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REISSUE BID # 5160000014

OKLAHOMA STATE AND EDUCATION

EMPLOYEES GROUP INSURANCE BOARD

REQUEST FOR PROPOSAL

(RFP)

PHARMACY BENEFIT MANAGER

(PBM)

Effective: January 1, 2008

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ACRONYMS

ALJ:	Administrative Law Judge
AWP:	Average Wholesale Price
CCIP:	(Medicare) Chronic Care Improvement Program
CMS:	Centers for Medicare and Medicaid Services
COB:	Coordination of Benefits
COP:	(Medicare) Conditions of Participation
CSC:	Clinical Sub Committee
DCS:	Department of Central Services
DEA:	Drug Enforcement Administration
DRS:	Department of Rehabilitation Services
EAC:	Estimated Acquisition Cost
EITA:	Electronic and Information Technology Accessibility
EOB:	Explanation of Benefits
FDA:	Federal Drug Administration
FSA:	Flexible Spending Account
HealthChoice:	Health, Dental, Life and Disability Plans Administered by Oklahoma State and Education Employees Group Insurance Board
HHS:	Health and Human Services
HIC:	Health Identification Claim
HIPAA:	Health Insurance Portability and Accountability Act
HMO:	Health Maintenance Organization
HPMS:	Health Plan Management System
I/T/U:	Indian Health Service, Indian Tribe and Tribal Organization, and Urban Indian Organization (I/T/U)
IRE:	Independent Review Entity

ITB:	Invitation to Bid
LIS:	Low Income Subsidy
LTC:	Long Term Care
MAC:	Maximum Allowable Cost
MDCN:	Medicare Data Communications Network
MMA:	Medicare Modernization Act
MTM:	Medication Therapy Management
NCPDP:	National Council for Prescription Drug Programs
OAC:	Oklahoma Administrative Code
OSEEGIB:	Oklahoma State and Education Employees Group Insurance Board
P&T:	Pharmacy and Therapeutics Committee
PBM:	Pharmacy Benefits Manager
PDP:	Pharmacy Drug Plan
PIN:	Provider identification Number
POS:	Point of Service
RFP:	Request for Proposal
SPAP:	State Pharmaceutical Assistance Programs
TDD:	Telecommunication Devices for the Deaf
TPA:	Third Party Administrator
TrOOP:	True Out of Pocket Expenses
TRR:	Transaction Reply Report
U&C	Usual and Customary
VPN:	Virtual Private Network

I. Introduction

A. Statement of Purpose

The Oklahoma State and Education Employees Group Insurance Board, "OSEEGIB," requests proposals from Pharmacy Benefit Managers, "PBM", to provide processing services for prescription drug claims, support services and other professional services for the prescription drug benefit offered by and through OSEEGIB's indemnity health insurance plans known as HealthChoice. The PBM is to provide additional support services, subject to OSEEGIB's annual renewal of its contract with the Centers for Medicare and Medicaid Services (CMS), as a Medicare Part D Prescription Drug Plan (PDP) for eligible members. This Request for Proposal, "RFP," defines OSEEGIB requirements to qualify a PBM for a contract award and describes requested PBM services.

The Contract, as defined in Section VI, paragraph (K), shall be awarded for one (1) year, effective January 1, 2008, with the option in OSEEGIB's sole discretion of four (4) one-year renewals. The State Purchasing Director may negotiate provisions in an RFP to reduce costs and/or improve the level of service in conjunction with the acquisition of computer technology systems. 74 O.S. (2001) § 85.9D

B. Objectives

OSEEGIB intends to utilize the PBM's national network of pharmacies and terms of the PBM's national contract reimbursement rates. However, the PBM contract with Oklahoma pharmacies shall reimburse claims at the OSEEGIB rate of reimbursement. The PBM shall provide Point-Of-Service (POS) electronic claims processing, paper claims processing, identification cards, retrospective, concurrent and prospective Drug Utilization Review, with a focus on quality and cost containment suited for the needs of all HealthChoice members and shall be Health Insurance Portability and Accountability Act (HIPAA) compliant. The PBM shall provide data analysis and report claims experience in an accurate and useful manner, while maintaining an efficient and friendly customer service program. Subject to CMS approval of OSEEGIB's yearly contract as a PDP, OSEEGIB intends for the PBM to provide necessary support services for the PDP contract with CMS.

OSEEGIB understands a PBM's desire to have clients adhere to the PBM's standard business practices. However, OSEEGIB has identified several characteristics that make it a specialized client for PBMs. OSEEGIB intends to contract with a PBM that acknowledges the unique aspects of contracting with OSEEGIB and describes in its executive summary the PBM's ability both from a systems and organizational perspective to deal with these unique qualities. The non-standard business practices included in this RFP identified by OSEEGIB include:

1) Copayment Logic

- a) Multi-sourced Brand – the copayment is complex and detailed in Exhibit A.

SEE EXHIBIT A – Copayment Logic

- b) OSEEGIB utilizes minimum and maximum copayments in multiple tiers, based on the percentage of the cost of the medication as opposed to a capitated copayment;
- c) Mail Service. All retail copayments apply but may be a 90-day supply. In some cases, a member could be obligated for three (3) copayments for a 90-day supply.

2) ID Card Logic

- a) OSEEGIB requires all active and pre-Medicare covered family members' names to print on the card;
- b) OSEEGIB requires each Medicare eligible member to have his/her own card.

3) State Treasury File

- a) OSEEGIB requires drafts on one of its bank accounts as opposed to the PBM's for pharmacy reimbursement checks;
- b) The PBM must create a custom check register to be provided to OSEEGIB as checks are created;
- c) As a result, adjustments and re-issuance of voided, stale-dated and stop-payment checks are more complicated.

4) Customized Formularies; Pharmacy Access

- a) The PBM must update formularies monthly and post the updates to the website;
- b) The exception and prior authorization forms must be linked to the formulary on the website;
- c) OSEEGIB's customized formularies may require the PBM to do extensive website setup and maintenance;
- d) The formulary, the pharmacy network and exception and appeal forms must be accessible via the internet.

- 5) Interagency Agreement
 - a) OSEEGIB administers certain benefit plans for other entities in Oklahoma. As of January 1, 2008, the Oklahoma Department of Rehabilitative Services (DRS) is one such plan and will require a separate set up as if it were a separate client.
- 6) Claim Billing File
 - a) OSEEGIB requires a complete electronic download of claims information following each claims cycle.
- 7) Paid Claims and Lag Report
 - a) OSEEGIB requires these reports for premium rating purposes. Generally, these will key off of special fields in the eligibility file.
- 8) Eligibility File Requirements – Eligibility information must reflect information including the following fields which is generally unique to OSEEGIB:
 - a) By Plan - HealthChoice High, Basic and USA as well as over twenty Medicare plans;
 - b) State, Education, Local Government;
 - c) Out-of-State Retirees;
 - d) Actives, Pre-Medicare and Medicare;
 - e) Rate Class:
 - i) Member
 - ii) Spouse
 - iii) Dependent – 1 Child
 - iv) Dependent – 2 or more children
- 9) Split Families
 - a) Individuals with the same member numbers are in different plans (i.e., the primary member is in a Medicare plan and the spouse is in a non-Medicare plan).
- 10) Retro-term Overpayment Process
 - a) OSEEGIB serves over 1,100 employer groups with multiple retirement systems. There are a significant number of terminations that occur on a retroactive basis. Some retroactive terminations encompass a period exceeding six months. This scenario results in overpayment and requires the PBM to collect money from former members who utilized benefits when in fact they should not have had coverage. The PBM

must identify those members who have overpayments, calculate the amount due, and maintain the account balance following any partial repayments.

11) Prior Authorization Set Up/Quantity Limit Program

- a) OSEEGIB has thousands of prior authorizations in place for members with medical exceptions. The PBM must load all current prior authorizations. A PBM not using FirstDataBank may have additional coding issues.
- b) OSEEGIB has an extensive Quantity Limit program.

12) Non-Medicare Coordination of Benefits

- a) OSEEGIB captures other group insurance coverage for non-Medicare members and the PBM must be able to process coordination of benefits, both electronically (POS) and by paper claim. The PBM must load other health insurance information from the eligibility file OSEEGIB sends on a daily basis.

13) Accumulators

- a) OSEEGIB currently has a pharmacy lifetime maximum benefit. The current balances for members will have to be loaded into the PBM's system and future transactions will accumulate to this balance. The information will not be exported to a health claims administrator.
- b) The PBM must track annual True Out-of-Pocket (TrOOP) expenses for the Medicare members.

14) Mail Service

- a) Out-of-State inactive members are the only members eligible for Home Delivery (Mail Service).

15) Quantity of Medications

- a) OSEEGIB's standard benefit for medication quantity is 34 days or 100 units, whichever is greater. Some exceptions apply based on Federal Drug Administration (FDA) recommendations or other criteria.

16) Ostomy Bags and Wafers

- a) Ostomy bags and wafers are covered under the pharmacy benefit, not the medical benefit.

17) Unique Identification Numbers

- a) OSEEGIB uses unique identification numbers for each of its primary members which must be utilized in processing pharmacy claims. Oklahoma law prohibits the use of a member's Social Security Number on the member's identification card.

18) Plan Design

- a) Over twenty plan designs are required due to Medicare Part D Low Income Subsidy (LIS) and a high and low option.

C. Identification of OSEEGIB

OSEEGIB was established by, and operates pursuant to, the Oklahoma State and Education Employees Group Insurance Act, 74 O. S. (2001) § 1301, et seq., hereinafter "Act." The Act was established for the benefit of state and education employees, employees of other state governmental entities and quasi-state governmental entities authorized by the Act to participate in the plans offered by OSEEGIB. The insurance plans offered by OSEEGIB are known as the HealthChoice plans. Pharmacy plan components are described in Paragraph D of this section. OSEEGIB makes decisions on all policy matters affecting the group insurance plans, including participant benefits, premium rates and the investment of premiums.

Pursuant to legislative authority, OSEEGIB Rules set forth the eligibility, type of participation and benefit guidelines for all participating employers. A copy of the official agency Rules is on file with the Office of the Secretary of State beginning at Oklahoma Administrative Code Title 360:1-1-1, or the Rules may be found at www.sib.ok.gov (Go to Site Map, then "About OSEEGIB")

Medco Health Solutions, Inc. is the current PBM for pharmacy benefits and required PDP services.

Fiserv Health Harrington is the current third party administrator for health, dental and life claims.

D. Current Pharmacy Program

The pharmacy plan design and benefits generally include:

- 1) point of service;
- 2) participant eligibility records;
- 3) out-of-state network benefits;
- 4) non-network paper claims processing;
- 5) generic mandatory program;

- 6) prescriber identification;
- 7) quantity limits and unit of use;
- 8) formulary (preferred single source, brand name product);
- 9) out-of-pocket maximum (differs for non-Medicare and Medicare members);
- 10) prior authorization (restrictive coverage or waiver of higher non-preferred copayment and brand/generic differential);
- 11) limited mail service;
- 12) defined pharmacy provider reimbursement methodology;
- 13) vacation supplies;
- 14) drugs not covered;
- 15) CMS Employer Direct Prescription Drug Plan requirements;
- 16) Point-of-sale coordination of benefits;
- 17) participant copays;
- 18) coinsurance;
- 19) identification cards;
- 20) handling and responding to all correspondence;
- 21) compound prescription claim processing; and
- 22) restrictions on claim payment due to the age of claim.

Pharmacy benefits are administered as a separate component of OSEEGIB's health plan named "HealthChoice." HealthChoice membership is comprised of approximately 180,000 lives each of whom may utilize pharmacy benefits. These participants are primarily State, local government, education employees, retirees and dependents. Pursuant to an interagency agreement with the Department of Rehabilitation Services (DRS), OSEEGIB furnishes PBM services to approximately 12,000 DRS lives.

OSEEGIB's HealthChoice pharmacy plan design and benefit structure are generally described by the following numbered paragraphs. OSEEGIB and the PBM that receives the award of the Contract will prepare documentation that contains specific requirements and specific documentation for implementation of these benefits and plan design.

1) Participant Eligibility Records:

Each participant's records are maintained in an Oracle database that is identified by participant number, specific group, health plan, eligibility date, and other industry standard information. The PBM issues an identification card to the participant. The OSEEGIB participant eligibility file is updated daily and incremental changes are transmitted to the PBM

via a dedicated line.

2) Out-of-State Network Benefits:

Pharmacy services obtained at an out-of-state network pharmacy are presently covered in the same manner as if an in-state network pharmacy is utilized.

3) Formulary:

The formulary identifies the listed medications as preferred and non-preferred. The participant is required to pay the cost of the medication up to \$25 if the cost of the preferred medication is \$100 or less, and 25% of the cost of preferred medication costing greater than \$100, up to a maximum of \$50 if using one of the preferred medications. The participant is required to pay the cost of the medication up to \$50 if the cost of the non-preferred medication is \$100 or less and 50% of the cost of the non-preferred medication up to a maximum of \$100 when the cost is greater than \$100.

If the physician believes that a member should have a medication in the non-preferred grouping, at a preferred copayment, a letter of medical necessity is required. If approved by the PBM, based on protocols authorized by OSEEGIB or as a result of a grievance decision, the non-preferred medications may be available to the participant for the preferred copayment. See: www.sib.ok.gov for OSEEGIB's Medicare and non-Medicare formularies.

4) Out-of-Network Claims:

Out-of-Network claims are subject to the following:

- a) The participant pays the retail cost of the medication up to \$75.00 plus the dispensing fee for preferred products;
- b) The participant pays the retail cost of the medication up to \$125.00 plus the dispensing fee for non-preferred products.

5) Generic Mandatory Program:

If a member chooses to purchase a brand name medication when a generic is available, the member pays the copay for the generic medication plus the difference in cost between the generic and brand name medication unless the member has met the medical necessity requirement. OSEEGIB is responsible for the dispensing fee.

6) Provider Identification Number (PIN):

For each pharmacy claim, the PBM shall capture and report the prescriber's Drug Enforcement Administration (DEA) number, Oklahoma Medicaid Provider Number, or unique National Provider Identifier (NPI) developed by the

Federal government.

7) Quantity Limits and Unit of Use:

The pharmacy benefit covers prescription medications with one copayment per thirty-four (34) days supply or one hundred (100) units (tablets, capsules), whichever is greater. Some medications have a maximum quantity limitation because the recommended therapy is less than thirty-four (34) days and/or one hundred (100) units (tablets, capsules) and/or the dosage form is not a tablet or capsule. Some diabetic and ostomy/colostomy supplies are covered.

8) Out-of-Pocket and True Out-of-Pocket (TrOOP) Maximums:

A \$2,500 per calendar year out-of-pocket maximum applies for all active and pre-Medicare participants. Once the member pays \$2,500 in prescription benefit copayments for in-network preferred products, the member will no longer be charged a copayment for in-network preferred products for the remainder of the calendar year.

The TrOOP maximum is established annually by CMS for Medicare participants. All costs incurred for formulary drugs, whether preferred or non-preferred, apply toward TrOOP.

9) Prior Authorization:

Prior Authorization is a tool to manage access to certain medications that are not covered unless prior approval is obtained. Prior Authorization is currently required for the specific medications and general categories of drugs listed in Exhibit B.

SEE EXHIBIT B - Medications/Categories for Prior Authorization

10) Mail Service:

Mail service is currently available only to inactive primary members and their dependents that live outside the State of Oklahoma.

11) Reimbursement Methodology:

The pharmacy provider's reimbursement is issued by the PBM on OSEEGIB check stock.

The pharmacy provider's reimbursement per prescription includes a dispensing fee plus the cost of the medication. The dispensing fees have historically always been paid by OSEEGIB for POS pharmacy claims. The cost of the medication is based on the lower of:

- a) MAC for a multisource medication;

- b) the pharmacy's Estimated Acquisition Cost (EAC) for the product { Average Wholesale Price (AWP) less a discount};
- c) the pharmacy's Usual and Customary charge (U&C) for the prescription; or,
- d) the pharmacy's submitted cost of medication.

12) Reimbursement Rates:

- a) for urban independents in Oklahoma:
 - i) Brands: AWP- 13% + \$2.50
 - ii) Generics: AWP – 13% or MAC + \$2.50
- b) for rural independents in Oklahoma:
 - i) Brands: AWP – 10% + \$3.00
 - ii) Generics: AWP – 10% or MAC + \$3.00
- c) for national network and chains in Oklahoma:
 - i) Brands: AWP – 13% + \$2.00
 - ii) Generics: AWP – 13% or MAC + 2.50
- d) for paper claims, the reimbursement rate is as follows:
 - i) AWP-13%+\$2.50 dispensing fee.

Claims received over the benefit maximum shall be calculated at the benefit level using a unit-calculated amount, not a percentage of the claim.

13) Vacation Supplies:

Members may be prior authorized to receive an additional supply. The member is responsible for paying a copayment for each thirty-four (34) days supply or one hundred (100) units, whichever is greater, or the respective limit on unit-of-use.

14) Drugs Not Covered:

There are certain medications that are not covered under the plan such as:

- a) appetite suppressants;
- b) impotency medications;
- c) investigational and/or experimental medications;
- d) prescription medications with over-the-counter equivalents; and,
- e) medications available without a prescription.

E. Identification of Plans

In addition to the HealthChoice plans, OSEEGIB administers a plan for the Department of Rehabilitation Services (DRS), an Oklahoma State Agency. OSEEGIB agreed with DRS pursuant to an interagency agreement to provide DRS with claims processing, quality assurance, reporting, customer service, and drug utilization review. This plan's activity must be reported separately. This plan of benefits requires that all medications have prior authorization. Identification cards are not required to be produced by the PBM for this plan. The DRS is federally funded, and eligibility information is provided to the PBM by DRS.

F. Identification of Participants

The number of participants in OSEEGIB Plans as of May 31, 2006 is identified in Exhibit C, sorted by Member categories.

The statistical information contained in Exhibit C and throughout this document, is believed to be accurate for the date specified but is not intended as, and must not be considered, an express or implied warranty by OSEEGIB.

SEE EXHIBIT C - Number of Insured Lives Sorted by Member Categories

G. Eligibility and Accounting System

OSEEGIB uses the V3 application for its Eligibility and Premium Accounting system developed by Vitech Systems Group, Inc. This system is currently operating in a Windows server environment utilizing an Oracle database.

H. Pharmacy and Therapeutics Committee (P&T) and Clinical Subcommittee (CSC)

1) OSEEGIB's Pharmacy and Therapeutics Committee (P&T)

OSEEGIB's P&T provides management with recommendations, advice and/or consultation regarding cost-effective medication utilization, pharmacy benefit design and optimization of pharmaceutical therapies. The P&T generally schedules bi-monthly meetings at OSEEGIB's office where it reports to management and serves as a policy advisory body.

The PBM will actively participate and present information to this proactive committee.

2) Clinical Subcommittee (CSC)

The CSC provides management with recommendations regarding member second-line appeals and cost-effective pharmaceutical therapies. The first appeal is adjudicated solely by the PBM. The CSC reports to management

and serves as a policy advisory body. The PBM furnishes requested participant and PBM information concerning participant appeals. For Medicare Part D appeals, the CSC reviews the initial denial of benefits as an intermediary determination before the member files a request of review by the Independent Review Entity (IRE) under contract with CMS.

II. Schedule of Events

- A. Department of Central Services Releases RFP..... Thursday, September 21, 2006
- B. Responses Due 3:00 p.m., Thursday, October 5, 2006
- F. Pre-Award On-Site Visits (if necessary).....November 2006
- G. Negotiation Meeting(s) (if necessary)December 2006/January 2007
- H. OSEEGIB's Recommendation..... January 26, 2007
to Department of Central Services
- I. Department of Central Services Awards Contract February 2007
- J. Implementation Period.....February through December 31, 2007
- K. Print 2008 Formulary..... August 1, 2007
- L. Post 2008 Formulary to WebsiteSeptember 1, 2007
- M. Customer Service Staff Prepared to Answer
Member/Potential Member QuestionsSeptember 15, 2007
- N. Eligibility Must Be Functional December 1, 2007
- O. Contract Effective DateJanuary 1, 2008

All PBMs interested in receiving claims history data at the pre-proposal conference shall provide DCS with a Notice of Intent to Bid.

OSEEGIB reserves the right to alter these dates, issue amendments to this RFP, cancel or re-issue this RFP at any time for any reason.

The PBM must agree to make any of its facilities available to OSEEGIB if it is determined that an on-site visit would be beneficial and utilized as part of the final evaluation process.

III. Minimum Requirements

The PBM shall comply with all requirements in this section and provide appropriate documentation in its response to each Minimum Requirement. The PBM's compliance with the requirements in this section shall be determined according to the sole unrestricted discretion of OSEEGIB. The PBM must state in its response exactly how it will comply, and provide detailed information, stating affirmatively its understanding of the requirement and its agreement to comply with that requirement for the duration of the contract. Bids failing to meet Minimum Requirements shall not be considered.

A. Financial Information

The PBM must demonstrate its financial stability by providing OSEEGIB with copies of audited financial statements for the PBM's three (3) fiscal years previous to the date of its response. OSEEGIB shall exercise its sole discretion in evaluating such information. The selected PBM shall provide such financial information and a SAS 70 report to OSEEGIB on an annual basis.

B. Experience

The PBM shall demonstrate its experience in performing the requested services and exchanging Prescription Drug Event (PDE) records or Retiree Drug Subsidy information and cost reports with CMS and explain, in narrative, additional experience resulting from the Medicare Modernization Act.

The PBM shall disclose what percentage of its full service book of business would be represented by OSEEGIB if it has or were to have had OSEEGIB as a client in 2006.

C. References

Provide contact names of at least three (3) non-affiliated clients, addresses, telephone numbers, email addresses, fax numbers, types of services provided and the number of participants. If applicable provide contacts for CMS required services. If applicable, please offer one client that has dealt with transparency issues.

D. License

To be eligible to submit a proposal under this RFP, an organization must meet all legal requirements for doing business in the State of Oklahoma. The PBM must provide a copy of its administrator's license issued by the Insurance Commissioner for the State of Oklahoma. If the PBM is not currently licensed by

the State of Oklahoma, it must act with due diligence in obtaining said license upon notification of award of this contract and give a statement to this effect as part of its response.

E. No Commissions

The PBM agrees:

- 1) to and shall perform all services described in this RFP and the final OSEEGIB/State of Oklahoma contract, strictly according to a fee-for-services basis;
- 2) that absolutely no commissions or finder's fees shall be paid to anyone or any organization resulting from the State of Oklahoma's contract, either arising from an agreement to pay a commission or finder's fee prior to or during the term of this contract; and,
- 3) to provide a statement as part of its response to this RFP, and prior to each contract renewal, that absolutely no commissions or finder's fees are to be paid to any subcontractor, broker, agent or other individual, organization or entity.

F. Conflict

The PBM shall disclose any apparent or potential conflict of interest or affirm that it has none. The PBM shall have no interest, direct or indirect, that could be perceived to conflict in any manner or degree with the performance of services required under this contract. The PBM shall not engage in any conduct that violates or induces others to violate provisions in the Oklahoma Statutes regarding the conduct of public employees. See: The Anti-Kickback Act of 1974 at 74 O.S. 2001, § 3401, et seq., and the Conflict of Interest provision in the Oklahoma Central Purchasing Act at 74 O. S. 2001, § 85.3.

G. Lawsuits and Litigation

The PBM must disclose unless prohibited by securities laws any prior lawsuits and litigation, violations of administrative rules and hearings, or any lawsuits and litigation threatened or impending, involving itself and the State of Oklahoma or any political subdivisions, and/or any state officer and/or any state employee acting in the capacity of a state employee, and any settlements, compromises or Judgments of Record resulting from the foregoing described litigation or administrative proceedings for the past five (5) years or affirm there are none. If the PBM determines the aforementioned information to be confidential, it shall provide a statement of that fact.

The PBM shall list and disclose contract cancellations or negligent causes of

action that arose from work performed that is the same or similar to work identified in the Scope of Services in this RFP that was initiated by persons or entities other than the PBM and resulted in a settlement with or judgment against the PBM in any jurisdiction in the United States in an amount of One Hundred Thousand Dollars (\$100,000) or more within the previous five (5) years, or affirm there are none.

The PBM shall disclose any data security breaches and specifically any HIPAA security breaches.

H. Federal Exclusion List

The PBM affirms and agrees that it complies with the federal statutes and regulations concerning persons who are listed on the Excluded Parties List System maintained by the General Services Administration, or excluded from receiving payment from federal government programs by the Department of Health and Human Services, Office of Inspector General.

I. Fraud, Waste & Abuse Compliance Program

The PBM must acknowledge OSEEGIB's Fraud, Waste & Abuse Compliance Program. The compliance program can be viewed at www.sib.ok.gov (Go to Site Map, then click on Fraud Waste and Abuse Program, then Compliance Program.) The PBM must include in its Fraud, Waste & Abuse training efforts at least one hour annually of training for applicable PBM employees.

J. Statement of Compliance

Other than what is specified as a Minimum Requirement, certain conditions may preclude the PBM from meeting each and every detail specified in this RFP. It is also foreseeable that the PBM will have a better method of accomplishing the requirements of the RFP. The PBM should outline in its response how the PBM would accomplish OSEEGIB's requirements as stated and then outline alternative ways of doing business offered by the PBM and alternative pricing, if applicable.

OSEEGIB and the Department of Central Services shall determine, at their discretion, whether an alternative method offered by the PBM is acceptable to OSEEGIB.

Any alternative method or exceptions to terms, conditions or other requirements in any part of the RFP must be described in both the appropriate section of the proposal and listed in the Statement of Compliance attached to and made a part of this RFP. Otherwise, OSEEGIB shall consider that all items offered are in strict compliance with the RFP and the PBM shall be responsible for compliance. OSEEGIB shall specify at the time of the awarding of the contract what, if any, optional, alternative methods are accepted.

Notwithstanding anything to the contrary herein, any and all decisions as to suitability, competency, ability to perform, conflicts of interest or the appearance thereof, responsiveness of the PBM's proposal, acceptability of such proposal, or other decisions of qualifications with performance, shall be at the sole discretion of OSEEGIB and/or the Department of Central Services.

IV. Scope of Services

The PBM shall comply with all requirements in this section. The PBM must state in its response exactly how it will comply, providing detailed information and stating affirmatively its understanding of the requirement(s). Any alternative method offered by the PBM to the required Scope of Services shall be considered as to whether the alternative method is or is not in the best interest of the plan, and shall be evaluated accordingly. Said alternative method(s) shall be listed by the PBM in the attached Statement of Compliance.

In the event the PBM proposes a service requirement by different procedures with a similar result, the PBM shall explain in detail and provide the potential impact to OSEEGIB, its members and pharmacists. No such alternative method may be substituted by the PBM without express written approval of OSEEGIB.

All services required in this RFP are all-inclusive, and the PBM shall not charge any additional fees including, but not limited to line charges, upgrades, mailings and postage. Any additional services that the PBM intends to provide OSEEGIB, and which are included in the fees quoted in the response to this RFP, should be described in the PBM's response. Any additional services that the PBM intends to provide OSEEGIB, and which are not included in the administrative fees quoted, shall be itemized in the PBM's financial proposal.

PART ONE – PBM Administration Services (Generally Non-Medicare)

The services required in Part One shall apply to Part Two unless specifically addressed and thereby superseded in Part Two.

A. Pharmacy Network

- 1) The PBM shall have developed and maintained an Oklahoma statewide network within one hundred twenty (120) days after the award of the contract. The network shall be comprised of no fewer than ninety-five percent (95%) of Oklahoma community pharmacies.

The PBM must state:

- a) How many participating pharmacies are currently in the PBM's network in the State of Oklahoma?
 - b) What percentage of the total number of Oklahoma pharmacies does the PBM expect to be in the PBM's network?
- 2) The PBM shall have developed and maintained a national network of at least 35,000 pharmacies.

The PBM must state:

- a) How many participating pharmacies are currently in the PBM's national network?
- b) What growth in the PBM's national network is anticipated for each year of this contract?
- 3) The PBM shall contract with the network pharmacies in a pass-through arrangement ensuring that OSEEGIB's reimbursement is accepted as the complete reimbursement and that the pharmacists shall collect all applicable copayments, coinsurance, deductibles, taxes, if applicable, and/or dispensing fees. There shall be no claims processing line charges or claims transmittal costs charged to Oklahoma network pharmacies. The PBM must fully answer the following questions:
 - a) If OSEEGIB agrees to a pharmacy reimbursement other than the pass-through it is presently requiring, how would this impact OSEEGIB?
 - b) Does the PBM have a pharmacy relations department? If so, please describe.
 - c) What are the distinguishing features of the PBM's network(s)?
 - d) Describe the PBM's network contracting philosophy.
 - e) List the criteria and standards used to initially credential a network pharmacy.
 - f) Describe the PBM's established re-credentialing practices and explain the need and frequency to re-credential.
 - g) Describe the PBM's process for investigating and resolving customer complaints and quality of care issues with the PBM's network pharmacies.

B. Claims Administration

- 1) The PBM shall calculate the pharmacy benefits. The 2006 HealthChoice pharmacy benefits may be found on OSEEGIB's website at the following address: www.sib.ok.gov (Go to Site Map and view Handbooks)

SEE EXHIBIT A – Copayment Logic

- a) Describe how the following plan provisions are handled by the system:
 - i) unit of use,

- ii) individual deductible limits,
 - iii) calendar year member maximum,
 - iv) TrOOP,
 - v) single deductible with coinsurance,
 - vi) two tier copays and percentage copays,
 - vii) maximum quantity limits, and
 - viii) lifetime maximum for pharmacy
- b) Describe in detail the PBM's ability to capture and report all previous and on-going pharmacy claims history on a member-level basis for the purposes of calculating the pharmacy lifetime maximum of Two Million Dollars (\$2,000,000).
- c) Describe the PBM's ability to adjudicate claims electronically (POS) at the pharmacy.
- d) Describe in detail the PBM's capabilities to coordinate benefits for secondary claimants for both paper claims and electronic POS claims and the PBM's ability to capture the primary insured's name, effective date and termination date of the primary plan.
- e) Describe the PBM's ability to assign benefits and pay providers directly, such as the Veteran's Medical Center, Indian facilities, Medicaid, and health care providers.
- f) Describe the processing turn-around time for paper claims and identify the department within the organization that processes these claims. If this service is performed by an entity under contract with the PBM, fully identify the subcontractor and its experience with the PBM.
- 2) The PBM must have the ability to process and adjudicate the Generic Mandatory Program, quantity limits, OSEEGIB's formularies, customized prior authorization procedures, mail service, vacation supplies, compounds, claims age and medications not covered according to OSEEGIB plan design and reimbursement methodology.
- a) Provide a detailed explanation as to how the PBM will comply with these requirements.
- 3) The PBM shall provide the forms for out-of-network paper claims and mail service.
- a) Provide a sample claim form and the information that is sent to members to access mail service.
- 4) Presently the PBM offers a free glucometer to members newly diagnosed with

diabetes.

- a) Identify whether the PBM intends to continue this program and describe any similar programs that it currently offers.
- 5) OSEEGIB utilizes DEA, DHS and NPI numbers, but does not currently require an online edit validating the information being transmitted by the pharmacy. The PBM shall have the ability if requested by OSEEGIB to edit submitted prescriber data online for valid values.
- a) What physician-specific data is captured and reported for all pharmacy network drug claims?
 - b) Describe the options available to OSEEGIB for capturing, reporting, editing and checking validity of prescriber information to be utilized in outcome studies and provider mailings.
- 6) Upon written instruction from OSEEGIB, the PBM shall be able to limit and/or restrict plan privileges to a pharmacy, physician, medication, or member.
- a) Explain how the PBM will accomplish this task.
- 7) The PBM shall provide and distribute an Explanation of Benefits (EOB), claims history profile, or a report by an “on-request” basis for a specific time frame as requested by members and/or OSEEGIB.
- a) Provide a copy of the EOB, claims history profile or a report that will be generated to the member or OSEEGIB for patient history of benefits on an “on-request” basis.
 - b) Provide a copy of an EOB, claims history profile or a report(s) that will be generated to the network pharmacies and the Veterans’ Administration facility for claim payment.
 - c) What is the time frame from receipt of an EOB request to the time the EOB is sent to the requester?
- 8) The PBM must actively pursue all outstanding and future overpayments to members, providers and pharmacies and provide procedures to reimburse OSEEGIB in a reasonable period.
- a) Describe in detail the PBM's recoupment of overpayment process and procedures.
 - b) Describe the PBM's ability to actively pursue overpayments that were incurred by the previous PBMs.

- c) Describe the PBM's ability and timeframes to make payment to a member when it is determined the member has been overcharged.
- 9) The PBM must identify all overpayments to members who are terminated retroactively. The PBM must apply payments and send letters notifying members. This also includes the loading and tracking of overpayments identified by the previous PBM
- a) Describe the process by which the PBM will identify the overpayments, notify the member of the overpayment, and track any payments received by the member.
 - b) Describe the PBM's ability to actively pursue overpayments that were incurred by the previous PBMs.
- 10) The PBM shall send all returned mail on a weekly basis to the address provided by OSEEGIB and shall not change or modify addresses without the specific consent of OSEEGIB.
- a) Describe the PBM's process for accomplishing this requirement and the frequency of the notification.
- 11) The PBM shall respond to all inquiries (written, telephonic, and email) from pharmacies, providers or members within forty-eight (48) hours of receipt.
- a) Describe in detail the PBM's procedures and response time.
- 12) The PBM must have registered pharmacists available on a full-time basis to act as liaisons with the network pharmacy community regarding specific drug questions. Registered pharmacists shall also be available to review questionable medication claims, such as exceptions to the mandatory generic program.
- a) How many registered pharmacists does the PBM currently have acting as liaisons?
- 13) The PBM shall be responsible for the MAC pricing program, including the breadth of the list, the frequency of updates, and the MAC price calculation.
- a) Provide the credentials of the person(s) responsible for selecting and assuring the quality of the MAC program and in general terms describe the process for determining the MAC.
 - b) Currently, what percentage of drugs dispensed are on the MAC list?
 - c) What is the effective discount for generic drugs that have a MAC price?

- d) What is the discount and dispensing fees for generic drugs that do not have a MAC price?
 - e) What is the discount for all generics and will the PBM guarantee the discount?
 - f) Is the PBM willing to guarantee annual increases in the percent of total prescriptions that are generic and if so, state the guarantee for each year of the contract?
- 14) The PBM shall administer a rebate program with pharmaceutical manufacturers. OSEEGIB considers a rebate to be all upfront, concurrent, or retrospective payments, reimbursements or discounts (other than a purchase price discount) received by the PBM from a pharmaceutical manufacturer, distributor, wholesaler, or other entity, including but not limited to monetary amounts associated with formulary, market share, utilization, clinical allocations, formation and administration of rebate contracts with pharmaceutical manufacturers, distributors, wholesalers or other entities and other administrative or data fees including those earned through formulary switching programs, Pharma relationships, Pharma-funded disease management programs, educational grants, academic detailing or other pharmaceutical manufacturer service agreements. The PBM shall submit claims for rebates to the pharmaceutical manufacturers quarterly.

The PBM, its subsidiaries and subcontractors, must fully disclose all relationships with pharmaceutical manufacturers and all income, whether rebates or fees, received from pharmaceutical manufacturers, that relate to OSEEGIB's business. All rebate and fee activity shall be reported quarterly to OSEEGIB on the first 9 digits of the 11 digit National Drug Code (NDC) level. Drug therapies should not be influenced solely by pharmaceutical manufacturers' rebates. The decision to prescribe drugs must be left up to the professional discretion of the member's physician.

- a) Describe the PBM's collection procedures for rebates and the turnaround time for remitting payment to OSEEGIB.
- b) If the PBM is owned by a drug chain store, insurance company and/or pharmaceutical manufacturer, describe the policies and procedures in place to ensure independence with respect to formulary decisions.
- c) State the PBM's definition of "full disclosure."
- d) Is the PBM willing to guarantee a minimum rebate amount payable to OSEEGIB? If so, please state the minimum rebate guarantee on a per prescription basis.
- e) Disclose whether the PBM contracts with the drug manufacturers are based

on individual drugs or contingent upon multiple drugs being named on the formulary?

- 15) The PBM must demonstrate its ability to administer a customized formulary. The PBM shall make a statement confirming its understanding that OSEEGIB reserves the right to maintain the breadth of medications within therapeutic classes, maintaining consistency of the formulary for its membership.

Note: OSEEGIB maintains its formulary in conjunction with the PBM's activities in its rebate program.

- a) Describe in detail the process the PBM will use to review and provide recommendation to OSEEGIB for changes to the current HealthChoice formulary.
- b) What is the PBM's policy regarding the addition of newly approved generic drugs to its formulary both for new chemical elements and new generics for drugs due to go off patent?

- 16) The PBM shall administer prior authorization procedures.

- a) Describe the PBM's procedures and timeframes for prior authorization of medications.
- b) Can prior authorization criteria be customized to OSEEGIB criteria? If so, what is the implementation process and timeline?
- c) Identify the department(s) within the PBM organization that administers prior authorizations for access, Brand/generic, lower copayments and quantity limits.
- d) Describe the PBM's ability to simultaneously review prior authorizations for access to medications and for lower copayments.

- 17) Currently all medications for DRS require a prior authorization before a claim is processed. The prior authorization has a specific tracking number. DRS would like a mandatory process that requires pharmacies to submit this DRS tracking number prior to the claim processing.

- a) Describe the ability and willingness of the PBM to create an edit or other process that requires a pharmacy to enter this number prior to a claim processing.

- 18) The PBM agrees that the benefit determination shall be at the sole discretion of OSEEGIB and that no additional charges shall be made to OSEEGIB for administrative services as a result of changes in the benefits.

- a) Describe the extent of pharmacy benefit modeling and consultation OSEEGIB can expect to receive from the PBM.
- 19) The PBM will administer a mail service program for OSEEGIB that is limited in participants and the volume is minimal at this time. Currently, OSEEGIB processes approximately eighty (80) mail order claims per month.
- a) Describe the PBM's mail order system or the PBM's alternative method for accommodating this requirement.
- 20) The PBM shall provide the State's Flexible Spending Account (FSA) debit card administrator, presently "Evolution Benefits," with financial data related to adjudicated prescription drug transactions. This data shall be used for the sole purpose of verifying that transactions on the debit card that take place in pharmacy settings are allowed by the FSA program.
- a) Can the PBM transmit the data in real time or by batch; and if the latter, what is the frequency?
- 21) The PBM shall provide a voluntary specialty pharmacy program subject to OSEEGIB's quarterly review and approval of the drugs included in the program and the fee schedule for those drugs.
- a) Describe in detail the specialty pharmacy program and anticipated savings.
 - b) Provide historical utilization trends for specialty pharmacy programs.
 - c) Address the financial impact of voluntary versus mandatory specialty pharmacy programs.
 - d) Provide a schedule identifying all specialty drugs offered through this program and the drugs corresponding fee.

C. Customer Service

- 1) The PBM shall maintain a toll-free customer service call center that manages telephone inquiries concerning verification of eligibility, plan benefits, status of claims, and explanation of claims payment of benefits. The customer service representative for member inquiries shall have access to all eligibility and claims systems. This means that the PBM must comply with at least the following:
- i) call center operates 24 hours a day, seven days a week;
 - ii) eighty percent (80%) of all incoming customer calls are answered within thirty (30) seconds;

- iii) the abandonment rate of all incoming customer calls does not exceed five percent (5%);
 - iv) call center provides thorough information about the benefit plan, including copayments, deductibles, and network pharmacies;
 - v) call center features an explicit process for handling customer complaints;
 - vi) call center shall provide service to non-English speaking and hearing impaired OSEEGIB members; and
 - vii) call center shall adequately staff for any holiday it observes that are not observed by the State of Oklahoma.
- a) Disclose the PBM's call center quarterly statistics for the most recent 12-month period addressing average answering speed and abandonment rate.
 - b) Describe how the PBM intends to perform the aforementioned services for this contract.
- 2) With respect to customer service to be provided under this contract describe the customer service support available for OSEEGIB members.
- a) How is the customer service department staffed? Indicate how many customer service representatives will be needed to handle the volume of calls for this program, which totaled an average of one hundred (100) calls per day in 2005 and whether the staff is dedicated to the OSEEGIB account.
 - b) Describe the initial and ongoing training programs for customer-service representatives, including any special training for dealing with seniors, Medicare participants, and Telecommunication Devices for the Deaf (TDDs).
 - c) Indicate the tools that supervisors and managers have online to manage and evaluate the quality of customer service representative performance.
 - d) Indicate the items to which customer service representatives have online access:
 - i) eligibility;
 - ii) claim form (POS and paper);
 - iii) prescription history/status retail;
 - iv) prescription history/status - mail order;
 - v) benefit coverage;
 - vi) status of questions/complaints;
 - vii) formulary;
 - viii) prior authorization history and status;

- ix) participating pharmacy locator;
 - x) ID card request;
 - xi) other (list)
- e) Describe how high call volume during peak days or specific peak time periods is managed.
 - f) Describe the procedures for answering members' questions regarding the status of a claim.
 - g) Can a customer service representative adjudicate a claim? If yes, under what circumstances can adjudication take place?
 - h) Describe how the customer service representatives can access registered pharmacists to address clinical questions.
 - i) Do members have access to a pharmacist 24 hours per day, 7 days per week? If so, how will members contact a pharmacist during non-business hours?
 - j) Describe the process and the speed with which the PBM can alert its customer service staff to a unique problem that may develop with a customer's plan.
 - k) Does the PBM measure the satisfaction levels of patients, pharmacies, physicians, and clients? If so, describe the instruments used for measurement and the outcomes of these measures for the last two years.
- 3) OSEEGIB performs an annual enrollment beginning in September for the plan year beginning the following January. By September 15 of each plan year, the PBM must be prepared and able to handle current and prospective member inquiries regarding the next year's benefit plan.
- a) To what extent will be the PBM be able to provide access to specific OSEEGIB plan information through its website (including formularies) to members and prospective members by September?
 - b) What is the process the PBM will use to have upcoming pharmacy plan information/changes available to its call center customer service representatives?
 - c) Describe any other processes not otherwise addressed above that the PBM has that could aid members or prospective members who have questions regarding the upcoming pharmacy plan to obtain the necessary information.

- 4) Toll-free numbers shall be provided at the expense of the PBM for both local (Oklahoma) and out-of-state lines. The PBM shall provide, maintain and train staff for communications with a Telecommunication Device for the Deaf (TDD).
 - a) Describe the telephone system and its capabilities.
 - b) Does the telephone system record customer inquiries?
 - c) Describe in detail the PBM's method for tracking telephone calls and indicate the categories being monitored.
- 5) The PBM shall provide a separate toll-free assistance line for access by the pharmacies. It shall provide access 24 hours a day, 365 days a year. Representatives assisting pharmacists shall have clinical and/or technical expertise.
 - a) Describe how the PBM will comply with this requirement.
 - b) Disclose the PBM's Pharmacy Help Line quarterly call center statistics for the most recent 12-month period addressing average answering speed and abandonment rate.
- 6) Any forms or member materials requested through the PBM customer service line shall be mailed within 48 hours of the request.
 - a) Describe the forms or materials that can be ordered or sent by the customer service representatives.
- 7) The PBM shall not provide members and/or providers of services written information about plans offered or administered by OSEEGIB regarding benefits and/or claim filing procedures, unless the document has previously been approved by OSEEGIB. The PBM is responsible for production, mailing and postage of all pharmacy benefit communications sent to participants, arising from the normal course of business, included, but not limited to, the dissemination of formularies, to all members and providers, prior authorization materials, marketing materials, claim forms, maintenance list and ID cards.
 - a) Describe the PBM's ability to develop, produce, and disseminate communication materials. Provide sample member, physician and client communication materials that will be used for this program.
 - b) Provide examples of the PBM's current participation in educating members about pharmacy benefits, including how to be better-informed consumers.

- 8) The PBM shall have a dedicated unit to assist OSEEGIB's pharmacy unit with member issues including claim adjustments, benefit questions, or any type of related issue. The PBM shall have this unit staffed from 8:00 a.m. to 7:00 p.m., CST.
 - a) Describe the unit being proposed and special capabilities to resolve issues quickly and accurately.
- 9) The aforementioned dedicated unit shall utilize OSEEGIB's web-based software for tracking member complaints. This software is called "Workflow" and it is used to respond to inquiries sent to the PBM by OSEEGIB. OSEEGIB expects routine member issues to be resolved in forty-eight hours, important issues in twenty-four hours and critical issues in three hours or less.
 - a) Provide definitions for "routine," "important" and "critical" and offer penalties to be assessed if the unit does not meet the defined performance standards.

D. Drug Utilization Review

- 1) The PBM shall provide a clinical representative who actively participates and provides written recommendations at OSEEGIB's P&T Committee and the CSC meetings.
 - a) Provide the credentials of the PBM's staff that will participate in the CSC and OSEEGIB P&T meetings.
 - b) Describe responsibilities and credentials of the PBM's P&T committee.
- 2) The PBM shall identify and report all new, changed and/or terminated prescription medications to OSEEGIB's P&T Committee.
 - a) Describe the PBM's process, how notification is provided, and the timeframe involved in both processes.
- 3) The PBM shall perform retrospective, concurrent and prospective DUR. The utilization management activities of the PBM shall include enhancing quality of care for patients by optimizing medication therapies.
 - a) Define and describe the scope of the PBM's perspective of medication utilization management.
 - b) Describe in detail the PBM's system options and/or services for the management of medication therapies by individual recipients to achieve optimum medication utilization.

- 4) The PBM shall identify, educate and perform outcome studies of members and providers regarding quantity, under-utilization, over-utilization, maximums, time limitations, and trends for medications utilized by members.
 - a) Describe in detail how the PBM can identify, educate and perform outcome analyses of members and providers.
 - b) If over-utilization is determined on a specific member, describe the process for the PBM to address the over-utilization, upon OSEEGIB consent, with the prescribing physician and the member.

PART TWO - Services Required for OSEEGIB'S PDP

A. CMS Contractual Requirements

- 1) The PBM agrees to contract with OSEEGIB to administer its PDP and to assume full responsibilities to perform all duties and responsibilities assigned to PBM in this Contract. The PBM warrants that its performance of services set forth in this Contract are compliant with any and all of OSEEGIB's contractual obligations with CMS as a PDP sponsor, and shall perform in accordance with current and future requirements and regulations of CMS, and abide by all applicable Federal and State laws.
 - a) Does the PBM agree?
- 2) The PBM shall abide by all applicable State and Federal privacy and security requirements, including the confidentiality and security provisions stated in the regulations for the PDP at 42 CFR § 423.136.
 - a) Does the PBM agree?
- 3) The PBM shall make its books and other records available in accordance with 42 CFR § 423.505(i)(2) which in general terms gives the Comptroller General of the Health and Human Services (HHS) division of the Federal Government or its designees the right to inspect, evaluate and audit books and any and all other records and that these rights continue for a period of ten (10) years from the final date of the contract period or the date of audit completion, whichever is later.
 - a) Does the PBM agree?
- 4) The PBM shall maintain for ten (10) years, books, records, and other documents, and other evidence of accounting procedures and practices consistent with 42 CFR § 423.505(d) or shall cause to be returned to OSEEGIB for proper maintenance should the Contract terminate prior to the

ten (10) year storage requirement.

a) Does the PBM agree?

5) The PBM acknowledges that any agreed upon service as it relates to this Contract may be revoked if CMS or OSEEGIB determine the PBM or a subcontractor has not performed satisfactorily.

a) Does the PBM agree?

6) The PBM acknowledges that OSEEGIB, a PDP sponsor, shall monitor, in accordance with this Contract, the compliance and performance of the PBM as those services relate to this Contract or as required by CMS under applicable law.

a) Does the PBM agree?

7) The PBM shall adjudicate and process pharmacy claims at the point of sale.

a) Does the PBM agree?

8) The PBM shall negotiate with prescription drug manufacturers and others for rebates, discounts, or other price concessions on prescription drugs.

a) Does the PBM agree?

9) The PBM shall administer and track enrollees' drug benefits in real time.

a) Does the PBM agree?

10) The PBM shall coordinate with other drug benefit programs, including, for example, Medicaid, state pharmaceutical assistance programs, or other insurance.

a) Does the PBM agree?

11) The PBM shall maintain a pharmacy network.

a) Does the PBM agree?

12) The PBM shall maintain a pharmacy benefit program that performs customer service functionality that includes serving seniors and persons with a disability.

a) Does the PBM agree?

13) The PBM shall provide OSEEGIB with a model pharmacy contract for each pharmacy type for its approval and agrees that OSEEGIB retains the right to approve, suspend, or terminate any arrangement with a network pharmacy under contract with the PBM, consistent with applicable law.

a) Does the PBM agree?

14) The PBM shall ensure that OSEEGIB members are not held liable for fees that are the responsibility of OSEEGIB.

a) Does the PBM agree?

15) The PBM acknowledges that, as required by CMS, its network pharmacy contracts include language generally providing for the following:

- i) description of the functions to be performed by the subcontractor, as well as any reporting requirements the subcontractor has to OSEEGIB;
- ii) contain language obligating the subcontractor to abide by all applicable Federal and State laws and regulations and CMS instructions;
- iii) contain language ensuring that the subcontractor shall make its books and other records available in accordance with 42 CFR § 423.505(i)(2);
- iv) contain language that the subcontractor shall ensure that OSEEGIB members are not held liable for fees that are the responsibility of the PDP sponsor;
- v) contain language that if OSEEGIB, as a PDP sponsor, delegates an activity or responsibility to the PBM and its subcontractors, that such activity or responsibility may be revoked if CMS or OSEEGIB determines the subcontractor has not performed satisfactorily. The subcontract may include remedies in lieu of revocation to address this requirement;
- vi) contain language specifying that OSEEGIB, upon becoming a PDP sponsor, shall on an ongoing basis monitor the compliance and performance of the PBM and pharmacies under contract with the PBM regarding the terms of this Contract and applicable CMS regulations.

a) Does the PBM agree?

- 16) If there is a government action, change in law or regulation, or change in the interpretation of law or regulation, or action by CMS that has a material adverse affect on the scope or nature of services provided hereunder, the parties agree to meet and discuss in good faith such change and modify this Contract as necessary to comply with such change and to preserve the relative economics of the parties prior to such change.
 - a) Does the PBM agree?
- 17) The PBM shall forward within one (1) business day any communication from CMS that is specific to OSEEGIB's account.
 - a) Does the PBM agree?

B. General PDP Services

The PBM shall provide OSEEGIB with necessary services to support the Prescription Drug Program as set forth below.

- 1) The PBM shall be responsible for capturing and reporting to CMS all required data fields as required by CMS in accordance with applicable law in the Prescription Drug Event (PDE) Record Data Elements.
 - a) Does the PBM have experience reporting PDE records to CMS? If so, describe the experience and the size of client/PDE records provided to CMS.
 - b) Has CMS requested any adjustments/corrections from the PBM on the PDE records?
- 2) The PBM shall be responsible for building and implementing OSEEGIB's PDP benefit plans for the 2008 program and each future benefit year, subject to the terms of this Contract.
 - a) Considering the LIS plans required by CMS, how many plan designs do the PBM's clients typically have?
 - b) What difficulties has the PBM experienced with multiple plan designs?
- 3) The PBM shall be responsible for submitting all drug claims data to CMS on behalf of OSEEGIB as required by CMS in accordance with applicable law.
 - a) Describe how the PBM intends to submit drug claims data to CMS.
- 4) The PBM shall be responsible for exchanging all eligibility data to CMS on behalf of OSEEGIB as required by CMS in accordance with applicable law.

- a) Describe in general how the PBM shall exchange eligibility data to CMS.
- 5) The PBM shall be responsible for forwarding to OSEEGIB premium payment data received from CMS on behalf of OSEEGIB, within one (1) business day after receipt. The premium payment from CMS will be wired directly to OSEEGIB's account at its designated bank.
 - a) Describe the PBM's payment reconciliation processes and the delegation of duties between OSEEGIB and the PBM.
 - 6) The PBM shall assist OSEEGIB with its renewal application to CMS as a PDP sponsor, if necessary, and provide all of the necessary data that are required by CMS in a timely manner to assist OSEEGIB in renewing its CMS Contract by the required dates established by CMS. In addition, the PBM shall provide OSEEGIB with any applicable waiver requests that should be obtained from CMS.
 - a) Describe the services provided by the PBM in assisting OSEEGIB in meeting CMS requirements.
 - 7) The PBM shall assist OSEEGIB with its formulary submission to CMS and provide all of the necessary data that is required by CMS in a timely manner to assist OSEEGIB in completing its submission by the required dates established by CMS. The upcoming plan year formulary shall be provided to OSEEGIB at least ten (10) business days prior to the required due date. The monthly formulary update shall be provided not less than five (5) business days prior to the first day that the update can be made.
 - a) Will the PBM allow OSEEGIB to customize its Medicare Formulary or must OSEEGIB select from the PBM's standard Medicare formularies that have been approved by CMS?
 - b) If the PBM's standard Medicare formulary is used, how different is this formulary from its "commercial" formularies?
 - c) Describe the PBM's procedures for updating the Medicare formulary including time frames, approval by P&T, additions and deletions.
 - 8) The PBM shall host, on behalf of OSEEGIB, any site visit requested by CMS. In addition, the PBM shall:
 - i) Participate in all conference calls with CMS during the CMS review process;
 - ii) Provide training, during at least two (2) meetings with OSEEGIB, to coordinate policies and issues that CMS will review, prior to the first site visit from CMS; and,
 - iii) Train PBM employees who will be assigned to the Insurance

account in regard to OSEEGIB's Medicare plans.

- a) Has the PBM had, or does it anticipate a site visit from CMS? If so, what were the results of the site visit?
 - b) If applicable, what steps did the PBM take to prepare for the site visit?
- 9) The PBM shall update the website formulary at least monthly, or in accordance with CMS guidelines.
- a) Describe the PBM's procedures for updating the website for formulary changes.
- 10) The PBM will update the abridged and comprehensive formulary guidelines quarterly. The first formulary guides for Plan Year 2008 will be due August 1, 2007.
- a) State whether the PBM is presently providing these services.
 - b) Describe how the PBM intends to perform the aforementioned services for this contract.
 - c) Describe a cost-effective method for providing an abridged and comprehensive formulary for members and providers.

C. Pharmacy and Therapeutics (P&T) Committee

- 1) The PBM shall develop and use a P&T committee to review OSEEGIB's PDP formulary and to ensure by working with OSEEGIB's P&T Committee that the formulary is appropriately revised to adapt to both the number and types of drugs on the market, as required by CMS, and that they are consistent with applicable law and applicable professional principles.
 - a) Describe how the PBM's P&T committee will work with OSEEGIB's P&T committee to accomplish mutual goals of formulary selection.
 - b) What difficulties does the PBM envision when OSEEGIB's formulary is different from the formulary recommended by the PBM's P&T?
- 2) The majority of the membership of PBM's P&T committee shall be practicing physicians and/or practicing pharmacists.
 - a) Does the PBM agree to meet CMS's requirements for the membership of the PBM's P&T committee?
- 3) The membership of the PBM's P&T committee shall include at least one practicing physician and at least one practicing pharmacist who are free of conflict with respect to the PBM's organization, OSEEGIB and with pharmaceutical

manufacturers.

- a) Does the PBM agree to meet CMS's requirements for the membership of the PBM's P&T committee?
- 4) The membership of the PBM's P&T committee shall include at least one practicing physician and at least one practicing pharmacist who are experts in the care of the elderly or disabled persons.
 - a) Does the PBM agree to meet CMS's requirements for the membership of the PBM's P&T committee?
- 5) The PBM shall verify that the PBM's P&T committee members do not appear on the HHS Office of the Inspector General's Exclusion List.
 - a) Verify that the PBM's current P&T committee members do not appear on the HHS Office of the Inspector General's Exclusion List.
- 6) The PBM shall provide OSEEGIB with the names of the members of the PBM's P&T Committee and indicate which members are practicing physicians, practicing pharmacists and/or experts in the care of the elderly or disabled. The PBM shall assure OSEEGIB complies with CMS requirements that the P&T committee members are not employees of the PBM, beyond the number set forth by CMS. Certifications and evidence of expertise shall be provided to OSEEGIB within ninety (90) days of appointment to the P&T committee.
 - a) Does the PBM agree to provide the required documentation?
- 7) The PBM's P&T committee shall first look at medications that are clinically effective. When two or more drugs have similar or nearly the same therapeutic advantages in terms of safety and efficacy, the committee may review economic factors that achieve appropriate, safe, and cost-effective drug therapy.
 - a) Describe how the PBM's P&T committee reviews medications for inclusion on the formulary.
- 8) The PBM shall assure OSEEGIB that the PBM's P&T committee uses appropriate scientific and economic considerations to consider utilization management policies that affect access to drugs, such as exception processing of non-formulary drugs, prior authorization, step therapy, generic substitution, and therapeutic interchange protocols. The PBM shall provide OSEEGIB upon its reasonable written request, with information on these programs and provide information for new drugs that the PBM receives from pharmaceutical manufacturers for consideration by OSEEGIB for formulary inclusion.
 - a) Describe how the PBM's P&T committee determines what utilization management policies apply to affected drugs.

- 9) The PBM shall adhere to CMS rules and regulations pertaining to information and operations of P&T committee which may include but not be limited to membership, conflict of interest, meeting schedule, meeting minutes, therapeutic classes, drug review and inclusion, formulary management, utilization management and review, formulary exceptions, and educational programs for providers.
 - a) Does the PBM agree to adhere to CMS rules and regulations pertaining to information and operations of the PBM's P&T committee?

- 10) The PBM's P&T committee shall make a reasonable effort to review within ninety (90) days of new drugs released to the market, and shall make a decision on each new chemical entity, and new FDA approved clinical indications, within one hundred eighty (180) days of its release onto the market, or a clinical justification shall be provided if this timeframe is not met.
 - a) Describe the PBM's timeframes for reviewing new drugs released to the market and for reviewing new chemical elements and new clinical indications.

- 11) The PBM will inform OSEEGIB of the decisions made by the PBM's P&T committee to the PBM's standard Medicare formulary and shall advise OSEEGIB regarding the inclusion or exclusion of the therapeutic classes in OSEEGIB Medicare formulary on at least an annual basis.
 - a) Describe the procedures for informing OSEEGIB of the decisions made by the PBM's P&T committee.

- 12) The PBM will provide OSEEGIB, upon the written request of OSEEGIB, with the protocols and procedures of the PBM's P&T Committee and the PBM's P&T Committee will review, upon reasonable written request, OSEEGIB's protocols and procedures for the timely use of and access to both formulary and non-formulary drug products.
 - a) Does the PBM agree to provide OSEEGIB with the protocols and procedures of the PBM's P&T committee?

D. Utilization Management Standards

- 1) The PBM shall maintain policies and procedures to prevent over-utilization and under-utilization of prescribed medications, including but not limited to the following elements:
 - i) compliance programs designed to improve adherence/persistency with appropriate medication regimens;
 - ii) monitoring procedures to discourage over-utilization through multiple prescribers or multiple pharmacies;
 - iii) quantity versus time edits;

- iv) early refill edits;
 - v) duration of therapy edits; and
 - vi) duplicate therapy edits.
- a) Describe the PBM's utilization management standards to prevent over-utilization and under-utilization of prescribed medications.
- 2) The PBM shall maintain methods to ensure cost-effective drug utilization management. Examples of these tools include, but are not limited to:
- i) step therapy;
 - ii) prior authorization;
 - iii) tiered cost-sharing; and
 - iv) coinsurance cost-sharing.
- a) Describe the PBM's utilization management tools which the PBM finds most cost effective.
- 3) The PBM shall make OSEEGIB members aware of utilization management program requirements through information and outreach materials.
- a) Describe how the PBM shall make OSEEGIB members aware of such utilization management tools.
- 4) The PBM shall develop incentives to reduce costs when medically appropriate such as, but not limited to, encouragement of generic utilization. The PBM shall report to OSEEGIB on at least an annual basis newly developed incentive programs. Said programs must be approved by OSEEGIB prior to implementation in its benefit plans.
- a) Describe methods to increase OSEEGIB's generic utilization rate.
- 5) The PBM shall provide to OSEEGIB not less than five (5) business days prior to the required CMS due dates, data for utilization management standards in the manner prescribed by CMS.
- a) Overall, for the PBM's current client base, what is the generic utilization rate?
 - b) What are the highest and lowest generic utilization rates by specific clients?

E. Quality Assurance and Patient Safety

- 1) The PBM shall establish a quality assurance program, and provide the contents of that program to OSEEGIB, that includes measures and reporting systems such as,

but not limited to:

- i) reducing medication errors; and
 - ii) reducing adverse drug interactions.
- a) Describe the PBM's quality assurance program to reduce medication errors and reduce adverse drug interactions. What is the success rate of this program?
- 2) The PBM shall perform drug utilization review at a minimum of what is specified in the regulation 42 CFR § 423.153 (c) (2) and (3).
 - a) Does the PBM agree to this requirement?
- 3) The PBM shall ensure patient counseling is offered to OSEEGIB members, when appropriate.
 - a) Describe the patient counseling that is offered to members and when such counseling is appropriate.
- 4) The PBM shall develop and implement internal medication error identification and reduction systems.
 - a) Describe the PBM's internal medication error identification and reduction systems.
- 5) The PBM shall ensure network pharmacies implement a method for maintaining up-to-date OSEEGIB member information such as, but not limited to:
 - i) OSEEGIB member demographic information; and
 - ii) OSEEGIB member allergy information (drug and food).
 - a) Describe how network pharmacies are informed of member demographics and allergy information.
- 6) The PBM shall report to OSEEGIB not less than five (5) business days prior to the CMS required due dates, data for quality assurance standards in the manner prescribed by CMS.
 - a) Describe the PBM's proposed timeframe and quality review procedures for obtaining and providing OSEEGIB with the quality assurance standards to be reported to CMS.
- 7) The PBM shall establish and implement appropriate transition policies and procedures for OSEEGIB members on drug regimens that are not on OSEEGIB's formulary. These policies and procedures must address all the elements specified in formulary transition guidance by CMS.
 - a) Describe the PBM's transition policy and if it exceeds CMS requirements.

- 8) The PBM shall provide OSEEGIB at least five (5) business days prior to the CMS required due dates, the transition policies and procedures.
 - a) Describe the PBM's proposed timeframe and quality review procedures for obtaining and providing OSEEGIB with the transition policies and procedures.
- 9) The PBM shall establish policies and procedures for the PBM's P&T Committee's involvement in revising non-formulary drug requests to ensure utilization management tools are appropriate in situations in which a new member is already stabilized on a drug.
 - a) Describe the aforementioned policies.
- 10) The PBM shall establish and implement appropriate policies and procedures for addressing the immediate needs of OSEEGIB members who are Long Term Care (LTC) residents in situations where there is a disparity between CMS requirements and the Medicare Conditions Of Participation (COP) for LTC facilities.
 - a) Describe the aforementioned policies.
- 11) The PBM shall provide OSEEGIB a description of its approach to address the immediate needs of OSEEGIB members who are LTC residents in situations where there is a disparity between CMS requirements and the Medicare COP for LTC facilities.
 - a) Describe the PBM's proposed approach.
- 12) The PBM shall establish appropriate time frames and "first fill" procedures to non-formulary Part D medications in LTC and retail settings.
 - a) Describe the aforementioned timeframes and procedures.

F. Medication Therapy Management (MTM)

- 1) The PBM shall develop, implement and provide to OSEEGIB a MTM Program designed to:
 - i) ensure optimum therapeutic outcomes for targeted OSEEGIB members through improved medication use; and
 - ii) reduce the risk of adverse events, including adverse drug interactions.
 - a) Describe the PBM's MTM program and how it targets members.
- 2) The PBM shall develop the MTM program in cooperation with licensed and practicing pharmacists and physicians.

- a) Describe how practicing pharmacists and physicians assist in the development of the MTM program.
- 3) The PBM shall target OSEEGIB members for enrollment in the MTM program based on all three of the following criteria:
 - i) OSEEGIB member must have multiple chronic diseases, such as diabetes, asthma, congestive heart failure, hyperlipidemia, and hypertension as determined by the parties;
 - ii) OSEEGIB member must be taking multiple covered Part D medications as specified by the parties and CMS; and
 - iii) OSEEGIB member must be identified as likely to incur annual costs for covered drugs that exceed the CMS designated value.
- a) Which chronic diseases has the PBM selected and why?
- 4) The PBM shall not establish discriminatory exclusion criteria. If a member meets all three of the required criteria, the member should be eligible for MTM intervention.
 - a) Does the PBM agree to include all identified members in the MTM program?
- 5) The PBM shall establish appropriate policies and procedures for its MTM program, including, but not limited to, services, payments, evaluation and criteria used for identifying OSEEGIB members eligible for the MTM program.
 - a) Does the PBM agree to this requirement?
- 6) The PBM agrees to submit to OSEEGIB no less than five (5) business days prior the CMS required due date a description of its MTM program including, but not limited to, policies, procedures, services, payments, measurements, reporting and criteria provided above used for identifying OSEEGIB members eligible for the MTM program, in the format required by CMS.
 - a) Although the results for the first half of 2006 may not be available, please provide the PBM's total number of members who met the PBM's MTM criteria for a designated period and the total number of members who participated during the designated period. What were the savings achieved through the PBM's MTM program?
- 7) The PBM shall coordinate the MTM program with the Medicare Chronic Care Improvement Program (CCIP) under Section 1807 of the Social Security Act, 42 USCA §1395b-1.
 - a) Does the PBM agree to this requirement?

- 8) The PBM shall provide drug claims data in a timely fashion to CCIP for those OSEEGIB members that are enrolled in CCIPs in a manner specified by CMS.
 - a) Does the PBM agree to this requirement?
- 9) The PBM shall report to OSEEGIB no less than five (5) business days prior to the CMS required due dates, the specified data on MTM information in the manner prescribed by CMS.
 - a) Describe the PBM's proposed timeframe and quality review procedures for obtaining and providing OSEEGIB with the MTM information to be reported to CMS.
- 10) The PBM shall establish an appropriate policy and recommendation for OSEEGIB approval as to how the PBM would set MTM fees to pharmacists or others providing MTM services for covered drugs. The policy shall explain how the PBM's fee or payment structure takes into account the resources used and the time required by those providing MTM services.
 - a) Describe how the PBM sets fees to pharmacies or others providing MTM services.
- 11) The PBM shall submit to OSEEGIB not less than five (5) business days prior to the required CMS due dates a description on how the PBM would set MTM fees to pharmacists or others providing MTM services for covered drugs. The policy shall explain how the PBM's fee or payment structure takes into account the resources used and the time required by those providing MTM services.
 - a) Does the PBM agree to this requirement?
- 12) The PBM shall establish an appropriate MTM enrollment policy in which once enrolled, beneficiaries will not be disenrolled from the MTM program if they no longer meet one or more of the MTMP eligibility criteria and will remain in the MTMP program for the remainder of the calendar year.
 - a) Describe how and when a member will be terminated from the MTM program.
- 13) The PBM shall establish and maintain appropriate interventions for its MTM program for all enrollees who meet all three of the required criteria regardless of setting (i.e., ambulatory, long-term care, etc.).
 - a) Describe how the setting (e.g., ambulatory, long-term care) affects participation in the MTM program.
- 14) The PBM shall establish and maintain safeguards against discrimination based on the nature of its MTM interventions (i.e., TTY if phone based, Braille if mail

based, etc.).

- a) Describe how the PBM safeguards against discrimination of its MTM interventions.

G. Electronic Prescription Program

- 1) The PBM shall agree to implement an electronic prescription program that supports electronic prescribing with pharmacies as well as physicians according to prescribing standards published by CMS.
 - a) Describe what steps the PBM has taken to support electronic prescribing. Upon issuing the final standards by CMS, how soon will the PBM be able to implement all of the required standards?

H. Pharmacy Access

- 1) The PBM shall contract for OSEEGIB's PDP network any pharmacy that is willing to accept and meets the PBM's standard terms and conditions. However, terms and conditions may vary, particularly with respect to payment terms to accommodate geographical areas (e.g. rural pharmacies) or different types of pharmacies (e.g. mail order, Indian Health services, and retail), provided that all similarly situated pharmacies are offered the same standard terms and conditions.
 - a) Does the PBM agree to this requirement?
- 2) The PBM shall provide OSEEGIB the unsigned standard terms and conditions offered for all versions of OSEEGIB's PDP network pharmacy contract servicing OSEEGIB's PDP (or addenda to the contract) for each of the following types of pharmacies:
 - i) retail (urban and rural);
 - ii) mail order;
 - iii) home infusion;
 - iv) Indian Health services; and
 - v) long-term care.
 - a) If the PBM is the successful bidder, does the PBM agree to provide OSEEGIB the unsigned standard terms and conditions offered for each type of pharmacy?
- 3) The PBM shall not require a pharmacy to accept insurance risk as a condition of participation in OSEEGIB PDP's network.
 - a) Does the PBM agree to this requirement?
- 4) The PBM's OSEEGIB PDP network pharmacy contracts shall contain

provisions governing claims submission to a real-time claims adjudication system.

- a) Does the PBM agree to this requirement?
- 5) The PBM's OSEEGIB PDP network pharmacy contracts shall contain provisions governing providing access to negotiated prices as defined in 42 CFR 423.100.
 - a) Does the PBM agree to this requirement?
 - 6) The PBM's OSEEGIB PDP network pharmacy contracts shall contain provisions regarding charging/applying the correct cost-sharing amount, including that which applies to OSEEGIB members qualifying for the low-income subsidy.
 - a) Does the PBM agree to this requirement?
 - 7) The PBM's OSEEGIB PDP network pharmacy contracts shall contain provisions governing informing OSEEGIB members at the point of sale (or at the point of delivery for mail order drugs) of the lowest-priced, generically equivalent drug, if one exists for OSEEGIB member's prescription, as well as any associated differential in price.
 - a) Does the PBM agree to this requirement?
 - 8) The PBM shall maintain a contract log as specified in CMS guidance.
 - a) Does the PBM agree to maintain a contract log as specified in CMS guidance?
 - 9) Upon request, the PBM shall provide to OSEEGIB and/or CMS electronic lists of the Pharmacy Access Contract Citations demonstrating that the pharmacy access requirements and any other CMS requirements are included in OSEEGIB's PDP pharmacy contracts. If required by CMS, the PBM shall submit this data to CMS in the required format by the required due date.
 - a) If the PBM is the successful bidder, does the PBM agree to provide Pharmacy Access Contract Citations upon request?
 - b) Do at least ninety percent (90%) of OSEEGIB PDP members in urban areas live within two (2) miles of a network pharmacy?
 - c) Do at least ninety percent (90%) of OSEEGIB PDP members in suburban areas live within five (5) miles of a network pharmacy?
 - d) Do at least seventy percent (70%) of OSEEGIB PDP members in a rural area live within fifteen (15) miles of a network pharmacy?

I. Network Pharmacy

- 1) The PBM affirms that its entire network of pharmacies will serve the OSEEGIB membership and has agreed to participate in the Medicare Prescription Drug benefit program and the flow-down clauses requiring their activities are consistent and comply with CMS requirements and OSEEGIB's contractual obligations as a PDP sponsor.
 - a) Does the PBM agree to this requirement?
- 2) The PBM shall provide OSEEGIB with documentation sufficient to meet CMS standards that OSEEGIB's networks are sufficient to meet the needs of its retiree population, including situations involving emergency access. This documentation should include a brief description of how sufficient access will be assured. Upon request, the PBM shall provide OSEEGIB with an electronic list of retail pharmacies under contract with the PBM.
 - a) Describe how the PBM's network is sufficient to meet OSEEGIB's needs, including situations involving emergency access.
- 3) The PBM acknowledges that CMS may review the adequacy of the plan's pharmacy networks and potentially require expanded access in the event of beneficiary complaints or for other reasons it determines in order to ensure that the plan's network is sufficient to meet the needs of its retiree population.
 - a) Describe the timelines and how the PBM intends to perform the aforementioned services for this contract;
 - b) Has CMS directed the PBM to expand its pharmacy access?
- 4) The PBM shall permit OSEEGIB members to receive benefits that may include a 90-day supply as required by CMS of covered drugs at any of its network pharmacies that are retail pharmacies, and said pharmacies agree by Contract to do so, instead of at a network mail-order pharmacy.
 - a) Does the PBM allow the same day supply to be filled at a retail pharmacy as it does at a mail-order pharmacy? If so, describe the copay required for the same day fill at both settings.

J. Out-of-Network Pharmacy

- 1) The PBM shall ensure that OSEEGIB members have adequate access to covered drugs dispensed at out-of-network pharmacies when an OSEEGIB member cannot reasonably be expected to obtain such drugs at a network pharmacy and provided such OSEEGIB member does not access drugs at an out-of-network pharmacy (or a physician's office) on a routine basis.
 - a) Describe how OSEEGIB's members access out-of-network pharmacies.

- 2) The PBM shall ensure that OSEEGIB members have adequate access to covered drugs dispensed at physician offices for covered drugs that are appropriately dispensed and administered in physician offices (e.g., covered vaccines).
 - a) Describe how OSEEGIB's members have access to covered Part D drugs dispensed at physician offices.
- 3) The PBM shall abide by 42 CFR § 423.124(b) relating to the financial responsibility for out-of-network access to covered drugs and may require OSEEGIB members accessing covered drugs to assume financial responsibility for any differential between the out-of-network pharmacy's usual and customary price and OSEEGIB's PDP allowance, consistent with the requirements of 42 CFR § 423.104(d)(2)(i)(B) and § 423.104(e).
 - a) Does the PBM agree to this requirement?
- 4) The PBM shall develop and implement policies and procedures governing reasonable rules to appropriately limit out-of-network access and to guarantee out-of-network access when a member:
 - i) runs out of or loses his or her covered drugs or becomes ill and needs a covered drug, and cannot access a network pharmacy;
 - ii) is traveling outside OSEEGIB's service area within the United States is not able to obtain a covered drug in a timely manner within his or her service area because, for example, there is no network pharmacy within a reasonable driving distance that provides 24/7 service;
 - iii) is filling a prescription for a covered drug and that particular drug (for example, an orphan drug or other specialty pharmaceutical) is not regularly stocked at an accessible network retail or allowed through mail-order pharmacy; and
 - iv) is provided covered drugs dispensed by an out-of-network institution-based pharmacy while a patient is in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting.
 - a) Does the PBM agree to this requirement?

K. Mail Order Pharmacy

- 1) The PBM shall limit offering mail order pharmacy benefits to only those OSEEGIB inactive members who reside outside of the State of Oklahoma to the extent permissible under Medicare Modernization Act (MMA), CMS rules, regulations, guidance and applicable laws.
 - a) Does the PBM agree to this requirement?

- 2) The PBM shall provide OSEEGIB with documentation sufficient to meet CMS standards that OSEEGIB's mail order pharmacy networks are sufficient to meet the needs of its out-of-state retiree population. This documentation should include a brief description of how sufficient access will be assured. Upon request, the PBM shall provide OSEEGIB with an electronic list of mail order pharmacies under contract with the PBM.
 - a) Does the PBM agree to this requirement?

L. Home Infusion Pharmacy

- 1) The PBM shall provide OSEEGIB members adequate access to home infusion pharmacies as required by CMS.
 - a) Describe the PBM's current home infusion pharmacy network.
- 2) The PBM shall agree that its OSEEGIB PDP network contracts shall address drugs delivered in the home setting through home infusion therapy pharmacies.
 - a) Does the PBM agree to this requirement?
- 3) The PBM shall provide OSEEGIB with documentation and assurance that OSEEGIB's home infusion pharmacy networks are sufficient to meet CMS standards. This documentation should include a brief description of how sufficient access will be assured. Upon request, the PBM shall provide OSEEGIB with an electronic list of home infusion pharmacies under contract with the PBM.
 - a) Does the PBM agree to this requirement?

M. Long-Term Care (LTC) Pharmacy

- 1) The PBM shall offer to OSEEGIB's PDP network LTC pharmacies standard contracting terms and conditions to all long-term care pharmacies in its service area and/or identified by OSEEGIB to the PBM. These terms and conditions must include all the performance and service criteria for long-term care pharmacies according to CMS specifications.
 - a) Does the PBM agree to this requirement?
- 2) The PBM shall contract with a sufficient number of LTC pharmacies to provide all of OSEEGIB's institutionalized members with convenient access to benefits as required by CMS. If LTC pharmacy access is not sufficient as of the date of this Contract, the PBM shall provide OSEEGIB with a strategy for completing contracting with LTC pharmacies within

120 days of this contract's award.

- a) Describe the PBM current LTC pharmacy network.
- 3) The PBM agrees to comply with the long-term care guidelines that are posted at the CMS website.
 - a) Does the PBM agree to this requirement?
 - 4) The PBM shall provide OSEEGIB with documentation sufficient to meet CMS standards that OSEEGIB's LTC pharmacy networks are sufficient to meet the needs of its institutionalized members as required by CMS. This documentation should include a brief description of how sufficient access will be assured, as well as how the PBM will account for dosages on the unit level. Upon request, the PBM shall provide OSEEGIB with an electronic list of LTC pharmacies under contract with the PBM.
 - a) Describe how the PBM accounts for dosages on the unit level;
 - b) Does the PBM agree to this requirement?

N. Indian Health Service, Indian Tribe and Tribal Organization, and Urban Indian Organization (I/T/U) Pharmacy

- 1) The PBM shall offer standard terms and conditions that conform to the model contract addenda as specified by CMS to all OSEEGIB's PDP I/T/U pharmacies in OSEEGIB's service area.
 - a) Does the PBM agree to this requirement?
- 2) The PBM shall contract with a sufficient number of I/T/U pharmacies to provide all of OSEEGIB's Indian members with convenient access to the benefit as required by CMS. If I/T/U pharmacies are not sufficient as of the date of this Contract, the PBM shall provide OSEEGIB with a strategy for completing contracting with I/T/U pharmacies by June 30, 2007.
 - a) Describe the PBM's current I/T/U pharmacy network.
- 3) Upon request, the PBM shall provide OSEEGIB with documentation sufficient to meet CMS standards that OSEEGIB's I/T/U pharmacy networks are sufficient to meet the needs of its Indian members. This documentation should include a brief description of how sufficient access will be assured. Upon request, the PBM shall provide OSEEGIB with an electronic list of I/T/U pharmacies under contract with CMS.
 - a) Does the PBM agree to this requirement?

O. Enrollment and Eligibility

- 1) The PBM shall collect and transmit data elements specified by CMS for the purposes of enrolling and disenrolling beneficiaries in accordance with the CMS Eligibility and Enrollment and Disenrollment Guidance.
 - a) Does the PBM perform eligibility services itself or subcontract these services? If subcontracted, provide subcontractor information along with the description of interface and data flow between member, subcontractor, PBM and CMS.
 - b) Describe in detail the PBM's current procedures to collect the required data elements, which elements are automatically added to the data files, and how soon OSEEGIB data is transmitted to CMS.

- 2) The PBM shall accept and process disenrollment requests from beneficiaries, communicate these requests to CMS, and make the disenrollment effective according to the effective date policy associated with the enrollment period in which the disenrollment request is received.
 - a) Describe in detail the PBM's current disenrollment procedures for PDPs.

- 3) The PBM shall ensure that information necessary to access the plan benefits, such as an ID card, is provided according to the timeframe described in the Eligibility and Enrollment and Disenrollment Guidance.
 - a) Describe how the PBM intends to perform the aforementioned services for this contract.

- 4) Prescription drug benefits for Medicare members shall be available on the effective date of coverage transmitted by OSEEGIB. The PBM shall develop the eligibility process for OSEEGIB in such a way that allows a member OSEEGIB has enrolled, to obtain point-of-sale access to prescription drug benefits while the enrollment is still pending at CMS and to flag the enrollment so that PDE information is not sent to CMS until the enrollment is accepted.
 - a) Describe the proposed flow of eligibility information from OSEEGIB to the PBM and then to CMS.
 - b) Describe the PBM's proposed process and timeframes when an enrollment or disenrollment is accepted by CMS.
 - c) Describe the PBM's proposed process and timeframes when an enrollment or disenrollment is rejected by CMS.

- d) How will the PBM allow a member access to benefits while suppressing the submission of PDE information if the enrollment has not been accepted by CMS? Is this a process already handled by the PBM or does it require custom programming?
- 5) The PBM shall accept an electronic eligibility file from OSEEGIB on a daily basis, as defined in Part Four-General Administration, of this RFP. OSEEGIB's preference is for one daily eligibility file to contain non-Medicare and Medicare eligibility. The PBM shall submit applicable eligibility to CMS on a daily basis.
 - a) Does the PBM's process allow for daily files from OSEEGIB and daily submission of files to CMS?
 - b) Are daily file exchanges a current standard for the PBM?
- 6) The PBM shall provide CMS-required notification to members within CMS timeframes as detailed in EXHIBIT D. The PBM shall provide any additional notification that CMS requires unless OSEEGIB determines it to be OSEEGIB's responsibility. Many items of notification are unique to OSEEGIB and deviate from the standard CMS model.

SEE EXHIBIT D – Medicare Part D Eligibility and Enrollment Required Notification

- a) Describe how CMS required enrollment or disenrollment notification is triggered and how custom notification will work with any automated process the PBM currently uses to generate the notification.
- 7) The PBM shall mail OSEEGIB's PDP identification card to members to be received by the first day of the plan year, consistent with CMS requirements. The PBM shall mail OSEEGIB's PDP identification card and welcome packet to new enrollees within five business days of receipt of the CMS Transaction Reply Report indicating an accepted enrollment.
 - a) What is the PBM's current turnaround time for mailing ID cards after an enrollment is reported as accepted by CMS?
 - b) Describe in detail the process of mailing the ID cards and new member information.
- 8) The PBM shall accept and process coverage or indicative changes from OSEEGIB on a daily basis. The PBM shall accept, process and track multiple coverage or indicative changes for a single member sent within the same week in separate daily eligibility files. The PBM shall accept, process and track multiple coverage or indicate changes from OSEEGIB even if CMS has not yet accepted enrollment or if the member has already disenrolled. The PBM shall not require OSEEGIB to resubmit changes to coverage after CMS

approves the enrollment.

- a) Describe in detail what the PBM's electronic process would be in the following situations:
 - i) an enrollment has been submitted to the PBM and forwarded to CMS but has not yet been accepted by CMS. The effective date was entered incorrectly at OSEEGIB and a change in effective date is forwarded to the PBM on the daily eligibility file.
 - ii) an enrollment has been submitted to the PBM and forwarded to CMS but has not yet been accepted by CMS. OSEEGIB discovers the HICN is incorrect and submits a change in the HICN to the PBM on the daily eligibility file.
 - iii) an enrollment has been submitted to the PBM but was rejected by CMS. Upon review of the rejection, OSEEGIB learns the member was not Medicare eligible. OSEEGIB terminates the member from the Medicare plan and enrolls the member in a pre-Medicare plan.
- 9) The PBM shall accurately determine which changes submitted to the PBM from OSEEGIB must be forwarded to CMS.
 - a) Describe in detail how the PBM will meet this requirement.
 - b) Describe in detail the PBM's process when OSEEGIB changes a member's coverage from one low-income premium subsidy category to another. The change will be forwarded to the PBM on an enrollment file.
- 10) The PBM shall manage retroactive enrollment and disenrollment as outlined by CMS and shall seek regional office approval as necessary in accordance with CMS guidelines.
 - a) Describe the PBM's process for handling a retroactive enrollment.
 - b) Describe the PBM's process for handling a retroactive disenrollment including the process for recovering claim payments.
- 11) The PBM must process each weekly and monthly Transaction Reply Report (TRR) prior to the cutoff date for the following TRR. OSEEGIB intends to review a list of TRR codes with the PBM in the implementation process to determine the method for handling each code.
 - a) Does the PBM agree to review the process for each TRR code and to develop an appropriate action for each code that is mutually agreeable to the PBM and OSEEGIB?
 - b) Describe the PBM's process for handling accepted enrollments or disenrollments reported on the TRR. Include turnaround times for

- updating eligibility and sending CMS-required notification to beneficiaries.
- c) Describe the PBM's process for handling rejected enrollments or disenrollments reported on the TRR. Include turnaround times for updating eligibility and sending CMS-required notification to beneficiaries.
- 12) The PBM must designate a contact person and a backup contact person with the ability to update the PBM's eligibility system and forward changes to CMS to work directly with OSEEGIB's enrollment unit to resolve specific issues on the Transaction Reply Report that cannot be resolved without manual intervention. Resolution is expected within twenty-four (24) hours of the time an issue is brought to the PBM's attention.
- a) Are there designated individuals that have the authority and ability to make direct changes to the eligibility database?
- b) Will the PBM designate a person to work with an OSEEGIB designee to resolve eligibility issues?
- c) Will the PBM's designated person manually update OSEEGIB's eligibility to resolve issues if eligibility is incorrect in the PBM's database?
- d) Describe current PBM procedures that may prevent an immediate solution to an OSEEGIB eligibility issue.
- 13) The PBM must provide all OSEEGIB Transaction Reply Reports, in their entirety to OSEEGIB within twenty-four (24) hours of receipt of the report from CMS.
- a) Describe the PBM's ability to meet this requirement.
- 14) The PBM must obtain the LIS bi-weekly report from CMS and forward to OSEEGIB within twenty-four (24) hours of its availability from CMS.
- a) Describe the PBM's ability to meet this requirement.
- 15) The PBM shall provide OSEEGIB the Monthly Membership Detail Report in its entirety to OSEEGIB within twenty-four (24) hours of availability from CMS.
- a) Describe the PBM's ability to meet this requirement.
- 16) The PBM must provide any additional report(s) received from CMS on OSEEGIB's behalf to OSEEGIB within twenty-four (24) hours of receipt of the report from CMS.
- a) Describe the PBM's ability to meet this requirement.

P. Grievances, Exceptions and Appeals

- 1) The PBM shall establish and maintain a process designed to track and address members' grievances and adopt appropriate timelines, policies and procedures and train the relevant staff and subcontractors on such policies and procedures in accordance with 42 CFR § 423.564.
 - a) Describe the PBM's process to track and address member grievances.
 - b) For the first half of 2006, how many grievances did the plan track? What was the average time it took to resolve a grievance?
- 2) The PBM shall make enrollees aware of the grievance process through information and outreach materials.
 - a) How does the PBM make enrollees aware of the grievance process?
- 3) The PBM shall accept grievances from enrollees at least by telephone and in writing (including facsimile).
 - a) Does the PBM agree to this requirement?
- 4) The PBM shall maintain, and provide upon request by CMS or OSEEGIB, access to records on all grievances received both orally and in writing, that includes, at a minimum:
 - i) date of receipt of the grievance;
 - ii) mode of receipt of grievance (i.e. fax, telephone, letter, etc.);
 - iii) person or entity that filed the grievance;
 - iv) subject of the grievance;
 - v) final disposition of the grievance; and
 - vi) date the enrollee was notified of the disposition.
 - a) Does the PBM agree to this requirement?
- 5) The PBM shall provide OSEEGIB with all documents used supporting its determination in the appeal process every Thursday by 1:30 p.m. (CST) when OSEEGIB is required to consider a re-determination.
 - a) Does the PBM agree to this requirement?
- 6) The PBM shall advise OSEEGIB as to policies and procedures for benefit coverage determination, exceptions, and appeals consistent with 42 CFR § 423 subpart M.

- a) Does the PBM agree to this requirement?
- 7) The PBM shall comply with 42 CFR § 423.578(a) and 423.578 (b) which requires OSEEGIB to grant a tiering or off-formulary exception whenever it determines an exception is medically appropriate because the preferred drug (or non-formulary drug in the case of a formulary exception request):
- i) would not be as effective for the enrollee as the requested drug; or
 - ii) would have adverse effects for the enrollee, or
 - iii) both.
- a) Does the PBM agree to this requirement?
- 8) The PBM shall comply with the exceptions policy and the regulatory timelines for processing standard coverage determinations and exceptions requests: as expeditiously as the member's health condition requires, but no later than 72 hours after receipt of the request/supporting statement.
- a) Does the PBM agree to this requirement?.
- 9) The PBM shall comply with the exceptions policy and with the regulatory timelines for processing expedited coverage determinations and exceptions requests: as expeditiously as the member's health condition requests, but no later than 24 hours after receipt of the request/supporting statement.
- a) Does the PBM agree to this requirement?
- 10) The PBM shall comply with the exceptions policy and with the regulatory timelines for processing expedited coverage determinations and exceptions requests, including but not limited to forwarding the member's request to IRE and OSEEGIB within 24 hours of the expiration of the appropriate adjudication timeframe if a decision could not be made.
- a) Does the PBM agree to this requirement?
- 11) The PBM shall establish and maintain a process designed to track and address in a timely manner members' exceptions requests, requests for benefit coverage determination, requests for reconsideration by the Independent Review Entity (IRE), and requests for review by the Administrative Law Judge (ALJ) received both orally and in writing, that includes, at a minimum:
- i) date of receipt;
 - ii) date of any notification;
 - iii) disposition of request; and

iv) date of disposition.

a) Does the PBM agree to this requirement?

12) The PBM shall make available to CMS upon CMS request, exception and appeals records in accordance with 42 CFR § 423.505(i)(2).

a) Does the PBM agree to this requirement?

13) The PBM shall ensure the exceptions process will not be overly burdensome or onerous.

a) Does the PBM agree to this requirement?

14) The PBM shall ensure that the approved non-formulary drugs must be assigned to the same standard tier.

a) Does the PBM agree to this requirement?

15) The PBM may not restrict the number of exception requests submitted by a member.

a) Does the PBM agree to this requirement?

Q. Coordination of Benefits (COB)

1) The PBM shall comply with the COB guidance that is posted at the CMS website.

a) Does the PBM agree to this requirement?

2) The PBM shall develop and operate a system for collecting information from members about members other health insurance, including whether such insurance covers out-patient prescription drugs.

a) Describe how the PBM intends to perform the aforementioned services for this contract.

3) The PBM shall be familiar with rules that determine when other payers are primary or secondary to Medicare.

a) Does the PBM agree to this requirement?

4) The PBM shall permit State Pharmaceutical Assistance Programs (SPAP) and other third party payers to coordinate benefits as required by the regulations in 42 CFR § Subpart J Part 43. For example, an SPAP might pay the premium for supplemental benefits on behalf of a member.

- a) Does the PBM agree to this requirement?
- 5) The PBM shall survey members for COB information on an annual basis as required by CMS.
 - a) Does the PBM agree to this requirement?
- 6) The PBM shall not impose fees on SPAPs or other third-party insurers unrelated to the cost of the coordination of benefits.
 - a) Does the PBM agree to this requirement?
- 7) The PBM shall coordinate payment of claims by members' other health insurance, including SPAPs, as required by CMS.
 - a) Does the PBM agree to this requirement?

R. Tracking True Out-of-Pocket Costs (TrOOP)

- 1) The PBM shall track each member's true out-of-pocket (TrOOP) costs reflecting the amount the member has spent out-of-pocket during a plan year on covered drugs and provide this information to OSEEGIB upon request.
 - a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 2) The PBM shall accept data concerning third party payers in a format to be specified by CMS for use in PBM's TrOOP calculation.
 - a) Does the PBM agree to this requirement?
- 3) The PBM shall provide each OSEEGIB member with a report on their TrOOP status at least monthly or as otherwise established by OSEEGIB and approved by CMS. Currently, OSEEGIB is subject to alternative disclosure requirements and is not reporting TrOOP on a monthly basis to its members, but is providing the information upon request by the member.
 - a) Provide a sample beneficiary report indicating TrOOP.
 - b) Does the PBM agree to this requirement?
- 4) The PBM shall provide OSEEGIB members daily access to their current TrOOP status through the PBM's toll-free customer service phone number.
 - a) Does the PBM agree to this requirement?
- 5) In the event of disenrollment, the PBM agrees to provide TrOOP

status of OSEEGIB member as of the effective date of the disenrollment.

- a) Does the PBM agree to this requirement?

S. Marketing/OSEEGIB Communications

- 1) The PBM shall maintain a toll-free customer service call center that is open during usual business hours and provides customer telephone service in compliance with standard business practices. This means that the PBM must comply with at least the following:
 - i) call center operates 24 hours daily, seven days a week;
 - ii) eighty percent (80%) of all incoming customer calls are answered within thirty (30) seconds;
 - iii) the abandonment rate of all incoming customer calls does not exceed five percent (5%);
 - iv) call center provides thorough information about the PDP benefit plan, including copayments, deductibles, and network pharmacies;
 - v) call center features an explicit process for handling customer complaints; and
 - vi) call center shall provide service to non-English speaking and hearing impaired OSEEGIB members.
- a) For the second quarter of 2006, what percent of incoming calls were answered within thirty (30) seconds?
- b) For the second quarter of 2006, what percent of Medicare calls were abandoned?
- c) Describe how the PBM intends to perform the aforementioned services for this contract.
- 2) In a form understandable to members and on at least a monthly basis, for those months in which OSEEGIB members use their Medicare Part D benefits or as otherwise established by OSEEGIB and approved by CMS, the PBM shall provide OSEEGIB's members, an explanation of benefits that states:
 - i) the item or service for which payment was made;
 - ii) notice of the member's right to an itemized statement;
 - iii) a year-to-date statement of the total Medicare Part D benefits provided in relation to deductibles, coverage limits, and annual out-of-pocket thresholds;
 - iv) cumulative year-to-date total of incurred costs; and
 - v) applicable formulary changes.

Currently, OSEEGIB is subject to alternative disclosure requirements and is not reporting Explanation Of Benefits on a monthly basis to its members, but is providing the information upon request by the member.

- a) Provide an example of the Explanation of Benefits.
 - b) Describe how the PBM intends to perform the aforementioned services for this contract.
- 3) The PBM shall provide OSEEGIB with sample communications, documents that will be sent to OSEEGIB members, including but not limited to:
- i) inquiries;
 - ii) denials of benefit coverage;
 - iii) explanation of benefits; and
 - iv) enrollment and eligibility notification required by CMS as listed in Exhibit D.

SEE EXHIBIT D – Medicare Part D Eligibility Required Notification

- a) Describe how the PBM intends to perform the aforementioned services for this contract.

T. Provider Communications

- 1) The PBM shall operate a toll-free call center to respond to inquiries from pharmacies and providers regarding OSEEGIB's Medicare Prescription Drug Benefit. Inquiries shall concern such operational areas as claims processing, benefit coverage, claims submission, and claims payment.
 - a) Does the PBM agree to this requirement?
- 2) The PBM hours of operation shall be 24 hours a day and seven days a week. The call center must meet the following operating standards:
 - i) eighty percent (80%) of incoming calls must be answered within 30 seconds;
 - ii) abandonment rate of all incoming calls not to exceed 5 percent.
 - a) For the second quarter of 2006, what percent of calls were answered within thirty (30) seconds?
 - b) What percent of calls were abandoned?
- 3) The PBM shall operate a toll free call center to respond to physicians and other providers during normal business hours, but not less than 8:00 a.m. to 6:00 p.m. Central Time Zone. Voicemail can be used provided that the following information is provided:

- i) indicates the voicemail is secure;
 - ii) lists information that must be provided so that the case can be worked (e.g., provider identification, beneficiary identification, exception being requested, whether an expedited exception is being requested);
 - iii) articulates and follows a process for resolution within one calendar day of call for expedited exceptions;
 - iv) provides and follows a process for immediate access in situations where a member's life or health is in serious jeopardy.
- a) Describe how the PBM intends to perform the aforementioned services for this contract.

U. Compliance Plan

- 1) The PBM shall implement a compliance plan that consists of written policies, procedures, and standards of conduct articulating the PBM's commitment to abide by all applicable Federal and State standards. Upon written request, the PBM shall provide OSEEGIB with access to the PBM's compliance plan.
 - a) Does the PBM agree to this requirement?
 - b) Briefly describe the PBM's compliance plan and how it meets or exceeds the Part D requirements.
- 2) The PBM shall implement a compliance plan that designates a compliance officer and compliance committee accountable to senior management. PBM shall provide OSEEGIB with the name of the compliance officer, his/her resume, and describe his/her place in the PBM's organization.
 - a) Does the PBM agree to this requirement?
- 3) The PBM shall implement a compliance plan that includes effective training and education between the compliance officer, organization employees, contractors, agents, and directors. The PBM shall provide OSEEGIB with a description of the PBM's training and education policy.
 - a) Does the PBM agree to this requirement?
- 4) The PBM shall implement a compliance plan that includes effective lines of communication between the compliance officer and organization employees, contractors, agents and directors and members of the compliance committee.
 - a) Does the PBM agree to this requirement?
- 5) The PBM shall implement a compliance plan that includes disciplinary standards that are well publicized. The PBM shall provide OSEEGIB with a

description of how the reporting of potential fraud and abuse issues are publicized within the PBM.

a) Does the PBM agree to this requirement?

- 6) The PBM shall implement a compliance plan that includes procedures for internal monitoring and auditing. The PBM shall provide OSEEGIB with a description of the PBM's procedures for internal monitoring and auditing to protect waste, fraud and abuse in the PDP programs including frequency and responsible staff.

a) Does the PBM agree to this requirement?

- 7) The PBM shall implement a compliance plan that includes procedures for ensuring prompt response to detected offenses and development of corrective action initiatives, relating to OSEEGIB's contract as a Medicare Part D sponsor. The PBM shall, provide OSEEGIB with a description of the process the PBM's staff will follow to identify possible offenses and how these matters would be reported to CMS and/or OSEEGIB.

a) Does the PBM agree to this requirement?

- 8) The PBM shall implement a compliance plan that includes a comprehensive plan to detect, correct, and prevent fraud, waste and abuse and to report such findings to the appropriate governmental authority and shall provide to OSEEGIB.

a) Does the PBM agree to this requirement?

- 9) The PBM shall fully cooperate with compliance plan operations, procedures, or investigations conducted by OSEEGIB for purposes of permitting OSEEGIB and/or CMS to determine the PBM's compliance with CMS rules, regulations, instructions and guidance.

a) Does the PBM agree to this requirement?

V. Reporting Requirements

- 1) The PBM shall manage and report claims data to CMS and to OSEEGIB on behalf of OSEEGIB's PDP.

i) The PBM shall have access to data management processes and data systems capable of accomplishing collection of prescription drug claims data in either a National Council for Prescription Drug Programs (NCPDP) or XI2 format. Data to be collected shall encompass quantity, type, and costs of pharmaceutical prescriptions filled for OSEEGIB members. The PBM must link this information to Medicare beneficiary identification numbers and Health Identification Claim (HIC) numbers.

ii) The PBM shall have access to data management processes and

data systems capable of accomplishing submission of prescription drug claims information for OSEEGIB PDP members in the format required by CMS, using batch submission processes. Data to be submitted shall encompass quantity, type and costs of pharmaceutical prescriptions filled for OSEEGIB members. The PBM must link this information to Medicare beneficiary identification numbers and HIC numbers.

- iii) The PBM shall have access to data management processes and data systems capable of accomplishing submissions of data to CMS via the Medicare Data Communications Network (MDCN).
 - iv) The PBM shall have access to data management processes and data systems capable of accomplishing performance of data edit and quality control procedures to ensure accurate and complete prescription drug data.
 - v) The PBM shall have access to data management processes and data systems capable of accomplishing correction of all data errors identified by CMS.
 - vi) The PBM shall have access to data management processes and data systems capable of accomplishing collection of data for dates of service within the coverage period with a closeout period specified by CMS for the submission of remaining unreported claims data.
 - vii) The PBM shall have access to data management processes and data systems capable of accomplishing provision of additional information for the purposes of reconciliation of risk factors, low-income subsidy payments, and reinsurance payments as required by CMS.
 - viii) The PBM shall send and receive claims data for third party payers from the CMS contractor that will serve as the clearinghouse for all OSEEGIB PDP members' outpatient drug claims.
- a) Describe how the PBM intends to perform the aforementioned services for this contract.

2) The PBM shall report Rebate Data to CMS and OSEEGIB.

- i) The PBM shall have accounting systems capable of accomplishing the provision of documentation, as specified by CMS, to support the accuracy and completeness of rebate data. Documentation shall be provided to CMS and OSEEGIB in response to an audit-based request.
- ii) The PBM shall report to OSEEGIB and CMS rebate dollars on a quarterly basis at the manufacturer/brand name level (unique

- strength and package size not required) in the manner specified by CMS.
- iii) The PBM shall have accounting systems capable of accomplishing the production of financial reports to support rebate accounting. The rebate accounting must allow for step-down cost reporting in which rebates received at the aggregate level may be apportioned down to the level of plan enrollees.
- a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 3) The PBM shall report Utilization Management data to OSEEGIB not less than five (5) business days prior to the CMS due date.
- i) The PBM shall report the generic dispensing rate which is calculated as the number of generic drugs dispensed to the patient divided by the total number of drugs dispensed within a given time period.
 - ii) The PBM shall report information about the use of formulary management tools. Such information may include, but is not limited to:
 - the number of pharmacy transactions denied due to the need for prior authorization;
 - the number of prior authorizations requested;
 - the number of prior authorizations approved.
 - iii) The PBM shall report information related to the implementation of its MTM program that may include, but is not limited to:
 - number of OSEEGIB members targeted;
 - number of OSEEGIB members participating;
 - number of OSEEGIB members declined; and
 - total drug cost for patients in MTM on a per enrolled MTM OSEEGIB member per month basis.
- a) Does the PBM agree to this requirement?
- 4) The PBM shall report the following information related to exceptions and appeals that may include, but is not limited to:
- i) number of step edits attempted;
 - ii) number of step edits failed;

- iii) number of appeals;
- iv) number of appeals overturned;
- a) Does the PBM agree to this requirement?
- 5) The PBM shall provide OSEEGIB with information to report to CMS routine administrative reports pursuant to 42 CFR 423.514(a) on a variety of measures that concern OSEEGIB's performance in the administration of OSEEGIB's PDP benefit. Such reports shall be submitted according to instructions issued with timely notice by CMS.
 - a) Does the PBM agree to this requirement?
- 6) The PBM shall provide financial and organizational conflict of interest reports to OSEEGIB, pursuant to instructions by CMS.
 - a) Does the PBM agree to this requirement?
- 7) The PBM shall supply all operational, clinical, financial, and ad hoc reporting required by CMS provided the cost of any customized reports shall be billed to OSEEGIB in accordance with Section VII of this Contract.
 - a) Does the PBM agree to this requirement?

W. Data Exchange with CMS

- 1) The PBM shall establish and maintain connectivity to CMS by a specified T-1 data line or other method that complies with CMS requirements for the purpose of exchanging information with CMS on OSEEGIB's behalf. The PBM shall maintain enough bandwidth to comply with all CMS data transmission deadlines. The PBM shall provide OSEEGIB all the necessary information regarding the PBM's connectivity to CMS. OSEEGIB shall be responsible for establishing connectivity to CMS through the Health Plan Management System (HPMS).
 - a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 2) The PBM shall use a User ID and Password issued by CMS when exchanging data with CMS.
 - a) Does the PBM agree to this requirement?
- 3) The PBM shall submit to CMS, in a format acceptable to CMS and OSEEGIB, data files containing enrollment, disenrollment and change transactions to communicate membership information to CMS each month.
 - a) Describe how the PBM intends to perform the aforementioned services for this contract.

- 4) The PBM shall reconcile OSEEGIB data to CMS enrollment/payment report within forty-five (45) days of availability.
 - a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 5) The PBM shall provide OSEEGIB enrollment/payment attestation five (5) business days prior to the CMS due date.
 - a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 6) The PBM shall track all records sent to CMS and rejection codes received from CMS when necessary to meet CMS submission and resubmission requirements.
 - a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 7) The PBM shall have the appropriate system logic to correctly identify when an eligibility change transmitted to the PBM from OSEEGIB will need to be sent to CMS or not sent to CMS. One example occurs when CMS determines the appropriate LIS plan and notifies OSEEGIB in the Transaction Reply file. OSEEGIB then moves the member to the appropriate LIS plan and resubmits this change to the PBM, yet it should not be transmitted to CMS.
 - a) Describe how the PBM intends to perform the aforementioned services for this contract.

X. Privacy and Security

- 1) The PBM and all its agents and subcontractors shall comply with any applicable standards, implementation specifications and requirements in the Standards for Privacy of Individually Identifiable Health Information under 45 CFR Part 160 and 164 subparts A-E when performing functions on OSEEGIB's behalf.
 - a) Does the PBM agree to this requirement?
- 2) The PBM and all of its agents and subcontractors shall comply with any applicable standards, implementation specifications and requirements in the Security Standards under 45 CFR Parts 160, 162 and 164.
 - a) Does the PBM agree to this requirement?
- 3) The PBM shall comply with any applicable standards, implementation specifications and requirements in the Standard Unique Health Identifier for Health Care Providers under 45 CFR Part 160.
 - a) Does the PBM agree to this requirement?

- 4) The PBM shall comply with any applicable standards, implementation specifications, and requirements in the Standards for Electronic Transactions at 45 CFR Parts 160 and 162 subparts I *et seq.*

- a) Does the PBM agree to this requirement?

Y. Record Retention

- 1) The PBM shall maintain books, records, documents, and other evidence of accounting procedures and practices consistent with 42 CFR 423.505(d).

- a) Does the PBM agree to this requirement?

- 2) The PBM shall contract with pharmacies for the Part D benefit, maintain prescription records in their original format for the greater of three (3) years or the period required by State law and allow those records to be transferred to an electronic format that replicated the original prescription for the remaining seven (7) years of the ten (10) year record requirement.

- a) Does the PBM agree to this requirement?

- 3) The PBM shall keep all other records, except prescription records, that must be retained for Medicare under Part C and Part D in the format(s) required by State or other applicable law or regulations.

- a) Does the PBM agree to this requirement?

Z. Claims Processing

- 1) The PBM shall warrant, develop and operate an on-line pharmacy transaction claims processing system that operates in virtual real time to ensure accurate and timely payment of all claims submitted by network pharmacies on behalf of OSEEGIB members in accordance with all plan benefit specifications. The system shall operate according to the following standards:

- i) ninety eight percent (98%) response within 4 seconds;
- ii) ninety nine percent (99%) of all claims paid with no errors; and
- iii) ninety nine percent (99%) system availability per month.

- a) Describe how the PBM intends to perform the aforementioned services for this contract.

- b) For the second quarter of 2006, what is the PBM's response percentage for claims paid:

- i) within four (4) seconds?
- ii) with no errors?

- iii) for system availability? Describe “system available rate”.
- 2) In implementation of OSEEGIB's PDP, the PBM shall conduct testing and otherwise monitor for the impact of TrOOP system interfaces with the claims processing systems, and adjust these standards as appropriate, if necessary.
- a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 3) The PBM shall develop and operate a paper claims processing system designed to pay claims submitted by non-network pharmacies on behalf of OSEEGIB PDP members. The PBM shall process claims according to the following standards:
- i) one hundred percent (100%) of claims requiring no intervention handled within 15 calendar days;
- ii) one hundred percent (100%) of claims requiring intervention handled within 30 calendar days;
- iii) ninety nine percent (99%) of all manually keyed claims paid with no errors.
- a) Describe how the PBM intends to perform the aforementioned services for this contract.
- b) What percent of paper claims were handled:
- i) with no intervention within fifteen (15) calendar days?
- ii) with intervention required within thirty (30) calendar days?
- iii) manually-keyed claims paid with no errors?
- 4) For mail order pharmacy for out-of-state OSEEGIB PDP inactive members, the PBM's mail order processing shall meet the average three (3) business day turnaround time from the point of receipt of prescription for in-stock items with no intervention to the point of shipment as required by CMS.
- a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 5) For mail order pharmacy for out-of-state OSEEGIB inactive members, the PBM's mail order processing meets the average five (5) business day turnaround time from the point of receipt of prescription for in-stock items with intervention to the point of shipment as required by CMS.
- a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 6) The PBM shall warrant, develop and have available for CMS or OSEEGIB

inspection, a complete description of its claims adjudication system including:

- i) hardware and software;
 - ii) operating system;
 - iii) MediSpan or First Data Bank database, including number of iterations saved;
 - iv) number of sites processing claims, including disaster recovery back up system; and
 - v) system volume in covered lives, including the number of transactions the system can support per day and per hour.
- a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 7) The PBM shall develop and have available to CMS or OSEEGIB, upon written request, policies and procedures that include a complete description and flow chart detailing the claims adjudication process for each:
- i) network pharmacy under contract with the PBM;
 - ii) out-of-network pharmacy;
 - iii) paper claim;
 - iv) batch-processed claim; and
 - v) manual claim entry (e.g., for processing direct member reimbursement).
- a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 8) At least monthly, the PBM shall adjust claims for members retroactively moving to a LIS or Dual Eligible group. The monthly claims adjustment shall also apply to members moving between the Medicare High and Low plans. The PBM shall adjust urgent claims within forty-eight (48) hours of notification from OSEEGIB.
- a) Describe the PBM's process to identify underpaid and overpaid claims.
- 9) The PBM shall develop and shall make available to CMS or OSEEGIB, upon written request, policies and procedures that include a complete description of claim detail management, including:
- i) the length of time that detailed claim information is maintained online (not less than 12 months);
 - ii) the data storage process after it is no longer online; and
 - iii) the length of time that detailed claim information is stored when it is no longer online (not less than 10 years).

- a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 10) The PBM shall develop and have available to CMS or OSEEGIB, upon written request, policies and procedures that include a complete description of the accessibility of OSEEGIB PDP member information for data capture purposes and flow chart of the claims data retrieval process for each:
- i) entire claims history file;
 - ii) encounter data required by state laws;
 - iii) encounter data required by alternate funding sources; and,
 - iv) out-of-pocket maximum/deductible files.
- a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 11) The PBM shall develop and have available to CMS or OSEEGIB, upon written request, policies and procedures that include a description of the recovery procedures for overpayments as well as a description for handling underpayments to pharmacies and to OSEEGIB members.
- a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 12) The PBM shall develop and have available to CMS or OSEEGIB, upon written request, policies and procedures that include a complete description of procedures surrounding disputed claims, including:
- i) the steps that a pharmacy and/or OSEEGIB member must follow to dispute a claim reimbursement;
 - ii) the minimum, maximum and average amount of time needed to resolve a claims dispute; and
 - iii) turnaround time standards and performance guarantees for dispute resolution.
- a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 13) The PBM shall have a robust testing process that shall identify and correct any plan configuration errors.
- a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 14) The PBM shall electronically accept from OSEEGIB eligibility files and any prior claims data in a standardized NCPDP format.

- a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 15) The PBM shall document the manner and extent to which it has tested benefit designs such as prior authorizations, drug exclusions or quantity limitations and plan parameters such as copayments or benefit maximums. PBM shall provide OSEEGIB with a report of said testing and a resolution plan to bring any weaknesses or incorrect plan designs up to current expectations.
- a) Describe how the PBM intends to perform the aforementioned services for this contract.
- 16) Upon written request, the PBM shall develop and have available to CMS or OSEEGIB its policies and procedures that include a complete description of its systems' programming for the processing of copayments for OSEEGIB members qualifying for the low-income subsidy.
- a) Describe how the PBM intends to perform the aforementioned services for this contract.

PART THREE - Quality Assurance/Performance Standards

A. Claims Auditing Process

- 1) The PBM shall utilize a formal internal claim auditing process for ongoing verification for appropriateness of claims processing.
 - a) Describe the PBM's claims auditing process.

B. Quality Assurance Program

- 1) The PBM shall utilize a formal quality assurance program on an ongoing basis to determine that its internal controls and its system's adjudication processes are sufficient to achieve reliable results. OSEEGIB shall be furnished with a copy of reports or findings within fifteen (15) calendar days of issuance.
 - a) Describe the PBM's quality assurance program.
 - b) What percentage of claims is reviewed to assure accuracy of payment?
 - c) Can the percentage be increased upon client request?
 - d) What is the frequency of such review?
 - e) Provide a copy of the internal performance standards, the resources from which they were developed and the company-wide results as measured by

those standards for the last two (2) years.

- f) What parameters trigger a desk audit?
- g) Explain any controls the PBM has in place to detect fraud and abuse by members or pharmacies.
- h) Does the PBM perform quality checks at the retail and mail service levels?

C. Performance Standards

- 1) The PBM shall adhere to the performance standards included in this RFP. Failure to meet the minimum performance standards shall constitute a breach of this contract and may result in termination, liquidated damages and/or disqualification from bidding on future Invitations To Bid (ITBs) and Request For Proposals (RFPs) issued by the State of Oklahoma for a period of time not to exceed three (3) years.
 - a) Does the PBM agree to this requirement?
- 2) OSEEGIB shall incur no damages for the PBM's failure to meet the minimum performance standards.
 - a) Does the PBM agree to this requirement?
- 3) The results of the PBM's internal quarterly audits shall be used to determine liquidated damages. OSEEGIB shall withhold the damaged amount from the administration fee then payable to the PBM. However, OSEEGIB reserves the right to periodically conduct audits to verify the performance standards are being met. The findings of the audits performed by OSEEGIB shall be conclusive.

Standard	Description	Performance Level	Liquidated Damages
System Availability	The PBM's point-of-service processing system will be available 24 hours a day outside of scheduled down time.	99.5% to 100% 97% to 99.4% Below 97% (Per Month)	No Damages \$2,500 \$5,000 Monthly Basis
Eligibility Processing Turnaround Time	Eligibility received in the approved format must be loaded by the PBM the day of receipt, except during scheduled down time as approved by OSEEGIB.		\$250 per occurrence.

Pharmacy Benefits Manager RFP

On-line Claims Processing	The on-line system must operate in virtual real time ensuring accurate and timely payment of all claims.	98.0% Response within 4 seconds 99.0% of all claims paid with no errors 99.0% system availability	For each component, \$300 penalty for each failure to meet any of the 3 standards
Paper Claims Processing	Non-network pharmacies, VA pharmacies and Indian Health pharmacies, Medicaid pharmacies, and COBs	100% processed within 15 calendar days with no intervention 100% processed within 30 calendar days with intervention 99.0% of manually keyed claims with no errors	99%-100%, No Penalty 96-99%, \$2,500 Penalty 95-96% \$5,000 Penalty Monthly Basis
Claim Adjustments	Any adjustment to a set of claims due to a system problem	Must be adjusted in 30 calendar days from the date identified.	\$250 occurrence

Standard	Description	Performance Level	Liquidated Damages
ID Card	Must be mailed within five (5) business days of receipt of eligibility information from which it is prepared. For Medicare members, the ID card must be mailed within five (5) business days of receipt of an accepted enrollment per the CMS TRR.		\$200 per day per batch that does not meet this standard.
Report Delivery	The PBM shall deliver all reports listed in Exhibit G and identified in Part Two paragraph V by the due date.		\$100 per day per report or tape from the date it is due until the date it is delivered
Eligibility Comparison	The PBM's system must accurately reflect eligibility information transmitted from OSEEGIB and eligibility information for Medicare members should be accurately transmitted to CMS.	99% to 100% Below 99% (Only discrepancies where PBM is at fault will be considered)	No damages \$5,000 per month until the error rate falls below 1%
Call Center Customer Service Calls	The PBM must answer customer service calls within a certain period of time and cannot abandon calls more than 5% of the time.	80% of calls in 30 seconds Abandonment rate must not be more than 5%	80%-100% No Penalty 75-75.9% = \$1,500 Below 75% = \$3,000 0-5% = \$0 5.1-7%=\$1,500 Above 7%=\$3,000 Monthly Basis
Corrective Action Plan	Any compliance failure due to the PBM's action that results in a Corrective Action Plan being filed with CMS.	100%	PBM assumes all Corrective Action Plan costs and damages as assessed by CMS.

- a) Does the PBM agree to these requirements?
- b) Other than what is required by the performance standards of this RFP, what performance guarantees is the PBM willing to make to OSEEGIB?
- c) State the guaranteed level of performance and the amount of liquidated damages the PBM is willing to risk, including information regarding:
 - i) implementation action steps and key dates;
 - ii) global system fixes (claims not processing correctly, eligibility issues or anything causing a member to not obtain a prescription;
 - iii) turnaround time for mail service;
 - iv) claims payment/adjudication accuracy;

- v) telephone response time and telephone abandonment rates for the pharmacy help line and prior authorization lines.
- 5) OSEEGIB recognizes “transparency” is the key word in the PBM industry.
- a) Define the PBM’s interpretation of transparency and how the PBM will guarantee OSEEGIB auditable and organizational transparency.

D. Delegation of Authority

OSEEGIB maintains the right and responsibility to provide oversight of all services performed by the PBM on behalf of OSEEGIB for OSEEGIB to be and remain compliant with CMS requirements.

By and through this Contract, OSEEGIB has delegated to the PBM services required to maintain OSEEGIB’s status as a PDP upon annual approval by CMS. OSEEGIB intends to complete a routine on-site review of the PBM’s documentation and policies & procedures for determination as to whether the PBM’s standards meet or exceed OSEEGIB’s standards and CMS requirements.

OSEEGIB’s site visits will be scheduled at times mutually agreed upon between OSEEGIB and the PBM, and shall be scheduled no less than once a year or more frequently, provided an audit discovers a material error of non-compliance or, at OSEEGIB’s discretion, provided the cost of any such additional audit is borne by OSEEGIB.

Through the actions of its Executive Committee, OSEEGIB shall review and adopt all policies and procedures which shall be in compliance with and consistent with applicable CMS regulations necessitated by the PBM providing services per this contract.

In accordance with CMS requirements, the PBM and OSEEGIB shall, on a quarterly basis, meet and review any material modifications related to providing of Part D services.

If it is determined that the PBM’s services are being provided at a level below the CMS required standards, OSEEGIB retains the right and responsibility to evaluate the effectiveness and compliance of the PBM’s services and provide feedback to and assist in the development of corrective action plans established by CMS requirements.

The PBM shall comply with reasonable requests and recommendations arising from such site visits and action plans.

The PBM shall keep OSEEGIB advised of changes in the applicable law or regulations which may have a material effect on any of the areas of responsibility delegated to the PBM under this Contract.

The PBM and OSEEGIB will take reasonable steps to coordinate the audit for the Part D services and the audit for the general pharmacy benefits services, but under no circumstances shall OSEEGIB's oversight responsibilities be compromised.

- a) Does the PBM agree to this requirement?

PART FOUR – General Administration

- A) The PBM shall provide and issue warrants or drafts in reimbursement to the pharmacy providers, drawn upon a designated account of OSEEGIB. The drafts shall be drawn pursuant to the requirements of the State Treasurer of Oklahoma and required HIPAA transaction set standards. These warrants or drafts are payable through the Federal Reserve System.

The PBM shall provide OSEEGIB the following information by electronic transfer:

- 1) A claims experience history file created on a regular basis, coinciding with the issuing of checks. The claims history shall be the claims used in that check issue run and the amount paid will have the same total on the check register.
 - a) Describe how the PBM intends to perform the aforementioned services for this contract.
 - b) Provide the PBM's preferred file layout for a claims experience history file to be submitted to OSEEGIB.
- 2) A check register file which shall be produced as a separate file for the checks written on each check cycle. The current format of this file is referenced in Exhibit E. The check register file must be sent to OSEEGIB on the same day checks are released.

SEE EXHIBIT E – Record Layout for Check Register File

- a) Provide a delineation of the PBM's billing client payment and pharmacy payment cycles.
 - b) Describe the security procedures for checks and warrants.
- B) The PBM must demonstrate the ability to interface effectively, electronically and operationally with OSEEGIB's eligibility system. The PBM must demonstrate its ability to receive and process eligibility maintaining an accurate representation of OSEEGIB member data on its system, providing timely and detailed error reporting in an electronic batch form as deemed acceptable to OSEEGIB. The

PBM shall accept daily eligibility and enrollment data from OSEEGIB. The PBM shall use the eligibility data in the file format provided in Exhibit F. If modifications are necessary to OSEEGIB's current export process, the PBM shall provide adequate programming resources to assist with the modifications. The current export is written and maintained in PL/SQL. If a new implementation is required, the PBM shall load and test files in a mutually agreed upon process that meets OSEEGIB's requirements. Testing of all files and data shall be at the direction of OSEEGIB for quality assurance and final approval. The daily transfer of eligibility data shall include but not be limited to, changes, new hires and terminations. The PBM shall use reasonable data compression when interfacing with OSEEGIB. OSEEGIB would consider a real-time replicated data environment as an alternative to batch form if offered by the PBM.

SEE EXHIBIT F – Layout for Eligibility File

- a) If the PBM offers an alternative to the eligibility layout as described in Exhibit F, the PBM must provide a written detailed description as to why it is unable or unwilling to adapt to the layout described.
 - b) Provide the PBM's policies and procedures for accepting daily eligibility and enrollment data.
 - c) State how long detailed claim records are maintained online and the accessibility of that data when it is no longer online.
 - d) Describe the following:
 - i) backup policies, procedures and storage,
 - ii) fire suppression system and redundancies,
 - iii) environmental controls and redundancies,
 - iv) percent down-time for the last year,
 - v) recovery provisions, Hotsite/Coldsite
 - vi) contingency plan if hardware is destroyed, and
 - vii) contingency test results.
- C) All operational data, including but not limited to batch eligibility files, reports and pre-edits, shall be encrypted and transmitted daily between the PBM and OSEEGIB via a T-1 direct line or Permanent Virtual Circuit (PVC) implemented and maintained at the PBM's expense. The PBM shall additionally establish with OSEEGIB an alternate communication path utilizing an encrypted Virtual Private Network (VPN) via the Internet.
- a) Provide a network diagram showing the complexity of the PBM's existing supported network connections, preferred carrier for data lines and preferred remote connection type.

- D) OSEEGIB intends to perform a full eligibility comparison on a quarterly basis with both CMS and with the PBM. The PBM shall correct differences found as a result of these comparisons as directed by OSEEGIB within one week of the direction.
- a) Describe the PBM's ability to perform full eligibility comparisons.
 - b) Describe the resources and personnel the PBM will have available to resolve eligibility issues found in the quarterly comparisons.
- E) The PBM shall provide OSEEGIB with a daily file, listing all editing eligibility updates. The PBM shall reconcile the full eligibility file on a quarterly basis and as needed, as major eligibility changes occur.
- a) Provide the PBM's standard procedures for pre-processing and reporting of the eligibility and enrollment data.
 - b) Provide the PBM's standard procedures for reconciliation of the eligibility and enrollment data.
- F) The PBM shall provide a pre-edit report generated from each daily eligibility file, detailing potential file processing actions. The pre-edit report shall list counts for each transaction type.
- a) Provide a description of the pre-edit process utilized for current clients.
- G) The PBM shall provide an electronic file to OSEEGIB as part of the pre-edit processing procedures containing a copy of each record submitted in the daily file with rejection codes identifying any and all errors. This file will be in the same eligibility layout as defined in Exhibit F. The codes shall identify why the record was rejected and clearly identify if the rejection was a hard rejection or soft rejection. A soft rejection will be known as an error whereby the PBM still processed the record or caused some update to its eligibility system. A hard rejection will be known as an error whereby the PBM did not process the record or update its eligibility system in any way.

See Exhibit F – Record Layout for Eligibility File

- a) Provide a description of how rejected records are tracked and communicated with current clients.
- H) The PBM shall provide a detailed table of all rejection codes with recommended actions to be taken by OSEEGIB for each code.
- a) Provide a table or description of the current rejection codes utilized with an existing client.

- I) All electronic mail between the PBM and OSEEGIB shall be routed across the established dedicated circuit or VPN and not traverse the Internet. The PBM shall dedicate an experienced networking specialist to serve as a liaison to OSEEGIB for network related issues.
 - a) Provide the PBM's network specialist liaison's title, relevant skills and years of experience.
 - b) Explain how daily operational email is routed between the PBM and existing clients.
 - c) Describe any methods used by the PBM to encrypt email between the PBM and clients.
 - d) Describe how PBM employees may access email remotely via laptops, Blackberries or other portable devices.
 - e) Describe or provide a copy of internal policies the PBM has in place to protect client email.

- J) All PBM authorized users, contractor, consultants, temporaries, and other workers including all personnel affiliated with third parties utilizing VPN's to access the OSEEGIB network must be managed in a manner designed to minimize risk, ensure user and data confidentiality over an unsecured medium such as the Internet and maintain the integrity of the connecting client system and OSEEGIB systems that the user connects to through the VPN. All VPN connections will use no less than 128 bit encryption to secure the data transmission between OSEEGIB and third parties.
 - a) Describe any existing VPN connections currently in place with other clients. Provide any specific hardware or software that is required, bit rate of encryption and type.

- K) The PBM shall provide a dedicated primary technical contact for OSEEGIB. The technical contact must be an experienced developer with extensive knowledge of the PBM's eligibility system. The technical contact must be reasonably available to assist with any modifications necessary to OSEEGIB's eligibility export process at any time during the life of the contract. The PBM shall additionally designate an alternate contact with the same or similar credentials. The primary contact shall be available to work with OSEEGIB and at OSEEGIB's site during critical phases and throughout an implementation, if necessary.
 - a) Provide the PBM's technical contact title, relevant skills and years of experience.

- L) The PBM must verify and commit that during the length of the contract, it shall not undertake a major conversion for, or related to, the system used to deliver

services to OSEEGIB without specific written notice to OSEEGIB and offered no less than six (6) months prior to use in production. Notice of minor program changes, fixes, modifications and enhancement that may impact the exchange of eligibility must be provided to OSEEGIB no less than thirty (30) days prior to use in production. The PBM shall provide the following information for all systems used to satisfy the requirements of this RFP:

- a) The PBM must provide a data directory of all fields that are operational in any system proposed. This data directory must include the length of the field and a specific description of the data stored in each field.
 - b) The PBM shall use appropriate security and encryption to protect the confidentiality of OSEEGIB's data. OSEEGIB currently uses Pretty Good Privacy (PGP) as its standard encryption application.
 - c) The PBM shall describe its business recovery strategy to restore full business functionality in the event of a disruption in service or disaster.
 - d) The PBM shall provide OSEEGIB a copy or describe its policies and procedures designed to control, limit or prevent the transportation and storage of client data on laptop computers, compact disks, flash memory devices or any other portable memory device.
- M) The PBM shall effectively interface electronically and operationally with OSEEGIB's Health Claims Administrator and other applicable administrators, as the need arises. The interface requirements are for effective communication for all operation initiatives. The PBM shall give timely notice to OSEEGIB of a dispute between itself and third party administrators that affects the performance of this agreement. Disputes arising between the PBM and other OSEEGIB Third Party Administrators (TPA) shall be resolved at the direction of OSEEGIB.
- a) Demonstrate in detail the PBM's experience to interface with other administrators.
- N) It is the intention of OSEEGIB for the PBM to assume all processing functions on January 1, 2008 for new claims, paper claims, prior authorizations, correspondence, and outstanding overpayments received, as well as run-in claims. The PBM shall be responsible for processing, within sixty (60) calendar days of the contract date, all outstanding unprocessed or pended pharmacy claims received from the former PBM and for administrative services to resolve outstanding adjustments, returned checks, correspondence and overpayments.
- a) Describe in detail the PBM's procedures to meet the above objectives.

- b) Describe the PBM's claims processing and eligibility system, specifically identifying the following information:
 - i) internally maintained by the PBM or externally maintained pursuant to an independent contract;
 - ii) location of data center where eligibility and claims data will be housed;
 - iii) location, number, skills and experience of developers;
 - iv) timeline for future modifications/enhancements;
 - v) identify when the PBM's system was put into production.

- O) The PBM shall be responsible for furnishing and mailing an accurate identification card to each eligible primary active and pre-Medicare member and each Medicare member. The PBM is not required to provide identification cards to the DRS members. The PBM shall be responsible for sending a new card to each member and their dependents prior to January 1, 2008, as well as any new enrollment or additional and replacement cards. The PBM is responsible for providing all inserts and envelopes, as well as the cost of mailing the cards. Cards for new members or updated cards for existing members shall be mailed within five (5) days of the PBM receiving the eligibility notice.

Currently the identification card issued for members is in the National Council for Prescription Drug Programs (NCPDP) format. OSEEGIB reserves the right to customize the content of the reverse side of the card to provide other information relating to its plans. The estimated numbers of participants in the following categories are:

- i) Non-Medicare Primary Member Only – 99,247
 - ii) Pharmacy Medicare Lives – 34,056
-
- a) Describe in detail the PBM's ability to meet the requirements as stated above.
 - b) Describe in detail the PBM's ability to meet the industry standard format as defined by NCPDP.
 - c) Differentiate between any applicable difference that would apply should the magnetic stripe be a national standard or one which is required by the State of Oklahoma.
 - d) In the event OSEEGIB is mandated to have a magnetic stripe, that would contain member-specific information, how would the PBM accommodate this requirement and what would the cost be to OSEEGIB?
 - e) OSEEGIB currently has an eight digit identification code for non-Medicare members that are system generated by OSEEGIB's system. The

Medicare members have an alpha numeric suffix at the end of this eight digit numeric number (i.e., D00 for Member, D01 for Spouse and D10 for Medicare child). Please confirm there are no issues continuing this process.

- f) Does the standard card provided by the PBM permit the use of color? If so, please detail what is available. If not, is there any cost difference in providing pharmacy cards with four colors?
 - g) Indicate the difference in pricing based upon the following scenarios:
 - i) two cards sent to every primary member
 - ii) one card sent to primary members with no dependents and two cards sent to primary members with one or more dependents
 - h) Provide a sample of the PBM's identification card.
- P) The PBM shall provide new members a Welcome Letter, ID card and Formulary Guide in a format approved by OSEEGIB with the printing and mailing expense absorbed by the PBM.
- a) Describe in detail the PBM's ability to meet the requirement as stated above.
 - b) If the award of this contract results in an implementation, the Welcome Letter, ID cards, Pharmacy Benefit brochures and Formulary Guides must be mailed by December 10, 2007 or 5 working days after eligibility is received by the PBM, whichever is later. Please describe how the PBM will accomplish this task.
- Q) The PBM shall review and update the Formulary Guide for the HealthChoice Formulary at least quarterly, at dates agreed on by OSEEGIB. The PBM shall mail guides to all members on an annual basis.
- a) How does the PBM propose providing members with Formulary Guides following the annual mailing?
- R) The PBM shall provide educational articles in OSEEGIB's member and provider newsletters and review for accuracy all pharmacy articles and other communications originating at OSEEGIB.
- a) OSEEGIB produces monthly website articles, quarterly member and provider newsletters and other information on demand. Provide examples of plan-specific articles directed toward member and provider audiences respectively.

- b) Describe the PBM's ability to support a quarterly "Ask A Pharmacist" feature of no more than three (3) questions for OSEEGIB's online newsletter written at the member level.
- S) The PBM shall provide all documentation and witnesses requested by OSEEGIB for grievance hearings and litigation arising from pharmacy claims.
 - a) Does the PBM agree to this requirement?
- T) The PBM shall be represented at periodic meetings or functions as requested by OSEEGIB.
 - a) Does the PBM agree to this requirement?
- U) The PBM shall identify and communicate with members at the PBM's expense regarding expiring prior authorizations and drugs changing tier status.
 - a) Is the PBM currently communicating with members in this regard and if so, describe or propose a communication process.
- V) The PBM shall prepare and update at least semi-annually, a Business Requirements Document for OSEEGIB's non-Medicare, Medicare and DRS business. The document shall track all plan design, current and future changes, eligibility set-up, ID card logic, system malfunctions, dates malfunctions corrected, and other business processes applicable to this contract. The initial document shall be available January 1, 2008.
 - a) Describe the PBM's experience preparing business requirements documents?
- W) The PBM shall provide the timeframe within which it would notify OSEEGIB, unless prohibited by securities law, of any current or prospective "significant event" on an ongoing basis. As used in this provision, a "significant event" is any occurrence or anticipated occurrence which might reasonably be expected to have a material effect upon the PBM's ability to meet its obligations including, but not limited to, any of the following:
 - i) disposal of major assets;
 - ii) any major computer software conversion, enhancement or modification to the operating systems, security systems, and application software, used in the performance of this contract termination or modification of any contract or subcontract, if such termination or modification may have a material effect on the PBM's obligations under this contract;
 - iii) the PBM's insolvency or the imposition of, or notice of the intent to impose, a receivership, conservatorship or special regulatory

- monitoring or any bankruptcy proceedings, voluntary or involuntary, or reorganization proceedings;
 - iv) the withdrawal of, or notice of the intent to withdraw, any license required under state or federal law;
 - v) default on a loan or other financial obligations;
 - vi) impairment of the security offered as a performance guarantee;
 - vii) strikes, slow-downs or substantial impairment of the PBM's facilities or of other facilities used by the PBM in the performance of this contract;
 - viii) changes in background information about the PBM or its subcontractor(s);
 - ix) reduction in key personnel and any fluctuation of claims examiners, customer service representatives or claims adjusters;
 - x) known or anticipated merger or acquisition;
 - xi) known, planned or anticipated stock sales;
 - xii) any reorganization;
 - xiii) any litigation filed by a member against the PBM; and
 - xiv) any sale or corporate merger.
- a) Does the PBM anticipate any changes in the organization's basic ownership structure or any other significant changes in the organization within the next twelve (12) to twenty-four (24) months? If yes, please explain.
 - b) Describe the organization and its history, legal structure, ownership, affiliations and related parties. Supply an organizational chart and resumes of key personnel. Also, provide an organizational chart for the PBM that includes the department/divisions and positions of those individuals with ultimate responsibility for OSEEGIB's account.
- X) The PBM account staff will deal directly with OSEEGIB's benefit administration staff.
- a) Describe the size, qualifications and experience of the PBM's account staff and how they will provide support to OSEEGIB.
 - b) Identify those individuals located in the PBM's home office who will have ultimate responsibility for OSEEGIB's account.

- Y) The PBM shall provide a detailed business plan, within thirty (30) days of the award of this contract, with time-commitments for each objective and task, specific to OSEEGIB's current status, as well as a separate business plan for DRS. The PBM shall demonstrate its understanding of the complexities involved in converting and implementing a large public sector account. The business plan shall include identification of all steps that the PBM considers necessary to commence claims processing on January 1, 2008, including, but not limited to:
- i) transfer of claims history file to include all open and active prior authorizations;
 - ii) implementing all prior authorization and quantity limit programs;
 - iii) eligibility;
 - iv) ongoing training for all areas to include OSEEGIB and DRS;
 - v) coordinating with OSEEGIB and other contractors for requirements of this RFP, including the transfer of functions performed by the current PBM under contract with OSEEGIB;
 - vi) establishing communications and satisfactory computer interface with OSEEGIB and its other contractors with respect to present as well as new or modified communications and computer systems;
 - vii) providing all hardware, software and telecommunications equipment required to adjudicate claims;
 - viii) expanding the PBM's business where necessary to administer the contract;
 - ix) production of identification cards in accordance with specifications to be provided by OSEEGIB;
 - x) addressing how the PBM will minimize formulary disruption, retail network disruption and member disruption associated with differences in Prior Authorization criteria and quantity limits; and
 - xi) interfacing with CMS for eligibility and prescription drug event records;
 - xii) completion of all required CMS PDP Attestations, reports and/or exhibits;
 - xiii) meeting CMS pharmacy access standards, including home infusion, Indian Health Services and Long-Term Care facilities;
 - xiv) completing CMS compliance plan and training requirements;
 - xv) internal training necessary to handle calls from members/prospective members during the annual option period in September through October 2007; and

- xvi) Website functionality to show formulary information by September 1, 2007.
 - a) Does the PBM agree to this requirement?
- Z) OSEEGIB pharmacy trend has been eight and one-half percent (8.5%).
 - a) What services can the PBM offer to minimize that trend?
 - b) Are the aforementioned services included in the PBM's administrative fee or are they being offered at additional cost to OSEEGIB? If the latter, please identify in Financial Proposal.
- AA) The PBM shall describe its website capabilities available to OSEEGIB members and OSEEGIB management.
 - a) Does the PBM have a dedicated member website? If so, what information is available on the website?
 - b) Does the PBM have a website for OSEEGIB to review online, member claims, reports, and member prior authorizations? Fully describe all information available including update capabilities.
 - c) Please provide a CD demonstrating internet services available to members, pharmacies, clients, and physicians.
- BB) OSEEGIB is a progressive and innovative plan that will consider additional services and opportunities that the PBM would like to include in the RFP for consideration by OSEEGIB.
 - a) Describe in detail what additional services and opportunities that the PBM can provide beyond the services required in this RFP, at no cost to OSEEGIB. Please identify the program, the savings potential, how savings are measured, and the PBM's willingness to guarantee savings.
 - b) Describe in detail the additional services, opportunities and the associated itemized costs that the PBM can provide beyond the services required in this RFP. Please identify the program, the savings potential, how savings are measured, and the PBM's willingness to guarantee savings.
 - c) Identify specific challenges facing OSEEGIB in regard to this RFP.
 - d) Within the pharmacy benefit management industry, what sets your company apart from the competition?

- e) What added value could the PBM provide other than PBM services required by this RFP?
- f) Can the PBM compare OSEEGIB's data to national and regional normative pharmacy data for outcome analysis, and report that analysis to OSEEGIB? If so, is there an additional cost, or is this included in the PBM's cost?

PART FIVE - Reporting Requirements

In addition to the Medicare reporting requirements in Part Two, Section V:

A) When applicable, reports shall be configured to provide data within the following parameters:

- 1) Plan:
 - i) HealthChoice High and Basic
 - ii) HealthChoice USA
 - iii) HealthChoice Medicare Plans
 - 2) Accounts:
 - i) State
 - ii) Education
 - iii) Local government
 - 3) Category:
 - i) Active
 - ii) Retired Pre-Medicare
 - iii) Medicare
 - 4) Rate Class:
 - i) Member
 - ii) Spouse
 - iii) Dependent – 1 child
 - iv) Dependent – 2 or more children
 - 5) DRS:
 - i) Location
 - ii) Client
- a) Describe the PBM's ability to meet these reporting requirements and provide examples, if available.

B) The PBM shall comply with the reporting requests found in EXHIBIT G

SEE EXHIBIT G: Reporting Requirements

- a) Provide report examples that are listed in EXHIBIT G, or provide reports the PBM is offering that would better serve OSEEGIB's needs. Custom report examples are included in EXHIBIT G.
- b) Describe the PBM's ability to communicate information such as reports via the internet and electronic mail.
- c) Should OSEEGIB desire additional reports beyond those specifically identified in this RFP, describe the options available for standard and ad hoc reporting.
- d) What is the maximum turnaround time associated with an ad hoc report request?

C) The PBM shall provide OSEEGIB with a quarterly report sixty (60) days after a quarter-end and an annual report sixty (60) days after year end for OSEEGIB and DRS.

SEE EXHIBIT G – Reporting Requirements

- a) Provide a description and example of this requirement.

D) The PBM shall submit to OSEEGIB for its approval any reports to be submitted to CMS on behalf of OSEEGIB at least five (5) working days prior to submission to CMS. The PBM shall incorporate changes requested by OSEEGIB and provide OSEEGIB with a final copy of any reports submitted to CMS on behalf of OSEEGIB. The PBM shall not be liable or responsible for modifications made to reports at the direction of OSEEGIB.

- a) Does the PBM agree to this requirement?

V. Bidding Requirements

A. Issuing Office

This RFP is issued by the Department of Central Services on behalf of the Oklahoma State and Education Employees Group Insurance Board (OSEEGIB).

All proposals must be submitted in accordance with the policies, procedures, requirements and dates set forth below:

No late proposal will be accepted. An original and twelve (12) copies of the proposal must be submitted by **3:00 p.m., Thursday, September 21, 2006** to:

Irene Bowman, Contracting and Procurement Officer
Department of Central Services
Central Purchasing Division
Will Rogers Building, First Floor, Suite 116
Oklahoma City, Oklahoma 73152-8803
Phone: (405) 521-4058
Fax: (405) 522-1078
Email: Irene.Bowman@dcs.state.ok.us

The original must be so marked and **must contain the completed Department of Central Services, Central Purchasing Division Solicitation Request sheets and must have a Competitive Bid Noncollusion Affidavit with an original signature of a person authorized to make commitments for the company, must be signed in ink, and must be notarized.** A facsimile or photocopy of an original signature will not be accepted. **These documents should be placed at the front of the submitted proposal.** Proposals must be delivered to the Department of Central Services, Central Purchasing Division. **Proposals failing to be delivered to the proper address or without proper signatures shall be eliminated from further consideration.**

B. Proposal Process

The PBM shall submit with its proposal an executive summary no longer than two (2) pages, outlining significant features of the proposal. The summary should highlight the PBM's philosophy, its experience with similar programs and the administrative approach presented in the proposal. The summary must also include a description of the PBM's understanding of OSEEGIB's RFP along with organizational and conceptual approaches to be used.

The proposal will be received by the Department of Central Services. After

opening, it will be reviewed by the DCS for conformation with the Proposal Submission Requirements. Non-conforming proposals will not be considered further. DCS will then forward the acceptable proposals to OSEEGIB.

OSEEGIB's Evaluation Committee will in turn review for compliance with Minimum Requirements. Proposals that do not meet Minimum Requirements will not be considered further.

OSEEGIB will then review the acceptable proposals in their entirety. The end result of that process will result in the identification of proposals, which, in the opinion of OSEEGIB would result in an acceptable PBM. References will then be checked and OSEEGIB will invite selected PBMs to Oklahoma City for discussions and demonstrations or OSEEGIB may request a PBM site visit.

If OSEEGIB determines that one of the proposals is preferred and acceptable, the DCS will be notified and the negotiations with that PBM will begin. If the PBM and OSEEGIB cannot conclude this negotiation phase, OSEEGIB may begin negotiations with the next ranked PBM. If one proposal is not preferred, OSEEGIB may simultaneously negotiate with more than one PBM.

When negotiations are finished, the DCS will complete its processes, likely resulting in a contract award and all vendors submitting responses will be notified.

C. Proposal Format

Proposals shall be prepared in the format described below. Failure to comply with the specified format may lead to a PBM's proposal being declared non-responsive. OSEEGIB is especially concerned that the format of the proposal sequentially responds to the requested services, Minimum Requirements and other questions that may be addressed within the RFP. The PBM should restate the service, requirement, or question and then state its response. The PBM shall assign consecutive page numbers in its response.

Appendices should be similarly sequential. Any other information thought to be relevant, but not applicable to the prescribed format, should be provided as appendices to the proposal. If a bidder supplied a publication to respond to a requirement, the response should include references to the publication and page number. Proposals without this reference shall be considered to have no reference materials included.

An official copy of the RFP is obtainable only through the DCS.

The proposal shall be configured to arrive at the designated office in one physical container (the "Outer Container"). FAX or electronic submissions are not acceptable.

D. Proposals Are Subject to Oklahoma Open Records Act

To the extent permitted by the Oklahoma Open Records Act (51 O. S. § 24A.1-27), the PBMs' proposals will not be disclosed, except for purposes of evaluation, prior to approval by the Department of Central Services of the resulting contract. All material submitted becomes the property of the State of Oklahoma. Proposals will not be considered confidential after a contract is awarded.

Submitted proposals may be reviewed and evaluated by any person designated by OSEEGIB, other than one associated with a competing bidder. OSEEGIB reserves the right to use any and all ideas presented in any response to the RFP. Selection or rejection of a proposal does not affect this right.

Proposals marked as proprietary and/or confidential will not be considered. If a bidder believes that any information in its proposal constitutes a trade secret and needs such information not to be disclosed if requested by a member of the public, the bidder shall submit that portion of its response in a sealed envelope accompanied by a letter explaining in detail why such information is a trade secret and requires the privilege of confidentiality. Such privilege will be determined by the sole discretion of the Department of Central Services.

E. Restrictions on Communication with OSEEGIB Staff

From the issue date of this RFP until a PBM is selected, PBMs are not allowed to discuss this RFP with any OSEEGIB member, employee or any Consultant to OSEEGIB. This restriction shall not prohibit discussions needed by the current PBM to perform its job. Any violation of this restriction shall result in disqualification.

F. Sole Contact

If the PBM has questions regarding any bidding requirements of the RFP, the contact is:

Irene Bowman, Contracting and Procurement Officer
Department of Central Services
Central Purchasing Division
Will Rogers Building, First Floor, Suite 116
Oklahoma City, Oklahoma 73152-8803
Phone: (405) 521-4058
Fax: (405) 522-1078
Email: Irene.Bowman@dcs.state.ok.us

G. Information from One Bidder Concerning Another Is Prohibited

PBMs are advised that OSEEGIB is not interested in, nor will it consider, allegations of lack of qualification or of impropriety made or initiated by any PBM concerning another PBM at any point during the competitive bid process. Inclusion of such information in the RFP response or communication of such information to any state officials, state staff or its contractors after proposal submission shall be grounds for disqualification. This clause in no way limits the right to file a protest or appeal under the laws or rules governing the State of Oklahoma.

H. Revisions to the RFP and/or Responses

OSEEGIB may at any time hereafter supplement the RFP, the proposal and the resulting contract for purposes of enumerating, defining, and clarifying services, duties and functions, but not to add new services, duties or functions unless approved by the Department of Central Services.

During the evaluation period, the PBMs may be requested to present supplemental information clarifying its proposal. This supplemental information will be requested by DCS and the information must be submitted in writing to DCS and will be included as a formal part of the PBM's proposal.

I. Proposal Withdrawal

***Next time around, we may want to revise this language...* Prime withdrew its bid per a telephone conversation with DCS on October 20, 2006 – the opening date was October 5, 2006.**

Before the proposal opening date and time, a submitted proposal may be withdrawn by a written request signed by the proposer to:

Irene Bowman, Contracting and Procurement Officer
Will Rogers Building
Department of Central Services, Central Purchasing Division
Oklahoma City, Oklahoma 73152-8803

and

Kathy Pendarvis, General Counsel to the Administrator
Oklahoma State and Education Employees Group Insurance Board
3545 NW 58th, Suite 1000

Oklahoma City, Oklahoma 73112

J. Incurred Expenses

OSEEGIB will not be responsible for any costs a proposing PBM may incur in preparing and submitting a proposal, making an oral presentation, providing a demonstration, or performing any other related activities.

K. Notification of Award

Notification will be made to the successful PBM by issuance of a purchase order. Public information releases pertaining to this project shall not be made without prior written approval by OSEEGIB and then only in conjunction with OSEEGIB.

L. Subcontractors

In the event a proposal is jointly submitted by more than one entity, one of the organizations must be designated as the prime contractor. All other members should be designated as subcontractors. Any planned or proposed use of subcontractors must be clearly documented in the proposal. The prime contractor shall be completely responsible for all contract services to be performed. Prime contractors must demonstrate that all aspects of system integration have been carefully and completely considered.

Additionally, those PBMs who have experience with subcontractors being utilized in this RFP should name the subcontractor, define the relationship, and clearly state the years of experience. Failure to adequately demonstrate the ability to timely integrate systems shall result in the elimination of the proposal.

Each subcontractor must independently satisfy the Minimum Requirements and sign a Statement of Compliance.

VI. General Contractual Provisions

As stated in Section III, Minimum Requirements, of this RFP, the PBM must affirm its understanding of all contractual provisions and agree to comply with those provisions for the duration of the contract.

A. Acceptance of Offer

The submission of a proposal shall constitute a binding offer to perform those services described within the proposal. The proposal shall remain in effect for six (6) months after submission. OSEEGIB shall have the option of accepting the proposal at any time within that six (6) month period. If the proposal is accepted more than six (6) months after submission, OSEEGIB and the PBM will agree to adjust the time lines up to six (6) months. The PBM is advised that its proposal may be accepted any time within that six (6) month period, even if OSEEGIB accepted another PBM's proposal and subsequently that contract was terminated.

By submitting a proposal, the PBM agrees not to make any claims for, or have any right to, damages because of any misunderstanding or misrepresentation of the specifications or because of any misinformation or lack of information.

If a PBM fails to notify OSEEGIB of an error, ambiguity, conflict, discrepancy, omission or other error in the RFP known to the PBM, or an error that reasonably should have been known by the PBM, the PBM shall submit a proposal at its own risk; and, if awarded the contract, the PBM shall not be entitled to additional compensation, relief or time by reason of the error or its later correction.

B. Contractual Term

The contract term is for a one year (1 year) term effective January 1, 2008, with four (4) one-year (1-year) renewals at the option of OSEEGIB. OSEEGIB intends to renew the contract for the additional four (4) years subject to the terms and conditions of the contract, unless OSEEGIB determines in its sole discretion that re-bidding the services is in the members' best interest.

C. Termination

Within thirty (30) days after the date the PBM receives notice of termination, the PBM shall, at no additional cost to OSEEGIB, copy and deliver to OSEEGIB all files and data bases in an agreed upon electronic format, together with necessary and appropriate documentation (including record layouts of the data bases and their application) used in the administration of the program. Coordination of this transfer is vital to the continuity of OSEEGIB's business

and the PBM must do whatever is necessary to facilitate a timely and accurate transfer. Administrative procedures, both internal and external, and other related material necessary to operate the plan shall also be delivered. Between notification of termination and the termination date, additional information must be provided as requested.

At the close of business on the termination date, the PBM shall transfer to OSEEGIB all remaining files, databases, correspondence and any other information pertaining to the plan. All unprocessed claims including, but not limited to, adjustments, correspondence, returned checks and pended claims shall be delivered to OSEEGIB immediately upon termination.

The PBM shall give OSEEGIB at least one hundred eighty (180) days written notice prior to cancellation. The PBM shall also provide one hundred eighty (180) days written notice prior to non-renewal.

OSEEGIB and the Department of Central Services may terminate this contract for cause upon giving the PBM thirty (30) days written notice. Termination for cause is defined as the failure of the PBM to maintain the quality of its services provided for by this contract to the satisfaction of OSEEGIB. OSEEGIB and the DCS may terminate this contract without cause upon giving the PBM one hundred eighty (180) days written notice.

Following the effective date of termination, this contract shall be of no further force and effect, except that each party shall remain liable for any obligations or liabilities arising from activities carried on by it hereunder prior to the effective date of termination of this contract.

The PBM, OSEEGIB and the Department of Central Services shall agree that each party reserves the right to terminate this contract if funds are not available to support the continuation of this benefit program administered by OSEEGIB, or if it is otherwise determined by OSEEGIB, at its sole discretion, that it is in the best interest of the State to terminate the contract.

D. Electronic and Information Technology Accessibility (EITA) Standards

All electronic and information technology procurements, agreements, and contracts shall comply with Oklahoma Information Technology Accessibility Standards issued by the Oklahoma Office of State Finance. Electronic Information Standards may be found at www.ok.gov/DCS/Central_Purchasing

Upon request, the PBM shall provide a description of conformance with the applicable Oklahoma Information Technology Accessibility Standards for the proposed product, system or application development/customization by means of either a Voluntary Product Accessibility Template or other comparable document.

The PBM shall indemnify and hold harmless the State of Oklahoma and any Oklahoma governmental entity purchasing the product, system or application developed and/or customized by the PBM from any claim arising out of the PBM's failure to comply with the aforementioned requirements.

E. Performance Security

The PBM must provide to OSEEGIB within thirty (30) days after contract execution, the original of a blanket, no deductible fidelity bond in the amount of One Million Dollars (\$1,000,000), with OSEEGIB as the sole beneficiary. The PBM shall further provide a performance bond in the amount of Three Million Dollars (\$3,000,000). In lieu of the fidelity bond and the performance bond, the PBM may provide an irrevocable letter of credit in the amount of One Million Dollars (\$1,000,000) for a fidelity breach and Three Million Dollars (\$3,000,000) for breach of performance. If the PBM is a subsidiary of another corporation, the parent corporation must additionally guarantee and indemnify the performance of the subsidiary. This bond and/or irrevocable letters of credit should be issued from a reliable surety company or national bank that is acceptable to OSEEGIB.

Additionally, the PBM shall contemporaneously furnish a Certificate of Insurance from an insurer to OSEEGIB, certifying that liability coverage is in effect and that OSEEGIB is the sole beneficiary. Written notice must be received by OSEEGIB at least 20 days prior to date of cancellation.

F. Confidentiality and HIPAA Requirements

The PBM agrees that it maintains internal practices, policies, books and records, including policies and procedures relating to the use and disclosure of OSEEGIB confidential information and will provide OSEEGIB a summary description of those policies and procedures upon request. All OSEEGIB member information concerning this RFP is the sole property of the State of Oklahoma and shall remain confidential. It shall not be used by the PBM nor transmitted to others for any reason whatsoever, except as shall be required to administer and implement the Scope of Services described in this RFP, or with prior written approval from OSEEGIB.

The PBM, as a "Business Associate," agrees to the following 'Business Associate Agreement' between OSEEGIB and the PBM as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) statutes and regulations.

1) Definitions

- a) "Business Associate" shall have the meaning given to Business Associate under the Privacy Rule, including, but not limited to, 45 CFR§ 160.103.

- b) “Contract” shall mean the definition of contract as defined in Section VI, paragraph (K) of the RFP.
- c) “Data Aggregation” shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR § 164.501.
- d) “Designated Record Set” shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR § 64.501.
- e) “Health Care Operations” shall have the meaning given to such term under the Privacy Rule including, but not limited to, 45 CFR § 164.501.
- f) “HIPAA” means Health Insurance Portability and Accountability Act of 1996.
- g) “Individual” shall have the same meaning as the term “individual” as used in 45 CFR § 164.501 and shall include a person who qualifies as a “personal representative” in accordance with 45 CFR § 164.502(g), and shall also mean the person or “individual” who is the subject of information that constitutes PHI, and has the same meaning as the term “individual” as used in 45 CFR § 160.103
- h) “OSEEGIB” shall have the meaning given to the term ‘Covered Entity’ under the Privacy Rule including, but not limited to, 45 CFR § 160.103 for purposes of this Business Associate Agreement only and to the extent required by law.
- i) “Privacy and Security Rule” shall mean the HIPAA Regulations codified at 45 CFR Parts 160 through 164.
- j) “Protected Health Information” or “PHI” means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR § 160.103 [45 CFR §§160.103]
- k) “Protected Information” shall mean PHI provided by OSEEGIB to or created or received by the PBM on OSEEGIB’s behalf.
- l) “Required by Law” shall have the same meaning as the term “required by law” in 45 CFR §164.103
- m) “Security Incident” shall have the same meaning as “security incident” in

45 CFR §164.304.

2) Obligations of the PBM

- a) Permitted Uses. The PBM shall not use Protected Information except for the purpose of performing the PBM's obligations under the Contract and as permitted under the Contract. Further, the PBM shall not use Protected Information in any manner that would constitute a violation of the Privacy Rule if so used by OSEEGIB, except that the PBM may use Protected Information (i) for the proper management and administration of the PBM, (ii) to carry out the legal responsibilities of the PBM, or (iii) for Data Aggregation purposes for the Health Care Operations of OSEEGIB, and also as permitted in Section (3) of this Business Associate Agreement [45 CFR §§ 164.504(e)]
- b) Permitted Disclosures. The PBM shall not disclose Protected Information in any manner that would constitute a violation of the Privacy Rule if disclosed by OSEEGIB, except that the PBM may disclose Protected Information (i) in a manner permitted pursuant to the Contract (ii) for the proper management and administration of the PBM, (iii) as required by law, or (iv) for Data Aggregation purposes for the Health Care Operations of OSEEGIB and as permitted in Section (3) of this Business Associate Agreement. Unless agreed otherwise herein, to the extent that the PBM discloses Protected Information to a third party, the PBM must obtain, prior to making any such disclosure, (i) reasonable assurance from such third party that such Protected Information will be held confidential and secure and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and (ii) an agreement from such third party to notify the PBM of any breaches of confidentiality or security of the Protected Information, to the extent it has obtained knowledge of such breach. [45 CFR §§ 164.504(e)]
- c) Appropriate Safeguards. The PBM shall use appropriate safeguards and train its workforce according to PBM procedures as necessary to prevent the use or disclosure of Protected Information; and ensure the integrity and availability of electronic protected information that the PBM creates, receives, maintains or transmits. The PBM shall implement administrative, technical and physical safeguards that are reasonable and appropriate to the size and complexity of the PBM's operations and the nature and scope of its activities. [45 CFR § 164.504(e)] [45 CFR § 164.306(a)]
- d) PBM's Agents. The PBM shall ensure that any agents, including subcontractors to whom it provides Protected Information, agree to the same restrictions and conditions that apply to the PBM with respect to such PHI. [45 CFR § 164.504(e)(2)(ii)(D)] The PBM shall maintain sanctions against agents and subcontractors that violate such restrictions

and conditions and shall mitigate the effects of any such violation. [45 CFR § 164.530(e)(1) and 164.530(f)]

- e) Access to Protected Information. The PBM shall make Protected Information, maintained in a Designated Record Set by the PBM or its agents or subcontractors, available to OSEEGIB for inspection and copying within ten (10) days of a request by OSEEGIB to enable OSEEGIB to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524. [45 CFR § 164.504(e)(2)(ii)(E)]

- f) Amendment of PHI. Within ten (10) days of receipt of a request from OSEEGIB for an amendment of Protected Information in a Designated Record Set or other record about an individual, the PBM or its agents or subcontractors shall make such Protected Information, within its possession, available to OSEEGIB for amendment and incorporate any such amendment to enable OSEEGIB to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526. If any individual requests an amendment of Protected Information directly from the PBM or its agents or subcontractors, the PBM must notify OSEEGIB in writing within five (5) days of the request. Any denial of amendment of Protected Information maintained by the PBM or its agents or subcontractors shall be the responsibility of OSEEGIB. [45 CFR § 164.504(e)(2)(ii)(F)]

- g) Accounting Rights. Within ten (10) days of notice by OSEEGIB of a request for an accounting of disclosures of Protected Information, the PBM and its agents or subcontractors shall make available to OSEEGIB the information required to provide an accounting of disclosures to enable OSEEGIB to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.528. As set forth in, and as limited by, 45 CFR § 164.528, the PBM may account for but is not required to provide an accounting to OSEEGIB of disclosures described as exceptions to an accounting for disclosures in 45 CFR § 164.528 (a)(1) (I through ix). The PBM agrees to implement a process that allows for an accounting to be collected and maintained by the PBM and its agents or subcontractors, subject to the exceptions, to enable OSEEGIB to respond to a request for an accounting of disclosures. At a minimum, such information shall include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. In the event that the request for an accounting is delivered directly to the PBM or its agents or subcontractors, the PBM shall within five (5) days of a request forward it to OSEEGIB in writing and provide OSEEGIB an accounting according to 45 CFR § 164.528 (b)(c)(d) to the extent applicable to PBM.

It shall be OSEEGIB's responsibility deliver any such accounting requested to the individual. [45 CFR § 164.504(e)(2)(ii)(G)]

- h) Governmental Access to Records. The PBM shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") for purposes of determining OSEEGIB's compliance with the Privacy Rule. [45 CFR § 164.504(e)(2)(ii)(H)] The PBM agrees to notify OSEEGIB with the date it provides access to OSEEGIB Protected Information to the Secretary and a general description of any OSEEGIB Protected Information it provides to the Secretary.
- i) Minimum Necessary. The PBM and its agents or subcontractors shall only request, use and disclose the minimum amount of Protected Information necessary to accomplish the purpose of the request, use or disclosure. [45 CFR § 164.514(d)(3)]
- j) Data Ownership. The PBM acknowledges that the PBM has no ownership rights with respect to the Protected Information.
- k) Retention of Protected Information. The PBM and its subcontractors or agents shall transmit the Protected Information described in the Contract to OSEEGIB on scheduled basis according to Contract terms. The PBM shall maintain all Protected Information that has not been previously transmitted to OSEEGIB for a period of six (6) years after the date it was created or the last effective date, whichever is later or transmit it to OSEEGIB for receipt and storage. [See 45 CFR §§ 164.530 (j)(1)(2)]
- l) Notification of Breach. During the term of this RFP, PBM agrees to notify OSEEGIB within three (3) days of discovery of any use or disclosure of PHI not authorized by this agreement or the terms of the Contract, of which the PBM becomes aware. Within thirty (30) days after the date discovered, PBM agrees to report to OSEEGIB the following: the nature of the non-permitted use or disclosure; the OSEEGIB PHI used or disclosed; who made the non-permitted or violating use or received the non-permitted or violating disclosure; what corrective actions PBM has taken or will take to prevent further non-permitted or violating uses or disclosures; and what PBM did or will do to mitigate any deleterious effect of the non-permitted or violating use or disclosure. The PBM shall also notify OSEEGIB of a finding or stipulation that the PBM has violated any standard or requirement of the HIPAA Regulations or other security or privacy laws arising from any administrative or civil proceeding in which the PBM has been joined. The PBM agrees that OSEEGIB and the PBM will investigate an actual breach; however, the PBM will coordinate with OSEEGIB to control the investigation or any notification procedures related to the incident.

With regard to implementation of the HIPAA Security Rule, 45 CFR Part 164, Subpart C, Oklahoma Statute 74 O.S. § 3113.1 and the occurrence of a Security Incident, PBM agrees to report to OSEEGIB any successful (i) unauthorized access, use, disclosure, modification, or destruction of OSEEGIB electronic PHI or (ii) interference with PBM system operations that contain OSEEGIB member information of which PBM becomes aware. PBM will make such report to the OSEEGIB HIPAA Security Officer immediately after PBM learns of any successful Security Incidents. To avoid unnecessary burden on either party, PBM will only be required to report, upon OSEEGIB's request, attempted, but unsuccessful unauthorized access, use, disclosure, modification, or destruction PBM electronic PHI or interference with system operations in PBM information systems that involve OSEEGIB electronic PHI of which PBM becomes aware, provided that OSEEGIB's request shall be made no more often than is reasonable based upon the relevant facts, circumstances and industry practices.

- m) Audits, Inspection and Enforcement. Upon request, the PBM agrees that OSEEGIB or its designee, may conduct a reasonable inspection of PBM facilities, systems, books, records, policies and procedures relating to the use or disclosure of Protected Information pursuant to the Contract for the purpose of determining whether the PBM has complied with HIPAA; provided, however, that (i) the PBM and OSEEGIB shall mutually agree in advance upon the scope, timing and location of such an inspection, (ii) OSEEGIB shall protect the confidentiality of all confidential and proprietary information of the PBM to which OSEEGIB has access during the course of such inspection; and (iii) OSEEGIB shall execute a nondisclosure agreement, upon terms mutually agreed upon by the parties, if requested by the PBM. The fact that OSEEGIB inspects, or fails to inspect, or has the right to inspect, the PBM's facilities, systems, books records, policies and procedures does not relieve the PBM of its responsibility to comply with these terms of the Contract between PBM and OSEEGIB. OSEEGIB's failure to detect deficiencies or failure to notify the PBM or require the PBM's remediation of any unsatisfactory practices, does not constitute acceptance of such practices or a waiver of OSEEGIB's enforcement rights under the Contact between PBM and OSEEGIB.

3) Special Uses and Disclosures

- a) PBM may create, receive, use, or disclose PHI related to OSEEGIB Plan participants only in a manner that is consistent with the terms of the Contract and the Privacy Rule, and only in connection with providing the services to OSEEGIB that are related to the administration of prescription drug benefits and/or identified in the Contract. PBM may de-identify OSEEGIB PHI, provided PBM complies with 45 CFR §164.514(b); does not violate the Privacy Rule if done by OSEEGIB; and the PBM provides written assurances to OSEEGIB regarding use and disclosure of the de-

identified data.

- b) PBM may, consistent with the Privacy Rule, use or disclose PHI that Business Associate receives in its capacity as manager of prescription drug benefits and in its capacity as Business Associate to OSEEGIB if such use relates to the proper management and administration of the Business Associate or to carry out legal responsibilities of Business Associate under the RFP. “Legal responsibilities” of the Business Associate used herein shall mean responsibilities imposed by law or regulation, but (unless otherwise expressly permitted by OSEEGIB) shall not mean obligations PBM may have assumed pursuant to contracts, agreements, or understandings other than the terms of the Contract.
 - c) PBM may engage in “data aggregation services” related to OSEEGIB in a manner permitted by the Privacy Rule at 45 CFR § 164.504(e)(2)(i)(B) and that complies with the terms of the Contract. “Data aggregation services” as used herein shall mean the combining of PHI by PBM with PHI received by PBM in its capacity as a business associate of another covered entity, to permit analysis of data that relates to the health care operations of OSEEGIB or another covered entity.
 - d) PBM may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 CFR § 164.502.
 - e) Any right of PBM to create, use, or disclose PHI pursuant to this Agreement shall not include the right to ‘de-identify’ or aggregate PHI, except as provided for in this Business Associate Agreement or as expressly permitted by OSEEGIB or the Privacy Rule, provided that such use or disclosure would not violate the Privacy Rule if done by OSEEGIB.
- 4) Obligations of OSEEGIB
- a) OSEEGIB shall be responsible for using appropriate safeguards to maintain and ensure the confidentiality, privacy and security of PHI transmitted to the PBM pursuant to this RFP, in accordance with the standards and requirements of the Privacy and Security Rules, until such PHI is received by the PBM.
 - b) OSEEGIB shall notify PBM of any limitation(s) in its notice of privacy practices of OSEEGIB in accordance with 45 CFR § 164.520, to the extent that such limitations may affect PBM use or disclosure of PHI, and shall also notify PBM of any material change in privacy practices and procedures of OSEEGIB.
 - c) OSEEGIB shall notify PBM of any changes in, or revocation of, permission by an Individual to use or disclose PHI to the extent such changes may affect PBM use and disclosure of PHI.

- d) OSEEGIB shall notify PBM of any restrictions in the use or disclosure of PHI that OSEEGIB has agreed to in accordance with 45 CFR § 164.522, to the extent such restriction may affect PBM use or disclosure of PHI. Prior to agreeing to any restriction, OSEEGIB will consult with PBM regarding whether the proposed restriction will affect its functions, activities, or services under the Contract.
- e) If OSEEGIB or PBM receives a request from an Individual for confidential communication of PHI by alternative means or at alternative locations in accordance with 45 CFR 164.522(b), both OSEEGIB and PBM will accommodate the request to the extent feasible
- f) OSEEGIB shall not request PBM to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if such use or disclosure were made by OSEEGIB.

5) Termination

- a) Material Breach. A breach by the PBM of any material provision of the terms of the Business Associate Agreement Section of the Contract may constitute a material breach of the Contract and provide grounds for immediate termination of the Contract by OSEEGIB pursuant to Termination Section of the Contract. [45 CFR § 164.504(e)(2)(iii)]
- b) Reasonable Steps to Cure Breach. If OSEEGIB knows of a pattern of activity or practice of the PBM that constitutes a material breach or violation of the PBM's obligations under the provisions of the terms of the Business Associate Agreement Section, OSEEGIB shall provide PBM with an opportunity to cure the breach and end the violation. If PBM does not cure the breach with ninety (90) days after OSEEGIB notifies PBM of the opportunity to cure, then, within the sole discretion of OSEEGIB, OSEEGIB shall take reasonable steps to cure such breach or end such violation, as applicable. If OSEEGIB's efforts to cure such breach or end such violation are unsuccessful, OSEEGIB shall either (i) terminate the Contract, if feasible or (ii) if termination of this the Contract is not feasible, OSEEGIB shall report the PBM's breach or violation to the Secretary of the Department of Health and Human Services. [45 CFR § 164.504(e)(1)(ii)]
- c) Effect of Termination. Upon termination of the Contract for any reason, the PBM shall return all OSEEGIB Protected Information to OSEEGIB that the PBM or its agents or subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If return is not feasible, the PBM shall continue to extend the protections described in the Contract to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. PBM may destroy the PHI, upon written approval from OSEEGIB. If the PBM elects to destroy the PHI, the PBM shall certify in writing to OSEEGIB

that such PHI has been destroyed. [45 CFR § 164.504(e)(ii) (I)]

G. Appropriated Funds

The parties understand and agree that none of the sums to be paid under this agreement are appropriated funds. Should there be a revenue shortfall, OSEEGIB will not seek appropriations and will not use appropriated funds to pay for this obligation. The most recent financial statement of OSEEGIB is posted on OSEEGIB's website: www.sib.ok.gov (Go to Site Map, Annual Financial Statement)

H. Records

The PBM shall maintain full and adequate records relating to the services it is performing under this agreement and shall allow OSEEGIB to review and copy such records upon request. The PBM shall provide adequate safeguards for all books and records. The PBM shall reveal to OSEEGIB the specifics of its safeguarding program.

I. Right to Audit

OSEEGIB intends to audit claim records to verify the accuracy of claim payments, compliance with plan design and contract provisions. OSEEGIB shall be authorized to examine all claim records and data of the PBM which are directly related to the performance of this contract, including reasonable access to contracts, accounting records and other documents relating to income received from pharmaceutical manufacturers that relate to OSEEGIB's business. Appropriate data and personnel shall be available during normal business hours upon reasonable notice.

J. Ownership of Data

The PBM shall recognize that all data generated during the performance of this contract by OSEEGIB, the PBM, or its subcontractor and/or affiliates, is proprietary and confidential to OSEEGIB and shall not be used by the PBM for purposes not recognized by this RFP. The PBM shall recognize OSEEGIB's exclusive ownership of all data and information and shall not reveal or sell any portion of such to any third party or otherwise use for its own financial gain without notice and consent by OSEEGIB.

OSEEGIB shall have local access to all data whether stored at the local office or any other site. Upon request of OSEEGIB, the PBM shall deliver forthwith to OSEEGIB specifications, plans, charts, photographs and exhibits which were prepared, developed or kept in connection with, or as part of, this contract. All other material and records of whatsoever nature prepared, developed, or kept in

connection with, or as part of, this contract's work products shall likewise be available to OSEEGIB at its request.

Prior to the expiration, or upon the earlier termination of this Contract, all work products shall become the property of OSEEGIB. This paragraph does not apply to any records or documents pertaining to the operation of the PBM's business unless such records or documents affect the performance of this contract. The PBM may retain copies of those records or documents which it considers necessary for proof of performance. Upon request, the PBM shall provide OSEEGIB with any data as requested, in the form of hard copy and/or computer storage media without notice and consent by OSEEGIB.

K. Contract Defined

This RFP, together with the PBM's response, exhibits, written questions and clarifications, amendments or revisions signed by both parties and presented to the Department of Central Services and the Department of Central Services' purchase order, constitute the entire and final agreement between OSEEGIB and the PBM relating to the rights granted and the obligations assumed by the parties and is the contract when the Oklahoma Department of Central Services awards the contract to the successful PBM.

Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this RFP and the PBM's response thereto, not expressly set forth, are of no force or effect.

L. Hold Harmless

The PBM shall be responsible for the work, direction, and compensation of PBM employees, agents and subcontractors. Neither OSEEGIB nor the State of Oklahoma shall be liable, directly or indirectly, for the work and direction of PBM employees, agents or subcontractors. The PBM agrees to indemnify and hold harmless OSEEGIB, its employees and agents, and the State of Oklahoma from damages, loss, or liability to persons or property arising from claims of any kind, including, but not limited to compensation by PBM employees, agents, and subcontractors of the PBM against the PBM; negligent or willful acts of the PBM its employees or agents in performance of this Contract; acts, omissions or liabilities of the PBM acting in any capacity that relate to the Contract; and damages, costs, fines or penalties arising from HIPAA violations committed by PBM employees, agents or subcontractors. The State of Oklahoma does not waive, compromise, concede, surrender, or relinquish any rights, privileges, immunities, or remedies that the State of Oklahoma and its employees possess under State or Federal law.

M. Fiduciary

The PBM shall become a fiduciary to OSEEGIB as defined at 74 O. S. 2001 § 1305.2.

N. Designation of Personnel

OSEEGIB may designate personnel or professionals under contract with OSEEGIB to administer any of the terms or conditions of this contract referenced herein, and any and all duties or acts required of OSEEGIB.

O. Severability

The terms and provisions of this contract shall be deemed to be severable one from the other, and any determination at law or in a court of equity that one term or provision is unenforceable, shall have no effect on the remaining terms and provisions of this contract, or any one of them, in accordance with the intent and purposes of the parties hereto.

P. Notice

Any notice required to be given, pursuant to the terms and provisions of the contract, shall be in writing, and delivered either by hand delivery with written receipt, or delivered by the U. S. Postal Service, (USPS) postage prepaid, by certified mail, return receipt requested, to OSEEGIB at 3545 N.W. 58th, Oklahoma City, Oklahoma 73112, or the PBM at the address listed on the DCS purchase order. The USPS notice shall be effective on the date indicated on the return receipt.

Q. Supremacy of State Statutes

This contract is subject to all applicable Oklahoma State Statutes, OSEEGIB's Rules and Administrative Directives. Any provision of this contract which is not in conformity with existing or future legislation shall be considered amended to comply with such legislation. Any interpretation or disputes with respect to contract provisions shall be resolved according to the laws of the State of Oklahoma. Jurisdiction and venue for any litigation between OSEEGIB and the PBM shall occur in either a State or Federal court in Oklahoma County, Oklahoma.

R. Force Majeure

Neither party shall be liable for any delay or failure of performance under this contract due to an act of God, or due to war mobilization, insurrection, rebellion, riot, sabotage, explosion, fire, flood or storm.

S. Assignments

This contract may not be assigned in whole or in part.

VII. Financial Proposal

In accordance with Oklahoma State Statutes, OSEEGIB shall compensate the PBM on a monthly basis for services that have been performed over the preceding month, pursuant to the terms of this contract. All invoices and payments of invoices are subject to subsequent adjustments based upon proper documentation.

This Administrative Fee assumes OSEEGIB, or other TPAs of OSEEGIB, will perform all eligible-person enrollment and billing. The PBM will provide OSEEGIB with a detailed Administrative Fee invoice including a total for the number of claims processed in accordance with the PBM's claims cycle. OSEEGIB shall pay the Administrative Fee invoices in full within fifteen (15) days of the invoice date.

A. PART ONE – PBM Administration Services

OSEEGIB intends for all services described in the PBM's response to be included in the Administrative fee unless the fee and the service are specifically identified as a separate charge.

OSEEGIB will only accept financial proposals calculated on a per prescription per month basis. The PBM cannot charge separate start-up costs.

1) Administrative Fees:

2008	2009	2010	2011	2012
_____	_____	_____	_____	_____

2) Rebates:

The PBM shall provide OSEEGIB one hundred percent (100%) of rebate income, as defined by this Contract, generated by OSEEGIB's account. The PBM shall offer a minimum guaranteed rebate on a per prescription basis for each renewal period of the contract. Rebates received by the PBM will be paid to OSEEGIB via check 180 days after the end of each quarter. Rebates due OSEEGIB under this Contract that are received by the PBM within eighteen (18) months after termination or expiration of this Contract will be paid to OSEEGIB.

Guaranteed rebate income per prescription:

2008	2009	2010	2011	2012
_____	_____	_____	_____	_____

B. PART TWO – OSEEGIB PDP Services

OSEEGIB will pay to the PBM a Part D Administrative Fee per prescription per month processed by PBM under the Medicare Pharmacy Program. The Part Two Administrative Fee shall be in addition to the administrative fee applicable under Part One – PBM Administration Services.

1) Administrative Fees:

2008	2009	2010	2011	2012
_____	_____	_____	_____	_____

2) Administrative Fees If OSEEGIB Interfaces Eligibility With CMS:

It is anticipated that at some date in the future, OSEEGIB may exchange eligibility information directly with CMS. Upon this occurrence, identify how Administrative Fees might be impacted.

2008	2009	2010	2011	2012
_____	_____	_____	_____	_____

3) Rebates

The PBM shall provide OSEEGIB one hundred percent (100%) of rebate income, as defined by this Contract, generated by OSEEGIB’s account. The PBM shall offer a minimum guaranteed rebate on a per prescription basis for each renewal period of the contract. Rebates received by the PBM will be paid to OSEEGIB via check 180 days after the end of each quarter. Rebates due OSEEGIB under this Contract that are received by the PBM within eighteen (18) months after termination or expiration of this Contract will be paid to OSEEGIB.

Guaranteed rebate income per prescription:

2008	2009	2010	2011	2012
_____	_____	_____	_____	_____

4) Medication Management Therapy Program

The PBM shall bid the Medication Management Therapy program as a separate cost.

2008	2009	2010	2011	2012
_____	_____	_____	_____	_____

5) Medicare Explanation of Benefits

The PBM shall bid the required Explanation of Benefits administration for the Medicare population as a separate cost.

2008	2009	2010	2011	2012
_____	_____	_____	_____	_____

C. Additional Services

Customized reporting shall be billed in accordance with this Contract at an hourly rate.

If the base administrative fees do not cover all services, the PBM must list each additional service and proposed fee.

2008	2009	2010	2011	2012
_____	_____	_____	_____	_____

- a) Provide detailed documentation demonstrating how the financial proposal was determined, including the specific elements and methodology of the bid, assumptions used in pricing elements of the bid and the inflation factor used for each year of the contract.
- b) How does the PBM propose to profit from this contract?
- c) If the PBM is offering services that are not included in the PBM's administration fee, identify those services separately and the fees associated thereto.

STATEMENT OF COMPLIANCE

Each bidder shall be required to submit to this Request for Proposal as it is written. Any bidder who wishes to propose exceptions or alternatives to any term, condition or requirement of this RFP must specify the exception and/or alternative and submit a proposal for each deviation. If a Statement of Compliance is not returned to the Insurance Board with the bidder's original proposal, the bid may be excluded from further consideration. If a Statement of Compliance is submitted with deviations, the Insurance Board will consider such exceptions and/or alternatives in the evaluation process or such exception and/or alternative may constitute grounds for rejection of the proposal.

The proposal submitted to the Insurance Board is in strict compliance with this RFP, and if selected, the PBM will be responsible for meeting all requirements of this RFP.

The proposal submitted to the Insurance Board contains deviations from the specifications of this RFP. The deviations are attached.

Name: _____ Company: _____

Signature: _____ Address: _____

Title: _____ _____

Phone: _____ Fax: _____

EXHIBIT A

Multi-Source Medication Copayment Logic

Generic Drug			
When generic is < copayment	When generic Is > \$25, Less than \$100	When generic Is > \$100.00	Explanation
\$ 20.00 N/A <u>\$ 20.00</u> \$ 0.00	\$ 85.00 N/A <u>\$ 25.00</u> \$ 60.00	\$ 125.00 <u>x .25%</u> <u>\$ 31.25</u> \$ 93.75	Covered Amount of Medication (After Discount) Generic Copayment percentage Member Copayment Plan Obligation (Plus Dispensing Fee)
Multi-Source Brand Drug in a Preferred or a Non-Preferred Status			
(Copayment Logic requires all Multi-sourced Brands to be calculated at the Generic Copayment)			
When generic is < copayment	When generic Is > \$25, Less than \$100	When generic Is > \$100.00	Explanation
\$275.00 <u>- 20.00</u> \$255.00	\$275.00 <u>- 85.00</u> \$190.00	\$ 275.00 <u>- 125.00</u> \$ 150.00	Covered Amount of Medication (After Discount) Covered Amount of Generic Cost Difference
\$ 20.00 N/A \$ 20.00	\$ 85.00 N/A \$ 25.00	\$ 125.00 <u>x .25%</u> \$ 31.25	Covered Amount of Medication (After Discount) Generic Copayment percentage Member Copayment
\$255.00 <u>+ 20.00</u> \$275.00 \$ 0.00	\$190.00 <u>+ 25.00</u> \$215.00 \$ 60.00	\$ 150.00 <u>+ 31.25</u> \$ 181.25 \$ 93.75	Cost Difference Generic Copayment Member Copayment Plan Obligation (Plus Dispensing Fee)
Note: All multi-sourced brand drugs, whether in a preferred or a non-preferred status are processed in the same manner.			
Definition of Covered Amount – is the cost of the medication that the pharmacy provider will be reimbursed based upon the provider network contract.			

EXHIBIT B**HealthChoice MEDICARE
Prior Authorization Medications
June 2006**

Akylating Agents	PARAPLATIN (<i>carboplatin</i>), BICNU (<i>carmustine</i>), GLIADEL (<i>carmustine/polifeprosan</i>), CYTOXAN (<i>cyclophosphamide</i>), IFEX (<i>ifosfamide</i>), IFEX/MESNA (<i>ifosfamide/mesna</i>), MUSTARGEN (<i>mechlorethamine</i>), ELOXATIN (<i>oxaliplatin</i>), ZANOSAR (<i>streptozocin</i>), THIOPLEX (<i>thiotepa</i>)
Anabolic Steroids	ANADROL-50 (<i>oxymetholone tablets</i>), WINSTROL (<i>stanozolol tablets</i>), OXANDRIN (<i>oxandrolone tablets</i>), DECA-DURABOLIN , KABOLIN (<i>nandrolone decanoate injection</i>)
Androgens	ANDROGEL , TESTIM (<i>testosterone gel</i>), FIRST-TESTOSTERONE (<i>testosterone propionate ointment</i>) TESTODERM PATCH, TESTODERM TTS, ANDRODERM (<i>testosterone transdermal system</i>), METHITEST , ORETON , METHYL , ANDROID (<i>methyltestosterone tablets</i>), TESTRED , VIRILON (<i>methyltestosterone capsules</i>), HALOTESTIN (<i>fluoxymesterone tablets</i>)
Androgens – Injectable	VIRILON (<i>methyltestosterone injection</i>), HISTERONE , TESAMONE , TESTANDRO , TESTRO (<i>testosterone aqueous injection</i>), ANDRO-CYP , DEPOANDRO , DEPOTEST , DEPO-TESTOSTERONE , VIRILON IM (<i>testosterone cypionate injection</i>), ANDRO L.A. , ANDROPOSITORY , DELATESTRYL , DURATHATE , EVERONE , TESTRO-LA (<i>testosterone enanthate injection</i>), MALOGEN (<i>testosterone propionate injection</i>)
Antidepressive Agents	WELLBUTRIN SR (bupropion sustained release), WELLBUTRIN XL (bupropion extended release, bupropion immediate/sustained release generic)
Antiemetics	ZOFRAN (<i>ondansetron</i>), KYTRIL (<i>granisetron</i>), ANZEMET (<i>dolasetron</i>), EMEND (<i>aprepitant</i>)
Anti-Infective Agents	ZYVOX (linezolid), VFEND (voriconazole)
Anti-Infective Inhalant Agents	TOBI (<i>tobramycin solution for inhalation</i>)
Antimetabolite Agents	LEUSTATIN (<i>cladribine</i>), CLOLAR (<i>clofarabine</i>), TARABINE PFS (<i>cytarabine</i>), DEPOCYT (<i>cytarabine liposome</i>), FLOXURIDINE (<i>floxuridine</i>), FLUDARA (<i>fludarabine</i>), FLUOROURACIL (<i>fluorouracil</i>), GEMZAR (<i>gemcitabine</i>), METHOTREXATE INJECTION (<i>methotrexate</i>), ALIMTA (<i>pemetrexed</i>)

EXHIBIT B

Antineoplastics – Miscellaneous	PLENAXIS (<i>abarelix</i>), CAMPATH (<i>alemtuzumab</i>), ELSPAR (<i>asparaginase</i>), VIDAZA (<i>azacitidine</i>), AVASTIN (<i>bevacizumab</i>), BLENOXANE (<i>bleomycin</i>), VELCADE (<i>bortezomib</i>), BUSULFEX INJ (<i>busulfan</i>), ERBITUX (<i>cetuximab</i>), DACARBAZINE (<i>dacarbazine</i>), COSMEGEN (<i>dactinomycin</i>), DAUNOXOME (<i>daunorubicin liposomal</i>), CERUBIDINE (<i>daunorubicin</i>), ONTAK (<i>denileukin diftitox</i>), TAXOTERE (<i>docetaxel</i>), ADRIAMYCIN, ADRIAMYCIN PFS (<i>doxorubicin</i>), DOXIL (<i>doxorubicin liposomal</i>), ELLENCE (<i>epirubicin</i>), EMCYT (<i>estramustine</i>), ETOPOPHOS (<i>etoposide</i>), MYLOTARG (<i>gemtuzumab</i>), VANTAS (<i>histrelin</i>), IDAMYCIN, IDAMYCIN PFS (<i>idarubicin</i>), ZEVALIN (<i>ibritumomab</i>), ELIGARD, LUPRON DEPOT, LUPRON DEPOT-3 MONTH, LUPRON DEPOT-PED (<i>leuprolide</i>), VIADUR (<i>leuprolide/lidocaine</i>), ALKERAN (<i>melphalan</i>), MUTAMYCIN (<i>methotrexate oral, mitomycin</i>), NOVANTRONE (<i>mitoxantrone</i>), SANDOSTATIN LAR (<i>octreotide acetate</i>), ABRAXANE (<i>paclitaxel</i>), TAXOL (<i>paclitaxel</i>), ONCASPARGASE (<i>pegaspargase</i>), NIPENT (<i>pentostatin</i>), MITHRACIN (<i>plicamycin</i>), PHOTOFRIN (<i>porfimer</i>), RITUXAN (<i>rituximab</i>), VUMON (<i>teniposide</i>), Hycamtin (<i>topotecan</i>), BEXXAR (<i>tositumomab</i>), HERCEPTIN (<i>trastuzumab</i>), TRIPTORELIN (<i>triptorelin</i>), VALRUBICIN (<i>valrubicin</i>), VELBAN (<i>vinblastine</i>), ONCOVIN (<i>vincristine</i>), VINOVELBINE (<i>vinorelbine</i>)
Antiviral Agents	RELENZA (<i>zanamivir</i>), TAMIFLU (<i>oseltamivir</i>)
Botulinum Toxins	BOTOX (<i>botulinum toxin type a injection</i>) MYOBLOC , (<i>botulinum toxin type b injection</i>)
CNS Stimulants	ADDERALL , ADDERALL XR (<i>amphetamine/dextroamphetamine</i>), FOCALIN (<i>dexmethylphenidate</i>), DEXEDRINE , DEXEDRINE SPANSULES , DEXTROSTAT (<i>dextroamphetamine</i>), DESOXYN , DESOXYN GRADUATE (<i>Methamphetamine</i>), RITALIN , RITALIN SR , CONCERTA , METADATE CD , METHYLIN ER (<i>methylphenidate</i>), STRATTERA (<i>pemoline & atomoxetine</i>)
Colony Stimulating Factors	G-CSF (<i>granulocyte colony-stimulating factor</i>), NEUPOGEN (<i>filgrastim</i>), GM-CSF (<i>granulocyte-macrophage colony-stimulating factor</i>), LEUKINE (<i>sargramostim</i>), NEULASTA (<i>pegfilgrastim</i>)
COX2 Inhibitor [COX1 Sparing Agents]	CELEBREX (<i>celecoxib</i>)
Erythroid Stimulants	EPOGEN , PROCRIT (<i>epoetin alfa injection</i>), ARANESP (<i>darbepoetin alfa injection</i>)
Erectile Dysfunction - Impotence	VIAGRA (<i>sildenafil tablets</i>), LEVITRA (<i>ardenafil</i>), MUSE (<i>alprostadil urethral inserts</i>), CAVERJECT , EDEX (<i>Alprostadil Inj</i>), CIALIS (<i>tadalafil</i>)
Growth Hormones	Geref (<i>sermorelin</i>), GENOTROPIN , GENOTROPIN MINIQUICK , HUMATROPE , NORDITROPIN , NUTROPIN , NUTROPIN AQ , NUTROPIN DEPOT, SAIZEN , ZORBTIVE (<i>somatropin</i>), PROTROPIN (<i>somatrem</i>)

EXHIBIT B

Biological Response Modulator: Human Growth Factor	NEUMEGA (<i>oprelvekin</i>)
Immunosuppressant Agents	THYMOGLOBULIN (<i>antithymocyte globulin</i>), SANDIMMUNE, NEORAL (<i>azathioprine, cyclophosphamide cyclosporine</i>), ZENAPAX (<i>daclizumab</i>), ORTHOCLONE OKT3 (<i>muromonab-CD3</i>), CELLCEPT, MYFORTIC (<i>mycophenolate</i>), RAPAMUNE, (<i>prednisone, prednisolone, sirolimus</i>), PROGRAF (<i>Tacrolimus</i>)
Injectable Medications – Miscellaneous	Acyclovir injection, Aldurazyme injection, Amphotericin B injection, Anzemet injection, Avelox injection, Baclofen injection, BCG vaccine, Camptosar injection, Cerezyme injection, Ciprofloxacin injection, Cis-platin injection, Cladribine injection, Dobutamine injection, Dopamine injection, Doxycycline injection, Eligard, Fabrazyme injection, Faslodex injection, Fludarabine injection, Foscarnet injection, Gallium Nitrate injection, Ganciclovir injection, Geodon, haloperidol decanoate, Imiglucerase, Kytril injection, Laronidase, Mesna, Metronidazole injection, Milrinone injection, Nexium injection, Nitroglycerin injection, Ofloxacin injection, Pentamidine injection, perphenazine injection, Prolastin injection, Proleukin injection, Protonix injection, Remicade (<i>infliximub</i>), Risperdal Consta, Trisenox injection, Vfend injection, Vitrasert, Zithromax injection, Zofran injection, Zoladex
Intravenous Immune Globulins	GAMIMUNE N, GAMMAGARD , GAMMAR –IV, IVEEGAM , SANDOGLOBULIN , VENOGLOBULIN
Keratinocyte Growth Factor	KEPIVANCE (<i>palifermin</i>)
Leukotriene Receptor Antagonists/Formation Inhibitors	SINGULAIR (<i>montelukast</i>), ACCOLATE (<i>zafirlukast</i>), ZYFLO (<i>zileuton</i>)
Nebulized Drugs	MUCOMYST , MUCOMYST-10 , MUCOSIL (<i>acetylcysteine</i>), ACCUNEB (<i>albuterol sulfate</i>), DUONEB (<i>albuterol sulfate/ipratropium bromide</i>), TORNALATE (<i>bitolterol</i>), PULMICORT (<i>budesonide</i>), CROLOM (<i>cromolyn sodium</i>), DECADRON , MAXIDEX (<i>dexamethasone</i>), ROBINUL (<i>glycopyrrolate</i>), ATROVENT (<i>ipratropium bromide</i>), XOPENEX (<i>isoetharine, levosalbutamol hydrochloride</i>), ALUPENT (<i>metaproterenol</i>), NEBUPENT (<i>pentamidine isethionate</i>), BRETHINE (<i>terbutaline sulfate</i>)
Osteoporosis Therapy Agents	FORTEO (<i>teriparatide</i>)
Proton Pump Inhibitors	ACIPHEX (<i>rabeprazole Sodium</i>), PREVACID (<i>lansoprazole</i>)
Respiratory Agents	XOLAIR (<i>omalizumab</i>), PULMOZYME (<i>recombinant dornase alfa inhalation solution</i>), XOPONEX (<i>Levalbuterol 0.31 mg, 0.63 mg, 1.25 mg inhalation solution</i>)
Respiratory (RSV) Agents	SYNAGIS (<i>palivizumab</i>)
Sedative-Hypnotic Agents	PROSOM (<i>estazolam</i>), LUNESTA (<i>eszopiclone</i>), DORAL (<i>quazepam</i>), RESTORIL (<i>temazepam</i>), HALCION (<i>triazolam</i>), SONATA (<i>Zaleplon</i>), AMBIEN (<i>Zolpidem</i>), BUTISOL (<i>butabarbital</i>), VARIOUS (<i>chloral hydrate</i>)
Smoking Deterrent Agents	NICOTINE PATCH-RX (<i>nicotine transdermal systems</i>), NICOTROL NS- RX (<i>nicotine nasal spray</i>), NICOTROL INHALER-RX (<i>nicotine inhalation system</i>), ZYBAN – RX (<i>bupropion sustained-release tablet</i>)
Growth Hormone Receptor Antagonist	SOMAVERT (<i>Pegvisomant</i>)
Topical Retinoid Agents	TAZORAC (<i>Tazarotene</i>) – All Dosage Forms
Topical Tretinoin Agents	DIFFERIN (<i>adapalene</i>) topical tretinoin agents All Dosage Forms

EXHIBIT B

**HealthChoice NON MEDICARE
Prior Authorization Medications
June 2006**

Angiotensin II Inhibitors	<p>Atacand (<i>candesartan</i>) Atacand HCT (<i>candesartan/HCTZ</i>) Avalide (<i>irbesartan/HCTZ</i>) Avapro (<i>irbesartan</i>) Benicar (<i>olmesartan</i>) Benicar HCT (<i>olmesartan/HCTZ</i>) Cozaar (<i>losartan</i>) Diovan (<i>valsartan</i>) Diovan HCT (<i>valsartan/HCTZ</i>) Hyzaar (<i>losartan/HCTZ</i>) Micardis (<i>telmisartan</i>) Micardis HCT (<i>telmisartan/HCTZ</i>) Teveten (<i>eprosartan</i>) Teveten HCT (<i>eprosartan/HCTZ</i>)</p>
Anti-Depressive Therapy	Wellbutrin SR and XL (<i>bupropion</i>) – all strengths
Anti-Influenza Agents	<p>Relenza (<i>zanamivir</i>) Tamiflu Capsules/Suspensions (<i>osteltamivir</i>)</p>
Antineoplastic Therapy	Iressa (<i>gefitinib</i>)
COX II Inhibitors	Celebrex (<i>celecoxib</i>)
CNS Stimulants – Prior Authorization required for age 21 and older	<p>Adderall, Adderall XR (<i>amphetamine/dextroamphetamine combination</i>) Cylert (<i>pemoline</i>) Desoxyn (<i>methamphetamine</i>) Dexedrine, Dexedrine Spansules, Dextrostat (<i>dextroamphetamine</i>) Focalin (<i>dexmethylphenidate</i>) Ritalin, Ritalin SR, Ritalin LA, Metadate CD, Concerta, Methylin ER (<i>methylphenidate</i>) Strattera (<i>atomoxetine</i>)</p>
Erythroid Stimulants	<p>Aranesp (<i>darbepoetin</i>) Procrit/Epogen (<i>rythropoietin</i>)</p>
Growth Hormones	<p>Genotropin (<i>somatropin</i>) Geref (<i>somatropin</i>) Humatrope (<i>somatropin</i>) Norditropin (<i>somatropin</i>) Nutropin (<i>somatropin</i>) Protropin (<i>somatropin</i>) Saizen (<i>somatropin</i>)</p>
Growth Hormones, cont.	<p>Serostim (<i>somatropin</i>) Somavert (<i>somatropin</i>)</p>

EXHIBIT B

Impotency Agents – Prior Authorization approved only if member has had radical retropubic prostatectomy surgery.	Aphrodyne (<i>yohimbine HCL</i>) Caverject, Edex Injection (<i>alprostadil</i>) Cialis (<i>tadalafil</i>) Levitra (<i>vardeafil</i>) Muse (<i>alprostadil</i>) Viagra (<i>sildenafil</i>)
Leukotriene Inhibitors	Accolate (<i>zafirlukast</i>) Singulair (<i>montelukast</i>) Zyflo (<i>zileuton</i>)
Myeloid Stimulants	Leukine (<i>sargramostim</i>) Neulasta (<i>pegfilgrastim</i>) Neumega (<i>oprelvekin</i>) Neupogen (<i>filgrastim</i>)
Osteoporosis Therapy	Forteo Injection (<i>teriparatide, RDNA origin injection</i>)
Pain Therapy	Stadol Nasal Spray (<i>butorphanol</i>)
Proton Pump Inhibitors	Aciphex (<i>rabeprazole</i>) Prevacid (<i>lansoprazole</i>) Protonix
Smoking Cessation Therapy	Nicotrol Inhaler (<i>nicotine</i>) Nicotrol Nasal Spray (<i>nicotine</i>) Zyban (<i>bupropion</i>)
Topical Retinoids – Prior Authorization required for age 23 and older	Differin (<i>adapalene</i>) all dosage forms Retin-A (<i>tretinoin</i>) all dosage forms Tazorac (<i>tazarotene</i>) all dosage forms

Exhibit C

NUMBER OF INSURED LIVES SORTED BY MEMBER CATEGORIES

Census as of May 31, 2006		
<i>Health</i>	Primaries	Dependents
Active	89,409	50,883
Pre-Medicare	9,838	2,480
Medicare	29,017	5,039
Total	128,264	58,402

EXHIBIT D

Medicare Part D – Enrollment and Eligibility

Expected PBM Responsibility for CMS Required Notification

CMS EXHIBIT #	DESCRIPTION	RESPONSIBILITY	FREQUENCY/TURNAROUND	ADDITIONAL INFORMATION
4	Notice to Confirm Enrollment	PBM	Within 5 business days of CMS approval	
7	Notice for CMS Rejection of Enrollment	PBM	Within 5 business days of a reported rejection	Custom notification – action taken varies based on the reason for denial
8	Notice to Send Out Disenrollment Form	BOTH OSEEGIB AND PBM	Within 1 day of request	Custom notification sent by OSEEGIB or PBM depending on where the request is made
9	Disenrollment Form	BOTH OSEEGIB AND PBM	Within 1 day of request	Custom form
10A	Notice to Confirm Voluntary Disenrollment Identified Through TRR	PBM	Within 5 business days of a voluntary disenrollment request received on a TRR	Custom notification
12	Notice for CMS Rejection of Disenrollment	PBM	Within 5 business days of receipt of a valid disenrollment rejection report on a TRR	
13	Notice of Disenrollment Due to Death	PBM	Within 5 business days of receipt of a notice of death on a TRR	
14	Notice of Disenrollment Due to Loss of Medicare	PBM	Within 5 business days of receipt of a notice of disenrollment on a TRR due to loss of Medicare	Custom notification
21	Notice of Failure to Pay Plan Premium – Confirmation of Involuntary Disenrollment	PBM	Within 5 business days of confirmation from CMS that a disenrollment for non-payment of premium has been accepted	Custom notification

Note: CMS exhibit number references coincide with exhibits provided in CMS’ PDP Guidance – Enrollment, Eligibility and Disenrollment. Future notification requirements set forth by CMS will be considered the responsibility of the PBM unless OSEEGIB specifically takes responsibility.

EXHIBIT E

RECORD LAYOUT FOR CHECK REGISTER FILE

AGENCY A.C.E.S. ISSUE FILE - 250 Bytes (FILE SENT TO OST FROM EACH AGENCY)				
RECORD NUMBER ONE SEE POSITION NUMBER 250				
DESCRIPTION	TYPE	POSITION	LENGTH	VALUE
1. Key				
a. Account number	Numeric	1 - 7	7	Right justify
b. Effective date	Numeric	8 - 13	6	YYMMDD
c. Warrant number	Numeric	14 - 22	9	Right justify
2. Amount	Numeric	23 - 33	11	Right justify
3. Claim number	Alpha	34 - 48	15	Optional
4. Payee name	Alpha	49 - 78	30	Required
5. Payee address line 1	Alpha	79 - 108	30	Optional
6. Payee city	Alpha	109 - 128	20	Optional
7. Payee state	Alpha	129 - 130	2	Optional
8. Payee zip	Alpha	131 - 141	11	Optional
9. Payee address line 2 or Description field	Alpha	142 - 171	30	Optional
10. Reserved	Alpha	172 - 181	10	
11. Pay type	Alpha	182 - 182	1	See Table 1
12. Participant ID	Alpha	183 - 197	15	For Pay Type A,E,S
13. Class ID	Alpha	198 - 200	3	For Pay Type A,E,S
14. Transit Number	Numeric	201 - 209	9	For Pay Type A
15. Bank Account number	Alpha	210 - 226	17	For Pay Type A
16. Checking/Savings Flag	Alpha	227 - 227	1	'C' or 'S'
17. CFDA Number	Alpha	228 - 236	9	Optional
18. Revenue Code	Apha	237 - 241	5	For Pay Type S
19. Revenue Code Extension	Alpha	242 - 243	2	For Pay Type S
20. OSF-Budget-Acct	Alpha	244 - 249	6	Optional
21. Record ID	Alpha	250 - 250	1	SPACE or '1'

**NOTE: THE REVENUE CODE IS REQUIRED WHEN SENDING PAY TYPE 'S'.
WHEN THE CLASS CODE IS 'IRS' RECORD NUMBER TWO IS REQUIRED.**

EXHIBIT E

Table 1 – Pay Type
A = Create Auto. EFT E = Create EFT P = Create Paper Warrant S = Create ON-US transfer T = Create wire transfer C = Create wire transfer, W = Create Issue Record

CHECK REGISTER TRAILER RECORD

AGENCY A.C.E.S ISSUE FILE – 250 Bytes (Trailer Record On The Issue File Sent To OST)				
DESCRIPTION	TYPE	POSITION	LENGTH	VALUE
1. Account Number	Numeric 9(7)	1 – 7	7	9999999
2. Effective Date	Numeric 9(6)	8 – 13	6	Right Justify
3. Total Number Records	Numeric 9(9)	14 – 22	9	Right Justify
4. Total Dollar Amount	Numeric 9(9)V99	23 – 33	11	Right Justify 2 Dec.
5. Filler	Alpha X(248)	34 – 181	148	Filler
6. Record Type	Alpha X(1)	182 – 182	1	'T'
7. Reserved	Alpha X(68)	183 – 250	68	Filler

Export Overview

I. Business Overview

The following is a list of various eligibility transactions included in a typical daily incremental file. Any of the following could have future or retroactive effective dates.

- 1) New member/dependent enrollment
- 2) Member/dependent termination
- 3) Member/dependent adding and/or dropping various benefits
- 4) Member moves between participating employer groups
- 5) Dependent moves from participating primary member to another primary member
- 6) Member/dependent status changes from active to retiree or COBRA status
- 7) Member/dependent becomes eligible for Medicare
- 8) A lapse is added to a member/dependent coverage
- 9) Member address changes.

The above listing is provided for informational purposes and should not be considered an all-inclusive list of eligibility transactions.

Currently, the Insurance Board processes approximately one thousand (1,000) changes to eligibility information per day, except during certain months when the daily volume can reach as many as eight thousand (8,000) changes in a day.

This export file will contain enrollment eligibility records for member and dependent enrolled in Health and Dental funds for HealthChoice plans. A daily incremental file will be sent to the PBM for claims processing. A reconciliation full file will be sent quarterly

File layout: Fixed length 650
Save as options: Text File
Of Files Generated: 1 File for each parameter
of records per member: Multiple
Data formatting: Alphanumeric: Left justified and padded with trailing spaces
 Dates: YYYYMMDD format
 Numeric fields: Should be right justified and padded with leading spaces
General: Fields without values must be left blank and space filled, should not contain zeroes

II. Export Sections and Sequence

Sort Order

Records must be sorted in ascending order by SSN, then by Person code and then by record type, and then by effective date (opt-out records are listed first).

Seq #	Record Type	Description/Selection Logic	Optional / Required
1	Header	Uniquely identifies the export	R
2	Detail	Person eligibility data	R
3	Trailer	Tracking and verification information for the Export	R

III .Export Parameters

Variables	Type	Description (include default value)	Format
File Name	Text	File name	
As of Date	Date	Time stamp when the export is run. Default to current date and time for incremental file	MM/DD/YYYY
File Type	Text	Values = I for 'Incremental', A for 'Active', and F for 'Full'	

IV. Selection Criteria

1. Each eligible member and dependent will have his or her own record. Fields with demographic information should be specific to the member or dependent i.e. the dependent record will contain the dependent name, address, date of birth and gender.
2. The Members/Dependents should be selected for following Fund/Plan combination in

Fund	Plan
Health	HealthChoice

3. The member and their elected dependents for each file type must be selected as follows

- File Type: Active File

The file must include all ACTIVE members and their ELECTED dependents as of the date of the export. ACTIVE is defined as Members and ELECTED dependents whose Enrollment Termination date is > the export As of Date OR Blank. (The full file will contain future enrollment. For example, if member is enrolled 1/1/2006-12/31/2006 and 1/1/2007 – open. On the export file of 6/1/2006, both the records will be included)

- File Type: Full File

The file must include all members and their ELECTED dependents as of the date of the export. Full is defined as Members and ELECTED dependents who have termed coverage, current coverage, or future coverage.

- For type of file = Incremental

Eligibility is being tracked at a benefit level for each covered person. The benefit being tracked includes the coverage, the level of coverage, the tier code and the start and stop dates of the coverage. Any change, creation, or term of a PBM eligible benefit (HealthChoice Health/Dental) will be communicated on the effected individuals.

The incremental export will send current and future coverage, (if no current or future coverage exists, send the last coverage that was in effect) for an individual who has or did have HealthChoice coverage, if a change is made to any of the following:

EXHIBIT F

Indicative changes or Custom field changes made to: SSN(*dependent only*), First Name, Last Name, Middle Name, Sex, Birth Date, Marital Status, Student, Disabled, Apply Pre-Existing, Dental Limitation Date, HICN, Alternate Insurance Indicator, Person Code, Alternate ID Code, Alternate ID Number, Converted Original Effective Date, Override Alternate Insurance Indicator, Pend Claim (*member only*), Request Pharmacy Card(*member only*), Alternate Effective Date(*member only*), Alternate Termination Date(*member only*), OK Health Initiative Plan Year(*member only*).

Address changes made to the Correspondence address of an individual, or if no correspondence address exists, an address change made to the residential address.

The incremental export will send eligibility changes to changed coverage only. I.e., it will not send a term record and new start record if the benefit didn't change. Additionally, if a health benefit terms, but a new one is starting with either a different coverage level or different tier code, we will only send the new record with the new tier code or benefit level, since the PBM would intuitively know that the old benefit is stopping if new is starting.

We will continue to send opt-out records if we had coverage that was entered in error and must be deleted.

- a) Inserts: Select all NEW member and NEW dependents that have been added since the last export date (time stamp). This would also include members who enroll in the above listed plan for the first time.

For example, a Member changes plan from Health PacifiCare to Health HealthChoice, this member should be identified as new member.

- b) Updates: Select all covered persons whose information has been updated. For each change identified, send only the covered persons that were affected by the change.

For example, if a member +spouse + child are covered under HealthChoice high as of 1/1/2006. Dependent name is changed/corrected on 3/31/2006. On the incremental file of 3/31/2006 the file will include only the dependent whose name changed.

4. Identify the record type

Record Type 2

If this is the first time the member/dependent has been communicated, then Record type = 2.

Record Type 3

If the member/dependent has been communicated previously then Record type = 3

EXHIBIT F

Record type 4.

For record type 4 only the following fields will be populated

- i. Carrier
- ii. Account
- iii. Group
- iv. Member ID
- v. From Account
- vi. From Group
- vii. From Member ID+ prior person code
- viii. Effective Date
- ix. Person Code

Record Type 4 is created for following events:

- i. When a dependent becomes a primary member:*
The Carrier, Account, Group, Division, Member ID, Person code will contain the Dependents data and From group, from Account and From Member ID, person code will contain primary member's data under whom this person was a dependent
 - ii. Primary member becomes dependent:*
The Carrier, Account, Group, Division, Member ID, person code will contain the new member's data under whom this person has become dependent and From group, from Account and From Member ID, person code will contain primary member's data
 - iii. When the SSN of member or dependent is changed:*
The Carrier, Account, Group, Member ID will contain the new Account, Group and Member ID information and From Account, From Group, From Member ID will indicate the old Account, Group and member ID from which they moved. Effective date should contain the effective date of change. All the other fields for the record type 4 should be blank.
 - iv. Group to Group Transfer:*
The Carrier, Account, Group, Member ID will contain the new Account, Group and Member ID information and From Account, From Group, From Member ID will indicate the old Account, Group and member ID from which they moved. Effective date should contain the effective date of change. All the other fields for the record type 4 should be blank.
5. Deletes: When a Dependent is opted-out of benefit or a benefit or enrollment period is deleted for the Member, the records will be moved to enrollment history. These records should be identified as a change and sent over on the file. On these records the termination date should be populated with Effective date – 1. That is, the termination date must be one day less than the effective date.
6. Calculate Tier Code

For each Member SSN, find out the relationship of the dependents covered under that member and accordingly populate following values based on the dependents covered for the given enrollment period:

EXHIBIT F

- M = Member Only
- M1 = Member & Spouse
- M2 = Member, Spouse & Child
- M3 = Member, Spouse & Children (More than one child)
- M4 = Member & Child
- M5 = Member & Children (More than one child)
- S = Spouse Only
- S1 = Spouse & Child
- S2 = Spouse & Children (more than one child)
- C = Child Only
- C1 = Children (More than one child)

For deletes, the tier code prior to the delete or opt-out should be populated on the record.

V. Record Layouts

Header

Start Position	Stop Position	Field Name	Length	Data Type	Required	Format	Value/Default	Description
1	1	Record type		A/N	Y		1	Indicates header file
2	10	Carrier		A/N	Y			Number assigned by the PBM.
11	35	Address1		A/N	N			3545 NW 58 th Street
36	60	Address2		A/N	N			Suite 110
61	80	City		A/N				Oklahoma City
81	82	State		A/N	N			OK
83	92	Zip		A/N	N			73112
93	102	Phone		A/N	N			405-717-8888
103	110	Creation Date		N	Y	YYYYMMDD		Creation date of this file.
111	650	Filler						

EXHIBIT F

Detail

Start Position	Stop Position	Field Name	Vitech Length	Data Type	Required	Format	Value/Default	Description
1	1	Record type	1	A/N	Y		2, 3, 4 or F for full file	Indicate if the record type is an Add record or a change record or a move record.
2	10	Carrier	9	A/N	Y			Number assigned by the PBM.
11	20	Account	10	A/N	Y		40 = State, 42 = Education, 43 = Local Government	Indicates Group Association.
21	30	Group	10	A/N	Y			Member's employer code
31	39	Member_SSN	9	A/N	Y			If SSN is less than 9 digits, left justify and pad leading zeroes
40	41	Person Code	2	A/N	Y			Unique identifier for this person record as he/she relates to the member. Member or Dependent Custom field
42	43	Relationship	2	A/N	Y			Relationship code of this person to the member. Ex: S-spouse, C-child
44	93	Last Name	50	A/N	N			The last name of this person record.
94	143	First Name	50	A/N	N			The first name of this person record.
144	144	Middle Initial	1	A/N	N			The middle initial of this person record.
145	145	Sex	1	A/N	Y			The sex of this person record.
146	153	Date of Birth	8	N	Y	YYYY MMDD		The birth date of this person record.
154	161	Effective Date	8	N	Y	YYYY MMDD		The Enrollment Start date for this person's coverage
162	169	Termination Date	8	N	Y	YYYY MMDD		The Enrollment Stop date for this person's coverage

EXHIBIT F

Start Position	Stop Position	Field Name	Vitech Length	Data Type	Required	Format	Value/Default	Description
170	229	Address1	60	A/N	N			Correspondence Address_Line1 of this person record, if it doesn't exist then use the Member Address_Line1.
230	259	Address2	30	A/N	N			Correspondence Address_Line2 of this person record, if it doesn't exist then use the Member Address_Line2.
260	309	City	50	A/N	N			City of this person record, if it doesn't exist then use the Member City
310	311	State	2	A/N	N			State of this person record, if it doesn't exist then use the Member State
312	321	Zip	10	A/N	N			Zip of this person record, if it doesn't exist then use the Member Zip. The first character should be a space. If zip code is less than 9 than pad trailing zeroes. If Country Not= 'US' then use Postal_code
322	331	Home Phone	10	A/N	N			Home Phone of this person record, if it doesn't exist then use the Member phone
332	332	Alt Ins Indicator	1	A/N	N			Identifies whether member has alternate insurance. "Y" or "N" or <blank>, used for coordination of benefits. Member or Dependent Custom field

EXHIBIT F

Start Position	Stop Position	Field Name	Vitech Length	Data Type	Required	Format	Value/Default	Description
333	342	Alt Ins Code	10	A/N	N			Name of alternate insurance responsible for payment of products dispensed. Member or dependent Custom Field
343	360	Alt Ins ID	18	A/N	N			This would be the member ID that this person has for the alternate insurance. Member or dependent Custom Field
361	369	Alt physician Id						Member Custom Primary Care Provider- Not used. Leave Blank
370	379	Status	10	A/N	N			Member or dependents rate status code. For example, Active, Medicare, cobra etc.
380	389	Plan	10	A/N	N			Selected benefit level, elected by the member. Examples HealthChoice high option, HealthChoice low option etc. (Enrollment type ID)
390	397	Plan Eff Date	8	N	N			Not Used.
398	398	New card Flag	1	A/N	Y			Indicates whether new prescription card should be sent to this person, Member Custom field. This field should be reset to blank after the export file has been generated. (NOT USED)

EXHIBIT F

Start Position	Stop Position	Field Name	Vitech Length	Data Type	Required	Format	Value/Default	Description
399	400	Marital Status	2	A/N	Y			The marital status of this person record
401	410	Work Phone	10	A/N	N			The work phone of this person
411	418	Hire Date	8	N	N	YYYYMMDD		Not Used
419	427	Dependent Social	9	A/N	Y			For member record leave blank, For dependent record put dependents SSN. If dependent SSN is not available leave blank. DO NOT PUT MEMBER SSN
428	428	ID Handicap Code	1	A/N	N			If dependent is handicapped, just a Y or N or blank, Only applies to dependents. (Disabled Child Indicator)
429	429	Student Code	1	A/N	N			If dependent is a student, the value should YES else NO or Blank. Applies to dependents only. Blank for member
430	439	Tier code	10	A/N	Y			Indicates who is covered. For example member only, member and spouse, spouse and children etc. (Coverage Level) (Refer to note for populating tier code)
440	449	Division	10	A/N	Y			Member's employer-division code.(Billing_entity_code)

EXHIBIT F

Start Position	Stop Position	Field Name	Vitech Length	Data Type	Required	Format	Value/Default	Description
450	457	Alt Ins From Date	8	N	N			Should be populated with the alternate insurance effective date, if alternate insurance used. Can be equal to or different from the member's effective date. Member or dependent custom field
458	465	Alt Ins Thru Date	8	N	N			Should be populated with the alternate insurance termination date, if alternate insurance used. Can be equal to or different from the member's effective date. Member or dependent Custom field
466	466	Pend Claim	1	A/N	N		Y or N	Claims pending. Member custom field
467	467	Pre Ex	1	A/N	N		Y or N	Pr-existing – Member or dependent Custom Field
468	478	HICN	11	A/N	N			HCIN Number, SSN+ 1 or 2 special code to ID Medicare person. Member/Dependent Custom
479	488	From Group	10	A/N	N			Moved from group-
489	498	From Account	10	A/N	N			Moved from account
499	509	From Member ID	11	A/N	N			SSN + Person code concatenated
510	517	Original Eff Date	8	N	N	YYYY MMDD		Original health effective date with no lapse in coverage. Member custom field

EXHIBIT F

Start Position	Stop Position	Field Name	Vitech Length	Data Type	Required	Format	Value/Default	Description
518	525	Dental Penalty	8	N	N	YYYY MMDD		Late dental enrollee – Member Custom Field (NOT USED)
526	533	Life Insurance Amt	8	N	N	999999. 99		Elected Amount Of Life Insurance (NOT USED for PBM)
534	548	Country	15	A/N	N			Country Code of the Address
549	551	Change_ Type	3	A/N	N			1 st Position-Eligibility 2 nd Position-Address 3 rd Position-Indicative
552	561	Member_ Code	10	N	N	Right-Justified		System Generated member_codes
562	563	OK Health Plan Yr	2	N	N	YY (Ex. 09, 10)		OK Health Initiative Coverage Plan Year (NOT USED for PBM)
564	650	Filler						For future Additions.

Trailer

Start Position	Stop Position	Field Name	Length	Vitech Length	Data Type	Required	Format	Value/Default	Description
1	1	Record Type	1	1	A/N			9	Indicates trailer record
2	10	Carrier	9	9	A/N				Number assigned by the PBM.
11	19	Total records	9	9	N				Do NOT include header and trailer = Adds+ Changes+ History+ Accums+Replace – Total count of records on the file
20	28	Total Adds	9	9	N				Total Number of Add Records. Total count of record type 2
29	37	Total Changes	9	9	N				Total Number of Change Records. Total count of record type 3
38	46	Total Move History	9	9	N				Number of Records performing a History Move. Total Count of record type 4
47	650	Filler							

EXHIBIT F

VI. Contact Information

Name	Phone	E-Mail

VII. Open Issues

#	Author	Date Opened	Issue	Resolution	Date Closed

VIII. Assumptions

#	Author	Assumptions

IX. Document Change Log

Date of change	Author	Change Description
		Document Created
		Added new field – Pos 562-563
		Updated the Contact Information.
		Updated to bring the file layout up to date, etc.

X. Sign-off

Reviewed by: _____

Date: _____

Approved by: _____

Date: _____

EXHIBIT G

LIST OF REPORTS

Daily Reports	Cycle Reports	Monthly Reports	Quarterly Reports	Annual Reports
Eligibility Update Changes (This includes all rejections, adds, changes etc. Rejected records will be detailed)	Check Register (1 Business day after checks run)	Retro Term Report	Members with utilization of \$4000 or more	Summary Satisfaction Survey Findings
	File (Check for Treasurer's Dept) (1 Business day after checks run)	Claim Report identifying paper claims mail received, outstanding pended claims with aging	Member Utilization of 20 or more unique medications, 3 or more physicians and 2 or more pharmacies	Internal Audit Report SAS 70
	Claims Billing File (Claims Detail) (4 Business days after checks run)	Hemophiliac Paid Claims Report	All Performance Standards	
	Paid Claims Report (4 Business days after checks run)		Quarterly Savings Report	
	Lag Report (4 Business days after checks run)		Pharmacy Audit Prod Summary	
			Lifetime Accumulator Threshold	
			Management Report providing a clear picture of the working relationship between the PBM and the Insurance Board including an executive summary, findings, clinical analysis, observations and recommendations	
			Compound RX Report	
Morning after file is run	See Individual Reports	15 days after month end	All quarterly reports are due 60 days after the end of the quarter	Due Annually

EXHIBIT G

DRS Reports				
Monthly Savings Report 15 Calendar days after the end of the month	Standard Quarterly Utilization Reports 60 days after the end of the quarter			
Electronic Pharmacy File (Listing of Oklahoma Network Pharmacies)				

Paid Claim Report

	Primary	Spouse	One Child	Two Children	Total
High Option					
Education					
Active					
Pre-Medicare					
Medicare					
Part D					
Non-Part D					
LIS1					
LIS2					
LIS3					
LIS4					
LIS5					
LIS6					
LIS7					
Local Govt					
Active					
Pre-Medicare					
Medicare					
Part D					
Non-Part D					
LIS1					
LIS2					
LIS3					
LIS4					
LIS5					
LIS6					
LIS7					
State					
Active					
Pre-Medicare					
Medicare					
Part D					
Non-Part D					
LIS1					
LIS2					
LIS3					
LIS4					
LIS5					
LIS6					
LIS7					

EXHIBIT G

Subtotal					
Active					
Pre-Medicare					
Medicare					

Grand Total					
-------------	--	--	--	--	--

Low Option

Education					
Active					
Pre-Medicare					
Medicare					
Part D					
Non-Part D					
LIS1					
LIS2					
LIS3					
LIS4					
LIS5					
LIS6					
LIS7					

Local Govt					
Active					
Pre-Medicare					
Medicare					
Part D					
Non-Part D					
LIS1					
LIS2					
LIS3					
LIS4					
LIS5					
LIS6					
LIS7					

State					
Active					
Pre-Medicare					
Medicare					
Part D					
Non-Part D					
LIS1					
LIS2					
LIS3					
LIS4					
LIS5					
LIS6					
LIS7					

EXHIBIT G

Subtotal					
Active					
Pre-Medicare					
Medicare					

Grand Total					
-------------	--	--	--	--	--

Basic

Education					
Active					
Pre-Medicare					

Local Govt					
Active					
Pre-Medicare					

State					
Active					
Pre-Medicare					

Subtotal					
Active					
Pre-Medicare					

Grand Total					
-------------	--	--	--	--	--

USA

Education					
Active					
Pre-Medicare					

Local Govt					
Active					
Pre-Medicare					

State					
Active					
Pre-Medicare					

Subtotal					
Active					
Pre-Medicare					

Grand Total					
-------------	--	--	--	--	--

Grand Total (All Plans)

Education

Active				
Pre-Medicare				
Medicare				
Part D				
Non-Part D				
LIS1				
LIS2				
LIS3				
LIS4				
LIS5				
LIS6				
LIS7				

Local Govt

Active				
Pre-Medicare				
Medicare				
Part D				
Non-Part D				
LIS1				
LIS2				
LIS3				
LIS4				
LIS5				
LIS6				
LIS7				

State

Active				
Pre-Medicare				
Medicare				
Part D				
Non-Part D				
LIS1				
LIS2				
LIS3				
LIS4				
LIS5				
LIS6				
LIS7				

Subtotal

Active				
Pre-Medicare				
Medicare				

Grand Total

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EXHIBIT G

Lag Reports

For each custom grouping on the Paid Claim Report, a correspondence Lag report is required.

Paid Date	Pre-May	May-05	June-05	July-05	Aug-05	Sept-05	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06	Total

EXHIBIT G**DRS Savings Report 1/2006**

NetRxs	Brand/Generic Fill Indicator	Total Days Supply	Total AWP	Total Ingredient Cost		Total Amount Paid	Total Dispensing Fee
105	Generic Only	1,800	\$4,997.95	\$2,306.43		\$2,600.93	
4	Multiple Source Brand	85	\$162.08	\$138.22	\$0.00	\$149.22	\$11.00
60	Single Source Brand	1,568	\$6,654.13	\$5,874.57	\$0.00	\$6,032.57	\$158.00
169		3,453	\$11,814.16	\$8,319.22	\$0.00	\$8,782.72	\$463.50