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Department of MANAGEMENT SERVICES
We serve those who serve Florida

4050 Esplanade Way
Tallahassee, FL 32399-0950

Ron DeSantis, Governor
Pedro Allende, Secretary

CONTRACT
FOR
THIRD PARTY ADMINISTRATIVE SERVICES FOR
PHARMACY BENEFIT MANAGEMENT SERVICES
DMS-22/23-047
BETWEEN
STATE OF FLORIDA
DEPARTMENT OF MANAGEMENT SERVICES
AND
OPTUMRX, INC.

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Contract

This Contract is between the STATE OF FLORIDA, DEPARTMENT OF MANAGEMENT SERVICES (Department), an agency of the State of Florida with offices at 4050 Esplanade Way, Tallahassee, Florida 32399-0950, and OptumRx, Inc. (Contractor), with offices at 11020 Optum Circle, Eden Prairie, MN 55344, each a "Party" and collectively referred to herein as the "Parties".

WHEREAS, the Contractor responded to the Department's Invitation to Negotiate (ITN) No. DMS-22/23-047 for Third Party Administrative Services for Pharmacy Benefit Management Services (PBM) and was selected for award; and

WHEREAS, the Parties enter into this Contract in accordance with the terms and conditions of the solicitation.

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

SECTION 1 DEFINITIONS

The following capitalized terms used in this Contract (including the Attachments and any attachments thereto) have the meanings ascribed below:

"Business Day" means any day of the week excluding weekends and holidays observed by State agencies pursuant to subsection 110.117(1)(a)-(j), Florida Statutes.

"Calendar Day" means any day in a month, including weekends and holidays.

"Claim(s)" means an application for payment of or reimbursement for health care expenses, including prescription drugs, incurred by Participants, which is filed in accordance with the Benefits Document and the Service Provider's and/or Department's requirements.

"Confidential Information" means information in the possession or under control of the State or Vendor that is exempt from public disclosure pursuant to section 24, Article I of the Constitution of the State; the Public Records Law, Chapter 119, Florida Statutes; or to any other Florida law, federal law or regulation that serves to exempt information from public disclosure.

"Contract" means this agreement between the Department and Contractor consisting of, in order of precedence, the following documents:

1. This agreement and its attachments, in the following order of precedence:
    a. Attachment 8: Privacy, Security, and Confidentiality Business Associate Agreement;
    b. Attachment 1: Administrative Requirements;
    c. Attachment 2: Performance Guarantees;
    d. Attachment 3: Cost Reply / Price Sheet
    e. Attachment 4: Department Selected Portions of Attachment B – Technical
    f. Attachment 5: Department Selected Portions of Attachment C – Network
    g. Attachment 6: List of Department approved Subcontractors
    h. Attachment 7: Department selected portions of the Vendor's BAFO

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In the event of conflict between this document and the Attachments, this document will control.

2. The General Contract Conditions - PUR 1000 form, which is incorporated by reference, and available at the weblink listed below. The Parties agree that the following provisions of the PUR 1000 are not applicable to this Contract: 2-13, 17, 20-23, 26-29, 31-32, 34-35, 38-39, 42, 45.

   https://www.dms.myflorida.com/content/download/2933/11777/PUR_1000_General_Contract_Conditions.pdf

"Contract Administrator" means the person designated pursuant to subsection 10.5 of this Contract.

"Contract Manager" means those persons designated pursuant to subsection 10.6 of this Contract.

"Data" or "State of Florida Data" means a representation of information, knowledge, facts, concepts, computer software, or computer programs or instructions (including any that it is exempt; confidential; or Protected Health Information protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. §§ 160 and 164, the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"), and the regulations promulgated thereunder, or section 110.123(9), Florida Statutes), that is received by the Contractor, or created by the Contractor, in the performance of the Services under the Contract. State of Florida Data may be in any form including, but not limited to, storage media, computer memory, in transit, presented on a display device, or in physical media such as paper, film, microfilm, or microfiche. State of Florida Data includes the original form of the State of Florida Data and all metadata associated with the State of Florida Data.

"Department" means the Florida Department of Management Services or its designee, which may include a third-party administrator contracted to assume responsibility for the Department's administration of this Contract pursuant to section 110.123(3)(d)1., Florida Statutes.

"Deliverables" mean those services, items and/or materials provided, prepared, and delivered to the Department in the course of performance under this Contract by the Contractor.

"Division" means the Department's Division of State Group Insurance."Effective Date" means the date the Contract is fully executed by all Parties.

"Drug Classification" means the process whereby Service Provider uses the indicators of Medi-Span Master Drug Database ("Medi-Span"), and their associated files, as updated regularly by Medi-Span (or other disclosed nationally available recognized reporting service of pharmaceutical drug information) to determine the classification of drugs (i.e., legend vs. over the counter, Brand vs. Generic, single-source vs. multi-source) for purposes of this Contract. Brand and Generic drugs must be classified as such using the standard manufacturer designations. Reclassification of any drug using any proprietary methodology or algorithms is not permitted. Neither the availability nor supply of a drug will be used as criteria to classify the drug as a Brand Drug or Generic Drug under this Contract. Service Provider shall classify drugs consistently at retail, mail, and specialty pharmacies, based on data provided by sources such as Medi-Span or First DataBank, pharmaceutical manufacturers, and the Food and Drug Administration, or other sources disclosed to the Department. Service Provider will notify the Department if/when it has classified a drug(s) differently than classified by the selected single pricing source noted above.

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“Effective Date” means the date the Contract is fully executed by all Parties.

“Eligible Dependent” means a Dependent of a Subscriber, as defined by the Florida Administrative Code and statutes.

“Estimating Conference Report” means the State Employees’ Group Health Insurance Trust Fund Report on the Financial Outlook, typically published twice a year and developed pursuant to section 216.134, Florida Statutes.“Generic Drug” means off-patent single-source generic, multi-source generics, trademarked generics, at risk generics, and any generic products involved in patent litigation, determined in accordance with the Drug Classification requirement of this Contract. As clarification, not limitation, Generic Drugs will include all MAC’d generics and non-MAC’d generics; all multi-source generics and single-source generics (i.e., generics during their exclusivity period) regardless of availability or supply. If a covered drug has been classified as a Generic Drug by Service Provider, it shall remain classified as a Generic Drug unless the initial classification was in error. For pricing guarantee purposes Generic Drugs will be (a) all claims with Medi-Span Brand Name Code = “T” with a Medi-Span Multi-Source Code = “Y” on the date dispensed; and (b) all claims with Medi-Span Brand Name Code = “B” or “G” on the date dispensed. Service Provider's proprietary brand / generic drug algorithm(s) must not be used to classify drugs as Brand or Generic when reconciling Service Provider's aggregate Semi-annual Generic AWP Discount Guarantees.

“Generic Product Identifier (GPI)/Generic Code Number (GCN)” means the drug categorization identifier as reported by the source entity (First Databank for GCN and Medi-Span for GPI).

“House Generic” means those drugs which are issued as an originator Brand Drug dispensed and adjudicated as an equivalent Generic Drug, and that will be identified by a DAW code of 5.

“Implementation Date” means January 1, 2024, at 12:00 A.M., Eastern Time (EST).

“Implementation Plan” means the written description provided by Contractor, as approved by the Department, of the schedule of actions necessary to implement the services and begin fulfilling the Contract in a timely manner.

“Implementation Period” means the period between the Effective Date and the Implementation Date.

“Limited Distribution Drugs” or “LDDs” means drugs for which Service Provider’s specialty pharmacy does not have a direct purchase agreement with the manufacturer or wholesaler distributor of that product. If the manufacturer has designated a product as “limited distribution” or “exclusive distribution”, but Service Provider is able to maintain access and distribution rights to the product, the product will not be considered Limited Distribution Drug for the purposes of this Contract. Limited Distribution Drugs will be billed as specified in Specialty at Retail.

“MAC” or “Maximum Allowable Cost” means the unit price that has been established by the Service Provider as maximum allowable cost payment, consistent with the terms of Attachment 2: Administrative Requirements, X. Clinical Services, 114., for an off-patent drug. The payment schedules specify the maximum unit ingredient cost payable by the Department for drugs on the MAC List, which unit price may be amended as frequently as weekly by the Service Provider in maintaining its generic pricing program. Provider will not set MAC rates (on a Generic Product Identifier (GPI) or Generic Code Number (GCN) level) higher than the discounted brand AWP in

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the same GPI/GCN.

“MAC List” means the list of drugs priced on a MAC basis. The MAC List applicable to the Department is not the same as the MAC List published by CMS (formerly known as the Health Care Financing Administration, or “HCFA MAC”). The list and associated unit prices may be amended as frequently as weekly by the Service Provider in maintaining its generic pricing program. The same MAC product shall be used for retail and mail such that the MAC unit cost of every individual product on the MAC product list at Mail Order shall always be equal to or lower than under the Retail Pharmacy Program.

“Maintenance Drugs” means medications prescribed for chronic, long-term conditions and are taken on a regular, recurring basis.

“Manufacturer Payments” means, but is not limited to, compensation received by the Service Provider from pharmaceutical manufacturers (branded and generic), attributable to the purchase or utilization of covered drugs (including Specialty Drugs) by an eligible Participant. Compensation includes, but is not limited to: discounts; credits; payments received in accordance with agreements with pharmaceutical manufacturers for formulary placement and, if applicable, drug utilization; rebates, regardless of how categorized; market share incentives; commissions; any fees received for the sale of utilization data to a pharmaceutical manufacturer; educational grants received from manufacturers in relation to the provision of utilization data to manufacturers for rebating, marketing and related purposes; manufacturer administrative fees; and all compensation from manufacturers including rebates paid by a manufacturer as a result of product inflation caps and/or guarantees negotiated by the Service Provider. Manufacturer Payments do not include purchase discounts based on invoiced purchase terms when the Service Provider is operating in the capacity of a pharmacy that is purchasing stock; and fees under products and services agreements; and patient assistance or copay or coinsurance dollars provided by manufacturers to Participants in order to offset drug costs.

“Mathematically Accurate” means that the instruments, methods, data, numbers, assumptions, and calculations are a correct representation of the outcomes.

“Member” means those persons defined as a “health plan member” in subsection 110.123(2)(e), Florida Statutes.

“MMA” means the Medicare Modernization Act of 2003, and as may be amended.

“Notice” means written notification from one Party to the other Party regarding performance under the Contract.

“Participants” means all Subscribers and their enrolled Eligible Dependents.

“Pass-Through Pricing” means Service Provider shall provide pricing to the Department whereby all payments made by the Plan for claims pursuant to this Contract are: 1) equivalent to the payments the Service Provider makes to a dispensing pharmacy or provider for such drugs, including any contracted professional dispensing fee between the Service Provider and its network of pharmacies and such dispensing fee would be paid if the pharmacy benefits plan or program was making the payments directly; and 2) passed through in their entirety by the Plan or Service Provider to the pharmacy or provider that dispenses the drugs, and the payments are made in a manner that is not offset by any reconciliation. Spread pricing will not be used at retail.

“People First” means the enterprise-wide suite of services used by the State to manage human capital including the administration of human resources, benefits, payroll, and staffing. People

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First is the State's system of record for Plan eligibility.

"PEPM" means per Subscriber per month.

"PEPY" means per Subscriber per year.

"Performance Guarantees" means specific measurement indicators assigned to Contract tasks representing timeliness and quality of task output.

"Plans" means any of the insurance coverages offered through the Department, as authorized in section 110.123, Florida Statutes.

"Plan Year" means the calendar year from January 1 to December 31.

"PMPM" means per Participant per month.

"PMPY" means per Participant per year.

"Program" means the State Group Insurance Program defined in sections 110.123(3) and 110.12315, Florida Statutes.

"Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

"Program" means the State Group Insurance Program defined in sections 110.123(3) and 110.12315, Florida Statutes.

"Protected Health Information" is defined in HIPAA at 45 CFR 160.103, and as used in this Agreement also refers to the term "Protected Health Information," as defined in the HITECH Act.

"Rural Area" means approximately less than 1,000 persons per square mile.

"Run-Out Claims" means Claims for pharmacy expenses incurred by a Plan Participant during the term of the Contract which are received by the Service Provider within one hundred eighty (180) days after termination of the Contract and within sixteen (16) months from the date that the pharmacy services relating to such Claims were rendered.

"ROI" means "Return on Investment," which is the guarantee of the annual gross savings realized from a program relative to the cost of the program.

"Secretary" means the Secretary of the Department or his or her designee.

"Services" means services to be performed by Contractor as specified in this Contract, including the requirements of the Attachments to this Contract. The term "Services" includes, but is not limited to, all Deliverables and any unspecified service that is inherent in proper delivery of a specified service or Deliverable. During the term of the Contract, the Department will have the right to add or delete services and products. If the Department elects to add services or products, the Contractor and the Department will negotiate a mutually agreed amendment to the Contract.

"Service Provider" or "Contractor" means OptumRx, Inc., the Pharmacy Benefits Manager.

"Specialty Drugs" means drugs that require a customized medication management program that includes medication use review, patient training, coordination of care, and adherence management for successful use such that more frequent monitoring and training may be required; and must meet a minimum of two (2) or more of the following characteristics:

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- Produced through DNA technology or biological processes
- Target chronic or complex disease
- Route of administration could be oral, inhaled, infused, or injected
- Unique handling, distribution and/or administration requirements

In addition, a follow-on-biologic (i.e. biosimilars) or generic product will be considered a Specialty Drug if the innovator drug is a Specialty Drug and meets the criteria above. Medications that do not meet the above criteria will be dispensed via mail at the standard Mail Order pricing rates (and included in the Semi-annual and/or annual, as appropriate, Mail Order pricing guarantees) or via Retail at the standard retail rates (and included in the Semi-annual and/or annual, as appropriate, Retail pricing guarantees).

“Specialty Drug Price List” means the list of covered prescription drug products which identifies the reimbursement rates applicable under this Contract, and included in Attachment 6: Fees, Claims, Clinical Programs, and Drug Lists, which is maintained and updated by Service Provider from time to time as new prescription drug products come to market. Such Specialty Drug Price List shall be subject to the provisions of Attachment 2: Administrative Requirements.

“State” means the State of Florida.

“Standard Reporting” means periodic reports as described in Attachment 1: Administrative Requirements.

“Subcontractor” means the Contractor’s subcontractors and agents that deliver the Services required by this Contract. The term “Subcontractor” does not include health care providers.

“Subscriber”, “Enrollee”, “Member”, or “Participant” means the enrolled employee, retiree, surviving spouse, or Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) participant that is the primary insured, as defined in Florida law.

“Suburban Area” means approximately between 1,000 to 3,000 persons per square mile.

“Urban Area” means approximately greater than 3,000 persons per square mile.

SECTION 2 CONTRACT DOCUMENTS

2.1 Rules of Interpretation

The following rules of interpretation shall apply, unless otherwise indicated:

a. Reference to, and the definition of, any document (including any attachments) shall be deemed a reference to such document as it may be amended, supplemented, revised or modified;
b. The table of contents and section headings and other captions are for the purpose of reference only and do not limit or affect the content, meaning or interpretation of the text;
c. Defined terms in the singular shall include the plural and vice versa and the masculine, feminine or neutral-genders shall include all genders;
d. The words “hereof,” “herein,” “hereunder,” and words of similar import, shall refer to this Contract as a whole and not to any particular provision of this Contract;
e. The words “include,” “includes” and “including” are deemed to be followed by the phrase “without limitation”;

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f. Any reference to a governmental entity or person shall include the governmental entity's or person's authorized successors and assigns; and
g. The words "quarterly," "on a quarterly basis," "quarterly meeting" or other similar terms mean, unless otherwise stated herein, once every three (3) months, beginning January 01, 2024.

SECTION 3 TERM, SCOPE, AND PAYMENTS

3.1 Term

3.1.1 Initial term

The initial Contract term is three (3) years and Services will commence on the Effective Date and end December 31, 2026, unless extended, terminated, or renewed as provided herein. The Parties acknowledge that the Plan will not be administered under this Contract until January 1, 2024. While implementation services will be required, premium payments from Enrollees will not be collected until December 2023, for coverage effective January 1, 2024.

3.1.2 Renewals

At its sole option and discretion, the Department may renew the Contract for up to three (3) additional one (1) year renewal terms. Such renewal will be binding on the Contractor and may be in one (1) year or multiple year increments at the Department's sole option. Renewal in whole or in part shall be at the sole discretion of the Department. The Department shall also consider whether the Contractor has been subject to any performance violations and/or liquidated damages in complying with any of the Contract requirements. Any renewal shall be in writing and signed by both Parties.

The Contractor shall not charge any fees and/or costs for renewing the Contract.

Pursuant to section 287.057(13), Florida Statutes, this Contract may be extended if the failure to meet the criteria set forth in the contract for completion of the Contract is due to events beyond the control of the Contractor, as determined by the Department.

3.2 Department's Right to Terminate for Convenience

The Department, by sixty (60) Calendar Days advanced written notice to Contractor, may terminate the Contract for any reason or no reason at all when the Department determines in its sole discretion that it is in the Department's best interest to do so. The Contractor shall not perform any Services after the effective date of the termination, except as necessary to complete the continued portion of the Contract, if any. The Contractor will not be entitled to recover any lost profits, consequential, special, punitive, or indirect damages, or any other damages other than the payment amounts due for performance until the effective date of termination. If this Contract is terminated for convenience prior to January 1, 2024 the Department shall reimburse Contractor for direct costs actually incurred for Services authorized by the Department and satisfactorily performed prior to receipt of the notice of termination.

3.3 Scope of Work

The Contractor will provide all labor, materials, and supplies necessary to provide the Services as described in this Contract. Contractor agrees to periodic reviews by the Department on Contractor's performance to improve delivery of the scope of work.

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Corrective work to comply with the requirements of this Contract will be performed by the Contractor at its expense, and the Contractor will not be entitled to any compensation for such corrective work.

3.4 Modifications and Changes

The Department, by written change order, may unilaterally require changes altering, adding to, or deducting from the Services, products, or Contract specifications, provided that such changes are within the general scope of the Contract. If Services or products are added, the Contractor and the Department will negotiate a mutually agreed amendment to the Contract. The Department may make an equitable adjustment in the Contract price or delivery date if changes to Contract specifications affect the cost or time of performance. Such equitable adjustments require the written consent of the Contractor, which shall not be unreasonably withheld. If the Parties fail to agree to an equitable adjustment, such dispute must be resolved pursuant to the Dispute Resolution procedures identified in section 10.7.

The Contract, including its Attachments, contains all the terms and conditions agreed upon by the Parties, which shall govern all transactions under the Contract. Other than as specified above, the Contract may only be modified or amended upon mutual written agreement of the Department and Contractor. No oral agreements or representations shall be valid or binding upon the Department or Contractor. Contractor may not unilaterally modify the terms of the Contract by incorporating terms onto Contractor's order or fiscal forms or other documents forwarded by Contractor for payment. The Department's acceptance of Service or processing of documentation on forms furnished by Contractor for approval or payment will not constitute amendment to this Contract or waiver of a default.

3.5 Department's Right to Suspend Work

The Department may in its sole discretion suspend any or all Services under the Contract, at any time, when in the best interests of the Department to do so. The Department will provide Contractor written Notice outlining the particulars of suspension. Examples of the reason for suspension include, but are not limited to, budgetary constraints, declaration of emergency or other like circumstances. After receiving a suspension Notice, the Contractor will comply with the Notice.

3.6 Department's Obligation to Supply Data to Contractor

The Department shall supply all eligibility and personnel data and information necessary for Contractor to provide the Services.

3.7 Bills for Travel

Bills for travel expenses are not permitted under this Contract.

3.8 Payments

The Contractor agrees to perform all Services for the compensation and financial arrangements set forth in Attachment 3: Cost Reply/Price Sheet. No additional compensation will be allowed.

3.9 Specific Appropriation

The State of Florida's performance and obligation to pay under this Contract is contingent upon an annual appropriation by the Legislature. The following is the specific state funds from which the state will make payment under the Contract:

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2023-24 GAA Line item(s) # 2926 - Special Categories: Prescription Drug Claims Administration: from State Employees Health Insurance Trust Fund: 72 7275 73 2 668003 72750200 00, Appropriation Category Code: 101530, Organization Code: 7275 02 00 803. Budget Entity – 72750200, Fund – 2668

3.10 Non-Exclusive Contract

Nothing herein is intended to assure the Contractor that it is the only vendor providing these Services to the State, nor does it prohibit the State from procuring these services from additional vendors during the term of the Contract.

SECTION 4 CONTRACT ADMINISTRATION

4.1 Ownership of Deliverables and Retention of Records

All Deliverables, papers, documents, materials, work, and other items prepared by the Contractor and provided to the State for purposes of the Contract are the property of the Department and shall be available to the Department at any time. The Department has the right to use the same without restriction and without payments to Contractor other than that specifically provided by the Contract. Data deemed proprietary, trade secret or confidential shall be subject to compliance with Florida Statutes and federal laws and regulations. The Contractor does not waive its rights in any Deliverables not prepared specifically for the Department that are also provided to other clients of Contractor for substantially the same purpose as they are provided to the Department, however, Contractor hereby grants a license to the Department to use such documents.

Contractor shall retain sufficient documentation to substantiate Claims for payment under this Contract, and all other records, electronic files, papers, and documents, which were made for purposes of the Contract. Such records shall include magnetic tapes, CD-ROM, diskettes, or other electronic media files maintained by the Contractor directly relating to the Services, including file labels, complete file layouts, data element descriptions and detailed processing logic to assist the Department auditor in processing or utilizing files. Contractor shall retain all such records, papers, and documentation in compliance with record retention schedules published by the State of Florida Department of State.

4.2 Contractor Obligations

4.2.1 General

Contractor will provide any and all labor, materials and supplies necessary to perform the Services in the manner prescribed by this Contract. The Contractor will meet or exceed the Minimum Service Requirements set forth in Attachment 2: Performance Guarantees.

4.2.2 Major Organizational Changes

The Parties agree that in order for efficient and effective communication to occur, clear lines of authority and areas of responsibility need to be identified for each Party. Each Party agrees to promptly notify the other in the event of any material change in personnel, address, or phone number.

The Contractor recognizes and agrees that award of the Contract was predicated upon features of Contractor's business organization as represented by the Contractor in their response to the ITN. If the Contractor transfers or sells fifty

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percent (50%) or more of its equity interests (whether in a single transaction or series of transactions) or allows a sale of substantially all of its assets, the Contractor shall notify the Department in writing no less than thirty (30) Calendar Days prior to such transfer or sale.

4.2.3 Subcontractors

Contractor is responsible for the acts or omissions of all Subcontractors, if any, it uses in the provision of the Services during the term of the Contract. The Department will have no liability of any kind for Subcontractor demands, loss, damage, negligence, or any expense relating, directly or indirectly, to Subcontractors.

Contractor will not subcontract any of the Services or enter into any subcontracts or change approved Subcontractors as listed in Attachment 6: List of Department approved Subcontractors (including their key personnel and/or location of processes for the Services) without providing the Department prior Notice of at least sixty (60) Calendar Days or, in case of an emergency, as soon as practicable and receiving approval from the Department. Each approved Subcontractor will be subject to the same terms and conditions as outlined in this Contract. For purposes of this section, pharmacy providers are not considered to be Subcontractors.

4.2.4 Background Screening and Record Retention

All of Contractor's employees, Subcontractors and agents performing work under the Contract must comply with all security and administrative requirements of the Department.

4.2.4.1 Background Screening

In addition to any background screening required by the Contractor as a condition of employment, the Contractor warrants that it will conduct a criminal background screening of, or ensure that such a screening is conducted for each of its employees, Subcontractor personnel, independent contractors, leased employees, volunteers, licensees, or other person, hereinafter referred to as "Person" or "Persons," operating under their direction who directly perform services under the Contract, whether or not the Person has access to State of Florida Data, as well as those who have access, including indirect access, to State of Florida Data, whether or not they perform services under the Contract. The Contractor represents and warrants that all Persons will have passed the background screening described herein prior to, but no longer than five (5) years before, they gain access to State of Florida Data or begin performing services under the Contract. The look-back period for such background screenings shall be for a minimum of six (6) years where six (6) years of historical information is available.

"Access" means to review, inspect, approach, access, instruct, communicate with, store data in, retrieve data from, transmit, or otherwise make use of any data, regardless of type, form, or nature of storage or the ability to review, inspect, approach, instruct, communicate with, store data in, retrieve data from, or otherwise make use of any data, regardless of type, form, or nature of storage. Access to a computer system or network includes local and remote access.

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"Data" or "State of Florida Data" is as defined in section 1 of this Contract.

The minimum background check process must include a check of the following databases through a law enforcement agency or a Professional Background Screener accredited by the National Association of Professional Background Screeners, the National Committee for Quality Assurance, or a comparable standard:

- Social Security Number Trace; and
- Criminal Records (Federal, State and County criminal felony and misdemeanor, national criminal database for all states which make such data available).

  The Contractor agrees that each Person has been screened as a prior condition for performing services under the Contract or having access to State of Florida Data.

The Contractor is responsible for any and all costs and expenses in obtaining and maintaining the criminal background screening information for each Person described above. The Contractor will maintain, or cause to be maintained, documentation of the screening in the Person's employment file. The Contractor will abide by all applicable laws, rules, and regulations including, but not limited to, the Fair Credit Reporting Act and/or any equal opportunity laws, rules, regulations, or ordinances. The Department may require the Contractor to exclude the Contractor's employees, agents, representatives, or Subcontractors based on the background check results.

The Department may refuse access to, or require replacement of, any Contractor, employee, Subcontractor, or Subcontractor employee, or agent for cause, including, but not limited to, technical or training qualifications, quality of work, change in security status, or non-compliance with the Department's security or other requirements. Such approval shall not relieve the Contractor of its obligation to perform all work in compliance with the Contract. The Department may reject and bar from any facility for cause any of the Contractor's employees, subcontractors, or agents.

4.2.4.2 Disqualifying Offenses

If at any time it is determined that a Person has a criminal misdemeanor or felony record regardless of adjudication (e.g., adjudication withheld, a plea of guilty or nolo contendere, or a guilty verdict) within the last six (6) years from the date of the court's determination for the crimes listed below, or their equivalent in any jurisdiction, the Contractor is required to immediately remove that Person from any position with Access to State of Florida Data or directly performing services under the Contract. The disqualifying offenses are:

(a) Computer-related crimes;
(b) Information technology crimes;
(c) Fraudulent practices;
(d) False pretenses;
(e) Frauds;

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(f) Credit card crimes;
(g) Forgery;
(h) Counterfeiting;
(i) Violations involving checks or drafts;
(j) Misuse of medical or personnel records;
(k) Felony theft; and
(l) Identity Theft.

If the Contractor finds a Disqualifying Offense for a Person within the last six (6) years from the date of the court's disposition, it may obtain information regarding the incident and determine whether that Person should continue providing Services under the Contract or have Access to State of Florida Data. The Contractor will consider the following factors only in making the determination: i.) nature and gravity of the offense, ii.) the amount of time that lapsed since the offense, iii.) the rehabilitation efforts of the person and iv.) relevancy of the offense to the job duties of the Person. If the Contractor determines that the Person should be allowed Access to State of Florida Data, then Contractor shall maintain all criminal background screening information and the rationale for such Access in the Person's employment file.

The Contractor shall require all Persons to self-report within three (3) Business Days of adjudication to the Contractor any adjudication of guilt as described above for the Disqualifying Offenses. The Contractor shall immediately disallow that Person Access to any State of Florida Data or from directly performing Services under the Contract. Additionally, the Contractor shall require that the Person complete an annual certification that he or she has not received an adjudication of guilt as described above for the Disqualifying Offenses and shall maintain that certification in the employment file.

4.2.4.3 Refresh Screening

The Contractor will ensure that all background screening will be refreshed every five (5) years from the time initially performed for each Person during the term of the Contract.

4.2.4.4 Department's Ability to Audit Screening Compliance and Inspect Locations

The Department reserves the right to audit the Contractor's background screening process upon two (2) days prior written Notice to the Contractor during the term of the Contract. Department will have the right to inspect the Contractor's working area, computer systems, and/or location upon two (2) Business Days prior written notice to the Contractor to ensure that Access to the State of Florida Data is secure and in compliance with the Contract and all applicable state and federal rules and regulations.

4.2.4.5 Record Retention

The Contractor shall retain a list of all Persons with Access to State of Florida Data, including a statement confirming that each Person has passed the Background Screening required herein. Such a statement shall not include the substance of the screening results, only that the Person has passed the screening.

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The Contractor shall create a written policy for the protection of State of Florida Data, including a policy and procedure for Access to State of Florida Data.

The Contractor shall document and record, with respect to each instance of Access to State of Florida Data:

1) The identity of all individual(s) who Accessed State of Florida Data in any way, whether those individuals are authorized Persons or not;
2) The duration of the individual(s)' Access to State of Florida Data, including the time and date at which the Access began and ended;
3) The identity, form, and extent of State of Florida Data accessed, including, but not limited to, whether the individual Accessed partial or redacted versions of State of Florida Data, read-only versions of State of Florida Data, or editable versions of State of Florida Data; and
4) The nature of the Access to State of Florida Data, including whether State of Florida Data was edited or shared with any other individual or entity during the duration of the Access, and, if so, the identity of the individual or entity.

The Contractor shall retain the written policy and information required in this subsection for the duration of this Contract and a period of no less than five (5) years from the date of termination of this Contract and any Contract extensions. The written policy and information required in this subsection shall be included in the Department's audit and screening abilities as defined in subsection 4.2.4 of this Contract. The written policy and information required in this subsection shall also be subject to prompt disclosure upon written or oral demand at any time by the Department or its designated agents or auditors.

Failure to compile, retain, and disclose the written policy and information as required in this subsection shall be considered a breach of the Contract. The resulting damages to the Department from a breach of this subsection are by their nature impossible to ascertain presently and will be difficult to ascertain in the future. The issues involved in determining such damages will be numerous, complex, and unreasonably burdensome to prove. The Parties acknowledge that these financial consequences are liquidated damages, exclusive of any other right to damages, not intended to be a penalty, and solely intended to compensate for unknown and unascertainable damages. The Contractor therefore agrees to credit the Department the sum of $10,000 per event, for each breach of this subsection.

4.2.5 Data Security

4.2.5.1 Work Locations, No Offshoring of Data

Contractor, including its employees, Subcontractors, Subcontractor personnel, independent contractors, leased employees, volunteers, licensees, or other persons operating under their direction, are prohibited from (i) performing any of the Services under the Contract outside of the U.S., or (ii) sending, transmitting, or accessing any State of Florida Data outside of the U.S. The Parties agree that a violation of this provision will:

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(a) result in immediate and irreparable harm to the Department, entitling the Department to immediate injunctive relief, provided, however, this shall not constitute an admission by the Contractor to any liability for damages under subsection (c) below or any claims, liability, or damages to a third party, and is without prejudice to the Contractor in defending such claims.
(b) entitle the Department to a credit of $50,000 per violation, with a cumulative total cap of $500,000 per event. This credit is intended only to cover the Department's internal staffing and administrative costs of investigations and audits of the transmittal of State of Florida Data outside the U.S.
(c) entitle the Department to recover damages, if any, arising from a breach of this subsection and beyond those covered under subsection (b).

The credits in subsection (b) are a reasonable approximation of the internal costs for investigations and audits from a violation. The credits are in the nature of liquidated damages and not intended to be a penalty on the Contractor. By executing this Contract, Contractor acknowledges and agrees the costs intended to be covered by subsection (b) are not readily ascertainable and will be difficult to prove. Contractor agrees that it will not argue, and is estopped from arguing, that such costs are a penalty or otherwise unenforceable. For purposes of determining the amount of credits due hereunder, a group of violations relating to a common set of operative facts (e.g., same location, same time period, same off-shore entity) shall be treated as a single violation. The credits will be applied against the monthly invoices submitted by the Contractor, and are exclusive of any other right to damages.

4.2.5.2 Contractor's Responsibility to Notify Department for a Breach

For purposes of subsection 4.2.5.3 of this Contract, the following definitions apply:

"Breach" means a confirmed event that compromises the confidentiality, integrity, or availability of information or State of Florida Data, or unauthorized access of State of Florida Data in electronic form containing personal information. Additional requirements related to breaches of HIPAA information are covered in Attachment 8: Privacy, Security, and Confidentiality Business Associate Agreement.

"Incident" means a violation or imminent threat of violation, whether such violation is accidental or deliberate, of information technology security policies, acceptable use policies, or standard security practices. An imminent threat of violation refers to a situation in which the state agency has a factual basis for believing that a specific incident is about to occur.

4.2.5.3 Notice of Breach

Notwithstanding any provision of this Contract to the contrary, the Contractor shall notify the Department promptly upon discovering any Breach or Incident regarding State of Florida Data; any unauthorized access of State of Florida Data (even by persons or companies with authorized access for other purposes); any unauthorized transmission of State of Florida Data; or any credible allegation or suspicion of a material violation of the above. This notification is required whether the event affects one Member or the entire population. The notification shall be clear and conspicuous and include a description of the following:

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(a) The Breach or Incident in general terms.

(b) The type of personal information that was subject to the unauthorized Access and acquisition.

(c) The number of individuals who were, or potentially have been, affected by the Breach or Incident.

(d) The actions taken by the Contractor to protect the State of Florida Data information from further unauthorized Access. However, the description of those actions in the written notice may be general so as not to further increase the risk or severity of the Breach.

Upon becoming aware of an alleged Breach or Incident, the Contractor shall set up a conference call (via a telephone call and email) with the Department's Contract Manager and any necessary parties. The conference call invitation shall contain a brief description of the nature of the event. When possible, a thirty (30) minute notice shall be given to allow Department personnel to be available for the call. If the designated time is not practical for the Department, an alternate time for the call shall be scheduled. All available information shall be shared on the call. The Contractor shall answer all questions based on the information known at that time and shall answer additional questions as additional information becomes known. The Contractor shall provide the Department with final documentation of the incident including all actions that took place. If the Contractor becomes aware of a Breach or Incident outside of normal business hours, the Contractor shall notify the Department's Contract Manager as soon as possible, and in all events, within forty-eight (48) hours.

The Contractor's failure to perform the obligations in this subsection shall also be an Event of Default, and will entitle the Department to recover any other damages it incurs arising from a failure to perform the obligations in this subsection (including any actual out-of-pocket expenses incurred by the Department to investigate and remediate the violation) and/or to pursue injunctive relief.

4.2.5.3.1 Contractor's Responsibility to Notify Members

The Contractor shall, at Contractor's sole expense, notify all Members whose State of Florida Data was accessed by any Breach, unauthorized access or transmission is determined by the Department to have been caused by the Contractor or its Subcontractors no later than thirty (30) Calendar Days after the determination of a Breach or reason to believe a Breach occurred. If the Contractor cannot identify the specific persons whose data may have been accessed, such notice shall be provided to all persons whose data reasonably may have been accessed. The Department shall pay all costs to notify such persons related to any Breach determined by the Department to not have been caused by the Contractor or its Subcontractors. Nothing in this subsection will alter or replace the application of section 501.171, Florida Statutes, as to the Contractor's obligations and liability for Breaches concerning confidential personal information.

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4.2.5.3.2 Credit Monitoring and Notification

The Contractor shall include credit monitoring services at its own cost for those Members affected or potentially affected by an alleged Breach for no less than a period of one (1) year following the Breach.

The Contractor shall provide the Department of Legal Affairs written notice of a Breach that affects 500 or more Members as soon as practicable, but not later than thirty (30) Calendar Days after the determination of the Breach or reason to believe a Breach has occurred. The Contractor shall provide the Department a copy of the written notice to the Department of Legal Affairs. If a Breach impacts more than 1,000 Members at a single time, the Contractor shall notify, without unreasonable delay, all consumer reporting agencies that compile and maintain files on consumers on a nationwide basis, as defined in the Fair Credit Reporting Act, 15 U.S. Code Section 1681a (p), of the timing, distribution, and content of the notices required pursuant to Contract subsections 4.2.5.2 ("Contractor's Responsibility to Notify Department") and 4.2.5.3.1 ("Contractor's Responsibility to Notify Members") of this Contract.

4.2.5.4 Duty to Provide Secure Data

The Contractor will maintain the security of State of Florida Data including, but not limited to, a secure area around any display of such State of Florida Data or State of Florida Data that is otherwise visible. The Contractor will also comply with all state and federal rules and regulations, as well as industry standards, related to security of information and cybersecurity . This includes, but is not limited to, Chapter 282, F.S., Rule Chapter 60GG-2, F.A.C., and all requirements set forth in the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act of 2009, and their implementing regulations, as amended. The Contractor agrees to cooperate with the Department and perform all actions necessary to assist with all tasks in furtherance of the Department's efforts to comply with the obligations under Chapters 60FF and 60GG of the Florida Administrative Code, as applicable. State of Florida Data cannot be disclosed to any person or entity that is not directly approved to participate in this Contract.

4.2.5.5 Loss of Data

In the event of loss of any State of Florida Data or record where such loss is due to the negligence of Contractor or any of its Subcontractors or agents, Contractor shall be fully responsible for recreating such lost State of Florida Data in the manner and on the schedule set by the Department, in addition to any other damages the Department may be entitled to by law or this Contract. Contractor shall bear the full cost for recreating any lost State of Florida Data and will not be entitled to any compensation by the Department for those costs. This subsection shall survive termination of this Contract.

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4.2.6 E-Verify

The Contractor (and its subcontractors) have an obligation to utilize the U.S. Department of Homeland Security's (DHS) E-Verify system for all newly hired employees. By executing this Contract, the Contractor certifies that it is registered with, and uses, the E-Verify system for all newly hired employees. The Contractor must obtain an affidavit from its subcontractors in accordance with paragraph (2)(b) of section 448.095, Florida Statutes, and maintain a copy of such affidavit for the duration of the Contract. In order to implement this provision, the Contractor shall provide a copy of its DHS Memorandum of Understanding (MOU) to the Contract Manager within five (5) days of Contract execution.

This section serves as notice to the Contractor regarding the requirements of section 448.095, Florida Statutes, specifically sub-paragraph (2)(c)1, and the Department's obligation to terminate the Contract if it has a good faith belief that the Contractor has knowingly violated section 448.09(1), Florida Statutes. If terminated for such reason, the Contractor will not be eligible for award of a public contract for at least one year after the date of such termination. The Department reserves the right to order the immediate termination of any contract between the Contractor and a subcontractor performing work on its behalf should the Department develop a good faith belief that the subcontractor has knowingly violated section 448.09(1), Florida Statutes.

4.2.7 Scrutinized Companies – Termination by the Department

The Department may, at its option, terminate the Contract if the Contractor is found to have submitted a false certification as provided under subsection 287.135(5), F.S., or been placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, or been engaged in business operations in Cuba or Syria, or to have been placed on the Scrutinized Companies that Boycott Israel List or is engaged in a boycott of Israel.

4.2.8 Employment of State Workers

During the term of the Contract, Contractor shall not knowingly employ, subcontract with or sub-grant to any person (including any non-governmental entity in which such person has any employment or other material interest as defined by section 112.312(15), Florida Statutes) who is employed by the State or who has participated in the performance or procurement of this Contract, except as provided in section 112.3185, Florida Statutes.

4.3 Acceptance of Deliverables

The Department will conduct its acceptance review in a manner so as to identify whether the Deliverables fail to conform to the Contract. The Department shall notify the Contractor in writing of failures of a Deliverable to conform to the Contract and specify how the Deliverable failed to meet the requirements of the Contract. Within five (5) Business Days of such notice, Contractor will give written notice of one of the following:

- The correction of the nonconformity and the details of the correction;
- A written corrective action plan for correcting the nonconformity; or

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- Its disagreement as to the nature or scope of the nonconformity and the reasons therefore.

The Department will either accept or reject the Contractor's reply (with or without modifications from the Department) and provide notice of the Department's decision and proposed remedy, if any.

4.4 Warranty

Generally. Contractor warrants that the Services shall be delivered in a professional workman-like manner in accordance with the standards and quality prevailing among first-rate nationally recognized firms in the industry and in accordance with this Contract and this warranty will remain in effect for a period of three hundred, sixty-five (365) Calendar Days following delivery of the Services ("Warranty Period").

Remedies. In the event that the Department discovers that the Services are not delivered in accordance with the foregoing warranties during the Warranty Period, the Department will provide Notice to the Contractor, and the Contractor will promptly correct, cure, replace or otherwise remedy such performance at no cost to the Department.

This subsection 4.4 (Warranty) shall survive termination of this Contract.

SECTION 5 AUDIT RIGHTS

The Department has the right to conduct performance and/or compliance audits of any and all areas of the Contractor and/or Subcontractors activities related to this Contract. The Department may at any time enter and inspect the Contractor's physical facilities where operations required under this Contract are performed, within reasonable notice. Except in emergency situations, reasonable notice will be provided for audits conducted at Contractor's premises, which notice will not be less than 10 (ten) Business Days. Audits may include, but not be limited to, audits of procedures, computer systems, claims files, provider contracts, service records, accounting records, internal audits, quality control assessments, and any and all applicable provider contracts, including contracts with pharmaceutical manufacturers, and service programs related to this Contract. Contractor will cooperate and work with any representatives selected by the Department to conduct said audits and inspections, including but not limited to, other state agencies. The Contractor will make available all data and information requested by the Department in furtherance of any audit. Prior to the commencement of this audit, the Contractor may request to enter into a mutually agreeable confidentiality agreement with any third-party auditor. However, no such agreement shall limit the Department's access to this audit report or any other document, and must be consistent with section 10.4 of this Contract, Article 1, section 24 of the Florida Constitution, and Chapter 119, Florida Statutes.

The Contractor recognizes and acknowledges that release statements from its healthcare providers are not required for the Department or its designee to conduct compliance and performance audits on any of the Contractor's contracts relating to this Contract. The Contractor shall comply with section 626.8825(2)(c), F.S., and understands that the Department's audits may include audits related to ensuring that the Contractor is only using or distributing funds received in relation to the Contract pursuant to the Contract or as otherwise required by applicable law.

The right of the Department to perform audits and inspections will survive the expiration or termination of this Contract. The Department will use reasonable efforts to minimize the number and duration of such audits or inspections conducted and to conduct such audits and inspections in a manner that minimizes disruption to Contractor's business operations.

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This provision does not operate to limit the rights of the Inspector General (as required by section 20.055, Florida Statutes) or other state agencies or officers, such as the state's Chief Financial Officer and the Office of the Auditor General, to perform audits and inspections. Contractor shall be responsible for any taxes or any other liabilities imposed as a result of such audits and inspections. The Department will be responsible for the independent third-party auditor costs associated with any audit performed on the Department's behalf.

Any disputes regarding the audit findings of the Department or its designated auditor shall be resolved in accordance with section 10.7 (Dispute Resolution, Governing Law and Venue) of this Contract.

SECTION 6 DIVERSITY

It is the policy of the State that Minority Business Enterprises, Woman-Owned Business Enterprises, and Service-Disabled Veteran Business Enterprises (as those terms are defined by Florida Statutes), have the maximum practicable opportunity to participate in performing contracts let by any State agency. Contractor will carry out this policy in the awarding of subcontracts to the fullest extent consistent with efficient Contract performance by reasonably considering such business enterprises as Subcontractors for the Services. Contractor further agrees to comply with all controlling laws and regulations respecting the participation of such business enterprises in the provision of the Services and to reasonably cooperate in any studies or surveys as may be conducted by the State to determine the extent of Contractor's compliance with this section.

SECTION 7 LIQUIDATED DAMAGES

7.1 Generally

Time is of the essence in performing the Contract; this is true generally and particularly with respect to providing Services on the Effective Date and meeting the Performance Guarantees. Contractor acknowledges that untimely performance or other material noncompliance will damage the Department, but by their nature such damages are impossible to ascertain presently and will be difficult to ascertain in the future. The issues involved in determining the amount of damages will be multiple and complex, and will be dependent on many and variant factors, proof of which would be burdensome and require lengthy and expensive litigation, which the Parties desire to avoid. Accordingly, the Parties agree that it is in the Parties' best interests to agree upon a reasonable amount of liquidated damages, which are not intended to be a penalty and are solely intended to compensate for unknown and unascertainable damages. The Parties acknowledge that liquidated damages are contemplated and required by subsection 110.123(3)(d)3, Florida Statutes.

7.2 Implementation Delays

Untimely Implementation of Services. If Contractor fails to meet deadlines set forth in the Department approved Implementation Plan, it shall pay liquidated damages of $10,000 per Calendar Dayfor each unmet deadline, unless any such delay is due to the Department's failure to comply with the defined timeline. Contractor will pay this amount of liquidated damages for every full or partial Calendar Day until a deadline set forth in the Department approved Implementation Plan has been met.

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7.3 Failure to Meet Performance Guarantees

a. Contractor agrees to payment of liquidated damages if it fails to meet the Minimum Service Requirements set forth in Attachment 2: Performance Guarantees.
b. Liquidated damages are intended only to cover the Department's internal staffing and administrative costs and the diminished value of the Services provided under the Contract. In accepting any form of liquidated damages, the Department does not waive its right to pursue other remedies provided for under this Contract for other breaches.
c. Notwithstanding anything in the Contract to the contrary, the total of any and all liquidated damages paid or to be paid by Contractor pursuant to this Contract for any calendar quarter will not exceed one hundred percent (100%) of the payment due under subsection 3.8 of this Contract.
d. Upon mutual agreement of the Parties, Performance Guarantees may be suspended from time to time for special circumstances. Suspension of a Performance Guarantee will not excuse Contractor from accumulating data relevant to that Performance Guarantee and reporting such data to the Department as part of the management reports delivered pursuant to this Contract.
e. Contractor will provide the Department with a Performance Guarantee report showing Service levels as set forth in Attachment 2: Performance Guarantees. The Department may, at its option, provide Contractor with a Performance Guarantee report template, which must be used. For each Performance Guarantee that the Contractor fails to meet, the Contractor will remit the applicable Performance Guarantee payment to the Department within forty-five (45) Calendar Days of the Department's written approval of the Contractor's Performance Guarantee report. The Department is not required to Notice (other than the aforementioned written approval of the Performance Guarantee report), or invoice the Contractor for payment.
f. The Department may require the Contractor to propose and implement a reasonable corrective action plan to address and correct the root cause of any missed Performance Guarantee.
g. The inclusion of the Performance Guarantees in this Contract is intended to address unsatisfactory performance in the context of ongoing operations without resort to the default provisions set forth in Section 9: Events of Default and Remedies. However, if Contractor's performance falls below the minimum level of performance for the same Performance Guarantee for three consecutive (3) quarters, or reporting periods, and such failure is not otherwise excused, then the Department may declare an Event of Default and pursue alternative remedies in lieu of accepting Performance Guarantees.
h. Contractor will be excused for failing to meet any Performance Guarantee to the extent such failure is caused by the Department not performing any of its obligations under the Contract.
i. Contractor will advise the Department in writing as soon as possible of any circumstance or occurrence which could excuse or affect Contractor's ability to achieve any of the Performance Guarantees. In all such cases, Contractor will cause to make all reasonable efforts to achieve the Performance Guarantees.

SECTION 8 INSURANCE

8.1 Insurance Coverage

During the Contract term, Contractor will, at its sole expense, continuously maintain commercial insurance of such a type and with such terms and limits as may be reasonably associated with this Contract and as required by law. Providing and maintaining adequate insurance coverage is a material obligation of Contractor and performance may not commence on this Contract until

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such time as insurance is secured by the Contractor and is approved by the Department. The Department will not unreasonably withhold or delay such approval. The limits of coverage under each policy do not limit Contractor's or Subcontractor's liability and obligations under the Contract. Unless otherwise agreed in writing by the Department, all insurance policies must be through insurers authorized or eligible to write policies in Florida. The Contractor shall notify the Department immediately if the Contractor loses any liability insurance coverage.

a. Commercial General Liability. The Contractor must continuously maintain commercial general liability insurance (inclusive of any amounts provided by an umbrella or excess policy) in the face amount of at least five million dollars ($5,000,000) per annual aggregate.
b. Business Interruption Insurance. Contractor must continuously maintain business interruption insurance coverage in the face amount of at least five million dollars ($5,000,000) per annual aggregate.
c. Workers' Compensation Insurance. The Contractor shall continuously maintain workers' compensation insurance as required under the Florida Workers' Compensation Law or the workers' compensation law of another jurisdiction where applicable. The Contractor must require all Subcontractors to similarly provide workers' compensation insurance for all of the latter's employees. In the event work is being performed by the Contractor under the Contract and any class of employees performing the work is not protected under Workers' Compensation statutes, the Contractor must provide, and cause each Subcontractor to provide, adequate insurance satisfactory to the Department, for the protection of employees not otherwise protected.
d. Professional Indemnity Insurance. The Contractor must continuously maintain professional indemnity insurance that must cover professional liability and error and omissions in the face amount of at least five million dollars ($5,000,000) per annual aggregate. Contractor will indemnify, defend and hold harmless the Department and its employees and agents, from and against any third-party claims, demands, loss, damage or expense caused by Contractor in connection with the performance of the Services related to professional liability and error and omissions. Contractor will also indemnify the Department and Enrollees for any financial loss caused by Contractor's failure to comply with the terms of this Contract in accordance with section 110.123(5)(f), F.S. Each insurance certificate for such policy must include an agreement that the insurer will provide thirty (30) Calendar Days prior written Notice to the Department of cancellation for any coverage.

8.2 Performance Bond

In accordance with section 110.123(3)(d)2, Florida Statutes, within thirty (30) days of executing the Contract, Contractor shall deliver to the Department's Contract Manager, without additional cost to the Department, a payment and performance bond or, if approved by the Department, a negotiable irrevocable letter of credit or other form of security (collectively the bond) for the payment and performance of work under the Contract in an amount equal to or greater than the lesser of 1) Contractor's share of the estimated annual total pharmacy costs, or 2) five percent (5%) of the estimated annual total pharmacy cost. However, at no time will the penal sum of the bond be less than $20,000,000. The annual pharmacy cost estimate will be as established by the most current Estimating Conference Report projections available at the time the bond is established. The bond or letter of credit shall be used to guarantee at least satisfactory performance by Contractor throughout the term of the Contract (including renewal years). The bond shall be maintained throughout the term of the Contract, issued by a reliable surety company which is licensed to do business in the State of Florida, and otherwise approved by the Department, and must include the following conditions.

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1) Obligee: The Department shall be named as the obligee/beneficiary of the bond. Contractor's bond will provide that the insurer or bonding company shall be obliged to provide performance or payment remuneration directly to the Department.
2) Notice of Attempted Change: The Contractor shall provide Department with thirty (30) Calendar Days prior written Notice or immediate Notice upon knowledge of any attempt to cancel or to make any other material change in the status, coverage, or scope of the required bond or of the Contractor's failure to pay bond premiums.
3) Premiums: The Department shall not be responsible for any premiums or assessments on the bond.
4) Purpose of Bond: The bond is to protect the Department and the State against any loss sustained through failure of the Contractor or any of its employees, officers, directors, agents and representatives to accurately perform the Services required by the Contract for the entire term of the Contract.

No compensation shall be due to the Contractor until the performance bond is in place and approved by the Department in writing.

Upon execution of the Contract and by the start of each Plan Year following the Effective Date, the Contractor shall provide the Department with a surety bond continuation certificate or other acceptable verification that the bond is valid and has been renewed for an additional year.

As an alternative to the surety bond described in this subsection, the Contractor may use an irrevocable, letter of credit on an annually renewable basis, which in the reasonable judgment of the Department, provides substantially equivalent protection.

SECTION 9 EVENTS OF DEFAULT AND REMEDIES

9.1 Contractor Events of Default

Any one (1) or more of the following events by Contractor, which is not cured within ten (10) Calendar Days after receipt of notice thereof by the Department, may constitute an "Event of Default" on the part of Contractor:

(a) Contractor fails to pay any sum of money due hereunder;
(b) Contractor fails to provide the Services required under this Contract;
(c) Contractor knowingly employs an unauthorized alien in the performance of any work required under this Contract;
(d) Contractor fails to correct work that the Department has rejected as unacceptable or unsuitable;
(e) Contractor discontinues the performance of the work required under this Contract;
(f) Contractor fails to resume work that has been discontinued within the time prescribed by the Department in its notice;
(g) Contractor abandons the project;
(h) Contractor becomes insolvent or is declared bankrupt;
(i) Contractor files for reorganization under the bankruptcy code;
(j) Contractor commits any other action towards the initiation of bankruptcy or insolvency proceedings, either voluntarily or involuntarily;
(k) Contractor fails to promptly pay any and all taxes or assessments imposed by and legally due the Department, State or federal government;
(l) Contractor makes an assignment for the benefit of creditors without the approval of the Department;
(m) Contractor makes or has made a material misrepresentation or omission in any materials provided to the Department;
(n) Contractor commits any material breach of this Contract;

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(o) Contractor transfers ownership in violation of the Contract;
(p) Contractor fails to furnish and maintain the performance bond;
(q) Contractor fails to procure and maintain the required insurance policies and coverages required by this Contract;
(r) The Department determines that the surety company issuing a bond securing Contractor's performance of its obligations hereunder becomes insolvent or unsatisfactory;
(s) Contractor utilizes a Subcontractor in the performance of the work required by this Contract, which has been placed on the State's Convicted Vendor List, Discriminatory Vendor List, or the Antitrust Violator Vendor List;
(t) Contractor is suspended or is removed as an authorized Contractor by any State or federal agency; or Contractor is convicted of a felony; is placed on the State's Convicted Vendor List, Discriminatory Vendor List, Suspended Vendor List, or the Antitrust Violator Vendor List; or has its license suspended or revoked;
(u) Contractor refuses to allow public access to all documents, papers, letters or other material subject to the provisions of Chapter 119, Florida Statutes, made or received by Contractor in conjunction with this Contract and not otherwise deemed confidential, proprietary or a trade secret;
(v) Contractor refuses to allow any access required to comply with the audit provisions of the Contract;
(w) Violation of subsection 4.2.5.1,Work Locations, No Offshoring of Data of this Contract, or Contractor's permitting State of Florida Data to be transmitted, viewed, or accessed outside of the United States;
(x) Contractor's change of Subcontractors in violation of section 4.2.3, Subcontractors, of the Contract;
(y) The Contractor, upon discovery or notice thereof, fails to notify the Department within seven (7) Calendar Days of problems or issues impacting provision of Services or compliance with the terms of the Contract not already subject to a shorter notification timeframe set forth herein;
(z) For any other cause whatsoever that Contractor fails to perform in accordance with the Contract, including, but not limited to, failure to meet performance standards and/or pay associated guarantees;
(aa) Failure to meet the same Performance Guarantee for at least three (3) consecutive performance periods.

9.2 Department Remedies in the Event of Default

Upon the occurrence of an Event of Default on the part of Contractor, the Department is entitled at its sole discretion, to any one or all of the following remedies:

(a) To terminate this Contract for cause, in whole or in part, if Contractor commits an Event of Default under section 9.1, of this Contract. If the Contract is terminated for cause, the Contractor shall be liable for any re-procurement costs. The Contractor shall continue work on any part of the Contract not terminated. Except for an Event of Default of Subcontractors, Contractor shall not be liable for any excess costs if the failure to perform the Contract arises from events completely beyond the control, and without the fault or negligence, of Contractor. If the failure to perform is caused by the Event of Default of a Subcontractor, and if the cause of the Event of Default is completely beyond the control of both the Contractor and the Subcontractor, and without the fault or negligence of either, the Contractor shall not be liable for any excess costs for failure to perform, unless the subcontracted Services were obtainable from other sources in sufficient time for the Contractor to meet the required delivery schedule. If, after termination, it is determined

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that Contractor was not in default, or that the default was excusable, the rights and convenience of the Parties shall be the same as if the termination had been issued for the convenience of the Department;

(b) To institute legal proceedings against Contractor to collect payment of any damages or sums owed by Contractor hereunder, including liquidated damages and the costs of re-procurement, and such equitable relief as is appropriate; and

(c) Upon notice to Contractor, to perform the Services (or cause the Services to be performed) on behalf of, and at the reasonable expense of, Contractor. If, at any time and by reason of such default, the Department is compelled to pay, or elects to pay, any sum of money or do any act, which will require the payment of any sum of money, or is compelled to incur any expense in the enforcement of its rights hereunder or otherwise, such sum or sums (with a rate of interest if not established herein then as statutorily set by the State's Chief Financial Officer) will be promptly repaid by the Contractor to the Department upon receipt of a bill from the Department.

The rights and remedies of the Department in section 9 are in addition to any other rights and remedies provided by law or under the Contract.

9.3 Department Events of Default

Any one (1) or more of the following events shall, after the required Notice(s) and opportunity to cure, except as otherwise provided below, constitute an Event of Default on the part of the Department:

The Department fails to timely pay all non-disputed amounts. The cure period for failure to pay shall be forty-five (45) Calendar Days from receipt of Notice of failure to pay, unless State law allows a longer period to pay; or

The Department breaches any other material obligations under this Contract. The cure period for a material breach by the Department shall be forty-five (45) Calendar Days from receipt of Notice of material breach.

9.4 Contractor Remedies in the Event of Default

Upon occurrence of an "Event of Default" on the part of the Department, Contractor is entitled to any one (1) or all of the following remedies.

(a) Equitable Relief. Contractor shall be entitled to any and all equitable relief available at law or in equity.

(b) Monetary Damages. Contractor is entitled to recover any compensation due under subsection 3.8, Payments, of this Contract for Services provided in accordance with the Contract but not paid by the Department. Contractor is not entitled to, and will not seek, any other reimbursement or payment, or damages, including but not limited to lost profits, consequential, indirect, or punitive damanges, or other costs, fees, expenses, losses, or damages. Prior to the Department's payment to Contractor as the result of termination, Contractor will have satisfied all undisputed obligations to third parties relating to the Contract.

9.5 Rights Cumulative, No Waiver

The rights and remedies provided and available to the Department and Contractor in this Contract are distinct, separate, and cumulative remedies, and no one of them, whether or not exercised by

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a Party, shall be deemed to be in exclusion of any other. The election of one (1) remedy shall not be construed as a waiver of any other remedy.

SECTION 10 GENERAL PROVISIONS

10.1 Advertising

(a) Contractor shall not publicly disseminate any information concerning the Contract without prior written approval from the Department, including, but not limited to, mentioning the Contract in a press release or other promotional material, identifying the Department or the State as a reference, or otherwise linking Contractor's name and either a description of the Contract or the name of the State or the Department in any material published, either in print or electronically, to anyone except Enrollees, network health care providers, or potential or actual Subcontractors. Within a reasonable time after the Effective Date, the Parties may issue a mutually agreeable joint press release regarding the Contract and the Services to be provided hereunder.

(b) Contractor may use its logos, symbols, trademarks, trade names, or service marks on Plan identification cards and other Department-approved forms, and to publicize Contractor's relationship with the State to Participants and potential or existing network providers. Contractor will not use the State seal, name or logo of the Department or State, or Contractor's relationship to the Plan, for any purpose without the prior written consent of the Department.

(c) Contractor will not publish or release the results of its engagement without prior written approval from the Department. However, Contractor may refer to the Contract as an experience citation with other customers without prior approval.

10.2 Assignment, Acquisition by Third Party

The Contractor shall not sell, assign, or transfer any of its rights, duties or obligations under the Contract without the prior consent of the Department. In the event of any proposed sale, transfer or assignment, the Contractor shall notify the Department in writing no less than thirty (30) Calendar Days prior to such transfer or sale. The Department may agree to enter into a novation of the Contract with the proposed purchaser, assignee, or transferee at its sole discretion. No change in Contractor's organization, if any, will operate to release the Contractor from its liability for the prompt and effective performance of its obligations under this Contract.

10.3 Change of Statute or Regulation or Governmental Restrictions

In the event Contractor knows or should have known that any federal or state policies, operating procedures, laws, rules, or regulations applicable to its performance under the Contract have been or will be changed, created, or otherwise modified so as to materially change or impact, either directly or indirectly, the Services, Plan, this Contract, or the responsibilities of the Parties (herein referred to as "Changes"), Contractor will promptly notify the Department, indicating the specific law, rule, regulation, draft or pending legislation, and/or policies and procedures.

10.4 Compliance with Laws, Including HIPAA

(a) Generally: Contractor shall comply with all laws, rules, codes, ordinances, and licensing requirements that are applicable to the conduct of its business, including those of federal, State, and local agencies having jurisdiction and authority. By way of non-exhaustive example, section 110.123 of the Florida Statutes and Chapter 60P of the Florida Administrative Code govern the Contract. By way of further non-exhaustive example,

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Contractor shall comply with the Immigration and Nationalization Act, the Americans with Disabilities Act, and all prohibitions against discrimination on the basis of race, religion, sex, creed, national origin, handicap, marital status, or veteran's status. Violation of such laws shall be grounds for Contract termination. The Contractor shall notify the Department immediately if the Contractor loses any licenses.

(b) Anti-Kickback Statute: Each Party certifies that it will not violate the following laws with respect to the performance of its obligations under this Contract: the federal anti-kickback statute, set forth in 42 U.S.C. 1320a-7b(b); Florida's Anti-Kickback Law, set forth in section 409.920, Florida Statutes; the federal Stark law, set forth in 42 U.S.C. 1395nn; the Patient Self-Referral Act of 1992, set forth in section 456.053, Florida Statutes; the Patient Brokering Act, set forth in section 817.505, Florida Statutes; and the Florida False Claims Act, set forth in sections 68.081 – 68.092, Florida Statutes.

(c) Compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA): Contractor shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, and its rules and regulations, including but not limited to the provisions governing the privacy and security of records as well as administrative simplification. Contractor shall commit to implementation and compliance by the statutory deadlines set forth in the statute and associated regulations. Contractor shall assist the State in implementing its compliance with this legislation as it relates to employee health benefits including, but not limited to, executing Attachment 8: Privacy, Security, and Confidentiality Business Associate Agreement.

(d) Internal Revenue Service Reporting: Contractor will make all necessary reports to the Internal Revenue Service regarding benefit payments made to health care Contractors as required by law.

(e) Equal Employment Opportunity: Contractor will not discriminate in its employment practices based on race, color, religion, age, sex, marital status, political affiliation, national origin or handicap, except as provided by law.

(f) Pharmacies: In accordance with section 626.8825(2)(e)2., F.S., the Contractor shall offer a provider contract to licensed pharmacies physically located on the physical site of providers that are:

1. Within the Plan's geographic service area and that have been specifically designated as essential providers by the Agency for Health Care Administration pursuant to section 409.975(1)(a), F.S;
2. Designated as cancer centers of excellence under section 381.925, F.S., regardless of the Plan's geographic service area;
3. Organ transplant hospitals, regardless of the Plan's geographic service area;
4. Hospitals licensed as specialty children's hospitals as defined in section 395.002, F.S.; or
5. Regional perinatal intensive care centers as defined in section 383.16(2), F.S., regardless of the Plan's geographic service area.

Such provider contracts must be solely for the administration or dispensing of covered prescription drugs, including biological products, which are administered through

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infusions, intravenously injected, or inhaled during a surgical procedure or are covered parenteral drugs, as part of onsite outpatient care.

Further, in accordance with section 626.8825(2)(f), F.S., the Contractor shall not condition participation in one pharmacy network on participation in any other pharmacy network or penalize a pharmacy for exercising its prerogative not to participate in a specific pharmacy network.

Lastly, in accordance with section 626.8825(2)(g), F.S., the Contractor shall not institute a network that requires a pharmacy to meet accreditation standards inconsistent with or more stringent than applicable federal and state requirements for licensure and operation as a pharmacy in Florida. However, the Contractor may specify additional specialty networks that require enhanced standards related to the safety and competency necessary to meet the United States Food and Drug Administration's ("USFDA's") limited distribution requirements for dispensing any drug that, on a drug-by-drug basis, requires extraordinary special handling, provider coordination, or clinical care or monitoring when such extraordinary requirements cannot be met by a retail pharmacy. For purposes of this paragraph, drugs requiring extraordinary special handling are limited to drugs that are subject to a risk evaluation and mitigation strategy approved by the USFDA and that:

1. Require special certification of a health care provider to prescribe, receive, dispense, or administer; or
2. Require special handling due to the molecular complexity or cytotoxic properties of the biologic or biosimilar product or drug.

For participation in a specialty network, the Contractor may not require a pharmacy to meet requirements for participation beyond those necessary to demonstrate the pharmacy's ability to dispense the drug in accordance with the USFDA's approved manufacturer labeling.

10.5 Contract Administrator

The Department will name a Contract Administrator during the term of this Contract whose responsibility will be to maintain this Contract. As of the Effective Date, the Contract Administrator is:

Andew Fier
Departmental Purchasing
Department of Management Services
4050 Esplanade Way, Suite 260
Tallahassee, FL 32399-0950
Email: dms.purchasing@dms.myflorida.com

The Department will provide Notice to Contractor of any changes to the Contract Administrator; provided, such changes will not be deemed Contract amendments.

10.6 Contract Managers

Each Party will designate a Contract Manager during the term of this Contract who will oversee the Party's performance of its duties and obligations pursuant to the terms of this Contract. As of the Implementation Date, the Department's Contract Manager is:

Marta Leyva

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State Group Insurance
Department of Management Services
4050 Esplanade Way, Suite 215.3X
Tallahassee, FL 32399-0950
Telephone: (850) 921-1643
Email: marta.leyva@dms.fl.gov

Contractor's Account Manager is:

Lauren Carney
Account Executive
OptumRx, Inc.
11020 Optum Circle
Eden Prairie, MN 55344
Telephone: 508-612-1668
Email: Lauren.Carney@optum.com

Each Party will provide prompt written Notice no later than five (5) Business Days to the other Party of any changes to the Party's Contract/Account Manager or his or her contact information. Such changes will not be deemed Contract amendments.

10.7 Dispute Resolution, Governing Law and Venue

Any dispute concerning performance of the Contract shall be decided by the Department's Contract Manager, who will reduce the decision to writing and serve a copy to the Contractor. The decision of the Department's Contract Manager shall be final and conclusive. Exhaustion of this administrative remedy is an absolute condition precedent to the Contractor's ability to pursue legal action related to the Contract or any other form of dispute resolution. The laws of the State of Florida govern the Contract. The Parties submit to the jurisdiction of the courts of the State of Florida exclusively for any legal action related to the Contract. Further, the Contractor hereby waives any and all privileges and rights relating to venue it may have under Chapter 47, Florida Statutes, and any and all such venue privileges and rights it may have under any other statute, rule, or case law, including, but not limited to those based on convenience. The Contractor hereby submits to venue in the county chosen by the Department.

This section shall survive termination of this Contract.

10.8 Entire Contract

This Contract constitutes the full and complete Contract of the Parties hereto and supersedes any prior contracts, arrangements and communications, whether oral or written, with respect to the subject matter hereof. Each Party acknowledges that it is entering into the Contract solely on the basis of the representations contained herein, and for its own purposes and not for the benefit of any third party.

10.9 Further Assurances

The Parties will, subsequent to the Effective Date, and without any additional consideration, execute and deliver any further legal instruments and perform any acts that are or may become necessary to effectuate the purposes of this Contract.

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10.10 Defense of Third-Party Claims

10.10.1 Notice of Claims

Contractor shall promptly, and in no event later than five (5) Business Days, notify the Department of any Plan-related legal actions or proceedings brought or initiated against Contractor, the Department, or the Plan, of which Contractor becomes aware. The Department shall promptly notify Contractor of any Plan-related legal actions or proceedings, brought or initiated against Contractor, the Department, or the Plan, of which the Department becomes aware.

10.10.2 Department as Real Party in Interest

If a Member files suit against Contractor regarding eligibility, enrollment or coverage that is the legal administrative responsibility of the Department without previously requesting an administrative hearing pursuant to Chapter 120, Florida Statutes, Contractor shall file a motion to dismiss or any other appropriate motions and shall notify the Department of its action. Contractor shall, when possible, notify the Department prior to the filing of such motion and shall notify the Department no later than seven (7) Business Days after the filing of any such motion. Prior to filing any such motions, Contractor shall, when possible, advise the party filing the suit, as appropriate, that issues regarding eligibility, enrollment, or coverage that is the legal administrative responsibility of the Department require the exhaustion of administrative remedies and/or in such instances the real party in interest is the Department. In reference to legal proceedings regarding eligibility, enrollment, or coverage that is the legal administrative responsibility of the Department, the Department may support Contractor's motions, as specified in this subsection, to drop Contractor and/or to substitute the Department, if the Department is not already a party to the lawsuit, as the real party in interest when requested by Contractor. If the Department is a codefendant in any such lawsuit, the Department may support any appropriate motion(s) to drop Contractor from the lawsuit.

10.10.3 Contractor as Real Party in Interest

In the event a lawsuit is filed against Contractor, which raises a recognized cause of action or claim for relief based on Contractor's own policies or procedures to the administration of the Plan, Contractor shall, at its expense, defend such lawsuit. Contractor shall support the Department in any motion filed to drop the Department from any lawsuit where the damages sought by the filing litigant allegedly arise out of the policies and procedures of Contractor that do not concern eligibility, enrollment, or coverage that is the legal administrative responsibility of the Department.

10.10.4 Cooperation in the Defense of Administrative and/or Legal Actions

The Parties shall, upon request, cooperate fully with each other concerning any administrative or legal proceeding brought or initiated against them individually or jointly by Plan Enrollees or other persons relating to the administration of the Plan or Contract. In this regard, the Parties shall use their best efforts to keep each other apprised of any significant developments relating to such litigation or proceedings and the status of such legal matters as may be requested by their respective attorneys. In all administrative or legal proceedings, Contractor shall make available all files and documents requested by Department and Contractor attorneys, investigate the facts related to allegations raised in the proceedings, and make available, as required by the Department, and at no additional cost, witnesses for depositions, administrative hearings, and/or trial in any such proceedings.

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10.10.5 Administrative Proceedings

The Department, as an agency of the State, shall be responsible, in accordance with State law, for handling and defending any administrative actions or proceedings brought by Members in accordance with sections 120.569, 120.57 or 120.574, Florida Statutes. Upon request, Contractor shall promptly provide the Department with all records, including but not limited to, materials, available data, schedules, guidelines, audit trail, protocols, or other materials that are necessary for the preparation of the defense in such proceedings.

10.10.6 Support and Communication with Contractor's Legal Affairs Department

Contractor shall, upon request of the Department, assist attorneys representing the Department by providing information and support in administrative and legal proceedings being contested by Members. Contractor shall advise the Department in writing within thirty (30) Calendar Days after the Effective Date of the Contract of the representative who will assist the Department's attorneys.

Subsection 10.10 shall survive termination of this Contract.

10.11 Right of Setoff

The State may, in addition to other remedies available to it at law or equity and upon notice to Contractor, retain such monies from amounts due Contractor as may be necessary to satisfy any claim for damages, penalties, costs and the like asserted by or against the State. The State may set off any liability or other obligation of Contractor or its affiliates to the State against any payments due Contractor under any contract with the State.

Premium must be paid per the policy. The setoff of any liabilities of other Contractor entities may not be applied toward premiums for this agreement.

10.12 Independent Contractor Status

Contractor, together with its agents, Subcontractors, officers and employees, shall have and always retain under the Contract the legal status of an independent Contractor, and in no manner shall they be deemed employees of the State or deemed to be entitled to any benefits associated with such employment. Contractor remains responsible for all applicable federal, State, and local taxes and all FICA contributions.

10.13 Inspection at Contractor Site

The Department reserves the right to inspect, at any reasonable time with prior Notice, the equipment or other facilities of a Contractor or Subcontractor to assess conformity with Contract requirements and to determine whether they are adequate and suitable for proper and effective Contract performance.

10.14 Intellectual Property

Any ideas, concepts, know-how, data processing techniques, software, documentation, diagrams, schematics, or blueprints developed exclusively by Contractor's personnel in connection with this Contract, and specifically for the Department, will be the exclusive property of the Department as part of delivering the required Services. Any joint or future software development effort will be subject to a separate agreement signed by Department and Contractor, wherein all ownership and license rights to such developed product shall be specified in detail. In the absence of such agreement, each Party shall maintain sole ownership of its own protectable proprietary materials, which are developed or owned solely by Department or Contractor, respectively. Unless otherwise agreed in writing,

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intellectual property rights in property existing prior to this Contract will remain with Contractor. The Department shall have the right to use all documents and materials prepared and provided by Contractor for purposes of this Contract without restriction and without payments to Contractor other than that specifically provided by this Contract.

10.15 Notices

All Notices between the Parties regarding this Contract shall be in writing as follows:

To the Department by certified mail, return receipt requested, by reputable courier service or delivered personally to:

Marta Leyva
State Group Insurance
Department of Management Services
4050 Esplanade Way, Suite 215.3X
Tallahassee, FL 32399-0950
Email: marta.leyva@dms.fl.gov

To the Contractor by certified mail, return receipt requested, by reputable courier service, or delivered personally to:

Lauren Carney
Account Executive
OptumRx, Inc.
11020 Optum Circle
Eden Prairie, MN 55344
Email: Lauren.Carney@optum.com

The Parties agree that any change in the above-referenced address or name of the contact person shall be submitted in a timely manner to the other Party. All Notices and other communications under this Contract shall be in writing and shall be deemed duly given either when delivered in person to the recipient named above, upon confirmation of courier delivery to the intended recipient; or three (3) Business Days after mailed by certified U.S. mail, return receipt requested, postage prepaid, addressed by name and address to the Party intended.

10.16 Cooperation with the Inspector General

Pursuant to section 20.055(5), Florida Statutes, the Contractor and any subcontractors understand and will comply with their duty to cooperate with the Inspector General in any investigation, audit, inspection, review, or hearing.

10.17 Public Record

Any and all records produced or used regarding this Contract are subject to Florida's public records law, as set forth in Chapter 119 of the Florida Statutes. Service Provider must comply with all applicable provisions of Florida's public records law. Violation of this section shall constitute grounds for termination of the Contract.

10.17.1 Access to Public Records

The Department may unilaterally cancel this Contract for refusal by the Contractor to comply with this section by not allowing public access to all documents, papers, letters or other material made or received by the Contractor in conjunction with the Contract, unless

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the records are exempt from section 24(a) of Article I of the State Constitution and section 119.07(1), Florida Statutes.

10.17.2 Redacted Copies of Confidential Information

If the Contractor considers any portion of any documents, data, or records submitted to the Department to be confidential, proprietary, trade secret, or otherwise not subject to disclosure pursuant to Chapter 119, Florida Statutes, the Florida Constitution or other authority, the Contractor must simultaneously provide the Department with a separate redacted copy of the information it claims as Confidential and briefly describe in writing the grounds for claiming exemption from the public records law, including the specific statutory citation for such exemption. This redacted copy shall contain the Contract name and number, and shall be clearly titled "Confidential." The redacted copy should only redact those portions of material that the Contractor claims is confidential, proprietary, trade secret, or otherwise not subject to disclosure.

10.17.3 Request for Redacted Information

In the event of a public records or other disclosure request pursuant to Chapter 119, Florida Statutes, the Florida Constitution, or other authority, to which documents that are marked as "Confidential" are responsive, the Department will provide the Contractor-redacted copies to the requestor. If a requestor asserts a right to materials, which Contractor has identified as confidential, pursuant to section 10.17.2 of this Contract, the Department will notify the Contractor such an assertion has been made. It is the Contractor's responsibility to assert that the information in question is exempt from disclosure under Chapter 119 or other applicable law. If the Department becomes subject to a demand for discovery or disclosure of the Confidential Information of the Contractor under legal process, the Contractor shall be responsible for defending its determination that the redacted portions of its records are confidential, proprietary, trade secret, or otherwise not subject to disclosure.

10.17.4 Indemnification

The Contractor shall protect, defend, and indemnify the Department for any and all claims arising from or relating to the Contractor's determination that the redacted portions of its records are confidential, proprietary, trade secret, or otherwise not subject to disclosure. If the Contractor fails to submit a redacted copy of information it claims is Confidential, the Department is authorized to produce the entire documents, data, or records submitted to the Department in answer to a public records request or other lawful request for these records.

10.17.5 Contractor as Agent

Solely for the purposes of this section, the Contract Manager is the agency's custodian of public records. If, under this Contract, the Contractor is providing services and is acting on behalf of a public agency, as provided by section 119.0701, Florida Statutes, the Contractor shall:

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a) Keep and maintain public records required by the public agency to perform the service.
b) Upon request from the public agency's custodian of public records, provide the public agency with a copy of the requested records or allow the records to be inspected or copied within reasonable time and at a cost that does not exceed the cost provided in Chapter 119, Florida Statutes, or as otherwise provided by law.
c) Ensure that public records that are exempt or confidential and exempt from public records disclosure are not disclosed except as authorized by law for the duration of the Contract term and following the completion of the Contract if the Contractor does not transfer the records to the public agency.
d) Upon completion of the Contract, transfer, at no cost, to the public agency all public records in possession of the Contractor or keep and maintain public records required by the public agency to perform the service. If the Contractor transfers all public records to the public agency upon completion of the Contract, the Contractor shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If the Contractor keeps and maintains public records upon completion of the Contract, the Contractor shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the public agency, upon request from the public agency's custodian of public records, in a format that is compatible with the information technology systems of the public agency.
e) IF THE CONTRACTOR HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO THE CONTRACTOR'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS CONTRACT, CONTACT THE CUSTODIAN OF PUBLIC RECORDS AT THE TELEPHONE NUMBER, EMAIL ADDRESS AND MAILING ADDRESS PROVIDED FOR THE CONTRACT MANAGER.

10.18 Rights to Records
Contractor agrees that all documents and materials prepared by Contractor for purposes of this Contract, and specifically for the Department, shall be the sole property of the Department and shall be available to the Department at any time. The Department shall have the right to use the same without restriction and without payments to Contractor other than that specifically provided by this Contract.

In accordance with section 216.1366, F.S., the Department is authorized to inspect the: (a) financial records, papers, and documents of the Contractor that are directly related to the performance of the Contract or the expenditure of state funds; and (b) programmatic records, papers, and documents of the Contractor which the Department determines are necessary to monitor the performance of the Contract or to ensure that the terms of the Contract are being met. The Contractor shall provide such records, papers, and documents requested by the Department within 10 Business Days after the request is made.

10.19 Organizational Conflicts of Interest
By executing this Contract, Contractor represents that either it has disclosed all Organizational Conflicts of Interest to the Department in writing, or no Organizational Conflicts of Interest exist. The term "Organizational Conflicts of Interest" means the existence any past, present or currently planned interests of Contractor that either directly or indirectly (through a client, contractual, financial, organizational or other relationship) relates to the Services and which may diminish

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Contactor's capacity to give impartial, technically sound, objective assistance and advice, or may give Contractor unfair negotiating advantage with respect to the Department.

10.20 Best Pricing Clause

Contractor acknowledges and recognizes that the State wants to take advantage of any improvements in premium pricing over the course of the Contract period. To that end, the pricing indicated in this Contract is the guaranteed maximum price.

The Contractor's premium pricing under this Contract will not exceed the Contractor's pricing for substantially the same Plan(s) provided to any other substantially similar clients. During the term of the Contract, if Contractor provides substantially the same Plan(s) to any other substantially similar clients, whether a public or private entity, with pricing terms more favorable than the premium pricing in this Contract, then Contractor agrees to offer equivalent pricing terms to the Department and the Department and Contractor may execute an amendment of this Contract to adopt the equivalent pricing terms if determined acceptable to the Department. In addition, Services and programs not currently part of the benefits offered to Participants, but offered to substantially similar clients, shall be proposed for the Department's consideration to offer to Participants for the same or lower price. This does not include or apply to other Plan Design offerings.

10.21 Convicted Vendor, Discriminatory Vendor, Antitrust Violator Vendor, and Suspended Vendor Lists

Pursuant to sections 287.133, 287.134, and 287.137, Florida Statutes, the following restrictions are placed on the ability of persons placed on the State's Convicted Vendor List, the Discriminatory Vendor List, or the Antitrust Violator Vendor List:

1) A person or affiliate who has been placed on the State's Convicted Vendor List following a conviction for a public entity crime may not submit a bid, proposal, or reply on a contract to provide any goods or services to a public entity; may not submit a bid, proposal, or reply on a contract with a public entity for the construction or repair of a public building or public work; may not submit bids, proposals, or replies on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and may not transact business with any public entity in excess of the threshold amount provided in section 287.017, Florida Statute, for CATEGORY TWO for a period of thirty-six (36) months following the date of being placed on the State's Convicted Vendor List.
2) An entity or affiliate who has been placed on the State's Discriminatory Vendor List may not submit a bid, proposal, or reply on a contract to provide any goods or services to a public entity; may not submit a bid, proposal, or reply on a contract with a public entity for the construction or repair of a public building or public work; may not submit bids, proposals, or replies on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and may not transact business with any public entity.
3) A person or an affiliate who has been placed on the Antitrust Violator Vendor List following a conviction or being held civilly liable for an antitrust violation may not submit a bid, proposal, or reply for any new contract to provide any goods or services to a public entity; may not submit a bid, proposal, or reply for a new contract with a public entity for the construction or repair of a public building or public work; may not submit a bid, proposal, or reply on new leases of real property to a public entity; may not be awarded

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or perform work as a contractor, supplier, subcontractor, or consultant under a new contract with a public entity; and may not transact new business with a public entity.

In accordance with section 287.1351, F.S., a vendor placed on the Suspended Vendor List may not enter into or renew a contract to provide any goods or services to an agency after its placement on the Suspended Vendor List.

10.22 Section 508 Compliance

The Contractor will comply with section 508 of the Rehabilitation Act of 1973, as amended, and 29 U.S.C. s. 794(d), including the regulations set forth under 36 C.F.R. part 1194. Section 282.601(1), Florida Statutes, states that "state government shall, when developing, competitively procuring, maintaining, or using electronic information or information technology acquired on or after July 1, 2006, ensure that State employees with disabilities have access to and are provided with information and data comparable to the access and use by State employees who are not individuals with disabilities, unless an undue burden would be imposed on the agency."

10.23 Conduct of Business

The Contractor must comply with all laws, rules, codes, ordinances, and licensing requirements that are applicable to the conduct of its business, including those of federal, state, and local agencies having jurisdiction and authority.

Nothing contained within this Contract shall be construed to prohibit the Contractor from disclosing information relevant to performance of the Contract or purchase order to members or staff of the Florida Senate or Florida House of Representatives.

Pursuant to section 287.057(26), F.S., the Contractor shall answer all questions of, and ensure a representative will be available to, a continuing oversight team.

The Contractor will comply with all applicable disclosure requirements set forth in section 286.101, F.S. In the event the Department of Financial Services issues the Contractor a final order determining a third or subsequent violation pursuant to section 286.101(7)(c), F.S., the Contractor shall immediately notify the Department and applicable Customers and shall be disqualified from Contract eligibility.

SIGNATURE PAGE IMMEDIATELY FOLLOWS

SO AGREED by the Parties' authorized representatives on the dates noted below:

DEPARTMENT OF MANAGEMENT SERVICES

Signature: DocuSigned by: Pedro Allende 4947...

Pedro Allende, Secretary

Date: 9/28/2023 | 12:43 PM EDT

OPTUMRX, INC.

Signature: DocuSigned by: Kathryn Carey 1BB0...

Print Name and Title: Kathryn Carey CFO

Date: 9/27/2023 | 11:06 AM EDT

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PRIVACY, SECURITY, AND CONFIDENTIALITY BUSINESS ASSOCIATE AGREEMENT
THIRD PARTY ADMINISTRATIVE SERVICES
FOR
PHARMACY BENEFIT MANAGEMENT SERVICES
CONTRACT NO. DMS-22/23-047

This Privacy, Security, and Confidentiality Business Associate Agreement ("Agreement") is between the State of Florida, DEPARTMENT OF MANAGEMENT SERVICES ("Agency"), and OPTUMRX, INC. ("Business Associate"), with an effective date of the last date of execution below.

WHEREAS, Business Associate has agreed to perform services for or on behalf of the Division of State Group Insurance ("Covered Entity"), a division of the Agency;

WHEREAS, such services may involve the use or disclosure of Protected Health Information that is protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"), and the regulations promulgated thereunder; and section 110.123(9), Florida Statutes; and

WHEREAS, this Agreement is intended to satisfy the requirements for Business Associate contracts under 45 C.F.R. § 164, subparts C and E, and the HITECH Act, and to address the confidentiality requirements of section 110.123(9), Florida Statutes.

NOW THEREFORE, in consideration of the mutual covenants provided herein and other good and valuable consideration, Covered Entity hereby agrees to provide certain information to Business Associate, and Business Associate hereby agrees to comply with this Agreement; the applicable provisions of 45 C.F.R. §§ 160 and 164; the HITECH Act; and sections 110.123(9) and 501.171, Florida Statutes; and to assist Covered Entity with its compliance therewith, as follows:

1. DEFINITIONS

Terms used but not otherwise defined in this Agreement shall have the same meaning as defined in 45 C.F.R. §§ 160 and 164 and/or the HITECH Act.

(a) "Agency" means the Department of Management Services, an executive agency of the State of Florida, which includes the Division of State Group Insurance, with its principal place of business at 4050 Esplanade Way, Tallahassee, FL 32399-0950.

(b) "Agreement" means this Privacy, Security, and Confidentiality Business Associate Agreement.

(c) "Breach" when referring to a breach of PHI means the acquisition, access, use, or disclosure of PHI that is not permitted by 45 C.F.R. § 164, subpart E, which compromises the security or privacy of PHI.

(d) "Business Associate" refers to OptumRx, Inc. which hereby agrees to provide services to the Covered Entity as a business associate, as that term is defined in 45 CFR §160.103.

(e) "Business Day" refers to the ordinary business hours of 8:00 a.m. until 5:00 p.m. E.T., Monday through Friday, inclusive, excluding holidays observed pursuant to section 110.117, Florida Statutes.

(f) "Covered Entity" shall generally have the same meaning as the term "covered entity" in 45 CFR § 160.103, and in reference to the party to this agreement, shall

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mean the Division of State Group Insurance, a division of the Agency.

(g) "Contract" means the contract awarded to the Business Associate pursuant to DMS-22/23-047.

(h) "Health Insurance Portability and Accountability Act of 1996" ("HIPAA") means 45 C.F.R. §§ 160 and 164.

(i) "Health Information Technology for Economic and Clinical Health Act of 2009" (the "HITECH Act") means 42 U.S.C. §300jj et seq.; §§17901 et seq.; and any regulations promulgated thereunder.

(j) "Individual" has the same meaning as the term "individual" in 45 C.F.R. §160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

(k) "Parties" mean collectively the Agency and Business Associate. A "Party" means either the Agency or Business Associate.

(l) "Protected Health Information" ("PHI") means individually identifiable health information as defined in 45 C.F.R. § 160.103, whether secured or unsecured, and in any format.

(m) "Plans" means the insurance coverages offered through Covered Entity, as authorized in section 110.123, Florida Statutes.

(n) "Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information set forth in 45 C.F.R. § 160 and 45 C.F.R. § 164, subparts A and E, as amended.

(o) "Secretary" means the Secretary of the U.S. Department of Health and Human Services or designee.

(p) "Security Incident" has the same meaning as the term "security incident" in 45 C.F.R. § 164.304, which currently reads, "the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system."

(q) "Security Rule" means the security provisions set forth in 45 C.F.R. § 160 and § 164, subparts A and C, as amended.

(r) "Standard Transaction" has the same meaning as the term "standard transaction" in 45 C.F.R. § 162.103.

2. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

Business Associate agrees to:

(a) Comply with all applicable provisions of 45 C.F.R. §§ 160 and 164, subparts A, C, and E; the HITECH Act; sections 110.123(9) and 501.171, Florida Statutes; and the terms of this Agreement.

(b) Not use or disclose PHI other than as permitted or required by this Agreement or as required under federal or Florida law.

(c) Ensure the confidentiality, integrity, and availability of all PHI Business Associate

creates, receives, maintains, or transmits.

(d) Ensure that every agent and subcontractor that creates, receives, maintains, or transmits PHI on behalf of Business Associate agrees to and complies with the restrictions, conditions, and requirements contained in this Agreement, HIPAA, and the HITECH Act.

(e) Make any amendment(s) to PHI in a designated record set that Covered Entity or an Individual directs or agrees to pursuant to 45 C.F.R. § 164.526 in a prompt and reasonable manner and to take other measures as necessary to satisfy Covered Entity's obligation(s) under 45 C.F.R. § 164.526.

(f) Create and retain all records necessary to determine compliance with HIPAA, the HITECH Act, and any other applicable federal or Florida law.

(g) Make its internal practices, books, and records available to the Secretary in a time and manner designated by Covered Entity or the Secretary, for purposes of determining compliance with HIPAA and the HITECH Act.

(h) Cooperate with any investigations by the Secretary to determine compliance with HIPAA and the HITECH Act.

(i) Document disclosures of PHI and provide to an Individual, at the request of Covered Entity or an Individual, an accounting of such disclosures in accordance with 45 C.F.R. § 164.528. Business Associate shall assist Covered Entity in complying with HIPAA regulations relating to the required disclosure, amendment, and accounting of disclosures of PHI pursuant to 45 C.F.R. § 164.

(j) Certify that it is in compliance with all applicable provisions of HIPAA standards for electronic transactions and code sets, also known as the "Electronic Data Interchange ("EDI") Standards," in accordance with 45 C.F.R. § 162; and the annual guidance as issued by the Secretary pursuant to section 42 U.S.C. § 17931. Business Associate further agrees to ensure that every agent and subcontractor that conducts Standard Transactions on its behalf agrees to comply with the EDI Standards and the annual guidance.

(k) Use the Minimum Necessary type and amount of PHI required to perform services in accordance with 45 C.F.R. § 164, subpart E.

(l) Comply with all requirements of 45 C.F.R. § 164, subpart E, that apply to Covered Entity to the extent Business Associate carries out any obligations(s) of the Covered Entity under 45 C.F.R. § 164 subpart E.

3. PERMITTED AND REQUIRED USES AND DISCLOSURES OF PHI BY BUSINESS ASSOCIATE

(a) Use to Provide Contract Services. Business Associate may use or disclose PHI as necessary and required for the purpose of performing its obligations for Covered Entity pursuant to the Contract.

(b) Disclosure to Third Parties. Except as expressly permitted in this Agreement or the Contract or as required by law, Business Associate shall not divulge, disclose, or communicate PHI to any third party without prior written approval from Covered Entity.

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(c) Data Aggregation Services. Except as otherwise limited in this Agreement, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

(d) Compliance with Subpart E. Business Associate must comply with 45 C.F.R. § 164, subpart E, and may not use or disclose PHI in violation of 45 C.F.R. § 164, subpart E.

(e) Reporting Violations of Law. Business Associate may use and disclose PHI to report violations of law to appropriate federal and state authorities, consistent with 45 C.F.R. § 164.502(j)(1).

(f) Use for Management and Administration. Business Associate may use and disclose PHI for Business Associate's proper management and administration, provided that: (1) Business Associate obtains reasonable assurances from the person to whom PHI is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person; and (2) the person notifies Business Associate of any instances of the Breach of PHI for which it is aware. Business Associate also may make disclosures that are required by law. Business Associate's use of PHI as described in this paragraph is subject to and limited as described in 45 C.F.R. § 164.504(e)(2) and (4).

(g) Limited Data Sets. Business Associate may create a Limited Data Set pursuant to 45 C.F.R. § 164.514 only as necessary and required for the purpose of performing its obligations and services for Covered Entity, provided that Business Associate complies with the provisions of this Agreement.

(h) Disclosure to the Secretary. Business Associate shall disclose PHI when required by the Secretary to investigate or determine Covered Entity's or Business Associate's compliance with 45 C.F.R. § 164, subpart E.

(i) Designated Record Sets. Business Associate shall provide access to PHI in a designated record set as required under 45 C.F.R. § 164.524.

(j) Disclosure to Covered Entity and Individual. Business Associate shall, upon request by Covered Entity or Individual, disclose PHI to Covered Entity, Individual, or Individual's designee, as necessary to satisfy Covered Entity's obligations under 45 C.F.R. §§ 164.502(a)(4)(ii), 164.524(c)(2)(ii), and 164.524(c)(3)(ii) with respect to an Individual's request.

4. OBLIGATIONS OF COVERED ENTITY

Covered Entity agrees to:

(a) Notify Business Associate, upon request, of any limitation(s) in Covered Entity's Notice of Privacy Practices in accordance with 45 C.F.R. § 164.520, to the extent that such limitation(s) may affect Business Associate's use or disclosure of PHI.

(b) Notify Business Associate of any changes in, or revocation of, authorization by an Individual or his or her personal representative regarding the use or disclosure of PHI, if such changes affect Business Associate's use or disclosure thereof.

(c) Notify Business Associate of any restriction on the use or disclosure of PHI that

Covered Entity has agreed to or is required to abide by under 45 C.F.R. § 164.522, if such restriction may affect Business Associate's use or disclosure thereof.

(d) Not provide Business Associate with more PHI than that which is minimally necessary for Business Associate to provide the services and, where possible, Covered Entity shall provide any PHI needed by Business Associate to perform the services in the form of a Limited Data Set, in accordance with 45 C.F.R. § 164.504(e)(3)(iv).

(e) Not request that Business Associate use or disclose PHI in any manner that would violate HIPAA, the HITECH Act, or applicable federal or Florida law.

(f) Obtain all authorizations necessary for any use or disclosure of any PHI as contemplated under the Contract.

5. PHI SECURITY REQUIREMENTS

(a) Protection of PHI. Business Associate shall protect against any reasonably anticipated threats or hazards to the confidentiality, security, or integrity of PHI and protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under 45 C.F.R. § 164, subpart E. Business Associate shall implement policies and procedures to prevent, detect, contain, and correct security violations.

(b) Security of PHI. Business Associate shall develop, implement, maintain, and use administrative, technical, and physical safeguards to prevent security violations and the unpermitted acquisition, access, use, or disclosure of PHI in accordance with 45 C.F.R. § 164, subpart C.

(c) Business Associate's Due Diligence. Business Associate shall make a good-faith effort to identify any unpermitted acquisition, access, use, or disclosure of any type of PHI or unauthorized acquisition, access, use, or disclosure of information or interference with system operations in an information system.

(d) Compliance. Business Associate shall ensure that its agents and subcontractors comply with 45 C.F.R. § 164, subparts A, C, and E, and all applicable standards relating to all PHI.

(e) Compliance Date. Business Associate certifies compliance with this section of the Agreement on or before the date on which its representative signs this Agreement as set forth in the signature blocks at the end of this document.

6. NOTIFICATION AND REPORTING REQUIREMENTS

(a) Reporting of Security Incidents. Within two (2) Business Days of discovery, Business Associate shall report to the Covered Entity any Security Incident that involves the (1) unpermitted acquisition, access, use, or disclosure of PHI; (2) modification or destruction of PHI; (3) interference with system operations in an information system containing PHI. For any other type of Security Incident, Business Associate shall report such incident to Covered Entity upon request. Such reports shall include a description of the incident, identification of any Individuals affected, and the types of PHI involved (if any). The day the Security Incident is discovered or would have been discovered with the exercise of reasonable diligence will be considered the first Business Day of the reporting

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period.

(b) Notification to Covered Entity Regarding a Breach of PHI. Within two (2) Business Days of discovery, Business Associate shall notify Covered Entity of any Breach of unsecured PHI in accordance with 45 C.F.R. § 164.410. The notice pursuant to this subparagraph shall comply with the notification requirements of 45 C.F.R. § 164.410(c), including the identification of each affected Individual, the types of PHI involved in the Breach, and a description of the incident. The day the Breach is discovered or would have been discovered with the exercise of reasonable diligence will be considered the first Business Day of the reporting period.

(c) Notification to Individuals. In the case of a Breach of unsecured PHI, Business Associate shall first notify Covered Entity of the details of the Breach within two (2) Business Days of discovery of the Breach. Upon approval by Covered Entity, Business Associate shall notify each Individual whose unsecured PHI was Breached in accordance with 45 C.F.R. § 164.404. Notification shall be in writing and delivered by first-class mail to the Individual, the Individual's personal representative, or the Individual's next of kin (if the individual is deceased) at the last known address of the Individual, next of kin, or personal representative, as applicable. The notification may be delivered by e-mail if requested by the recipient. When there is insufficient or out-of-date contact information (including a phone number, email address, or any other form of appropriate communication) that precludes written or electronic notification, a substitute form of notice shall be provided. When there are ten (10) or more Individuals for whom there is insufficient or outdated contact information, Business Associate shall place a conspicuous posting on its website or run the notice in major print or broadcast media, including major media in the geographic areas where the Individuals likely reside. In any case deemed by Business Associate to require urgency due to possible imminent misuse of unsecured PHI, Business Associate may also provide information to Individuals by telephone or other means, as appropriate.

(d) Notification to Media. When Business Associate reasonably believes there has been a Breach of unsecured PHI involving more than 500 persons, after prior approval by Covered Entity, Business Associate shall provide notice to prominent media outlets serving the state or the relevant portion of the state involved, in accordance with 45 C.F.R. § 164.406.

(e) Notification to the Secretary. Business Associate shall cooperate with Covered Entity to provide notice to the Secretary of the Breach of unsecured PHI in accordance with 45 C.F.R. § 164.408. When Business Associate reasonably believes that there has been a Breach of Unsecured PHI involving 500 or more individuals, such notice must be provided immediately. If the Breach was with respect to fewer than 500 individuals, Business Associate may maintain a log of the Breach and annually submit such log to Covered Entity so that it may satisfy its obligation to notify the Secretary of Breaches.

(f) Content of Notices. All notices must comply with the minimum notice provisions set forth in 45 C.F.R. §§ 164.404, 164.406, 164.408, and 164.410, and section 13402(f) of the HITECH Act, as applicable, except that any references therein to a "covered entity" shall be read as references to Business Associate.

(g) Financial Responsibility. Business Associate shall be responsible for reasonable costs related to the notices required under this Agreement.

(h) Mitigation. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate regarding the access, acquisition, use, modification, destruction, or disclosure of any type of PHI not permitted by this Agreement.

(i) Florida Law. The requirements related to notification and reporting of breaches pursuant to section 501.171, Florida Statutes, are addressed in the Contract.

7. SECURITY AND CONFIDENTIALITY UNDER FLORIDA LAW

(a) Section 110.123(9), Florida Statutes, Requirements. Business Associate agrees to observe the confidentiality requirements of section 110.123(9), Florida Statutes. In general, the referenced statute provides that patient medical records and medical claim records of state employees, former state employees, and their covered dependents are confidential and exempt from the provisions of section 119.07(1), Florida Statutes. Any person who willfully, knowingly, and without authorization discloses or takes data, programs, or supporting documentation, including those residing or existing internal and external to Covered Entity's computer system, commits an offense in violation of section 815.04, Florida Statutes.

(b) Subpoena. These confidentiality requirements protect the disclosure of all Covered Entity's records and information, in whatever form, including the copying or verbally relaying of confidential information. If Business Associate is served with a subpoena requiring the production of Covered Entity's records or information, Business Associate shall immediately contact the Agency's Office of the General Counsel, at (850) 487-1082.

A subpoena is an official summons issued by a court or an administrative tribunal, which requires the recipient to do one or more of the following:

i. Appear at a deposition to give sworn testimony and/or require that certain records be brought to be examined as evidence.

ii. Appear at a hearing or trial to give evidence as a witness and/or require that certain records be brought to be examined as evidence.

iii. Produce certain records for examination.

(c) Agents and Subcontractors. Business Associate acknowledges that the confidentiality requirements herein apply to all its agents and subcontractors.

(d)

(e) Data Access and Storage. Unless otherwise agreed to in writing, Business Associate shall not allow any PHI to be accessed or stored outside of the United States.

8. TERM AND TERMINATION OF AGREEMENT

(a) Term. This Agreement shall commence as of the Effective Date of this Agreement and will naturally terminate when (i) the Contract terminates or expires, or (ii) all of the PHI in Business Associate's possession, custody, or control is destroyed or returned to Covered Entity or, if it is not feasible to return or destroy PHI,

protections are extended to such information, in accordance with the termination provision in this section, whichever is later.

(b) Termination for Cause. Without limiting any other termination rights of the Parties, Covered Entity may terminate this Agreement and the Contract if Covered Entity determines Business Associate has violated a material term of the Agreement. Covered Entity may provide Business Associate an opportunity to cure the breach or end the violation. If the Business Associate does not cure the breach or end the violation within a reasonable time as specified by Covered Entity, Covered Entity shall have the right to immediately terminate the Agreement. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(c) Return or Destruction of PHI Upon Termination. Upon termination or expiration of the Contract, Business Associate, with respect to PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, shall:

i. Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

ii. Return to Covered Entity or, if agreed to by Covered Entity, destroy the remaining PHI that the Business Associate still maintains in any form;

iii. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI;

iv. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set forth in Section 3 of this Agreement which applied prior to termination; and

v. Return to Covered Entity or, if agreed to by Covered Entity, destroy the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

Upon notice of termination of this Agreement, Business Associate shall destroy or return to Covered Entity any and all PHI created or received by Business Associate in the same manner required for all state data under the Contract.

Within fifteen (15) calendar days of any notice of termination of this Agreement, Business Associate shall notify Covered Entity in writing as to whether Business Associate elects to return or destroy such PHI.

Except as provided in subsection (d), within thirty (30) calendar days of the notice of termination of this Agreement, Business Associate shall return to Covered Entity or destroy any and all PHI maintained by Business Associate in any form and shall retain no copies thereof. Business Associate also shall recover and return or destroy, within such time period, any and all PHI in the possession of its subcontractors or agents.

If Business Associate elects to destroy PHI, Business Associate shall obtain written confirmation from Covered Entity that such actions will not violate the State

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of Florida's record retention policies. Upon destruction, Business Associate shall provide written certification to Covered Entity that such PHI has been destroyed. If any subcontractor or agent of Business Associate elects to destroy PHI, Business Associate shall require that such subcontractor or agent to provide written certification to Business Associate and to Covered Entity when such PHI has been destroyed.

(d) Written Explanation. If it is not feasible for Business Associate to return or destroy any PHI, Business Associate shall notify Covered Entity in writing that Business Associate has determined that it is not feasible to return or destroy the PHI and the specific reasons for such determination.

If it is not feasible for Business Associate to obtain any PHI in the possession of the subcontractor or agent, Business Associate shall provide a written explanation to Covered Entity and require the subcontractor or agent to agree to extend any and all protections, limitations, and restrictions set forth in this Agreement to the subcontractor's or agent's use or disclosure of any PHI retained after the termination of this Agreement, and to limit any further use or disclosure to the purposes that make the return or destruction of the PHI not feasible.

9. MISCELLANEOUS

(a) Material Breach. A violation of any provision of this Agreement shall be deemed a material breach of this Agreement and the Contract.

(b) Warranties and Representations. Covered Entity makes no warranty or representation that compliance by Business Associate with this Agreement, HIPAA, or HITECH Act will be adequate or satisfactory for Business Associate's own purposes.

(c) Assignment. Except as provided in the Contract, Business Associate shall not assign either its obligations or benefits under this Agreement without the express written consent of Covered Entity, which shall be at the sole discretion of Covered Entity.

(d) Regulatory References. A reference in this Agreement to a section of HIPAA, the Privacy Rule, the Security Rule, or HITECH Act means the section as in effect or as amended and for which compliance is required.

(e) Amendment. Upon the enactment of any law or regulation affecting the use or disclosure of PHI, Standard Transactions, the security of PHI, HIPAA, or the HITECH Act; the publication of any decision of a court of the United States or any state relating to any such law; or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, either Party may, by written notice to the other Party, amend this Agreement in such manner as such Party determines necessary to comply with such law or regulation. If the other Party disagrees with such Amendment, it shall notify the first Party in writing within thirty (30) calendar days' notice. If the Parties are unable to agree on an amendment within thirty (30) calendar days thereafter, then either of the Parties may terminate the Agreement on thirty (30) calendar days written notice to the other Party.

(f) Survival. The terms and conditions of this Agreement which by their nature would

extend beyond the termination or expiration of this Agreement shall continue until fulfilled. This includes, but is not limited to, Business Associate's rights and obligations under Section 8 of this Agreement.

(g) Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with HIPAA, the HITECH Act, and Florida Statutes.

(h) No Third-Party Beneficiary. Nothing expressed or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assignees of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

(i) Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Florida to the extent not preempted by applicable federal law.

(j) Venue. The exclusive venue of any proceedings shall be the appropriate federal or state court in Leon County, Florida.

(k) Liability and Indemnification. Business Associate's liability and indemnity requirements hereunder are the same as those required by the Contract and, for the avoidance of doubt, this Business Associate Agreement will be treated as a part of the Contract for such purposes.

(l) Independent Entities. Business Associate and Covered Entity are independent entities, and this Agreement will not establish any relationship of partnership, joint venture, employment, franchise, or agency between Business Associate and Covered Entity. Neither Business Associate nor Covered Entity will have the power to bind the other or incur obligations on the other Party's behalf without the other Party's prior written consent, except as otherwise expressly provided in this Agreement.

(m) Conflicts. In the event that any terms of this Agreement are inconsistent herein or with the terms of any other contract between the Parties, the more restrictive of the terms will control.

SO AGREED by the Parties' authorized representatives on the dates noted below:

DEPARTMENT OF MANAGEMENT SERVICES

DocuSigned by:
Gregory Mauldin
8F46A4CC8A07474...
Director of
Division of State Group Insurance

9/22/2023 | 3:04 PM EDT
Date

PHARMACY BENEFIT MANAGEMENT SERVICES

DocuSigned by:
Kathryn Carey
1BB0BBDC82BB4F7...
Authorized Signature

Kathryn Carey CFO
Print Name and Title

9/27/2023 | 11:06 AM EDT
Date

Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services (the Department)

Pharmacy Benefit Management Services
Administrative Requirements

Respondent Name:
OptumRx, Inc.

Instructions: The following are Administrative Requirements (AR) that the Department expects the awarded Respondent to provide. Enter the answer to each question in the space provided.

I.	Implementation
1	Awarded Respondent shall submit the final Implementation Plan to the Department for approval not later than ten (10) business days following execution of the Contract. If the Implementation Plan is not determined by the Department to be sufficient, Awarded Respondent will diligently work to deliver a final Implementation Plan satisfactory to the Department and recognizes that time is of the essence in completing an Implementation Plan. The Implementation Plan shall contain a detailed description and manner in which all work is to be performed and detail all steps necessary to begin full performance of the Contract on January 1, 2024 at 12:00 A.M., Eastern Time, specify expected dates of completion of all such steps, and identify the persons responsible for each step. The Implementation Plan shall include, but is not limited to, the following Implementation Milestones:
	a. The Awarded Respondent shall establish an interactive website exclusive for State of Florida Participants
	b. The Awarded Respondent shall establish exclusive toll-free phone line(s);
	c. The Awarded Respondent shall develop and obtain Department approval for all communications in advance of the fall 2023 Open Enrollment period;
	d. The Awarded Respondent shall participate in the fall 2023 Open Enrollment benefit fairs coordinated by the Department;
	e. The Awarded Respondent shall participate in regular Implementation status meetings with the Department's Contract Manager. The Awarded Respondent shall be responsible for recording detailed meeting minutes and follow up action items on behalf of all team members during implementation meetings;
	f. The Awarded Respondent shall conduct background checks in accordance with section 4.2.4 of the Contract
	g. The Awarded Respondent shall apply the Plan provisions of the Benefits Document and/or certificates of coverage for all covered drugs and supplies, exclusions, limitations, etc.; establishing and successfully implementing any necessary edits, controls or other functions to ensure accurate Plan coverage;
	h. The Awarded Respondent shall test eligibility files, reviewing key procedures and program process controls (i.e. approval, design, testing, acceptance, user involvement, segregation of duties, and documentation). Functional acceptance approval by the Department is required;
	i. The Awarded Respondent shall conduct a pre-implementation audit of approximately two hundred (200) to three hundred (300) manually created claims;
	j. The Awarded Respondent shall finalize and validate billing procedures, invoice design, manufacturer revenue payments and reports, and all other financial processes that must be approved by the Department;
	k. The Awarded Respondent shall design and present to the Department for approval all communication materials to be used for Plan Participants. Communication materials include but are not limited to ID Cards, brochures, explanation of benefit statement forms, paper claim (reimbursement) forms, standard letters, system generated letters, templates, envelopes, clinical program notices and letters, and posters;
	l. The Awarded Respondent shall provide complete details of the Awarded Respondent's plan to educate and enforce Plan benefits, utilization management, and other Plan specifics to network pharmacies;
	m. The Awarded Respondent shall participate in all activities related to a readiness assessment prior to the Effective Date.
	i. The development and execution of the Implementation Plan is subject to PG 1 and the liquidated damages of Section 7 of the Contract for failure to meet the milestones identified therein.

	ii. The Awarded Respondent shall establish an Implementation Team, which shall be detailed as part of the final Implementation Plan, including names, roles and responsibilities of team members. The Account Manager shall participate full-time on the Implementation Team.
	iii. The Awarded Respondent agrees that the Department may, upon request, require the immediate addition or removal of staff from the Implementation Team.
	iv. The Awarded Respondent shall be one hundred percent (100%) operational prior to the Implementation Date of January 1, 2024 at 12:00 A.M., Eastern Time. Awarded Respondent is subject to the liquidated damages of Section 7 of the Draft Contract for failure to meet this milestone.
	v. The Awarded Respondent shall mail ID Cards (without Social Security Numbers) to all Participants the earlier of December 20, 2023 or ten (10) Business Days after the receipt of a clean and accurate Open Enrollment eligibility file subject to PG 2c.
	vi. The Awarded Respondent shall facilitate the transition of open mail order and specialty prescriptions/refills from the previous PBM vendor, as applicable, using electronic transfer of refills, with the exception of controlled substances, compounds and expired prescriptions.
	vii. The Awarded Respondent shall facilitate the transition of open prior authorizations from the previous PBM vendor, as applicable, using appropriate electronic transfer of information.
	viii. The Awarded Respondent shall facilitate the transition of the required paid claims history from the previous PBM vendor, as applicable, using appropriate electronic data transfer.
II.	**Account Management**
	Account Manager
	a.) The Awarded Respondent shall assign a dedicated Account Manager as a primary contact(s) for the Department.
	b.) The Account Manager shall participate full-time on the Implementation Team.
2	c.) If requested by the Department, the Account Manager shall be replaced with one that the Department is allowed to interview and approve.
	d.) The Awarded Respondent shall inform the Department Contract Manager in advance of any planned periods of unavailability of the Account Manager.
	e.) The Account Manager shall have the responsibility and authority for the vendor to manage the entire range of services discussed in the resultant Contract and must be able to respond immediately to changes in plan design, changes in claims processing procedures, or general administrative problems identified by the Department or the Department' third party consultant.
	Account Director/Executive
	a.) The Awarded Respondent shall assign a dedicated Account Director/Executive as a primary contact(s) for the Department.
	b.) If requested by the Department, the Account Director/Executive shall be replaced with one that the Department is allowed to interview and approve.
3	c.) The Awarded Respondent shall inform the Department Contract Manager in advance of any planned periods of unavailability of the Account Director/Executive.
	d.) The Account Director/Executive shall have the responsibility and authority for the vendor to manage the entire range of services discussed in the Contract and must be able to respond immediately to changes in plan design, changes in claims processing procedures, or general administrative problems identified by the Department or the Department' third party consultant.
	Account Management Team
	a. Awarded Respondent shall assign a dedicated, but not necessarily Account Management Team, which shall include an executive sponsor, an account director/executive, an Account Manager, a customer service manager, a data/fiscal analyst, and a registered pharmacist or PharmD.
4	b. The Awarded Respondent shall provide the Department reasonable advance notice of any changes to Awarded Respondent's Account Management Team; post change notice shall be provided within fifteen (15) Calendar Days of such change.
	c. The Awarded Respondent agrees that the Department may, upon request, require the immediate addition or removal of staff from the Account Management Team.
	d. The Awarded Respondent shall inform the Department in advance of any planned periods of unavailability by the Account Management Team.
	e. The Account Management Team shall devote the time and resources necessary to successfully manage the State of Florida account, including being available for frequent telephonic, email, and on-site consultations.
	Quarterly Meetings
	a. The Account Management Team (excluding the executive sponsor) shall attend all quarterly meetings at the Department's offices in Tallahassee, Florida, or via conference call, as determined by the Department. The Awarded Respondent shall not be entitled to additional compensation for meeting preparation or attendance. The meetings shall be scheduled no later than fifty (50) Calendar Days following the end of each reporting quarter. The meeting to review the fourth quarter of a calendar year is considered both a quarterly and year-end meeting.

5	b. The Awarded Respondent shall provide, for Department approval, a draft agenda five (5) Business Days in advance of a meeting, allowing changes to the agenda and a reasonable opportunity to prepare for the meeting. At a minimum, during the meeting the Awarded Respondent and Department will discuss goals, expectations and priorities; review the Awarded Respondent's quarterly reports and other issues such as performance guarantees, quality assurance, operations, benefit and program changes or enhancements, legislative issues, audits, trends, utilization, program outcomes, customer service issues, future goals and planning; and consider any other issues reasonably related to the Contract and the prescription drug industry in general. The Awarded Respondent shall address past performance and anticipated future performance and compare the Plan's experience to national trends and the Awarded Respondent's total book of business, and other similar governmental clients.
	c. Within five (5) Business Days after any meeting, the Awarded Respondent shall provide the Department detailed and well-documented draft meeting minutes. the Department will review and revise the draft minutes as appropriate and return to the Awarded Respondent. The Awarded Respondent shall provide the Department with final minutes within five (5) Business Days after receipt of the revised minutes. Minutes shall include a clear and detailed account of the meeting, a list and description of all deliverables, identify the responsible party(ies) and provide projected delivery dates.
	d. Progress meetings, issue meetings, and emergency meetings shall be held as needed. Either Party may call such a meeting, subject to reasonable notice.
	e. Any meeting held in person shall be at the Department's offices in Tallahassee, Florida. The Awarded Respondent shall not be entitled to additional compensation for meeting preparation or attendance.
III.	**Support Services**
6	Benefit Fairs
	a. Awarded Respondent shall participate in all locations of the annual Open Enrollment Benefit Fairs that are sponsored by the Department or its designee. (Number and locations may vary each year, and Open Enrollment Benefit Fairs may be virtual.) Awarded Respondent representatives attending the Benefit Fairs shall be employees of Awarded Respondent (not subcontractors or temporary personnel) and adequately trained and knowledgeable about the Plan. Open Enrollment is held annually in the Fall for enrollment coverage effective the following January 1. Participation in the Open Enrollment Benefit Fairs is subject to PG 5.
	b. The Awarded Respondent shall be responsible for all costs associated with participating in Benefit Fairs including travel, a proportionate share of facility fees.
	c. The Awarded Respondent shall share in any expenses for the printing and distribution of the Benefits Document or other Benefit Fair documentation distributed by the Department, the cost for which shall be shared equally among all benefit plan providers including prescription drug and medical plans offered by the Department.
7	**Plan Materials**
	a. No promotional, educational, or any other materials or written communication related to the Plan may be distributed or otherwise communicated without the prior review and written approval of the Department. The Department shall be provided the opportunity to customize, including editing, revising, and co-branding, all such communications. The final materials used by the Awarded Respondent must not differ in form or utility from those approved by the Department. This requirement will not apply in situations of a drug recall and other instances in which the immediate health and safety of a patient may be in question. Recall notices must be provided to the Department before or no later than the time they are disseminated to Participants and are subject to post-review by the Department.
	b. Subject to the Department's customization and prior written approval, Awarded Respondent shall be responsible, at no additional cost, for the development (including, but not limited to, the writing, printing, distributing and mailing thereof) of all Plan-related printed materials, including, but not limited to:
	i. Mail order forms;
	ii. Participant educational materials;
	iii. Member ID cards and replacement ID cards;
	iv. Benefit brochures (including, but not limited to, open enrollment materials);
	v. Claim forms;
	vi. Retail pharmacy directory/list (upon request);
	vii. Two (2) benefit statements (one (1) year-to-date in conjunction with Open Enrollment, to be received no later than the first day of Open Enrollment and one (1) distributed no later than February 15th of each year reflecting the full prior calendar year) for all members. Benefit statements must show complete claim details, including plan and member cost share, date of service, drug name, delivery method, deductible, out-of-pocket maximum, etc. Each adult Participant (age eighteen (18) years and older) shall receive their own Benefit Statements and claims for minor Dependents (less than eighteen (18) years) shall be included on the Benefit Statements for the Subscriber. Awarded Respondent shall have a mechanism in place so that Members may opt out of receiving a hard copy of the benefit statement and instead receive the benefit statement electronically or print from the Awarded Respondent's website;
	viii. Explanation of Benefits (EOBs);

	ix. Letters and correspondence related to all aspects of appeals and external reviews; and
	x. Any other materials such as notices, preformatted letters, clinical program notices, templates, system generated letters and notifications, other correspondence including those delivered electronically, global email blasts, and similar material.
	c. The Awarded Respondent shall assist the Department (i.e., review, clarify, edit as necessary and confirm accuracy) as requested in the development of Department communications regarding the Plan, including, but not limited to, the annual Benefits Guide and the Department's benefit website (www.mybenefits.myflorida.com).
	d. When the Awarded Respondent mails membership materials, the Awarded Respondent may include a customized greeting and form letter to new Participants. The greeting and letter are subject to Department customization and approval.
	e. Upon request of the Participant, the Awarded Respondent shall provide printed materials in a medium widely accepted for the visually impaired.
	f. Upon request of the Participant, the Awarded Respondent shall provide Plan materials in a culturally and linguistically appropriate manner, as defined by section 2719 of the Public Health Service Act (PHSA).
	g. Awarded Respondent shall provide a list each October 1st to the Department of any Participants residing in a county outside the state of Florida and impacted by Section 2719 of the PHSA along with the language requirement for each Participant.
	h. All printed materials provided by the Awarded Respondent shall be provided in electronic format with final versions submitted to the Department in PDF file format.
8	**ID Cards**
	The Awarded Respondent shall provide Subscribers with ID cards either as a new Subscriber, when there are changes in the card's elements, or when reported as lost at no additional cost to the Subscribers or the Department. The design of the ID card is subject to the approval and customization of the Department.
	a. The Awarded Respondent shall mail one (1) ID card for each individual contract and at least one (1) additional ID card for each family contract.
	b. The Awarded Respondent will provide additional ID cards as requested by the Subscriber.
	c. A unique Subscriber-identifying number that is not a Social Security Number (SSN) shall be displayed on the ID Cards. Although never displayed, the SSN shall be the number-of-record maintained in the Awarded Respondent's information system. ID cards shall be compliant with State of Florida and NCPDP standards.
	d. ID cards, including those mailed in the fall of 2023 for the 2024 coverage year, annual Open Enrollment periods, and otherwise as required due to Plan or law changes, shall be mailed in accordance to the provisions of PG 2.
9	**Special Post Office Boxes**
	The Awarded Respondent shall maintain dedicated and exclusive United States Post Office boxes which shall be used as a single point of contact for the Plan and Plan Participants for mailed materials from all Plan Participants, including, but not limited to, letters and correspondence, inquiries, appeals, paper prescriptions and paper claim forms.
10	**Responding to Requests, Department Inquiries, and Dispute Support**
	The Awarded Respondent shall, upon request of the Department or its attorneys and at no additional cost, make available all necessary resources (including, but not limited to, the Account Management Team, analytics and outcomes, research and development, actuarial support, and government relations departments/units) to assist the Department in responding to any aspect of services delivered under the Contract, including but not limited to, Departmental inquiries or those received by the Department from Participants, pharmacy providers, or any other persons or entities.
	Such requests shall:
	1) be given a priority status,
	2) be subject to a method of tracking,
	3) result in the delivery of all requested information, documentation, etc., and
	4) be overseen by a lead staff person specific to the subject matter area. When the Department is required to provide immediate responses to inquiries, the Awarded Respondent shall immediately assist the Department in preparing its reply which includes providing data and documentation within the timeframes prescribed by the Department at that time.
	Responding to Requests for Legislative Initiatives

11	The Awarded Respondent shall make available all necessary resources (including, but not limited to, the Account Management Team, analytics and outcomes, research and development, actuarial support, and government relations departments) to assist the Department in responding to bill analysis, legislative inquiries and requests related to any aspect of services delivered under the Contract. The Awarded Respondent shall respond within the timeframe set by the Department, which shall be determined at the time of the inquiry depending upon the scope and complexity of the request. All costing estimates and/or fiscal impact determinations shall be made on a PEPM (PEPM to include all Subscribers) basis unless otherwise requested by the Department. Support for such legislative initiatives shall be at no additional cost to the Department.
12	**Public Records Requests and Subpoenas**
	a. Awarded Respondent shall, upon request and at no additional cost, provide the Department with any necessary data, documents, etc. to enable the Department to timely (as defined by the Department) respond to Public Record Requests and subpoenas related to any aspect of services delivered under the Contract, as required by law.
	b. Awarded Respondent may receive record requests, subpoenas or other inquiries relating to the Plan. The Awarded Respondent shall notify the Department immediately in writing of such inquiries, and shall refer the requester to the Department to make the request directly, as provided in section 119.0701(3)(a), Florida Statutes. Any response or material responding to such an inquiry shall be submitted to the Department for approval prior to the Department disseminating it.
13	**Underwriting and Actuarial Services**
	Awarded Respondent shall provide the Department with underwriting and/or actuarial services as needed at no additional cost to the Department.
14	**Returned Mail**
	Mail returned to the Awarded Respondent shall be held for thirty (30) days during which time the Awarded Respondent shall search for an updated address with each subsequent enrollment file received from People First. After thirty (30) days, the Awarded Respondent shall store copies on its document imaging system in such a manner as can be easily retrieved based on the Participant's name and destroy the returned mail. Any returned mail containing personal health information shall be shredded.
15	Online Reporting and Management Tools: Computer Access to Plan Data
	At no additional cost to the Department, Awarded Respondent shall provide for online access, for unlimited users from the Department, to its reporting and management services, systems, programs, customer service call notes and logs, and any Participant-specific correspondence.
	a. The Awarded Respondent shall provide corresponding manuals and any other printed or digital material used in connection with the systems (related documents). This online tool shall have data accumulation, claims specific, and ad-hoc reporting capabilities.
	b. Online access shall include access to the same information visible to the Awarded Respondent's customer service representatives including, but not limited to, complete unique Participant claim (retail, mail order, specialty, Medicare secondary drugs, paper claims, and supplies) details and call notes for any nonclinical staff assisting Participants.
	c. Awarded Respondent shall, as necessary and upon request of the Department, provide designated Department staff with training at the Department's facilities for the online reporting and management tools. Additional training beyond the initial training following Contract implementation may be requested from time to time as system updates occur, new Department staff is hired and in need of training, or other factors with all expenses to be paid by the Awarded Respondent.
	d. All call notes and logs shall be provided in plain language with sufficient detail that the exact purpose of the call, the dialog exchange between the Participant and the Awarded Respondent, and the detailed resolution are documented and easily ascertained;
	e. the Department shall have access to add, delete and update eligibility in real time and review claim history;
	f. the Department shall have the ability to print and order ID Cards; and,
	g. vaccinations
	Plan Website and Mobile App
	The Awarded Respondent shall provide and maintain a Plan specific website, with access twenty-four (24) hours a day, seven (7) days a week, for prescription drug and general health information, subject to the Department's customization and approval. The website shall be accessible to non-members of the Plan as well as Participants. Without logging in to the website as a Participant, the website shall provide at a minimum: Plan benefit information, the current preferred drug list, current maintenance drug list, current specialty drug list, and, if applicable, current list of drugs requiring prior authorization to be covered by the Plan. The website shall also include links to the Department website, health plan websites, and other state, federal, disease state and/or condition specific websites, and general health websites as appropriate to make available a multitude of information to Participants. For Participants, such web-based access shall include the ability to, at a minimum:
	a. track Plan accumulators (medical and pharmacy) including separate tracking for both individual and family coverage (annual coinsurance maximum, annual deductible, and annual in-network out-of-pocket maximum);

16	b. track other required or mandated medical and prescription drug accumulator information;
	c. access online refills, check order status and track mail and specialty drug order shipments, in real time;
	d. view and print prescription (retail, mail order, specialty, Medicare secondary) history (three (3) years minimum);
	e. find prescription drug price/costs (retail, mail order, specialty, Medicare secondary);
	f. find lower cost prescription alternatives (retail, mail order, specialty, Medicare secondary);
	g. locate participating retail pharmacies, including location, phone number, and an indicator for twenty-four (24) hour pharmacy and drive-through services;
	h. order replacement ID cards;
	i. download and print temporary ID cards;
	j. communicate with a pharmacist or a customer service representative;
	k. view the current preferred drug list;
	l. view the current maintenance drug list;
	m. view the current specialty drug list;
	n. view the current list of drugs requiring prior authorization to be covered by the Plan;
	o. view Plan benefit information;
	p. view and/or download and print forms and brochures;
	q. download and print mail order form(s) in PDF format;
	r. download and print paper claim form(s) in PDF format;
	s. access preventive educational information;
	t. access Shared Savings Program/transparency information;
	u. access general health, prescription compliance, and chronic disease information;
	v. add credit card information for member cost share for mail order and specialty pharmacy prescriptions
17	**Fraud, Waste, Abuse, Misuse, and Suspicious Activity Investigative Services** The Awarded Respondent shall develop and/or maintain protocols, procedures, and/or system edits to aggressively monitor fraud, abuse, waste, and suspicious activities, and shall provide the Department with a monthly report of all activities and discoveries relating to this Contract subject to the timeliness and accuracy provisions of PGs 22-23. The protocols, procedures and/or system edits shall be provided to the Department upon request and are subject to the Department's customization and approval. The Awarded Respondent shall investigate any fraudulent, suspected fraud, or suspicious activity, which it believes to be fraudulent or abusive whenever detected by the Awarded Respondent or brought to the attention of the Awarded Respondent by the Department or other persons relating to the Plan. The Awarded Respondent shall notify the Department within thirty (30) days of detection of any fraudulent or abusive Claims or other activities relating to the Plan which it uncovers and shall fully cooperate with and assist the Department, law enforcement, and State in their investigations or inquiries regarding any such matters and in any related recovery efforts. Along with any findings, the Awarded Respondent shall submit a corrective action plan to the Department to mitigate the reoccurrence of the finding. the Department shall be notified immediately if law enforcement is involved in any action or potential action taken against or related to a Plan Participant.
IV.	**Customer Service**
18	The Awarded Respondent shall maintain a dedicated and exclusive Customer Service Unit comprised of dedicated and exclusive employees of the Awarded Respondent (not contracted or temporary labor) that shall perform all aspects of customer service for Participants and prospective Participants regarding any and all aspects of the Plan, including, but not limited to, retail, mail, specialty pharmacy, and Medicare secondary drugs and supplies. The Awarded Respondent shall staff this dedicated and exclusive Customer Service Unit with sufficient numbers of personnel to meet or exceed related performance guarantees. the Department expects that in the event of overflow calls, a secondary call center(s) (not dedicated and exclusive) may assist Participants. The dedicated and exclusive Customer Service Unit shall include a state-of-the-art call center.
	a. The Customer Service Unit shall have the capability to adequately provide service and issue resolution, as well as sufficient numbers of qualified personnel trained in the administration of the Plan to meet or exceed related Performance Guarantees. In the case of infrequent and unexpected overflow calls, Participants shall have access to secondary call centers and customer service units.
	b. The Customer Service Unit shall have adequately trained customer service representatives to handle calls from Participants and shall be knowledgeable of the State Plan, including but not limited to, network pharmacies, formulary, medical plans, and plan designs. Any customer service deficiencies noted by the Department shall be immediately rectified by the Awarded Respondent to the Department's satisfaction.
	c. The Customer Service Unit shall include multi-lingual staff or service to assist Participants in Spanish and any other language pursuant to the most recent Culturally and Linguistically Appropriate Services county data as defined by Section 2719 of the Public Health Service Act (PHSA). For languages other than English and Spanish, the multi-linguistic customer service function supporting the Department may be provided by personnel outside of the dedicated and exclusive Customer Service Unit (including by an approved Subcontractor).

	d. The Customer Service Unit shall have staff with skills, services, and equipment to assist hearing and vision impaired Participants.
	e. The Customer Service Unit shall have the ability to assist Participants who contact the unit with only their name and/or SSN.
	f. The Customer Service Unit shall have a process or procedure for handling emergency Participant requests (i.e., vacation requests, early fills, etc.) in accordance with the Plan.
	g. The Customer Service Unit shall maintain an exclusive toll-free telephone number, for use by Participants and prospective participants, accessible from anywhere in the United States.
	h. The Awarded Respondent shall maintain an adequate number of incoming telephone lines dedicated to servicing Participants and pharmacy/provider inquiries.
	i. The toll-free telephone line shall be supported by live dedicated and exclusive customer service representatives twenty-four (24) hours a day, seven (7) days a week.
	j. Any automated voice-response telephone system shall provide an option for the caller to opt-out to a live representative at any time during the call.
	k. One hundred percent of all calls to Awarded Respondent's Customer Service Unit or the Customer Service Centers staffed by the specialty drug provider shall be recorded throughout the term of the Contract and the Awarded Respondent shall have the ability to retrieve and deliver an audio recording to the Department of any calls requested within three (3) Business Days.
	l. All complaint types received by the Customer Service Unit related to the Plan shall be documented and reported to the Department on a monthly basis which shall include Awarded Respondent's corrective action plan to address recurring complaint types.
	m. The Awarded Respondent shall make available to Department staff the ability to listen to and monitor calls to and from the dedicated and exclusive Customer Service Unit.
	n. The Customer Service Unit shall document Participant calls (all issues, concerns of the Participant, all responses, and feedback of the Awarded Respondent) in complete detail such that Department staff with online access to Plan data can fully understand the contents of the call.
19	**Service Disruption Plan** The Awarded Respondent shall maintain a service disruption plan or procedure to continue customer servicing activities (i.e. continue to fill all prescription requests and handle Participant inquiries) using alternative sites or locations as reasonably necessary and appropriate when existing service is temporarily unavailable due to either scheduled or unforeseen events (e.g., relocating offices, repairing/restoring utility or power supply, upgrading telephone systems, and other events.) The Awarded Respondent shall notify the Department within five (5) Business Days in advance for scheduled disruptions and as soon as possible for other events. In accordance with section 626.8825(2)(h), F.S., if the State revises its formulary of covered prescription drugs during a plan year, the Awarded Respondent shall process claims to continue to provide a 60-day continuity-of-care period in which the covered prescription drug that is being revised from the formulary continues to be provided at the same cost for the Participant for a period of 60 days. The 60-day continuity-of-care period commences upon notification to the Participant. This requirement does not apply if the covered prescription drug: 1) has been approved and made available over the counter by the USFDA and has entered the commercial market as such; 2) has been removed or withdrawn from the commercial market by the manufacturer; or 3) is subject to an involuntary recall by state or federal authorities and is no longer available on the commercial market. Beginning January 1, 2024, and annually thereafter, the Awarded Respondent shall submit to the Department a statement attesting to its compliance with the requirements of this subsection.
	a. The Awarded Respondent shall respond to and resolve all Participant inquiries within the timeframe specified in PG11.
V.	**Retail Network Requirements**

20	The Awarded Respondent shall provide a statewide and a nationwide retail pharmacy network in accordance with the provisions of the Draft Contract (Attachment A) and subject to the standards described in PGs 28a-c and 29a-b. In accordance with section 626.8825(2)(e)4., F.S., for the in-person administration of covered prescription drugs, the Awarded Respondent shall not require a Participant to receive pharmacist services from an affiliated pharmacy or an affiliated health care provider. Further, in accordance with section 626.8825(2)(e)5., F.S., the Awarded Respondent shall not offer or implement pharmacy networks that require or provide a promotional item or an incentive, defined as anything other than a reduced cost-sharing amount or enhanced quantity limit allowed under the benefit design for a covered drug, to a Participant to use an affiliated pharmacy or an affiliated health care provider for the in-person administration of covered prescription drugs; nor shall the Awarded Respondent advertise, market, or promote an affiliated pharmacy to Participants. Subject to the foregoing, the Awarded Respondent may include an affiliated pharmacy in communications to Participants regarding network pharmacies and prices, provided that the Awarded Respondent includes information, such as links to all nonaffiliated network pharmacies, in such communications and that the information provided is accurate and of equal prominence. This is not be construed to prohibit the Awarded Respondent from entering into an agreement with an affiliated pharmacy to provide pharmacist services to Participants.
21	**Retail Pharmacy Reimbursement** a. The Awarded Respondent shall reimburse network retail pharmacies based on an amount determined as the lowest of: (a) the contracted discount price with the retail pharmacy plus dispensing fee; (b) MAC plus dispensing fee; or (c) the usual and customary (U&C) (cash) price or sale price, if any. U&C claims shall not be subject to a dispensing fee. The payment to the pharmacy shall be equal to the amount determined above less (a) retail copayment or coinsurance, less (b) retail convenience fee, if applicable, and/or less (c) the deductible, if applicable. All information and claims data pertaining to U&C claims shall accurately reflect the specific data elements and amounts applicable to the calculation of the U&C pricing. b. The Awarded Respondent shall adjudicate all retail claims according to the "lowest of" logic such that Participants always pay the lowest of the applicable copayment or coinsurance, the contracted price, or the retail pharmacy's U&C amount (including the pharmacy's sale price, if any). The Awarded Respondent shall not be allowed to adjudicate based on "zero balance logic" or on a minimum copayment or coinsurance amount and retail pharmacies shall not be allowed to collect a minimum payment.
22	**Coordination of Benefits at Retail** a. The Plan shall be the secondary payer for all drugs and supplies covered by Medicare Part B for any Participants in a retiree subscriber class (coverage code) and enrolled in Medicare Part B. The Awarded Respondent shall provide complete details and documentation of such process and the parties shall finalize the process during the Implementation Period. b. As a secondary payer, the Awarded Respondent shall reimburse as specified in the Coordination of Benefits section of the appropriate Benefits Document or Certificate of Coverage. c. As a secondary payer, the Awarded Respondent shall coordinate with Medicare and benefits shall be paid up to the lesser of 1) the covered expenses Medicare does not pay, up to the Medicare allowance; or 2) the amount this Plan would have paid if the Participant had no other coverage.
23	Awarded Respondent shall assist the Department in retrieving prescription details/information from the Awarded Respondent's network retail pharmacies upon request and at no additional charge.
24	The Awarded Respondent shall provide written notice to the Department of anticipated material changes to the retail pharmacy network which may impact Plan Participants. Such written notice shall be provided at least ninety (90) Calendar Days in advance or as soon as possible if the terminating pharmacy or pharmacy chain gives the Awarded Respondent less than ninety (90) Calendar Days' notice.
25	The Awarded Respondent shall provide impacted Participants ninety (90) days written notice or as soon as possible if the terminating pharmacy (or pharmacy chain) gives the Awarded Respondent less than ninety (90) days' notice. For the purposes of this requirement, Participant shall mean a Participant who has had a prescription filled within the last one hundred and eighty (180) Calendar Days or a Participant that has an active refill on file with the terminating pharmacy or pharmacy chain.
26	The Awarded Respondent shall, upon request of the Department, add additional pharmacies to the retail network on a general, regional, or other specific basis. Awarded Respondent shall not charge the Department an administrative fee to recruit and contract with targeted retail providers. Additionally, the Awarded Respondent shall remove pharmacies from the retail network upon the request of the Department.
27	The Awarded Respondent shall accept nominations from Participants of pharmacies to be included in the retail network.
28	The Awarded Respondent shall not contact, solicit from, or issue point of service messaging to the Department's Participants regarding Awarded Respondent's contract or rate negotiations with a retail pharmacy. In situations where a retail contract has been terminated, and/or a patient safety issue is noted, then the Awarded Respondent will work directly with the Department to determine the communication strategy and outreach to the affected Participants.

29	The Awarded Respondent shall provide a toll-free number for pharmacy/physician inquiries that is answered twenty-four (24) a day, seven (7) days a week, by a live representative of the Awarded Respondent. It shall be acceptable for pharmacy/physician inquiries to be routed through an interactive voice response (IVR) system.
30	a. All of the Awarded Respondent's contracts with participating pharmacies shall include requirements for compliance with all applicable local, state and federal laws and regulations. In the event a pharmacy is out of compliance with these contractual requirements (i.e. dispensing counterfeit drugs), the pharmacy will be subject to removal from the Awarded Respondent's retail networks.
	b. The Awarded Respondent shall utilize the List of Excluded Individuals/Entities (LEIE) from federal and/or state governments to ensure that prescription claims written by listed excluded prescribers will not be paid under this plan.
31	The Awarded Respondent shall, at no additional cost to the Department, defend the Department, the State and/or Participants against any litigation brought by participating network providers (pharmacies / pharmacists) seeking payment for Covered Services provided by such providers in excess of the applicable payment negotiated by the Awarded Respondent. The Awarded Respondent agrees to pay all resulting damages awarded or settlement amounts in any such litigation, provided that the Department, the State and/or the affected Participants provided timely written notification to the Awarded Respondent of such litigation and provided that the Awarded Respondent had sole control of the defense of such litigation and any related settlement negotiations.
VI.	**Mail Order and Specialty Pharmacy**
32	The Awarded Respondent's mail order and specialty pharmacy or pharmacies shall be licensed, permitted, or registered as required by law.
33	The Awarded Respondent shall have the ability to override mail order prescriptions and provide coverage for a drug from a participating retail pharmacy, if approved by the Department (e.g., due to out-of-stock and/or backordered drugs). Pursuant to section 626.8825(2)(e)3., F.S., the Awarded Respondent shall not require a Participant to receive a prescription drug by United States mail, common carrier, local courier, third-party company or delivery service, or pharmacy direct delivery unless the prescription drug cannot be acquired at any retail pharmacy in the Awarded Respondent's network for the Plan. This does not prohibit the Awarded Respondent from operating mail order or delivery programs on an opt-in basis at the sole discretion of a Participant, provided that the Participant is not penalized through the imposition of any additional retail cost-sharing obligations or a lower allowed-quantity limit for choosing not to select the mail order or delivery programs.
34	The Awarded Respondent shall, at any time during the Contract, assist Participants with the transfer of a prescription to the Awarded Respondent's mail order or specialty pharmacy.
35	The Awarded Respondent shall have the ability to arrange with another drug provider if you are unable to fill and deliver a Participant's prescription(s) to avoid any disruption of therapy; such arrangement shall not delay the prescription for more than three (3) Business Days.
36	**Mail Order Pharmacy Reimbursement**
	a. The Awarded Respondent shall adjudicate network mail order and specialty pharmacy claims at the lesser of: (a) the contracted discount plus dispensing fee or (b) MAC plus dispensing fee.
	b. The Awarded Respondent shall ensure that the mail order and specialty pharmacy adjudicate all mail order claims according to the "lower of" logic such that the Participants always pay [redacted] The Awarded Respondent shall not be allowed to adjudicate based on a minimum mail order or specialty pharmacy copayment.
	c. Awarded Respondent agrees that in the event a Participant pays [redacted] of a prescription, the Department will not be billed for any portion of the claim. The mail order and specialty pharmacy will not be allowed to collect a minimum fee or charge from a Participant or the Department.
	d. The Plan will not be responsible for any Participant contributions (e.g., deductible, coinsurance, copayments) owed to the Awarded Respondent. Collecting such fees will be the sole responsibility of the Awarded Respondent.
	e. The Awarded Respondent shall offer consistent pricing (i.e. discounts, dispensing fees, and Rebates/ Manufacturer Payments) for all standard mail order prescriptions regardless of the days' supply (i.e., Awarded Respondent will not apply retail pricing to any mail order claims).
	f. The Awarded Respondent shall not charge the Department a higher AWP price for any repackaged products assigned a new NDC number by a re-packager, a manufacturer, or at mail order, than the original manufacturer/labeler AWP price for the same product (drug name, form, and strength).
37	**Coordination of Benefits at Mail Order and Specialty**
	a. The Plan shall be the secondary payer for all drugs and supplies covered by Medicare Part B for any participants in a retiree subscriber class (coverage code) and enrolled in Medicare Part B. The Awarded Respondent shall provide complete details and documentation of such process and the parties shall finalize the process during the Implementation Period.
	b. As a secondary payer, the Awarded Respondent shall reimburse as specified in the Coordination of Benefits section of the appropriate Benefits Document or Certificate of Coverage.

	c. As a secondary payer, the Awarded Respondent shall coordinate with Medicare and benefits shall be paid up to the lesser of 1) the covered expenses Medicare does not pay, up to the Medicare allowance; or 2) the amount this Plan would have paid if the Participant had no other coverage.
38	**Automatic Refills** a. The Awarded Respondent shall have the ability for Participants to elect automatic refill and automatic renewal for mail-order prescriptions. b. The Awarded Respondent shall not automatically refill or renew any prescription without the Participant so electing (e.g., opting in). c. Participants shall be required to have a valid credit card on file with the Awarded Respondent in order to elect automatic refill service.
39	The Awarded Respondent shall not require the State to pay outstanding balances owed by the Subscriber/ Participant.
40	The Awarded Respondent shall dispense and ship mail order and specialty prescriptions in accordance with PG 20a.
41	The Awarded Respondent shall provide a current and complete Specialty Drug Price list effective as of January 1, 2024, no later than December 1, 2023; and each December 1st for the following year throughout the term of the Contract. Only newly FDA-approved and launched drugs, and drugs not on the market as of December 1, 2024, may be considered for addition to the Specialty Drug Price List after this date. The Awarded Respondent's list will identify limited distribution drugs. The Awarded Respondent shall not add any drugs to the Department's Specialty Drug Price List that were previously available to Participants through non-specialty mail order unless there is a change to the specialty distribution or labeling due to regulatory or manufacturer requirements.
42	The Awarded Respondent may modify the Specialty Drug Price List and corresponding pricing terms, if the resulting pricing terms are improved, on sixty (60) days advance written notice to the Department along with an explanation of the rationale for such modifications. The Awarded Respondent shall permit the State to override any additions that do not meet required criteria. All updates shall be reported quarterly.
43	Pricing for Specialty Drugs added to the Specialty Drug Price List on or after January 1, 2024 shall be competitive in the marketplace and considered on an individual drug and/or therapeutic category basis and shall not automatically default to a minimum discount.
44	Awarded Respondent discounts for Brand Specialty Drugs dispensed through the specialty pharmacy channel shall always be [redacted] Awarded Respondent discounts for Generic Specialty Drugs dispensed through the specialty pharmacy channel shall always be [redacted] fee). All drugs that are classified as specialty but are designated by the FDA as generic shall be priced as generics.
45	All non-specialty products dispensed out of the Awarded Respondent's specialty mail pharmacy shall be subject to Awarded Respondent's proposed standard mail-order pricing terms (discounts, dispensing fees, and rebates guarantees).
46	All products being dispensed or prepared for automatic dispensing shall be visually inspected by a pharmacist for correct color, shape, and other identifying markings. Additionally, Awarded Respondent shall verify that all drugs from primary or secondary vendors have either been purchased directly from the manufacturer or Awarded Respondent will provide sufficient documentation to the Department to ensure the Awarded Respondent is not buying from secondary markets. Secondary wholesalers will only be used to cover for shortages that have occurred with the primary vendor and/or for limited distribution products. Awarded Respondent shall notify the Department when a secondary wholesaler is being used for this purpose(s).
47	Awarded Respondent's mail order pharmacy shall ship multiple drugs to the same Participant separately if a new prescription or refill needs additional information or authorization independent of other new prescriptions or refills.
48	The Awarded Respondent shall not contact Participants via any method (i.e., mail, telephone, text, or email) except when absolutely necessary to process new prescriptions or refills, unless specifically requested or approved by the Department.
49	The Awarded Respondent shall use all commercially reasonable efforts to immediately contact and communicate any delays in fulfillment of any mail order prescriptions to the Participant.
50	The Awarded Respondent shall allow for each adult (eighteen years of age and older) Participant to maintain his or her own respective credit card or other payment information on file for use of filling prescriptions.
51	The Awarded Respondent shall allow for each adult Participant to maintain an alternate address for the mailing of a prescription. Such alternate address shall only be used for the mailing of a single fill of a prescription medication (unless provided as the alternate address for the next fill and/or prescription) and shall not supersede the official address of record provided to the Awarded Respondent by the Department.
52	The Awarded Respondent shall provide Subscriber/Participant with written notification of any credits/overpayments on their accounts.
53	Awarded Respondent shall subject all mail order prescriptions to a human quality assurance check prior to packaging and shipping.

54	The Awarded Respondent shall ship all prescriptions via US Postal Service or other appropriate carrier(s) to the address provided by the Department, its designee, or the Participant. The Awarded Respondent shall not increase its mailing/postage fees to the Department or its Participants during the Contract term.
55	**Temperature Sensitive Drugs**
	a. For all temperature sensitive drugs, the Awarded Respondent shall maintain information from drug manufacturers and/or the Federal Drug Administration (FDA) regarding storage and shipping requirements of specific medications.
	b. The Awarded Respondent shall provide the Department and Participant(s) written information from the manufacturer and/or FDA detailing acceptable temperatures and timeframes for shipping (not limited to storage).
	c. Drugs that require special handling with regard to temperature sensitivity shall be packaged with cold packs which maintain the temperature of the medication at or below the recommended threshold for two (2) days.
	d. Only climate-controlled equipment for which the Awarded Respondent has provided documentation to ensure its suitability for temperature and humidity requirements should be considered for use in packaging temperature sensitive medications.
	e. If the temperature at the shipping destination will exceed eighty (80) degrees within the next three (3) days, the package shall be delivered via overnight shipping.
	f. If the temperature at the shipping destination will be below eighty (80) degrees for the next three (3) days, the package shall be shipped using second day delivery.
	g. Drugs that do not require refrigeration may be shipped by priority mail (two (2) to three (3) day delivery).
	h. Cold pack and overnight delivery shipping shall be available for prescription drugs upon the request of the Participant and the Department.
56	The Awarded Respondent shall ensure that items requiring special handling dispensed via its mail order and/or specialty pharmacy will have those conditions clearly indicated in the labeling for the product and packaging.
57	The Awarded Respondent shall make available generic drugs produced by specific manufacturers when the prescribing physician states that such manufacturer's product is medically necessary. Making such specific product available to a participant shall not delay the prescription more than three (3) Business Days. Vendor reserves the right to facilitate participant receipt of medically necessary product through retail channel if unavailable through mail order.
VII.	**Data and Interface Requirements**
58	Awarded Respondent shall be fully capable of accepting and implementing all Plan related information via FTP on or before October 1, 2023.
59	The Awarded Respondent shall not use, or otherwise disseminate, sell, copy, or make available to any person or entity, data relating to any aspect of performance of the Services, for any purpose other than what is necessary in order to perform the Services. If Awarded Respondent licenses aggregate, de-identified claims data to various entities, Awarded Respondent shall not include or provide the Department's data to these entities. Therefore, Awarded Respondent shall receive no such fees for the Department's data, and no such fees are included as Manufacturer Payments passed to the Department. This requirement shall survive the termination of the Contract.
60	**System Upgrades, Enhancements and Problems**
	a. The Awarded Respondent shall provide at least six (6) months' notice of any significant planned platform and/or system upgrades or changes, including but not limited to claims, customer service, eligibility, mail order pharmacy, retail pharmacy contracting, operating systems and any other changes that may materially affect the administration of the Plan. Changes shall be discussed with and are subject to prior written approval by the Department.
	b. The Awarded Respondent shall immediately notify the Department upon the discovery of problems or issues with any systems, platforms, etc. that in any manner impact the Plan or Participants. Failure to timely notify the Department shall be considered a material breach of the Contract.
	c. The Awarded Respondent shall advise the Department of all corrective actions related to systemic problems or issues that in any manner impact the Plan.
	Eligibility File Transfers from the Department
	a. The Awarded Respondent shall maintain an information system capable of electronically receiving and updating Participant eligibility information (e.g., eligibility, name, address, coverage code). The Awarded Respondent shall accurately convert and load the Department' eligibility files.
	b. The Awarded Respondent shall maintain eligibility records for all Participants based on the Department' eligibility files submitted to the Awarded Respondent.
	c. The maintenance of eligibility records shall be compliant with the required HIPAA standards.
	d. the Department's eligibility file shall be the official system of record and the Awarded Respondent shall not overwrite, update or in any way change the eligibility information without express direction from the Department.
	e. The Awarded Respondent shall accept the eligibility files in a format and frequency as required by the Department.

61	f. In addition to the file schedule agreed to in paragraph (e), the Awarded Respondent shall accept an Open Enrollment eligibility file (generally provided at the end of November following Open Enrollment) for the purpose of generating ID cards for distribution prior to the coverage effective date. The Open Enrollment eligibility file shall not be loaded into production by the Awarded Respondent.
	g. The eligibility files, excluding the Open Enrollment eligibility file, and eligibility updates (including manual reinstatements and terminations) from the Department or the Department' HR vendor shall be processed as required in PG 21a-b at no additional cost to the Department.
	h. Eligibility file transfers and subsequent discrepancy reports between the Awarded Respondent and the Department or the Department's HR Vendor shall be exchanged as determined by the Department.
	i. File transfers with other entities shall be exchanged in a secure method approved by the Department.
	j. The Awarded Respondent shall maintain eligibility reconciliation between Awarded Respondent files and the Department' eligibility files.
	k. The Awarded Respondent shall provide discrepancy reports following every eligibility file load to the Department and the Department's HR vendor.
62	Paid Claims File to the Department. The Awarded Respondent shall provide, to the Department and/or its authorized third party(ies), a complete and detailed paid claims file (inclusive of all claims activity related to the Plan) in the method, timeframe, and format specified by the Department. Failure to timely submit complete, properly formatted data shall be considered a material breach of the Contract and is subject to PG 18a.
63	Paid Claims File to the Department' Health Insurance Management Information System (HIMIS) Vendor. The Awarded Respondent shall provide to the Department's HIMIS vendor a complete and detailed paid claims file in the timeframe and format specified by the Department or HIMIS vendor. Failure to timely submit complete, properly formatted data shall be considered a material breach of the Contract and shall be subject to PG 18d.
64	Paid Claims File Exchange with the Department' Health Plan Vendors. The Awarded Respondent shall exchange paid claims files with the Department' health plan vendors at least monthly. Such paid claims files are not required to contain pricing and/or cost data. Such paid claims files shall be provided in a format specified by the Department. Failure to timely submit complete, properly formatted data shall be considered a material breach of the Contract and shall be subject to PG 18e.
65	Accumulator Exchange with Health Plan Vendors. On a daily basis (or more frequently, if necessary) the Awarded Respondent shall:
	a. Provide a file of all Participant accumulator information to each health plan vendor and/or other required third parties as determined by the Department. The file shall be in a format specified by the Department and/or the health plan vendor and is subject to PG 18e. The Awarded Respondent and the health plan vendor shall be responsible for the member medical drug spend accumulator information/data.
	b. Accept a file of all Participant accumulator information from each health plan vendor and/or other required third parties.
66	Paid Claims File, Accumulator File, Other Data Files. The Awarded Respondent shall provide to any of the Department's additional authorized third parties complete data files in a timeframe and format/layout specified by the Department. Failure to timely submit complete, properly formatted data shall be considered a material breach of the Contract and is subject to PG 18c.
67	Upon termination of the Contract between Awarded Respondent and the Department for any reason, the Awarded Respondent shall provide the Department and subsequent Awarded Respondent with a file in the timeframe and format specified by the Department and to transfer Participant's current mail and/or specialty pharmacy prescriptions at no additional cost. The file transfer shall be subject to PG 18e.
68	The Awarded Respondent shall provide the Department, within thirty (30) Calendar Days of notice of contract termination, either for convenience or for cause, all data and records required by the Department.
VIII.	**Reporting and Deliverables**
69	The Awarded Respondent shall provide the required data and forecasts in support of the State Employee Group Program's Revenue Estimating Conference Report. Such data shall be provided in the timeframes and layout specified by the Department.
70	The Awarded Respondent shall prepare and provide, at no additional cost, ad hoc reports in formats required by the Department. The Awarded Respondent shall provide the Department with priority positioning for delivery of ad hoc report requests made by the Department or its designee regarding Plan-specific financial and statistical files, prescription processing, Participant services, network adequacy, patient management, and drug utilization reports. The Awarded Respondent shall acknowledge report requests within one (1) business day and shall provide an expected timeline for completion and delivery. Ad hoc reports are subject to PG 24a-b
71	**The Department requires regular weekly, monthly, quarterly, Semi-annual, and annual reports and/or deliverables.**
	a. Reports shall be provided in a format subject to customization and approval of the Department that provide utilization, claims reporting, rebates, and administrative services data both by total Plan, total PPO, total HMOs, and by subgroup. The subgroups at a minimum are: Agency SAMAS code, Active, COBRA, Retirees Under 65, and Retirees 65 and over. Note: Department anticipates that the subgroups will ultimately include variable hour (hourly) employees. The Department shall have access to these reports to provide assistance in Program Integrity inquiries.

	b. Reports shall contain all such data/details as required by the Department.
	c. Reports shall be delivered electronically to the Department and/or its designee, and in hard copy by request. Reports that contain proprietary, trade secret and/or confidential information shall also be delivered in a redacted format at the same time as the non-redacted format; the redacted report is only required to be delivered electronically.
72	Complete and detailed backup/supporting documentation must be provided **with submission** of each report. Backup/supporting documentation must identify the source of the material. Each weekly, monthly, quarterly, Semi-annual and annual report and/or deliverable shall be subject to the timeliness and accuracy provisions of PGs 22-23
73	**Weekly Reports and Deliverables:**
	a. Enrollment File Reject Records Report, this report is to notify the Department of enrollment file discrepancies identified by the Service Provider that result in a record being rejected in the Service Provider's enrollment system; format and detail as prescribed by the Department.
	b. Enrollment File Duplicate Records Report, this report is to notify the Department of enrollment file discrepancies identified by the Service Provider that result in a record being duplicated in the Service Provider's enrollment system: format and detail as prescribed by the Department.
	Monthly Reports and Deliverables:
	a. Paid Claims Report. On a monthly basis the Awarded Respondent shall provide a paid claims report showing paid claims by pharmacy type (retail, mail order, or specialty), number of Subscribers and number of Participants, both by total Plan, PPO Plan, HMO Plans and by Subscriber subgroup (Agency SAMAS Code, Active, OPS, COBRA, Retirees Under 65, Retirees 65 and Over, single coverage level and family coverage level).
74	b. RDS Interim Cost Report. On a monthly basis the Awarded Respondent shall calculate and submit Retiree Drug Subsidy (RDS) interim cost reports as described in AR 160 or as otherwise prescribed by the Department.
	c. Complaints to Customer Service. The Awarded Respondent shall provide the Department with a report of complaints received from Participants, healthcare providers, and pharmacies related to the Plan in accordance with the provisions of AR 18n.
	d. Fraud, Waste, Abuse, Misuse, and Suspicious Activity Report. The Awarded Respondent shall provide a report with complete details of all instances of fraud, waste, abuse, misuse, and suspicious activity in accordance with AR 17.
	Quarterly Reports and Deliverables:
	a. Appeals Report. The Service Provider shall provide a report detailing the number of appeals received during the reporting period along with the nature, status, and final determination of such appeals.
	b. Utilization Summary Report. The Service Provider shall provide a utilization summary report in a format subject to customization and approval of the Department to the Department and/or its designee.
	c. Performance Guarantee Summary Report (PG Report). The Service Provider shall deliver the PG Report. Upon delivery of this report, the Service Provider shall include complete detailed backup/supporting documentation, as approved by the Department, for each performance standard (i.e., system generated call center stats/reports, etc.) with the submission of the Performance Standards Guarantee Report. Service Provider shall provide a detailed Corrective Action Plan within thirty (30) Calendar Days of submission of the PG Report that addresses each missed standard and that includes complete details of any proposed corrective action(s), the implementation date of such corrective action(s), the complement or validation date of such corrective action(s), and a schedule for monitoring to ensure future success of any implemented corrective action(s). The Performance Guarantee Report shall be provided in a format customized and approved by the Department. Failure to provide performance for each standard and all required back up documentation shall result in the PG Report being late, inaccurate, or both.
	d. Trend Analysis Report. The Service Provider shall provide a report explaining/detailing any unusual trend results (high/low) relative to the industry, the Service Provider's book of business, best-in-class and similar groups (e.g. large government).

	e. PBM Revenues Report. In accordance with section 626.8825(2)(d), F.S., the Service Provider shall pass 100 percent of all prescription drug manufacturer rebates, including nonresident prescription drug manufacturer rebates, received to the Plan, if the contractual arrangement delegates the negotiation of rebates to the pharmacy benefit manager, for the sole purpose of offsetting defined cost sharing and reducing premiums of covered persons. Any excess rebate revenue after the Service Provider and the Plan have taken all actions required purusant to the preceding sentence must be used for the sole purpose of offsetting copayments and deductibles of covered persons. The Service Provider shall provide in complete detail one hundred percent (100%) of any and all revenue sources of the PBM related to the Plan including all rebates, revenues, payments, compensation, offsets, remuneration and any and all other forms of consideration of any kind. Such report shall provide, at a minimum, details of the following revenues received directly or indirectly in connection with the Plan:
	i. Prescription Pricing Components (e.g., retail, mail and specialty pharmacy AWP, AWP discounts, dispensing fees, etc.);
	ii. Manufacturer Payments (e.g., formulary rebates, administrative fees, educational grants, detailing payments, bonuses, patient assistance dollars, etc.), including amount and source;
	iii. Administrative fees or payments from labelers or wholesalers (e.g., discounts, rebates, grants, detailing payments, bonuses, etc.) including amount and source;
	iv. Outreach and outcomes of any other arrangement(s) from which the PBM may profit; and
	v. The value and nature of any and all other Third-party Consideration from each source.
	f. Preferred Drug List (Formulary Management) Report. The Awarded Respondent shall provide in complete detail quarterly updates of formulary management information, including at a minimum:
	i. Mail Maximum Allowable Cost (MAC) and retail MAC lists that identify changes by drug name, dosage and NDC number. (Note: If the MAC lists are the same for mail and retail, only one set of changes need be provided.)
	ii. Preferred Drug List and Formulary changes that impact the second (i.e., "preferred") tier and third (i.e., "non-preferred") tier and shall identify changes by drug name, dosage, and NDC number;
	iii. The rationale used to make the MAC/formulary/PDL changes;
	iv. The process for notifying Participants impacted by the formulary or PDL changes;
	v. Projected Plan and Participant impact (e.g., number of Participants, costs, savings, etc.) by drug; and,
75	vi. Any arrangements with prescribing healthcare providers, medical groups, pharmacy providers, individual practice associations, or other persons associated with activities of the Awarded Respondent to encourage formulary compliance or otherwise manage prescription benefits, including a description of outreach efforts and outcomes.
	g. Maintenance Drug List Report. The Awarded Respondent shall provide in complete detail quarterly updates of its maintenance drug list in a format approved by the Department. The Awarded Respondent shall list separately those maintenance drugs added to the list and those maintenance drugs deleted from the list. The Awarded Respondent shall permit the State to override any additions that do not meet required criteria. Included with each quarterly update, the Awarded Respondent shall provide the following:
	i. The rationale used to make such changes;
	ii. The process for notifying those impacted by the maintenance drug list changes;
	iii. Projected Plan and Participant impact (e.g., number of Participants, costs, savings, etc.) by drug; and,
	iv. Any arrangements of the Awarded Respondent to encourage appropriate use and/or otherwise manage the utilization of the maintenance drug in question, including a description of outreach efforts and outcomes.
	h. Cost Containment Report. The Awarded Respondent shall provide, to the extent applicable to the Plan design in place, full disclosure and quarterly reports of utilization management programs (e.g., prior authorization, drug limitation, etc.) including, but not limited to, affected drugs, costs, savings, outcomes, and number of impacted Participants.
	i. Cost Savings Recommendations. The Awarded Respondent shall provide recommendations to the Department based on Plan experience that would positively impact the costs associated with the Plan.

	j. Pharmacy Audit Results Report. Based on the results of the Awarded Respondent's on-site audits as required by PGs 30a-b, the Awarded Respondent shall provide a report detailing the audit, its findings, and financial impact to the Plan and Participants. The Pharmacy Audit Report shall be subject to the provisions of PGs 30a-b and 31
	k. Benchmark Cost and Utilization Report. The Awarded Respondent shall provide benchmark data on pharmacy costs and utilization for clients of similar size and complexity.
	l. Specialty Drug List Report. The Awarded Respondent shall provide in complete detail quarterly updates of its Specialty Drug List in a format approved by the Department. If any modifications have been made during the reporting quarter, Awarded Respondent shall provide the Department with a revised and complete list noting the effective date(s) of each modification. The Awarded Respondent shall list separately those Specialty Drugs added to the list and those Specialty Drugs deleted from the list. Included with each quarterly update, the Awarded Respondent shall provide the following:
	i. The rationale used to make such changes;
	ii. The process for notifying those impacted by the specialty drug list changes;
	iii. Projected Plan and Participant impact (e.g., number of Participants, costs, savings, etc.) by drug; and,
	iv. Any arrangements of the Awarded Respondent to encourage appropriate use and/or otherwise manage the utilization of the specialty drug in question, including a description of outreach efforts and outcomes.
	m. Pipeline Report. The Awarded Respondent shall provide a report that lists brand drugs which are expected to lose patent protection during the following twenty-four (24) months. The report shall include the expected date of the change in status from brand to generic, and the projected utilization and cost impact to the Plan.
	n. Retail Pharmacy Network Report. The Awarded Respondent shall provide a report of the number of retail pharmacies in the network as of the first and last days of the reporting quarter. Results are subject to the provisions of PGs 28a-c and 29a-c.
	o. Clinical Program Report in general, this report will explain all clinical programs utilized by the Department, participation levels, and outcomes; specific format and content as prescribed by the Department.
76	**Semi-Annual Reports and Deliverables:**
	a. Retail Pharmacy Satisfaction Survey. The Awarded Respondent shall survey a statistically valid sample of Participants using retail prescription services to verify satisfaction levels relating to the Awarded Respondent's customer service unit and other related services and to gauge satisfaction with the Plan. The survey instrument is subject to the customization and approval of the Department. The results shall be reported in a format prescribed or otherwise approved in advance by the Department. Survey results are subject to the provisions of PG 14a. Awarded Respondent shall provide a detailed Corrective Action Plan within thirty (30) Calendar Days of submission of the Satisfaction Survey Report that addresses each survey question where the responses were below the required standard and that includes details of the proposed corrective action(s), the implementation date of such corrective action(s), the complement or validation date of such corrective action(s), and a schedule for monitoring to ensure future success of any implemented corrective action(s).
	b. Mail Order Pharmacy Satisfaction Survey. The Awarded Respondent shall survey a statistically valid number of Participants using the mail order prescription services to verify satisfaction levels relating to the Awarded Respondent's customer service unit and other related services and to gauge satisfaction with the Plan. The survey instrument is subject to the customization and approval of the Department. The results shall be reported in a format prescribed or otherwise approved in advance by the Department. Survey results are subject to the provisions of PG 14b. Awarded Respondent shall provide a detailed Corrective Action Plan within thirty (30) Calendar Days of submission of the Satisfaction Survey Report that addresses each survey question where the responses were below the required standard and that includes details of the proposed corrective action(s), the implementation date of such corrective action(s), the complement or validation date of such corrective action(s), and a schedule for monitoring to ensure future success of any implemented corrective action(s).
	Annual Reports and Deliverables:
	a. RDS Final Reconciliation Report. The Awarded Respondent shall calculate and submit annually the Final Reconciliation cost report for the Retiree Drug Subsidy (RDS) program as described in AR 160.
	b. Best Pricing / Contribution Development Report. The Awarded Respondent shall deliver to the Department written verification that it continues to provide the Department its Best Pricing as prescribed in section 11.29 of the Draft Contract which, at the discretion of the Department, may be verified by an independent third party with audit expertise in the PBM industry. Such written verification shall be provided to the Department by September 30, 2024, and every September 30th thereafter that this Contract is in effect. The written verification shall include at a minimum:

77	i. The affidavit on Best Pricing in Section 10.20 of the Draft Contract
	ii. Projected costs for renewal year;
	iii. Estimate of IBNR at end of current year, including the most recent thirty-six (36) months of incurred / paid triangular report
	iv. Complete documentation of the methodology and assumptions used to develop the projected costs; and
	v. Disclosure of supporting data and assumptions used in the calculations, including monthly paid claims, enrollment, large claims analysis, trend analysis, demographic analysis, etc.
	c. Performance Bond and Insurance Report. The Awarded Respondent shall provide the Department with verification of sufficient coverage and that a sufficient bond is valid and will remain in force for the calendar year as prescribed in section 8.2 of the Draft Contract (Attachment E).
	d. Awarded Respondent shall provide an annual list of any Participants living in a county as prescribed by Section 2719 of the PHSA in accordance with AR 7g.
	e. The Awarded Respondent shall provide an annual report of manufacturer-funded clinical or medication adherence programs in accordance with AR 124.
	f. Statement on Standards for Attestation Engagements 18 (SSAE 18) Report. The Service Provider shall undergo, at its expense, an annual audit in accordance with the AICPA Statement of Auditing Standards, A.U. Section 324-Reports on Processing of Transactions by Service Organizations, specifically reporting on the policies and procedures placed in operation and tests of operating effectiveness. The report shall cover the twelve (12) month time period of October 1st through September 30th of each year; the report for the first year will cover January 1st through June 30th. The audit shall be performed by an independent auditing firm.
IX.	**Claims Processing**
78	Claims Processing and Adjudication. The Awarded Respondent shall establish and perform all aspects of Claims processing, coordination of benefits, claims reimbursement, point-of-sale transactions, adjudication, and payment in accordance with the Benefits Document. The Awarded Respondent shall verify benefits and eligibility before authorizing prescriptions and billing the Department.
79	The Awarded Respondent shall maintain computerized control of ingredient pricing through the use of a single, auditable industry resource (e.g., Medi-Span) and applicable to both mail order (including Specialty) and retail prescriptions.
80	Awarded Respondent shall select and disclose to the Department, the single source selected to price and classify covered drugs at retail, mail order and specialty pharmacy.
81	Explanation of Benefits Statement (EOB). The Awarded Respondent shall furnish an Explanation of Benefits Statement (EOB) to the Participant via regular U.S. Mail to the last known address within seven (7) days or less following each paper claim processed. Such EOB design is subject to the customization and approval of the Department. The EOB shall include all specific claim details including accumulative balances, as applicable. A per-claim electronic EOB is permitted in lieu of a hard copy EOB, subject to the authorization of the Participant.
82	Appeal Services. The Awarded Respondent shall, at no additional cost, administer Level I appeals for Plan Participants in accordance with the appeals process described in the Benefits Document and as otherwise specifically required and determined by the Department. Appeal services include medical review/assistance to the Department for Level II appeals (including disposition or documentation related to the original appeal), administrative hearings, and external reviews by the Awarded Respondent's Independent Review Organization (IRO) subsequent to the denial of a Level II appeal. Any and all correspondence, letters, communications, etc. related to any part of the appeals process is subject to the customization and approval of the Department.
83	Independent Review Organization. The Awarded Respondent shall, at no additional charge to the Department, contract with an independent vendor or vendors to assist the Department in resolving appeals following the denial of a Level I appeal specific to medical necessity opinions, consistent with the appeals program as described in the Benefits Document. The Awarded Respondent agrees it will enter into contracts with independent vendor(s) that reflect the Department's statutory requirement to resolve all Level II appeals. Through its independent vendor, the Awarded Respondent shall, at no additional charge to the Department, assist with Participant requested reviews of prescription drug denials as allowed by and in accordance with the Patient Protection and Affordable Care Act (PPACA).
84	Awarded Respondent shall provide copies of any and all clinical and/or medical policy guidelines upon the request of the Department.

85	**Medical Necessity Determination and Review.** a.) Prior to any denial of an appeal as not-medically-necessary, experimental and/or investigational, the appealed claim shall be reviewed by an appropriate medical professional. Awarded Respondent shall apply the definition of "Medically Necessary," as set forth in the Benefits Document and in accordance with Awarded Respondent's medical policy guidelines then in effect. The Awarded Respondent shall create, maintain and annually update medical guidelines that are thoroughly researched using current published medical literature. Such guidelines shall be publicly available via the Awarded Respondent's website, and available to Participants through the U.S. mail, upon request, and provided immediately to the Department upon Department's request. Except for eligibility appeals, Department may request a medical review in any other instance. Department shall have full and final decision making authority concerning eligibility, coverage, benefits, claims and interpretation of the Benefits Document.
86	Coordination of Benefits. The Awarded Respondent shall provide coordination of benefits as secondary payor for Medicare Part B and Medicare Part D enrollees at no additional cost to the Department. This includes, but is not limited to, differentiating Medicare Part B vs. Part D claims. The Awarded Respondent shall have in place all necessary systems and processes to ensure accurate electronic (real time) and paper claim submissions for processing and coordination of benefits in accordance with all COB provisions of the Plan.
87	Accounting System. The Awarded Respondent shall maintain an accounting system and employ accounting procedures and practices conforming to generally accepted accounting principles and standards. The Awarded Respondent's accounting records and procedures shall be open to inspection by the Department, or its authorized representatives, at any time during the Contract period and for so long thereafter as the Awarded Respondent is required to maintain records. Any such inspections shall be subject to confidentiality protocol requirements. All charges, costs, expenses, etc., applicable to the Contract shall be readily ascertainable from such records. Supporting documentation for all charges, fees, guaranteed savings and rebate payments including reimbursement invoices for prescription drug payment shall be readily ascertainable from such records.
88	**General Pricing Requirements.**
	a. Awarded Respondent's pricing offer shall be based on and shall not require any changes to the Department's Rx Plan design(s), clinical programs, rules, and edits. Awarded Respondent's pricing offer shall not be contingent upon implementing any additional step therapy, prior authorization, and/or therapeutic switch programs.
	b. Awarded Respondent shall administer the days' supply currently allowed for Specialty and non-specialty Drugs by the Department's plans without penalty, additional charge, or reduction in rebates.
	c. Awarded Respondent shall provide pricing for an Exclusive specialty benefit (Specialty Drugs are only covered if filled by Awarded Respondent's specialty mail pharmacy).
	d. Awarded Respondent shall disclose the pricing and guarantee reconciliation methodology that will be applied for the Department in its entirety, including but not limited to any pricing methodologies applied during claims adjudication, any definition or any contractual clause that might cause a drug to be billed and filled under different drug classifications, the use of re-bucketing drugs during reconciliation to affect any guarantee (e.g. classifying drugs adjudicated as brands as generic under the GDR guarantee) exclusion of any drugs from the reconciliation calculation, and any other pricing or reconciliation strategy that is not specifically requested or covered within the Contract.
	e. Awarded Respondent's proprietary brand/generic drug algorithm(s) shall not be used to classify drugs as Brand or Generic when reconciling Awarded Respondent's aggregate Semi-annual Brand or Generic AWP Discount Guarantees.
	f. Awarded Respondent shall not use its "standard" or "book of business" practices when reconciling the Department's pricing guarantees unless they are clearly outlined in the Contract. If there is a dispute regarding a practice that is not outlined in this Contract, Awarded Respondent shall agree to stop such practice immediately and comply with the terms of the Contract.
	g. Awarded Respondent shall agree that the financial attachment or section in the Contract shall encompass all aspects of pricing and reconciliation, and Awarded Respondent shall not be allowed to add, remove, change or otherwise alter these methodologies during the life of the Contract unless there is a corresponding change in state or federal law that necessitates such change. In the event such a change in law occurs, Awarded Respondent shall agree that any change made will maintain the relative economics of the Contract and shall be disclosed to the Department in writing within ninety (90) days advance notice or as much notice as is reasonably allowed in the event that ninety (90) days' notice is not possible.
	h. Any dollars associated with copay or patient assistance programs and/or copay accumulator programs shall not be treated in any way as discounts on claim costs. These dollars shall be tracked separately and shall not be used to reconcile guaranteed discounts, rebates, or dispensing fees.
	i. There shall be no additional fees to the Department if the Department elects to enroll in Awarded Respondent's copay accumulator program.
	j. All monies received from copay or patient assistance programs, not directly offsetting Participant's liability, shall be reimbursed to the Department.

	k. Awarded Respondent's shall provide a "Pass-Through Pricing" arrangement, whereby all claims adjudicated and dispensed by retail network pharmacies shall be the same as the actual discounted ingredient costs and dispensing fees billed by the retail pharmacy, which in turn shall be passed through and billed by Awarded Respondent in the same amount to the Department. Spread pricing shall not be used at retail. In addition, Awarded Respondent shall provide aggregate Semi-annual discount guarantees and dispensing fee guarantees for retail brand and retail generic drugs as outlined below.
	l. Claims filled at retail network pharmacies in Rural Areas shall be treated as any other retail network pharmacy for purposes of all "Retail" pricing guarantees noted below.
	m. Each and every Dispensing Fee and AWP Discount Guarantee quoted in the Cost Reply (Appendix B) shall be measured, reconciled, and guaranteed semi-annually on an individual component basis (e.g. each brand/generic and mail/retail guarantee independent of others). There shall be no cross subsidization among guarantees, within a distribution channel, or among distribution channels.
	n. Guaranteed Semi-annual AWP discounts and dispensing fees shall be measured, reported, and reconciled separately by Awarded Respondent, and Awarded Respondent shall pay or credit the Department one hundred percent (100%) of any shortfall between the actual result and the guaranteed results, with no offsets, reductions or adjustments. the Department shall not accept pricing offers that payout shortfalls based on "sponsor's net cost", limited to claims with "sponsor liability", or with any zero-balance due (ZBD) adjustment. the Department shall retain one hundred percent (100%) of any additional savings achieved above each guarantee, with no cross-subsidization within distribution channel, or among distribution channels. Shortfalls in one guarantee shall not be offset by overages in any other guarantee, with the exception of rebates which shall be reconciled in aggregate across all channels.
	o. All aggregate Semi-annual AWP discount guarantees shall exclude 340b claims, Participant submitted claims, compound drugs, vaccines, and flu shots. Aggregate Semi-annual AWP discount guarantees shall include covered OTC prescriptions.
	p. "Limited Distribution Drugs" means those Specialty Drugs only available through select pharmacy providers as determined by the drug manufacturer.
	q. "New to Market" Specialty Drugs are Specialty Drugs that are newly introduced for sale by pharmaceutical manufacturers and made available for dispensing at pharmacies and that are not included on the current Specialty Drug Price List. Once a drug meeting the criteria outlined in Specialty Drug definition is added to the Department's Specialty Drug Price List, it will be considered a Specialty Drug and no longer considered "new to market".
89	**AWP Discount Guarantees for Brand Drugs. The Awarded Respondent's minimum aggregate guarantee shall be calculated as (1- [(total discounted Brand Drug ingredient cost of applicable Brand Drug Claims, excluding dispensing fees and prior to application of co-payments) divided by (total undiscounted Brand Drug AWP cost of such Claims based upon the eleven (11) digit NDC as submitted by the Pharmacy)]).**
	a. This guarantee shall include all Brand Drugs dispensed at retail network pharmacies, and the minimum aggregate Semi-annual mail order AWP Discount Guarantees for Brand Drugs shall include all Brand Drugs dispensed at Awarded Respondent's mail order pharmacy.
	b. At retail, this guarantee shall exclude Specialty Brand Drug claims dispensed at retail network pharmacies and shall include Brand Drug claims priced at U&C. When calculating the retail AWP Discount Guarantee, the ingredient cost for U&C claims shall [redacted]
	c. At mail order, this guarantee shall exclude Specialty Drugs dispensed at Awarded Respondent's specialty mail pharmacies.
	d. Awarded Respondent will measure these guarantees and pay/credit the Departmen[redacted] any shortfall within ninety (90) days of each Semi-annual period, with the Department [redacted] of any additional savings achieved; shortfalls in one guarantee may not be offset by a surplus in any other guarantee.
90	**AWP Discount Guarantees for Generic Drugs. The Awarded Respondent's guarantee shall be calculated [redacted] Claims based upon the eleven (11) digit NDC as submitted by the Pharmacy)]).**
	a. Awarded Respondent's minimum aggregate Semi-annual retail AWP Discount Guarantees for Generic Drugs will [redacted] pharmacy.
	b. At retail, this guarantee shall exclude Specialty Drugs dispensed at retail network pharmacies and shall include U&C claims. When calculating the retail AWP Discount Guarantee, [redacted]
	c. At mail order, this guarantee shall exclude Specialty Drugs dispensed at Awarded Respondent's specialty mail pharmacies.

	d. Awarded Respondent shall measure these guarantees and pay/credit the Department [redacted] any shortfall within ninety (90) days of each Semi-annual period, with the Department [redacted] of any additional savings achieved; shortfalls in one guarantee shall not be offset by a surplus in any other guarantee.
91	**Retail Specialty Drug AWP Discount Guarantees. The Awarded Respondent's guarantee shall be calculated** [redacted] **cost of such Claims based upon the eleven (11) digit NDC as submitted by the Pharmacy)]).**
	a. Awarded Respondent's minimum aggregate Semi-annual Retail Specialty Drug AWP Discount Guarantees shall include all covered Specialty Drug Claims including all New to Market Specialty Drugs, biosimilar products, as well as all exclusive distribution and Limited Distribution Drugs dispensed at retail network pharmacies.
	b. The minimum aggregate Semi-annual Retail Specialty Drug AWP Discount Guarantees shall exclude the value of rebates, manufacturer coupons, and monies associated with copay or patient assistance programs, and shall not be subject to day supply proration, reduction or adjustment.
	c. Awarded Respondent shall measure these guarantees and pay/credit the Department [redacted] any shortfall within ninety (90) days of each Semi-annual period, with the Department [redacted] of any additional savings achieved; shortfalls in one guarantee shall not be offset by a surplus in any other guarantee.
92	**Specialty Pharmacy AWP Discount Guarantees. The Awarded Respondent's guarantee shall be calculated** [redacted] **based upon the eleven (11) digit NDC as submitted by the Pharmacy)]).**
	a. Awarded Respondent's minimum aggregate Semi-annual Specialty Pharmacy AWP Discount Guarantees shall include all covered Specialty Drug Claims including all New to Market Specialty Drugs, biosimilar products, as well as all exclusive distribution and Limited Distribution Drugs dispensed at Awarded Respondent's specialty mail order pharmacy.
	b. The minimum aggregate Semi-annual Specialty Pharmacy AWP Discount Guarantees shall exclude the value of rebates, manufacturer coupons, and monies associated with copay or patient assistance programs, and shall not be subject to day supply proration, reduction or adjustment.
	c. Awarded Respondent shall measure these guarantees and pay/credit the Department [redacted] any shortfall within ninety (90) days of each Semi-annual period, with the Department [redacted] of any additional savings achieved; shortfalls in one guarantee shall not be offset by a surplus in any other guarantee.
93	For prescriptions dispensed via Retail pharmacies, AWP shall be based on the actual package size submitted by the retail pharmacy for the eleven (11) digit NDC, on the date dispensed.
94	For prescriptions dispensed via Mail Order and Awarded Respondent's specialty mail pharmacy, AWP shall be based on the larger of the following pack sizes for the drug dispensed:
	a. The actual package size
	b. Covered Drugs will be priced based on the package size from which the product is dispensed. All compound drugs dispensed at retail and mail order will be processed using the National Council for Prescription Drug Programs (NCPDP) multi ingredient transaction; compound drugs will not be subject to a mark-up.
95	**Generic Drugs at Mail Order.** If a multi-source brand medication is dispensed at mail order in lieu of a generic equivalent, such claims shall always be adjudicated as generic regardless of DAW coding, whereby:
	a. The ingredient cost billed will always reflect the generic drug pricing (e.g., the MAC price or the non-MAC generic discount applied to the generic AWP cost); and
	b. The Participant's cost share (e.g., deductible, copay, coinsurance) shall always be determined as if the generic equivalent was dispensed.
96	**Compound Drugs.** Compound drugs dispensed at retail, mail order and specialty pharmacy shall be reimbursed using the National Council for Prescription Drug Programs (NCPDP) multi-ingredient transaction. Compound claims shall be adjudicated based on an allowable ingredient costs for each NDC using lesser of logic—comparing the discounted AWP cost, MAC price (if applicable), and the submitted ingredient cost for each ingredient of the compound. The individual allowable ingredient costs for each NDC are added to create a Total Final Ingredient Cost for the claim. The Total Calculated Cost shall equal the Total Final Ingredient Cost, plus the pharmacy's contracted dispensing fee, plus the pharmacy's contracted Professional Service Fee (if any). The final gross charge for the compound claim shall equal the lesser of the Total Calculated Cost and the pharmacy-submitted total Usual & Customary price for the compound.
	Zero Pay Claims. The calculation of all proposed AWP discount guarantees (e.g., retail brand, retail generic, mail brand, mail generic, specialty pharmacy) shall include zero pay claims (claims where the participant pays the full cost of the drug, and the Plan pays zero) based on the actual adjudicated Ingredient Cost; the AWP discount for zero pay claims shall not be included at one hundred percent (100%) discount.

	Any claims where the dispensing pharmacy does not provide a charge to either the Participant or the Plan shall not be included in the AWP discount guarantees.
97	**Member Pay the Difference Claims.** For any instance where Participants must pay the difference between the brand and generic gross drug cost when choosing a brand name drug when a generic alternative is available, such gross drug cost difference shall not be treated as a discount when reconciling Awarded Respondent's proposed AWP discounts or Ingredient Cost discounts.
	Retail Refill Limits/Penalties. For any plans where Participants are charged a higher cost-share when filling a prescription at retail rather than via mail order or specialty pharmacy, such cost-share shall not be treated as a discount when reconciling AWP discount guarantees, nor be used in any way to lower the amount otherwise due to the Department.
	Fill vs. Bill. Awarded Respondent agrees that if a single source generic drug is dispensed (filled), the Participant shall be financially responsible for the generic copayment/coinsurance and the Department's discount (bill) shall be the generic discount. Awarded Respondent agrees that if a multi-source brand drug is dispensed, the Participant shall be financially responsible for the brand copayment/coinsurance and the Department's discount shall be the generic discount.
98	**Dispensing Fees.** Dispensing Fees processed at the retail pharmacies shall be based on paid claims, NOT claims that are reversed, rejected or not billed to the Department. Awarded Respondent shall measure all Dispensing Fee guarantees annually and pay/credit the Department [redacted] any shortfall within ninety (90) days of each annual period, with the Department [redacted] any additional savings achieved; shortfalls in one guarantee shall not be offset by a surplus in any other guarantee.
	Mandatory Maintenance ninety (90) claims filled at retail shall be adjudicated at the lesser of:
99	[redacted]
100	Awarded Respondent shall ensure that Participants always pay the lower of the contracted price, applicable copayment/coinsurance, or the actual cost of the drug. Participants shall never be charged more than the "cash" price for a drug.
X.	**Clinical Services**
101	The Awarded Respondent shall provide ongoing utilization management including monitoring and enforcement of compliance with best industry practices using nationally recognized standards.
102	The Awarded Respondent shall, at no cost to the Department, implement Plan design system, program and process / procedural changes at the direction of the Department. Generally, plan design changes are a result of changes to Florida or federal law.
103	Returned Drug Process. The Awarded Respondent, subject to the Department's approval and in compliance with state law, shall have in place a process for handling prescription drugs returned to its facility. This policy shall document the entire process including but not limited to how credit for returned drugs is applied to the Department.
104	Preferred Drug List (PDL) Management. The Awarded Respondent shall actively manage and maintain the PDL, at no additional cost, including but not limited to:
	a. Maintaining independence with respect to decisions about the PDL if the Awarded Respondent is owned by a pharmaceutical manufacturer or drug store chain.
	b. The Awarded Respondent shall immediately notify the Department of any drug removed from the PDL due to safety concerns or regulatory action requiring that the Awarded Respondent remove the drug.
	c. The PDL is subject to the review and the approval of the Department. The PDL shall be updated at least quarterly. The Awarded Respondent shall provide the Department at least thirty (30) days advance notice of any additions or deletions to the PDL. The Awarded Respondent shall provide affected Participants at least thirty (30) days prior written notice and no more than a ninety (90) day grace period following receipt of such notice. Additionally, an updated PDL shall be mailed to the Department and posted on the Awarded Respondent's Plan specific website. Upon request an updated PDL shall be mailed to a Participant.
	d. Exclusions of drugs from the benefit Plan are considered Plan design decisions. Therefore, exclusions of medication may not be implemented in PDL changes, unless the Department implements formulary control management including drug exclusions.
	e. If the Department implements formulary control management including drug exclusions, Awarded Respondent shall provide its formulary drug list exclusions to the Department no later than October 1st preceding the following January 1st effective date. Such list shall identify the excluded drugs and the associated alternative covered drug.
105	**Specialty Drug List.** The Awarded Respondent shall actively maintain and provide immediate and unlimited access to a listing of drugs that are considered Specialty Drugs that must be obtained through the specialty pharmacy. The Awarded Respondent shall list separately those Specialty Drugs added or deleted from the list. Updated specialty drug lists shall be immediately provided to the Department and posted to the Awarded Respondent's website.

106	**Maintenance Drug List.** The Awarded Respondent shall actively maintain and provide immediate and unlimited access to the Department of a listing of drugs that are considered long-term and/or maintenance drugs. The maintenance drug list is subject to the review and the approval of the Department and shall be updated no more frequently than quarterly. The Awarded Respondent shall provide the Department at least 30 days advance notice of any additions or deletions to the maintenance drug list.
107	The Awarded Respondent shall maintain any and all drug lists, Preferred Drug List, Specialty Drug List, Maintenance Drug List, and Excluded Drug Lists on any and all Participant-facing website required by this Contract. Such drug lists shall be posted and available to Participants and providers on the effective date of such drug list.
108	**Auto-generic Substitution Programs**. The Awarded Respondent shall provide, at no additional cost to the Department, an auto-generic substitution program. The savings from the auto-generic substitution program shall not be included in any other program savings calculations.
109	**Generic Drugs.** The Awarded Respondent shall create and provide MAC pricing at both mail order and retail pharmacies (MAC List(s)). The MAC List(s) shall be made available to the Department upon request. The MAC pricing applied at mail shall be at least equivalent to the MAC pricing applied at retail but in no case shall it produce a higher cost to the Plan than the retail MAC on a drug by drug basis.
110	**Generic Substitution Rate.** The Awarded Respondent shall meet or exceed the Generic Substitution Rate prescribed in PG 26.
111	If a written prescription is returned to a Participant, a written explanation as to why it could not be dispensed shall be provided to the Participant.
112	**Utilization and Benefit Management Program Decisions.** Any and all utilization and benefit management program decisions shall be made solely to determine coverage and benefits, if any, for the Plan. The Parties shall do nothing to restrict the options of healthcare pharmacy providers to consult fully with patients about treatment options.
113	The Awarded Respondent shall provide, upon request of the Department, a description of all Drug Utilization Review (DUR) Programs available to the Department, the protocols for each program, a complete list of drugs subject to these programs and the cost to the Department, if any, for the implementation of any such programs.
114	**Concurrent Drug Utilization Review (DUR).** The Awarded Respondent shall perform at no additional fee concurrent utilization review by contracting with participating pharmacies using an online system prior to dispensing drugs. The Awarded Respondent's mail order and specialty pharmacy services shall also be required to process prescriptions through an online system prior to dispensing drugs.
115	The Awarded Respondent shall provide, at no additional cost to the Department, a computerized Concurrent DUR Program that monitors Participant's drug therapies in a real-time, online data processing environment. The system shall provide concurrent DUR capabilities to the participating retail, mail order and specialty pharmacies to allow intercession and counseling of Participants regarding their drug therapy. Criteria to be analyzed during the concurrent review include but are not limited to:
	a. Drug-drug interactions;
	b. Drug-age contraindications;
	c. Drug-disease contraindications;
	d. Drug-allergy contraindications;
	e. Over utilization or under-utilization;
	f. Early refills (defined as cases where seventy-five percent (75%) of previous prescription would have been depleted if used as prescribed to prevent early refills);
	g. Inappropriate or excessive dosages;
	h. Therapeutic duplication; and,
	i. Other situations that may endanger the health and welfare of program Participants.
116	**Retrospective Drug Utilization Review (DUR). The Awarded Respondent shall perform, at no additional cost to the Department, retrospective DUR that analyzes drug prescribing, dispensing and utilization patterns of practitioners and Participants. Critical components of the retrospective review include but are not limited to:**
	a. The appointment of a multi-disciplinary committee of relevant healthcare professionals comprised of physicians and pharmacists skilled in drug therapy, pharmacology and medical therapeutics to oversee retrospective reviews.
	b. The multi-disciplinary committee shall analyze detailed system-generated patient and practitioner profiles based on the top one hundred (100) prescribing practitioners (physician profiling).
	c. A comprehensive educational intervention program shall be used to notify practitioners of potential therapeutic complications, duplications or other situations that may endanger the health and welfare of Participants.
	d. The objective of the retrospective DUR program includes but is not limited to:
	i. Duration of therapy;
	ii. Therapy duplication;
	iii. Drug and disease appropriateness;

	iv. Contraindications;
	v. Preferred Drug List compliance;
	vi. Generic utilization;
	vii. Fraud and abuse; and
	viii. Monitoring the interaction among various treatments, medicines, and therapies.
	e. Geriatric management services shall be included as part of the Awarded Respondent's retrospective DUR concurrent case management program at no additional cost to the Department.
117	**Clinical Program Savings. With respect to clinical program savings included in Attachment D or any other programs implemented during the term of the contract, the Awarded Respndent shall:**
	a. Return one hundred percent (100%) of actual savings to the Department from clinical programs;
	b. Not use any savings achieved in excess from one clinical program to subsidize short falls in savings resulting from any other clinical program in any contract year;
	c. Exclude savings from Concurrent DUR and administrative edits (including but not limited to "refill too soon"), from Awarded Respondent's proposed bundled clinical savings guarantee; and
	d. Provide the Department with full authority to reject or "turn-off" any edits (e.g., quantity limit, step therapy) that the Department does not want to implement or continue.
118	**Other Utilization Management/Concurrent Case Management. The Awarded Respondent shall administer a Concurrent Case Management or individual benefits management program. Concurrent Case Management is defined as the management of cost-effective pharmacy services and supplies prior to or during the use of such services and supplies for Participants having catastrophic or chronic health conditions.**
119	The Awarded Respondent shall provide clinical resources to the Department to assist in interpreting pharmacy data and developing cost management strategies.
120	The Awarded Respondent shall disclose by October 1st of each year all manufacturer-funded clinical or medication adherence programs administered by Awarded Respondent at retail, mail, specialty pharmacy or through direct participant solicitation, and for which Awarded Respondent proposes to include Participants for the following calendar year. the Department reserves the right to decline participation without adversely affecting the financial guarantees applicable for that calendar year.
121	The Awarded Respondent shall provide quarterly reporting of clinical programs which shall include the number of participant specific encounters, the impact of such encounters and savings calculated from real vs. inferred data.
XI.	**Audits**
122	Readiness Assessment. the Department and/or its authorized third party may conduct or have conducted a readiness assessment of specific claims or other areas of the Awarded Respondent as determined by the Department prior to the Effective Date. Such assessment may include, but shall not be limited to, procedures, computer systems, claims files, customer service records, accounting records, internal audits, and quality control assessments.
123	The Awarded Respondent shall require and guarantee that all retail pharmacy claims, and subsequent paid claim files will include any and all information, data elements, and codes to support an audit and clearly identify the reason the claim was approved or denied. Any and all coding (i.e. DAW codes, overrides, exceptions, modifiers, etc.) shall be submitted to and approved by the Department in advance and all such codes shall be included on the mail order pharmacy, specialty pharmacy and retail pharmacy paid claim files of any and all type including those files used for audits and other reporting requirements.
124	The Awarded Respondent shall be financially responsible for any and all claims paid by and identified by the Department, or its authorized representative (i.e., consultant/auditor) without all previously approved appropriate and identifying codes. All such codes shall be addressed, explained and documented in complete detail and signed off by the Department during Implementation.
125	**Inaccurate Payments**
	The Awarded Respondent is prohibited from recouping overpayments to network pharmacies and retaining such recoupments.
	a. Upon discovery, notification, or recoveries as part of audits or other activities, the Awarded Respondent shall fully rectify the inaccurate payment or other situation, including but not limited to collecting overpayments or mis-payments, whenever payment is made that is not in accordance with the terms of the Benefit Document and/or the Certificate of Coverage and to the extent such recoveries are attributable to the Plan. The Awarded Respondent shall assume full liability and recover these overpayments and refund 100 percent to the Department regardless of recovery status. The Awarded Respondent shall be responsible for correcting inappropriate payment issues. Such overpayments shall not be reduced by contingency fees or other fees charged by an auditor or other recovery service.
	b. The Awarded Respondent shall reimburse the Participant in the event that a recovery impacts the Participant's cost share.
	c. The Awarded Respondent shall refrain from initiating litigation to recover such overpayment unless authorized by the Department.

	d. If the inaccurate payment or other situation is systemic in nature, the Awarded Respondent shall submit a corrective action plan to the Department for approval, including a written plan for implementation and a timeline, which will resolve the issue within thirty (30) Calendar Days. If a thirty (30) Calendar Day resolution is not reasonably possible, the Awarded Respondent shall propose a resolution date to the Department for approval. The Awarded Respondent shall also provide to the Department weekly status updates and/or other documents (i.e., project plan, system test results, written status report, etc.) related to the corrective action to the Department.
	The Awarded Respondent shall give the Department full access rights to perform audits or reviews, or have audits or reviews performed by a third party, as determined necessary or required to ensure and validate that the State and its Participants are receiving best value, that State funds are being expended timely, efficiently and within compliance of all governing Florida Statutes, and the contract between the Awarded Respondent and the Department. the Department's audit rights include, but are not limited to:
126	a. Pre-implementation audit to include but not be limited to the accuracy of plan set up, application of contractual discounts and benefit design, pricing, cost share, clinical edits, exclusions, communications, file transmissions, mail order transition, refill override code edits and triggers, DAW override codes and triggers, call center and customer service readiness, set up of CMS RDS subsidy management or any other operational, analytical or data necessary to validate accurate implementation.
	b. Compliance and Performance Audits to include but not be limited to:
	i. Verification of the validity of submitted claims;
	ii. Verification of claim adjudication and reimbursement based on benefit design and contract pricing;
	iii. Verification of pharmacy reimbursement based on contracted agreement with no limitation on the number of contracts that can be reviewed. The full contract will be provided for each pharmacy selected;
	iv. Verification of Awarded Respondent compliance with reimbursement to the Department all financial benefits the Awarded Respondent receives including but not limited to rebates, discounts, credits, fees, grants, chargebacks, or other payments based on contracts between Awarded Respondent and manufacturers, retailers, third parties and all others from which the Awarded Respondent receives financial benefits;
	v. Verification of validity and accuracy of administrative fee invoices;
	vi. Verification of self-reported Performance Guarantees;
	vii. Verification of Medicare Part D coordination of Benefits, management of CMS RDS program, accuracy of program eligibility, claims pricing, subsidy payments and reconciliation;
	viii. Review of all operational controls, policies and procedures; and
127	ix. Review of facilities including but not limited to mail order facilities, customer service and call center operations, training facilities, clinical and therapeutic service delivery centers, and all other facilities identified for review by the Department.
128	Awarded Respondent shall provide all claim data in an industry-standard format within ten (10) Business Days of request. Data files shall include but not be limited to billed ingredient amount, discount, dispensing fees (where applicable), taxes, member copays and penalties, DAW codes (if applicable), refill override codes (mail, retail, and specialty), and all other data elements identified at the inception of or during the audit.
129	Awarded Respondent shall make a designated, internal audit representative available to the Department or its designee throughout the entire audit process.
130	Awarded Respondent shall provide copies of, or if considered confidential and proprietary, make available all physical documents, contracts pertaining to Rebates and/or Manufacturer Payments or network arrangements, agreements and records requested for audit within ten (10) days of request.
131	Awarded Respondent shall provide copies of pharmacy records including original prescriptions related to Participant prescriptions within ten (10) Business Days of receiving the request.
132	Awarded Respondent shall research discrepancies identified during the audit and report the results of this research within ten (10) Business Days of the identification of the discrepancies. If claim error sample quantity exceeds 100 claims, the Department may allow a longer timeframe at the Department's discretion.
133	Awarded Respondent shall review a statistically valid sample of all audit findings within each specific category or test scenario of the audit whereby the electronic data and supporting documentation cannot prove the results of all potential financial errors within that specific category or test scenario.
134	Awarded Respondent shall review draft audit reports and provide written responses within ten (10) Business Days of receipt. Awarded Respondents response will be included in final report. The Department may allow a longer timeframe at the Department's discretion.
135	Awarded Respondent shall provide one non-redacted response to the audit and one redacted response to the audit in the event confidential or proprietary information is contained within the report. Only confidential or proprietary information should be redacted.
136	Awarded Respondent shall provide a corrective action plan to address all audit findings in the manner and timeframe designated by the Department. All audit findings are to be completely remediated (system corrections, financial impact analyses and reimbursement – where applicable) within sixty (60) Calendar Days of the issuance of the audit report.

137	Awarded Respondent shall reimburse the Department for any financial findings identified during the audit within twenty (20) Calendar Days of notification from the Department as to the final amount due.
138	**Audit Trail. The Awarded Respondent shall establish and maintain an effective audit trail for each claim/ prescription received/filled. Each data element in any paid claim file used for the purpose of audit shall be populated with codes, data, etc. approved by the Department during the Implementation Period. The Awarded Respondent shall be financially responsible for the inclusion of any coding not previously approved by the Department.**
139	the Department and/or its designee(s) shall have the right to perform onsite case reviews for randomly selected specialty pharmacy patients. These reviews do not qualify as an annual audit (claims audit or performance audit).
140	The Awarded Respondent shall perform, no less frequently than quarterly, internal audits of a statistically valid sample of claims and shall report results to the Department quarterly. Results shall be used to validate self-reported quarterly performance metrics for claim timeliness, processing accuracy, payment accuracy and financial accuracy. Awarded Respondent's results shall include any and all system generated reports, source documents, etc. used to support the audit results. Such supporting documentation must be made available to the Department immediately upon request.
141	the Department shall not be responsible nor assessed a charge for any of the Awarded Respondent's expenses related to operational or financial audits and CMS compliance audits, including the costs to provide necessary records.
	Quality Assurance Reviews for the Auditors. On a regularly scheduled basis, the Awarded Respondent shall review its procedures and processes to assess quality performance on claims, suspense, adjustments, overrides, prior authorization, as well as customer service inquiries by telephone, mail, email, etc. At the time of the audit, the Awarded Respondent shall advise the Department on how the following areas are handled to ensure quality:
	a. Technical;
	b. Mail order prescription fill;
	c. Prescription and inquiry turnaround times;
	d. Financials;
	e. Telephone and customer service; and,
XII.	f. Paper claims payments and reimbursement.
142	**Payment Specifications**
	The Awarded Respondent shall accept payment processed through normal State transmittal process (i.e., EFT transfer to the Awarded Respondent) and timeliness guidelines.
	Methods of Payment
	a. The Awarded Respondent shall provide the Department a detailed (itemized) invoice for Prescription Drug administrative and clinical program fees and other charges no later than the 15th Calendar Day of each month following the month services were rendered. Required supporting documentation for such invoices shall be as specified by the Department and shall provide sufficient detail for pre- and post-audit. Invoices shall be based on the last weekly eligibility file of the coverage month and shall separately include detail regarding any enrollment adjustments (i.e., to capture manual adds/deletes). Each fee type, e.g. Medicare Retiree Drug Subsidy fee, shall be identified individually on the invoice. Invoices and supporting documentation shall be provided electronically and, upon request, via paper hard copy.
143	b. Upon determination by the Department that the invoices are satisfactory, and that payment is due, the Department shall process each invoice in accordance with the provisions of section 215.422, Florida Statutes. the Department shall forward payment through electronic funds transfer to the Awarded Respondent for the invoiced amount. If the Department contests the invoice charges as submitted, additional documentation may be requested, and payment will not be processed until contested charges are resolved.
	c. Such payment method is contingent upon specific annual legislative appropriation in the General Appropriations Act (GAA). In the absence of any such appropriation, an insufficient appropriation, or upon notification by the Department, the parties agree payment shall be made using method two (2).
	d. For payment method two (2): The Awarded Respondent shall net approved monthly administrative and clinical program fees against the quarterly minimum guarantee rebate payment. Any such netting shall: (1) be fully disclosed and identified on the corresponding minimum guarantee rebate payment documentation; (2) shall be based on the last weekly eligibility file of the coverage month; and (3) shall separately include detail regarding any enrollment adjustments (i.e., to capture manual adds/deletes). Each fee type, e.g. Medicare Retiree Drug Subsidy fee, shall be identified individually. Supporting documentation shall be provided electronically and, upon request, via paper hard copy. Required supporting documentation shall be as specified by the Department and shall provide sufficient detail for pre- and post-audit.
	e. Supporting documentation, invoice or fee, and rebate information/ documentation shall be customized and approved by the Department.

144	**Invoicing for Prescription Costs. The Awarded Respondent shall furnish the Department with an itemized PPO Plan and HMO Plans invoice and corresponding claims detail files (in such detail as required for AR-63) for reimbursement of prescription claims costs on a weekly basis for mail, retail and specialty prescriptions separately and in the aggregate. The invoice shall include but not be limited to appropriate dispensing fees, the agreed upon discounted ingredient costs, and net member out-of-pocket costs. The design, format and documentation for invoices is subject to the customization and approval of the Department.**
	a. Weekly invoices shall be specific to a given month with the last invoice perhaps being less than a full seven days to capture the period from the ending date of the previous invoice to the end of the specific month.
145	b. Invoices and supporting documentation shall be provided electronically and, upon request, via paper hard copy.
146	All invoices (e.g., weekly prescription cost invoices, monthly fees' invoices) shall be as specified by the Department for a proper pre-audit and post-audit.
147	The Awarded Respondent agrees that, upon contract termination or expiration, the cost of any work required by a new provider to bring records in unsatisfactory condition up to date shall be the obligation of the new provider and such expenses shall be reimbursed by the Awarded Respondent within three (3) months of the end of the contract term. Records shall be requested in and industry standard format; and if such records are provided by the Awarded Respondent in an industry standard format, the Awarded Respondent shall not be required to reimburse the new provider any costs associated with converting or revising such records.
148	**Remittance of Manufacturer Payments. Quarterly payments for the minimum Guaranteed Rebate Amounts shall be paid to the Department no later than the 60th day following the end of the calendar quarter. The first minimum guarantee rebate payment shall be due May 30, 2024, if the Awarded Respondent is different from the Vendor in 2023. If the Awarded Respondent in 2024 is the Vendor in 2023 for this Contract, then the first minimum guarantee rebate payment is due Feb 28th. Subsequent payments shall be due each August 28th, November 29th, February 28th and May 29th. Payment shall be made through electronic funds transfer. The Awarded Respondent shall provide the Department a detailed report, as specified and customized by the Department, and supporting documentation, as specified and customized by the Department, for each rebate payment.**
	Remittance of Manufacturer Payments in excess of Minimum Guaranteed Rebate Payment.
	a. The Awarded Respondent shall pay to the Department, no later than the 90th day following payment for the minimum Guaranteed Rebate Amounts, any Manufacturer Payments received by the Awarded Respondent and not previously remitted to the Department, that are in excess of the minimum Guaranteed Rebate Amount for each of the previous quarters of the Contract. The first "additional actual Manufacturer Payments collected" payment shall be due September 28, 2024, if the Awarded Respondent is different from the Vendor in 2023. If the Vendor in 2024 is the Awarded Respondent for this Contract, payments shall continue as established. Subsequent payments shall be due each September 28th, December 29th, March 31st, and June 29th. Payment shall be made through electronic funds transfer. The Awarded Respondent shall provide the Department a detailed report accompanying and supporting the "additional" Manufacturer Payment based upon a format specified by the Department.
	b. Awarded Respondent shall provide the Department the greater of one hundred percent (100%) pass-through of actual Manufacturer Payments (as defined in section 1.2 of the ITN) or specified Per Prescription Rebate Guarantees or Per Brand Prescription Rebate Guarantees (as defined below). Whether Awarded Respondent will provide the Department with Per Prescription Rebate Guarantees or Per Brand Prescription Rebate Guarantees is determined at the sole discretion of the Department. the Department shall communicate its election of Per Prescription Rebate Guarantees or Per Brand Prescription Rebate Guarantees in writing annually, on a calendar year basis, prior to the start of the applicable calendar year. Annual election will remain as is if Department does not notify the Awarded Respondent prior to September 15 for January 1. If notification occurs after September 15, then election will become effective the first of the month following next calendar quarter (For example, if notified December 1, election change will be effective April 1.)
	c. Awarded Respondent shall not assess a rebate management fee to the Department.
	d. Under Awarded Respondent's proposed "Per Prescription Rebate Guarantees", specified amounts shall apply to all covered prescriptions (e.g., all Generic Drugs regardless of generic exclusivity status, formulary brand, non-formulary brand, and specialty drug prescriptions regardless of delivery channel) dispensed under the Plan; including covered prescriptions where the participant paid the full cost of the drug and the Plan paid zero.
	i. Per Prescription Rebate Guarantees shall be provided without minimum average days' supply requirements; there shall be no day supply proration, reduction or adjustment to the Per Brand Prescription Rebate Guarantees.
	ii. Per Prescription Rebate guarantees shall also include all New to Market Specialty Drugs, Exclusive Distribution, and Limited Distribution Drugs.
	iii. Per Prescription Rebate Guarantees shall not apply to Participant submitted paper claims, claims pursuant to a 100% Member Copayment or assistance plan, and or 340b pharmacy claims.

	iv. Per Prescription Rebate Guarantees shall apply to all Brand Drug products based on channel/network that was used to dispense the prescription. The Specialty Pharmacy Per Prescription Rebate Guarantees shall apply to all Specialty Claims dispensed at Awarded Respondent's specialty mail pharmacy (including but not limited to HIV and Hep-C).
149	e. In lieu of the "Per Prescription Rebate Guarantees" the Department may, at its sole discretion, choose the Awarded Respondent's proposed "Per Brand Prescription Rebate Guarantees". Under the Per Brand Prescription Rebate Guarantees option, specified amounts will apply to all Brand Drug prescriptions (e.g. all formulary brand drugs and all non-formulary brand drugs,) dispensed under the Plan; including OTC Brand Drug products and covered prescriptions where the Participant paid the full cost of the drug and the Plan paid zero; and excluding brand drugs dispensed in lieu of a generic at generic pricing levels (House Generics).
	i. Awarded Respondent's proprietary brand/generic drug algorithm(s) shall not be used to classify drugs as Brand or Generic for determining Per Brand Prescription Rebate Guarantees.
	ii. Per Brand Prescription Rebate Guarantees shall be provided without minimum or average days' supply requirements; there shall be no day supply proration, reduction or adjustment to the Per Brand Prescription Rebate Guarantees.
	iii. Per Brand Prescription Rebate guarantees shall also include: DAW 1&2 claims that process with a mandatory generic penalty, all New to Market Specialty Drugs., Exclusive Distribution, and Limited Distribution Drugs.
	iv. Per Brand Prescription Rebate Guarantees shall not apply only exclude to Participant submitted paper claims, claims pursuant to a one hundred percent (100%) Member Copayment or assistance plan, and or 340b pharmacy claims.
	v. Per Brand Prescription Rebate Guarantees shall apply to all Brand Drug products based on channel/network that was used to dispense the prescription. The Specialty Pharmacy Per Brand Prescription Rebate Guarantees shall apply to all Brand Drug claims dispensed at Awarded Respondent's specialty mail pharmacy (including but not limited to HIV, PCSK9 and Hep-C).
	f. The Awarded Respondent agrees that the rebate process, including the agreements with Pharmaceutical Manufacturers, can be audited by the State or the State's independent designated representative.
	g. The Awarded Respondent shall be subject to rebate payment and reconciliation standards as prescribed in PG 27.
150	h. All rebate payments shall, at a minimum, be reported by corresponding quarter and by the following groups: Total Plan, Total PPO, Total by each PPO Plan (standard and high deductible health plan), Total HMOs, Total by each HMO and each HMO Plan type (standard and high deductible health plan), Minimum Guaranteed Rebate amount, Other Manufacturer Payments Amount. Reporting categories shall be updated if there are changes to the number / types plans (i.e. PPO, HMO) offered by the Department.
	Rebate Availability. If one or more of the following changes relative to the Department's population, then Awarded Respondent or Department may initiate a review to determine if the relative economics of the current contract require revision as a direct result of the below change(s):
	• Industry-wide or universal marketplace changes regarding rebate availability;
	• Pharmaceutical company revision of rebate payment policy; or,
	• Governmental policy change on tax laws related to rebate payments.
	Such revision shall be limited to an equitable adjustment to the "Pricing Guarantees" (guaranteed AWP discounts, dispensing fees, administrative fees, and/or rebate guarantees), solely as necessary to maintain the contracted economic position of both parties prior to such change(s). This review may be initiated by Awarded Respondent or Client. Awarded Respondent will give thirty (30) days' notice to Client and Client will complete its review of relative economics within forty-five (45) days of said notice or as soon as administratively possible. Said revised Pricing Guarantees shall only apply to future utilization, with an effective date no sooner than thirty (30) days after Awarded Respondent and Client agree to such revision.
	Awarded Respondent shall provide Client details of and reason for the proposed change, an explanation of the manner in which the proposed change will account for the impact of the event triggering the proposed change, with an illustration that details the impact of the proposed change. The illustration shall be specific to Client utilization and will show the impact of the Client-specific change(s). The illustration shall show current utilization and costs based on current Client utilization and the impact to Awarded Respondent and Client as a result of the proposed change. Awarded Respondent shall disclose any necessary facts and data for Client and/or Client's benefit consultant to conduct an independent analysis. Such facts may include (but is not limited to) rebate contractual amendments in cases where rebate-ability is compromised by the Awarded Respondent. If both parties agree to revised Pricing Guarantees, then the revised pricing guarantees shall be implemented and shall be monitored on a quarterly basis to assure that Client-specific economics are preserved.

XIII.	Awarded Respondent shall ensure that the value of any lost rebates will be negotiated into the purchase price of medications between Awarded Respondent and Pharma. Any such value shall be passed back to Client once changes go into effect to ensure the relative economics of the agreement are maintained.
151	**Special Provisions**
	All claim records and eligibility data used by the Awarded Respondent shall remain the property of the State as Plan sponsor and Plan administrator.
	In the event of a change in vendors, expiration of this Contract, or termination of this Contract with or without cause, the Awarded Respondent shall, at the direction of the Department and at no additional charge provide any such new vendor with all participant and plan information reasonably required to successfully transition services, including:
152	a. Claims History Files: a complete claims history file for at least twenty-four months in the industry standard NCPDP PAL 700-byte layout or if requested in another industry standard at the time of the file transfer;
	b. Open Mail Service, including Specialty, Refill Files: one (1) test file and two (2) post-transition files that do not include compounds or controlled drugs in the industry standard NCPDP PTS v2.0 1600-byte layout or if requested in another industry standard at the time of the file transfer;
	c. Prior Authorization Files: one (1) test file and up to two (2) post-transition files in the industry standard 600-byte layout or if requested another industry standard at the time of the file transfer;
	d. Accumulation Files: one (1) test file and up to two (2) post-transition files in the industry standard format.
	Medicare Modernization Act (MMA) Services. The Respondent will work with Department decision-makers in understanding and maximizing their options in serving the retiree health benefit market, e.g., accessing federal subsidies for qualified employer-sponsored coverage, or employing health savings account (HSA) strategies. The Awarded Respondent must support the Department's needs in the following areas:
	a. Enrollment and eligibility;
	b. Marketing and communication outreach;
	c. Reporting;
	d. Compliance;
	e. CMS connectivity;
	f. Website capabilities;
	g. Benefits and Plan design;
	h. Retail network set-up and management;
	i. Claims processing (including coordination of benefits, electronic prescribing, and rebates/discounts);
153	j. Drug lists and clinical management;
	k. Finance;
	l. Customer Care Centers;
	m. Grievance and appeals processes;
	n. Mail service and specialty pharmacy;
	o. Accreditation;
	p. Record retention;
	q. Administrative matters;
	r. Additional Medicare Part D services include:
	i. Differentiating Medicare Part B vs. Part D claims;
	ii. Reporting;
	iii. Audit accountability (False Claims Act issues);
	iv. RDS Subsidy Calculations;
	v. Subsidy Report Submission to CMS;
	vi. Eligibility Tracking and Reconciliation; and
154	vii. Other Part D support as agreed to between the Department and the Awarded Respondent (e.g. Employer Group Waiver Plan (EGWP)).
155	The Awarded Respondent shall be knowledgeable of actual or pending State and federal laws, regulations, policies, procedures, and rules specific to employee benefit plans, pharmacy benefit management, pharmacy and prescription drugs, and other topics related to the provisions of this Plan and shall, at no additional cost, provide the Department with interpretation as to the impact of such laws or regulations on the Plan.
	The Awarded Respondent shall stay up-to-date with notices, announcements, developments, etc. from the U.S. Food and Drug Administration (FDA).
	a. Awarded Respondent shall immediately notify the Department of any development from the FDA that impacts or touches the Plan or the Plan's membership.
156	b. Failure to timely notify the Department of such action by the FDA shall be considered a material breach of the Contract.
	The Awarded Respondent shall absorb the cost of programming any benefit design changes.

	Retiree Drug Subsidy Program. While the State is participating in the Retiree Drug Subsidy program, the Awarded Respondent shall calculate and submit to CMS the RDS Final Reconciliation cost report for each plan year and interim subsidy cost reports on a monthly basis, or as required by the Department or CMS, which includes at least the following:
	a. At least Semi-monthly eligibility submission to CMS, in CMS-required formats, and response file management/coordination with the Department;
157	b. At least Semi-monthly extraction of data elements from the CMS response files and the load of that data into the maintained eligibility records;
	c. Monthly submission of claims data to CMS via the Retiree Drug Subsidy website pertaining to the Plan's Participants, application for subsidy, and the submission of the final reconciliation file due within fifteen (15) months after the end of the Plan Year. (Such claims shall be in the format specified by CMS and shall be sent at a frequency required by CMS in future guidance so that the State will receive payments on a timely basis).
	d. The Awarded Respondent shall upon receipt of weekly and monthly notification and response files from CMS 1) forward immediately forward all files to the Department through secured protocols, 2) perform processes as determined by the Department for handling participant records included in the files, and 3) notify the Department when all files have been processed accordingly.
158	e. The Awarded Respondent shall begin working with the Department on the annual reconciliation at the request of the Department, which shall be no earlier than June 1st.
159	the Department reserves the right to move from the Retiree Drug Subsidy Plan to an Employer Group Waiver Plan
160	The Awarded Respondent shall "hold harmless" the Department for audit liabilities as a result of the Awarded Respondent's management of the retiree drug program, including any penalties imposed by CMS.
	In the event of a change in vendors or expiration of this Contract, at the termination with or without cause or expiration of this Contract, the Awarded Respondent shall be responsible for the administration of claims incurred through the termination or expiration date for a run-out period of one hundred eighty (180) Calendar Days.
161	The Awarded Respondent agrees to adhere to leading industry practices in the development, implementation and application of administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the protected health information that the Awarded Respondent creates, receives, maintains or transmits in the Awarded Respondent's administration of the Plan, as required by the HIPAA security standards. Records shall be retained for ten (10) years after the later of :
	(i) the final disposition of a claim,
	(ii) the expiration of this Contract,
162	(iii) the conclusion of any judicial or administrative proceedings or audits or other action. Records may be retained in a digital imaging format. Prior to the destruction of any such claims records, Awarded Respondent shall consult with and obtain the prior written approval of the Department.
163	The Awarded Respondent shall comply with Chapter 717, Florida Statutes, governing unclaimed property and/or escheatment.
	Disaster Recovery Plan
	The Awarded Respondent shall develop, implement, and maintain a Disaster Recovery Plan for all programs which shall be delivered to the Department on or before the effective date of this Contract. At a minimum, the plan shall maintain backup of State files/data and shall be fully operational within twenty-four (24) hours of a disaster. The plan shall guarantee the same or better level of service as before the Disaster Recovery Plan was activated. Any revisions to the Awarded Respondent's Disaster Recovery Plan shall be delivered to the Department as soon as administratively possible. The Awarded Respondent shall activate and/or test its Disaster Recovery Plan at least annually.

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Department of MANAGEMENT SERVICES

Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services (DMS)

Pharmacy Benefit Management Services

Performance Guarantees

Respondent Name:

OptumRx, Inc.

Instructions: By submitting a Reply, the Respondent accepts the following Performance Guarantees (PG) as written for purposes of evaluation. During the Negotiation phase, the Parties may negotiate alternatives to achieve best value; however, the Department is not obligated to accept any alternatives to the Performance Guarantees.

Implementation
[redacted]

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Department of MANAGEMENT SERVICES

Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

Rx Definitions

Respondent Name:
OptumRx, Inc.

Instructions: Please read each of these factors below and confirm if Respondent agrees with each factor. Use Column "Explanation" to provide a brief explanation.Written Replies and Explanations within this excel Attachment must be limited to 400 characters or less. Written Replies and Explanations beyond 400 characters will not be evaluated. These responses will be used in the financial analysis.

	Definitions	Do you agree with the stated definition? If not, please explain.	Explanation
1.	**"340B Claim(s)"** means a Claim that receives 340B program pricing and is dispensed from a 340B program covered entity. 340B claims are identified by the submission of "20" in the 'Submission Clarification Code' field (420-DK) AND includes a covered entity owned pharmacies 340B status coded as "38" or "39" in the NCPDP DataQ database.	Disagree	**CONFIDENTIAL** A Claim identified by the submission of "20" in the 'Submission Clarification Code' field (420-DK), a Claim dispensed by a pharmacy whose 340B status is coded "39" in the NCPDP DataQ database, or any other Claim deemed to be a 340B Claim by a pharmaceutical manufacturer for which a Rebate is not paid for the Claim. 340b codes are submitted in the basis for reimbursement fields.
2.	**"Adjusted Rx"** means a 30-day supply claim equivalent, that shall be calculated as follows: Adjusted Rx = [Claim Days Supply] / [30 days]. For avoidance of doubt, a Claim with a 90-day supply would constitute three (3) Adjusted Rx. A claim with a 10 (ten) day supply would constitute 1/3 (one-third) of an Rx.	Fully Agree	
3.	**"Administrative Fee(s)"** means the fee paid to PBM for agreed upon PBM services.	Fully Agree	
4.	**"PBM Affiliates"** of a party shall mean an entity: (i) which is directly or indirectly, through one or more intermediaries, controlling such party; (ii) which is under the same direct or indirect ownership or control as such party; or (iii) which is directly or indirectly, through one or more intermediaries, owned or controlled by such party. For purposes of this definition and the Agreement, "control" (including the terms controlling, controlled by or under common control with) means (a) the possession, direct or indirect, (b) the power to direct or cause the direction of the management or policies of an entity, or (c) the ability to direct an entity's affairs or to control the composition of its board of directors or equivalent body, whether through (i) 50% of more of voting securities, (ii) partnership or membership interests, (iii) by contract or (iii) any other means. Further, a Group Purchasing Organization shall also be considered a PBM Affiliate to the extent the GPO meets the	Fully Agree	
5.	**"Average Wholesale Price"** or **"AWP"** means the average wholesale unit price for a product on the date the product is dispensed as set forth from the most current pricing information provided to PBM by Medi-Span Prescription Guide including supplements multiplied by the Fill Quantity. For determining the AWP, the actual 11-digit NDC package size dispensed on the date the product is dispensed will be used.	Fully Agree	
6.	**"Authorized Generics"** means an approved Brand Drug that is marketed without the brand name on its label. Other than the fact that it does not have the brand name on its label, it is the exact same drug product as the branded product. An Authorized Generic may be marketed by the brand name drug company, or another company with the brand company's permission. Authorized Generics will be identified using Medi-Span Multisource Code of "M" (co-branded product) with a Brand Drug Code of "B" (Branded Generic Name) or "G" (generic).	Fully Agree	
7.	**"Biosimilar Product" or "Biosimilar"** means a Specialty Drug that is a biological product that is highly similar to a US-licensed reference biological product notwithstanding minor differences in clinically inactive components, and for which there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product as defined in the Biologics Price Competition and Innovation Act of 2009 at 42 U.S.C. §262(i)(2) and approved under Section 351(k) of the Public Health Services Act and as identified in the Purple Book.	Fully Agree	

Department of MANAGEMENT SERVICES

Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

Rx Definitions

Respondent Name:
OptumRx, Inc.

Instructions: Please read each of these factors below and confirm if Respondent agrees with each factor. Use Column "Explanation" to provide a brief explanation.Written Replies and Explanations within this excel Attachment must be limited to 400 characters or less. Written Replies and Explanations beyond 400 characters will not be evaluated. These responses will be used in the financial analysis.

	Definitions	Do you agree with the stated definition? If not, please explain.	Explanation
8.	**"Brand Drug" or "Brand Product"** means an FDA approved drug, or a drug that is designated by FDA a DESI (Drug Efficacy Study Implementation) drug, or product, which is manufactured and distributed by an innovator drug company, or its licensee , set forth in Medi-Span's National Drug Data File (MS) as a brand drug identified by all of the products meeting at least one of the following criteria: 1. Brand Name code of "T" (trademarked) and Multisource Code "M" 2. Brand Name code of "B" or "T" and Multisource Code of "N" 3. Brand Name code of "B" or "T" and Multisource Code "O" and a DAW code of 0, 1, 2, 7, 8, or 9 For avoidance of doubt, Brand Drugs may include, but are not limited to: vaccines, supplies, medical devices, kits, diabetic supplies, OTCs, and test strips.	Fully Agree	
9.	**"Claim(s)"** means any electronic or paper request for payment or reimbursement processed through PBM's on-line claims adjudication system or otherwise transmitted or processed in accordance with the terms of an agreement in connection with DMS's Plan, including claims in which the Member pays the full cost and DMS has no cost liability, but does not include requests for payment or reimbursement that (i) rejected due to system edits designed to enforce DMS's pharmacy benefit programs or were reversed or cancelled from the claim payment system.	Fully Agree	
10.	**"Compound Drug"** shall mean a mixture of two (2) or more ingredients when at least one of the ingredients in the preparation is an FDA approved federal legend drug, and the mixture of which is not otherwise generally available in an equivalent commercial form or strength in response to a physician's prescription to create a medication tailored to the specialized medically required need for an individual patient.	Fully Agree	
11.	**"Coordination of Benefits or COB Claim(s)"** means a Claim where more than one health insurance program, policy, or other form of coverage, including governmental or non-governmental coverage, has payment and a primary and secondary carrier liability is determined.	Fully Agree	
12.	**"Data Fees"** means fees received by PBM for the sale of aggregate blinded data to a limited group of third parties including nationally recognized data integration firms.	Fully Agree	
13.	**"Days of Supply"** means the number of days supplied for a Claim as submitted to PBM by the dispensing Pharmacy.	Fully Agree	
14.	**"Dispensing Fee(s)"** means the fee paid to the dispensing pharmacy for the professional service of filling a claim and is equal to the Total Claim Cost less the Ingredient Cost and less the applicable sales tax. U&C Claims will always have a zero dollar Dispensing Fee.	Fully Agree	
15.	**"Fill Quantity"** means the number of units dispensed for a Claim as submitted to PBM by the dispensing Pharmacy.	Fully Agree	
16.	**"Formulary Rebate(s)" or "Access Rebate(s)"** means a rebate collected by PBM or PBM Affiliates from pharmaceutical companies for products where the implemented formulary encourages Member use over other products and is attributable to DMS' specific utilization.	Fully Agree	
17.	**"Generic Drug" or "Generic Product"** means an FDA approved drug, or a drug that is designated by FDA a DESI (Drug Efficacy Study Implementation) drug, or product, that is therapeutically equivalent to other pharmaceutically equivalent products, as set forth in Medi-Span's National Drug Data File (MS) as a generic drug identified by all products meeting at least one of the following criteria: 1. Brand Name code of "G" (generic) for all Multisource Codes (M, N, O, and Y) 2. Multisource Code of "Y" (generic) 3. Multisource Code of "M" (co-branded product) with a Brand Drug Code of "B" (Branded Generic Name) 4. "O" (originator brand) with a DAW code of 3, 4, 5, or 6. For avoidance of doubt, Generic Drugs may include, but are not limited to: drugs, vaccines, supplies, medical devices, kits, diabetic supplies, OTCs, and test strips.	Fully Agree	

Department of MANAGEMENT SERVICES

Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

Rx Definitions

Respondent Name:
OptumRx, Inc.

Instructions: Please read each of these factors below and confirm if Respondent agrees with each factor. Use Column "Explanation" to provide a brief explanation.Written Replies and Explanations within this excel Attachment must be limited to 400 characters or less. Written Replies and Explanations beyond 400 characters will not be evaluated. These responses will be used in the financial analysis.

	Definitions	Do you agree with the stated definition? If not, please explain.	Explanation
18.	**"Group Purchasing Organization" or "GPO"** is an entity that aggregates the purchasing power of a group of businesses to obtain discounts or rebates from pharmaceutical manufacturers. These services may include contracting with manufacturers for Manufacturer Payments or any similar service conducted on behalf of the PBM. Any entity who provides the same or similar services as the PBM on behalf of the PBM under this Agreement shall also be considered a GPO. For purposes of this Agreement, rebate aggregators or any similar/competing entity shall also be a GPO. PBM represents and warrants that PBM's agreements with a Group Purchasing Organization shall contain (and will continue to contain through the term of this Agreement) provisions or obligations that are substantially similar to any provision or obligation contained in this Agreement which directly or indirectly relates to any service under this Agreement that is or may be performed by a GPO as defined herein. A breach of this representation and warranty shall be considered a material breach of this Agreement.	Partial Agree	Confirmed. We agree to how GPO is defined, however, PBM represents and warrants that PBM's agreements with a Group Purchasing Organization shall not impair or limit PBM's obligations with respect to any service under this Agreement that is or may be performed by a GPO as defined herein. A breach of this representation and warranty shall be considered a material breach of this Agreement.
19.	**"Guaranteed Minimum Manufacturer Payment"** or **"Rebate Guarantee"** is the average Rebate per Brand Claim or per Claim. The performance will be calculated for the annual period using the following formula for each dispensing Channel independently: [Total Rebate payable to DMS] / [Total Brand Drug Rx Count] OR [Total Rebate payable to DMS] / [Total Paid Claim Count]	Fully Agree	
20.	**"Home Infusion Pharmacy or HIF"** means a Retail Pharmacy-based, decentralized patient care organization with expertise in USP 797-compliant sterile drug compounding that provides care to patients with acute or chronic conditions generally pertaining to parenteral administration of drugs, biologics and nutritional formulae administered through catheters and/or needles in home and alternate sites. These Pharmacies are identified by a National Council for Prescription Drug Program's (NCPDP's) dispenser type code of 6.	Fully Agree	
21.	**"House Generics"** means a Brand Drug submitted with a Dispense As Written (DAW) 5 code in place of the generic equivalent and where the pharmacy is reimbursed at a Generic Drug rate, including MAC, as applicable. For reconciliation of the Generic Drug discount guarantees, the AWP of House Generic drugs shall be the per unit AWP of the generic equivalent and not the AWP of the Brand Drug. House Generics will be identified using Medi-Span Multisource Code M, N, O, or Y and a Dispense as Written (DAW) code of 5.	Fully Agree	
22.	**"Incentive Rebate(s)"** means a rebate collected by PBM from pharmaceutical companies for products where restrictions on competitor products have been put in place and is attributable to DMS' specific utilization.	Fully Agree	
23.	**"Indian Health Services, Tribal or Urban Indian Health or I/T/U"** means a Retail Pharmacy operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization as defined in Section 4 of the Indian Health Care Improvement Act, 25 U.S.C. 1603. These Pharmacies are identified by a National Council for Prescription Drug Program's (NCPDP's) dispenser type code of 8.	Fully Agree	
24.	**"Inflation Protection Payments"** means payments received by Respondent (if any; and whether separately made or in the form of increased Rebates) from a pharmaceutical manufacturer for the purpose of adjusting for year over year price inflation of the manufacturer's price to Respondent for prescriptions on which Rebates are paid; in accordance with and pursuant to applicable pharmaceutical manufacturer agreements.	Partial Agree	"Price Protection" means the monies from pharmaceutical manufacturers via inflation protection negotiations.
25.	**"Ingredient Cost"** means the discounted AWP cost of a claim and is equal to the Total Claim Cost less the applicable Dispensing Fee and less the applicable sales tax.	Fully Agree	
26.	**"Limited Distribution Specialty Drugs"** are those Specialty Drugs only available through select pharmacy providers as determined by the drug manufacturer.	Fully Agree	
27.	**"Long Term Care Pharmacy or LTC"** means a Retail Pharmacy that dispenses medicinal preparations delivered to patients residing within an intermediate or skilled nursing facility, including intermediate care facilities for mentally disabled, hospice, assisted living facilities, group homes, and other forms of congregate living arrangements. These Pharmacies are identified by a National Council for Prescription Drug Program's (NCPDP's) dispenser type code of 4.	Fully Agree	
28.	**"Mail Order Pharmacy"** means a Pharmacy that is owned, licensed, operated or identified by PBM, where Claims are filled and delivered through the mail to Members.	Fully Agree	
29.	**"Manufacturer Administrative Fee(s)" or "Rebate Administrative Fee(s)"** means fees for services rendered to pharmaceutical manufacturers in relation to administrative duties in connection with aggregation, allocating, collecting, and invoicing for rebates.	Partial Agree	**CONFIDENTIAL** "Manufacturer Administrative Fees" means the administrative fees paid by Drug Manufacturers to Administrator for Administrator's provision of Rebate administration services.

Department of MANAGEMENT SERVICES

Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

Rx Definitions

Respondent Name:
OptumRx, Inc.

Instructions: Please read each of these factors below and confirm if Respondent agrees with each factor. Use Column "Explanation" to provide a brief explanation.Written Replies and Explanations within this excel Attachment must be limited to 400 characters or less. Written Replies and Explanations beyond 400 characters will not be evaluated. These responses will be used in the financial analysis.

	Definitions	Do you agree with the stated definition? If not, please explain.	Explanation
30.	**"Manufacturer Payments"** includes Rebates, Manufacturer Administrative Fees, Inflation Protection Payments, and Data Fees, but excludes Other Pharma Revenue.	Partial Agree	Data Fees are not included as part of Manufacturer Payments.
31.	**"Market Share Rebate(s)" or "Performance Rebate(s)"** means a rebate collected by PBM from pharmaceutical companies that is based on the utilization of a rebated product compared to the utilization of competitor products and is attributable to SMD' specific utilization.	Fully Agree	
32.	**"Maximum Allowable Cost or MAC"** means the price that has been established by PBM for a Brand Drug or Generic Drug included on its MAC drug list, which may be amended from time to time by PBM. A copy of such MAC drug list shall be provided to DMS, prior to execution and upon DMS's reasonable request, and shall be updated by PBM in its sole discretion. The same MAC list will be used for a Retail Pharmacy, a Mail Order Pharmacy, and a Specialty Pharmacy (i.e. same number of drugs, same drugs). The Mail Order Pharmacy and Specialty Pharmacy MAC list price points for individual drugs/generic class numbers shall be equal to or less (i.e., more deeply discounted) than the Retail Pharmacy MAC price points for the same drugs/generic class numbers.	Fully Agree	
33.	**"Member(s)"** means each individual who DMS identifies in the eligibility file to be eligible for prescription drug benefits under its plan.	Fully Agree	
34.	**"Member Cost Share"** means the amount which a Member is required to pay for a Claim in accordance with DMS' benefit design, which may be a deductible, a percentage of the Claim price, a fixed amount and/or other charge or penalty.	Fully Agree	
35.	**"Member-Submitted Claim(s) or Paper Claim(s)"** means a Claim submitted to PBM for reimbursement by a Member for which the Member paid cash.	Fully Agree	
36.	**"Military Pharmacy"** means a Retail Pharmacy whose primary function is to store, prepare and dispense pharmaceuticals and other associated items to uniformed services beneficiaries. These pharmacies may be associated with Department of Defense or U.S. Coast Guard clinic, Department of Defense hospital or freestanding. Usually associated with outpatient services. Associated with taxonomy code "332000000X". These Pharmacies are identified by a National Council for Prescription Drug Program's (NCPDP's) dispenser type code of 17.	Fully Agree	
37.	**"Open Preferred Drug List or Open Formulary"** will be defined as a listing of all FDA-approved prescription drugs. No FDA-approved prescription drugs will be excluded from an open formulary without the express written consent of DMS.	Fully Agree	
38.	**"Other Pharma Revenue"** means Pharmacy Purchase Discounts (i.e.. Mail Order Volume Discounts), Transmission Fees, and Specialty Service Fees.	Fully Agree	
39.	**"Over-the-Counter"** or **"OTC"** Claim(s) means a Claim for items that do not require a prescription for a Member to purchase that DMS has chosen to or has been required to include as covered products under the prescription drug benefit. OTC Claims are defined as having an 'O' or 'P" indication in Medi-Span's Rx-OTC Indicator Code.	Fully Agree	
40.	**"Participating Pharmacy"** means a Retail Pharmacy, Mail Order Pharmacy, Specialty Pharmacy, non-traditional pharmacy (such as I/T/U, LTC, HIF, Military, TER or VA) or other Pharmacy that participates in the PBM's network of Participating Pharmacies pursuant to an agreement between the Participating Pharmacy and PBM or between the Participating Pharmacy and DMS for such Pharmacy's dispensing of Covered Drugs to Members.	Fully Agree	~~"Participating Pharmacy" or "Participating Pharmacies" means, any or all network pharmacies, mail pharmacies, specialty pharmacies and each licensed pharmacy contracted to provide pharmacy services to PBM. Participating pharmacies include "any willing providers".~~
41.	**"Pass Through Pricing"**, **"Pass through"**, or **"Transparent Pricing"** means a pricing structure comprised of fixed guaranteed discounts at PBM's Mail Order Pharmacy and Specialty Pharmacy and a full pass through of PBM's contracted rates with Participating Pharmacies and pharmaceutical manufacturers. In this arrangement, PBM retains the difference between Mail Order and specialty acquisition costs and the amounts guaranteed to DMS. PBM passes through (1) its contracted rates with Participating Pharmacies and (2) all Manufacturer Payments it receives from pharmaceutical manufacturers in excess of the DMS's guaranteed Manufacturer Payments. The amount billed to DMS at Retail Pharmacies will be equal to the amount paid by PBM to the Retail Pharmacies.	Fully Agree	

Department of MANAGEMENT SERVICES

Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

Rx Definitions

Respondent Name:
OptumRx, Inc.

Instructions: Please read each of these factors below and confirm if Respondent agrees with each factor. Use Column "Explanation" to provide a brief explanation.Written Replies and Explanations within this excel Attachment must be limited to 400 characters or less. Written Replies and Explanations beyond 400 characters will not be evaluated. These responses will be used in the financial analysis.

	Definitions	Do you agree with the stated definition? If not, please explain.	Explanation
42.	**"Pharmacy"** means a pharmacy that participates in the PBM network pursuant to an agreement between the pharmacy and PBM.	Fully Agree	~~"Network Pharmacy" means a retail pharmacy, Home Delivery Pharmacy, Specialty Pharmacy or other facility that is duly licensed to operate as a pharmacy and is owned or operated by OptumRx (or an affiliate) or has entered into a Network Pharmacy Agreement.~~
43.	**"Pharmacy Purchase Discount(s)" or "Mail Order Volume Discount(s)"** means discounts, paid at time of purchase, or retrospectively, received by PBM or its affiliates from pharmaceutical manufacturers, which are attributable to or based on products purchased by PBM affiliated dispensing pharmacies.	Fully Agree	
44.	**"Preferred Specialty Network"** means a network arrangement where a copay/coinsurance Member Share differential distinguishes preferred versus non-preferred Specialty Pharmacies.	Fully Agree	
45.	**"Pricing Source"** means Medi-Span Prescription Guide including supplements.	Fully Agree	
46.	**"Rebates"** means the return of partial payments from a pharmaceutical manufacturer, pursuant to the terms of a rebate contract, negotiated directly or indirectly with a pharmaceutical company by PBM, PBM Affiliates, or a GPO, on behalf of all plan sponsors, and directly or indirectly attributable to the utilization of certain prescriptions by members. Rebates shall include Formulary Rebates (i.e. Access Rebates), Market Share Rebates (i.e. Performance Rebates), Incentive Rebates, Value-Based Rebates, Medical Drug Rebates (if carve-in with a Health Plan), and Non-Preferred Rebates. Rebates do not include the value of manufacturer coupons applied at the pharmacy or other patient assistance programs.	Fully Agree	
47.	**"Retail Pharmacy"** means a Pharmacy that is not a Mail Order Pharmacy nor a Specialty Pharmacy.	Fully Agree	
48.	**"Sales Tax"** means a tax imposed by local, state, or federal government at the point of sale on a Claim that is collected by the dispensing Pharmacy	Fully Agree	
49.	**"Single Source Generic(s) or SSG(s)"** are Generic Drugs that are manufactured by one generic drug manufacturing company.	Fully Agree	
50.	**"Specialty Drugs"** are defined as certain pharmaceuticals, biotech or biological drugs, that are used in the management of complex or genetic disease that meet at least one of the first two criteria (a and b) and all of the last three criteria (c-e) in order to be placed on Respondent's specialty drug list: a) Produced through DNA technology or biological processes b) Targets a complex disease caused by a combination of genetic, environmental and lifestyle factors c) Unique handling, distribution, and/or administration requirements such that the drug cannot be safely dispensed from a mail service pharmacy d) Requires a customized medication management program that includes medication use review, patient training, coordination of care and adherence management for successful use such that more frequent monitoring and training is required e) Are not a device, supply, medical food, or durable medical equipment. Lastly, only newly FDA-approved and launched drugs, and drugs not on the market as of January 1, 2024 may be considered for addition to the specialty pharmacy drug price list after this date, unless the Specialty Pharmacy gains access to a previously unavailable Limited Distribution Specialty Drug.	Disagree	

Department of MANAGEMENT SERVICES

Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

Rx Definitions

Respondent Name:
OptumRx, Inc.

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	Definitions	Do you agree with the stated definition? If not, please explain.	Explanation
51.	**"Specialty Pharmacy"** means (a) an automated Pharmacy that processes prescriptions at one or more central locations and delivers them through the mail or other third-party delivery service to the locations of Members, and does not have a physical Member-facing storefront, (b) the PBM Specialty Pharmacies, (c) a pharmacy that dispenses a Limited Distribution Specialty Drug, and (d) any other Pharmacy that the parties agree in writing is a Specialty Pharmacy for purposes of this definition. If such a Pharmacy dispenses Specialty Drugs and non-Specialty Drugs, such Specialty Pharmacy shall constitute a Specialty Pharmacy only with respect to the dispensing of Specialty Drugs and shall constitute a Mail Pharmacy (in the case of clause (a) of the preceding sentence) or a Retail Pharmacy (in the case of clause (b) and (d) of the preceding sentence) with respect to the dispensing of non-Specialty Drugs.	Disagree	"Specialty Pharmacy" means (a) an automated Pharmacy that processes prescriptions at one or more central locations and delivers them through the mail or other third-party delivery service to the locations of Members, and does not have a physical Member-facing storefront. "Specialty Pharmacy" includes pharmacies that are owned or operated by Optum Rx, or an affiliate.
52.	**"Specialty Service Fees"** means fees collected by a PBM from pharmaceutical companies for certain costs or services associated with stocking, handling and dispensing certain Specialty Drugs, such as distribution data reporting, inventory tracking and management, FDA Risk Evaluation and Mitigation Strategy (REMS) support and enhanced adverse even reporting and coordination.	Fully Agree	
53.	**"Subrogation Claim"** means a claim submitted by any state or a person or entity acting on behalf of a state under Medicaid or similar United States or state government health care programs, for which Client is deemed to be the primary payor by operation of applicable federal or state laws.	Fully Agree	
54.	**"Territory Pharmacy or TER"** means a Retail Pharmacy located in one of the United States territories, i.e. American Samoa, Guam, Northern Mariana Islands, Puerto Rico, United States Virgin Islands. These Pharmacies are identified by an ISO 3166 code (state code) of AS, GU, MP, PR, and VI.	Fully Agree	
55.	**"Total Claim Cost"** is equal to the Ingredient Cost plus the applicable Dispensing Fee plus the applicable sales tax.	Fully Agree	
56.	**"Transmission Fees"** fees paid by Participating Pharmacies that directly or indirectly arise from claims or covered drugs dispensed to Client Members. These fees shall not constitute pharmacy rebates if a) such fees do not in aggregate exceed $0.15/claim (b) such fees constitute a fair and reasonable compensation for services actually performed by PBM for a Participating Pharmacy and (c) the receipt and retention of such fees by PBM are in compliance with all applicable laws.	Fully Agree	~~Transmission Fees means fees from participating pharmacy providers that are used to offset costs incurred to support network services. Item "A" should not be included in this definition.~~
57.	**"Usual and Customary Price(s)" or "U&C(s)"** means the cash price available to the general public as submitted by the Retail Pharmacy for a Claim on the date such Claim is dispensed. A U&C Claim is one in which the Claim is adjudicated at the Usual and Customary Price and always has a Dispensing Fee of $0.00.	Fully Agree	
58.	**"Vaccine Claim(s)"** means a Claim in which the dispensed product is a preparation used as a preventative inoculation to confer immunity against a specific disease, usually employing an innocuous form, fragment, toxin, or DNA of the disease agent to stimulate antibody production, and for which the purchase price includes the Ingredient Cost, the Dispensing Fee, the vaccine fee and the cost to administer the vaccine. These Claims are identified with a Medi-Span Generic Product ID (GPI-4) of 1710, 1720, 1799, 1800 or 1899, or has an AHFS Extended Therapeutic Class Code of 8012000 or 80080000.	Fully Agree	

Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

Rx Definitions

Respondent Name:
OptumRx, Inc.

Instructions: Please read each of these factors below and confirm if Respondent agrees with each factor. Use Column "Explanation" to provide a brief explanation.Written Replies and Explanations within this excel Attachment must be limited to 400 characters or less. Written Replies and Explanations beyond 400 characters will not be evaluated. These responses will be used in the financial analysis.

	Definitions	Do you agree with the stated definition? If not, please explain.	Explanation
59.	**"Veteran Affairs Pharmacy or VA"** means a Retail Pharmacy under veteran affairs jurisdiction where drugs are dispensed and pharmaceutical care is provided to enrolled veterans, by licensed pharmacists. These Pharmacies are identified by a National Council for Prescription Drug Program's (NCPDP's) dispenser type code of 9.	Fully Agree	
60.	**"Value-based Rebates"** mean payments collected by PBM from pharmaceutical companies when pharmaceutical companies' drug therapies underperform by not meeting certain effectiveness criteria.	Fully Agree	
61.	**"Zero Balance Due"** or **"ZBD"** claim means any claim where the member pays the total amount of the claim, including any applicable sales tax, and the plan pays zero	Fully Agree	

Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

Pricing Factors - Rx

Respondent Name:
OptumRx, Inc.

Instructions: Please read each of these factors below and confirm if Respondent agrees with each factor. Use Column "Explanation" to provide a brief explanation.Written Replies and Explanations within this excel Attachment must be limited to 400 characters or less. Written Replies and Explanations beyond 400 characters will not be evaluated. These responses will be used in the financial analysis.

	Pricing Factors	Reply	Explanation
1.	All applicable financial terms (including but not limited to adjudication formulas, AWP discounts, dispensing fees, administrative and clinical program fees, Manufacturer Payments, specialty discounts, and specialty dispensing fees) submitted by Respondent will be guaranteed as specified for the full contract period and incorporated into the contract.	Fully Agree	
2.	The financial terms you reply are DMS-specific, and not book of business averages.	Fully Agree	
3.	The financial guarantees you reply do NOT require DMS to make any plan design changes or implement any programs that are different from the current plan design(s).	Fully Agree	~~OptumRx's guaranteed rebate amounts are contingent on adoption of the formularies provided.~~
4.	Respondent will utilize the brand/generic indicator available from only one nationally recognized source (e.g., Medi-Span) unless a change in the indicator will lower the price for DMS or DMS agrees that the change is acceptable. In your response, please indicate which source will be used.	Fully Agree	Our pricing source is Medi-Span.
5.	[redacted]		
6.	Respondent's replied dispensing fees per claim are based on paid claims only, NOT claims that are reversed or rejected.	Fully Agree	
7.	Usual & Customary priced claims at retail will NOT be assessed a dispensing fee.	Fully Agree	
8.	Retail claims priced using the U&C price (or submitted price, etc.) will be NOT be included in the guaranteed maximum dispensing fee per claim.	Fully Agree	
9.	The dispensing fee per claim listed for mail, if any, is not an average but the guaranteed maximum amount that will apply per paid claim.	Fully Agree	
10.			

Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

Pricing Factors - Rx

Respondent Name:
OptumRx, Inc.

Instructions: Please read each of these factors below and confirm if Respondent agrees with each factor. Use Column "Explanation" to provide a brief explanation.Written Replies and Explanations within this excel Attachment must be limited to 400 characters or less. Written Replies and Explanations beyond 400 characters will not be evaluated. These responses will be used in the financial analysis.

11.	**Please indicate whether you fully agree, partially agree, or disagree with the below:** **Adjudication for Mail Order Pharmacy Claims:** For each Claim processed and dispensed to a member through a mail order pharmacy, DMS shall pay PBM the Total Claim Cost less the member cost share plus any applicable administrative fees. The Total Claim Cost is defined to be the lowest of: i. The AWP minus the Brand Drug discount + Dispensing Fee + sales tax (Brand Drugs); ii. The AWP minus the non-MAC discount + Dispensing Fee + sales tax (Generic Drugs); or, iii. MAC + Dispensing Fee + sales tax.	Fully Agree	
12.	**Please indicate whether you fully agree, partially agree, or disagree with the below:** **Member Cost Share:** At the point of sale, members will pay the lowest of: i. The Total Claim Cost as defined by dispensing channel above; or, ii. The applicable copayment as defined by the benefit plan; the member will never pay more than the cash price for the prescription	Fully Agree	
13.	Confirm Respondent will adjudicate multi-ingredient Compound Drug claims using the NCPDP D.0 standard.	Confirmed	
14.	For any Compound Drug claims submitted for reimbursement under the pharmacy benefit plan, Respondent will request a copy of the written recipe to verify that the claim has been submitted in accordance with contractual and NCPDP standards.	Fully Agree	~~Pharmacies request payment for compounds by submitting the appropriate National Council of Prescription Drug Programs (NCPDP) claim format, including the compound segment plus the negotiated dispensing fee. We request that pharmacies submit the cost and quantity used of each individual ingredient.~~
15.	Respondent will collect the following elements for each Compound Drug claim from every pharmacy submitting a claim for a Compound Drug: 1. Compound Indicator 2. NDC, Quantity, Submitted ingredient cost for each individual component in the recipe 3. Total Quantity and the total Usual & Customary price 4. Level of Effort value	Fully Agree	
16.	[redacted]		
17.	New to Market Limited Distribution Specialty Drugs may be defaulted to an initial rate for the first 60 calendar days. After 60 calendar days of acquiring access to a Limited Distribution Specialty Drug, Respondent will renegotiate the price on the specialty drug list with DMS to a market competitive rate.	Partial Agree	Agree, New to Market Specialty Drugs (including New to Market Limited Distribution Drugs) may be defaulted to an initial rate for the first 60 calendar days before a permanent rate is established. The Specialty Drug list is for illustrative purposes only, as OptumRx is not offering NDC level guarantees.

Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

Pricing Factors - Rx

Respondent Name:
OptumRx, Inc.

Instructions: Please read each of these factors below and confirm if Respondent agrees with each factor. Use Column "Explanation" to provide a brief explanation.Written Replies and Explanations within this excel Attachment must be limited to 400 characters or less. Written Replies and Explanations beyond 400 characters will not be evaluated. These responses will be used in the financial analysis.

18.	Split fills for specialty products will not be assessed two dispensing fees.	Fully Agree	~~OptumRx Specialty Pharmacy will not charge a dispencing fee for every split fill; however, specialty products dispensed outside of our specialty pharmacy may assess two dispensing fees.~~
	Reconciliation of Discount and Dispensing Fee Guarantees	**Reply**	**Explanation**
19.	All pricing discounts and dispensing fees guarantees will be reconciled on an individual component basis in each delivery channel (Brand, Generic, Retail, Retail 90/Mail at Retail/ Narrow Retail 90, Mail Order, Specialty) comparing actual discounts and dispensing fees achieved with guaranteed discounts and dispensing fees. The reconciliation will be guaranteed dollar for dollar, meaning that a surplus in one pricing component will not be allowed to make up for a shortfall in another component within or across delivery channels. No other savings (Example: manufacturer payments) can be used to offset the above discounts and guarantees.	Fully Agree	
20.	Respondent will calculate the achieved discounts with the following formula: [1-(total discounted AWP ingredient cost –excluding dispensing fees and penalties due to DAW claims and prior to application of copayments –of applicable prescription drug claims for the measurement period divided by total undiscounted AWP ingredient cost (both amounts will be calculated as of the date of adjudication) for the measurement/guarantee period)]. Discounted ingredient cost will always be the lowest of the AWP discount, MAC or U&C adjudication methodology.	Fully Agree	
21.	**Brand Discount Guarantees.** Respondent will include all Brand Drugs in the brand drug discount guarantees. Brand drugs shall include single-source and multi-source brand drugs. Respondent will not include any Generic Drugs (including but not limited to Single-Source Generics, House Generics, new to market generics, patent litigation generics, Authorized Generics and limited supply generics) in the brand discount guarantee nor reclassify any generics to adjudicate at the brand discount. If you do not fully agree to this requirement, your brand discounts will be reduced in the financial analysis of your offer.	Fully Agree	
22.	**Generic Discount Guarantees.** Respondent will include all generics (including but not limited to generic drugs with an approved ANDA, Authorized Generics, House Generics, multi-source generics, generics subject to MAC pricing, new to market generics, Single-Source Generics, generics involved in patent litigation, and limited supply generics) in the overall generic discount and will not reclassify any Generics to adjudicate at the Brand Drug discount. Respondent will not include any multi-source brand claims where a DAW penalty is assessed in the generic discount calculation. If you do not fully agree to this requirement, your generic discounts will be reduced in the cost analysis of your offer.	Fully Agree	
23.	**Specialty Brand Discount Guarantees.** Respondent will include all Specialty Brand Drugs dispensed through your preferred Specialty Pharmacy (including but not limited to Biosimilars, new to market Specialty Drugs, Exclusive/Limited Distribution Specialty Drugs) in the Overall Effective Discount (OED). Respondent will not include any specialty generic drugs in the calculation.	Fully Agree	

Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

Pricing Factors - Rx

Respondent Name:
OptumRx, Inc.

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24.	In addition, Respondent's replied specialty pricing will include varying ingredient cost discounts by Specialty Drug. The ingredient cost discount replied for each specialty drug shall be guaranteed and Respondent will adjudicate specialty claims filled in your preferred specialty pharmacy using the lesser of MAC or the "locked-in" drug discount.	Disagree	OptumRx is offering a separate Brand Specialty Discount Guarantee and a separate Generic Specialty Discount Guarantee. The Specialty Drug list is for illustrative purposes only.
25.	Respondent will include all specialty generic drugs dispensed through your preferred Specialty Pharmacy in the non-specialty Retail Pharmacy Generic Drug discount and dispensing fee guarantees.	Disagree	OptumRx is offering a separate Brand Specialty Discount Guarantee and a separate Generic Specialty Discount Guarantee.
26.	Respondent agrees to include all Specialty Drugs dispensed at a Retail Pharmacy will be included in the reconciliation of the non-specialty retail 30 minimum Brand and Generic discount and dispensing fee guarantees in the "**Rx-Pricing**" Worksheet.	Fully Agree	~~Updated from Fully Agree to Partial Agree based on the request for Open Specialty. Agree for Exclusive Specialty. Disagree for Open Specialty. Under an Open Specialty offer, Specialty Drugs filled at a Retail Pharmacy will be included in the Specialty reconciliation (brand or generic) discount and dispensing fee guarantees.~~
27.	[redacted]		
28.	**Calculation of the discount and dispensing fee guarantees shall only exclude the following types of claims:** a. Compounds, bulk chemicals, powders; b. Secondary COB claims; c. Subrogation claims d. Prescriptions filled at VA Hospitals e. Claims processed at 340b pricing f. In-house pharmacy claims if in-house pharmacy is not part of retail network g. Out of Network Paper claims	Fully Agree	
29.			

Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

Pricing Factors - Rx

Respondent Name:
OptumRx, Inc.

Instructions: Please read each of these factors below and confirm if Respondent agrees with each factor. Use Column "Explanation" to provide a brief explanation.Written Replies and Explanations within this excel Attachment must be limited to 400 characters or less. Written Replies and Explanations beyond 400 characters will not be evaluated. These responses will be used in the financial analysis.

30.	Respondent will not pass on future increases in postage/mailing fees for your Mail Order Pharmacy and your preferred Specialty Pharmacy to DMS during the contract term.	Fully Agree	
31.	Respondent will adjudicate non-MAC generics with a discount that is better than the minimum guaranteed discount for Brand Drugs in the same channel. Please specify your Non-MAC discount and dispensing fee guarantees in the "Rx-Pricing" worksheet.	[redacted]	
32.	Regardless as to whether an Agreement has been executed by a Client, Respondent will measure, report, reconcile and pay any discount, dispensing fee shortfall as well as minimum guaranteed manufacturer payments in accordance with the terms specified below.	Fully Agree	~~Confirmed based upon a signed contract or Letter of Agreement.~~
	Reconciliation and Payment of Manufacturer Payment Guarantees	**Reply**	**Explanation**
33.	Respondent's offer of Manufacturer Payments will be the greater of the minimum guaranteed amounts or 100% pass through of Manufacturer Payments.	Fully Agree	
34.	Respondent's offer assumes the Manufacturer Payment guarantees are NOT based on an average days' supply or pro-rated in any fashion.	Fully Agree	
35.	Respondent will provide a quarterly reconciliation of the 100% pass-through of Manufacturer Payments and pharma revenue and minimum guaranteed Manufacturer Payments.	Partial Agree	An annual reconciliation is performed 180 days of the end of the contract year and reconciles the rebate pass-through percentage against guaranteed minimums. Any additional collections received from manufacturers after the annual reconciliation period are remitted thereafter on a quarterly basis (90 days) if applicable.

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Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")
Pharmacy Benefit Management Services
Rx Technical Questionnaire

Respondent Name:
OptumRx, Inc.

Instructions: Enter the answer to each question using the "Reply" column. Use the "Explanation" column to provide an explanation, if applicable. Written Replies and Explanations within this excel Attachment must be limited to 400 characters or less. Written Replies and Explanations beyond 400 characters will not be evaluated. The questions indicated with a "¥" will not be scored by the Evaluators, as described in section 4.3 of this ITN.

SECTION L

		NETWORK ACCESS/PHARMACY NETWORK MANAGEMENT	Answer Format	Reply	Explanation
1		Proposed Network Plan Name	text	**Narrow Pharmacy Network:** Our retail 90-day supply programs offer new pharmacy solutions that drive improved outcomes for customers and members with an effective and convenient delivery of medications at affordable prices. Members have a choice to fill 90-day prescriptions for maintenance medications at their local CVS retail pharmacy or through our Home Delivery Pharmacy.	CVS offers customers the flexibility in member access based on their demographics with over 9,000 retail locations for either national chain. Members are allowed two grace fills at any retail network pharmacy before being formally directed to the preferred retail chain or OptumRx Home Delivery Pharmacy for their 90-day maintenance medications.
2		Network Model Type	text	Retail	
3		Pharmacy Network Operational Date	text	1993	
4		Pharmacy Network Ownership/Controlling Interest	text	We do not have any ownership interests in, or management contracts with, any retail pharmacy chains or pharmaceutical manufacturing services, however, we do maintain ownership of mail service and specialty pharmacy distribution facilities.	
		Participating Pharmacies - Internal Audits	**Answer Format**	**Reply**	**Explanation**
5		Does Respondent conduct desktop audits on at least 10.0% of scripts submitted by Retail Pharmacies during each contract year?	drop down box	No	OptumRx's desktop audits are initiated when a more expanded review is needed, including analyzing the pharmacy's historical data and considering member and prescriber information. Our desktop audits examine claim transactions and we request extensive source documentation from the pharmacy for review. Over 10 percent of our pharmacy network is subjected to desktop auditing each year.
6		Does Respondent perform onsite audits of up to 5 specific Participating Pharmacies during each Contract year? If requested by the Client, Participating Pharmacy Audits will be limited to 3 times per year.	drop down box	Yes	
7		Does Respondent comply with all state and federal laws and regulations pertaining to fraud and abuse, including without limitation Medicare Part D fraud and abuse requirements?	drop down box	Yes	
8		Does Respondent take appropriate action in the event that any pharmacy audits discover fraud or overpayment, including without limitation recoupment of such overpayments from pharmacies for services and/or products provided to Members?	drop down box	Yes	
9		Will Respondent notify the Client in writing if it learns that any Participating Pharmacy is under investigation for fraud or similar allegation of wrongdoing? Will this notification be within 30 days of discovery? In the event that any pharmacy is under investigation for fraud or similar allegation of wrongdoing, will the Client have the right to direct the Respondent to redirect Members to other Participating Pharmacies, and/or to suspend the Participating Pharmacy under investigation from the Pharmacy network?	text	Yes	OptumRx will notify the Department within 30 days of the completion of an audit where findings related to suspected fraud are identified. It is up to the Department to determine if they want to share the findings with other parties.
10		In the event that the Respondent discovers evidence of fraud or engagement in inappropriate business practices by a Participating Pharmacy, will Respondent notify Department and the appropriate governmental authorities for investigation? This notification should be within 30 days of discovery of such evidence.	drop down box	Yes	OptumRx will the Department within 30 days of the completion of an audit where findings related to suspected fraud are identified. It is up to the Department to determine if they want to share the findings with other parties.
	a.	Confirm the Department has the right to require the termination of such pharmacy as a Participating Pharmacy.	drop down box		
11		Will Respondent ensure that no Participating Pharmacy is listed on the list of excluded providers of the Office of the Inspector General or of the General Accounting Office Excluded Party List System ("Excluded Provider Lists")?	drop down box	Yes	
12		Will Respondent obligate Participating Pharmacies to ensure that no employee or vendor of any Participating Pharmacy is listed on the Excluded Provider Lists?	drop down box	Yes	
13		Will Respondent ensure that none of its employees or vendors are listed on the Excluded Provider Lists?	drop down box	Yes	
14		Will Respondent remove any non-compliant pharmacy from the network of Pharmacies, and promptly notify the Client if the Respondent removes a Pharmacy from the network due to a sanction listing or for any other reason?	drop down box	Yes	
15		Indicate the percentage of network pharmacies in Respondent's retail network for which you have conducted the following audits:			
	a.	On-site audits are conducted annually	Percent,1	7.0%	
	b.	Desktop audits are conducted annually	Percent,1	10.0%	2021 results were impacted by COVID-19 restrictions.
16		In the event that the Respondent recovers any amounts related to any Claim from any Pharmacy as a result of a pharmacy audit, will Respondent pass through to the Department 100.0% of said amounts?	drop down box	Yes	
	a.	Furthermore, will Respondent pay 100% of all audit recoveries (retail, mail, and specialty) to the Department on a quarterly basis within 30 calendar days from the close of the contract quarter?	drop down box	Yes	
		Retail Network	**Answer Format**	**Reply**	**Explanation**
17		Please describe the process if Respondent proposes a network change that impacts more than 5% of all pharmacies in the network (add, drop certain chains, etc.) and/or one of the top 5 pharmacy chains by store count before the effective date and or during the contract term. Will Respondent provide a detailed analysis describing member disruption and impact to pricing with all underlying assumptions disclosed to Department at least 90 calendar days prior to the effective date of the proposed network change?	text	We agree to provide the Department with a detailed analysis at least 90 days in advance of a proposed network change. While we do not foresee such a material change, our process would include an extensive review of the impact to the Department and an analysis of member disruption and any necessary restructuring of the pricing agreement.	
18		Please describe the process should the number of retail pharmacies in Respondent's network be reduced by more than 3% of all pharmacies in the network (add, drop certain chains, etc.) and/or one of the top 5 pharmacy chains by store count before the effective date and or any point during the contract term. Will Respondent provide Client with an improved pricing offer for the proposed reduced retail network at least 90 calendar days prior to the effective date of such change?	text	To provide the highest level of financial stewardship we regularly re-contract with network pharmacies on behalf of all of our customers. In the event a major network change occurs, OptumRx reviews the impact to the customer and determine if any restructuring of the pricing agreement is necessary.	OptumRx will work directly with the Department should any changes result in opportunities to revisit the pricing guarantees.
19		Please describe the process if the revised pricing that results from any change in the pharmacy network is not acceptable to the Department, Will the Department reserve the right to renegotiate pricing or terminate the agreement with 30 calendar days notice without penalty or compensation to Respondent?	text	Agree	OptumRx will work directly with the Department should any changes result in opportunities to revisit the pricing guarantees.
		Mail Order and Specialty Pharmacies - General	**Answer Format**	**Reply**	**Explanation**
20		Please describe the process of communicating any delays beyond three calendar days in the delivery of prescriptions to members.	text	Any delays in processing Home Delivery Pharmacy prescriptions are communicated to members by telephone within 48 hours of receipt.	Our system uses multiple triggers to alert intervention staff to delays, which may occur when: • The order requires prior authorization. • The order is out-of-stock. • Intervention staff has contacted the prescribing physician to clarify an order, but has not received a response.
21		What is the timing and the frequency of the reporting to such delays to clients?	text	While we make every effort to meet delivery guidelines, delays are sometimes unavoidable. Our mail service systems use multiple triggers to alert the intervention staff to any delays and if a delay occurs, we contact the member by phone within 48 hours to notify them of their order status. If circumstances dictate, and to maintain the member's medication adherence, the order can be re-prioritized to expedite processing. Individual instances are not reported but may be examined through standard, custom and ad hoc reporting options as needed.	
22		Please describe if Respondent arranges and pays for a short-term retail supply of a delayed or incorrectly processed mail order and/or specialty pharmacy prescription caused by Respondent? In addition, does Respondent charge Clients' members for expedited delivery of the mail order and/or specialty pharmacy prescription if the prescription delay is caused by Respondent?	text	We may authorize a partial fill for a mail order prescription at retail. The criteria used to authorize a partial retail supply is dependent on each situation. We work with the retail pharmacy to obtain step copayments for the partial supply and arrange for the member to pick up the portion of their prescription at the retail pharmacy.	When we can ship the remainder of the prescription, the remaining copayment is applied. There is no charge for expedited (overnight) shipping.

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Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")
Pharmacy Benefit Management Services
Rx Technical Questionnaire

Respondent Name:
OptumRx, Inc.

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23	In the event of a natural disaster or national emergency, please describe Respondent's process to continue to fill all prescription requests, proactively obtaining any necessary overrides to facilitate this process, and provide members with expedited delivery to convenient locations.	text	Our facilities are positioned in geographically diverse locations and have integration and redundancy in operation that positions us to fill all prescription requests in the event of a natural disaster or national emergency.	We work with local vendors and retail locations to confirm timely delivery to the Department's members during critical conditions, disasters, or circumstances that may disrupt our normal shipping process. We work with members to keep them informed of the situation and their options as we monitor conditions to provide continuance of service.
24	Please describe Respondent's process to assure that 100% of all mail order and specialty pharmacy prescriptions will be imaged and entered when received? Is Respondent able to electronically track 100% of all mail order and specialty pharmacy prescriptions throughout the filling process, on a timely basis, from the point of prescription is received until it is shipped to the member?	text	Upon receipt of a prescription, we scan the information into our system using imaging software. This initiates our electronic documentation process. The prescription is assigned a barcode to maintain accurate tracking through the dispensing process.	Once the order is logged into our system, a technician reviews the prescription. If the prescription is not complete or is not legible, the technician contacts the member or prescriber to get the necessary information.
25	Please describe Respondent's process to assure that, within 24 hours, Respondent will contact prescribers and/or members via a telephone call or email for 100% of incomplete mail order and specialty pharmacy prescriptions that require additional information?	text	Any delays in processing Home Delivery Pharmacy prescriptions are communicated to members by phone within 48 hours of receipt.	
26	Please describe the shipping insurance provided to all your Client's members who receive Rx(s) via mail order.	text	No additional shipping insurance is provided by OptumRx beyond what is provided by the carrier.	
27	Please describe Respondent's processes for email, telephone voicemail, and text messaging capabilities to communicate to members their mail order and/or specialty pharmacy prescription has been delivered and the date the order has been shipped to members.	text	After an order has been packaged and manifested in our system, a file is exported to the host system. The file contains complete tracking of the order's fulfilment. Based on the member's communication preferences, we notify the member with an IVR call, a text notification and/or an email confirming the order is shipped.	
28	Please describe what happens if a shipped mail order or specialty pharmacy package is lost, stolen or not delivered. Does Respondent charge the Client or the plan participant for the cost of the drug?	text	Medications that are lost, stolen or damaged before being received by the member are replaced at our expense.	
29	If any current member calls and says they have not received their prescription, and despite all discussions, the member still does not have the drug, what is the procedure to provide a replacement supply?	text	If there is a delivery issue, we reissue the medication at no cost to the member or the Department, unless otherwise requested by the Department. We send the replacement medication and require a recipient signature upon delivery. A refill is not used to provide the replacement supply unless it is determined to be member error, in which case, a refill may be used for the replacement.	
30	Please describe the process for the replacement supply. Is a refill used?	text	A refill is not used to provide the replacement supply unless it is determined to be member error, in which case, a refill may be used for the replacement.	
31	Please describe who pays for the missing drug? Is the client charged?	text	If there is a delivery issue, we reissue the medication at no cost to the member or the Department, unless otherwise requested by the Department.	
32	Please describe who pays for the missing drug? Is the member charged an additional copay?	text	If there is a delivery issue, we reissue the medication at no cost to the member or the Department, unless otherwise requested by the Department.	
33	Please describe the follow up process with the member. Does Respondent follow up with the member over the next few days to find out if they received the medication?	text	Home Delivery Pharmacy member communications include "package delivered" messaging which would be by their preferred method of text, email, phone. This would include prescriptions sent out to correct errors or lost drugs.	
34	What is the procedure if the member admits they received two prescriptions?	text	If a member received two shipments and the drug is considered stable, we instruct the member to properly store it for use in the subsequent month. If it is considered not stable, we have the medication returned and process the next fill when the member is due for a refill.	
35	Please describe Respondent's process for shipping to members choice of location. Will your Specialty pharmacy ship to members choice of location (i.e., physician office, etc.)?	text	Yes. Members can have deliveries shipped to their home, or an alternate site including work, hospital, provider office, or a UPS Access Point or FedEx Hold at Location (HAL) site.	
36	Please describe Respondent's procedure for accepting early refill orders and suspending or "queueing" these orders in your system until the earliest refill date for processing.	text	We collaborate with the Department to determine the most appropriate method for administering early refill requests. Depending on the benefit design, early refill requests can result in a claim rejection or a DUR hold. For requests that result in a DUR hold, we suspend the claim for a few days until our system indicates that the prescription is eligible for refill.	The maximum holding period for a queued or held order is 14 days.
37	Please describe your ability to accept major credit cards and store credit card number(s) by member account for future mail order and specialty pharmacy prescriptions? Does Respondent advise members 30 days in advance of the date their credit card number is going to expire?	text	We accept Visa, MasterCard, Discover and American Express as forms of credit card payment. Credit cards are stored in our system for member convenience.	We send a notification at 30 and 15 days prior to the expiration of a member's stored credit card to avoid delay or disruption. Credit cards that have not been used for an extended length of time may be removed from our system for security purposes.
38	If requested, please describe Respondent's procedure to provide members with checks for monies owed to them instead of maintaining credits at your mail order and specialty pharmacy facilities?	text	In the event a member overpays the copayment for his or her prescription order, the excess amount is retained as a credit on the member's account. Unused credits are automatically returned to the member after 120 days. If the member decides that he or she prefers a refund to an account credit, the member can call customer service and request a refund check to be mailed within eight days.	
39	Confirm Respondent can support a floor limit for accepting prescription orders from members without the correct payment? What is your recommended floor limit?	text	Yes, we recommend a $200 floor limit.	
40	When there are outstanding balances owed by membership, please describe your process. Does Respondent require a Client to pay outstanding balances?	text	We attempt to collect outstanding balances from members primarily through mailed communications. An invoice in the order package mailed to the member states the amount due if the payment was insufficient or a credit card is not on file. If an account has a balance of more than $13.00 for longer than six months, future orders are held until payment is made.	We do not bill the Department for outstanding balances on delinquent accounts.
41	Describe Respondent's process for changing the floor limit. Do Clients have the right to advise you in writing to change the floor limit for all members or just those with unpaid balances after 120 days of dispensing?	text	The floor limit is set at the plan level for all members and cannot be modified for select members based on the aging of unpaid balances.	
42	If requested, does Respondent provide members who are currently using the incumbent's mail facility an 800-number that may be called to provide you the information necessary to transfer their current mail order and/or specialty prescriptions to your mail order or specialty pharmacy facility? Please describe this process.	text	Yes. Information regarding the transfer of prescriptions to our Home Delivery and Specialty Pharmacies is included in the welcome materials that the Department's members receive. Members can call to request an OptumRx technician reach out to the physician and obtain a new prescription.	
43	If requested, does Respondent provide members who are currently using the incumbent's specialty pharmacy facility an 800-number that may be called to provide you the information necessary to transfer their current specialty prescriptions to your specialty pharmacy facility? Please describe this process.	text	To promote proactive communication of our Specialty Pharmacy Program, we recommend sending letters to existing patients using specialty medications approximately 30 days before the Department's official start date.	Optum Specialty Pharmacy attempts to contact each patient by phone to introduce the Specialty program, answer questions and schedule the first delivery to provide continuity of care and avoid lapse in therapy.
44	Please describe if Respondent is able to prorate copays at mail order for claims that are processed for less than or equal to a 60 day supply?	text	Yes. We have the ability to offer copayment proration for prescriptions filled at our Home Delivery Pharmacies for a 30- and-60-day supply. We are available to discuss this option in further detail with the Department.	

Mail Order Facilities	Answer Format	Reply	Explanation
45 **Provide information on the proposed Mail Order Facilities for Department (use the Census file to understand employee locations and determine the most geographically appropriate mail order facility):**			
a. **Primary Mail Order Facility Location: ¥**	text	Overland Park, Kansas	
Address:			
Street Address ¥	text	6860 W. 115th Street, Suite 150	
City ¥	text	Overland Park	
State ¥	text	Kansas	
Zip Code ¥	text	66211	

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Rx Technical Questionnaire

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b.	What are the standard hours of operation? ¥	text	(CST) Monday to Friday 6 a.m. to 2:30 p.m. (first shift); Sunday to Thursday 3:00 p.m. to 11:30 p.m. (second shift)	
c.	**Secondary Mail Order Facility Location(s) ¥**			
	Address: ¥			
	Street Address ¥	text	5627 University Heights, Suite108	
	City ¥	text	San Antonio	
	State ¥	text	Texas	
	Zip Code ¥	text	78249	
	Service Statistics for all Mail Order Facilities:	**Answer Format**	**Reply**	**Explanation**
46	Quarterly Dispensing Capacity	number	18.2M	
47	Number of Prescriptions Dispensed in the Most Recent Quarter	number	44,784,962	
48	Ratio of Pharmacists to Pharmacy Technicians	text	Our Home Delivery Pharmacy Program meets or exceeds the required pharmacist to technician ratio defined by each state's regulations, while also meeting all OptumRx business and service commitments.	
49	Average Number of Prescriptions Dispensed per Pharmacist per Hour	number	26.45	
50	Average turnaround time in the most recent quarter for prescriptions that:			
a.	Required intervention (in days)	number	1.46	
b.	Did not require intervention (in days)	number	0.63	
51	Mail Order Dispensing Accuracy (Percentage):	number	99.998	
52	Member Satisfaction with Mail Order service (score out of total)	number	96.9	
	Preferred Specialty Pharmacy Facilities	**Answer Format**	**Reply**	**Explanation**
53	**Is Respondent's Specialty Pharmacy wholly owned or outsourced?**	drop down box	Wholly Owned	
54	**Provide information on the proposed Specialty Pharmacy Facilities for Department (Use the Census file to understand employee locations and determine the most geographically appropriate specialty pharmacy facility):**			
a.	**Primary Specialty Pharmacy Facility Location: ¥**	text	Jeffersonville, Indiana	
	Address: ¥			
	Street Address ¥	text	1050 Patrol Road	
	City ¥	text	Jeffersonville	
	State ¥	text	Indiana	
	Zip Code ¥	text	47130	
	Percentage of calls handled ¥	percentage	More than 97%	
b.	**Secondary Specialty Pharmacy Facility Location(s) ¥**			
	Address: ¥			
	Street Address ¥	text	This is not applicable.	
	City ¥	text	This is not applicable.	
	State ¥	text	This is not applicable.	
	Zip Code ¥	text	This is not applicable.	
	Service Statistics for all Specialty Pharmacy Facilities:	**Answer Format**	**Reply**	**Explanation**
55	Quarterly Dispensing Capacity	number	88%	
56	Number of Prescriptions Dispensed in the Most Recent Quarter	number	374,000 per month	
57	Ratio of Pharmacists to Pharmacy Technicians	text	Our Specialty Pharmacy Program meets or exceeds the required pharmacist to technician ratio defined by each state's regulations, while also meeting all OptumRx business and service commitments.	
58	Average Number of Prescriptions Dispensed per Pharmacist per Hour	number	88 percent capacity per pharmacist per hour.	
59	Average turnaround time in the most recent quarter for prescriptions that:	number	For 2021, our average turnaround time for all specialty prescriptions (including clean and exception) is 5.3 calendar days.	
60	Required intervention (in days)	number	Separate turnaround time statistics for clean versus exception fills is not available.	
61	Did not require intervention (in days)	number	Separate turnaround time statistics for clean versus exception fills is not available.	
62	Specialty Pharmacy Dispensing Accuracy (Percentage):	number	100.00%	
63	Member Satisfaction with Specialty Pharmacy service (provide both the scoring scale and member satisfaction score received)	number	[redacted]	
	Specialty Call Center	**Answer Format**	**Reply**	**Explanation**
64	Does Respondent's specialty call center have experience with patient placement? Please provide the number of years the facility has provided patient placement services and include the average tenure of the team at the call center providing these services.	text	[redacted]	
65	Is there a designated team of call center representatives who handle patient placement?	drop down box	Yes	
66	What is the ratio of licensed staff (e.g., RPh, RN, LPN) to unlicensed staff in this team?	number	488 / 1024	
67	Provide the number of licensed staff and designation for each staff member.	number	229 Pharmacists; 259 Pharmacy Techs	
68	Provide the number of unlicensed staff.	number	1024	
69	Does Respondent's specialty call center offer provider assistance to providers in your network?	drop down box	Yes	
70	Confirm specialty customer service representatives shall have access to the following information to support member inquiries:			
a.	Member profile	drop down box	Yes	
b.	Utilization history	drop down box	Yes	
c.	Complete benefit plan design information	drop down box	Yes	
d.	Claims status and procedures (retail, mail order, specialty)	drop down box	Yes	
e.	Location of a mail service prescription in the dispensing process	drop down box	Yes	
f.	Explanation of benefit payments	drop down box	Yes	
g.	Explanation of benefit denials	drop down box	Yes	
h.	Literature fulfillment information, including the status of any literature being mailed to a member	drop down box	Yes	
i.	Member-specific comment history	drop down box	Yes	
	Specialty Product Distribution	**Answer Format**	**Reply**	**Explanation**
71	Please indicate if the pharmacy ships Priority Mail or Next Day delivery.	text	UPS is our primary carrier for overnight delivery. Orders may also ship with FedEx or United States Postal Service (USPS) Express Mail. The shipping department analyzes the member's geographical destination and selects the carrier believed to perform most efficiently and reliably within that region.	
72	Who is the primary carrier for delivering Specialty Products?	text	UPS is our primary carrier for overnight delivery. Orders may also ship with FedEx or United States Postal Service (USPS) Express Mail. The shipping department analyzes the member's geographical destination and selects the carrier believed to perform most efficiently and reliably within that region.	
73	Does Respondent utilize cold-packs and other special packaging for sensitive products? Please explain what prompts the use of cold-packs or other specialized packaging and shipping.	drop down box	Yes	Medications have both an upper and lower range temperature that must be maintained, so our packaging is designed to protect medications in the event of a shipping delay, or seasonal temperature variations.

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74		Does Respondent's specialty pharmacy process claims as both a specialty pharmacy and a retail pharmacy in your network? If so under what rules do you distinguish the two?	text	Yes	Medicare Part D Specialty falls under retail, the specialty pharmacy must adhere to CMS retail guidelines.
		Specialty Coordination of Benefits	**Answer Format**	**Reply**	**Explanation**
75		**Please indicate Respondent's ability to do the following:**			
	a.	Coordinate NDC billing through the Rx plan from medical providers.	drop down box	Yes	
	b.	Coordinate J-Code billing through the Rx plan from medical providers.	drop down box	Yes	
	c	Coordinate billing for applicable Medicare reimbursed products under Part A & B.	drop down box	Yes	
	d	Indicate maximum balance due allowed by your specialty service pharmacy.	drop down box	Yes	
	e	What are the average number of days-outstanding for Specialty DMRs?	text	OptumRx Specialty pharmacy will facilitate member education and connect members with entities to process Direct Member Reimbursements. Since these transaction are processed outside of our pharmacy we would not be able to track or report on status of such transactions.	
	f	Will Respondent bill the medical benefit through the use of a HCFA 1500?	drop down box	Yes	
	g	Will Respondent bill the medical benefit through the use of a UB92?	drop down box	Yes	
	h	Does Respondent offer coordination of care with Home Health Agencies when indicated?	drop down box	Yes	
	i	If yes, are these Home Health Agencies clinically credentialed to ensure appropriate levels of competency?	text	Yes	
	j.	Do you have the experience processing both pharmacy and medical claims for specialty pharmacy?	drop down box	Yes	
	k.	If yes, please describe. If not do you have plans to develop this capability and on what timeframe?	text	If the medication is covered under the medical benefit, we submit claims through electronic claim formats, such as 837, 835, 850, 270 and E1, or manually on a HCFA 1500 claim form.	If preferred by the Department, we may bill its medical vendor through a UB92 claims form. In some cases, we use a medical policy clinical review tool to manage medical benefit medications to determine if they meet intended therapy needs.
		Patient Assistance Programs	**Answer Format**	**Reply**	**Explanation**
76		What kind of resources are committed to supporting patient assistance programs?	text	All eligible patients receiving therapy are offered manufacturer copayment assistance if the patient states they are unable to afford their medication. Our patient assistance teams check that all requirements are met prior to applying copayment assistance based on manufacturer guidelines.	
77		What is the staffing level to identify programs and help educate/enroll eligible patients?	text	Our PAD team has access to a web-based tool to search for programs that may provide foundational assistance or grant options for members. This team handles thousands of member requests for additional funding per month and utilizes all resources available to secure funding for eligible patients. They work with all available foundations to support a broad spectrum of diagnoses.	
78		What is your commitment to supporting patient assistance programs in the future?	text	Optum supports patient assistance programs for specialty drugs. We proactively screen all prescriptions for available manufacturer copayment assistance, per the patient's plan guidelines. If the patient qualifies for free medication through a manufacturer's patient assistance program, our team coordinates with the manufacturer's HUB or other entity to secure access on behalf of the patient.	We send the patient and the prescriber's office a letter identifying the manufacturer for the prescribed medication, information pertaining to the duration of the subsidy offered by the manufacturer, and notification that the subsidy does not impact their out-of-pocket costs. In 2021, Optum Specialty Pharmacy secured approximately $601.5 million using manufacturer copayment assistance.
79		Do you have plans to expand your patient assistance programs to further help clients and patients?	drop down box	Yes	Our PAD team has access to a web-based tool (Patient Assistance Program Database) to search for programs that may provide foundational assistance or grant options for the Department's members. The PAD team continually researches additional programs for future inclusion to offer comprehensive financial assistance for those in need of additional coverage for their specialty medication.
80		**Indicate for the following Specialty medication category if Respondent provides triage assistance and/or enrollment support for members who require financial assistance.**			
	a.	Growth Hormones	text	Yes	
	b.	Hemophilia	text	Yes	
	c.	Viral Hepatitis	text	Yes	
	d.	Infertility	text	Yes	
	e.	Multiple Sclerosis	text	Yes	
	f.	HIV/AIDS	text	Yes	
	g.	Arthritis/psoriasis	text	Yes	
	h.	Crohn's Disease	text	Yes	
	i.	Oncology	text	Yes	
	j.	Cystic Fibrosis	text	Yes	
	k.	Transplant	text	Yes	
	l.	RSV	text	Yes	
	m.	Hemophilia	text	Yes	
	n.	Other (Please List)	text	We proactively screen all prescriptions for potential available manufacturer copayment assistance, per the patient's plan guidelines.	
		Copay Assistance Programs	**Answer Format**	**Reply**	**Explanation**
81		Describe how Respodent allocates coinsurance and copayment dollars with respect to deductible and out-of-pocket accumulators that are covered by a manufacturer coupon or copay card.	text	Our accumulator adjustment solution provides a real-time solution to exclude copay card dollars from members' accumulators. Applying copay card dollars towards a member's deductible and out-of-pocket maximums increases the plan sponsor's liability throughout the plan year.	Preventing the application of the copay card towards a member's deductible and out-of-pocket maximums allows the benefit design to work as intended to drive plan sponsor savings.
82		Describe how Respondent's Specialty pharmacy administers manufacturers discount coupons (accept/not accept coupons, accept only at Retail, etc.).	text	We accept coupons or copayment cards for prescriptions adjudicated and dispensed through Optum Specialty Pharmacy, if the customer is exclusive to our specialty pharmacy.	Coupons and copayment cards for high dollar specialty prescriptions may be accepted as part of our patient assistance efforts. These situations involve processing a secondary, coordinated claim to allow the member the benefit of a discount.
83		Describe how Respondent's Specialty pharmacy administers copay assistance programs.	text	We screen all patient prescriptions to determine the availability of copay assistance. If manufacturer copay assistance is not available, or plan guidelines do not allow the use of manufacturer copay assistance and the member states financial hardship, our patient care coordinators investigate options for alternative assistance.	We work to assist patients in obtaining financial support through a variety of sources, both needs based and non-needs based.
84		Does Respondent communicate adjustments to the provider who manages the member share accumulators (deductible/out-of-pocket maximums) based on monies received from copay assistance? If yes, please describe your process to do this using the "Explanation" column.	drop down box	Yes	We complement traditional communications with a real-time provider portal; it encourages providers to use it to gain on-demand access and visibility into medication status, tracking shipments, and patient engagement. We offer tailored communication, leveraging analytics and holistic clinical management to deliver on high value clinical touch points, driver outcomes and lower medical costs.
85		Does Respondent communicate adjustments to the provider who manages Health Reimbursement Account (HRA) balances (or other account balances) based on monies received from copay assistance? If yes, please describe your process to do this.	drop down box	Yes	We complement traditional communications with a real-time provider portal; it encourages providers to use it to gain on-demand access and visibility into medication status, tracking shipments, and patient engagement. We offer tailored communication, leveraging analytics and holistic clinical management to deliver on high value clinical touch points, driver outcomes and lower medical costs.

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86	Does Respondent have a program where members are allowed to use manufacturer discount cards to help them pay for specialty drugs but not have these funds apply against a member's deductible or out-of-pocket maximum? Please explain how this program works.	drop down box	Yes	We offer our accumulator adjustment solution as an opt-in offering for customers with our mandatory mail benefit design programs. The real-time solution excludes copay card dollar amounts from the members' accumulators (member deductible and out-of-pocket maximum). This shift helps maintain the integrity and intention of the pharmacy benefit plan.
87	Does Respondent have a specialty drug copay assistance program where the payer can use the copay assistance to decrease the amount paid? Please explain your program using the "Explanation" column.	drop down box	Yes	Our variable copayment solution aids customers in reducing plan costs by maximizing pharmaceutical manufacturer-sponsored funds within the manufacturer copayment assistance program on certain specialty drugs filled at Optum Specialty Pharmacy. Our solution varies member cost-share to take advantage of copayment card funds for the customer, thereby decreasing the customer's cost-share.
88	Explain how Respondent will assist Client in managing the exceptionally high cost of ultra-orphan and gene therapy products that will impact the outpatient pharmacy budget? Please address both clinical management and innovations on the payment side in your Reply.	text	OptumRx has specific programs in place to manage costs of orphan drugs and gene therapy products. We target specific high-cost orphan drugs, perform clinical pharmacist interventions and work with member providers to close care gaps and prevent drug-to-drug interactions. We monitor the gene and cell therapy pipeline closely to anticipate risk exposure and work with customers to control costs.	Our Orphan Drug program provides advanced clinical counseling to address unique member and medication needs. Our Gene Therapy Solutions include outcomes-based contracting administration and payment model innovation. We incorporate outcomes-based manufacturer agreements tying drug price to patient outcomes tracked over time and provide care management and patient navigation to maximize outcomes.

	For EGWP Rx: Medicare Part B Coordination of Benefits (COB)	Answer Format	Reply	Explanation
89	Does Respondent currently offer a real-time Medicare Part B Coordination Of Benefits (COB) solution at mail order? ¥	drop down box	Yes	
90	Provide a process flow for the Medicare Part B COB solution at mail order program and explain which entity provides these services. Please name the file: [Respondent's Name]_Process Flow. ¥	drop down box	Yes	Please see OptumRx_Process Flow.
91	Are all of your mail order pharmacies, including specialty pharmacies, enrolled as Medicare Part B Suppliers? If no, are some of your mail order pharmacies, including specialty pharmacies, enrolled as Medicare Part B Suppliers? If yes, how many? Provide the total number of mail order pharmacies and specialty pharmacies in the "Explanation" column. ¥	text	Yes	We have 6 home delivery pharmacies and 14 specialty pharmacies.
92	If some or all of your pharmacies are Medicare Part B Suppliers, which classes of drugs and supplies are currently dispensed to Medicare Part B members? ¥	text	We dispense all classes of drugs and supplies to Medicare Part B members, as the benefit plan design dictates.	

SECTION II.

	CLINICAL AND QUALITY CARE PROGRAMS/WELLNESS PROGRAM ABILITIES Respondent Accreditations	Answer Format	Reply	Explanation
1	Does Respondent currently have URAC accreditation for items a-c below? Please include the expiration date of these accreditation/certifications in the "Explanation" column.			
a.	Pharmacy Benefit Management	drop down box	Yes	1/1/2025
b.	Specialty Pharmacy	drop down box	Yes	6/1/2024
c.	Mail Order Pharmacy	drop down box	Yes	11/1/2023
2	NCQA Disease Management Program Accreditation			
a.	Expiration date of accreditation/certification ¥	date	1/1/2022	Not applicable. We do not have NCQA accreditation for Disease Management.
3	NCQA Utilization Management Certification ¥	drop down box	Yes	
a.	Expiration date of accreditation/certification ¥	date	11/25/2022	
4	List any other accreditations for which Respondent has been certified and include the expiration date for any other accreditations provided.	text	We hold the following accreditations: URAC accreditation for Workers' Compensation and Property and Casualty Pharmacy Benefit Management (9/1/25); National Association of Boards of Pharmacy - NABP Digital Pharmacy Accreditation for OptumRx (4/20/23); and Accreditation Commission for Health Care (ACHC) for Specialty Pharmacy (6/18/23).	
5	Please provide your CMS STAR-rating issued in the Fall of 2021 that pertains to your 2023 contract(s) that you are proposing for the EGWP Rx Plan. ¥	text	In October 2021, CMS released the 2022 Star Ratings (using plan year 2020 data). The Summary Medicare Part D Star Rating that the OptumRx Employer Group Waiver Plan (EGWP) contract received was a 4.5 star.	
6	Will Respondent provide the methodology for calculating ROI prior to the start of the program?	drop down box	Yes	
a.	Will your form change the methodology during the life of the program?	drop down box	No	
7	Does Respondent exclude savings from Concurrent DUR and administrative edits, including but not limited to "refill too soon", from any clinical savings guarantee?	drop down box	Yes	
8	Will Respondent's reporting clearly outline the performance of each individual clinical edit separately, in addition to summary level reporting.?	drop down box	Yes	
9	Will savings assumptions be based on Client-specific utilization and not on book of business measures?	drop down box	Yes	
10	Will savings reported be direct savings associated with the pharmacy benefit and will not include any inferred medical savings?	drop down box	Yes	
11	Does Respondent provide a fixed fee per letter, if any, to provide and mail communications pieces to participants to help them lower costs (e.g., switching to generics, mail, etc.)?	drop down box	No	Members receive mail and digital communications on ways to help lower medication costs. Examples include: information on Optum Home Delivery, which can help members save on 3-month supplies of medication and Proactive Savings Alerts, which provide emails to members with ways to save on their medication. In-depth customization of any member communications may incur additional fees.
12	Does Respondent accept prior authorization calls from physicians to review coverage requests by reason of medical necessity as they arise?	drop down box	Yes	A dedicated team of licensed pharmacists, registered nurses, and pharmacy technicians manage our Prior Authorization (PA) process and work with physicians to administer clinical guidelines. If the request meets the guidelines, it is approved and an approval is sent to the physician. If not approved, a notification is sent with the reason for denial, therapeutic alternatives, as appropriate.
13	Does Respondent actively promote therapeutic substitution of clinically equivalent generic drugs as alternatives to brand name drugs?	drop down box	Yes	
14	Does Respondent communicate with participants about alternative medications or places of service when a change will save both the participant and Client money before the application of rebates?	drop down box	Yes	
15	Does Respondent allow the Client the ability to 'opt-out' of clinical programs, which include but are not limited to therapeutic substitution programs and impose no penalties for opting out?	drop down box	Yes	Opting-out of clinical programs may impact rebates; in which case, we will offer a shared decisioning process with the Department.
16	Is Respondent capable of providing reporting specific to the activity and outcomes associated with all of the utilization management tools and programs as frequently as the plan requests?	drop down box	Yes	

	Pharmacy & Therapeutics (P&T) Committee	Answer Format	Reply	Explanation
17	**Respondent's Pharmacy & Therapeutics Committee employs:**			
a	Academy of Managed Care Pharmacy's (AMCP's) PDL submission process	drop down box	Yes	
b	Data provided by one or more of your employees	drop down box	Yes	OptumRx Clinical Pharmacists prepare the drug monographs reviewed by the external, independent P&T Committee.
c	Multi-disciplinary approach	drop down box	Yes	
d	Outcomes data	drop down box	Yes	

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e	Pharmaceutical manufacturer representatives or their prepared data in decision-making	drop down box	Yes	FDA approved prescribing information is referenced within drug monographs; dossiers may be referenced as supporting material; pharmaceutical representatives are not permitted to participate in any P&T related activities.
f	Pharmacoeconomical data	drop down box	Yes	
18	**Respondent utilizes a Pharmacy & Therapeutics Committee to develop and maintain:**			
a	Respondent's PDL(ies)	drop down box	Yes	
b	Utilization management programs and coverage rules	drop down box	Yes	
19	**Provide the following information concerning the Pharmacy & Therapeutics Committee (Committee):**			
a	Frequency of meetings	number	monthly	
b	Number of physicians	number	10	
c	Number of pharmacists	number	2	
d	Number of nurses	number	0	
e	Number of PBM employees	number	21,656	Our employee profile as of 01/01/2022: Includes full and part-time employees, and does not include contractors.
f	Do PBM employees have voting rights?	drop down box	No	
g	List disciplines represented	text	Cardiology Endocrinology Epidemiology Geriatrics Hematology/oncology Internal medicine Pain Medicine Rheumatology Pediatrics Psychiatry	
h	The Committee considers the non-clinical considerations like member impact and the costs of products, net of rebates, during their review for PDL representation.	drop down box	No	The P&T Committee proceedings do not include discussion of drug costs so as not to bias clinical determinations. Once P&T Committee deliberations are complete, an internal Formulary Management Committee determines final formulary status for each drug based on clinical designations assigned by the P&T Committee, projected financial impact, member and physician disruption, and generic availability.
i	The Committee accepts funds from pharmaceutical manufacturers.	drop down box	No	
j	The Committee considers the costs of products, including rebates, during its review for PDL representation.	drop down box	No	
k	Respondent's PDL always follows the recommendations of the P&T Committee.	drop down box	Yes	

SECTION III.

	SERVICES AND ADMINISTRATION	Answer Format	Reply	Explanation
	Reporting			
1	Attach a sample management and utilization report(s) that could be prepared for a client's population. **Name the file: [Respondent's Name]_MgmtRptgPkg.**	drop down box	Attached	Please see OptumRx_MgmtRptgPkg.
	Customer Service	**Answer Format**	**Reply**	**Explanation**
2	Describe Respondent's process for allowing the Department the right to review the on-line scripting for call center representatives prior to the implementation/effective date. Please confirm Respondent will implement any suggested changes after the Department reviews the scripting.	text	The Department can review the scripting (IVR greeting) prior to the implementation/effective date. At this time, customers have limited ability to modify, change, or customize our scripting (telephony/IVR, policies and procedures, and training) as it is an integral part of our overall customer service training and process.	
3	Describe your procedure if member/provider service representatives require access to a pharmacist in the event the call requires the attention of a clinician.	text	Our customer service unit includes pharmacists whom members and providers can speak with 24 hours a day, seven days a week through our call center, our website through a click-to-call feature or Optum Live which provides real-time, face-to-face video consultation. Our clinicians have experience in retail, hospital, long-term care and home health care settings.	
4	Please describe your process in notifying a Client of any customer service disruptions lasting more than an hour. Customer service disruptions include but are not limited to unexpected technical issues, scheduled maintenance, or known unknown risks (e.g., weather-related).	text	We inform the Department of any customer service disruptions by notifying the assigned client management team. In turn, the assigned client team keeps the Department informed of any status updates related to the customer service disruption.	Examples of customer service disruptions include unexpected technical issues, scheduled maintenance or known and unknown risks, such as those related to weather events.
5	Describe Respondent's process for escalated issues. Does the customer service representatives offer the name and phone number of the "manager/supervisor", if requested?	text	Yes. We track member, provider service, and prior authorization inquiries by annotating the member's record in our online customer service systems. Our Customer Service Advocates (CSAs) also create a work case in the event that additional action is required for resolution.	CSAs track multiple inquiry types and categories, including complaints and grievances on member records using specific call tracking reason codes and sources.
6	How many and which languages does your call center support?	text	Our call centers are staffed 24 hours a day, seven days a week with bilingual representatives to assist both English- and Spanish-speaking members. We also contract with LanguageLine Solutions®, a company that provides real-time, around-the-clock translation for over 240 languages.	Please see OptumRx_Customer Service Language Line List for a list of languages available through LanguageLine Solutions.
7	Describe if Respondent's customer service representatives have access to an application that allows them to run "test claims" (to obtain prices) for members requesting this information.	text	Yes	
8	Describe your capabilities to provide versions of your members site in multiple languages. Do they offer the same functionality as the English version?	text	Our member website is available in English. A language assistance link directs members to the customer service department for help translating and using the website. However, we work with the Department to discuss the development of a website in additional languages to meet member needs.	
9	Please describe Respondent's online web-based member service capabilities and if they are able to support the following customer service functions: mail service refill/order tracking capabilities, pharmacy locator, PDL support, drug pricing tool, requests for explanation of benefits (EOB), appeal forms, and direct member reimbursement forms?	text	Yes, our web-based member service capabilities include mail service refill/order tracking capabilities, pharmacy locator, formulary support, drug pricing tool, requests for explanation of benefits (EOB), appeal forms, and direct member reimbursement forms.	
10	Does Respondent hold call calibration meetings, where a Client can listen to selected member calls and provide feedback?	text	Yes	
11	Describe Respondent's telephone tracking system for specific member/provider telephone inquiries. Confirm Respondent will provide monthly reports of call volume, first call resolution rates, average wait times and abandonment rates?	text	We can provide the Department with reports that identify our call center performance results for it's members. Metrics captured include call volume, first call resolution rates, average wait times and abandonment rates. Performance reports are available in an electronic format at a frequency that helps support the Department's business needs.	
12	Describe Respondent's capability in opening telephone lines as early as one month prior to open enrollment and in following contract years. Can Respondent add additional staff during open enrollment to answer calls from prospective members?	text	Yes. Our digital member onboarding program provides a simplified, personalized open enrollment experience that reduces member disruption and maintains medication adherence rates by proactively engaging members before prescription drug coverage begins.	This differentiated member experience provides members with digital and telephonic support to reduce the likelihood running out of medication during the transition to OptumRx.

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13	Describe Respondent's processes and procedures to provide all member services and provider service staff with training on new Client programs at least 10 calendar days prior to opening telephone lines and 30 calendar days before launch date, respectively.	text	We educate our CSAs on the Department and its benefit plans using the following resources: • Monthly bulletins outlining specifics about the benefit plans • Information on special member programs • Media board slides throughout our call centers announcing the Department as a new customer • Computer-based and classroom training • Secret shopper calls to provide proactive coaching for CSAs.	
14	Describe the process of recurring training, as needed, for newly assigned staff and/or in the event of benefit modification?	text	We offer a comprehensive and robust training program for our team of CSAs. We work with the Department to customize training specific to its benefit and culture requirements. Training includes: Department-specific products, services, culture and systems; detailed claims processing edits, drug coverage, and services; and privacy and confidentiality policies.	We will work with the Department to assure training is customized to your needs and will train CSAs in the event of a benefit modification.
	EGWP Rx Retiree Website/Online Tools	**Answer Format**	**Reply**	**Explanation**
15	**Medicare retiree members will have access to a web-based application, which allows them to:**			
a.	Review pharmacy locations ¥	drop down box	Yes	
b.	Review Alternative drug therapies (i.e., PDL status, generic alternatives available, etc.) and cost of each. ¥	drop down box	Yes	
c.	Compare price of a medication at retail versus mail order. ¥	drop down box	Yes	
d.	Price a medication (including comparative retail pricing from local retail pharmacies) ¥	drop down box	Yes	
e.	Review EGWP Rx standard and enhanced PDL, with drug lookup capabilities (not just a list of PDL drugs). ¥	drop down box	Yes	
f.	Request mail order refills. ¥	drop down box	Yes	
16	**Confirm that Respondent provides the following online tools/capabilities for retirees:**			
a.	To model drug spend throughout the year, based on retiree entry of drugs, with easy lookup for drug entry ¥	drop down box	Yes	
b.	To see a picture of the drug dispensed, and information on the drug ¥	drop down box	Yes	
17	Respondent offers a mobile app designed for seniors. ¥	drop down box	Yes	
	Implementation Support	**Answer Format**	**Reply**	**Explanation**
18	Does Respondent design, submit for a client's approval, and print forms with Client's logo for claims submissions, where required?	drop down box	Yes	We have a standard direct member reimbursement (DMR) claims form that the customer can co-brand with their logo. We do not do design work, but for example, if the Department housed our DMR form on their company Intranet, they could have their logo on it too.
19	Provide member enrollment materials for both the Commercial and EGWP Rx population. Name the file: [Respondent's Name] Enrollment Materials. ¥	drop down box	Attached	
20	Does Respondent provide customized and targeted mailings to Clients?	drop down box	Yes	Some materials are customizable in order to illustrate the Department's benefit/plan design structure. Other materials are standard and not customizable. For our EGWPs, we work with the Department to create open enrollment marketing materials for its EGWP program.
21	Does Respondent accept and load all open mail order and specialty pharmacy refills, prior authorization histories, and at least six months of historical claims data, at no additional cost to a Client during the implementation process?	drop down box	Yes	
	Account Management	**Answer Format**	**Reply**	**Explanation**
22	Please provide biographies for the Executive Sponsor, Strategic Account Executive, Day-to-Day Account Manager, Customer Service Representative, Customer/Claims Advocate for Escalated Claims, Implementation Manager, Communication Liaison, and any other Key Personnel who may be assigned to service a new client. Name the file: **[Respondent's Name]_Biographies**	drop down box	Attached	Please see OptumRx_Biographies for Key Personnel assigned to the Department.
23	Describe Respondent's detailed plan for managing a client's account, including periodic reviews of cost and utilization and recommendations for plan design changes. Name the file: **[Respondent's Name]_Account Management Plan.**	drop down box	Attached	Please see OptumRx_Account Management Plan.
24	Is Respondent able to provide multilingual plan representative support for open enrollment meetings? Please list other languages in the "Explanation" column.	drop down box	Yes	Please see OptumRx_Customer Service Language Line List for a list of languages available through LanguageLine Solutions.
	Experience - EGWP Rx	**Answer Format**	**Reply**	**Explanation**
25	Indicate the number of years that Respondent has offered EGWP Rx plans. ¥	number	[redacted]	
26	Provide Respondent's beginning of year membership for EGWP Rx plans for the past five years (year by year from Jan 2017 to Jan 2021). ¥	number		
27	How many new EGWP Rx members did Respondent add in the last three years (year by year 2019 through 2021). ¥	number		
28	What percentage of Respondent's 2020 total group membership for EGWP Rx renewed for the 2021 plan year? ¥	percent,1		
29	Describe any CMS program or issue audits related to Respondent's proposed contracts for Part D that have been completed in 2017 – 2020 and CMS's findings and/or actions. ¥	text	The blinded results of our last five CMS Program Audits before the Validation Audit are below: **Program Audits Pre-Validation**** **CMP: No** **ICAR: Yes* last in 2018** **CAR: Yes* last in 2019** **CAP: Yes* last in 2021** **Observation: Yes* last in 2018** **Sanctions: No***	These results are based on our last five Program Audits (going back to 2018). Please note, the service delegation models vary by customer. Audit notes: * Customer does not delegate some or all CDAG responsibilities to OptumRx. **Audit Results are not considered final by CMS until the Final Audit Report is issued. We have included draft audit results as Final Audit results are not always shared.
30	Briefly describe Respondent's EGWP Rx experience, with respect to enhanced EGWP Rx coverage, and experience integrating with EGWP Medicare Advantage (EGWP MA) plans. ¥	text	We have held a Medicare Part D Employer Group Waiver Plan (EGWP) Prescription Drug Plan (PDP) contract with CMS since 2007. We have extensive experience administering complex state employer groups. Our experience encompasses all aspects of Medicare Part D including CMS enrollment, member communications, claims adjudication, clinical programs, and compliance.	The OptumRx EGWP is an 800-Series EGWP PDP and, as such, recognizes that retirees may be covered under a stand-alone Medicare Advantage (MA) Plan. Pursuant to the CMS waiver authority, retirees can elect to enroll in a stand-alone MA plan provided the plan is an 800-Series coordinated care plan.
	Infrastructure and Security	**Answer Format**	**Reply**	**Explanation**
31	Has Respondent had a data security breach? If so, how many in the past 24 months and how many lives has it affected? Use **"Explanation"** box.	text	Yes	In 2014, OptumRx's PBM had a breach involving a misdirected mailing that affected more than 500 individuals. The breach was reported to the U.S. Department of Health and Human Services, media, and the individuals involved. We took appropriate corrective actions to confirm we would not have another breach. Since that incident, OptumRx's PBM has not had another significant data/security breach.
32	If Respondent have had a data security breach, what corrective action has been taken to prevent it from happening again?	text	The breach was reported to the U.S. Department of Health and Human Services, media, and the individuals involved. In response to that breach, we took appropriate corrective actions to confirm we would not have another breach.	

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33	In the event of a security breach, what services and communication do you provide to your members?	text	Our notification process is detailed and includes review of applicable state and federal laws to determine notification obligations specific to the impacted individual resulting from an incident. After identifying the legal obligations for notification, the contractual obligations are assessed and identified to confirm they are accounted for in the development of the notification communication.	
34	Please confirm that Respondent carries cyber liability insurance.	drop down box	Yes	
35	Describe Respondent's fraud management operations in the "Explanation" column. Please provide a copy of a sample report. **Name the file: [Respondent's Name]_Sample Fraud Report.**	drop down box	Attached	
	Administrator and Member User Security	**Answer Format**	**Reply**	**Explanation**
36	Is there the ability to set roles and assign security levels to a role? (i.e. can Respondent's application support or delegate administrator access for the benefits office to go in and review changes?)	drop down box	Yes	
37	What is your standard user ID and password policy? Can Respondent force password resets? If so, how often?	text	We use HealthSafe ID, and there is an ability to reset passwords with no limit of frequency for password reset. HealthSafe ID is the updated, secure way for members to sign in to their accounts. It enables members to choose one username and one password to access nearly all of their health benefits information.	Registration is a simple process you can complete using your ID card or enrollment materials. To keep your account secure, we'll ask you to confirm your email or phone number. Then you can start using your username and password to sign in each time you return.
38	Upon contract termination, for how long would a member be able to access his/her claims information on the member website?	text	Members are able to access claims information on the member website for 18 months after contract termination.	
39	What are your protocols on purging data beyond the agreed upon retention period? Does Respondent provide a certificate upon completion of data destruction? ¥	text	Customer information is retained for the minimum time necessary to meet legal, regulatory, and operational requirements. Once the retention obligations are fulfilled, the information (regardless of the storage media) is eligible for destruction. The retention of all records, regardless of PHI status, is based on federal and state recordkeeping obligations.	The longest retention period cited in all applicable legal sources is selected and assigned to the Retention Schedule. If the state retention period is the maximum requirement, it would not be exceeded. Based on the services provided, the maximum retention obligation generally does not exceed ten years. We provide customers with a certification of destruction for any applicable media destruction.
40	Provide details on your disaster recovery process. Specifically, are there any caveats in the recovery that Department needs to be aware of? How does Respondent keep track of when to destroy records and when do you provide proof that those records have been destroyed to the Department? Use the "Explanation" column.	text	Records are retained according to UnitedHealth Group's Records and Information Management Policy and Records Retention Schedule. Notification is sent after the on-site vendor witnesses the destruction. Due to the sensitive nature of the information, our complete business continuity and disaster recovery plans are considered proprietary and confidential.	Please refer to the document titled: UnitedHealth Group - Records Management – Enterprise Records and Information Management ERIM Policy.pdf Please refer to the document titled: UnitedHealth Group - BCP-DR - Enterprise Resiliency and Response Customer Response Document.pdf
41	What happens if the database server is unavailable?	text	As a matter of good practice, UnitedHealth Group does not disclose specific information concerning business disruptions. UnitedHealth Group has never needed to implement our disaster recovery plans in response to a catastrophic outage of technology at our production data centers.	
42	Describe Respondent's back-up and off-site storage procedures. a) How often is the database backed up? b) How accessible are archived records? c) What is your record retention policy? d) Does Respondent have any plans to improve or enhance this system?	text	We back up our claims system daily. Member profiles, eligibility history, and adjudicated claims are stored within our online system for at least 24 months. After removal, these records are archived off-site for a minimum of 10 years.	Scanned images of paper claims are maintained electronically for 10 years. Financial records are retained for at least 10 years. We can restore archived data upon the Department's request. Data retrieval may take up to one week.
43	Describe Respondent's process in place for identifying member fraudulent activities, specifically what is the member identification process for providers? How do providers confirm that the member is actually the person who possesses the ID card?	text	The network pharmacy is responsible for validating the authenticity of a member's identity through a government issued photo ID, in alignment with state dispensing requirements. If there is any suspected or potential fraud, waste or abuse (FWA) the pharmacy is required to report such by contacting the Pharmacy Network Relations Department or the number on the back of the member ID card.	Network pharmacies have access to an OptumRx portal they may use which gives them instructions on procedures such as identifying and reporting stolen cards. If a network pharmacy provider suspects any fraud or abuse by a member or managed care organization (MCO), the network pharmacy provider must report this to OptumRx and the applicable federal and state agency.
	IT	**Answer Format**	**Reply**	**Explanation**
44	What coverage tiers can Respondent's system administer?	text	RxClaim is an extremely flexible claim adjudication system that empowers OptumRx to implement and administer plan designs built to the specifications of our customers. The system's flexibility accounts for issues such as: drug coverage, exclusions and limitations; formulary applicability; varying copayments or coinsurance; closed plan designs; and complex group hierarchy.	
45	Is Respondent's system capable of administering claims for dual plan years? For example, can the system process 2024 eligibility after the 2024 eligibility file is received on 12/1/23?	drop down box	Yes	
46	How often is data refreshed (real time or batch)?	text	We support industry standard near-real-time exchange.	
47	Can data be refreshed without any down time?	drop down box	Yes	Scheduled maintenance does not result in downtime.
a.	Are inputs visible in real time?	drop down box	Yes	
b.	If not, is a scheduled update run over night?	drop down box	No	
48	Are there are any upgrades currently being planned or tested? How often are upgrades performed in the claims and eligibility systems? Use "Explanation" box.	drop down box	Yes	Our strategic product management group and technical staff continually work on new enhancements. As enhancements are completed, they are gathered into a Major Modification (MOD) release and installed as part of the core system functionality.
49	Does Respondent have the ability to accept files, electronic or other format, from selected third party vendors (e.g. medical carrier)?	drop down box	Yes	
	General	**Answer Format**	**Reply**	**Explanation**
50	Is Respondent's standard policy to ensure that "once a generic, always a generic." In other words, will members pay a generic copay for single-source and multi-source generics regardless of your drug-type classification policy?	drop down box	Yes	
51	Does Respondent use the "maintenance medication indicator" provided in a nationally recognized drug information source (e.g., Medi-Span) to identify/define "maintenance medications" for purposes of a mandatory mail program, a program that charges a penalty for refills obtained at retail pharmacies instead of mail, a traditional retail 90 program, or a "Custom EDS" program that allows up to a 90 day supply of maintenance drugs to be dispensed from certain retail pharmacies with mail-like pricing?	drop down box	Yes	
52	In the event there are changes in the marketplace to the pricing benchmark (e.g., AWP) methodology used to determine a drug's ingredient cost, or the pricing source used for a Client, even if Respondent uses an alternate pricing source for all clients, will Respondent notify the Department at least 120 calendar days in advance of the effective date of any such change and provide an analysis that demonstrates that costs will not increase as a result of the change through the contract term based on up to 12 months worth of data? Does Respondent provide full documentation justifying the reason for such change and the adjusted terms must be agreed upon before any changes are made? Will the terms will be adjusted accordingly to provide an equivalent ingredient cost after the change to the Department?	text	Yes	Please refer to Attachment D for ROR language within tabs: Rx Pricing MFP Comm and Rx Pricing MFP EGWP.
53	Does Respondent pay amounts owed to a Client during the course of the contract term, including but not limited to EGWP Rx subsidies, Manufacturer Payments, guarantee shortfalls, recoveries identified during claims audits, by the appropriate due date? If there are any amounts unpaid 10 calendar days after the stated due date, does Respondent bear interest at the greater of LIBOR plus 1% per month or the highest interest rate allowed by law?	text	Yes	
54	Is Respondent's pricing contingent upon Clients maintaining a minimum number of active or retiree lives throughout the contract term? Please review the Read Me First workbook which explains the request for a pharmacy benefit admin. fee that varies by population awarded.	drop down box	Yes	The pricing provided is based on 343k Commercial lives. If the life count were to decrease then the administrative fee would be modified as reflected in the RFP. Rebate guarantees would also potentially need to be adjusted if there is a change in greater than 10% of lives.
	Medicare Part D: RDS	**Format Type**	**Reply**	**Explanation**
	Is Respondent able to provide the following assistance and reporting to the client related to its Medicare Part D Retire Drug Subsidy (RDS):			
55	Is Respondent capable to administer RDS Services?	drop down box	Yes	

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Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")
Pharmacy Benefit Management Services
Rx Technical Questionnaire

Respondent Name:
OptumRx, Inc.

Instructions: Enter the answer to each question using the "Reply" column. Use the "Explanation" column to provide an explanation, if applicable. Written Replies and Explanations within this excel Attachment must be limited to 400 characters or less. Written Replies and Explanations beyond 400 characters will not be evaluated. The questions indicated with a "¥" will not be scored by the Evaluators, as described in section 4.3 of this ITN.

56	Does Respondent provide all standard reporting to the Client at no charge?	drop down box	Yes	
57	If requested, does Respondent provide all standard reporting to CMS on behalf of a Client at no charge?	drop down box	Yes	
58	Upon request of a Client, does Respondent provide notice of creditable coverage to members at no charge?	drop down box	No	OptumInsight does not send Notices of Creditable Coverage to members. If requested, your client management team can coordinate a member mailing using our print vendor for an additional fee.
59	Does Respondent assist Clients in the course of any CMS audits?	drop down box	Yes	
60	Does Respondent provide Clients with reports separating out the Part D population for reporting purposes?	drop down box	Yes	
61	Does Respondent comply with CMS guidance and include language in your contract in compliance with CMS guidance?	drop down box	Yes	
62	Does Respondent provide required RDS reconciliation support to a Client for up to two years after termination at no additional cost?	drop down box	Yes	OptumRx will follow what is outlined in the signed contract.
	EGWP Requirements	**Format Type**	**Reply**	**Explanation**
63	Respondent has the capability to support an enhanced Prescription Drug Plan (PDP) Employee Group Waiver Program (EGWP) 800 Series or "EGWP+Wrap", both as fully self-funded. An enhanced PDP is defined as a contract with a PDP sponsor for coverage equal to or greater than the standard Medicare benefit. Please confirm your capability to offer an EGWP + Wrap Product. ¥	drop down box	Yes	
64	For purposes of determining the federal subsidy, confirm the proposed regulations provide that no administrative costs may be included in dispensing fees and that administrative costs may not be offset by any manufacturer or pharmacy discounts, chargebacks, Rebates or similar price concessions ¥	drop down box	Yes	
65	Will Respondent notify a client of any Part D participant who qualifies for the Low-Income Subsidy (LIS) and automatically provide a client with LIS proceeds (once the participant's premium is reduced to zero)? ¥	drop down box	Yes	
66	Respondent meets all requirements regarding coordination with CMS for billing, reconciliation, and reporting for Employer Group Waiver Plans (EGWP). This includes reconciliation of capitation payments, administration of Low-Income Subsidies, reporting requirements related to rebates, TrOOP, and "Prescription Drug Event" requirements. ¥	drop down box	Yes	
67	Respondent maintains and administers CMS requirements for benefit design, networks, PDL, rebate management, clinical program management, and Medication Therapy Management for EGWP plans. ¥	drop down box	Yes	
68	Respondent maintains and administers CMS requirements for member customer service, member enrollment, and member materials for EGWP plans. ¥	drop down box	Yes	
	Liability/Regulatory	**Answer Format**	**Reply**	**Explanation**
69	Describe any judgment or settlement during the past three years or pending litigation that could result in judgments or settlements in excess of $100,000.	text	We are involved in the types of legal actions that arise in the normal course of business. Based on current information, including consultation with our attorneys, we are confident that any liability that may ultimately arise from these actions would not materially affect our consolidated financial position, operational status, cash flow or business prospects.	
	Compliance - General	**Answer Format**	**Reply**	**Explanation**
70	Does Respondent maintain a dedicated individual or staff responsible for resolving HIPAA issues?	drop down box	Yes	
71	Does Respondent provide support for class action settlements and notify Clients of litigation against Respondent?	drop down box	Yes	
	Preferred Drug List (PDL)	**Answer Format**	**Reply**	**Explanation**
72	For the 4-tier enhanced PDL EGWP Rx plan, if requested, will the Respondent provide an Enhanced PDL to minimize the disruption in covered Rx, including "buy-ups" to the Part D PDL for non-Part D covered drugs (including but not limited to, lifestyle drugs) and drugs currently taken by Department Medicare retiree members? ¥	drop down box	Yes	
73	**Should a Client elect to adopt a PDL with exclusions, does Respondent agree to the following:**			
a.	Does Respondent provide written notice to a Client at least 180 calendar days in advance of any PDL changes that narrow the PDL, with the exception of changes due to safety and FDA driven issues?	drop down box	No	OptumRx agrees to provide the Department at least 90 to 120-days notice of any additions or deletions to the PDL.
b.	Does Respondent provide written notice to members 120 calendar days in advance of any PDL changes that narrow the PDL, with the exception of changes due to safety and FDA driven issues, for which notification must be provided to the Department and plan members within five business days?	drop down box	No	We can provide the state 90 day notice and members 60 and 30 days notice of any negative changes.
c.	Does Respondent provide written notice to a Client and members within five business days for any PDL changes that narrow the PDL due to safety and FDA driven issues?	drop down box	Yes	
d.	Does Respondent provide medical necessity exception process for drugs excluded from your PDL?	drop down box	Yes	
74	If a Client does not agree to such PDL change as described directly above, does Client reserve the right to implement a custom PDL or terminate for cause, with 60 calendar days written notice?	drop down box	Yes	Custom Formulary and Utilization Management Services are Quoted upon request.
75	Does Respondent provide a Client with a client-specific analysis identifying the financial impact (i.e. ingredient cost before and after Manufacturer Payments) and member impact of the additional exclusions on a drug-by-drug basis and in total at least 120 calendar days in advance of any changes that narrow the PDL? If earned Manufacturer Payments for products remaining on the PDL increase as a result of the additional exclusions, does Respondent's analysis identify the financial impact (i.e. ingredient cost before and after Manufacturer Payments) of these improvements on a drug-by-drug basis? There will be no arbitrary or book of business adjustment applied to Clients' guaranteed Manufacturer Payments.	text	Yes	
76	How many products are excluded from Respondent's proposed exclusions-based PDL? Provide a complete list of the drugs excluded from this PDL.	number	Our Select Formulary is a three-tier open formulary that does not include drug exclusions. Our Premium Formulary is an open formulary that excludes coverage of approximately 600 brand-name drugs or generics that do not offer a clinical advantage over other less costly alternatives to drive value. Please see Exhibit XX_OptumRx_Preferred Drug List_Premium Formulary Exclusion List for a list of exclusions.	
a.	How many of these exclusions are Traditional drugs?	number	More than 500	
b.	How many of these exclusions are Specialty Drugs?	number	60	
77	Does Respondent standard PDL include at least two drugs in every therapy class and disease state and provide clinically appropriate access to a sufficient number of pharmaceutical products available in the marketplace?	drop down box	Yes	
78	How many biosimilars and/or generic products on the market are NOT covered under Respondent's regular suggested PDL due to rebate incentives from pharmaceutical companies?	number	N/A	Our formulary strategy includes a focus on lowest net cost by identifying where there is more than one high quality and clinically-appropriate drug in a particular case and selecting drugs – generic or biosimilars where available – that provide a lower net cost (that is, WAC less available rebates) for that therapeutic class. This fits into our broader approach to control drug costs for customers.
	Compound Drugs	**Answer Format**	**Reply**	**Explanation**
79	For any Compound Drug claims submitted for reimbursement under the pharmacy benefit plan, does Respondent request a copy of the written recipe to verify that the claim has been submitted in accordance with contractual and NCPDP standards?	drop down box	Yes	
80	Does Respondent adjudicate multi-ingredient Compound Drug claims using the NCPDP D.0 standard?	drop down box	Yes	

Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")
Pharmacy Benefit Management Services
Rx Technical Questionnaire

Respondent Name:
OptumRx, Inc.

Instructions: Enter the answer to each question using the "Reply" column. Use the "Explanation" column to provide an explanation, if applicable. Written Replies and Explanations within this excel Attachment must be limited to 400 characters or less. Written Replies and Explanations beyond 400 characters will not be evaluated. The questions indicated with a "¥" will not be scored by the Evaluators, as described in section 4.3 of this ITN.

81	Adjudication for Compound Drug Claims: For each Compound Drug claim processed and dispensed to a member through a retail pharmacy, do Clients pay the PBM the Total Compound Drug Claim Cost less the member cost share plus any applicable administrative fees or LOE fees? Where the Total Compound Drug Claim Cost is defined to be the lowest of: i. The AWP minus the Brand Drug discount + Dispensing Fee + sales tax (Brand Drugs); and ii. The AWP minus the non-MAC discount + Dispensing Fee + sales tax (Generic Drugs); and iii. MAC + Dispensing Fee + sales tax; for each ingredient in the Compound Drug recipe; OR iv. The dispensing pharmacy's U&C + sales tax for the Total Compound Drug Claim Cost of all ingredients in aggregate.	drop down box	Yes	
82	As a standard practice, does Respondent review each and every Compound Drug claim greater than $200 and complete an audit of the recipe when claims appear aberrant?	drop down box	Yes	
83	Does Respondent review all pharmacies that submitted a Compound Drug claim quarterly to be measured against peer groups to control for fraud, waste and abuse?	drop down box	Yes	Pharmacies submitting compounds are reviewed at least quarterly to identify outliers, the degree to which clients are being impacted, types of ingredients being submitted in the compounds, inappropriate utilization patterns, cost information, and other criteria that may indicate error or abuse in order to flag for potential further review.
	Eligibility	**Answer Format**	**Reply**	**Explanation**
84	Describe how Respondent's system handles eligibility and enrollment history and retroactive coverage changes.	text	We maintain two rolling years of eligibility data in our system. We retain historical eligibility data including member information to support retroactive claim processing or adjustments that may be required. Eligibility data retention is subject to change based on new regulations and storage requirements.	We maintain four years of eligibility data for our Medicare Part D customers. We retain historical eligibility data including member information to support retroactive claim processing or adjustments that may be required. Eligibility data retention is subject to change based on new regulations and storage requirements.
a.	For EGWP Rx: Briefly describe Respondent's standard ongoing enrollment procedures. Does Respondent recommend a specific process for new retirees who "age in" to the Medicare program? ¥	text	CMS guidance stipulates that the plan (customer) is responsible for determining whether enrollees are qualifying covered retirees and for providing required creditable coverage notices with respect to an EGWP. The enrollment requirements must be received from the customer, which precludes any process where OptumRx obtains member records from the commercial coverage.	Also, calculating a member's age based on their date of birth does not provide the following member information: a qualifying retiree; disabled and may not be 65 years of age; a member who is retired within the plan; Medicare Part A/Medicare Part B criteria; and Medicare Beneficiary Identifier. For these reasons, it is not our best practice to manage a customer's "Age Ins".
85	Briefly describe how Respondent's EGWP Rx program differentiates from your competitors. ¥	text	The key differentiators of our EGWP program for the Department include: • Resources to support any plan design • Extensive experience with all aspects of Medicare Part D • We use a member first approach to provide an optimal experience in all aspects of their interactions with OptumRx • Dedicated government programs subject matter experts to support Medicare Part D and EGWPs	We have held a Medicare Part D EGWP PDP contract with CMS since 2007 and have the experience to administer the Department's groups. Our service model can be implemented quickly and accurately for the Department. It is also flexible and enables employer groups to customize EGWP benefit designs, including formulary offerings which can match current group benefits and minimize member disruption.

SECTION IV.

	ONGOING SERVICES, RENEWALS	**Answer Format**	**Reply**	**Explanation**
1	Please describe what Respondent will provide in terms of definition of all terms and an itemization of all assumptions used including projected claims, trend factors and the formula involved, plus a complete explanation of the logic inherent in the final renewal rate package.	text	OptumRx is happy to work with the client to satisfy this request; however, OptumRx considers this proprietary information.	

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Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Pharmacy Benefit Management Services

Open Preferred Drug List (Least Restrictive) Disruption Request

Respondent Name:

OptumRx, Inc.

Instructions: Please indicate the Open Preferred Drug List (Least Restrictive) status and tier of the drugs and complete the empty cells in the table below in the Respondent Replies column. Please be sure to complete the name of the preferred drug list and include the total number of excluded products in the cells below.

Open Preferred Drug List (Least Restrictive) Name:	Select Formulary
Total Number of Excluded Products:	None

Utilization Rank (Highest to Low by # Claims)	NDC 11	Therapeutic Class (GPI-4)	Drug Name	Preferred Drug List Status (Preferred Drug List, Non-Preferred Drug List, Excluded)	Tier (1, 2, 3)	Specialty (Y/N)	Limited Distribution (Y/N)	Biosimilar (Y/N)	Additional Comments/Notes (ex, ACA Medication, Preventive List Drug, Generic Now Available)
[redacted]									

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PHARMACY BENEFIT MANAGEMENT SERVICES SUBCONTRACTORS' LIST

Company Name	Services	Contact	Address	Telephone
S.A. Nelson & Associates	Benefit Brochure Design and Printing Services	Sophia Nelson	5883 Caribbean Blvd., West Palm Beach, FL 33407	561-531-1876

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Plan Year	Rebate Guaranteed Amount			
	Retail Pharmacy	Retail 90 Pharmacy	Narrow Retail 90 & Home Delivery	Specialty
Year 1	$200.00 PNPB	$645.00 PNPB	$655.00 PNPB	$2,860.00 PNPB
Year 2	$240.00 PNPB	$738.00 PNPB	$775.00 PNPB	$3,330.00 PNPB
Year 3	$270.00 PNPB	$780.00 PNPB	$860.00 PNPB	$3,750.00 PNPB

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Credits	Description
Pharmacy Management Allowance (PMA)	Client shall receive a pharmacy management allowance (PMA) of up to $5.00 per Member annually, which must be utilized within the applicable year and will not carry over to the following year. This PMA allowance is to be used by Client to offset the cost of actions intended to maximize the value of the pharmacy program. Funds may be used for items including, but not restricted to, programming for customization, design and implementation of clinical or other programs, communications, documented expenses related to staff education and industry conference attendance, auditing, data integration and analytics, consulting fees (excluding market checks), and engagement of relevant vendors that impact the pharmacy program strategy and results. Client will be required to submit documentation to support the expenses for which it seeks reimbursement. If Client terminates this Agreement for any reason before the end of the Initial Term, Client shall refund to Optum Rx within 30 days after the effective date of such termination the full PMA allowance applicable to the year of termination. It is the intention of the parties that, for the purposes of the Federal Anti-Kickback Statute, this PMA allowance shall constitute and shall be treated as a discount against the price of drugs within the meaning of 42 U.S.C. 1320a-7b(b)(3)(A). To the extent required by Laws or contractual commitment, Client agrees to fully and accurately disclose and report any such discount to Medicare, Medicaid or other government health care programs as a discount against the price of the Prescription Drugs provided under this Agreement. ***The PMA can be used to offset the costs of programs including but not limited to: Polypharmacy, Advanced Pharmacy Audit Services (APAS), Review My Care and Specialty Standards.***
Implementation Allowance	Optum Rx shall provide Client with a one-time implementation allowance of up to $10.00 per net new Member to cover expenses associated with the transition of services to Optum Rx. This allowance may be used by Client to offset legitimate, necessary and commercially reasonable expenses that are related to the Client's transition from its previous pharmacy benefit manager to Optum Rx. Client shall be responsible for all other transition expenses in excess of the implementation credit herein provided to Client. Eligible expenses shall include any printing or postage related to special communications required for the transition, customized ID cards, customized programming or, upon mutual agreement, third-party transitional consulting expenses. The implementation allowance must be utilized within the first six months after the Effective Date. Client will be required to submit documentation to support the expenses it may seek reimbursement for. If Client terminates this Agreement for any reason before the end of the Initial Term, Client shall refund to Optum Rx within 30 days after the effective date of such termination the full implementation allowance. It is the intention of the parties that, for the purposes of the Federal Anti-Kickback Statute, this implementation allowance shall constitute and shall be treated as a discount against the price of drugs within the meaning of 42 U.S.C. 1320a – 7b(b)(3)(A). To the extent required by Laws or contractual commitment, Client agrees to fully and accurately disclose and report any such discount to Medicare, Medicaid or other government health care programs as a discount against the price of the Prescription Drugs provided under this Agreement.
Annual Innovation Credit	Optum Rx shall provide Client with an innovation credit of up to $1,000,000 annually ("Innovation Credit"). The Innovation Credit will apply to mutually agreed upon innovation related services on a prorate basis across all Commercial lines of business and any subsequent lines of business added to the Agreement. Any unused portion of the $1,000,000 will be expire at the end of the calendar year. If Client terminates this Agreement for any before the end of the Initial Term, Client shall refund to PBM, within thirty (30) days after the effective date of such termination, the pro-rata share of the Innovation Credit. The Parties acknowledge that the Annual Innovation Credit provided by Optum Rx for the innovation related services represent fair market value. To the extent applicable, the parties acknowledge and agree that this Innovation Credit shall constitute and shall be treated as a discount, within the meaning of 42 U.S.C. §1320a-7b(b)(3)(A), provided to Client against the price of Prescription Drugs provided under this Agreement. To the extent required by Laws, Client agrees to fully and accurately disclose and report this Innovation Credit to Medicare, Medicaid or other government health care programs as a discount against the price of the Prescription Drugs provided under this Agreement. Upon Client's request, Optum Rx will provide additional information necessary to support Client's government reporting requirement. ***The Innovation Credit can be used to offset the costs of programs including but not limited to: Polypharmacy, Advanced Pharmacy Audit Services (APAS), Review My Care and Specialty Standards.***

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Value Add Offerings	Description
Staffing - Dedicated Pharmacist Academic Detailer	At no additional cost to Client, Optum Rx has included a Dedicated Pharmacist Academic Detailer. The Pharmacist Academic Detailer responsibilities include but are not limited to: •Provider education programs, training, relations and service •follow-up after pharmacy audit and audit assistance •academic detailing of prescribers and pharmacy providers •Department compliance initiatives •DUR and Provider Practice Activity follow up •education and assistance for Providers in working with the Department utilization management programs (i.e. PA requests, attestations, emergency supply) •work closely with client and Optum Rx Account Director and Clinical team
Staffing - Dedicated Stakeholder Relations Specialist	At no additional cost to the State, Optum Rx has included a Dedicated Stakeholder Relations Specialist. The Stakeholder Relations Specialist serves as the expert on the State's member communications requirements. This individual works as the liaison between the OptumRx operational staff / Marketing team and the State staff to ensure the documented communication strategy meets the State's needs. The Stakeholder Relations Specialist is responsible for overseeing all health benefit or open enrollment fairs and member communications needed to support the State's pharmacy benefit program. Primary Responsibilities of this role include: •Accountability for understanding the primary business objectives of the State, translating the value of the State's pharmacy program to customized communications and strategies, and supporting the State with in-person engagement with their membership. •Understand OptumRx products and services to participate in discussions with the State on the operational, clinical and financial value they can bring to the State's program and membership. •Lead the development of Customer Service documentation to ensure accuracy, and participate in call calibration sessions. •Provide regular input to the account management team and operational areas regarding the State's benefit structure and requirements. •Maintain consistent communication with the State •Participate in all utilization performance review discussions with the State and other formal presentations.

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Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

RX-Pricing, Transparent, Admin. Fees

Respondent Name:

OptumRx, Inc.

PLEASE NOTE:

Currently, all DMS members have a carved-out pharmacy benefit, regardless of medical carrier or plan design, except for a small MAPD benefit not included in this ITN. Retirees have the option to stay on the commercial plan and are considered RDS members. DMS is considering several different scenarios for their pharmacy benefit effective 1/1/24.
In the future:
a. HMO plan lives may move to carve-in pharmacy arrangements with HMOs, if awarded to the HMO
b. RDS lives may move to an EGWP under Part D, or may move to carve-in PBMs of medical carriers bidding on HMO plans

Commercial Pharmacy Benefit Administrative Fees	Acknowledgment
All cost components and financial guarantees of all carve-in and carve-out PBM replies must stay constant regardless of the size or makeup of the population awarded, except for a commercial administrative fee that may vary with the size of the population awarded. Annually, the commercial administrative fee will be determined based on the number of Plan Subscribers identified by the Department who are eligible for prescription drug benefits under its Plan(s) and receiving benefits pursuant to an agreement with Respondent, as provided in the Department's eligibility file or otherwise communicated by the Department in a mutually agreeable format. The administrative fee will be paid only on enrollment in Commercial Plans (including RDS subscribers). If the Department approves an EGWP, a separate EGWP fee is paid on only EGWP subscribers. Per the table below, the enrollment thresholds or "Tiers" are determined based on the total enrollment (subscribers) in your firm (EGWP and Commercial), but only paid for Commercial covered lives. If EGWP is approved, the Department will only pay the Tier's applicable Commercial Pharmacy Benefit Administrative Fee on commercial plan Subscribers. DMS will pay a separate administration fee for EGWP plan Subscribers which is within the Rx-Pricing Trans (EGWP) tab, and not the table below.	Acknowledged

Tier 1

Optional Contract Term

If awarded subscriber population, including actives and retirees, is:	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
<10,000 Subscribers						
Per Enrollee Per Month Commercial Pharmacy Benefit Administration Fee	[redacted]					

Tier 2

Optional Contract Term

If awarded subscriber population, including actives and retirees, is:	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
10,000 - 19,999 Subscribers						
Per Enrollee Per Month Commercial Pharmacy Benefit Administration Fee						

Tier 3

Optional Contract Term

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RX-Pricing, Transparent, Admin. Fees

Respondent Name:

OptumRx, Inc.

PLEASE NOTE:

Currently, all DMS members have a carved-out pharmacy benefit, regardless of medical carrier or plan design, except for a small MAPD benefit not included in this ITN. Retirees have the option to stay on the commercial plan and are considered RDS members. DMS is considering several different scenarios for their pharmacy benefit effective 1/1/24.
In the future:
a. HMO plan lives may move to carve-in pharmacy arrangements with HMOs, if awarded to the HMO
b. RDS lives may move to an EGWP under Part D, or may move to carve-in PBMs of medical carriers bidding on HMO plans

If awarded subscriber population, including actives and retirees, is: 20,000 - 34,999 Subscribers

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Per Enrollee Per Month Commercial Pharmacy Benefit Administration Fee	[redacted]					

Tier 4 — Optional Contract Term

If awarded subscriber population, including actives and retirees, is: 35,000-69,999 Subscribers

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Per Enrollee Per Month Commercial Pharmacy Benefit Administration Fee						

Tier 5

If awarded subscriber population, including actives and retirees, is: 70,000-99,999 Subscribers

Per Enrollee Per Month Commercial Pharmacy Benefit Administration Fee	

Tier 6

If awarded subscriber population, including actives and retirees, is: 100,000-125,000 Subscribers

Per Enrollee Per Month Commercial Pharmacy Benefit Administration Fee	

Tier 7 — Optional Contract Term

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Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

RX-Pricing, Transparent, Admin. Fees

Respondent Name:

OptumRx, Inc.

PLEASE NOTE:

Currently, all DMS members have a carved-out pharmacy benefit, regardless of medical carrier or plan design, except for a small MAPD benefit not included in this ITN. Retirees have the option to stay on the commercial plan and are considered RDS members. DMS is considering several different scenarios for their pharmacy benefit effective 1/1/24.
In the future:
a. HMO plan lives may move to carve-in pharmacy arrangements with HMOs, if awarded to the HMO
b. RDS lives may move to an EGWP under Part D, or may move to carve-in PBMs of medical carriers bidding on HMO plans

If awarded subscriber population, including actives and retirees, is: 125,000+ Subscribers

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Per Enrollee Per Month Commercial Pharmacy Benefit Administration Fee	[redacted]					

Retiree Drug Subsidy (RDS) Administrative Fees	Acknowledgment
If DMS does not approve an EGWP and RDS lives remain under the commercial plan, the following RDS administrative fees will apply to Medicare eligible Participants not enrolled in Medicare Part D regardless of the size of the RDS population, in addition to the above administrative fees. If EGWP is implemented, RDS administrative fees will not be applicable. RDS administrative fees are based on RDS lives only.	Acknowledged

	Optional Contract Term					
RDS Fees per month per Medical Eligible Participant Not Enrolled in Part D	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Core Administrative Services (PMPM)						
Drug Cost Report Upload and Reconciliation (PMPM)						
Eligibility Submission and Reconciliation (PMPM)						
Letter of Creditable Coverage (per mailing)						

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Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

RX-Pricing, Transparent, Admin. Fees

Respondent Name:

OptumRx, Inc.

PLEASE NOTE:

Currently, all DMS members have a carved-out pharmacy benefit, regardless of medical carrier or plan design, except for a small MAPD benefit not included in this ITN. Retirees have the option to stay on the commercial plan and are considered RDS members. DMS is considering several different scenarios for their pharmacy benefit effective 1/1/24.
In the future:
a. HMO plan lives may move to carve-in pharmacy arrangements with HMOs, if awarded to the HMO
b. RDS lives may move to an EGWP under Part D, or may move to carve-in PBMs of medical carriers bidding on HMO plans

Supplemental Customized Reporting (per hour of programming), if required	*Priced Upon Review of Request*	*Priced Upon Review of Request*	*Priced Upon Review of Request*	*Priced Upon Review of Request*	*Priced Upon Review of Request*	*Priced Upon Review of Request*

Department of MANAGEMENT SERVICES

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Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

RX-Pricing, Transparent, Commercial Plans

Respondent Name:
OptumRx, Inc.

Instructions: Please complete every cell on this worksheet. Your pricing offer must be on a post-AWP rollback basis. All proposed terms are guaranteed including adjudication formulas.

PLEASE NOTE:
Today, the Department has a national network minus a national retailer (Walgreens). There is a custom national narrow Retail90 network that is used to solicit pharmacies to participate and match the PBM's mail discount. For PPO plans, after 3 30-day fills, a member filling a maintenance medication experiences "mandatory 90-day fill" meaning they must fill 90DS at a participating 90-day retail pharmacy or mail order, for the same member cost share. HMO plans do not have the maintenance medication requirement. Please review the plan documents for full plan design information. Plan documents can be obtained by following the instructions within Attachment A - Administrative Requirements.

BROADEST RETAIL 30 (INCLUDING SPECIALTY FROM NON-PREFERRED SPECIALTY VENDORS)						
Type of Network:	**Broadest Network**					
	Base Contract Term			Optional Contract Term		
Number of Pharmacies Nationwide	This network is comprised of more than 67,000 pharmacies which equates to over 93 percent of available retail pharmacies.			This network is comprised of more than 67,000 pharmacies which equates to over 93 percent of available retail pharmacies.		
Please confirm Specialty Drugs filled at Retail Pharmacy are included in the guarantees below. If not, please indicate how they are priced and provide pricing guarantees.	Confirmed			Confirmed		
Please confirm Specialty Generic Drugs filled at your preferred Specialty Pharmacy are included in the Generic Drug discount guarantees below. If not, please indicate how they are priced and provide pricing guarantees	Not Confirmed. Generic Specialty Drugs filled at OptumRx Specialty Pharmacies are included in the Generic Specialty Discount Guarantee.			Not Confirmed. Generic Specialty Drugs filled at OptumRx Specialty Pharmacies are included in the Generic Specialty Discount Guarantee.		
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Minimum Semi-annual AWP Discount Guarantees						
Brand Drug Discount Guarantee	[redacted]					
Generic Effective Rate (MAC+Non-MAC) Discount Guarantee						
Generic Drug Non-Mac Discount Guarantee						
Average Dispensing Fee per Paid Claim						
All Brands						
All Generics						

NARROW RETAIL 30 (INCLUDING SPECIALTY FROM NON-PREFERRED SPECIALTY VENDORS)		
Type of Network:	**Narrow Retail 30 Network**	
	Base Contract Term	Optional Contract Term
Number of Pharmacies Nationwide	Our Standard Select CVS Network is our best value offering for optimized savings and nationwide member access. This network provides more aggressive discounts than our Broad Pharmacy Network with minimal member shift and access to approximately 50,000 retail pharmacies.	Our Standard Select CVS Network is our best value offering for optimized savings and nationwide member access. This network provides more aggressive discounts than our Broad Pharmacy Network with minimal member shift and access to approximately 50,000 retail pharmacies.
List excluded chain(s)	Walgreens	Walgreens
Please confirm Specialty Drugs filled at Retail Pharmacy are included in the guarantees below. If not, please indicate how they are priced and provide pricing guarantees.	Confirmed	Confirmed

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Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

RX-Pricing, Transparent, Commercial Plans

Respondent Name:
OptumRx, Inc.

Instructions: Please complete every cell on this worksheet. Your pricing offer must be on a post-AWP rollback basis. All proposed terms are guaranteed including adjudication formulas.

PLEASE NOTE:
Today, the Department has a national network minus a national retailer (Walgreens). There is a custom national narrow Retail90 network that is used to solicit pharmacies to participate and match the PBM's mail discount. For PPO plans, after 3 30-day fills, a member filling a maintenance medication experiences "mandatory 90-day fill" meaning they must fill 90DS at a participating 90-day retail pharmacy or mail order, for the same member cost share. HMO plans do not have the maintenance medication requirement. Please review the plan documents for full plan design information. Plan documents can be obtained by following the instructions within Attachment A - Administrative Requirements.

Please confirm Specialty Generic Drugs filled at your preferred Specialty Pharmacy are included in the Generic Drug discount guarantees below. If not, please indicate how they are priced and provide pricing guarantees.	Not Confirmed. Generic Specialty Drugs filled at OptumRx Specialty Pharmacy are included in the Generic Specialty Discount Guarantee.			Not Confirmed. Generic Specialty Drugs filled at OptumRx Specialty Pharmacy are included in the Generic Specialty Discount Guarantee.		
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Minimum Semi-annual AWP Discount Guarantees						
Brand Drug Discount Guarantee	[redacted]					
Generic Effective Rate (MAC+Non-MAC) Discount Guarantee						
Generic Drug Non-Mac Discount Guarantee						
Average Dispensing Fee per Paid Claim						
All Brands						
All Generics						

BROAD RETAIL 90 (INCLUDING SPECIALTY FROM NON-PREFERRED SPECIALTY VENDORS)

Type of Network:	Broad Retail 90 Network					
	Base Contract Term			Optional Contract Term		
Number of Pharmacies Nationwide	More than 66,000			More than 66,000		
Please confirm Specialty Drugs filled at Retail Pharmacy are included in the guarantees below. If not, please indicate how they are priced and provide pricing guarantees.	Confirmed			Confirmed		
Please confirm Specialty Generic Drugs filled at your preferred Specialty Pharmacy are included in the Generic Drug discount guarantees below. If not, please indicate how they are priced and provide pricing guarantees.	Not Confirmed. Generic Specialty Drugs filled at OptumRx Specialty Pharmacies are included in the Generic Specialty Discount Guarantee.			Not Confirmed. Generic Specialty Drugs filled at OptumRx Specialty Pharmacies are included in the Generic Specialty Discount Guarantee.		
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Minimum Semi-annual AWP Discount Guarantees						
Brand Drug Discount Guarantee	[redacted]					
Generic Effective Rate (MAC+Non-MAC) Discount Guarantee						
Generic Drug Non-Mac Discount Guarantee						
Maximum Dispensing Fee per Paid Claim						
All Brands						
All Generics						

Department of MANAGEMENT SERVICES

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Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

RX-Pricing, Transparent, Commercial Plans

Respondent Name:
OptumRx, Inc.

Instructions: Please complete every cell on this worksheet. Your pricing offer must be on a post-AWP rollback basis. All proposed terms are guaranteed including adjudication formulas.

PLEASE NOTE:
Today, the Department has a national network minus a national retailer (Walgreens). There is a custom national narrow Retail90 network that is used to solicit pharmacies to participate and match the PBM's mail discount. For PPO plans, after 3 30-day fills, a member filling a maintenance medication experiences "mandatory 90-day fill" meaning they must fill 90DS at a participating 90-day retail pharmacy or mail order, for the same member cost share. HMO plans do not have the maintenance medication requirement. Please review the plan documents for full plan design information. Plan documents can be obtained by following the instructions within Attachment A - Administrative Requirements.

Type of Network:	**Narrow Retail-90 Network** **Narrow Retail 90 Network: Any Pharmacy May Participate If Agree to Match Mail Pricing**					
	Base Contract Term			Optional Contract Term		
Anchor Chains	CVS			CVS		
Number of Pharmacies Nationwide	For the CVS90 Saver Network, Members may only obtain retail 90 Prescriptions Drugs at a CVS pharmacy or OptumRx's Home Delivery Pharmacy, with the exception that up to 2 (two) retail 30 Prescription Drug Claims ("Grace Fills") may be filled at any Network Pharmacy. Members shall be incentivized to use the CVS90 Saver Network through copayment design, with the exception of Grace Fills. Members shall pay 50 percent of the cost of any retail 90 Prescription Drug Claims filled outside of a CVS Pharmacy or OptumRx's Home Delivery Pharmacy, with the exception of Grace Fills. All pricing guarantees for CVS90 Saver are contingent upon OptumRx's Home Delivery Pharmacy acting as the exclusive mail provider. Maintenance status of a Claim is defined by the Pricing Source maintenance indicator.			For the CVS90 Saver Network, Members may only obtain retail 90 Prescriptions Drugs at a CVS pharmacy or OptumRx's Home Delivery Pharmacy, with the exception that up to 2 (two) retail 30 Prescription Drug Claims ("Grace Fills") may be filled at any Network Pharmacy. Members shall be incentivized to use the CVS90 Saver Network through copayment design, with the exception of Grace Fills. Members shall pay 50 percent of the cost of any retail 90 Prescription Drug Claims filled outside of a CVS Pharmacy or OptumRx's Home Delivery Pharmacy, with the exception of Grace Fills. All pricing guarantees for CVS90 Saver are contingent upon OptumRx's Home Delivery Pharmacy acting as the exclusive mail provider. Maintenance status of a Claim is defined by the Pricing Source maintenance indicator.		
List excluded chain(s)	All chains except for CVS. However, members are allowed two grace fills at any retail network pharmacy before being formally directed to the preferred retail chain or OptumRx Home Delivery Pharmacy for their 90-day maintenance medications.			All chains except for CVS. However, members are allowed two grace fills at any retail network pharmacy before being formally directed to the preferred retail chain or OptumRx Home Delivery Pharmacy for their 90-day maintenance medications.		
Please confirm Specialty Drugs filled at Retail Pharmacy are included in the guarantees below. If not, please indicate how they are priced and provide pricing guarantees.	Confirmed			Confirmed		
Please confirm Specialty Generic Drugs filled at your preferred Specialty Pharmacy are included in the Generic Drug discount guarantees below. If not, please indicate how they are priced and provide pricing guarantees	Not Confirmed. Generic Specialty Drugs filled at OptumRx Specialty Pharmacies are included in the Generic Specialty Discount Guarantee.			Not Confirmed. Generic Specialty Drugs filled at OptumRx Specialty Pharmacies are included in the Generic Specialty Discount Guarantee.		
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Minimum Semi-annual AWP Discount Guarantees						
Brand Drug Discount Guarantee	[redacted]					
Generic Effective Rate (MAC+Non-MAC) Discount Guarantee						
Generic Drug Non-Mac Discount Guarantee						
Average Dispensing Fee per Paid Claim						
All Brands						
All Generics						

MAIL ORDER (EXCLUDING SPECIALTY DRUGS DISPENSED THROUGH YOUR PREFERRED SPECIALTY PHARMACY)						
	Base Contract Term			Optional Contract Term		
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Minimum Semi-annual AWP Discount Guarantees						

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Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

RX-Pricing, Transparent, Commercial Plans

Respondent Name:
OptumRx, Inc.

Instructions: Please complete every cell on this worksheet. Your pricing offer must be on a post-AWP rollback basis. All proposed terms are guaranteed including adjudication formulas.

PLEASE NOTE:
Today, the Department has a national network minus a national retailer (Walgreens). There is a custom national narrow Retail90 network that is used to solicit pharmacies to participate and match the PBM's mail discount. For PPO plans, after 3 30-day fills, a member filling a maintenance medication experiences "mandatory 90-day fill" meaning they must fill 90DS at a participating 90-day retail pharmacy or mail order, for the same member cost share. HMO plans do not have the maintenance medication requirement. Please review the plan documents for full plan design information. Plan documents can be obtained by following the instructions within Attachment A - Administrative Requirements.

Brand Drug Discount Guarantee	[redacted]
Generic Effective Rate (MAC+Non-MAC) Discount Guarantee	
Generic Drug Non-Mac Discount Guarantee	
Maximum Dispensing Fee per Paid Claim	
All Brands	
All Generics	

SPECIALTY (THROUGH YOUR PREFERRED SPECIALTY VENDOR)

	Base Contract Term			Optional Contract Term		
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Open Network:						
Minimum Semi-annual AWP Discount Guarantee: All Brands						
Minimum Semi-annual AWP Discount Guarantee: All Generics						
Exclusive Network - Exclusive of Manufacturer Payments						
Minimum Semi-annual AWP Discount Guarantee: All Brands						
Minimum Semi-annual AWP Discount Guarantee: All Generics						
Maximum Dispensing Fee per Paid Claim (Open and Exclusive)						
All Brands and Generics						

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Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

RX-Pricing, Transparent, Commercial Plans

Respondent Name:
OptumRx, Inc.

Instructions: Please complete every cell on this worksheet. Your pricing offer must be on a post-AWP rollback basis. All proposed terms are guaranteed including adjudication formulas.

PLEASE NOTE:
Today, the Department has a national network minus a national retailer (Walgreens). There is a custom national narrow Retail90 network that is used to solicit pharmacies to participate and match the PBM's mail discount. For PPO plans, after 3 30-day fills, a member filling a maintenance medication experiences "mandatory 90-day fill" meaning they must fill 90DS at a participating 90-day retail pharmacy or mail order, for the same member cost share. HMO plans do not have the maintenance medication requirement. Please review the plan documents for full plan design information. Plan documents can be obtained by following the instructions within Attachment A - Administrative Requirements.

Compound Drug Claims						
	Base Contract Term			Optional Contract Term		
Level of Effort values (Non-Sterile Only)	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
11 - Single ingredient batched capsule; any combination of commercially available	[redacted]					
12 - Two or Three ingredient batched capsule; transdermal gel						
13 - Four or more ingredient batched capsule; three or less ingredient cream/ointment/gel: suppository; two or less ingredient capsule: noncomplex suspension; tablet triturate						
14 - Topical containing controlled ingredient; three or more ingredient troche; four or more ingredient capsule; complex suspensions (i.e. pediatric); custom capsule (includes rapid dissolution preparations); chemotherapy cream/ointment/gel; hormone therapy (capsules, troches, and suppositories).						
Retail GDR Guarantee						
Mail GDR Guarantee						

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Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

RX-Pricing, Manufacturer Payments

Respondent Name:
OptumRx, Inc.

Instructions: Please complete every cell on this worksheet. All proposed terms are guaranteed.

PLEASE NOTE:
Other than select plan exclusions such as fertility and cosmetic medications (see plan documents), Department currently utilizes an open Preferred Drug List. Please review the plan documents by following the instructions within Attachment A - Administrative Requirements to review the full plan details.

BASED ON OPEN PREFERRED DRUG LIST (LEAST RESTRICTIVE)	Guaranteed Manufacturer Payment Amount Per Claim	
	Base Contract Term	Optional Contract Term
Manufacturer Payment Percentage shared with the Plan **Guaranteed Minimum Manufacturer Payment**	[redacted]	
Name of Preferred Drug List Proposed		
	Year 1 Year 2 Year 3 Year 4 Year 5 Year 6	
Per Retail Claim	[redacted]	
Per Retail 90 Claim		
Per Mail and Narrow Retail 90 Network Claim (excluding Specialty)		
Per Retail Specialty Claim (Non-preferred specialty Respondent)		
Per Specialty Claim (Preferred Specialty Pharmacy)		

BASED ON OPEN PREFERRED DRUG LIST (LEAST RESTRICTIVE)	Guaranteed Manufacturer Payment Amount Per Brand Claim	
	Base Contract Term	Optional Contract Term
Manufacturer Payment Percentage shared with the Plan **Guaranteed Minimum Manufacturer Payment**	[redacted]	
Name of Preferred Drug List Proposed		
	Year 1 Year 2 Year 3 Year 4 Year 5 Year 6	
Per Retail Brand Claim	[redacted]	
Per Retail 90 Brand Claim		
Per Mail and Narrow Retail 90 Network Claim (excluding Specialty)		
Per Retail Specialty Brand Claim (Non-preferred specialty Respondent)		
Per Specialty Brand Claim (Preferred Specialty Pharmacy)		

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Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

RX-Pricing, Manufacturer Payments

Respondent Name:
OptumRx, Inc.

Instructions: Please complete every cell on this worksheet. All proposed terms are guaranteed.

PLEASE NOTE:
Other than select plan exclusions such as fertility and cosmetic medications (see plan documents), Department currently utilizes an open Preferred Drug List. Please review the plan documents by following the instructions within Attachment A - Administrative Requirements to review the full plan details.

BASED ON EXCLUSION PREFERRED DRUG LIST - LEVEL I (MORE RESTRICTIVE)	Guaranteed Manufacturer Payment Amount Per Claim	
	Base Contract Term	Optional Contract Term
Manufacturer Payment Percentage shared with the Plan **Guaranteed Minimum Manufacturer Payment**	[redacted]	
Name of Preferred Drug List Proposed		
Number of Excluded Products on Preferred Drug List as of today		

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Per Retail Claim	[redacted]					
Per Retail 90 Claim						
Per Mail and Narrow Retail 90 Network Claim (excluding Specialty)						
Per Retail Specialty Claim (Non-preferred specialty Respondent)						
Per Specialty Claim (Preferred Specialty Pharmacy)						

BASED ON EXCLUSION PREFERRED DRUG LIST - LEVEL I (MORE RESTRICTIVE)	Guaranteed Manufacturer Payment Amount Per Brand Claim	
	Base Contract Term	Optional Contract Term
Manufacturer Payment Percentage shared with the Plan **Guaranteed Minimum Manufacturer Payment**	[redacted]	
Name of Preferred Drug List Proposed		
Number of Excluded Products on Preferred Drug List as of today		

Per Retail Brand Claim	[redacted]
Per Retail 90 Brand Claim	
Per Mail and Narrow Retail 90 Network Claim (excluding Specialty)	
Per Retail Specialty Brand Claim (Non-preferred specialty Respondent)	
Per Specialty Brand Claim (Preferred Specialty Pharmacy)	

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Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Attachment D - Cost Reply

RX-Pricing, Manufacturer Payments

Respondent Name:
OptumRx, Inc.

Instructions: Please complete every cell on this worksheet. All proposed terms are guaranteed.

PLEASE NOTE:
Other than select plan exclusions such as fertility and cosmetic medications (see plan documents), Department currently utilizes an open Preferred Drug List. Please review the plan documents by following the instructions within Attachment A - Administrative Requirements to review the full plan details.

BASED ON EXCLUSION PREFERRED DRUG LIST - LEVEL II (MOST RESTRICTIVE)	Guaranteed Manufacturer Payment Amount Per Claim					
	Base Contract Term			Optional Contract Term		
Manufacturer Payment Percentage shared with the Plan	[redacted]					
Guaranteed Minimum Manufacturer Payment	[redacted]					
Name of Preferred Drug List Proposed	See Premium Formulary response above.					
Number of Excluded Products on Preferred Drug List as of today	See Premium Formulary response above.					
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Per Retail Claim	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.
Per Retail 90 Claim	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.
Per Mail and Narrow Retail 90 Network Claim (excluding Specialty)	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.
Per Retail Specialty Claim (Non-preferred specialty Respondent)	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.
Per Specialty Claim (Preferred Specialty Pharmacy)	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.

BASED ON EXCLUSION PREFERRED DRUG LIST - LEVEL II (MOST RESTRICTIVE)	Guaranteed Manufacturer Payment Amount Per Brand Claim					
	Base Contract Term			Optional Contract Term		
Manufacturer Payment Percentage shared with the Plan	[redacted]					
Guaranteed Minimum Manufacturer Payment	[redacted]					
Name of Preferred Drug List Proposed	See Premium Formulary response above.					
Number of Excluded Products on Preferred Drug List as of today	See Premium Formulary response above.					
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Per Retail Brand Claim	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.
Per Retail 90 Brand Claim	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.
Per Mail and Narrow Retail 90 Network Claim (excluding Specialty)	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.
Per Retail Specialty Brand Claim (Non-preferred specialty Respondent)	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.
Per Specialty Brand Claim (Preferred Specialty Pharmacy)	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.	See Premium Formulary response above.

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Invitation[illegible]ate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Respondent Name:
OptumRx, Inc.

Instructions: Please complete every cell on this worksheet. All proposed terms are guaranteed. Please indicate the charges/fees associated with the following types of utilization

Commercial Other Costs Table 1

Current Programs Offered at No Additional Fee - Core Services	Confirm there is no additional fee	Notes
A concurrent DUR program at the Mail Pharmacy that ensures appropriate utilization of drugs based on product choice, quantity dispensed, dosing, and duration of therapy.	Confirmed	Concurrent Drug Utilization Review Program Our concurrent drug utilization review (CDUR) program identifies drug related issues prior to dispensing. CDUR is supported by our claims adjudication platform and Medi-Span Master Drug Database files. During claim adjudication, our system evaluates the member's claims history, demographic information and other evidence, to determine potential drug issues that could be harmful to the member or that are not in alignment with plan benefits.
A retrospective DUR program at the Retail Pharmacy that ensures the appropriate utilization of drugs based on product choice, quantity dispensed, dosing, and duration of therapy.	Confirmed	Medication Safety Management Program (RDUR) Included in the admin fee per RFP request [redacted]
Clinical initiatives based on evidence-based guidelines to assist a physician in optimizing patient care through the identification of potential gaps in care in a patient's treatment.		Care Gap Management Program: $0.05 PMPM
A program that promotes adherence to certain chronic conditions, including but not limited to Asthma, COPD, Cholesterol, Diabetes, Heart Failure and High Blood Pressure.		OptumRx Meds on Track Medication Adherence Program [redacted]
Prior Authorization		Clinical Prior Authorizations - Technician/Pharmacist Review [redacted] in-shore - State-mandated Physician Revie[redacted]view on-shore
Specialty drug management program (including but not limited to Allergic Asthma, Growth Hormone, Hepatitis C, Psoriasis, Rheumatoid Arthritis, Respiratory Syncytial Virus and Neutropenia/Anemia).	Confirmed	Optum Therapy Solutions As part of our specialty management approach, we deliver clinical care and coordinated services through Optum Therapy Solutions, a concierge model that supports more than 200 disease states and empowers patients to confidently manage their medications and connect with available resources, including Optum Specialty Pharmacy and Optum Infusion Pharmacy.
Compliance program (including but not limited to Diabetes, Heart Failure, Coronary Artery Disease, Hypertension, Gastroesophageal Reflux Disease, Primary Biliary Cirrhosis, Cholesterol, Chronic Dry Eye, Benign Prostatic Hypertrophy, Breast Cancer).		Meds on Track for Top 3 Conditions (Diabetes, Hypertension, and High Cholesterol), plus Chronic Non-Specialty plus Specialty Medications, plus Behavior Health (BH) Medications plus Meds on Track Program for Medication Assisted Therapy (MAT) [redacted]
POS messaging	Confirmed	Our system allows for the Department to customize messages received by pharmacists at the point of service. The initial custom message allows up to 120 characters, however, the Department may specify any number of extension message segments of 120 characters each.
Quantity Limits	Confirmed	Clinical Services - Administrative Prior Authorization, Step Therapy, Quantity Limits The OptumRx Quantity Limits program prevents doses or quantities from exceeding evidence-based recommended levels and
Prescription monitoring for fraud, waste and abuse, and suspect activities; evaluation of the appropriateness of controlled substances and other targeted drugs, ensuring safe and appropriate utilization; and communication to physicians via mail as necessary.	Confirmed	Standard Pharmacy Audit Services: If a prescription is written for a quantity greater than the established limit, a prior authorization request is needed for coverage to be approved.
Identification of Participants who have received a medication that is FDA approved for once-daily dosing prescribed for twice or more daily.	Confirmed	Medication Safety Management Program (RDUR) Included in the admin fee per RFP reques[redacted] OptumRx Medication Safety Management, targets unsafe and clinically inappropriate therapy utilization while improving quality of
Mail service program that automatically substitutes a generic for a brand alternative when the prescribing physician has authorized generic substitution.	Confirmed	To increase generic utilization, the Department may implement mandatory generic substitution. For multi-source products, blocking the brand-name agent incents a switch to the generic product. We offer online edits to maximize generic usage. We customize these edits to meet the Department's needs.
Retail adherence program		Meds on Track for Top 3 Conditions (Diabetes, Hypertension, and High Cholesterol), plus Chronic Non-Specialty plus Specialty Medications, plus Behavior Health (BH) Medications plus Meds on Track Program for Medication Assisted Therapy (MAT[redacted]
Generic Utilization Programs to maximize the use of generic medications.	Confirmed	
Formulary and Channel Optimization to include tools Participants can use to determine most appropriate formulary and channel solutions.	Confirmed	MyScript Finder Tool - OptumRx.com: The OptumRx website features our MyScript Finder tool to help the Department's members find the medications they need and compare pricing and maximize savings.
Senior DUR (safety) program	Confirmed	Medication Safety Management Program (RDUR) Included in the admin fee per RFP reques[redacted] OptumRx Medication Safety Management, targets unsafe and clinically inappropriate therapy utilization while improving quality of
Clinical review (population Gaps in Care report)	Confirmed	
Therapeutic/Formulary Interchange	Confirmed	
Hemophilia and other Rare Disease support	Confirmed	Our Hemophilia Clinical Management Program provides our patients expert care and a seamless pharmacy experience. Because the team is dedicated to bleeding disorders, they understand the nuances required to balance optimal patient care with the high costs associated with factor products.
Dose optimization are drug limitations designed to promote use of the most cost-effective dosage (e.g., 20mg QD versus 10mg BID). Dose optimization program to identify opportunities where a higher-strength, single daily dose can be used in place of multiple daily doses, when available and clinically appropriate.	Confirmed	There is no formal name for this program: Included in our utilization management guidelines are dose optimization edits, which are a component of our Quantity Limits Program. Dose optimization encourages use of higher strengths of certain medications instead of multiple doses of lower strengths. Although we do not have a standalone dose optimization program, we may work with the Department to create a dose
Drug exclusions (outside of formulary exclusions) including but not limited to Fertility, Cosmetic drugs, Weight Management drugs (exception- DSGI grants override for Participants in pilot program)	Confirmed	

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Invitation ... ate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Respondent Name:
OptumRx, Inc.

Instructions: Please complete every cell on this worksheet. All proposed terms are guaranteed. Please indicate the charges/fees associated with the following types of utilization

Diabetes meter program where the manufacturer provides a preferred glucose meter at no cost.	Confirmed	
DAW intervention has a communication to the physician when prescriptions for multisource brands are written "dispense as written".	Confirmed	There is no formal name for this program. We process DAW codes 0-9 in a variety of ways according to the Department's needs.
Therapeutic Equivalent Alternatives Solution/Strategy	Confirmed	Medication Safety Management Program (RDUR) Included in the admin fee per RFP request [redacted] OptumRx Medication Safety Management, targets unsafe and clinically inappropriate therapy utilization while improving quality of
Basic Safety and Monitoring		Opioid Risk Management Solution • Utilization Management - Standard UM/transactional fees • Enhanced cDUR - Standard included. Customization: [redacted]
Dosage Formulation Solution/Strategy designed to promote the most cost-effective formulation (e.g. tablet vs. capsule or lotion vs. gel)	Confirmed	There is no formal name for this program. Our internal audit team is staffed with over 200 licensed and certified pharmacy technicians. This team also consults with our clinical department when professional judgment or clinical evaluation is required. Our audit staff undergoes annual fraud, waste and abuse training to reinforce their ability to identify, react and resolve situations indicative of misuse.
Enhanced or Optional Safety and Monitoring		Opioid Risk Management Solution • Utilization Management - Standard UM/transactional fees • Enhanced cDUR - Standard included. Customization: [redacted]
Internal Pharmacy Audit	Confirmed	There is no formal name for this program. Our internal audit team is staffed with over 200 licensed and certified pharmacy technicians. This team also consults with our clinical department when professional judgment or clinical evaluation is required. Our audit staff undergoes annual fraud, waste and abuse training to reinforce their ability to identify, react and resolve situations indicative of misuse.
Current Programs Offered at No Additional Fee - Optional Services	**Confirm there is no additional fee**	**Notes**
Automated prior authorization (PA) is PA that utilizes claims history to "auto approve" select therapies under the clinical criteria.	Confirmed	
Generic notification involves sending letters to Participants using select brand medications that have gone or are about to go off patent.	Confirmed	Although letters aren't delivered to members, our Proactive Savings Alert program provides members with easy to understand and actionable ways to save on medication costs. It delivers a medication's lowest price through proactive, tailored notifications to a member's email. These clear, actionable directions advise members on savings opportunities, price transparency, and increased affordability, increasing the likelihood of them filling a prescription.
Retail to mail targeted mailings to Participants filling maintenance prescriptions at retail encouraging them to use mail service. Describe offerings based on approach for mandatory mail (PPO Plan) versus open mail order policy (HMO plan).	Confirmed	There is no formal name for this program. We proactively target promotional mailings to members on maintenance prescriptions who are not taking advantage of the Home Delivery Pharmacy Program. Those mailings often include copay dollar coupons and other incentives. Promotional mailings take place on a quarterly basis.
Specialty Copay Card	Confirmed	There is no formal name for this program. OptumRx supports manufacturer copay assistance programs for patients suffering from rare diseases or conditions that only have a single source or brand-name treatment without generic or lower-cost therapeutically equivalent alternatives.
Vaccination Services		There is no formal name for this program. We have the ability to adjudicate claims for vaccines at retail pharmacies, where the pharmacist would administer the vaccine. We contract with retail pharmacies and apply an associated administration fee. The Department may choose how broad or narrow of a vaccine offering to implement
Physician profiling encompassing a review of physician utilization patterns with targeted interventions (via phone, letter or in person) to education about cost-savings alternatives.		Patterns of Care: Patterns of Care allows customers to understand primary care providers' prescribing patterns and their patients' utilization behavior. The program helps reduce costs and improve quality by increasing adherence using insights and targeted provider engagement, improving compliance to clinical guidelines and reducing use of branded prescriptions when safe and effective generic options are available.
A physician consultation program where the PBMs pharmacist- consultants provide physicians with relevant clinical and patient- specific information through face-to-face interactions in an effort to enhance their prescribing decisions.	Confirmed	Academic Detailing Our program improves the quality of care and manages total health care costs by using data to identify physicians practicing cost-efficient, evidence-based medicine and those whose patterns deviate from their peers. Our engagement includes the detailed patient-level information--delivered digitally, telephonically, and by direct consult--providers need to facilitate effective health care decisions.
Participant drug savings report is comprehensive savings report mailed to Participants highlighting savings from mail service, generics and formulary brands.	Confirmed	Proactive Savings Alerts Our Proactive Savings Alert program provides members with easy to understand and actionable ways to save on medication costs. It delivers a medication's lowest price through proactive, tailored notifications to a member's email. These clear, actionable directions advise members on savings opportunities, price transparency, and increased affordability in near real-time.

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Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services ("Department")

Respondent Name:
OptumRx, Inc.

Instructions: Please complete every cell on this worksheet. All proposed terms are guaranteed. Please indicate the charges/fees associated with the following types of utilization

Programs that can be offered at an additional fee	Response	If offered at additional cost, list cost below		Unit	Notes
Specialty Copay Card Plan Design - Copay Optimization	Offered at additional cost	TBD	per	PMPM	Requires Optum Specialty Pharmacy exclusivity
Medical Benefit Management: Drug Benefit Assignment	Offered at additional cost	[redacted]			Medical Insights Management - Comprehensive set of clinical alerts utilizing both pharmacy and medical claims data. Retrospective program that identifies clinical opportunities on a daily basis and notifies prescribers.
Medical Benefit Management: Site of Care Alignment	Offered at additional cost				Specialty Redirection Program
Transform Care(e.g., Diabetes, Pre-Diabetes, Hypertension, Oncology)	Offered at additional cost				Diabetes High-Risk member counseling (pmpy) + Diabetes-Focused Meds on Track (pmpm) + Diabetes-Focused OptumRx Care Gap Management Program (pmpm).
Drug Savings Review	Offered at no additional cost				MyScript Finder - Proactive Savings Alert
Pharmacy Advisor Counseling	Offered at additional cost				Personalized RxCounselor
Point Solution Management	Not Offered				N/A
Care Management: AccordantCare Rare/CareTeam Advanced	Offered at additional cost				Orphan Drug Program
Medication Therapy Management is a program designed to optimize drug therapy with the intent of improved therapeutic outcomes for individual patients.	Offered at additional cost				Personalized RxCounselor
Health Advisor - Comprehensive database analyzing medical, Rx and lab data to identify opportunities to improve care and intervene with Participants and/or physicians, as appropriate	Offered at additional cost				Medical Insights Management - Comprehensive set of clinical alerts utilizing both pharmacy and medical claims data. Retrospective program that identifies clinical opportunities on a daily basis and notifies prescribers.
Employer Group Waiver Program (EGWP)	Not Offered				Specific to EGWP not Commercial
Respondent acknowledges that programs available may evolve. Programs that are not specifically identified shall be quoted upon request of the Department.	Yes				

Additional Information	Response
In Attachment B - Technical, Rx Clinical Programs tab, Respondents had the opportunity to provide additional information on the below items. For any items applicable to you Reply, please include the cost associated here.	
Provide a complete list of all prior authorization edits (traditional and automated) organized as follows: –Core (no charge, recommended) –Standard (additional charge, recommended) –Optional (additional charge, available but not recommended) –Custom (additional charge, built client specific) Include program costs, anticipated savings and guaranteed savings for each PA.	Please see attached Prior Authorization List.
Provide a complete list of all step therapy modules including the following information: –Target (second line) medications with brand/generic and formulary status –Preferred (first line) medication with brand/generic and formulary status –Ability to support with or without grandfathering current users of target medications –Available pre-implementation communications (general and targeted) –Available post edit communications (to follow up on targeted Participants with no subsequent fill) Include program costs, rebate impact/enhancement, anticipated savings, and guaranteed savings for each module.	Please see attached Step Therapy List.

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Commercial Other Costs Table 2

Additional Programs Required at No Cost	Confirm there is no additional fee	Is this the same program as one of the programs in Table 1? If yes which #?	Notes
Post-Termination Services - Upon termination of the Agreement between PBM and the Client, PBM will provide all necessary post-termination services, including (but not limited to):			
Post-Termination Services - All CMS regulatory support functions (e.g. PDE, Data Validation, DIR, and other CMS audits and requirements) to meet all CMS deadlines, reporting, and data requirements	Yes	No - There is no formal program name for post termination services.	We agree to meet all CMS requirements, including regulatory support functions for all post-termination services.
Post-Termination Services - Audit support	Yes	No - There is no formal program name for post termination services.	A post-termination audit can be conducted for up to 2 years after the contract is terminated at no charge. The Department must notify OptumRx in writing of its intent to audit within 90 days, after the effective date of termination.
Post-Termination Services - Claims files (pharmacy claim detail, prior authorizations, accumulators, etc.)	No	No - There is no formal program name for post termination services.	We provide the following transition-period services: • Create open refill transfer files for members using our Home Delivery Pharmacy based upon current eligibility files. • Produce a prescription claims history file.
Post-Termination Services - Client reporting portal access	Yes	No - There is no formal program name for post termination services.	Access to the client reporting tool can be granted through the agreed upon claim run out period.
Post-Termination Services - Explanation of benefits	Yes	No - There is no formal program name for post termination services.	We provide an EOB where applicable related to any post termination run off claims that are processed post termination of the contract.
Post-Termination Services - Financial reports	Yes	No - There is no formal program name for post termination services.	We provide the following transition-period services: • Create open refill transfer files for members using our Home Delivery Pharmacy based upon current eligibility files. • Produce a prescription claims history file.
Post-Termination Services - Run-out claims processing	Yes	No - There is no formal program name for post termination services.	We provide run-out claims processing from participating pharmacies and from eligible members for a mutually agreed-upon duration. The annual reconciliation is considered final, binding and conclusive.

Additional Programs - Optional	Offered at No Additional Fee?	If no, optional Service Fee ($)		Unit	Is this the same program as one of the programs in Table 1? If yes which #?	Notes
Clinical Programs - Clinical support (pharmacist support, drug monographs, therapy class reviews, etc.)	Yes		per		No - There is no formal name for this program.	Our Drug Intelligence team provides the following support for drug monographs and therapeutic class reviews: • Drug Monographs: Comprehensive reviews of recently approved drugs include a product summary, disease overview, clinical trials review, dosing and administration, adverse effects, and drug interactions. • Drug Class Reviews: Detailed, evidence-based reviews of clinical efficacy and safety for a therapeutic class, based upon pharmacotherapeutic classification, indication or treatment of a disease state.
Clinical Programs - Dose/duration of therapy edits	Yes	CDUR - included Medication Safety Management Program (RDUR) included in the admin fee per RFP request [redacted] Care Gap Management [redacted]	per		Medication Safety Management Program Care Gap Management Program	Through our Drug Utilization Review (DUR) programs, we identify and act on potentially inappropriate drug therapies to reduce total cost of care. Our DUR programs include: Utilization Management (UM) Concurrent Drug Utilization Review (CDUR) Retrospective Drug Utilization Review (RDUR)

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Clinical Programs - Opioid Retro DUR	No	Opioid Risk Management Solution • Utilization Management - Standard UM/transactional fees • Enhanced cDUR - Standard included. Customization: [redacted] Enhanced Benefit Design • Adjust Refill Window Standard included. Customization: [redacted] • Enhanced DEA edit by scope of practice - Standard included. Customization: [redacted] Opioid Risk Management Solution (Add-On offerings) • Refill Window 90% Scheduled II-V Controlled Drugs (80% Specialty-Mail) = [redacted] • Comprehensive UM option = [redacted] fees will apply • UM à la carte option = Included, PA fees will apply Opioid Risk Management Solution (Buy-Up offerings) • Member Education = [redacted] • Retrospective Intervention on Abused Meds = [redacted] • Intensive Case Management = [redacted] Opioid Risk Management Solution (Member Opioid Risk Analysis) • Monthly Subscription [redacted] • One-Time Request = [redacted]	per		Opioid Risk Management Program	Our Opioid Risk Management Program is a multi-dimensional solution designed to stop opioid dependence before it starts, while preventing the progression to misuse, abuse and addiction. The program is a comprehensive solution that uses advanced analytics and evidence-based clinical rules to decrease overprescribing, prevent opioid misuse, identify, and intervene with high-risk members, and support those with dependency through successful recovery.
Clinical Programs - Overutilization monitoring system	Yes	CDUR - included Medication Safety Management Program (RDUR) Included in the admin fee per RFP request [redacted] Care Gap Management [redacted]	per		Medication Safety Management Program Care Gap Management Program	Through our Drug Utilization Review (DUR) programs, we identify and act on potentially inappropriate drug therapies to reduce total cost of care. Our DUR programs include: Utilization Management (UM) Concurrent Drug Utilization Review (CDUR) Retrospective Drug Utilization Review (RDUR)
Clinical Programs - Participation in value-based contracting programs	Yes		per			We initially focused on specific drug-level contracts, but we are looking to mature our programs into a broader based disease-state approach which emphasizes the total cost-of-care value proposition. Value-based contracting has allowed us to negotiate opportunities in high cost drug classes like oncology and gene therapies in delivering on their expected value. Value-based contracting has also allowed us to move from volume to value in terms of how we contract.
Clinical Programs - Pharmacogenomics testing	No	[redacted]	per	per tested member year 1/ year 2+		This program impacts total cost of care by anticipating a patient's aversion to a drug before it is prescribed, thereby reducing spend on ineffective therapies. The program uses pharmacogenomic information and a team of Pharmacogenomic Certified Pharmacists to advocate on behalf of tested members and help guide doctors and members with actionable results leading to medication adjustments.
Clinical Programs - Therapeutic interventions (retail, mail order)	Yes		per		Concurrent Drug Utilization Review (CDUR)	OptumRx's CDUR is a drug monitoring program, driven by Medi-Span® drug database edits, designed to check real time prescription claims against the member's prescription history. At the point of service, our system checks for potential drug related problems to improve the safety, quality, and cost effectiveness of dispensed medications by ensuring all prescriptions are clinically appropriate.
Coordination of Benefits – Standard COB administration	No	Direct claim forms: Included plus postage, shipping and handling. Explanation of Benefits (EOB): [redacted] COB forms: [redacted]	per	claim		We provide coordination of benefits (COB) electronically at the point of service. We collaborate with the Department to confirm that the correct COB information is provided in the eligibility file for members who have another primary insurance carrier. This data is stored as an element in the system and can be supplied on claims encounter files. If a COB indicator is present on the eligibility file of a member who has coverage through another primary carrier, the system denies the claim.

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Interoperability - Integrated medical and pharmacy reporting	No	Medical Data Mart Ongoing Annu [redacted] CMS Interops extracts [redacted] Ongoing Annual = [redacted] month CMS Interops APIs - [redacted] Ongoing Annual = [redacted] transactions Alternative options for claims, network, and formulary files – [redacted]	per		No - There is no formal name for this program.	OptumRx connects with clients and their vendors for varying reasons including for Interoperability including if needed medical and pharmacy reporting. OptumRx has a Medical Data Mart which can intake medical data and then if needed produce applicable reporting if needed versus the medical and pharmacy data coming from their own location. The applicable reporting would vary depending on actual ask.
Interoperability - Weekly file feeds to other vendors	No	FHIR extracts – [redacted] Ongoing Annual = [redacted] FHIR APIs – 3 APIs - Annual = [redacted] Non FHIR extracts standard summary claims, network, and formulary [redacted]	per		No - There is no formal name for this program.	OptumRx connects with clients and their vendors for varying reasons including for Interoperability. There have been a few different types of requests however OptumRx would be willing to discuss how those integrations are done either with data feeds that have been used to build out the API requirement or using an API FHIR integration.
Interoperability - Monthly uptake of medical claims by PBM, for use in reporting, clinical decision-making, DUR edits, clinical programs, etc.	Yes	CDUR - included Medication Safety Management Program (RDUR) Included in the admin fee per RFP request [redacted] Care Gap Management [redacted]	per		Medication Safety Management Program Care Gap Management Program	Through our Drug Utilization Review (DUR) programs, we identify and act on potentially inappropriate drug therapies to reduce total cost of care. Our DUR programs include: Utilization Management (UM) Concurrent Drug Utilization Review (CDUR) Retrospective Drug Utilization Review (RDUR)
Misc Fee Items - Member communications	Yes	Member Communications • Welcome Booklet with ID cards (two per family); Postage, shipping and handling cost are pass through	per			Each household is mailed a welcome kit letter that explains the member's benefits and how to get started. The kit also introduces our home delivery and specialty pharmacy programs. In addition, we create and distribute tailored notifications throughout the year as needed. Examples include changes to the member's pharmacy benefit plan, formulary, or network.
Misc Fee Items - Client Portal Access to systems for eligibility	Yes		per			The RxView Web-based application is accessed through a secured, customer-specific URL, and uses RxClaim as the data repository. The Department's benefit staff can look forward to a full-featured website that provides the ability for real-time eligibility updates within RxView. In addition, a wealth of customer-specific information to support all facets of program management is available to the Department's benefit staff through our Web-based customer portal.
Misc Fee Items - Client Portal Access to systems for prior authorizations	Yes	Online Client Website Access • Access to general and plan-specific information • Setup and training for up to twenty users • [redacted] • [redacted] • Pharmacy locator, refill Home Delivery Pharmacy, claims history • Health, wellness and disease education	per			We do not offer customers external access to our proprietary prior authorization (PA) system that enables them to perform their own reviews as part of a standard offering. Customers who opt to fully delegate PA services to OptumRx are provided view-only access to our online PA system. Customers may track their member's PAs using this system. In addition, compliance and oversight reporting can be provided to the customer for proactive and retrospective monitoring and oversight.
Misc Fee Items - E-prescribing services	Yes		per			Our e-prescribing vendor, Surescripts, operates the nation's largest e-prescription network. They connect prescribers throughout the United States to the leading payers, and pharmacies. They facilitate and help us process electronic prescriptions submitted by pharmacies and technology vendors who also have a relationship with them.

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Misc Fee Items - Implementation fees	No	$10.00	per	Per member		OptumRx shall provide Client with a one-time implementation allowance of up to $10.00 per net new Member to cover expenses associated with the transition of services to OptumRx. This allowance may be used by Client to offset legitimate, necessary and commercially reasonable expenses that are related to the Client's transition from its previous pharmacy benefit manager to OptumRx. Client shall be responsible for all other transition expenses in excess of the implementation credit herein provided to Client. Eligible expenses shall include any printing or postage related to special communications required for the transition, customized ID cards, customized programming or, upon mutual agreement, third-party transitional consulting expenses. The implementation allowance must be utilized within the first six months after the Effective Date. Client will be required to submit documentation to support the expenses it may seek reimbursement for. If Client terminates this Agreement for any reason before the end of the Initial Term, Client shall refund to OptumRx within 30 days after the effective date of such termination the full implementation allowance. It is the intention of the parties that, for the purposes of the Federal Anti-Kickback Statute, this implementation allowance shall constitute and shall be treated as a discount against the price of drugs within the meaning of 42 U.S.C. 1320a – 7b(b)(3)(A). To the extent required by Laws or contractual commitment, Client agrees to fully and accurately
Misc Fee Items - Interactive/online ad hoc user report creation and queries	No	RxTRACK License Fee [redacted]	per	Annual fee	RxTrack	We make it easy for the Department to monitor and review plan performance at your convenience through our RxTrack reporting platform. The online platform gives you flexibility to analyze and filter data through established parameters or create ad hoc reports and customized views to meet your needs. RxTrack captures claims and utilization data, member eligibility files, as well as prescriber and pharmacy information to provide comprehensive analytics and reporting.
Misc Fee Items - Transition fill letter to member and provider	Yes		per			Upon termination of the agreement, OptumRx does not provide post-termination services, such as a transition fill letter. We only provide member communications during a current contract.
Misc Fee Items - UR/QI Programs	No	[redacted]	per	case		Layered on current strategies, Optimization adds a verification requirement to obtain approval for select drugs. Value comes from increased clinical appropriateness and safe access to medications via a more rigorous review process, lower out-of-pocket costs for members who switch to lower-cost medications, and savings through moves from high-cost medications to lower cost formulary-based options.
Post-Termination Services - Account team support	Yes		per			Your assigned account team will be assessable and assist with transition support activities and questions post termination.
Risk Management Programs - Gene and Cell Therapy Stop Loss - price to ASO groups	No	For the 2023 plan year, 7 gene therapies are included at a price point of [redacted] (subject to state approval). As additional drugs are approved by the FDA, the product will be refreshed and repriced annually.	per			The Gene Therapy Risk Protection solution helps administrative services-only (ASO) plan sponsors, with or without stop loss, manage risk exposure by spreading the cost of unexpected million-dollar therapies into manageable and predictable per member per month (PMPM) fees. The solution also includes cost and quality management services. For the 2023 plan year, 7 gene therapies are included at a price point of $0.99PMPM (subject to state approval). As additional drugs are approved by the FDA, the product will be refreshed and repriced annually.

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Risk Management Programs - Gene and Cell Therapy Stop Loss - price to health plan	No	For the 2023 plan year, 7 gene therapies are included at a price point of [redacted] (subject to state approval). As additional drugs are approved by the FDA, the product will be refreshed and repriced annually.	per			The Gene Therapy Risk Protection solution helps administrative services-only (ASO) plan sponsors, with or without stop loss, manage risk exposure by spreading the cost of unexpected million-dollar therapies into manageable and predictable per member per month (PMPM) fees. The solution also includes cost and quality management services. For the 2023 plan year, 7 gene therapies are included at a price point of $0.99PMPM (subject to state approval). As additional drugs are approved by the FDA, the product will be refreshed and repriced annually.

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Additional Optional Commercial Programs Recommended by Respondent, add rows as necessary. Note - If Respondent provided additional programs in this space in Attachment B, please include cost information here. Add rows as necessary.	Formal Name of Your Program	Optional Service Fee ($)		Unit
Please see below for new programs added. All recommended programs are provided above. Please note: This is not an inclusive list. OptumRx may charge for any products or services not specifically represented herein.			per	
The OptumRx Polypharmacy Value Management program identifies members at a higher risk of medication overload, utilizes a case management approach to evaluate medications, and coordinates decision-making between the member and their provider to optimize treatment- whether to stop, adjust or change a medication	Polypharmacy Value Management	[redacted]		
Proactive FWA enhances APAS to identify high-risk, potentially fraudulent pharmacy scenarios and claims in near real-time, post-adjudication. This program combines advanced analytics such as predictive modeling and machine learning as well as the expertise of investigators on our case management team.	Advanced Pharmacy Audit Services (APAS) + Proactive FWA			
Identifies treatment-experienced members on specialty medications with clinical or cost optimization opportunities such as deprescribing, alternative therapy, surplus supply correction, and dose adjustment. Qualified members are engaged for a live consultation with an Optum Rx Care Ambassador who conducts a specialty drug value assessment to deliver provider interventions based on the member's individual clinical response to therapy in accordance with their plan benefit design.	Review My Care			
Through the Specialty Standards program, immediate cost savings is realized by modernizing the benefit and increasing the benefit rigor applied to specialty drugs. This solution applies net new components within the benefit, ensuring members have a seamless experience without the carve-out chaos and confusion. In addition, Specialty Ambassadors within Optum are integrated into the member experience, reaching out to members who are impacted by high out of pocket events or available for members with questions regarding their specialty benefits.	Specialty Standards			
Optum Rx Price Edge provides the lowest cost to members on generic drugs, whether covered on their prescription benefit or not. To make sure members are getting a competitive rate for their generic drugs under their benefit coverage, we regularly gauge cash market pricing and compare it to the member's out of pocket cost share to ensure that they are always receiving the lowest available price, resulting in members being less inclined to price shop and reinforcing the value of their drug benefit and the brand of the plan sponsor. These claims adjudicate on-benefit, have clinical programs and safety checks in place, and apply to accumulators and out of pocket maximums. Optum Rx is committed to confirming members are able to access the full value of their plan sponsor's PBM relationship. As such, a solution for drugs not covered on the benefit is a required component of Price Edge and operates separately from the lower-of logic. These claims continue to be treated as off-benefit, but members get discounts up to 85 percent off of retail with an average savings of 47 percent. These claims are included in clinical programs and safety checks. There is no charge for Price Edge. Impacted claims are reconciled with the customer's existing generic discount guarantee	Price Edge			

Clinical Programs - Savings & Reporting	Reply	Explanation
Does Respondent agree that clinical programs included in your cost reply have no shared savings and the fee will not be based on Client's average membership?	Yes	
Are Respondent's clinical programs guaranteed dollar-for-dollar, and does Client receive 100% of any/all savings achieved in excess of any minimum guaranteed savings within 90 calendar days from the end of each contract year?	Yes	Our clinical program ROI guarantees are as follows: If the Guaranteed ROI is not achieved, PBM will refund a prorated portion of customer's total payment to PBM for intervention services to make sure that the achieved ROI is equal to the Guaranteed ROI based upon actual savings realized.
Does Respondent's utilization management programs have a positive ROI for the entire time period they are in place?	No	Upon aware of the life count ROI can be revisited.
Does Respondent provide the methodology for calculating ROI prior to the start of the program and does the methodology change during the life of the program without prior Client consent?	No	Upon aware of the life count ROI can be revisited.
Confirm any savings achieved in excess from one clinical program will not be used to subsidize shortfalls in savings resulting from any other clinical program in any contract year.	Yes	
Will savings assumptions must be based on Client-specific utilization and not on book of business measures?	Yes	
Will savings reported be direct savings associated with the pharmacy benefit and not include any inferred medical savings?	Yes	For most clinical programs, the reported savings is based exclusively on direct savings associated with the pharmacy benefit. However, for select programs that are more specifically designed to enhance quality of care and patient-specific therapeutic outcomes, savings are derived from inferred medical savings.
Does Respondent will provide a fixed fee per letter, if any, to provide and mail communications pieces to participants to help them lower costs (e.g., switching to generics, mail, etc.)?	Yes	
Does Respondent have a process flow for the Medicare Part B COB solution at mail order program? Explain which entity provides these services. Please name the file **[Respondent's Name]_Process Flow.**	Attached	Please see OptumRx_Process Flow.