D), beginning after the Go-Live date, on a quarterly and annual basis during the Term.

b. Based on the SLA Scorecard, Contractor shall send the State an At-Risk Performance Payment (if applicable) quarterly and annually during the Term in accordance with Contract Attachment D. These payments are due within forty-five (45) calendar days of the SLA Scorecard assessment.

C.6. Purchase Order in lieu of Invoice. The State will generate a purchase order and initiate monthly payments for the administration fee based upon enrollment totals of those eligible as of the first day of the month utilizing the terms and rates in C.3. above.

C.7. Invoice Requirements. The Contractor shall invoice the State only for goods delivered and accepted by the State or services satisfactorily provided at the amounts stipulated in Section C.3., above. Contractor shall submit invoices and necessary supporting documentation, no more frequently than once a month, and no later than thirty (30) days after goods or services have been provided to the following address:

Heather Pease, Director of Procurement and Contracts
Finance and Administration, Division of Benefits Administration
William R. Snodgrass TN Tower, 19th Floor
312 Rosa L. Parks Ave.
Nashville, TN 37243
heather.pease@tn.gov

a. Each invoice, on Contractor's letterhead, shall clearly and accurately detail all of the following information (calculations must be extended and totaled correctly):

(1) Invoice number (assigned by the Contractor)
(2) Invoice date
(3) Contract number (assigned by the State)
(4) Customer account name: Department of Finance & Administration, Division of Benefits Administration
(5) Customer account number (assigned by the Contractor to the above-referenced Customer)
(6) Contractor name
(7) Contractor Tennessee Edison registration ID number
(8) Contractor contact for invoice questions (name, phone, or email)
(9) Contractor remittance address
(10) Description of delivered goods or services provided and invoiced, including identifying information as applicable
(11) Number of delivered or completed units, increments, hours, or days as applicable, of each good or service invoiced
(12) Applicable payment methodology (as stipulated in Section C.3.) of each good or service invoiced
(13) Amount due for each compensable unit of good or service; and
(14) Total amount due for the invoice period.

b. Contractor's invoices shall:

(1) Only include charges for goods delivered or services provided as described in Section A and in accordance with payment terms and conditions set forth in Section C

(2) Only be submitted for goods delivered or services completed and shall not include any charge for future goods to be delivered or services to be performed
(3) Not include Contractor's taxes, which includes without limitation Contractor's sales and use tax, excise taxes, franchise taxes, real or personal property taxes, or income taxes; and
(4) Include shipping or delivery charges only as authorized in this Contract.

c. The timeframe for payment (or any Discounts) begins only when the State is in receipt of an invoice that meets the minimum requirements of this Section.

C.8. Payment of Purchase Order. A payment by the State shall not prejudice the State's right to object to or question any payment, purchase order, or other matter. A payment by the State shall not be construed as acceptance of goods delivered, any part of the services provided, or as approval of any amount reflected on the purchase order.

C.9. Payment of Invoice. A payment by the State shall not prejudice the State's right to object to or question any payment, invoice, or other matter. A payment by the State shall not be construed as acceptance of goods delivered, any part of the services provided, or as approval of any amount invoiced.

C.10. Reconciliation of Payment. The Contractor shall reconcile, within ten (10) Business Days of receipt, payment information provided by the State. Upon identification of any discrepancies, the Contractor shall immediately advise the State.

C.11. Payment Reductions. The Contractor's payment shall be subject to reduction for amounts included in any invoice, purchase order, or payment that is determined by the State, on the basis of audits conducted in accordance with the terms of this Contract, to not constitute proper compensation for goods delivered or services provided.

C.12. Deductions. The State reserves the right to deduct from amounts, which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the State of Tennessee, any amounts that are or shall become due and payable to the State of Tennessee by the Contractor.

C.13. Prerequisite Documentation. The Contractor shall not invoice the State under this Contract until the State has received the following, properly completed documentation.

a. The Contractor shall complete, sign, and present to the State the "Authorization Agreement for Automatic Deposit Form" provided by the State. By doing so, the Contractor acknowledges and agrees that, once this form is received by the State, payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee, may be made by ACH; and

b. The Contractor shall complete, sign, and return to the State the State-provided W-9 form. The taxpayer identification number on the W-9 form must be the same as the Contractor's Federal Employer Identification Number or Social Security Number referenced in the Contractor's Edison registration information.

C.14 Compensation Disclosure. All indirect or transactional arrangements that result in payment or compensation to the Contractor and any and all PBM Affiliates, including GPOs, must be approved by the State In Writing, upon a review and determination that the arrangement Benefits the State or plan Members. Approval of such arrangements shall be based upon a full explanation of the services provided, compensation received by the Contractor and any and all PBM Affiliates, including GPOs, and regular reporting, no less than annually, related to the services and compensation. The Contractor, and any and all PBM Affiliates, including GPOs,shall submit an annual disclosure detail statement of all financial and compensation arrangements including but not limited to direct, indirect, transactional, Spread, incentive, fee, Manufacturer Payments, and other forms of compensation, within sixty (60) calendar days prior to the end of

the year for the subsequent calendar year. The annual disclosure detail statement shall be updated and submitted to the State within sixty (60) calendar days of any changes throughout the year.

D. MANDATORY TERMS AND CONDITIONS:

D.1. Required Approvals. The State is not bound by this Contract until it is duly approved by the Parties and all appropriate State officials in accordance with applicable Tennessee laws and regulations. Depending upon the specifics of this Contract, this may include approvals by the Commissioner of Finance and Administration, the Commissioner of Human Resources, the Comptroller of the Treasury, and the Chief Procurement Officer. Approvals shall be evidenced by a signature or electronic approval.

D.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract shall be in writing and shall be made by certified, first-class mail, return receipt requested and postage prepaid, by overnight courier service with an asset tracking system, or by email or facsimile transmission with recipient confirmation. All communications, regardless of method of transmission, shall be addressed to the respective Party at the appropriate mailing address, facsimile number, or email address as stated below or any other address provided in writing by a Party.

The State:

Heather Pease Director of Procurements & Contracts
Finance and Administration, Division of Benefits Administration
William R. Snodgrass TN Tower, 19th Floor
312 Rosa L. Parks Ave.
Nashville, TN 37243
heather.pease@tn.gov
Telephone # 615-253-1652
FAX # 615-253-8556

The Contractor:

Contractor Contact Name & Title
Contractor Name
Address
Email Address
Telephone # Number
FAX # Number

All instructions, notices, consents, demands, or other communications shall be considered effective upon receipt or recipient confirmation as may be required.

D.3. Modification and Amendment. This Contract may be modified only by a written amendment signed by all Parties and approved by all applicable State officials.

D.4. Subject to Funds Availability. The Contract is subject to the appropriation and availability of State or federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate this Contract upon written notice to the Contractor. The State's exercise of its right to terminate this Contract shall not constitute a breach of Contract by the State. Upon receipt of the written notice, the Contractor shall cease all work associated with the Contract. If the State terminates this Contract due to lack of funds availability, the Contractor shall be entitled to compensation for all conforming goods requested and accepted by the State and for all satisfactory and authorized services completed as of the termination date. Should the State exercise its right to terminate this Contract due to unavailability of funds, the Contractor

shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages of any description or amount.

D.5. Termination for Convenience. The State may terminate this Contract for convenience without cause and for any reason. The State shall give the Contractor at least thirty (30) days written notice before the termination date. The Contractor shall be entitled to compensation for all conforming goods delivered and accepted by the State or for satisfactory, authorized services completed as of the termination date. In no event shall the State be liable to the Contractor for compensation for any goods neither requested nor accepted by the State or for any services neither requested by the State nor satisfactorily performed by the Contractor. In no event shall the State's exercise of its right to terminate this Contract for convenience relieve the Contractor of any liability to the State for any damages or Claims arising under this Contract.

D.6. Termination for Cause. If the Contractor fails to properly perform its obligations under this Contract in a timely or proper manner, or if the Contractor materially violates any terms of this Contract ("Breach Condition"), the State shall have the right to immediately terminate the Contract and withhold payments in excess of compensation for completed services or provided goods. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any Breach Condition and the State may seek other remedies allowed at law or in equity for breach of this Contract.

D.7. Assignment and Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the goods or services provided under this Contract without the prior written approval of the State. Notwithstanding any use of the approved subcontractors, the Contractor shall be the prime contractor and responsible for compliance with all terms and conditions of this Contract. The State reserves the right to request additional information or impose additional terms and conditions before approving an assignment of this Contract in whole or in part or the use of subcontractors in fulfilling the Contractor's obligations under this Contract.

D.8. Conflicts of Interest. The Contractor warrants that no part of the Contractor's compensation shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Contractor in connection with any work contemplated or performed under this Contract.

The Contractor acknowledges, understands, and agrees that this Contract shall be null and void if the Contractor is, or within the past six (6) months has been, an employee of the State of Tennessee or if the Contractor is an entity in which a controlling interest is held by an individual who is, or within the past six (6) months has been, an employee of the State of Tennessee.

D.9. Nondiscrimination. The Contractor hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied Benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor on the grounds of handicap or disability, age, race, creed, color, religion, sex, national origin, or any other classification protected by federal or state law. The Contractor shall, upon request, show proof of nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

D.10. Prohibition of Illegal Immigrants. The requirements of Tenn. Code Ann. § 12-3-309 addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.

a. The Contractor agrees that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document at Attachment A,

semi-annually during the Term. If the Contractor is a party to more than one contract with the State, the Contractor may submit one attestation that applies to all contracts with the State. All Contractor attestations shall be maintained by the Contractor and made available to State officials upon request.

b. Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the Term, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work under this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work under this Contract. Attestations obtained from subcontractors shall be maintained by the Contractor and made available to State officials upon request.

c. The Contractor shall maintain records for all personnel used in the performance of this Contract. Contractor's records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.

d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Tenn. Code Ann. § 12-3-309 for acts or omissions occurring after its effective date.

e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not: (i) a United States citizen; (ii) a Lawful Permanent Resident; (iii) a person whose physical presence in the United States is authorized; (iv) allowed by the federal Department of Homeland Security and who, under federal immigration laws or regulations, is authorized to be employed in the U.S.; or (v) is otherwise authorized to provide services under the Contract.

D.11. Records. The Contractor shall maintain documentation for all charges under this Contract. The books, records, and documents of the Contractor, for work performed or money received under this Contract, shall be maintained for a period of five (5) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.12. Monitoring. The Contractor's activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

D.13. Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.

D.14. Strict Performance. Failure by any Party to this Contract to require, in any one or more cases, the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the Parties.

D.15. Independent Contractor. The Parties shall not act as employees, partners, joint venturers, or associates of one another. The Parties are independent contracting entities. Nothing in this Contract shall be construed to create an employer/employee relationship or to allow either Party to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one Party are not employees or agents of the other Party.

D.16 Patient Protection and Affordable Care Act. The Contractor agrees that it will be responsible for compliance with the Patient Protection and Affordable Care Act ("PPACA") with respect to itself and its employees, including any obligation to report health insurance coverage, provide health

insurance coverage, or pay any financial assessment, tax, or penalty for not providing health insurance. The Contractor shall indemnify the State and hold it harmless from any costs to the State arising from Contractor's failure to fulfill its PPACA responsibilities for itself or its employees.

D.17. Limitation of State's Liability. The State shall have no liability except as specifically provided in this Contract. In no event will the State be liable to the Contractor or any other party for any lost revenues, lost profits, loss of business, decrease in the value of any securities or cash position, time, goodwill, or any indirect, special, incidental, punitive, exemplary or consequential damages of any nature, whether based on warranty, contract, statute, regulation, tort (including but not limited to negligence), or any other legal theory that may arise under this Contract or otherwise. The State's total liability under this Contract (including any exhibits, schedules, amendments or other attachments to the Contract) or otherwise shall under no circumstances exceed the Maximum Liability. This limitation of liability is cumulative and not per incident.

D.18. Limitation of Contractor's Liability. The Contractor's liability for all Claims arising under this Contract shall be limited to an amount equal to one (1) times the total Paid Claims as defined in Contract Section A.2 that have processed throughout the one year of contract performance immediately preceding the breach. If the breach occurs in the first year of the contract, the calculation will be based on processed Claims from the beginning of contract performance until the date of the breach, prorated to equal one year; PROVIDED THAT in no event shall this Section limit the liability of the Contractor for: (i) intellectual property or any Contractor indemnity obligations for infringement for third-party intellectual property rights; (ii) any Claims covered by any specific provision in the Contract providing for liquidated damages; or (iii) any Claims for intentional torts, criminal acts, fraudulent conduct, or acts or omissions that result in personal injuries or death. For clarity, except as otherwise expressly sInet forth in this Section, Contractor's indemnification obligations and other remedies available under this Contract are subject to the limitations on liability set forth in this Section.

D.19. Hold Harmless. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all Claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Contractor, its employees, or any person acting for or on its or their behalf relating to this Contract. The Contractor further agrees it shall be liable for the reasonable cost of attorneys' fees, court costs, expert witness fees, and other litigation expenses for the State to enforce the terms of this Contract.

In the event of any suit or Claim, the Parties shall give each other immediate notice and provide all necessary assistance to respond. The failure of the State to give notice shall only relieve the Contractor of its obligations under this Section to the extent that the Contractor can demonstrate actual prejudice arising from the failure to give notice. This Section shall not grant the Contractor, through its attorneys, the right to represent the State in any legal matter, as the right to represent the State is governed by Tenn. Code Ann. § 8-6-106.

D.20. HIPAA Compliance. The State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Health Information Technology for Economic and Clinical Health ("HITECH") Act and any other relevant laws and regulations regarding privacy (collectively the "Privacy Rules"). The obligations set forth in this Section shall survive the termination of this Contract.

a. Contractor warrants to the State that it is familiar with the requirements of the Privacy Rules and will comply with all applicable requirements in the course of this Contract.

b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by the Privacy Rules, in the course of performance of the Contract so that both parties will be in compliance with the Privacy Rules.

c. The State and the Contractor will sign documents, including but not limited to business associate agreements, as required by the Privacy Rules and that are reasonably necessary to keep the State and Contractor in compliance with the Privacy Rules. This provision shall not apply if information received or delivered by the parties under this Contract is NOT "Protected Health Information" as defined by the Privacy Rules, or if the Privacy Rules permit the parties to receive or deliver the information without entering into a business associate agreement or signing another document.

d. The Contractor will indemnify the State and hold it harmless for any violation by the Contractor or its subcontractors of the Privacy Rules. This includes the costs of responding to a breach of Protected Health Information, the costs of responding to a government enforcement action related to the breach, and any fines, penalties, or damages paid by the State because of the violation.

e. The Contractor shall not sell Member information or use Member information unless it is aggregated blinded data, which is not identifiable on a Member basis. The State must approve, In Writing, the use of and sale of any of our Member or Plan data, even if being used in an aggregated, blinded data format.

f. The Contractor shall not use Plan Member identified or non-aggregated information for advertising, marketing, promotion or any activity intended to influence sales or market share of any product or service except when permitted by the State, such as advertisements of the Program for enrollment purposes.

g. The Contractor shall have full financial responsibility for any penalties, fines, or other payments imposed or required as a result of the Contractor's non-compliance with or violation of HIPAA or HITECH requirements, and the Contractor shall indemnify the State with respect to any such penalties, fines, or payments, including the cost of credit protection. At the request of the State, the Contractor shall offer credit protection for those times in which a Member's PHI is accidentally or inappropriately disclosed.

D.21. Tennessee Consolidated Retirement System. Subject to statutory exceptions contained in Tenn. Code Ann. §§ 8-36-801, *et seq*., the law governing the Tennessee Consolidated Retirement System ("TCRS"), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established under Tenn. Code Ann. §§ 8-35-101, *et seq.*, accepts State employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this Contract is that of "employee/employer" and not that of an independent contractor, the Contractor, if a retired member of TCRS, may be required to repay to TCRS the amount of retirement Benefits the Contractor received from TCRS during the Term.

D.22. Tennessee Department of Revenue Registration. The Contractor shall comply with all applicable registration requirements contained in Tenn. Code Ann. §§ 67-6-601 – 608. Compliance with applicable registration requirements is a material requirement of this Contract.

D.23. Debarment and Suspension. The Contractor certifies, to the best of its knowledge and belief, that it, its current and future principals, its current and future subcontractors and their principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department or agency;

b. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or

local) transaction or grant under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

c. are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses detailed in section b. of this certification; and

d. have not within a three (3) year period preceding this Contract had one or more public transactions (federal, state, or local) terminated for cause or default.

The Contractor shall provide immediate written notice to the State if at any time it learns that there was an earlier failure to disclose information or that due to changed circumstances, its principals or the principals of its subcontractors are excluded, disqualified, or presently fall under any of the prohibitions of sections a-d.

D.24. Force Majeure. "Force Majeure Event" means fire, flood, earthquake, elements of nature or acts of God, wars, riots, civil disorders, rebellions or revolutions, acts of terrorism or any other similar cause beyond the reasonable control of the Party except to the extent that the non-performing Party is at fault in failing to prevent or causing the default or delay, and provided that the default or delay cannot reasonably be circumvented by the non-performing Party through the use of alternate sources, workaround plans or other means. A strike, lockout or labor dispute shall not excuse either Party from its obligations under this Contract. Except as set forth in this Section, any failure or delay by a Party in the performance of its obligations under this Contract arising from a Force Majeure Event is not a default under this Contract or grounds for termination. The non-performing Party will be excused from performing those obligations directly affected by the Force Majeure Event, and only for as long as the Force Majeure Event continues, provided that the Party continues to use diligent, good faith efforts to resume performance without delay. The occurrence of a Force Majeure Event affecting Contractor's representatives, suppliers, subcontractors, customers or business apart from this Contract is not a Force Majeure Event under this Contract. Contractor will promptly notify the State of any delay caused by a Force Majeure Event (to be confirmed in a written notice to the State within one (1) day of the inception of the delay) that a Force Majeure Event has occurred and will describe in reasonable detail the nature of the Force Majeure Event. If any Force Majeure Event results in a delay in Contractor's performance longer than forty-eight (48) hours, the State may, upon notice to Contractor: (a) cease payment of the fees for the affected obligations until Contractor resumes performance of the affected obligations; or (b) immediately terminate this Contract or any purchase order, in whole or in part, without further payment except for fees then due and payable. Contractor will not increase its charges under this Contract or charge the State any fees other than those provided for in this Contract as the result of a Force Majeure Event.

D.25. State and Federal Compliance. The Contractor shall comply with all State and federal laws and regulations applicable to Contractor in the Contractor's performance of this Contract.

D.26. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee, without regard to its conflict or choice of law rules. The Tennessee Claims Commission or the state or federal courts in Tennessee shall be the venue for all Claims, disputes, or disagreements arising under this Contract. The Contractor acknowledges and agrees that any rights, Claims, or remedies against the State of Tennessee or its employees arising under this Contract shall be subject to and limited to those rights and remedies available under Tenn. Code Ann. §§ 9-8-101 - 408.

D.27. Entire Agreement. This Contract is complete and contains the entire understanding between the Parties relating to its subject matter, including all the terms and conditions of the Parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the Parties, whether written or oral.

D.28. Severability. If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions of this Contract shall not be affected and shall remain in full force and effect. The terms and conditions of this Contract are severable.

D.29. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

D.30. Incorporation of Additional Documents. Each of the following documents is included as a part of this Contract by reference. In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this Contract, these items shall govern in order of precedence below:

a. any amendment to this Contract, with the latter in time controlling over any earlier amendments
b. this Contract with any attachments or exhibits (excluding the items listed at subsections c. through f., below), which includes:
    i. Contract Attachment A
    ii. Contract Attachment B
    iii. Contract Attachment C
    iv. Contract Attachment D: and
    v. Contract Attachment E
c. any clarifications of or addenda to the Contractor's proposal seeking this Contract
d. the State solicitation, as may be amended, requesting responses in competition for this Contract
e. any technical specifications provided to proposers during the procurement process to award this Contract; and
f. the Contractor's response seeking this Contract.

D.31. Iran Divestment Act. The requirements of Tenn. Code Ann. § 12-12-101, *et seq*., addressing contracting with persons as defined at Tenn. Code Ann. §12-12-103(5) that engage in investment activities in Iran, shall be a material provision of this Contract. The Contractor certifies, under penalty of perjury, that to the best of its knowledge and belief that it is not on the list created pursuant to Tenn. Code Ann. § 12-12-106.

D.32. Insurance. Contractor shall maintain insurance coverage as specified in this Section. The State reserves the right to amend or require additional insurance coverage, coverage amounts, and endorsements required under this Contract. Contractor's failure to maintain or submit evidence of insurance coverage, as required, is a material breach of this Contract. If Contractor loses insurance coverage, fails to renew coverage, or for any reason becomes uninsured during the Term, Contractor shall immediately notify the State. All insurance companies providing coverage must be: (a) acceptable to the State; (b) authorized by the Tennessee Department of Commerce and Insurance ("TDCI"); and (c) rated A- / VII or better by A.M. Best. All coverage must be on a primary basis and noncontributory with any other insurance or self-insurance carried by the State. Contractor agrees to name the State as an additional insured on any insurance policy with the exception of workers' compensation (employer liability) and professional liability (errors and omissions) insurance. All policies must contain an endorsement for a waiver of subrogation in favor of the State. Any deductible or self-insured retention ("SIR") over fifty thousand dollars ($50,000) must be approved by the State. The deductible or SIR and any premiums are the Contractor's sole responsibility. The Contractor agrees that the insurance requirements specified in this Section do not reduce any liability the Contractor has assumed under this Contract including any indemnification or hold harmless requirements.

To achieve the required coverage amounts, a combination of an otherwise deficient specific policy and an umbrella policy with an aggregate meeting or exceeding the required coverage amounts is acceptable. For example: If the required policy limit under this Contract is for two million dollars ($2,000,000) in coverage, acceptable coverage would include a specific policy covering one million dollars ($1,000,000) combined with an umbrella policy for an additional one million dollars ($1,000,000). If the deficient underlying policy is for a coverage area without

aggregate limits (generally Automobile Liability and Employers' Liability Accident), Contractor shall provide a copy of the umbrella insurance policy documents to ensure that no aggregate limit applies to the umbrella policy for that coverage area. In the event that an umbrella policy is being provided to achieve any required coverage amounts, the umbrella policy shall be accompanied by an endorsement at least as broad as the Insurance Services Office, Inc. (also known as "ISO") "Noncontributory—Other Insurance Condition" endorsement or shall be written on a policy form that addresses both the primary and noncontributory basis of the umbrella policy if the State is otherwise named as an additional insured.

Contractor shall provide the State a certificate of insurance ("COI") evidencing the coverages and amounts specified in this Section. The COI must be on a form approved by the TDCI (standard ACORD form preferred). The COI must list each insurer's National Association of Insurance Commissioners (NAIC) number and be signed by an authorized representative of the insurer. The COI must list the State of Tennessee – CPO Risk Manager, 312 Rosa L. Parks Ave., 3rd floor Central Procurement Office, Nashville, TN 37243 as the certificate holder. Contractor shall provide the COI ten (10) Business Days prior to the Effective Date and again thirty (30) calendar days before renewal or replacement of coverage. Contractor shall provide the State evidence that all subcontractors maintain the required insurance or that subcontractors are included under the Contractor's policy. At any time, the State may require Contractor to provide a valid COI. The Parties agree that failure to provide evidence of insurance coverage as required is a material breach of this Contract. If Contractor self-insures, then a COI will not be required to prove coverage. Instead, Contractor shall provide a certificate of self-insurance or a letter, on Contractor's letterhead, detailing its coverage, policy amounts, and proof of funds to reasonably cover such expenses. The State reserves the right to require complete copies of all required insurance policies, including endorsements required by these specifications, at any time.

The State agrees that it shall give written notice to the Contractor as soon as practicable after the State becomes aware of any Claim asserted or made against the State, but in no event later than thirty (30) calendar days after the State becomes aware of such Claim. The failure of the State to give notice shall only relieve the Contractor of its obligations under this Section to the extent that the Contractor can demonstrate actual prejudice arising from the failure to give notice. This Section shall not grant the Contractor or its insurer, through its attorneys, the right to represent the State in any legal matter, as the right to represent the State is governed by Tenn. Code Ann. § 8-6-106.

The insurance obligations under this Contract shall be: (1)—all the insurance coverage and policy limits carried by the Contractor; or (2)—the minimum insurance coverage requirements and policy limits shown in this Contract; whichever is greater. Any insurance proceeds in excess of or broader than the minimum required coverage and minimum required policy limits, which are applicable to a given loss, shall be available to the State. No representation is made that the minimum insurance requirements of the Contract are sufficient to cover the obligations of the Contractor arising under this Contract. The Contractor shall obtain and maintain, at a minimum, the following insurance coverages and policy limits.

a. Commercial General Liability ("CGL") Insurance

1) The Contractor shall maintain CGL, which shall be written on an ISO Form CG 00 01 occurrence form (or a substitute form providing equivalent coverage) and shall cover liability arising from property damage, premises and operations products and completed operations, bodily injury, personal and advertising injury, and liability assumed under an insured contract (including the tort liability of another assumed in a business contract).

The Contractor shall maintain single limits not less than one million dollars ($1,000,000) per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this policy or location of

occurrence or the general aggregate limit shall be twice the required occurrence limit.

b. Workers' Compensation and Employer Liability Insurance

1) For Contractors statutorily required to carry workers' compensation and employer liability insurance, the Contractor shall maintain:

i. Workers' compensation in an amount not less than one million dollars ($1,000,000) including employer liability of one million dollars ($1,000,000) per accident for bodily injury by accident, one million dollars ($1,000,000) policy limit by disease, and one million dollars ($1,000,000) per employee for bodily injury by disease.

2) If the Contractor certifies that it is exempt from the requirements of Tenn. Code Ann. §§ 50-6-101 – 103, then the Contractor shall furnish written proof of such exemption for one or more of the following reasons:

i. The Contractor employs fewer than five (5) employees

ii. The Contractor is a sole proprietor

iii. The Contractor is in the construction business or trades with no employees

iv. The Contractor is in the coal mining industry with no employees

v. The Contractor is a state or local government; or

vi. The Contractor self-insures its workers' compensation and is in compliance with the TDCI rules and Tenn. Code Ann. § 50-6-405.

c. Automobile Liability Insurance

1) The Contractor shall maintain automobile liability insurance which shall cover liability arising out of any automobile (including owned, leased, hired, and non-owned automobiles).

2) The Contractor shall maintain bodily injury/property damage with a limit not less than one million dollars ($1,000,000) per occurrence or combined single limit.

d. Professional Liability Insurance

1) Professional liability insurance shall be written on an occurrence basis or on a Claims-made basis. If this coverage is written on a Claims-made basis, then:

i. The retroactive date must be shown, and must be on or before the earlier of the Effective Date of the Contract or the beginning of Contract work or provision of goods and services

ii. Insurance must be maintained, and evidence of insurance must be provided for at least five (5) full years from the date of the final Contract payment; and

iii. If coverage is canceled or non-renewed, and not replaced with another Claims-made policy form with a retroactive date on or prior to the

Contract Effective Date, the Contractor must purchase "extended reporting" or "tail coverage" for a minimum of five (5) full years from the date of the final Contract payment.

2) Any professional liability insurance policy shall have a limit not less than one million dollars ($1,000,000) per Claim and two million dollars ($2,000,000) in the aggregate; and

3) If the Contract involves the provision of services by medical professionals, a policy limit not less than three million ($3,000,000) per Claim and three million dollars ($3,000,000) in the aggregate for medical malpractice insurance.

e. Technology Professional Liability (Errors & Omissions)/Cyber Liability Insurance

1) The Contractor shall maintain technology professional liability (errors & omissions)/cyber liability insurance appropriate to the Contractor's profession in an amount not less than ten million dollars ($10,000,000) per occurrence or Claim and ten million dollars ($10,000,000) annual aggregate, covering all acts, Claims, errors, omissions, negligence, infringement of intellectual property (including copyright, patent and trade secret); network security and privacy risks, including but not limited to unauthorized access, failure of security, information theft, damage to destruction of or alteration of electronic information, breach of privacy perils, wrongful disclosure and release of private information, collection, or other negligence in the handling of confidential information, and including coverage for related regulatory fines, defenses, and penalties.

2) Such coverage shall include data breach response expenses, in an amount not less than ten million dollars ($10,000,000) and payable whether incurred by the State or Contractor, including but not limited to consumer notification, whether or not required by law, computer forensic investigations, public relations and crisis management firm fees, credit file or identity monitoring or remediation services and expenses in the performance of services for the State or on behalf of the State hereunder.

f. Crime Insurance

1) The Contractor shall maintain crime insurance, which shall be written on a "loss sustained form" or "loss discovered form" providing coverage for third party fidelity, including cyber theft and extortion. The policy must allow for reporting of circumstances or incidents that may give rise to future Claims, include an extended reporting period of no less than two (2) years with respect to events which occurred but were not reported during the term of the policy, and not contain a condition requiring an arrest or conviction.

Any crime insurance policy shall have a limit not less than one million dollars ($1,000,000) per Claim and one million dollars ($1,000,000) in the aggregate. Any crime insurance policy shall contain a Social Engineering Fraud Endorsement with a limit of not less than two hundred and fifty thousand dollars ($250,000). This insurance may be written on a Claims-made basis, but in the event that coverage is cancelled or non-renewed, the Contractor shall purchase an extended reporting or "tail coverage" of at least two (2) years after the Term.

D.33. Major Procurement Contract Sales and Use Tax. Pursuant to Tenn. Code Ann. § 4-39-102 and to the extent applicable, the Contractor and the Contractor's subcontractors shall remit sales and use taxes on the sales of goods or services that are made by the Contractor or the Contractor's subcontractors and that are subject to tax.

D.34. Confidentiality of Records. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State that is regarded as confidential under state or federal law shall be regarded as "Confidential Information." Nothing in this Section shall permit Contractor to disclose any Confidential Information, regardless of whether it has been disclosed or made available to the Contractor due to intentional or negligent actions or inactions of agents of the State or third parties. Confidential Information shall not be disclosed except as required or permitted under state or federal law. Contractor shall take all necessary steps to safeguard the confidentiality of such material or information in conformance with applicable state and federal law.

The obligations set forth in this Section shall survive the termination of this Contract.

D.35. Boycott of Israel. The Contractor certifies that it is not currently engaged in, and covenants that it will not, for the duration of the Contract, engage in a Boycott of Israel, as that term is defined in Tenn. Code Ann. § 12-4-119.

D.36. Prohibited Contract Terms. The prohibited contract terms and conditions enumerated in Pub. Ch. 113, § 5, shall be a material provision of this Contract. The Contractor acknowledges, understands, and agrees that the inclusion of a term or condition prohibited by Pub. Ch. 113, § 5, shall be null and void and the Contract shall be enforceable as if the Contract did not contain such term or condition

E. SPECIAL TERMS AND CONDITIONS:

E.1. Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Contract, the special terms and conditions shall be subordinate to the Contract's other terms and conditions.

E.2. Contractor Commitment to Diversity. The Contractor shall comply with and make reasonable business efforts to exceed the commitment to diversity represented by the Contractor's Response to RFP #31786-00174 (Attachment 6.2) and resulting in this Contract.

The Contractor shall assist the State in monitoring the Contractor's performance of this commitment by providing, as requested, a monthly report of participation in the performance of this Contract by small business enterprises and businesses owned by minorities, women, service-disabled veterans, and persons with disabilities. Such reports shall be provided to the State of Tennessee Governor's Office of Diversity Business Enterprise in the TN Diversity Software available online at: https://tn.diversitysoftware.com/FrontEnd/StartCertification.asp?TN=tn&XID=9810.

E.3. Additional lines, items, or options. At its sole discretion, the State may make written requests to the Contractor to add lines, items, or options that are needed and within the Scope but were not included in the original Contract. Such lines, items, or options will be added to the Contract through a Memorandum of Understanding ("MOU"), not an amendment.

a. After the Contractor receives a written request to add lines, items, or options, the Contractor shall have ten (10) Business Days to respond with a written proposal. The Contractor's written proposal shall include:
   (1) The effect, if any, of adding the lines, items, or options on the other goods or services required under the Contract
   (2) Any pricing related to the new lines, items, or options
   (3) The expected effective date for the availability of the new lines, items, or options; and
   (4) Any additional information requested by the State.

b. The State may negotiate the terms of the Contractor's proposal by requesting revisions to the proposal.

c. To indicate acceptance of a proposal, the State will sign it. The signed proposal shall constitute a MOU between the Parties, and the lines, items, or options shall be incorporated into the Contract as if set forth verbatim.

d. Only after a MOU has been executed shall the Contractor perform or deliver the new lines, items, or options.

E.4. Prohibited Advertising or Marketing. The Contractor shall not suggest or imply in advertising or marketing materials that Contractor's goods or services are endorsed by the State. The restrictions on Contractor advertising or marketing materials under this Section shall survive the termination of this Contract.

E.5. Liquidated Damages. If the Contractor fails to perform in accordance with any term or provision of this contract, only provides partial performance of any term or provision of the Contract, violates any warranty, or any act prohibited or restricted by the Contract occurs, ("Liquidated Damages Event"), the State may assess damages on Contractor ("Liquidated Damages"). The State shall notify the Contractor of amounts to be assessed as Liquidated Damages. The Parties agree that due to the complicated nature of the Contractor's obligations under this Contract it would be difficult to specifically designate a monetary amount for Contractor's failure to fulfill its obligations regarding the Liquidated Damages Event as these amounts are likely to be uncertain and not easily proven. Contractor has carefully reviewed the Liquidated Damages contained in Attachment B and agrees that these amounts represent a reasonable relationship between the amount and what might reasonably be expected in the event of a Liquidated Damages Event and are a reasonable estimate of the damages that would occur from a Liquidated Damages Event. The Parties agree that the Liquidated Damages represent solely the damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party. The Contractor agrees that the Liquidated Damages are in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or any other sections of this Contract.

The State is not obligated to assess Liquidated Damages before availing itself of any other remedy. The State may choose to discontinue Liquidated Damages and avail itself of any other remedy available under this Contract or at law or equity.

E.6. Personally Identifiable Information. While performing its obligations under this Contract, Contractor may have access to Personally Identifiable Information held by the State ("PII"). For the purposes of this Contract, "PII" includes "Nonpublic Personal Information" as that term is defined in Title V of the Gramm-Leach-Bliley Act of 1999 or any successor federal statute, and the rules and regulations thereunder, all as may be amended or supplemented from time to time ("GLBA") and personally identifiable information and other data protected under any other applicable laws, rule or regulation of any jurisdiction relating to disclosure or use of personal information ("Privacy Laws"). Contractor agrees it shall not do or omit to do anything which would cause the State to be in breach of any Privacy Laws. Contractor shall, and shall cause its employees, agents and representatives to: (i) keep PII confidential and may use and disclose PII only as necessary to carry out those specific aspects of the purpose for which the PII was disclosed to Contractor and in accordance with this Contract, GLBA and Privacy Laws; and (ii) implement and maintain appropriate technical and organizational measures regarding information security to: (A) ensure the security and confidentiality of PII; (B) protect against any threats or hazards to the security or integrity of PII; and (C) prevent unauthorized access to or use of PII. Contractor shall immediately notify State: (1) of any disclosure or use of any PII by Contractor or any of its employees, agents and representatives in breach of this Contract; and (2) of any disclosure of any PII to Contractor or its employees, agents and representatives where the purpose of such disclosure is not known to Contractor or its employees, agents and representatives. The State reserves the right to review Contractor's policies and procedures used to maintain the security and confidentiality of PII and Contractor shall, and cause its employees, agents and representatives to, comply with all reasonable requests or directions from the State to enable the State to verify or ensure that Contractor is in full compliance with its obligations under this Contract in relation to PII. In accordance with the timeframe for audits

listed in Contract Section D.11 and in consultation with the State, Contractor shall immediately return to the State any and all PII which it has received under this Contract and shall destroy all records of such PII.

The Contractor shall report to the State any instances of unauthorized access to or potential disclosure of PII in the custody or control of Contractor ("Unauthorized Disclosure") that come to the Contractor's attention. Any such report shall be made by the Contractor within twenty-four (24) hours after the Unauthorized Disclosure has come to the attention of the Contractor. Contractor shall take all necessary measures to halt any further Unauthorized Disclosures. The Contractor, at the sole discretion of the State, shall provide no cost credit monitoring services for individuals whose PII was affected by the Unauthorized Disclosure. The Contractor shall bear the cost of notification to all individuals affected by the Unauthorized Disclosure, including individual letters and public notice. The remedies set forth in this Section are not exclusive and are in addition to any Claims or remedies available to this State under this Contract or otherwise available at law. The obligations set forth in this Section shall survive the termination of this Contract.

E.7. Contractor Hosted Services Confidential Data, Audit, and Other Requirements

a. "Confidential State Data" is defined as data deemed confidential by State or Federal statute or regulation. The Contractor shall protect Confidential State Data as follows:

1. The Contractor shall ensure that all Confidential State Data is housed in the continental United States, inclusive of backup data.

2. The Contractor shall encrypt Confidential State Data at rest and in transit using the current version of Federal Information Processing Standard ("FIPS") 140-2 or 140-3 (current applicable version) validated encryption technologies. The State shall control all access to encryption keys. The Contractor shall provide installation and maintenance support at no cost to the State.

If the scope of the most recent SOC audit report does not include all of the current State fiscal year, upon request from the State, the Contractor must provide to the State a letter from the Contractor or Subcontractor stating whether the Contractor or Subcontractor made any Material Changes to their control environment since the prior audit and, if so, whether the changes, in the opinion of the Contractor or Subcontractor, would negatively affect the auditor's opinion in the most recent audit report.

No additional funding shall be allocated for these certifications, authorizations, or audits as these are included in the Maximum Liability of this Contract.

3. The Contractor must annually perform Penetration Tests and Vulnerability Assessments against its Processing Environment. "Processing Environment" shall mean the combination of software and hardware on which the Application runs. "Application" shall mean the computer code that supports and accomplishes the State's requirements as set forth in this Contract. "Penetration Tests" shall be in the form of attacks on the Contractor's computer system, with the purpose of discovering security weaknesses which have the potential to gain access to the Processing Environment's features and data. The "Vulnerability Assessment" shall be designed and executed to define, identify, and classify the security holes (vulnerabilities) in the Processing Environment. Contractor shall provide a letter of attestation that the penetration testing and vulnerability assessments in accordance with NIST 800-115 have been performed annually and any material weaknesses have been remediated.

4. Upon State request, the Contractor shall provide a copy of all Confidential State Data it holds. The Contractor shall provide such data on media and in a format determined by the State

5. Upon termination of this Contract and in consultation with the State, the Contractor shall destroy all Confidential State Data it holds (including any copies such as backups) in accordance with the current version of National Institute of Standards and Technology ("NIST") Special Publication 800-88. The Contractor shall provide a written confirmation of destruction to the State within ten (10) Business Days after destruction.

b. Minimum Requirements

1. The Contractor and all data centers used by the Contractor to host State data, including those of all Subcontractors, must comply with the State's Enterprise Information Security Policies as amended periodically. The State's Enterprise Information Security Policies document is found at the following URL: https://www.tn.gov/finance/strategic-technology-solutions/strategic-technology-solutions/sts-security-policies.html.

2. The Contractor agrees to maintain the Application so that it will run on a current, manufacturer-supported Operating System. "Operating System" shall mean the software that supports a computer's basic functions, such as scheduling tasks, executing applications, and controlling peripherals.

3. If the Application requires middleware or database software, Contractor shall maintain middleware and database software versions that are at all times fully compatible with current versions of the Operating System and Application to ensure that security vulnerabilities are not introduced.

c. Comptroller Audit Requirements

Upon reasonable notice and at any reasonable time, the Contractor and Subcontractor(s) agree to allow the State, the Comptroller of the Treasury, or their duly appointed representatives to perform information technology control audits of the Contractor and all Subcontractors used by the Contractor. Contractor will maintain and cause its Subcontractors to maintain a complete audit trail of all transactions and activities in connection with this Contract. Contractor will provide to the State, the Comptroller of the Treasury, or their duly appointed representatives access to Contractor and Subcontractor(s) personnel for the purpose of performing the information technology control audit.

The information technology control audit may include a review of general controls and application controls. General controls are the policies and procedures that apply to all or a large segment of the Contractor's or Subcontractor's information systems and applications and include controls over security management, access controls, configuration management, segregation of duties, and contingency planning. Application controls are directly related to the application and help ensure that transactions are complete, accurate, valid, confidential, and available. The audit shall include the Contractor's and Subcontractor's compliance with the State's Enterprise Information Security Policies and all applicable requirements, laws, regulations or policies.

The audit may include interviews with technical and management personnel, physical inspection of controls, and review of paper or electronic documentation.

For any audit issues identified, the Contractor and Subcontractor(s) shall provide a corrective action plan to the State within 30 days from the Contractor or Subcontractor receiving the audit report.

Each party shall bear its own expenses incurred while conducting the information technology controls audit.

d. Business Continuity Requirements. The Contractor shall maintain set(s) of documents, instructions, and procedures which enable the Contractor to respond to accidents, disasters, emergencies, or threats without any stoppage or hindrance in its key operations ("Business Continuity Requirements"). Business Continuity Requirements shall include:

    1. "Disaster Recovery Capabilities" refer to the actions the Contractor takes to meet the Recovery Point and Recovery Time Objectives defined below. Disaster Recovery Capabilities shall meet the following objectives:

        i. Recovery Point Objective ("RPO"). The RPO is defined as the maximum targeted period in which data might be lost from an IT service due to a major incident: [NUMBER OF HOURS/MINUTES]

        ii. Recovery Time Objective ("RTO"). The RTO is defined as the targeted duration of time and a service level within which a business process must be restored after a disaster (or disruption) in order to avoid unacceptable consequences associated with a break in business continuity: [NUMBER OF HOURS/MINUTES]

    2. The Contractor and the Subcontractor(s) shall perform at least one Disaster Recovery Test every three hundred sixty-five (365) days. A "Disaster Recovery Test" shall mean the process of verifying the success of the restoration procedures that are executed after a critical IT failure or disruption occurs. The Disaster Recovery Test shall use actual State Data Sets that mirror production data, and success shall be defined as the Contractor verifying that the Contractor can meet the State's RPO and RTO requirements. A "Data Set" is defined as a collection of related sets of information that is composed of separate elements but can be manipulated as a unit by a computer. The Contractor shall provide written confirmation to the State after each Disaster Recovery Test that its Disaster Recovery Capabilities meet the RPO and RTO requirements.

e. The Contractor and any Subcontractor used by the Contractor to host State data, including data center vendors, shall be subject to an annual engagement by a CPA firm in accordance with the standards of the American Institute of Certified Public Accountants ("AICPA") for a System and Organization Controls for service organizations ("SOC") 2 Type II audit. The State shall approve the SOC audit control objectives. The Contractor shall provide the State with the Contractor's and Subcontractor's annual audit report within 30 days from when the CPA firm provides the audit report to the Contractor or Subcontractor. The Contractor shall submit corrective action plans to the State for any issues included in the audit report within 30 days after the CPA firm provides the audit report to the Contractor and Subcontractor.

    If the scope of the most recent SOC audit report does not include all of the current State fiscal year, upon request from the State, the Contractor must provide to the State a letter from the Contractor or Subcontractor stating whether the Contractor or Subcontractor made any Material Changes to their control environment since the prior audit and, if so, whether the changes, in the opinion of the Contractor or Subcontractor, would negatively affect the auditor's opinion in the most recent audit report.

    No additional funding shall be allocated for these audits as they are included in the Maximum Liability of this Contract.

E.8. Extraneous Terms and Conditions. Contractor shall fill all orders submitted by the State under this Contract. No purchase order, invoice, or other documents associated with any sales, orders, or supply of any good or service under this Contract shall contain any terms or conditions other than as set forth in the Contract. Any such extraneous terms and conditions shall be void, invalid and unenforceable against the State. Any refusal by Contractor to supply any goods or services under this Contract conditioned upon the State submitting to any extraneous terms and conditions shall be a material breach of the Contract and constitute an act of bad faith by Contractor.

E.9. Survival. The terms, provisions, representations, and warranties contained in this Contract which by their sense and context are intended to survive the performance and termination of this Contract, shall so survive the completion of performance and termination of this Contract.

IN WITNESS WHEREOF,

CONTRACTOR LEGAL ENTITY NAME:

CONTRACTOR SIGNATURE **DATE**

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION,
STATE INSURANCE COMMITTEE,
LOCAL EDUCATION INSURANCE COMMITTEE,
LOCAL GOVERNMENT INSURANCE COMMITTEE:

James E. Bryson, CHAIRMAN **DATE**

ATTACHMENT A

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	
CONTRACTOR LEGAL ENTITY NAME:	
EDISON VENDOR IDENTIFICATION NUMBER:	

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

CONTRACTOR SIGNATURE

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. Attach evidence documenting the individual's authority to contractually bind the Contractor, unless the signatory is the Contractor's chief executive or president.

PRINTED NAME AND TITLE OF SIGNATORY

DATE OF ATTESTATION

LIQUIDATED DAMAGES

To effectively manage contractual performance, the State has established Liquidated Damages associated with the Contractor's obligations with respect to the Contract. The Contractor is expected to perform according to a certain level of standards. If these standards are not met, the State may impose liquidated damage assessments. Damages are included in this Attachment.

The Parties agree that the Liquidated Damages represent solely the anticipated damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party.

Payment of Liquidated Damages: It is agreed by the State and the Contractor that any liquidated damages assessed by the State shall be due and payable to the State within forty-five (45) calendar days after Contractor receipt of the Invoice containing an assessment of Liquidated Damages. If payment is not made by the due date, the Liquidated Damages amount may be withheld from future payments by the State without further notice.

1. Program Go-Live Date	
Guarantee	The Pharmacy benefit for the Plans shall take effect and be fully Operational on the go-live date specified in Contract Section A.33. "Operational" is defined as the ability to accurately enroll Members, accept and process POS Claims, accept and process Mail Order prescriptions, and provide all other PBM services outlined in the Contract.
Assessment	Twenty-five thousand dollars ($25,000) for each Business Day beyond the go-live date that the Program is not operational up to thirty (30) Business Days.
Justification	Program go-live is an imperative performance guarantee listed in the Contract. If there is a delay in this, the State is unable to provide Pharmacy Benefits coverage to our Members. This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Assessed, reported, and reconciled no later than three (3) months after go-live date.
2. Implementation	
Guarantee	The Contractor shall comply with all tasks, deliverables, and milestones included in the project implementation plan, as required in Contract Section A.4, necessary to install the Program by the go-live date.
Assessment	One thousand dollars ($1,000) for each Business Day for each deliverable and/or milestone leading up to and by the go-live date specified in Contract Section A.33.
Justification	This is a critical portion of the implementation of a new contract and needed before starting implementation to ensure all aspects of implementation are enacted accurately and timely. This assessment calculates the potential impact of missed or inaccurate implementation milestones.
Measurement	Assessed, reported, and reconciled no later than three (3) months after go-live date.
3. Operational Readiness	

Guarantee	The Contractor shall resolve all noncompliance with contract terms identified by the State during its operational readiness review including all milestones required in Contract Section A.4.f, prior to go-live date
Assessment	Ten thousand dollars ($10,000) for each Business Day per finding that is not resolved
Justification	Operational readiness review requires the Contractor and the State to investigate and navigate any potential issues, deadlines, and milestones leading up to go-live and operations.
Measurement	Assessed and reported no later than three (3) months after go-live date.
4. Plan Design	
Guarantee	Plan design per written communications with Benefits Administration (including covered services, excluded services, Member Cost Share, and Ingredient Cost pricing) will be implemented correctly, as required in Contract Sections A. 4. and A.10.
Assessment	Twenty-five thousand dollars ($25,000) per each incorrect plan design setup such as, but not limited to, incorrect Member Cost Share, incorrect covered services or excluded services.
Justification	Plan design information must be timely and accurate as to not cause confusion or financial hardship to Members. This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Assessed and reported three (3) months after go-live date and each successive Plan Year.
5. Enrollment File Set-Up	
Guarantee	As required in Contract Section A.18.d, enrollment information must be loaded, tested, verified and available online for use no later than thirty (30) days prior to the go-live date specified in Contract Section A.33.
Assessment	Ten thousand dollars ($10,000) for each Business Day beyond the date specified in Contract Section A.18.d.
Justification	Enrollment file set-up is a critical step in providing Members Pharmacy Benefits. Without the accurate and timely set-up of this file, there is a potential harm to Members financially and in receiving prescription medication. This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Assessed, reported, and reconciled no later than three (3) months after go-live date.
6. Network Access	
Guarantee	As required in Contract Section A.8.e, the Contractor shall maintain a network of Retail-30 Pharmacy Providers to provide the covered services that met the following access standards using a Quest or comparable report:

Access standard	Percentage	Measure
Urban area	at least ninety percent (97%) of Members	Member(s) live within one and one-half (1.5) miles of a Retail Pharmacy participating in the Contractor's network

	Suburban area	at least ninety percent (97%) of Members	Member(s) live within three (3) miles of a Retail Pharmacy participating in the Contractor's network
	Rural area	at least ninety percent (97%) of Members	Member(s) live within ten (10) miles of a Retail Pharmacy participating in the Contractor's network

Assessment	Fifty thousand dollars ($50,000) per year until such time as any of the access standards listed above are met.
Justification	The Contract requires minimum access standards and without those, Members do not have access to pharmacies within the access standards and therefore the potential to go without prescription medication and increased financial hardship. This assessment and amount takes into account the State's increased staff time for Member inquiries, resolution of additional Member issues, and increased legislative inquiries.
Measurement	Assessed, reported and reconciled annually using the Quest or comparable report provided by the Contractor.
7. URAC Accreditation	
Guarantee	As required in Contract Section A.3.d, the Contractor shall possess and maintain full Pharmacy Benefit Management accreditation status with URAC during the entire term of this contract.
Assessment	Twenty thousand dollars ($20,000) annually if the accreditation is not met.
Justification	This accreditation sets out minimum standards and measurement that a Contractor must meet to receive URAC accreditation. This assessment and amount takes into account the State's increased oversite and management of the Contractor without this accreditation.
Measurement	Assessed, reported, and reconciled annually.
8. Privacy and Security of Protected Health Information Impacting 1 to 499 Members	
Guarantee	To comply with Contract Section D.20 and Contract Attachment E, the Contractor shall not violate the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act). Pursuant to 45 CFR 164.402, breach is defined as the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI.
Assessment	The guarantee and assessment estimates the impact on the State including the unpredictability of the timing of a breach; specifics of the breach's scope; length of time of investigation completion; number of Member calls to the BA service center; and level of legislative inquiries.

Justification	Four Thousand Eight Hundred dollars ($4,800) per violation until resolved. This assessment is based on the previous experience BA has had in responding to similar incidents impacting less than five hundred (500) Members which includes the following predicted costs to BA: 1. HIPAA Compliance Officer time including investigating the breach, monitoring the HIPAA privacy hotline and email address estimated at seventy-five (75) hours 2. Director of Financial Management and Program Integrity time and work estimated at seven and half (7.5) hours 3. Program Director associated with this contract time and work estimated at fifteen (15) hours 4. Executive Director's time and work estimated at one (1) hour 5. Department attorney time including legal review estimated at one (1) hour; and 6. Service Center staff time and work answering Member questions/concerns estimated at fifteen (15) hours.
Measurement	Assessed, reported, assessed, and paid after each occurrence.
9. Privacy and Security of Protected Health Information Impacting 500 or more Members	
Guarantee	In accordance with Contract Section D.20 and Contract Attachment E, the Contractor shall not violate the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act). Pursuant to 45 CFR 164.402, breach is defined as the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under subpart E of the Privacy Rule which compromises the security or privacy of the PHI.

Assessment	Nineteen Thousand dollars ($19,000) per incident basis violation until resolved This assessment is based on the previous experience BA has had in responding to similar incidents impacting five hundred (500) or more Members which includes the following predicted costs to BA: 1. HIPAA Compliance Officer time including investigating the breach, monitoring the HIPAA privacy hotline and email address estimated at one hundred thirty (130) hours 2. Director of Financial Management and Program Integrity time and work estimated at thirty (30) hours 3. Program Director associated with this Contract time and work estimated at forty-five (45) hours 4. Executive Director's time and work estimated at eighteen (18) hours 5. Department attorney time including legal review estimated at thirty (30) hours 6. Service Center staff time and work answering Member questions/concerns estimated at one hundred (100) hours 7. Public Information Officer ("PIO")'s time and work estimated at forty-five (45) hours; and 8. Communications Director's time and work estimated at thirty (30) hours.
Justification	The guarantee and assessment estimate the impact on the State including the unpredictability of the timing of a breach; specifics of the breach's scope; length of time of investigation completion; number of Member calls to the BA service center; and level of legislative inquiries. A breach impacting five hundred (500) or more Members has additional required steps and procedures including notification to the Office of Civil Rights ("OCR") with the U.S. Department of Health & Human Services ("HSS"); documentation to OCR for a required investigation; the drafting and mailing of Member notification letters; and a federally required media release to media outlets across the State.
Measurement	Reported after each occurrence. Measured, reconciled and assessed quarterly.

Contract Attachment C

REPORTING REQUIREMENTS

As required by this Contract, the Contractor shall submit reports to the State. Reports shall be submitted electronically, in the format approved by the State, and shall be of the type and at the frequency indicated below, or as otherwise directed by the State. The State reserves the right to modify reporting requirements as deemed necessary to monitor contract implementation. The State will provide the Contractor with at least sixty (60) days' notice prior to implementation of a report modification.

Unless otherwise directed by the State, the Contractor shall submit reports as follows:

1. Monthly reports shall be submitted by the 15th of the following month
2. Quarterly reports shall be submitted by the 20th of the following month; and
3. Annual reports shall be submitted within ninety (90) days after the end of the calendar year.

Note: Any report due on a State Holiday or weekend will then be due on the following Business Day.

Reports shall include, at a minimum (not an all-inclusive list; refer to contract for all specifics):

1. **Business Continuity/Disaster Recovery results,** December 1, 2024, and annually thereafter.
2. **Network Access Report** submitted annually.
3. **Quarterly Network Changes Report,** submitted within five (5) Business Days of the end of each calendar quarter after go-live date.
4. **Formulary Compliance Report,** submitted quarterly after go-live date.
5. **Therapeutic substitution and Generic Drug dispensing program report** submitted annually.
6. **PA reporting,** submitted quarterly after go-live date.
7. **Rebate reporting** submitted no later than sixty (60) days following the end of each quarter after go-live.
8. **Rebate Annual Reconciliation,** no later than one hundred fifty (150) days after the end of the calendar year for the previous calendar year.
9. **Financial Reporting,** no later than ninety (90) days following the end of each quarter and annually during the first calendar quarter showing Contractor's compliance with financial terms/targets (e.g., AWP minus %, Dispensing Fees, etc.) and outcomes.
10. **Operational/Performance Reporting,** monthly within fifteen (15) days of the end of the previous month.
11. **Compliance Report (aka report card)** submitted no later than sixty (60) days following the end of each calendar quarter showing for the previous quarter the Contractor's outcome for each of the measurements in the Contract Attachment B and Contract Attachment D of this Contract, as well as any payment amount due for that quarter (if applicable).

12. **Rebate Payments report** submitted no later than sixty (60) days following the end of each calendar quarter after go-live and annually no later than one hundred fifty (150) days after the end of each calendar year.

13. **SOC2 Type II report,** submitted within thirty (30) days of the Contract Effective Date, annually thereafter, and in addition to periodic bridge reports as requested by the State in compliance with Contract Section E.7.

14. **Out-of-network Claims report,** if requested by the State, submitted quarterly for the previous calendar quarter to the State's TPAs. At a minimum, the data fields to include are: Member account ID (Edison ID), Member name, Member date of birth, Member address, Member city, Member state, Member zip code, Claim fill date, GPI 4 class code, brand/generic indicator, prescriber NPI, prescriber full name, prescriber address, prescriber city, prescriber state, prescriber zip code, Pharmacy NCPDP ID, Pharmacy name, Pharmacy address, Pharmacy city, Pharmacy state, Pharmacy zip code, prescription Claim number, total dispensed quantity, total Days' Supply, total Ingredient Cost paid, total Dispensing Fee, total sales tax, total member cost amount, total net cost, total prescriptions, and total deductible applied amount. See A.19.e.

15. **Customer service/call center statistics**, provided quarterly in compliance with A.22.m.

16. **Enrollment file error report** submitted daily within two Business Days of receipt of the daily file.

17. **Other Reports,** as specified in this Contract and using templates prior approved In Writing by the State.

Service Level Agreement Scorecard

The SLA Scorecard and associated KPIs below are used to measure the Contractor's performance against the desired outcomes. KPIs shall be evaluated, scored, and reconciled via the SLA Scorecard with relevant documentation. Contractor must submit the SLA Scorecard for each KPI at the frequency listed (e.g., quarterly, annually, per occurrence) documenting the Contractor's outcome for each KPI during that time period. The State will provide the required reporting format during implementation. Based on the scores, the State will determine, and may assess, any At-Risk Performance Payments. Amounts due will be a percentage of administration fees earned during the time period the KPI was measured (see Tables A and B below) and/or the per occurrence amount listed in Table C.

It is agreed by the State and the Contractor that any At-Risk Performance Payment assessed by the State shall be due and payable to the State within forty-five (45) calendar days after Contractor receipt of the Invoice containing an assessment. If payment is not made by the due date, the At-Risk Performance Payment amount may be withheld from future payments by the State without further notice.

TABLE A - Quarterly						
KPI		**Description**	**Performance Requirement**	**Contractor Performance**	**Score if Met**	**Quarterly Score**
1.	POS System Availability	POS system, used by contracted pharmacies to process Pharmacy Claims, as required in Contract Section A.6.m shall be accessible and operational ninety-nine point nine percent (99.90%) of the time.	99.90%	99.90% or greater	9	
				97.98-99.89%	6	
				97.0-97.97%	3	
				Less than 97%	0	
2.	POS System Processing	As required in Contract Section A.6.d, the Contractor shall process ninety-nine point five percent (99.5%) of POS Claims on a daily basis within five (5) seconds.	99.5%	99.5% or greater	5	
				98.0-99.4%	3	
				97.0-97.9%	1	
				Less than 97%	0	
3.	Claims Processing Accuracy	Claims Processing Accuracy, as required in Contract Section A.6.k, shall be greater than or equal to ninety-nine point nine 99.9% at Retail, and greater than or equal to ninety-nine point nine nine 99.99% at Mail Order and Specialty.	99.9%	99.9% or greater	6	
				97.0-98.9%	4	
				95.0-96.9%	2	
				Less than 95%	0	
4.		Claims payment accuracy, as required in	99.9%	99.9% or greater	6	

TABLE A - Quarterly						
KPI		**Description**	**Performance Requirement**	**Contractor Performance**	**Score if Met**	**Quarterly Score**
	Claims Payment Accuracy	Contract Section A.7.e, shall be ninety-nine-point nine percent (99.9%) or higher.		97.0-99.8%	4	
				95.0-96.9%	2	
				Less than 95%	0	
5.	Generic Drug Substitution - Mail Order	As required in Contract Section A.9.j.(1), ninety-five percent (95%) or more of Mail Order prescriptions for Multi-source drugs shall be dispensed with a Generic Drug product.	95%	95% or greater	6	
				93.0-94.9%	4	
				91.0-92.9%	2	
				Less than 91%	0	
6.	Generic Drug Substitution - Retail	As required in Contract Section A.9.j(1), ninety percent (90%) or more of retail prescriptions for Multi-source drugs shall be dispensed with a Generic Drug product.	90%	90% or greater	8	
				88.0-89.9%	4	
				86.0-87.9%	2	
				Less than 86%	0	
7.	PA Evaluation	As required in Contract Section A.12.h(4), the Contractor's PA staff shall evaluate ninety-nine percent (99%) of PA requests within twenty-four (24) hours.	99%	99% or greater	6	
				97.0-98.9%	4	
				95.0-96.9%	2	
				Less than 95%	0	
8.	Eligibility Discrepancies	Resolve all discrepancies (any difference of values between the State's database and the Contractor's database) identified by the processing of the enrollment file within two (2) Business Days of identification, as required in Contract Section A.19.a(4).	100%	100%	6	
				98.0-99.9%	5	
				96.0-97.9%	4	
				Less than 96%	0	
9.	Pre-Service Appeals	Ninety-nine percent (99%) of Pre-Service Appeals shall be decided within fifteen (15) calendar days from receipt of appeal, as	99%	99% or greater	4	
				95.0-98.9%	3	
				91.0-94.9%	2	

TABLE A - Quarterly						
KPI		**Description**	**Performance Requirement**	**Contractor Performance**	**Score if Met**	**Quarterly Score**
		required in Contract Section A.21.c.		Less than 91%	0	
10.	Post-Service Appeals	Ninety-nine percent (99%) of Post-Service Appeals within thirty (30) days from receipt of appeal, as required in Contract Section A.21.c.	99%	99% or greater	4	
				95.0-98.9%	3	
				91.0-94.9%	2	
				Less than 91%	0	
11.	Telephone Coverage	The Contractor shall provide uninterrupted telephone coverage for twenty-four (24) hours a day/seven (7) days a week for Claims, systems and customer service and Pharmacy Provider inquiries, as required in Contract Section A.22.a. Excluded from this are contracted-planned down times or Force Majeure Events as listed in Contract Section D.24.	100%	100%	8	
				98.0-99.9%	6	
				96.0-97.9%	4	
				Less than 96%	0	
12.	Speed of Answer	All inbound calls to the Contractor's call center and/or toll-free customer service lines shall be answered within an average time of twenty (20) seconds or less, including calls routed to an IVR, as required in Contract Section A.22.j	20 seconds	20 Seconds or less	8	
				21-30 seconds	6	
				31-40 seconds	4	
				Greater than 40 seconds	0	
13.	Distribution of Ongoing Member ID Cards/Welcome Packets	Ninety-eight percent (98%) of ongoing welcome packets and ID cards shall be produced and mailed within four (4) business days of receipt of complete and accurate eligibility information, as required in Contract Section A.26.	98%	98% or greater	6	
				96.0-97.9%	4	
				91.0-95.9%	2	
				Less than 91%	0	
14.	Splash Page	Provide a Splash Page that can sustain ninety-nine-point nine percent (99.9 %) continuous	99.9%	99.9% or more	8	
				98.0-99.8%	4	

TABLE A - Quarterly						
KPI		**Description**	**Performance Requirement**	**Contractor Performance**	**Score if Met**	**Quarterly Score**
		uptime as required in Contract Section A.27.j.		96.0-97.9%	2	
				Less than 96%	0	
15.	Contractor Website	Maintain a Contractor website that is available twenty-four (24) hours a day, three hundred sixty-five (365) days a year except for maintenance windows as required in Contract Section A.27.n	24 hours, 365 days	100%	8	
				98.0-99.9%	6	
				96.0-97.9%	2	
				Less than 96%	0	
16.	Claims Data Submission	The Contractor shall submit Claims data to the State's DSS contractor no later than ten (10) days following the end of each month, or more frequently as approved by the State, as required in Contract Section A.19.d.1-7	Data shared with DSS contractor within ten days of the end of each month	<= 10 days: 100%	8	
				11 days: 99%	4	
				12 days: 98%	2	
				>12 days: 97%	0	
17.	Data Transmission to Third Party Contractors	Unless otherwise directed by the State, the Contractor shall provide daily accumulator data feeds to the State's third-party contractors listed in Contract Section A.19.e. until all Claims incurred during the Term have been paid.	Data accumulator feeds to be shared each day with the State's TPAs	Daily: 100%	8	
				98%-99.9% of daily files shared timely	4	
				96%-97.9% of daily files shared timely	2	
				Less than 96% of daily files shared timely	0	
18.	Claims Data Quality	As assessed by the State's DSS contractor, the Contractor's data submission to the DSS contractor shall meet the following measures as required in Contract Section A.19.d.8. Date of birth: Data missing for ≤ 3% of Claims Pharmacy Provider ID missing: Data missing for ≤ 1.5% of Claims NDC or NDC 11 missing: Data missing for ≤ 1.5% of Claims	3 measures met	3 measures met	4	
				2 measures met	3	
				1 measure met	1	
				0 measures met	0	
19.	Quarterly Reporting	The Contractor shall distribute to the State all	90%	90-100%	10	

TABLE A - Quarterly						
KPI		**Description**	**Performance Requirement**	**Contractor Performance**	**Score if Met**	**Quarterly Score**
		reports required in the Contract within the time frame and in the format specified in the Contract as required in Contract Attachment C.		80-89.9%	8	
				70-79.9%	6	
				60-69.9%	4	
				Less than 60%	0	
Total Quarterly Points Available						128
Total Quarterly Points Achieved						# TBD
Quarterly Score (Total Quarterly Points Achieved / Total Quarterly Points Available)						% TBD
At-Risk Performance Payment Due • Quarterly Score determines at risk performance payment % (See At Risk Performance Payment % table below) • Payment due = reporting quarter's total admin. fees * corresponding at risk performance payment % based on the Quarterly Score						$TBD

TABLE B – Annually						
KPI		**Description**	**Performance Requirement**	**Contractor Performance**	**Score if Met**	**Annual Score**
20.	Annual Reporting	The Contractor shall distribute to the State all reports required in the Contract within the time frame and in the format specified in the Contract as required in Contract Attachment C	90-100%	90-100%	10	
				80-89.9%	8	
				70-79.9%	6	
				60-69.9%	4	
				Less than 60%	0	
21.	Member Satisfaction Survey	The level of overall Member satisfaction, as measured annually through the Member satisfaction survey, shall be equal to or greater than eighty-five percent (85%) in the first year of the Contract, and shall be equal to or greater than ninety percent (90%) in all subsequent year(s) within the contract term as required in Contract Section A.29	85% year 1 of contract	85% or greater	10	
				83-84.9%	8	
				81-82.9%	6	
				79-80.9%	4	
				Less than 79%	0	
			90% in years 2-4 of contract	90% or greater	10	
				88-89.9%	8	
				86-87.9%	6	
				84-85.9%	4	
				Less than 84%	0	

Total Annual Points Available	20
Total Annual Points Achieved	# TBD
Annual Score (Total Annual Points Achieved / Total Annual Points Available)	% TBD
At-Risk Performance Payment Due • Annual score determines at risk performance payment % (See At Risk Performance Payment % table below) • Payment due = (total annual admin. fees * corresponding at risk performance payment % based on the Annual Score) * 20%	$TBD

Score	At Risk Performance Payment % for Tables A and B
>=96	0% of previous quarter Administrative Fees
91 – 95.9	.25% of previous quarter Administrative Fees
86 – 90.9	.50% of previous quarter Administrative Fees
81 – 85.9	.75% of previous quarter Administrative Fees
76 – 8.9	1% of previous quarter Administrative Fees
71 – 75.9	1.5% of previous quarter Administrative Fees
66 – 70.9	2% of previous quarter Administrative Fees
61 – 65.9	3% of previous quarter Administrative Fees
<61	4% of previous quarter Administrative Fees

TABLE C – Per Occurrence				
KPI		**Description**	**Performance Requirement**	**At Risk Performance Payment**
22.	**Unauthorized Usage of Information**	Unless prior approved In Writing by the State, and in compliance with state and federal law, the Contractor shall not use information gained through this Contract, including but not limited to utilization and pricing information, in marketing or expanding non-State business relationships or for any pecuniary gain.	If Contractor uses data without prior approval	$50,000
23.	**Key Staff Vacancies**	As required in Contract Section A.5.k, if any Key Staff become vacant, the Contractor shall employ an adequate replacement within sixty (60) days of the vacancy unless the State grants an exception to this requirement.	Vacancy filled within 60 days	$1,000 for each Business Day exceeding the 60- day requirement until resolved.
24	**Member Communications**	The Contractor shall provide the State with draft versions of all communications materials and letters at least fourteen (14) Business Days prior to planned printing, assembly, and/or distribution (including web posting). as required in Contract Section A.24.b.	100%	$1,000 per incident

Contract Attachment E

HIPAA BUSINESS ASSOCIATE AGREEMENT
COMPLIANCE WITH PRIVACY AND SECURITY RULES

THIS BUSINESS ASSOCIATE AGREEMENT (hereinafter "Agreement") is between **The State of Tennessee, Finance and Administration, Division of Benefits Administration** (hereinafter "Covered Entity") and _____ (hereinafter "Business Associate"). Covered Entity and Business Associate may be referred to herein individually as "Party" or collectively as "Parties."

BACKGROUND

Parties acknowledge that they are subject to the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 as amended by Public Law 111-5, Division A, Title XIII (the HITECH Act), in certain aspects of its operations.

Business Associate provides services to Covered Entity pursuant to one or more contractual relationships detailed below and hereinafter referred to as "Service Contracts."

LIST OF AGREEMENTS AFFECTED BY THIS BUSINESS ASSOCIATE AGREEMENT:

Contract Name:	**Execution Date:**
Pharmacy Benefits Manager (PBM) services	**April 1, 2024**

In the course of executing Service Contracts, Business Associate may come into contact with, use, or disclose Protected Health Information ("PHI"). Said Service Contract(s) are hereby incorporated by reference and shall be taken and considered as a part of this document the same as if fully set out herein.

In accordance with the federal privacy and security regulations set forth at 45 C.F.R. Part 160 and Part 164, Subparts A, C, D and E, which require Covered Entity to have a written memorandum with each of its Business Associates, the Parties wish to establish satisfactory assurances that Business Associate will appropriately safeguard PHI and, therefore, make this Agreement.

DEFINITIONS

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 CFR §§ 160.103, 164.103, 164.304, 164.402, 164.501, and 164.504.

1.1 "Breach of the Security of the [Business Associate's Information] System" shall have the meaning set out in its definition at T.C.A. § 47-18-2107

1.2 "Business Associate" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.3 "Covered Entity" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.4 "Designated Record Set" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.5 "Electronic Protected Health Information" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.6 “Genetic Information” shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.7 “Health Care Operations” shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.8 “Individual” shall have the same meaning as the term “individual” in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

1.9 “Information Holder” shall have the meaning set out in its definition at T.C.A. § 47-18-2107

1.10 “Marketing” shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.11 “Personal information” shall have the meaning set out in its definition at T.C.A. § 47-18-2107

1.12 “Privacy Official” shall have the meaning as set out in its definition at 45 C.F.R. § 164.530(a)(1).

1.13 “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, subparts A, and E.

1.14 “Protected Health Information” shall have the same meaning as the term “Protected Health Information” in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

1.15 “Required by Law” shall have the meaning set forth in 45 CFR § 164.512.

1.16 “Security Incident” shall have the meaning set out in its definition at 45 C.F.R. § 164.304.

1.17 “Security Rule” shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Parts 160 and 164, Subparts A and C.

2. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Privacy Rule)

2.1 Business Associate is authorized to use PHI for the purposes of carrying out its duties under the Services Contract. In the course of carrying out these duties, including but not limited to carrying out the Covered Entity’s duties under HIPAA, Business Associate shall fully comply with the requirements under the Privacy Rule applicable to "business associates," as that term is defined in the Privacy Rule and not use or further disclose PHI other than as permitted or required by this Agreement, the Service Contracts, or as Required By Law. Business Associate is subject to requirements of the Privacy Rule as required by Public Law 111-5, Section 13404 [designated as 42 U.S.C. 17934] In case of any conflict between this Agreement and the Service Contracts, this Agreement shall govern.

2.2 The Health Information Technology for Economic and Clinical Health Act (HITECH) was adopted as part of the American Recovery and Reinvestment Act of 2009. HITECH and its implementing regulations impose new requirements on Business Associates with respect to privacy, security, and breach notification. Business Associate hereby acknowledges and agrees that to the extent it is functioning as a Business Associate of Covered Entity, Business Associate shall comply with HITECH. Business Associate and the Covered Entity further agree that the provisions of HIPAA and HITECH that apply to business associates and that are required to be incorporated by reference in a business associate agreement have been incorporated into this Agreement between Business Associate and Covered Entity. Should any provision not be set forth specifically, it is as if set forth in this Agreement in its entirety and is effective as of the Applicable Effective Date, and as amended.

2.3 Business Associate shall use appropriate administrative, physical, and technical safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement, Services Contract(s), or as Required By Law. This includes the implementation of Administrative, Physical, and Technical Safeguards to protect the Covered Entity’s PHI reasonably and appropriately against any reasonably anticipated threats or hazards, utilizing the technology commercially available to the Business Associate. The Business

Associate shall maintain appropriate documentation of its compliance with the Privacy Rule, including, but not limited to, its policies, procedures, records of training and sanctions of Members of its Workforce.

2.4 Business Associate shall require any agent, to whom it provides PHI received from, maintained, created or received by Business Associate on behalf of Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to PHI or other confidential information, to agree, by written contract with Business Associate, in accordance with 164.502(e)(1)(ii), ensure that any subcontractors that create, receive, maintain, or transmit Protected Health Information on behalf of business associate agree to the same restrictions and conditions that apply to the business associate with respect to such information.

2.5 Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

2.6 Business Associate shall require its employees, agents, and subcontractors to promptly (up to five (5) days) report, to Business Associate, immediately upon becoming aware of any use or disclosure of PHI in violation of this Agreement. Business Associate shall report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement. Business Associate will also provide additional information reasonably requested by the Covered Entity related to the breach.

2.7 As required by the Breach Notification Rule, Business Associate shall require its subcontractor(s) to, maintain systems to monitor and detect a Breach of Unsecured PHI, whether in paper or electronic form.

2.7.1 Business Associate shall provide to Covered Entity notice of an Actual Breach of Unsecured PHI immediately upon becoming aware of the Breach.

2.7.2 Business Associate shall cooperate with Covered Entity in timely manner providing the appropriate and necessary information to Covered Entity.

2.7.3 Covered Entity shall make the final determination whether the Breach requires notification and whether the notification shall be made by Covered Entity or Business Associate.

2.8 If Business Associate receives PHI from Covered Entity in a Designated Record Set, Business Associate shall provide access, at the request of Covered Entity, to PHI in a Designated Record Set to Covered Entity, in order to meet the requirements under 45 CFR § 164.524, provided that Business Associate shall have at least thirty (30) Business Days from Covered Entity notice to provide access to, or deliver such information.

2.9 If Business Associate receives PHI from Covered Entity in a Designated Record Set, then Business Associate shall make any amendments to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to the 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity, provided that Business Associate shall have at least thirty (30) Business Days from Covered Entity notice to make an amendment.

2.10 Business Associate shall make its internal practices, books, and records including policies and procedures and PHI, relating to the use and disclosure of PHI received from, created by or received by Business Associate on behalf of, Covered Entity available to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule.

2.11 Business Associate shall document disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosure of PHI in accordance with 45 CFR § 164.528.

2.12 Business Associate shall provide Covered Entity or an Individual, in time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §

164.528, provided that Business Associate shall have at least thirty (30) Business Days from Covered Entity notice to provide access to, or deliver such information which shall include, at minimum, (a) date of the disclosure; (b) name of the third party to whom the PHI was disclosed and, if known, the address of the third party; (c) brief description of the disclosed information; and (d) brief explanation of the purpose and basis for such disclosure. Business Associate shall provide an accounting of disclosures directly to an individual when required by section 13405(c) of Public Law 111-5 [designated as 42 U.S.C. 17935(c)].

2.13 Business Associate agrees it must limit any use, disclosure, or request for use or disclosure of PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request in accordance with the requirements of the Privacy Rule.

2.13.1 Business Associate represents to Covered Entity that all its uses and disclosures of, or requests for, PHI shall be the minimum necessary in accordance with the Privacy Rule requirements.

2.13.2 Covered Entity may, pursuant to the Privacy Rule, reasonably rely on any requested disclosure as the minimum necessary for the stated purpose when the information is requested by Business Associate.

2.13.3 Business Associate acknowledges that if Business Associate is also a covered entity, as defined by the Privacy Rule, Business Associate is required, independent of Business Associate's obligations under this Memorandum, to comply with the Privacy Rule's minimum necessary requirements when making any request for PHI from Covered Entity.

2.14 Business Associate shall adequately and properly maintain all PHI received from, or created or received on behalf of, Covered Entity

2.15 If Business Associate receives a request from an Individual for a copy of the individual's PHI, and the PHI is in the sole possession of the Business Associate, Business Associate will provide the requested copies to the individual and notify the Covered Entity of such action. If Business Associate receives a request for PHI in the possession of the Covered Entity, or receives a request to exercise other individual rights as set forth in the Privacy Rule, Business Associate shall notify Covered Entity of such request and forward the request to Covered Entity. Business Associate shall then assist Covered Entity in responding to the request.

2.16 Business Associate shall fully cooperate in good faith with and to assist Covered Entity in complying with the requirements of the Privacy Rule.

3 OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Security Rule)

3.1 Business Associate shall fully comply with the requirements under the Security Rule applicable to "business associates," as that term is defined in the Security Rule. In case of any conflict between this Agreement and Service Agreements, this Agreement shall govern.

3.2 Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the covered entity as required by the Security Rule and Public Law 111-5. This includes specifically, but is not limited to, the utilization of technology commercially available at the time to the Business Associate to protect the Covered Entity's PHI against any reasonably anticipated threats or hazards. The Business Associate understands that it has an affirmative duty to perform a regular review or assessment of security risks, conduct active risk management and supply best efforts to assure that only authorized persons and devices access its computing systems and information storage, and that only authorized transactions are allowed. The Business Associate will maintain appropriate documentation to certify its compliance with the Security Rule.

3.3 Business Associate shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI received from or created for Covered Entity or that carries out any duties for the Business

Associate involving the use, custody, disclosure, creation of, or access to PHI supplied by Covered Entity, to agree, by written contract (or the appropriate equivalent if the agent is a government entity) with Business Associate, in accordance with 164.502(e)(1)(ii), ensure that any subcontractors that create, receive, maintain, or transmit Protected Health Information on behalf of business associate agree to the same restrictions and conditions that apply to the business associate with respect to such information.

3.4 Business Associate shall require its employees, agents, and subcontractors to report to Business Associate within five (5) Business Days, any Security Incident (as that term is defined in 45 CFR § 164.304) of which it becomes aware. 45 CFR 164.314(a)(2)(C) requires that business associate shall report to the covered entity any security incident of which is becomes aware, including breaches of unsecured protected health information as required by 164.410. Business Associate shall promptly (up to 48 hours) report any Security Incident of which it becomes aware to Covered Entity. Provided however, that such reports are not required for attempted, unsuccessful Security Incidents, including trivial and routine incidents such as port scans, attempts to log-in with an invalid password or username, denial of service attacks that do not result in a server being taken off-line, malware, and pings or other similar types of events.

3.5 Business Associate shall make its internal practices, books, and records including policies and procedures relating to the security of electronic PHI received from, created by or received by Business Associate on behalf of, Covered Entity available to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Security Rule.

3.6 Business Associate shall fully cooperate in good faith with and to assist Covered Entity in complying with the requirements of the Security Rule.

3.7 Notification for the purposes of Sections 2.8 and 3.4 shall be In Writing made by email/fax, certified mail or overnight parcel immediately upon becoming aware of the event, with supplemental notification by facsimile and/or telephone as soon as practicable, to:

State of Tennessee
Benefits Administration
Attn: Chanda Rainey
HIPAA Privacy & Security Officer
312 Rosa L. Parks Avenue
1900 W.R.S. Tennessee Towers
Nashville, TN 37243-1102
Phone: (615) 770-6949
Facsimile: (615) 253-8556

With a copy to:

State of Tennessee
Benefits Administration
Director of Procurements and Contracts
312 Rosa L. Parks Avenue
1900 W.R.S. Tennessee Towers
Nashville, TN 37243-1102
Phone: (615) 532-4598
Facsimile: (615) 253-8556

3.8 Business Associate identifies the following key contact persons for all matters relating to this Agreement:

Business Associate shall notify Covered Entity of any change in the key contact during the term of this Agreement in writing within ten (10) Business Days.

4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in Service Contract(s), provided that such use or disclosure would not violate the Privacy and Security Rule, if done by Covered Entity. Business Associate's disclosure of PHI shall be subject to the limited data set and minimum necessary requirements of Section 13405(b) of Public Law 111-5, [designated as 42 U.S.C. 13735(b)]

4.2 Except as otherwise limited in this Agreement, Business Associate may use PHI as required for Business Associate's proper management and administration or to carry out the legal responsibilities of the Business Associate.

4.3 Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or provided that, if Business Associate discloses any PHI to a third party for such a purpose, Business Associate shall enter into a written agreement with such third party requiring the third party to: (a) maintain the confidentiality, integrity, and availability of PHI and not to use or further disclose such information except as Required By Law or for the purpose for which it was disclosed, and (b) notify Business Associate of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the PHI is breached immediately upon becoming aware.

4.4 Except as otherwise limited in this Agreement, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 45 CFR § 164.504(e)(2)(i)(B).

4.5 Business Associate may use PHI to report violations of law to appropriate Federal and State Authorities consistent with 45 CFR 164.502(j)(1).

4.6 Business Associate shall not use or disclose PHI that is Genetic Information for underwriting purposes. Moreover, the sale, marketing or the sharing for commercial use or any purpose construed by Covered Entity as the sale, marketing or commercial use of Member's personal or financial information with Affiliates, even if such sharing would be permitted by federal or state laws, is prohibited.

4.7 Business Associate shall enter into written agreements that are substantially similar to this Business Associate Agreement with any subcontractor or agent which Business Associate provides access to Protected Health Information.

4.8 Business Associates shall implement and maintain information security policies that comply with the HIPAA Security Rule.

5. OBLIGATIONS OF COVERED ENTITY

5.1 Covered Entity shall provide Business Associate with the Notice of Privacy Practices that Covered Entity produces in accordance with 45 CFR § 164.520, as well as any changes to such notice. Covered Entity shall notify Business Associate of any limitations in its notice that affect Business Associate's use or disclosure of PHI.

5.2 Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses.

5.3 Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use of PHI.

6. PERMISSIBLE REQUESTS BY COVERED ENTITY

6.1 Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy or Security Rule, if done by Covered Entity.

7. TERM AND TERMINATION

7.1 Term. This Agreement shall be effective as of the date on which it is signed by both parties and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, Section 7.3. below shall apply.

7.2 Termination for Cause.

7.2.1. This Agreement authorizes and Business Associate acknowledges and agrees Covered Entity shall have the right to immediately terminate this Agreement and Service Contracts in the event Business Associate fails to comply with, or violates a material provision of, requirements of the Privacy and/or Security Rule or this Memorandum.

7.2.2. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

7.2.2.1. Provide a reasonable opportunity for Business Associate to cure the breach or end the violation, or

7.2.2.2. If Business Associate has breached a material term of this Agreement and cure is not possible or if Business Associate does not cure a curable breach or end the violation within a reasonable time as specified by, and at the sole discretion of, Covered Entity, Covered Entity may immediately terminate this Agreement and the Service Agreement.

7.2.2.3. If neither cure nor termination is feasible, Covered Entity shall report the violation to the Secretary of the United States Department of Health in Human Services or the Secretary's designee.

7.3 Effect of Termination.

7.3.1. Except as provided in Section 7.3.2. below, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of, Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

7.3.2. In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible. Upon mutual agreement of the Parties that return or destruction of PHI is unfeasible, Business Associate shall extend the protections of this Memorandum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction unfeasible, for so long as Business Associate maintains such PHI.

8. MISCELLANEOUS

8.1 Regulatory Reference. A reference in this Agreement to a section in the Privacy and or Security Rule means the section as in effect or as amended.

8.2 Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security

Rules and the Health Insurance Portability and Accountability Act, Public Law 104-191, including any amendments required by the United States Department of Health and Human Services to implement the Health Information Technology for Economic and Clinical Health and related regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended, including, but not limited to changes required by the American Recovery and Reinvestment Act of 2009, Public Law 111-5.

8.3 Survival. The respective rights and obligations of Business Associate under Section 7.3. of this Memorandum shall survive the termination of this Agreement.

8.4 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity and the Business Associate to comply with the Privacy and Security Rules.

8.5 Notices and Communications. All instructions, notices, consents, demands, or other communications required or contemplated by this Agreement shall be in writing and shall be delivered by hand, by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below, or to such other party, facsimile number, or address as may be hereafter specified by written notice.

COVERED ENTITY:
State of Tennessee
Department of Finance and Administration
Benefits Administration
ATTN: Chanda Rainey
HIPAA Privacy & Security Officer
312 Rosa L. Parks Avenue
1900 W.R.S. Tennessee Towers
Nashville, TN 37243-1102
Phone: (615) 770-6949
Facsimile: (615) 253-8556
E-Mail: benefits.privacy@tn.gov

With a copy to:
ATTN: Heather Pease
Director of Procurements & Contracts
At the address listed above
Phone: (615) 253-1652
Facsimile: (615) 253-8556
E-Mail: heather.pease@tn.gov

BUSINESS ASSOCIATE:

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the date of hand delivery; as of the date specified for overnight courier service delivery; as of three (3) Business Days after the date of mailing; or on the day the facsimile transmission is received mechanically by the facsimile machine at the receiving location and receipt is verbally confirmed by the sender.

8.6 Strict Compliance. No failure by any Party to insist upon strict compliance with any term or provision of this Agreement, to exercise any option, to enforce any right, or to seek any remedy upon any default of any other Party shall affect, or constitute a waiver of, any Party's right to insist upon such strict compliance, exercise that option, enforce that right, or seek that remedy with respect to that default or any prior, contemporaneous, or subsequent default. No custom or practice of the Parties at variance with any provision of this Agreement shall affect, or constitute a waiver of, any Party's right to demand strict compliance with all provisions of this Agreement

8.7 Severability. With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by

such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect.

8.8 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee except to the extent that Tennessee law has been pre-empted by HIPAA.

8.9 Compensation. There shall be **no** remuneration for performance under this Agreement except as specifically provided by, in, and through, existing administrative requirements of Tennessee State government and services contracts referenced herein.

8.10 Security Breach A violation of HIPAA or the Privacy or Security Rules constitutes a breach of this Business Associate Agreement and a breach of the Service Contract(s) listed on page one of this agreement, and shall be subject to all available remedies for such breach.

IN WITNESS WHEREOF,

CONTRACTOR NAME	**Date:**
James E. Bryson, Commissioner of Finance & Administration	**Date:**